COUNTY OF SANTA CLARA
Behavioral Health Services

Fiscal Year 2021 through Fiscal Year 2023
Mental Health Services Act (MHSA)
Three-Year Program & Expenditure Plan

WELLNESS • RECOVERY • RESILIENCE

Plan Adopted June 2, 2020.

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Table of Contents

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

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Clara

Local Mental Health Director	**Program Lead**
Sherri Terao, EdD (408) 885-7581 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 Three-Year Program 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.

DocuSigned by:
Sherri Terao
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Sherri Terao
Mental Health Director/Designee (PRINT)

Signature

6/4/2020
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, EdD (408) 885-7581 sherri.terao@hhs.sccgov.org	Alan Minato (408) 299-5201 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.

Sherri Terao
Mental Health Director/Designee (PRINT)

DocuSigned by:
Sherri Terao
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Signature

6/4/2020
Date

I hereby certify that for the fiscal year ended June 30, 2019, 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, 2019. 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.

Alan Minato
County Auditor Controller/City Financial Officer (PRINT)

DocuSigned by:
Alan Minato
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Signature

6/11/2020
Date

Introduction

The County of Santa Clara Behavioral Health Services Department (BHSD) is pleased to present the following Mental Health Services Act (MHSA) *Three-Year Program and Expenditure Plan Fiscal Year 2021 – Fiscal Year 2023 (FY21-FY23).*

The County's initial MHSA Plan was authorized by the Board of Supervisors on December 13, 2005 and approved by the California Department of Mental Health (DMH) on June 30, 2006. This report, submitted over ten years after the first three-year plan, is a testament to the ways in which MHSA funding has enabled the County of Santa Clara to make substantial improvements in the type, scope, and availability of behavioral health services, including services for people with the most serious mental health needs and to expand the reach of behavioral health services through prevention and early intervention at various community settings, including schools, community centers, and at home. MHSA funding has also provided the community with innovative ideas to behavioral health services such as *allcove*, the first in the country, to serve as a one-stop shop for youth ages 12-25 to access and receive a suite of services targeting their needs and stages of need.

I. Background

Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in 2004 to expand and transform the public mental health system. MHSA represented a statewide movement toward a better coordinated and more comprehensive system of care for those with serious mental illness. MHSA defined an approach to the planning and the delivery of mental health services that are embedded in the MHSA values of community collaboration, cultural competence, consumer and family driven services, focus on wellness, recovery and resiliency, and integrated service experience.

MHSA is funded through a one percent tax on individual annual income exceeding one million dollars. California counties receive MHSA allocations from the state, which typically make up about 30-50% of a county's total behavioral health budget. Counties determine how to distribute these funds at the local level through a Community Program Planning (CPP) process which culminates in a three-year plan, with annual plan updates in the remaining two years of the initial plan.

MHSA funding is distributed across five funding categories to support all facets of the public mental health system throughout the lifespan of consumers:

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Innovation (INN)

- ❖ Workforce Education and Training (WET)
- ❖ Capital Facilities and Technology Needs (CFTN)

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

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

By focusing resources on serving underserved and unserved individuals, MHSA endeavors to reduce historical disparities in access and quality of care that some populations have experienced. MHSA intends to serve individuals who are historically ***unserved*** or ***underserved*** by the public mental health care system as defined in the California Code of Regulations.[1]

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

In September 2019, the BHSD began the Community Program Planning (CPP) process for its combined FY20 MHSA Annual Plan Update and MHSA *Three-Year Program and Expenditure Plan FY21- FY23.* This catch-up approach was approved by the Mental Health Services Oversight and Accountability Commission in order to align county plans with reporting guidelines and requirements*. This final Document chronicles only the programs for FY21-FY23 Planning. The FY20 MHSA Annual Plan Update is compiled in a separate report.*

The Community Program Planning process included data gathering from listening sessions, surveys for clients/consumers and family members of consumers, the MHSA Planning Forum, BHSD program staff and the County's Stakeholder Leadership Committee (SLC). The BHSD contracted with Palo Alto University to conduct an intensive analysis and report of the qualitative and quantitative elements of the community input across the county. A full report of their findings appears on the Appendix section of this report.

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

The resulting Three-Year Plan describes the BHSD's CPP process, provides an assessment of the needs identified and prioritized by the robust stakeholder outreach and engagement activities, and proposes program modifications and expenditures to support a mental health system based on wellness and recovery. At the same time, the BHSD is mindful of the potential reductions in MHSA revenues in the coming years due to the impact of COVID-19. Counties across the state requested and did not receive flexibilities that may have allowed additional program modifications. The flexibilities that were requested were not available at the time this Three-Year Plan was approved and finalized. The guiding element for the next three years of MHSA programs and services is founded on building on existing programs' successes as well as focusing on existing, effective programming for those at highest risk and need. This Three-Year Plan includes the following sections:

- **Overview of the Community Program Planning (CPP) process** that took place in the County from September 2019 through April 2020. BHSD's CPP process built upon the meaningful involvement and participation of mental health consumers, family members, County staff, providers, and many other stakeholders.

- **Client Consumer Input** via community listening sessions, client/consumer surveys and MHSA Planning Forum that identified both strengths and opportunities to improve the mental health service system in County of Santa Clara.

- **Descriptions of County of Santa Clara MHSA programs** by age group for direct services and by component for indirect services, including a detailed explanation of each program, its target population, the mental health needs it addresses, and its goals and objectives. This section of the plan also provides information on the expected number of unduplicated clients to be served and each program's budget.

The CPP process focused its efforts on enhancing the mental health services offered by current MHSA programs still in development, planning or early stages of implementation from the previous extensive Plan of FY18-FY20. This current Three-Year Plan reflects the deep commitment of BHSD leadership and staff, providers, consumers, family members, and other stakeholders to the meaningful participation of the community as a whole in designing MHSA programs that are wellness and recovery focused, client and family driven, culturally competent, integrated, and collaborative.

III. Stakeholder Participation

Stakeholder Engagement and Outreach for Community Planning Activities

The Community Program Planning (CPP) process included a variety of stakeholder groups reflective of the geographic and cultural diversity of County of Santa Clara as well as the affiliations listed in the MHSA for CPP processes. This included representatives from the following groups:

- BHSD staff, managers, and senior leadership
- Community-based providers
- Consumers of services
- Family members and other loved ones
- Law enforcement
- County Office of Education and community college representatives
- Culture-specific consumers and family
- Staff from social services
- Representatives from veteran organizations

The CPP process leveraged several existing meetings, including meetings of the following bodies:

- Behavioral Health Advisory Board
- Stakeholder Leadership Committee
- Community partners

Outreach efforts were developed to ensure that the planning process reached a broad spectrum of stakeholders and the process was driven by community input. Prior to the planning process, BHSD launched an MHSA Stakeholder Leadership Committee (SLC) recruitment search among stakeholders to form an expanded MHSA SLC group representative of County of Santa Clara. Recruitment fliers and the final list of committee members are included in the Appendix. This expansion included an additional five consumer/client representatives. The CPP launch was announced via email to list-serves and participants from previous meetings, as well as current and former SLC members and in collaboration with the Behavioral Health Board leadership. The announcement was also sent to all BHSD staff and Department Managers were asked to share broadly with community service providers and the public. All community-planning activities were included in a timeline flyer that was distributed at meetings and via email. Additionally, all meetings were posted on BHSD's website on a timely manner.

Efforts to Include Consumers and Unserved and Underserved Populations

The CPP was an inclusive process that sought to include participation of the linguistic and cultural diversity of Santa Clara County. During the community input phase, culture-specific outreach and input gathering sessions were held across the County reaching the following communities: African and African Ancestry, Latino/Hispanic, Asian/Pacific Islander, the Reentry, post custody population, people experiencing homelessness, and LGBTQ+ communities.

Community members were asked to provide data through an online survey, listening sessions and to attend an MHSA Planning Forum. Surveys were available in English, Spanish, Chinese, Tagalog and Vietnamese, while listening sessions were either conducted in Spanish (with translator present) or asked to request translation services. Transportation needs were also assessed and provided when needed. For all meetings conducted after 4:00pm, food and/or refreshments were offered to participants.

Collaboration Efforts with Justice, Courts and Probation

The BHSD Criminal Justice System (CJS) programs provide access and support to clients, youth and adults that are involved in the justice system as they prepare to re-enter the community and after they have been released from custody. Programs collaborate with the Courts, the County Sheriff's Department, County Probation Department and other law enforcement agencies to successfully reintegrate clients into the community by providing direct mental health services, housing and flex fund support to address livelihood and other reintegration needs. The CJS also works collaboratively with the faith community to connect clients to support systems in faith-based settings as they learn new skills and create new friendships that can sustain their wellness and recovery. In FY20, the total estimated investment in justice involved clients was $15,381,293.

MHSA Prudent Reserve Transfer

The MHSA requires that counties establish and maintain a Prudent Reserve to ensure that county MHSA programs will continue to operate should MHSA revenues decrease. In April 2019, Senate Bill (SB) 192 established new regulations on the upper limits of the MHSA allocations in the County's MHSA Prudent Reserve. Under Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 19-017, new parameters were established. Under these new guidelines, counties must establish a Prudent Reserve that does not exceed 33 percent. To determine the average amount allocated to the CSS component, a county must calculate the sum of all distributions from the Mental Health Services Fund (MHSF) from July 1, 2013 through June 30, 2018, multiply that sum by 76 percent, and divide that product by five. Based on this new method, BHSD identified a total of $2,045,839 in excess funds that would be transferred from the prudent reserve by June 30, 2020. As required, $1,547,519 were transferred to CSS and $498,320 were transferred to Prevention and Early Intervention (PEI) to ensure funds remain in proportion to the original allocation transferred from each MHSA component in FY2020. The prudent reserve must be reassessed and certified every five years as part of the MHSA Three-Year Plan Annual Update. The MHSA Prudent Reserve in County of Santa Clara is $18,703,637 as of June 30, 2020. Please refer to MHSUDS Info. Notice 19-017 on the Appendix.

Data Analysis and Summary of Recommendations from Broad Community Input

The following is a summary excerpt of both quantitative and qualitative data analysis conducted by an evaluation team led and developed by Dr. Joyce Chu, PhD, Professor at Palo Alto University, Director of Diversity and Community Mental Health Program, and Co-Director at the Center for Excellence in Diversity at Palo Alto University. The full summary is available in the Appendix section of this document.

Families and Children (F&C)

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

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

Although the data point to the quality of existing services being positive, the following consumer-driven strategies integrated in this three-year plan, will aim to serve children and families not currently served in the current behavioral health system:

F&C.1	**Examine the cultural responsiveness of access and the service system** to address unique needs of specific diverse populations and to ensure provision of culturally-responsive options (e.g., for the working poor, homeless RV families, Latinx, immigrants, refugees, non-English speaking consumers).
F&C.2	**Increase accessibility by addressing gaps in service linkage points and continuity of care** between county systems (e.g., improved triage screening, detection, referrals, and school collaborations).
F&C.3	**Expand school-related services and staffing** (e.g., beyond school hours; increase staffing in and collaboration with schools; improve programmatic and funding coordination between school-linked services and PEI).
F&C.4	**Explore innovative outreach efforts** (e.g., social media, movie clips, mental health specialists in schools, comprehensive psychoeducation) to decrease access barriers (e.g., stigma, wait times, low awareness about services, unmet daily living needs).

Transitional Age Youth (TAY)

Stakeholders pointed to many areas of strength in the Transitional Age Youth (TAY) system, such as suicide prevention programming, gatekeeper trainings, Full Service Partnership (FSP) programs, efforts to integrate trauma-informed services, and Flex Funds. Stakeholder feedback from the Listening Sessions and the 2020 MHSA Community Planning Forum were consistent with the idea of a developing and maturing TAY system of care.

Overall feedback suggested that greater definitional clarity about *who* qualifies as TAY and attention to the specific needs of TAY would benefit the next stage of TAY service development. The following represent the top four stakeholder-driven strategies guiding this three-year plan:

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

TAY.2 **Provide more definitional clarity around who transitional age youth are**, and what their specific services look like.

i. Clarify who falls under TAY category and how they differ from child/youth or adult groups (e.g. "aged out" foster care children).
ii. Provide definitions for transient versus chronically homeless TAY.

TAY.3 **Further develop services tailored to TAY-specific needs**

i. Stakeholders discussed the importance of greater integration of family members into the care of TAY, especially given the legal barriers to family involvement (e.g. HIPAA).
ii. Data also pointed to needs for TAY-specific housing (particularly long-term supportive housing to prevent trauma), increased lengths of rapid TAY housing to 24 months, a TAY specific emergency shelter, increased programming and interventions designed to build life-skills, greater financial assistance (e.g., universal basic income), and a substance withdrawal program for TAY abusing ADHD medications.
iii. Integrated collaboration may be particularly important, such as through partnership with colleges, outreach to youth outside the school systems (e.g., immigrant youth, human trafficking, transition from incarceration, working TAY), or connectivity with the foster care and substance use service systems. Some also suggested that connectivity among service providers with TAY services be improved.

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

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

Adult and Older Adult (AOA)

Feedback from the Listening Sessions and the MHSA Community Planning Forum suggested that adults and older adult services include some strong programs that are encouraged to continue and expand. The

data analysis confirmed that the county is doing well in other areas such as servicing refugees, offering in-home peer respite programs, and expanding Full-Service Partnerships. Other stakeholders recommended that case management housing support for the chronically homeless and services for individuals involved in the criminal justice system (e.g., those on parole or probation) should be continued.

Suggestions to improve the adult and older adult system yielded several key areas of focus:

AOA.1	**Culture and Diversity Needs** i. Increase outreach and education to culturally diverse and underserved adult and older adult communities. ii. Focus and tailor staffing and programming towards the needs of cultural and diverse adult and older adult communities.
AOA.2	**Consider the need for a broader offering of post-crisis intervention** (tertiary prevention) options that promote recovery and prevent relapse.
AOA.3	**Assess points of coordination and collaboration** between county behavioral health and other entities (e.g., for veterans and incarcerated individuals at re-entry into the community).
AOA.4	**Increase the availability and accessibility of general and specialized housing** for homeless and at-risk populations.
AOA.5	**Improve adult/older adult workforce recruitment, training, and retention**.

30-Day Public Comment Period and Next Steps

The 30-day public comment period opened on April 11, 2020 and closed on May 10, 2020. The County BHSD announced and disseminated the Draft Plan to the 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 Draft Plan was posted to the County's website and available for download. An online comment form was created and link provided (https://www.surveymonkey.com/r/2020MHSA_PublicCommentForm) for easy comment submission. The public was also asked to email the MHSA Coordinator at mhsa@hhs.sccgov.org. Paper copies were not be made available at BHSD offices in San Jose, as in the past, due to the County's Public Health Officer's COVID-19 Shelter in Place Ordinance during this critical time in our community. Any interested party was able to request an electronic copy of the Draft Plan by submitting a written or verbal request to the MHSA Coordinator at mhsa@hhs.sccgov.org or by calling (408) 401-6117 (Mobile number) or by downloading it from the MHSA website provided here. If needed, copies would be made and sent by mail to anyone requesting a printed copy. This public comment period resulted in a total of 18 question. The responses to these questions are found on the appendix section of this report.

Governor's Guidance Regarding Public Meetings During the COVID-19 Shelter in Place Executive Order

Pursuant to the provisions of California Governor's Executive Order N-29-20, issued on March 17, 2020, the Public Hearing of the Behavioral Health Board (BHB) was held by teleconference only on Monday, May 11, 2020.

The BHB hosted this virtual public hearing to provide additional opportunity for stakeholders to engage in the review process and to provide feedback about the County of Santa Clara's *FY21-FY23 MHSA Three-Year Program and Expenditure Draft Pla*n. The Draft Plan was recommended 7 to 1 by the Behavioral Health Board to be presented at the County Board of Supervisors for approval and adoption. According to Executive Order N-29-20, quorum requirement is waived. The Board of Supervisors approved and adopted the Draft Three-Year Plan on June 2, 2020 via virtual meeting. The BHSD is on track to submit the MHSA Plans by the June 30, 2020 deadline as required by the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC).

MHSA Three-Year Program Plan (Draft Plan)

Services for Children, Youth, and Families

Services for children, youth, and families provide an array of supports to meet consumers at whatever point they are at in their stage of development as well as level of need. As in the previous MHSA Plan, services are organized into the following larger initiatives:

Community Services and Supports:

- **Full Service Partnership for Children and Youth:** FSP programs for children and TAY provide an array of wraparound services for consumers with the most serious mental health needs to provide "whatever it takes" to treat children and youth in the community.
- **Outpatient Services for Children and Youth:** This initiative includes outpatient services, intensive outpatient services, ethnic specific outpatient services, and specialty services for consumers with eating disorders or integrated mental health and substance use disorders.
- **Foster Care Development:** The foster care development initiative provides mental health services for foster youth at the Receiving, Assessment, and Intake Center (RAIC); services for Commercially Sexually Exploited Children (CSEC); and an Independent Living Program (ILP) for youth.
- **Crisis and Drop-In Services for Children and Youth:** This initiative provides crisis support through the Uplift Mobile Crisis services and drop-in services for youth through the Youth Drop-In Centers.
- **Interdisciplinary Service Teams**: Interdisciplinary service teams provide a spectrum of resources to youth that support their mental health and help launch them into adulthood.

Prevention and Early Intervention:

- **School Linked Services**: School linked services provide outreach and clinical services to school-age children at selected school sites throughout the County.

- **Prevention Services for Children and Youth, and Families:** Prevention services provide support for parents through several related trainings and services as well as a violence reduction program for youth.
- **Access and Linkage for Children 0-5 and Their Families:** Through KidConnections Network (KCN), BHSD works with First 5 to bridge 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.
- **Early Intervention:** The Early Intervention Program for youth called Raising Early Awareness Creating Hope (REACH) works towards successful futures for youth through early detection and prevention of psychosis. REACH provides early detection, prevention, and intervention services to youth experiencing signs and symptoms of early onset psychosis and schizophrenia.

Overview of Services for Children and Youth

Initiative	Program	Description	Status and Stakeholder Priority Addressed	FY21 Total Allocation Cost per person
	Community Services and Supports: Full Service Partnership			
Full Service Partnership for Children, Youth, and Families	Intensive Children's and 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 children/TAY living with serious mental illness to reach their wellness and recovery goals.	***Modified budget based on actual client utilization*** ***F&C.2 Increase accessibility/ service linkage/continuity of care*** ***TAY.1-TAY.3 Increase budget/Provide definitional clarity/Develop services tailored to TAY specific needs***	***F&C Total: $8,969,861*** ***F&C N=260 $34,499 cost per F&C client*** ***TAY Total: $9,318,410*** ***TAY N=340 $27,407 cost per TAY client***
	Community Services and Supports: General System Development			
Outpatient Services for Children and Youth	Children and Family Behavioral Health 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.	**Continuing** **F&C.2 Increase accessibility** **F&C.3 Explore innovative outreach efforts** **TAY.3 Develop services tailored to TAY-specific needs**	***Total: $36,131,734 N=3,177 $11,373 cost per client***
	TAY Outpatient Services/	Outpatient programs for TAY ages 16-24 aim to prevent chronic mental illness while	**Continuing**	**Total:**

	Intensive Outpatient Services (TAY)	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.	**TAY.1 budget transparency** **TAY.3 Develop services tailored to TAY-specific needs** **F&C.2 Increase accessibility**	***$2,401,143*** ***N=330*** ***$7,276 cost per client***
	Specialty Services: Integrated MH/SUD	Outpatient integrated behavioral health services to children and youth with co-occurring mental health and substance abuse needs	**Continuing** **F&C.2 Increase accessibility** **TAY.3 Develop services tailored to TAY-specific needs**	**Total:** ***$992,200*** ***N=156*** ***$6,360 cost per client***
	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	**Continuing** **F&C.2 Increase accessibility** **TAY.3 Develop services tailored to TAY-specific needs**	***Total:*** ***$1,400,000*** ***N=100*** ***$14,000 cost per client***
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)	**Continuing** **F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility** **TAY.3 Develop services tailored to TAY-specific needs**	**Total:** ***$1,246,596*** ***N=200*** ***$6,232 cost per client***
	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	***Modified Budget*** *based on actual client utilization* **TAY.2 Provide clarity around who TAY are** **TAY.3 Develop services tailored to TAY-specific needs**	***Total:*** ***$55,707*** ***N=45*** ***$1,238 cost per client***
	Commercially, Sexually Exploited Children (CSEC) Program	Services and mental health support to children and young people ages 10-21 who have experienced commercial sexual exploitation to help them recover from emotional, physical, and sexual trauma	**Continuing** **F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility** **TAY.3 Develop services tailored to TAY-specific needs**	***Total*** ***$886,649*** ***N=100*** ***$8,866***
Juvenile Justice Development	Services for Juvenile Justice Involved Youth	Education, training, and intensive case management services for justice-involved children/youth including aftercare services	***Modified Budget*** *for aftercare services based on actual client utilization*	***Total:*** ***$3,273,457***

		to assist them and their families in developing life skills that will improve their ability to live and thrive in community	**TAY.1 Increase budget transparency** **TAY.3 Develop services tailored to TAY-specific needs**	***N=140*** ***$23,381 cost per client***
	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	**To launch in FY21** **TAY.1 Increase budget transparency** **TAY.2 Provide clarity around who TAY are** **TAY.3 Develop services tailored to TAY-specific needs**	**Total:** ***$1,648,813*** ***N=200*** ***$8,244 cost per client***
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	***Modified Budget*** *based on pending RFP for Mobile Crisis Services.* **F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility** **TAY.1 Increase budget transparency** **TAY.2 Provide clarity around who TAY are** **TAY.3 Develop services tailored to TAY-specific needs**	**Total:** ***$314,594*** ***N=500*** ***$629 cost per client***
	TAY Crisis and Drop-In Center	Safe, welcoming, and inclusive spaces for youth to receive access to behavioral health resources and overnight respite	**Continuing** **TAY.1 Increase budget transparency** **TAY.2 Provide clarity around who TAY are** **TAY.3 Develop services tailored to TAY-specific needs**	**Total:** ***$539,822*** ***N=165*** ***$3,271 cost per client***
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	**To launch in FY21** **TAY.1 Increase budget transparency** **TAY.2 Provide clarity around who TAY are** **TAY.3 Develop services tailored to TAY-specific needs**	**Total:** ***$1,500,00*** ***N=667*** ***$2,248 cost per client***
	Prevention and Early Intervention			
Prevention Services for	Support for Parents	An array of support initiatives that are intended to prevent or intervene early in the	***Modified Budget*** *based on actual utilization.*	

Children, Youth, and Families		development of emotional and behavioral problems in young children by providing the parents with outcome-based parenting strategies, support services, and classes	**F&C.1 Examine the cultural responsiveness pf access and service system** **F&C.4 Explore innovative outreach efforts**	**Total:** ***$660,000*** ***N=2,000*** ***$330 cost per person***
Access and Linkage for Children 0-5 and their Families	Services for 0-5	Array of services to promote early identification of early signs of mental health and developmental delays; provide access and linkage to treatment for children 0-5 and their families	***Modified Budget*** *based on First 5 decrease in County's allocation.* **F&C.1 Examine the cultural responsiveness access and service system** **F&C.2 Increase accessibility** **F&C.4 Explore innovative outreach efforts**	**Total:** ***$388,527*** ***N=1,100*** ***$353 cost per person***
Prevention and Early Intervention	Raising Early Awareness Creating Hope (REACH)	An array of early detection, prevention and intervention services to youth experiencing signs and symptoms related to the early onset of psychosis and schizophrenia	***Modified Budget*** *based on actual utilization.* **F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility** **TAY.1 Increase budget transparency** **TAY.2 Provide clarity around who TAY are** **TAY.3 Develop services tailored to TAY-specific needs**	***Total:*** ***$1,428,361*** ***N=78 clients & 1,365 outreach counts*** ***$990 estimated cost per person***
	School Linked Services	Screening, identification, referral, and counseling services for school age children/youth in school-based settings	***Modified*** *- moved from CSS to PEI to serve a broader community.* **F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility** **F&C.3 Expand school-related services and staffing** **F&C.4 Explore innovative outreach efforts**	***Total:*** ***$19,167,234*** ***N=6,273*** ***$3,073 estimated cost per person***

Children's System of Care (0-15)

CSS: Full Service Partnership

Children Full-Service Partnership				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 15	☐ Transitional Age Youth Ages 16 – 24	☐ Adult Ages 24 – 59	☐ Older Adult Ages 60+
Service Category:	CSS: Full Service Partnership			

Program Description

Full Service Partnership (FSP): Children & Youth refers to the 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. County of Santa Clara's FSP provides intensive, comprehensive services for seriously emotionally disturbed (SED) children within a wraparound model. Continuing on the work from FY20, the FY21-FY23 Draft Plan continues the commitment and expansion of a higher level of service for children. This demonstrates an increase by 100 more slots in the intensive services offered by FSPs.

Intensive FSP: 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 children/TAY living with serious mental illness to reach their wellness and recovery goals. This expansion has accommodated an additional 100 spots.

FSP: Like IFSP, this step-down level of service also 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.

All FSP services include a team-based planning process intended to provide individualized and coordinated family-driven care. FSP should increase the "natural support" available to a family—as they define it— by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships.[2] FSP aims to engage underserved children and their families who have not yet benefited from traditional outpatient mental health services due to complex risk factors including substance abuse, community violence, interpersonal family violence, general neglect, and exposure to trauma. FSP requires that family members, providers, and key members of the child's social support network collaborate to build a creative plan that responds to the particular needs of the child and their support system. FSP services should build on the strengths of each child and their support system and be tailored to address their unique and changing needs. Services may include:

- Mental health treatment, including individual and family/group therapy
- Alternative treatment and culturally specific treatment approaches
- Family support including respite care and transportation of children/youth to their mental health appointments

[2] http://www.cebc4cw.org/program/wraparound/detailed

- Case management to assist the client and, when appropriate, the client's family in accessing needed medical, educational, social, vocational, rehabilitative, and/or other community services
- Supportive services to assist the client and the client's family in obtaining and maintaining employment, housing, and/or educational opportunities
- Referrals and linkages to community-based providers for other needed social services, including housing and primary care

Goals and Objectives			
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		
Number to be served FY 2021:	260	**Proposed Budget FY 2020 - 21:**	$8,969,861
Cost per Person FY2021:	$34,499	**Total Proposed Budget FY 2021-23:**	$26,909,583

CSS: General System Development

Outpatient Services for Children and Youth

Children & Family Behavioral Health Outpatient/Intensive Outpatient Services				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 16	☒Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

Outpatient (OP) mental health programs serve children and youth to help address mental health symptoms and associated functional impairments. County of Santa Clara 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. OP services include:

- Individual, family, and/or group therapy
- Case management services
- Dual-diagnosis treatment
- Screening
- Psychological assessment
- Service linkages
- Crisis intervention
- Therapeutic behavior support

The Intensive Outpatient Program (IOP) provides intensive, comprehensive, age-appropriate services for SED children, combining critical core services within a wraparound model. 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 homeless youth.

To ensure quality accessible services for underserved/unserved populations, numerous OP/IOP providers specialize in providing culture-specific services. OP/IOP centers are culturally and linguistically proficient to meet the needs of their populations, which may include African/African Ancestry, Southeast Asian refugees/immigrants, Asian Americans, American Indian/ Native Americans, and Latinos.

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

Number to be served FY 2021:	3,177	**Proposed Budget FY 2020 - 21:**	$36,131,734
Cost per Person FY2021:	$11,373	**Total Proposed Budget FY 2021-23**	$108,395,200

Specialty Services - Integrated MH/SUD

Status:	☐New	☒Continuing		☐Modified
Priority Population:	☒ Children Ages 0 – 17	☒ Transitional Aged Youth Ages 16 – 24	☐ Adult Ages 24 – 59	☐ Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program 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 experiencing difficulty 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.

All services are individualized, taking into consideration age, maturity, culture, educational functioning, and physical health. Services place a special emphasis on family values and structure, and family involvement in therapy.

Services can include:

- Mental health and substance abuse counseling
- Individual, family, and/or group therapy
- Case management
- Crisis intervention
- Referral and linkage to additional services and/or group treatment as needed

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

Number to be served FY 2021:	156	**Proposed Budget FY 2020 - 21:**	$992,200
Cost per Person FY2021:	$6,360	**Total Proposed Budget FY 2021-23:**	$2,976,600

Specialty and Outpatient Services- Eating Disorders for Children and Adults

Status:	☐New	☒Continuing		☐Modified
Priority Population:	☒ Children Ages 0 – 17	☒ Transitional Aged Youth Ages 18 – 24	☒ Adult Ages 25 – 59	☐ Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

County of Santa Clara 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.

Youth who experience eating disorders require medical supervision beyond what mental health providers are equipped to provide. The County's outpatient services for eating disorders combine the necessary medical services with mental

health support throughout a continuum of care that provides services of varied intensiveness to meet consumers' needs. The eating disorder continuum of care offers various levels of care to meet the specific needs of youth.

The County's outpatient services for eating disorders combine the necessary medical services with mental health support throughout a continuum of care that provides services of varied intensiveness to meet consumers' needs. 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 follow-up care. For the other non-residential services, consumers are referred through the County's Inpatient Coordinator. Services include:

- **Center for Discovery (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.
- **Cielo House (partial hospitalization program):** Cielo House provides 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.
- **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.
- **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.
- Previously funded by General Fund.

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 services in the community		
Number to be served FY 2021:	100	**Proposed Budget FY 2020 - 21:**	$1,400,000
Cost per Person FY2021:	$14,000	**Total Proposed Budget FY 2021-23:**	$4,200,000

Foster Care Development Initiative

Foster Care Development				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒ Children Ages 0 – 17	☒ Transitional Aged Youth Ages 16 – 24	☐ Adult Ages 24 – 59	☐ Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

ster Care Development program provides short-term clinical mental health services for children and youth placed at the Receiving, Assessment, and Intake Center (RAIC). 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.

IC 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 supports the RAIC team by providing two clinical social workers to assess and treat children and youth. Additionally, the two social workers work together with the RAIC Behavioral Health team to provide 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 or in the community.

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

Number to be served FY 2021:	200	**Proposed Budget FY 2020 - 21:**	$1,246,596
Cost per Person FY2021:	$6,232	**Total Proposed Budget FY 2021-23:**	$3,739,788

Crisis and Drop-In Services for Children and Youth

Children's Mobile Crisis				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 16	☒Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

The Mobile Crisis program—also known as the EMQ Families First Child and Adolescent Crisis Program (CACP) program and 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.

Uplift 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. 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. 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

Uplift Mobile Crisis services conclude once a child is taken to the Crisis Stabilization Unit (CSU) or brought home with a safety plan.

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		
Number to be served FY 2021:	500	**Proposed Budget FY 2020 - 21:**	$314,594
Cost per Person FY2021:	$629	**Total Proposed Budget FY 2021-23:**	$943,782

Prevention Services for Children, Youth, and Families

School Linked Services (SLS) Initiative				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 16	☒Transitional Age Youth Ages 16 – 17	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	PEI: Early Intervention			
Program Description				

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. This program utilizes school campuses as a hub for service delivery to improve access to and coordination of services among students and their families. The SLS program provides support to 11 partnering school districts and schools identified as high need areas using community mapping and based on determinants of health strategies. The program provides a SLS Coordinator at partnering campuses to coordinate services provided by schools, public agencies, and community-based organizations throughout the County, thereby improving results, enhancing accessibility, and supporting children's successes in school and life. Additionally, SLS Coordinators engage families and service providers, manage referrals, provide consultations with school referring parties and facilitate parent-involved activities. 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. To receive SLS Prevention and Early Intervention or SLS Mental Health clinical services, children and youth need to have a mental health diagnosis, children and youth are referred to SLS Prevention and Early Intervention (PEI) or SLS clinical services. For students with higher needs, SLS mental health clinical services provide longer term clinical services such as psychiatry, individual therapy, family therapy, and medication support. All services are co-located at school sites. All programs and services provided by SLS are now funded under the Prevention and Early Intervention (PEI) component of MHSA. This is not a transfer of CSS funding into PEI, it is an increased PEI allocation to accommodate existing SLS programs moved from the CSS component. The portion that was transferred is the clinical services portion back into the PEI service model (Prevention and Early Intervention) to appropriately serve children and family needs. If stepped up services are required or behavioral health interventions last longer than 18 months, clients would be referred to more intensive Community Services and Supports, FSP or General System Development programs to comply with existing MHSA regulations.

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

Number to be served FY 2021:	6,273	**Proposed Budget FY 2020 - 21:**	$19,167,234
Cost per Person FY2021:	$3,073	**Total Proposed Budget FY 2021-23:**	$57,501,702

Support for Parents

Status:	☐New	☒Continuing	☐Modified

Priority Population:	☒Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	PEI: Prevention			

Program Description

BHSD provides an array of support initiatives that are intended to prevent or intervene early in the development of emotional and behavioral problems in young children by providing the parents with outcome-based parenting strategies, support services, and classes.

Family support and engagement services include:

- **Reach Out and Read:** In partnership with Valley Medical Center (VMC) Pediatric Clinics, Reach Out and Read (ROR) is a literacy and education program. The mission is to make literacy promotion a standard part of pediatric health care. At every well child check-up, VMC's pediatric providers give each child a new, developmentally appropriate book to take home and read with their parents. Physician screening for developmental delays is part of the program, and children with identified developmental delays are referred to specialists for further services, ensuring that problems are addressed quickly before adverse effects are fully realized in a school setting.
- **Nurse Family Partnership (NFP) Program:** NFP is a countywide, community-based program providing first time mothers who reside in the County's high-risk communities with prenatal and postpartum support. NFP targets low-income mothers who are pregnant with their first child before the 28th week of pregnancy. Priority is given to expectant mothers involved with the mental health system, foster care system, juvenile/criminal justice systems, and schools in identified investment communities. NFP is comprised of a team of seven public health nurse home visitors. Each public health nurse is able to carry a caseload of 25 first-time mothers to deliver home visits from pregnancy until the child's second birthday.
- **Mentor Parents Program:** The Mentor Parents Program provides early intervention supports to a selective population of substance dependent parents whose children have been or currently are at risk of being removed from their care. Mentor parents work in conjunction with Dependency Advocacy Center (DAC) attorneys to encourage early engagement in recovery-oriented services and provide guidance to parents in addressing barriers impacting recovery and reunification. Mentor parents, because of their own previous involvement with the child welfare system, can share lived experiences with parents currently at risk of or engaged in the dependency system.
- **Triple P Parenting:** Triple P is a program that provides support to parents to guide their child's behavior in a positive way that reduces stress and builds strong family relationships. Triple P offers parenting support and simple tips for supporting the development of a child. Triple P's elements target the developmental periods of infancy toddlerhood, pre-school, primary school and adolescence.

Goals and Objectives

Outcome 1:	Engage and encourage parent/guardian involvement in their child's academic success and school
Outcome 2:	Strengthen parent/guardian and child's relationship and support a healthy relationship
Outcome 3:	Support maintaining a child at home with parent/ guardian

Number to be served FY 2021:	2,000	**Proposed Budget FY 2020 - 21:**	$660,000

Cost per Person FY2021:	$330	**Total Proposed Budget FY 2021-23:**	$1,980,000

Access and Linkage for Children 0-5 and their Families

Services for Children 0-5				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	PEI: Access and Linkage to Treatment			

Program Description

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 multi-disciplinary 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.

General services for children ages 0-5 include:

- Screenings & Assessments
- Behavioral Health Therapeutic Services
- Behavioral Health Home Visitation Services
- Linkage to Community Resources and Services

Goals and Objectives

Outcome 1:	Support the healthy development of children ages 0-5 and enrich the lives of their families and communities
Outcome 2:	Increase children and families' access to screening, treatment, and service linkages

Number to be served FY 2021:	1,100	**Proposed Budget FY 2020 - 21:**	$388,527
Cost per Person FY2021:	$353	**Total Proposed Budget FY 2021-23:**	$1,165,580

TAY System of Care (16-25)

CSS: Full Service Partnership

TAY Full Service Partnership				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☐Adult Ages 26 – 59	☐Older Adult Ages 60+
Service Category:	CSS: Full Service Partnership			

Program 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. The following are key services and activities of TAY FSP:

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

Intensive FSP: Full range of community and clinical services that provides a higher per client 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 TAY living with serious mental illness to reach their wellness and recovery goals. This expansion has accommodated an additional 100 spots.

FSP: Like IFSP, this step-down level of service also serves youth ages 16-25 with SED or SMI, 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.

Goals and Objectives			
Outcome 1:	Reduce out-of-home placements		
Outcome 2:	Increase service connectedness		
Outcome 3:	Reduce involvement in child welfare and juvenile justice		
Number to be served FY 2021:	340	**Proposed Budget FY 2020 - 21:**	$9,318,410
Cost per Person FY2021:	$27,407	**Total Proposed Budget FY 2021-23:**	$27,955,230

CSS: General System Development

Outpatient Services for Children and Youth

TAY Outpatient Services/ Intensive Outpatient Program (IOP)				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☐Adult Ages 26 – 59	☐Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

Outpatient programs for TAY ages 16-24 aim to prevent chronic mental illness while improving quality of life for youth. 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.

Specific services include:

- Assessments
- Treatment planning
- Referral hotline
- Brief crisis intervention
- Case management
- Self-help and peer support
- Outreach and engagement activities.

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 in 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 Medi-Cal. 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. IOP services include:

- Counseling and therapy
- Case management services
- General rehabilitation
- Medication support

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		
Number to be served FY 2021:	330	**Proposed Budget FY 2020 - 21:**	$2,401,143
Cost per Person FY2021:	$7,276	**Total Proposed Budget FY 2021-23:**	$14,406,858

Foster Care Development

Independent Living Program (ILP)

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☐Adult Ages 26 – 59	☐Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

ILP services are available to help 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.

Specific services available to help foster care youth transition into adulthood include:

- Independent life skills
- Daily living skills
- Education resources
- Assistance with student aid applications
- Employment assistance
- Money management
- Decision making

- Self-esteem building
- Housing resources

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		
Number to be served FY 2021:	45	**Proposed Budget FY 2020 - 21:**	$55,707
Cost per Person FY2021:	$1,238	**Total Proposed Budget FY 2021-23:**	$167,121

Commercially, Sexually Exploited Children (CSEC) Program

Status:	☒New	☐Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 15	☒Transitional Age Youth Ages 10 – 21	☐Adult Ages 26 – 59	☐Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program 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
- Linkage to additional services and benefits.

Additional services include financial support and connection to primary and secondary school or other education programs. The multidisciplinary treatment teams that treat CSEC youth consist of case managers and clinical therapists that provide culturally competent care.

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		
Number to be served FY 2021:	100	**Proposed Budget FY 2020 - 21:**	$886,649
Cost per Person FY2021:	$8,866	**Total Proposed Budget FY 2021-23:**	$2,659,947

Juvenile Justice Development

Services for Juvenile Justice Involved Youth				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 15	☒Transitional Age Youth Ages 10 – 21	☐Adult Ages 26 – 59	☐Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

Services for juvenile justice involved youth focus on the wellness and recovery of youth returning to their communities. Specific services include the **Aftercare program** and **competency development program**.

The **Aftercare program** 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** 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.

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		
Number to be served FY 2021:	140	**Proposed Budget FY 2020 - 21:**	$3,273,457
Cost per Person FY2021:	$23,381	**Total Proposed Budget FY 2021-23:**	$9,820,371

TAY Triage to Support Reentry

Status:	☐New	☐Continuing	Modified	
Priority Population:	☐Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☐Adult Ages 26 – 59	☐Older Adult Ages 60+
Service Category:	CSS: Outreach and Engagement			

Program Description

TAY Triage staff would help youth successfully transition back into their communities from jail or Emergency Psychiatric Services (EPS). Triage staff are case managers who are trained specifically to address youth-specific problems in youth with mental illness in jail and EPS, through providing connections to peer and family support, education, mental health services, and/ or housing, as needed. These services are meant to reduce rates of recidivism and use of EPS.

Triage staff would use a youth-specific model of care to help prepare youth for their discharge and reentry from jail or EPS. Co-located in jail and EPS, Triage staff conduct assessments, determine youths' psychosocial needs, and connect youth to a spectrum of community-based organizations that provide services specifically for TAY.

TAY Triage is not designed to supplant requirements of jail or EPS. Unlike the adult system, services for TAY are not provided through the County. The Triage program therefore provides case management and connections to clinical and mental health treatment outside of jail and EPS. This project will be county-operated to better manage client/consumer transitions between county departments and referrals.

The BHSD is exploring this project in conjunction with the recent expansion of Adult Intensive Services and the new In Home Outreach Teams.

Goals and Objectives			
Outcome 1:	Support TAY as they exit jail or EPS and return to their communities		
Outcome 2:	Identify psychosocial needs of TAY and increase connectedness to TAY services		
Outcome 3:	Reduce rates of recidivism and use of EPS		
Number to be served FY 2021:	200	**Proposed Budget FY 2020 - 21:**	$ 1,648,813
Cost per Person FY2021:	$ 8,244	**Total Proposed Budget FY 2021-23:**	$ 4,946,439

Crisis and Drop-In Services for Children and Youth

TAY Crisis and Drop In Center				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 15	☒Transitional Age Youth Ages 18 – 25	☐Adult Ages 26 – 59	☐Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program 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 need respite as a result of crisis or who are at risk of homelessness. Respite services allow TAY to self-manage and remain in their community, which may impede crisis escalation. The centers also offer services to unsponsored/ uninsured youth and allow the TAY homeless population to access needed supports. Additionally, services specifically for LGBTQ TAY are offered.

Specific mental health outpatient service offered include:

- Assessments
- Treatment planning
- Brief crisis intervention
- Case management
- Self-help and peer support
- Outreach and engagement activities for homeless TAY

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		
Number to be served FY 2021:	165	**Proposed Budget FY 2020 - 21:**	$539,822
Cost per Person FY2021:	$3,272	**Total Proposed Budget FY 2021-23:**	$1,619,466

Interdisciplinary Services Teams

TAY Interdisciplinary Service Team				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☐Adult Ages 26 – 59	☐Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

The TAY interdisciplinary service team provides a spectrum of resources to youth, including those who are homeless that support their mental health and help launch them into adulthood. Service teams operate in centers that provide a safe, welcoming, and inclusive environment for TAY outreach, engagement, and direct access to behavioral health resources. Service teams consist of case managers, clinicians, psychiatrists, substance use treatment services youth counselors, and peer support. Youth served are 16-25 years of age.

In addition to a standard range of outpatient mental health services, interdisciplinary service teams focus on youth-specific needs. This includes individual and group interventions, peer support, socialization, access to education and employment services, and medication management.

Unlike Full Service Partnership (FSP), which is primarily mobile and provides service for severe emotional disturbance or serious mental illness, interdisciplinary service teams are office-based and provide a lower intensity of mental healthcare. Referrals to interdisciplinary service teams occur through TAY Triage staff and other service providers throughout the County. TAY are welcome to stay in the program as long as clinically necessary. Procurement has been completed and a contract provider has been selected for this program. Services will launch in FY21.

Goals and Objectives

Outcome 1:	Increase service connectedness		
Outcome 2:	Reduce later need for higher intensity of care		
Number to be served FY 2021:	667	**Proposed Budget FY 2020 - 21:**	$ 1,500,000
Cost per Person FY2021:	$2,248	**Total Proposed Budget FY 2021-23:**	$ 4,500,000

Prevention Services for Children and Youth, and Families

Raising Early Awareness Creating Hope (REACH)				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☐Adult Ages 26 – 59	☐Older Adult Ages 60+
Service Category:	PEI: Early Intervention			

Program Description

Raising Early Awareness Creating Hope (REACH) works towards successful futures for youth through early detection and prevention of psychosis. REACH provides early detection, prevention, and intervention services to youth experiencing signs and symptoms of early onset psychosis and schizophrenia. REACH places an emphasis on TAY ages 16-25, and all services are guided by the practices and requirements described in the *PIER (Portland Identification and Early Referral)* model. Treatment is culturally competent and evidence-informed. REACH aims to provide services for youth before they experience multiple psychotic episodes, thereby reducing and preventing long-term impacts on development and functioning.

The REACH treatment team may consist of a family specialist, parent or partner, education and employment specialist, occupational therapist, psychiatrist, and an overarching supervisor. Services are provided in community settings including the youth's home, clinic, school, or community-based service agency.

REACH typically serves youth for one year, with the possibility of adding up to an additional year when required by family crises, hardship, or clinical necessity. Criteria for admission is based on the *Structured Interview for Prodromal Syndromes (SIPS)* assessment. If clients are eligible, treatment services include:

- Assessment
- Medication evaluation
- Support services
- Crisis intervention
- Individual, group, collateral, and family therapy
- Rehabilitation treatment
- Case management/ brokerage services

Goals and Objectives

Outcome 1:	Increase early detection of psychosis and schizophrenia
Outcome 2:	Increase service connectedness
Outcome 3:	Increase prevention of psychosis and schizophrenia

Number to be served FY 2021:	78 clients 1,365 outreach	**Proposed Budget FY 2020 - 21:**	$1,428,361
Cost per Person FY2021:	$990	**Total Proposed Budget FY 2021-23:**	$4,285,083

Services for Adults and Older Adults

The system for adults and older adults is composed of a series of programs that together make up initiatives to meet the needs of consumers wherever they are at in their stage of life. Following the plan organization from the previous Three Year Plan, the adult and older adult system includes the following initiatives:

Community Services and Supports:

- **Full Service Partnership for Adults and Older Adults:** The Full Services Partnership Program for Adults and Older Adults is composed of a new Assertive Community Treatment program; Intensive Adult FSP; Intensive Older Adult FSP; Criminal Justice FSP program; and, a Forensic Assertive Community Treatment program. Combined, these programs provide an array of intensive "whatever it takes" services to meet the needs of adults and older adults with the most serious mental health needs.
- **Permanent Supportive Housing:** Enhanced Permanent Supportive Housing (PSH) – Care Connection combines low-barrier affordable housing, health care, and supportive services to help individuals with mental illness and their families to lead more stable lives. Adding the Homeless Engagement Access Team (HEAT) will provide ongoing street-based outreach, engagement and mental health treatment for mentally ill homeless individuals who have been difficult to engage and linking them to appropriate treatment and stabilizing services which may include interim housing. This is in collaboration with the Office of Supportive Housing.
- **Outpatient Clinical Services for Adults and Older Adults:** The Outpatient Clinical Services Initiative provides an array of clinical and case management programs for Adults and Older Adults with mental health needs. Programs include County Clinics, Integrated Mental Health and Autism Services, CalWORKs Community Health Alliance, Specialty Services for Eating Disorders, and Outpatient Services for Older Adults.
- **Older Adult Community Services:** This initiative provides an array of services and supports to older adults in the community including Clinical Case Management for Older Adults Program; and a Connections Program that works with Adult Protective Services.
- **Criminal Justice:** As is the case across the country, in County of Santa Clara there are a large number of individuals with serious mental illness who cycle in and out of the justice system. In order to help ensure that the County has the appropriate supports and services in place for these individuals, the County's Criminal Justice Initiative funds residential treatment services and outpatient services - including intensive outpatient treatment services - for justice involved individuals who need aftercare support, as well as treatment and support for co-occurring disorders.
- **Crisis and Hospital Diversion**: This initiative is composed of seven programs that support adults and older adults at risk of or in crisis and divert individuals from higher levels of care. Services include a Mental Health Urgent Care; Crisis Stabilization Until and Crisis Residential Unit; Community Placement Teams, an IMD Alternative, and new In-Home Outreach Teams.

Prevention and Early Intervention:

- **Peer and Family Support:** This initiative provides a number of services that were formerly part of the Consumer and Family Wellness and Recovery Initiative including the Office of Consumer Affairs, and the Office of Family Affairs. It also includes a new Older Adult In-home Respite program.

Overview of Services for Adults and Older Adults

Initiative	Program	Description	Status and Stakeholder Priority Addressed	FY21 Total Allocation Cost per person
	CSS: Full Service Partnership			
Intensive Full Service Partnership (IFSP) for Adults and Older Adults	Assertive Community Treatment (ACT)	Multidisciplinary team approach with assertive outreach in the community to provide "whatever it takes" services in the community to serve consumers with the most severe mental health needs	***Modified budget*** *to expand and to provide flex funds at the appropriate level.*	***Total: $7,017,696 N=200 $35,088 cost per consumer***
			AOA.1 Culture and diversity needs AOA.2 Consider the need for a broader offering of post crisis intervention AOA.3 Assess points of coordination and collaboration AOA.4 Increase the availability and accessibility of general and specialized housing collaboration	
	IFSP for Adults/Older Adults	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 intensive service slots for individuals and will assist AOA living with serious mental illness to reach their wellness and recovery goals. Flex funds will follow the client as they transition from higher levels of care into outpatient services and between providers.		***Total: $9,318,410 N=300 $31,061 cost per consumer***
	Forensic Assertive Community Treatment (FACT)	Forensic Assertive Community Treatment (FACT) is an evidence-based behavioral health program for justice-involved consumers with serious mental illness who are at risk of or would otherwise be served in institutional settings (e.g. jails/prisons) or experience homelessness. When implemented to fidelity, FACT produces reliable results that decrease negative outcomes such as hospitalization, incarceration, and homelessness, and improves psychosocial outcomes.		***Total: $5,251,874 N=100 $52,518 cost per consumer***

	Adult/Older Adult FSPs	Continuation of the FSP model from previous approved plans, as a level of care in the Adult/Older Adult System. The FSP programs serve as a step down from Intensive FSP for those individuals that still need comprehensive services to manage severe mental illness symptoms, or who may still need services, including housing support, to remain successful and connected in the community.	**AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration** **AOA.4 Increase the availability and accessibility of general and specialized housing**	***Total: $2,855,962 N=100 $28,559 cost per consumer***
	Criminal Justice FSPs	Continuation of the FSP model from previously approved plans. This tier of service will ensure that justice-involved individuals receive the appropriate level of care to meet their clinical needs and housing support, to remain successful in the community.	**Continuing** **AOA.3 Assess points of coordination and collaboration** **AOA.4 Increase the availability and accessibility of general and specialized housing**	***Total: $3,953,178 N=100 $39,531 cost per consumer***
	CSS: General System Development			
Permanent Supportive Housing	Permanent Supportive Housing	Consists of County-operated services designed to meet the housing and service needs of chronically homeless individuals with severe mental health needs. Adding the Homeless Engagement and Access Team (HEAT) as an effort to improve behavioral health access and outcomes for homeless individuals with mental illness.	***Modified budget** to include outreach and engagement team.* **AOA.1 Culture and diversity needs** **AOA.3 Assess points of coordination and collaboration** **AOA.4 Increase the availability and accessibility of general and specialized housing**	***Total: $4,380,990 N=250 $17,523 per consumer***

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 in the community serving diverse, ethnic communities.	**Modified budget** by deleting unfilled, vacant positions. **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	***Total: $9,057,352*** ***N=2,300*** ***$3,938 cost per consumer***
	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.	**Continuing** **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	***Total: $547,988*** ***N=750*** ***$730 cost per consumer***
	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	**Continuing** **AOA.3 Assess points of coordination and collaboration**	***Total: $2,610,386*** ***N=630*** ***$4,143 cost per consumer***
	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	**Continuing** **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	***Total: $2,173,893*** ***N=1,120*** ***$1,940 cost per consumer***
Criminal Justice Initiative		Outpatient and residential services provided at a wellness and recovery	**Continuing**	

	Criminal Justice Residential and Outpatient	centers for individuals who are involved in the criminal justice system to meet the needs of re-entering the community	**AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.4 Increase the availability and accessibility of general and specialized housing**	***Total:*** ***$7,411,765*** ***N=300*** ***$24,705 cost per consumer***
	Criminal Justice Outpatient	Outpatient and intensive outpatient services for individuals who are involved in the criminal justice system to meet the needs of re-entering the community	**Continuing** **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	**Total:** ***$1,724,820*** ***N=300*** ***$5,749 cost per consumer***
	Faith-based Resource Centers	Service coordination to individuals reentering the community from jail provided by multi-agency faith-based resource centers	**Continuing** **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	**Total:** ***$1,848,688*** ***N=340*** ***$5,437 cost per consumer***
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	**Continuing** **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	**Total:** ***$2,370,030*** ***N=1,600*** ***$ 1,481 cost per consumer***
	Crisis Stabilization, Crisis Residential, and	Crisis support, counseling, and linkage services up to 24-hour stabilization unit and CRT. Mental Health Triage modification will add a dedicated team to work with law enforcement in the	***Modified - Mental Health Triage:*** *Located at the Mission Street Sobering Center,*	

	Mental Health Triage	field and pick up individuals without need for an EPS visit. This addresses the number of individuals dropped off at EPS who do not meet 5150 criteria, however, they would benefit from mental health linkages and support. Up to 10 mental health chairs would be dedicated to this service, slated to begin in FY2021.	*adding 10 mental health chairs.* **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	***Total: $29,799,429 N=1000 $29,799 cost per consumer***
	Adult Residential Treatment	This program was designed with a plan to purchase potential facilities that would provide a full range of clinical and support services for consumers needing Adult Resident Treatment. The BHSD worked closely with the County's Office of Supportive Housing and Fleet and Facilities to develop a Request for Statement Qualifications, first, followed by a Request for Proposal. Procurement resulted in a lack of qualified proposal submissions.	**On hold** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.4 Increase the availability and accessibility of general and specialized housing**	***Procurement resulted in a lack of qualified proposal submissions for facilities. The BHSD will explore other potential options with the Office of Supportive Housing.***
	Community Placement Team Services/ Institution of Mental Disease (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	**Continuing** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.4 Increase the availability and accessibility of general and specialized housing** **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	***$5,337,635 N=100 $53,376 cost per consumer***
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,	**To Launch in FY21**	**Total:**

		limited mobility, health issues, or stigma associated with receiving mental health services in a clinic	**AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	**$2,300,000** **N=100** **$23,000 cost per consumer**
	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	**Continuing** **AOA.3 Assess points of coordination and collaboration**	**Total:** ***$151,000*** ***N=275*** ***$549 cost per consumer***
CSS: Outreach & Engagement				
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)	**Continuing** **AOA.1 Culture and diversity needs** **AOA.3 Assess points of coordination and collaboration**	**Total:** ***$2,260,000*** ***N=300*** ***$7,533 estimated cost per consumer***
Prevention and Early Intervention				
	Integrated Prevention Services for Cultural Communities formerly known as: Primary Care/Behavioral Health Integration (PCBHI) Services for Cultural Communities (Adults and Older Adults)	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.	**RFP to be released in FY21** **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	**Total:** ***$1,098,390*** ***N=120*** ***$9,153 cost per consumer***
	Re-Entry Services Team	This is a multi-disciplinary team housed at the Re-Entry Resource Center that	**Continuing**	

		provides custodial and non-custodial individuals with referral and wrap around services. The program offers linkage to: mental health outpatient services; alcohol and drug treatment and care; resources to the faith communities; peer mentoring; housing; general assistance benefits; health referrals; transitional case management; and a clothes closet. This overall assessment and wraparound services including custody health, mental health, probation, DADS, SSA, housing, and peer mentors	**AOA.1 Culture and diversity needs** **AOA.3 Assess points of coordination and collaboration** **AOA.4 Increase the availability and accessibility of general and specialized housing**	**Total:** ***$473,146*** ***N=500*** ***$947 cost per consumer***
Peer and Family Support	Office of Consumer Affairs	Three programs focused on connecting consumers to support from peers who have a shared lived experience of navigating the mental health system and are uniquely qualified to offer support, encouragement, and hope to consumers	***Modified budget*** *by deleting unfilled, vacant position.* **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	**Total:** ***$580,197*** ***N=1,400*** ***$415 cost per person***
	Office of Family Affairs	Education support and resources to assist families in navigating the behavioral health system through offering direct support, information, and education, with the goal of providing recovery and hope	***Modified budget*** *by deleting unfilled, vacant positions, and actual client utilization.* **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	**Total:** ***$773,377*** ***N=231*** ***$3,348 cost per person***
	Older Adult In-Home Peer Respite	Free supportive counseling, visitation, and respite services provides caregivers of older adults a break from caregiving while simultaneously providing older adult consumers with companionship and social support	**Expected launch is FY2021** **AOA.1 Culture and diversity needs** **AOA.3 Assess points of coordination and collaboration**	**Total:** ***$400,000*** ***N=200*** ***$2,000 cost per person***

	Older Adult Collaboration with Senior 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	*The BHSD explored this potential opportunity, however the plan is to consolidate older adult outreach efforts across the system.*	
	Elders' Story Telling	The new Elders' Storytelling Program will serve culturally isolated older adults with mild to moderate depression using the culturally proficient technique of life review and storytelling (reminiscence) and incorporate innovative service components to help reduce the elder client's depressive symptoms and restore their position of social connectedness with their family, friends, caregivers and community.	**Expected to launch FY2021** **AOA.1 Culture and diversity needs AOA.3 Assess points of coordination and collaboration**	**Total:** ***$400,000*** ***N=500*** ***$800 cost per person***

Adult System of Care (26-59)

CSS: Full Service Partnership

Assertive Community Treatment				
Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: Full Service Partnership (FSP)			

Program Description

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. Modified budget to expand and to provide flex funds at the appropriate level.

Goals and Objectives	
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.

Number to be served FY 2021:	200	**Proposed Budget FY 2020 - 21:**	$ 7,017,696
Cost per Person FY2021:	$ 35,088	**Total Proposed Budget FY 2021 - 23:**	$ 21,053,088

Adult Full Service Partnership

Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS: Full Service Partnership (FSP)			

Program Description

County of Santa Clara 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 seek to engage people with serious mental illness into intensive, wraparound services with a low staff to consumer ratio (1:10), and provide a "whatever it takes" approach to:

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

Intensive FSPs (IFSP): A 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 intensive service slots for adult/older adults living with serious mental illness to reach their wellness and recovery goals. Flex funds will follow the client as they transition from higher levels of care into outpatient services and between providers.

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.[3, 4]

For 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; and
- They are in one of the following situations:
    - 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.

FSPs provide the full spectrum of community services necessary to attain the goals identified in each person's Individual Services and Supports Plan (ISSP), as well as any services that may be deemed necessary through collaborative planning between the County, the consumer, and/or the consumer's family to address unforeseen

[3] Section 5898, Welfare and Institutions Code

[4] Sections 5801, 5802, 5850 and 5866, Welfare and Institutions Code

circumstances in the consumer's life that could be, but have not yet been included in the ISSP. The full spectrum of community services that must be available for inclusion in a person's ISSP consists of the following:

- Mental health services and supports including, but not limited to:
  - Mental health treatment, including alternative and culturally specific treatments
  - Peer support
  - Supportive services to assist the consumer, and— when appropriate— the consumer's family, in obtaining and maintaining employment, housing, and/or education
  - Wellness centers
  - Alternative treatment and culturally specific treatment approaches
  - Personal service coordination/case management to assist the consumer, and when appropriate the consumer's family, to access needed medical, educational, social, vocational rehabilitative and/or other community services
  - Needs assessment
  - ISSP development
  - Crisis intervention/stabilization services
  - Family education services
- Non-mental health services and supports including, but not limited to:
  - Food
  - Clothing
  - Housing, including, but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
  - Cost of health care treatment
  - Cost of treatment of co-occurring conditions, such as substance abuse
  - Respite care

Modified budget to expand and provide flex funds at the appropriate level. There are no changes to programming.

Goals and Objectives	
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

Number to be served FY 2021:	300	**Proposed Budget FY 2020 - 21:**	$ 9,311,071
Cost per Person FY2021:	$31,036	**Total Proposed Budget FY 2021 - 23:**	$27,933,212

Forensic Assertive Community Treatment

Status:	☐New	☒Continuing		☐Modified
Priority Population:	☐Children	☐Transitional Age Youth	☒Adult	☒Older Adult

	Ages 0 – 17	Ages 16 – 24	Ages 24 – 59	Ages 60+
Service Category:	CSS: Full Service Partnership (FSP)			

Program Description

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

- 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 FACT team members know and work with all FACT consumers, and 2) a practicing ACT team leader spends more than 50% of their time providing direct services to ACT consumers.
- 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 FACT 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. A budget increase was necessary to appropriately execute the program to fidelity.

Goals and Objectives

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.

Number to be served FY 2021:	100	**Proposed Budget FY 2020 - 21:**	$5,251,874

Cost per Person FY2021:	$ 52,518	**Total Proposed Budget FY 2021 - 23:**	$ 15,755,622

Criminal Justice Full Service Partnership				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS: Full Service Partnership (FSP)			

Program Description

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

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

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

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

FSP programs provide a collaborative relationship between the County, the consumer, and— when appropriate— the consumer's family. Through this partnership, providers plan for and provide a full spectrum of community

services so that the consumer can achieve his/her identified goals and reduce their criminogenic risks and needs.[5] [6]

FSPs provide Criminal Justice FSP consumers with the full spectrum of community services necessary to attain the goals identified in each person's Individual Services and Supports Plan (ISSP), as well as any services that may be deemed necessary through collaborative planning between the County, the consumer, and/or the consumer's family to address unforeseen circumstances in the consumer's life that could be, but have not yet been included in the ISSP. As a part of this process, a criminogenic risk and needs assessment is performed on adults enrolled in the Criminal Justice FSP, and consumers are connected with programs to address areas such as criminogenic thinking and antisocial behavior. The services to be provided may also include services that the County, in collaboration with the consumer and when appropriate the consumer's family, believe are necessary to address unforeseen circumstances in the consumer's life that could be, but have not yet been included in the ISSP.

The full spectrum of community services that must be available for inclusion in a person's ISSP consists of the following:

- Mental health services and supports including, but not limited to:
    - Mental health treatment, including alternative and culturally specific treatments
    - Peer support
    - Supportive services to assist the consumer, and when appropriate the consumer's family, in obtaining and maintaining employment, housing, and/or education
    - Wellness centers
    - Alternative treatment and culturally specific treatment approaches
    - Personal service coordination/case management to assist the consumer, and when appropriate the consumer's family, to access needed medical, educational, social, vocational rehabilitative and/or other community services
    - Needs assessment
    - ISSP development
    - Crisis intervention/stabilization services
    - Family education services
- Non-mental health services and supports including, but not limited to:
    - Food
    - Clothing
    - Housing, including, but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
    - Cost of health care treatment
    - Cost of treatment of co-occurring conditions, such as substance abuse
    - Respite care
    - Criminogenic thinking

Service capacity increased by 100 in Fiscal Year 2020 and will be fully functional by Fiscal Year 2021.

[5] Section 5898, Welfare and Institutions Code

[6] Sections 5801, 5802, 5850 and 5866, Welfare and Institutions Code

Goals and Objectives			
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		
Number to be served FY 2021:	100	**Proposed Budget FY 2020 - 21:**	$ 3,953,178
Cost per Person FY2021:	$ 39,531	**Total Proposed Budget FY 2021 - 23:**	$ 11,859,534

CSS: General System Development

Permanent Supportive Housing

Permanent Supportive Housing				
Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS: GSD			

Program Description

Permanent Supportive Housing (PSH) –

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

Key components of PSH-Care Connection that facilitate successful housing tenure include:

- 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
- 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.

Modifications Include:

- Increasing the outreach and engagement teams by adding 9 Full Time positions.

Goals and Objectives			
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)		
Number to be served FY 2021:	250	**Proposed Budget FY 2020 - 21:**	$ 4,380,990
Cost per Person FY2021:	$ 17,523	**Total Proposed Budget FY 2021 - 23:**	$ 12,836,523

Outpatient Clinical Services for Adults and Older Adults

County Clinics				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

Santa Clara's two county-operated outpatient mental health clinics are located in San Jose, where they provide 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.

- **Downtown Mental Health Center Service Teams (DTMH):** The goal of DTMH is to assist individuals within the context of a mutual partnership effort to achieve higher levels of functioning, develop community/family support systems wherever possible, promote self-reliance and self-sufficiency, and encourage individuals to work or to return to work whenever possible. Service teams work with clients suffering from serious mental illness who exhibit severe problems in normal daily functioning, offering a full array of mental health services including case management services, crisis intervention and medication support services. DTMH has two full-time service teams operating Monday through Friday, and serves more than 700 clients. All teams are comprised of case managers and a psychiatrist. While both clinics are standard outpatient clinics that serve homeless consumers, the Valley Homeless Healthcare Program locates some of its health care services for homeless residents at DTMH to facilitate convenient access to care.
- **Central Wellness Benefits Center (CWBC):** The goal of the CWBC is to assist clients in accessing health benefits while managing their medication needs. If qualified for coverage, CWBC links clients to more extensive behavioral health outpatient services within County of Santa Clara. Clients are referred to CWBC for basic behavioral health and crisis intervention services. CWBC also provides ongoing medication services and assists clients with benefits enrollment services as needed. CWBC is co-located at Valley Medical Center with Barbara Arons Pavilion (BAP), Emergency Psychiatric Services (EPS), and Mental Health Urgent Care (MHUC). Services are available in English, Spanish, Russian, Portuguese, Farsi, Tamil, Telugu and Vietnamese.

Goals and Objectives

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		
Number to be served FY 2021:	2,300	**Proposed Budget FY 2020 - 21:**	$ 9,057,352
Cost per Person FY2021:	$ 3,938	**Total Proposed Budget FY 2021 - 23:**	$ 30,042,660

Hope Services: Integrated Mental Health and Autism Services

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

The mission of Hope Services is 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:

- **Behavioral Health:** May include psychotherapy, rehabilitation counseling, cognitive behavior therapy, supportive therapy, behavior therapy, play therapy and other modalities as necessary to assist the individual in controlling troubling symptoms such as anxiety, depression, and more severe cognitive and mood disorders
- **Case Management Services:** May involve linking the consumer to other community services to improve their quality of life
- **Psychiatric Services:** Including assessment by a psychiatrist and medication if warranted
- **Registered Nurse Services:** Available to clients and their families
- **Behavioral Health-Management Groups:** Available to assist clients with management of health behaviors to promote longevity and healthy living
- **Family Support and Education:** Educational and support meetings for parents, caregivers, significant others, and Board and Care staff who serve individuals with mental health needs and developmental disabilities
- **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 co-existing behavioral health problems

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

Goals and Objectives			
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		
Number to be served FY 2021:	750	**Proposed Budget FY 2020 - 21:**	$ 547,988
Cost per Person FY2021:	$ 730	**Total Proposed Budget FY 2021 - 23:**	$ 1,643,964

CalWORKs Community Health Alliance

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

The CalWORKs Community Health Alliance (Health Alliance) provides behavioral health services to adult clients enrolled in the Welfare-to-Work (WTW) Program who experience mental health and substance abuse issues. Health Alliance is a partnership between County of Santa Clara Social Services Agency, Santa Clara Valley Health and Hospital Systems' Department of Alcohol and Drug Services (DADS), and BHSD. The purpose of this partnership is to provide comprehensive behavioral health services for CalWORKs clients and their family members. CalWORKs places mental health services within the employment support program to help address issues that prevent people with mental health issues from obtaining and maintaining employment which can help them transcend poverty.

Health Alliance uses a behavioral health model that focuses on the health of the whole person by providing individualized counseling and other services to enhance and support self-sufficiency. These holistic services include:

- 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 issues
- Substance abuse issues
- Relationship issue
- Mental health issue
- Stress management
- Trauma and abuse
- Psychosocial functioning
- 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.

Goals and Objectives			
Outcome 1:	Consumers develop increased self-sufficiency and work readiness		
Number to be served FY2021:	630	**Proposed Budget FY 2020 - 21:**	$ 2,610,386
Cost per Person FY2021:	$ 4,143	**Total Proposed Budget FY 2021 - 23:**	$ 7,831,158

Criminal Justice Initiative

Criminal Justice Residential and Outpatient Treatment Programs				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS: GSD			

Program 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 the criminal justice system:

- Housing support
- Extended housing for up to one year
- 24 hour support including:
    - Peer 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.

Goals and Objectives			
Outcome 1:	Increase stability and quality of life		
Outcome 2:	Decrease homelessness		
Number to be served FY 2021:	300	**Proposed Budget FY 2020 - 21:**	$ 7,411,765
Cost per Person FY2021:	$24,705	**Total Proposed Budget FY 2021 - 23:**	$14,213,886

Criminal Justice Outpatient Services

Status:	☐New	☒Continuing		☐Modified
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS: GSD			

Program 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 County of Santa Clara 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 3-4 hours of treatment per day 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

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 County of Santa Clara, such as Evans Lane's Residential Treatment Facility.

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.

Goals and Objectives			
Outcome 1:	Increase stability and quality of life		
Outcome 2:	Decrease signs and symptoms of mental illness		
Number to be served FY 2021:	300	**Proposed Budget FY 2020 - 21:**	$1,724,820
Cost per Person FY2021:	$5,749	**Total Proposed Budget FY 2021 - 23:**	$5,174,460

Faith Based Resource Centers

Status:	☐New	☒Continuing	☐Modified
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS:GSD		

Program Description

There are four Faith-Based Resource Center (FBRC) which are operated by three different faith-based organizations in geographically diverse locations within County of Santa Clara. The FBRCs are sites where services are provided to people leaving jail or prison and returning to the County of Santa Clara community. The County of Santa Clara 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 County of Santa Clara 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 the Santa Clara Mental Health Department 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 SCCMHD staff for an assessment and orientation to the Innovation 06 project. If the individual wants to participate in one of the FBRCs, SCCMHD 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.

The FBRCs provide services for individuals seeking assistance in conjunction with other Resource Centers and faith-based providers, SCCMHD, and the Faith Reentry Collaborative. FBRCs provide the following services to participants:

- ❖ Linkages to faith, spiritual, and social community support connections.
- ❖ Social support services including, but not limited to: job skills development, recovery/substance abuse programs, housing assistance, family reunification, child care, counseling, anger management, education needs, computer literacy, benefits assistance, health care, and obtaining a California identification/driver's license.
- ❖ Volunteer mentors to offer social, emotional, spiritual support, advocacy, and linkages to other available community resources.
- ❖ Reentry support funds (or Flex-Funds) for the purposes of supporting services on the basis of individual's need. Examples include transportation (bus and train passes), car repairs (on case-by-case basis), employment (training classes, equipment, tools, and clothing), education, grooming (hygiene needs and supplies), housing, household goods, clothing, living expenses, medical, dental, vision treatments, storage, program incentives (when needed), food, emotional pet support, and child care.

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		
Number to be served FY 2021:	340	**Proposed Budget FY 2020 - 21:**	$1,848,688
Cost per Person FY2021:	$5,437	**Total Proposed Budget FY 2021 - 23:**	$5,546,064

Crisis and Hospital Diversion Initiative

Mental Health Urgent Care				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General System Development			
Program Description				

Mental Health Urgent Care (MHUC) is an outpatient clinic for County of Santa Clara residents who are experiencing behavioral health crises. MHUC is co-located near Emergency Psychiatric Services (EPS), Barbara Arons Pavilion, and Valley Medical Center to facilitate ease of access for consumers. MHUC's goal is to provide crisis intervention, psychosocial assessment, and brief treatment to meet the immediate needs of people experiencing a crisis and refer them to the appropriate follow-up treatment. The program is designed to help consumers avoid involuntary hospitalization and incarceration, as well as to be an alternative to EPS. Consumers may either refer themselves as a "walk-in" or be referred by a provider, police officer, or family member.

MHUC operates a walk-in crisis clinic with a psychiatrist on duty that is open 24 hours a day, seven days a week for those seeking voluntary services, including:

- Crisis intervention for people who do not require a 5150 hold or a secure environment
- Brief treatment to stabilize the individual and conduct a psychosocial assessment to determine needs for follow-up care
- Linkage to ongoing services as appropriate, in addition to continuing temporary treatment for up to 60 days while consumers wait to be connected to ongoing services

MHUC staff are able to provide services is several languages spoken by the communities served, including English, Farsi, Korean, Spanish, and Vietnamese.

Goals and Objectives

Outcome 1:	Consumers are connected to urgent mental health care services and experience fewer visits to EPS and episodes of hospitalization

Number to be served FY 2021:	300	**Proposed Budget FY 2020 - 21:**	$ 2,370,030
Cost per Person FY2021:	$1,481	**Total Proposed Budget FY 2021 - 23:**	$7,110,090

Crisis Stabilization Unit, Crisis Residential Treatment, and Mental Health Triage

Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program 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.

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.

Mental Health Triage Center: Located at the Mission Street Sobering Center, the Mental Health Triage team will work with law enforcement in the field. This addresses the needs of individuals dropped off at EPS who do not meet 5150 criteria (harm to self or others or gravely disabled) but would otherwise benefit from mental health linkages and support. Up to 10 mental health chairs would be dedicated to this service, slated to begin in FY2021.

Goals and Objectives

Outcome 1:	Consumers experiencing crises access the support they need to avoid unnecessary hospitalizations or incarceration as a result of crisis episodes.

Number to be served FY 2021:	1000	**Proposed Budget FY 2020 - 21:**	$ 29,799,429
Cost per Person FY2021:	$29,799	**Total Proposed Budget FY 2021 - 23:**	$ 60,301,197

Adult Residential Treatment

Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

Adult Residential Treatment (ART) facilities provide up to 24 months of residential treatment for adults with serious mental illness. ARTs are designed for persons who are able to live in the community but who would be at risk of returning to a hospital without the support of counseling and a therapeutic community. This program is designed for persons who may be expected to move toward a more independent living setting within three months to one year. ARTs are licensed, certified, and Medi-Cal billable treatment environments. Without the option of an ART placement, individuals would remain in Mental Health Rehabilitation Centers (MHRCs) for extended periods of time, which can lead to increased rates of relapse once back in the community. The FY20 BHSD procurement resulted in a lack of qualified proposal submissions, so there is not a facility in place at this time that can provide these services.

Key activities of the ART include:

- Providing psychosocial and clinical services to adults with serious mental illness who are at risk of or transitioning from MHRC placement, including medication monitoring;
- Providing a safe, supportive, supervised, recovery-oriented environment for adults who do not require a secure treatment setting to stabilize; and
- Providing individual, family, and group treatment for mental health and co-occurring disorders, including milieu and activity-based interventions.

The plan is that County staff would operate three ARTs, each with a capacity of 16 beds. All would be voluntary alternatives to psychiatric hospitalization. Two of the ARTs would serve as a step-down from institutional treatment settings back to the community. These ARTs would also serve as an alternative to Institution of Mental Disease (IMD) placements for consumers who are living in the community and require residential treatment due to escalating symptoms. All three ARTs would have capacity to serve consumers with co-occurring diagnoses, but the third ART will be distinct in its dedication to serving consumers with the highest level of substance use and mental health needs. Implementation will depend on the success of identifying appropriate facilities for these services. Procurement resulted in a lack of qualified proposal submissions for facilities in Fiscal Year 2020. BHSD will explore other potential options with the Office of Supportive Housing. This program is currently on hold.

Goals and Objectives	
Outcome 1:	Fewer consumers will be placed in institutional settings and safe transitions back into the community will increase
Outcome 2:	ARTs will promote recovery outcomes for consumers by reducing length of hospital stay, and increasing the number of consumers who are able to receive services in the least restrictive setting within their home community
Outcome 3:	ARTs may also increase family and social connectedness by keeping consumers placed within the County, eliminating the need for families to travel long distances to participate in their loved one's recovery

Number to be served FY 2021:	100	**Proposed Budget FY 2020 - 21:**	$ 3,099,398 estimated once facilities are available
Cost per Person FY2021:	$30,993	**Total Proposed Budget FY 2021 - 23:**	$ 10,052,100 estimated once facilities are available

Community Placement Team Services and Institution of Mental Disease (IMD) Alternative

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

The Community Placement Team (CPT) coordinates placement at MHSA-funded residential and temporary housing programs for consumers being discharged from Emergency Psychiatric Services (EPS) and/or the Barbara Arons Pavilion (BAP) who are also high utilizers of mental health services. The 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 CPT may authorize placement into crisis residential, a board and care/room and board facility (Crossroads Village), or transitional housing (La Casa), as well as transportation for clients admitted to outlying acute inpatient facilities. In addition, the CRT acts as a liaison to acute hospitals troubleshoots any placement, admission, and discharge issues that arise.

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. Many consumers who live at Crossroads Village concurrently participate in outpatient specialty mental health services at the same location, although this is not a requirement for participation in transitional housing; some consumers receive specialty mental health services from other outpatient mental health providers. Additionally, not all consumers who receive outpatient services at Crossroads Village reside there. Crossroad Village uses a recovery-oriented approach to 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.

Goals and Objectives			
Outcome 1:	Increased connection to care to reduce the number of consumers cycling between institutional settings and homelessness		
Number to be served FY 2021:	100	**Proposed Budget FY 2020 - 21:**	$ 5,337,635
Cost per Person FY2021:	$53,376	**Total Proposed Budget FY 2021 - 23:**	$16,012,905

CSS: Outreach and Engagement

In-Home Outreach Teams				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: Outreach and Engagement			
Program Description				

The County will implement two models of In Home Outreach Teams (IHOT) based on models demonstrated to be effective through their use in Alameda, San Diego, and Ventura Counties.

County-Run IHOT: County of Santa Clara's IHOT team is modeled after the RISE team in Ventura County. The Ventura model is a "Rapid Integrated Support Team," a mobile team of clinicians and peer specialists who receive referrals from the community and follow-up with people post-crisis for 30 to 60 days to assess needs and facilitate connection to mental health services. This team serves as the main entry point into the mental health system and plays "air traffic control" for referrals to mental health services in the County. The County team is staffed with clinicians and peers. When the County team receives a call from someone seeking mental health services or someone who wishes to refer someone to mental health services, the team will make a determination of whether to refer the call to the appropriate service, or conduct initial outreach and engagement with the individual referred to determine the appropriate level of care. Once needs are assessed, the IHOT team will facilitate a warm hand-off to the appropriate services, which may include the community-based IHOT described below. Throughout this process, the County IHOT will conduct outreach and engagement as necessary to engage.

Community-Based IHOT: The community-based IHOT team is modeled after the Alameda and San Diego County IHOTs, and is comprised of non-clinical staff such as peers, family members, and case managers. This type of IHOT team receives referrals from the community and works with referred consumers for up to four months to facilitate their connection to mental health services. The only source of referrals for the community-based IHOT is the County-run IHOT team. When a consumer is referred to the community-based IHOT, staff work with the consumer to facilitate their referral to needed services and their movement through different levels of care.

Goals and Objectives	
Outcome 1:	Targeted outreach and engagement would meet people "where they're at" and facilitate connection to the appropriate level of services per consumer
Outcome 2:	Utilization of higher cost services will decrease as utilization of more cost effective and levels of care that appropriately meet consumers' needs will increase

Number to be served FY 2021:	300	**Proposed Budget FY 2020 - 21:**	$ 2,260,000
Cost per Person FY2021:	$ 7,533	**Total Proposed Budget FY 2021 - 23:**	$ 6,780,000

Prevention and Early Intervention

Integrated Prevention Services for Cultural Communities

formerly known as: Primary Care/Behavioral Health Integration (PCBHI) Services for Cultural Communities for Adults and Older Adults

Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Early Intervention			

Program Description

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 16 and older; and
2. Implement an integrated behavioral health services model within local Federally Qualified Health Centers that serve underserved ethnic minorities building on successes from previous years.

In light of new MHSA PEI regulations, programs in this category are now tasked with collecting, analyzing and reporting on actual program impact, referrals to care, and fulfill specific project outcomes based on specific deliverables. The target population for these services are adults/older adults at risk of mental health issues instead of those already experiencing mental health problems. Serving the needs of participants in the mild to moderate range. In FY21, the BHSD will release an RFP for these services under the new program name, Integrated Prevention Services for Cultural Communities.

Goals and Objectives

Outcome 1:	Consumers and the members of their support networks are supported in accessing the services they need to support their recovery and wellness		
Number to be served FY 2021:	120	**Proposed Budget FY 2020 - 21:**	$1,098,390
Cost per Person FY2021:	$ 9,153	**Total Proposed Budget FY 2021 - 23:**	$ 3,295,170

Peer and Family Support Initiative

Office of Consumer Affairs				
Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Access and Linkage to Treatment			

Program Description

BHSD's Office of Consumer Affairs runs three programs focused on connecting consumers to support from peers who have a shared lived experience of navigating the mental health system and are uniquely qualified to offer support, encouragement, and hope to consumers. To accomplish this, the County created Mental Health Peer Support Worker positions to enable hiring of consumers and family members into the mental health workforce. Mental Health Peer Support Workers provide individual and group support on a variety of topics such as talking about feelings of isolation; helping with access to medical benefits; and providing information about health, substance abuse, and other related topics. Peer support services complement the clinical support offered by licensed professionals through providing services in clinics and self-help centers, including the following locations:

Zephyr and Esperanza Self-Help Centers: Zephyr (San Jose) and Esperanza (Gilroy) are drop-in centers that provide peer support to assist consumers in achieving wellness and recovery; participating in meaningful activities; and obtaining education, employment, and housing. Self-help centers have capacity to serve English- and Spanish-speaking consumers with the following resources:

- Peer-supported events and social activities
- One-on-one peer support as well as peer-facilitated support groups
- Wellness Recovery Action Plan (WRAP) groups
- Self-Help for TAY (Zephyr); Self-Help Center (Esperanza)
- Computer workshops and classes to support consumer empowerment at the Consumer Learning Center

Clinic Peer Support: Mental health clinical staff may also refer consumers to peer support at County clinics, which provide the following services:

- WRAP groups at five clinics: Sunnyvale, Central Wellness Benefit Center (CWBC), Downtown, East Valley and South County
- Tobacco Cessation Groups
- Mindfulness groups

Modified budget by deleting unfilled, vacant positions.

Goals and Objectives			
Outcome 1:	Consumers and the members of their support networks are supported in accessing the services they need to support their recovery and wellness		
Number to be served FY 2021:	1,400	**Proposed Budget FY 2020 - 21:**	$ 580,197
Cost per Person FY2021:	$ 414	**Total Proposed Budget FY 2021 - 23:**	$ 1,740,591

Office of Family Affairs				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+

Service Category:	PEI: Access and Linkage to Treatment

Program Description

The mission of the Office of Family Affairs (OFA) is to empower family members and loved ones of mental health consumers with accessible education, support, and resource opportunities. The OFA assists families in navigating the behavioral health system through offering direct support, information, and education, with the goal of providing recovery and hope.

OFA operates at facilities that provide a more intensive level of care, and focuses on meeting the needs of family members of people with mental health issues through the following services:

- Individual Peer Support
- Family Support Groups
- Family WRAP 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

OFA also provides Mental Health First Aid (MHFA) trainings through an 8-hour course that prepares members of the public to provide MHFA to those in need. Modified budget by deleting unfilled, vacant positions, and actual client utilization.

Goals and Objectives

Outcome 1:	OFA provides consumers' families and loved ones with education and support to navigate the mental health system and support their loved one's recovery		
Number to be served FY 2021:	231	**Proposed Budget FY 2020 - 21:**	$ 773, 377
Cost per Person FY2021:	$ 3,348	**Total Proposed Budget FY 2021 - 23:**	$ 2,230,131

Re-Entry Services Team

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 15	☐Transitional Age Youth Ages 16 – 25	☒Adult Ages 26 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Access and Linkage to Treatment			

Program Description

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 linkage to: mental health outpatient services; alcohol and drug treatment and care; resources to the faith communities; peer mentoring; housing; general assistance benefits; health referrals; transitional case management; and a clothes closet. This overall assessment and wraparound services including custody health, mental health, probation, DADS, SSA, housing, and peer mentors.

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.

Goals and Objectives	
Outcome 1:	Collaborate with the justice involved adults and their families to support re-entry
Outcome 2:	Reduce stigma associated with mental health status among those in the CJS
Outcome 3:	Increase service connectedness to mental health resources among CJS individuals

Number to be served FY 2021:	500	**Proposed Budget FY 2020 - 21:**	$ 473,146
Cost per Person FY 2021:	$ 946	**Total Proposed Budget FY 2021-2023:**	$ 1,419,438

Older Adult System of Care (60 and older)

CSS: Full Service Partnership

Older Adult Full Service Partnership				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: Full Service Partnership (FSP)			

Program Description

The County's Older Adult Full Service Partnership (FSP) program provides intensive, wraparound services to individuals with serious mental illness in a low staff to consumer ratio (1:10) through a "whatever it takes" approach, to:

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

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

As with the Adult FSP program, County of Santa Clara 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.

County of Santa Clara 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:

3. 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;
4. Due to mental functional impairment and circumstances, they are likely to become so disabled as to require public assistance, services, or entitlements; and
5. They are in one of the following situations:
    - 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.

The services to be provided for each FSP consumer include the Full Spectrum of Community Services necessary to attain the goals identified in each person's Individual Services and Supports Plan (ISSP). The services to be provided may also include services that the County— in collaboration with the consumer and, when appropriate, the consumer's family— believe are necessary to address unforeseen circumstances in the consumer's life that could be, but have not yet been included in the ISSP. The Full Spectrum of Community Services that must be available for inclusion in a person's ISSP consists of the following:

- Mental health services and supports including, but not limited to:
    - Mental health treatment, including alternative and culturally specific treatments
    - Peer support
    - Supportive services to assist the consumer, and when appropriate the consumer's family, in obtaining and maintaining employment, housing, and/or education
    - Wellness centers
    - Alternative treatment and culturally specific treatment approaches.
    - Personal service coordination/case management to assist the consumer, and when appropriate the consumer's family, to access needed medical, educational, social, vocational rehabilitative and/or other community services

- Needs assessment
- ISSP development
- Crisis intervention/stabilization services
- Family education services

- Non-mental health services and supports including, but not limited to:
  - Food
  - Clothing
  - Housing, including, but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
  - Cost of health care treatment
  - Cost of treatment of co-occurring conditions, such as substance abuse
  - Respite care

Goals and Objectives	
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

Number to be served FY 2021:	100	**Proposed Budget FY 2020 - 21:**	$2,855,962
Cost per Person FY2021:	$28,559	**Total Proposed Budget FY 2021 - 23:**	$8,567,886

CSS: General System Development

Outpatient Clinical Services for Adults and Older Adults

Outpatient Services for Older Adults				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program 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. County of Santa Clara'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.

Outpatient Program:

Outpatient Service Programs (including what was formerly the Prevention and Early Intervention Outpatient Services program) provide assessment, counseling, and case management services. Service focuses on understanding of the unique combination of needs that older adults may face, including psychiatric, medical, life cycle, and social issues.

Specific services include:

- Assessment
- Treatment planning
- Brief crisis intervention
- Short and longer term counseling
- Case management
- Self-help and peer support
- Outreach and engagement activities

Consumers who were previously part of the Prevention and Early Intervention (PEI) Outpatient services are adults 60 and over who have presenting mental health needs, have been involved with the specialty mental health system for less than 12 months, and need a range of assessment and support services to address previously unmet needs.

Intensive Outpatient Program:

Intensive Outpatient Programs (IOPs) aim to improve quality of life for older adults while preventing the need for higher intensity care. IOPs provide long-term clinical care and case management to older adults, engaging consumers in mental health services, promoting recovery, and reducing the likelihood that higher levels of care (such as FSP) will be needed.

IOPs serve older adults who meet medical necessity for specialty mental health services and are eligible for Medi-Cal. IOPs focus on multidisciplinary, structured services for up to 4 hours per day, up to 5 days per week. IOPs are distinct from FSP in being generally office-based rather than community-based, and by engaging older adults consumers at a lower level of intensity and frequency than would an FSP. IOP services include:

- Counseling and therapy
- Case management services
- General rehabilitation
- Medication support

Golden Gateway Comprehensive Older Adult Program:

For older adults who may not be able to access outpatient clinical services, but do not meet the requirements for FSP, the Golden Gate Comprehensive Older Adult program includes two full-time clinicians who provide clinical services to older adults in their homes or out-of-home placements. The services provided are similar to that of the Outpatient Program but directed at isolated older adults who are homebound.

Goals and Objectives	
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		
Number to be served FY 2021:	1,120	**Proposed Budget FY 2020 - 21:**	$ 2,173,893
Cost per Person FY2021:	$ 1,940	**Total Proposed Budget FY 2021 - 23:**	$ 6,521,679

Older Adult Community Services Initiative

Clinical Case Management Team for Older Adults

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

The Clinical Case Management Team for Older Adults or Elder Health Community Treatment Services (EHCT) program seeks 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. The program will provide multicultural and responsive outpatient services including:

- Medication management
- Clinical support to meet a variety of mental health needs related to depression, PTSD, suicidality, crisis support, specialized refugee support, and dementia; including alternative and culturally specific treatments
- Health education for clients and families
- Social connectedness
- Housing and daily living resources

To increase usage and mitigate barriers to access, services and interventions will be provided in community locations such as individual residences, senior centers, community-based organizations, County clinics, and medical centers. Services will be delivered by Peer Navigators, Geriatric Pharmacists, Geriatric Nurses, and trained clinicians, all of whom will be linguistically and culturally reflective of their assigned populations.

- Peer Navigators conduct culturally appropriate and non-traditional outreach and engagement targeting clients and their families; engage with clients to create trusting relationships and assist with resource navigation; conduct presentations in communal locations; and build connections and relationships with stakeholders, gatekeepers, and key community organizations
- Geriatric Pharmacists assist with medication management
- Trained Clinicians provide therapy both in-home and at community-based provider locations
- Geriatric Nurses focus on the intersection of medical and behavioral health needs that affect older adults as they age

Adult community members will have various modes for access to program services, and can be referred by family members, community centers, County call centers, primary care physicians, psychiatrists, and more. A robust outreach and engagement program conducted by Peer Navigators will also create linkages and increase access. An Older Adult Committee will be established in target communities to shape engagement activities and ensure they are culturally and linguistically responsive.

Goals and Objectives

Outcome 1:	Older adults will experience increased recovery and improved quality of life
Outcome 2:	Participants will experience decreased perception of stigma associated with mental health challenges
Outcome 3:	BHSD's capacity to meet the needs of older adults will increase

Number to be served FY 2021:	100	**Proposed Budget FY 2020 - 21:**	$ 2,300,000
Cost per Person FY2021:	$ 23,000	**Total Proposed Budget FY 2021 - 23:**	$ 6,900,000

Connections Program

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General Systems Development			

Program 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.

APS, under the Social Services Agency (SSA), responds to calls regarding potential elder and dependent adult abuse and neglect. The Connections Program started as a pilot program in February 2012 to connect vulnerable older adults who come in to contact with APS with behavioral health services. 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.

When APS receives a call that may be appropriate for referral to the Connections Program, staff at APS alert the Connections program clinician. The Connections program clinician, along with APS staff and a Public Health Nurse,

provide coordinated consultation and assessment to the referred consumers. The Connections team provides phone and in-home follow-up for assessment, short-term case management, and linkages to County mental health services. The Connections program clinician specifically assesses for unmet behavioral health needs and possible connections to existing County services, while the APS staff focus on safety and risk assessment.

Goals and Objectives			
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		
Number to be served FY 2021:	275	**Proposed Budget FY 2020 - 21:**	$151,000
Cost per Person FY2021:	$549	**Total Proposed Budget FY 2021 - 23:**	$453,000

Outreach for Increasing Recognition of Early Signs of Mental Illness

Peer and Family Support Initiative

Older Adult In-Home Peer Respite Program				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Outreach for Increasing Recognition of Early Signs of Mental Illness			

Program Description

The Older Adult In-Home Peer Respite Program mobilizes peers from the community to provide free supportive counseling, visitation, and respite services. Peer respite providers offer companionship and supervision as well as peer counseling services for older adults who may be troubled by loneliness, depression, loss of loved ones, illness, or other concerns of aging. The program provides caregivers of older adults a break from caregiving while simultaneously providing older adult consumers with companionship and social support. The program serves adults aged 60 and older who live with a full-time caregiver. Services are voluntary, consumer-directed, and strengths-based. In-home respite care takes place in the home. Depending on the needs of the caregiver and the availability of the peer, in-home respite can occur on a regular or occasional basis and can take place during the day or evening hours.

This program addresses the specific need for peer services to support older adults and their caregivers. By providing psychosocial supports to consumers and respite supports to caregivers, the program assists older adults to live in the community for as long as reasonably possible and to age in place in their homes. Additionally, the respite support offered to caregivers will in turn reduce stress and mental health needs that may arise from providing ongoing caregiving.

Respite providers are overseen by BHSD staff and receive a standardized training and ongoing oversight and support from BHSD. Staff and peer providers are trained in wellness and recovery principles; strategies for addressing both immediate and long-term needs of program members; resources and ways to link consumers to other behavioral health services; and best practices in delivering services in a timely manner and with sensitivity to the cultural needs of those served. Respite provides will also coordinate with Older Adult In-Home Outreach team to provide opportunities for earlier interventions to avoid crisis situations for older adults, and to create more access to behavioral health services for those older adults displaying signs and symptoms of a serious mental health need.

The program will support outcomes of improved support and wellness for caregivers, increased service access and connection for older adults, and prolonged healthy and safe independent living by:

- Recruiting, screening, and coordinating all peer respite providers;
- Training peer counselors in mental health resources, signs of mental illness, and how to work with older adults experiencing mental illness;
- Visiting older adults in the home or community to provide companionship and social support;
- Coordinating with the In-Home Outreach Teams for immediate assessment and linkage to services and crisis response; and
- Referring and linking consumers to other community-based providers for other needed social services and primary care.

Goals and Objectives

Outcome 1:	Improve quality of life for caregivers of older adults who may experience stress and burnout putting consumers at risk of out of home placement
Outcome 2:	Promote the early identification of mental health symptoms in older adults
Outcome 3:	Increase wellness and social connection among older adults who live at home and may be isolated
Outcome 4:	Support Older Adults to live independently in the community for as long as reasonably possible, while ensuring their mental and physical wellbeing

Number to be served FY 2021:	200	**Proposed Budget FY 2020 - 21:**	$ 400,000
Cost per Person FY2021:	$ 2,000	**Total Proposed Budget FY 2021 - 23:**	$ 1,200,000

Elders' Storytelling Program

Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Early Intervention			

Program Description

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 slate to begin in Fiscal Year 2021.

Goals and Objectives			
Outcome 1:	Connect older adults to programs and services		
Outcome 2:	Decrease isolation for home-bound and monolingual older adults by creating community connections		
Outcome 3:	Decrease depressive symptoms and improve quality of life		
Number to be served FY 2021:	500	**Proposed Budget FY 2020 - 21:**	$ 400,000
Cost per Person FY2021:	$ 800	**Total Proposed Budget FY 2021 - 23:**	$1,200,000

Community Wide Initiatives

In addition to the direct service Prevention and Early Intervention (PEI) programs described in the systems of care, BHSD has planned the following programs to support outreach for increasing recognition of early signs of mental illness, access and linkage to treatment, stigma and discrimination reduction, and suicide prevention.

Overview of PEI Community Wide Programs

Initiative/ Program	Description	Status and Stakeholder Priority Addressed	FY21 Total Allocation/ Cost per Person
PEI: Outreach for increasing recognition of early signs of mental illness			
Community Wide Outreach and Training	An array of trainings to non-mental health professionals including community-based providers, community members, and caregivers who live and/or work in the County to expand the reach of individuals with knowledge and skills to respond to/ prevent a mental health crisis in the community, and to reduce the stigma associated with mental illness	**Continuing** **F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility** **AOA.1 Culture and diversity needs** **AOA.5 Improve adult/older adult workforce recruitment, training, and retention**	**$150,000** ***N=10,000*** ***$15 cost per person***
Law Enforcement Trainings	Trainings and collaboration through the Law Enforcement Liaison Team Program (LEL) that utilizes Interactive Video Stimulation Training (IVST) for increased recognition of mental health and de-escalation skill-building. Trauma-Informed Policing Trainings to increase understanding and awareness of the impact of trauma and develop trauma-informed responses	**Continuing** **F&C.4 Explore innovative outreach efforts** **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	**$304,244** ***N=1,500*** ***$203 cost per person***
PEI: Prevention			
Violence Prevention Program: Intimate Partner Violence Prevention	In partnership with communities and County Departments, redirecting attention to a growing community need regarding intimate partner violence.	**Continuing** **AOA.1 Culture and diversity needs** **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration**	**$449,020** ***N=300*** ***$1,497 cost per person***
Promotores	Culturally and linguistically targeted outreach within communities and neighborhoods to	**Continuing**	

	create enhanced linkages/referrals from and to nearby clinics to community services provided by Peer Health Educators	**F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility** **F&C.4 Explore innovative outreach efforts** **TAY.4 Increase workforce recruitment, education, and training from TAY communities** **AOA.1 Culture and diversity needs** **AOA.5 Improve adult/older adult workforce recruitment, training, and retention**	**$900,000** ***N=1,000*** ***$900 cost per person***
PEI: Stigma and Discrimination Reduction			
New Refugees Program	An array of outreach, engagement, and prevention activities treatment for new refugees	**Continuing** **F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility** **F&C.3 Expand school-related services and staffing** **F&C.4 Explore innovative outreach efforts** **AOA.1 Culture and diversity needs** **AOA.3 Assess points of coordination and collaboration**	***$691,043*** ***N=350*** ***$1,974 cost per person***
Cultural Communities Wellness Program, formerly known as Ethnic and Cultural Community Advisory Committees (ECCAC)	Peer support, outreach, engagement and educational services to underserved and unserved communities to reduce stigma and discrimination and increase access to mental health services	**F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility** **F&C.4 Explore innovative outreach efforts** **TAY.3 Develop services tailored to TAY-specific needs** **TAY.4 Increase workforce recruitment, education, and training from TAY communities** **AOA.1 Culture and diversity needs** **AOA.3 Assess points of coordination and collaboration** **AOA.5 Improve adult/older adult workforce recruitment, training, and retention**	***$1,850,000*** ***N=6,000*** ***$308 cost per person***
Culture Specific Wellness Centers	A variety of healing services, community engagement activities, and health education occurs specifically designed and implemented for specific cultural communities	**F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility**	***$1,454,769*** ***N=20,000*** ***$73 cost per person***

		F&C.4 Explore innovative outreach efforts **TAY.3 Develop services tailored to TAY-specific needs** **TAY.4 Increase workforce recruitment, education, and training from TAY communities** **AOA.1 Culture and diversity needs** **AOA.3 Assess points of coordination and collaboration** **AOA.5 Improve adult/older adult workforce recruitment, training, and retention**	
PEI: Access and Linkage to Treatment			
LGBTQ+ Access and Linkage and Technical Assistance	Connect LGBTQ individuals and their families in a timely manner to access appropriate mental health prevention and early intervention services. Expand LGBTQ+ across the system to build capacity for this cultural group. Additionally, the project will support youth and their families by integrating across the lifespan, a best practice model for training and technical assistance for families and providers to better serve, understand and support LGBTQ+ youth in our communities.	**F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility** **F&C.4 Explore innovative outreach efforts** **TAY.3 Develop services tailored to TAY-specific needs** **TAY.4 Increase workforce recruitment, education, and training from TAY communities** **AOA.1 Culture and diversity needs** **AOA.3 Assess points of coordination and collaboration** **AOA.5 Improve adult/older adult workforce recruitment, training, and retention**	***$649,500*** ***N=1,000*** ***$650 cost per person***
PEI: Suicide Prevention			
Suicide Prevention Strategic Plan	An array of programs and services for targeted high-risk populations, and a community education and information campaign to increase public awareness of suicide and suicide prevention	**F&C.1 Examine cultural responsiveness** **F&C.2 Increase accessibility** **F&C.3 Expand school-related services and staffing** **F&C.4 Explore innovative outreach efforts** **TAY.3 Develop services tailored to TAY-specific needs** **TAY.4 Increase workforce recruitment, education, and training from TAY communities**	***$1,900,636*** ***N=10,000*** ***$190 cost per person***

		AOA.1 Culture and diversity needs **AOA.2 Consider the need for a broader offering of post crisis intervention** **AOA.3 Assess points of coordination and collaboration** **AOA.5 Improve adult/older adult workforce recruitment, training, and retention**	

Prevention and Early Intervention

Prevention

Promotores				
Status:	☐New	☒Continuing		☐Modified
Priority Population:	☐Children Ages 0 – 5	☒ Transitional Age Youth Ages 16 – 24	☒ Adult Ages 24 – 59	☒ Older Adult Ages 60+
Service Category:	PEI: Prevention			
Program Description				
BHSD will be implementing *Promotores*, an evidence-based model that utilizes community-based, peer mental health workers to deliver mental health education and serve as connectors between consumers and providers to promote mental health among traditionally underserved populations. *Promotores* live in the communities where they work, share similar life experiences as the consumers they are trying to reach, and create relationships based on trust. Due to their rooted nature with the community, *Promotores* know the social networks and strengths of their communities and can leverage them to engage with hard-to-reach populations. The *Promotores* program will have a specific focus on adults and teens living within zip codes where significant need has been demonstrated. *Promotores* can play an important role in providing culturally relevant community health education, promotion, and referral efforts. Utilizing *Promotores* improves information dissemination to the community, specifically targeting engagement challenges arising because of mental illness stigma. The *Promotores* program will encompass training programs, build relationships among community groups, and identify clinics for bi-directional referrals. Appropriate candidates will be identified through community spaces such as churches, community-based organizations, and schools.				
Goals and Objectives				
Outcome 1:	Build *Promotores* capacity in neighborhoods to create linkages/referrals from and to nearby clinics to community for both adults and teens			

Outcome 2:	Reduce the barriers to health education and services that are common for native-born and immigrant communities		
Outcome 3:	Empower traditionally underserved/unserved communities to engage in mental health services as needed		
Number to be served FY 2021:	1,000	**Proposed Budget FY 2020 - 21:**	$ 900,000
Cost per Person FY 2021:	$ 900	**Total Proposed Budget FY 2021-23:**	$ 2,700,000

Outreach for increasing recognition of Early Signs of Mental Illness

Community Wide Outreach and Training				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Outreach for Reducing the Signs of Mental Illness			

Program Description

The Community Wide Outreach and Training program provides an array of trainings to non-mental health professionals including community-based providers, community members, and caregivers who live and/or work in the County. The purpose of these training programs is to expand the reach of individuals with knowledge and skills to respond to/ prevent a mental health crisis in the community, and to reduce the stigma associated with mental illness. This Training will include the following programs:

Applied Suicide Intervention Strategies Training (ASIST)

ASIST is a national suicide prevention training program for caregivers of individuals who are at risk of committing suicide. Over the course of a two-day training, caregivers learn how to recognize the risk and learn how to intervene to prevent the immediate risk of suicide.
(www.livingworks.net/programs/asist).

SafeTALK

SafeTALK is a three-hour training that prepares anyone over the age of 15 to identify people with thoughts of suicide and connect them to suicide first aid resources. SafeTALK curriculum emphasizes three main skills:

- How to move beyond common tendencies to miss, dismiss, or avoid suicide.
- How to identify people who have thoughts of suicide.
- Apply the TALK steps: Tell, Ask, Listen, and KeepSafe.

These steps will prepare someone to connect a person with thoughts of suicide to first aid and intervention caregivers.
(www.livingworks.net/programs/safetalk).

Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) Certifications

Both Mental Health First Aid and Youth Mental Health First Aid are eight-hour courses designed to teach individuals in the community how to help someone who is developing a mental health problem or experiencing a mental health crisis. Trainees are taught about signs and symptoms of mental illness— including anxiety, depression, psychosis, and substance abuse. Youth Mental Health First Aid is especially designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, providers, and other individuals how to help adolescents (ages 12 – 18) who are experiencing mental health or substance abuse problems, or who are in mental health crisis situations. The training covers mental health challenges for youth, offers information on adolescent development, and includes a 5-step action plan to help young people in both crisis and non-crisis situations.
(www.mentalhealthfirstaid.org).

QPR

QPR (Question—Persuade—Refer), is a 90-minute training designed to teach three simple steps anyone can learn to help save a life from suicide. QPR provides innovative, practical, and proven suicide prevention training that reduces suicidal behaviors by training individuals to serve as gatekeepers—those in a position to recognize a crisis and the warning signs that someone may be contemplating suicide. QPR will train anyone to be a gatekeeper—parents, friends, neighbors, teachers, ministers, doctors, nurses, office workers, caseworkers, firefighters—anyone who may be strategically positioned to recognize and refer someone at risk of suicide.
(https://www.qprinstitute.com/about-qpr).

Many of these trainings were previously part of separate initiatives and have been combined in this plan into one Community Wide strategy to organize all training for non-mental health professionals. Examples of services from the last plan include the following:

- PEI 1: ECCAC (WRAP, MHFA, YMHFA, QPR)
- Office of Family Affairs (WRAP, MHFA)
- PEI 5: Suicide Prevention (ASIST, SafeTALK, YMHFA, QPR, online QPR)

These trainings will support improved mental health education and early identification by:

- Training community and family members to recognize the signs of persons in need of mental health support
- Training community and family members to recognize the signs of persons who are at risk of suicide or of developing a mental illness
- Training and working with families and caregivers in order to develop plans and strategies that are tailored to their loved one's needs
- Training participants to address the specific needs of certain populations, including youth
- Offering trainings in multiple languages to ensure accessibility for all interested persons
- Offering trainings to an intentionally diverse group of community members, family members, and partners, to ensure that persons are trained across a variety of populations in order to meet the needs of those in crisis and non-crisis situations

• Promoting wellness, recovery, and resiliency			
Goals and Objectives			
Outcome 1:	Expand the reach of the mental health system through the training of individuals who have the knowledge and skills to respond to or prevent a mental health crisis in the community		
Outcome 2:	Expand the reach of mental health and suicide prevention services		
Outcome 3:	Reduce the risk of suicide through prevention and intervention trainings		
Outcome 4:	Promote the early identification of mental illness and of signs and symptoms of suicidal behavior		
Number to be served FY 2021:	10,000	**Proposed Budget FY 2020 - 21:**	$ 150,000
Cost per Person FY2021:	$ 15	**Total Proposed Budget FY 2021 - 23:**	$ 450,000

Law Enforcement Training and Mobile De-Escalation Response

Status:	☐New	☒Continuing		☐Modified
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Outreach for Reducing the Signs of Mental Illness			

Program Description

County of Santa Clara 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 County of Santa Clara, mental health professionals from BHSD provide specialized training to police officers through the LEL Team to improve their responses to a person with a mental health issue. The mission of the LEL Team is to build and enhance teamwork, training, discussion, and collaboration with law enforcement agencies throughout the County. The ultimate goal of the LEL Team is to provide police officers 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, mobile crisis staff travel to the individual's location and conduct a mental health assessment to determine which additional services or treatment will most appropriately 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 transport people experiencing crisis to Emergency Psychiatric Services (EPS) or Mental Health Urgent Care (MHUC) as needed. The mobile crisis team may also place 5150 holds. Mobile crisis staff are co-located with MHUC and are trained to meet the specific needs of youth, adults, and older adults.

Goals and Objectives	
Outcome 1:	Increase collaboration and enhance teamwork between law enforcement and Behavioral Health Care Services
Outcome 2:	Increase the ability of law enforcement to interact more effectively and safely with those experiencing a mental health related crisis
Outcome 3:	Connect individuals experiencing mental health crisis to appropriate services

Number to be served FY 2021:	1,500	**Proposed Budget FY 2020 - 21:**	$304,244
Cost per Person FY 2021:	$ 203	**Total Proposed Budget FY 2021 - 23:**	$912,732

Stigma and Discrimination Reduction

New Refugees Program				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☒Adult Ages 26 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Stigma and Discrimination Reduction			
Program Description				

The New Refugee Program's early intervention services aim to reduce stigma and increase awareness of available mental health services for newly arrived refugees and intervene at the early signs of mental health issues. The program provides linguistically and culturally appropriate outreach, engagement, and prevention activities to help refugees successfully settle in the County. *One modification of this program will be that the New Refugee program will begin to allow services to children and will serve refugee clients who have lived in the County for seven years or less (instead of five).*

The New Refugee program is responsible for bringing together multiple community partners who serve the refugee population. The program fosters collaboration and coordinates a system of referrals, providing and organizing numerous culturally and linguistically appropriate outreach activities and mental health services. Outreach mostly occurs in the refugee's native language, with videos of the refugees' compatriots. Understandably, refugees often distrust government/authority figures, and many have endured public scorn, intense discrimination, and threatening behavior based on their ethnicity or religion. Refugee clients are provided with responsive engagement and intervention services, up to and including torture survivor support services. Additionally, refugee clients are connected to other specialty mental health services that may help them live and thrive in the County.

Goals and Objectives			
Outcome 1:	Identify newly settled refugees and increase connectedness to mental health services		
Outcome 2:	Increase collaboration among community partners who serve refugee clients		
Number to be served FY 2021:	350	**Proposed Budget FY 2020 - 21:**	$691,043
Cost per Person FY 2021:	$1,974	**Total Proposed Budget FY 2021-2023:**	$2,073,129

Cultural Communities Wellness Program

formerly known as Ethnic and Cultural Communities Advisory Committees (ECCACs)

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☒Adult Ages 26 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Stigma and Discrimination Reduction			

Program Description

The Cultural Communities Wellness Program (formerly known as Ethnic and Cultural Community Advisory Committees or ECCAC) utilize the unique experiences and knowledge of culturally and ethnically diverse community members in support of mental health. ECCACs envision communities where consumers and family members from all cultures have quality of life, are free from stigmas associated with mental health status, and are empowered to move within mental health systems. ECCACs aim to increase knowledge of mental illness,

reduce stigma and discrimination within the context of culture, and increase community prevention and healing capacity through natural support systems.

County of Santa Clara's ECCACs serve nine specific ethnic/culture groups: African Heritage, African Immigrant, Chinese, Filipino, Latino, Native American, Vietnamese, LGBTQ+, and Veterans. The ECCACs activities are categorized into three main components:

- **Community Outreach and Engagement** involving site outreach, community events, mental health workshops and presentations, support groups, and one-on-one peer support services
- **Mental Health Literacy Campaign** providing Mental Health First Aid (MHFA), Question Persuade, and Refer (QPR), and Wellness Recovery Action Plan (WRAP) trainings
- **Culture-Specific Programs** collaborating with community agencies to organize events targeting underserved ethnic communities

ECCAC staff are multicultural and multilingual, representing at least 10 cultural communities and speaking at least 12 languages. The intent of ECCACs is to break down cultural barriers to seeking mental healthcare, decrease stigma and discrimination, and act as cultural ambassadors to community members in need of services.

Goals and Objectives

Outcome 1:	Collaborate with un-, under-, and inappropriately served ethnic groups
Outcome 2:	Reduce stigma associated with mental health status
Outcome 3:	Increase service connectedness to mental health resources

Number to be served FY 2021:	6,000	**Proposed Budget FY 2020 - 21:**	$1,850,000
Cost per Person FY 2021:	$308	**Total Proposed Budget FY 2021-2023:**	$5,550,000

LGBTQ+ Access and Linkage

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☒Adult Ages 26 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Access and Linkage to Treatment			

Program Description

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

The goal is to connect LGBTQ individuals and their families in a timely manner to access appropriate mental health prevention and early intervention services.

Expand LGBTQ+ across the system to build capacity for this cultural group.

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

Goals and Objectives

Outcome 1:	Collaborate with the LGBTQ+ community
Outcome 2:	Reduce stigma associated with mental health status among LGBTQ+ individuals
Outcome 3:	Increase service connectedness to mental health resources among LGBTQ+ individuals
Outcome 4:	Increase public and provider competence supporting young people in LGBTQ+community

Number to be served FY 2021:	1,000	**Proposed Budget FY 2020 - 21:**	$ 649,500
Cost per Person FY 2021:	$ 650	**Total Proposed Budget FY 2021-2023:**	$ 1,948,500

Violence Prevention Program & Intimate Partner Violence Prevention

Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☐Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☒Adult Ages 26 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Prevention			

Program Description

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. We need your help to spread awareness about dating abuse and to let everyone know that they deserve a safe and healthy relationship.

Additional to support Intimate Partner violence prevention program will focus on

1. Healthy Relationships (Intimate Partner Violence Prevention): a program of the Public Health Department 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 would 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 the work, BHSD will partner with County's Office of Women's Policy to better address an alarming growing trend on intimate partner violence. Intimate partner violence (IPV) is 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.

Goals and Objectives

Outcome 1:	Increase knowledge about safe and healthy relationship skills		
Outcome 2:	Disrupt the developmental pathways toward partner violence		
Outcome 3:	Support survivors to increase safety and lessen harms		
Number to be served FY 2021:	300	**Proposed Budget FY 2020 - 21:**	$ 449,020
Cost per Person FY 2021:	$1,497	**Total Proposed Budget FY 2021-2023:**	$1,347,060

Culture-Specific Wellness Centers

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☒Adult Ages 26 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Improve Timely Access to Services for Underserved Populations			

Program Description

Culture-Specific Wellness Centers offer space for un-, under-, and inappropriately served groups to gather and participate in community caregiving and healing. Wellness Centers are designed specifically for Latino, African American, LBGTQ+, Asian/Pacific Islander, and Native American populations and communities. Wellness Centers offer low-barrier access to mental health services, community building and culture-specific practices, and other recovery-oriented activities. Understanding that some populations have historically faced discrimination from government 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.

Wellness Centers are culture-specific, embracing healing practices that may not necessarily be a part of un-, under-, and inappropriately served communities. Activities may include addressing trauma related to immigration, family disruptions in LGBTQ+ communities, and healing circles. There are age-specific activities for youth, adults, and older adults. Additionally, opportunities for intergenerational sharing are encouraged. Wellness Centers recognize that a different kind of healing may occur when different age groups come together to talk about stress, trauma, and self-care. This project is expected to launch on Fiscal Year 2021.

Goals and Objectives

Outcome 1:	Provide un-, under-, and inappropriately served groups space for community caregiving		
Outcome 2:	Organize age-specific and intergenerational activities		
Outcome 3:	Encourage culture-specific forms of healing		
Number to be served FY 2021:	20,000	**Proposed Budget FY 2020 - 21:**	$ 1,454,769

Cost per Person FY 2021:	$ 73	**Total Proposed Budget FY 2021-2023:**	$ 4,364,307

Suicide Prevention

Suicide Prevention Strategic Plan and SACS				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 15	☒Transitional Age Youth Ages 16 – 25	☒Adult Ages 26 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Suicide Prevention			

Program Description

The Suicide Prevention Strategic Plan (SPSP) aims to increase suicide prevention for everyone. Through early intervention, education, and awareness, this plan seeks to reduce risk of suicide among all age groups in the County. The plan consists of five distinct but related strategies:

- Implementation and coordination of **suicide intervention programs and services** for targeted high-risk populations
- Implementation of a **community education and information campaign** to increase public awareness of suicide and suicide prevention
- Development of **local communication "best practices"** to improve media coverage and public dialogue related to suicide
- Implementation of **policy and governance advocacy** to promote systems change in suicide awareness and prevention
- Establishment of a robust **data collection and monitoring system** to increase the scope and availability of suicide-related data and evaluation of suicide prevention efforts

This plan aims to provide 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 work groups.

Goals and Objectives

Outcome 1:	Reduce cases and rates of suicide
Outcome 2:	Increase access to suicide prevention programs
Outcome 3:	Improve communication channels for suicide awareness
Outcome 4:	Improve data monitoring systems for suicide-related data

Number to be served FY 2021:	10,000	**Proposed Budget FY 2020 - 21:**	$ 1,900,636
Cost per Person FY 2021:	$ 190	**Total Proposed Budget FY 2021-2023:**	$ 5,701,908

Learning Partnership

Decision Support, Research and Evaluation (Learning Partnership)		
Status:	☐New	☒Continuing
Program Description		
The BHSD Learning Partnership is comprised of three areas: Decision Support (data gathering and evaluation) , Cultural Competency (ensures the cultural needs of the County's ethnic and racial populations are met by the Department), and Continuous Learning (staff development, consumer and family services and workforce education and training). These three units work collaboratively to support the BHSD System, including the county, contract providers and community partners to strengthen the entire system and promote wellness and recovery in each of these areas. This program is a carve out of Community Services and Supports and it is categorized in the MHSA Administration section.		

Proposed Budget FY 2020 - 21:	$ 2,194,165	**Total Proposed Budget FY 2021 - 23:**	$ 6,582,495

Workforce Education and Training (WET)

Workforce Education and Training Coordination		
Status:	☐New	☒Continuing
Program Description		
The original WET allocation, a one-time funding source that accompanied the passage of Proposition 63 was exhausted in June 2016. County of Santa Clara has allocated funding to WET as a carve out of its CSS funding. The mission of the MHSA WET is to address community-based occupational 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 following are the activities of WET: 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. 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.		

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.

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.

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.

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 County of Santa Clara BHSD seeks to serve.

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.

Based on MHSA stakeholder feedback, the WET Program will collaborate with community partners to develop a TAY Workforce Plan to increase youth representation in the workforce. The intent will be to increase the engagement of youth, including youth with lived experience, through proactive actions to address barriers and engage high school and college students in county behavioral health (e.g., scholarships, stipends, outreach to students of color, outreach at university events). The goals of the Workforce Education and Training (WET) have been:

- To have a workforce that is fully integrated and reflective of the cultural and ethnic diversity of consumers and family members at all levels of the workforce, including employees, interns, and volunteers;
- To provide employment opportunities and integrated support mechanisms throughout the system to enhance employment and retention of consumers and family members;
- To enhance staff training and develop opportunities and career pathways for county and community based organization (CBO) staff, including management development opportunities;
- To provide training and educational opportunities in the mental health system, with local educational institutions and the community at large.

The MHSA Planning team will work with community stakeholders to revisit the priority areas under WET and to align with the new 5 year plan developed by the Office of Statewide Health Planning and Development (OSHPD) as part of the regional partnership agreement with Bay Area counties. This will be reflected in the FY2022 MHSA Annual Plan Update to commence this Summer-Fall 2020.

Budget

Proposed Budget FY 2020 - 21:	$3,129,104	**Total Proposed Budget FY 2021 - 23:**	$9,387,312

Capital Facilities and Technological Needs

General Feasibility for Acquisitions and HealthLink Maintenance		
Status:	☐New	☒Continuing

Program Description

BHSD believes in producing long-term impact with lasting benefits that move the mental health system towards the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families which promote reduction in disparities to underserved groups. The following efforts include development of a variety of technology uses and strategies as well as potential purchase or upgrades to community-based facilities which support integrated service experiences that are culturally and linguistically appropriate and that are county operate.

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. Staffing costs for this effort will utilize $1,241,566 annually during Fiscal Years 2021-2023.
2. **Adult Residential Treatment Facilities:** Estimated costs associated with the potential purchase of facilities to house the approved Adult Residential Treatment (ARTs) Program for treatment of adults with serious mental illness. Procurement resulted in a lack of qualified proposal submissions.

These items are funded through CSS, 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.

Budget

Proposed Budget FY 2020 - 21:	$ 1,241,566	**Total Proposed Budget FY 2021 - 23:**	$ 3,724,698

Innovation

Approved Programs in the Implementation Phase

Client and Consumer Employment				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	INN			

Program Description

The Client and Consumer Employment project aims to transform how the overall system views employment and promoting employment as a wellness goal for consumers. This project builds on the premise that having a job contributes to a person's overall sense of well-being and can be a significant contributor toward achieving and maintaining recovery from mental illness. Employment also can promote stability and help consumers develop tools for managing life circumstances. The Client and Consumer Project was approved by MHSOAC on November 16, 2017 and this program is in full implementation.

To leverage employment as a means of achieving stability and improving recovery outcomes, this project adapts the evidence-based Individual Placement & Support Supported Employment (IPS/SE) model, a widely-researched practice developed to significantly increase employment outcomes.[7] IPS/SE employment helps people with serious mental illness work at regular jobs of their choosing. Until the development of the IPS/SE model, there were no alternatives to the traditional delivery of employment supports specifically targeted for people with serious mental illness. It is an evidenced-based practice with practitioners focusing on each person's strengths. IPS/SE works in collaboration with state rehabilitation counselors and uses a multi-disciplinary team approach. Services are designed to be individualized and long lasting. Long-term studies show that 49% of IPS/SE consumers maintained employment, compared to 11% of those receiving traditional employment services. The IPS/SE model will enhance employment-based programming for individuals with serious mental illness by including employment among their treatment goals. The Dartmouth Psychiatric Research Center (2014) provides the following eight IPS/SE practice principles:

- **Focus on Competitive Employment:** Agencies providing IPS/SE services are committed to competitive employment as an attainable goal for people with serious mental illness seeking employment

[7] Bonds, G. (2016). Evidence for the Effectiveness of Individual Placement and Support Model of Supported Employment [PowerPoint slides]. Retrieved from https://www.ipsworks.org/wp- content/uploads/2016/08/16-ips-evidence-7-28-16-rev.pptx

- **Eligibility Based on Client Choice:** People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement
- **Integration of Rehabilitation and Mental Health Services:** IPS/SE programs are closely integrated with mental health treatment teams
- **Attention to Worker Preferences:** Services are based on each person's preferences and choices, rather than on providers' judgments
- **Personalized Benefits Counseling**: Employment specialists help individuals to obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements
- **Rapid Job Search:** IPS/SE programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counseling
- **Systematic Job Development:** Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences
- **Time-Unlimited and Individualized Support:** Job supports are individualized and continue for as long as each worker wants and needs the support

Goals and Objectives

Outcome 1:	This project supports consumers with serious mental illness in developing employment recovery goals and achieving those goals

Number to be served FY 2021:	150	**Proposed Budget FY 2020 - 21:**	$ 818,432
Cost per Person FY 2017-18:	$ 5,456	**Total Proposed Budget FY 2021 - 23:**	$1,644,578

Faith-Based Training and Supports Project

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	INN			

Program Description

This two-year project aims to increase access to faith-based services through the development of customized behavioral health training plans for faith/spiritual leaders, enhancing their knowledge, skills and responses to individuals seeking their help. In turn, faith/spiritual leaders will enhance behavioral health services providers' understanding of the role of spirituality in client/consumer wellness and recovery goals. Project was approved by MHSOAC on November 16, 2017 and this program is in full implementation.

The project seeks to achieve the following measurable objectives:

1. Reduce stigma associated with mental illness treatment;
2. Educate faith/spiritual community leaders on behavioral health;
3. Decrease stigma among faith/spiritual communities by normalizing help seeking behaviors, and provide timely access and referrals to behavioral health services;
4. Increase access to and knowledge of mental health and substance use treatment services;
5. Increase access to underserved groups;
6. Increase natural networks of supportive relationships; and
7. Increase a faith/spirituality-informed approach to treatment among behavioral health direct care providers.

A service contract has been executed with NAMI Santa Clara County and an evaluator has been secured. NAMI is in full implementation of this project. NAMI has been conducting focus groups with faith-based ethnic communities to assess priorities and barriers around mental health stigma. Curricula is being developed and piloted in various faith communities.

Goals and Objectives

Outcome 1:	Improve faith/spiritual community leaders' knowledge, attitude, and behavior in the identification, support, and referral of clients with behavioral health and/or substance use issues
Outcome 2:	Effectively train faith/spiritual community leaders to identify behavioral health issues presented by their community members in order to help increase access to mental health and substance use treatment services;
Outcome 3:	Implement strategies that promote the reduction of stigma among faith/spiritual communities participating in the faith-based trainings
Outcome 4:	Improve the mental health status of clients receiving treatment using faith/spirituality-informed recovery plans and interventions.

Number to be served FY 2021:	200	**Proposed Budget FY 2020 - 21:**	$ 308,551
Cost per Person FY 2017-18:	$ 1,541	**Total Proposed Budget FY 2021 - 23:**	$ 308,551

Psychiatric Emergency Response Team (PERT) and Peer Linkage

Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	INN			

Program Description

The Psychiatric Emergency Response Team (PERT) and Peer Linkage project are designed to reduce utilization of EPS and acute psychiatric hospitalization services for County of Santa Clara residents experiencing acute mental health crises. The PERT model is a co-response crisis intervention model

staffed by a licensed mental health clinician paired with a law enforcement officer. The PERT model was initially implemented in San Diego County and has demonstrated that it is an effective community-based crisis intervention program. The innovative aspect of this project is that it adapts the PERT model to County of Santa Clara and integrates a Peer Linkage component for peer support post-crisis services. The intent of the PERT and Peer Linkage project is to provide immediate behavioral health assessment and service referrals to ensure that individuals are referred to community-based treatment as appropriate. The project also connects individuals to peer support services post-crisis to support their recovery and prevent future suicide attempts.[8] A study conducted by the Centers for Disease Control and Prevention found that 62% of suicide deaths in County of Santa Clara between 2005 and 2015 were among individuals aged 20 – 24.[1] This finding points to the County's need crisis services specifically for individuals ages 18-25. By linking individuals ages 18-25 to rapid connection to behavioral health services coupled with peer support services post-crisis, the PERT and Peer Linkage increase access to services and decrease future suicide attempts.

The PERT and Peer Linkage project is also piloting two County-operated PERT Teams in the initial six months of the project: Palo Alto, CA, partnering with the City of Palo Alto Police Department and County of Santa Clara Sheriff's Office. After the initial six months, the project will assess preliminary results for rollout and adjust as needed and rollout. Two additional PERT teams in other local jurisdictions are focused on the central area of the County. PERT Teams are comprised of one law enforcement officer and one behavioral health clinician. At the start of the project, the PERT team staff are trained on the PERT model, CIT Training, and other related BHSD law enforcement training. Hours of operation are from 11:00 AM to 11:00 PM. The PERT Project was approved by MHSOAC on November 16, 2017 and the County is preparing for implementation.

Goals and Objectives	
Outcome 1:	Increase access to services for Transition Age Youth experiencing mental health crisis.
Outcome 2:	Improve outcomes for youth participating in peer linkage project as a result of increased help-seeking behavior
Outcome 3:	Comparison analysis with existing stand-alone CIT efforts with PERT model to demonstrate benefits of a combined approach
Outcome 4:	Improve law enforcement attitudes and abilities to safely respond to mental health related calls, link people to mental health services, and to some degree reduce the number of persons with mental illnesses entering the front door of the criminal justice system

Number to be served FY 2021:	1000	**Proposed Budget FY 2020 - 21:**	$ 1,572,043
Cost per Person FY 2017-18:	$ 1,572	**Total Proposed Budget FY 2021 - 23:**	$ 1,572,043

[8] U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (2011). The Evidence: Consumer-Operated Services. Retrieved from http://store.samhsa.gov /shin/ content/ /SMA11-4633CD-DVD/TheEvidence-COSP .pdf

***Allcove* Implementation Project**				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	INN			

Program Description

The ***Allcove*** Innovation project is a framework of mental health services for youth ages 12-25 that provides equitable access regardless of ability to pay or type of healthcare coverage for in a "one-stop shop" setting. ***Allcove*** centers provide integrated health and mental health care, on-site psychiatric services, alcohol and drug treatment, education, and employment services to meet the overlapping needs of youth with mental health issues. Co-locating services distinguishes headspace from other youth mental health care models, assists providers in identifying early warning signs of mental health issues and suicide risk, and provides more effective primary health care. There are two ***Allcove*** centers located in the intended service areas of Central San Jose and North County (Palo Alto/Mountain View).

The ***Allcove*** treatment model was developed in Australia (known as ***headspace***) and is designed to create an innovative culture of youth health that reduces the burden of mental illness through early detection and treatment. County of Santa Clara partnered with the Stanford Psychiatry Center for Youth Mental Health and Wellbeing to conduct a feasibility study for introducing the ***Allcove*** model in the U.S. and to design a framework to ramp up ***Allcove*** implementation. The County first launched its ramp up phase with implementation phase beginning July 1, 2020. During the ramp up phase, the County designed a framework to adapt and implement ***Allcove*** in County of Santa Clara. BHSD and Stanford Psychiatry Center on Youth Mental Health and Wellbeing developed the framework with input from two youth advisory groups with a total of 24 members who live in the service areas. The ***Allcove*** framework addresses issues related to the multi-service components of the two centers, as well as the need for a public/private insurance structure to support all youth regardless of their insurance coverage. During the implementation phase, it is estimated that 1,000 youth will seek services and supports from each of the two ***Allcove*** centers annually. Services at headspace centers will be culturally responsive and consider the needs of youth of different ages, gender identities, race, ethnicity, sexual orientation, and languages. The centers will also use a coordinated care approach that will welcome all youth and support their needs while limiting interruptions to care.

Goals and Objectives

Outcome 1:	***Allcove*** increases youth connection to needed mental health services and provides support during the early stages of mental health issues.

Number to be served FY 2021:	1,000	**Proposed Budget FY 2020 - 21:**	$ 3,762,320
Cost per Person FY 2017-18:	$ 3,762	**Total Proposed Budget FY 2021 - 23:**	$ 10,652,986

Independent Living Facilities Project				
Status:	☒New	☐Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	Innovations			

Program Description

There is an urgent need for housing for County of Santa Clara´s individuals who are disabled, homeless, and at-risk of homelessness. Licensed board and care and independent living facilities, also referred to as "room and boards," provide critically needed housing and services for this population including persons with serious mental illness. This need was expressed by stakeholders during the FY21-23 MHSA Community Program Planning process and during FY19 MHSA Annual Plan Update. Increasing numbers of licensed board and care facilities in County of Santa Clara have shut down resulting in higher numbers of the most vulnerable individuals being routed into independent living homes. Some licensed board and cares transitioned to independent living or operate "under the radar" as unlicensed board and cares to avoid the fees, required training, and oversight required by Community Care Licensing. Operators of independent living facilities often do not understand or follow existing laws and regulations related to the operation of their type of housing. Without adequate support, both licensed board and cares and independent livings are not able to address the needs of residents in crisis which frequently results in evictions, hospitalizations, or incarceration. BHSD, in partnership with the Community Living Coalition, will create residential facility oversight 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 Project will 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.

Key components of the plan to improve the quality of independent living facilities in County of Santa Clara include:

- Create a system of oversight, support, coordination and ongoing quality improvement for independent living facilities;
- Assess Independent Living Facilities and offer owners assistance to improve the quality of the facility to meet the evidence-based quality standards for living facilities.

BHSD, in partnership with the Community Living Coalition, will participate in the search of independent living experts/vendors to help guide the project to establish the foundation work to achieve the following core activities:

1) Establish a Community Living Coalition Steering Committee;
2) Create residential facility oversight to support CLC operators and residents with comprehensive Independent Living Facilities Project information and resources;
3) Develop a directory and website with high-quality information about licensed board and care and independent living options for consumers, family members, and community members;
4) Engage peer providers and consumers and ensure their participation at all levels of Independent Living Project, including management, steering committee leadership, training, site reviews, ethnic community outreach and support, data analysis/program evaluation;
5) Design and implement education and training plans for operators, residents, and community members;
6) Build a Peer Review and Accountability Team (PRAT) to conduct initial and ongoing visits/inspections and oversee quality standards;
7) Develop a policy and education agenda to bring awareness to issues with licensed board and care and independent living facilities and the unique issues of residents;
8) Conduct a comprehensive data and evaluation/return on investment analysis to assess program goals and impact.

It is expected that the first year will be foundational with maintenance work during the following years. The Department will seek approval from the Mental Health Oversight and Accountability Commission (MHSOAC) following Board of Supervisor approval. The Department will prioritize release of Request for Proposal (RFP) during FY 2021 following MHSAOC approval for use of INN funds.

Goals and Objectives	
Outcome 1:	Create a system of oversight, support, coordination, and ongoing quality improvement for independent living facilities and licensed board and care (with Community Care Licensing).
Outcome 2:	Improve the quality of life for independent living facility and licensed board and care residents by improving quality standards, providing peer support services, and preserving and improving the quality of homes.
Outcome 3:	Increase the availability of quality housing stock for extremely low-income seniors and persons with disabilities in County of Santa Clara.
Outcome 4:	Reduce the number of people experiencing homelessness and prolonged institutionalization due to declines in quality living environments for extremely low-income residents

Number to be served FY 2021:	TBD	**Proposed Budget FY 2020 - 21:**	TBD
Cost per Person FY 2021:	TBD	**Total Proposed Budget FY 2021 - 23:**	$990,000

MHSA Three-Year Expenditure Plan

The documents enclosed in the following section are submitted in compliance with the Mental Health Services Oversight and Accountability Commission's (MHSOAC) *FY 21 Through FY 23MHSA Three-Year Program and Expenditure Plan Submittals* (www.mhsoac.ca.gov) instructions for documenting the expenditure of the proposed MHSA programs.

(State Fiscal forms here individually for each year FY21 (final), FY22 (plan update to commence in July 2020) and FY23 (plan update to commence in July 2021).

Note: mid-year fiscal updates are allowed if done by December of that year).

FY 2020-21 Through FY2022-23 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Santa Clara Date: 5/29/20

	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 2020/21 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	33,270,955	18,788,323	17,205,372	0	6,931,096	
2. Estimated New FY2020/21 Funding	77,201,068	19,300,267	5,079,018			
3. Transfer in FY2020/21[a/]	(3,129,104)			3,129,104		
4. Access Local Prudent Reserve in FY2020/21						0
5. Estimated Available Funding for FY2020/21	107,342,919	38,088,590	22,284,389	3,129,104	6,931,096	
B. Estimated FY2020/21 MHSA Expenditures	83,773,828	25,889,255	8,087,736	3,129,104	5,241,566	
C. Estimated FY 2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	23,569,091	12,199,336	14,196,653	0	1,689,530	
2. Estimated New FY2021/22 Funding	78,248,204	19,562,051	5,147,908			
3. Transfer in FY2021/22[a/]	(6,681,140)			3,129,104	3,552,036	
4. Access Local Prudent Reserve in FY2021/22						0
5. Estimated Available Funding for FY2021/22	95,136,154	31,761,387	19,344,562	3,129,104	5,241,566	
D. Estimated FY2021/22 MHSA Expenditures	83,773,828	25,889,255	6,267,067	3,129,104	5,241,566	
E. Estimated FY 2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	11,362,326	5,872,132	13,077,495	0	0	
2. Estimated New FY2022/23 Funding	80,138,540	20,034,635	5,272,272			
3. Transfer in FY2022/23[a/]	(4,370,670)			3,129,104	1,241,566	
4. Access Local Prudent Reserve in FY2022/23						0
5. Estimated Available Funding for FY2022/23	87,130,197	25,906,767	18,349,767	3,129,104	1,241,566	
F. Estimated FY2022/23 MHSA Expenditures	83,773,828	25,889,255	4,702,585	3,129,104	1,241,566	
G. Estimated FY2022/23 Unspent Fund Balance	3,356,368	17,512	13,647,182	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2020	18,703,637
2. Contributions to the Local Prudent Reserve in FY 2020/21	0
3. Distributions from the Local Prudent Reserve in FY 2020/21	0
4. Estimated Local Prudent Reserve Balance on June 30, 2021	18,703,637
5. Contributions to the Local Prudent Reserve in FY 2021/22	0
6. Distributions from the Local Prudent Reserve in FY 2021/22	0
7. Estimated Local Prudent Reserve Balance on June 30, 2022	18,703,637
8. Contributions to the Local Prudent Reserve in FY 2022/23	0
9. Distributions from the Local Prudent Reserve in FY 2022/23	0
10. Estimated Local Prudent Reserve Balance on June 30, 2023	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 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Clara Date: 5/29/20

	Fiscal Year 2020/21					
	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	8,969,861	2,302,232	3,553,481		3,114,149	
2. T01 Transitional Age Youth FSP	9,318,410	2,146,071	3,923,420		3,248,918	
3. A01 Adult Full Service Partnership	9,311,071	4,750,265	4,560,806			
4. A03 Criminal Justice FSP	3,953,178	1,336,236	2,616,942			
5. A03 Forensic Assertive Community Treatment	5,251,874	3,450,504	1,801,370			
6. OA01 Older Adult Full Service Partnership	2,855,962	1,720,820	1,135,142			
7. A02 Assertive Community Treatment	7,017,696	4,464,572	2,553,124			
8. A02 Crisis Stabilization Unit and Crisis Residential Treatment	9,699,033	4,333,648	5,365,385			
9. A03 Criminal Justice Residential and Outpatient Treatment Programs	3,173,654	3,173,654				
10. A04 Mental Health Urgent Care	1,716,229	490,351	1,225,878			
11. C02 Children's (Uplift) Mobile Crisis	471,890	330,323	141,567			
12. HO01 Permanent Supportive Housing	4,380,990	3,439,303	917,687			24,000
Non-FSP Programs						
1. C03 Children & Family Behavioral Health Outpatient/IOP Services	36,131,734	5,990,686	18,042,011		12,099,037	
2. Specialty Services- Eating Disorders --- Child/Adult/Other combined	1,400,000	1,400,000				
3. C02 Specialty Services - Integrated MH/SUD	992,200	496,100	496,100			
4. C03 Foster Care Development	1,246,596	812,617	433,979			
5. A02 Community Placement Team Services and IMD Alternative Program	5,337,635	5,337,635				
6. C02 Children's (Uplift) Mobile Crisis	314,594	220,216	94,378			
8. T02-04 TAY Outpatient Services	1,861,321	712,706	927,793		220,822	
9. Intensive Outpatient Program (IOP)	539,822	539,822				
10. C03 Independent Living Program (ILP)	55,707	20,252	35,455			
11. C02 CSEC Program	886,649	886,649				
12. C03 Services for Juvenile Justice Involved Youth	3,273,457	1,756,298	874,446		217,779	424,934
13. T02-04 TAY Triage to Support Reentry	1,648,813	898,813	750,000			
14. T02-04 TAY Crisis and Drop In Center	539,822	539,822				
15. T02-04 TAY Interdisciplinary Service Teams	1,500,000	750,000	750,000			
16. A02/A04 County Clinics	9,057,352	3,556,692	5,110,339			390,321
17. A02 Hope Services: Integrated Mental Health and Autism Services	547,988	399,492	148,496			
18. A02 CalWORKs Community Health Alliance	2,610,386	1,223,206	705,340			681,840
19. A03 Criminal Justice Residential and Outpatient Treatment Programs	4,238,111	4,238,111				
20. A03 Criminal Justice Outpatient Services	1,724,820	871,410	853,410			
21. A03 Faith Based Resource Centers	1,848,688	450,000				1,398,688
22. A04 Mental Health Urgent Care	2,370,030	1,144,152	1,225,878			
23. A02 Crisis Stabilization Unit and Crisis Residential Treatment	20,100,396	8,586,448	11,513,948			
24. A02 Adult Residential Treatment	3,099,398	1,424,048	1,675,350			
25. OA02-04 In-Home Outreach Teams	2,260,000	2,260,000				
26. OA02-04 Outpatient Services for Older Adults	2,173,893	1,840,308	333,585			
27. OA02-04 Clinical Case Management for Older Adults	2,300,000	1,150,000	1,150,000			
28. OA02-04 Connections Program	151,000	151,000				
29. LP01 Learning Partnership	2,194,165	2,194,165				
CSS Administration	1,985,202	1,985,202				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	178,509,625	83,773,828	72,915,309	0	18,900,705	2,919,783
FSP Programs as Percent of Total	78.9%					

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Clara Date: 5/29/20

	Fiscal Year 2021/22					
	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	8,969,861	2,302,232	3,553,481		3,114,149	
2. T01 Transitional Age Youth FSP	9,318,410	2,146,071	3,923,420		3,248,918	
3. A01 Adult Full Service Partnership	9,311,071	4,750,265	4,560,806			
4. A03 Criminal Justice FSP	3,953,178	1,336,236	2,616,942			
5. A03 Forensic Assertive Community Treatment	5,251,874	3,450,504	1,801,370			
6. OA01 Older Adult Full Service Partnership	2,855,962	1,720,820	1,135,142			
7. A02 Assertive Community Treatment	7,017,696	4,464,572	2,553,124			
8. A02 Crisis Stabilization Unit and Crisis Residential Treatment	9,699,033	4,333,648	5,365,385			
9. A03 Criminal Justice Residential and Outpatient Treatment Programs	3,173,654	3,173,654				
10. A04 Mental Health Urgent Care	1,716,229	490,351	1,225,878			
11. C02 Children's (Uplift) Mobile Crisis	471,890	330,323	141,567			
12. HO01 Permanent Supportive Housing	4,380,990	3,439,303	917,687			24,000
Non-FSP Programs						
1. C03 Children & Family Behavioral Health Outpatient/IOP Services	36,131,734	5,990,686	18,042,011		12,099,037	
2. Specialty Services- Eating Disorders --- Child/Adult/Other combined	1,400,000	1,400,000				
3. C02 Specialty Services - Integrated MH/SUD	992,200	496,100	496,100			
4. C03 Foster Care Development	1,246,596	812,617	433,979			
5. A02 Community Placement Team Services and IMD Alternative Program	5,337,635	5,337,635				
6. C02 Children's (Uplift) Mobile Crisis	314,594	220,216	94,378			
8. T02-04 TAY Outpatient Services	1,861,321	712,706	927,793		220,822	
9. Intensive Outpatient Program (IOP)	539,822	539,822				
10. C03 Independent Living Program (ILP)	55,707	20,252	35,455			
11. C02 CSEC Program	886,649	886,649				
12. C03 Services for Juvenile Justice Involved Youth	3,273,457	1,756,298	874,446		217,779	424,934
13. T02-04 TAY Triage to Support Reentry	1,648,813	898,813	750,000			
14. T02-04 TAY Crisis and Drop In Center	539,822	539,822				
15. T02-04 TAY Interdisciplinary Service Teams	1,500,000	750,000	750,000			
16. A02/A04 County Clinics	9,057,352	3,556,692	5,110,339			390,321
17. A02 Hope Services: Integrated Mental Health and Autism Services	547,988	399,492	148,496			
18. A02 CalWORKs Community Health Alliance	2,610,386	1,223,206	705,340			681,840
19. A03 Criminal Justice Residential and Outpatient Treatment Programs	4,238,111	4,238,111				
20. A03 Criminal Justice Outpatient Services	1,724,820	871,410	853,410			
21. A03 Faith Based Resource Centers	1,848,688	450,000				1,398,688
22. A04 Mental Health Urgent Care	2,370,030	1,144,152	1,225,878			
23. A02 Crisis Stabilization Unit and Crisis Residential Treatment	20,100,396	8,586,448	11,513,948			
24. A02 Adult Residential Treatment	3,099,398	1,424,048	1,675,350			
25. OA02-04 In-Home Outreach Teams	2,260,000	2,260,000				
26. OA02-04 Outpatient Services for Older Adults	2,173,893	1,840,308	333,585			
27. OA02-04 Clinical Case Management for Older Adults	2,300,000	1,150,000	1,150,000			
28. OA02-04 Connections Program	151,000	151,000				
29. LP01 Learning Partnership	2,194,165	2,194,165				
CSS Administration	1,985,202	1,985,202				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	178,509,625	83,773,828	72,915,309	0	18,900,705	2,919,783
FSP Programs as Percent of Total	78.9%					

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Clara Date: 5/29/20

	Fiscal Year 2022/23					
	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	8,969,861	2,302,232	3,553,481		3,114,149	
2. T01 Transitional Age Youth FSP	9,318,410	2,146,071	3,923,420		3,248,918	
3. A01 Adult Full Service Partnership	9,311,071	4,750,265	4,560,806			
4. A03 Criminal Justice FSP	3,953,178	1,336,236	2,616,942			
5. A03 Forensic Assertive Community Treatment	5,251,874	3,450,504	1,801,370			
6. OA01 Older Adult Full Service Partnership	2,855,962	1,720,820	1,135,142			
7. A02 Assertive Community Treatment	7,017,696	4,464,572	2,553,124			
8. A02 Crisis Stabilization Unit and Crisis Residential Treatment	9,699,033	4,333,648	5,365,385			
9. A03 Criminal Justice Residential and Outpatient Treatment Programs	3,173,654	3,173,654				
10. A04 Mental Health Urgent Care	1,716,229	490,351	1,225,878			
11. C02 Children's (Uplift) Mobile Crisis	471,890	330,323	141,567			
12. HO01 Permanent Supportive Housing	4,380,990	3,439,303	917,687			24,000
Non-FSP Programs						
1. C03 Children & Family Behavioral Health Outpatient/IOP Services	36,131,734	5,990,686	18,042,011		12,099,037	
2. Specialty Services- Eating Disorders --- Child/Adult/Other combined	1,400,000	1,400,000				
3. C02 Specialty Services - Integrated MH/SUD	992,200	496,100	496,100			
4. C03 Foster Care Development	1,246,596	812,617	433,979			
5. A02 Community Placement Team Services and IMD Alternative Program	5,337,635	5,337,635				
6. C02 Children's (Uplift) