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

WELLNESS • RECOVERY • RESILIENCE

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

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.

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

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

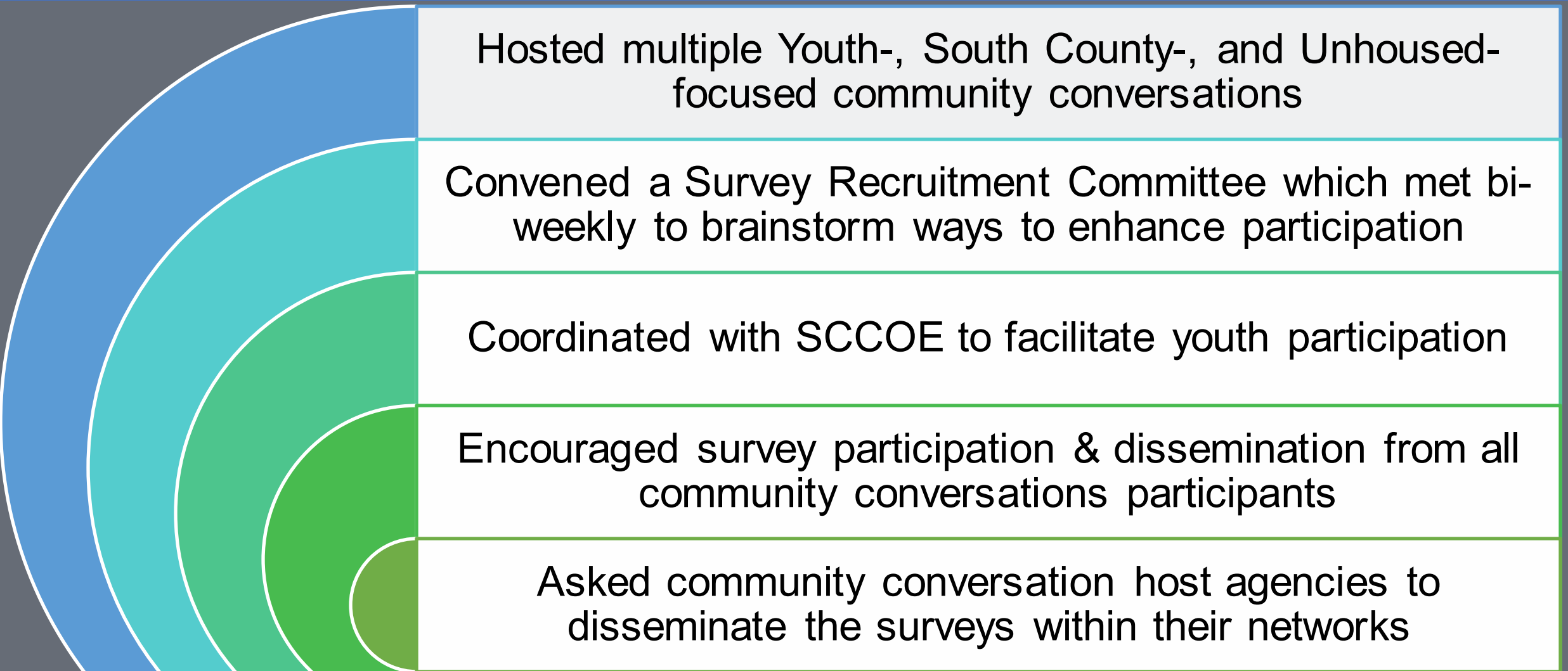
Gabby Olivarez

Jennifer Pham

Elania Reis

Juan Troy

Efforts to Boost South County, Unhoused, and Youth Participation



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 Eastern 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

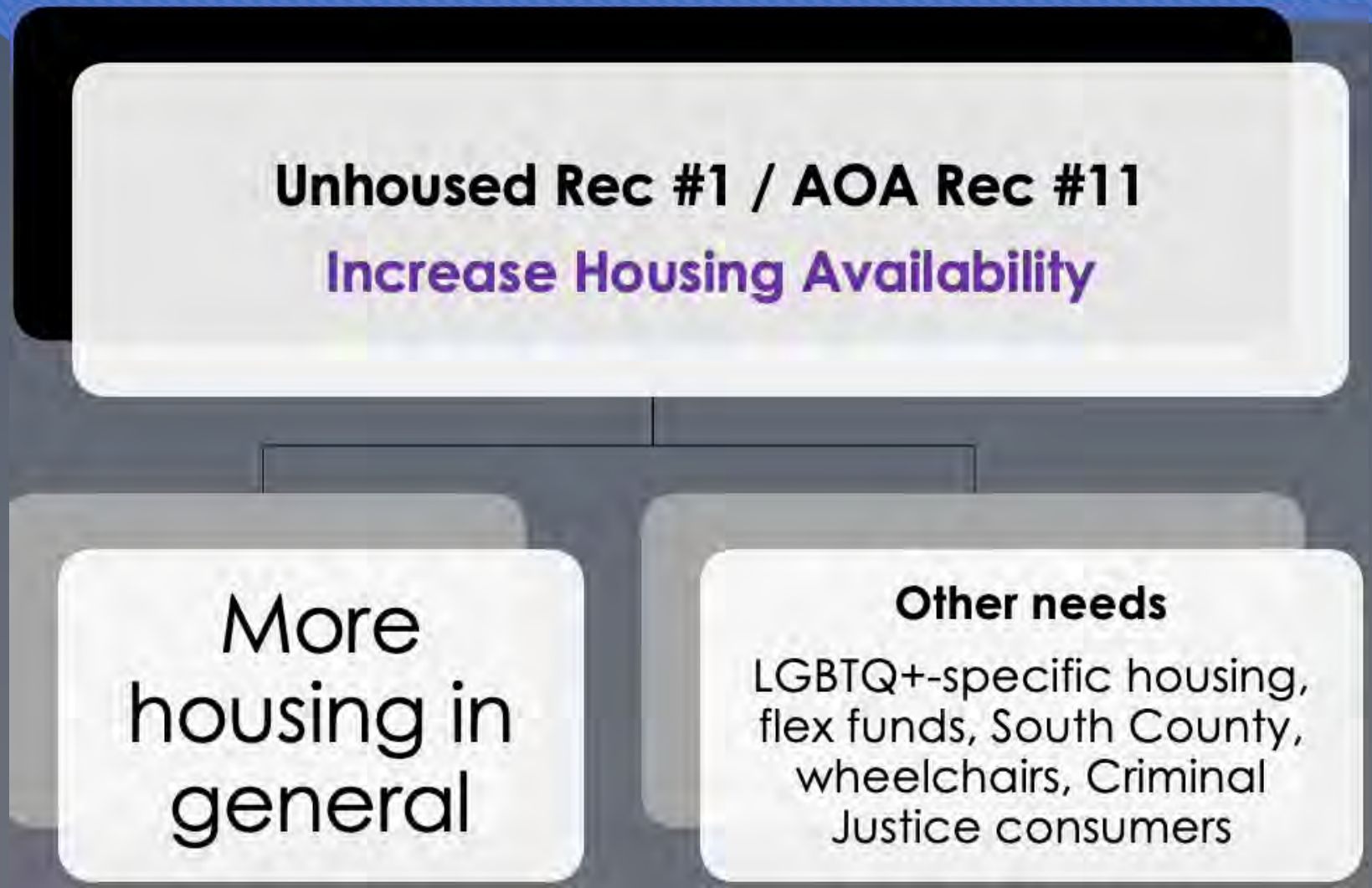
Disability accommodations need to be improved (n=4)	Services should be helpful (n = 4)
Services should employ more peer support staff (i.e., people with similar experiences) (n = 4)	Service providers should talk to each other and coordinate services with other agencies (n = 4)

Unhoused Recommendation #1/ AOA Rec #11

BHSD Priority #2 (Housing)

Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter

(62 comments)



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

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

WET Recommendation #4

Staff Trainings *(43 comments)*

Cultural Trainings

- LGBTQ+
- Diversity, Equity, & Inclusion
- Middle Eastern culture
- Black & African Ancestry culture

Other Trainings

- 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.

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

Unhoused Recommendation #6
Workforce, Education, & Training

(20 comments)

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 <u>where to go</u> to access services (2.92) and that it is "mostly true" that they know <u>who to call</u> 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.

Questions or Comments?

joycepchu@gmail.com

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

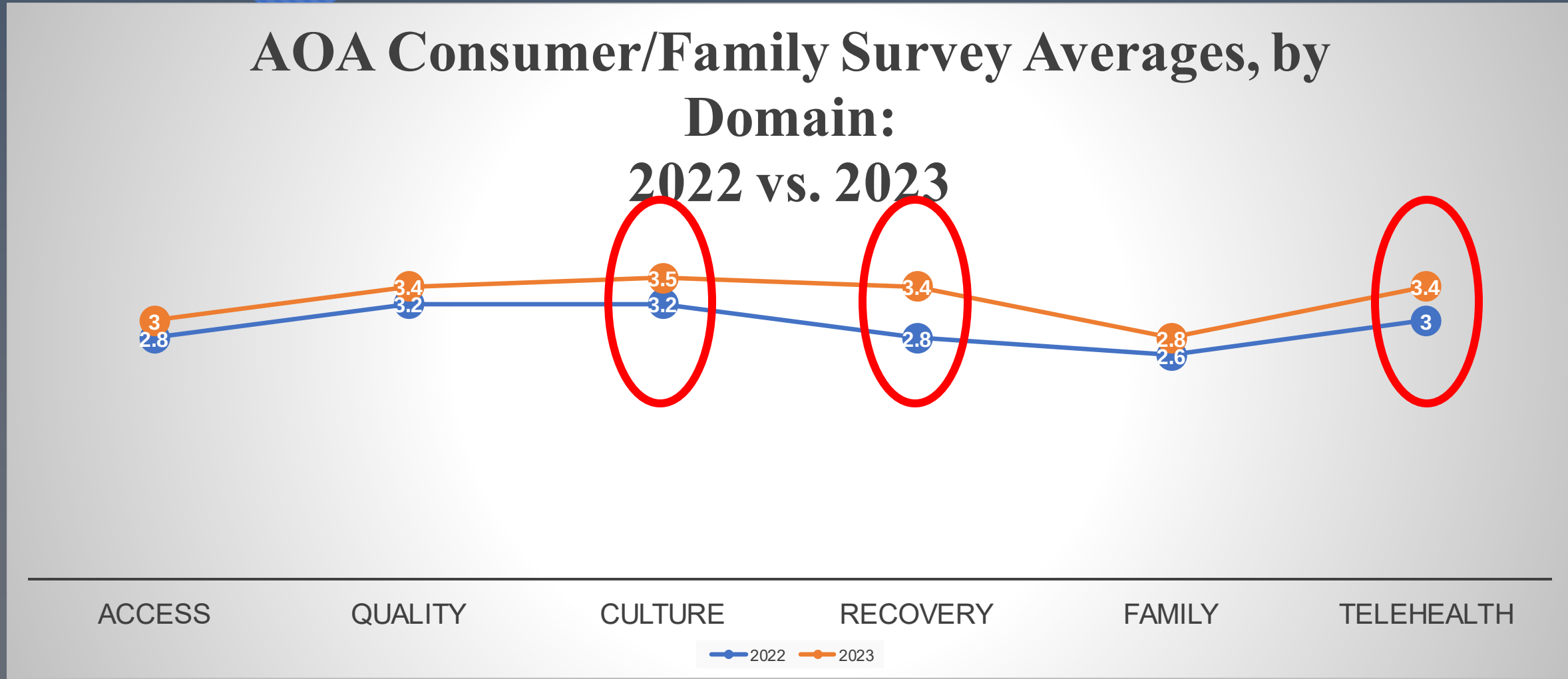
Criminal Justice Services

- 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

#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 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)

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

AOA Recommendation #1

Keep AOA Outpatient Services Flexible with Expanded Offerings to Meet the Changing Needs of the Community

(76 comments)

Most Commonly Requested

- Services to reduce isolation
- Supported Employment
- Services in client's homes
- Support groups
- Step-down treatment services after hospitalization
- Longer-term treatment

Other Outpatient Services

- 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

(31comments)

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

BHSD Priority #3 (WET)

Develop Innovative Solutions to Address Professional Workforce Shortages

AOA Recommendations

Workforce, Education, & Education

(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)

Questions or Comments?

joycepchu@gmail.com

BREAK

Q&A

ONLINE FEEDBACK FORM

SCAN QR CODE OR

AVAILABLE AT:

HTTPS://TINYURL.COM/MHSA2025

DATA FINDINGS FROM ADULT/OLDER ADULT& HOUSING SYSTEM OF CARE

PROGRAM UPDATES

AOA Systems
BHSD Housing

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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.

