COUNTY OF SANTA CLARA
Behavioral Health Services

Fiscal Year 2020

Mental Health Services Act

Annual Plan Update

WELLNESS • RECOVERY • RESILIENCE

Adopted June 2, 2020

Table of Contents

* The Behavioral Health Board is not scheduled to meet again until August 2020.

Overview and Executive Summary

In November 2004, California voters passed Proposition 63, also known as the Mental Health Services Act (MHSA). The Act implemented a 1% state tax on income over $1 million and emphasizes transforming the mental health system to improve the quality of life for individuals living with mental illness and their families.

In consultation with the Mental Health Services Oversight and Accountability Commission (MHSOAC), County of Santa Clara was approved to conduct a community program planning process that would inform the Fiscal Year (FY) 2020 MHSA Annual Plan Update as well as the new Three-Year Plan (Draft) for FY 2021-2023. This request and approval were validated by the local Stakeholder Leadership Committee (SLC) on October 1, 2019 and the Behavioral Health Board on October 4, 2019. Each report (Plan Update and Three-Year Plan) will be sectioned separately to provide clarity and transparency. This process will allow the County of Santa Clara to align all MHSA reporting requirements with the State's deadlines and expectations and keep our County updated with all reporting requirements related to MHSA.

Following existing precedent, the Behavioral Health Services Department (BHSD) has used a comprehensive stakeholder process to develop local MHSA programs and services that range from direct consumer care to innovative ideas aiming to change the behavioral health system. Central to the development and implementation of all programs is the focus on community collaboration; cultural competence; consumer and family-driven services; service integration for consumers and families; prioritization of serving the unserved and underserved; and a focus on wellness, recovery and resilience. The revamped SLC committee with the added five (5) additional client/consumer only seats provided an increased client/consumer lens in the development and validation of these services. The SLC convened during the FY 2020 MHSA Annual Plan Update.

The FY 2020 MHSA Plan Update represents the culmination of planned and stakeholder approved program and service expansions, modifications and introduction of new programs. These changes amount to an annual budget of $123,536,780 for FY2020.

The County of Santa Clara's FY2020 MHSA Annual Plan Update ("Plan Update" or "Update") to the Three-Year Program and Expenditure Plan for FY 2018-2020 marked the final year of existing approved planning. This draft plan update was posted for the required 30-day public comment period from April 11 – May 10, 2020. The Public Hearing hosted by the Behavioral Health Board was held on May 11, 2020 and submitted for approval and adoption at the June 2, 2020 meeting of the Board of Supervisors. The Annual Plan Update was adopted unanimously. Considering the COVID-19 Shelter in Place order by the County of Santa Clara Public Health Department, the Behavioral Health Board Public Hearing of the draft plans will be conducted virtually via zoom in accordance with the Governor's Executive Emergency Order N-29-20.

MHSA Components and Funding Categories

MHSA funding is broken down into five components that are defined by the Act: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN).

This Plan Update seeks to increase direct services funding for all MHSA components in FY2020, but most significantly in Community Services and Supports due to the expansion of Full Service Partnerships to meet service gap needs. Existing MHSOAC-approved projects in the INN component were granted extensions of 2-3 years on February 5, 2020 by the MHSOAC. A brief description and the funding level for each of these areas is provided below.

Community Services and Supports Component

CSS is the largest of all five MHSA components, 76% percent is allocated for program maintenance, expansion and transfers to other components, such as the WET and CFTN components. CSS supports comprehensive mental health treatment for people of all ages living with serious emotional disturbance (SED) or serious mental illness (SMI). CSS develops and implements promising or proven practices designed to increase underserved groups' access to services, enhance quality of services, improve outcomes and promote interagency collaboration. The component's total MHSA annual budget is $82,592,455 in FY 2020.

Prevention and Early Intervention Component

MHSA dedicates 19% of its allocation to PEI, which is intended to prevent mental illness from becoming severe and disabling and to improve timely access for people who are underserved by the mental health system. The component's total MHSA annual budget is $21,388,741 in FY 2020.

Innovation Component

MHSA designates 5% of a County's allocation to the INN component, which specifically and exclusively dedicates funds to trying new approaches that contribute to learning rather than expanding service delivery. Projects are time-limited to a maximum of five years and evaluated for effectiveness and consideration for continued funding through an alternative source. This component's annual budget is $11,714,914 in FY 2020.

Workforce Education and Training Component

WET is intended to increase the mental health services workforce and to improve staff cultural and linguistic competency. The total transfer from CSS to WET funding for FY 2020 is $3,129,104.

Capital Facilities and Technological Needs Component

The CFTN component funds a wide range of projects necessary to support the service delivery system and is currently funded through CSS in the County of Santa Clara[1]. The annual budget is $4,711,566 in FY 2020.

[1] Pursuant to the **Welfare and Institutions Code Section 5892(b)**, Counties may use a portion of their CSS funds for WET, CFTN and the Local Prudent Reserve. It is further specified that the total amount of CSS funding used for this purpose shall

Annual Prevention and Early Intervention Report

Pursuant to Title 9, California Code of Regulations, Sections 3560.010 (a)(1), each County must submit an Annual Prevention and Early Intervention (PEI) and Annual Innovations Report to the MHSOAC as part of a Three Year Program and Expenditure Plan or Annual Update within 30 calendar days of Board of Supervisors approval of the Plan or Update by June 30, 2020. Both Annual PEI Report and Innovations Update (as programs are not fully implemented) are included in this Plan Update.

Summary of Changes for Fiscal Year 2020

The County of Santa Clara lists its services not by component, but by system of care. Within each system of care, several changes to CSS, PEI and CFTN programs were incorporated into the FY 2020 Annual Plan Update. These are those changes:

Programs for Children, Youth and Families (CYF) Proposed Changes

Increase Capacity

- Increased capacity to facilitate implementation of Children and Transition Age Youth Intensive Full Service Partnerships (IFSP).
- Increased allocation to the Youth Therapeutic Integrated Program (YTIP) to provide more intensive and integrated services.
- Increased Families and Children's outpatient services caseloads at two critical service locations, Alum Rock and Uplift, to meet both network adequacy and timeliness as required by Department of Health Care Services.

Redesign and Realign

- Redesigned the Children and Youth Mobile Response and Stabilization services Children in Youth and Families Cross Systems Initiatives Division to efficiently address youth and children related crisis calls to the County's Call Center.
- Exploring the TAY Triage to Support Re-entry Program to meet the needs of youth coming out of juvenile detention, Emergency Psychiatric Services and hospital stays.
- Transferred the clinical portion of School Linked Services back into Prevention and Early Intervention to appropriately serve children and family needs.

Programs for Adults and Older Adults (AOA) Proposed Changes

Increase Capacity

- Increased capacity to facilitate implementation of Adult and Older Adult Intensive Full-Service Partnerships (IFSP) and Assertive Community Treatment (ACT).
- Increased capacity and allocation to facilitate implementation of the Forensic Assertive Community Treatment (FACT) for justice-involved adults with an SMI.

not exceed 20% of the total average amount of funds allocated to that County for the previous five years. Once allocated to either the WET or CFTN Plan, in order to expend those funds, the County must also conduct a public process to specifically outline the intended use of those monies and receive final approval from their Board.

- Increased Adult/Older Adult outpatient services caseloads at two critical service locations, Gardner and Goodwill, to meet both network adequacy and timeliness requirements.
- Increased allocation for the Transitional Housing Unit (Rainbow) for 15 women coming out of custody and receiving mental health services (expansion of services).

Workforce Education and Training

- Realign the WET work plan with the state's new requirements.
- Extensive community prioritization will be implemented at the start of Summer-early Fall 2020 to review WET planning in light of the WET Regional Partnerships guidance from the California's Office of Statewide Health Planning and Development (OSHPD).

☐**Three-Year Program and Expenditure Plan**
☒**Annual Update**

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Clara

Local Mental Health Director	**Program Lead**
Sherri Terao, Ed.D. (408) 885-5776 sherri.terao@hhs.sccgov.org	Evelyn Tirumalai, MHSA Manager (408) 885-3982 Evelyn.tirumalai@hhs.sccgov.org
Local Mental Health Mailing Address: County of Santa Clara Behavioral Health Services Department Mental Health Administration 828 South Bascom Avenue, Suite 200 San Jose, CA 95128	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city, and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate.

The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____June 2, 2020.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.
All documents in the attached annual update are true and correct.

Sherri Terao	DocuSigned by: Sherri Terao DAB699BA2A1544D...	6/4/2020
Mental Health Director/Designee (PRINT)	Signature	Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

☐**Three-Year Program and Expenditure Plan**
☒**Annual Update**
☐**Annual Revenue and Expenditure Report**

County: Santa Clara

Local Mental Health Director	**County Auditor-Controller/City Financial Officer**
Sherri Terao, Ed.D. (408) 885-5776 sherri.terao@hhs.sccgov.org	Alan Minato Telephone Number: 408-299-5201 E-mail: alan.minato@fin.sccgov.org
Local Mental Health Mailing Address: County of Santa Clara Behavioral Health Services Department Mental Health Administration 828 South Bascom Avenue, Suite 200 San Jose, CA 95128	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years. I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

DocuSigned by:
Sherri Terao 6/4/2020
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Sherri Terao
Mental Health Director/Designee (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, 2018, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ended June 30, 2018. I further certify that for the fiscal year ended June 30 2019, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund. I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

DocuSigned by:
Alan Minato 6/11/2020
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Alan Minato
County Auditor Controller/City Financial Officer (PRINT) Signature Date

Community Program Planning Process

The County of Santa Clara's FY 2020 MHSA Annual Plan Update ("Plan update" or "Update") to the Three-Year Program and Expenditure Plan for Fiscal Years 2018 through 2020 has been carried out as required by the California Code of Regulations (CRR) Section 3300. With approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC), the Department was able to carry out a combined community planning process to inform the Draft FY20 MHSA Annual Plan Update and the Draft FY21-FY23 Program and Expenditure Plan ("Draft Three Year Plan" or "Plan Document") found in Section II of this document. This was requested and approved in light of the requirements to provide timely approved plans and to realign our reporting with expected State deadlines.

The planning team was led by Toni Tullys, Director of the Behavioral Health Services Department; Sherri Terao, Deputy Director, Systems of Care; Todd Landreneau, Deputy Director, Managed Care Services; Virginia Chen, Senior Departmental Fiscal Officer; Roshni Shah, Prevention and Early Intervention Manager; Gina Vittori, Innovation Manager; and, Evelyn Tirumalai, MHSA Senior Manager. The planning team carried out multiple community meetings and information-gathering activities, including a client/consumer survey, engaging stakeholders in all stages of the planning and update process in order to ensure that the Plan Update and Three-Year Plan Draft Documents reflect their experiences and suggestions. An annual MHSA Planning Forum was held in January 2020 as a culmination of all community listening sessions, client/consumer surveys and its analysis is included in the Appendix. The Draft Three Year Plan (in a separate section) draws upon those recommendations and includes any changes as a result of the public review process. Planning activities and their corresponding dates are presented in the table below. Materials, handouts and stakeholder comment summaries from these meetings are included in the Appendix.

The review stage of the planning process included two additional meetings with the SLC (February 13 and in April 9, 2020) prior to the required 30-day public comment period. The 30-day public comment period opened in April 11, 2020 and closed on May 10, 2020. The County announced and disseminated the Combined FY20 Draft Plan Update and the FY21-23 MHSA Program and Expenditure Plan (Draft Plan) to the MHSA Stakeholder Leadership Committee, Board of Supervisors, Behavioral Health Board, County staff, service providers, consumers, family members, and those whose email addresses are associated with the stakeholder email list compiled throughout this planning process. A public notice was posted on the County's MHSA website **www.sccbhsd.org/mhsa**. The Combined FY20 Draft Plan Update and the FY21-23 MHSA Program and Expenditure Plan links were posted to the County's website in downloadeable formats. The public submitted comments directly to mhsa@hhs.sccgov.org as well as link created in light of the shelter in plan order that came into effect on March 16, 2020. A link was created for online comment entries: https://www.surveymonkey.com/r/2020MHSA_PublicCommentForm.

Due to the current COVID-19 Shelter in Place mandate from the Public Health Officer, no walk ins were taken at the administration office as in the past public comment periods. Electronic

copies of the Draft Plans were accessible and easy to retrieve at www.sccbhsd.org/mhsa. This was in accordance with the California Governor's Executive Order N-29-20, issued on March 17, 2020. To date, counties have not received additional direction from the Department of Health Care Services or the Mental Health Services Oversight and Accountability Commission regarding flexibility in posting requirements or delays to the review process due to the lack of access to the documents some stakeholders may experience. For this reason, a direct phone line to the MHSA Coordinator can be used for details about the Draft Plan and, if necessary, the MHSA coordinator would send the document by postal service as needed. The direct number to contact the MHSA Coordinator is (408) 401-6117. During the 30-day posting period, there were no requests for paper copies of the Draft Plans.

At the end of the 30-day public comment period, the Behavioral Health Board (BHB) hosted a Public Hearing of the Combined FY20 Draft Plan Update and the FY21-23 MHSA Program and Expenditure Plan (Draft Plan). This took place on May 11, 2020, during which stakeholders were engaged to provide feedback about the Combined FY20 Draft Plan Update and the FY21-23 MHSA Program and Expenditure Plan (Draft Plan). This meeting was held virtually over Zoom and in accordance with the requirements with shelter in place issued by the Health Officer and the Governor's Executive Order N-29-20. The purpose of the Public Hearing was for the public to provide comment and for the BHB to take action on the recommended Draft Plans prior to submission to the Board of Supervisors' (BOS) June 2, 2020 meeting. The Plans were approved and adopted by the Board of Supervisors unanimously. The combined FY20 Draft Plan Update and the FY21-23 MHSA Program and Expenditure Plan and New Innovation Project will be sent to the Mental Health Services Oversight and Accountability Commission as required by MHSA regulations and on time to meeting June 30, 2020 submission date.

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. At the beginning of each MHSA planning cycle, the BHSD holds MHSA SLC meetings to discuss MHSA related business and programs. In 2018, the MHSA SLC was redesigned to include additional consumer representation by adding 5 client/consumer only additional seats to the group. The 30-member committee list of current members is listed on the Appendix.

The MHSA SLC hosted the following meetings kicking off the community program planning process on October 1, 2019. Community Listening Sessions Commenced in September 2019 and community input and review continued through May 10, 2020. The following is a complete list of all planning community meetings:

Community Program Planning Activities and Dates. All meetings are open to the public.

Stakeholder Trainings and Kick Off	Community Planning Process	Plan Review
July – September 2019 MHSA SLC new member recruitment and training **October 1, 2019** 3:00pm – 5:00pm Overview of CPPP and Timeline Review of MHSA Components Legislative Update	**September 17, 2019 6:00pm – 8:00pm** Rebekah Children's Services **September 23, 2019 1:00pm – 3:00pm** Bill Wilson Center **October 4, 2019 9:00am – 11:00am** Behavioral Health Board **October 9, 2019 3:30pm – 5:30pm** Mitchell Park Community Center **October 15, 2019 3:30pm – 6:30pm** Santa Clara Valley Specialty Center **October 29, 2019 4:00pm – 6:00pm** Evergreen City College Extension – Milpitas Campus **November 6, 2019 5:30pm – 7:30pm** Milpitas Unified School District *(due to an MUSD emergency the District provided input via survey)* **November 12, 2019 3:00pm – 5:00pm** County Office of Education, ERC3 **December 19, 2019 8:30 am – 9:30am** South County Collaborative Briefing **January 21, 2020 8:00am – 2:00pm** MHSA Forum County Office of Education	**February 13, 2020 4:30-pm – 6:30pm** MHSA SLC Validation Meeting **April 9, 2020 2:30pm – 4:00pm** MHSA SLC Review of Programs Virtual Meeting via Zoom https://zoom.us/j/946132517 **April 11 – May 10, 2020** 30-Day Public Comment Period of Draft Plans Accessed here: www.sccbhsd.org/mhsa Public Comments can be sent using this link: https://www.surveymonkey.com/r/2020MHSA_PublicCommentForm By email at: MHSA@hhs.sccgov.org By telephone: (408) 401-6117 **May 11, 2020 10:45am – 11:45am** Behavioral Health Board Public Hearing of MHSA Draft Plans Virtual Meeting via Zoom **June 2, 2020** Request Board of Supervisor Review and Approval of Draft Plans **June 30, 2020** Submission of Approved and Adopted Plans to DHCS and MHSOAC

Overview of Programs and Services for Children and Youth: Fiscal Year 2020

Initiative	Program	Description	Proposed Changes
CSS: Full Service Partnership			
Full Service Partnership for Children, Youth, and Families	Maintenance Children & TAY Full Service Partnership	Continuation of the FSP model from previously approved plans. This tier of services will ensure that individuals that currently receive FSP services will continue to receive care without any reduction in service. The FSP Maintenance service is a step down from Intensive FSP for those who may still needs services, including housing support, to remain successful in the community. Maintain current number of FSP slots: Child, TAY, Adult, Older Adult, and Criminal Justice.	No changes
	Intensive Children & TAY Full Service Partnership	Full range of community and clinical services that provides a higher per person funding allocation that was not previously available to serve people with serious mental health needs. These services represent new intensive service slots for individuals and will assist youth living with serious mental illness to reach their wellness and recovery goals.	**Increased** budget to meet service needs.
CSS: General System Development			
Outpatient Services for Children and Youth	Children and Family Outpatient/ Intensive Outpatient Services	Counseling, case management, and medication management services for children who meet medical necessity Long-term counseling, case management, and medication management services provided at a greater frequency and intensity for intensive outpatient treatment	No Changes
	TAY Outpatient Services/ Intensive Outpatient Services	Outpatient programs for TAY ages 16-24 aim to prevent chronic mental illness while improving quality of life for youth; long-term clinical care and case management to youth ages 8-12 to improve quality of life for youth while preventing the later need for high intensity care	No changes
	Specialty Services: Integrated MH/SUD	Outpatient integrated behavioral health services to children and youth with co-occurring mental health and substance abuse needs	No changes
	Specialty Services: Eating Disorders for Children and Adults	Specialty clinical services such as counseling and case management for children, youth and adults with eating disorders	No Changes

Foster Care Development	Foster Care Development	Short-term clinical mental health services for children and youth placed at the Receiving, Assessment, and Intake Center (RAIC)	No Changes
	Independent Living Program (ILP)	Clinical, counseling and case management services to youth who are involved in child welfare services and are transitioning to independent living	No Changes
	CSEC Program	Services and mental health support to children and young people ages 10-21 who have experienced commercial sexual exploitation to help them recover from emotional, physical, and sexual trauma	No Changes
Juvenile Justice Development	Services for Juvenile Justice Involved Youth	Education, training, and intensive case management services for justice-involved children/youth including aftercare services to assist them and their families in developing life skills that will improve their ability to live and thrive in community	No Changes
	TAY Triage to Support Re-Entry	An array of peer counseling, case management, and linkage services provided by dedicated TAY triage staff at EPS and Jail to support re-entry	No changes
Crisis and Drop-In Services for Children and Youth	Children's Mobile Crisis (Uplift)	Onsite rapid-response crisis assessment and intervention for children who are depressed, suicidal, or having acute psychological crisis	No Changes
	TAY Crisis and Drop-In Center	Safe, welcoming, and inclusive spaces for youth to receive access to behavioral health resources and overnight respite	No Changes
School Linked Services	School Linked Services	Screening, identification, referral, and counseling services for school age children/youth in school-based settings	Moved to PEI (from CSS) in order to increase access to program services for FY2020 (include mild to moderate)
TAY Interdisciplinary Services Teams	TAY Interdisciplinary Services Teams	Clinical and non-clinical services provided by interdisciplinary service teams located at community college sites, South and North County Youth wellness spaces, and other youth friendly spaces	No Changes

Prevention and Early Intervention Program Summaries and Report appear in the *Prevention and Early Intervention Annual Report* Section.

Community Services and Supports: Full Service Partnership

Full Service Partnership

Children Full Service Partnership			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Modified	☒Children ages 0-15	FSP	224
Goals			
Outcome 1:	Improve success in school and at home, and reduce the institutionalization and out of home placements		
Outcome 2:	Increase service connectedness for FSP enrolled children		
Outcome 3:	Reduce involvement in child welfare and juvenile justice		
Outcome 4:	Increase school engagement, attendance, and achievement		

Maintenance FSP refers to the continuation of the FSP model from previously approved plans. This tier of services will ensure that individuals that currently receive FSP services will continue to receive care without any reduction in service. The FSP Maintenance service is a step down from Intensive FSP for those who may still needs services, including housing support, to remain successful in the community. This strategy maintains the current number of FSP slots.

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

Description:

Children Full Service Partnership collaborative relationship between the County and the parent of a child with serious emotional disturbance through which the County plans for and provides the full spectrum of wraparound services so that the child can achieve their identified goals. Santa Clara County's FSP provides intensive, comprehensive services for seriously emotionally disturbed (SED) children within a wraparound model. FSP serves children ages six years old to 15 years old with SED, particularly African American, Native American, and Latino children and youth. Children and youth served may be at risk of or transitioning from out-of-home placement; engaged with child welfare and/or the juvenile justice system; or at risk of homelessness, incarceration or hospitalization. FSP is a team-based planning process intended to provide individualized and coordinated family-driven care. FSP should increase the "natural support" available to a family—as they define it— by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. FSP aims to engage underserved children and their families who have not yet benefited from traditional outpatient mental health services due to complex risk factors including substance abuse, community violence, interpersonal family violence, general neglect, and exposure to trauma.

FSP requires that family members, providers, and key members of the child's social support network collaborate to build a creative plan that responds to the needs of the child and their support system. FSP

services should build on the strengths of each child and their support system and be tailored to address their unique and changing needs.

Children's Full Service Partnership

ETHNICITY	FY18		FY19
ASIAN/Pacific Island	7		10
Black/African American	16		16
Hispanic	135		148
Mixed Race	0		0
Native American	2		3
Other Race	4		8
Unknown	2		4
White	24		35
Total	**190**		**224**
GENDER			
Male	80		101
Female	110		123
LANGUAGE			
English	159		182
Mandarin	0		0
Spanish	29		40
Tagalog	0		0
Vietnamese	0		0
Other	2		2

Summary of Achievements:

- 74% of clients had successful discharges from the program.
- 5% reduction in Risk Behaviors and Emotional Needs as demonstrated on the FY2019 CANS assessment reports. This is an incremental increase compared to last year.

Program Improvements:

- Provider staff attrition continues to be a factor in
- treatment success. Transition between treatment teams interrupts service delivery which may impact a client's progress. Due to the attrition, additional training on completion of discharge coding would be required.
- BHSD will review success measures with providers to have better understanding of the population.

Proposed Program Changes to Improve Consumer Impact:

- Create a warm hand off process which would help minimize interruptions of service delivery and begin engagement/rapport building early on.
- Ongoing training and technical assistance with new employees on accurately completing discharge coding forms.
- Increase awareness of referral and linkages to increase pro-social activities which may help decrease Youth Risk Factors and increase opportunity to develop more natural supports to increase Life Functioning Domain.
- Due to the nature of the clients referred addressing behavioral and emotional needs are often higher

priorities for the consumer and with improvement, Youth Risk Factors and life functioning can be better addressed and continuously supported.

Community Services and Supports: General System Development (GSD)

Outpatient Services for Children and Youth

Children and Family Outpatient (OP)/Intensive Outpatient Services (IOP)/Ethnic Outpatient (EOP)			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Children Ages 0-15 ☒ TAY Ages 16-24	GSD	4013 (OP) 961 (IOP) 228 (EOP)
Goals and Objectives			
Outcome 1:	Reduce the need for a higher level of care for consumers		
Outcome 2:	Reduce symptoms and impacts of mental illness for consumers who qualify for specialty mental health services		

Description

Outpatient (OP) mental health programs serve children and youth to help address mental health symptoms and associated functional impairments. Santa Clara County contracts with various community-based organizations that provide an array of outpatient support services for children and youth. OP programs serve children and youth ages 0-16, particularly those from unserved and underserved ethnic and cultural populations. Children and youth who meet medical necessity can access outpatient services.

The Intensive Outpatient Program (IOP) and Ethnic Outpatient (EOP) provide intensive, comprehensive, age-appropriate services for SED children, combining critical core services within a wraparound model in the ethnic cultural context of the client/consumer. The purpose of IOP is to engage children and youth in mental health services, maintain a healthy level of day-to-day functioning, and work toward optimal growth and development at home and in the community.

IOP serves children and youth ages 6-21 who meet medical necessity for specialty mental health services. Qualifying children and youth receive individualized services to incorporate their strengths and cultural contexts. Services include intensive in-home support services, long-term counseling, individual, and or group therapy, case management, crisis intervention, and medication support services. Services are provided at a greater frequency and intensity than routine outpatient treatment.

OP/ IOP service delivery has a strong focus on providing services for unserved and underserved children and youth, particularly those who are justice involved, uninsured, and from cultural/ethnic backgrounds. All OP/IOP services are available to children and youth with Medi-Cal who meet medical necessity, as well as children and families who are undocumented, unsponsored, or otherwise unfunded and youth experiencing homelessness or youth at-risk of homelessness.

Summary of Achievements:

- 73% of those discharged from the program demonstrated successful outcomes.

- 44% of clients served in EOP showed reduction in their behavioral and emotional needs and 7% in risk behaviors; 28% of clients in IOP showed reduction in behavioral emotional needs and 49% in risk factors; 34% reduction in behavioral and emotional needs and 16% reduction in risk factors.

Program Improvements:

- FY20 provided an opportunity to increase the size of the F&C IOP programs so that clients do not have to be sent to F&C OP when they really need IOP.
- Program will be monitored to determine continued needs in the system.

Proposed Program Changes to Improve Consumer Impact:

- Continue to conduct in depth assessments where needed and to match Evidenced Based Practices (EBP) and Promising Practices (PP) to client needs and client conditions.
- Provide training and support to providers specific to their target population may support their abilities to match EBPs and PPs to their clients' needs.
- Increase capacity to support availability and to ensure appropriate access to care.

Community Services and Supports: General System Development (GSD)

Outpatient Services for Children and Youth

Specialty Services: Integrated MH/SUD			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Children Ages 0 – 15 ☒ TAY Ages 16-24	GSD	166
Goals and Objectives			
Outcome 1:	Treat and ameliorate the behavioral health symptoms and dysfunction of children and adolescents, and their families, in the least restrictive manner.		
Outcome 2:	Improve the quality of life for children and families dealing with co-occurring disorders.		

Description:

BHSD has contracted with four providers to provide outpatient integrated behavioral health services to children and youth with co-occurring disorders. Services consist of culturally relevant outpatient mental health and substance use treatment services to help children and their families who are having trouble functioning personally and, in their relationships, and environments.

Integrated behavioral health service programs work with children ages 6 to 24 and their families to support and address co-occurring mental health and substance abuse needs. BHSD has recognized the need to provide such services both for adolescents as well as for younger children who are beginning to struggle with co-occurring disorders. Children and youth who qualify—based on individual need and Medi-Cal eligibility—receive comprehensive biopsychosocial assessments to determine medical necessity and the appropriate level of care for issues related to trauma, substance abuse, mental health, and family challenges. Integrated mental health/substance abuse providers work together in care planning efforts with other child-serving agencies to ensure a comprehensive continuum of care.

Summary of Achievements:

- 53% of client discharges from MH services connected successfully with outpatient services.
- 33% of clients improved their Life Functioning Domain as demonstrated by CANS data.

Program Improvements:

- Ensure that all clinicians and appropriate staff are trained in co-occurring treatment and interventions, receiving adequate supervision and support.
- Ensure that clients and their families are connected to additional supports as needed to support the progress made in treatment services long term. Programs such as support groups or youth spaces can support ongoing work to improve life functioning for children and families.

Proposed Program Changes to Improve Consumer Impact:

- Increase capacity and quality of services.
- Foster natural supports for clients and assist clients access additional services that may be needed as they move through their recovery (e.g. social services, housing, and employment resources).

Outpatient Services for Children and Youth

Specialty and Outpatient Services: Eating Disorders for Children, Youth and Adults			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Children Ages 0 – 15 ☒ TAY Ages 16-24 ☒ Adults Ages 25-59	GSD	13 (Residential)
			27 (Partial Hosp)
			27 (IOP)
			14 (FFS)
Goals and Objectives			
Outcome 1:	Support recovery with an age appropriate approach.		
Outcome 2:	Increase self-help and consumer/family involvement.		
Outcome 3:	Increase access to specialty eating disorder services in the community.		

Description:

Santa Clara County offers a continuum of care for young people and their families that provides the help and support they need in recovering from eating disorders. Service providers offer comprehensive youth-oriented programs where participants can feel safe, nurtured, and hopeful. Clients/Consumers with the most intensive needs enter the continuum through the Family & Children's Division (children/youth) and 24-Hour Care Unit (adults) where a team evaluation determines the appropriate level of residential care. For the other nonresidential services, clients/consumers are referred through the County's Inpatient Coordinators. Services include:

Unlocked Residential: This level of care provides structured supervision and monitoring of patients' meals in a residential setting to avoid further weight loss and decompensation. This residential treatment program assists with stabilizing medical and psychological symptoms of eating disorder prior to beginning outpatient treatment. The 24-Hour-Care unit authorizes placement in this level of treatment.

Update:

- Program had difficulty with getting clients to commit to treatment; impaired cognition from malnutrition interferes with rational thought processes.

- Served 13 clients/consumers (youth and adult)

Partial Hospitalization Program: This is a structured and focused level of outpatient services where individuals diagnosed with eating disorders participate in personalized outpatient treatment five days a week. During this time, clients have two supervised meals and one afternoon snack. Patients also participate in two weekly individual/family therapy sessions, nutritional counseling, psychiatric evaluation, and medication management.

Update:

- Clients needed increased levels of care followed by successful step-downs in treatment to eventual successful discharge.
- Served 27 clients/consumers (youth and adults)

Intensive Outpatient: This level of care is a step down from partial hospitalization and provides half-day treatment three times a week to monitor and assist patients with the recovery process. Intensive outpatient care includes access to doctors, frequent monitoring of vitals and medication compliance, and access to labs as necessary. Patients are provided with weekly individual and family therapy sessions, psychiatric and medical consultations, daily to weekly weigh-ins, monitoring of calorie intake and therapeutic groups.

Update:

- Difficulty with getting clients and families to continue to commit to treatment; impaired cognition from malnutrition interferes with rational thought processes.
- Served 27 clients/consumers (youth and adults)

Fee-for-Service Outpatient Services: Treatment includes clinical evaluations, assessment, crisis intervention, supportive counseling, individual and family therapy, and referrals and linkages to community-based mental health services for ongoing stabilization. Outpatient services are staffed with licensed social workers, marriage and family therapists, psychiatrists, and psychologists who specialize in working with patients diagnosed with mental health issues and eating disorders.

Update:

- Recorded successful discharges out of eating disorders treatment
- Served 14 clients/consumers (youth and adults)

Community Services and Supports: General System Development (GSD)

Foster Care Development Initiative

Foster Care Development			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Children Ages 0 – 15 ☒ TAY Ages 16-24	GSD	747
Goals and Objectives			
Outcome 1:	Provide mental health services that limit further trauma to the child/youth and address the trauma that they have experienced.		
Outcome 2:	Support continuum of care and services by providing linkages to services in the community.		
Outcome 3:	Assess children/youth to address immediate mental health needs.		

Description:

The Foster Care Development program provides short-term clinical mental health services for children and youth placed at the Receiving, Assessment, and Intake Center (RAIC), a facility operated by Social Services Agency. Children that have been removed from their homes due to parent, legal guardian, or caregiver abuse or neglect stay for a short period at the RAIC to be assessed for thoughtful placements. The RAIC operates as a 24-hour facility, 365 days a year.

The RAIC serves as a transition point for children and youth experiencing a removal, placement disruption, or new pending placement, while also addressing their interim needs. Children can remain at the RAIC for up to 23 hours and 59 minutes, until an appropriate and safe placement is determined. During the time that children and youth are at the RAIC, they receive assessments of their emotional, psychological, medical, and behavioral needs. BHSD provides the assessments, emotional support, counseling, and linkages and referrals to the children's system of care. All services are exclusive to child welfare involved children and are provided at the RAIC.

Summary of Achievements:

- 100% of youth at the RAIC received Behavioral Health screening and support.
- 100% of youth were linked to behavioral health services in the community from discharge from the RAIC.

Program Improvements:

- Monitor closely a subgroup of youth for whom it is difficult to close the loop on the linkage to services. These are the youth placed out of county, or those awaiting a placement change.
- All youth are referred to services, in-county or out-of-county. However, at times youth engagement in these referred services is difficult. Youth need to have adequate support of caregivers to support their engagement.

Proposed Program Changes to Improve Consumer Impact:

- Work with service providers addressing warm-handoffs as well as coordination of care with social workers, to support engagement after a referral has been made.
- BHSD is looking at co-location options at the RAIC. Hours have expanded on the weekdays to 9pm, looking to expand to weekend hours by early 2020 or sooner depending on staff recruitment.

Community Services and Supports: General System Development (GSD)

Crisis and Drop-In Services for Children and Youth

Children's Mobile Crisis (*Uplift*)			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Modified	☒ Children Ages 0 – 15 ☒ TAY Ages 16-24	GSD	546 (unduplicated)
Goals and Objectives			
Outcome 1:	Improve the overall crisis response of community.		
Outcome 2:	Reduce the trauma and stigma of crisis experience for children and families.		
Outcome 3:	Reduce unnecessary, over-utilization of law enforcement resources and hospitalizations.		

Description:

The Mobile Crisis program— formerly known as the EMQ Families First Child and Adolescent Crisis Program (CACP) program or Uplift Mobile Crisis — provides 24-hour stabilization and support services to children, youth, and families in the community who are depressed, suicidal, a potential danger to themselves or others, or in some other form of acute psychological crisis. Services include a 5150 assessment, safety planning, and referrals to community-based mental health services. All children and youth in the County can receive services regardless of placement or funding. Children and youth are typically referred to mobile crisis from parents, family members, caregivers, friends, school, police officers, community service providers, or health professionals. Length of service is two to four hours. Children's Mobile Crisis teams consult, assess for risk and safety, and intervene with the hope of promoting community stabilization. Through a family-centered, strengths-based approach, clinicians utilize the least intrusive and restrictive means to work with children and families on finding tools that promote ongoing health and growth and help maintain children in their homes and communities. Contract services were expanded in FY2020 to increase access to youth needing assessment and crisis intervention.

These tools consist of practical strategies to stabilize current and future crises, improve communication, and facilitate positive outcomes; case-specific referrals; and access to information for ongoing treatment and other supports. The CACP staff is diverse, multi-lingual, and multi-disciplinary. All CACP clinicians are authorized 5150 evaluators and can place youth on 72-hour holds. Children's Mobile Crisis services conclude once a child is taken to the Crisis Stabilization Unit (CSU) or brought home with a safety plan.

Crisis response includes:

- Diagnostic interview

- Assessment of mental and emotional status
- Risk assessment
- Strengths-based family evaluation,
- Safety planning
- Facilitation of emergency hospitalizations
- Crisis counseling, therapeutic supports
- Case-specific referrals for follow-up or access to services

Summary of Achievements:

- 68% of youth were successfully diverted from inpatient hospitalization

Program Improvements:

- Capacity to meet demand for crisis services continues to be a challenge.

Proposed Program Changes to Improve Consumer Impact:

- Youth and Families Cross Systems Initiatives Division has proposed a Children and Youth Mobile Response and Stabilization Services Children redesign to efficiently address youth and children related crisis calls to the County's Call Center
- RFP set to release in FY2020 to address gaps in services for crisis services

Community Services and Supports: General System Development (GSD)

School-Linked Services

School Liked Services (SLS) Initiative			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Modified	☒ Children Ages 0 – 15	GSD	1129
Goals and Objectives			
Outcome 1:	Increase student connectedness and relationship building skills.		
Outcome 2:	Reduce in school suspensions and/or in office referrals for discipline.		
Outcome 3:	Prevent of the development of mental health challenges through early identification.		
Outcome 4:	Improve care coordination for children, youth, and families attending SLS schools.		

Description:

The School Linked Services (SLS) program portion that supports 13 school district partners and schools has been categorized in the Prevention and Early Intervention (PEI) component of this MHSA Plan Update, following new PEI regulations. Only the corresponding SLS clinical services are included in this CSS section.

As a response to the need for enhanced school-based service coordination, School Linked Services (SLS) are designed to prevent, reduce, and eliminate emotional and behavioral challenges that may be inhibiting academic success and family wellness for elementary, middle school-aged youth, and youth experiencing homelessness or are at-risk of experiencing homelessness. Services aim to understand students' needs, and link students and their families to the appropriate level of mental health services in the home, school, and community. This program utilizes school campuses as a hub for service delivery to improve access to and coordination of services among students and their families. To best support children's successes in school, SLS clinical services provides services to students and families that aim to improve knowledge, attitude, and behavior relative to academic success and family wellbeing. Based on medical necessity, children and youth are provided services such as psychiatry, individual therapy, family therapy, and medication support. In order to receive SLS clinical services, youth must meet medical necessity and Medi-Cal eligibility. All services are co-located at school sites. This program moved to the Prevention and Early Intervention component for FY2020.

Summary of Achievements:

- 77% successful discharges (program goal was 60%)
- 20% improvement in life functioning/social health (program goal was 50%)

Program Improvements:

- Intervention services primarily focused on reducing risk behaviors and emotional needs and were not targeting improvement in life functioning. Intervention services primarily focus on reducing risk behaviors and emotional needs.
- Maintain engagement over the summer months and school breaks
- Improve caregiver active participation

Proposed Program Changes to Improve Consumer Impact:

- Increase access to services in locations outside of school.
- Encourage the participant of care givers in the youth's life
- Initially in Community Services and Supports, it is recommended SLS (Clinical) reverts back to Prevention and Early Intervention in FY2020 to increase access and provide services to mild and moderate clients in the school environment. This report reflects FY19 implementation efforts under CSS component.

Community Services and Supports: Full Service Partnership

Full Service Partnership

TAY Full Service Partnership			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒TAY ages 16-25	FSP	277
Goals			
Outcome 1:	Reduce out-of-home placements		
Outcome 2:	Increase service connectedness		
Outcome 3:	Reduce involvement in child welfare and juvenile justice		

Maintenance FSP refers to the continuation of the FSP model from previously approved plans. This tier of services will ensure that individuals that currently receive FSP services will continue to receive care without any reduction in service. The FSP Maintenance service is a step down from Intensive FSP for those who may still needs services, including housing support, to remain successful in the community. This strategy maintains the current number of FSP slots.

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

Description:
The TAY Full Service Partnership (FSP) is a comprehensive, intensive mental health service designed specifically to help TAY launch successfully into adulthood. FSP provides an individualized, team approach that aims to address the entire family, as defined by the youth. Through a coordinated range of services, FSP supports youth as they develop social, educational, and vocational skills.

FSP serves youth ages 16-25 who are experiencing physical, social, behavioral, and emotional distress. Through its family-centered approach, FSP also provides support for parents or adult caregivers, and helps youth improve their interpersonal relationships.

FSP Outreach Services assess the desire and readiness of youth for entering into partnership with the BHSD for services. Using age-appropriate strategies during a maximum 30-day outreach period, FSP informs potential clients about available services and determines if a referral will be opened. Once youth enter the program, FSP requires chosen family, providers, and key members of the youth's social support network to collaborate in building a creative plan responsive to the particular needs of the youth and their support system.

Summary of Achievements:

- 62% of consumers had successful discharges from the program.
- 21% improvement in life functioning/social health for clients served.
- 34% improvement in risk factors and a 19% improvement in behavioral emotional needs among participants as measured by CANS.

Program Improvements:

- Provider staff attrition continues to be a factor in treatment success. Transition between treatment teams interrupts service delivery which may impact a client's progress. Due to the attrition, additional training on completion of discharge coding would be required.
- BHSD will review success measures with providers to have better understanding of the population.

Proposed Program Changes to Improve Consumer Impact:

- Create a warm hand off process which would help minimize interruptions of service delivery and begin engagement/rapport building early on.
- Ongoing training and technical assistance with new employees on accurately completing discharge coding forms.
- Increase awareness of referral and linkages to increase pro-social activities which may help decrease Youth Risk Factors and increase opportunity to develop more natural supports to increase Life Functioning Domain.
- Due to the nature of the clients referred addressing behavioral and emotional needs are often higher priorities for the consumer and with improvement, Youth Risk Factors and life functioning can be better addressed and continuously supported.
- Increase Transition Age Youth Full Service Partnership capacity and allocation to facilitate the implementation of Intensive FSPs.

ETHNICITY	FY18	FY19
Asian/Pacific Island	19	19
Black/African American	11	18
Hispanic	124	161
Mixed Race	2	0
Native American	1	0
Other Race	11	13
Unknown	9	11
White	35	55
GENDER		
Female	101	141
Male	111	136
LANGUAGE		
English	186	256
Mandarin	1	0
Spanish	20	20
Tagalog	1	0
Vietnamese	2	0
Other	2	1

Community Services and Supports: General System Development (GSD)

Outpatient Services for Children and Youth

TAY Outpatient Services/Intensive Outpatient Program (IOP)			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ TAY Ages 14-25	GSD	278
			86 (LGBTQ)
Goals and Objectives			
Outcome 1:	Improve functioning and quality of life for youth.		
Outcome 2:	Reduce symptoms and impacts of mental illness for youth.		
Outcome 3:	Reduce the need for a higher level of care for youth.		

Outpatient programs for TAY ages 14-25 aim to prevent chronic mental illness while improving quality of life for youth and include age-appropriate services and gender- responsive services. Outpatient programs for TAY place a particular emphasis on treatment for co-occurring disorders and trauma-informed care. Programs are focused on preventing or improving symptoms that may lead to chronic mental illness while keeping youth on track developmentally. Outpatient services for LGBTQ youth, in particular, include confidential counseling and medication services.

Intensive Outpatient Programs (IOPs) aim to improve quality of life for youth while preventing the later need for high intensity care. IOPs provide long-term clinical care and case management to youth ages 8 – 24. These programs engage youth, many of whom may be homeless, and provide mental health services, promote recovery, and reduce the likelihood that youth served will later require higher levels of care such as FSP.

IOPs serve youth who meet medical necessity for specialty mental health services and are eligible for MediCal. IOPs focus on multidisciplinary, structured services for up to 4 hours per day, up to 5 days per week. IOPs are distinct from FSPs in that they are generally office-based rather than community-based and engage youth at a lower levels of intensity and frequency than an FSP.

Summary of Achievements:

- 40% of successful discharges from the program
- 29% of consumers served reported improvement in Life Functioning/Social Health Domain

LGBTQ Outpatient

- 84% of successful discharges from the program.
- There was no change in life functioning/social health domain for consumers served in FY19 as reported on CANS assessment. However, improvement was reported on emotional/behavioral health and a reduction of risk behaviors.

Program Improvements:

- Clients experienced changes in their treatment teams which may have impacted their progress due to direct care services providers' staff attrition.
- TAY clients bridging into childhood and adulthood, may need consistent support in life functioning to continue progress, well past therapeutic interventions.
- Engagement in school, home and activities may sometimes be difficult to LGBTQ clients.

Proposed Program Changes to Improve Consumer Impact:

- Emphasize warm handoff process for consumers who transition to minimize interruptions of service delivery and begin engagement/rapport building early on.
- Focus on training and technical assistance on accurately completing discharge coding forms with existing and new direct care services staff. Clients may have a higher rate of successful discharges if they have less staff transitions while receiving services. More accurate capture of discharge information with ongoing staff training.
- Increase awareness and resources in supporting referrals and linkage to natural supports/community resources that can support life functioning domain progress well past therapeutic interventions.

Community Services and Supports: General System Development (GSD)

Foster Care Development

Independent Living Program (ILP)			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ TAY Ages 16-25	GSD	44
Goals and Objectives			
Outcome 1:	Increase self-sufficiency and independent living skills		
Outcome 2:	Increase access to education and employment opportunities		
Outcome 3:	Increase service connectedness		

Description:

ILP services are available to help youth (including Dually-Involved Youth) achieve self- sufficiency and launch into adulthood prior to and after exiting the foster care system. These services are available for current and former foster youth between 16-25 years old.

ILP consists of psychiatric and medication services, case management support, individual and family therapy, community linkage, housing placement, and a variety of rehabilitation services to help youth develop the functional and emotional skills necessary for recovery and independence.

Summary of Achievements:

- 45% successful discharge from mental health services.

Program Improvements:

- Due to the special needs of this population, TAY involved with child welfare, youth may require higher levels of care as a result of their transition to independent living resulting in the reporting of an unsuccessful discharge from this level of care.
- Improvements in the direct care service provider's understanding, due to staff turnover, of how to complete discharge forms to accurately capture the reason for discharge.

Proposed Program Changes to Improve Consumer Impact:

- Additional support and training around discharge coding to accurately capture reasons for discharge. Equipping providers with resources in the community that can be added to their therapeutic support to facilitate progress in services.

- Consumers will be better connected to community resources that can support their progress in services and provide ongoing support after therapeutic support is completed. Training of staff on accurate reporting of discharges will impact the client by accurately reporting their successes.

Community Services and Supports: General System Development (GSD)

Commercially, Sexually Exploited Children (CSEC)			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Children Ages 0 – 15 ☒ TAY Ages 16-21	GSD	66
Goals and Objectives			
Outcome 1:	Identify CSEC youth and ensure their safety from sexual exploitation		
Outcome 2:	Provide trauma-informed care and support		
Outcome 3:	Increase service connectedness		

Description:

The program for Commercially Sexually Exploited Children (CSEC) provides services and mental health support to children and young people ages 10-21 who have experienced commercial sexual exploitation to help them recover from emotional, physical, and sexual trauma. Referral to the CSEC program occurs through a number of community sources including the juvenile hall; the Receiving, Assessment and Intake Center (RAIC); school system; pediatrician or public health nurse; and KidConnections (KCN). Once a referral is received, the youth is connected to an advocate that helps ensure their safety from exploitation. The youth is then assessed using the Child and Adolescent Needs and Strengths (CANS) module and other developmental, mental health, and substance use assessments. Treatment for CSEC youth includes Trauma-focused Cognitive Behavioral Therapy, case management, medication management, coordination with advocates and linkage to additional services and benefits. Due to the low number of youth that have completed the program, current CANS assessment data related to engagement in school, home, and activities is not available for FY2019 (the reporting timeframe for this report).

Summary of Achievements:

- 20% successful discharge from mental health services.

Program Improvements:

- Youth who are in the CSEC program have multiple risk factors, including parental support, substance use, mental health needs, involvement in the criminal justice system, social services and previous sexual, physical or emotional abuse. Engagement in services is extremely challenging and often youth will leave program after starting services. After a year of implementation, BHSD is working on partnering with the Department of Social Services and Juvenile Probation Department to solidify protocols and coordinate care across systems.

Community Services and Supports: General System Development (GSD)

Juvenile Justice Development

Services for Juvenile Justice Involved Youth			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Children Ages 0 – 15 ☒ TAY Ages 16-21	GSD	132
Goals and Objectives			
Outcome 1:	Support juvenile justice involved youth as they return to their communities.		
Outcome 2:	Reduce recidivism for juvenile justice involved youth.		
Outcome 3:	Increase service connectedness.		

Description:

Services for juvenile justice involved youth focus on the wellness and recovery of youth returning to their communities as well as youth exiting into homelessness or unstable housing. Specific services include the **Aftercare Program** and **Competency Development Program.**

The **Aftercare Program (ACP)** uses a strengths-based approach to help juvenile justice involved youth exit detention and ranch programs and successfully reenter their communities. With the support of their families, youth in this program develop life skills that allow them to thrive and possibly return to a school setting. The average length of stay in the program is 8 months, with the possibility of additional time due to family crises, hardship, or clinical necessity.

One arm of the Aftercare Program supports Seriously Emotionally Disturbed (SED) youth and youth with specific treatment needs using evidenced-informed community treatment, medication support, and case management. The diagnostic spectrum of youth in this arm of Aftercare includes schizophrenia and other psychotic disorders, major affective disorders, post-traumatic stress disorder, disorders of behavior and bodily function, anxiety and adjustment disorders, and dual diagnosis (mental health, developmental disability, or drug and alcohol related diagnoses). These youth are identified through the Healthy Returns Initiative (HRI), the current Multi-Disciplinary Team (MDT) at ranch facilities, and the Mental Health Juvenile Treatment Court's MDT.

After assessing youth and family needs and strengths, the Aftercare program then employs a behavior positive plan to identify appropriate interventions and resources to help youth develop functional skills around self-care, self-regulation, and address other functional impairments through decreasing or replacing non-functional behavior. Gender specific programming is available as needed.

The **Competency Development Program (CDP)** aims to remediate youth determined incompetent to stand trial. Juvenile competency restoration services are provided to juveniles who have been charged with a delinquency offense before a juvenile justice court, found incompetent by the court, and ordered to receive restoration services. Services include education, training, and intensive case management, and are provided two to three times a week in the youth's home, the home of another family member or caretaker, the school, a juvenile detention center, or a jail. An initial judicial review occurs approximately 30 days after the court order and additional reviews occur every 30-90 days. Restoration to competency will allow the youth to

continue with their court proceedings and potentially avoid time in detention centers awaiting restoration to competency. If competency cannot be restored the court may civilly commit the juvenile to a mental health facility, refer the juvenile for disability services, establish a conservatorship for the juvenile, or dismiss the charges.

Summary of Achievements:

- 49% successful discharges from mental health services among participants in ACP.
- 25% improvement in Youth Behavioral Emotional Needs among ACP participants.
- 14% improvement in Life Domain Functioning as measured by CANS.
- 100% successful discharges from mental health services among Competency Development Program participants.

Program Improvements:

- Continue to work on implementation of strategies focused on engagement as soon as youth leaves the detention facility.
- Increase the dosage of services at onset and taper as youth and family become engaged and motivated.
- Work on mapping of programs in light of new programs developed and implemented by the Juvenile Justice Department.
- Determine feasibility of this program as it exists now.

Proposed Program Changes to Improve Consumer Impact:

- Work with system partners to expedite the ordering of competency services, including more expedient evaluations, and work with probation in making more timely recommendations.
- Begin competency services early in order to resolve issues of failure to stand trial due to competency concerns.

Community Services and Supports: General System Development (GSD)

Crisis and Drop-In Services for Children and Youth

TAY Crisis and Drop-In Center			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ TAY Ages 18-25	GSD	124
Goals and Objectives			
Outcome 1:	Provide a safe and inclusive environment for TAY		
Outcome 2:	Increase service connectedness to behavioral health resources		
Outcome 3:	Reduce the need for a higher level of care for youth		

Description:

The TAY Crisis and Drop-In Centers provide safe, welcoming, and inclusive space for youth to receive access to behavioral health resources. The centers conduct outreach and engage youth about their mental health and basic needs. The centers provide outpatient mental health services and overnight respite services to youth 18-25 years of age. Respite services can accommodate up to 10 TAY who are in need of respite as a result of crisis or who are at risk of homelessness. Respite services allow TAY to self- manage and remain in their community, which may impede crisis escalation. The centers also offer services to unsponsored/ uninsured youth and allow the TAY homeless population to access needed supports. Additionally, services specifically for LGBTQ TAY are offered. Specific mental health outpatient service offered include: Assessments, treatment planning, brief crisis intervention, case management, self-help and peer support, outreach and engagement activities for homeless TAY.

Summary of Achievements:

- 66% successful discharges from mental health services

Program Improvements:

- Discussion with provider to better understand the population that most utilizes these services and create new ways of engaging clients and create programming that suites the population's needs.
- Better training on discharge coding to accurately capture information.

Proposed Program Changes to Improve Consumer Impact:

- Increase awareness and resources in supporting referrals and linkage to natural supports/community resources that can support life functioning domain progress well past therapeutic interventions.
- Implement new ways of engagement, programming and remove any barriers for these clients, and serve more clients.

Overview of Programs and Services for Adults and Older Adults: Fiscal Year 2020

Initiative	Program	Description	Proposed Changes
Community Services and Supports CSS: Full Service Partnership (FSP)			
Full Service Partnership for Adults, Older Adults and Justice Involved	Assertive Community Treatment (ACT) and Forensic ACT (for justice-involved consumers)	Assertive Community Treatment (ACT) is an evidence-based behavioral health program for people with serious mental illness who are at risk of or would otherwise be served in institutional settings (e.g. hospitals, jails/prisons) or experience homelessness. The ACT model is a comprehensive community-based model of treatment, support, and rehabilitation for individuals with serious mental illness who are unwilling or unable to engage in mental health services and who are experiencing frequent and repetitive hospitalizations and/or incarcerations, likely to be homeless, and may suffer from a co-occurring disorder. FACT's structure is similar to ACT for justice-involved consumers.	**Increased** per person allocation
	Intensive FSP	Intensive FSP refers to the full range of community and clinical services that provide higher per person funding allocation that was not previously available to serve clients with serious mental health needs. These services represent new intensive service slots that will assist children living with serious emotional disturbances and serious mental illness to reach their wellness and recover goals with fewer barriers with support from comprehensive services. New service contracts were initiated this reporting year with expected reporting outcomes for Fiscal Year 2020-2021.	**Increased** per person allocation
	FSP Maintenance	Continuation of the FSP model from previously approved plans during FY2020. This FSP level provides needed, ongoing services for consumers with SMI addressing needs that include housing support and other clinical services.	No changes
Permanent Supportive Housing	Permanent Supportive Housing	Consists of County-operated services designed to meet the housing and behavioral health service needs of chronically homeless individuals with severe mental health needs.	No changes
CSS: General System Development			

Outpatient Clinical Services for Adults and Older Adults	County Clinics	An array of mental health supports including basic mental health services and medication support. The County's clinics expand access to mental health services by co-locating at health facilities people are likely to go to or be familiar with.	No changes
	Hope Services	Counseling, case management, and psychiatric services to children, adolescents, young adults, adults, and senior citizens with a qualifying mental health diagnosis and a developmental disability.	No changes
	CalWORKs Community Health Alliance	behavioral health services to adult clients enrolled in the Welfare-to-Work (WTW) Program who experience mental health and substance abuse issues	No changes
	Outpatient Services for Older Adults	Counseling, case management, and medication management services for adults who meet medical necessity to improve quality of life, address unique mental health needs, and prevent higher intensity care by supporting aging in place whenever possible. Increase funding allocation at these critical service locations: Gardner and Goodwill (Mekong pending) in AOA outpatient services.	**Modified**: increased funding allocation to meet network adequacy and timeliness requirements.
Criminal Justice System Services Initiative	Criminal Justice System Services Residential and Outpatient	Outpatient and residential services provided at a wellness and recovery centers for individuals who are involved in the justice system to meet the needs of re-entering the community	**Modified:** Increased the emergency housing budget to accommodate current need at Evan's Lane, Justice System Services
	Criminal Justice System Services IOP/Outpatient	Outpatient and intensive outpatient services for individuals who are involved in the justice system to meet the needs of re-entering the community	No changes
	Faith-based Resource Centers	Service coordination to individuals reentering the community from jail provided by multi-agency faith-based resource centers	No changes
Crisis and Hospital Diversion Initiative	Mental Health Urgent Care	Screening, assessment, brief medication management, and referral to other community resources at walk-in outpatient clinic for County residents who are experiencing behavioral health crises	No changes
	Crisis Stabilization and Crisis Residential	Crisis support, counseling, and linkage services in up to 24-hour stabilization unit and CRT	No changes
	Adult Residential Treatment	Full range of clinical and support services to consumers who need an IMD/hospital diversion or who have substance abuse and serious mental illness located at two new Institution of Mental Disease (IMD) Stepdown/Diversion centers and	Slated to begin in FY21

		one Co-occurring Treatment center	
	Community Placement Team	Case management, housing, and linkage support by a 24-hour case management unit that provides services to consumers returning to the community from other settings	No changes
	IMD Alternative Program	Comprehensive treatment services in a supportive, structured environment as an alternative to a locked setting serving up to 45 consumers for approximately 6-months	No changes
	Mobile Crisis	Immediate crisis support services including assessment, crisis support, and linkage provided by clinicians housed at Mental Health Urgent Care	No changes
Older Adult Community Services Initiative	Clinical Case Management Team for Older Adults	An array of services provided to engage older adults who may be reluctant or unable to access needed mental health services due to geographic barriers, limited mobility, health issues, or stigma associated with receiving mental health services in a clinic	Slated to begin in FY21
	Connections Program	Case management and linkage services for older adults who are at risk of abuse as part of a collaboration with Adult Protective Services	No changes
	Older Adult Collaboration with San Jose Nutrition Centers	Expansion of mental health outreach, awareness, and training at Senior Nutrition Sites to provide community training and workshops and referral to mental health services	Slated to begin in FY21
	Elder's Storytelling	The new Elders' Storytelling Program will serve culturally isolated older adults with mild to moderate depression to help reduce depressive symptoms and restore social connectedness with their family, friends, caregivers and community.	Slated to begin in FY21, RFP released
CSS: Outreach			
In Home Outreach	In Home Outreach	Targeted outreach and engagement teams to identify and connect consumers with mental health needs to services (based on RISE model from Ventura County and IHOT model from Alameda County)	Slated to begin in FY21

Prevention and Early Intervention Program Summaries and Report appear in the *Prevention and Early Intervention Annual Report* Section.

Community Services and Supports: Full Service Partnership

Assertive Community Treatment			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Adult Ages 25-59 ☒ Older Adult Ages 60+	FSP	Contracted 200
Goals			
Outcome 1:	Promote recovery and increase quality of life		
Outcome 2:	Decrease negative outcomes such as incarceration, hospitalization, and homelessness		
Outcome 3:	Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports.		

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

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

When implemented to fidelity, ACT produces reliable results that decrease negative outcomes such as hospitalization, incarceration, and homelessness, and improve psychosocial outcomes. When the ACT model is modified, the reliability of expected outcomes is lessened. In other words, modified ACT programs are still likely to produce similar results, but to a lesser degree and with less consistency. A budget increase was necessary to appropriately execute the program to fidelity.

Program Update:

- Adjust the budget to accommodate the comprehensive services under the ACT model serving the Adult and Older Adult (AOA) population and increase FSP services to an additional 200 adults.
- Contracts awarded this reporting period.

Intensive Full Service Partnership			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Adult Ages 25-59 ☒ Older Adult Ages 60+	FSP	Contracted 400
Goals			
Outcome 1:	Promote recovery and increase quality of life		
Outcome 2:	Decrease negative outcomes such as incarceration, hospitalization, and homelessness		
Outcome 3:	Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports.		

Description

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

Program Update:

- Adjust the budget to accommodate the comprehensive services under the Intensive FSP model serving the Adult and Older Adult (AOA) population and increase FSP services to an additional 400 adults.
- Contracts awarded this reporting period.

Adult Full Service Partnership (FSP)			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Adult Ages 25-59	FSP	488
Goals			
Outcome 1:	Promote recovery and increase quality of life		
Outcome 2:	Decrease negative outcomes such as hospitalization, incarceration, and homelessness		
Outcome 3:	Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports		

Description:

Santa Clara County has identified the need for multiple levels of Full Service Partnership (FSP) in order to appropriately and efficiently serve individuals with varying levels of mental health needs, because the intensity and frequency of service engagement should vary considerably based on level of need. FSP programs provide a collaborative relationship between the County, the consumer, and— when appropriate— the consumer's family. Through this partnership, providers plan for and provide a full spectrum of community services so that the consumer can achieve his/her identified goals.

Summary of Achievements:

- 560 consumers enrolled in an FSP compared to 356 contracted slots.
- Based on the number of consumers served for this period, the program has been functioning above expected target goals based on enrollment data. Clients obtained housing, some reported to have obtained employment, and most discharged to outpatient services due to increased functioning.

Program Improvements:

- The Adult FSP program continues to be challenged by stepping consumers to lower levels of care due to the gap between FSP level of care and the outpatient level of care.
- There is a lack of available housing for consumers discharged into the FSP level of care from IMD and or main jail.
- The BHSD will strategize opportunities to increase consumer participation and involvement into an FSP after referral is received.

Proposed Program Changes to Improve Consumer Impact:

- Make available a housing structure with subsidy or patches for all consumers enrolled in this program to help decrease homelessness and support recovery.
- Possibly make available funds to contract or increase shelter beds for those consumers who may prefer this living arrangement.
- A stable housing/living environment would help achieve and maintain success towards consumer recovery and quality of life.

Success Story: *50+ year old male, divorced, with work experience was first referred to FSP Adult in 2014 for help with managing his mental health symptoms associated with Schizoaffective Disorder of auditory hallucinations, depression, isolation and difficulty concentrating and suicidal ideation. He was homeless for 3 years after working for 30 years as a plumber. Client made progress towards treatment goals of going to church, spending time with his family and close friends. He can still be paranoid and hear voices. His voices cause him anxiety. He is working towards being more open and less guarded and letting people into his life. He has recently gotten approved for independent housing at a partner housing unit and is very excited to have more stability in his life and not have to live in his car.*

Adult Full Service Partnership

Ethnicity	**FY18**	**FY19**
Asian/Pacific Island	76	78
Black/African American	41	40
Hispanic	85	95
Mixed Race	2	2
Native American	9	7
Other Race	22	24
Unknown	52	61
White	167	181
Gender	FY18	FY19
Female	180	178
Male	274	310
Language	**FY18**	**FY19**
English	397	421
Mandarin	2	1
Spanish	13	18
Tagalog	0	1
Other	14	10
Unknown	8	17
Vietnamese	20	20

Community Services and Supports: Full Service Partnership

Justice Involved FSP

Forensic Assertive Community Treatment			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Modified	☒ Adult Ages 25-59 ☒ Older Adult Ages 60+	FSP	Contracted 100
Goals			
Outcome 1:	Promote recovery and increase quality of life		
Outcome 2:	Decrease negative outcomes such as incarceration, hospitalization, and homelessness		
Outcome 3:	Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports.		

Description

The Justice Systems (JS) The FACT program is an alteration of the Assertive Community Treatment (ACT) program and focuses specifically on the treatment of justice involved individuals in order to decrease criminal justice involvement. FACT program is to provide comprehensive evidence-based behavioral health services to justice involved individuals (individuals) diagnosed with severe mental health and/or co-occurring conditions. Services shall be the highest level of outpatient services, an intensive community-based service that uses a multi-disciplinary team of behavioral health professionals and trained peers to provide and/or coordinate treatment, rehabilitation, and community support services for clients who are recovering from severe mental health conditions. Treatment focus is on addressing the factors that precipitated access to this service (e.g., changes in the consumer's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the client's condition can be safely, efficiently, and effectively treated with the support of the program. Service shall utilize a multidisciplinary team (Team) approach by which clients are the responsibility of the collective Team, and all Team members are expected to know and work with all FACT clients. Although the physical program location shall be considered the home base for staff, it is expected that 80%-90% of outreach and services will be delivered in the community (e.g., jail, school, home, homeless shelter, etc).

Program Update:

- Adjust the budget to accommodate the comprehensive services under the FACT model serving the Adult and Older Adult (AOA) population and increase FSP services to an additional 100 adults.
- Contracts awarded this reporting period.

Criminal Justice Full Service Partnership			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Adults Ages 25-59	FSP	461
Goals			
Outcome 1:	Promote recovery and increase quality of life		
Outcome 2:	Decrease negative outcomes such as incarceration, hospitalization, and homelessness		
Outcome 3:	Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports		

Description:

The Criminal Justice FSP programs provide wrap around services and support through a "whatever it takes" philosophy to adults and older adults with severe mental health and/or co-occurring (mental health and substance abuse) conditions who are involved in the criminal justice system. Services are provided in a clinical setting, as well as, in the field, where clients conduct their lives and include individual/group therapy, medication support services, case management services, and crisis residential services. Services focus on behavioral health issues, including alcohol and drug problems, medication misuse and are guided by the principles of cultural competence, recovery and resiliency with an emphasis on building the client's strengths, and resources in the community, with family, and with their peer/social network. Individuals served have a history of utilizing correctional institutions, Institutes of Mental Disease (IMD), inpatient/state hospitals, and are high users of EPS, crisis residential services, and/or frequent and extended hospitalizations.

Summary of Achievements:

- 461 consumers enrolled in an FSP in FY2019.

Program Improvements:

- Increase access to affordable and permanent supportive housing for this population
- Increase access to vocational and education resources for this population.
- Increase outreach efforts to individuals in custody or those who have one AWOL following release from custody.
- Increase access to FSP Services to individuals being released from correctional settings and individuals needing a lower/higher level of care and increase access to residential, permanent settings.

Criminal Justice FSP

ETHNICITY	FY18	FY19
Asian/Pacific Island	35	45
Black/African American	70	72
Hispanic	135	145
Mixed Race	1	2
Native American	14	7
Other Race	27	23
Unknown	17	28
White	141	139
GENDER	FY18	FY19
Female	119	128
Male	321	333

Community Services and Supports: General System Development (GSD)

Permanent Supportive Housing

Permanent Supportive Housing			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Adult 25-59	GSD	256
Goals			
Outcome 1:	Remove barriers for obtaining and maintain housing as a part of recovery		
Outcome 2:	Decrease homelessness		
Outcome 3:	Increase stability and quality of life		
Outcome 4:	Reduce costs to various public service agencies, including health care (e.g., emergency room visits, inpatient hospital services)		

Description:

Permanent Supportive Housing (PSH) – Care Connection Program (CCP) combines low-barrier affordable housing, health care, and supportive services to help individuals with mental illness and their families to lead more stable lives. The PSH model incorporates mobile care teams and peer case managers to support individuals with mental illness who need intensive outpatient treatment, and who are not currently enrolled in a Full Service Partnership or PSH program, with the goal of enabling them to successfully obtain and maintain

housing as a part of their recovery. Key components of PSH-Care Connection that facilitate successful housing tenure include: 1) Individually tailored and flexible supportive services that are voluntary, can be accessed 24 hours a day/7 days a week, and are not a condition of ongoing tenancy; Leases that are held by the tenants without limits on length of stay; and 2) Ongoing collaboration between service providers, property managers, and tenants to preserve tenancy and resolve crisis situations that may arise. This model has been shown to not only impact housing status, but also result in cost savings to various public service systems, including health care.

Summary of Achievements:

- BHSD continues to implement the Coordinated Outreach System, increased staffing to be able to provide services to more homeless individuals and added resources to better reach out to Transition Aged Youth.
- 85.5% of CCP clients had maintained housing for at least 12 months according to data form the HMIS, which exceeds the program's 80% goal.
- Current mental health penetration rate is 36.89%.
- The CCP partnered with Homeless Medical services to enhance medical care for this population.
- These changes have resulted in improved health outcomes and increased mental health penetration for PSH consumers.

Program Improvements:

- The high expense of housing in Santa Clara County combined with low vacancy rate is one major barrier to program improvement as the program's major outcome measure if housing stability.

Community Services and Supports: General System Development (GSD)

Outpatient Services for Adults and Older Adults

County Clinics			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Adult Ages 25-59 ☒ Older Adult Ages 60+	GSD	2,309
Goals			
Outcome 1:	Consumers are able to access medication and behavioral health support needed to manage their symptoms and maintain wellness, as well as avoid the need for more intensive interventions such as hospitalization		

Description:

Central Wellness and Benefit Center (CWBC) provides ongoing medication management and monitoring, short-term mental health services and limited case management. CWBC is open Monday - Friday from 8 am- 5 pm. CWBC is a mental health outpatient clinic for Santa Clara County residents who are uninsured and are experiencing mental health issues. CWBC serves those who are dual diagnosed, homeless and/or recently released from jail. CWBC also provides psychosocial assessment, crisis intervention, referrals, linkages, brief therapy, rehabilitation & benefit enrollment services for adults (18 y/o & older). There are two levels of care within CWBC: Specialty and the Mild to Moderate Program.

Downtown Mental Health Center Service Teams (DTMH) assists individuals within the context of a mutual partnership effort to achieve higher levels of functioning, develop community/family support systems wherever possible, promote self-reliance and self-sufficiency, and encourage individuals to work or to return to work whenever possible. Service teams work with clients suffering from serious mental illness who exhibit severe problems in normal daily functioning, offering a full array of mental health services including case management services, crisis intervention and medication support services. DTMH has two fulltime service teams comprised of case managers and a psychiatrist operating Monday through Friday. Valley Homeless Healthcare Program locates some of its health care services for homeless residents at DTMH to facilitate convenient access to care. Languages available at this center are English, Cantonese, Mandarin, Russian, Spanish, & Vietnamese. Additionally, clients can participate in the onsite Wellness and Recovery Action Plan (WRAP) Services that offer group experiences to prevent crises, promote adaptive behaviors, and develop skills to maintain mental health stability. DTBH has served a total of 721 consumers during this reporting period.

Summary of Achievements:

- 2,309 consumers were served at theses clinics which included 1,480 unduplicated individuals enrolled in the CWBC Specialty Program and 108 unduplicated individuals were served at CWBC- Mild to Moderate program during FY 2019.

Program Improvements:

- Various general improvements are recommended on the following areas:
- Hours of operation:
- CWBC is open Monday - Friday from 8 am- 5 pm. CWBC is not open during the weekends nor Holidays. A majority of the clients that we serve in both programs work during the day and can benefit from late hours for appointments (i.e. after 5 pm and/or weekends).
- Consumers that arrive close to closing time are briefly screened, triaged and then linked to EPS for further screening and assessment.
- Same day medication appointments for consumers that need them can improve consumer wellness.
- Safety Infrastructure:
- Metal detectors, cameras and security guards are needed as consumers can get aggravated compounded by wait times and lack of medication in the waiting areas.
- Staffing at both clinics is limited based on the increased flow of consumers coming to county clinics.
- Low capacity at referral clinics makes it difficult to transfer consumers to their proper level of care.
- Not having enough Senior Financial Counselors to assist clients with benefit enrollment is also challenging.

Community Services and Supports: General System Development (GSD)

Hope Services: Integrated Mental Health and Autism Services			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Children Ages 0 – 15 ☒ TAY Ages 16-24 ☒ Adult Ages 25-59 ☒ Older Adult Ages 60+	GSD	750
Goals			
Outcome 1:	Individuals who have developmental disabilities and mental health issues are able to access needed services to support their wellbeing		
Outcome 2:	Consumers are stabilized or experience improved integration in social settings		

Description:

Hope Services was designed to improve the quality of life for individuals with developmental disabilities through providing counseling, case management, and psychiatric services to children, adolescents, young adults, adults, and senior citizens with a qualifying mental health diagnosis and a developmental disability. Hope Services supports consumers by providing treatment that supports both autism and mental health issues. Without these combined services, consumers may engage in behaviors that result in institutionalization, hospitalization, and arrest. Eligible consumers receive the following services at the San Andreas Regional Center (SARC), where Hope Services is embedded within SARC's outpatient services:

Wellness and Recovery Action Plan (WRAP) Services: Group experience to prevent crises, promote adaptive behaviors, and develop skills to maintain mental health stability. Autism and Co-Occurring Disorders: Mental health treatment for people with autism and coexisting behavioral health challenges.

Hope Services staff are fluent in 13 languages besides English: Russian, Spanish, Japanese, Italian, French, Catalan, Cantonese, Mandarin, Portuguese, Hindi, Tagalog, German, and Vietnamese.

Summary of Achievements:

- The program has been functioning above expectation due to the ongoing readiness to take on more clients despite the staffing challenges.
- The program's biggest challenge is with capacity. Nevertheless, the program maintains average and above average overall functioning despite the capacity issues.

Program Improvements:

- Additional staffing to accommodate the ongoing capacity issues.
- Provide wellness and medication services to consumers who are not requiring ongoing services but on their way to recovery and good quality of life.

Community Services and Supports: General System Development (GSD)

CalWORKs Community Health Alliance			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2018**
Continuing	☒ Adult Ages 25 – 59	GSD	634
Goals and Objectives			
Outcome 1:	Consumers develop increased self-sufficiency and work readiness.		

Description:
The CalWORKs Community Health Alliance (Health Alliance) provides behavioral health services to adult clients enrolled in the Welfare-to-Work (WTW) Program who experience mental health and substance use challenges. Health Alliance is a partnership between Santa Clara County Social Services Agency, Substance use Treatment Services (SUTS, formerly known as DADS) and BHSD. The purpose of this partnership is to provide comprehensive behavioral health services for CalWORKs clients and their family members. CalWORKs places mental health services within the employment support program to help address issues that prevent people with mental health issues from obtaining and maintaining employment which can help them transcend poverty.

Health Alliance uses a behavioral health model that focuses on the health of the whole person by providing individualized counseling and other services to enhance and support self-sufficiency. These holistic services include: on-site short-term solution-based therapy/counseling for clients who drop-in or call-in for short-term issues; long-term off-site therapy/counseling for clients who require services longer than 3-4 visits; emotional wellbeing; behavioral challenges; stress management; psychosocial functioning; and transitional housing services. Health Alliance also partners with community college and adult education programs to provide on-site individual counseling, support groups, and educational forums to clients. Community-based providers leverage Medi-Cal to fund services while the County CalWORKs team is completely funded by CalWORKs funds.

Summary of Achievements:
- Consumers were linked to services within a set of Performance Learning Guidelines.
- Consumers continued to pursue college classes and obtain employment.
- Consumers received referrals for Psychiatric Evaluations and medication support. There was a reportedly significant reduction in self harm.

Program Improvements:
- Work on reducing stigma associated with receiving Behavioral Health Services as an educational goal. Develop strategies to improve follow up after a referral has been made. Program participation has declined in recent years.
- Increase outreach to Community Colleges where CalWORKS enrolled beneficiaries attend school to improve consumer admission.
- Conduct psychoeducational sessions at Social Services Sites to provide needed education and outreach to CalWORKS clients in collaboration with direct care service providers.
- Develop outreach materials for Behavioral Health to send out to all CalWORKS beneficiaries.

Success Story:

Client came to therapy after leaving a long-term abusive relationship. After a long period of not working and being isolated, she left the relationship, and moved to a shelter with her children. Not only did she make huge life changes, she also regularly reached out to others in a similar position to help. She stepped down from intensive counseling, receiving full time employment and permanent housing.

Justice Services Initiative

Criminal Justice Residential and Outpatient Treatment Programs			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Adult Ages 25-59	GSD	236 (outpatient) 205 (residential)
Goals			
Outcome 1:	Increase stability and quality of life.		
Outcome 2:	Decrease homelessness.		

Description:

Evans Lane Wellness and Recovery Center

Evans Lane Wellness and Recovery Center is dedicated to serving adults who suffer from mental health illness, substance abuse issues, and involvement with the criminal justice system. The Center provides both residential treatment through transitional housing, and a separate outpatient program. The philosophy of the Center is grounded in the Wellness and Recovery Model which supports recovery by enabling consumers to take responsibility for their lives, enhancing their self-sufficiency, developing their abilities and confidence, enhancing their support network, assisting them in finding meaningful roles in the community, mitigating health and behavior risks, and teaching them to manage their mental illness through a WRAP® (Wellness Recovery Action Plan). Individuals can be connected to the Center through the following mechanisms:

- Gardner
- Community Solutions
- Catholic Charities
- Probation Department
- Parole
- Drug Treatment Court

Evans Lane – Residential Treatment Program

Evans Lane's Residential Treatment Program provides the following services for individuals involved with justice system services: housing support, extended housing for up to one year, 24 hour support (support, group counseling, group activities, evening and weekend group activities), services and activities are focused on integrating the participants into the community so that they can be stepped down to the Center's Outpatient Treatment Program.

Evans Lane – Outpatient Treatment Program

The Outpatient Treatment Program is comprised of a psychiatrist, clinical managers, and community workers that work in collaboration with the participant to provide psychiatric assessments, comprehensive case management services, medication management, and representation in areas of legal implication. Clinical managers work with participants to provide individualized treatment plans, which include individualized and/or group therapy. While enrolled, clients are coached and encouraged to establish themselves back into society with the proper tools and resources.

Success Story:

Client enrolled at the Evans Lane Wellness & Recovery Center on early January 2019, after having served 14 years in jail and designated as a high-risk client. Initially, the client was observed as mostly quiet and reserved during his first thirty days, but would engage and provide his feedback and experience to other group members regarding the changes he was making to meet his end goals, which included maintaining his sobriety, getting a job, car, housing and completing his supervision term successfully.

The client methodically began to work on achieving his goals by applying for SSI and General Assistance (GA) during the 30- day restriction. After completing his 30-day restriction, the client was proactive in getting a job. The client took advantage of the HVAC training classes offered by a community partner agency and went on a couple of interviews to start building his HVAC network. During that time, the client also met with the Evans Lane Rehabilitation Counselor regarding getting connected to housing services. Within the therapy process, the client utilized the session to continue to process his transition out of custody and adapting to the technological world for which he now was exposed. The client ensured that he had a routine scheduled set, kept his appointments and took his medication as needed.

Within four months of being in the program, the client was able to buy a car with the money he saved up from working at the local community partner agency as well as part of the SSI money for which he had been approved. The client started a new job as a van driver, providing transportation to patients with medical needs. The client although frustrated at times on the requirements requested of him, ensured compliance with all the requests made by the Evans Lane program. Around August 2019, the client disclosed that he had been called for a housing opportunity. The client made certain that he met his housing appointments, communicated with staff and his employer to confirm all the necessary documentation could be provided. The client was approved to move out in early September 2019 but did not move immediately in order to notify and obtain approval from all staff on his multidisciplinary team. With most of the clients that move out of Evans Lane, they are offered to continue with outpatient services but rarely show up; however, The client has been attending his appointments and has been engaged in processing his recent transition out of Evans Lane Residential program. Upon his discharge he plans on moving back to the Central Valley to help care for his aging mother.

Criminal Justice Services - Outpatient Services			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Adult Ages 25-59	GSD	311
Goals			
Outcome 1:	Increase stability and quality of life		
Outcome 2:	Decrease signs and symptoms of mental illness		

Description:

Outpatient Treatment Programs

The County's outpatient treatment programs for justice-involved individuals provide culturally and linguistically appropriate services including individual, group, and family counseling and education on wellness, recovery, and resiliency. These programs offer comprehensive, coordinated services that vary in level of intensity. Outpatient programs may address a variety of needs, including situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, and substance use disorders and other addictive behaviors. There are three outpatient treatment program types in Santa Clara County that serve justice involved individuals with mental illness:

Intensive Outpatient Treatment Program – Momentum

Momentum's Intensive Outpatient Treatment Program teaches justice involved consumers how to manage stress, and better cope with emotional and behavioral issues. The program provides the following services: Group, individual, and family therapy, frequent visits at home or in the community (usually 3-5 days per week), and an average of 34 hours of treatment for a set period of time (often 4-6 weeks, depending on the program). Individuals enrolled in the program may work and continue with normal daily routines. The advantage of this type of program is that people have the support of the program, along with other people working on similar issues.

Proposed Program Changes and Consumer Impact:

- Increase capacity in the stepped/down levels of care so more individuals ready to start lower levels of care can be discharged into appropriate outpatient care services. This would reduce the bottle neck currently observed in the IOP services program.

Aftercare Outpatient Treatment Program – Caminar

Caminar's Outpatient Treatment Program provides the services described above for justice-involved individuals who have been stepped down from a residential treatment program in Santa Clara County, such as Evans Lane's Residential Treatment Facility.

Proposed Program Changes and Consumer Impact:

- Increase available capacity to lower levels of care, including programs within BHSD, as individuals in this program who graduate from justice system services have difficult transitioning. Individuals in need of lower levels of care, having graduated from justice system services can transition to other BHSD programs where they will continue to receive mental health services, opens up capacity for others waiting to transition into the Aftercare Outpatient Treatment Program.

Co-Occurring Outpatient Treatment – Community Solutions

Community Solutions provides outpatient services for individuals with co- occurring mental health issues and substance use disorders. This programs has an increased emphasis on providing alcohol and/or drug treatment services in additional to group, individual, or family therapy intended to support recovery from mental health related issues.

Proposed Program Changes and Consumer Impact:

- Increase access to residential placements for individuals transitioning from incarceration into the community.

Success Story:

50-year old client was referred to Community Solutions by Judge Manley in Department 61 Drug Court originally into the AB-109 program. When we first met the client, client was experiencing depression, isolation, poor boundaries, and emotional more days than not. After 11-months in the AB-109 program, the client successfully stepped down into the Aftercare program. Once stepping down, the client is medication compliant, has established boundaries, and is constantly smiling and joyful. When the client stepped down into Aftercare the client came with beginning skills and strategies to better manage their mental health and daily living skills. Since being enrolled, the client reports having "better developed mindfulness skills through group and working with their case manager" and really appreciated the support they get from the staff.

The client expressed gratitude for the program and Community Solutions as a whole. The client stated "utilizing coping skills, practicing patience with peers and self, setting boundaries, money management, building safe relationships, and safety awareness" since joining the program. The client and case manager are working towards linking the client to a Primary Care Physician for continued medication support. A few recent personal successes for the client inlcude a new lease on housing, purchased a car, and client is now engaged! The client's Self Mantra: "Success through Determination"

Community Services and Supports: General System Development (GSD)

Faith Based Resource Centers			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Adult Ages 24-59	GSD	790
Goals and Objectives			
Outcome 1:	Successful re-entry into community.		
Outcome 2:	Increase in quality of life and stability for those re-entering the community.		

Description:

There are four Faith- Based Resource Center (FBRC) which are operated by three different faith-based organizations in geographically diverse locations within Santa Clara County. The FBRCs are sites where services are provided to people leaving jail or prison and returning to the Santa Clara County community. The Santa Clara County Reentry Resource Center, located in downtown San Jose, serves as the main point of entry for people leaving jail and entering the community. The Reentry Resource Center operates in collaboration with several Santa Clara County departments including the Office of the County Executive, Probation Department, Office of the Sheriff, Department of Correction, Mental Health Department, Department of Alcohol and Drugs, Custody Health, and the Social Services Agency.

Staff from BHSD that represent the Faith Reentry Collaborative are co-located at the Reentry Resource Center. When an individual at the Reentry Resource Center expresses interest in receiving reentry services in a faith-based setting, he or she receives a warm handoff to the BHSD staff for an assessment and orientation to the Innovation 06 project. If the individual wants to participate in one of the FBRCs, BHSD will request FBRC staff meet the individual at the Reentry Resource Center or will arrange the participant's intake at one of the FBRCs. FBRC staff from the three organizations also rotate staffing the County's Reentry Resource Center to assist in the warm handoff.

Summary of Achievements:

- Over 75% were housed or assisted with rental assistance).
- Over 65% gained employment or enrolled in a training program).
- 100% of clients in need of clothes for employment received it (i.e., uniforms or proper footwear and attire).

Success Story:

One of the greatest needs faced by individuals coming out of jail or prison is regaining a sense of hope and self-esteem. While Faith-Based Resource Centers help clients with their initial needs such as food, clothing, housing, employment and transportation, what most clients value most is the moral support they receive at the FBRCs. When one of the clients was released from prison in 2018, she sought help at the Reentry Resource Center (RRC) in San Jose which connected her to one of RRC's Faith-Based partners. The client feels the staff there sincerely care about her, especially her case manager who calls regularly to check on her and provide her with resource opportunities. "It makes me feel good that people believe in me and that there's still hope," the client said.

At 34, the client is ready to turn things around. FBRC helped her with clothing and job interviews as well as educational opportunities and by providing her with a sense of community. The client attends church at the Bible Way Christian Center. "It's a big help, it's like a big community, everyone is so kind. I go and feed my spirit every week," she said. Since being released from custody, the client has regained her Driver's License, received placement in a sober living environment, has

become self sufficient, pays rent, is taking a college course, works more than full time, has kept up with court mandated therapy sessions and participates in Native American dance classes. "She just never gives up and she's always employed," the client's case manager said. The client currently works full time. She also volunteers at FBRC distributing food and helping with events. The client's dream is to open a nonprofit recovery home and she is currently enrolled in a local Community College's Criminal Justice Peer Mentor education program at the Reentry Resource Center (RRC) to become a certified drug and alcohol recovery peer mentor. She was recently selected for a paid internship as a peer mentor at the RRC. For those just coming out of incarceration she stresses the importance of persistence. "Just let people know, don't give up, just keep on pushing forward and it will all work out," the client said, one of the client's favorite inspirational quotes.

Community Services and Supports: General System Development (GSD)

Mental Health Urgent Care			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ TAY Ages 16-24 ☒ Adult Ages 25-59	GSD	1,996
Goals and Objectives			
Outcome 1:	Consumers are connected to urgent mental health care services and experience fewer visits to EPS and episodes of hospitalization.		

Description:

Mental Health Urgent Care (MHUC) is open every day including Holidays from 8 am- 10 pm. MHUC is a walk-in outpatient clinic for Santa Clara County residents who are experiencing a mental health crisis. MHUC provides needs and risks screening and assessment, 5150 screening and assessment, psychosocial assessment, crisis intervention, consultation, referrals, linkages, psychiatric evaluation, brief medication management services up to fifty-nine 59 days and short-term treatment for adolescents (16 y/o & older) and adults (18 y/o & older). MHUC also conducts on- call consultation to Law Enforcement and responds to critical incidents. Law Enforcement Liaison, clinician and the police conduct community crisis outreach and assessment services as needed.

Summary of Achievements:

- MHUC successfully links clients to the proper level of care: a higher level of care (Full Services Partnership Programs) or to lower level of care (Outpatient Clinics and/or Primary Care Behavioral Health Clinics).
- County Clinic staff and clinicians divert consumes from Emergency Psychiatric Services (EPS), Emergency Department (ED) and/or jail by de-escalating and stabilizing clients.

Program Improvements:

- Adding MHUC facilities/satellites in South County or North County to improve access to urgent care services from consumers in those geographical areas that may not be able to drive up or down to the one mental health urgent clinic in the county.
- Staffing at both clinics is limited based on the increased flow of consumers coming to county clinics.
- Low capacity at referral clinics makes it difficult to transfer consumers to their proper level of care.
- Add Senior Financial Counselor positions stationed at MHUC to assist clients with signing up or reactivating

their benefits (i.e Medi-Cal and Medi/Medi Insurance).
- Increase safety infrastructure (add metal detector, cameras, security guards, etc.).

Community Services and Supports: General System Development (GSD)

Crisis Stabilization Unit and Crisis Residential Treatment			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Adult Ages 25-59 ☒ Older Adult Ages 60+	GSD	368 (CSU) 677 (CRT)
Goals and Objectives			
Outcome 1:	Consumers experiencing crisis access the support they need to avoid unnecessary hospitalizations or incarceration as a result of crisis episodes.		

Description:
The County's Crisis Stabilization Unit and Crisis Residential Program provides an unlocked, community-based alternative to hospitals for individuals experiencing a mental health crisis who do not need services in a locked setting. They support consumers in avoiding hospitalizations or incarcerations as a result of experiencing crisis episodes.

Crisis Stabilization Unit (CSU): The CSU provides specialty mental health crisis stabilization lasting less than 24 hours to/on behalf of a beneficiary for a mental health condition that requires a more immediate response than a regularly scheduled mental health visit. The CSU serves as an alternative to Emergency Psychiatric Services (EPS) and provides consumers with a secure environment that is less restrictive than a hospital. The CSU accepts individuals admitted on a voluntary basis. Services include crisis stabilization, psychosocial assessment, care management, medication management, and mobilization of family/significant other support and community resources.

Summary of Achievements:
- Supported 368 consumers who would otherwise frequent emergency psychiatry services for brief stabilization.
- CSU provides observation services in a less restrictive environment in order to prevent hospitalization.

Crisis Residential Treatment (CRT): In a continuum of care, CRTs are typically used for people who don't need involuntary treatment and are used instead of inpatient hospitalization (I/P) or a Psychiatric Health Facility (PHF) because they are less costly and they serve as home-like environments which facilitates an easier to transition back into one's own home than from a hospital. In CRTs, the consumers assist with daily household tasks like cooking a meal and doing the dishes, in addition to receiving psychiatric/recovery services.

Summary of Achievements:
- Served 677 individuals during this reporting period with crisis residential facilities at capacity on any given day.

Success Story

"I was too much in my mind," says 60-year-old female. "I just wanted to go away." On the eve of Chinese New Year, her boyfriend of three years said that his wife was coming to the U.S. — the client did not know he was married. Lost in "the dark space," hurt herself with the intention of ending her life. The program met the client two months later when she was transferred from the psychiatric hospital to our Crisis Residential program. The client is thriving and looking forward to a new chapter

Community Services and Supports: General System Development (GSD)

Community Placement Team Services and Institution of Mental Disease (IMD) Alternative			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ TAY Ages 16-24 ☒ Adult Ages 25-59 ☒ Older Adult Ages 60+	GSD	77
Goals and Objectives			
Outcome 1:	Increased connection to care to reduce the number of consumers cycling between institutional settings and homelessness		

Description:

The Community Placement Team (CPT) coordinates placement at MHSA-funded residential and temporary housing programs for consumers being discharged from Emergency Psychiatric Services (EPS) and/or the Barbara Arons Pavilion (BAP) who are also high utilizers of mental health services. The goal of the CPT is to provide a smooth transition for consumers after they experience a crisis by identifying and facilitating a supportive "landing pad" as they return to the community, preventing future crisis, and increasing participation in services. CPTs may refer consumers to services that support breaking the cycle of hospitalization, institutionalization, and homelessness. Such services include FSPs, clinic appointments, or supportive housing.

The Institution of Mental Disease (IMD) Alternative Program utilizes MHSA funds to provide intensive day treatment services for consumers transitioning from IMDs back to the community. Services are co-located at board and care facilities— Drake House and Crossroads Village— which provides housing to consumers stepping down from an IMD level of care. Crossroads Village has a 45- bed capacity and serves adults ages 18-59 with serious mental illness or co- occurring diagnoses. Crossroad Village uses a recovery-oriented approach to developing treatment plans through an equal partnership between the individual and treatment team. Services include clinical and psychosocial supports. Drake House offers quality residential programs and mental health treatment services to adults and older adults in Monterey County. Services include: 24/7 Staffing, Nursing Support Services and Medication Assistance.

Summary of Achievements:

- 77 consumers served in FY2019.

Older Adult System of Care (60 and older)

Community Services and Supports: Full Service Partnership

Full Service Partnership

Older Adult Full Service Partnership (FSP)			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Older Adult Ages 60+	FSP	64
Goals			
Outcome 1:	Promote recovery and increase quality of life		
Outcome 2:	Decrease negative outcomes such as hospitalization, incarceration, and homelessness		
Outcome 3:	Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports.		

Description:

As with the Adult FSP program, Santa Clara County has identified the need for multiple levels of Older Adult FSP in order to appropriately and efficiently serve individuals with varying levels of mental health needs, because the intensity and frequency of service engagement should vary considerably based on level of need. Santa Clara County estimates that approximately 500 adults and older adults are in need of FSP services and require high levels of intensity and frequency of services in order to maintain connected with their integrated service team. The County also estimates the need for a lighter level of touch for a majority of individuals who are currently engaged with the County's FPSs (approximately 320 individuals), because they have become stable through engagement with the program. For older adults, the following criteria must be met for FSP enrollment: Their mental disorder results in substantial functional impairments or symptoms, or they have a psychiatric history that shows that, without treatment, there is an imminent risk of decompensation with substantial impairments or symptoms; due to mental functional impairment and circumstances, they are likely to become so disabled as to require public assistance, services, or entitlements.

They are unserved and experience one of the following:

- Homeless or at-risk of becoming homeless;
- Involved in the criminal justice system; and/or
- Frequent users of hospital or emergency room services as the primary resource for mental health treatment.

They are underserved and at-risk of one of the following:

- Homelessness; involvement in the criminal justice system and/or institutionalization.
- FSP programs provide a collaborative relationship between the County and the consumer and when appropriate the consumer's family. Through this partnership, providers plan for and provide a full spectrum of community services so that the consumer can achieve his/her identified goals.

Summary of Achievements:

- 64 consumers enrolled in an FSP during this reporting period
- Clients were assisted with funding for housing.
- Each client that did not have a primary care physician at the time of enrollment was successfully linked to primary care services.

Older Adult Full Service Partnership (FSP)

ETHNICITY	FY18	FY19
Asian/Pacific Island	9	5
Black/African American	1	1
Hispanic	14	12
Mixed Race	0	0
Native American	0	0
Other Race	4	4
Unknown	9	8
White	33	34
GENDER		
Female	39	42
Male	31	22
LANGUAGE		
English	57	56
Mandarin	0	0
Spanish	4	3
Tagalog	0	0
Other	6	4
Vietnamese	3	1

Community Services and Supports: General System Development

Outpatient Clinical Services for Adults and Older Adults

Outpatient Services for Older Adults			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Older Adult Ages 60+	GSD	1,123
Goals			
Outcome 1:	Improve functioning and quality of life for older adults.		
Outcome 2:	Reduce symptoms and impacts of mental illness for older adults.		
Outcome 3:	Reduce the need for a higher level of care for older adults.		

Description:

Outpatient programs for older adults aim to improve quality of life, address unique mental health needs, and prevent higher intensity care by supporting aging in place whenever possible. Santa Clara County's older adult outpatient programs provide a continuum of Outpatient and Intensive Outpatient services to adults age 60 and over who are often dealing with symptoms of depression, anxiety, and mental health issues due to the loss of loved ones, job loss or retirement, reduced income and status, isolation, medical issues, and changes in living situation. Programs under this category: Outpatient Program (formerly PEI Outpatient Services Program); Intensive Outpatient Program; and, Golden Gate Comprehensive Older Adult Program.

Summary of Achievements:

- 1,123 older adult consumers were served at a lower level of care resulting in reduced hospitalizations.
- Assisted older adults with funding for housing.
- Assessed clients with needing medication services were linked to a psychiatrist.
- Linked older adult clients to clinician, a peer support worker or a resource specialist based on needs.

Community Services and Supports: General System Development

Older Adult Community Services Initiative

Connections Program			
Program Status	**Priority Population**	**Service Category**	**Numbers Served in 2019**
Continuing	☒ Older Adult Ages 60+	GSD	1,810
Goals			
Outcome 1:	Improve functioning and quality of life for older adults at risk of abuse and neglect.		
Outcome 2:	Reduce symptoms and impacts of mental illness for older adults.		
Outcome 3:	Reduce risk of abuse and neglect.		

Description:

The Connections Program is a collaboration with Adult Protective Services (APS) to provide case management and linkage services to older adults who are at risk of abuse or neglect and have come to the attention of APS. The Connections Program primarily serves older adults with mental illness who are very isolated, homebound, and not currently connected to mental health services. In addition to mental health needs, older adults who come through APS referrals are often at risk for physical and financial abuse and neglect. Many of the older adults who receive services through Connections have a serious mental illness— including schizophrenia, anxiety, and bipolar disorder— and are experiencing untreated symptoms. Additionally, serious financial abuse, the risk of losing one's home, and lack of a support system are among the risk factors commonly faced by consumers of this program.

Summary of Achievements:

- 1,810 clients 60 years and older received behavioral health services during FY2018, a 2% increase over the previous year.
- 1,228 (68%) continued in treatment and 583 were discharged. 22% of the discharges were successful, an improvement compared to 17% in the prior year.

Workforce Education and Training (WET)

Program Status: Continuing

Description:

The original WET allocation, a one-time funding source that accompanied the passage of Proposition 63 was exhausted in June 2016. Santa Clara County has continued to allocate funding to WET as a carve-out of CSS funding. The mission of the MHSA WET is to address community-based workforce shortages in the public mental health system. It seeks to train community members and staff to develop and maintain a culturally and linguistically competent workforce that includes consumers and family members. The WET activities include:

1. Training Coordination (W1): Positions budgeted for Workforce, Education and Training infrastructure are charged entirely to this budget. The infrastructure supports the education and training of underrepresented populations to enter the mental health workforce and advance within the system as desired.
2. Promising Practice-Based Training (W2): This activity expands training for BHSD and contract CBO management and staff, consumers and family members, and other key stakeholders. The training will promote and encourage the integration of Wellness and Recovery methods, the value of providing peer support, and the use of staff with "lived experience" via a continuous learning model.
3. Improved Services and Outreach to Unserved and Underserved (W3): This project expands specialized cultural competency training for all staff to improve services to ethnic and cultural populations. Ethnic and cultural populations are broadly defined to include marginalized populations such as, people of color, the elderly, youth, people with disabilities, LGBTQ individuals, immigrants and refugee populations.
4. Welcoming Consumers and Family Members (W4): This activity develops and implements training, workshops and consultations that support an environment that welcomes consumers and family members as contributing
   partners in the public mental health system. It creates a Consumer/Family Member Training Coordinator whose focus will be to advance the educational, employment, and leadership opportunities for consumers and family members in public mental health.
5. WET Collaboration with Key System Partners (W5): This project builds on the collaboration between the Mental Health Department and key system partners to develop and share training and educational programs so that consumers and family members receive more effective integrated services.
6. Mental Health Career Path (W6): This includes a position and overhead budgeted to support the development of a model that supports BHSD's commitment to developing a workforce that can meet the needs of its diverse population. This action plan includes a program staff who is trained in the principles of recovery, strength-based approaches and culturally competent interventions. The needed "cultural change" in the transformation process is expected to occur as the workforce's composition changes to include more individuals who have "lived experiences" as consumers and family partners and who come from the diverse cultural, ethnic and linguistic underserved and unserved communities that the Santa Clara

County BHSD seeks to serve.

7. Stipends and Incentives to Support Mental Health Career Pathways (W7):
   This activity provides financial support through stipends and other financial incentives to attract and enable consumers and family and community partners to enroll in a full range of educational programs that are prerequisites to employment and advancement in public mental health.

Achievements:

Workplan	Clients Served	Achieved Outcomes	Barriers to Success	Program Improvements
W1. Training Coordination	n/a	n/a	n/a	Continuing staffing levels to support WET implementation
W2. Promising Practice-Based Training	4909 (duplicated)	Improved outcomes for clients – clients are receiving higher quality of services by a trained and competent workforce.	No shows and poor attendance rate of trainings – due to busy schedules and workforce demands. No shows and poor attendance rate of trainings – due to busy schedules and workforce demands.	Continue funding for workforce training as staff/community based direct services providers are required to attend evidenced based trainings and collect continuing education units to maintain their licensure.
W3. Improved Services and Outreach to Un-, Underserved Populations	1057 (duplicated)			Continue funding for workforce training as staff are required to annually attend culturally competent/cultural humility/CLAS trainings and collect continuing education units to maintain their licensure.
W4. Welcoming Consumers and Family Members	196 (duplicated)			Continue funding for workforce training to further the skills and expertise of peer staff in BHSD
W5. WET collaboration with Key System Partners	478 (duplicated)			Continue funding for law enforcement and other community and system partners trainings.

W6. Mental Health Career Path	Provided educational support for the level I Marriage, Family Therapists (MFT) and Psychiatric Social Workers (PSW)	● Mental Health Peer Support Worker career ladder established in Santa Clara County. ● Increased opportunities for entry level positions. ● Increased opportunities for staff development.	● Time frame to develop career ladder for the Mental Health Peer Support Worker is longer than expected due to challenges hiring the Consumer/Family Affairs Division Director ● Busy workloads affect participation in the educational support groups.	Continue funding so that work can continue to develop career ladder for multiple Mental Health Peer Support Worker levels.
W7. Stipends and Incentives to Support Mental Health Career Pathways	County and Contractor staff, students and consumers/family members. -Seven students received scholarships at SJSU. *31 County Student Interns *2 County Peer Interns *16 CBO Student Interns *7 CBO Peer Interns	● Increase in workforce capacity ● Better client outcomes	External organizations offer competitive internship opportunities	Continue to fund intern program to continue attracting people to work in the behavioral health workforce
WET Administration	This component supports managerial and clerical positions in Behavioral Health Administration, Contracts, Finance, Information Systems, Quality Assurance and other system-wide administrative functions as it related to MHSA programs and services.			

Capital Facilities and Technological Needs (CFTN)

Program Status: Continuing

Description:

The Capital Facilities & Technological Needs (CFTN) component works towards the creation of facilities that are used for the delivery of MHSA programs and services consumers and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families. The following efforts include development of varies capital facilities needs and technology uses and strategies. This includes upgrades to community-based facilities, potential opportunity to purchase Adult Residential Treatment services facilities which would support integrated service experiences that are therapeutic and provide low-barriers in access to care.

Pursuant to the **Welfare and Institutions Code (WIC) Section 5892(b)**, Counties may use a portion of their CSS funds for WET, CFTN and the Local Prudent Reserve. It is further specified that the total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years. Once allocated to either the WET or CFTN Plan, in order to expend those funds, the County must also conduct a public process to specifically outline the intended use of those monies and receive final approval from their Board. Furthermore, funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund, WIC § 5892, (h)(1).

1. **CFTN Support Staff:** Leads, project team members and subject matter experts are participating in the EPIC/ HealthLink electronic health record and Netsmart/ Practice Management System Solution implementation. Participants include line staff and mid-managers with expertise in clinical, billing and registration workflows. An annual budget of $1,711,566 for this effort.
2. **Potential purchase of residential care facilities for adults with serious mental illness** at a cost of $8 million. If the county is successful in purchasing these properties, the intent would be to house the BOS-approved, new Adult Residential Treatment (ARTs) programs for adults with serious mental illness, who are stepping down from intensive services. Without the option of an ART placement, individuals would remain in Mental Health Rehabilitation Centers (MHRCs) for extended periods of time, which could lead to increased rates of relapse once back in the community.

Innovations Projects (INN) Report Update

The Innovations projects, listed below, will support service delivery transformation; integrated, culturally-sensitive approaches to wellness; and a new prevention/early intervention model for youth, modeled after an internationally recognized best practice.

Client/Consumer Individual Placement and Support (IPS) Employment Program: This three-year project seeks to transform how the service delivery system views and supports employment, shifting from a single service to a critical component of recovery and element of treatment. Using the consumer-driven Individual Placement and Support (IPS) evidence-based practice, this project integrates employment as a wellness goal for clients/consumers and provides an array of individual supports to help clients and consumers achieve their goals. A contract with Rockville Institute was executed to provide training, technical assistance, and evaluation services. Partner IPS agencies have been secured and they include Catholic Charities, Fred Finch, and Momentum. In June 2019, Rockville Institute conducted a fidelity training for providers and will be conducting fidelity reviews at each agency from January through March 2020. Additionally, an IPS trainer, hired by County of Santa Clara will be leading the fidelity reviews to build capacity for IPS within the county system. Monthly provider meetings led by Rockville Institute take place to discuss challenges and successes. In the first quarter, the competitive employment rate was 28% and participants worked a median of 20 hours per week at a median wage of $15.00/hour. Most jobs were in service occupations or clerical and sales occupations. Momentum hired an IPS specialist and had 30 clients enrolled and 5 placements. They shared a story about a Momentum client that started working at Safeway. Every aspect of this client's life is chaotic but his job is going well. Another provider, Catholic Charities shared that they have strong demand for the program with 40 participants enrolled in the program and 15 people placed in jobs. All positions are competitive market employment. Fred Finch, a provider serving transitional age youth said that there is an extremely high level of engagement with the IPS model and the TAY population. Families and case managers are working together. All providers shared that the zero-exclusion principle and the employment specialist being an embedded member of the mental health team were reasons for the program's success. Future activities include establishing a relationship with Department of Rehabilitation to provide additional services to participants.

Faith-Based and Spiritual Training and Supports: Often times congregants first seek faith and spiritual leaders' assistance when experiencing mental health distress. This two-year project aims to increase faith-based leaders behavioral health knowledge, skills, and responses to individuals seeking their help through the development of customized behavioral health training plans. In turn, faith and spiritual leaders will enhance behavioral health services providers' understanding of the role of spirituality in client/consumer wellness and recovery goals. A service contract has been executed with NAMI Santa Clara County and an evaluator has been secured. NAMI SCC is in the process of hiring and training staff. Focus groups are being conducted with spiritual leaders from five priority populations: African-American, Chinese, Filipino, Latino, and Vietnamese. Behavioral Health 101 training plans and curriculum are being developed and piloted in various faith cultural communities to increase knowledge about behavioral health resources, promote referrals to services, and decrease mental health stigma.

Psychiatric Emergency Response Teams (PERTs) and Peer Linkage Project: This two-year project will utilize a co-response intervention model with teams that include a licensed clinician paired with a law enforcement officer. The goals are to de-escalate crisis situations, prevent unnecessary hospital visits, connect individuals to appropriate services and provide post-crisis peer support services. The project will take place in Palo Alto and discussions have been occurring with Palo Alto Police Department and the Sheriff's Office. An evaluation contractor has been secured and meetings are taking place on a bi-weekly basis. An informational interview was held with San Diego County's PERT to learn about best practices. A

PERT and peer linkage workflow and an evaluation plan are in the process of being developed. This project has experienced challenges and delays, which include difficulty in hiring clinicians and in executing MOUs with law enforcement. Recruitment is underway for clinicians and there is now agreement with the law enforcement agencies on the role of clinicians working with officers.

allcove (formerly headspace) Integrated Youth Health Centers Ramp-Up and Implementation: This four-year project is presented in partnership with Stanford University's Center for Youth Mental Health and Wellbeing. The project will develop a "one stop shop" integrated health and mental health care prevention center for youth ages 12-25, which will include on-site counseling and psychiatric services, alcohol and substance use services, primary care, and educational and employment resources. Two centers are expected to open in Palo Alto and San Jose in 2020. The centers will be youth-friendly, culturally and linguistically responsive, and accessible to youth, with involvement from a youth advisory group (YAG), helping to develop the centers from the ground up. With direct youth input and guidance from the YAG, the services will be tailored to meet the needs of the adolescents and young adults served in each of the centers.

Learning goals include:

- Will an integrated service model increase access to services?
- What are the best approaches to engage youth in the design?
- What are the barriers and facilitators to accessing the sites?
- What financial model will be adopted?
- Will allcove improve social, emotional, physical well being indicators?

The YAG, which consists of 27 youth and young adult members representing the county's diverse population worked in partnership with IDEO.org to develop the allcove name, branding guidelines, and a playbook which reflects the look, feel, and experience of the centers. The meaning behind allcove is "all" stands for "all are welcome" and "cove" represents a "safe space for youth." Partnerships with community-based organizations, Alum Rock Counseling Center, County of Santa Clara Facilities and Fleet, Santa Clara Valley Medical Center Primary Care, County Counsel, Compliance, and others are being established in preparation to launch implementation planning meetings in August 2019.

Innovations Projects: Discontinued

After close consideration and weighing in of feasibility of implementation in the current environment, the Department is recommending the following innovation projects are discontinued and not pursued at the current time.

Multi-Cultural Center

The Multi-Cultural Center (MCC) Project, approved in 2010 in the amount of $481,791, develops a model to increase access to underserved and inappropriately served ethnic communities by establishing a Multi-Cultural Center to house activities and services for multiple ethnic communities delivered by peer and family partners. This project aims to create a welcoming, accessible, and safe place where members of all ethnic communities can experience cultural resonance, belonging, and support. The project provides peer support to individuals with mental health issues and engages individuals in mental health services, including prevention and early intervention and offers opportunities for videos and life presentations of testimonials from ethnic community members recovering from mental illness to de-stigmatize the condition, discuss deep-seated cultural beliefs, and reduce fear about using mental health service.

The County of Santa Clara Behavioral Health Services Department (BHSD) Leadership decided not to move forward with implementation of the MCC as an Innovation project due to challenges in finding space for the center. However, BHSD will use Prevention and Early Intervention (PEI) funds in the amount of $1. 5 million to establish five culture-specific Wellness Centers. Culture-Specific Wellness Centers offer space for un-, under-, and inappropriately served groups to gather and participate in community caregiving and healing. Wellness Centers are designed specifically for Latino, African American, LBGTQ+, Asian/Pacific Islander, and Native American populations and communities. Wellness Centers offer low-barrier access to mental health services, community building and culture specific practices, and other recovery-oriented activities. Understanding that some populations have historically faced discrimination from government and/or mental health systems, Wellness Centers focus on building trust between the community and service providers. Unlike traditional Medi-Cal authorized services, Wellness Centers operate with an open-door policy. Clinical mental health services are co-located in the centers with non-clinical cultural activities and programs. Individuals participating in these non-clinical cultural activities and programs are welcome to participate without limit. This project launched in 2019-2020.

Room Match

Santa Clara County has identified insecure housing as a barrier to mental health care access and consistent utilization of mental health services. The Room Match Innovation Project Proposal was designed to support the housing needs of consumers receiving or in need of mental health services through systemized connections to available rooms within the community. Meeting housing needs and incorporating choice for both consumers and renters would aim to reduce the risk of homelessness, relapse, hospitalization, and arrest for individuals with mental health needs. This proposed housing project was designed to seek out available bedrooms in homes that might be used for both short- and long-term housing. Given the current housing crisis, homeless youth and young adult consumers who have serious mental health issues, including hospitalizations, are increasingly vulnerable to housing insecurity that can result in their cycling through institutionalizations without consistent long-term care. The program would target these individuals, as well as older adults, for services that would link them to individuals and families within the community that have rooms available for rent. The project proposal included specific recommendations for both short-term 3-6 months “bridge” housing and long-term

rentals and provided detailed recommendations for the project.

Following meetings with the County's Office of Supportive Housing (OSH), it became evident the proposed project would not move forward. OSH is currently funding a similar "Room Match Program" for LGBTQ youth in partnership with a community-based organization, so it was decided that this project would no longer be considered innovative. Additionally, after researching the cost of development of an app, BHSD determined that it would be very expensive and cost prohibitive and the app would not support the complexity of the matching process. A coordinator and case manager would be needed to oversee the matching process to ensure a good fit for both the client/consumer and renter and updating the app would be time intensive. This project was not presented for approval at the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Friendly Calling Older Adult In-Home Outreach Team/Reach Out, Engage, and Connect

The Friendly Calling Older Adult In-Home Outreach Team/Reach Out, Engage, and Connect project is a proposed project that will provide culturally responsive mental health services for isolated adults over 60 in Santa Clara County via a multilingual phone line. This project will target underserved or unserved older adults who experience isolation and/or depression and who may be homebound. For this population, isolation may be the result of many factors such as the loss of a life-long partner or other loved ones, medical problems, financial constraints, unstable housing, and caregiving responsibilities. Mental health resources that could benefit isolated older adults tend to be inaccessible to them due to a lack of information and support in accessing services. Friendly Calling is designed to connect isolated older adults to supportive services they would otherwise have difficulty accessing. The program will be widely publicized and referrals will come from consumers' family, faith-based community resources, senior community centers, senior housing programs, and the medical community. The service will be staffed with Elder Peer staff, who have been trained in this specialized service and who will serve as Navigators or *Promotores* to help consumers navigate the system of care. The staff will call and engage each consumer, establish and build trust, provide understanding and a sense of connection, and help to address the individualized needs of each consumer. Elder Peers will visit consumers in their homes as necessary and make "warm handoff" referrals to mental health and community services that meet each consumer's needs. This project was not presented for approval at the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Due to the immediate need for this project, the BHSD decided that this will not be an Innovation project, but instead will be incorporated into the Adult/Older Adult System of Care. The project will become a component of an existing program, which is already mobilizing peers from the community to provide counseling and visitation to support older adults.

Technology Suite for Community Mental Health

Santa Clara County originally was interested in joining multiple counties across California in implementing the Innovative Tech Suite. This project intended to bring interactive technology tools into the public mental health system through a highly innovative suite of applications designed to educate users on the signs and symptoms of mental illness, improve early identification of emotional/behavioral destabilization, connect individuals seeking help in real time, and increase user access to mental health services when needed. The Department met with the MHSA SLC to discuss and strategize on the recommended applications and content and identify those which would be the most beneficial to the populations we serve.

After meetings with CalMHSA, it was determined that this project would not be a good fit for County of

Santa Clara. Joining the cohort requires a large financial investment. Additionally, the project was launched two years ago and has yet to have any County adopt an application or report positive health outcomes. Stakeholders have expressed concern about privacy and additional concerns that peers providing chat support in the application do not have lived experience or enough training. An additional challenge is linkage to local emergency services when crisis situations might occur. This project was not presented for approval at the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Mental Health Services Act FY19 Annual Prevention and Early Intervention Programs Report

SANTA CLARA COUNTY BEHAVIORAL HEALTH SERVICES DEPARTMENT

JULY 1, 2018 – JUNE 30, 2019.

PREVENTION AND EARLY INTERVENTION (PEI) DESCRIPTION

The MHSA PEI programs are intended to implement strategies that prevent mental illness from becoming severe and disabling. Prior to the new PEI definitions and revised PEI regulations of October 15, 2015, Santa Clara County had developed and adopted PEI programs that emphasized reaching and serving individuals and families who are subject to cumulative risk factors (prevention, early intervention) as well as reducing disparities in access to services (access and linkage to treatment). The PEI program priorities, based on those definitions, emphasize a lifespan approach, founded on strong system partnerships, rooted in cultural competency throughout, and focused on connectedness.

In 2018, Santa Clara County released its FY 2018 – 2020 three-year plan along with the Santa Clara County MHSA Needs Assessment Report conducted by Resource Development Associates (RDA). At this time, the new PEI regulations, including program categories and program strategies, were incorporated, aligned and measured. This served as the foundation for the categorization of PEI programs in the three-year plan, and helped to initiate efforts to collect data for the programs in each of the strategies.

The FY2021 – 2023 MHSA Three-Year Plan community program planning process is set to begin in January 2020, following the selection and orientation of the new MHSA Stakeholder Leadership Committee (SLC). An innovative and collaborative MHSA Planning Forum will be held in January 2020. At this planning forum, which will be widely publicized to community partners, consumers, providers and staff, the Santa Clara County MHSA team will provide an overview of the MHSA Community Program Planning Process, share preliminary data and findings from listening sessions, identify system strengths, service gaps and opportunities, and provide participants with the opportunity to share their input on current and future MHSA programming. The findings and recommendations will serve as the foundation for the planning process.

For the purposes of this report, the state-defined categories are being aligned with Santa Clara County's existing PEI program structure. Additionally, the state-defined PEI strategies are being aligned based on program goals and objectives in all existing PEI programs. As required, Santa Clara County MHSA PEI programs all are stand-alone programs.

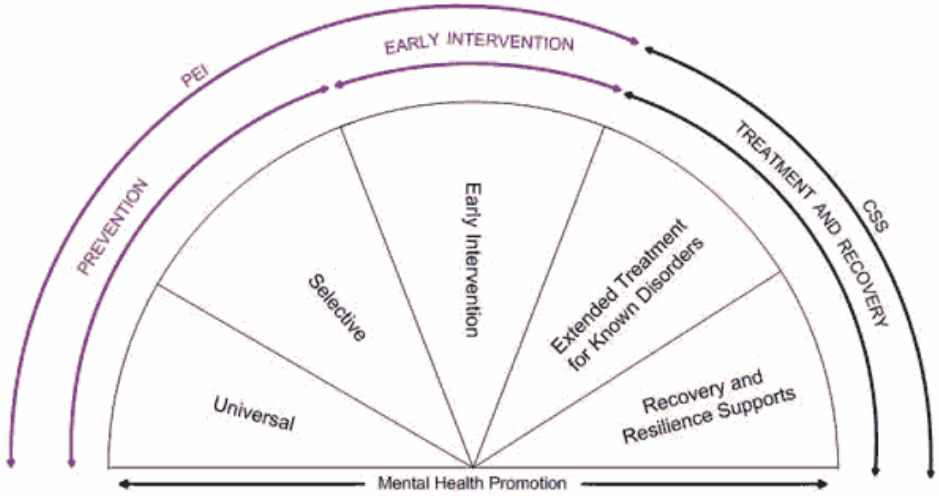
KEY STATE DEFINED PEI PROGRAMS

1. Prevention Program
2. Early Intervention Program
3. Outreach for Increasing Recognition of Early Signs of Mental Illness Program
4. Access and Linkage to Treatment Program
5. Stigma and Discrimination Reduction Program
6. Timely Access to Services for Underserved Population Program
7. Suicide Prevention Program

KEY STATE DEFINED PEI STRATEGIES

1. Access and Linkage to Treatment
2. Improving Timely Access to Services for Underserved Populations
3. Strategies that are Non-Stigmatizing and Non-Discriminatory
4. Outreach for Increasing Recognition of Early Signs of Mental Illness

This diagram shows the spectrum of MHSA services from prevention through treatment and recovery. For purposes of this report, Prevention and Early Intervention programs will be addressed.



SANTA CLARA COUNTY PEI PROGRAM INITIATIVES

There are currently five PEI overarching initiatives offering a broad range of services and system improvements targeted to age groups across the lifespan. Each initiative may have multiple program components. These are the key PEI Program Initiatives:

1. PEI P1: Community Engagement and Capacity Building for Reducing Stigma and Discrimination
2. PEI P2: Strengthening Families and Children
3. PEI P3: PEI Interventions for Individuals Experiencing Onset of Serious Psychiatric Illness
4. PEI P4: Primary Care and Behavioral Health Integration for Adults and Older Adults
5. PEI P5: Suicide Prevention Strategic Plan

STAKEHOLDER DEFINED PRIORITY POPULATIONS IN SANTA CLARA COUNTY

The FY 2019 PEI report focuses on the five key PEI priority populations that resulted after the three-year community planning process in the FY2018 – 2020 Three Year Plan:

1. Underserved Cultural Populations
2. Trauma Exposed Individuals
3. Children and Youth in Stressed Families
4. Children and Youth at Risk for School Failure
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement

LOCAL PEI PROGRAM ALIGNMENT WITH STATE REQUIREMENTS

Current County PEI Plan	PEI Program Name	State Defined PEI Program
1. Community Engagement and Capacity Building for Reducing Stigma and Discrimination	Elder Story Telling	• Early Intervention Program
	Community Wide Outreach and Training	• Outreach for Increasing Recognition of Early Signs of Mental Illness Program
	Law Enforcement Training	• Outreach for Increasing Recognition of Early Signs of Mental Illness Program
	Ethnic and Cultural Community Advisory Committee (ECCAC)	• Stigma and Discrimination Reduction Program
	Culture is Prevention	• Stigma and Discrimination Reduction Program
	Office of Consumer Affairs	• Access and Linkage to Treatment Program
	Office of Family Affairs	• Access and Linkage to Treatment Program
	Mental Health Advocacy Project	• Access and Linkage to Treatment Program
	Re-entry	• Access and Linkage to Treatment Program
	LGBTQ	• Access and Linkage to Treatment Program
2. Strengthening Families and Children	Violence Prevention Program	• Prevention Program
	Intimate Partner Violence Prevention	• Prevention Program
	Support for Parents	• Prevention Program
	Nurse Family Partnership Program	• Prevention Program
	Reach Out and Read	• Prevention Program
	School Linked Services – school site coordinators	• Early Intervention Program
	School Linked Services – school based services	• Early Intervention Program
	Triple P – Positive Parenting Program	• Prevention Program

3. Interventions for Individuals Experiencing Onset of Serious Psychiatric Illness	Raising Early Awareness and Creating Hope (REACH)	• Early Intervention Program
4. Behavioral Health Integration for Adults and Older Adults	New Refugees Program	• Stigma and Discrimination Reduction
5. Suicide Prevention Strategic Plan	Suicide and Crisis Services (SACS)	• Access and Linkage to Treatment
	Suicide Prevention Strategic Plan	• Suicide Prevention

PEI P2 PLAN – VIOLENCE PREVENTION PROGRAM

Dating violence is more common than many people think. One in three teens in the U.S. will experience physical, sexual or emotional abuse by someone they are in a relationship with before they become adults. The good news is dating violence can be prevented through community education and evidence-based strategies, which are offered through the Healthy Relationships program, described below.

1. Healthy Relationships: a program of the Public Health Department (PHD) using evidence-based strategies to increase awareness about community resources and healthy relationships among youth. Outreach and education are a major component reducing violence in youth and younger groups. Teams work with PHD to better educate and increase the public's knowledge on healthier ways to interact with each other and when to seek help.
2. In addition to this program, BHSD will partner with the County's Office of Women's Policy to better address an alarming growing trend on intimate partner violence (IPV). The Centers for Disease Control (CDC) describes IPV as a serious, preventable public health problem that affects millions of Americans. The term "intimate partner violence" describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. The goal is to stop IPV before it begins.

The planning for the Violence Prevention Program is in progress, and the Behavioral Health Department hopes to work with county partners and stakeholders to launch this soon.

PEI P1 PLAN – ELDER STORYTELLING

The new Elders' Storytelling Program will serve culturally isolated older adults with mild to moderate depression using the culturally proficient technique of life review and storytelling (reminiscence) and incorporating innovative service component to help reduce the elder client's depressive symptoms and restore their position of social connectedness with their family, friends, caregivers and community.

The storytelling practice model includes (1) a community outreach component to engage and screen the elder participants who may be reluctant to seek mental health services and (2) the storytelling intervention delivered by bilingual Peer Specialists with the ability to engage and support the elder population and trained in delivering the storytelling practice model while being supervised by licensed clinicians. The service is provided to elders who are screen to have mild to moderate depressive symptoms. (Those elders identified as having severe depression will be referred to existing outpatient mental health treatment services.)

Integral to the success of the model is the incorporation of the language, culture and life experience of the clients served. Each client shares his/her story as it is elicited and documented by the Peer Specialist who speaks the client's language and is knowledgeable of their culture and life experience. The service include family members, has a pre-tests and post-tests component, and service duration of 12 weeks which concludes with a community event where the participants may share their story or related art pieces with family and members of their community. This project is slated to begin in Fiscal Year 2021.

PEI P1 PLAN – MENTAL HEALTH ADVOCACY PROJECT

The Mental Health Advocacy Project (MHAP) was established in 1978 through the Law Foundation of Silicon Valley, and provides legal and advocacy services to over 5,000 clients per year. MHAP is the only legal assistance organization in Santa Clara County that provides specialized services for people identified as having mental health issues or developmental disabilities. MHAP works to expand the rights and promote the social dignity of consumers by participating in the reform of the political, economic, and social structures that affect their lives, and by increasing public awareness of the social problems they experience. MHAP's mission is to empower people identified as having mental health issues or developmental disabilities to live more independent, secure, and satisfying lives through the enforcement of their legal rights and the advancement of their social and economic wellbeing.

MHAP provides free legal and advocacy assistance through the work of advocates and attorneys in three practice units:

- **Economic Rights** provides assistance with public benefits, mainly SSI, SSDI, Medi-Cal, Medicare, CalWORKs, Healthy Families, and General Assistance; some consumer rights; and equal access to public services.
- **Housing Rights** addresses issues of housing and homelessness by defending against evictions; assisting with housing complaints including discrimination, reasonable accommodations, abuse and neglect, landlord/tenant conflicts, and habitability; addressing Section 8 voucher and public housing terminations; and opposing shelter discharges.
- **Patients' Rights** works on both the individual and system levels to ensure compliance with laws governing mental health patients' rights in psychiatric facilities and programs, and represents patients in mental health due process hearings. They also help individuals with autism, mental retardation, and similar conditions with complaints about developmental services, including access to regional center services. All residents of Santa Clara County who are or have been identified, or who self-identify, as having mental or developmental disabilities qualify for services.

MHAP also provides information and referral in the areas of rehabilitation, employment, family, and criminal law. During FY2019, this project expanded to increase service capacity.

PEI P1 PLAN – RE-ENTRY RESOURCE CENTER

The Re-Entry Resource Center is a multi-disciplinary team that provides custodial and non-custodial individuals with referral and wrap around services. The program offers linkages to: mental health outpatient services; alcohol and drug treatment and care; resources to the faith communities; peer mentoring; housing; general assistance benefits; health referrals; transitional case management; and a clothes closet. This overall assessment and wraparound services include custody health, mental health, probation, DADS, SSA, housing, and peer mentors.

In collaboration with the CJS, community based-service providers, peer navigators in this project will conduct outreach and engagement activities to increase connectedness to behavioral health resources and services among justice involved adults. The goal is to connect justice involved adults and their families in a timely manner to access appropriate mental health prevention and early intervention services upon release from incarceration and into community services. This program continued to progress in FY 2019.

PEI P1 PLAN – LGBTQ+ ACCESS AND LINKAGE

This project will specifically address the disparities in access to mental health services for the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ+) population of Santa Clara County. A team of LGBTQ+ Peer Navigators, in collaboration with the Department's Ethnic and Cultural Communities Advisory Committee (ECCAC), County Office of LGBTQ+ Affairs and community based-service providers, will conduct outreach and engagement activities to increase connectedness to behavioral health resources and services.

The goals are to connect LGBTQ+ individuals and their families in a timely manner to access appropriate mental health prevention and early intervention services and to expand LGBTQ+ across the system to build capacity for this cultural group.

Additionally, the project will support youth and their families by integrating support across the lifespan, using a best practice model for training and technical assistance for families and providers to better serve, understand and support LGBTQ+ youth in our communities.

This program is in process. The program started to hire staff and has started planning and executing trainings for the LGBTQ+ community in FY 2020.

PEI P1 Plan – ETHNIC AND CULTURAL COMMUNITIES ADVISORY COMMITTEES (ECCACs)

CULTURAL COMMUNITIES WELLNESS PROGRAM, FORMERLY KNOWN AS ETHNIC AND CULTURAL COMMUNITY ADVISORY COMMITTEES (ECCAC), aims to reduce disparities in service access by unserved and underserved communities, increase knowledge of behavioral health conditions; reduce stigma and discrimination within the context of culture; and increase community prevention and healing capacity through natural support systems. Services include community engagement and education through 1) outreach to ethnic communities and their cultural leaders and community based organization, and 2) provide workshops and trainings to providers who serve cultural communities, consumers, family members and community members.

UNDUPLICATED NUMBER SERVED:

- **INDIVIDUAL SERVICES: 224**
- **TRAININGS/EVENT SERVICES: 8,033**

NUMBER OF INDIVIDUAL FAMILY MEMBERS SERVED (INCLUDED IN UNDUPLICATED COUNT ABOVE):

- **INDIVIDUAL SERVICES: 59**
- **TRAININGS/EVENT SERVICES: 3,998**

POSITIVE RESULTS

- We have a new program name that is reflective of our current program activities: Cultural Communities Wellness Program.

PEI P1 Plan – ETHNIC AND CULTURAL COMMUNITIES ADVISORY COMMITTEES (ECCACs)

- We continue to maintain and create new collaborations with ethnic/cultural organizations, City of San Jose, City and County libraries, schools, faith-based organizations, housing programs and shelters, community centers, and law enforcement and the criminal justice system.
- We started advertising our Mental Health First Aid Trainings widely and received a lot more requests for trainings for providers and service recipients. This has enhanced our efforts to increase knowledge about mental health and how to assist someone who is experiencing mental health concerns.
- The Department continues to contract with a community organization to provide services to the LGBTQ community.

IMPLEMENTATION CHALLENGES

- It is difficult to recruit and retain culturally and linguistically competent staff with lived experience as consumers and family members. We currently have five vacancies, including the program support position.
- It is difficult to respond to community needs and provide services in a timely and culturally appropriate manner due to the complexity and time consuming County processes.
- We have a high percentage of decline to answer for demographic data. We have made attempts and will continue to find ways to help participants feel comfortable providing demographic information. We believe it's due partly to minority groups' mistrust in "government."
- Attempts to collect disability, gender identity and sexual orientation data resulted in participants expressing concerns about violation of privacy, and refusal to answer these questions, or worse, the whole questionnaire.
- We stopped entering demographic data to our existing database because we are working with IS to create a new and improved database that could be shared among all programs employing Peer Support Workers.

LESSONS LEARNED

- Having staff with lived experience who have strong connections with their communities and speak the languages of the communities contribute greatly to program success.
- Continuous training and support for program staff contribute to staff career development and program success.
- Having a database where staff can record their work provide details on services, areas of success and improvement, ease of reporting, and feedback for staff on their work.

RELEVANT EXAMPLES OF SUCCESS

- We have ongoing partnership with HomeFirst. We are providing Mental Health First Aid and Question, Persuade, and Refer trainings to all their staff at different locations. In FY2019, we provided trainings to 126 health care professionals and staff.

PEI P1 Plan – ETHNIC AND CULTURAL COMMUNITIES ADVISORY COMMITTEES (ECCACs)

- We also have ongoing relationship with Evergreen Valley College where we have ongoing Mental Health First Aid and Question, Persuade, and Refer trainings. In FY2019, we provided trainings to 261 students and staff.

Success story from a Program staff:

One important thing I would like to share is whenever we inform our participants that we are mental health peer support workers and we come with our lived experience, we always get at least one or two people thanking us for sharing our story. I think it is really important to share our own personal story when it comes to our journey to wellness and recovery because it has a humanistic touch. It shows the good, the bad, and the reality of living with mental illness. And that there is hope!

One in particular which I will never forget is when we did our first QPR training for HomeFirst agency. There was a particular staff member who was so touched by our sharing, that he also opened up. He said it was his first time in 45 years to share about his own battle with mental illness, and as a man who struggled with mental illness, it was not easy for him to accept his illness both culturally and socially. After the training, he was teary eyed, proud of himself, approached us and thanked us for the work that we do out in the community. He said that it really touched him and inspired him to be educated more on mental health and to inspire others that there is hope!

PEI P1 PLAN – ETHNIC AND CULTURAL COMMUNITIES ADVOCACY COMMITTEES (ECCACS)

OUTREACH ACTIVITIES

A total number of **695** potential responders were reached during this reporting period. The following table describes the settings in which the potential responders were engaged.

Type of Setting(s) **(ex: school, community center)**	Type(s) of Potential Responders **(ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.**
Adult Day Health Care Center	Service providers and recipients
Behavioral Health Services Department (BHSD)	Service providers (County and Contract), consumers, family members, community members
BHSD self-help centers	Staff, consumers, family members, community members
Charities: Goodwill, Salvation Army	
Cities: Morgan Hill, San Jose, Santa Clara, Milpitas, Cupertino, Sunnyvale	
Community based organizations	Service providers and recipients, family members, community members
Cultural Groups	
Cultural specific organizations	African American, Ethiopian, Eritrean, Somali, Chinese, Filipino, Latino, Native American Vietnamese, LGBTQ and other cultural communities
Funeral Homes	
Homeless Shelters/Housing Programs	Service Providers and recipients
Hospitals and medical services	Service Providers, patients, volunteers

Housing and Homeless services	
Law enforcement, custody	Sherriff: enforcement and custody, police officers
Law offices	
Local Businesses	Service providers and recipients
Mother and infant care	
Professional Groups	
Public Libraries: San Jose, Santa Clara	Administrators, managers, supervisors, staff, community members
Santa Clara County Departments: Social Services Agency, Valley Health Center, Probation, Public Health, District Attorney	Service providers and recipients, family members, community members
School Districts	Administrators, teachers, staff, parents, community members
Schools: elementary, middle school, high schools, school districts, colleges, universities, vocational schools, academies, and student clubs	Principals, teachers, staff, parents, professors, faculty, students, community members
Senior services	
Skilled nursing and subacute facilities	Care providers
Spiritual and faith-based organizations, churches, temples, mosques	Priests, monks, ministers, imams, scholars, rabbis, congregation, worshipers, community members
Subacute Skilled Care	
Substance use treatment center	Service providers and recipients.
Transportation services providers	Drivers
Veteran Affairs (VAs)	Providers for veterans, veterans
Volunteer groups	Volunteers

FISCAL YEAR 2019 PROGRAM DEMOGRAPHICS

(COMBINED TRAINING AND OUTREACH ACTIVITIES)

Race/Ethnicity (n= 4,057)	%
American Indian or Alaska Native	2
Asian	15
Black of African American	5
Native Hawaiian or other Pacific Islander	< 1
Hispanic	12
White	4
More than one race	< 1
Declined to Answer	61
Primary Language (n=4,058)	%
English	21
Spanish	5
Other Non-English	5
Declined to Answer	70
Sexual Orientation (n=4,116)	%
Gay or Lesbian	< 1
Heterosexual/Straight	14
Bisexual	< 1
Questioning or unsure of sexual orientation	< 1
Genderqueer	< 1
Another sexual orientation	< 1
Declined to Answer	84

Disability Status (n=4,047)	%
Yes	< 1
No	8
Declined to Answer	92
Veteran Status (n=4, 058)	%
Yes	< 1
No	9
Declined to Answer	91
Assigned sex at birth*	N/A
Current Gender Identity (n=4,057)	%
Male	23
Female	40
Transgender	< 1
Another Gender Identity	< 1
Declined to Answer	37
Age Group (n=4, 057)	%
CYF (0-15)	< 1
TAY (16-25)	2
Adults (26-64)	11
Older Adults (65+)	2
Declined to Answer	84

*Data not available

PEI P2 PLAN – STRENGTHENING FAMILIES AND CHILDREN

KIDCONNECTIONS NETWORK (KCN) is a coordinated system that identifies children through age five with
suspected developmental delays and/or social-emotional and behavioral concerns. KCN utilizes an innovative model that blends First 5 and MHSA funds. Through KCN, BHSD bridges children ages

Prenatal to 5 years and their families to services to support their optimal growth and development. Children receive assessment and treatment services aimed to intervene and address early signs of mental health and developmental delays. Services for children ages 0-5 focus on providing quality screening, assessment, early intervention and intervention services, and service linkages that promote the healthy growth and development of children. Children who are Medi-Cal, Healthy Kids, and/or FIRST 5 eligible qualify for these services.

MHSA funds a system of care manager appointed to oversee behavioral health services provided through KCN for children ages 0-5. BHSD also provides a clinic manager to oversee therapeutic and developmental services provided through KidScope. KidScope is a comprehensive assessment center that serves children suspected of having complex developmental delays, serious behavioral problems, or other undetermined concerns. As part of these services, KidScope provides targeted diagnostic assessments (TDA) Level 2 for children and families needing this level of care. TDAs are multidisciplinary assessments that include parent conferences to discuss developmental, medical, and/or mental health findings and recommendations. BHSD supports TDA services by providing a manager to oversee TDAs provided at KidScope.

UNDUPLICATED NUMBER SERVED: 1,666
INDIVIDUAL FAMILY MEMBERS SERVED: 1,666

POSITIVE RESULTS

- BHSD Call Center is providing a more robust triage to families referred supporting the process of timely access for families to prevention or early intervention services that are appropriate to meet their reported needs.
- KCN served 1,666 children and their families in FY18. 1,129 new referrals and 537 children continuing services from previous fiscal year.
- 348 children referred to a higher level of assessment through KidScope's Targeted Diagnostic Assessment (TDA) and of those, 266 children received a TDA to better understand needs and linkage to services.
- A total of 1,599 referrals were made to community resources that included KidScope's TDA clinic and services such as FIRST 5 funded family resource centers, School Districts, Early Start Program and San Andreas Regional Center.

IMPLEMENTATION CHALLENGES

- Having enough capacity to support families that are referred into BHSD Call Center needing KCN services in order to ensure timely access.
- Ensuring timely access to meet DHCS final rule of 10 business days to access for families needing services.

LESSONS LEARNED

- Referrals into BHSD Call Center are receiving a more robust triage process that is supporting timely access to appropriate services but there is still more work needed to be done to decrease the days to service once a family is referred and then open to services.
- Referrals into BHSD continue to have a small percentage that do not pan out when contacted for triage by BHSD call center staff which informs that there needs to be better outreach and education to referral sources on KCN services.

Number of individuals with SMI or SED referred to BHSD treatment system (includes county and CBO providers): 1,426

Type of treatment referred to:

- KCN is a BHSD system of care. All children and families linked to BHSD Call Center receive a screening to determine linkage to a county or CBO provider for KCN services.
- Targeted Diagnostic Assessment – deeper level assessment within KidConnections Network

Number of individuals who followed through on referral & engaged in treatment: 1,129

Number of referrals to a **Prevention** program: 2,144

Number of referrals to an **Early Intervention** program: 1,426

Number of individuals followed through on referral & engaged in early intervention treatment services: 1,129

Average time between referral and participation in treatment: 16 days

FISCAL YEAR 2019 PROGRAM DEMOGRAPHICS

*Data not available

Age (n=1,666)	%
Children/Youth (0—15)	100
Race (n=1,666)	%
Asian	9
Black of African American	3
White	9
Other	70
More than one race	9
Ethnicity (n=31)	%
Non-Hispanic	100
Primary Language (n=4,058)	%
English	51
Spanish	40
Other Non-English	9
Sexual Orientation*	N/A
Disability*	N/A
Veteran Status*	N/A

PEI P2 PLAN – STRENGTHENING FAMILIES AND CHILDREN

CULTURE IS PREVENTION PROGRAM, in partnership with Indian Health Center, is designed to provide culturally-specific services to Indian/Alaska Native (AI/AN) adults that include, but not limited to, traditional dancing, arts and crafts, ceremonies, and gatherings to identify and address early onset of behavioral health issues, counter stressors, and build self-esteem and coping skills. The program also provides outreach and engagement services in a variety of settings, including home, community clinics, schools, and community agencies as needed depending on consumer needs. Additionally, program staff promote mental health wellness, education, cultural sharing, outreach, and community collaboration through workshops, trainings, presentations, and partnerships with local community organizations.

Program Description:

San Jose Native Youth Empowerment Program:

A creative space for native youth to learn about their culture, higher education, art, health education, healthy living, and to make positive changes in their community.

Song and Dance:

Song and Dance class was designed to improve and promote self-esteem, self-image, intergenerational connectedness, and cultural native pride by teaching and providing a space to participate in powwow singing and dancing.

Parenting Class:

Traditional Paths to Wellness Workshop is a six-week workshop series designed for American Indian/Alaskan Native families to learn about cultural identity, health & fitness, traditional foods, and healthy relationships.

Cultural Arts Classes:

Cultural Arts Workshops offered are traditional Native American practices that have social uses and meanings that make them different from other arts: They strengthen the community and bind the people closely together and reinforce a sense of tribal identity. Community artists teach beadwork, sewing, quillwork, basketry and other forms of cultural expression.

UNDUPLICATED NUMBER SERVED: 133

POSITIVE RESULTS

- The program has had great success with its prevention programs including youth group, positive parenting workshops, dance and drum class and other cultural activities.

IMPLEMENTATION CHALLENGES

- The main challenge in the program was primarily adjusting the registration form to match the reporting requirements.

- In addition, tracking referrals has also been a challenge due to prevention services being a separate program from behavioral health services

LESSONS LEARNED

- The program needed additional staff, which they plan to hire in the Fall of 2019.

RELEVENT EXAMPLES OF SUCCESS

- Overall, the program serviced 133 community members this year. It feels honored to assist in helping to support a healthy community.

OUTREACH ACTIVITIES

A total number of **2,694** potential responders were reached during this reporting period. The following table describes the settings in which the potential responders were engaged.

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Community Event: Summer Softball Slam	Community, Leaders, Teachers, Providers, Youth, Parents, Consumers
Community Event: The Gathering	Community, Leaders, Teachers, Providers, Youth, Parents, Elders, Consumers
Community Event: NAHN at Oakland A's Stadium	Community at Large
Community Event: NAHN at SJ Earthquakes Stadium	Community at Large
Community Event: Mini Pow Wow	Community, Leaders, Teachers, Providers, Youth, Parents, Elders, Consumers
School: Yerba Buena High, Community Event	Community, Leaders, Teachers, Providers, Youth, Parents, Elders, Consumers
Community Event: AIA Holiday Dinner	Community, Leaders, Teachers, Providers, Youth, Parents, Elders, Consumers
Community Center: FGT gift distribution	American Indian Community at Large
Community Event: AIA New Year's Pow wow	Community, Leaders, Teachers, Providers, Youth, Parents, Elders, Consumers
School: Independence High, Youth	American Indian / Alaskan Native Youth ages 14-17

Workforce	
Community Event: Mexica New Year at Prush Park	Community, Leaders, Teachers, Providers, Youth, Parents, Elders, Consumers
Community Center	Community Leaders, Providers, Teachers
Community Gathering at Public Park	Community, Leaders, Teachers, Providers, Youth, Elders, Consumers
School- College	Community, Leaders, Teachers, Providers, Youth, Parents, Elders, Consumers, Students
Community Center	Providers, Community Workers, Leaders
School- High School	Community at Large

FISCAL YEAR 2018-2019 PROGRAM DEMOGRAPHICS

Race/Ethnicity (n=133)	%
American Indian or Alaska Native	45
Asian	1
Black of African American	0
Native Hawaiian or other Pacific Islander	0
Hispanic	0
White	3
Other	16
More than one race	7
Declined to Answer	29
Primary Language (n=133)	%
English	95
Spanish	3
Other Non-English	2
Sexual Orientation* (n=133)	N/A
Disability Status* (n=133)	N/A

Veteran Status* (n=133)	N/A
Assigned sex at birth (n=133)	%
Male	35
Female	59
Declined to Answer	7
Current Gender Identify* (n=133)	N/A
Age Group (n=133)	%
CYF (0-15)	32
TAY (16-25)	20
Adults (26-64)	35
Older Adults (65+)	9
Declined to Answer	4

*Data not available.

PEI P1 PLAN – Office of Family Affairs

OFFICE OF FAMILY AFFAIRS (OFA) provides families with direct support, information and education, with the goal of providing recovery and hope. OFA provides Individual Peer Support and Family Wellness Recovery Action Plan (WRAP) groups available in English and Spanish. WRAP is a wellness tool that families and individuals can use to develop a plan that supports wellness and recovery for everyone in the family.

UNDUPLICATED NUMBER SERVED: 231
NUMBER OF INDIVIDUAL FAMILY MEMBERS: 231

POSITIVE RESULTS

- Effective working relationships with Court system – Family Affairs able to work collaboratively with the Public Defender's office that leads to better outcomes for the clients – decreased or no jail time for clients suffering from Mental Illness.
- Family Affairs staff able to increase understanding of mental illness to other court staff
- Family Affairs staff provides education to law enforcement cadets and officers at CIT Trainings

IMPLEMENTATION CHALLENGES

- Family Members existing support system lacks understanding of mental illness and recovery – leads to misinformation and conflict.
- Lack of resources and services for clients who want to leave a locked/correctional facility. Clients stay longer than necessary in correctional sites because there are not openings for placement that increases stressors for family members.
- Peer Support Workers provide resources to individuals, but do not make referrals based on a person's SMI or SED status

LESSONS LEARNED

- Family Affairs staff would have benefited of having a better understanding of the court system so that could be stronger advocates for the clients they serve.
- Staff to attend more trainings dealing with clients suffering from both Mental Illness and Substance Use.

RELEVANT EXAMPLES OF SUCCESS

- Clients have decreased jail times and increased treatment services
- Family members report that EPS visits have declined for their loved one in crisis due to having a Family WRAP.
- Family members able to network and get support with other family members at the Family WRAP groups.

OUTREACH ACTIVITIES

The following table describes the settings in which the potential responders were engaged.

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
7/18/18 American Legion	Clients, General Public
4/8/19 Pathways Society	Clients, Clinicians
5/4/19 Gilroy Public Library	Clients, Providers, General Public, Community Members and Organizations
5/17/19 Gilroy Senior Center	Clients, Senior Citizens, Providers, Community Members and Organizations
6/20/19 Gilroy Compassion Center	Clients, Homeless Community, Providers
2/6/19 Litteral House Crisis Residen	Clients, Residents, Providers

FISCAL YEAR 2018-2019 PROGRAM DEMOGRAPHICS

Race (n=231)	%
American Indian or Alaska Native	0
Asian	0
Black of African American	0
Native Hawaiian or other Pacific Islander	< 1
White	5
Other	9
More than one race	0
Declined to Answer	85
Primary Language (n=231)	%
English	13
Spanish	3
Other Non-English	84
Sexual Orientation*	N/A
Disability Status*	N/A
Veteran Status*	N/A
Assigned sex at birth (n=231)	%
Male	15
Female	6
Decline to Answer	79
Current Gender Identify*	N/A
Age Group (n=231)	%
CYF (0-15)	< 1
TAY (16-25)	6
Adults (26-64)	13
Older Adults (65+)	1
Declined to Answer	79

*Data not available.

PEI P1 PLAN – Office of Consumer Affairs

OFFICE OF CONSUMER AFFAIRS (OCA) provides peer support in three clinics and two Self-Help centers. Self-Help Centers provide a safe, confidential and supportive environment for those dealing with mental illness. Operated by and for mental health consumers and some family members, these Centers provide support for individuals who want to take control of their lives. Individuals who share a disability have something to offer each other which cannot always be provided by traditional services. The Centers are run by welcoming and friendly consumer staff, who provide services with respect and dignity. The Centers are drop in. Peer Support Services at Behavioral Health Clinics provide clients with psychoeducational and recovery support groups, one-on-one recovery support, psychoeducational presentations. The Mental Health Peer Support Worker (MHPSW) maintains communication with psychiatrists, therapists, rehabilitation counselors, and community workers via clinical consult meetings and staff meetings regarding clients' needs. The MHPSW provides supplemental support to clients in the form of a professional peer-relationship based on shared lived experience, an understanding of the ups and downs of the recovery process, the sharing of healthy coping tools, and building hope within the recovery journey. Peer support helps consumers with behavioral health challenges with wellness and recovery groups, individual support, and linkages to community resources. Peer support differs from clinical services as it provides trained peer staff with lived experience in navigating the system and finding their own path to wellness and recovery.

UNDUPLICATED NUMBER SERVED: 1,368
NUMBER OF INDIVIDUAL FAMILY MEMBERS: 28

POSITIVE RESULTS

- We had the addition of two staff at Esperanza Self-Help Center which has helped immensely.
- We have offered Educational and Community Program Presentations ranging from Alexian Brother Homeless Clinic and services, Independent Living Programs, Economic Rights, Disability Rights, Patient Rights, Resident Rights, Social Security programs, and Transformational Care.
- We have also provided social events such as our Valentine's Day Dance, Annual Art Show, May is Mental Health Month, Halloween Dance, Arts & Crafts Fair, Thanksgiving Event, and our Annual Holiday Party.

IMPLEMENTATION CHALLENGES

- Collecting PEI demographic data while protecting PHI and using EHR Unicare has been challenging. We have collected some PEI demographics but have not entered ongoing returning clients to update the new PEI requirements of PEI demographics. (We are challenged programmatically because we need more staffing in the clinics because we have lost peer support in two clinics. We need peer support in the Self-Help Centers for staffing coverage.)
- We need additional office support to help with administrative tasks for the entire Consumer Affairs Program. Right now, the peer support staff is doing many administrative duties, which takes away from their peer support duties. We are in the process of recruiting an office support staff.

LESSONS LEARNED

- We are trying to figure out a better way to collect PEI on MHSA data by implementing better data collection procedures.

- We have streamlined distribution of tasks at Zephyr with the loss of a Lead Mental Health Peer Support Worker.

RELEVANT EXAMPLES OF SUCCESS

- We have supported clients getting employed or linked up to employment services for self-sufficiency.
- Clients have been housed, placed in shelters, peer respite, connected to supportive housing, and registered in the VI-SPDAT homeless database.
- Clients have been placed into detox programs and entered substance abuse rehabilitation programs.
- Clients have been supported and completed the legal process of probation and supported with other legal issues with positive outcomes.
- We have connected clients to many resources in the community for financial assistance with security deposits, utility bills, past due rents, and first month's rent to obtain or maintain their housing.
- We have supported clients with issues involving their Social Security Disability Income (SSI/SSDI) payments, debit cards and overpayments.
- We have supported clients with hording cleanup assistance and post clean-up support.
- We have connected clients to in-home support services and other community independent living programs and services to support their desire for independence with the least amount of support.
- We have connected clients to financial aid for going back to school.

OUTREACH ACTIVITIES

The following table describes the settings in which the potential responders were engaged.

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
7/7/17 Litteral House	Clients
8/22/17 The Hub	Clients, Clinicians
11/14/17 Home First	Clients, clinicians
3/08/18 VA 05/19/18 Gilroy Mental Health Fair 05/23/18 Gilroy Clinic 06/14/18 Mariposa Alcohol Treatment & Drug Addiction & Recovery Center 06/14/18 Pathways Addiction Services 06/25/18 Gilroy Veterans Hall 07/18/18 American Legion Hall	Veterans, clients, clinicians
3/21/18 Litteral House	clients
4/24/18 Re-entry Center	Homeless, clients, health care providers
5/19/18 Gilroy MH Fair	General public, clients, providers
5/23/18 Gilroy Clinic	Clinicians, doctors
6/14/18 Mariposa Recovery	Clients, clinicians
6/25/18 Gilroy Veteran's Hall	Veterans, clients, clinicians
7/18/18 American Legion	Clients, general public

PEI P1 PLAN – Office of Consumer Affairs

FISCAL YEAR 2018-2019 PROGRAM DEMOGRAPHICS

Race (n=262)	%
American Indian or Alaska Native	11
Asian	10
Black of African American	3
Native Hawaiian or other Pacific Islander	7
White	34
Other	14
More than one race	2
Declined to Answer	18
Primary Language (n=109)	%
English	86
Spanish	5
Other Non-English	9
Sexual Orientation*	N/A
Disability Status*	N/A
Veteran Status*	N/A
Current Gender Identity (n=1177)	%
Male	14
Female	10
Decline to Answer	76
Assigned sex at birth*	**N/A**
Age Group (n=1369)	%
CYF (0-15)	< 1
TAY (16-25)	2
Adults (26-64)	91
Older Adults (65+)	5
Declined to Answer	2

*Data not available.

PEI P2 PLAN – Dependency Advocacy Center

DEPENDENCY ADVOCACY CENTER (DAC) provides the Mentor Parent Program, a program designed to provide guidance to parents in the child welfare system who are struggling with drug and/or alcohol addiction. This program provides the opportunity for parents involved in the child welfare system and Dependency Wellness Court (DWC) to be paired with a Mentor Parent who has first-hand experience navigating the system and supporting recovery efforts.

UNDUPLICATED NUMBER SERVED: 244
NUMBER OF INDIVIDUAL FAMILY MEMBERS: 147

POSITIVE RESULTS

- DAC has been able to support DWC clients with Mentor Parents that are bilingual.
- Outreach efforts continue, to engage fathers.
- Research done through a partnership with San Jose State University School of Social Work noted the percentage of parents who were able to reunify or in progress of reunification with their child was higher among program graduates than clients who withdrew before graduation.
- Research also showed that clients achieved greater self-sufficiency in all areas over the course of their participation in DAC and DWC services.

IMPLEMENTATION CHALLENGES

- Engagement of fathers into this program has been a challenge.
- Engagement of parents in custody and advocating for incarcerated parents to have the opportunity to participate in Dependency Wellness Court (DWC) continues to be a challenge.

LESSONS LEARNED

- Efforts to engage the underserved population of fathers and incarcerated parents requires an increase in outreach and advocacy.
- More robust data tracking to present successful outcomes for this program needs to be in consideration and discussion.

RELEVANT EXAMPLES OF SUCCESS

- 85% of graduates were able to reunify or were working towards reunification with their child(ren).
- Parents felt more self-sufficient and overall improvement in their wellbeing was reported.

FISCAL YEAR 2018-2019 PROGRAM DEMOGRAPHICS

Race (n=110)	%
American Indian or Alaska Native	5
Asian	18
Black of African American	15
White	56
Declined to Answer	5
Ethnicity (n=275)	%
Hispanic/Latino	36
Non-Hispanic/Latino	64
Primary Language (n=241)	%
English	89
Spanish	10
Vietnamese	1
Sexual Orientation (n=244)	%
Heterosexual or Straight	73
Gay or Lesbian	0
Bisexual	1
Queer	0
Questioning or unsure of sexual orientation	0
Another Sexual Orientation	1
Declined to Answer	23
Disability Status (n=244)	%
Yes (Overall)	17
Difficulty Seeing	*5*
Mental Domain	*3*
Physical/Mobility Domain	*2*
Chronic Health Condition	*2*
Other	*5*
No	73
Declined to Answer	10

Veteran Status (n=2)	%
Yes	100
Assigned sex at birth (n=243)	%
Male	41
Female	59
Current Gender Identify (n=244)	%
Male	38
Female	54
Transgender	0
Genderqueer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity	0
Decline to Answer	8
Age Group (n=244)	%
CYF (0-15)	0
TAY (16-25)	14
Adults (26-64)	86
Older Adults (65+)	0

PEI P2 PLAN – Nurse-Family Partnership Program

THE NURSE-FAMILY PARTNERSHIP PROGRAM is an intensive Public Health Nursing home visitation program for low-income, first time mothers and their families. A Public Health Nurse is paired with a pregnant, first time mom, who follows the client through pregnancy, delivery, and until the child is age 2 years old.

UNDUPLICATED NUMBER SERVED: 305
NUMBER OF INDIVIDUAL FAMILY MEMBERS: 158

POSITIVE RESULTS

- NFP has found innovative ways to problem solve staffing changes by training a Generalist PHN into the NFP Program as a reserve PHN. She will continue to provide home visiting services to 2-3 clients and will serve as a backup PHN to future staff who will be out on medical leave or retirement
- NFP successfully hosted an NFP Graduation on October 15, 2018. They had 29 graduates from the program.
- NFP successfully hosted the NFP Store event on June 12, 2018. At this event, NFP clients receive free items for participating in the program. There were 69 clients who attended the NFP Store event.

IMPLEMENTATION CHALLENGES

- Staffing changes (i.e. Leaves, Retirements, County contract negotiations, Promotions, Transfers to other Public Health program outside of NFP) affected caseload building and capacity.
- Client attrition (i.e. moving out of area to less expensive area)
- Not enough staff to properly serve high risk/vulnerable areas, such as in South County
- The client resources needed in the community were not available or difficult to obtain (i.e. Housing, childcare).

LESSONS LEARNED

- Continued outreach in the community is important to maintain a steady flow of client referrals
- Partnering and collaborating with other community agencies is vital in obtaining needed resources for clients
- Continued contact with clients during staffing changes is important in keeping clients engaged with the program and to decrease attrition

RELEVANT EXAMPLES OF SUCCESS

- 100% of mothers who delivered during this time period initiated breastfeeding.
- There were no children during this time period that required an emergency room visit or hospitalization for injury or ingestion

- Of the 15 children that were screened using the ASQ during this time period, 2 children were identified as needing further evaluation. The PHNs provided education on developmental activities, as well as continued to monitor these children for the need of possible linkage to developmental resources

PEI P2 PLAN – Nurse-Family Partnership Program

FISCAL YEAR 2019 PROGRAM DEMOGRAPHICS

Race (n=305)	**%**
American Indian or Alaska Native	1
Asian	16
Black of African American	1
Native Hawaiian or other Pacific Islander	1
White	60
Other	0
More than one race	1
Declined to Answer	20
Ethnicity (n=305)	%
Hispanic/Latino	72
Non-Hispanic/Latino	21
Declined to Answer	7
Primary Language (n=305)	%
English	47
Spanish	40
Cantonese	< 1
Filipino Dialect	< 1
Vietnamese	6
Other Non-English	6
Russian	
Age Group (n=305)	%
CYF (0-15)	48
TAY (16-25)	31
Adults (26-64)	63
Older Adults (65+)	0

Sex Assigned at Birth*	N/A
Sexual Orientation*	N/A
Veteran Status*	N/A
Disability Status (n=305)	%
Yes	31
-Difficulty Seeing	0
-Difficulty hearing, or having speech understood	< 1
-Chronic Health Condition	52
-Mental Domain	29
-Physical/Mobility Domain	0
-Other	18
No	69
Current Gender Identify (n=305)	%
Male	26
Female	74
Transgender	0
Genderqueer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity	0
Decline to Answer	0

*Data not available

PEI P2 PLAN – Reach Out and Read

REACH OUT AND READ (ROR) is an early literacy and education program, administered by the Valley Medical Center Foundation, in partnership with Santa Clara Valley Medical Center (SCVMC) pediatric clinics to make early literacy promotion an essential part of pediatric health care. ROR is an evidence-based practice that has been demonstrated to increase the frequency of parents reading to their children, improve parent child relationships, and increase kindergarten readiness for participating children. At every well-child check-up, from six (6) months through five (5) years, pediatric providers give each child a new and developmentally appropriate book to take home and read with parents. Physician screening for developmental delays is part of the program, and children with identified developmental delays are referred to specialists for further services to ensure that problems are addressed early, before adverse effects are fully realized in a school setting

UNDUPLICATED NUMBER SERVED: 556

POSITIVE RESULTS

- Over 12,000 families were provided books to support caregiver/child interactions and early literacy.
- Books are now available to various languages for families with limited English capacity (Vietnamese, Chinese, Spanish)

IMPLEMENTATION CHALLENGES

- Obtaining consistent engagement and support from pediatricians in various clinics due to transitions of MD staff and residents is an ongoing challenge for the program.
- Another issue the program faces is capturing accurate data on the numbers served through ROR due to limited staffing support for this program.

LESSONS LEARNED

- The program has learned that there is a need to develop more robust tracking method to ensure follow through and follow up with families engaged in the ROR program.
- Families appreciate books that are age appropriate to support caregiver/child interactions.

PEI P2 PLAN – Reach Out and Read

RELEVANT EXAMPLES OF SUCCESS

- 30% of parents surveyed reported their relationship with their child has greatly improved, and 23% of parents surveyed reported that their relationship with their child has somewhat improved after enrolling in the program.

FISCAL YEAR 2019 PROGRAM DEMOGRAPHICS

Race/Ethnicity (n=201)	%
American Indian or Alaska Native	0
Asian	40
Black of African American	13
Native Hawaiian or other Pacific Islander	3
White	22
Other	2
More than one race	17
Declined to Answer	1
Primary Language (n=555)	%
English	43
Spanish	46
Chinese Dialect	1
Filipino Dialect	2
Vietnamese	4
Other Non-English	4
Russian	< 1
Sexual Orientation (n=556)	%
Declined to Answer	100

*Data not available.

Disability Status (n=556)	%
Declined to Answer	100
Veteran Status (n=556)	%
Yes	0
No	100
Assigned sex at birth (n=556)	%
Male	0
Female	0
Decline to Answer	100
Current Gender Identify*	N/A
Age Group (n=556)	%
CYF (0-15)	100
TAY (16-25)	0
Adults (26-64)	0
Older Adults (65+)	0

PEI P2 PLAN – School Linked Services: School Based Program

SCHOOL LINKED SERVICES (SLS) program portion supports 11 school district partners and schools. As a response to the need for enhanced school-based service coordination, School Linked Services (SLS) are designed to prevent, reduce, and eliminate emotional and behavioral challenges that may be inhibiting academic success and family wellness for elementary and middle school-aged youth. Services aim to understand students' needs, and link students and their families to the appropriate level of mental health services in the home, school, and community. This program utilizes school campuses as a hub for service delivery to improve access to and coordination of services among students and their families.

To best support children's successes in school, SLS provides services to students and families that aim to improve knowledge, attitude, and behavior relative to academic success and family wellbeing. Based on medical necessity, children and youth are referred to SLS Prevention and Early Intervention (PEI) or SLS clinical services.

For students with higher needs, SLS clinical services provide long-term clinical services such as psychiatry, individual therapy, family therapy, and medication support. In order to receive SLS clinical services, youth must meet medical necessity and Medi-Cal eligibility. All services are co-located at school sites.

The attached report provides demographic and outcome data for the SLS program.

PEI P2 PLAN – School Linked Services (SLS) Coordinators

SCHOOL LINKED SERVICES (SLS) COORDINATORS PROGRAM The School Linked Services (SLS) Program through the SLS Coordinators at the thirteen (13) school districts provides family engagement and service coordination for students and families to community resources. Service linkage may pertain to, but not limited to, behavioral health services, food, and clothing. Family engagement programs relate to prevention and early intervention, including parenting skills, anti-bullying and health education workgroups.

UNDUPLICATED NUMBER SERVED: 6,273

POSITIVE RESULTS

In Fiscal Year (FY) 2018, SLS program provided 6,273 unduplicated students and their families with SLS-related services, including linkages to behavioral health services and workshops on family engagement. The SLS Coordinators administered 528 post surveys in FY 2018. The surveys were administered after a family engagement event at schools. Following their participation in SLS activities, 76% of families felt strongly that the SLS family engagement activity or event provided them with tools to improve their children's academic success. The events also taught parents how to advocate for their children (71%), how to support their children's health and well-being (69%) and who to go to for help at school (78%). In addition, almost all families expressed that their experience participating in a SLS activity or event made them feel much more comfortable and welcomed (86%) and connected to the school community (78%). Nearly all families said they learned things that would help them change the way they interact with their children (75%) and learned about available resources for their families (75%). The majority of families who attended an SLS activity would recommend the activity to other parents (91%).

IMPLEMENTATION CHALLENGES

Part of SLS program implementation includes data collection. One improvement area of the SLS program is streamlining data collection processes. Collecting data from families, school data systems, and SLS Coordinators make it complex to enter and streamline all data variables into one data system. SLS program is partnering with school districts and County Office of Education on the DataZone project to help streamline data collection and analysis. In FY 2019, an SLS application was created in DataZone to allow three of the 13 partnering districts to pilot a streamlined data collection system.

LESSONS LEARNED

Schools are often seen by community members and family as natural community settings, and partnering with schools is critical in reaching and providing behavioral health and wellbeing family engagement services to students and families. Having a point person, such as the SLS Coordinators, at the school and district level is important in streamlining services and resources among students and families. Some school districts informed BHSD that prior to implementing SLS with SLS Coordinators, districts were not aware of services (e.g., basic community resources and mental health services) being offered and organizations being located at their school sites.

RELEVANT EXAMPLES OF SUCCESS

Overall, 76% of service referrals provided by the SLS Coordinators at the school site or district level resulted in successful linkage in FY 2018. The SLS qualitative assessment in FY 2018 with the SLS Coordinators at the 13 school districts yielded a few themes related to the impact of SLS on school systems. The following are some case samples:

- **SLS strengthens school partnerships with community agencies and providers.** One of the SLS Coordinators at the Alum Rock Union School District (ARUSD) developed partnership with South Baptist Community Church to allow English Language Learning students to receive free weekly tutoring by the pastors at the church. The church typically implements a summer camp through a fee. To ensure families have access to summer tutoring programs, the Church has provided admission to the camp free of charge to ARUSD students. At Mount Pleasant Elementary School District (MPESD), the SLS District Coordinator partnered with multiple agencies (e.g., Foothill Community Health Center, Bill Wilson and Alum Rock Counseling Center) to provide anti-bullying presentations and workshops to students. This was the first time the District has partnered with multiple agencies to provide an anti-bullying program.
- **SLS allows schools to address the rising social-emotional wellbeing needs of students through preventive engagement programs.** At the Milpitas Unified School District, the SLS District Coordinator implemented mindfulness practice, every Friday, with fourth, fifth and sixth grade students at Rose Elementary School. This engagement activity reached 165 students. At Campbell Union School District (CUSD), students and families referred to counseling services also participated in SLS-sponsored folklorico classes. Families reported being “happier” after participation in the classes and mentioned that their children were able to learn more about and embrace their cultural background.
- **SLS helps students to improve their academic and behavioral wellbeing.** At both CUSD and ARUSD, students enrolled in a SLS-sponsored tutoring program (e.g., Sylvan Tutoring) saw a one-grade level increase in their math assessment from pre to post intervention. The SLS at MPESD helped a student

from being referred to the office every week for behavioral issues to receiving a scholarship to a summer robotics program. The student and family worked with the SLS District Coordinator throughout the school year to positively transform the student's behavior and academic prospects.

OUTREACH

Approximately 200 potential responders were reached during this reporting period. At schools, the types of responders involved School Linked Services Coordinators, teachers and school administrators. In faith-based organizations, the types of responders involved parents/guardians, students/children, community leaders and school administrators.

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Schools	School Linked Services Coordinators, teachers, and school administrators.
Faith-based organizations	Parents and guardians, students/children, community leaders, school administrators.

ACCESS AND LINKAGE TO TREATMENT STRATEGY

Number of individuals with SMI or SED referred to BHSD treatment system (includes county and CBO providers):

The SLS program provides resource and linkage referrals through a universal prevention approach. To this end, all families and students are able to receive referrals to basic community resources and BHSD services based on different referral sources. Given the service referral is a universal prevention approach, SLS program does not capture data on whether referred individuals have SMI, SED or not.

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

Target population: Students and family members at the 13 partnering school districts

Number of referrals to a Prevention program: 5,157

Number of referrals to an Early Intervention program: 544

Number of individuals followed through on referral & engaged in early intervention treatment services: Overall, of the 5,701 total referrals (i.e., prevention and early intervention), 4,462 were successfully linked (76%)

Number of referrals to BHSD treatment system (beyond early onset): SLS program focuses on universal prevention and early intervention program referrals; not beyond early onset.

FISCAL YEAR 2018-2019 PROGRAM DEMOGRAPHICS

Category	%
Gender	
Male	54
Female	46
Declined to Answer	< 1
Age Group	
CYF (0-15)	94
TAY (16-25)	6
Declined to Answer	< 1
Race/Ethnicities	
Hispanic/Latino	77
Asian/Pacific Islander	9
White	6
African American	3
Multiracial	4
Declined to Answer	1
Primary Language	
English	37
Spanish	56
Vietnamese	4
Other	3
Sexual Orientation*	N/A
Disability*	N/A
Veteran Status*	N/A

*Note: Data not available.

PEI P2 PLAN – Triple P (Positive Parenting Program)

TRIPLE P (POSITIVE PARENTING PROGRAM) is a parenting series implemented throughout Santa Clara County to support families in learning positive parenting techniques to foster positive relationships in the family and reduce challenging behaviors in children zero through 12. Triple P provides various levels and lengths of workshops to support various behavioral and parenting challenges (levels 2, 3, 4, and 5).

UNDUPLICATED NUMBER SERVED: 49

POSITIVE RESULTS

- Santa Clara County is able to provide various levels of Triple P to meet the various needs in the community, from targeted 3 day workshops addressing specific behavioral topics (level 2) to 8 session groups, workshops or individual sessions addressing overall positive parenting (level 4) to sessions focused on co-parenting, divorce or separation, and parental mood and adjustment (level 5).
- Lower level services (level 2 and 3) geared towards specific behavioral topics through 3 day workshops provided high referrals and retention for providers facilitating these levels of service.
- Services are provided in various community settings, such as schools or family resource centers.

IMPLEMENTATION CHALLENGES

- Turnover of staff trained in various levels of Triple P, making recruitment for level 5 trainings difficult as this requires the completion of lower level 4 training.
- Difficulty sustaining attendance for group Triple P workshops. Providers who participate in the various trainings do not always stay in their employment which reduces the agency's ability to provide this service to families they serve.

LESSONS LEARNED

- Supporting training opportunities for individuals motivated to sustain their current employment and utilize this evidenced base practice in their work through an application process proved more return on investment than opening up training opportunities to all providers within Santa Clara County.

RELEVANT EXAMPLES OF SUCCESS

- Parents/caregivers that participate in Triple P services have expressed value in the information they acquired from the workshop and have been able to implement change within their family.
- Service providers who have been trained in various levels of Triple P have expressed their appreciation of tools that they can utilize to support families that require parenting support

FISCAL YEAR 2018-2019 PROGRAM DEMOGRAPHICS

All data are for parents in the program

Race (n=18)	**%**
Asian	16
White	83
Ethnicity (n=52)	%
Hispanic	65
Non-Hispanic	35
Primary Language (n=49)	%
English	100
Sexual Orientation (n=49)	%
Declined to Answer	100
Disability Status (n=49)	%
Yes	0
No	100
Veteran Status (n=49)	%
Yes	0
No	0
Declined to Answer	100

Assigned sex at birth (n=49)	%
Male	6
Female	94
Current Gender Identify (n=49)	%
Male	0
Female	0
Transgender	0
Genderqueer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity	0
Decline to Answer	100
Age Group (n=49)	%
CYF (0-15)	0
TAY (16-25)	0
Adults (26-64)	100
Older Adults (65+)	0

PEI P3 PLAN – RAISING EARLY AWARENESS CREATING HOPE (REACH)

RAISING AWARENESS CREATING HOPE (REACH) is a collaborative effort between Momentum for Mental Health and Starlight Community Services. Together, REACH is committed to providing early intervention and prevention services throughout Santa Clara County. Our mission is to raise awareness and understanding of mental illness, specifically early signs of psychosis, within the community while offering culturally competent and evidence-informed treatment to underserved youth and young adults, ages 10-25, and their families.

Program services include case management, therapy, psychiatry, occupational therapy, education and employment support, peer and parent mentorship, and various groups, including Multi-Family Group.

UNDUPLICATED NUMBER SERVED: 78
NUMBER OF INDIVIDUAL FAMILY MEMBERS: 130
TOTAL NUMBER OF POTENTIAL RESPONDERS (OUTREACH AUDIENCE): 1365

POSITIVE RESULTS

- Consumers meeting their treatment goals, graduating from the program, and/or transitioning to lower level of care within 12 months of service
- Consumers and their families are actively engaged in services, attending MFG, therapy sessions if needed
- Increase in the number of outreaches, screenings and referrals which led to an increase of consumers served
- Increase in the level of collaboration and partnership with schools
- Increase in the number of outreaches to school settings
- School staff and administration are receptive to outreaches and reinforce techniques they can utilize with students to build skill sets and awareness.

IMPLEMENTATION CHALLENGES

- There is a lack of training in the Structured Interview for Prodromal Symptoms (SIPS) measure, Cognitive Behavior Therapy for Psychosis (CBTP) training certifications, and training refreshers in Multi-Family Groups, PIER model.
- Maintaining fidelity to the models used
- Receiving appropriate referrals with early symptoms to psychosis not primarily related to substance abuse or trauma.
- Hiring, retaining, staff
- Finding appropriate linkage or step down for consumers under the age of 18 on an anti-psychotic medication. PCP's are hesitant to take over the medication support and there is no step down for mediation support and case management. Transfer processes from our program to a Health Center and Primary Care Physician (PCP) can take 6 to 8 months for the due to delays.

LESSONS LEARNED

- Maintain in-the-know of new interventions, training, and education for this population.
- Continue building relationships with other entities (i.e. schools, providers, health systems) to identify school, community, and individuals needs and to increase collaboration, awareness and

referrals.

- There is an ongoing need to retain and hire skilled and dedicated staff to provide services to this specific population.
- It is important to reiterate to outreach attendees to provide referrals early to reduce the time of untreated mental illness
- With the challenges in linking adult clients a step down program that will provide medication services and light case management, REACH has taken a proactive approach and will work with the client, link them to a PCP at the same clinic and, then we begin titration of services down to a level that mirrors the health center, to assist with the transfer process. At the same time, the REACH supervisor will assist with the transfer and will provide weekly communication and follow up emails to review the status of the transfer.

RELEVANT EXAMPLES OF SUCCESS

- An increase in capacity to server more clients by the REACH program.
- An increase in outreach has shown an increase in screenings and referrals.
- Due to ongoing psychoeducation about mental illness and the program model, family participation in MFG groups have increased.
- We responded rapidly to referrals (less than 24 hours) to engage individuals in a timely manner.
- REACH has been working with schools which has led to several trainings request in identifying early warning signs and obtain support, which has led to quality referrals from school social workers.

OUTREACH ACTIVITIES

A total number of **1,365** potential responders were reached during this reporting period. The following table describes the settings in which the potential responders were engaged.

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
School District Offices	Administrators (Superintendents, Director of Student Services, etc), School staff, Parents, Students, ELAC meeting coordinators,
School Districts	Social Workers and Counselors, School Linked Services Coordinators
Elementary schools	Administrators, School coordinators, Students, Teachers, Academic Counselors, Counselors, Social Workers, School Psychologist, Parents/caregivers of students
Middle schools	Administrators, School coordinators, Students, Teachers, Academic Counselors, Counselors, Social Workers, School Psychologist, Parents/caregivers of students
High schools	Administrators, School coordinators, Students, Teachers, Academic Counselors, Counselors, Social Workers, School Psychologist, Parents/caregivers of students

Charter Schools	Middle school students, Teachers
Continuation/Charter school	Administrative staff, Students, Teachers
Colleges/Universities	Students, Professors, Interns
Behavioral Health Providers	Managers, Clinicians, Paraprofessionals, Case Managers, Psychiatrists, Mentors, Leadership Team
Residential facilities	Staff, Non-clinical staff, Clinicians,
Hospitals	Clinicians, Social Workers, Urgent Care department
Community Centers	Staff, Community (families, adults, youth, children), Clinical Staff, Non-Clinical Staff, Peer mentors, Community leaders and organizers
Day Care Centers	Staff, Parents
Migrant Advisory Committee	Parents, School staff
Conferences	College students, staff, professors.
REACH call line	Clinicians, Community members, MD, Families, School staff
Health Fairs	Community members, Community Organizers
Mexican Consulate	Community, Staff, Community leaders/organizers
Mental Health Day	MDs, Nurses, Health providers
Santa Clara County Public Health	Mental health providers
Mental Health First Aid Instruction Class	Mental health providers, Peer mentors.
Mid Pen Housing	Adults and children
NAMI of Santa Clara County	Paraprofessionals, Administrative staff

Number of individuals with SMI or SED referred to BHSD treatment system (includes county and CBO providers): 94

Type(s) of treatment referred to:

Individuals were connected to other levels of care within the Behavioral Health Services Department. Levels of care include Transitional Age Youth (TAY) Outpatient, Full Service Partnership (FSP), Wellness Centers. Individuals were also referred to School counseling services.

Number of individuals who followed through on referral & engaged in treatment: 41

Average duration of untreated mental illness: 2-3 months

Average time between referral and participation in treatment: 16.8 days

Improving Timely Access to Services for Underserved Populations *Strategy:*

Target population: African American, American Indian, and Vietnamese ethnic populations

Number of referrals to a **Prevention** program: 58

Number of referrals to an **Early Intervention** program: 31

Number of individuals followed through on referral & engaged in early intervention treatment services: 27

Average time between referral and participation in treatment: 16.8 days

Number of referrals to BHSD **treatment system (beyond early onset):** 4

FISCAL YEAR 2018-2019 PROGRAM DEMOGRAPHICS

Race (n= 78)	%
American Indian or Alaska Native	1
Asian	6
Black of African American	7
White	8
Other	56
More than one race	21
Ethnicity (n= 78)	%
Hispanic/Latino	58
Non-Hispanic/Latino	42
Primary Language (n= 78)	%
English	68
Spanish	29
Vietnamese	3
Sexual Orientation (n= 78)	%
Gay or Lesbian	4
Heterosexual or Straight	58
Bisexual	9
Questioning or unsure of sexual orientation	1
Another sexual orientation	23
Declined to Answer	5
Disability Status (n= 78)	%
No	100
Veteran Status (n= 78)	%
No	100
Assigned sex at birth (n= 78)	%
Male	44
Female	56
Current Gender Identify (n= 78)	%
Male	44
Female	56
Age Group (n= 78)	%
CYF (0-15)	40
TAY (16-25)	60

PEI P1 PLAN – LAW ENFORCEMENT TRAINING

LAW ENFORCEMENT LIAISON (LEL) AND INTERACTIVE VIDEO SIMULATION TRAINING (IVST) provides a collection of support mechanisms for police officers— who are often the first to respond to a mental health crisis— because police officers' ability to assess a situation and respond appropriately is critical in creating positive outcomes. The County's Law Enforcement Liaison (LEL) Team provides specialized training, including trauma-informed police training, to improve officer responses to people with mental health issues, while also working to enhance relationships with law enforcement through greater collaboration and information sharing so that officers can support individuals they come into contact with by connecting them with mental health services. Additionally, the LEL Team develops and implements Interactive Video Simulation Trainings (IVST) for officers looking to increase their ability to interact more effectively and safely with those experiencing a mental health related crisis.

Law Enforcement Liaison (LEL) Team

In Santa Clara County, mental health professionals from BHSD provide specialized trainings to police officers through the LEL Team to improve their responses to a person with a mental health issue. The mission of the LEL Team is to build and enhance teamwork, training, discussion, and collaboration with law enforcement agencies throughout the County. The ultimate goal of the LEL Team is to provide police officers with the support and tools they need to improve their responses to someone experiencing a mental health crisis. The training is also meant to provide law enforcement departments with information, so they can help residents get the mental health services and support they need.

Interactive Video Simulation Training (IVST)

One of the hallmarks of the LEL Team is the ongoing development and implementation of IVST. IVST is a four-hour program that was developed for officers to increase their ability to interact more effectively and safely with those experiencing a mental health related crisis. The focus is on greater understanding, sensitivity, recognition, and effective de-escalation techniques. As part of the training, participants apply what they have learned in interactive video simulations. These simulations depict people experiencing a myriad of mental health related challenges.

Trauma-Informed Policing

In order to cultivate and sustain effective relationships with the individuals police officers come into contact with, it is critical for police officers to able to recognize and address trauma. Trauma-Informed Policing trainings present a framework for law enforcement which acknowledges the prevalence of trauma and its related symptoms and employs response tactics accordingly. Some of the key elements of trauma-informed police training include identifying signs and symptoms of trauma and learning appropriate genera- and situation specific (e.g., interaction with victim of domestic violence) trauma-informed responses.

Mobile Response to a Crisis (De-escalation)

Law enforcement or contracted law enforcement liaisons act as liaisons between BHSD, especially the MCRT team and Law Enforcement Agencies, to identify services or treatments that are most appropriate to meet the individual's needs. Depending on the level of risk, mobile crisis staff may provide immediate support to stabilize the person and then make a same-day referral to a mental health clinic, or arrange transportation for people experiencing crisis to Emergency Psychiatric Services (EPS) or Mental Health Urgent Care (MHUC) as needed. The mobile crisis team may also place 5150 involuntary holds. Mobile crisis staff are co-located with MHUC and in Gilroy and are trained to meet the specific needs of youth, adults, and older adults.

POSITIVE RESULTS

On several occasions, police officers have contacted the LEL team after receiving training to share positive results. This usually involves the police officers using techniques discussed in the class provided by LELs on how to communicate with those with mental illnesses and have better outcomes. It is common to hear from past attendees that they tried the techniques and were actually able to better communicate and de-escalate the encounter.

IMPLEMENTATION CHALLENGES

The LEL program works best when as many Law Enforcement Officers are aware of the training and resources available for Law Enforcement via the LELs and Behavioral Health Department. Reaching the thousands of law enforcement officers in the county is time consuming. The work shifts, work dates and schedule demands and police department priorities all have an effect on when they can attend training we offer or refresher sessions.

LESSONS LEARNED

De-escalation is a perishable skill that needs to be practiced and maintained for effectiveness. Providing training once and never revisiting the training is not as effective as having periodic refreshers annually or every other year.

Relationships between Law Enforcement and Behavioral Health improve with regular meetings and interactions. Staff changes regularly in both Law Enforcement and Behavioral Health and these regular interactions help ensure consistency.

RELEVANT EXAMPLES OF SUCCESS

A local police department and the family of a client had been trying for years get the individual into services. The client was not willing to accept help. The PD and family had tried for years to show that the client needed a higher level of care and involvement. The client had been arrested several times.

The LEL team, the MCRT unit and the leadership of MCRT researched the client history and present the case to management as an individual who needed significant focus and intervention. The result is that the client was placed in an appropriate care facility for better evaluation and treatment.

Total number of potential responders (outreach audience): __1,563____

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
BHSD Staff Central Wellness	Clinicians
SCC Assessor's Office Staff	Staff
South County Re-Entry Staff	Staff
San Jose Police Dept. (SJPD) CIT Academy	Police Officers
SCC PSOs County Social Services Building	Staff
San Jose PD CSO Academy	Police officers
SCC CIT Academy at Santa Clara Mission Library	Police Officers
Mountain View/Los Altos PD SWAT Team	Police Officers
SCCSO Corrections	Staff, Police Officers
SCC CIT Academy Sunnyvale Sunnyvale DPS	Police officers
Gilroy PD	Police Officers
Stanford Dept. of Public Safety	Public Safety Staff, Officers
Bill Wilson Center Staff Santa Clara Veteran's Hospital PD. Palo Alto	Staff, Clinicians
Veteran's Hospital PD. Palo Alto	Police Officers
Los Altos PD	Police Officers
Santa Clara PD	Police Officers
SCCSO Deputies	Police Officers
Palo Alto Children's Health Council Staff	Staff

Santa Clara PD Reserve Officers Momentum for Mental Health Staff, S.J.	Police Officers
Momentum for Mental	Staff
SCC CIT Academy at MVPD Mountain View PD	Police officers at Mountainview
Veteran's Hospital HomeFirst Veteran Services Homeless Outreach	Staff
HomeFirst Veteran Services	Staff
San Jose PD CIT Academy	Police Officers
BHSD/SUTs	Substance Abuse Staff, Clinicians
South Bay Regional Explorer	Staff
Gardner Family Health	Staff, Clinicians

Number of individuals with SMI or SED referred to BHSD treatment system (includes county and CBO providers): 593

Type(s) of treatment referred to:

- Mobile Crisis Response Team
- Mental Health Urgent care (MHUC)
- Outpatients Services
- Community Resources

PEI P4 PLAN – PRIMARY CARE/BEHAVIORAL HEALTH INTEGRATION FOR ADULTS AND OLDER ADULTS

NEW REFUGEES PROGRAM, in collaboration with Asian Americans for Community Involvement (AACI) and Gardner Health Services, provides mental health prevention, outreach, and early intervention services that target refugees of all ages, and their families that have newly arrived in Santa Clara County and are unfamiliar with community mental health services or are reticent in identifying themselves or their family members as experiencing mental health symptoms.

UNDUPLICATED NUMBER SERVED: 119

POSITIVE RESULTS

Despite some challenges, we have seen many challenges overcome and small victories won. Clients with severe social anxiety are now able to sit with their family in a public place, clients who have previously suffered from severe PTSD have managed their symptoms to the point of being able to share part of their story in a public forum. One client is now able to check her email regularly without emotional support, and another can sit in a doctor's office without fighting back panic attacks. Others have learned to set healthy boundaries and are enjoying stable relationships for the first time in their lives. These small steps toward normalcy represent great victories for clients as they begin conquering these seemingly mundane tasks and reclaiming the trust and safety that were stolen from them through their torture experiences.

AACI/CST program continues to exceed the contracted target with respect to secured basic resources and basic needs met. Our team takes pride in the quality of service delivery. This makes sense given the hierarchy of needs that our clients present with when they first enter the program. What set us apart from the typical mental health provider is the ability to tailored intervention to the cultural perspective, of clients who generally have little or no experience with the western concept of mental health services. Roof above their heads and food on the table are immediate needs and without that they would not be able to go through a recovery process. Another finding to consider, proposed outcomes that were created in more stable and less turbulent political climates and our current outcomes' achievements with respect to mental health and social functioning should be considered a success.

IMPLEMENTATION CHALLENGES

Current world events continue to have a huge impact in a client's recovery process. Psychological/psychiatric needs for clients are primarily centered around PTSD, depression and anxiety. The recent political climate in regards to immigration has intensified the anxiety our clients are already experiencing. Many clients have great fear of approaching formal agencies for help (i.e. social services, doctor's office, etc.) because of torture experiences in their home countries. Political events have spiked numerous fears, some realistic and others spurred through community rumors, creating a significant barrier to access to outside services and in many cases, triggering regression in healing that was newly accomplished. With recent proposals to deny immigration status to some immigrants who have accessed social resources, some clients have even expressed fear of coming to therapy and case management sessions. Changes to the asylum process (cases being heard in reverse chronological order) have led to feelings of heightened anxiety for new applicants. They have very limited time and

resources to find and afford legal representation, prepare their case, and prepare psychologically for their proceedings. Conversely, those who have been waiting for years now must wait even longer, leading to feelings of hopelessness and overwhelm when they realize that their indefinite waiting period will now last even longer.

LESSONS LEARNED

Access to care has always been a concern with traumatized refugee population; however, we observed that it was becoming an increasing concern because of barriers to services. In regard to PTSD, the adage "time heals all wounds" is absolutely false. If a refugee is not actively receiving culturally competent trauma treatment, PTSD symptoms tend to get worse over time. This is why we see refugees suffering - even decades after finding asylum in the United States; without treatment, without processing the trauma in a safe environment and having one's physiological arousal modulated - remains just as symptomatic and feeling even more helpless. Mental healthcare (and physical health care) must often take a back seat to more immediate needs for these individuals. Clients that are long standing are having difficulty because of re-traumatization and because of the unique nature of living in the bay area of San Jose. The housing market in this area means that the majority of our clients must commute (sometimes taking 3 busses and paying $15) for long periods of time to access services. Similarly, in order to afford to live in even substandard housing and keep food on the table, most of our clients are forced to work several jobs. Their priorities are to access basic services such as childcare and food-banks (in languages that are not their own), and balance their own trauma related symptomatology. As is often the case, most of our clients sacrifice their own well-being in order to provide for their families and do not feel they can make time for therapy services.

RELEVANT EXAMPLES OF SUCCESS

Over the past year, a concern about changes (actual or proposed) to immigration policy has been pervasive among refugees' clients. Previously, clients who had refugee legal status tended to feel pretty secure in their immigration status, but over the past months this has changed. Clients, who have a refugee or asylum status, or even green card holders, are increasingly concerned that they will experience problems to adjust their status in the future. Longer wait times for processing of green card applications and for scheduling naturalization interviews have contributed to the overall anxiety. In addition, proposed changes to the public charge rule has significantly increased fear among clients that accessing health care services, including mental health services, nutrition services (even non-government affiliated food pantries), and apply for benefits such as SSI will prevent them from obtaining asylum becoming legal permanent residents, and/or becoming US citizens. Reassurances and education by CST staff and client attorneys are somewhat helpful in ameliorating clients' anxieties, but in an era of uncertainty, our clients understand that policies may continue to change in ways that would be unfavorable to them or harm their immigration prospects. Those clients that we have been able to successfully support through the process of connecting with legal support and going through the process (especially people who are able to get citizenship) generally experience a reduction in symptoms as a result of decreased stress.

OUTREACH ACTIVITIES

A total number of **2,989** potential responders were reached during this reporting period. The following table describes the settings in which the potential responders were engaged.

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
AACI	Potential clients: refugees, survivors of torture
Adult School	Potential clients: refugees, survivors of torture
Alum Rock Library	Potential clients: refugees, survivors of torture
Bazar Norooz	Potential clients: refugees, survivors of torture
Business owners	Business owners
Christmas Party	Refugees, survivors of torture
City Team	Potential clients: refugees, survivors of torture
Community	Potential clients: refugees, survivors of torture
Community business	Potential clients: refugees, survivors of torture
Cypress Community Center	Potential clients: refugees, survivors of torture
Dollar Value	Potential clients: refugees, survivors of torture
East Carnegie Branch Library	Potential clients: refugees, survivors of torture
Edenvale Branch Library	Potential clients: refugees, survivors of torture
Employment Connections Job Fair	Potential clients: refugees, survivors of torture
Escuela Popular	Potential clients: refugees, survivors of torture
Grace Adult Daycare	Potential clients: refugees, survivors of torture
Great Mall	Potential clients: refugees, survivors of torture
Halal Food	Potential clients: refugees, survivors of torture
Health and Music Festival	Potential clients: refugees, survivors of torture
Hillview Branch Library	Potential clients: refugees, survivors of torture
Home First	Potential clients: refugees, survivors of torture
Independence Adult School	Potential clients: refugees, survivors of torture
International Rescue Committee (IRC)	Potential clients: refugees, survivors of torture

Iranian Business	Potential clients: refugees, survivors of torture
Iranian Group	Potential clients: refugees, survivors of torture
Job Fair	Potential clients: refugees, survivors of torture
Kaiser	Potential clients: refugees, survivors of torture
Kaiser Farmers Market	Potential clients: refugees, survivors of torture
King Library	Potential clients: refugees, survivors of torture
Local Libraries	Potential clients: refugees, survivors of torture
Low Income Housing	Potential clients: refugees, survivors of torture
MCA	Potential clients: refugees, survivors of torture
Mexican Consulate	Potential clients: refugees, survivors of torture
Mission College Resources Fair	Students
National Night Out	Potential clients: refugees, survivors of torture
Non-Profit Organization in Milpitas	Potential clients: refugees, survivors of torture
Pars	Potential clients: refugees, survivors of torture
Persian Community	Potential clients: refugees, survivors of torture
Bachrodt Elementary School	Social services staff
BHB – Cultural Competency Advisory Committee	Mental health providers: providers, managers
Catholic Charity Presentation for Refugee Foster Care	Clinicians, case workers, attorneys, supervisors
Emmanuel House Board Meeting	Emmanuel House board members
Law Foundation of Silicon Valley	Attorneys and Legal Advocates
San Jose Unified School District	Student support counselors
Uplift Family Services	Community health centers, community organizing
Previous Clients	Potential clients: refugees, survivors of torture
Quina Community Center	Potential clients: refugees, survivors of torture
Refugee Day	Potential clients: refugees, survivors of torture
Sacred Heart Community Center	Potential clients: refugees, survivors of torture

San Jose City College Resource Fair	Students
Social Services Office	Potential clients: refugees, survivors of torture
Story Road Office	Potential clients: refugees, survivors of torture
Thanksgiving Party	Refugees, survivors of torture
Vision Literacy	Potential clients: refugees, survivors of torture
Wells Fargo Bank	Potential clients: refugees, survivors of torture
West Gate Mall	Potential clients: refugees, survivors of torture
West Valley Library	Potential clients: refugees, survivors of torture
West Valley Muslim Association	Potential clients: refugees, survivors of torture

Number of individuals with SMI or SED referred to BHSD treatment system (includes county and CBO providers): 145

List type(s) of treatment referred to:

DSM Code	Diagnosis for EI clients	Number of New Clients (n =127)
F43.20	Adjustment disorder, unspecified	44
F43.22	Adjustment disorder with anxiety	20
F43.12	Post-traumatic stress disorder, unspecified	26
F43.23	Adjustment disorder with mixed anxiety and depressed mood	20
F32.9	Major depressive disorder, single episode, unspecified	12
F41.9	Anxiety disorder, unspecified	5

Target population: New Refugees all ages and their families that have newly arrived in Santa Clara County

Number of referrals to a **Prevention** program: 165

Number of referrals to an **Early Intervention** program: 119

Number of individuals followed through on referral & engaged in early intervention treatment services: 102

Average time between referral and participation in treatment: 14.6 days Standard Deviation: 19.56

FISCAL YEAR 2018-2019 PROGRAM DEMOGRAPHICS

Race (n=119)	%
Asian	13
Black of African American	28
White	47
Other	12
More than one race	< 1
Ethnicity (n=119)	%
Hispanic/Latino	11
Non-Hispanic/Latino	89
Primary Language (n=119)	%
English	22
Spanish	9
Farsi	20
Arabic	8
Other Non-English	30
Unknown	10
Sexual Orientation (n=119)	%
Gay or Lesbian	3
Heterosexual or Straight	72
Declined to Answer	24
Disability Status*	N/A

Veteran Status (n=119)	%
Yes	0
No	100
Assigned sex at birth (n= 119)	%
Male	48
Female	52
Current Gender Identify (n= 119)	%
Male	36
Female	44
Transgender	< 1
Declined to Answer	19
Age Group (n=119)	%
CYF (0-15)	< 1
TAY (16-25)	21
Adults (26-64)	68
Older Adults (65+)	10

*Data not available

PEI P4 PLAN – Integrated Behavioral Health (IBH) Services

THE INTEGRATED BEHAVIORAL HEALTH (IBH) now called Primary Care Behavioral Health Integration (PCBHI) program provides low-to-moderate behavioral health services to patients. These services help patients cope with stressful situations, behaviors or moods that may affect their overall medical condition and recovery. Primary care providers and IBH staff work as a team to help patients learn how to cope with depression, anxiety, and other issues related to their medical condition; make appropriate lifestyle changes; and increase their self-efficacy.

People with mental and substance abuse disorders may die decades earlier than the average person — mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity, poor nutrition, smoking, and substance abuse. Barriers to primary care — coupled with challenges in navigating complex healthcare systems — have been a major obstacle to care.

At the same time, primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general healthcare needs. Integrated care offers a systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

This program intends to:
1. Provide outreach and services to people 18 and older; and
2. Implement an integrated behavioral health services model within local Federally Qualified Health Centers that serve underserved ethnic minorities building on successes from previous years.

The target population for these services include adults/older adults at risk of mental health issues instead of those already experiencing mental health problems.

UNDUPLICATED NUMBER SERVED: 813

POSITIVE RESULTS

Vendor 1

- Health Centers have expanded to location in East San Jose and two FTE medical doctors joined the team, which helped to increase the number of referrals.
- Low percentage of patients referred to a higher level of care (i.e., less than 10%)
- On average, patients had a 2.4 point decrease in their PHQ-9 total scores by discharge
- We added capacity for Spanish-speaking referrals, which helped increase access to care for Latinx community.
- Provided training and support to medical assistants and physicians in order to normalize behavioral health services and help providers feel more comfortable with referring to IBH.
- Our psychiatrist provides continuous support to the physicians and is available for consult by phone/in person.
- Expanded capacity by bringing on a psychiatric nurse practitioner who is Khmer speaking.

IMPLEMENTATION CHALLENGES

Vendor 1

- Stigma around mental health is the primary barrier that we experience with implementation of IBH services in our Health Center. Patients are not typically coming into our clinic seeking MH services and often choose not to continue services after one appointment due to stigma.
- Ongoing changes in staffing have also been challenging. In FY 18/19, we had the following changes in staffing: our full-time, Mandarin-speaking licensed psychologist left in October 2018. A Spanish-speaking licensed psychologist was hired in November 2018, but was on maternity leave from November 2018 to May 2019.

Vendor 2

Historically, staffing the IBH department has been a huge challenge since its inception. Currently, Gardner Health Services competes to hire the limited pool of bilingual and licensed clinicians with Kaiser and also with the county. Unfortunately, Gardner has not been able to compete with the wages and benefits of such organizations, thus retaining staff has been a huge challenge. In addition, the funding of the program has also being a factor that causes turn over. In the past staff has quit prior to the end of the fiscal year due to not knowing whether the funding for the program is secure which caused staff to get resumes ready and quit before the end of the fiscal year. Currently, we are fully staffed and many of our clinicians are able to provide appropriately linguistic services.

Most recently there has been a trend of patients who fail to show up for their intake appointment. This pattern has become more prominent in clinics that currently don't have an assigned peer partner who can provide a face to face warm hand off during their PCP's visit. Having a peer partner on site has shown to contribute to a decreased no show rate. Studies show that if a patient doesn't receive a warm hand off but is instead told to make an appointment at the front desk for a BH visit, about 80% of the patients will either not make the appointment, or not show up for the appointment.

Another challenge has been that many patients don't have medical insurance and despite the accessibility to a sliding fee program, due to their economic hardships they stop coming to sessions prematurely. Often times these patients without insurance need to be linked to specialty mental health services and the call center will send them to the Central and Wellness Center or Mental Health Urgent Care. Many patients come back reporting that they didn't feel they received the care they were looking for. Many of these patients know that they need ongoing therapy services along with med management in order to avoid EPS visits. This is a huge gap in services as many patients who encounter these circumstances, need a higher level of care however they don't qualify for medi-cal or can't afford insurance through California Covered. Thus they continue to use IBH services as their only source of mental health support. As these patients come back seeking services the previously discussed gaps continue to exist, making it nearly impossible for these patients to receive the adequate level of care.

Since the inception of the program IBH continues to receive complicated/challenging cases that can't be dealt with at the primary care level due the severity of their mental health symptoms. These patients participate in an intake which determines that a referral needs to be made to specialty mental health services. Over the years, there has been a bottle neck of referrals at the call center where patients are placed in a wait list or are given intake appointments for weeks later, causing the patients to become discouraged and cease participation in services. During this time period the patients continue to remain open with IBH and often times, the patients decide that they no longer want to be referred to call center

due to long wait and at the same time they are not receiving the level of care they need e.g. outpatient services.

Lastly, currently we don't have a mechanism in place that allows IBH department to track the dispositions made to specialty mental health services. Currently, patients remain open in IBH until they receive an intake for specialty mental health and it is through the patient's self reports that IBH clinicians can write on their chart that they are now opened in a specialty mental health clinic.

LESSONS LEARNED

Vendor 1

- Increasing communication between providers (e.g., medical doctors, psychiatrist, and psychologist) helps to improve patient care and overall results.
- Given the stigma around mental health, the importance of having bicultural/bilingual staff to help patients feel comfortable and open to communicating with IBH staff.
- More education around stigma reduction and trauma informed care for front desk and support staff would be beneficial.

Vendor 2

As a department IBH has been instrumental in recruiting patients referred by their PCP due to mental health concerns that otherwise may have gone undiagnosed or untreated or perhaps frequent visits to Emergency Psychiatric Services. IBH clinicians are equipped and trained in determining the level of care that a patient needs and through some of the most current data we have been able to determine that IBH keeps most of the patients referred to our department. This means that less and less patients are being referred to specialty mental health services or have to ensure suffering that can result from an untreated mental health illness. IBH has been shown to prevent patients from entering a higher level of care or before they develop a serious mental health illness.

Over the years IBH has also developed a true integration with the primary care providers which has lead to collaboration between colleagues that truly makes a difference in patient care. IBH staff often meets with providers on a monthly basis to discuss challenges, setbacks, and progress in the IBH department which foster education, training and communication. All IBH clinical staff is certified on how to write 5150 holds and they are constantly being utilized by providers as consultants whenever providers have questions about diagnosis, treatment, suicide risks, etc. IBH staff also attend monthly staff meetings at the clinic level to provide all staff support by providing updates, identify each clinic's needs, and explore solutions to these needs. Lastly, providers have access to the lead psychiatrist that they can contact for consultation about meds, diagnosis, etc.

In addition, IBH staff meets on a weekly basis to conduct a staff meeting that promotes consultation, training and challenges that may be unique to each clinic. During this meeting an emphasis is placed on case conferencing, case consultation, sharing resources and provide support to each other. A lead psychiatrist is present during this meeting along with the department director to ensure that staff feels supported in being able to verbalize their own needs whether is additional training or questions about the day to day operations. During this meeting the peer partners also participate in identifying and verbalizing their own struggles in the field and explore ways that clinicians, department director and psychiatrist can assist in addressing those barriers.

RELEVANT EXAMPLES OF SUCCESS

Vendor 1

- A patient was referred by medical doctor due to anxiety and frequent visits to Emergency

Department. After meeting with IBH psychologist for Cognitive Behavioral Therapy sessions, patient was better able to manage her anxiety and her visits to the ED decreased to zero.

- A patient with multiple chronic illnesses who experienced a sudden loss of her caretaker was able to find support through PCP and IBH clinician to navigate new reality and continue managing her overall health effectively.

Vendor 2

Despite the fact that currently IBH doesn't track successful outcomes in treatment it is not difficult for clinicians to recognize that patients do get better by participating in IBH services. This is extremely difficult to track because a patient can come to one visit and feel better while others may need additional visits before they start to notice a difference from participating in brief therapy. We have been receiving a lot of verbal anecdotes from patients who came into treatment without hope and after participating in services they are able to secure employment, keep employment, do better in school, develop meaningful relationships etc. Statistically patients can get better when they receive early intervention that prevents them from spiraling into a chronic disease state which could lead to involvement with Emergency Psychiatric Services, emergency room visits, mental health urgent care visits, etc.

It would be ideal to track successful outcomes for our patients and in order to do that it's important to define what a successful outcome looks like as it may be different from patient to patient. A patient may not be managing their diabetes because of their mental health and after participating in IBH services, they may have developed coping skills that helps them manager both. This is a success in itself and so is the patient who just broke up with their significant other and is having a difficult time adjusting to the loss and after a few sessions, the patient feels better and stops coming to services. It is somewhat challenging to define success in IBH as a successful outcome can vary from patient to patient.

OUTREACH ACTIVITIES

A total number of **807** potential responders were reached during this reporting period through trainings and outreach. The following table describes the settings in which the potential responders were engaged.

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers)
Foxdale Village Apartments May 20, 2019 (residential complex)	70 residents from the community attended event that included health screenings, resource tables, information on IBH services, as well as kid-friendly activities.
Grail Family Services May 10, 2019 (community center)	Roughly 10 Latina mothers were provided education by our pediatrician on developmental milestones for children. Psychologist also provided information about behavioral health services and how to access care with or without insurance.
Kaiser Permanente and Telemundo 48 March 23, 2019 (Eastridge Mall)	157 members of the community; provided flyers and answered questions about services at AACI Health Center, as well as insurance eligibility.

Day in the Park Fall Family Festival **October 13, 2018** **(park)**	200 members of the community; provided outreach and answered questions about services at AACI Health Center.
Moon Festival at Vietnamese American Cultural Center **Sept. 29, 2018**	Engaged with roughly 305 individuals in the community providing outreach on services available at AACI Health Center.
Music and Health Fair **Sacred Heart Community Center** **July 28, 2018**	Provided information on AACI's Health Center, services available and insurance eligibility to roughly 65 individuals in the community.

Vendor 1

Number of individuals with SMI or SED referred to BHSD treatment system (includes county and CBO providers): __5___

Type(s) of treatment referred to:

When a higher level of care is needed, IBH clinicians orient client to services available and explain the process to of transferring care. IBH clinician assists client with calling the county call center and also connects with AACI management to discuss capacity and clinical need for the client. In the case that a client is seeking a language specific provider that is not available at AACI's Health Center, we also help to facilitate a referral to the appropriate program (i.e., often in AACI's specialty MH services).

In FY 2018/19, we referred to AACI Specialty Mental Health (Family and Children; Adult/Older Adult) for psychological testing for questions around ADHD as well as cognitive impairment. We also referred to AOA for a higher level of care which includes individual counseling, collateral sessions, case management, and psychiatry. We also referred to our Domestic Violence program.

Number of individuals who followed through on referral & engaged in treatment: __5___

For both vendors

Average time between referral and participation in treatment: __10-14 days___

FISCAL YEAR 2018-2019 PROGRAM DEMOGRAPHICS

Race (n=813)	%
American Indian or Alaska Native	< 1
Asian	8
Black of African American	3
Native Hawaiian or other Pacific Islander	1
White	23
Other	3
More than one race	< 1
Declined to Answer	61
Ethnicity (n=813)	%
Hispanic/Latino	63
Non-Hispanic/Latino	37
Primary Language (n=812)	%
English	47
Spanish	49
Other Non-English	4
Sexual Orientation (n=813)	%
Gay or Lesbian	< 1
Heterosexual or Straight	54
Bisexual	1
Declined to Answer	45
Disability Status (n=69)	%
Yes (Physical/Mobility Domain)	62
No	38

Veteran Status (n=813)	%
Yes	< 1
No	81
Declined to Answer	18
Assigned sex at birth (n= 813)	%
Male	40
Female	60
Current Gender Identify (n= 813)	%
Male	18
Female	43
Another Gender Identity	39
Age Group (n=813)	%
CYF (0-15)	36
TAY (16-25)	15
Adults (26-64)	40
Older Adults (65+)	9

PEI P5 PLAN – SUICIDE AND CRISIS SERVICES (SACS)

SUICIDE AND CRISIS SERVICES (SACS) provides a suicide and crisis hotline 24 hours a day, 7 days a week, to assist individuals in crisis providing suicide assessment, crisis intervention, emotional support, and referrals of community resources to callers. In addition, we also provide an Emergency Department (ED) Outreach Program. This program provides face to face contacts with patients who received medical treatment at Emergency Department of Santa Clara Valley Medical Center (VMC) due to self-harm injuries/behaviors or suicide attempt. Through the ED Outreach Program, SACS volunteers/interns meet with patients, one on one, to provide resources and follow up support.

UNDUPLICATED NUMBER SERVED: 25,089

POSITIVE RESULTS

- More than 30% of crisis calls that reached the Suicide and Crisis hotline come from repeat callers. Anecdotally, the callers share that our services are truly helpful and effective due to the authentic and caring volunteers/crisis counselors that we have. This is the main reason that they call back for additional assistance and support in coping with their crisis situations.
- Regarding the ED program, none of the clients that were seen by a SACS volunteer/staff were readmitted to the ED/ER for re-attempt of suicide.

IMPLEMENTATION CHALLENGES

- Suicide and Crisis hotline volunteers/crisis counselors face challenges with gathering callers' demographic information. Most callers would like to remain anonymous. They hesitate and sometimes get suspicious/paranoid when asked about demographic information. A lot of the times, callers decided to end their phone calls or hang up when they did not want to provide the information. This is a challenge for the program, because the caller who hangs up might have been in a crisis situation at the time.

LESSONS LEARNED

- Suicide and Crisis hotline volunteers/counselors learned that for any calls that come in, they need to first assess suicide or crisis situation of the callers. After, they are able to build rapport, assist the callers to cope with their crisis situation, and then strategically ask the caller for their demographic information in non-threatening ways. Volunteers/crisis counselors will not interrupt callers if they determine the caller is at risk of suicide or self-harm to obtain information that might not be relevant to the crisis situation.

RELEVANT EXAMPLES OF SUCCESS

- In FY 2019, the Santa Clara County Suicide and Crisis hotline received on average 3-5 "Suicide in Progress" calls and 35-36 calls from individuals considered high risk of suicide. We initiated rescue procedures to "Suicide-in Progress" callers and helped high risk callers de-escalate and cope with their crisis situations. We assisted them in developing a Safety Plan and also conducted follow up calls to ensure their safety.

OUTREACH ACTIVITIES

A total number of **23** potential responders were reached during this reporting period through trainings and outreach. The following table describes the settings in which the potential responders were engaged.

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Santa Clara Valley Medical Center – Emergency Department	**Patients received medical treatment at Emergency Room due to suicide attempt or self-harm.**

FISCAL YEAR 2018-2019 PROGRAM DEMOGRAPHICS

Race/Ethnicity (n=24,938)	%
Asian	6
Black or African American	2
White	12
Hispanic	3
Other	< 1
More than one race	< 1
Declined to Answer	77
Primary Language (n=19,902)	%
English	99
Other Non-English	1
Sexual Orientation (n=25,809)	%
Gay or Lesbian	1
Heterosexual or Straight	8
Bisexual	< 1
Questioning or Unsure of Gender Identity	< 1
Another Sexual Orientation	< 1
Declined to Answer	91

Disability Status (n=8,941)	%
Mental Domain	92
Physical/Mobility Domain	8
Veteran Status (n=26)	%
Yes	100
Assigned sex at birth (n= 16,176)	%
Male	38
Female	62
Current Gender Identify (n= 8,814)	%
Transgender	< 1
Questioning or Unsure of Gender Identity	< 1
Declined to Answer	99
Age Group (n=25,089)	%
CYF (0-15)	3
TAY (16-25)	5
Adults (26-64)	11
Older Adults (65+)	2
Declined to Answer	79

PEI P5 PLAN – Suicide Prevention Strategic Plan – Suicide Prevention Program

THE SUICIDE PREVENTION PROGRAM seeks to reduce suicide among high-risk groups throughout Santa Clara County and is intended to directly support the implementation of the County's Suicide Prevention Strategic Plan (SPSP), which was approved by the Board of Supervisors in August 2010. The goal of the SPSP is to reduce suicide deaths and attempts in Santa Clara County. The County implements the five distinct but related strategies of the SPSP, resulting in comprehensive suicide prevention and awareness activities countywide. The SPSP's five strategies have multiple recommendations, all of which will be implemented over time, with input from the Suicide Prevention Oversight Committee (SPOC) and its workgroups.

The Suicide Prevention Program takes a population-level, public health approach to suicide prevention. Program activities include trainings with community members and community-serving agencies, community outreach, mass media campaigns, and policy advocacy and implementation.

UNDUPLICATED NUMBER SERVED:

- Trainings: 4,542
- Outreach: 1,357

COMMUNICATIONS CAMPAIGN ESTIMATED REACH: **1,464,260***

**Measured through social media impressions, promotional materials distributed, reach of transit and DMV ads. This program cannot differentiate among duplicated individuals as no PHI is collected among trainings, outreach activities, and communications campaigns. The reach of different communication campaign materials may also be duplicated; i.e., the same individual may have seen the campaign different times and on different channels.*

POSITIVE RESULTS & SUCCESS

Outcome: Increase early identification and support for people thinking about suicide

- **Large sustained increase in number of individuals trained**

  The number of community members and potential responders trained in evidence-based suicide prevention and mental health trainings increased from 1,850 in FY17 to 3,028 in FY18 to **4,542 people trained in FY19.** The gatekeeper trainings offered are all evidence-based and include (for adults) Question, Persuade Refer (QPR); SafeTALK; Applied Suicide Intervention Skills Training (ASIST); Youth Mental Health First Aid (YMHFA); Suicide to Hope; and Kognito.

  Consistent outcome measures were integrated to surveys across the gatekeeper trainings, and **statistically significant improvements in knowledge, attitudes, and preparedness around gatekeeping were demonstrated during Jan-Jun 2019 (see "Relevant Examples of Success/Impact")**.

- **Culturally competent trainings**

In 2018 partners at **Palo Alto University (PAU) completed a cultural competency review of the SP Program's gatekeeper trainings**, based on evidence about cultural differences in the way suicidality is expressed and experienced. As a result of this review, the SP Program and PAU began incorporating the review recommendations into the gatekeeper trainings. **In partnership with the training company LivingWorks Education, cultural adaptations were incorporated to the ASIST curriculum and piloted in Santa Clara County in FY19.** In addition, PAU and the SP Program began developing original, culturally competent training content. These trainings include introductions to mental health and suicide prevention, and are tailored to address the training needs of the County's diverse community members, as identified by the SP Program. These trainings, as well as a more advanced suicide prevention training for mental health clinicians, will continue to be piloted and refined by the PAU team in FY20. **The SP Program and PAU partners presented this work at the American Association of Suicidology's Annual Conferences in Washington, DC in 2018 and in Denver, CO in 2019.**

Outcome: Increase use of mental health services

- **Crisis Text Line**

  To improve and increase youth access to crisis services, the SP Program completed its agreement with Crisis Text Line (CTL) in 2018. CTL is a free crisis intervention service via SMS message, where roughly 75% of users nationally are under age 25 (crisistrends.org). **The SP Program launched the County CTL in December 2018 using social media, internal communications, and the local media, and followed with** a mass media campaign promoting the County's CTL in May 2019.

- **Campaign to increase help-seeking among older adults**

  Working with the Communications Workgroup, **the SP Program tested and developed an older adult suicide prevention during FY19 and launched the campaign in July 2019**. Consisting of a video, radio ad, digital ads, and print materials, the campaign aired for three months on YouTube health and news channels, in local newspapers, and on KCBS. The SP Program also strived to distribute the print materials and video to partners at senior centers, faith institutions, and health care centers. More information and resources are available on the campaign's website, www.scchope.org.

- **Community outreach**

  In FY19 SP Program outreach focused on reaching transitional-aged youth (16-25), middle aged adults (45-55), and older adults (65+). Activities included tabling, resource fairs, partnership-building with community-based organizations and colleges, and launching a volunteer program to expand outreach efforts. **A total of 1,357 community members were reached with resources through 47 tabling events attended by the SP Program.** Additionally, the program held two mental health resource fairs for September's Suicide Prevention Week and May's Mental Health Awareness Month. The Program began a volunteer initiative and recruited and onboarded five volunteers to support community outreach in FY19.

  In addition, **the SP Program developed new outreach materials to address the needs of specific cultural groups. Sample materials include a handout on LGBTQ+ mental health and suicide prevention resources, and a mental health guide for immigrants brochure**. A cultural competency

review of all outreach materials was conducted by Palo Alto University (PAU) team, to align information with current evidence on diversity and suicide. The new materials will be finalized and printed in FY20.

- **Grief support services**

The Program's Interventions Workgroup set a goal to increase the number of mental health providers in the County who are trained in providing grief support, particularly to suicide loss survivors, who are at increased risk of suicide themselves. After reviewing some grief support services and trainings available in the County and nationally, the Workgroup partnered with Dr. Janet Childs at the Bill Wilson Center for Living with Dying. **In January 2019 Dr. Childs piloted a grief support training for 25 County mental health clinicians and peer support workers.** The workgroup also created a resource of grief support services for community outreach.

Outcome: Strengthen community suicide prevention and response systems

- **School-based suicide prevention partnership**

In August 2018, **the SP Program launched a pilot training partnership with seven public school districts, to strengthen faculty and staff skills in supporting students who experience mental health distress.** The online training Kognito "At Risk" allows users to practice simulated conversations about mental health with students and parents. **Under the partnership, 2,379 school teachers and staff in nearly 80 Santa Clara County schools completed the Kognito "At Risk" training in the 2018-19 school year. Pre-/post-training survey results from the Kognito At-Risk online training showed statistically significant increases in knowledge and improved attitudes around suicide prevention (see "Relevant Examples of Success/Impact").**

Participating school districts are also receiving technical support from Stanford and the HEARD Alliance on implementing school-based suicide prevention and crisis response. The HEARD Alliance team completed consultations on suicide crisis protocols with administrators and staff from each of the seven participating school districts. **Initial evaluation data showed statistically significant improvements in school staffs' knowledge about their schools' action plans for students at low, medium, and high risk for suicide, as well as re-entry after a suicide attempt (see "Relevant Examples of Success/Impact").**

The SP Program is partnering with School-Linked Services and the County Office of Education to provide the Kognito training to the school districts, through a cost-sharing arrangement. Additional school districts have joined the partnership for the 2019-20 school year, and this work will continue in FY20. **The SP Program and partners presented about this partnership in various forums, including the County's first annual Suicide Prevention Conference in May 2019 and the annual conference of the National Association of City and County Health Officials (NACCHO) in July 2019. Additionally, in July 2019 the partners published a white paper describing the development and execution of the partnership in its first year.**

- **Suicide death response**

In 2018-19 the SP Program identified and reach out to 12 identified community groups who were affected by suicide loss, offering condolences and grief support resources. These community

groups included apartment complexes, businesses, the Department of Veterans' Affairs, and schools. **The Program also partnered with the County's Child Death Review Team to review and revise the support letter and list of grief support resources sent to next-of-kin who lose a child to suicide**, in accordance with postvention best practices and safe messaging around suicide.

Outcome: Reduce access to lethal means

- **Gun safety policies:** In 2018 safe storage policies were passed by cities of Morgan Hill and Saratoga. Additionally, the city of Sunnyvale was the first city in the County to ban the purchase of automatic rifles for youth under the age of 21.

- **Community outreach:** The SP Program supported gun safety efforts by supporting community conversations, and by distributing information and free gun locks. In FY19 the Program distributed approximately 400 suicide prevention outreach materials and free gun locks at two gun buyback events in North County (September 2018) and in San Jose (December 2018).

Outcome: Improve messaging in the media about suicide

- **Media monitoring and response:** Through weekly monitoring of the media, **the SP Program reviewed 163 local articles on suicide and has responded to reporters of 24 of these articles, either reminding them about or thanking them for following the safe messaging guidelines. The SP Program also conducted about 15 media interviews about suicide and suicide prevention.** In June 2019, the Health System's Public Information Office issued a press release on the County's low suicide rate and the decrease in the suicide rate over three years, resulting in at least four local news stories about suicide prevention efforts.

- **Media training:** In 2019, the SP Program's Communications Workgroup opted to begin making presentations to individual newsrooms about safe messaging, instead of holding annual trainings, which were a larger investment and traditionally not well-attended by media staff. In June, the SP Program and Health System Public Information Officer (PIO) met with editors at NBC Bay Area to discuss safe messaging. As a result of the meeting, editors began making calls to the PIO in advance of publication, to consult on ways to safely message stories about suicide.

Strengthen data and evaluation

- **Suicide death data**

  In a March 2019 state report, Santa Clara County was reported to have the lowest suicide rate in the state, from 2015-17. The rate and number of suicide deaths by County residents decreased in 2016 (143 deaths, or 7.9 per 100,000) and again in 2017 (137 deaths, or 7.6 per 100,000), reaching a ten-year low in 2017.

  In September 2018, the Public Health Department (PHD) launched its Open Data Portal (www.sccphd.org/healthdata), which includes a section on 8- and 10-year aggregate data on suicide

deaths and attempts by County residents (regardless of where in the state decedents died). The PHD participates in the SP Program's Data Workgroup and supports the SP Program's efforts using this data, which is gathered from the California Office of Statewide Health Planning and Development (OSHPD).

In 2018 the SP Program also partnered with Palo Alto University (PAU) to enter, clean, and analyze Medical Examiners' suicide data from 2009-2016, and to create a standard data report that could be recreated and compared year-to-year. In 2018 PAU completed the 2016 death data report and transferred its data analysis system to BHSD's Decision Support team. Decision Support completed the 2017 data report and will continue to produce the ME-C suicide data reports on an annual basis.

- **Improving evaluation efforts**

  Working from the program logic model developed in 2018, the SP Program began developing and incorporating metrics to measure progress for each of its outcome objectives. In FY19 streamlined metrics were incorporated across all gatekeeper training surveys offered by the SP Program. These metrics were gathered beginning January 2019, and an evaluation of the trainings program/Objective 1 was conducted in summer 2019. The SP Program also developed metrics and conducted a baseline media analysis for its work with the media on safe messaging. Efforts to define and gather outcomes-related data are continuing in FY20.

Other

- **The first annual Santa Clara County Suicide Prevention Conference was organized by the SP Program in May 2019, in a partnership between the County Office of Education and the Behavioral Health Services Department.** About 150 attendees and 50 presenters from Santa Clara County and surrounding counties participated in the conference.

RELEVANT EXAMPLES OF SUCCESS/IMPACT

Outcome: Increase early identification and support for people thinking about suicide

Change in suicide gatekeeper measures across all trainings, January-June 2019

Measures (Scores range from 1=Strongly Disagree to 5=Strongly Agree)	**Pre-Training**		**Post-Training**		**t-test**
	M	**SD**	**M**	**SD**	
I know the warning signs for suicide. (N=2508)	3.16	.835	4.06	.816	-58.01***
I am able to identify someone who is at risk for making a suicide attempt. (N=2510)	2.92	.816	3.97	.765	-73.30***

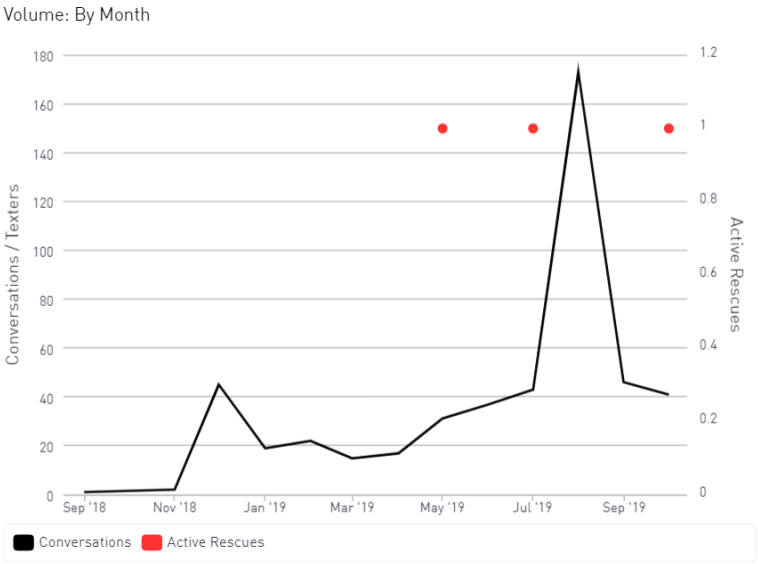
I feel prepared to discuss with someone my concern about the signs of suicidal distress they are exhibiting. (N=713)	3.44	1.03	4.22	.794	-16.23***
I am aware of the resources necessary to refer someone in a suicide crisis. (N=2508)	3.04	.917	4.10	.663	-62.39***
I am confident in my ability to make a referral for someone in a suicide crisis. (N=2507)	3.07	.929	4.12	.742	-64.42***
I have the skills necessary to support or intervene with someone thinking about suicide. (N=2510)	2.74	.893	3.93	.812	-74.56***

Note. M=Mean. SD=Standard Deviation. *** p < .001

Outcome: Increase use of mental health services

- **Crisis Text Line**

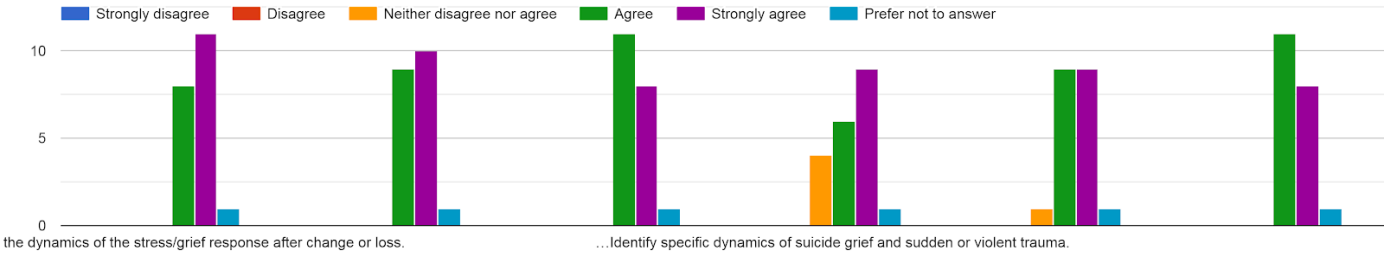
  From May 27 to June 30, 2019, the CTL campaign had achieved an estimated 1.2 million impressions on social media, reached 187,500 people through light rail ads, and reached another 50,388 people via a screen at the Gilroy DMV office. As of August 2019, 227 text conversations had taken place under the County's CTL code word RENEW. In FY20, 300 text conversations were reached under the code word, and CTL granted the SP Program access to a customized data dashboard with aggregated, population-level data on text conversations exchanged under RENEW. A spike in text conversations was seen in August (below), presumably associated with the mass shooting at the Gilroy Garlic Festival.



- **Campaign to increase help-seeking among older adults**

Evaluation results are available in FY20.

- **<u>Grief support services – post-training survey results</u>**



(From left to right):

- *Identify dynamics of stress/grief response after loss*
- *Recognize behaviors, thoughts, feelings related to grief/loss*
- *Articulate/ practice effective techniques for responding to grief*
- *Identify dynamics of suicide grief and sudden/violent trauma*
- *Recognize/ articulate stress responses in self and co-workers*
- *Apply principles of stress management in home and work environments*

Outcome: Strengthen community suicide prevention and response systems

- **<u>School-based suicide prevention partnership</u>**

Change in Gatekeeper Measures: Kognito

Measures *(scores range from 1=Strongly Disagree to 5=Strongly Agree)*	**Pre-Training**		**Post-Training**		
	Mean	**SD**	**Mean**	**SD**	**t-test**
1. I know the warning signs for suicide. (N=1794)	3.03	.755	3.96	.808	-4.57***
2. I am able to identify someone who is at risk for making a suicide attempt. (N=1794)	2.77	.703	3.87	.725	-5.65***
3. I feel prepared to discuss with a student my concern about the signs of psychological distress they are exhibiting. (N=636^; N=418^^)	2.75^ 2.71^^	.689 ^ .701^^	3.92^ 3.90^^	.732^ .776^^	-78.33***^ -60.60***^^
4. I am aware of the resources necessary to refer someone in a suicide crisis. (N=1791)	2.93	.864	4.03	.593	-5.40***
5. I am confident in my ability to make a referral for someone in a suicide crisis. (N=1793)	2.98	.872	4.07	.707	-4.99***
6. I have the skills necessary to support or intervene with someone thinking about suicide. (N=1793)	2.57	.784	3.86	.787	-6.38***
7. I understand and can identify a number of ways in which culture affects how suicide is expressed and experienced. (N=1788)	2.68	.831	3.72	.870	-5.62***
8. I feel prepared to help people from diverse cultural backgrounds with their suicidal distress. (N=1784)	2.34	.730	3.62	.912	-6.27***

Notes. SD=Standard Deviation ***p < .001 ^ data from high school educators ^^ data from middle school educators

Figure 12. Mean ratings by Kognito training participants: "I am confident that I know my school's action plan for a student…" (Items were on a 5-point scale, Strongly Disagree (1) to Strongly Agree (5))

	Pre-Test Mean (SD)	Follow-Up Mean (SD)	t-test
At low risk for suicide, e.g., those who have shown signs of emotional distress	E 3.07 (1.14)	E 3.58 (.94)	E 3.63**
	M 3.41 (1.04)	M 3.76 (.98)	M 2.74**
	H 3.25 (1.03)	H 3.82 (.81)	H 4.44***
At medium risk for suicide, e.g., those who have expressed suicidal thoughts	E 2.88 (1.13)	E 3.48 (.96)	E 5.49***
	M 3.33 (1.02)	M 3.71 (.97)	M 2.75***
	H 3.27 (1.02)	H 3.79 (.86)	H 3.80***
Who has made a suicide attempt	E 2.64 (1.11)	E 3.08 (1.01)	E 3.65***
	M 3.03 (1.08)	M 3.73 (1.08)	M 3.06***
	H 3.06 (1.09)	H 3.51 (1.02)	H 3.21**
Re-entering school after a suicide crisis	E 2.49 (1.08)	E 2.90 (.99)	E 3.73***
	M 2.84 (1.13)	M 3.31 (1.07)	M 3.43***
	H 3.00 (1.12)	H 3.43 (1.09)	H 3.09**

Notes. *** $p < .001$; ** $p < .01$; E: elementary; M: middle school; H: high school; N(E)=73, N(M)=69-70, N(H)=77

Outcome: Improve messaging in the media about suicide

- July 12, Mercury News: **Editorial: Bay Area county's suicide prevention effort is working**
- June 14, SF Gate: **County sees slight drop in suicides despite increase nationwide**
- June 14, Patch: **Suicide rate drops in Santa Clara County**
- June 12, KCBS: **Santa Clara County suicide rate bucking state and national trend**

IMPLEMENTATION CHALLENGES

- Balancing and addressing the three types of prevention—primary, secondary, tertiary—in one program and with limited resources. In particular, collaborating with multiple large programs on primary prevention efforts is a related challenge.
- Engaging with specific cultural communities where both stigma and suicide rates are high; for example, Pacific Islanders and Korean communities.
- Engaging with different systems on suicide prevention efforts, namely, the health system (especially primary care) and faith communities.
- Carrying out lethal means restriction for hangings, which are the first or second most commonly-used means for suicide in the County. Research and evidence-based approaches for restricting access to ligatures is limited.
- Keeping up with implementation of *numerous* mental health and suicide prevention-related policies that continue to be passed at the state level. This is a particular challenge for school districts.
- Lengthy and costly trainings that require significant time-commitment from participants and high cost for materials by the program. Making cultural adaptations to suit local needs with some gatekeeper training companies.
- Running a prevention program within a mental health care system has both benefits, such as close links to direct service providers, and challenges—some of these include misalignment of standards of measurement for impact and success, and the need to communicate clearly and provide constant education about the program's activities and approaches.
- Increasing and sustaining community stakeholder engagement through the Suicide Prevention Program's various workgroups.
- Onerous government processes to recruit and onboard volunteers create a disincentive for more community members to get involved with volunteer outreach efforts.
- Linking suicide attempt data in a meaningful way to suicide death data. The state provides suicide attempt data on about a three-year lag and does not permit access to PHI without IRB approval. PHI access would be the only way to connect suicide attempt and death data.
- Evaluating primary prevention efforts, such as access to lethal means/firearms or social connectedness.

LESSONS LEARNED

- Due to limited program capacity and resources, a concentrated focus of activities on select high-risk populations could result in greater impact on suicide, compared with a broad-sweep approach that attempts to impact a wide range of populations that each receive a low saturation of intervention.
- Work with school districts on suicide crisis response protocols moves at varying paces and in most cases requires more than one school year to accomplish. Strong relationships with school districts can be developed in a number of ways, including:
    - being highly responsive to feedback;
    - providing structure and clear/concrete technical support but also a degree of flexibility to account for different school contexts;
    - following up consistently;
    - translating concepts into jargon/language/models understood by educators (e.g. MTSS);

and
    - being highly selective about the amount of time demanded of school staff to sit in meetings or calls related to the work.
- Some school districts are attempting to combine threat assessment and suicide crisis protocols together, to varying degrees of success. In general districts feel overwhelmed with the number of topics they must address and policies they must implement, and could benefit from collaboration/streamlining among systems that support them.
- Evaluation data on gatekeeper trainings suggested that some gatekeeper trainings could be phased out or replaced. ASIST and Kognito are two gatekeeper trainings that receive consistently positive feedback and evaluation results.
- Brief individual newsroom meetings about safe messaging have the potential to be more effective than holding annual safe messaging trainings where reporters are asked to leave their offices and attend. Local reporters seem to understand the need to use safe terminology; however, more education could be done on the safe messaging guidelines, particularly around including warning signs and multiple resources.
- Firearm safe storage policies can be effective, but these efforts are undermined by less stringent firearm safety policies in surrounding states, where individuals may bring firearms purchased outside of the state into California.
- There are high levels of interest in suicide prevention efforts going on in-County, and deep appreciation for opportunities to share learnings and experiences, by County providers and community members as well as those outside of Santa Clara County.

OUTREACH ACTIVITIES

A total number of **5,899** potential responders were reached during this reporting period through trainings and outreach. The following table describes the settings in which the potential responders were engaged.

Type of Setting(s) (ex: school, community center)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Community based organization/non-profits	Volunteers, case managers, mental health professionals, older adults, homeless population, clients
Schools – K-12, college/university	Teachers, students, bus drivers, parents, counselors, psychologists
Emergency services location (fire department, police department)	EMS, firefighters, law enforcement, gun owners
Faith-based, church	Staff, faith leaders, congregation
Employment/workplace	Staff, youth camp leaders
Community center	Community members, law enforcement
Office of Education	Staff, mental health professionals, middle school students
Hospital/Health facility	Hospice care workers, nurses, social workers, home aides, clients
Library	Community members, youth librarians, youth, parents, older adults, staff
Parks	Parents, youth
Shopping center	Older adults, youth
Museum	Providers
City Hall	Older adults
Apartment complex	Residents, parents, staff, youth

FISCAL YEAR 2018-2019 PROGRAM DEMOGRAPHICS

Race (n= 3,470)	%
American Indian or Alaska Native	< 1
Asian	20
Black of African American	3
Native Hawaiian or other Pacific Islander	1
White	41
Other	18
More than one race	7
Declined to Answer	9
Ethnicity (n=4,453)	%
Hispanic/Latino	44
Non-Hispanic/Latino	56
Sexual Orientation* (n= 2,725)	%
Gay or Lesbian	2
Heterosexual or Straight	83
Bisexual	3
Questioning or unsure of sexual orientation	< 1
Queer	< 1
Another Sexual Orientation	< 1
Declined to Answer	11
Disability Status (n=2,764)	%
No	83
Yes	11
-Difficulty Seeing	4
-Difficulty hearing, or having speech understood	< 1
-Mental Domain	3
-Physical/Mobility Domain	< 1
-Chronic Health Condition	2
-Other	< 1
Declined to Answer	5

Primary Language (n= 3,617)	%
English	85
Spanish	8
Other Non-English	7
Veteran Status (n=2,717)	%
Yes	2
No	95
Declined to Answer	3
Assigned sex at birth (n= 2,724)	%
Male	26
Female	70
Declined to Answer	4
Current Gender Identify (n= 3,465)	%
Male	27
Female	69
Transgender	< 1
Genderqueer	< 1
Questioning or Unsure of Gender Identity	< 1
Another Gender Identity	< 1
Declined to Answer	3
Age Group (n=4,159)	%
CYF (0-15)	2
TAY (16-25)	12
Adults (26-64)	76
Older Adults (65+)	7
Declined to Answer	3

FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Santa Clara Date: 4/8/20

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	43,590,751	21,265,183	24,061,454		11,642,662	
2. Estimated New FY2019/20 Funding	73,854,244	18,463,561	4,858,832			
3. Transfer in FY2019/20[a/]	(1,581,585)	498,320		3,129,104		(2,045,839)
4. Access Local Prudent Reserve in FY2019/20						0
5. Estimated Available Funding for FY2019/20	115,863,410	40,227,064	28,920,286	3,129,104	11,642,662	
B. Estimated FY2019/20 MHSA Expenditures	82,592,455	21,438,741	11,714,914	3,129,104	4,711,566	

C. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	20,749,476
2. Contributions to the Local Prudent Reserve in FY 2019/20	0
3. Distributions from the Local Prudent Reserve in FY 2019/20	(2,045,839)
4. Estimated Local Prudent Reserve Balance on June 30, 2020	18,703,637

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2019/20 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Component Worksheet

County: Santa Clara Date: 4/8/20

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. C01 Child Full Service Partnership	8,427,364	2,478,591	2,961,857		2,986,917	
2. T01 Transitional Age Youth FSP	8,803,468	2,247,699	3,400,904		3,154,865	
3. A01 Adult Full Service Partnership	12,005,717	7,243,789	4,761,928			
4. A03 Criminal Justice FSP	9,165,083	5,372,342	3,792,741			
5. OA01 Older Adult Full Service Partnership	2,966,507	1,720,820	1,245,687			
6. A02 Community Placement Team Services and IMD Alternative Program	1,751,291	1,751,291				
7. A02 Crisis Stabilization Unit and Crisis Residential Treatment	7,563,188	3,638,088	3,925,100			
8. A03 Criminal Justice Residential and Outpatient Treatment Programs	3,173,654	3,173,654				
9. A04 Mental Health Urgent Care	1,716,229	490,351	1,225,878			
10. C02 Children's (Uplift) Mobile Crisis	471,890	330,323	141,567			
11. C02 CSEC Program	470,700	470,700				
12. C02 Specialty Services - Integrated MH/SUD	545,710	297,660	248,050			
13. C03 Foster Care Development	433,979	303,785	130,194			
14. C03 Independent Living Program (ILP)	34,231	8,216	26,015			
15. C03 Services for Juvenile Justice Involved Youth	655,835	328,167	262,334		65,334	
16. HO01 Permanent Supportive Housing	3,124,990	2,183,303	917,687			24,000
17. Specialty Services- Eating Disorders --- Child/Adult/Other combined	750,000	750,000				
18. T02-04 TAY Crisis and Drop In Center	269,911	269,911				
19. A02 Assertive Community Treatment	3,508,848	2,232,286	1,276,562			
Non-FSP Programs						
1. C03 Children & Family Behavioral Health Outpatient/IOP Services	36,397,954	6,160,589	18,092,708		12,144,657	
2. Specialty Services- Eating Disorders --- Child/Adult/Other combined	1,250,000	1,250,000				
3. C02 Specialty Services - Integrated MH/SUD	446,490	198,440	248,050			
4. C03 Foster Care Development	1,012,617	708,832	303,785			
5. A02 Community Placement Team Services and IMD Alternative Program	4,086,345	4,086,345				
6. C02 Children's (Uplift) Mobile Crisis	314,594	220,216	94,378			
7. T02-04 TAY Outpatient Services	1,965,177	729,549	973,589		262,039	
8. Intensive Outpatient Program (IOP)	539,822	539,822				
9. C03 Independent Living Program (ILP)	79,871	19,170	60,701			
10. C02 CSEC Program	415,949	415,949				
11. C03 Services for Juvenile Justice Involved Youth	2,884,574	1,695,082	612,112		152,445	424,934
12. T02-04 TAY Triage to Support Reentry	1,109,525	359,525	750,000			
13. T02-04 TAY Crisis and Drop In Center	269,911	269,911				
14. T02-04 TAY Interdisciplinary Service Teams	1,500,000	750,000	750,000			
15. A02/A04 County Clinics	9,084,589	3,583,929	5,110,339			390,321
16. A02 Hope Services: Integrated Mental Health and Autism Services	1,305,472	806,773	498,699			
17. A02 CalWORKs Community Health Alliance	2,403,008	959,381	761,787			681,840
18. A03 Criminal Justice Residential and Outpatient Treatment Programs	4,274,002	4,274,002				
19. A03 Criminal Justice Outpatient Services	1,924,820	1,071,410	853,410			
20. A03 Faith Based Resource Centers	1,848,688	450,000				1,398,688
21. A04 Mental Health Urgent Care	2,370,030	1,144,152	1,225,878			
22. A02 Crisis Stabilization Unit and Crisis Residential Treatment	17,438,683	8,280,115	9,158,568			
23. A02 Adult Residential Treatment	1,550,700	875,350	675,350			
24. OA02-04 In-Home Outreach Teams	1,860,000	1,860,000				
25. OA02-04 Outpatient Services for Older Adults	2,173,893	1,840,308	333,585			
26. OA02-04 Clinical Case Management for Older Adults	2,100,000	950,000	1,150,000			
27. OA02-04 Connections Program	151,000	151,000				
28. OA02-04 Older Adult Collaboration with Senior Nutrition Centers	0	starts FY21				
29. LP01 Learning Partnership	1,594,165	1,594,165				
CSS Administration	2,057,465	2,057,465				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	170,247,937	82,592,455	65,969,442	0	18,766,257	2,919,783
FSP Programs as Percent of Total	79.7%					

FY 2019/20 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Clara Date: 4/8/20

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. P2 Violence Prevention Program	199,020	199,020				
2. P2 Intimate Partner Violence Prevention	0	Starts FY21				
3. P2 Support for Parents	660,000	660,000				
4. P1 Promotores	0	Starts FY21				
PEI Programs - Early Intervention						
5. P3 Raising Early Awareness Creating Hope (REACH)	1,404,047	1,069,597	287,062		47,388	
6. P4 Integrated Behavioral Health	1,148,390	1,148,390				
7. P2 School Linked Services (SLS) Initiative	19,021,304	9,982,019	5,519,431		3,519,854	
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
8. P1 Older Adult In-Home Peer Respite Program	0	Starts FY21				
9. P1 Law Enforcement Training	311,236	311,236				
PEI Programs - Stigma and Discrimination Reduction						
10. P4 New Refugees Program	691,043	691,043				
11. P1 Ethnic and Cultural Communities Advisory Committees (ECCACs)	1,850,000	1,850,000				
12. P1 Culture is Prevention	54,769	54,769				
PEI Programs - Access and Linkage to Treatment						
13. P2 Services for Children 0-5	388,527	388,527				
14. P1 Office of Consumer Affairs	429,651	429,651				
15. P1 Office of Family Affairs	733,377	733,377				
16. P1 Re-Entry	151,396	151,396				
17. P1 LGBTQ	449,500	449,500				
PEI Programs - Suicide Prevention						
18. P5 Suicide Prevention Strategic Plan	1,655,636	1,655,636				
PEI Programs - Improve Timely Access to Services for Underserved Populations						
19. P1 Culture-Specific Wellness Centers	0	Starts FY21				
PEI Administration	1,414,580	1,414,580				
PEI Assigned Funds- CalMHSA	250,000	250,000				
Total PEI Program Estimated Expenditures	30,812,476	21,438,741	5,806,493	0	3,567,242	0

FY 2019/20 Mental Health Services Act Annual Update
Innovations (INN) Component Worksheet

County: Santa Clara Date: 4/8/20

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Faith Based Training and Supports Project	308,551	308,551				
2. Client and Consumer Employment	841,486	841,486				
3. Psychiatric Emergency Response Team (PERT) and Peer Linkage	1,572,043	1,572,043				
4. Allcove (headspace) Implementation Project	3,666,944	3,666,944				
5. Tech Suite	2,098,458	2,098,458				
6. Room Match	850,000	850,000				
7. Multi-Cultural Center	0	0				
8. Older Adult In-Home Outreach Team	1,200,000	1,200,000				
INN Administration	1,177,432	1,177,432				
Total INN Program Estimated Expenditures	11,714,914	11,714,914	0	0	0	0

FY 2019/20 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Component Worksheet

County: Santa Clara Date: 4/8/20

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. W1 WET Coordination	319,914	319,914				
2. W2 Promising Practice Based Training	609,120	609,120				
3. W3: Improved Svcs/Outreach to Unserved/Underserved Populations	487,142	487,142				
4. W4: Welcoming Consumers and Family Members	475,048	475,048				
5. W5: WET Collaboration with Key System Partners	25,000	25,000				
6. W6: Mental Health Career Pathway	195,454	195,454				
7. W7: Stipends and Incentive to Support MH Career Pathways	654,000	654,000				
WET Administration	363,426	363,426				
Total WET Program Estimated Expenditures	3,129,104	3,129,104	0	0	0	0

FY 2019/20 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Clara Date: 4/8/20

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. headspace Sites	3,470,000	3,470,000				
2.						
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. CFTN Support Staff	1,241,566	1,241,566				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	4,711,566	4,711,566	0	0	0	0

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: Santa Clara County

Fiscal Year: 2018-2019

Local Mental Health Director

Name: Toni Tullys

Telephone: 408-793-1846

Email: toni.tullys@hhs.sccgov.org

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Toni Tullys	DocuSigned by: Toni Tullys AB2AABE6ED30409...	5/9/2019
Local Mental Health Director (PRINT NAME)	Signature	Date

Considered: 06/02/2020

[1] Welfare and Institutions Code section 5892 (b)(2)

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA Stakeholder Leadership Committee (SLC) Kick Off Meeting
Valley Specialty Center, San Jose, CA
October 1, 2019

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1

AGENDA

TOPIC	TIME
1. Check-In	3:00 – 3:15
2. Welcome by Director/Executive Team	3:15 – 3:25
3. Overview of CPPP and Timeline	3:25 – 3:35
4. MHSA Legislative Updates	3:35 – 3:55
5. Break	3:55 – 4:05
6. MHSA Program Updates	4:05– 4:45
7. Next Steps	4:45– 5:00
8. Adjourn	5:00

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SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

2

MHSA ANNUAL PLAN UPDATES AND THREE-YEAR PLANS LEGISLATION

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) and Annual Updates for Mental Health Service Act (MHSA) programs and expenditures.

Plans and Annual Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after Board of Supervisor adoption.

WIC § 5848 states the mental health board shall conduct a public hearing on the draft three-year program and expenditure plan at the close of the 30-day comment period.

WIC § 5891 states that MHSA funds may only be used to pay for MHSA programs.

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3

3

MHSA ANNUAL PLAN UPDATES AND THREE-YEAR PLANS, CONTINUED

For this MHSA planning cycle and to align with state timelines by June 30, 2020, County of Santa Clara has been tasked with the following MHSA reports and plans:

- Annual Plan Update for FY20 – budget only for FY19/20
- Annual Plan Update for FY21 – outcomes (for FY19/20) and budget update for FY20/21
- Three Year Plan FY21-23 – estimated budgets for FY21/22, FY22/23

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Supporting Wellness and Recovery

4

4

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5

5

REVISED COMMUNITY PROGRAM PLANNING PROCESS
INTEGRATED FY21-23 PLAN AND FY20 UPDATE

Kick Off

October 1, 2019
3:00 - 5:00pm

Overview of CPPP and Timeline
Review MHSA Components
Legislative Updates

Community Program Planning Process

September 17, 2019
6:00pm – 8:00pm
Rebekah Children's Services

September 23, 2019
1:00pm – 3:00pm
Bill Wilson Center

October 4, 2019
9:00am – 11:00am
Behavioral Health Board

October 9, 2019
3:30pm – 5:30pm
Mitchell Park Community Center (Matadero)

October 15, 2019
3:30 – 6:30pm
Santa Clara Valley Specialty Center, BQ160

Additional Listening Sessions to be scheduled countywide

January 22, 2020
8:30am – 4:30pm
MHSA Symposium

Plan Review

March 2 – March 31
30-Day Draft Plans for Public Review

April 16, 2020
Behavioral Health Public Hearing of Draft Plans

June 2020
Date: TBD
Request Board of Supervisor Approval

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SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

6

MHSA LEGISLATIVE UPDATES

- September marks the end of the first year of a two-year legislative cycle. Today, we will cover bills that may become law in this first year and "2-year bills" or bills that will seek passage in the second year of this legislative session.
- Bills successfully passed by the Legislature are **"enrolled"** and have moved to the Governor for final action. The Governor has until October 13 to act on legislation. He can sign the legislation or not act on the legislation. Bills signed by the Governor or those not acted upon by October 13 are **"chaptered"** and become state law.

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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

7

MHSA LEGISLATIVE UPDATES

- **SB 192 (Beall – 2018 Chaptered)** Establishes a 33% cap of 5-year average of the CSS for prudent reserve and establishes a reversion account for funds that have not been spent or encumbered by July 1, 2020.
- **SB 1004 (Weiner – 2018 Chaptered)** Requires the MHSOAC to establish statewide priorities for the use of Prevention and Early Intervention (PEI) funds by January 1, 2020.
- **SB 389 (Hertzberg – 2019 Chaptered)** This bill amends the MHSA to authorize counties to use MHSA funds to provide services to persons who are participating in a presentencing or post-sentencing diversion program or who are on parole, probation, post-release community supervision, or mandatory supervision. (CBHDA position – Support)
- **SB 79 (Committee on Budget and Fiscal Review - Chaptered)** Budget Act of 2019, MHSOAC Innovation Timeline Language. This bill language improves the MHSOAC approval process for county innovation projects funded under the MHSA. The bill language extends the deadline for counties to expend MHSA Innovation funding from three years (for large counties) and five years (for small counties) to a deadline established by the terms of the project plan approved by the MHSOAC. (CBHDA position – Sponsor)

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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

8

MHSA LEGISLATIVE UPDATES

- **AB 1352 (Waldron – 2019 Enrolled):** Mental Health Boards – Clarifies the role of local mental health boards in California as advisory boards to the county board of supervisors and the responsibility of the local mental health board to review and evaluate the local mental health system delivered by county behavioral health. This bill also requires county behavioral health agencies to submit a report with the reasons why the county behavioral health agency did not accept substantive recommendations to the three-year MHSA program and expenditure plan from the local mental health board. (CBHDA position – Support after Amended)
- **SB 10 (Beall – Enrolled):** Mental Health Services: Peer Support Specialist Certification. Peer providers draw on lived experience with mental illness, addiction, and recovery to offer unique services and support for behavioral health clients. This legislation creates a standardized pathway for people with lived experience to attain care delivery skills through formal training. This bill requires DHCS to establish a statewide peer specialist certification program. DHCS would also be required to amend California's Medicaid State Plan to create both a new Medi-Cal provider type and a new, peer-based service. SB 10 allows DHCS to use MHSA funds to cover implementation costs if this funding is appropriated in the state budget process. (CBHDA position – Support)

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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

9

MHSA LEGISLATIVE UPDATES

NOT passed this legislative cycle:

- **SB 12 (Beall – 2019 2 Year Bill) Mental Health Services: Youth** – Establishes the Integrated Youth Mental Health Program (IYMHP) which would be administered by the Mental Health Services Oversight and Accountability Commission (MHSAOC). The bill seeks funds to develop centers which will provide integrated mental health, substance use, physical health, social support and other services to youth 12-25 years of age. The 2019-20 Budget Act allocated $15 million one-time MHSA state administrative set-aside dollars for the same purposes contained in this bill. (CBHDA position – Support)
- **SB 665 (Umberg – 2019 2 Year Bill) Mental Health Services Fund: County Jails** – Authorizes the use of MHSA funds to provide services to individuals incarcerated in a county jail or subject to mandatory supervision, except for individuals convicted of a felony. (CBHDA position – Oppose unless Amended)

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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

10

MHSA PROGRAM UPDATES

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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

11

Programs for Children, Youth, and Families

Initiative	Program	FY18-FY20 Plan
Community Services and Supports: Full Service Partnership		
Full Service Partnership for Children, Youth, and Families	Intensive Children's Full Service Partnership	New - Awarded
	Intensive TAY Full Service Partnership	New - Awarded
Community Services and Supports: General System Development		
Outpatient Services for Children and Youth	Specialty and Outpatient Services: Eating Disorders for Children, Youth and Adults	In full implementation
Foster Care Development	CSEC Program	In full implementation
Juvenile Justice Development	TAY Triage to Support Re-Entry	Program plan in development
TAY Interdisciplinary Services Teams	TAY Interdisciplinary Services Teams	In solicitation – BidSync

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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

12

Programs for Adults and Older Adults

Initiative	Program	FY18-FY20 Plan
CSS: Full Service Partnership		
Full Service Partnership for Adults and Older Adults	Assertive Community Treatment (ACT)	New - awarded
	Intensive Full Service Partnerships for Adults/OA	New - awarded
	Forensic ACT	New - awarded
CSS: General System Development		
Crisis and Hospital Diversion Initiative	Adult Residential Treatment	New - Program plan in development
Older Adult Community Services Initiative	Clinical Case Management for Older Adults (Elder Health Community Treatment Services)	New – Program plan in development
	Older Adult Collaboration with San Jose Nutrition Centers	Modified – Program plan in development
	Elder's Story Telling	Modified – Program plan in development
CSS: Outreach & Engagement		
In Home Outreach Team	In Home Outreach Teams (1 county-operated)	New - awarded
Prevention and Early Intervention		
Criminal Justice System PEI Enhancement	The Re-Entry Resource Center – PEI enhancement	New - In development
Peer and Family Support	Independent Living Facilities	New - For FY21 release
	Older Adult In-Home Peer Respite	New – Program plan in development

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SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

13

Community-Wide Programs

Initiative	Program	FY18-FY20 Plan
Prevention and Early Intervention		
Stigma and discrimination reduction	Culture Specific Wellness Centers	New - In development
Prevention	Violence Prevention and Intimate Partner Violence Prevention	Modified - In development
Access and Linkage	Promotores	New - In development
	LGBTQ+ Access & Linkage and Technical Assistance	New - In development
Innovation, Workforce Education and Training		
Innovation - Approved	Faith Based Training and Support Project	Vendor selected, implementation under way
	Client and Consumer Employment	Vendors selected, implementation under way
	Psychiatric Emergency Response Team and Peer Linkage	In Development
	Allcove Implementation	Evaluation vendor selected, CBO partner selected, Two sites identified
Innovation – Pending Approval	Technology Suite for Mental Health	Awaiting guidance from MHSOAC
	Reach Out and Connect	In planning process
	Room Match	Reviewing implementation feasibility

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SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

14

Community-Wide Programs

Initiative	Program	FY18-FY20 Plan
Capital Facilities and Technological Needs (CFTN)		
Capital Facilities/Technology (CFTN)	Facilities Acquisition and Remodel for Allcove Sites	Two sites identified, slated for a July 2020 opening
	Adult Residential Facilities (ART)	In Program Planning Phase

Transfers from Community Services and Supports to Capital Facilities and Technological Needs:
*Pursuant to the **Welfare and Institutions Code Section 5892(b)**, Counties may use a portion of their CSS funds for WET, CFTN and the Local Prudent Reserve. It is further specified that the total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years. The transferred funds have up to years to be spent.

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15

NEXT STEPS

- UPCOMING PLANNING MEETINGS
- COMPLETE THE STAKEHOLDER INPUT FORM

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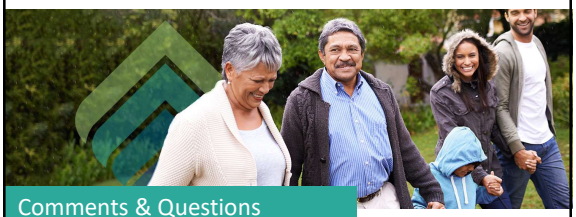

Comments & Questions

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SANTA CLARA COUNTY Behavioral Health Services

17

THANK YOU

Toni Tullys, MPA
Director, Behavioral Health Services

Deane Wiley, PhD
Deputy Director, Behavioral Health Services

For questions, additional information or other concerns, contact:
Evelyn Tirumalai, MPH - Senior Manager, MHSA
1-408-885-5785
Or email us at: MHSA@hhs.sccgov.org

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18

COUNTY OF SANTA CLARA
Behavioral Health Services

BEHAVIORAL HEALTH BOARD
SYSTEM PLANNING/ FISCAL SUB-COMMITTEE MEETING
DOWNTOWN MENTAL HEALTH, 2ND FLOOR
OCTOBER 4, 2019

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1

MHSA ANNUAL PLAN UPDATES AND THREE-YEAR PLANS LEGISLATION

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) and Annual Updates for Mental Health Service Act (MHSA) programs and expenditures.

Plans and Annual Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after Board of Supervisor adoption.

WIC § 5848 states the mental health board shall conduct a public hearing on the draft three-year program and expenditure plan at the close of the 30-day comment period.

WIC § 5891 states that MHSA funds may only be used to pay for MHSA programs.

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2

MHSA ANNUAL PLAN UPDATES AND THREE-YEAR PLANS, CONTINUED

For this MHSA planning cycle and to align with state timelines by June 30, 2020, County of Santa Clara has been tasked with the following MHSA reports and plans:

- Annual Plan Update for FY20 – budget only for FY19/20
- Annual Plan Update for FY21 – outcomes (for FY19/20) and budget update for FY20/21
- Three Year Plan FY21-23 – estimated budgets for FY21/22, FY22/23

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3

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4

REVISED COMMUNITY PROGRAM PLANNING PROCESS
INTEGRATED FY21-23 PLAN AND FY20 UPDATE

Kick Off

October 1, 2019
3:00 - 5:00pm

Overview of CPPP and Timeline
Review MHSA Components
Legislative Updates

Community Program Planning Process

September 17, 2019
6:00pm – 8:00pm
Rebekah Children's Services

September 23, 2019
1:00pm – 3:00pm
Bill Wilson Center

October 4, 2019
9:00am – 11:00am
Behavioral Health Board

October 9, 2019
3:30pm – 5:30pm
Mitchell Park Community Center (Matadero)

October 15, 2019
3:30 – 6:30pm
Santa Clara Valley Specialty Center, BQ160

Additional Listening Sessions to be scheduled countywide

January 23, 2020
8:30am – 4:30pm
MHSA Symposium

Plan Review

March 2 – March 31
30-Day Draft Plans for Public Review

April 13, 2020
Behavioral Health Public Hearing of Draft Plans

June 2020
Date: TBD
Request Board of Supervisor Approval

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5

MHSA LEGISLATIVE UPDATES

- September marks the end of the first year of a two-year legislative cycle. Today, we will cover bills that may become law in this first year and "2-year bills" or bills that will seek passage in the second year of this legislative session.
- Bills successfully passed by the Legislature are **"enrolled"** and have moved to the Governor for final action. The Governor has until October 13 to act on legislation. He can sign the legislation or not act on the legislation. Bills signed by the Governor or those not acted upon by October 13 are **"chaptered"** and become state law.

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6

MHSA LEGISLATIVE UPDATES

- **SB 192 (Beall – 2018 Chaptered)** Establishes a 33% cap of 5-year average of the CSS for prudent reserve and establishes a reversion account for funds that have not been spent or encumbered by July 1, 2020.
- **SB 1004 (Weiner – 2018 Chaptered)** Requires the MHSOAC to establish statewide priorities for the use of Prevention and Early Intervention (PEI) funds by January 1, 2020.
- **SB 389 (Hertzberg – 2019 Chaptered)** This bill amends the MHSA to authorize counties to use MHSA funds to provide services to persons who are participating in a presentencing or post-sentencing diversion program or who are on parole, probation, post-release community supervision, or mandatory supervision. (CBHDA position – Support)
- **SB 79 (Committee on Budget and Fiscal Review - Chaptered)** Budget Act of 2019, MHSOAC Innovation Timeline Language. This bill language improves the MHSOAC approval process for county innovation projects funded under the MHSA. The bill language extends the deadline for counties to expend MHSA Innovation funding from three years (for large counties) and five years (for small counties) to a deadline established by the terms of the project plan approved by the MHSOAC. (CBHDA position – Sponsor)

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7

MHSA LEGISLATIVE UPDATES

- **AB 1352 (Waldron – 2019 Enrolled):** Mental Health Boards – Clarifies the role of local mental health boards in California as advisory boards to the county board of supervisors and the responsibility of the local mental health board to review and evaluate the local mental health system delivered by county behavioral health. This bill also requires county behavioral health agencies to submit a report with the reasons why the county behavioral health agency did not accept substantive recommendations to the three-year MHSA program and expenditure plan from the local mental health board. (CBHDA position – Support after Amended)
- **SB 10 (Beall – Enrolled):** Mental Health Services: Peer Support Specialist Certification. Peer providers draw on lived experience with mental illness, addiction, and recovery to offer unique services and support for behavioral health clients. This legislation creates a standardized pathway for people with lived experience to attain care delivery skills through formal training. This bill requires DHCS to establish a statewide peer specialist certification program. DHCS would also be required to amend California's Medicaid State Plan to create both a new Medi-Cal provider type and a new, peer-based service. SB 10 allows DHCS to use MHSA funds to cover implementation costs if this funding is appropriated in the state budget process. (CBHDA position – Support)

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MHSA LEGISLATIVE UPDATES

NOT passed this legislative cycle:

- **SB 12 (Beall – 2019 2 Year Bill) Mental Health Services: Youth** – Establishes the Integrated Youth Mental Health Program (IYMHP) which would be administered by the Mental Health Services Oversight and Accountability Commission (MHSAOC). The bill seeks funds to develop centers which will provide integrated mental health, substance use, physical health, social support and other services to youth 12-25 years of age. The 2019-20 Budget Act allocated $15 million one-time MHSA state administrative set-aside dollars for the same purposes contained in this bill. (CBHDA position – Support)
- **SB 665 (Umberg – 2019 2 Year Bill) Mental Health Services Fund: County Jails** – Authorizes the use of MHSA funds to provide services to individuals incarcerated in a county jail or subject to mandatory supervision, except for individuals convicted of a felony. (CBHDA position – Oppose unless Amended)

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9

MHSA PROGRAM UPDATES

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10

Programs for Children, Youth, and Families

Initiative	Program	FY18-FY20 Plan
Community Services and Supports: Full Service Partnership		
Full Service Partnership for Children, Youth, and Families	Intensive Children's Full Service Partnership	New - Awarded
	Intensive TAY Full Service Partnership	New - Awarded
Community Services and Supports: General System Development		
Outpatient Services for Children and Youth	Specialty and Outpatient Services: Eating Disorders for Children, Youth and Adults	In full implementation
Foster Care Development	CSEC Program	In full implementation
Juvenile Justice Development	TAY Triage to Support Re-Entry	Program plan in development
TAY Interdisciplinary Services Teams	TAY Interdisciplinary Services Teams	In solicitation – BidSync

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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

11

Programs for Adults and Older Adults

Initiative	Program	FY18-FY20 Plan
CSS: Full Service Partnership		
Full Service Partnership for Adults and Older Adults	Assertive Community Treatment (ACT)	New - awarded
	Intensive Full Service Partnerships for Adults/OA	New - awarded
	Forensic ACT	New - awarded
CSS: General System Development		
Crisis and Hospital Diversion Initiative	Adult Residential Treatment	New - Program plan in development
Older Adult Community Services Initiative	Clinical Case Management for Older Adults (Elder Health Community Treatment Services)	New – Program plan in development
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12

Community-Wide Programs		
Initiative	**Program**	**FY18-FY20 Plan**
Prevention and Early Intervention		
Stigma and discrimination reduction	Culture Specific Wellness Centers	New - In development
Prevention	Violence Prevention and Intimate Partner Violence Prevention	Modified - In development
Access and Linkage	Promotores	New - In development
	LGBTQ+ *Access & Linkage and Technical Assistance*	New - In development
Innovation, Workforce Education and Training		
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SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

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Community-Wide Programs		
Initiative	**Program**	**FY18-FY20 Plan**
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14

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Supporting Wellness and Recovery

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NEXT STEPS

- **Upcoming Planning Meetings**
- **Complete the Stakeholder Input Form**

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Supporting Wellness and Recovery

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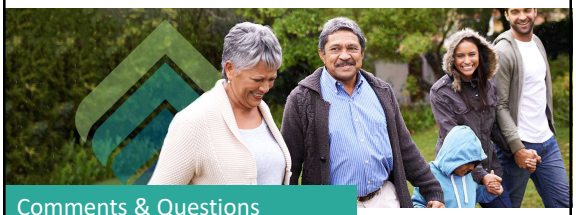

Comments & Questions

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SANTA CLARA COUNTY Behavioral Health Services

16

THANK YOU

Toni Tullys, MPA
Director, Behavioral Health Services

Deane Wiley, PhD
Deputy Director, Behavioral Health Services

For questions, additional information or other concerns, contact:
Evelyn Tirumalai, MPH - Senior Manager, MHSA
1-408-885-5785
Or email us at: MHSA@hhs.sccgov.org

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Supporting Wellness and Recovery

17

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA Stakeholder Leadership Committee (SLC) Community Program Planning
Valley Specialty Center, San Jose, CA
October 15, 2019 ❖ 3:30PM-6:30PM

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AGENDA

TOPIC	TIME
1. Check-In/Welcome by Director/Executive Team	3:30 – 3:45
2. MHSA Program Briefs -Legislative Update -Prevention and Early Intervention	3:45 – 4:00
3. MHSA Innovations Update	4:00 – 4:30
4. Break	4:30 – 4:45
6. Roundtable Planning by System of Care	4:45 – 5:45
7. Report Backs	5:45 – 6:15
8. Wrap Up and Adjourn	6:15 – 6:30

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SANTA CLARA COUNTY
Behavioral Health Services
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MHSA ANNUAL PLAN UPDATES AND THREE-YEAR PLANS LEGISLATION

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MHSA PROGRAM BRIEFS

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SANTA CLARA COUNTY Behavioral Health Services
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MHSA LEGISLATIVE UPDATES
POST 10.13.19

- **AB 1352 (Waldron – 2019 Chaptered):** Mental Health Boards – Clarifies the role of local mental health boards in California as advisory boards to the county board of supervisors and the responsibility of the local mental health board to review and evaluate the local mental health system delivered by county behavioral health. This bill also requires county behavioral health agencies to submit a report with the reasons why the county behavioral health agency did not accept substantive recommendations to the three-year MHSA program and expenditure plan from the local mental health board. (CBHDA position – Support after Amended)
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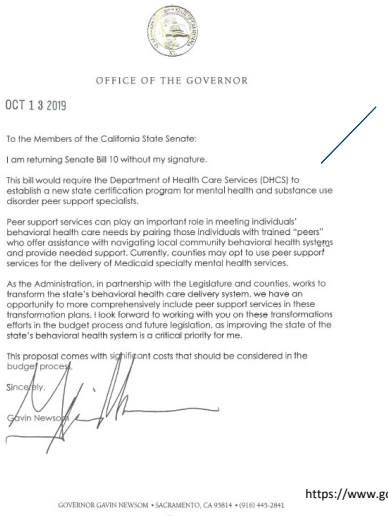
SANTA CLARA COUNTY
Behavioral Health Services
Supporting Wellness and Recovery

MHSA LEGISLATIVE UPDATES
SB 10 VETO MESSAGE



OFFICE OF THE GOVERNOR

OCT 13 2019

To the Members of the California State Senate:

I am returning Senate Bill 10 without my signature.

This bill would require the Department of Health Care Services (DHCS) to establish a new state certification program for mental health and substance use disorder peer support specialists.

Peer support services can play an important role in meeting individuals' behavioral health care needs by pairing those individuals with trained "peers" who offer assistance with navigating local community behavioral health systems and provide needed support. Currently, counties may opt to use peer support services for the delivery of Medicaid specialty mental health services.

As the Administration, in partnership with the Legislature and counties, works to transform the state's behavioral health care delivery system, we have an opportunity to more comprehensively include peer support services in these transformation plans. I look forward to working with you on these transformations efforts in the budget process and future legislation, as improving the state of the state's behavioral health system is a critical priority for me.

This proposal comes with significant costs that should be considered in the budget process.

Sincerely,

Gavin Newsom

GOVERNOR GAVIN NEWSOM • SACRAMENTO, CA 95814 • (916) 445-2841

"…As the Administration, in partnership with the Legislature and counties, works to transform the state's behavioral health care delivery system, we have an opportunity to more comprehensively include peer support services in these transformation plans. I look forward to working with you on these transformations efforts in the budget process and future legislation, as improving the state of the state's behavioral health system is a critical priority for me." Gov. Newsom

https://www.gov.ca.gov/2019/10/13/governor-newsom-takes-final-action-of-2019-legislative-season/

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Behavioral Health Services
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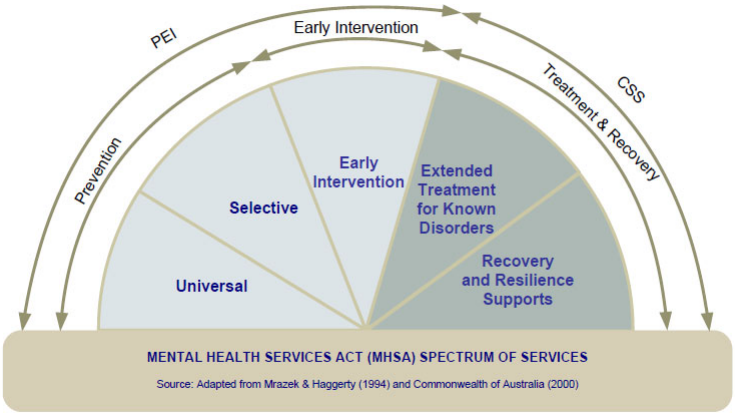
PREVENTION AND EARLY INTERVENTION



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Supporting Wellness and Recovery

PREVENTION AND EARLY INTERVENTION
SB1004

SB 1004 would create more oversight in how MHSA funds are spent and require counties to focus their PEI funds on five overarching categories:

1. Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
2. Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the life span.
3. Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
4. Culturally competent and linguistically appropriate prevention and intervention.
5. Strategies targeting the mental health needs of older adults.

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MHSA INNOVATIONS UPDATE

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FAITH BASED TRAINING AND SUPPORTS

- Design and implement customized faith-based behavioral health training for faith community leaders
- Design and implement faith-informed workshop series for behavioral health direct care providers to learn about spirituality and faith in assisting faith communities
- Amount: $608,964; Project Length: 24 months

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SANTA CLARA COUNTY Behavioral Health Services
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FAITH-BASED TRAINING AND SUPPORTS

SERVICE CONTRACT EXECUTED WITH NAMI SANTA CLARA COUNTY

EVALUATOR HAS BEEN AWARDED

HIRING AND TRAINING STAFF

NAMI HAS BEEN CONDUCTING FOCUS GROUPS WITH CULTURAL FAITH-BASED COMMUNITIES

MEETINGS/PRESENTATIONS WITH PASTORS AND FAITH LEADERS

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CLIENT AND CONSUMER EMPLOYMENT

Adopt Individual Placement & Support Supported Employment (IPS/SE) model

Employment is a wellness goal, integrated into the care plan, zero exclusions

Amount: $2,525,148

Project Length:

36 months

Vendors and evaluator selected

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SANTA CLARA COUNTY Behavioral Health Services
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CLIENT AND CONSUMER EMPLOYMENT

- Rockville Institute conducted a fidelity training in June 2019
  Fidelity review scheduled for November 2019
- IPS trainer hired
- Monthly meetings have been taking place to discuss challenges and successes

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Supporting Wellness and Recovery

One provider placed 8 clients into competitive work and has 29 participants enrolled. One participant said, "I have a lot of chaos in my life. My job is the one area of my life that is going well. I have been working at Safeway since April."
- Momentum

Another provider said they have 40 participants enrolled in the program and 15 people have been placed in jobs over the last two quarters. All positions are competitive market employment.
- Catholic Charities

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Another provider shared that they have had unusual success with this model and the TAY population. The level of engagement is extremely high. Families and case managers are working together and much of the success is due to the zero exclusion principle and the employment specialist being an embedded member of the mental health team.
– Fred Finch

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PSYCHIATRIC EMERGENCY RESPONSE TEAM (PERT) AND PEER LINKAGE

Utilize a co-response intervention model with teams that include a licensed clinician paired with law enforcement officer

Connect individuals to appropriate services and provide post crisis peer support services

Amount: $3,688,511; Project Length: 24 months

Evaluator has been secured

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Behavioral Health Services
Supporting Wellness and Recovery

ALLCOVE

Goal: Open two integrated health centers with behavioral health services (mental health and substance use), primary care, educational support and employment services, and peer support for youth ages 12 to 25 years old

First centers in California and the country

Centers designed for youth by youth, Youth Advisory Group (YAG)

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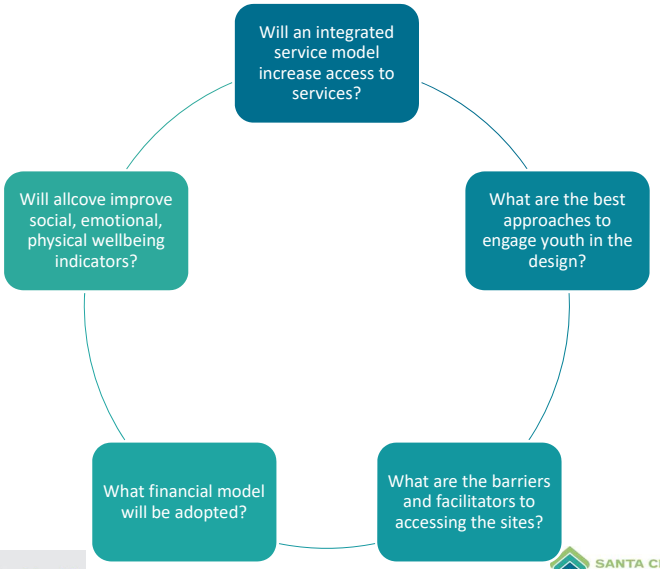
SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

LEARNING GOALS



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SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

PARTNERS

allcove

Stanford MEDICINE | Center for Youth Mental Health & Wellbeing
Department of Psychiatry & Behavioral Sciences

COUNTY OF SANTA CLARA
Behavioral Health Services

Alum Rock Counseling Center

SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

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SANTA CLARA COUNTY
Behavioral Health Services
Supporting Wellness and Recovery

ALLCOVE IMPLEMENTATION

Developed integrated service model: one-stop shop

Formed Youth Advisory Group (YAG) of 27 youth representing the County's diverse population

Sites found in San Jose and Palo Alto

San Jose lease approved by BOS, Palo Alto lease will go to BOS 10/22

YAG worked with IDEO.org to develop logo, brand, identity and name for the program, secured web domain and social media handles

Process evaluation completed

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SANTA CLARA COUNTY
Behavioral Health Services
Supporting Wellness and Recovery

ALLCOVE IMPLEMENTATION

RFP for CBO for community consortium/peer support and evaluator awarded

Sites expected to open July 2020

Amount: $16.5 million; Project Length: 48 months

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SANTA CLARA COUNTY
Behavioral Health Services

INNOVATIONS PROJECTS
PENDING MHSOAC APPROVAL

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Behavioral Health Services
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TECH SUITE

Santa Clara County in process of requesting to join Tech Suite cohort, a multi-county cohort across California to bring interactive technology tools into the public mental health system

Seeks to educate users on digital health literacy (ramp up), test out an innovative suite of applications designed on the signs and symptoms of mental illness, connect peers seeking help in real time through chat functionality, and increase user access to mental health services

Estimated amount: $6,000,000; Project Length: 36 months

In process of submitting proposal to MHSOAC

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Behavioral Health Services
Supporting Wellness and Recovery

REACH OUT, ENGAGE, AND CONNECT (REC)

REC is a proposed project that will provide culturally responsive mental health services for adults over 60 in Santa Clara County via a multilingual phone line and home visits. This project will target underserved or unserved older adults who experience isolation and/or depression and who may be homebound. REC is designed to connect older adults to supportive services they would otherwise have difficulty accessing.

Proposal for MHSOAC has been drafted

Estimate start in FY2021

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SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

ROOM MATCH

To support the housing needs of consumers receiving or in need of mental health services through systemized connections to available rooms within the community

Meeting housing needs and incorporating choice for both consumers and renters aims to reduce the risk of homeless, relapse, hospitalization, and arrest for individuals with mental health needs

This proposed housing project seeks out available bedrooms in homes that might be used for both short and long-term housing

This project is reviewing implementation feasibility

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SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

Break

MHSA ANNUAL PLAN UPDATES AND THREE-YEAR PLANS

For this MHSA planning cycle and to align with state timelines by June 30, 2020, County of Santa Clara has been tasked with the following MHSA reports and plans:

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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

REVISED COMMUNITY PROGRAM PLANNING PROCESS
INTEGRATED FY21-23 PLAN AND FY20 UPDATE

Kick Off

October 1, 2019
3:00 - 5:00pm

Overview of CPPP and Timeline
Review MHSA Components
Legislative Updates

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October 9, 2019
3:30pm – 5:30pm
Mitchell Park Community Center (Matadero)

October 15, 2019
3:30 – 6:30pm
Santa Clara Valley Specialty Center, BQ160

Additional Listening Sessions to be scheduled countywide

January 2020
8:30am – 4:30pm
MHSA Symposium

Plan Review

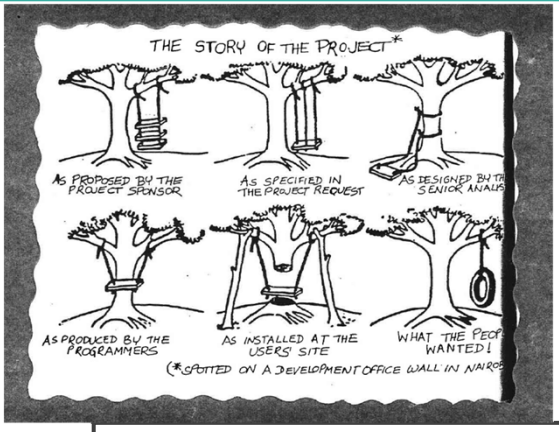
March 2 – March 31
30-Day Draft Plans for Public Review

April 13, 2020
Behavioral Health Public Hearing of Draft Plans

June 2020
Date: TBD
Request Board of Supervisor Approval

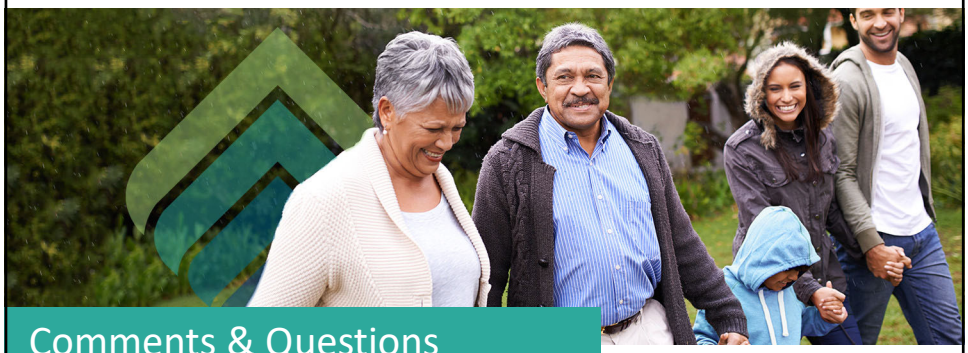
PlanForBetterHealth

SANTA CLARA COUNTY
Behavioral Health Services
Supporting Wellness and Recovery



PlanForBetterHealth

ROUNDTABLE
PLANNING BY SYSTEM OF CARE



Comments & Questions

PlanForBetterHealth

SANTA CLARA COUNTY Behavioral Health Services

THANK YOU

Toni Tullys, MPA
Director, Behavioral Health Services

Deane Wiley, PhD
Deputy Director, Behavioral Health Services

Roshni Shah, MPH
PEI Manager

Gina Vittori, MPH
INN Manager and Planner

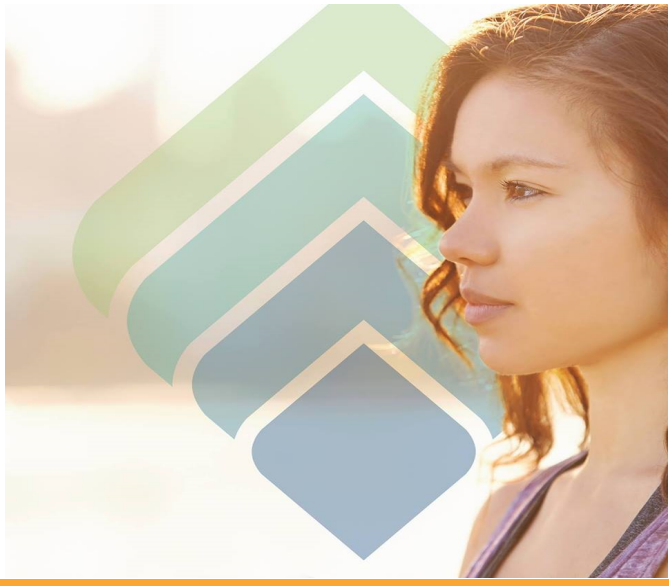
For questions, additional information or other concerns, contact:

Evelyn Tirumalai, MPH - Senior Manager, MHSA
1-408-885-5785
Or email us at: MHSA@hhs.sccgov.org

PlanForBetterHealth

SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

WELLNESS • RECOVERY • RESILIENCE



Mental Health Service Act (MHSA) Public Community Meeting

Open to the public! Join the conversation by providing input on MHSA funded programs and services.

Meeting objectives include:

- Provide input on MHSA Programs and Services
- Learn about the MHSA Community Program Planning Process

DATE

Monday, **September 23**, 2019
1:00 pm – **3**:00 pm

Bill Wilson Center
693 S 2nd Street, San José, CA 95112

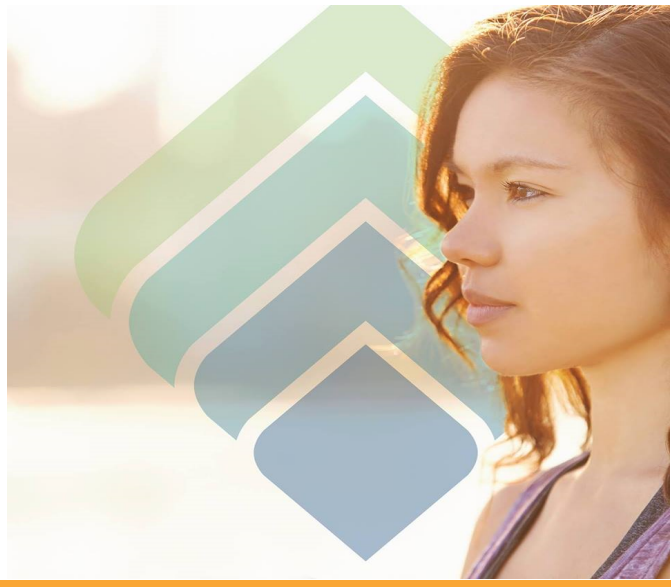
Translation services for clients/consumers available upon request: (408) 808-6150

Contact:
Evelyn Tirumalai, Sr. MHSA Manager
(408) 885-5785 ♦ mhsa@hhs.sccgov.org

COUNTY OF SANTA CLARA
Behavioral Health Services

The Mental Health Services Act (MHSA) provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income over $1 million.

WELLNESS • RECOVERY • RESILIENCE



Mental Health Services Act (MHSA)

Stakeholder Leadership Committee (SLC) Kick Off

Open to the public! Join the conversation by providing input on MHSA funded programs and services.

Meeting objectives include:

- Provide input on MHSA Programs and Services
- Learn about the MHSA Community Program Planning Process

DATE

Tuesday, October 1, 2019
3:00pm - 5:00pm

Valley Specialty Center - Rm BQ160
751 S Bascom Avenue, San José, CA 95112

Translation services for clients/consumers available upon request: (408) 808-6150.

Contact:
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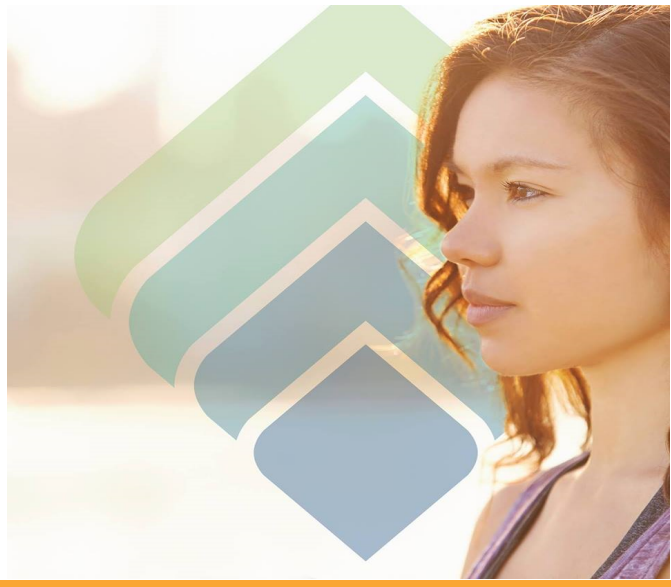

Mental Health Services Act (MHSA)
Community Program Planning Process

Open to the public! Join the conversation
by providing input on MHSA-funded programs and services

Meeting objectives include:

- Provide input on MHSA Programs and Services
- Inform the MHSA Community Program Planning Process

DATE and LOCATION

Tuesday, October 29, 2019 4:00pm-6:00pm

San Jose Evergreen Community College District
1450 Escuela Parkway, Milpitas, CA

Translation services for clients/consumers available upon request: (408) 808-6150.

Contact:
Evelyn Tirumalai, Sr. Manager
(408) 885-5785 ♦ mhsa@hhs.sccgov.org

SAN JOSÉ · EVERGREEN
Community College District

COUNTY OF SANTA CLARA
Behavioral Health Services

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LISTENING SESSION QUESTIONS

Thanks for making the time to join us today.

My name is _____ and this is _____.

The purpose of today is to help the BHSD identify and prioritize community needs, especially around MHSA, crisis, and outpatient psychiatric services. We are facilitating several discussion groups throughout Santa Clara County to better understand the mental health needs in the community. We're here today to hear from you. This is **your** process and **your** opportunity to make your voice heard about what is working well, what isn't working well, and what you feel is needed in upcoming years to improve the system.

This is your conversation, but part of my job as facilitator is to help it go smoothly and make sure that everyone has a chance to say what's on their mind in a respectful way. We have a few guidelines to help us do that. Please:

- Put your phone on silent and don't text
- Engage in the conversation – this is your meeting!
- Limit "side conversations" or "cross talk" so that everyone can hear what is being said
- And remember, there are no "wrong" or "right" opinions: please share your opinions honestly and listen with curiosity to understand the perspective of others

Does anyone have any questions before we begin? **Raise your hand if you've ever been part of a MHSA Community Planning Process.**

Introductions

We know you could be spending your time anywhere, and so we're interested to hear your name and what you're hoping to accomplish or contribute today.

Experience

1. Tell us about your experience receiving mental health services, including crisis, residential, and inpatient services.
   a. Access
      i. Who do you call when you need services?
      ii. Where do you go when you need services?

   b. What services are available?
      i. What types of services are available?
      ii. Where are these services located?

   c. What has been most helpful when receiving services?
      i. What about that experience was helpful?

   d. What's been challenging in your experience getting services?
      i. What gets in the way of getting the services you need?
      Prompt: Transportation, location of services, lack of in-county housing, hours of

operation, long waiting lines

e. What is missing?
i. What services do you wish were available?

Needs

2. Think about your community. Who's not getting served? Who may be falling through the cracks? ***Prompt: What services are so full that we need more?***
a. What is getting in the way of certain populations needs getting met?
b. What would be helpful to address this?

Improvements

3. How could the County improve its mental health services?
c. What should there be more of?
d. What should be fixed?
e. What should be created?

4. What do staff providers and programs need to improve its services?
Prompt: More culturally relevant training, staff training, recovery oriented services, increasing numbers of service providers

5. Considering the discussion, we've just had, what's the most important issue that the county should address?

Thank you! We will be emailing a link in the next week or so to confidential demographic survey, hope you get a chance to complete and submit additional input.

County of Santa Clara
Behavioral Health Services Department
FY20 Mental Health Services Act (MHSA) Annual Community Planning Process
September 23, 2019
Stakeholder Comment Form

PLEASE TELL US ABOUT YOURSELF

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- ☐ 16-24 yrs
- ☑ 25-59 yrs
- ☐ 60+ yrs

What is your gender?
- ☑ Male
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- ☐ Other_____

Male

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- ☐ Community Collaboration (CCR § 3200.060)
- ☐ Cultural Competency (CCR § 3200.100)
- ☐ Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120)
- ☑ Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5)
- ☐ Integrated Service Experience (CCR § 3200.190)

PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

better screening of I.I.C./P.n.d

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Your Voice Matters!

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Behavioral Health Services

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Behavioral Health Services Department
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Involve political activity to strengthen the effect of the community's cause and achieve greater goals.

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COUNTY OF SANTA CLARA
Behavioral Health Services

SANTA CLARA COUNTY MENTAL HEALTH SERVICES ACT

County of Santa Clara
Behavioral Health Services Department
FY20 Mental Health Services Act (MHSA) Annual Community Planning Process
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PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

Today I feel was very informative & helped me Realize what resources we need but don't have.

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better marketing for the resources we don't have

:) BETTER RESOURCES!!

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To Continue to Consider input from Clients.
Continue to strengthen outreach + Marketing

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My Goal is to leave California

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good presentation

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good home
job that paid good

good home
job that paid good

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Your Voice Matters!

COUNTY OF SANTA CLARA
Behavioral Health Services

County of Santa Clara
Behavioral Health Services Department
FY20 Mental Health Services Act (MHSA) Annual
Community Planning Process
September 23, 2019
Stakeholder Comment Form

PLEASE TELL US ABOUT YOURSELF

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- ☐ 0-15 yrs
- ☑ 16-24 yrs
- ☐ 25-59 yrs
- ☐ 60+ yrs

What is your gender?
- ☐ Male
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- ☐ Other_____

What group do you represent? (Check All that Apply)
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What is your primary system transformation interest?
- ☐ Community Collaboration (CCR § 3200.060)
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PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

- More public awareness/marketing
- Greater acceptances of insurance
- Smaller Waitlists.
- Housing Services.
- Services for foster-youth (Current/Former).

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I think it would be great for individuals who have serve anti-social behavior such as aspergers, psychopath

To have acess to housing program for those who seek isolation

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I Believe We need more marketing on the resources We do have. Better resources.

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Need collaboration and more older adult & cultural competence programs

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- Identify current gaps in continuum of care. (medication and stabilization

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It was a good overview. I would like to know what process/structure is in place to ensure ~~this~~ as programs are being developed, that there is an integrated, coordinated, systemic approach & leverage community systems & not be a silo program.

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Thank you for including the legislative update. Toni I appreciate the listing →

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I really wanted to see how things were progressing with the mental Health Serv. Act. I've attended meetings in the past & wanted to check-In and hear how things are going.

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Good Information. I will think of the housing part to improve the mental health point service.

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Great updates and summary to let us know where we are.
It's great to hear the legislative updates - And Wonderful to have Tani here also.

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where ever possible please do not use anachronisms — ex- O.A.C.
New here - would help to understand what is communicated

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Comprehensive program tracking that is accessible to programs, program managers + consumers.

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Great to come together for this next year. Enjoy re connecting with colleagues from last year & meeting new members. History was valuable to give context of field/work on ~~County~~ mental health by public sector. Inspired & reassured of prevention commitment. Legislative updates helped me identify areas to share with community
- Excellent job Evelyn with managing expectations proactively
- Great job with pacing & covering all key info.

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Your Voice Matters!

COUNTY OF SANTA CLARA
Behavioral Health Services

County of Santa Clara
Behavioral Health Services Department
FY20 Mental Health Services Act (MHSA) Annual Update

Kick Off
October 1, 2019
Stakeholder Comment Form

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Recovery & Resilience are so important for prevention & for long-term sustainability... both for caregivers & those we serve.

Can you facilitate a community meeting/outreach in Milpitas? cell
-I can find space & spread the word. (Nicole Steward 408.771.3950)

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Can meetings take place earlier in the day? At minimum 1-3. Or even on AM -

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Page 7, slide 14: would appreciate more "specific" information details than what is shown under "FY18-20 Plan" column, e.g., "in development" "in planning process" "implementation under way!"

Was especially interested in the INN "one-stop-shop mental health clinic." I learned about the project from various sources: Behavioral Health Svcs. Bulletin, www.sccbhsd.org "News and Stories" web page, Stanford University's Center for Youth Mental Health and Wellbeing Initiatives web page.

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COUNTY OF SANTA CLARA
Behavioral Health Services

Can you put more update content on sccbhsd.org/mhsa

SANTA CLARA COUNTY MENTAL HEALTH SERVICES ACT

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Behavioral Health Services Department
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As a part of a innovation project, this county's BHS should develop and implement a program to improve the workplace culture of mental health agencies ~~disparate~~ in the county. Some not significant support and trainings on selfcare for providers, it is not enough to counteract the malfunctioning of these community mental health workplace culture.

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Meeting was great.
Welcome By Director, History was good. How Did we get Where were are today?
prevention; Preventein.
1. We need to talk about innovation in future meetings.
Homeless

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Can't wait to get to work.
Let Start Planning.

can we have more plates hahaha!!!!

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FY20 Mental Health Services Act (MHSA) Annual Community Planning Process
October 9, 2019
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- SATELLITE MHMC AT PRIMARY CARE COUNTY CLINICS
- INTERGENERATIONAL ~~OERS~~ PEI SERVICES
- ACCESSIBILITY & CULTURAL TAILORED GATEKEEPER TRAINING, INTERVENTION, PEER SUPPORT & PREVENTION

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Behavioral Health Services

County of Santa Clara
Behavioral Health Services Department
FY20 Mental Health Services Act (MHSA) Annual Community Planning Process
October 9, 2019
Stakeholder Comment Form

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To learn what new services are being offered & what efforts are being made to improve systems & care. Find ways to join efforts with knowledge & partnership. To hope to have influence on where funds go. To make sure facilitators are listening

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Very helpful; good information

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I want to continue conversations about potential collaborations and learn how to get new projects going.

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I enjoyed learning about the different resources available as well as the various problems that face us. I'd like to be involved in helping with solutions, especially @ the school sites.

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Very informative. - MHSA Framework - Services.
I was able to address major concern for our organization and receive relevant resources
Thank you.

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Find ways to access the funding

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☒ Good work from all involved!

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Some people were a little confused about use of MHSA - maybe a quick refresher next time ←

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how about including a target population of maternal mental health for expected mothers & post pardem mothers.

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Anything on gang violence and services for older LGBT?

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OVERVIEW OF CURRENT PROGRAMS + BASIC ??'s TO EVALUATE

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- ☐ Community Collaboration (CCR § 3200.060)
- ☐ Cultural Competency (CCR § 3200.100)
- ☑ Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120)
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- ☐ Integrated Service Experience (CCR § 3200.190)

PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

Will flesh out + comment later.

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COUNTY OF SANTA CLARA
Behavioral Health Services

County of Santa Clara
Behavioral Health Services Department
FY20 Mental Health Services Act (MHSA) Annual Update
Community Program Planning Process
October 15, 2019
Stakeholder Comment Form

PLEASE TELL US ABOUT YOURSELF

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- ☐ 0-15 yrs
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A bit long but worth it

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more outcomes data on specific TAY programs.
We want to make our recommendations more educated
& based on data from current programs...

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Small group is good. but it's kind of hard to gather all the comments.

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It felt like we needed more peopee who were boots on the ground - people who try to connect people to services & follow those people. Many of us didn't seem to have much personal experience with these programs. How do we get these people in this room?

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Intervention support for providers/teachers

Workplace safety / supportive places of work

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PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

Very good meeting
productive - good Discussion - a lot of ideas
thankyou

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Good meeting to share thoughts!

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PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

Appreciated the meeting. It was great to be in Milpitas & hear from our community.
I'd love to have more opportunities to share needs.

Thank you!

We need services in Milpitas, please!!

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I think small group meeting is good. very productive. A lot of Information.

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City is supportive and has space for meetings and trainings. Contact me if you need room space tmclane@ci.milpitas.ca.gov

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great conversation & dialogue
- looking forward to seeing improvements in the mental health system
- ↑ increase access, ↑ true prevention

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One of my primary goals is for MHSA funding be utilized to provide prevention to ALL youth, not just Medical or unsponsored youth. Many of our students report moderate anxiety symptoms significantly impacting their lives. If ALL of our students could receive education around preventing anxiety, depression as well as basic coping skills, that would be great.

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What is your primary system transformation interest?
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- ☒ Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5)
- ☒ Integrated Service Experience (CCR § 3200.190)

PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

Please survey Youth, speak to Youth & Interview them as well as Careproviders. Youth including foster, homeless, involve justice, CSEC, african-American, Native American, etc

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Don't leave Youth out of Stakeholder input!

Your Voice Matters!

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How can we have students and families access when they are not medical, or have limited insurance. More options to be considered a tiered model. More access to prevention skills for all not just who are struggling or in crisis

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How can school systems be equipped and leveraged for prevention efforts and connecting families with available resources/ systems of care?

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Great opportunity to learn and share!

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It's good to have meeting with Education department people. I think today we talk about Mental Health for Education has a good Inputs point to me. It was great

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I appreciate the opportunity to have this conversation & hope to have more.

Thoughts about further communication that is publicy approachable

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collaborative care amongst systems
SSA, DFCS, BHS, SUTPS, SUTS, Probation, etc...

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Students with severe emotional disturbances and the alternative placements. Funding for innovation on a better alternative because the current is not serving their needs yet.

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To focus on adults too. Even though we service our students, I would like to focus on ourselves and direct families so we can then better serve our community. For example, my husband is 31 and diagnosed with AdHD and severe anxiety. So having to deal with that issue as an adult is very hard. It puts so much pressure.

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Trauma informed services
expand refugee family & children services
outreach and cultural activities

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Integrate SEL + resilience techniques K-12 - and provide for parents and educators for self care and child care.

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Lot of Info. I'm new to County, But this is very important as Silicon Valley is continually Growing & so is the Crisis, with Youth, Single parenting, Elderly & Many others.

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- We need more comprehensive services in South County (Morgan Hill + Gilroy) & just one city.
- Call Center needs to be easier to access/use (average time to be referred 90 mins.)
- We need ~~[illegible]~~ psychiatric services in Morgan Hill + Gilroy (med management)

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PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

Morgan Hill & Gilroy communities need a one stop "shop" for mental health services, one on one, family, group therapy, support groups, medication support, crisis intervention.

Thank you for taking the time to provide your input. Please visit www.sccbhsd.org/mhsa for information on the County's MHSA Programs and Services. Please contact us if you have questions: MHSA@hhs.sccgov.org or (408) 885-5785.

Your Voice Matters!

COUNTY OF SANTA CLARA
Behavioral Health Services

County of Santa Clara
Behavioral Health Services Department
Mental Health Services Act (MHSA)
Community Planning Process
December 19, 2019
Stakeholder Comment Form

PLEASE TELL US ABOUT YOURSELF

What is your age?
- ☐ 0-15 yrs
- ☐ 16-24 yrs
- ☑ 25-59 yrs
- ☐ 60+ yrs

What is your gender?
- ☑ Male
- ☐ Female
- ☐ Other_____

What group do you represent? (Check All that Apply)
- ☐ Family/Consumer of MH services
- ☐ Consumer of Mental Health Services
- ☐ Social Services Provider
- ☐ Law Enforcement
- ☐ Veterans and/or representatives
- ☐ MH and Substance use Provider
- ☐ Education
- ☐ Community Member
- ☐ Faith Community
- ☐ Cultural Competence and diversity
- ☐ Disabilities advocate
- ☑ Health care

What is your ethnicity?
- ☐ Latino/Hispanic
- ☐ African American
- ☐ American Indian/Native American
- ☐ Asian/Pacific Islander
- ☑ Caucasian/White
- ☐ Other_____

What is your primary system transformation interest?
- ☐ Community Collaboration (CCR § 3200.060)
- ☐ Cultural Competency (CCR § 3200.100)
- ☑ Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120)
- ☐ Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5)
- ☐ Integrated Service Experience (CCR § 3200.190)

PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

Process for obtaining project-specific/program-specific funds from MHSA.

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PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

We need more services/outreach in Morgan Hill / Gilroy / San Martin
We need CAH Center process to Get better.
(a very) difficult process - long, sometimes disconnected, etc..

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PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

We need more services in ~~Gilroy~~ Morgan Hill
- wrap
- transition
- high level

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PLEASE PROVIDE COMMENT/FEEDBACK BELOW Regarding today's meeting. What are your goals for future meetings?

Today's meeting was very informative to better understand the MHSA and how it effects South County

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Uday Kapoor, NAMI SCC VP Housing	1. As a family member and Vice President of Housing for NAMI Santa Clara County, I was exposed to and joined the volunteers and stakeholders from numerous organizations that were part of the multi-year Community Living Coalition (CLC) team. The CLC team were focused on independent living/ Board and Care homes as there is no oversight and residents live at the mercy of the owners. Consumers, family members and providers are distressed about conditions in many of these homes - abusive staff, vermin, unsanitary, unsafe and crowded. Most residents accept these conditions as they fear complaining will get them evicted. After many presentations to the BH Board over several years a program called Independent Living Facilities Project allowing for support and training for Board and Care operators and direction to ensure that their homes meet quality standards was approved in the 2019 MHSA Annual Update with a modest budget of $500K. It was based on the success of the San Diego County ILA that has been adopted by Alameda and Fresno Counties. The team was assured of and expecting an RFP from the Santa Clara County Behavioral Health to get this important initiative off the ground, but on Apr 9th of this year, after the MHSA "validation meeting" held in February, stakeholders were shocked to learn that this program was discontinued. There had been no discussion with the Stakeholders Leadership Committee or the public. Additionally, when asked, the BH Director said that the Supportive Housing Department 'does similar things'. This is absolutely not correct. We request that this project be included with an explanation of why it was not implemented in the FY20 Plan. We also urge that this project be reinstated into the 3 year plan. With COVID-19 shelter-in-place, the people living with mental illness and residing in unlicensed Board and Care homes are particularly vulnerable due to isolation.
	BHSD Response: Thank you, Mr. Kapoor for your comments in support of an initiative to address the needs of consumers seeking livable housing arrangements in a safe, clean, independent environment. The Department agrees with you and believes there is an opportunity to secure funding to address this local need in the Innovations Component of MHSA. As described previously, MHSA revenue will be facing an unprecedented impact, too early to measure, but significant for counties to move cautiously in new program planning and development. The Innovations Component funding can allow for startup and program infrastructure development accompanied by a strong evaluation requirement to demonstrate feasibility as well as sustainability of programming. The Department recommends requesting the Mental Health Services Oversight and Accountability Commission (MHSOAC) $990,000 for the *Independent Living Facilities Project* for a maximum duration of three years, FY 2021-FY2023. This project amount is on par with another Bay Area County conducting a similar project (i.e. Alameda County's $1.2M contracted allocation for 3.5yrs). This new project idea will be included in the FY21-FY23 MHSA Program and Expenditure Plan, listed under the Innovations Component.

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Frank Ly	2)_ a. Does the Department utilize contract services which heavily rely on "group therapy" as a service delivery method, with members of the general public or court ordered individuals? If so, how does a program based primarily on "group therapy" meet the needs of the individual in a person-centered way? **BHSD Response:** The FSP program is expected to provide an array of services that includes Case Management, Individual therapy, medication support, vocational services, group therapy and substance abuse services. Group therapy is just one type of mental health service among many. A typical program will provide other services such as individual rehabilitation, group rehabilitation, individual therapy, group therapy, collateral services, case management, medication support and crisis intervention services. When individuals are enrolled into an FSP program, a clinician/case manager is assigned to each individual client and is responsible for completing a mental health assessment and developing an individualized treatment plan with the client's input which is used to determine the best type of care for the individual.
	b. On average, how many hours of services a person receives in a FSP are one form or another of "group therapy" vs one-on-one individualized services? **BHSD Response:** The Adult/Older Adult FSP services is expected to provide six hours of services a month, services offered include group therapy, individual therapy medication services, vocational etc. An average dosage for Criminal Justice Services FSP is 8.60 hours per individual per month. As mentioned above, the type of services offered depends on the need of the individual, based on the assessment and treatment plan.
	b. How does the Department and or service providers protect the HIPAA rights of individuals enrolled in group therapy and legally prevent other "group members" from sharing Protected Health Information they learn just by virtue of being in a group with an individual diagnosed with a mental illness? **BHSD Response:** In group therapy clients are expected to honor confidentiality through the establishment of group rules, during group activities. Unfortunately trying to enforce confidentiality is very difficult. If a group member is not maintaining confidentiality, a client should notify the group facilitator as soon as possible. While clinical staff is bound by HIPAA laws and licensing boards, the individual therapy participants are not bound by these terms. Group members are expected to honor confidentiality. If one member determines that another member is not following group rules, the best way to address this situation is to bring it up in the group so that everyone can revisit the rules. If the member is not comfortable talking about it in

Received From	Comment
	group, the individual should talk about it with the clinical staff who is facilitating the group to determine the best course of action.
	c. Is there a process in place to track the Protected Health Information shared in a group setting, the people (not just clinicians) who gain access to that information, and any "leaks" of Protected Health Information that may occur? **BHSD Response:** Each group member is expected to sign forms that address confidentiality of information discussed in a group setting. Groups can be set up as a cohort, with a limited number of participants with a time limit. This usually helps manage group members. For example, groups on depression will have 8 group members, and no new members can join the group during the 6-8 weeks of the group therapy. As mentioned above, group members are not bound by HIPPA laws or any licensing boards. As a result, members are just expected to honor confidentiality and group rules, which should be revisited at the start of each group session. If one member feels that another member is not honoring these rules, the issue should be brought up to the group to address the concern together.
	d. Does the Department have a process in place to track, discipline or hold legally accountable the mentally ill group therapy members/participants/clients/consumers/patients who share another person's Protected Health Information? **BHSD Response:** Yes, the department has various ways of tracking and following up on complaints or grievances received on breach of confidentiality. The department has various options available for people to report the breach of confidentiality, such as calling quality improvement or writing a grievance on forms provided at different outpatient locations. The group facilitator or the manager of the FSP program should be notified if there is a breach of confidentiality. This is a private matter between the group members. Group members should revisit the rules and determine if the member who is not following the rules should be allowed to continue in the group.
	e. Does the Department have a process for insuring that recipients of group therapy give informed consent to the group therapy process including *being informed* that they will be asked to share Protected Health Information with mentally ill individuals who may or may not protect their Protected Health Information and giving consent to that specific facet of group therapy? **BHSD Response:** Yes, the department conducts annual audits for all FSP programs, where charts are reviewed to ensure that all appropriate documentation was gathered and placed in the client's chart in a timely manner. At the start of each group, the group rules should be revisited and discussed between the members. Group therapy is voluntary and if one member is not comfortable in a group setting, the member is not required to attend. As mentioned above, the confidentiality only applies to

Received From	Comment
	the clinician. If one member is not following the rules, then the group should discuss what should happen to that individual, whether he or she could continue or be asked to leave the group.
	f. Are their Department approved circumstances in which a person/consumer/client/patient/individual/member of the community can be forced to attend group therapy? **BHSD Response:** An individual may be asked by the court or probation to attend treatment in lieu of incarceration. If that is the case, that is between the individual and the court or probation. Services at BHSD are voluntary and the individual even if court ordered must still consent to treatment participation.
	g. Can/should a person/consumer/client/patient/individual/member of the community after being informed of the privacy risks associated with group therapy opt out of group therapy and receive individual therapy instead?. **BHSD Response:** If a program is court mandated and the only form of treatment offered is group therapy, then the individual will be expected to participate. If the individual does not feel comfortable participating in a group setting, then the provider should be notified. Any breach of confidentiality should be reported as soon as possible. This should be discussed with the program. As previously mentioned, a program typically offers an array of services, including individual therapy, individual rehabilitation, group therapy and group rehabilitation. If an individual is not comfortable with one type of service, the individual should talk to the program about what other types of services are available.
	h. If a person/consumer/client/patient/individual/member of the community has been assigned to forced group therapy and finds it to be un-therapeutic to themselves as an individual, do they have the option to opt out and receive individual therapy instead of group therapy? **BHSD Response:** Yes, these options should be discussed with either the group facilitator, or the manager of the program. Same as above – Services at BHSD are voluntary. This should be discussed with the program. As previously mentioned, a program typically offers an array of services, including individual therapy, individual rehabilitation, group therapy and group rehabilitation. If an individual is not comfortable with one type of service, the individual should talk to the program about what other types of services are available.

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	i. Has the Department ever considered that one-size-fits-all group therapy may be a modern form of warehousing mental patients all day and that there is no other physical disease that is supposedly controlled/managed by medication where an individual is forced to sit in a (usually uncomfortable) room for hours and is either asked share their deepest secrets with complete strangers or relive other people's trauma? **BHSD Response:** The department offers a wide array of services within the FSP program in different formats. An individual should file a complaint if they are uncomfortable with the services provided to them. An individual has the right to discuss alternative formats of treatment with the department, if they feel their concerns is not being addressed. FSP programs will provide other services such as individual rehabilitation, group rehabilitation, individual therapy, group therapy, collateral services, case management, medication support and crisis intervention services. When an individual is admitted into a program, a clinician will complete a mental health assessment and develop a treatment plan with the individual to determine the best type of care for the individual. As such, services are not restricted to only group therapy.
	j. Can/should a person/consumer/client/patient/individual/member of the community be informed that they may be exposed to narratives of multiple traumatic events and risk vicariously experiencing trauma during group therapy? **BHSD Response:** Yes, every group member should be informed of the cons of group therapy within the first or second session of group therapy so the individual is aware of what to expect in group therapy. There are risks associated with therapy, just as there are risks associated with any type of treatment. This should be discussed and explored in the group and/or individual sessions, depending on whatever treatment the individual is engaging in.
	k. Would the Department consider making group therapy optional after truly informed consent occurs, with individual therapy to occur between sessions of group therapy for those who need to process group issues and the option to "opt" out of the group at any time it becomes emotionally unsafe? **BHSD Response:** In certain FSP programs group therapy is optional. The individual needs to discuss treatment with the case manager, manager or quality improvement. Services at BHSD are voluntary. These specific requests should be discussed with the program. The assigned clinician and the individual should work on a treatment plan together to address any special requests or needs.

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	l. As a recipient of these services it is my observation that this is a glaring black hole that needs to be filled. I experience these group therapy sessions as a wholesale violation of my civil rights. I am scared of some of the people in my group and information from group therapy has been broadcast to my community. On many days it is like Groundhog Day and I am so bored it would be more interesting to read Leviticus out-loud, backwards. **BHSD Response:** No one should be forced to accept any treatment that makes them feel uncomfortable. It is important these concerns are addressed immediately. BHSD services are voluntary. No one is forced to accept any treatment. Please discuss your concerns with your program and assigned clinician.
	m. I have had no choice but to attend or face a different set of consequences. This is not mental health treatment. **BHSD Response:** If an individual is referred by the court or probation, it is a legal requirement between the individual and the court or probation officer. However, given that BHSD services are voluntary, the individual must consent to participate in treatment, and makes a conscious choice to attend treatment in order to comply with the legal requirement.
	n. There may be a treatment goal for me in my file like the example on page 39, "He is working towards being more open and less guarded and letting people into his life." **BHSD Response:** One can discuss these treatment plan goals with their case manager and update the treatment plan. The treatment plan should be a collaboration between the individual and clinician. It should be revisited and revised on a frequent basis to address changing needs. If an individual is not happy with the treatment plan, the individual can ask to make changes to it, in collaboration with the clinician.
	o. But that is a goal based on an unreality that most people in my world are trustworthy. Maybe there are perfectly legitimate reasons I am not open and being guarded keeps me safe from truly dangerous people. I no more need to let people into my life than the therapist who blocks themselves from truly personal relationship with clients does. **BHSD Response:** The treatment plans can be reviewed. The treatment plan is a living document and should be revised on a regular basis.

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	p. I was told I had no choice and the Judge was going to get a "bad report" if I didn't participate. **BHSD Response:** Individual should discuss treatment options with case manager, or QI or Program executive team to review other alternative treatment plans. If an individual is not happy with treatment, one option to consider is discuss available treatment options with the assigned clinician/case manager and/or program manager. Another option is to ask the Judge if there is a different way to address your legal requirements without participating in mental health treatment. Additionally, an individual has a right to file a grievance with the BHSD Quality Improvement Department. This is the link to the County of Santa Clara Grievances and Appeals information and contact page: https://www.sccgov.org/sites/bhd/info/Grievance/Pages/default.aspx or contact the **Quality Improvement Coordinator** at **1 (800) 704-0900.**
	q. Is there any way to go to court without my name publicly appearing on a searchable mental health docket or my information being publicly discussed in open court? **BHSD Response:** The reviews are technically in criminal court, so the hearings are open to the public and the calendars are part of the public record. When the person Opts-In for Mental Health Treatment Court, they sign two different waivers. Clause #8 States: "I will report to the Treatment Court as directed by the Judge or as otherwise required and I will engage in discussions in open court with the Judge as to my progress in the Treatment Court Program." In addition, there is a Release of Information where client agrees to the consent of information to the court and the agencies which participate in the treatment services.
	r. Are there any Judges or attorney's in the mix protecting these particular civil rights? **BHSD Response:** The Public Defender is ethically obligated to serve our clients in their criminal cases to achieve the best outcome, which can include assisting them in giving up some of their rights—like the right to trial. When it is in the client's best interest to resolve a case and accept treatment, they understand that they are giving up knowingly some of these rights to engage in treatment court. The information will be accessed by the treatment team and judge. It is otherwise protected. The opt-in agreement lays out who will have access to the information. You may contact the **Mental Health Advocacy Project at:** 1 (800) 248-MHAP **or** 1 (408) 294-9730.

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	s. Will the Department agree to close this loophole and protect my privacy rights? **BHSD Response:** The Department is required to conduct a thorough investigation to determine next steps. If there is a grievance with **clinicians** not protecting PHI (protected health information), this issue should be addressed with the program manager. Additionally, a grievance can be filed with the BHSD QI Department. This is the link: https://www.sccgov.org/sites/bhd/info/Grievance/Pages/default.aspx or contact the **Quality Improvement Coordinator** at **1 (800) 704-0900.**
	t. what does "whatever it takes" really mean? **BHSD Response:** It means the provider will go above and beyond the call of duty in certain circumstances to assist a client to maintain stability in the community. Whatever it takes signifies that the agency will complete a comprehensive assessment of the individual's treatment needs and would identify, with the client's input, specific areas related to behavioral health treatment, education, medication, peer relations, social activities, relapse prevention and other areas specific to each individual and would work on wrapping these services around the client to assist an individual to achieve their treatment and recovery goals.
John Hardy. I am a Santa Clara County resident, a BHSD employee and mental health consumer.	3) Once in a great while, Human Rights, Mental Health and cost saving measures can be solved by local action. In the case of Board and Cares in Santa Clara county, all three of these issues can be addressed and alleviated by a single program. While the issue of human rights might seem like a lofty concept for County government to take on and perhaps not necessary in our wealthy county, there is a group of people that are in great need of better treatment. Last year, the MHSA planning committee agreed to fund the Independent Living Facilities project by offering a $500,000 contract to address the independent living homes that house and feed so many disabled mentally ill in Santa Clara County. While the exact number of outpatients living boarding homes is not known, it can be safely said that the number is in the thousands. Conditions in these homes are not subject to any regulation by our county other than Landlord Tenant law and Public Health codes. Anecdotally, as someone who has lived experience and who has worked at the Zephyr Self Help Center for almost eleven years, I have a good understanding of how things really are for people living this way. Very often, those living in Independent Living homes pay their entire disability check for the month in order to depend on their home for shelter and food. The power

Received From	Comment
	differential is enormous. The food they are dependent on is up to the landlord to determine what is provided. To save money, the meals there are often reduced to substandard quantity and quality. There is a strong incentive for those who live this way to not complain, although some opt to vote with their feet and choose the tragic option of living on the streets. We often speak in our Behavioral Health Department of recovery, not just as a worthwhile goal for those living with mental illness, but also as a way for our county to save money and decreasing dependency on our services. While we speak of this concept of recovery in the abstract, how often do we take a good long look at how those living with mental health challenges are spending most of their time and money? Shouldn't this be an integral part of how we provide Behavioral Health services in our county? The model for Santa Clara County program is not one of punishment. We are not trying to put anyone out of business. It is based on the success of the San Diego County ILA that has been adopted by Alameda and Fresno counties. These counties have elected to tackle the issue head on, in the spirit of collaboration, by rewarding good homes and working with homes that face challenges. The decision by the MHSA planning committee to fund the program was welcome news for the Community Living Coalition that myself and others have been working on for several years. It is understood that our county faces many financial challenges in the coming years. I would like to propose that the issue of Independent Living homes is a cost saving issue and, if for no other reason, should not be dropped by the MHSA planning Committee.
	BHSD Response: Thank you for your comment. Please refer to the response for Question #1 above. This project has been added to the FY21-23 MHSA Program and Expenditure Plan.

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Lorraine Zeller	4)_ FY20 MHSA Plan Update The $500,000 project to improve conditions at independent living facilities/room and board homes and provide support to operators of these homes was included in the FY19 Annual Plan. Why is it not included in this plan or mentioned among the explanations of other discontinued programs? Please include this project in the FY20 plan write up with an explanation of why it was not implemented in FY20. Also please consider reinstating the Independent Facilities Project into the FY21-23 plan. COVID-19 has brought to light the extreme vulnerability of populations such as those living in the group home room and board environments. They need increased protections as there is no oversight of these facilities. **BHSD Response:** Thank you for your comment. Please refer to the response for Question #1 above. This project has been added to the FY21-23 MHSA Program and Expenditure Plan. Why is there no mention in either the annual update draft or FY21-23 draft plans of programs being discontinued except for the innovative programs? https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Documents/2020/MHSA-SLC-Review-of-Programs-April-9-2020.pdf Other than the innovative programs, notice of programs discontinued was only made in the presentation which took place on April 9th after the validation meeting in February. The presentation in the validation meeting made no mention of programs discontinuing MHSA Validation Meeting 2-13- 2020. Why did the validation meeting presentation show that a program was in the planning process Older Adult Collaboration with Senior Nutrition Centers: Currently in planning status and the subsequent review of programs meeting show the same program as being discontinued? Older Adult Collaboration with Senior Nutrition Centers: discontinued. How were these decisions made after the plans were "validated"? No directive for flexibility in funding due to COVID-19 had yet been received from state leadership. **BHSD Response:** All program changes in both the FY20 Annual Plan Update and the FY21-23 MHSA Program and Expenditure Plan (draft plans) are proposed changes or Department recommendations that demonstrate a prudent balance between resources and sustainability of current programming. These proposed changes were posted for the required 30-day public comment period, from April 11 – May 10, 2020. The Department has responded to the requests from the public and has revised the draft plans to accommodate public input received during the 30-Day required plans review. Following input from the Stakeholder Leadership Committee from the February 13, 2020 in-person meeting, the group asked the MHSA planning team for additional review of the plans and asked for another meeting which delayed the review process of the Draft Plans, pushing all other scheduled meetings back by another month. During this time, the COVID-19 Shelter in place was ordered by the local Public Health Officer. A follow up meeting that would have taken place in March did not happen until the virtual

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	April 9 meeting. At this time, the County of Santa Clara, along with other counties across the state asked for reporting flexibilities for MHSA Plans to allow for counties to re-evaluate program priorities. To date, the Department of Health Care Services has not allowed flexibilities in reporting in MHSA plan completions. The Department will reconvene the SLC and the public to carry out a county-wide review of programs when more information of the impact of COVID-19 on MHSA revenue is available. The Department plans to begin the process in mid-Summer, early Fall to put into place revisions to the FY 2022 Annual Plan Update. It is expected that the impact of COVID-19 on MHSA revenue will directly affect FY2022. Page 2 Why is there no info on PEI in this annual plan draft? PEI program(s) cut are not mentioned here. **BHSD Response:** The Prevention and Early Intervention Report appears in a different section of the FY20 MHSA Annual Plan Update (Draft Plan) as stated on the table of contents. The full report is available at this link found on the MHSA website, www.sccbhsd.org/mhsa: https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Documents/2020/FY19-MHSA-Annual-PEI-Report.pdf Page 3 Regarding Stakeholder Leadership Committee validation - What was the process for validation? How is validation confirmed? Page 3 How did the increased number of client/consumers on the SLC provide an increased client lens in the development and validation of these services? **BHSD Response:** MHSA regulations require counties to develop representative stakeholder committees that participate in the community program planning process. The addition of five more client/consumer seats was an effort to provide a majority client/consumer representation. Members of the SLC and the public were invited to participate in 13 listening sessions scheduled throughout the county. Additionally, a consumer/client and family member of consumer only surveys were administered in all threshold languages (including Spanish, Vietnamese, Chinese, Tagalog and English). Next, a MHSA Community Planning Forum and an independent evaluation of the efforts by Palo Alto University's Office of Diversity and Community Mental Health took place. This was followed by the proposed program recommendations virtual meeting on April 9, 2020 prior to the required 30-Day public comment period, April 11 – May 10, 2020. Validation is not a single event in MHSA, but a combination of various input processes and through a variety of venues. The Draft Plans were recommended by a vote of 7 (Yes) to 1 (No) by the Behavioral Health Board per requirement. The final step is the mandated Board of Supervisors' review and potential adoption scheduled at the June 2, 2020 meeting of the Board of Supervisors.

Public Comments Received During the 30-Day Public Comment Period (April 11 – May 10, 2020) *FY20 & FY21-FY23 MHSA Draft Plans Public Comments*	
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	Page 5 Summary of Changes for Fiscal Year - Where are the changes to the PEI programs? They are not included in the plan as indicated by "these are those changes". **BHSD Response:** The Prevention and Early Intervention Report appears in a different section of the FY20 MHSA Annual Plan Update (Draft Plan) as stated on the table of contents. The full report is available at this link found on the MHSA website, www.sccbhsd.org/mhsa: https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Documents/2020/FY19-MHSA-Annual-PEI-Report.pdf Page 8 Left Blank County Compliance Certification - Why is page 8 left blank? Will the compliance certificate be any different from the one in the FY21-23 draft plan which states This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. WIC Section 5848: Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. How does our County demonstrate this partnership as ensuring that the process includes each element of the process as described in WIC Section 5848? Can the certificate of compliance be signed to attest that the process adhered to WIC Section 5848 regulation? **BHSD Response:** The Draft Document shows a placeholder for the forms. All MHSA plans require signed forms and all signed forms will be added in the final, approved drafts. Compliance certificates cannot be signed unless the drafts are approved by the Board of Supervisors. Page 9 regarding meetings multiple community meetings which were held – How many stakeholders attended these meetings? Which stages in the planning and update process were they engaged in? How so? How does the plan reflect their experiences and suggestions? **BHSD Response:** Thank you for your comment. Please refer to the posted MHSA Community Program Planning Process Evaluation conducted by Palo Alto University's Office of Diversity and Community Mental Health. This is the link:

Public Comments Received During the 30-Day Public Comment Period (April 11 – May 10, 2020) *FY20 & FY21-FY23 MHSA Draft Plans Public Comments*	
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	https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Documents/2020/MHSA-Community-Planning-Process-Evaluation-Report-FY20_FY21-23.pdf Page 10 – How does the Stakeholder Leadership Committee serve as the primary advisory committee for MHSA activities? What is the difference in participation of the Stakeholder Leadership Committee and other community members who attend MHSA meetings? **BHSD Response:** County MHSA plans are required to "be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies and other important interests" (WIC § 5848(a)). The SLC is a representative group of the diversity of our county. This, however, does not mean that the general public will be excluded. All meetings are public and anyone can attend. This is stated on the County's SLC Roles and Responsibilities document found at this link: https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Documents/2018/2018-mhsa-slc-roles-responsibilities-01-08-18.pdf Page 11 – Correction: The December 19th South County Collaborative Briefing meeting was not open to the public as listed in the table of meetings held. **BHSD Response:** All meetings were open to the public. The South County Collaborative meeting was a members-only meeting at the request of the Chair (all public member representatives in South County) and it was a listening session for this representative group. Two SLC members arranged attendance prior to the event (one is already a member of the collaborative) with the MHSA planning staff and provided the representation the SLC is charged with. Page 65 regarding discontinued Innovative programs – How was the Stakeholder Leadership Committee involved in discussions regarding the discontinuance of these programs? Where did the money go? How was Stakeholder Leadership Committee involved in discussions regarding re-directing of moneys committed to these programs? **BHSD Response:** The MHSA Innovation Projects are time-limited to help develop or test an idea. The Department identified existing programs where those project aims were incorporated and established as part of the Adult System of Care because of their similar goals and objectives. The project ideas are being maintained in existing, funded programs with the exception of the Technology Suite. This idea will be explored further. A rationale was provided at the April 9, 2020 virtual meeting. Regarding the Innovation component allocation, the finance update was provided at both the February and the April meetings as part of

Received From	Comment
	the MHSA finance transparency. The Innovation funding is the only funding that requires approval by the Mental Health Services Oversight and Accountability Commission (MHSOAC). These projects were not presented to the MHSOAC for approval, therefore, no projected funds had been allocated by the department. Furthermore, the Department received 23 new Innovations ideas that will be reviewed in collaboration with the SLC and incorporated into the FY2022 MHSA Annual Plan Update.

Public Comments Received During the 30-Day Public Comment Period (April 11 – May 10, 2020) *FY20 & FY21-FY23 MHSA Draft Plans Public Comments*	
Received From	**Comment**

Jennifer Jones, Consumer Affairs Manager ***BHSD Response:***	5)_MHSA Statement We need to reconsider removing the Independent Living Facilities Project as an RFP for $500,000 from the FY19 Annual Plan. I request reinstating it for the following (FY21-23 MHSA year plan). My name is Jennifer Jones, I founded two Self Help Centers in 2003 and have been the manager for Consumer Affairs since 2007. In my experience with homeless behavioral health consumers/clients. I have heard repeatedly over the years and it has only got worse, "The board and cares are horrible, I don't want to live there and I rather be homeless!" This applies to some licensed board and cares but especially to the unlicensed board and cares or boarding homes which is independent living in our county. In 2011, concerned community members, behavioral health board members, peers, and advocates gathered to form the Board and Care Improvement project to address these horrible conditions in our county. This project morphed to the Community Living Coalition that is based on San Diego's Independent Living Association model. If we want to help solve the homeless situation in our county, the abysmal living conditions in these boarding homes need to be addressed. In 2019, it was decided to do an RFP for the MHSA FY19 Annual Plan to have this very important issue addressed in our county. I understand with the County's severe budget limitations and the COVID 19 crisis that there are fiscal limitations at play here. I hope you reinstate for years 2021 to 2023 the Independent Living Facilities Project to help address one of our County's highest priorities of addressing the very real homeless problem in our county and better the living conditions of our vulnerable behavioral health clients.
	BHSD Response: Thank you for your comment. Please refer to the response for Question #1 above. This project has been added to the FY21-23 MHSA Program and Expenditure Plan.
Anonymous	6)_Positive language, without a stigma, makes it easier for people to acknowledge when they aren't feeling right and will be more likely to seek help. Emphasize: Body Health, Brain Health
	BHSD Response: Thank you for your input. The Department shares your sentiment.
Anonymous	7)_Please consider deploying this social emotional learning educational tool to all children and families. This was created with a large collaboration of mental health professionals and educators to help address suicide, depression, anxiety, and other mental health problems. It is a Detection, Prevention and Early intervention online academy that can be used to help children, families, and adults during this challenging time. Our pediatrician told me that it will be about 18 months from now that a COVID-19 vaccine is available. These tools can be released to the public now to help keep us all healthy.

Public Comments Received During the 30-Day Public Comment Period (April 11 – May 10, 2020) *FY20 & FY21-FY23 MHSA Draft Plans Public Comments*	
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	Boldly Me Academy - Spanish and English **https://academy.boldlyme.org/** **Professor Murry Schekman, former Asst Superintendent:** **https://youtu.be/bQ8FB4weIp4**
	BHSD Response: Thank you for your comment. The department will review this information with the appropriate Family and Children's Division staff.
Jennifer Del Bono, Santa Clara County Office of Education	**8)_Page 26. School linked Services has not been successfully administered at the county or district level. There are no significant evidence-based outcomes warranting an increase in spending.**
	BHSD Response: Behavioral Health Services Department (BHSD) has implemented School Linked Services (SLS) throughout the County at numerous school districts. SLS has expanded to new school districts, such as Fremont Union High School District, Milpitas Unified School District, Campbell Union High School District and Orchard School District, over the MHSA 3-year plan (FY18-FY20). SLS Initiative has been implemented and fully operational at 15 school districts and 10 elementary/middle schools (feeder model schools). SLS Coordinators have served more than 10,000 students and their families annually. From FY18 to FY19, unduplicated number of students served, increased by 62.3%. SLS school based behavioral health serves 13 school districts, and an additional 11 school districts with focused prevention services. In total, SLS provides services to 152 schools countywide. School-based behavioral health services provide evidence-based practices (EBPs) such as Triple P, Brief Family Therapy, Trauma Focused Cognitive Behavior Therapy (TF-CBT), Skills Streaming, Strengthening Families Program, Motivational Interviewing, and Cognitive Behavior Therapy. Prevention-focused efforts utilize standardized tools to measure outcomes, such as: Youth Outcome Questionnaire, the Outcome Questionnaire, and the Eyberg Child Behavior Inventory. Overall, results have demonstrated that the supports and interventions provided to parents and students improved both child and parent functioning. In FY18, the prevention-focused program was measured utilizing the Child and Adolescent Needs and Strengths Questionnaire (CANS). The Parent Symptom Checklist 35 (PSC-35) and the CANS are state mandated functional assessment tools. A paired t-test analysis shows statistical significance ($p<.001$) on the mean total pre and post CANS scores. In FY19, SLS Behavioral Health Services was listed under the Community Services and Support (CSS) as part of the FY18-20 Three Year Plan. In light of the community program planning process and direct input from stakeholders regarding the service flexibility attributed in the PEI component, all SLS services are now listed under PEI. The increased in funding demonstrates the

Public Comments Received During the 30-Day Public Comment Period (April 11 – May 10, 2020) *FY20 & FY21-FY23 MHSA Draft Plans Public Comments*	
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	transitioning of all SLS services back into PEI (utilizing PEI allocation) and the Department's recognition that school behavioral health services are vital to the Prevention and Early Intervention efforts in County of Santa Clara.
Rola Cheikh, AACI	9)_Mental Health MHSA 3 years program Expenditures plan FY21-23 The New Refugee Program is the life tool for the newcomers who are arriving to a new country with loads of fear, uncertainty and hope. Due to the multiple reasons that drove them away from their homelands, they tend to fear being in official buildings, being interviewed or providing personal information. With the support of the New Refugees Programs, those individuals are supported, guided and taught while navigating the essential services such as health care, housing, social services and more. Without such workers helping them, they are afraid to reach out or express a need resulting in added trauma and suffering.
	BHSD Response: Thank you for your input. The Department shares your sentiment.
Salma Shaw	10)_MHSA Three-Year Program and Expenditure Plan FY 21- FY 23 As a proud nation, who's core fundamental was built by Refugees, we should promote Refugees' rights to safe asylum, and advocate for them to be allowed the same treatment and freedom as any other foreigner who is a legal resident in this country; but unfortunately permitting budget cuts and placing extreme limitations on Refugee programs, we are not only compromising a Refugee's sense of physical safety, but also we are jeopardizing their basic rights, such as freedom of thought, movement, and freedom from torture and degrading treatment. Cutting Refugee program funding is an unprecedented effort to demoralize the humblest of a humanitarian tradition that we as a nation should be upholding in the highest degree.
	BHSD Response: Thank you for your input. The Department shares your sentiment.

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Elisa Koff-Ginsborg, Behavioral Health Contractors' Association (BHCA)	11)_FY20 MHSA Plan Update Program Name: Workforce Education and Training Page Number in Document: page 61 Feedback: How are the 7 student scholarships different from what the student interns receive? **BHSD Response**: Thank you for your question. The 7 student scholarships would be for Marriage and Family Therapy (MFT) Trainees who are unable to receive a stipend per the State Board of Behavioral Science. Since MFT Trainees are only allowed to receive a wage, get a scholarship or volunteer, the WET scholarships bring the MFT Trainees into parity with the Masters of Social Work (MSW) students who do receive a stipend per the State Board of Behavioral Science. Previously we were in a bifurcated system in which the MSW students received a stipend and the MFT Trainees had to volunteer. This created an unequal playing field and a discrepancy between the two sets of students. One received a stipend and one received no financial assistance for the same work. As we have an intense shortage of Masters Level clinicians, we were not able to host and train as many MFT Trainees because trainees would select sites in which they can receive some payment. BHSD contract agencies are able to pay them a wage as they are not bound by the same regulations.
	12)_Independent Living Facilities Project. This $500,000 project to improve the conditions at board and care homes and provide support to board and care operators was included in the FY19 Plan Update. It is not included in this plan nor is there mention of it among the explanations of other discontinued programs. We ask for this project to be included with an explanation of why it was not implemented in FY20. We also urge that it be reinstated into the 3 year plan. Particularly with COVID-19 sheltering in place, the people living with mental illness and residing in unlicensed Board and Care homes are particularly vulnerable due to isolation. At the same time, the pandemic makes the jobs of those working in the Board and Care homes even more challenging. Under these circumstances, it is particularly important to continue this project which has been successful in other jurisdictions. **BHSD Response:** Thank you for your comment. Please refer to the response for Question #1 above.

Public Comments Received During the 30-Day Public Comment Period (April 11 – May 10, 2020) *FY20 & FY21-FY23 MHSA Draft Plans Public Comments*	
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	Regarding the delay in implementation during FY20 of the Independent Living Coalition project (approved May 21, 2019 under the PEI component), the AOA System of Care has undergone major programmatic changes during the FY18-20 MHSA Plan. This included an expansion of the FSP to include Intensive FSP, the addition of the rigorous, evidence-based Assertive Community Treatment (ACT), the development of the new In Home Outreach Teams (IHOT), addition of Older Adult In Home Peer Respite and Elder's Story Telling, as well as the new Clinical Case Management Team for Older Adults. This growth, in addition to existing programming oversight and review, was a huge lift for the department and utilized staff resources to execute programs in accordance with projected timelines.
	13)_Behavioral Health Contractors' Association (BHCA) Feedback on 3 year MHSA Plan Overall Feedback: The bulk of this plan was developed pre-COVID-19. Even since the opening of the comment period, there has been substantial new information from the County and State on economic impacts. BHSD has started to make adjustments that will be in place at the beginning of the next Fiscal Year. We request that the final version of this document incorporate any reductions currently being made. **BHSD Response:** Thank you for your comment. BHSD agrees that COVID-19 will have implications in future MHSA planning, particularly for Fiscal Year 2022. The Department will launch a comprehensive planning strategy for the FY2022 starting this summer or as soon as Public Health Officer's guidelines permit.
	14)_Independent Living Facilities Project. This $500,000 project to improve the conditions at board and care homes and provide support to board and care operators was included in the FY19 Plan Update. It is not included in this plan. Particularly with COVID-19 sheltering in place, the people living with mental illness and residing in unlicensed Board and Care homes are particularly vulnerable due to isolation. At the same time, the pandemic makes the jobs of those working in the Board and Care homes even more challenging. Under these circumstances, it is particularly important to continue this project which has been successful in other jurisdictions. **BHSD Response:** Thank you for your comment. Please refer to the response for Question #1 above.

Public Comments Received During the 30-Day Public Comment Period (April 11 – May 10, 2020) *FY20 & FY21-FY23 MHSA Draft Plans Public Comments*	
Received From	**Comment**
	15)_Program Name: School Linked Services (SLS) Initiative Page Number in Document: 25-26 Feedback: The chart indicates that this program is being modified but the narrative does not describe any modifications. Please provide information on the modifications. **BHSD Response:** Thank you for your comment. The referenced modification was related to the switch from the Community Services and Supports component (in FY19) and back to Prevention and Early Intervention for FY20 and FY21-23. There are no programmatic modifications. Apologies for the confusion.
	16)_Program Name: TAY Triage to Support Reentry Page Number in Document: 34-35 Feedback: What is the Total Proposed Budget FY 2021-23? **BHSD Response:** Thank you for your review. The MHSA allocation for the TAY Triage to Support Reentry Program is $1,648,813 (CSS $898,613 and MediCal FFP match $750,000) annually. This is a total of **$4,946,438** for FY21-23. This has now been entered on the Draft Plan.
	17)_Program Name: Adult Full Service Partnership Page Number in Document: 48-49 Feedback: The chart indicates that this program is being modified but the narrative does not describe any modifications. Please provide information on the modifications. **BHSD Response:** This program is continuing. The Draft Plan will be revised to reflect the appropriate status.

Public Comments Received During the 30-Day Public Comment Period (April 11 – May 10, 2020) *FY20 & FY21-FY23 MHSA Draft Plans Public Comments*	
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Kawal Daugherty, Law Foundation of Silicon Valley	18)-_The Law foundation of Silicon Valley writes to you as advocates for persons with mental health disorders in Santa Clara County. We worked with Community Living Coalition (CLC) to improve living conditions for mental health consumers living in Board and Care and Independent Living Homes in our community through The Independent Living Facilities Project. This project was approved in Spring FY2019 to receive $500,000 of MHSA PEI funding. We received notice that this project was discontinued when reviewing the PowerPoint from the MHSA SLC Review of Programs Virtual Meeting, which references FY 2021-2023 MHSA Program and Expenditure Plan Three Year Plan (Draft). However, the FY 2021-2023 Draft plan and the FY 2020 MHSA Annual Plan Update (Draft) do not mention the Independent Living Facilities Project at all. What we question is why both draft plans did not discuss the project, yet the FY 2020 MHSA Annual Plan Update does provide explanation for other projects that have been discontinued. We understand that our county is implementing changes rapidly in response to the current crisis. Discontinuing the Independent Living Facilities, however, without any explanation or input from the public is a departure from the stakeholder approval process designed to maintain the integrity of the MHSA. Stakeholder input is vital to ensuring adequate representation in the decisions being made on the community's behalf and thus should be included even as changes are being made in response to the crisis. Mechanisms can be put in place to allow for stakeholder input such as video conferencing, phone conferencing, polls, and surveys. We would like the Behavioral Health Services Department to - explore every avenue before the project is discontinued entirely. If there is simply not $500,000 available to continue funding this project the BHSD could allocate some funds towards the project so that the project can begin in a limited capacity. If the Independent Living Facilities Project is too difficult to implement this year, we encourage a continuation of discussion around this project to occur at the next MHSA plan rather than completely discontinuing it for the next three years. The project was approved for funding because it was a community need and even amongst the current crisis that need is still very present. **BHSD Response:** Thank you for your comment. Please refer to the response for Question #1 above. This project has been added to the FY21-23 Program and Expenditure Plan.

Public Comments Received During the 30-Day Public Comment Period (April 11 – May 10, 2020) *FY20 & FY21-FY23 MHSA Draft Plans Public Comments*	
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Nira Singh, AACI	19)_I am writing to advocate for the important services delivered through PEI: Stigma and Discrimination Reduction New Refugees Program. As I review the current plan, Page 69 lists a reduction from $ 691 to $491K- which will significantly decrease crucial resources for the vulnerable population of refugees, asylum seekers, asylees, unaccompanied minored, special immigrant visa holders in Santa Clara County. AACI, through our Center for Survivors of Torture (CST) New Refugee program, serves families who have fled torture or persecution in their home countries and have to start over here In a new country, culture and often new language, while managing the impact of multiple and complex trauma including atrocities experienced in their home countries and often during the journey to just get here. Each year, CST serves approximately 400 new clients from all over the world. Serving our new community members from diverse countries such as Iran, Afghanistan, Turkey, Eritrea, El Salvador, and Congo requires a trauma trained and culturally competent multi disciplinary team that is well versed in assessing, understanding and effectively addressing multi tiered needs. Our diverse multicultural/multilingual team have the training and experience to build relationships of trust and safety and empower clients to guide their own wellness plans. We address stigma, help clients navigate and connect to needed resources, identify and treat behavioral health issues early on, and identify and build natural and community supports. Reduction to this program will be more costly when unsupported clients will need higher levels of care or become high users of emergency services. **BHSD Response:** Thank you for your comment. The Department agrees with your sentiment. The approved, contracted allocation for the New Refugees Program under the Prevention and Early Intervention component of MHSA remains as in the existing contracts, the full $691K. This has been corrected on the State forms.

County of Santa Clara
Behavioral Health Board

DATE: May 11, 2020, Mental Health Services Act (MHSA) Public Hearing
TIME: 2:30 PM
PLACE: By Virtual Teleconference Only
San Jose, CA 95110

MINUTES

Opening

1. Call to Order/Roll Call.

Chair June Klein called the meeting to order at 2:30 p.m. A quorum was not present at that time. When Member Evelyn Vigil arrived, a quorum was present at 2:36 p.m via teleconference, pursuant to the provisions of Executive Order N-29-20 issued on March 17, 2020 by the Governor of the State of California.

Attendee Name	Title	Status	Arrived
June Klein	Chairperson	Remote	
Gary Miles	Vice Chairperson	Remote	
Charles Pontious	Second Vice Chairperson	Remote	
Mary Cook	Board Member	Absent	
Patrick Fitzgerald	Board Member	Remote	
Robert Gill	Board Member	Absent	
Brandon Ha	Board Member	Absent	
Thomas Jurgensen	Board Member	Remote	
Wesley Mukoyama	Board Member	Remote	
Sigrid Pinsky	Board Member	Absent	
RaeAnn Ramsey	Board Member	Remote	
David H Tran	Board Member	Remote	
Evelyn Irene Vigil	Board Member	Late	2:36 PM
Joel Wolfberg	Board Member	Absent	
Cindy Chavez	Board Member	Absent	

2. Welcome/Introductions.

Meeting participants were welcomed by Sherri Terao, Ed.D., Interim Behavioral Health Services Director and Todd Landreneau Ph.D, CHC, CPHQ Deputy Director of Managed Care Services.

3. **Public Comment- Members of the public who wish to address the BHB should enter your questions on comments in the chat section of the virtual zoom meeting related only to the topic of the agenda, the BHB Liaison, Debra Boyd, will read the comment or question in the order they are received.**

   Ten individuals addressed the Board.

4. **Overview of Hearing Process by Behavioral Health Board June Klein, Chair**

   Received Overview of the Mental Health Services Act (MHSA) Public Hearing Process from June Rumiko Klein, ED.D, MBA, CPA.

5. **Open Public Hearing Regarding Combined DRAFT FY20 Mental Health Services Act (MHSA) Annual Plan Update (Draft Plan) and Draft FY21-23 MHSA Program and Expenditure Plan (Draft Three Year Plan). To view the Draft Plans visit MHSA Website.** (ID# 101389)

   a. Motion to Close the Public Hearing

   b. Motion for the Behavioral Health Board to Take Action on the combined DRAFT FY20 Mental Health Services Act (MHSA) Annual Plan Update (Draft Plan) and Draft FY21-23 MHSA Program and Expenditure Plan (Draft Three Year Plan).

   The Behavioral Health Board voted to Close the Public Hearing and accept the combined DRAFT FY20 MHSA Annual Plan Update (Draft Plan) and Draft FY21-23 MHSA Program and Expenditure Plan (Draft Three Year Plan).

5 RESULT:	**APPROVED [7 TO 1]**
MOVER:	Patrick Fitzgerald, Board Member
SECONDER:	Gary Miles, Vice Chairperson
AYES:	Klein, Miles, Pontious, Fitzgerald, Jurgensen, Tran, Vigil
NAYS:	Mukoyama
ABSTAIN:	Ramsey
ABSENT:	Cook, Gill, Ha, Pinsky, Wolfberg

Adjourn

6. **Motion to Adjourn the May 11, 2020 Public Hearing**

   Chair Klein adjourned the meeting at 3:48 p.m.

Respectfully submitted,

Debra Boyd
Behavioral Health Board Liaison

The County of Santa Clara
California

Approved
Jun 2, 2020 9:30 AM

Report
101305

Consider recommendations relating to the adoption of the Fiscal Year 2020 Mental Health Services Act Draft Plan and the Fiscal Year 2021-2023 Mental Health Services Act Program and Expenditure Draft Plan.

Information

Department:	Mental Health Services (Santa Clara Valley Health and Hospital System)	**Sponsors:**	
Category:	Report		

Attachments

Printout
Attachment 1- 2019-2020 MHSA Expenditure Plan Funding Summary
Attachment 2-Prudent Reserve Certification
Attachment 3- 2020-2023 MHSA Expenditure Plan Funding Summary
Attachment 4- FY 2020 MHSA Draft Plan
Attachment 5- FY 2021-2023 MHSA Draft Plan
Attachment 6- FY 2020 MHSA SLC
Attachment 7- Evaluation Report for the MHSA Community Program Planning Process
Attachment 8- 30-Day Public Comments and BHSD Responses
Attachment 9- BHB Agenda and Minutes from May 11, 2020

Multiple Recommendations

Possible action:
a. Adopt the Fiscal Year 2020 Mental Health Services Act Annual Plan's Draft Update, which includes the Annual Prevention and Intervention Report.
b. Adopt the Fiscal Year 2021-2023 Mental Health Services Act Program and Expenditure Draft Plan.
c. Authorize the Behavioral Health Services Department to submit both plans to the Mental Health Services Oversight and Accountability Committee and the Department of Health Care Services by the June 30, 2020 deadline.
d. Authorize the Behavioral Health Services Department to submit a budget request to the Mental Health Services Oversight and Accountability Committee for the new Innovations Project for Independent Living Facilities.

Body

FISCAL IMPLICATIONS

Approval of the recommended action would have no net impact to the County General Fund.

Fiscal Year (FY) 2020 Mental Health Services Act (MHSA) Annual Plan Update (FY 2020 MHSA Draft Plan)

The current FY 2020 MHSA Draft Plan includes an expenditure budget of $123,586,780, which is incorporated in the FY 2020 Behavioral Health Services Department's (BHSD) budget. The total expenditures would be funded with the available funds from prior year and current year allocation. The details of the FY 2020 MHSA Draft Plan's expenditures are outlined in **Attachment 1- 2019-2020 MHSA Expenditure Plan Funding Summary**.

Senate Bill (SB) 192: Prudent Reserve Transfers

The MHSA authorizes a county to maintain a prudent reserve to ensure that services do not have to be significantly reduced in years where revenues are below the average of previous years. SB 192 clarifies that the value of a prudent reserve for a Local Mental Health Services Fund shall not exceed 33% of the average Community Services and Support (CSS) revenue received for the fund in the preceding five years. SB 192 further requires counties to reassess the maximum amount of the prudent reserve every five years and certify the reassessment as part of their three-year plans as required by the MHSA. In accordance with SB 192, BHSD has adjusted down the prudent reserve to the maximum amount allowed. A total of $2,045,839 has been reallocated, which represents a $1,547,519 distribution to the CSS fund and a $498,320 distribution to Prevention and Early Intervention (PEI) fund. A certification was sent to the Department of Health Care Services (DHCS) as required by SB 192 (**Attachment 2- Prudent Reserve Certification attachment**). This is included in the FY 2020 MHSA Draft Plan.

FY 2021-2023 MHSA Program and Expenditure Draft Plan (FY 2021-2023 MHSA Draft Plan)

The current FY 2021-2023 MHSA Draft Plan includes an expenditure budget of approximately $126,121,489 in FY 2021, $124,300,820 in FY 2022, and $118,736,338 in FY 2023. See **Attachment 3- 2020-2023 MHSA Expenditure Plan Funding Summary** for more details. The annual estimated expenditures would be funded with the projected annual allocation and prior year projected unspent funds. The BHSD intends to apply a utilization-based realignment of contract services, as well as a prioritized assessment of all MHSA funded programs to achieve financial sustainability based on assumptions of reduction in MHSA funding statewide due to the current COVID-19 pandemic and would return to the Board of Supervisors to approve any related appropriation modifications.

REASONS FOR RECOMMENDATION

Approval of the recommended actions would allow the BHSD to adopt the FY 2020 MHSA Draft Plan (**Attachment 4- FY 2020 MHSA Draft Plan**), the FY 2021-2023 MHSA Draft Plan (**Attachment 5- FY 2021-2023 MHSA Draft Plan**), and present both plans to the DHCS and the Mental Health Services Oversight and Accountability Commission (MHSOAC) on June 30, 2020. Additionally, approval of the recommended actions would allow BHSD to submit a new Innovation (INN) project to the MHSOAC for final approval. Per California Code of Regulations (CCR) Title 9, Division 1, Chapter 14, Article 9 (a), County mental health programs shall expend funds for new INN programs upon approval by the MHSOAC.

FY2020 MHSA Annual Plan's Draft Update

The FY 2020 MHSA Draft Plan, which includes an annual PEI Report, outlines the following increased capacity to services.

Children, Youth, and Families

- Increased capacity to facilitate implementation of Children and Transition Age Youth Intensive Full Service Partnerships (IFSP).
- Increased allocation to the Youth Therapeutic Integrated Program (YTIP) to provide more intensive and integrated services.
- Increased Families and Children's outpatient services caseloads at two critical service locations with Alum Rock Counseling center and Uplift Family Services, to meet DHCS network adequacy and timeliness requirements.

Increase Capacity: Adult and Older Adults

- Increased capacity to facilitate implementation of Adult and Older Adult Intensive Full-Service Partnerships (IFSP) and Assertive Community Treatment (ACT).
- Increased capacity and allocation to facilitate implementation of the Forensic Assertive Community Treatment (FACT) for justice-involved adults with a severe mental illness (SMI).
- Increased Adult and Older Adult outpatient services caseloads at two critical service locations with Gardner Family Health Network and Goodwill of Silicon Valley to meet DHCS network adequacy and timeliness requirements.
- Increased allocation for the Transitional Housing Unit (Rainbow) for 15 women coming out of custody and receiving mental health services.

The FY 2020 MHSA Annual Plan Update also includes the following redesigns and realignments.

- Redesigned the Children and Youth Mobile Response and Stabilization Services and the Children, Youth and Families Cross Systems Initiatives Division to efficiently address crisis calls to the BHSD Call Center.
- Exploring the TAY Triage to support re-entry programs to meet the needs of youth coming out of juvenile detention, Emergency Psychiatric Services (EPS) and hospital stays.
- Transferred the clinical portion of the School Linked Services (SLS) program back into Prevention and Early Intervention component of the plan to appropriately serve children and family needs.

FY 2021 – 2023 MHSA Draft Plan

The FY 2021-2023 MHSA Plan includes a series of modifications, additions, and an outline of the MHSA revenue forecast.

Modifications include enhanced supplemental health care beds for clients stepping down from Institutes for Mental Disease (IMD) in the Adult and Older Adult system of care and clients released from jail in the Criminal Justice System with length of stay for two years or more.

New additions include a Homeless Engagement Access Team (HEAT) to enhance the existing MHSA-funded Permanent Supporting Housing efforts and provide ongoing street-based outreach, engagement and mental health treatment for mentally ill homeless individuals who have been difficult to engage. Services link clients to appropriate treatment and stabilizing services which may include interim housing. The 2021-2023 MHSA Draft Plan also includes the addition of 10 Mental Health Triage beds at the Sobering Station for homeless consumers exhibiting mental health symptoms that do not meet 5150 requirements.

The current MHSA revenue forecast for FY 2022 is estimated to demonstrate a substantial decrease in MHSA funding statewide due to the current COVID-19 pandemic and delayed taxpayer's payments. In planning for this estimated loss of revenue in FY 2022, the BHSD is recommending suspension of MHSA allocations to the following undeployed program ideas and the Voluntary County Contribution to statewide prevention:

- Older Adult Collaboration with Senior Nutrition Centers: $304,000 annually (CSS Component). BHSD will consolidate this program with other older adult outreach efforts across the system.
- INN-14 - Independent Living Facilities Project: $500,000 annually (PEI Component). BHSD recommends this project be integrated into the INN component to allow for start-up and program infrastructure development costs that would be accompanied by strong evaluation requirements to demonstrate feasibility as well as

sustainability of programming. The Independent Living Facilities Project would seek to create a residential facility organization for independent living and licensed board and care operators with voluntary membership. The aim is to promote the highest quality home environments for very low-income adults with mental illness in County of Santa Clara. Participant operators commit to have their homes meet a set of eight quality living standards. In exchange, the Independent Living Facilities Project would connect operators to a variety of supportive resources. The objectives of this project are to expand the number of high-quality licensed board and care and independent living facilities and decrease the use of emergency services, incarceration, and homelessness of persons in County of Santa Clara with serious mental illness.

INN projects are funded for a limited time (two to five years) to develop, pilot, and evaluate innovative programs and services. During the implementation phase, BHSD would evaluate the need for an extension based on progress evaluation and following the completion of an INN project, BHSD would review the evaluation and outcomes conducted by an independent evaluator to determine if the project should be continued. If deemed successful, BHSD would determine the ongoing funding from the MHSA CSS or PEI components.

- Voluntary County Contribution to the California Mental Health Services Authority (CalMHSA) for statewide prevention efforts: $250,000 annually (PEI component). The BHSD will continue its contract with CalMHSA for out of county hospitalizations for children and youth.

The recommended actions support the County of Santa Clara Health System's Strategic Road Map goals by improving client experience and outcomes through the provision of accessible, integrated and comprehensive behavioral health services.

CHILD IMPACT

The recommended actions would have a positive impact on children and youth by ensuring that MHSA programs are sufficiently funded and implemented to serve this target population.

SENIOR IMPACT

The recommended actions would have a positive impact on seniors by ensuring that MHSA programs are sufficiently funded and implemented to serve the senior target population.

SUSTAINABILITY IMPLICATIONS

The recommended actions balance public policy and program interests and enhances the Board of Supervisors' sustainability goal of social equity and safety by maintaining current programming and preserving services that support the provision of direct and

indirect behavioral health services.

BACKGROUND

The California Welfare and Institutions Code (WIC) Section 5847 states that County Mental Health Plans shall prepare and submit a MHSA three-year program expenditure plan and annual updates to be adopted by the Board of Supervisors and submitted to the MHSOAC within 30 days after adoption. Per WIC Section 5848, each three-year program and expenditure plan and update must be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, seniors with severe mental illness, providers of services, and other stakeholders.

The MHSA Stakeholder Leadership Committee (SLC) is a representative stakeholder group tasked with providing input on community needs and priorities. In June 2019, the MHSA SLC was expanded to add five additional client seats to the existing 25-member committee in response to stakeholder input regarding increased client representation. See **Attachment 6- 2020 MHSA SLC** for more details. The MHSA SLC participated in a total of 13 community gatherings, listening sessions, and a public forum which were conducted to address the MHSA CSS, PEI, and Innovations components. In addition, a client specific survey was administered across the county which provided additional guidance to program needs and future planning. An extensive review of these stakeholder meetings and culminating MHSA Community Planning Forum was completed by Palo Alto University **(Attachment 7- Evaluation Report for the MHSA Community Program Planning Process**). The 30-day public comment period was conducted from April 11, 2020 through May 10, 2020. This review period resulted in the receipt of 19 public comments. Following the public comment period, the BHSD submitted responses to the comments and posted these responses on the BHSD MHSA website (**Attachment 8- 30-Day Public Comments and BHSD Responses**). This period was followed by a Behavioral Health Board (BHB) public hearing on May 11, 2020 for review and approval. The BHB recommended the FY 2020 MHSA Draft Plan and the FY 2021-2023 MHSA Draft Plan to move forward to be presented to the Board of Supervisors by a majority approval (6:1 ratio) in the presence of a quorum (**Attachment 9- BHB Agenda and Minutes from May 11, 2020**).

The FY 2020 MHSA Draft Plan and the FY 2021-2023 MHSA Draft Plan represent the BHSD's investment and continuation of a three-year vision to sustain and maintain needed services in the systems of care. This effort reflects the deep commitment of the BHSD leadership and staff, clients and their family members, service providers, partners, and community stakeholders to support MHSA programs that are wellness and recovery focused, client and family driven, culturally competent, and address the needs of Santa Clara County residents.

CONSEQUENCES OF NEGATIVE ACTION

Failure to approve the recommended actions would result in the BHSD's inability to present the FY 2020 MHSA Draft Plan, the FY 2021-FY 2023 MHSA Plan, and the INN project for Independent Living Facilities to the MHSOAC and DHCS. This would result in a disruption of services to be provided in FY 2021 as the current FY 2018-2020 MHSA Plan ends on June 30, 2020.

STEPS FOLLOWING APPROVAL

Upon approval, the Clerk of the Board is requested to send e-mail notifications to Virginia Chen (Virginia.W.Chen@hhs.sccgov.org), Evonne Lai (Evonne.Lai@hhs.sccgov.org), and Evelyn Tirumalai (Evelyn.Tirumalai@hhs.sccgov.org).

Meeting History

Jun 2, 2020 9:30 AM Video **Board of Supervisors** **Regular Meeting**

Three individuals addressed the Board.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Susan Ellenberg, Supervisor
SECONDER:	Dave Cortese, Supervisor
AYES:	Mike Wasserman, Cindy Chavez, Dave Cortese, Susan Ellenberg, S. Joseph Simitian