EVALUATION REPORT
FOR THE
MENTAL HEALTH SERVICES ACT (MHSA)
COMMUNITY PROGRAM PLANNING PROCESS

COUNTY OF SANTA CLARA
Behavioral Health Services

Prepared by:
Palo Alto University
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Informing the 2021-23 MHSA 3-Year Plan

EVALUATION REPORT FOR THE COUNTY OF SANTA CLARA MHSA COMMUNITY PROGRAM PLANNING PROCESS

Note: Click on each item to jump to its contents

TABLE OF CONTENTS

OBJECTIVES OF THE EVALUATION

Objectives of the evaluation were to integrate state-of-practice data approaches to community-engaged and community-led planning into the MHSA Community Program Planning Process for the County of Santa Clara. Stakeholder input was collected via multiple methods and languages: a paper-and-pencil and online Community Program Planning consumer survey, a large in-person MHSA Forum, and a focus group discussion ("listening session") of the Stakeholder Leadership Committee which represents the County of Santa Clara community members.

Both quantitative and qualitative data were analyzed in a mixed-methods approach, with input from a culturally diverse community stakeholder sample (inclusive of consumers, family members, providers, county staff, and other community members). Thematic analysis and statistical analysis were used to aggregate data into recommendations to inform future program planning and annual updates. A team from Palo Alto University completed the data evaluation process. Team leads included Joyce Chu, Ph.D. (Professor and Clinical Psychologist, jchu@paloaltou.edu), Lorna Chiu, M.S., Brandon Hoeflein, M.S., and Jordan Rine, B.A. Team members included Aishwarya Thakur, M.Sc., Leila N. Wallach, M.A., Jessica Lin, B.A, and Kevin Rodriguez.

METHODOLOGY

Stakeholder input data was collected from three sources:

1. The County of Santa Clara Consumer Survey

In 2018, Resource Development Associates created a consumer survey aimed at understanding consumers' and family members' experiences of behavioral health services in the County of Santa Clara. The survey includes thirty-five (35) questions that assess consumer experiences of mental health services throughout the County of Santa Clara across the following domains: Service Utilization and Access, Quality of Care (Provider Relationships, Front Desk Staff, Consumer Recovery Service Orientation, Referrals, and Coordinated Care), Culture and Diversity Considerations, Inclusion of Important Others in Care, and Satisfaction with Care. All items were answered on a 4-point Likert scale with 1=Not at all true, 2=A little bit true, 3=Mostly true, and 4=Very true. In December 2019 and January 2020, online links to the survey were sent by email across the county to major stakeholder constituents with requests to forward to potential respondents via a snowball sampling approach. Paper versions of the survey were also distributed through BHSD clinics, and at the 2020 MHSA Forum.

2. Stakeholder Leadership Community Listening Sessions

Since 2005, the Mental Health Services Act (MHSA) Stakeholder Leadership Committee (SLC) has been in place to provide input and to advise the County Behavioral Health Services Department (BHSD) in its MHSA planning and implementation activities. The MHSA 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 MHD holds MHSA SLC meetings to discuss MHSA related business and programs.

(https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Pages/SLC.aspx)

On October 15, 2019, thirty-four (34) consumers, family members of consumers, providers, other community members, and other members of the County of Santa Clara MHSA Stakeholder Leadership Committee (SLC) gathered to review and give feedback on the County of Santa Clara Behavioral Services for three focus populations: children and families, transitional age youth, and older adults. SLC members gave feedback according to four main questions: (1) What should stay the same?, (2) What should be changed?, (3) What should be added?, and (4) What should be removed? Feedback from the listening session was integrated into the findings of this report or included in the appendix of their respective results tables.

3. MHSA Planning Forum
BHSD organized a MHSA Planning Forum on January 21, 2020 that included 115 consumers, providers, community members, and stakeholders to gather input about the participants' experiences with the mental health system and their recommendations for improvement. Participants were asked to reflect on what works well in the current mental health system, system gaps, provider competence and training, and recommendations for future directions.

Recruitment for the MHSA Forum was conducted by email and word-of-mouth across the county and was designed to target all major stakeholder constituents. In particular, invitations to the Forum were sent to all of the following stakeholders: county clinics, all employees within the Santa Clara Valley Health and Hospital system, community-based organizations, program manager networks, community members via the MHSA Stakeholder Leadership Committee, department listservs, local NAMI chapters, the County Office of Education, and Board of Supervisors. The Forum was publicized in five languages (Chinese, Spanish, Tagalog, English, and Vietnamese), and advertisements were sent starting November of 2019.

To gather as much feedback as possible, the forum had three one-hour breakout sessions which were further separated into groups based on MHSA topics: Prevention and Early Intervention, Prevention of Homelessness, Workforce Education and Training, and Innovations. In the first two breakout sessions, the MHSA topic group was further divided by three systems of care groups: children and families, transitional age youth (TAY), and adults and older adults.

Each session began with a 10-20-minute introduction of current county efforts in the MHSA topic, and the remainder of the time was spent in discussion, with some subgroups reporting on their discussions to the full group at the end of the hour. Several county representatives facilitated and rotated through the different subgroups for each session. Otherwise, the subgroups were self-led discussions. A note-taker from the Palo Alto University evaluation team was present in each subgroup to record qualitative data. Attendees were welcome to attend as many breakout groups as they wished and some rotated through different subgroups during the breakout sessions.

Each subgroup in the sessions were asked to discuss their ideas for four target questions in relation to the breakout topic (i.e. prevention and early intervention, homelessness, workforce education and training) and their population focus (i.e. children and family, transitional age youth, older adults): (1) What should stay the same?, (2) What should be changed?, (3) What should be added?, and (4) What should be removed? Across the sessions, programmatic and service changes and

additions received the most feedback, whereas there was less input on what services should remain the same or be removed.

Structure and Schedule for Discussion Groups at the 2020 MHSA Forum

9:30 – 10:30	Breakout Group #1:
	Session A: Prevention and Early Intervention
	(1) Children and family, (2) TAY, (3) older adults
	Session B: Prevention of Homelessness
	(1) Children and family, (2) TAY, (3) older adults
10:40 – 11:40	Breakout Group #2:
	Session C: Prevention and Early Intervention
	(1) Children and family, (2) TAY, (3) older adults
	Session D: Workforce Education and Training
	(1) Children and family, (2) TAY, (3) older adults
12:30 – 1:30	Breakout Group #3:
	Session E: Innovations
	(1) Prevention and Early Intervention, (2) Prevention of Homelessness, (3) Workforce Education & Training

Findings of this report provide details regarding prominent themes that emerged in each of the 10 separate breakout discussions. Corresponding data tables are provided in the Appendices, with each frequency number ("N") representing the approximate number of times each theme was mentioned in the breakout groups. Executive Summaries and Recommendations are provided for each of the 10 breakouts. In addition, overall conclusions by age group (e.g., all children and family-related groups) and topic (e.g., all PEI-related groups) are provided in an Executive Summary at the beginning of the report.

COUNTY OF SANTA CLARA
2020 CONSUMER SURVEY RESULTS

EXECUTIVE SUMMARY

Findings from 93 mental health consumers indicate strong satisfaction with the County of Santa Clara's Behavioral Health Services Department, along with some suggestions for further improvement. Consumer data indicated the following:

- Moderate-strong satisfaction across each of the domains from the consumer survey
- In considering the County system overall, the greatest consumer-identified *strengths* included:
  - Consumers' positive experiences with mental health providers
  - Providers' abilities to include families and important others in consumers' recovery plans.
- The most apparent *areas for growth* included:
  - Increased varieties of mental health services (e.g., individual treatment, youth services, older adult services)
  - Accessibility of care (e.g., wait times, streamlined procedures for accessing care), quality of referrals (whether providers talk to consumers about services that may help them), and quality of coordinated care (whether their different services fit together well).

Based on aggregate results and specific comments, recommendations may include:

- Increasing access to care, including additional efforts to inform consumers of the easiest method for accessing care, improving coordination between services, and enhancing providers' discussion of referrals with consumers
- Further efforts to understand consumers' strong desire for more varied mental health services

Participants

A total of 253 participants initiated the consumer survey. Of these survey responses, 167 were excluded from the analysis as they did not fit the following parameters: (a) identifying as a consumer or family member, and (b) completing survey items. As such, data was available for a total of 93 mental health consumers in Santa Clara County. Of the 93 consumers who completed the survey, the majority self-identified as White, female, 24-49 years old, and living in San Jose or Milpitas. 41% of the sample were consumers and 23% were parents of consumers. A plurality of the sample (46%) identified as White/Caucasian, followed by Asian and/or Pacific Islander (25%). A majority of the sample identified as female (65%). A majority of the sample either lived in Milpitas (33%) or San Jose (27%).

Results by Consumer Survey Domain

Service Utilization and Access: Consumers reported moderate-high satisfaction with service utilization and access; the average response for this domain was "Mostly True" (2.79). This domain included 5 questions measuring knowledge of care locations, knowledge of phone numbers for care, appointment scheduling procedures, ease of scheduling a timely appointment, and wait room times. Consumers' highest ratings were knowledge of care locations (3.27 "Mostly True") and their lowest rating were accessibility of mental health services (2.21 "A Little Bit True").

Figure 1. Consumer Survey Respondents by Age

Below 16 Years 7%
16-24 Years 11%
24-59 Years 64%
Above 60 Years 18%
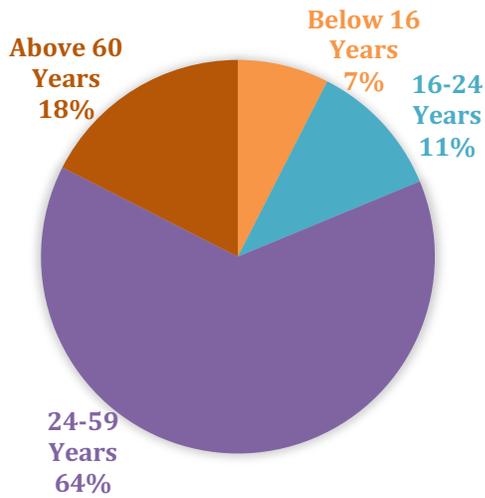
Figure 2. Consumer Survey Respondents by Relationship to Consumer

Self 49%
Parent 28%
Partner 3%
Child 3%
Other Family 6%
Friend 3%
Other 8%
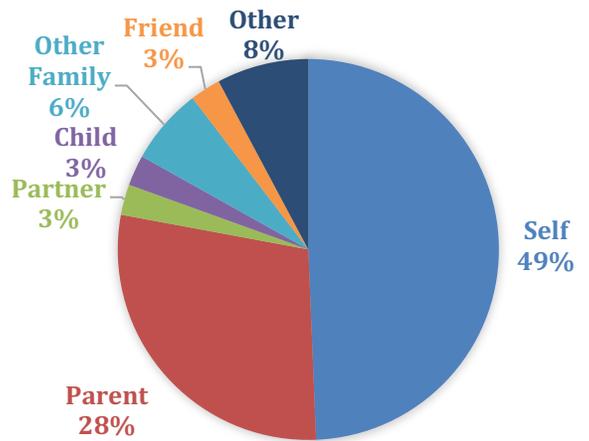
Figure 3. Consumer Survey Respondents by Gender

Female 76%
Male 14%
Prefer Not to Answer 6%
Other 3%
Intersex 1%
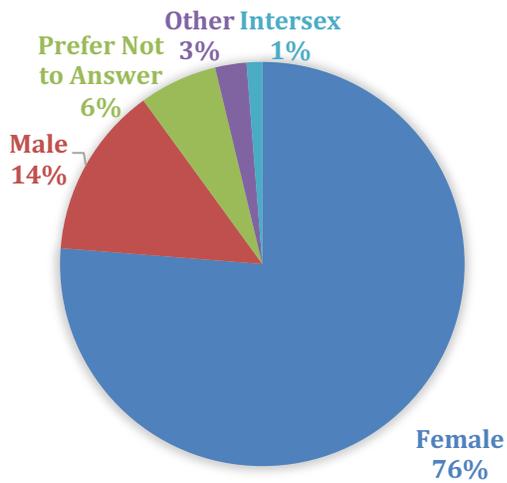
Figure 4. Consumer Survey Respondents by Race/Ethnicity

White/Caucasian, 43, 50%
Asian Pacific Islander, 23, 27%
Latino/a/x , 14, 16%
African American/Black, 5, 6%
American Indian/Native Alaskan, 1, 1%
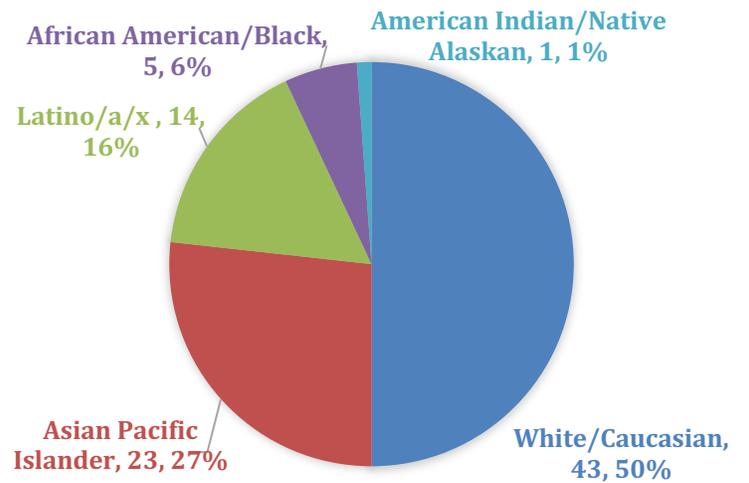
Figure 5. Consumer Survey Respondents by City
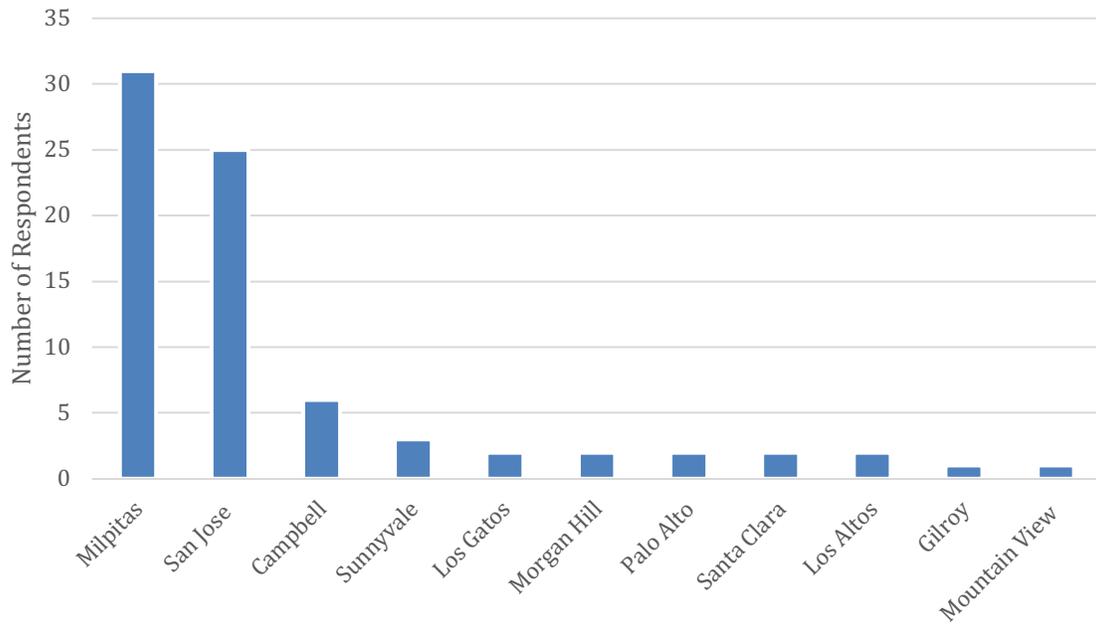
Figure 6. Summary of Survey Domain Results
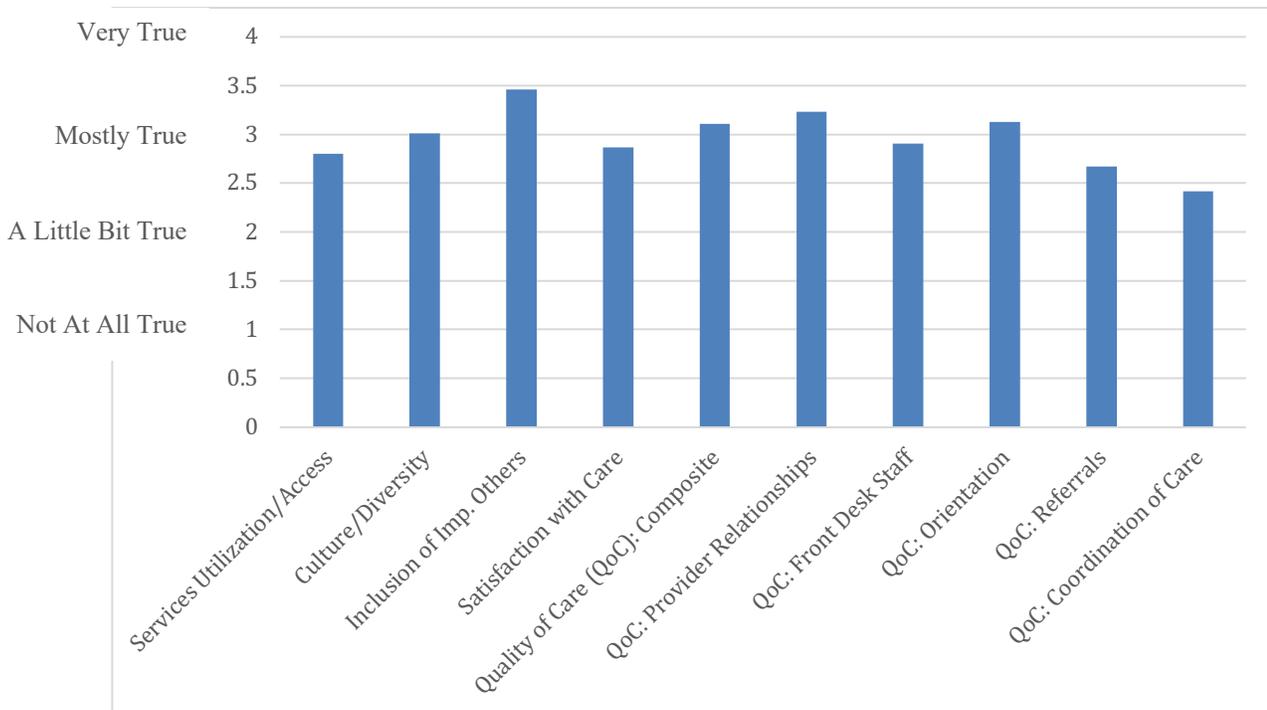
Quality of Care: Consumers reported moderate-high satisfaction with quality of care; the average response in this domain was "Mostly True" (3.11). This domain included 12 questions measuring referrals, care coordination, front desk staff, provider relationship, and consumer-recovery orientation. Consumers' highest ratings came when asked how much their providers respect them (3.43 "Mostly True"), and their lowest rating came when asked how well their services fit together (2.42, "A Little Bit True"). Results for each sub-domain of Quality of Care are detailed below:

> *Quality of Care: Provider Relationships:* This sub-domain included five questions assessing providers on the following: discussing consumer rights, answering consumer questions, respecting consumers, making consumers feel respected, and making consumers feel open to discuss their problems. Consumers reported moderate-high satisfaction with their provider experience; the average response was "Mostly True" (3.23).

> *Quality of Care: Front Desk Staff:* This sub-domain included three questions measuring front desk staff's likelihood to ask questions and behave in a friendly, helpful manner. Consumers reported moderate-high satisfaction with front desk staff; the average response was "Mostly True" (2.91).

> *Quality of Care: Consumer-Recovery Service Orientation:* This sub-domain included 4 questions measuring shared decision-making, consumer-focused goal-setting, and individualized recovery goals. Consumers reported moderate-high levels of recovery-oriented service provision; the average response was "Mostly True" (3.13).

> *Quality of Care: Referrals:* Consumers reported that it is "Very True" (2.67) that their providers talk to them about services that may help them.

> *Quality of Care: Coordinated Care:* Consumers reported that it is "A Little Bit True" (2.42) that their different services fit together well.

Culture & Diversity Considerations: When asked to rate the extent to which their providers understand their culture, consumers reported "Very True" (3.01). Limited sample size precluded further examination of differences across demographic subgroups (age, race/ethnicity, gender). For example, data only included 1 Native American/Native Alaskan consumer, 5 African American consumers, 3 gender minority individuals (e.g., transgender, gender non-binary, gender fluid), and 6 consumers less than 16 years old. There were 21 responses outside the cities of San Jose and Milpitas. Further, sexual orientation was not assessed on the consumer survey and was not included as a variable in this analysis.

Inclusion of Important Others: Consumers reported moderate-high satisfaction regarding the inclusion of important others in their mental health services; the average response was "Mostly True" (3.46). This domain included 4 questions measuring: providers asking whether to involved others, providers including identified others, providers empowering identified others as allies, and family members supporting recovery.

Satisfaction with Care: Consumers reported moderate-high satisfaction with their mental health care; the average response was "Mostly True" (2.87). This domain included 5 questions measuring services meeting consumer needs, services being helpful, satisfaction with services, and teams providing the requested type of care in a timely fashion.

Greatest Personal Benefit: When asked about their greatest personal outcome from mental health treatment, consumers were most likely to endorse increased coping skills (23.7%) and increased ability to speak up about needs and wants (19.4%). Of the five consumers who commented specifically on this question, their answers included statements such as "*I have been able to be myself and find true happiness because of treatment*" and "*I can learn to heal.*"

System Strengths: When asked to identify the greatest accomplishment of the mental health system, consumers were most likely to endorse that services are helpful (20.4%) and that services are recovery-oriented (19.4%). Two people specifically commented on this question; their responses lauded the services for young adults and the quality of care that being provided by the County.

System Gaps: When asked to identify the most pressing need of the mental health treatment system, consumers were most likely to identify a need for additional services (14.6%) and a need for different types of services (11.5%). Of the eight consumers who commented specifically on this question, suggestions included: additional programming resources for youth and older adults, greater access to individual treatment, clearer communication of the process for initiating treatment, and further work on LGBTQ+ outreach and clinician de-stigmatization.

Recommendations:

1. Further explore consumers' strong desire for **additional and more varied mental health services.** According to the consumer survey, the two most important areas for growth are to increase the *quantity* and *variety* of mental health treatment options. The County's BHSD may benefit from further efforts to understand consumers' needs for an increased range of mental health treatment options.

2. **Increase Access to Care**, including additional efforts to inform consumers of the easiest method for accessing care. Aggregate survey responses and written comments expressed consumers' desire for clarity on avenues for accessing care (e.g., streamlined process, increased marketing, additional outreach efforts, improving coordination between services, and enhancing providers' discussion of referrals with consumers).

MHSA FORUM & STAKEHOLDER LEADERSHIP COMMITTEE LISTENING SESSIONS

EXECUTIVE SUMMARIES & RECOMMENDATIONS
BY AGE GROUP

CHILDREN AND FAMILIES
OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS

Feedback from the MHSA Forum and SLC confirmed the idea that support for children's services is good and the quality of care in the children's behavioral health system is robust with strengths in several areas:

- Flexible child and family services placed in accessible locations, services for refugees and children under the age of six, allocation of funding priorities, and the increase of additional psychiatric beds.
- Several existing Workforce Education and Training programs have effectively targeted recruitment of youth stakeholders as eventual employees in the county (e.g. the Student Internship Program, a high school Career Summer Institute).
- Notable promising efforts in the area of homelessness among children and families such as MHSA's grassroots work in Milpitas, the Bill Wilson Center's measurement of program outcomes and case management, and recent policy advocacy work on mental health stability and rent stability.

However, stakeholder data also point to the idea that although the quality of existing services are good, there may be children and families that do "fall through the cracks" and are not served by the current behavioral health system. In order to address this problem, data pointed to the following potential strategies:

- Examine the *cultural responsiveness* of access and the service system to address unique needs of specific diverse populations and to ensure provision of culturally-responsive options (e.g., for the working poor, homeless RV families, Latinx, immigrants, refugees, non-English speaking consumers).
- *Increase accessibility* by addressing gaps in service linkage points and continuity of care between county systems (e.g., improved triage screening, detection, referrals, and school collaborations).
- *Expand school-related services and staffing* (e.g., beyond school hours; increase staffing in and collaboration with schools; improve programmatic and funding coordination between school-linked services and PEI).
- Explore *innovative outreach efforts* (e.g., social media, movie clips, mental health specialists in schools, comprehensive psychoeducation) to decrease access barriers (e.g., stigma, wait times, low awareness about services, unmet daily living needs).

"Cracks" in reaching children and families were particularly salient for homeless consumers. Consumers noted a lack of awareness about homelessness prevention efforts among providers and the community, pointing to a need for both outreach and service expansion. The perception was that school resources and housing services support are inadequate, and that more continuity of care for families and children across all changes are needed. With acknowledgement to a noted high

system-mistrust among homeless children and families, concentrated efforts to address access barriers and engage stakeholders may be particularly important. Finally, policy efforts to clarify definitions of homelessness in a way that ensures adequate access to care, along with the creation of a robust data evaluation system, was also cited as necessary to improve services.

To increase youth representation in the workforce, stakeholder data pointed to the potential to increase the engagement of youth (including youth with lived experience) through proactive county action to address barriers and engage high school and college students in county behavioral health (e.g., scholarships, stipends, outreach to students of color, outreach at university events). Additionally, MHSA initiatives could assess opportunities to bridge transition periods between graduation and employment, or to reach bachelor's and master's level graduates before they are diverted from county pathways.

TRANSITIONAL AGE YOUTH
OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS

Stakeholders pointed to many areas of strength in the Transitional Age Youth (TAY) system, such as suicide prevention programming, gatekeeper trainings, Full Service Partnership (FSP) programs, efforts to integrate trauma-informed services, and Flex Funds. Yet, findings from a needs assessment 2 years ago showed that the TAY system of care was less developed than other areas of the system, and needed more attention towards engaging new TAY consumers or transitioning TAY-involved in the child system to the TAY system of care.

Indeed, stakeholder feedback from the 2020 MHSA Forum and SLC were consistent with the idea of a developing and maturing TAY system of care. Overall feedback suggested that **greater definitional** clarity about who qualifies as TAY and **attention to the specific needs of TAY** would benefit the next stage of TAY service development:

1. Increase budget transparency and improve data systems for program evaluation

2. Provide more definitional clarity around who transitional age youth are, and what their specific services look like.
- Clarify who falls under TAY category and how they differ from child/youth or adult groups (e.g. "aged out" foster care children)
- Provide definitions for transient versus chronically homeless TAY.

3. Further develop services tailored to TAY-specific needs
- Stakeholders discussed the importance of greater integration of family members into the care of TAY, especially given the legal barriers to family involvement (e.g. HIPAA).
- Data also pointed to needs for TAY-specific housing (particularly long-term supportive housing to prevent trauma), increased lengths of rapid TAY housing to 24 months, a TAY-specific emergency shelter, increased programming and interventions designed to build life-skills, greater financial assistance (e.g. universal basic income), and a substance withdrawal program for TAY abusing ADHD medications.
- Integrated collaboration may be particularly important, such as through partnership with colleges, outreach to youth outside the school systems (e.g., immigrant youth, human

trafficking, transition from incarceration, working TAY), or connectivity with the foster care and substance use service systems. Some also suggested that connectivity among service providers with TAY services be improved.

4. Increase workforce recruitment, education, and training from TAY communities and for TAY-specific issues

- Education and training on TAY-specific issues: Ideas provided by community stakeholders included integrating trauma-informed care into provider trainings, disseminating more information on TAY services to community and providers, and attention to trauma-informed care in the foster care system.
- Promotion of behavioral health careers among TAY, particularly among non-English speaking, marginalized, and underrepresented communities.
  - Adapt outreach to reflect technology and social media use among TAY.
  - Engage non-English and ethnic minority youth.
  - Outreach to high school, junior college, and university students through initiatives such as campus activity participation, working to address university-level barriers, or offering stipends and scholarships.

ADULTS AND OLDER ADULTS
OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS

Feedback from the MHSA Forum and SLC suggested that adults and older adult services include some strong programs that are encouraged to persist *and* expand. In particular, **elder storytelling** was identified as a powerful and culturally-appropriate intervention that should be developed. Stakeholders confirmed that the county is doing well in other areas such as servicing refugees, offering in-home peer respite programs, and offering Full-Service Partnership eligibility. Other stakeholders recommended that case management providing housing support to chronically homeless as well as MHSA funding for individuals involved in the criminal justice system (e.g., those on parole or probation) should be continued.

Suggestions to improve the adult and older adult system yielded several key areas / recommendations.

1. Culture and Diversity Needs

- Increase outreach and education to culturally diverse and underserved adult and older adult communities
  - Stakeholders identified a need for improvements in the **engagement of and outreach to vulnerable and underserved groups** (e.g., older adults in general, LGBTQ+ older adults, diverse homeless older adults, veterans, Korean communities, Pacific Islander groups, African Americans, and incarcerated individuals with serious mental illness). For example, refugees may be dropping out of services because of recent political challenges, and additional time and effort may be needed to engage them.
  - Outreach approaches should focus on **reaching stakeholders within their own communities** (e.g., ethnic media outlets, churches, homes) and address the

difficulties that elderly (particularly isolated elderly) have in navigating available services.

- <u>Focus and tailor staffing and programming towards the needs of cultural and diverse adult and older adult communities</u>
    - o Data pointed to the importance of **increased cultural representation** in county staffing, cultural adaptations of existing programming (e.g., to tailor older adult programming to younger versus older elderly), and culturally-specific trainings.
    - o Increased hiring and better coordination between call centers and county-funded community-based organizations may be needed to **facilitate referral of services for non-English speaking clients**, particularly when there is insufficient availability of language-matched providers or cultural brokers within the county's' contracted community-based organizations.
    - o Pacific Islander, Korean, and LGBTQ+ **representation in staffing** (e.g., on the CCWP) was also identified as a potential need.

2. Consider the need for a broader offering of post-crisis intervention (tertiary prevention) options that promote recovery and prevent relapse

- Stakeholders highlighted a need for **more one-on-one interventions** (rather than groups) and more offerings other than WRAP and CBT, particularly for individuals after a mental health crisis to promote recovery and prevent a future crisis.

3. Assess points of coordination and collaboration between county behavioral health and other entities (e.g., for veterans and incarcerated individuals at re-entry into the community)

- Stakeholder identified a need for **improved collaborations** with VA medical centers to address the needs of veterans who are not served by the VA, better coordination between custody behavioral health and county behavioral health for incarcerated individuals at re-entry and release, and coordination of referrals between the call center and contracted clinics for non-English speakers.

4. Increase the availability and accessibility of general and specialized housing for homeless and at-risk populations

- **Increase housing availability and funding**
    - o Hire housing specialists; provide interim housing options; provide harm-reduction housing options; continue to assign case managers to homeless adults and older adults (AOA); continued funding for those involved in the criminal justice system.
- **Enhance clarity in housing and staffing roles**
    - o Clarify the definition of affordable housing; clarify the roles of case managers, housing specialists and peer support workers in providing assistance to access housing
- Enhance the **regulation of board and care facilities** (e.g., define maximum length of stay), and ensure support of AOA during transitions between different forms of housing.

5. Improve adult/older adult workforce recruitment, training, and retention

- <u>Expand recruitment to include more peer support workers and others</u>

- o Stakeholders called for more resources for peer support workers (e.g. peer respite programs, mental health community for trainees), and for their increased presence in assisting with mental health related services.
  - o Engagement of retired behavioral health workers.
- Improve workforce competency through more trainings and supervision
  - o Stakeholders called for **improvements in peer competency and skill through trainings**, greater offerings of training in substance use treatment skills for providers, and more clinical supervision for case managers.
- Improve workforce retention through incentives and reduction of staff burnout and stress
  - o Ideas to combat workforce attrition included continuing and expanding financial incentives for students in clinical programs, offering more professional development incentives for non-licensed providers, and reducing workload of staff.

MHSA FORUM & STAKEHOLDER LEADERSHIP COMMITTEE LISTENING SESSIONS

**EXECUTIVE SUMMARIES
BY TOPIC**

PREVENTION AND EARLY INTERVENTION
OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS

Existing Systems are Strong
Stakeholder input about PEI programming in the County of Santa Clara was reflective of a strong system of care informed by values of family involvement, trauma-informed care, an emphasis on culture and diversity, and community outreach. Areas of strength highlighted by stakeholders included:

- A children's behavioral health system with robust partnerships and provision of evidence-based practices throughout childhood in places where children and families reside.
- Community trainings, trauma-informed care, and suicide prevention for transitional-aged youth.
- Elder storytelling, in-home peer respite, and a dedication to refugee programs for older adults.

Suggestions to Improve Existing Systems
Although the quality of existing services is good, stakeholders offered suggestions to improve the existing system of care through:

- Data evaluation systems and funding transparency and accountability.
- Strengthen services through systematizing trauma-informed training and interventions, a greater diversity of intervention offerings post-crisis (particularly individual interventions rather than groups, more options other than WRAP or CBT), more integration of family involvement in TAY services, and more peer and case management offerings.

Some "Fall Through the Cracks"
Stakeholder data also highlighted that even though the current behavioral health system is strong, there are community members in need that "fall through the cracks" and are underserved by the current behavioral health system. These "cracks" may originate from several sources.

1. **The needs of specific populations may be unmet or unreached**. Examples include "working poor" families (no MediCal, but cannot afford copays), homeless RV families, veterans who do not qualify for VA services, or LGBTQ+ older adults. Many of these specific underserved populations were related to language needs and cultural identity.

2. **A need for additional improvements in culturally-responsive approaches** (particularly for adults and older adults).

- Korean and Pacific Islander groups with particularly high suicide rates, refugee and immigrant populations, Latinx children and families, and African American older adults were among those mentioned in need of increased attention.
- Culturally-responsive approaches may include outreach in places where communities spend time (e.g., ethnic media outlets, churches, and homes), increased representation in

county staffing, cultural adaptations of existing programming, or culturally-specific trainings. Examples include addressing the needs of refugees and non-English speakers via greater availability of language-matched providers or cultural brokers in county-contracted community-based organizations, or tailored engagement and prevention services to engage the trust of refugees in a challenging political environment.

3. **A need to address access barriers through innovative outreach and education**.
- Access barriers included mental health stigma across the lifespan, limited awareness about services for children, or system-oriented barriers such as wait times for service connection, and other system barriers (discussed below).
- Solutions proffered by stakeholders included the use of less stigmatizing language (e.g., wellness or behavioral health rather than mental health), greater distribution of an easily accessible list of services, and more psychoeducation trainings.

4. **System-oriented barriers related to gaps in linkages to and continuity of care, and communications and collaborations between care entities.**
- Stakeholders discussed that more connections with other related services (e.g., school-linked services, substance use treatment, law enforcement and Crisis Intervention Trained officers, housing services, custody behavioral health, hospitalization post-release) may increase service linkages for at-risk individuals, particularly during vulnerable times of transition. These connections may also link underserved individuals by meeting them where they reside in the community (e.g., faith communities, ethnic media).
- Improved triage screening and referral systems may also ensure that individuals are connected at points of prevention, before mental health crises or severity increases.

HOMELESSNESS PREVENTION
OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS
Stakeholder comments on the topic of homelessness reflected the complex challenges involved in providing behavioral health services within the context of preventing homelessness. Four trends emerged across data from all focus groups on homelessness:

1. Many stakeholders found it **difficult to understand the system of care** for behavioral health in homeless populations.
- Suggested ideas for improving awareness and understanding of services included: improving the referral system for homelessness prevention, disseminating list of homelessness prevention or intervention services to providers, discussing current homelessness efforts in a newsletter to county network, or offering homelessness services closer to other sources of services.

2. **More overall resources are needed to address the needs of homeless individuals and families.**
- Changes in policy (enhance regulation of board and care facilities) and definitional clarity (e.g., what counts as "permanent" supportive housing, "chronic" homelessness, and "affordable" housing) may be needed to improve services and access.

- Ideas for additional resources included: interim housing options, harm-reduction housing options, continued funding for those involved in the criminal justice system, and additional staffing (case managers, housing specialists, and peer support workers) with clear differentiation of roles.
- An improved data collection / tracking system is needed to determine service efficacy and capture accurate rates of homelessness and needs.

3. **Age-specific approaches are important**.
- For Children and Families, focused effort is needed to identify and engage individuals at-risk for eviction and homelessness, through after-school services, increased school connections, or campaigns to increase awareness of services (e.g., family resource centers).
- For Transitional Aged Youth, there is a need for programs and services directed to their population-specific needs. TAY-specific housing services encompassed TAY-specific housing and emergency shelters and increased lengths of rapid TAY housing to 24 months. TAY-specific programming included assessment tools tailored to TAY, life-skill and vocational services, and greater financial assistance (e.g. universal basic income).
- For Adults and Older Adults, feedback focused on how to achieve clarity and assistance in process of navigating through system of housing options (emergency housing, board and care, supportive housing, permanent housing, low-income housing). The need for more definition in the roles of different staff (housing support specialists, case managers, peer support) through system navigation was discussed.

4. There is a need to **improve engagement of clients in the service system.**
- Culturally-appropriate outreach and awareness is important.
- Reduce client engagement barriers of mistrust and stress, through more trauma-focused training for staff.
- Increase continuity and collaboration within the service system through efforts such as engagement of non-traditional partners, treatment of the entire family and children from birth to 18 years old, or universal release of information forms.

WORKFORCE EDUCATION AND TRAINING
OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS

Stakeholder feedback related to the area of Workforce Education and Training pointed to systemic difficulties in recruiting and retaining a qualified and community-representative behavioral health workforce, particularly with high cost of living in the Bay Area and tuition costs. Suggestions provided ideas to improve the recruitment pipeline, particularly for potential peer, youth, and cultural minority staff, and retain employees through financial incentives and programs to alleviate work-related stress. Additional suggestions for workforce training were also identified.

1. **Recruitment:** Implement **proactive recruitment outreach and programming** targeting youth, peer support or retired workers, and non-English speaking, marginalized, and underrepresented communities.
- Promote **outreach and programming to recruit youth** into the county workforce pipeline.

- o Explore proactive county action to address barriers and <u>engage high school and college students</u> in county behavioral health (e.g., scholarships, stipends, outreach to students of color, outreach at university events).
  - o Assess opportunities to <u>bridge transition periods</u> between graduation and employment, to reach bachelor and masters level graduates before they are diverted from county pathways.
  - o Adapt outreach techniques to reflect greater <u>technology use</u> among TAY (e.g. social media)
- Expand outreach and education to **non-English speaking, marginalized, and underrepresented communities.**
- Expand recruitment to include more **peer support or retired workers.**
  - o Explore incentives to encourage more peer support workers, particularly for the county warm lines.
  - o Outreach to retired workers to fill supervisory and training positions.

2. **Retention Efforts**: Retain existing employees through **incentives and reduction of burnout/stress.**
- Improve county workforce **retention through incentives.**
  - o Housing support for employees.
  - o Financial resources to equalize lower salaries in non-profit organizations compared to county entities.
  - o Continue and expand financial incentives for students in clinical programs.
  - o Offer more professional development incentives for non-licensed providers.
- **Reduce staff burnout and stress**.
  - o Implement and promote worker self-care and mental health programming and training.
  - o Reduce workload of staff.

3. **Training**: Improve workforce competency through more **trainings and supervision.**
- Continue provider trainings that integrate community, consumer, and family perspectives.
- Incorporate management and supervision trainings for clinical supervisors and case managers.
- Integrate more specialized mental health, addictions, and cultural competency worker training.
- More training for peer support workers.

INNOVATIONS
OVERALL EXECUTIVE SUMMARY

The innovations focus groups held at the 2020 MHSA Forum served as a space for creative brainstorming around improvements to the behavioral system with regards to: Prevention and Early Intervention, Homelessness Prevention, and Workforce Education and Training.
- Stakeholders offered innovative ideas for PEI services that **increase consumer engagement and access, improve mental health screening and detection, and provide innovative prevention-oriented services.**

- Ideas for Homelessness Prevention involved innovations in **outreach, advancements in information navigation systems**, a focus on families and justice-involved populations, and enhanced support programming.
- Innovative WET ideas specified ways to improve the behavioral health workforce through **recruitment** (e.g., of teens, peers, families), **trainings** to support consumer recovery, workforce support efforts, and initiatives to **enhance and retain existing staff**. A summary of these ideas is detailed in the Innovations Results portion of this report.

MHSA FORUM & SLC CONCLUSIONS BY BREAKOUT TOPIC (SUMMARY, RESULTS, AND RECOMMENDATIONS)

PREVENTION & EARLY INTERVENTION
CHILDREN AND FAMILIES

EXECUTIVE SUMMARY

Stakeholders confirmed findings from the MHSA needs assessment performed in 2018, suggesting that the children's behavioral health system is robust in its partnerships and provision of evidence-based practices throughout childhood in places where children and families reside. This previous needs assessment acknowledged, however, that its conclusions were drawn from data collected from children that were already service-connected. Thus, the ability to determine the extent to which children were "falling through the cracks" was limited.

Feedback from the MHSA Forum and SLC confirmed that current support for children's services is good and quality of care is high. Stakeholders remarked upon strengths such as flexible services placed in accessible locations, service of refugees and children under the age of six, allocation of funding priorities, and the increase of additional psychiatric beds.

However, stakeholder data also acknowledge that despite these excellent services, there may be children and families that do "fall through the cracks" and are not served by the current behavioral health system. These "cracks" may originate from:

- Unique needs of specific populations, along with a need for culturally-responsive options (e.g., the working poor, homeless RV families, Latinx, immigrants, refugees, language needs).
- Gaps in screening and continuity of care between county systems (gaps in triage screening, need for coordination between school linked services and PEI, collaboration with schools).
- Limited services in schools.
- Access barriers (e.g., stigma, wait times, low awareness about services, unmet daily living needs).

Recommendations included finding ways to decrease clients who may be unserved or "fall through the cracks" of the existing system, such as:

- Innovative outreach efforts (e.g., social media, move clips, mental health specialists in schools, comprehensive psychoeducation).
- Expanding coverage of school-linked services (e.g., beyond school hours, increased school collaborations and staff).
- Increasing accessibility by looking at service linkage points (e.g. greater linkage with Office of Education.
- Examining the cultural responsiveness of access and service system.
- Examining the coverage of funding outreach, prioritization, and planning process to ensure inclusion.

RESULTS
PREVENTION AND EARLY INTERVENTION: FAMILY AND CHILDREN

A total of 28 people provided feedback about PEI services for Family and Children in the County of Santa Clara at the MHSA Forum on January 21, 2020. In addition, some of the responses from the 34 people in the Stakeholder Leadership Committee Planning meeting were also incorporated into these results.

Programming and Services
When discussing changes to the county's services for children and families, the most cited themes were related to **programming** and **services** (N=42).

Client Care Access
Different forms of **challenges in consumers accessing appropriate care** emerged. Some participants mentioned the direct denial of service to families (N=3). A few participants discussed the difficulties of serving children and access to mental health services of individuals belonging to private insurance (N=3). Similarly, another participant noted the denial of services to families of children who have developmental disabilities like autism and recommended more oversight within county agencies before denial of services (N=1).
Systemic barriers also emerged (N=5) including difficulty navigating the referral system to access services in an effective and timely manner (e.g. lack of easily accessible list of services for client referral [N=1], long waiting periods for mental health services [N=1], needing to call multiple entities [N=1]). Other client barriers included consumers' challenges in accessing care due to lack of transportation (N=2) and food and child-care (N=1). Reduction of stigma of mental health in the community was also recommended to encourage client care access (N=2).

Staffing
Many stakeholders also recommended an **overall increase in providers** (N=7), including bilingual staff (e.g. interpreters, clinicians) (N=3), mental health providers and school coordinators (N=5) and substance use specialists on school grounds (N=2). One stakeholder also encouraged more training for providers (N=1).

Culturally-Responsive Care
Taking into account the ethnic diversity in the County of Santa Clara, there is also a great need for more **linguistically appropriate care** (N=5), which often went hand in hand with discussion of the need for more providers in the county, and for more programs focused on serving the refugee population (N= 3). More **trauma-informed training** among providers was also recommended to meet the needs of consumers (N=1). In addition, one stakeholder specifically recommended an increase in the amount of services that are currently being offered for Latinx families (N=1).

Care Triage
A few commenters cited the need for an improved system of mental health problem **screening and detection** (N=3) so that services are "*not just used when the kids are on fire*." A couple of participants (N=2) discussed the need for a better approach to connecting children/adolescents to appropriate systematic care in relation to child/adolescent suicide attempts and the following reintegration to the school and community (N=1). Another participant related this to the effects of the enforcement of Proposition 65 starting January 2020, which requires children and adolescents

to be screened for trauma (N=1). A participant recommended an improved system of referrals across treatment centers in general (N=1).

Service and Resource Awareness
Stakeholders also expressed a wish for more **clarity and awareness** of all services and resources offered in the county, especially for youth and families (N=4). One stakeholder recommended that school districts should be provided with information that directly relates to schools, school-aged youth, and families (N=1).

Other Support Services
Attention to **general daily living support services** was also recommended (N=5), including housing, child-care, transportation (e.g. to mental health services) and food assistance. These services would directly support the "working poor" population, which a stakeholder explained as those who do not qualify for Medi-Cal and experience other financial challenges, such as deciding between purchasing food or meeting medical copay costs (N=1). Stakeholders also recommended more wellness or access centers (N=2).

Structural Changes
When discussing changes to the county's services for children and families, the second most cited themes were related to structural changes (N=17).

Funding
Stakeholders had a number of recommendations related to funding (N=9), including publicizing MHSA grant opportunities more (N=2), removing funding silos (N=1), and leveraging existing resources rather than cutting funds (N=1). Stakeholders also discussed how there is a potentially problematic relationship between MHSA prevention and early intervention funds and school link services (SLS), in that there is a lack of clarity and potential overlap in the two (N=1). Another stakeholder stated that what SLS pays for is not practical and that sometimes funds are returned (N=1). Within the school system, since schools are reportedly required to notify parents twice a year about services, MHSA funds can be used to support this process more (N=1). A stakeholder also recommended the removal of the "inequitable distribution" of MHSA funds to address more youth in the county that need additional support (N=1). Supporting a process to bill Medi-Cal as a requirement to receive funding was also recommended as an idea (N=1).

Other Structural Changes
In other structural change feedback, two main themes emerged. Stakeholders asked for **more prevention and early intervention coverage** (N=4), including tending more to gap areas like South County (N=2) and Mid-County (N=1) and **more coverage across all schools** rather than just parts of the school districts (N=1). To add on, one stakeholder also noted the lack of equity of having planning meetings most frequently in San Jose, which may "omit the voices of those who need additional support" in other areas (N=1). Secondly, the responsibility of the Santa Clara County Office of Education (SCCOE) was also discussed and a stakeholder encouraged that the SCCOE is appropriately supporting school districts, since it acts as the conduit of districts (N=1). Another stakeholder recommended the positioning of a direct liaison between the County of Santa Clara Behavioral Health Services Department and SCCOE to coordinate school services (N=1).

Psychoeducation & Outreach

Psychoeducation

Another prominent theme that emerged was a need for **more psychoeducation programs** (e.g. for parents, teachers, medical professionals, and outreach programs) to train community members to recognize mental health issues among children and families (N=4). To encourage this, recommendations included financial incentives to encourage providers to attend trainings (N=1).

Outreach

Similarly, **more outreach efforts** (N=4) should also be considered, including the creation and dissemination of more educational entertainment focused on mental health (e.g. movies, documentaries, media) (N=2), and the presence of mental health agencies at school events or on school grounds (e.g. NAMI) (N=2).

School Linked Services

Another prominent theme was the flexibility of school linked services (SLS) (N= 5), particularly **expansion of hours coverage** to include after school, holidays, weekend, (N=2) and coverage across more schools (N=2). As one participant commented, "*The child may be getting services at school, but after 3pm, parents are working, there are long commutes, and we find out staff are struggling to support the kids and connecting them to services after school.*"

What should stay the same?

In discussion of programs and services for children and families that should remain the same, there were 7 distinct responses from stakeholders. A couple of participants stated that support for mental health services overall, its high standard of care (N= 2) and funding priorities for MHSA should stay the same (N=1). Flexibility of bringing services to families and children in accessible locations (N= 1), services for children under the age of six (N=1), existing refugee programs (N=1) were also praised. Participants also discussed the new psychiatric building in the County of Santa Clara and appreciated new additional beds it offered (N=1).

What should be removed?

Two stakeholders commented broadly on the **county system and approach.** One participant believed that the county's "focus on productivity" should be removed as it causes the agencies to focus more on "making the marks" at the sacrifice of providing holistic care to clients (N=1). Another client asked for the removal of "the red tape and bureaucracy" (N=1).

RECOMMENDATIONS
PREVENTION AND EARLY INTERVENTION: FAMILY AND CHILDREN

1. **Examine areas where client care can be made more accessible through the county system**
   Examples: Assist consumers with private insurance, reduce wait time for services, better triage and referral system, increase staffing, ensure cultural-responsiveness in care across agencies.
2. **Examine ways to increase accessibility of services by tending to individual client barriers**

Examples: Stigma reduction through more trainings, provide housing, child-care, transportation, and food assistance to consumers in need in order to seek mental health services.

3. **Increase community awareness of mental health issues through psychoeducation programs**

   Examples: Psychoeducation trainings for parents, teachers, medical professionals; financial incentives to encourage providers to attend trainings.

4. **More creative and interesting outreach efforts**

   Examples: Promoting psychoeducational shows or social media accounts for youth

5. **School services: Expand coverage and staffing of school-based services and attend to gaps in collaboration with schools**

   Examples: Expand hours of coverage to include after school, holidays, weekends; invite mental health agencies to school events; increase staffing in schools; improve coordination between school linked services and PEI; improve collaboration with schools and SCCOE.

PREVENTION & EARLY INTERVENTION
TRANSITIONAL AGE YOUTH

EXECUTIVE SUMMARY

Feedback from the MHSA Forum and SLC on PEI services for transitional age youth received high praise for the county's leading efforts in suicide prevention and trauma-informed care and its inclusivity of the community and consideration of the multidimensionality of TAY needs. In particular, stakeholders emphasized the necessity and positive impact of involving community members in these PEI efforts, particularly through gatekeeper trainings, and through other means like communicating through routine newsletters. Stakeholders appreciated the variety of services available to the county, including the Mobile Crisis Hotline, Institute for Local Government, culturally-responsive services across the lifespan, and easily accessible self-referral process for services.

Stakeholders agreed that while current existing services are very impactful, a number of challenges in providing comprehensive services to the TAY population emerged, including:

- **Gaps in collaboration and communication** between service providers (e.g. mental health services and substance use treatment, with law enforcement, colleges, and faith-based groups).
- **Gaps in continuity of care and care triage** (e.g. transition from incarceration or hospital into community).
- Need for **more systems of tracking, data collection, and use of outcome measures** to ensure quality of care and efficacy of services.
- Need for **integration of family members** into youth care (e.g. working with HIPAA regulations, supporting needs of family members of TAY consumers).
- Needs of **youth outside of school system** (e.g. incarceration, employment).
- **Gaps in daily living services** (e.g. housing, substance use, employment).

Potential Solutions
- Improvement of service connection (e.g. more providers and community members working with TAY equipped as service connectors, easier service navigation).
- Increase outreach efforts (e.g. increase number of requests for proposals, reduce stigma with trainings and careful language use).
- Implementing trauma-informed care at system level and individual provider level (e.g. mandatory trainings for all providers working with TAY).
- Increase service awareness throughout county (e.g. among providers, consumers, families).
- Greater transparency and accountability in funding.

RESULTS
PREVENTION AND EARLY INTERVENTION: TRANSITIONAL AGE YOUTH

A total of 22 people provided feedback about PEI services for Transitional Age Youth (TAY) in the County of Santa Clara at the MHSA Forum on January 21, 2020. In addition, some of the responses from the 34 people in the Stakeholder Leadership Committee Planning meeting were also incorporated into these results.

Structural Changes

The most commonly cited topics discussed for changes or additions among prevention and early intervention among transitional age youth were related to structural changes.

System Integration
Many comments related to system integration described a need for **more communication and collaboration** across agencies, programs, services, providers, etc. (N=11) to **ensure continuity of appropriate and necessary care and triage** to reduce risk of clients "falling through the cracks" and unnecessary repetition in services. In regard to continuity of care, the process of a consumer's transition out of the hospital and back into the community should be examined and improved (N=2). One stakeholder also commented that when individuals are identified as having mental health problems that they need to be appropriately referred to psychiatric services rather than jail (N=1). Stakeholders recommended more connections between mental health services and substance use treatment (N=3), mental health services and law enforcement, hospital and crisis housing/services, faith-based groups, colleges and prevention and early intervention efforts, family and care providers, and between providers.

Funding Transparency & Accountability
Stakeholders mentioned **greater transparency and accountability** of county funding and budgeting across agencies and systems (N=6). Stakeholders reported lack of clarity of sources of funding and how money is spent or not spent.

Program Outcomes & Data
Stakeholders (N=6) called for **more systems of tracking, data collection, and use of outcome measures** to determine whether programs are meeting community needs and upholding standards of care, the efficacy of county prevention efforts, presence of collaboration and communication between agencies, and clinician training compliance and quality. One stakeholder commented on the importance of determining how to **increase the sustainability of programs** through data so that the programs are "not just at the whim of legislators" (N=1). In addition, there was a call to re-examine the measures (e.g. screeners) currently being used for triage and to determine whether these measures are assessing appropriate, desired targets of interest (e.g. child trauma) (N=2).

Family Integration
The need for **greater involvement of family into youth's care** was commonly cited among stakeholders. A few participants discussed the challenge of parents and other family members being systematically and legally "locked out" of youth's care due to the legal age cut-off and HIPAA regulations. Greater integration of family into youth care was encouraged through case management, "intergenerational opportunities", more parent education on TAY issues, and communication with providers. One stakeholder also noted the need to also address the mental health needs of parents of children who have mental health challenges (N=1).

Community/Consumer Involvement
Greater involvement of **community and consumer input** on structural, systemic changes, programs, services, and in assisting in connecting potential consumers to county services was encouraged (N=4). A stakeholder specifically called for the creation of a system to encourage routine input from community and consumers for programmatic and service changes (N=1).

General Services & Other
Other comments related to structural changes included general strengthening of the county's capacity to execute **prevention and early intervention** efforts (N=1) and to create a system to improve consumer (potential and current) and provider **navigation of services** being offered in the county (N=1). One stakeholder commented that the number of requests for proposals (RFPs) have been reduced and efforts should be made to increase the numbers again (N=1). Another stakeholder discussed how "*lots of contractors are being changed, which is impacting families and children*" (N=1).

Outreach & Education
Trauma-Informed Care
The county's current efforts of **integrating trauma-informed care into their services and programs** were praised and also encouraged to continue to develop at the system level and individual provider level (N=7). Specifically, stakeholders called for more **trauma-informed training for providers**, especially clinicians (N=4). DBT training was recommended as a trauma-focused treatment option (N=1) and a stakeholder commented on the importance of enforcing mandatory trauma-informed training among clinicians and other providers (N=1). Stakeholders emphasized the importance of trauma-informed treatment across whole care systems (N=2), especially in the foster care system (N=1). One stakeholder mentioned a need for more psychoeducational information on trauma care to be made available to families (N=1).

Training
Stakeholders cited the importance of **training for providers** (N=7). Overlapping with the trauma-informed care section above, stakeholders encourage more trauma-informed training among providers. In addition, training of best practices among practitioners should also be offered (N=1), as well DBT training (N=1), and mental health training among police officers (N=1) and primary care physicians (N=1). Training for clinicians should then be tracked (N=1) and enforced(N=1).

Culture & Stigma
Stakeholders called for the need to **address and change the culture encouraging mental health stigma** (N=4), particularly through language (N=3). One stakeholder generally commented on the need to pay attention to how mental illness and service are talked about and another brought up the idea of changing "mental health" to "wellness" or "behavioral health" to reduce the stigma (N=1). Another discussed the necessity of considering cultural context in the use of the term "peer." Given by the stakeholder, an example of this would be that the LGBTQ+ community finds "significance and trust in the term 'peer'," – however, other unspecified cultural groups may be more uncomfortable with this term. In addition, the stakeholder explained that the use of "peer" often implies that they are "less than other providers," and suggested that "outreach" may be a more appropriate substitute. One stakeholder also commented on challenges that veterans experience in job opportunities and seeking services due to community mental health stigma (N=1). A stakeholder also reminded the group that youth outside of school systems also need to be remembered, especially for concerns such as homelessness, human trafficking, transition from incarceration or to workforce, and immigrant youth (N=1).

Service Awareness

A couple of stakeholders commented that there should be more **education and outreach** to families about existing TAY services (N=2). One of these stakeholders commented that *despite working with young adults for six years, she did not know about the currently existing TAY service*. One stakeholder recommended creating an easily accessible reference list of services for clients and families (N=1).

Programmatic & Interventions

Staffing

Stakeholders asked for **more peer support** staff, expansion of peer support programs, and increased community awareness and access to peer staff and groups (N=5). In addition, stakeholders also asked for more **case management staff and services**, as well as liaisons in the community (N=4). One stakeholder suggested "*train them better, give them smaller caseloads, and pay them higher salaries to alleviate turn-over*" (N=1). Stakeholders also asked for more staffing among clinicians (N=1) and crisis intervention trained (CIT) officers (N=1). One stakeholder provided written comment simply stating, "someone to listen and connect" (N=1).

Centers & Programs

Stakeholders appreciated programs and centers like the Bill Wilson Center (N=1) and asked for more locations, programs, and providers like it beyond San Jose (N=1). Stakeholders asked for more **wellness centers** particularly in South County (N=2) and East County (N=1). In addition, more cultural wellness centers to address other cultural populations is recommended (N=1). Other recommended programs include **substance withdrawal programs for youth** who want to gradually transition off medications (e.g. ADHD medications) (N=1), stress management/social-emotional learning/resiliency programs (N=1), and programs that support workforce development (N=1).

Housing

Stakeholders called for TAY emergency shelters "*that preserves dignity and ensures wellbeing*" that **help link TAY to long-term sustainable housing and mental health services** (N=1). Another stakeholder asked generally for more long-term supportive housing for TAY to prevent trauma (N=1). Another stakeholder commented "*respite programs are not actual shelters*" (N=1).

General & Other

Other general comments by stakeholders included the suggestion for more **flexibility and availability** in services available (N=2). One stakeholder stated that "*services are not getting to the root of the issues*" (N=1) and another believed that "*programming is too prescriptive,*" which may act as a challenge to providing best practices for specific communities. One stakeholder specifically asked for commercial insurance of the Raising Early Awareness and Creating Hope (REACH) program, which serves TAY at risk of mental health problems (N=1).

What should stay the same?
Programmatic & Interventions
Community Involvement & Gatekeeper Trainings

The gatekeeper trainings and other ways of involving the community for care connection were highly praised (N=6). Stakeholders appreciated the trainings' education on mental health issues and stigma reduction among non-providers. One stakeholder commented, "*it gave me the language*

to help others in my community." ASIST was individually commended, and online trainings were individually identified as beneficial trainings as "*anyone can take them to help alleviate fears around mental health and suicide.*" Other services involving the community that were praised included newsletters to the county network (N=1) and the availability and ease in accessing the self-referral process for services (N=1).

Trauma-Informed Care
Current efforts in integrating trauma-informed care into the county's programs and services was encouraged to continue and to expand. One stakeholder stated, "*the fact that Santa Clara County leads trauma-informed care makes me feel more comfortable.*" Trauma-focused cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) treatments were cited as effective clinical treatments for trauma.

Suicide Prevention
Two stakeholders mentioned suicide prevention related efforts (N=2). One stakeholder praised the county for being leader for "*prioritizing suicide prevention even though it's not mandatory*" and that the county is "*not just doing the bare minimum*" (N=1). The Mental Health Mobile Crisis Hotline was also commended.

General & Other Services
Stakeholders also commented some of the services and programs that should continue in the county, including the strong variety of services available (N=1), the Institute for Local Government (N=1), and drop-in centers (N=1).

Culture & Diversity
Cultural responsiveness in services and programs across the lifespan (N=1) and multigenerational cultural wellness centers (N=1) were identified as a strength and encouraged to continue.

What should be removed?
One stakeholder commented that "roadblocks" should be removed (N=1) and another asked for the **removal of funding silos** (N=1).

RECOMMENDATIONS
PREVENTION AND EARLY INTERVENTION: TRANSITIONAL AGE YOUTH

Service Connectivity and Collaboration
1. **Increase system integration and collaboration and communication between programs and appropriate care providers with special attention to services most relevant to transitional age youth (e.g. foster care system, case management, housing, employment, mental health services).**
   Examples: Transition from hospital or psychiatric inpatient back into schools or community, appropriate referral to psychiatric services instead of arrest, connection between mental health services and substance use treatment, determine ways to integrate family members into youth care
2. **Increase staffing in providers and community connectors to services.**
   Examples: More peer support, clinicians, case managers, CIT officers

Structural Improvements

3. **Increase funding and budgeting transparency.**

    <u>Examples:</u> Make funding and budgeting reports more publicly available or easily accessible; Increase Requests for Proposals (RFPs) to increase TAY programming

4. **Create more systems for evaluating program outcomes, data collection and tracking to determine efficacy, compliance, and encourage inclusion of community/consumer input.**

    <u>Examples:</u> Gathering community and consumer input routinely through data, determine whether current measures appropriately measuring targets of interest, assessing and tracking presence of collaboration and communication between agencies, evaluating for mandatory training compliance

Programming

5. **Increase outreach efforts and psychoeducation through more trauma-informed care, community and provider trainings and service awareness.**

    <u>Examples:</u> Providing more gatekeeper trainings to community members to reduce stigma, integrate trauma-informed care into provider trainings, disseminate more information on TAY services to community and providers

6. **Develop more wellness centers and programs that address specific TAY needs.**

    <u>Examples:</u> More wellness centers, substance withdrawal programs, work development programs, more transitional housing support

PREVENTION & EARLY INTERVENTION
ADULTS AND OLDER ADULTS

EXECUTIVE SUMMARY

Feedback from the MHSA Forum and SLC suggested that efforts in prevention and early intervention for adults and older adults include some strong programs that are encouraged to persist and expand. In particular, elder storytelling was identified as a powerful and culturally-appropriate intervention that should be kept. Stakeholders confirmed that the county is doing well in other areas such as servicing refugees, offering in-home peer respite programs, and offering Full-Service Partnership eligibility.

With regard to gaps, stakeholders agreed that there is a high need to **tailor outreach and services to specific cultural groups** that are particularly vulnerable and may not be receiving enough care, including:

- Refugees (who may be dropping out of services because of recent political challenges)
- Non-English speakers (who may not have sufficient language-matched providers or cultural brokers to be connected for services)
- Specific ethnic groups (e.g. Korean communities, Pacific Islander groups, African Americans)
- Other cultural populations: LGBTQ+ older adults, veterans, developmentally disabled older adults, older adults in general (especially isolated elderly)
- Other populations: homeless, incarcerated with serious mental illness, adult mothers

Recommendations to improve care for these cultural and especially vulnerable groups:

- Structural changes to **keep clients within system of care** (e.g. greater collaboration and communication between call centers and agencies to facilitate referral of services, extend 18-month time limit definition of PEI-qualifying services; improve collaboration with Veteran Affairs, improve transition from incarceration back into community)
- More **culturally-relevant, targeted approach to outreach and programming** (e.g., outreach through ethnic media outlets, churches, homes; increase representation of county staffing, cultural adaptions of existing programs, culturally-specific trainings; separation of programming for younger versus older elderly)

Other recommendations were made that do not specifically address cultural needs, including:

- Expand **mental health awareness and training** (e.g. more training and education around mental health awareness
- Identification for **helper groups** such as primary care or caregivers of older adults, standalone older adult division)
- Broader offering of **post-crisis intervention** (tertiary prevention) options that promote recovery and prevent relapse (e.g. Cultural Communities Wellness Program, WRAP group, more individual treatment).

RESULTS

PREVENTION AND EARLY INTERVENTION: ADULTS AND OLDER ADULTS

A total of 22 people provided feedback about PEI services for Adults and Older Adults (AOA) in the County of Santa Clara at the MHSA Forum on January 21, 2020. In addition, some of the

responses from the 34 people in the Stakeholder Leadership Committee Planning meeting were also incorporated into these results.

Cultural and Diversity-Related Needs

General Strategies

Increased **attention to culture and diversity** needs emerged as the most cited category of need. Four stakeholders discussed that non-English languages may not be available for ethnically and language-diverse clients seeking to get connected with services when referred by the call center, particularly in the community-based organizations. These **language-matched staff** (e.g., providers, cultural brokers) are needed to quickly find appropriate services for non-English speakers.

Several stakeholders (N=3) noted that ethnic minority communities who are not being currently served should be reached through their own community organizations (e.g., churches) or through ethnic newspapers and radios. One specific idea for **reaching ethnic communities "where they are"** involved adapting elder storytelling for African American and other ethnic minority communities in their homes, at senior food banks, and other community settings.

Specific Populations

Stakeholders also identified the needs of **specific communities**, including LGBTQ+ older adults, veterans, Korean communities, Pacific Islander groups, refugees, veterans, and African Americans. For example, one stakeholder highlighted insufficient attention in county PEI services for LGBTQ+ older adults (N=1), and two others reported a need for more training related to transgender populations starting from high school all the way to seniors (N=2). Additionally, because of notably high suicide rates for Pacific Islander and Korean populations in Santa Clara, one participant suggested more staffing representation for these two particular ethnic subgroups (N=1). Four stakeholders also discussed the need for **attention for veterans** within the county, particularly given that not all veterans qualify for VA services or receive the comprehensive services that they may need (N=4). Finally, two stakeholders drew attention to the need for improvements in the ways that refugees are served in the county, to counteract high service dropout because of recent political challenges (N=2).

Structural Changes

Structural changes were the second most cited category of need in PEI Adult and Older Adult Services, and encompasses three themes of policy and structural changes, staffing, and coordination and collaboration.

Policy and Structural Changes

Stakeholders mentioned the need for several larger-scale policy and structural changes. For instance, one stakeholder mentioned the need for a **standalone older adult division**, with a first step involving an assessment of the funding needed for such an initiative (N=1). Such an assessment might involve an innovations grant examining older adult mental health statistics in the county and the associated need for programming focusing on older adult mental health. Two other stakeholders discussed that, because of increased challenges involved in **engaging and building trust with refugee communities**, the 18-month time limit definition of PEI-qualifying services (i.e., 18 months prior to onset of mental illness) should be extended for refugees (N=2).

Staffing

Staffing needs were also mentioned for PEI adult and older adult services. Four stakeholders mentioned the need for **language-matched** staff (e.g., providers, cultural brokers) in community-based organization (N=4). Additionally, a stakeholder commented that LGBTQ+ representation for the Cultural Communities Wellness Program (CCWP) is currently contracted out to Caminar, and that the needs of LGBTQ+ older adults might be better served by bringing funding back internally to the CCWP group for LGBTQ+ representation (N=1). Korean and Pacific Islander representation in staffing across the system, and specifically on CCWP, was also mentioned as a specific need, particularly given the high rates of suicide in these two subgroups. One stakeholder suggested the addition of a **dedicated Wellness Recovery and Action Planning** (WRAP) coordinator to increase offering of WRAP groups throughout the behavioral health system (N=1).

Coordination and Collaboration

Finally, structural additions were identified in the area of potential collaborations and coordination. For example, stakeholders (N=4) called for **better coordination between call centers and county-funded community-based organizations around the referral of services** for non-English speaking clients. One stakeholder noted the need for more collaborations with VA centers to better serve the needs of veteran in the community and another encouraged greater communication between the government and county (N=1). Another person identified a need to focus more incarcerated individuals with serious mental illness through **coordination between custody behavioral health and county behavioral health** during periods of re-entry or release from jails (N=1). Similarly, another stakeholder noted the importance of generally ensuring smooth transition from care providers and systems (N=1).

Education and Outreach

Education and Training

Stakeholders identified outreach, education, and awareness as the third most cited area of need. With regards to training and education, participants mentioned the need for **more awareness about mental health warning signs and resource navigation** among older adults (N=2). For example, one stakeholder spoke about the difficulties they experienced in connecting their 89-year old mother with services, as an illustration of the need for improvements in education and outreach about navigating resources for elderly (particularly elderly who are isolated or do not have family caregivers).

Education was emphasized as a need for incarcerated individuals with serious mental illness who are often unaware of their mental health issues (N=1). Additionally, several helper groups (e.g., primary care providers, and families and caregivers for older adults) may benefit from **increased training and education about mental health** (or dementia) warning signs, in order to better support adults and older adults in need (N=2).

Education Topics

Topic suggestions for education efforts extended beyond mental health awareness, to specific topics such as more **trauma-informed training** (N=1) and the differential needs of younger versus middle versus older elderly groups (N=1).

Outreach

Stakeholders identified the need for **outreach directly to specific communities in need** (i.e. to engage them in services or provider more mental health education), encompassing the homeless (N=1) and underserved ethnic communities (N=1). Two stakeholders identified the need for improved outreach to refugees who are recently more likely to drop out of services because of fears and a challenging political environment (N=2).

Programming and Interventions

Several suggestions for additional programming or interventions were provided. The most frequently mentioned theme for **expansion of services were related to housing**, though the details of these additions and changes were not specified clearly. One stakeholder mentioned the need for more programming addressing the **needs of LGBTQ+ older adults**, noting that there is a dearth of such existing efforts (N=1). Other ideas included **more services for developmentally disabled elderly adults** that treat them in an age-appropriate manner, training in life management skills (e.g. budgeting, cooking), volunteer programs, and programs to support adult mothers.

The most frequently mentioned theme within this category of programming and interventions was the need for changes in **interventions offered to individuals after a mental health crisis**, in order to promote recovery and prevent a future mental health crisis. For example, 3 stakeholders reported a need for more group options post-crisis other than Wellness Recovery and Action Planning (WRAP, a consumer-led self-help group) (N=3). This idea was countered by one stakeholder who felt that more WRAP offerings and referrals are needed to serve more clients in need (N=1). One other focus group member echoed the call for more diversity in interventions, beyond cognitive behavioral therapy (CBT) as a main therapy modality (N=1). Stakeholders also discussed the need for more individual 1-on-1 interventions, particularly for adults between 40 and 60 (N=3). At the same time, another stakeholder also encouraged more psychiatric group treatment (N=1).

What should stay the same?

Stakeholders identified four existing county programs that are meeting community needs and should stay the same / be continued. First, **elder storytelling** was highlighted as important to continue, particularly because narrative therapy is culturally appropriate for older adults. In support of this idea, one participant mentioned that digital stories have been rated as the most powerful element of the Learning Partnership's efforts in digital storytelling programs (N=1). Second, two stakeholders mentioned the importance of keeping (and expanding resources to) **refugee programs** (which also include asylum seekers across the age range), particularly given the high stigma and dropout (and low engagement) of this community (N=2). Third, one stakeholder mentioned that the older adult **in-home peer respite program** was a good program that should stay the same (N=1). And lastly, Full Service Partnership (FSP) eligibility, which can include hospitalization, outpatient services, and housing flexibility funds, should stay the same.

What should be removed?

One stakeholder provided a written comment that services that have the lowest utilization should be removed (unless they are the least accessed because they are unknown) (N=1). No specifics were mentioned regarding an approach to assess this level of utilization.

RECOMMENDATIONS

PREVENTION AND EARLY INTERVENTION: ADULTS AND OLDER ADULTS

1. **Increase outreach and education to culturally diverse and underserved adult and older adult communities.**
   <u>Examples:</u> Improve engagement of refugees and non-English speakers; resource navigation for older adults; use ethnic media sources; meet communities where they reside

2. **Focus and tailor staffing and programming towards the needs of cultural and diverse adult and older adult communities.**
   <u>Examples:</u> Language-matched providers and cultural brokers in community-based organizations; Pacific Islander, Korean, LGBTQ+ representation (e.g., on CCWP); Programming for mothers and LGBTQ+ older adults

3. **Consider the need for a broader offering of post-crisis intervention (tertiary prevention) options that promote recovery and prevent relapse.**
   <u>Examples:</u> More individual interventions, more offerings of WRAP, groups other than WRAP, modalities other than CBT

4. **Assess points of coordination and collaboration between county behavioral health and other entities.**
   <u>Examples:</u> VA medical centers, coordination with contracted non-English speaking clinics, custody behavioral health

HOMELESSNESS PREVENTION
CHIDREN AND FAMILIES

EXECUTIVE SUMMARY

Stakeholders in the MHSA Forum and SLC agreed that one of the greatest strengths in the county's homelessness prevention services for children and families is the work performed by school coordinators stationed in some of the SCC schools. Overall discussions between stakeholders on were primarily focused on the c**hallenges of limited resources and limited connection of care entities**, as well as the heavy stress falling on the shoulders of both consumers and providers. As one stakeholder stated, "*homelessness itself is traumatizing*," and so integration of trauma-informed care throughout the system services and programs is important. To promote client access to quality care, the following recommendations and topics were discussed:

Clarification and Definitions

In both the forum and SLC, stakeholders had many clarification questions on existing homeless prevention efforts in the county, which demonstrated a need for county-wide service awareness and clarification for provider and consumer alike. In that same vein, participants discussed that the term "homelessness" and other related terms like "permanent housing" should be redefined in order to properly identify and serve more consumers in need.

Removing Barriers

Families who are homeless or at-risk experience a myriad of stressors that prevent service seeking and access, including mistrust of system-based care, and fear stemming from the current political climate. Recommendations to address these barriers included:

- More **empathetic, trauma-informed care** from providers and throughout the system (with a focus on providers who have direct consumer contact and opportunities to increase trust and service connection).
- Greater **collaboration and transfer of care between provider entities** (e.g. creation of a universal release of information form in compliance with HIPAA, services following children from birth to 18 years-old).

Improving Existing Services and Programs

Stakeholders identified multiple contexts where improvement of homelessness prevention services could occur:

- Schools – Increase **school services and resources** so that schools can help homeless or at-risk families by supporting the children and acting as service connectors (e.g. more afterschool programming and school service connectors).
- Housing – More involvement of **case management with housing services** (e.g. case management communication with housing management to de-escalate problems.
- Providers/staff – Staff stress could be alleviated through an **increase in staffing and resources** to ensure quality and compassionate care.
- Centering Resources – Centering resources for various services in closer proximity, **treating the whole family rather than individual members separately**.
- Policy.

Program Outcomes and Data

Stakeholders discussed that **data tracking** is especially important for the homeless population since the number of people in need is so difficult to measure (e.g. mistrust towards system-level care, individuals in hiding), yet very necessary in order to properly provide enough care and quality service for this group. Recommendations for change included:

- Assessment of efficacy of current services.
- Tracking whether agencies are integrating trauma-informed care into their approach.
- Hiring more staff to increase data work.

RESULTS
HOMELESSNESS PREVENTION: CHILDREN AND FAMILIES
A total of 13 people provided feedback about homelessness prevention services for families and children in the County of Santa Clara at the MHSA Forum on January 21, 2020.

What should be added?
Programming & Interventions
The most commonly mentioned topics on homelessness prevention services for families and children were related to programming and interventions.

Service Awareness
At the beginning of this breakout session, stakeholders had many clarification questions on existing homeless prevention efforts in the county, which demonstrated a **need for county-wide service awareness and clarification.** Other feedback that emerged from this group also included the need for services to also be made more visible to families (N=1) and the creation of a referral system to ensure appropriate triage of clients at risk of homelessness (N=1).

School Resources
Stakeholders encouraged an overall increase in school resources to serve families and children (N=8), particularly in **afterschool resources** (N=4) and more **school liaisons or cross-agency connections** that link mental health services and other services (e.g. food access, childcare for parents, etc.) (N=4). Afterschool services were encouraged to be linked to regular school services for more comprehensive care of its students (N=2). Stakeholders also believed that it would be beneficial if more community members and school staff could be trained to act as connectors for services in schools as a form of eviction prevention (N=1), especially since signs of risk of homelessness and discussions of need often emerge from classrooms and during afterschool programs and during lunch. Free lunches in schools were also noted as a form of homelessness prevention (N=1).

Housing Services
Four stakeholders commented on housing services and related case management (N=4). A couple of stakeholders believed that new housing units in the county described as "affordable housing" does not address the homeless population's need (N=2). **Greater case management** was called for as a way to support housing issues (N=2). For example, increasing case management support **and communication between case managers and landlords** would encourage a decrease in landlords calling law enforcement on clients (N=1). One stakeholder discussed the challenges of veterans remaining housed, especially if they have PTSD (N=1). The stakeholder stated, "*Veterans are on temporary housing. The problem is that after two years, they are on their own. Going from*

one agency to another, the way they follow-up with their clients is very different. For example, there is an apartment complex that is changing hands in management. The people who live there are very stressed out." The stakeholder believes that if case management followed the client or veteran through such changes, this would be beneficial for ensuring uninterrupted care of its clients.

Family Integration
One stakeholder encouraged more efforts in **integrating efforts in care for the whole family rather than focusing only one individual family members** (N=1). Another stakeholder requested that the county determine how to expand Medi-Cal benefits to cover the whole family (N=1).

Provider Competency
Two stakeholders called for better provider **competency** (N=2), particularly in cultural-responsiveness (N=1) and empathy (N=1).

Care Access
In order to encourage care access for families, a stakeholder recommended **placing resources closer together** for more warm handoffs (N=1) and another stakeholder suggested building more family resource centers (N=1).

Other
Other recommendations by stakeholders included placing more effort into policy to enact greater levels of change (N=1) and generally "more community" (not further specified) (N=1).

Program Outcomes & Data
Six stakeholders had recommendations on either **creating or expanding systems of evaluating program outcomes** or data collection and tracking (N=6). Specifically, data should be collected and evaluated to determine efficacy and outcomes of programs and services (which would affect funding) (N=1), to ensure agencies are implementing trauma-informed care (N=1) and to get accurate rates of homelessness (N=2). One stakeholder explained, "*This point in time might show one snapshot of the homelessness, but it's not necessarily accurate. There are people who are in hiding and others that are not accounted for that makes numbers look low.*" In order to meet the demands of implementing more data work, a couple of stakeholders also recommended hiring more staff to evaluate program outcomes and collect data (N=2). One stakeholder recommended the implementation of anti-displacement work group report (N=1).

System Integration
Four stakeholders made recommendations regarding system integration (N=4). System integration can be encouraged through collaboration across agencies, programs, services, providers, etc. In particular, **increasing collaborations** with "non-traditional partners in resources" was mentioned (N=2). Another suggestion was to provide schooling services before kindergarten and/or services that follow the children from birth to when they are 18 years-old (N=1). One stakeholder encouraged the exploration of creating a universal county release of information (ROI) form to **increase efficiency and ease of communication between agencies for coordinating client care**.

The stakeholder suggested that to avoid violating HIPAA, the ROI might specify "for living services" rather than "for mental health services."

What should be removed?
Stakeholders noted a number of challenges to families and children accessing care and in the county's ability to provide optimal quality care (N=15).

Clients' Barriers to Care Access
Client Mistrust
Stakeholders mentioned **mistrust of institutions, agencies, and system-based care** as a barrier to accessing care and services among potential consumers at risk of homelessness or are already homeless (N=5). **Building trust in system-based care through attentive, empathetic, trauma-informed care** through individual provider interactions and communication in the community was encouraged. In particular, mistrust of school-based services was commented on and efforts to increase trust of providers was encouraged, including through afterschool programs (N=2).

Client Stress
Stakeholders also discussed how **client stress causes difficulty in accessing care and services among consumers at risk of homelessness or are homeless** (N= 4). One stakeholder explained that the current political climate regarding immigration has caused fear among community members and prevents them from seeking services (N=1). Another stakeholder discussed how mental health problems can make the challenges of homelessness even more overwhelming (e.g. veterans with PTSD having problems with housing) (N=1). A stakeholder also stated, "*homelessness itself can be traumatizing and prevent clients from seeking assistance.*"

Staff Stress
Stakeholders also mentioned how county staff are stressed due to lack of adequate resources and staffing to meet client needs and demand (N=1).

What should stay the same?
School Resources
School resources were listed as strengths that should be continued. In particular, **school coordinators** were praised for their work in schools throughout the county (N=2). The Universal Access Program (UAP) was also commended for currently being piloted for providing schooling services before kindergarten (N=1).

Programming & Interventions
Various program and intervention related items were mentioned as strengths by stakeholders. One stakeholder praised the county's "mental health stability and rent stability" and added that "*MHSA is well-positioned to bring this data to 15 cities to board of supervisors and lead the county to the policy that will have a positive impact*" (N=1). Another stakeholder praised how MHSA **worked together through grassroots** in Milpitas, especially by assisting with data (N=1). One stakeholder discussed a strength of Bill Wilson Center's method of measuring program outcomes and efficacy by being mindful of waiting six months after a homelessness intervention was performed to evaluate student performance and wellbeing (N=1). This waiting period is important in outcome evaluation because significant change in homelessness prevention or intervention can take months.

The center's case management in tracking student daily school attendance was also praised. One stakeholder also commended existing family resource centers (N=1).

What should be changed?
Multiple stakeholders discussed the need to **redefine terms related to homelessness and housing** (N=3). At the beginning of the forum during the full breakout session, a number of stakeholders also needed **clarification of definitions**, thereby demonstrating a strong need to address this issue. Specifically, one stakeholder recommended the removal of the term "permanent housing" and another explained "*permanent support housing really means supportive housing for a certain amount of time before you transition to actual permanent housing*" (N=1). Another stakeholder noted that it is important to define what "chronic homelessness" entails, as some youth may not be receiving services because the current definition neglects some common youth homelessness experiences (e.g. couch surfing) (N=1).

RECOMMENDATIONS
HOMELESSNESS PREVENTION: CHILDREN AND FAMILIES

1. **Increase homelessness prevention efforts and services awareness among providers and community.**
   Examples: Creation of referral system for homelessness prevention, disseminating list of homelessness prevention or intervention services to providers, discussing current homelessness efforts in newsletter to county network, offer homelessness services closer to other sources of services
2. **Increase school and housing services support. Alleviate staff stress.**
   Examples: More afterschool services, school resource connectors, connection between case management of clients and housing management
3. **Creation of program outcome evaluation and data collection/tracking system to determine service efficacy and capture accurate rates of homelessness and needs.**
   Examples: More staff involved with program outcomes and data collection/tracking, evaluation of efficacy of programs
4. **More collaboration between parties of care and more continuity of care.**
   Examples: Services that cover a child from birth to 18 years-old, increase collaborations with non-traditional partners in resources, universal ROI form, treatment of whole family rather than individuals
5. **Address clients' barriers to care access by reducing client mistrust and stress.**
   Examples: More trauma-focused training so that providers can build trust individually with clients, assess consumers' greatest stressors preventing them from accessing care
6. **Examine definition of homelessness and related terms to expand care coverage.**
   Examples: Redefine "homelessness" with children and TAY experiences in mind, redefine "permanent housing"

HOMELESSNESS PREVENTION
TRANSITIONAL AGE YOUTH

EXECUTIVE SUMMARY

Feedback from the MHSA Forum showed an overarching need for TAY-related homeless services to take a more long-term, holistic approach of meeting youth's needs and to offer services specifically reserved for TAY rather than combining with adult services. As discussed in other sections on homelessness, stakeholders identified the importance of clarifying definitions of terms regarding homelessness (e.g. "chronic homelessness") and housing (e.g. "permanent housing"), as some youth are "falling through the cracks" with existing definitions (e.g. youth that "couch surf").

Recommendations for expansion of services included:
- Housing services (e.g. increase in incentives for rapid housing, TAY-specific housing).
- Vocational, career training (e.g. offered in TAY housing for better access).
- Mental health services (e.g. offered in TAY housing).
- Financial support (e.g. continue Full-Service Partnership and flex funds, try universal basic income).
- Increasing communication and collaboration between provider entities.
- Trauma-informed training among TAY providers.

RESULTS

PREVENTION OF HOMELESSNESS – TRANSITIONAL AGE YOUTH (TAY)

A total of 6 people provided feedback about Prevention of Homelessness for Transitional Age Youth (TAY) in the County of Santa Clara at the MHSA Forum on January 21, 2020.

Need for Definitional Clarity

Defining Homelessness and Housing

Stakeholders identified a lack of clarity in the current MHSA definitions of homelessness (N=6) Multiple stakeholders agreed that there is a need to more **clearly differentiate between transitory and chronic homelessness** (N=4). The different service needs of these groups were particularly highlighted, and clearer definitions would provide greater abilities to **tailor service availability and provision**. Stakeholders similarly noted a lack of clarity around permanent supportive housing (N=2), with one stakeholder commenting it was "not really permanent, given that services follow the client".

Defining Specific Sub-populations

Stakeholders noted that **specific sub-populations within TAY** lacked definitional clarity, which impacts the ability for them to access appropriate services. Specific mention of "extended foster care" for TAY was made and it was suggested that youth who do not stay in foster care until turning 18 years-old miss out on services and remain homeless (N=1). Additionally, one stakeholder suggested changing the name from "Transitional Age Youth (TAY)" to "Youth and Young Adults (YYA)" to better capture the population characteristics (N=1).

Structural Changes

Behavioral health and trauma informed training were highlighted as key areas of need for staff working with transitional age homeless youth, particularly property management (N=2).

Stakeholders additionally suggested a need to implement a **consistent interdisciplinary care team** in TAY housing and services. Multiple stakeholders noted that a lack of care coordination results in reduced ability to link youth to services, provide referrals, creating a major barrier to their ability to move out of homelessness (N=4).

Services, Programming and Interventions
Age Appropriate Housing
Multiple stakeholders noted that current housing policy makes use of the same **assessment tools and queue** for both adults and youth, which may be developmentally inappropriate. Similarly, stakeholders suggested a **need for TAY specific housing** to be set aside, to better cater to their service needs and prevent spill-over into adult groups. Stakeholders also suggested that incentives for TAY rapid housing be increased from 6 to 24 months. Stakeholders also recommend the inclusion of **supportive services in the housing environments**, such as vocational training and mental health services (N=3).

Financial Support
Stakeholders discussed and endorsed implementing a **universal basic income** for homeless TAY (N=1).

What should stay the same?
Stakeholders identified the Full Service Partnership (FSP) and Flex Funds as two current programs/services that should be maintained to continue to meet the needs of this population and community (N=2).

What should be removed?
Stakeholders did not provide feedback on this area.

RECOMMENDATIONS
PREVENTION OF HOMELESSNESS – TRANSITIONAL AGE YOUTH (TAY)

1. **Provide more definitional clarity around terms regarding homelessness and housing in regard to TAY contexts, and what their specific services look like.**
   Examples: Clarify who falls under TAY category and how they differ from child/youth or adult groups (e.g. "aged out" foster care children); provide definitions for transient versus chronically homeless TAY
2. **Increase age- and population- appropriate services.**
   Examples: Create TAY specific housing; Increase rapid TAY housing to 24 months; Increase programming and interventions designed to build life-skills; Implement greater financial assistance (e.g. universal basic income)
3. **Increase staff integration and training with regard to mental health and trauma informed care.**
   Examples: Improve connectivity among service providers with TAY services; Increase mental health and trauma informed training for TAY staff

HOMELESSNESS PREVENTION
ADULTS AND OLDER ADULTS

EXECUTIVE SUMMARY

MHSA Forum feedback from stakeholders regarding homelessness prevention among adults and older adults revolved around three themes: housing, outreach, and structural/system improvements of services.

Housing

As with other feedback regarding homeless prevention services, a need for reviewing current definitions in order to provide full care coverage emerged. In regard to housing services and programs, stakeholders had recommendations including:

- **Clarifying definitions** related to housing (e.g. "low-income housing," "affordable housing").
- **Increase the availability** of more housing options (e.g. rapid housing, interim housing, harm-reduction housing, and options for transitioning out of the criminal justice system).
- More **connections to current housing services** (e.g. more staff service connectors, clarification of roles of staff and how they can assist consumers with housing needs).

Outreach

Stakeholders called for efforts to **increase awareness of existing services** to promote equitable access to resources.

- Tailor outreach programs towards cultural minority populations (e.g. LGBTQ+ groups).

Structural/System Improvements of Services

Other services that stakeholders thought should be expanded or created include:

- Ensure **support during transitions** between different forms of housing (e.g. peer support groups, assign case managers to homeless individuals).
- Improve **oversight** of board and care facilities.

RESULTS
HOMELESSNESS PREVENTION: ADULTS AND OLDER ADULTS

A total of 25 people provided feedback regarding the prevention of homelessness for adults and older adults (AOA) in the County of Santa Clara at the MHSA Forum on January 21, 2020. The following themes of recommendations emerged from the discussion of stakeholders.

What should be changed?

Improve Housing Services

Taking steps to improve the current housing services was the most frequently cited recommendation (N = 20).

Policy and Structural Changes

Some stakeholders highlighted the need for some **concrete definitions and role clarifications**. Three stakeholders noted that some terms like 'low-income' and 'affordable' housing require clear and formal definitions (N=3). They elaborated that these concrete definitions are needed to

advocate for the homeless population since the meaning of such terms is relative. Furthermore, three stakeholders recognized the need to **differentiate between case managers, peer support staff, and housing support staff** in terms of their roles in providing assistance with housing (N=3).

Stakeholders also highlighted the shortage of available housing for homeless populations. Specifically, two individuals recommended **increasing the availability of interim emergency housing** (N=2). Two stakeholders also pointed to substance use issues among homeless populations and suggested the need to cater for **harm-reduction housing options** (N=2). Lastly, one stakeholder even suggested the provision of a **universal basic income** to prevent homelessness among AOA (N=1).

Housing Staff
Stakeholders put forth several suggestions relating to the importance and the role of housing support staff. Four stakeholders emphasized that **housing specialists and support staff** need to be hired to support the housing needs of the homeless population (N=4). Another four stakeholders emphasized that housing specialists are not billable under all programs, for instance in outpatient programs (N=4). As a result, some people might not gain access to appropriate housing resources. Therefore, to **ensure equitable access**, these four stakeholders suggested that the MHSA should be used to make housing specialists available across all programs. Some stakeholders (N=2) also highlighted that there is a need for better **communication and collaboration** between case managers and landlords in order to improve the coordination of care for AOA.

Improve Board and Care Facilities
The regulation and inclusion of additional support facilities in board and care sites was the second most frequently cited suggestion (N=12). Stakeholders identified specific changes to be implemented in the board and care system.

Regulation of Board and Care
Some stakeholders (N=2) emphasized that overall there is a need to **improve the supervision and management of board and care facilities**. Some stakeholders (N=3) also provided specific suggestions such as specifying the standard length of stay in board and care facilities. They elaborated that such specifications about the length of stay would facilitate rehabilitation and transition of AOA to other housing sites.

Additional support facilities in board and care
Stakeholders recognized the need to include additional services at board and care facilities. Several stakeholders (N = 5) agreed that the introduction of **peer support groups** at board and care would **build a support system and provide a sense of community** for AOA. They cited the example of the SHARE collaborative housing model in Los Angeles that utilizes the services of peer specialists to support homeless individuals. Borrowing from this model, stakeholders suggested that the peer support group leaders/specialists could be trained and stationed at the board and care facilities. Another recommendation was to make **rapid rehousing options** available to board and care residents. Two stakeholders discussed the importance of these rapid rehousing facilities in the context of situations when supportive housing is not immediately available to residents who are transitioning out of the board and care sites (N=2).

Awareness and Outreach

Implementing outreach and awareness programs was the third most common recurring theme (N=8) among the recommendations to prevent homelessness. Some stakeholders (N=2) discussed about organizing outreach programs for homeless populations with a **focus on mental health**. These stakeholders also underscored the value of including information about housing resources in all outreach events. Furthermore, addressing the stigma and shame associated with mental illness was considered as the overarching principle that should guide outreach and awareness events (N=2). Some stakeholders (N=3) drew attention towards the **specialized needs of cultural minority groups**. They suggested that targeted peer support initiatives and outreach events for cultural minority groups need to be created and organized. Stakeholders specifically highlighted the value of such programs for the LGBTQ+ population. Finally, one stakeholder acknowledged that the MHSA needs to focus on substance use and addiction (N=1). This stakeholder suggested the idea to collaborate with casinos to prevent substance use and problematic gambling.

What should stay the same?

Stakeholders identified two effective provisions in the county that should be continued in the future. Firstly, four stakeholders suggested that the practice of **assigning case managers** to support homeless populations should continue (N=4). They emphasized the vital role of case managers in connecting homeless individuals to housing resources. Secondly, three stakeholders shed light on the significance of **MHSA funding to prevent homelessness** among those involved in the criminal justice system (N=3). These stakeholders advocated for a persistent focus on individuals on parole and probation, who frequently struggle to identify appropriate resources.

What should be removed?

None of the stakeholders identified any specific programs or practices that should be removed.

RECOMMENDATIONS
HOMELESSNESS PREVENTION – ADULTS AND OLDER ADULTS

1. **Increase the availability and accessibility of general and specialized housing for homeless and at-risk populations.**
   Examples: Hire housing specialists; clarify the definition of affordable housing, provide interim housing options; provide harm-reduction housing options; clarify the roles of case managers, housing specialists and peer support workers in providing assistance to access housing; continue to assign case managers to homeless AOA; continued funding for those involved in the criminal justice system.
2. **Enhance the regulation of board and care facilities and streamline the transition of AOA to other housing options.**
   Examples: Start peer support groups; increase availability of rapid rehousing options; define the maximum length of stay at board and care sites.
3. **Increase culturally-appropriate outreach and awareness programs focused on mental health and housing resources.**
   Examples: Designing outreach events for cultural minority groups (e.g. LGBTQ+); increasing outreach events targeting the mental health stigma.

WORKFORCE EDUCATION AND TRAINING
CHILDREN AND FAMILIES

EXECUTIVE SUMMARY
Stakeholders in the Workforce Education and Training for Children and Families workgroup highlighted opportunities for improved recruitment, training, and retention at multiple stages of the pipeline: from high school to colleges/universities, through the transition to workforce membership and later workforce retention and training.

High School/University

At the high school and university level, stakeholders highlighted the need for more proactive county action to **address barriers and engage university students** in county behavioral health through initiatives such as:

- Campus activity participation
- Outreach to students of color
- Working to address university-level barriers
- Offering stipends and scholarships

Services Post-Graduation/Currently Employed

Post-graduation, stakeholders noted the following needs:

- More clear transitional **pathways to employment** (e.g., through collaborative employment opportunities, workshops or skills training to potential employee applicants).
- County employees with **lived experience** could be recruited by service providers highlighting job opportunities when they interact with clients.
- Once employees enter the workforce, there is need for **incentives for retention** (e.g. good clinical supervision).

RESULTS
WORKFORCE EDUCATION AND TRAINING: CHILDREN AND FAMILIES

A total of 17 people provided feedback about WET programming for Children and Families in the County of Santa Clara at the MHSA Forum on January 21, 2020. These stakeholders highlighted opportunities for improved **recruitment, training, and retention** at multiple stages of the pipeline: from high school to colleges/universities, through the transition to workforce membership and later workforce retention and training.

High School Recruitment
Two stakeholders mentioned the importance of outreach to high school students, with one isolated program as a model example that could be expanded: The Career Summers Institute (CSI). At CSI, students from one high school are educated by county providers for 1 week and receive a stipend.

College / Universities
In total, six stakeholders highlighted the need for more proactive county action to **address barriers and engage university students in county behavioral health** – particularly for students of color (N=1) and via campus activities and outreach (N=2). As an example of a university-level barrier to students engaging in county work, one stakeholder from a mental health agency shared that a major local public university disallows practicum students to drive to clients in their homes and

communities, which makes it difficult for these students to train in the county (N=1). Stakeholders urged the county to be assertive combatting these barriers in order to engage students.

As another example of a potential county engagement action, three stakeholders discussed tuition costs as a barrier for students getting trained in mental health careers. These participants discussed **creating stipends and internships** that will engage university and college students, across all years of programs and across diverse types of programs (e.g., not just MSWs but also MFTs) (N=3). One of these suggestions extended to the idea of direct scholarships for tuition (e.g., for MFTs), with a vetting process to ensure recruitment of culturally diverse students.

Workforce Recruitment

Post-Education Transition to Workforce

One stakeholder highlighted notable gaps during **transition periods between graduation** with both a bachelor's and a master's degree and suggested that the county find ways to bridge these gaps (N=1). For example, one Masters-level MFT participant shared that they experienced considerable challenges finding employment that allowed for accrual of hours towards licensure, particularly in the county. The same stakeholder also mentioned that a lack of skills (e.g., not knowing requirements for jobs, encountering challenges transitioning from submission of applications to interviewing) can serve as barrier for bachelor's degree graduates to entering the county behavioral health workforce. Two participants suggested that the county **provide skills training or workshops** to address these gaps in knowledge related to attaining employment in county behavioral health (N=2).

One participant described one such successful program that should be continued and expanded – the Student Internship Program; which provides professional development for students across a variety of education levels and provides a pathway to retention as a county employee.

Community Recruitment

In addition to recruitment of college and graduate school graduates, one stakeholder provided suggestions for **recruitment from the community.** Specifically, at home visits, service providers could inform clients and their families about job for individuals with lived experience (N=1).

Workforce Retention

Once individuals make the transition to county employment, MHSA Forum responses underscored the importance of efforts to retain employees with the provision of **incentives and good clinical supervision** (N=2). Clients become affected by high turnover and troubles retaining clinicians.

Trainings

The most common theme for suggested **trainings focused on community, consumer, and family perspectives**. For example, stakeholders suggested continuing trainings on consumer culture and how to provide mental health services situated in the community (N=2), and a training for clinicians on how to integrate family perspectives into mental health interventions for children, particularly through creation of a collaborative training system involving doctors, staff, and NAMI (N=1). Another stakeholder supported the continuation of access to existing training programs for interns and practicum students that are available to all contracted providers (N=1).

RECOMMENDATIONS

WORKFORCE EDUCATION AND TRAINING: CHILDREN AND FAMILIES

1. **Explore proactive county action to address barriers and engage high school and college students in county behavioral health**
   Examples: Scholarships, stipends, outreach to students of color, outreach at university events

2. **Assess opportunities to bridge transition periods between graduation and employment,**
   Examples: To reach bachelor and masters level graduates before they are diverted from county pathways.

3. **Attend to the need for incentives to retain county employees.**

4. **Continue trainings (e.g., for providers) that integrate community, consumer, and family perspectives.**
   Examples: Consumer culture, family perspectives, collaborative training

WORKFORCE EDUCATION AND TRAINING
TRANSITIONAL AGE YOUTH

EXECUTIVE SUMMARY

Stakeholders identified a couple of key areas for improvement for workforce education with transitional age youth (TAY) – outreach, engagement, and training, and structural/system changes.

Outreach, Engagement, Training

In terms of outreach and engagement, stakeholders discussed opportunities to engage workforce in recruitment of transitional age youth, including:

- Outreach targeting educational spheres (e.g. high schools and junior colleges).
- Educational outreach for early education, marginalized communities, and in STEAM/STEM fields (areas where mental health stigma may be very prevalent).
- Targeting culturally competent and multi-lingual practitioners and providers, to better meet the needs the communities being served.
- Improvements in education and training for behavioral health workers, specifically with respect to self-care, mental health, addictions and cultural competency.
- Need for more intensive managerial training for clinical supervisors.

Structural/System Changes

The following is a recommendation for change at the structural and system level.

- Decrease high attrition rates (e.g. decrease financial inequities across organizations and job sites, improve worker retention).

RESULTS

WORKFORCE EDUCATION AND TRAINING: TRANSITIONAL AGE YOUTH (TAY)

A total of 11 people provided feedback about Workforce Education for Transitional Age Youth (TAY) in the County of Santa Clara at the MHSA Forum on January 21, 2020.

Outreach and Engagement

Workforce Recruitment

Stakeholders were supportive of increased outreach to foster youth (N=4) and increasing outreach to transitional age youth about the requirements to be a mental health provider (N= 2). Stakeholders also acknowledged that a lack of public understanding of behavioral health may be limiting the number of individuals applying to behavioral health jobs. It was suggested that **outreach could focus on wider public education around behavioral health and the behavioral health job field** (N=1). Similarly, stakeholders suggested integration towards outreach in junior colleges and other alternative educational settings to facilitate a dialogue and promote behavioral health jobs (N=3). A stakeholder also proposed creating a speaker bureau for high school government classes to highlight careers in behavioral health (N=1).

Additionally, stakeholders specifically made mention of the need for linguistically appropriate and culturally competent service providers (e.g. Vietnamese speaking clinicians) and suggested that recruitment **target clinicians and workers that are able to provide services in the languages that the communities serve**.

Marginalized Communities
Stakeholders encouraged **targeting educational outreach to traditionally marginalized and under-resourced communities** (e.g. African immigrants, Pacific Islanders, Asian-Americans, refugees, oversea students) (N=3). Similarly, stakeholders suggesting expanding to early educational settings (e.g. high school) in culturally diverse communities (N=2).

Educational Outreach
Stakeholders provided discussion on **unique and novel forms of outreach to transitional age youth at a variety of levels.** Early intervention and prevention was highlighted and it was suggested that mental and behavioral health trainings could be implemented at early education levels, before youth reach "transitional" age (N=1). One stakeholder suggested that transitional age youth may be more engaged to connect to behavioral health services through **social media campaigns**, and possible a celebrity endorsement (N=1). Similarly, outreach to transitional age youth through **faith-based leaders** was discussed as an area to improve engagement (N=1). Stakeholders also discussed the high levels of mental health stigma in STEAM/STEM fields, which presents a key target area for outreach, advocacy, and education (N=1).

Policy Change
Stakeholders highlighted a **lack of financial equity** in across settings that results in staff migrating to county or hospital settings from non-profits, where there might be a greater need. A stipend retention initiative was suggested and supported to help offset these effects (N=3). Stakeholders noted that vulnerable populations would benefit from higher levels of case management and peer support (N=1).

Training
Education and Training
Clinical supervision training was a high area of discussion by stakeholders. It was noted by one stakeholder that "*just because they are great clinicians… they are not great at management*". Specialized trainings for management and supervision were supported as areas of improvement for MHSA workforce education (N= 4).

Specialized population and risk training were other areas identified by stakeholders to **increase worker competency**. Stakeholders discussed a need for more culturally sensitive trainings and education, with particular mention of Pacific Islander communities, who present with high suicide rates (N=2). Stakeholders additionally supported increased drug, alcohol and mental health training across the board (N=1).

Worker Retention and Mental Health
Stakeholders discussed the high levels of burn out in the behavioral health workforce as an important area of focus. Specialized and targeted provider trainings on **self-care and mental health among workers** in behavioral health were largely supported (N= 4).

What should stay the same?
Stakeholders largely supported maintaining current funds allocated to workforce education to "build upon what is currently available."

What should be removed?

Stakeholders did not provide feedback on this area.

RECOMMENDATIONS

WORKFORCE EDUCATION AND TRAINING: TRANSITIONAL AGE YOUTH (TAY)

1. **Promote behavioral health careers among TAY.**

   Examples: Outreach at high school and junior college levels; Increase public awareness and improve attitudes of behavioral health and careers; target employment among multi-lingual practitioners

2. **Expand outreach and education to marginalized groups and underrepresented communities.**

   Examples: Increase outreach among vulnerable and marginalized communities; Adapt outreach techniques to reflect greater technology use among TAY (e.g. social media)

3. **Strengthen focus on worker retention and mental health.**

   Examples: Implement and promote worker self-care and mental health programming and training; reduce financial inequity among non-profit workers

4. **Increase training opportunities, especially at supervisory levels.**

   Examples: Incorporate management trainings for clinical supervisors; integrate more specialized mental health, addictions, and cultural competency worker training

WORKFORCE EDUCATION AND TRAINING
ADULTS AND OLDER ADULTS

EXECUTIVE SUMMARY

The most cited themes for changes in service in regard to workforce education and training for adults and older adults were related to workforce recruitment, competency and retention.

Workforce Recruitment

Stakeholders had the most suggestions regarding workforce recruitment. Many of their suggestions involved **more peer support and creative ways to loop other professionals into clinical work**. Specific recommendations included:

- More resources for peer support workers (e.g. peer respite programs, mental health community for trainees, training to improve competency and skill).
- Increase peer presence in assisting with mental health related services (e.g. participating in facilitating group psychiatric treatment, working for county warmline).
- Outreach to retired behavioral health workers to fill trainer and supervisory positions to increase their engagement.
- Utilize providers who are not licensed clinicians to attend to basic mental health services so that consumers can receive care.

Workforce Competency

Due to the frequent overlap of responsibilities and high consumer need, stakeholder data indicated that it would be important to **define roles between different care providers**. Subsequently, initiatives could encourage workforce competency through trainings and better supervision for:

- Peer support workers
- Substance use treatment skills (since MHSA does not cover substance use issues)
- Case managers

Workforce Retention

Incentives were encouraged to both continue and be advertised to the community more (e.g. stipends and scholarship opportunities), expanded (e.g. more professional development experience for non-licensed providers), or be added (e.g. housing for mental health providers). In addition, stakeholders discussed that staff workload should be reduced in order to retain workers in the county.

RESULTS
WORKFORCE EDUCATION AND TRAINING: ADULTS AND OLDER ADULTS

A total of 10 people provided feedback about workforce education and training services for adults and older adults in the County of Santa Clara at the MHSA Forum on January 21, 2020.

Workforce Recruitment

Workforce recruitment was the most common theme that emerged in the workforce and education and training services for adults and older adults section (N=11).

Peer Support and Programs

Many stakeholders discussed greater involvement of peer support and expansion of peer support programs (N=8). To **increase peer competency and skill**, stakeholders recommended more

training for peer support workers and managers (N=2), a mental health community for peer support trainees, peer respite programs (N=1), more incentives for peer support facilitators (N=1), and more certification of peer support workers (N=1). Stakeholders mentioned different areas in which peer support workers could be more involved, including presence in group psychiatric treatment (N=1) and supporting the county warmline (N=1).

Other Recruitment
Other workforce recruitment related suggestions included generally more support (N=1) and **outreach to retired behavioral health workers to fill supervision, mentorship, training positions and increase their engagement** (N=1). One stakeholder recommended utilizing other providers to "fill in the gap" within mental health services so that consumers are not "waiting" for licensed clinicians (N=1).

Workforce Competency
Workforce competency was the second most cited theme in the workforce education and training services for adults and older adults section (N=6). Increase in **different types of training** were the most mentioned (N=4), including more substance use treatment skills embedded in trainings since MHSA does not cover substance use problems (N=1), more crisis intervention trainings and trainings for peer support workers (N=2). **More clinical supervision for case managers** are also recommended (N=1). One stakeholder also commented on the importance of defining roles between different care providers (e.g. psychologists, social workers, rehabilitation counselors, etc.) (N=1).

Workforce Retention
Four stakeholders commented on workforce retention. Incentives to encourage greater employment and retention of staff included more **stipend and scholarship opportunities** (N=1), housing for mental health providers (N=1), and **incentives for peer support facilitators** (e.g. supervision to earn hours that would contribute to licensure, "clinical supervisor" as job title) (N=1). In addition, a stakeholder commented on the need to **reduce the workload of social workers and case managers**, which would ease staff burnout (N=1).

Programming and Interventions
Two stakeholders agreed on the need to increase awareness in general and of stipend and scholarship opportunities (N=2).

System Integration
Stakeholders also called for more clinical support for case managers (N=1) and collaboration between the cities and county (N=1).

What should stay the same?
Stakeholders recommended that stipends and scholarship opportunities for students (N=1) and warmlines should continue (N=1).

RECOMMENDATIONS
WORKFORCE EDUCATION AND TRAINING: ADULTS AND OLDER ADULTS

Workforce Education and Training for Adults and Older Adults

1. **Expand recruitment to include more peer support workers and others.**

   <u>Examples:</u> More incentives to encourage more peer support workers, more peer workers supporting the county warmline, outreach to retired workers to fill supervisory and training positions, utilizing non-clinician providers to address basic mental health needs

2. **Improve workforce competency through more trainings and supervision.**

   <u>Examples:</u> Offer trainings in substance use treatment skills for providers, more training for peer support workers, more clinical supervision for case managers

3. **Improve workforce retention through incentives and reduction of staff burnout and stress.**

   <u>Examples:</u> Continue and expand financial incentives for students in clinical programs, offer more professional development incentives for non-licensed providers, reduce workload of staff

INNOVATIONS
PREVENTION AND EARLY INTERVENTION

Innovative ideas offered by stakeholders specified ways to improve Prevention and Early Intervention services through initiatives that increase consumer engagement and access, improve mental health screening and detection, and provide innovative prevention-oriented services. A summary of these ideas is detailed below.

Ideas to Increase Engagement and Access

Innovation to Increase Access to Resources

Stakeholders suggested that the county could **identify a point person** to find and constantly identify all resource information and put it on social media. This service could also provide a venue to share personal experiences with their efforts to access services as well.

Family and Community Readiness for Engagement

Identifying and connecting with **families or communities that may have needs but may not be "ready" to engage with services**. Identify what their barriers are and provide avenues for them to connect to services. Idea to add in questionnaires in a user-friendly format during normal pediatric or family health visits to gauge engagement or treatment/programming readiness. Will allow more families to connect to services, instead of being missed.

Family and Parent Training & Resource Access

Service providers could **partner with local cities, community centers and/or libraries** to hold events (e.g. resource fairs, classes) and/or continuing services to provide families with education, training and access to resources (e.g. food, childcare, transportation). Many services require parents and families to travel beyond their communities which limits access to resources.

Screening and Detection

Universal Trauma and Mental Health Pediatric Screening Initiative

Adding trauma and mental/behavioral health screening to pediatric pre-school developmental screenings and assessments. Currently there is a **lack of trauma trained clinicians in pediatric settings to screen and then triage children and families that may have needs**. These could be integrated into already existing screenings that children undergo for developmental assessments before starting school. This provides additional support at the front end and can connect families to wellness advocates and services.

Innovative Prevention Services

Supporting the Needs of Diverse Families

Providing support, education and access to services for **families with diverse needs.** Examples given were families where a parent or caregiver is incarcerated, or families where a young child is expressing gender curiosity. Families may not have the language, experience, or access to resources to provide care in these circumstances. This type of program could provide more individualized support to diverse families that may not be picked up by traditional child and family services.

Comprehensive Recreational Spaces/ After-school Programs

Stakeholders wanted **to integrate youth recreation centers with Allcove-style therapeutic services and mental health awareness components**. Center will be open during holiday hours, summers, weekends, and after-school. Services provided can include: health and wellness programs designed to support needs as identified by the community, peer support, youth mental health resources, informal tutor sessions, homework help, internet/computer lab and spiritual support (ex: healing circles, bible study groups). It can serve as a place where kids can socialize rather than spend time on electric devices (screen time) and **should be a free resource**.

County-wide Mindfulness-based Stress Reduction Support Groups for Parents
A suggestion for more **support and psychoeducation** to address concerns about a family's lack of space, direction, and education about what to do when impacted by a child's mental illness.

Inclusive Community Space with Resources and Support Groups
A suggestion for a **physical space to combat isolation**. A place where families impacted by a child's mental illness can come together to socialize, connect, and create informal peer connections.

INNOVATIONS
HOMELESSNESS PREVENTION

Innovative ideas offered by stakeholders specified ways to improve homeless prevention services through outreach, advancements in information navigation systems, a focus on families and justice-involved populations, and enhanced support programming. A summary of these ideas is detailed below.

Outreach and Engagement of Homeless into Services

Outreach to Homeless via "Storage Connect"

The county could provide storage units that allow homeless individuals to store their things in the storage. When the homeless individuals come there, they could be easily linked to services (e.g., food or health care services). This "Storage Connect" service is currently offered in San Diego and could be replicated in the County of Santa Clara.

Mental Health Outreach Events and Awareness building

There is still a huge knowledge gap in the homeless population about mental health and the existing resources that can be accessed by them. In addition, there is also limited knowledge about the housing options available to homeless population and the procedures they need to navigate through to access these options. Therefore, the county should **conduct more outreach events to increase awareness about the existing mental health and housing services** as well as the step by step procedures of how to make use of these services.

Information Navigation Systems

Creating a Registry for Available Board and Care and Other housing

The existing Homelessness management information system (HMIS) keeps track of only a section of the available housing for the homeless population. Due to this issue, individuals who are homeless have to wait for a longer time access housing. The county can **compile a registry and database of all available housing options for the homeless population**. This comprehensive database will help reduce the amount of time that homeless people have to be on a waitlist for getting housing.

24/7 Navigation Center

To help people navigate mental health and housing services, the county can start **24-hour support centers**. These 24-hour centers can act as one -stop centers where individuals can get information about all types of services (e.g. mental health, housing, employment etc.). Creation of such centers will be helpful in **improving the awareness and utilization of services** by homeless and other underserved populations.

Prevention of Homelessness in Justice-Involved Populations

Respite Homes for Individuals with Mental Illness on Parole or Recently Released from Jail

Senate-Bill 389 was passed in August 2019, which allows MHSA funding to be used for individuals on parole or probation. The Adult Probation Department is proposing the **development of respite homes as a treatment option for individuals who often "fall through the cracks"** – i.e. those who have mental health disorders, are court-ordered for treatment, and have been recently released from jail. The respite homes would have a maximum of 90 days for length of stay, easy access to peer and probation support, mental health clinicians, addictions specialists, and

psychiatrists for medication management. The respite homes are designed with the hope of offering a safe and well-supported space to stabilize before transitioning to permanent supportive housing. There would be three levels of homes depending on intensity of needs, with the highest level of care being a locked facility. Case management would then assist with transitions out of respite homes. In response to this idea, stakeholders brought up concerns about **conservatorship, cultural competency, ensuring safety** regarding substance use, and the potential assumption that homeless individuals are mentally ill.

Case Managers in the Criminal Justice System
Individuals involved in the criminal justice system can be vulnerable to homelessness, but do not have dedicated personnel to guide them. Those on parole and probation need guidance to find housing and other services; therefore, the county should take specific steps to support this population. County can employ **case managers for those who are in jail** and especially those who also have a mental illness. These case managers can provide support to access mental health, housing, employment and other useful resources.

Prevention of Homelessness in Families
Prioritizing Homeless Families with Children
Homeless **families with children are more vulnerable** to chronic homelessness; therefore, the county should give them first priority for housing. Furthermore, the county can provide subsidies to homeless families to break the cycle of future homelessness of their children. Such initiatives would facilitate the early prevention of homelessness.

Support Programming
Skill Training for Homeless Individuals/Homeless Ambassadors
The county can start a program to train homeless individuals to **develop skills** that can help them sustain housing (e.g. maintaining cleanliness, employment etc.). The county can train some homeless individuals who can serve as peer homeless ambassadors/trainers, who can train and empower other homeless individuals.

Peer Support Groups in Board and Care
To **improve social support and promote independent living,** the county could start peer support groups in board and care facilities. Peer support group leaders could be trained by the county and be stationed at the board and care homes to extend guidance to the board and care residents. Peer support groups can act as a community that can help residents at board and care facilities get information about housing and other resources which can ease their transition into stable and independent living.

INNOVATIONS
WORKFORCE, EDUATION, AND TRAINING

Innovative ideas offered by stakeholders specified ways to improve the behavioral health workforce through recruitment (e.g., of teens, peers, families), trainings to support consumer recovery, workforce support efforts, and initiatives to enhance and retain existing staff. A summary of these ideas is detailed below.

Ideas for Recruitment

Training Youth Peer Support Providers

In order to increase peer support and also address mental health issues of youth, the county could **develop a program for high school students who are interested in behavioral health**. The program could include one month where the youth are given a series of mental health trainings and presentations, and given "life skills" with the opportunity for students who are short on academic credits to earn units. At the end of the program, the high school students could be engaged as peer support providers during the school year. The program may need to include incentives to engage the target population (e.g., a Clipper Card, respite for parents with adult children with SMI).

Specialized Peer and Family Partners Support Training and Placement with Incentives

Stakeholders suggested the placement of these peers in the community, including **evidence-based peer programs**, and to have someone coordinate the programs to ensure they are evidence-based. Also, encourage students that are interested in behavioral health to support other young people in a mentorship style and **provide some incentives** such as financial incentives or certificates.

Trainings to Facilitate Recovery and Recruitment

Leveraging Teen Centers to Provide Support/Outreach

One stakeholder asked, "*How can we leverage teen centers to give teens the opportunity to provide support to others?*" Some teens need opportunities to play important peer support roles or leadership roles, and other teens need help themselves. Drop-in centers and teen centers (~10 existing centers) could be leveraged.

Degrees-At-Work to Address the Needs of Justice-Involved Individuals

Stakeholders suggested that the county could **transfer the idea of degrees-at-work** to people in jails/prisons (e.g., degrees as part of a re-entry program). The probation department could put it as requirements into one's probation. Some AB189 programs have been similarly helpful.

Workforce Support

Additional Mental Health Services Outreach to First Respondents

Stakeholders advocated for **trauma-focused mental health services and courses related to self-care** to first responders. Many officers, after witnessing a traumatic event, do not have the adequate coping mechanisms or self-care habits to cope with the traumatic event.

Enhancement and Retention of Existing Workforce

Training for Firefighters, Nurses, EMT, and Other Similar Providers in Mental Health

Provide mental health courses to first aid providers to help them deal with consumers with mental health issues. Some of the mentioned courses were **culture sensitivity, psychological first aid, crisis intervention, and management of psychosis**.

Degrees-At-Work to Increase MH Workforce
The county could **partner with universities to provide degree programs at work sites** in order to increase the qualifications of the mental health workforce. This idea would address the barriers of people not getting a higher education degree because they do not have the time outside of work. The program could also potentially pay county employees to return to school, for incentivization.

Housing Incentives for Behavioral Health Providers
Suggestions included **financial incentives** to behavioral health providers to be able to afford housing given the **gap between low salary and housing cost**. It is hard to maintain clinicians local due to not making enough to pay for housing.

PREVENTION AND EARLY INTERVENTION DATA TABLES

Table 1. MHSA Forum & SLC Data Table: PEI Children and Families

What should stay the same?	N
General	• Support for mental health services overall, its high standard of care (N= 2) • Funding priorities for MHSA should stay the same (N=1) • Flexibility of bringing services to families and children in accessible locations (N=1) • Services for children under the age of six (N=1) • Existing refugee programs (N=1) • Participants also discussed the new psychiatric building in the County of Santa Clara and appreciated many more beds it offered (N=1) **→ 7**

What should be changed, added, or removed?	N

| Programming & Services | Client Care Access (N=11)
• Denial of service to families (N=3)
   o Difficulties of serving children and access to mental health services of individuals belonging to private insurance (N=3), including Kaiser (e.g. Kaiser not providing denial letters frequently enough)
   o Similarly, another participant noted the denial of services to families of children who have developmental disabilities like autism and recommended more oversight within county agencies before denial of services (N=1)
• Systemic barriers (N=5):
   o Create easily accessible list of services to refer clients (N=1)
   o Long waiting periods to access mental health services (N=1); "don't make parents/patients call all over – intake and match." (N=1)
   o Barriers to access care like transportation, lack of food and child-care (N=1); make travel to services more possible (N=1)
• Reduce stigma of mental health in the community (N=2)

Staffing (N=7)
• Need for an overall increase in providers, particularly on school grounds, including (N=6):
   o Bilingual staff (e.g. interpreters, clinicians) (N=3)
   o Mental health providers and school coordinators (N=5)
   o Substance use specialists (N=2)
• More training for providers (N=1)

Culturally-Responsive Care (N=7)
Need for more linguistically appropriate care and for more programs focused on serving the refugee population (N=5) | 41 |

	• Trauma-informed training among providers (N=1)
	• Increase amount of services currently offered for Latinx families (N=1)
	
	Care Triage (N=4)
	• Improved system of mental health problem screening and detection (N=3) so that services are "*not just used when the kids are on fire.*"
	• Referrals across treatment centers (N=1)
	
	Service Awareness (N=5)
	• Lack of awareness of resources, especially for youth (N=4)
	• School districts should be provided with information that directly relates to schools, school-aged youth, and families (N=1)
	
	Other Support Services (N=7)
	• Consider daily living services (N=5)
	    o Attention to general daily living support services was also recommended, including housing, child-care, transportation (e.g. to mental health services) and food assistance (N= 4).
	    o Supporting the "working poor" (e.g. population without Medi-Cal, cannot afford food in order to meet copay costs) (N=1)
	• More wellness/access centers (N=2)	

Structural Changes	Funding (N=9)
	    • Publicizing MHSA grant opportunities more (N=2)
	    • Schools are required to notify parents twice a year about services and MHSA funds can be used for this (N=1)
	    • Leverage existing resources instead of cutting funds (N=1)
	    • Set up support to bill Medi-Cal as a requirement to get funding (N=1)
	    • Remove funding silos (N=1)
	    • "*Remove the inequitable distribution of MHSA funds to address youth in county that need additional support.*" (N=1)
	    • Lack of clarity and potential overlap in SLS and MHSA PEI funding (N=1)
	    • "*What SLS pays for is not practical, sometimes funds are returned.*" (N=1)
	
	Other Structural Changes (N= 7)
	    • PEI Expansion of Coverage (N=4)
	        o Expand prevention (N=1); cover gap areas, south county and mid-county (N=1)
	        o PEI should be in ALL schools, not just parts of districts (N=1)
	        o Creation of South County plan (N=1)
	        o Lack of equity by meeting continually in San Jose by omitting the voices of those who need additional support (N=1)
	    • Office of Education responsibility (N=2):
		17

	o "*Ensure that Santa Clara County Office of Education (SCCOE) has access to what is available for all school districts and how to access supports as it acts as the conduit for districts.*" (N=1) o Add a direct liaison from SCC BHSD to coordinate services for schools through the SCCOE (N=1) • Standardizing programs (N=1)	
Psychoeducation & Outreach	• More psychoeducation programs (e.g. for parents, teachers, medical professionals, and outreach programs) to train community members to recognize mental health issues among children and families (N=4) To encourage this, recommendations included: • Financial incentives to encourage providers to attend trainings (N=1) More outreach efforts (N=4) should also be considered, including: • The creation and dissemination of more educational entertainment focused on mental health (e.g. movies, documentaries, media) (N=2) School Linked Services (N=5) Flexibility of school linked services (SLS), particularly: • Expansion of hours coverage to include after school, holidays, weekend (N=2) • Coverage across more schools (N=2) o "*14 school districts have SLS coordinators, others do not.*" (N=1) Presence of mental health agencies at school events or on school grounds (e.g. NAMI) (N=2)	12
What should be removed?		**N**
General	• County's "focus on productivity" causes the agencies to focus more on "making the marks" at the sacrifice of providing holistic care to clients (N=1) • *"Remove the red tape and bureaucracy"* (N=1)	2

Table 2. MHSA Forum & SLC Data Table: PEI Transitional Age Youth

What should stay the same?		**N**
Programming & Interventions	Community Involvement & Gatekeeper Trainings (N=6) Current efforts in communicating with and involving the community should continue. • In particular, gatekeeper trainings (e.g. ASIST, online trainings) were identified as the most common service that should continue, especially for the trainings' education on mental health issues and stigma reduction to non-providers (N=4) • Continue newsletters to county network (e.g. community and work force) (N=1) • Continue availability and ease in accessing self-referral processes (N=1) Trauma-Informed Care (N=4)	15

	Current efforts in integrating trauma-informed care into services and programs should continue. • "*The fact that Santa Clara County leads trauma-informed care makes me feel more comfortable.*" • Continue offering trauma-focused cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) treatment Suicide Prevention (N=2) • The county was praised as a leader in its efforts towards suicide prevention "*Not just doing the bare minimum.*" (N=1) • The Mental Health Mobile Crisis Hotline (N=1) Other (N=3) • Variety of services available (N=1) • Institute for Local Government (N=1) • Drop-in centers (N=1)	
Culture & Diversity Related Needs	• Multigenerational cultural wellness centers (N=1) • Cultural responsiveness across the lifespan (N=1)	2
What should be changed or added?		**N**

Structural Changes	System Integration (N=11)
	Communication - Many comments related to system integration described a need for more communication and collaboration across agencies, programs, services, providers, etc. (N=9)
	• Continuity of appropriate and necessary care (N=7)
	    o Out of hospital into community (N=2)
	• Reduce risk of clients "falling through the cracks" (N=2)
	• Reduce unnecessary repetition in services (N=2)
	• Ensure appropriate triage (N=2)
	    o Psychiatric services rather than jail (N=1)
	• Connections between:
	    o Mental health services and substance use treatment (N=3)
	    o Mental health services and law enforcement (N=1)
	    o Hospital and crisis housing and services (N=1)
	    o Faith-based groups and prevention early intervention efforts (N=1)
	    o Family to care providers (N=1)
	    o Between providers (N=1)
	    o Colleges (N=1)
	
	Funding Transparency & Accountability (N=6)
	More transparency and accountability of funding and budgeting across agencies and systems.
		37

	Program Outcomes & Data (N=6)
	• More outcome measures, tracking, and data collection to determine:
	    ○ Whether programs are meeting community needs and upholding standard (N=3)
	    ○ Efficacy of county prevention efforts (N=1)
	    ○ Presence of collaboration and communication between agencies (N=1)
	    ○ Clinician training compliance and quality (N=1)
	    ○ How to increase sustainability of programs ("not just at the whim of legislators") (N=1)
	• Re-examine measures (e.g. screeners) currently being used and determine whether the measures are assessing appropriate, desired targets of interest. (N=2)
	
	Family Integration (N=6)
	• The challenge of parents and family being systematically/legally "locked out" of youth's care causes lack of challenges (N=4).
	• Encourage integration of family into youth's care (N=3) through:
	    ○ Case management (N=1)
	    ○ Intergenerational opportunities (N=1)
	    ○ Communication with providers (N=1)
	• Parent involvement/education of TAY issues (N=1)
	• Need to address mental health needs of parents in addition to the children (N=1)
	
	Community/Consumer Involvement (N=4)
	• Increase the involvement of the community and consumers in providing input on systemic changes, programs and services, and in connecting community members in need with county services. (N=3)
	• Create systems to encourage routine input from community and consumers (N=1)
	
	General (N=4)
	• Have a system to improve navigation of services available in county for current and potential consumers (N=1)
	• Strengthen the capacity to execute prevention and early intervention (N=1)
	• Number of request for proposals (RFPs) have been reduced and efforts should be made to increase numbers again. (N=1)
	• "*Lots of contractors are being changed, which is impacting families and children*" (N=1)	

Outreach &
Education
	Trauma-Informed Care (N=7)
	• More trauma-informed training for providers, especially clinicians (N=4)
	    ○ Include DBT Training (N=1)
	    ○ Enforcement of mandatory trauma-informed training (N=1)
	• Greater trauma-informed treatment, care and system (N=3)
	    ○ Especially in foster care systems (N=1)
	• More information available to families on trauma care (N=1)
		18

	Provider Training (N=7) • More training should be offered regarding: 　○ Trauma-informed care (N= 4) 　○ Individual level of practitioners following best practices (N=1) 　○ DBT (N=1) 　○ Mental health training among police officers (N=1) • Training for clinicians should be tracked (N=1) and enforced (N=1) • Train primary care providers, encourage assistance from the physiological side (N=1) Culture & Stigma (N=5) Culture encouraging stigma needs to be addressed. In particular: • Mental health language (N=3): 　○ Attention on how mental illness and services are talked about (N=1) 　○ Changing "mental health" to "wellness" or "behavioral health' (N=1) 　○ Adjusting the use of term "peer" depending on the cultural group. (e.g. LGBTQ finds significance and trust in the term "peer" and "peer and lived experience"). Suggestion to change to "outreach" in some contexts, as a way to change the impression that these providers are "less than" other providers (N=1) • Veterans – Loss of job opportunities and services due to stigma, particularly among veterans with mental health disorders (N=1) • Youth outside of school systems should also be prioritized for concerns like homelessness, human trafficking, transition from incarceration, workers, and immigrant youth (N=1) Service Awareness (N=3) • More education and outreach to families about existing TAY services (N=2) • Easy access of reference list of services for clients and families (N=1)	
Programming & Interventions	Staffing (N=5) • Peer Support (N=5) 　○ Increase number of peer support workers (N=2) 　○ Expansion of peer support programs (N=1) 　○ Increase awareness and access to peer workers and groups (N=1) • Case management and liaisons – More case management services and providers and liaisons in the community (N=4) 　○ "*Train them better, give them smaller caseloads, and pay them higher salaries to alleviate turn-over.*" (N=1) • More: 　○ Clinicians (N=1) 　○ CIT officers (N=1) 　○ "*Someone to listen and connect*" (N=1) Centers & Programs (N=6)	18

		N

	• Centers
	    o Expand cultural wellness centers to other populations/groups (e.g. Allcove) (N=1)
	    o Prioritize wellness centers in South County and East County (N=1)
	    o More programs like Bill Wilson Center (N=1), more providers and locations beyond San Jose (e.g. South County) (N=1)
	• Substance withdrawal program for young adults (e.g. on ADHD medications) on medications who want to stop them. Support with weening off medications, including physiological and psychological withdrawal issues (N=1)
	• More programs focused on stress management, social-emotional learning and resiliency (N=1)
	• More programs on workforce development (N=1)
	
	Housing (N=3)
	• TAY emergency shelter "that preserves dignity and ensures wellbeing" needed. Would link TAY to long-term sustainable housing and mental health services (N=1)
	• Create more long-term supportive housing for TAY to prevent trauma (N=1)
	• "Respite programs are not actual shelters." (N=1)
	
	General (N=4)
	• More flexibility and availability in services available (N=2)
	• "*Programming is too prescriptive,*" which may act as a challenge to providing best practices for specific communities (N=1)
	• "*Services are not getting to the root of the issues*" (N=1)
	• Add commercial insurance for Raising Early Awareness and Creating Hope (REACH) program, which serves TAY at risk of mental health problems (N=1)	

What should be removed?		N
Service Access	• "*Remove roadblocks*" (N=1)	1

Table 3. MHSA Forum & SLC Data Table: PEI Adults/Older Adults

What should be added?		N
Culture & Diversity Related Needs	• Increase representation within the system to address high county suicide rates in Pacific Islander and Korean populations (N=2) • Dearth of existing programming for LGBTQ+ older adults (N=1) • Training related to transgender populations from high school to older adulthood (N=2) • Need more attention to veterans in the county who may not have all needs met by the VA (N=4)	13

	• Outreach (i.e. media campaign) to ethnic communities who aren't being served (N=3) • Extend elder storytelling to serve specific ethnic communities (e.g., African Americans) (N=1)	
Programming & Interventions	Housing (N=4) • More housing (N=1) • "Neighborhood housing option? Room match pending, case manager" (N=1) • Club house model (N=1) • "Share collaborative housing" (N=1) • Increase coordination between psychologists, rehabilitation counselors, social workers, peer support workers (N=1) • More coordination between government and consumer providers (N=1) • More LGBTQ older adult programming (N=1) • More Wellness Recovery and Action Planning (WRAP) groups and referrals (N=1) • More programming for adult mothers (N=1) • Services for developmentally disabled elderly adults that treat them in age appropriate manner (N=1) • Training for life management skills (e.g. budgeting, cooking) (N=1) • More supervision in medications and food (N=1) • "Volunteer programs, earning points (e.g. Sunday Friends model)" (N=1)	13
Outreach & Education	• Education for older adults about mental health warning signs (N=1) • More "trauma-informed" training (N=1) • Training for primary care providers about mental health warning signs (N=1) • Outreach (i.e. media campaign) to ethnic communities who aren't being served (N=1) • Education for family and caregivers for older adults about early signs of mental illness and dementia (N=1) • Outreach to people who are isolated and unconnected to community (N=1) • Coordinated outreach to homeless (N=1) • Individuals in jails with serious mental illness (N=1)	8
Structural Additions: Funding, Staffing, Collaborations	• A standalone older adult division (N=1) • An innovations grant addresses the need for programming focus on older adult mental health needs (N=1) • Internal LGBTQ representation for the Cultural Communities Wellness Program (CCWP) (N=1) • Pacific Islander and Korean representation on CCWP and other staff because of high suicide rates (N=1) • Addition of a dedicated Wellness Recovery and Action Planning (WRAP) coordinator (N=1)	8

	• Collaborations with the VA (N=1) • Coordination between custody behavioral health and county behavioral health during periods of re-entry or release from jails (N=1) • Support during every transition (e.g. jail to board and care to housing services) (N=1)	
What should be changed?		**N**
Programming & Interventions	• Greater diversity in therapy intervention offerings (e.g., offer more than CBT) (N=1) • Need more 1-on-1 interventions (rather than groups) (N=3) • Need more tools post-crisis, other than WRAP groups (N=3)	7
Culture & Diversity Related Needs	• Increased non-English speaking staff (providers, cultural brokers) in clinics and non-profit organizations that see county clients (N=4) • Need for tailored approaches to reach refugees dropping out of services because of political challenges (N=2)	6
Structural Additions: Funding, Staffing, Collaborations	• Improved coordination of language-specific services between call centers and county-funded community-based organizations (N=4) • Extend the time limit definition of PEI services (18 months prior to major mental illness) for refugees who take longer to engage and build trust (N=2)	6
Outreach & Education	• Increase awareness about different needs of younger versus older elderly (N=1) • Increased awareness about resources for older adult case management services, to facilitate resource navigation (N=1) • Improve outreach to refugees to combat dropout due to political challenges and fear (N=2)	3
What should stay the same?		**N**
Programming	• Elder storytelling – it is culturally appropriate for older adults (N=2) • Refugee programs (now open to asylum seekers across the lifespan) – the need is great (N=2) • Older adult in-home peer respite program (N=1) • Full Service Partnership (FSP) eligibility (e.g. hospitalization, outpatient, housing flexibility funds) (N=1)	6
What should be removed?		**N**
Programming	• Remove the services are least utilized (unless they are the least accessed because they are unknown)	1

HOMELESSNESS PREVENTION DATA TABLES

Table 4. MHSA Forum & SLC Data Table: Homelessness Prevention Children and Families

What should stay the same?		N
Programming & Interventions	The county's "mental health stability and rent stability" was praised. "*MHSA is well positioned to bring this data to 15 cities to board of supervisors and lead us to the policy that will have a positive impact.*" (N=1) "*MHSA working together through grassroots in Milpitas,*" particularly through "helping with data for Milpitas" was praised. (N=1) Currently existing family resource centers were praised. (N=1) Bill Wilson Center's method of measuring program outcomes and efficacy was commended for its mindfulness of waiting six months after homelessness intervention was performed to evaluate student performance and wellbeing, since it can take months before significant change is observed after homelessness prevention intervention. The center's case management in tracking student daily school attendance was also praised. (N=1)	4
School Resources	School resources were listed as strengths that should be continued. In particular, school coordinators were praised for their work (N=2). Universal Access Program (UAP) that provides schooling services before kindergarten, currently being piloted was commended (N=1)	3
What should be changed?		**N**

Definitions	A few stakeholders commented on the need to redefine the meanings of words related to homelessness and housing.
	• "Permanent housing"
	   o Remove this term altogether (N=1)
	   o "*Permanent support housing really means supportive housing for a certain amount of time before you transition to permanent housing.*" (N=1)
	• Defining "chronic homelessness"
	   o Some youth may not be receiving services because the current definition neglects some experiences (e.g. couch surfing) (N=1)
		3

What should be added?		**N**
Programming & Interventions	Service Awareness Stakeholders' high number requests for clarification of homelessness prevention efforts in the county during the forum demonstrated a need for county-wide service awareness and clarification. In addition: • Services should be made more visible to families (N=1) • Referral system to ensure appropriate triage of clients at risk of homelessness (N=1) School Resources (N=8) • Stakeholders encouraged an increase in school resources. Particularly in:	20

	○ Afterschool resources (N=4)
	         ■ Afterschool services linked to regular school services (N= 2)
	      ○ School liaisons or cross-agency connections that link to mental health and other services (e.g. food access, childcare, etc.) (N=4)
	         ■ More community members to act as referral for services in schools for eviction prevention (N=1)
	• Free lunch in schools as a form of homelessness prevention (N=1)
	
	Housing Services (N=4)
	• New "affordable housing" does not address the homeless population's need (N=2)
	• More case management (N=2)
	      ○ Increase case management support and communication with landlords so that landlords do not call law enforcement (N=1)
	      ○ Case management regarding housing should follow the client (e.g. veterans), to prevent problems caused by changes in the housing management. (N=1)
	
	      "Veterans are on temporary housing. Problem is that after two years, they are on their own. Going from one agency to another, the way they follow-up with their clients is very different. For example, there is an apartment complex that is changing hands in management. The people who live there are very stressed out. Housing needs to follow the client or veteran, regardless of what happens to the building."
	
	Family Integration (N=2)
	• Stakeholders encouraged more efforts in integrating more whole family care for families rather than focusing only on family members individually.
	• Determine how to expand Medi-Cal benefits to cover the whole family
	
	Provider Competency (N=2)
	• Better provider competency
	      ○ Cultural-responsiveness (N=1)
	      ○ Empathy (N=1)
	Care Access (N=2)
	• Consider placing resources closer together to encourage warm handoffs and easier access to care (N=1)
	• More family resource centers (N=1)
	
	Other (N=2)
	• County should place more efforts into policy for greater levels of change (N=1)
	• *"More community"* (N=1)	

Program Outcomes/Data	• Create system of outcome measures, tracking, and data collection to determine:
	      ○ Demonstrate efficacy and outcomes (e.g. for funding purposes) (N=1)
	      ○ Accurate rates of homelessness (N=2)
	      ○ Ensure agencies are implementing trauma-informed care (N=1)
	• More staff to implement program outcome and data system. (N=2)
	• Implementation of anti-displacement work group report (N=1).
		6

	System Integration (N=4)	
System Integration	- Encourage system integration through collaboration across agencies, programs, services, providers, etc. - Encourage increasing collaborations with "non-traditional partners in resources" (N=2) - Providing schooling services before kindergarten and schooling services that are available to children from birth to 18 years old (N=1) - Encourage creation of a universal county release of information (ROI) form to increase efficiency and ease of communication between agencies for client care. (To avoid HIPAA violations, instead of specifying "for mental health services," change language to "living services.") (N=1)	4
What should be removed?		**N**
Clients' Barriers to Care Access	Client Mistrust (N=5) - Client mistrust of institutions, agencies, and systematic care was mentioned as a difficulty for accessing care and services among consumers at risk of homelessness or homeless. Building trust through attentive, empathetic, trauma-informed care through individual provider care in the community was encouraged. - Mistrust of school-based services was commonly mentioned and efforts to increase trust of providers was encouraged, including in afterschool programs. (N=2) Client Stress (N=4) - Client stress was mentioned as a difficulty for accessing care and services among consumers either at risk of homelessness or homeless. - The political climate regarding immigration causes fear among community members and prevents them from seeking services. (N=1) - Mental health problems can make the challenges of homelessness even more overwhelming (e.g. veterans with PTSD and having problems with housing) (N=1) - Homelessness itself can be traumatizing and prevent clients from seeking assistance (N=1)	9
Staff Stress	Stakeholders mentioned county staff stress due to lack of resources and not enough staff members to meet client needs.	5
General	Access barriers (N=1)	1

Table 5. MHSA Forum & SLC Data Table: Homelessness Prevention Transitional Age Youth

What should stay the same?		N
Funding	Full Service Partnership (FSP), Flex Funds	2

What should be changed or added?		N

Definitions	Defining Homelessness and Housing Terms (N=6)
	• Differentiate between "chronic homelessness" versus "homelessness" (N=4)
	• Clarification of "permanent housing" (N=2)
	   o *"Not really permanent given that services follow the client"*
	
	Defining Specific Subpopulation Terms (N=2)
	• Change acronym of "Transitional Age Youth" (TAY) to "Youth and Young Adults" (YYA) (N=1)
	• Defining "extended foster care" (N=1)
	   o *"If they don't stay in foster care until the age of 18, they will not qualify for services. A lot of foster kids stay homeless."*
		8

Structural Changes	• Increase connectivity with care and provider entities (N=4) o Greater continuity of care will identify barriers (N=1) • Require trauma-informed, behavioral health/mental health training for property management (N=2)	6

Programming & Interventions	• Housing services (N=4):
	   o Increase rapid rehousing incentives from 6 to 24 months and include supportive services like vocational training and mental health services (N=3)
	   o More housing specifically for TAY (N=1)
	   o Differentiate assessment tools and queue between adults and TAY
	• Financial support (N=1):
	   o Universal basic income for youth (N=1)
		5

Table 6. MHSA Forum & SLC Data Table: Homelessness Prevention Adults and Older Adults

What should be added?		N
Improve Housing Services	Policy and Structural Changes • Increasing availability of interim emergency housing (N=2) • Availability of harm reduction housing for those struggling with substance use (N=2) • Need to clarify the definition of 'low income' housing and 'affordable' housing (N=3) • Need to clarify the difference between case managers, peer support staff, and housing support staff (N=3) • Introducing 'universal basic income' to prevent homelessness (N=1) Housing Staff	20

	• Hiring housing specialists/support staff (N=4) • Housing specialist is not billable in certain programs such as outpatient programs; therefore, MHSA should be used to make it available across all programs (N=3) • Need for collaboration between case managers and landlords (N=2)	
Improve board & care facilities	Regulation of Board and Care • Time limit should be set for the maximum length of stay in board and care to promote smooth transition to other rehabilitation/residential sites (N=3) • Better oversight of board and care facilities (N=2) Additional support facilities in board and care • Peer support groups in licensed and unlicensed board and care facilities for at risk populations to promote independent living (N=5). • Rapid rehousing provisions for individuals transitioning from board and care facilities because supportive housing may not be immediately available (N=2)	12
Awareness & Outreach	• Outreach with a mental health focus and information about housing support in every outreach event (N=2) • Awareness programs to reduce the stigma and shame associated with mental illness (N=2) • Peer support and outreach tailored for cultural minority groups (e.g. LGBTQ+ support) (N=3) • Outreach and collaboration with casinos to reduce gambling and substance use (N=1)	8
What should stay the same?		**N**
Case management and funding	• Case managers for providing housing support to chronically homeless (N=4) • MHSA funding for individuals involved in the criminal justice system such as those on parole and probation (N=3)	7
What should be removed?		**N**
No responses were provided.		

WORKFORCE EDUCATION AND TRAINING DATA TABLES

Table 7. MHSA Forum & SLC Data Table: Workforce Education and Training Children and Families

What should be added or changed?		N

University/ College-level Engagement	• Proactive county action to address barriers and engage university students in county behavioral health (N=7)
	    ○ Create stipends and internships that will engage university students, across all years of programs and across diverse types of programs (e.g., not just MSWs but also MFTs) (N=4)
	    ○ Outreach on university and college campuses re: mental health career path education (N=2)
	    ○ Outreach to students of color (N=2)
	• Ensure inclusion of students across public (e.g., San Jose State University) and private universities in county work (N=1)
		7

Workforce Recruitment	Post-education Transition to Workforce • Address gap in intern-to-employee transitions and work opportunities during the first few post-graduate years for MFTs (N=1) • Employment outreach (e.g., skills training, information, workshops) to college graduates at bachelor's level (N=2) • Continue and expand the Student Internship Program as a model program that facilitates post-education transition to county employment (N=1) Community Recruitment • Inform consumers/family members are job opportunities for individuals with lived experience during service provider home visits (N=1)	5
Workforce Retention	• Increase incentives and good clinical supervision to retain clinicians (N=2)	2
Trainings	• Trainings focused on community, consumer, and family perspectives (e.g., consumer culture, how to provide mental health services situated in the community, how to integrate family perspectives into mental health interventions for children by collaborating with doctors, staff, and NAMI (N=3) • Continue access to training programs for interns and practicum students that are available to all contracted providers (N=1) • Continue annual cultural humility trainings (N=1)	5

Table 8. MHSA Forum & SLC Data Table: Workforce Education and Training Transitional Age Youth

What should be added?		N
Outreach & Engagement	• Target underserved and marginalized groups • Improve public and community perceptions of behavioral health • Target foster youth, high schools, junior colleges and STEAM/STEM fields • Target recruitment to multi-lingual practitioners	19

Policy Change	• Decrease financial inequities in non-profit divisions • Increase case management and peer support in vulnerable populations	4
Training	• Implement formalized management trainings for clinical supervisors • Improve mental health, addictions and cultural competency trainings • Support and emphasize worker mental health and self-care	11
What should stay the same?		**N**
Current Funding	• Maintain and expand current funding for workforce education development	2

Table 9. MHSA Forum & SLC Data Table: Workforce Education and Training Adults and Older Adults

What should be added, changed or removed?		N
Workforce Recruitment	Peer Support and Programs (N=8) • Training for peer support workers (N=2) • More full time peer support and mental health community for peer support trainees (N=1) • More incentives for peer support facilitators (N=1) • Peer respite programs (N=1) • More certification of peer support workers (N=1) • Peer mentors in more group psychiatric treatment (N=1) • Peer workers supporting county warmline (N=1) Other Recruitment (N=3) • Increase more support (N=1) • Outreach to retired behavioral health workers for supervision, mentorship, training and reengagement (N=1) • Utilizing other providers to "fill in the gap" within mental health services so that consumers are not "waiting" for licensed clinicians (N=1)	11
Workforce Competency	Trainings (N=4) • More substance use treatment skills embedded in trainings since MHSA does not include substance use (N=1) • Crisis intervention trainings (N=1) • Training for peer support workers (N=2) Defining roles among different providers (e.g. psychologist vs. social worker) (N=1) More clinical supervision for case managers (N=1)	6
Workforce Retention	Incentives (N=3) • Stipend and scholarship opportunities (N=1) • Housing for mental health providers (N=1) • Incentives for peer support facilitators (e.g. supervision to earn hours that would contribute to licensure, "clinical supervisor" as job title) (N=1)	4

	Reduce workload of social workers and case managers (N=1)	
Programming and Interventions	Service Awareness (N=2) • Increase awareness in general and in stipend and scholarship opportunities.	2
System Integration	• Increase collaboration between city and county (N=1) • More clinical support for case managers (N=1)	2
What should stay the same?		**N**
Incentives	Stipends and scholarship opportunities for students should continue. (N=1)	1
Warmlines	Warmlines should continue. (N=1)	1

Santa Clara County Consumer Survey

Introduction

1. The questions in this survey seek to gather feedback from consumers. Consumers include any individuals who receive services from doctors, psychiatrists, psychologists, therapists, counselors, case managers, practitioners, or any professionals that provide mental health services.

Are you currently a consumer or a family member of a consumer?

        ☐   Yes   →   *IF "YES": Go to question #2.*
        ☐   No   →   *IF "NO": Please do not complete this survey.*

2. **Which of the following best represents you as an individual?**
☐ I am a consumer.
☐ I am a family member of a consumer.
☐ I am both a consumer and a family member of a consumer.

3. **The following questions are about your experience in <u>getting help</u>:**

Getting services	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
I know where to **<u>go</u>** if I need mental health services.	☐	☐	☐	☐	☐
I know who to **<u>call</u>** if I need mental health services.	☐	☐	☐	☐	☐
Mental health services are easy to get to.	☐	☐	☐	☐	☐
I can get an appointment when I need one.	☐	☐	☐	☐	☐
I don't have to sit in the waiting room too long.	☐	☐	☐	☐	☐

4. **The following questions are about your experiences <u>getting referred</u> to other services:**

Referrals	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
Providers talk with me about services that might help me.	☐	☐	☐	☐	☐
My different services fit together well.	☐	☐	☐	☐	☐

5. The following questions are about your experiences <u>talking</u> with providers/staff<u>:</u>

Communication	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
Front desk staff are friendly.	❑	❑	❑	❑	❑
Front desk staff ask questions.	❑	❑	❑	❑	❑
Front desk staff are helpful.	❑	❑	❑	❑	❑
The provider discussed my rights with me.	❑	❑	❑	❑	❑
I feel like I can talk about problems or complaints with my provider.	❑	❑	❑	❑	❑
My provider answers my questions.	❑	❑	❑	❑	❑
My provider accepts me for who I am.	❑	❑	❑	❑	❑
My provider respects me.	❑	❑	❑	❑	❑

6. The following questions are about <u>cultural considerations</u> in service delivery<u>:</u>

Cultural Considerations	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
My provider understands my culture.	❑	❑	❑	❑	❑
My provider is from my culture/looks like me.	❑	❑	❑	❑	❑
Services are available in my language.	❑	❑	❑	❑	❑

7. The following questions are about your experiences with <u>recovery</u><u>:</u>

Recovery and Collaboration	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
My provider gives me choices.	❑	❑	❑	❑	❑
My provider asks me what I think.	❑	❑	❑	❑	❑
I choose what I get to work on.	❑	❑	❑	❑	❑
Services meet my needs.	❑	❑	❑	❑	❑
Services focus on my recovery.	❑	❑	❑	❑	❑
Services help me.	❑	❑	❑	❑	❑

8. **LOGIC -- Were you asked if you wanted family to be part of your treatment?**

☐ Yes → *IF "YES": Go to question 8a.*
☐ No → *IF "NO": Skip to question #9.*

8a. Please describe how your family is a part of your mental health care.

Family/Relationships	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
My provider asks me who I want involved in my recovery.	❑	❑	❑	❑	❑
My provider includes people I've identified as important to me.	❑	❑	❑	❑	❑

Family/Relationships	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
Providers have helped my family better support me.	❑	❑	❑	❑	❑
Family members support my recovery.	❑	❑	❑	❑	❑

9. How true are the following statements?

Satisfaction	Not at all true	A little bit true	Mostly true	Very True	Not Applicable
My mental health team provides me with **whatever** type of help I need.	❑	❑	❑	❑	❑
My mental health team provides as much help as I need **when** I need it.	❑	❑	❑	❑	❑
The mental health team acts professionally.	❑	❑	❑	❑	❑
I'm satisfied with my mental health services.	❑	❑	❑	❑	❑

10. What are you most proud of because of mental health treatment? Please select one.

☐ I have better relationships with my family and friends.
☐ I speak up more about what I need and want.
☐ I feel more confident in my recovery.
☐ I am able to be safe.
☐ I have better coping skills.
☐ I make better choices about my life and recovery.
☐ I have a job or go to school.
☐ I take more responsibility for my day-to-day life.
☐ I have a safe and comfortable place to live.
☐ I don't use drugs and alcohol anymore.
☐ I participate in my mental health services.
☐ I follow my treatment plan.
☐ Other (please specify): _____

11. What is the greatest accomplishment of the mental health system? Please select one.

☐ My mental health providers talk to each other.
☐ My mental health services coordinate with other services, like CPS or probation.
☐ Services are consumer and family driven.
☐ Services are provided by people who represent people being served.
☐ Services are focused on wellness, recovery, and hope.
☐ Services are helpful.
☐ I can get help from peers, people who have similar experiences.
☐ Service providers understand my needs.
☐ Services help me accomplish my goals.
☐ Services are easy to get to (e.g., easy to get appointments, good locations/times).
☐ Services are improving.
☐ I can get services in a crisis.
☐ Other (please specify): _____

12. What are the greatest needs of the mental health system? Please check all that apply.

- ☐ There aren't enough services.
- ☐ We need different types of services.
- ☐ Service providers should talk to each other.
- ☐ Mental health providers should talk to other types of programs (e.g., legal, child welfare).
- ☐ Services should focus on what I think is important.
- ☐ Services should be provided by people who look like me.
- ☐ Services should be available in my preferred language.
- ☐ Services should be focused on wellness, recovery and hope.
- ☐ Service providers should go out into the community.
- ☐ Services should employ more peer support staff (i.e. people with similar experiences).
- ☐ Service providers do not understand my needs.
- ☐ Services and referrals aren't helpful.
- ☐ Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours).
- ☐ Services have gotten worse over time.
- ☐ Other (please specify): _____

13. Is there anything else you would like to share about your experience?

Please write your comments in the box below:

Demographic Form

1. How are you related to the mental health consumer in your life?
   - ☐ Self
   - ☐ Parent
   - ☐ Partner
   - ☐ Child
   - ☐ Other Family Member
   - ☐ Friend
   - ☐ Other: _____

2. What is your stakeholder affiliation?
   - ☐ Community member
   - ☐ Government agency (City or County)
   - ☐ Government agency (State)
   - ☐ Community-based organization
   - ☐ Law Enforcement
   - ☐ Education agency
   - ☐ Social service agency
   - ☐ Veteran or Veterans Organizations
   - ☐ Provider of mental health services
   - ☐ Provider of alcohol and other drug services
   - ☐ Medical or health care organization
   - ☐ Other: _____

3. Please indicate your age range:
   - ☐ Under 16
   - ☐ 16-24
   - ☐ 25-59
   - ☐ 60 and older

4. What is your ethnicity?
   - ☐ Hispanic/Latino
   - ☐ Non-Hispanic/Latino

5. What is your race? (select all that apply)
   - ☐ White/Caucasian
   - ☐ African American/Black
   - ☐ Asian or Pacific Islander
   - ☐ American Indian/Native Alaskan
   - ☐ Multi-Race
   - ☐ Other: _____

6. In which part of Santa Clara County do you live?
   - ☐ Campbell
   - ☐ Cupertino
   - ☐ Gilroy
   - ☐ Los Altos
   - ☐ Los Gatos
   - ☐ Milpitas
   - ☐ Monte Sereno
   - ☐ Morgan Hill
   - ☐ Mountain View
   - ☐ Palo Alto
   - ☐ San Jose
   - ☐ Santa Clara
   - ☐ Saratoga
   - ☐ Sunnyvale
   - ☐ Other: _____

7. Please indicate your gender:
   - ☐ Female
   - ☐ Male
   - ☐ Transmale/transman
   - ☐ Transfemale/transwoman
   - ☐ Intersex
   - ☐ Genderqueer
   - ☐ Prefer not to answer
   - ☐ Other: _____

8. What is your preferred language?
   - ☐ English
   - ☐ Spanish
   - ☐ Vietnamese
   - ☐ Mandarin
   - ☐ Tagalog
   - ☐ Other: _____

Thank you for taking our survey!