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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

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COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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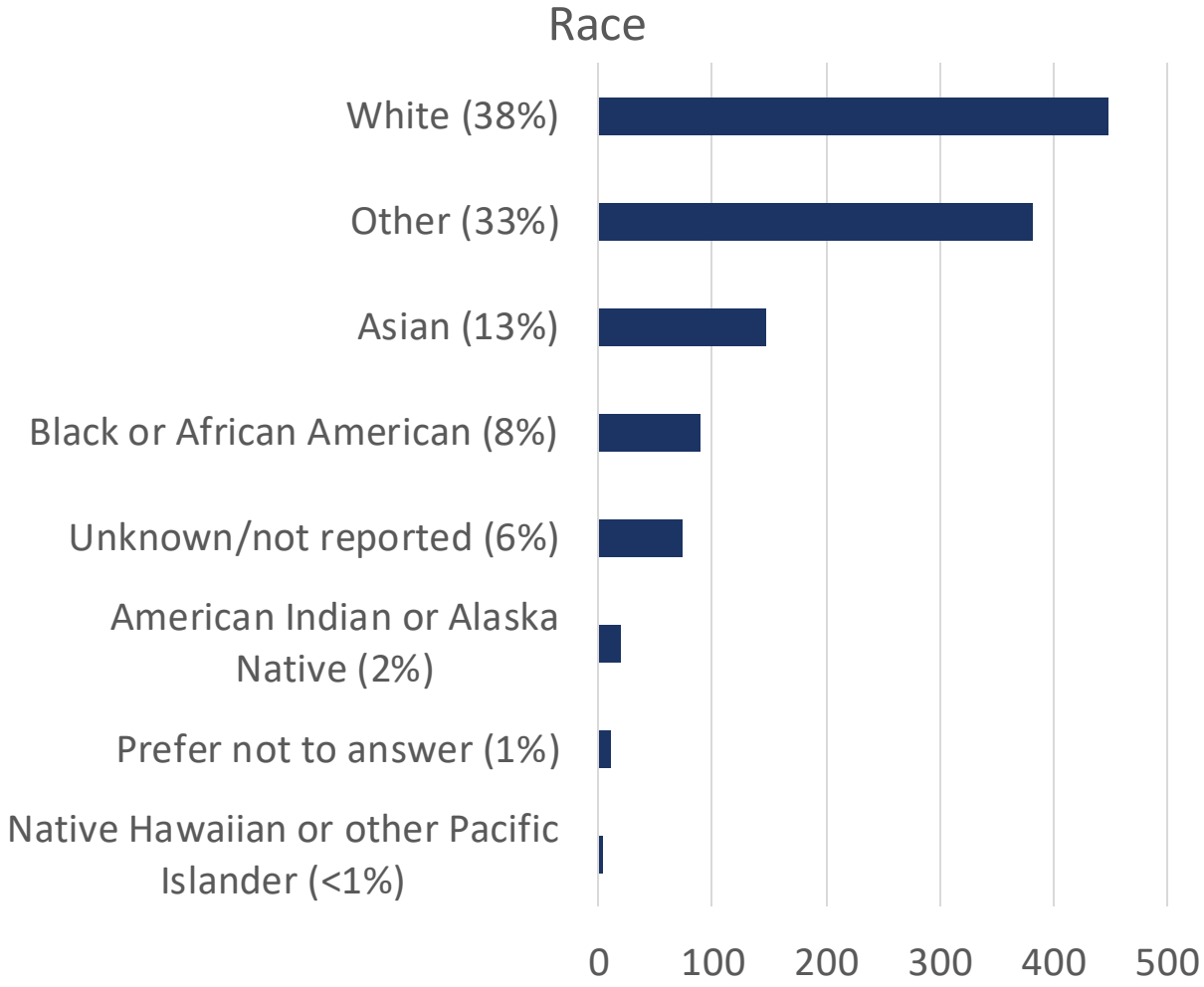

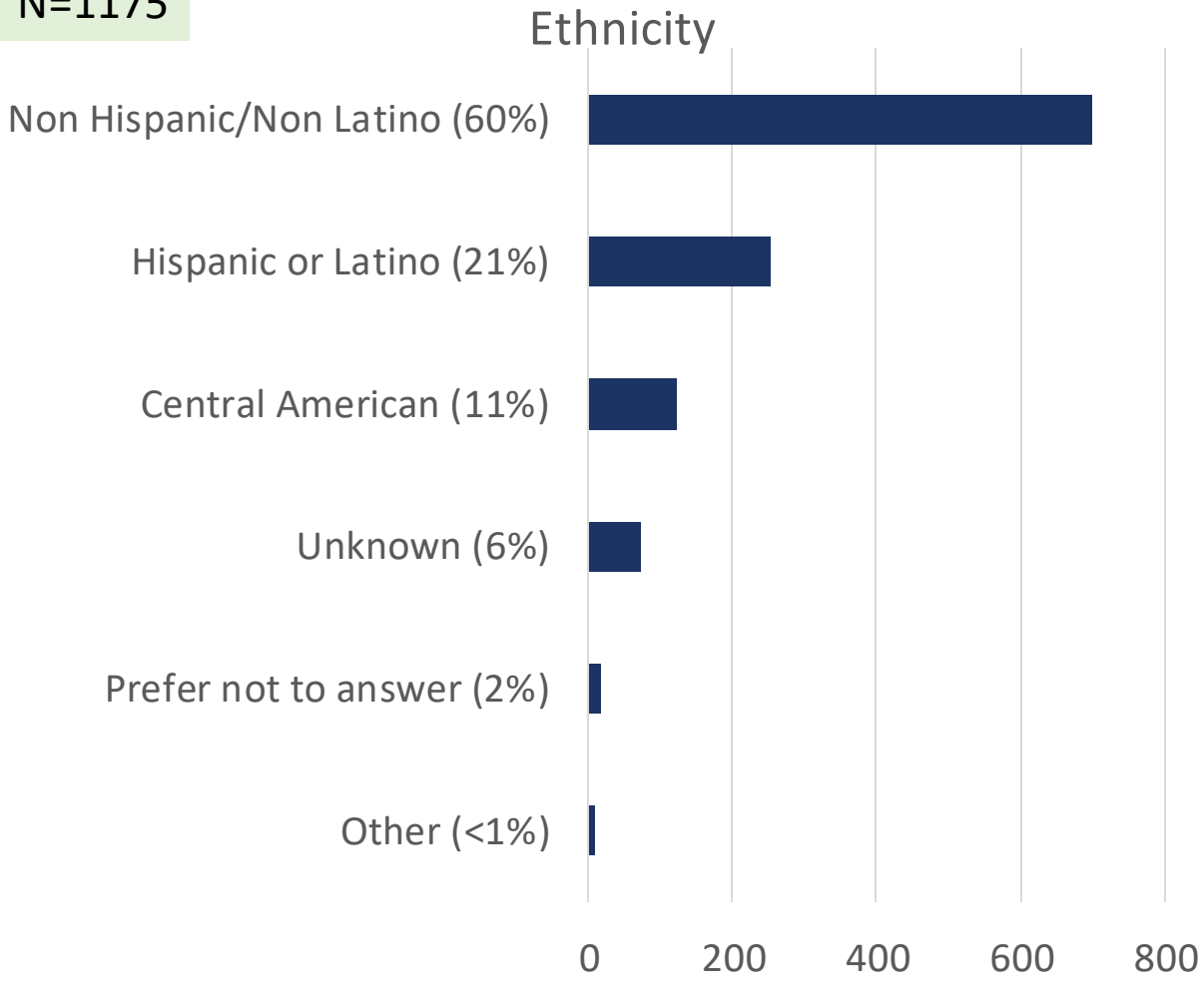

Full Services Partnership

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

- 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

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COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

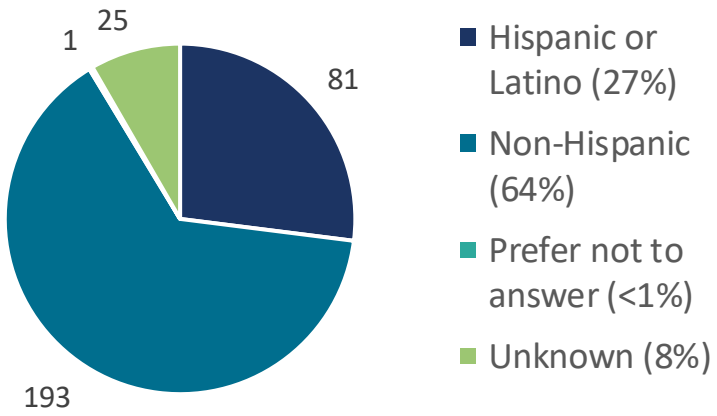
Assertive Community Treatment - ACT

- 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.

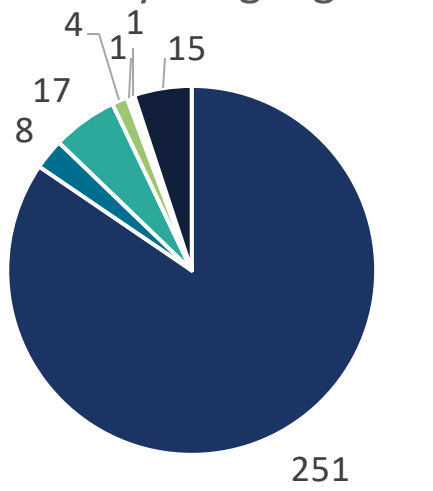
ACT FY23 Client Demographics

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

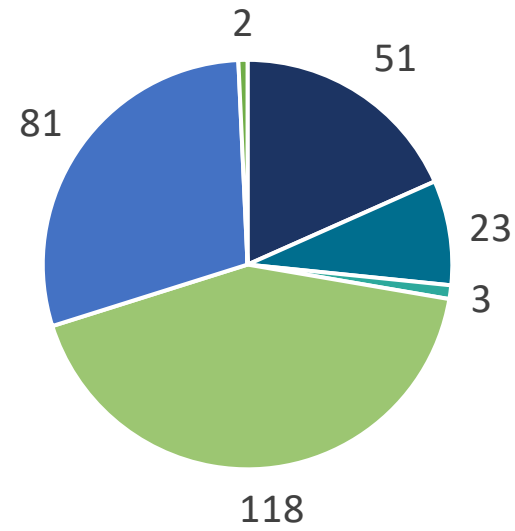
Ethnicity



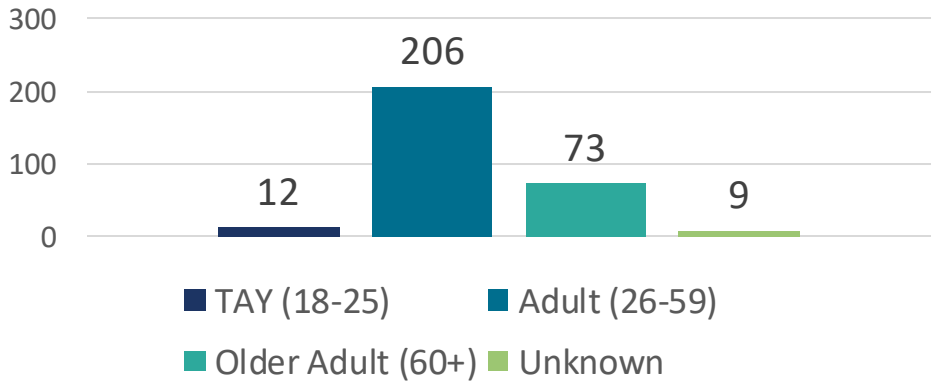
Primary Language



Race



Age



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Assertive Community Treatment

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

- 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

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COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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.

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

"Laura's Law" AB1421
AB1976

Go Live Date:
February 16, 2022

Voluntary and involuntary

AOT Petition-Civil Commitment process

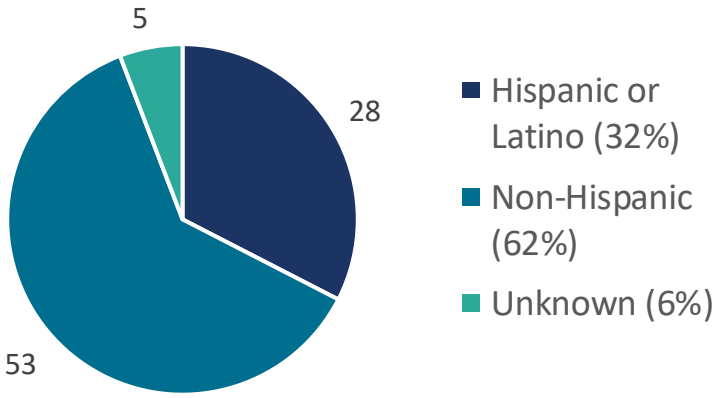
Criteria

Unlimited outreach and assertive engagement

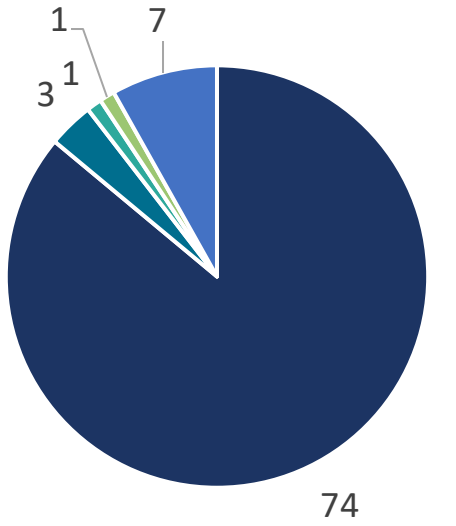
AOT FY23 Client Demographics

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

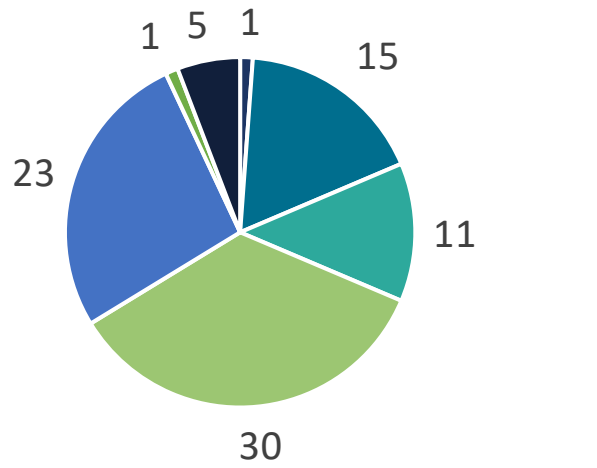
Ethnicity



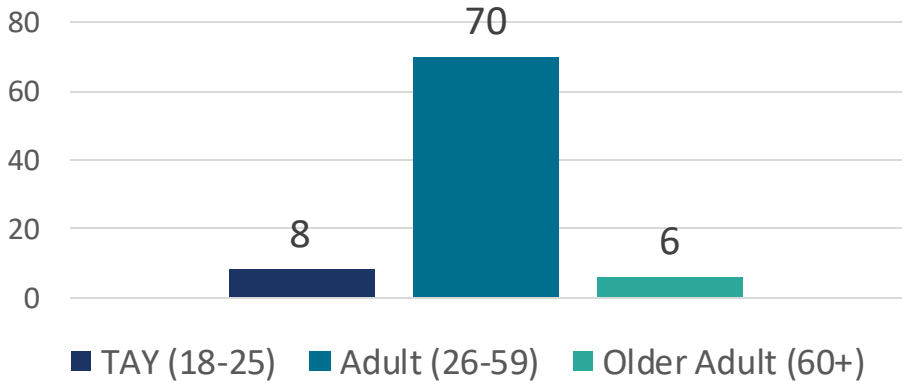
Primary Language



Race



Age



N=86

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

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

- 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

WELLNESS • RECOVERY • RESILIENCE

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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

Total Respondents
24

Prior to moving In, respondents experienced...

Time in Home

Changes experienced while living in their current homes...

Encounters with Police

Hospital Stays

Mental Health and Emotional Well-being

Tenant Experiences

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Responses were weighted from 1 (strongly disagree) to 5 (strongly agree)

CROSS SYSTEMS INITIATIVES DIVISION

Intimate Partner Violence Prevention Program

WELLNESS • RECOVERY • RESILIENCE

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

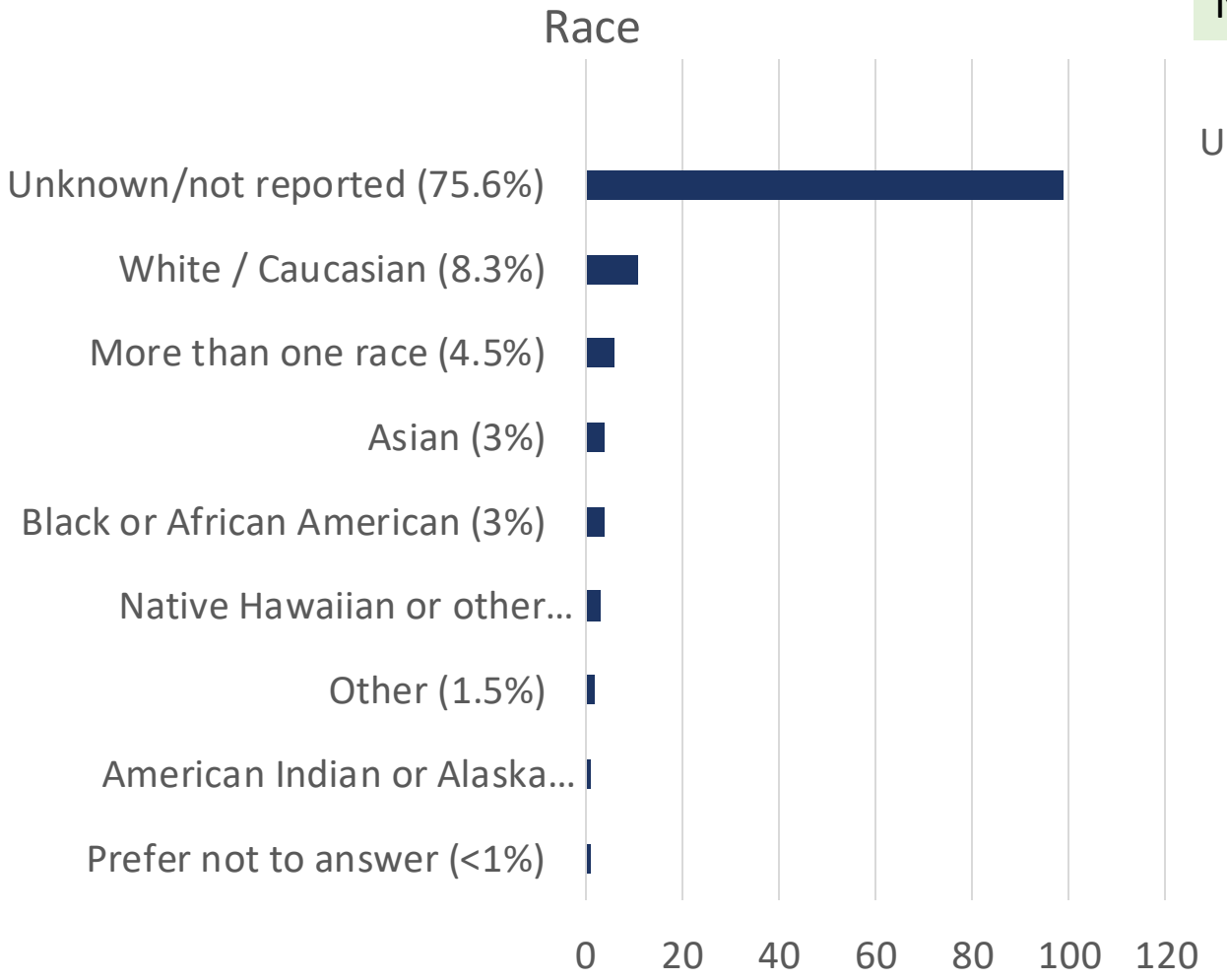
Intimate Partner Violence - IPV

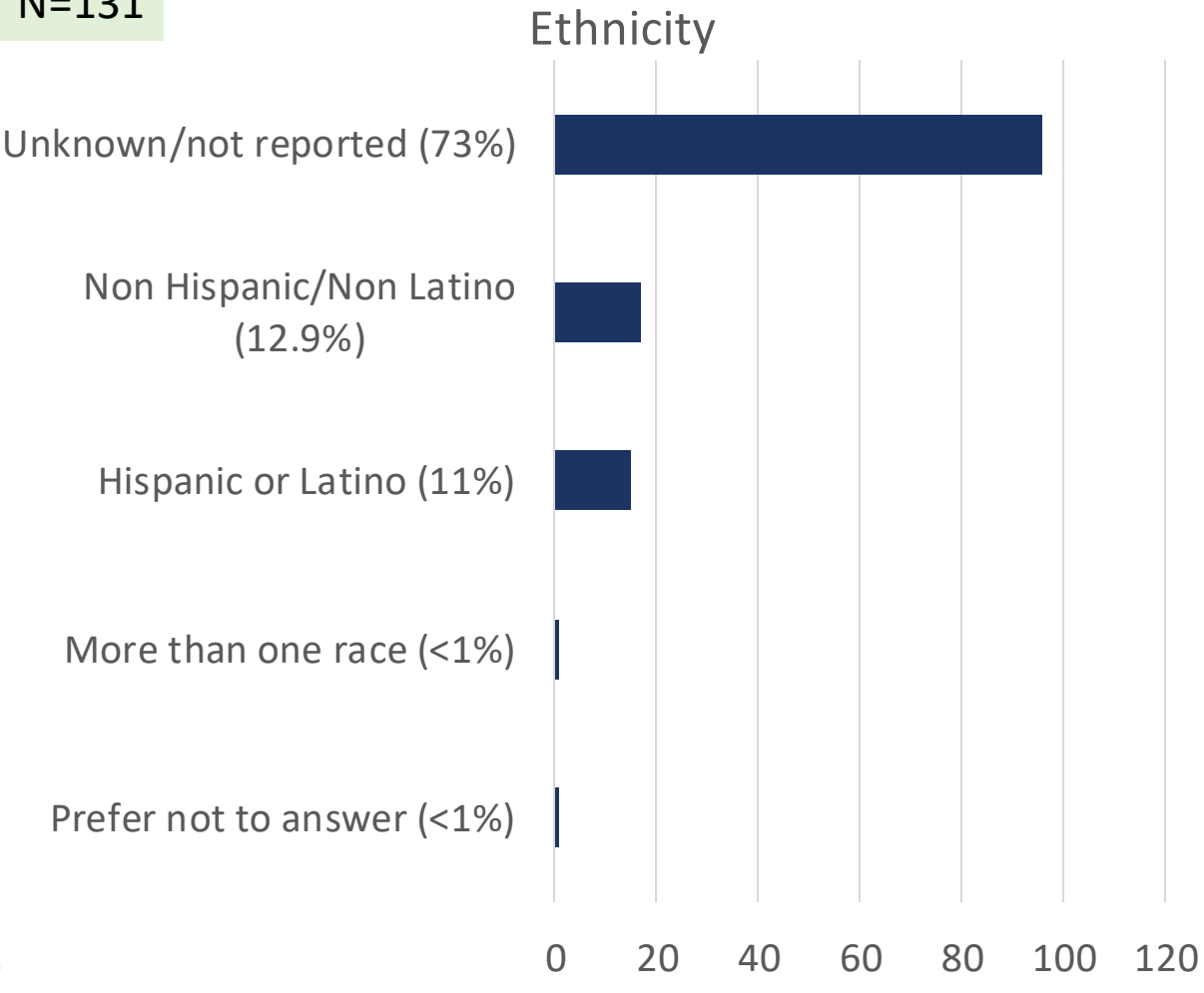
- IPV is funded under the Prevention and Early Intervention (PEI) component of MHSA. Program is to serve transitional aged youth (TAY), adult, and older adult individuals
- Focusing on education, trainings, and outreach
- Networking and collaborating with other community resources
- Linking clients to 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

N=131





IPV Program Highlights

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

- 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

ADULT AND OLDER ADULT SYSTEM OF CARE

Prevention and Early Intervention (approx. 1-4 hours/month)

Services

- In-Home Outreach Team
- In-Home Peer/ Caregiver Respite services
- Elder Story Telling
- OA Outpatient PEI
- Culturally Specific Wellness Centers
- Community Drop In-Center
- Re-Entry Center for Justice Involved
- Collaborative Courts Screening
- Jail Diversion
- Faith-Based Services
- Self-Help Centers-Zephyr & Esparanza
- Connections Program @ Adult Protective Services
- IPS/Employment Services
- Integrated Prevention Services for Cultural Communities (IPSCC)

- SUTs Transitional Housing

Outpatient (approx. 2-8 hours/month)

Services

- Outpatient Services (Behavioral health services provided by contracted providers and County-operated clinics)
- Substance Use Treatment
- Perinatal Substance abuse Program
- Psychiatric services
- Supportive Housing Services through OSH

Population-Specific Outpatient Programs:

- Ethnic Specific Outpatient Services
- Adult Protective Services-Connection Program
- CalWORKs
- Eating Disorder
- Hard of Hearing
- Beneficiaries with Developmental Disabilities

Intensive Outpatient (approx. 8-14 hours/month)

Services

- Assisted Outpatient Treatment (AOT)
- Assertive Community Treatment (ACT)
- Pay for Success Programs
- Full-Service Partnership (FSP)
- Intensive Full-Service Partnership (IFSP)
- Withdrawal Management
- IOP Services for Justice Involved
- Mission Street Recovery Services

Intensive Inpatient Programs

- 24 Hour Care authorization Unit
- IMD
- Contracted Skilled Nursing Services
- State Hospital placement
- Residential Care Supplemental

Older Adult Outpatient Services

Services

- Intensive Full-Service Partnership (IFSP)
- Full-Service Partnership (FSP)
- Outpatient Services
- OA PEI Outpatient
- Adult Protective Services-Connection Program
- In-Home Peer/Caregiver Respite
- Elder Story Telling

Crisis

Services

- Mobile Crisis
- Behavioral Health Urgent Care
- Crisis Stabilization Unit
- Crisis Residential
- In-Home Outreach Support
- Homeless Engagement & Access Team (HEAT)
- Short Term 30 days Residential Program
- Emergency Psychiatric Services
- Methadone, Suboxone, Vivitrol, Disulfiram, Naloxone

Residential Care Placement

- Super Board & Care & Residential
- 90 days Transitional Housing
- New Adult Residential Programs
- AOA Housing Expansion for SMI-Homeless population

BH Call Center Referred

Self/Family/Community Partner Referred

Crisis Services can be accessed across the continuum of care includes Mobile Crisis, In-Home Outreach, Behavioral Health Urgent Care, Crisis Stabilization Unit (CSU), Crisis Residential and Emergency Psychiatric 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

WELLNESS • RECOVERY • RESILIENCE

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

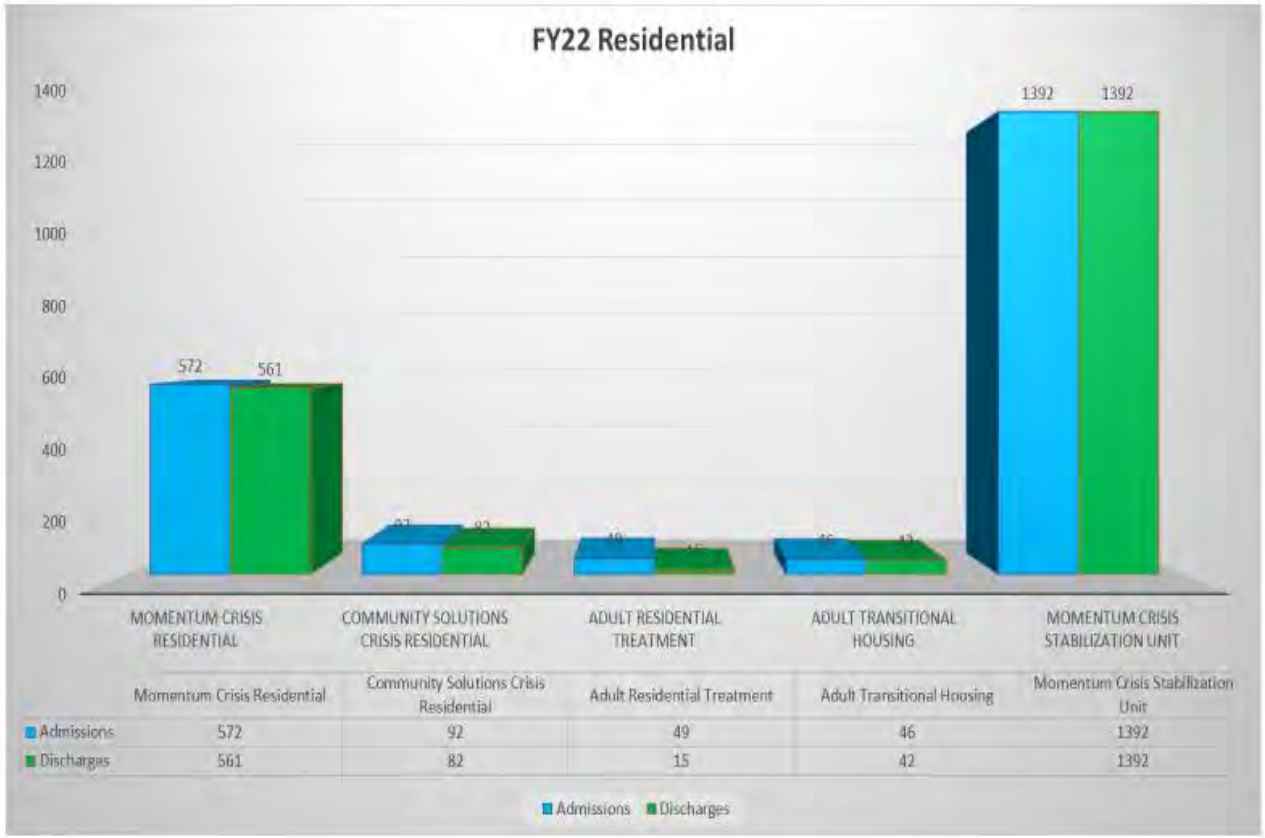
Program Description

- 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.

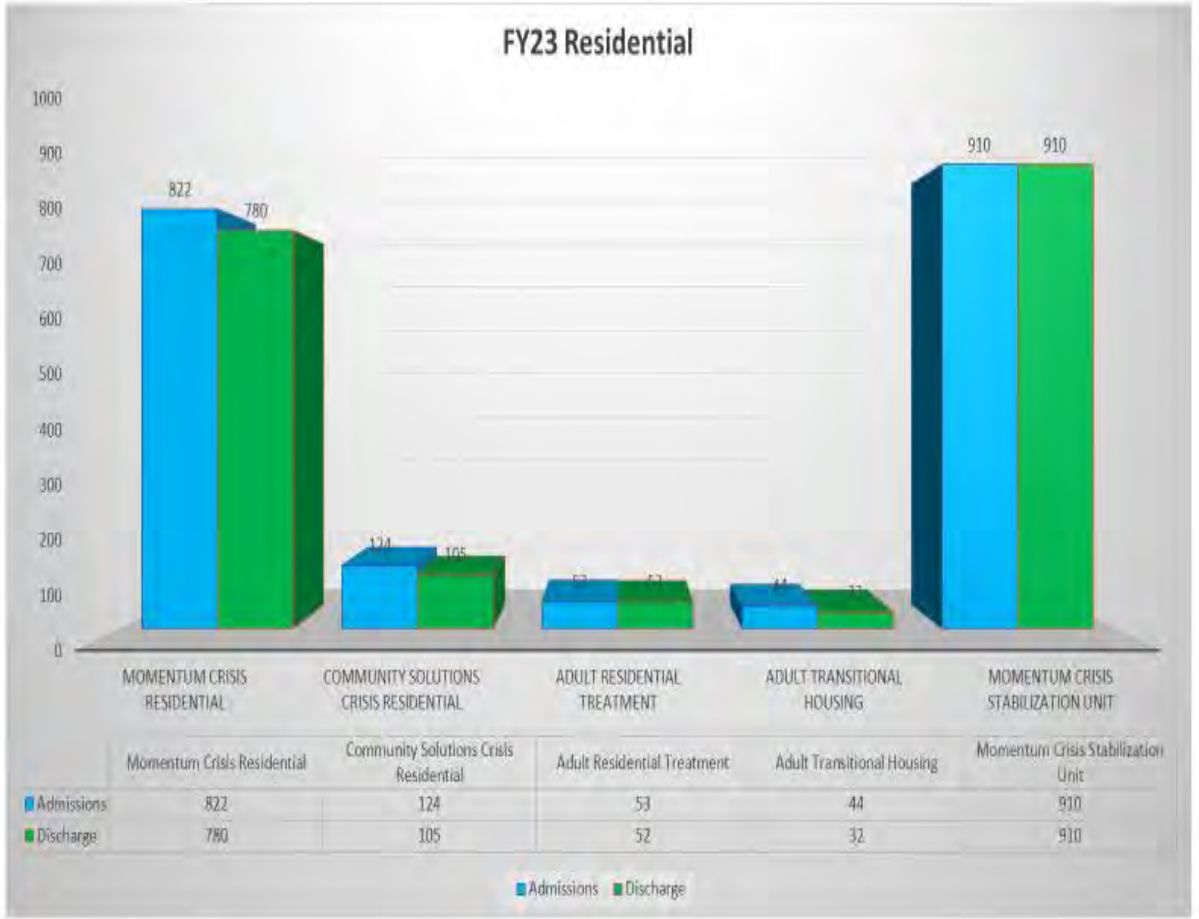
Program Goals

- 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



	Momentum Crisis Residential	Community Solutions Crisis Residential	Adult Residential Treatment	Adult Transitional Housing	Momentum Crisis Stabilization Unit
Admissions	572	92	49	46	1392
Discharges	561	82	15	42	1392



	Momentum Crisis Residential	Community Solutions Crisis Residential	Adult Residential Treatment	Adult Transitional Housing	Momentum Crisis Stabilization Unit
Admissions	822	124	53	44	910
Discharge	780	105	52	32	910

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

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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

WELLNESS • RECOVERY • RESILIENCE

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

CWS Program, Descriptions, Goals and Outcomes

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

VISION

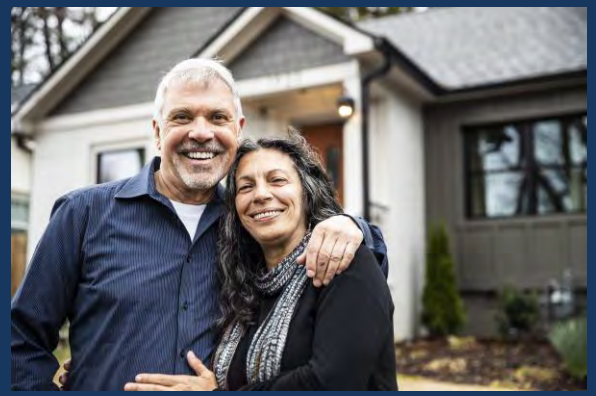
The Clinical and Wellness Services Division is committed to ensure that all Adults and Older Adults who reside in Santa Clara County can find hope and support to live a healthy and meaningful life.

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.

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE



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 to 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

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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."

/IVO's Citizenship Preparation Classes are very popular - Our proud record to date is 100% pass rate

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.

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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

WELLNESS • RECOVERY • RESILIENCE

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 treatme 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

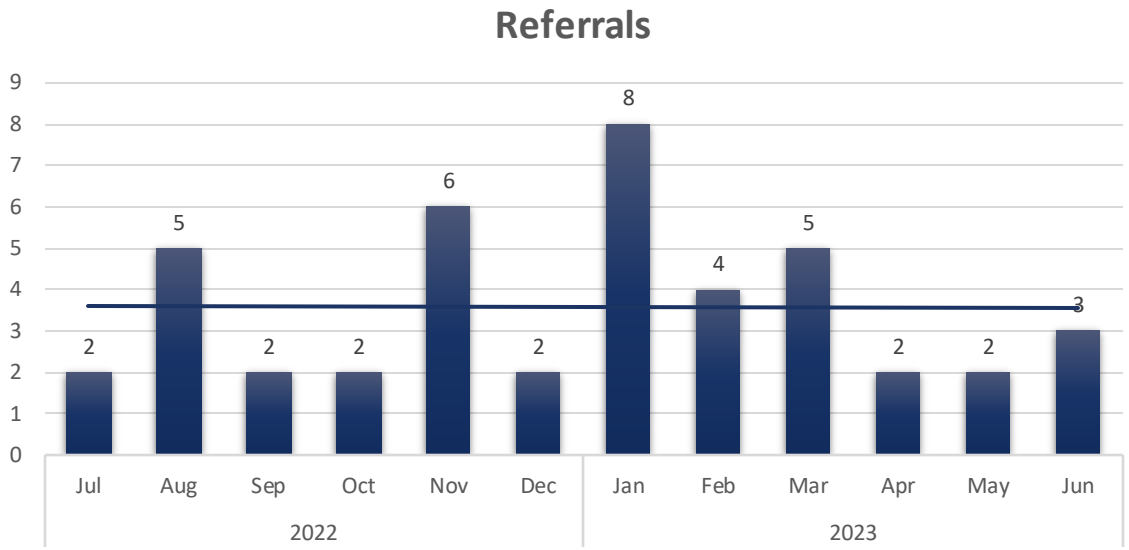
Goals

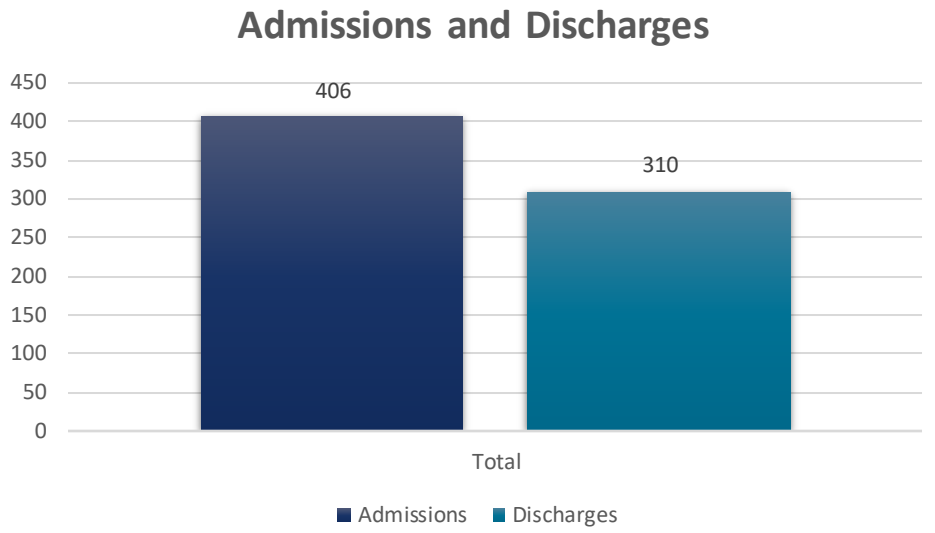
- Outreach and education to increase access to ethnic and culturally reflective, strength-based behavioral health treatment services, including housing, legal healthcare and preventive counseling.

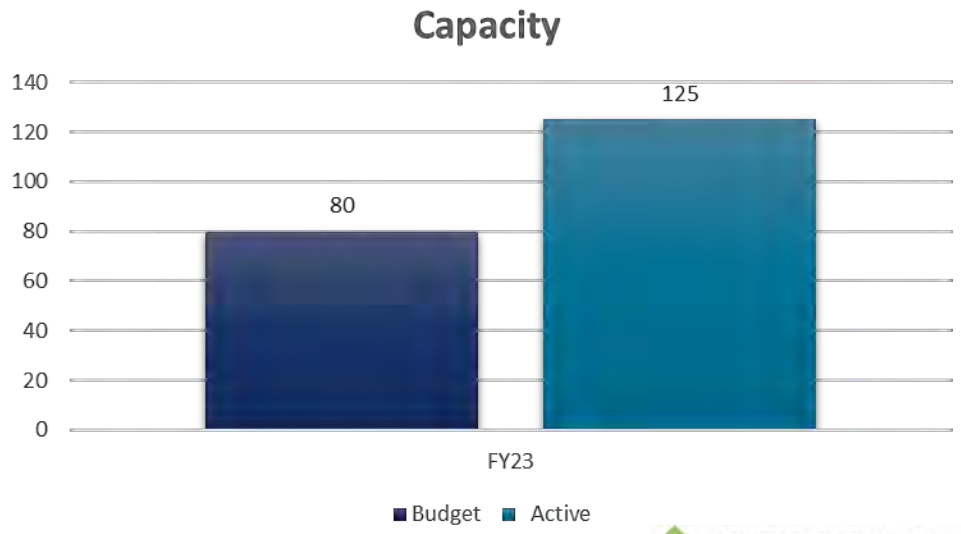
Outcomes

- 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



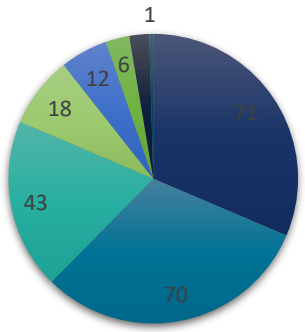




COUNTY OF SANTA CLARA
Behavioral Health Services

FY23 DEMOGRAPHICS – PEI PROVIDERS

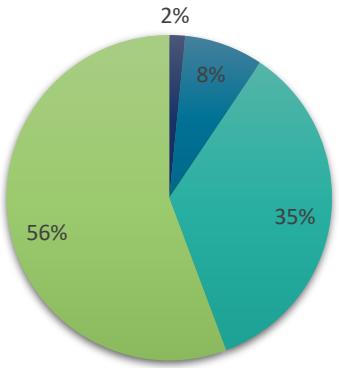
Language Provided



English | Unknown | Spanish | Other Non-English | Farsi | Vietnamese | Mandarin | Cambodian

16+ languages provided

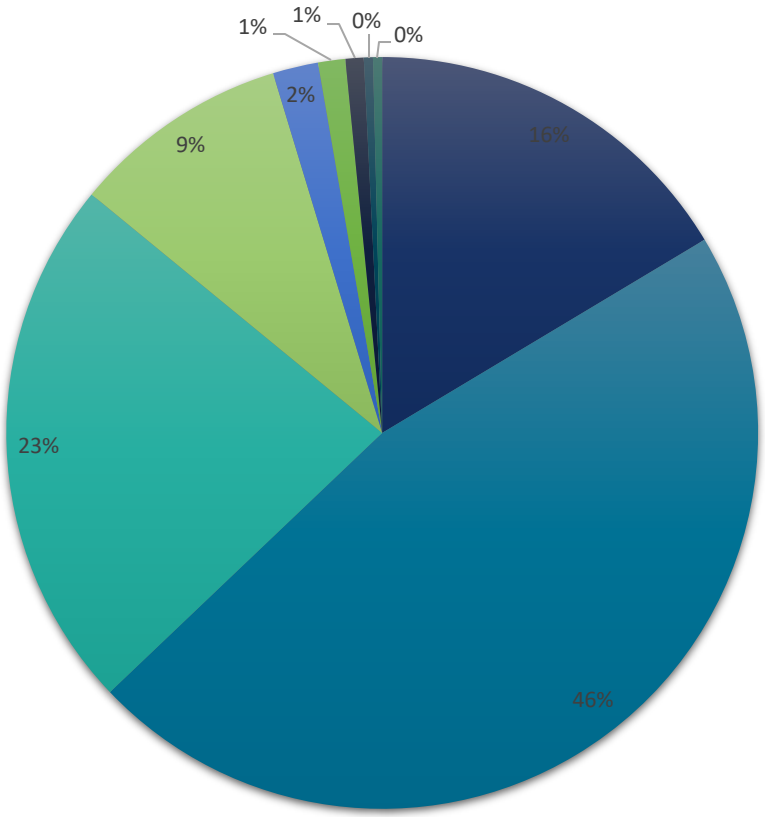
Age Group



Children/Youth | Transition Age Youth | Adult | Older Adult

110

Race



White | Other | Asian | Unknown/Not Reported | Black or African American | American Indian or Alaska Native | Declined to Answer | Native Hawaiian or other Pacific Islander | More than one race

COUNTY OF SANTA CLARA
Behavioral Health Services

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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
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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.

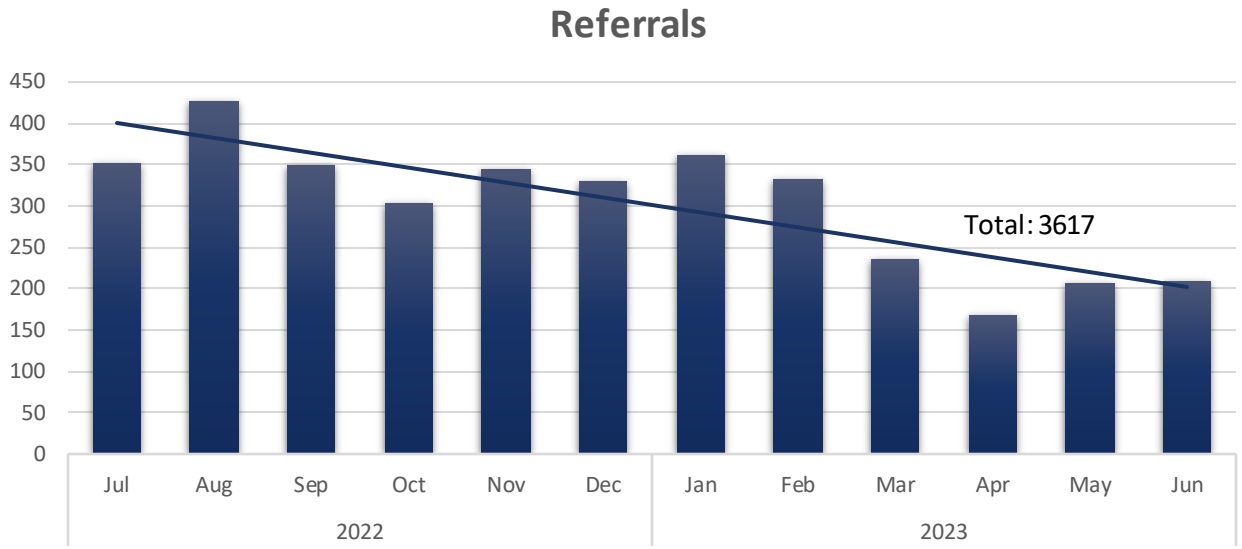
Goals

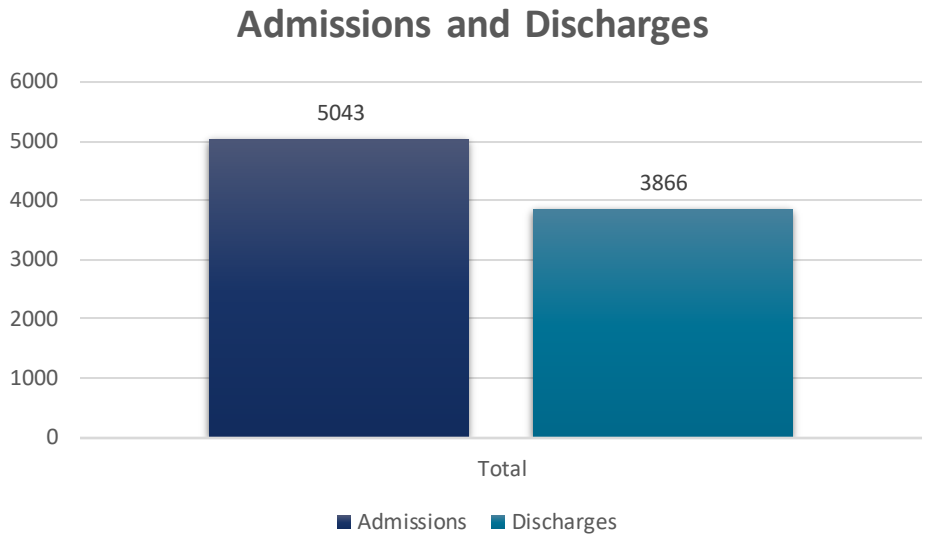
- BHSD clinician assesses SSA APS older adults and dependents clients referred to the program
- Provide short term mental health services and link to long term services and community resources.

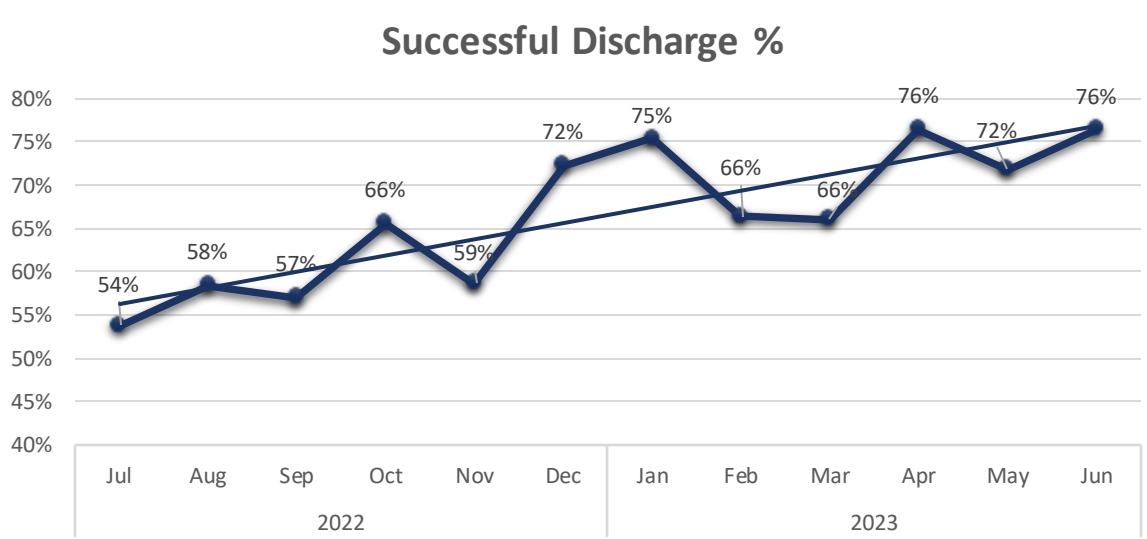
Outcomes

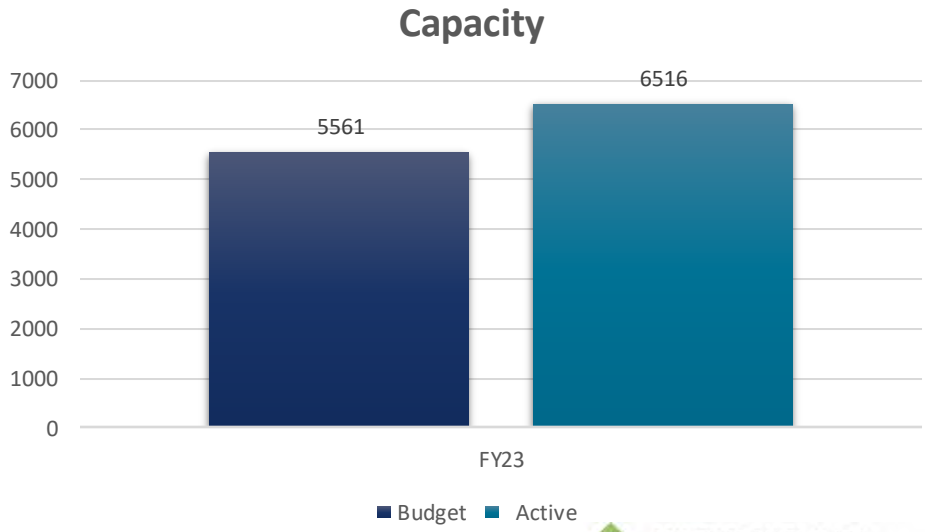
- This program served 98 unduplicated client's therapy and/or linkage services.
- 100% of participants transitioning from the program successfully met goals

FY23 DATA - CWS CONTINUUM OF CARE FOR CCP – OUTPATIENT PROVIDERS





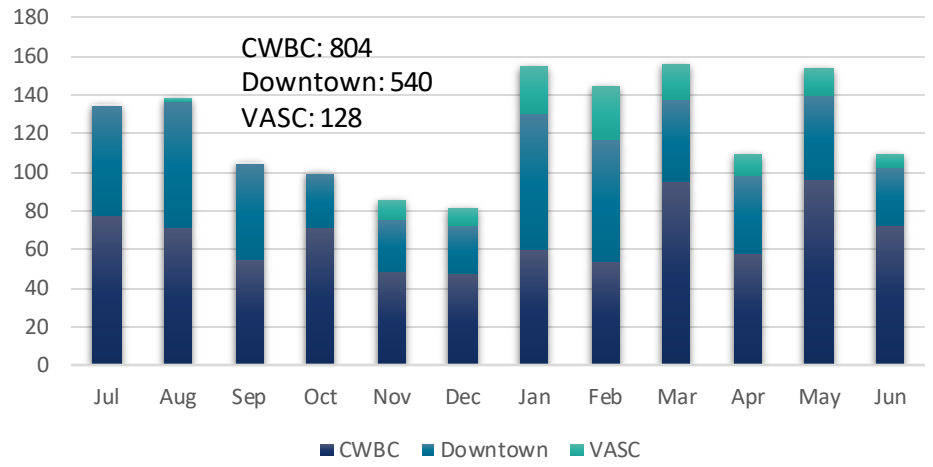




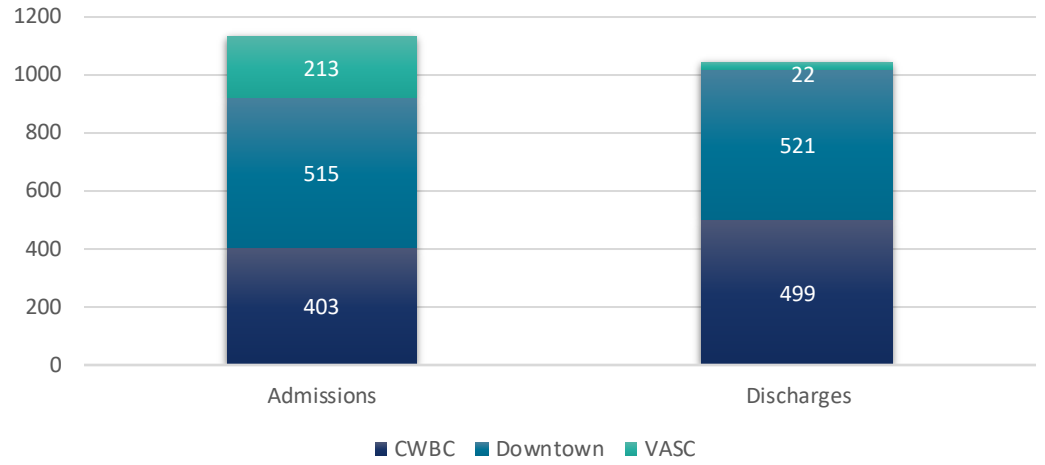
COUNTY OF SANTA CLARA
Behavioral Health Services

FY23 DATA - CWS CONTINUUM OF CARE FOR CCP – COUNTY PROVIDERS

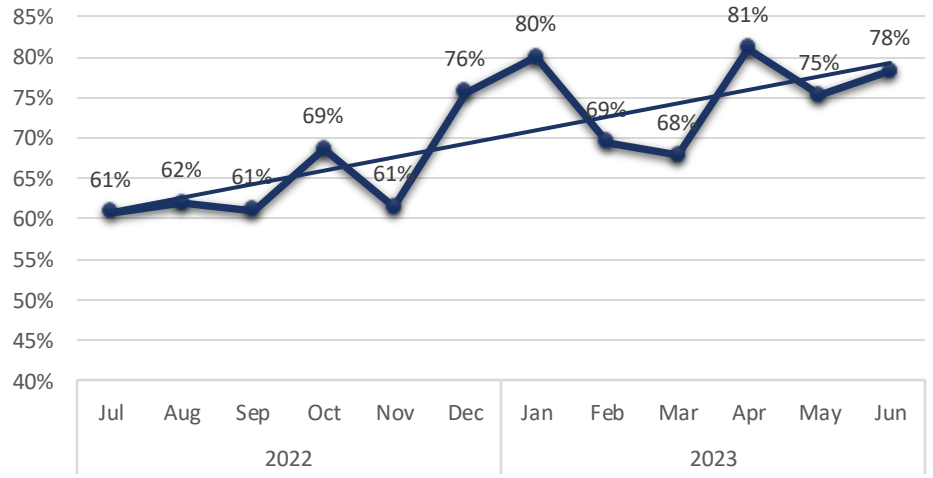
Referrals



Admissions and Discharges

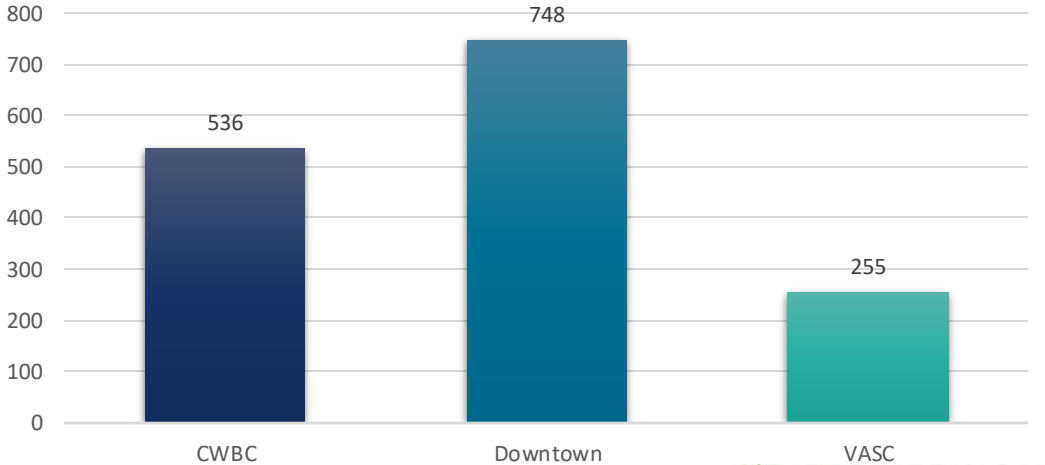


Successful Discharge %



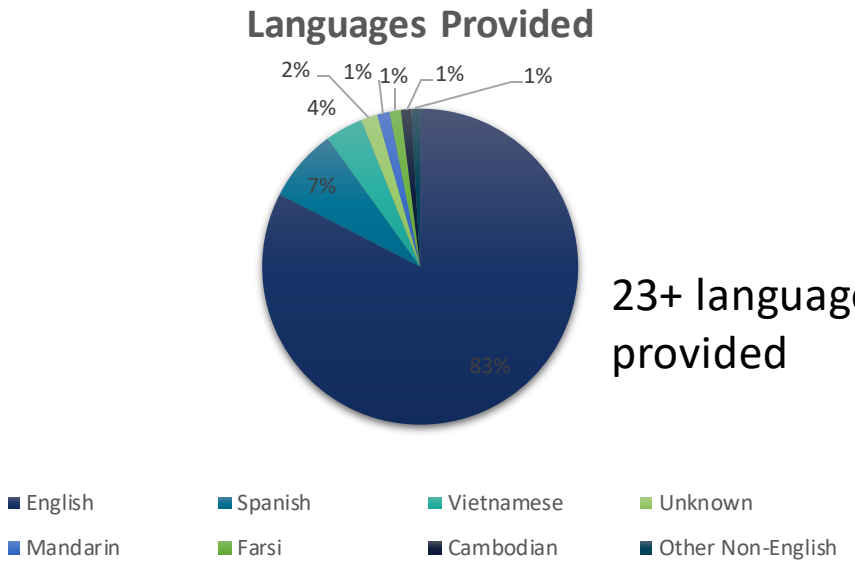
*Adult Outpatient Program Type, which also includes CCPs

Current Capacity

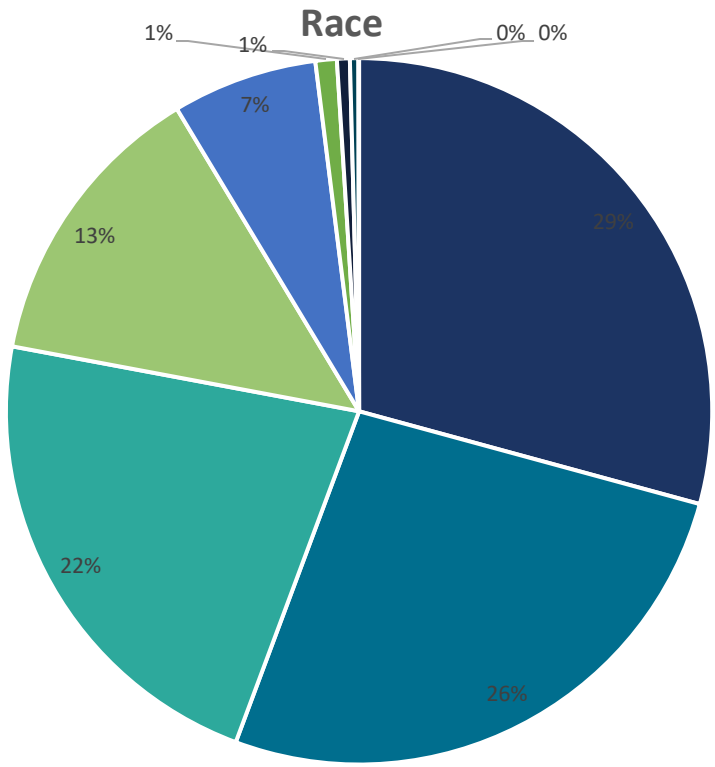


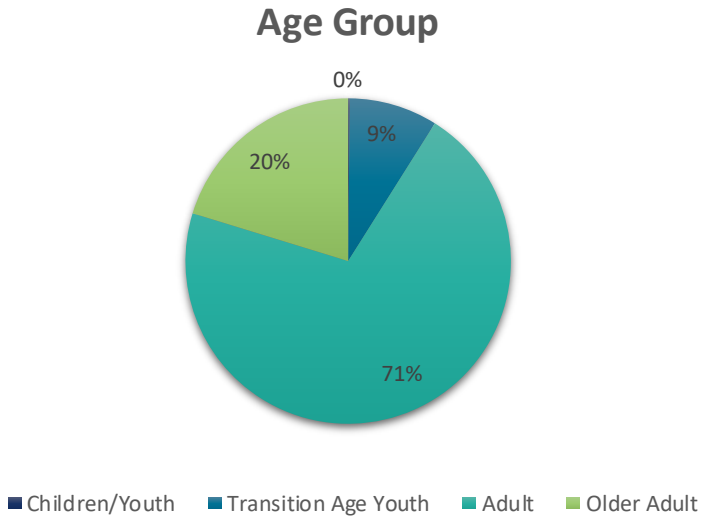
COUNTY OF SANTA CLARA
Behavioral Health Services

FY23 DEMOGRAPHICS – OUTPATIENT AND COUNTY PROVIDERS



23+ languages provided





COUNTY OF SANTA CLARA
Behavioral Health Services

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)

WELLNESS • RECOVERY • RESILIENCE

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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

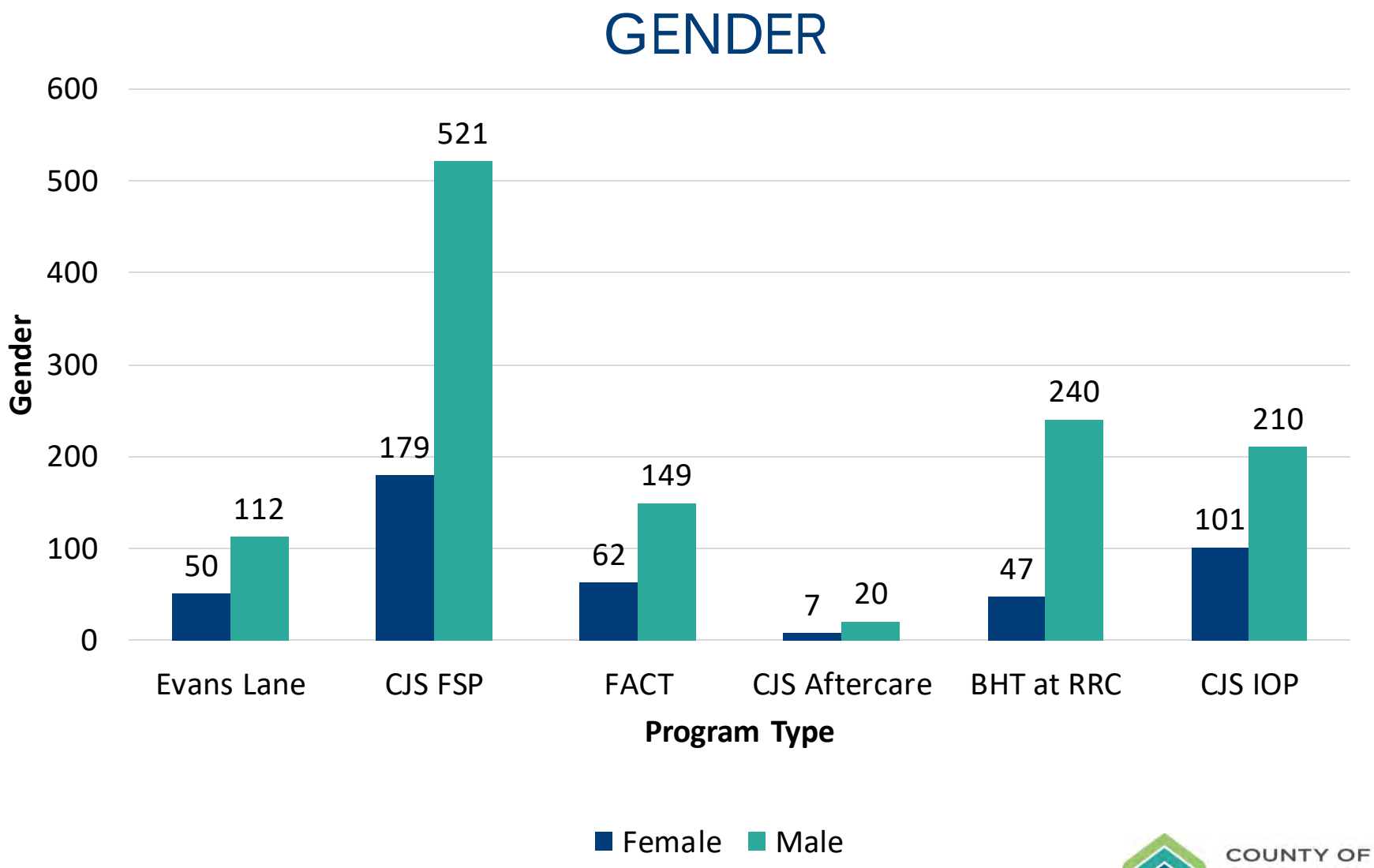
CRIMINAL JUSTICE SERVICES DIVISION: PROGRAMS DESCRIPTION & GOALS

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 socialization 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.

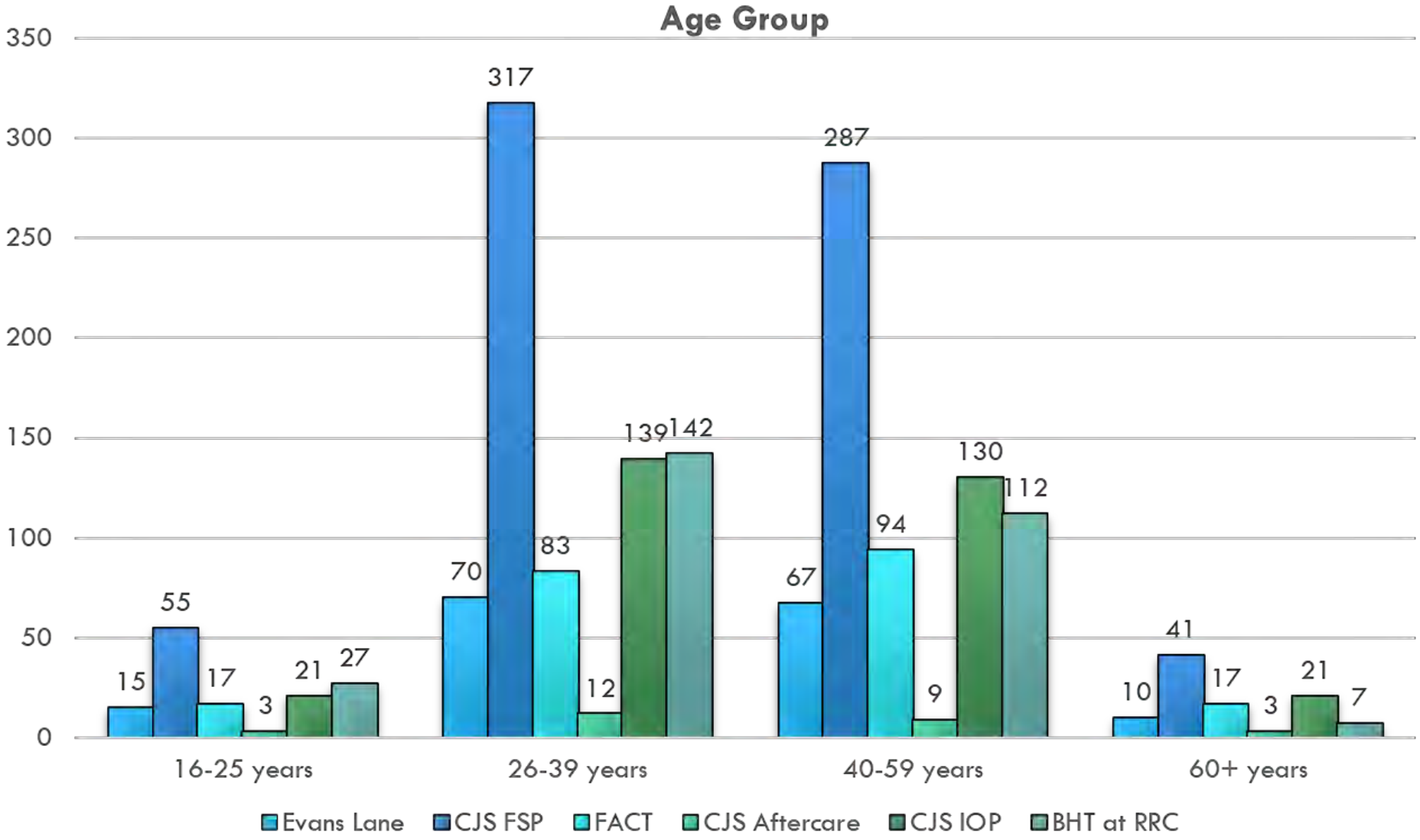
FY23 DEMOGRAPHIC INFORMATION



WELLNESS • RECOVERY • RESILIENCE

COUNTY OF SANTA CLARA
Behavioral Health Services

FY23 DEMOGRAPHIC INFORMATION



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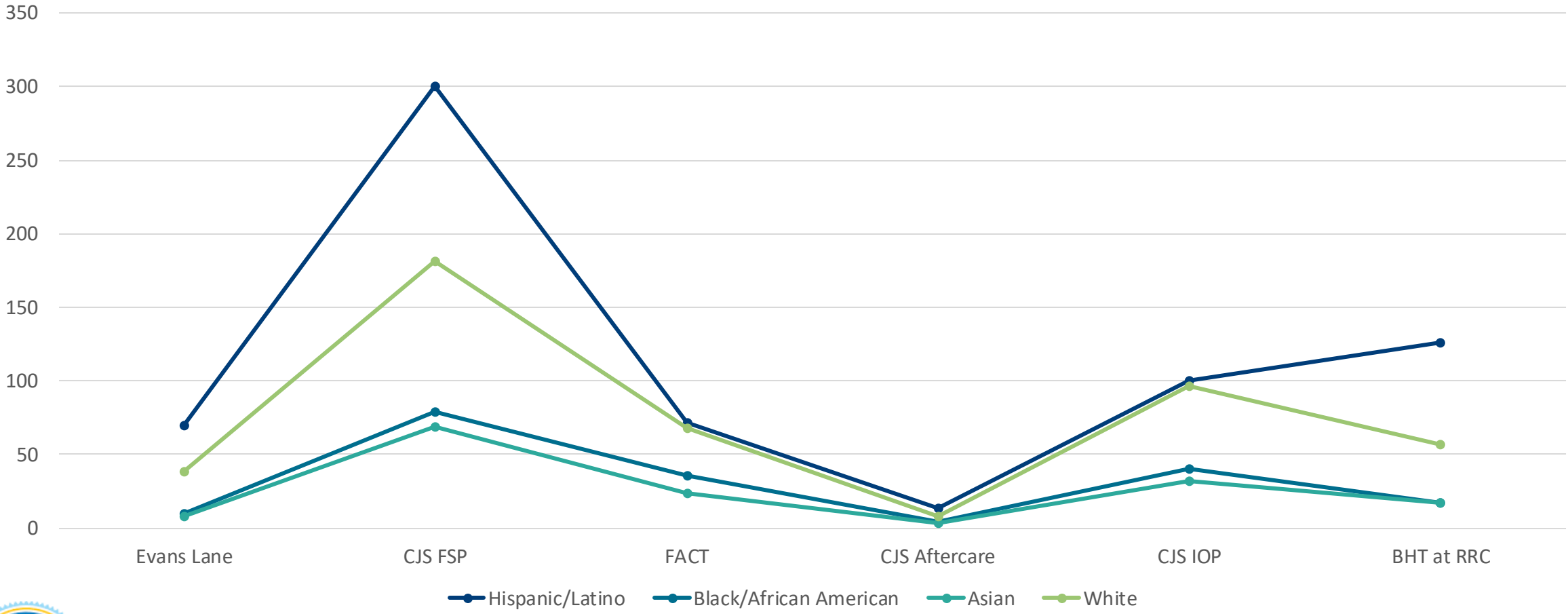
COUNTY OF SANTA CLARA
Behavioral Health Services

FY23 DEMOGRAPHIC INFORMATION

TOP FOUR (4) ETHNIC BACKGROUNDS

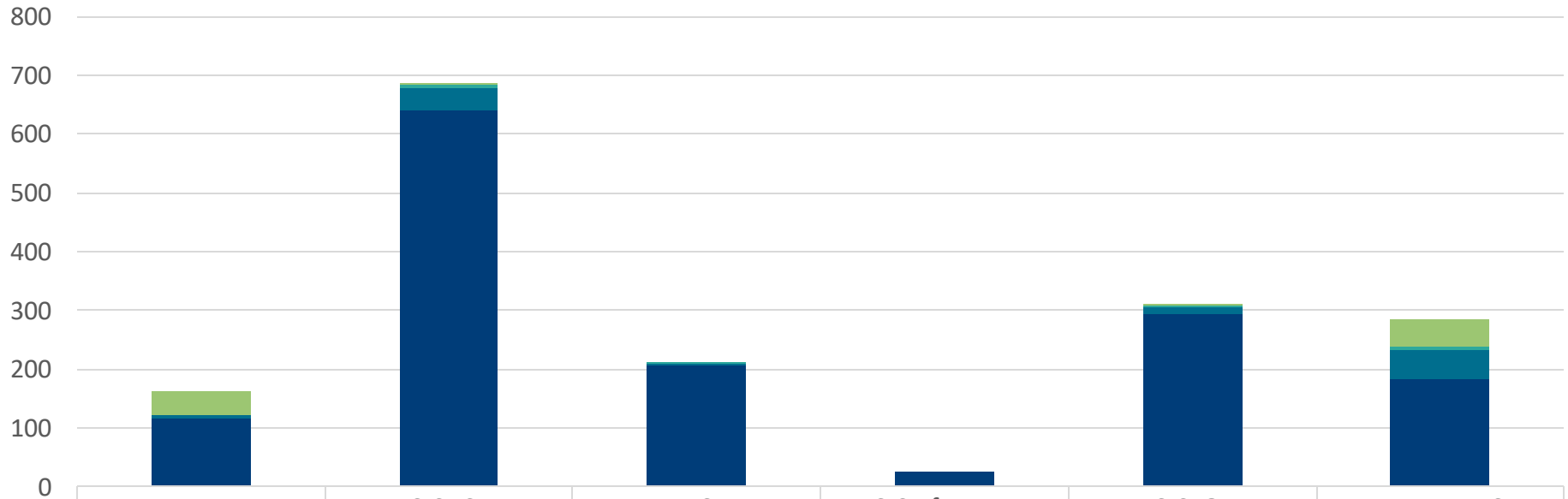


WELLNESS • RECOVERY • RESILIENCE

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

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

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

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.

Peer Services Division

(formerly known as Office of Consumer Affairs, Office of Family Affairs and Cultural Communities Wellness Program)

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COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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

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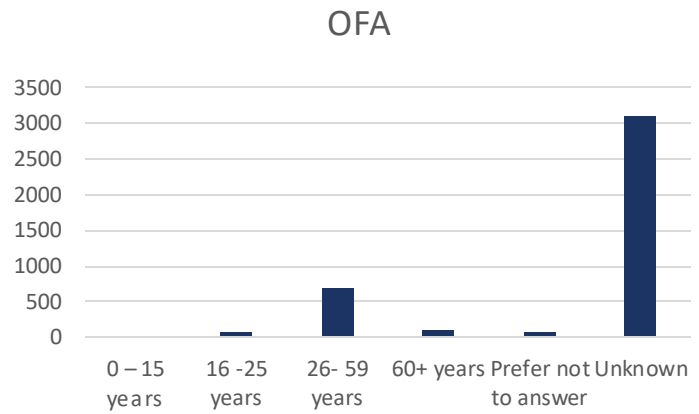
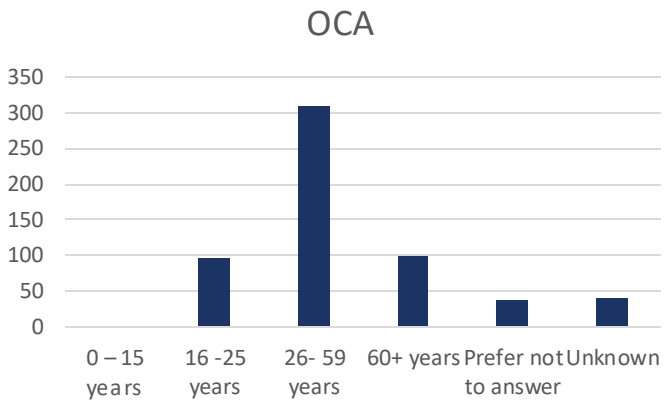
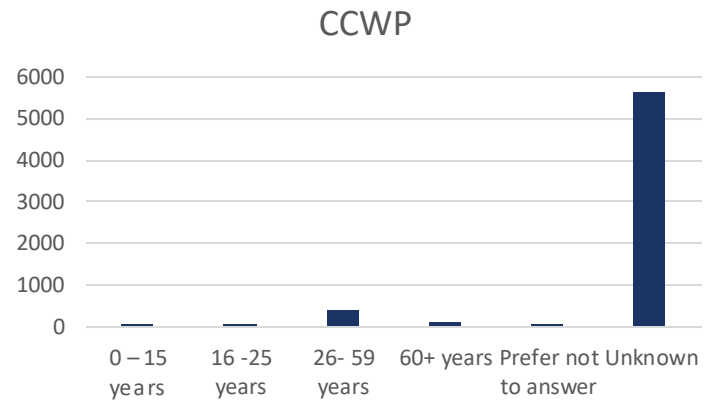
COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Demographic Info & Numbers Served

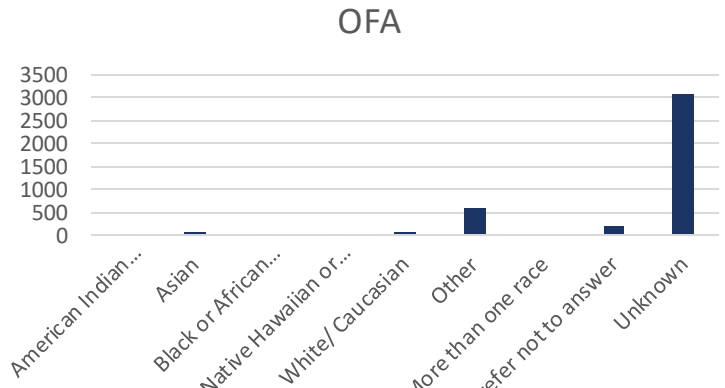
Age

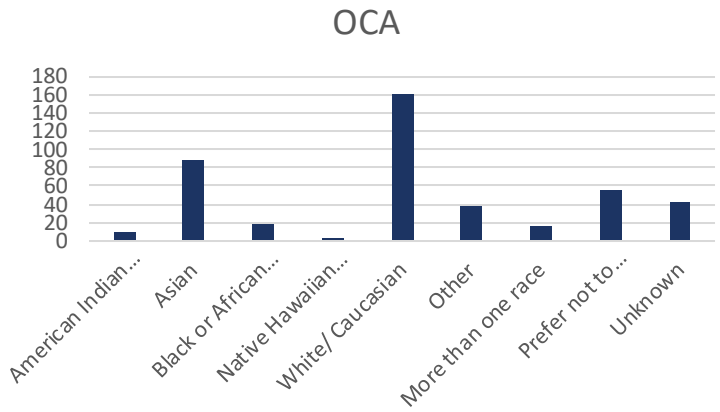


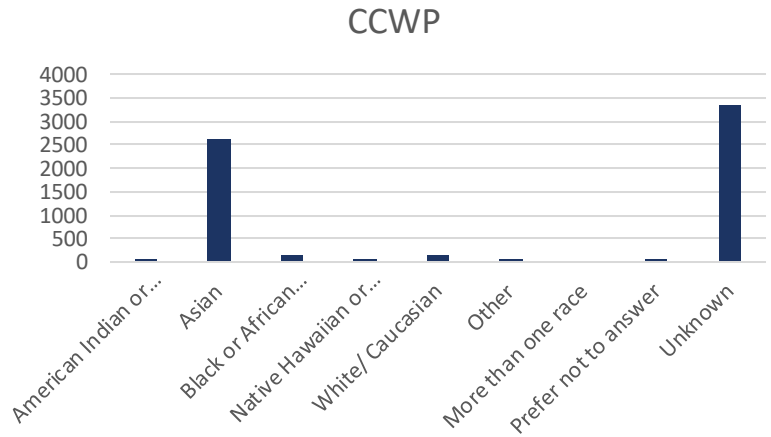




Race





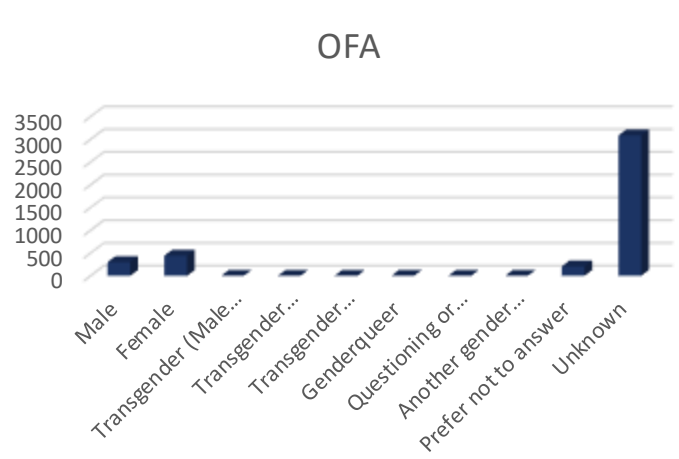


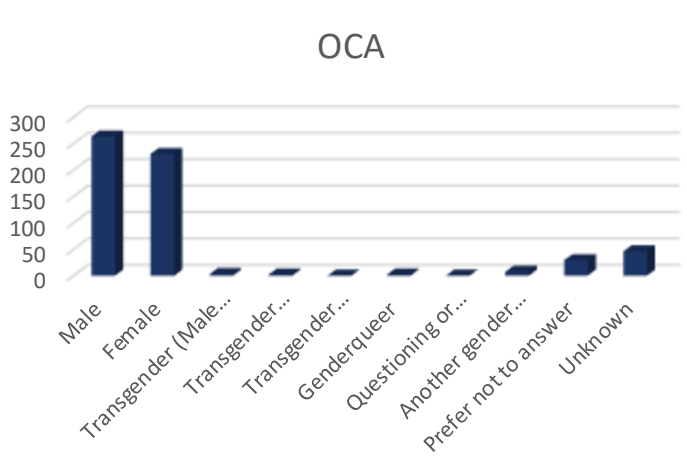
WELLNESS · RECOVERY · RESILIENCE

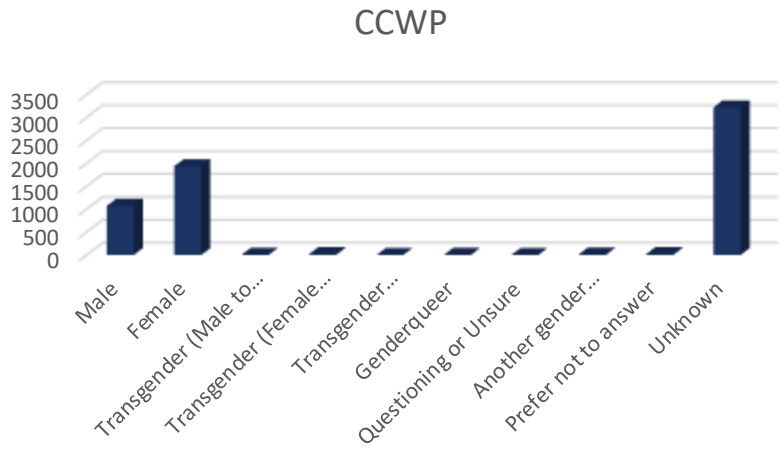
COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Demographic Info & Numbers Served continued

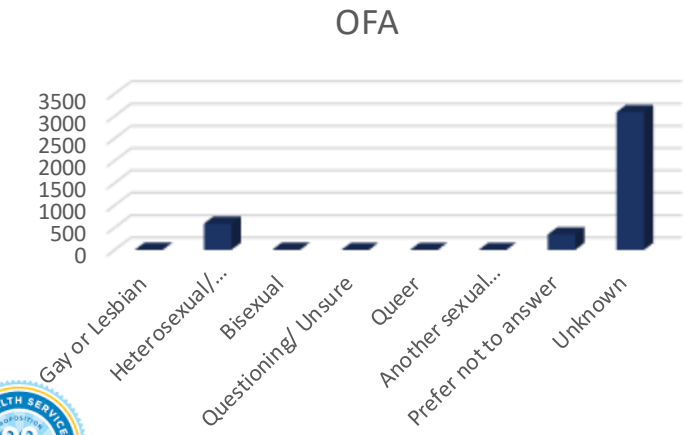
Gender Identity

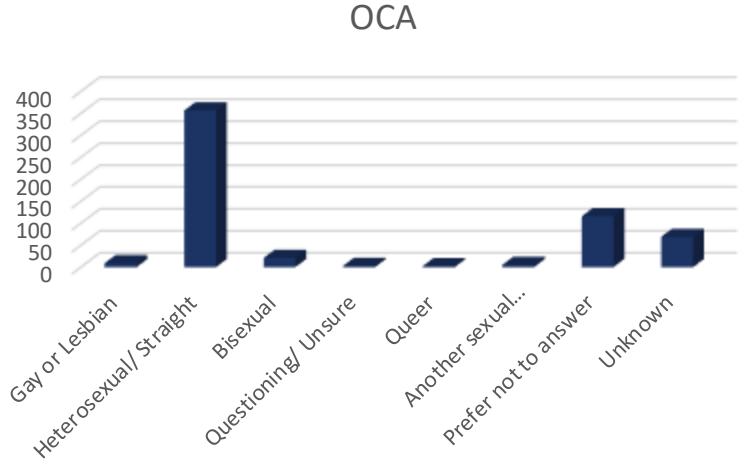


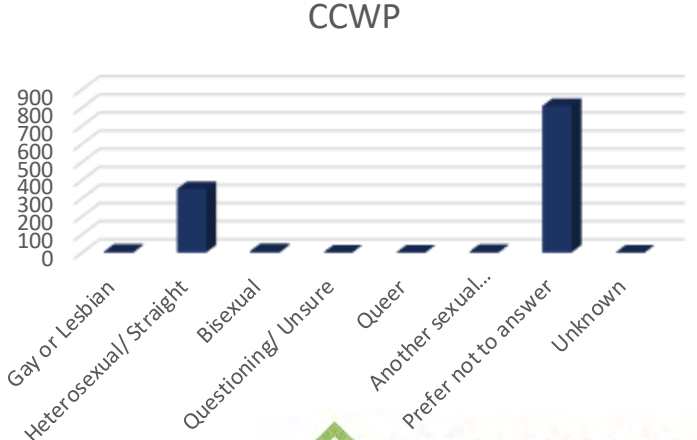




Sexual Orientation





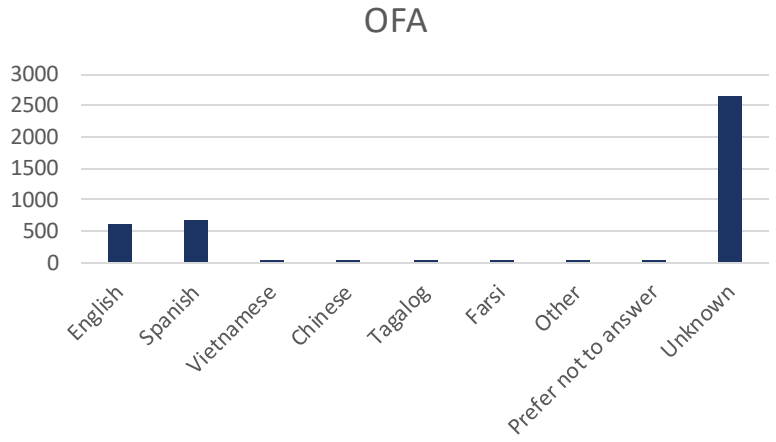


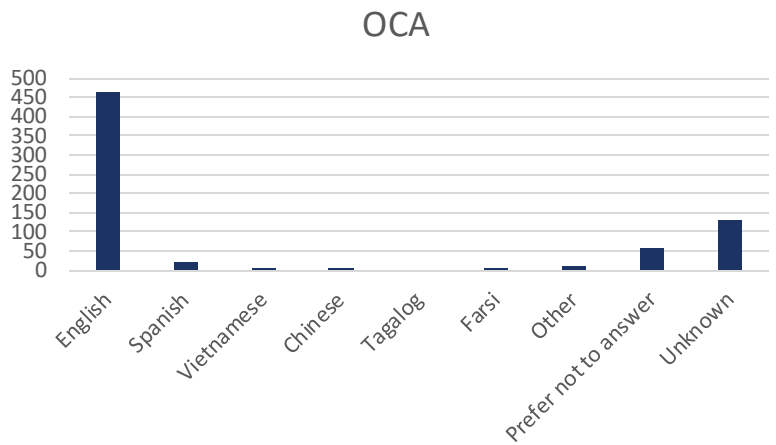
WELLNESS • RECOVERY • RESILIENCE

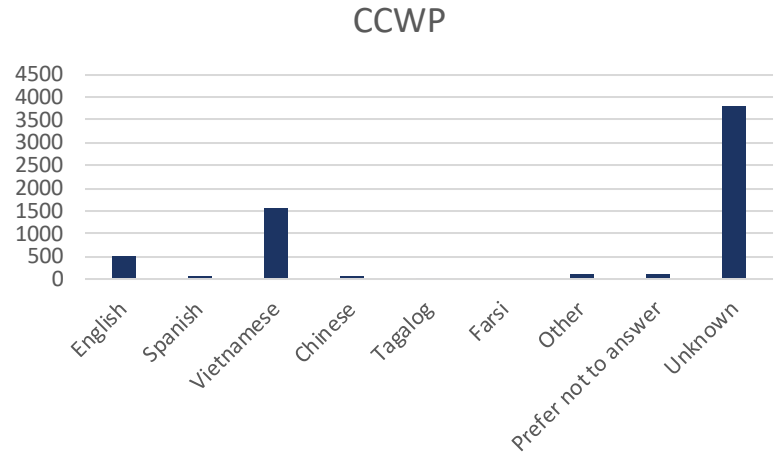
COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Demographic Info & Numbers Served continued

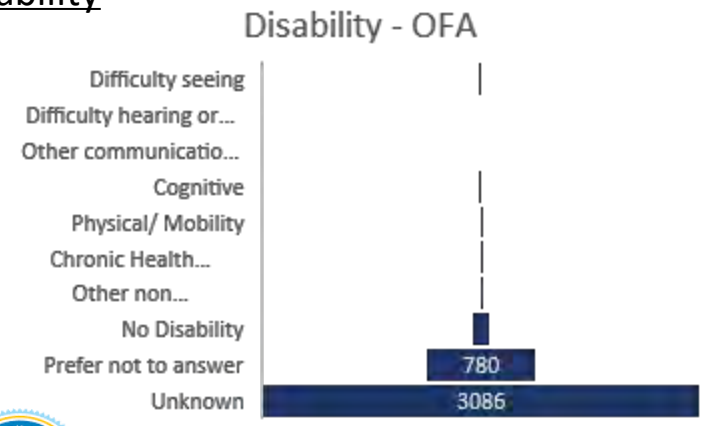
Language

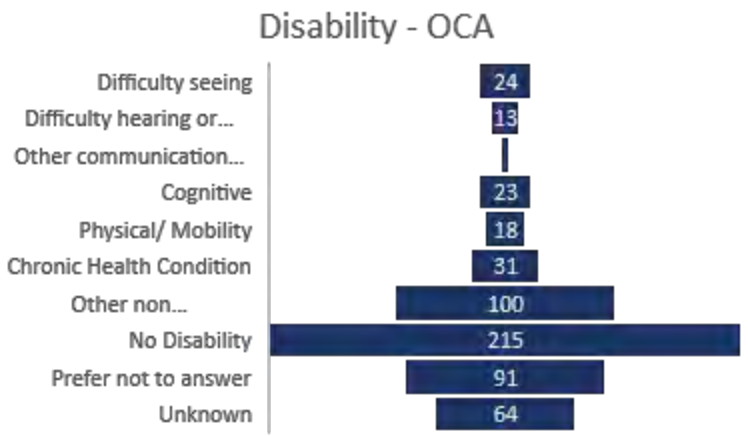


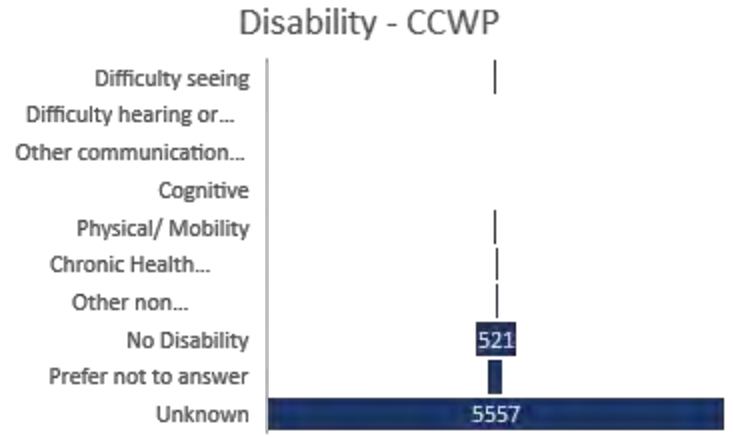




Disability





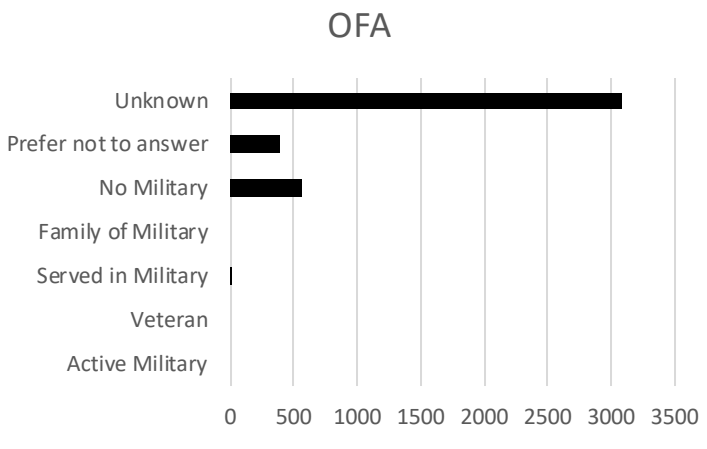


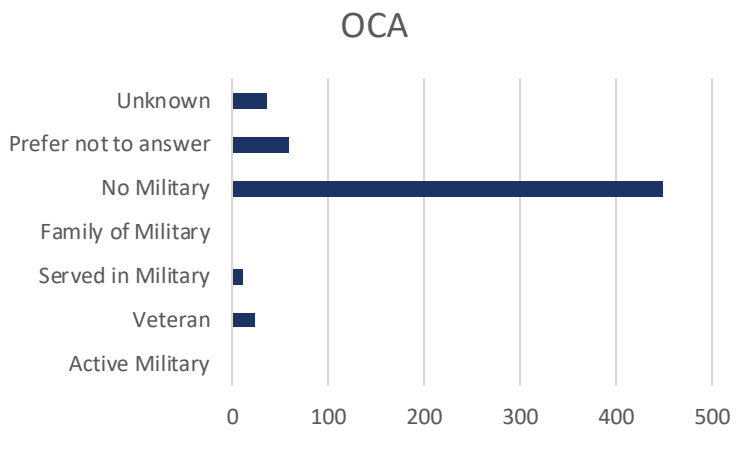
WELLNESS • RECOVERY • RESILIENCE

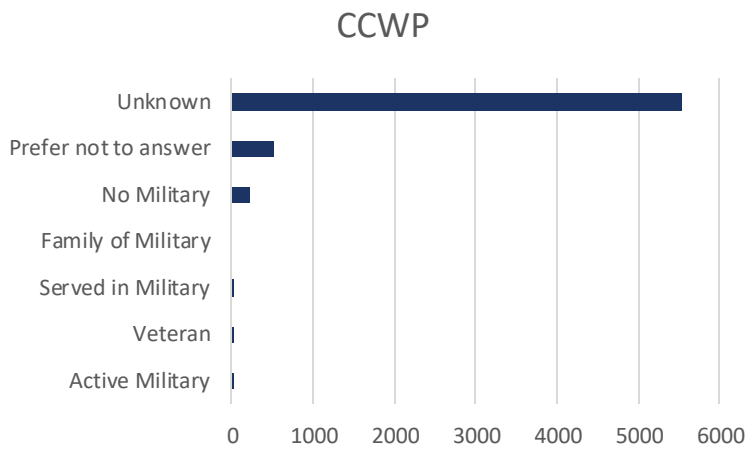
COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Demographic Info & Numbers Served continued.

Military







WELLNESS • RECOVERY • RESILIENCE

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

CLOSING REMARKS & NEXT STEPS

PLEASE TAKE A FEW MINUTES TO FILL IN THE SURVEY

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.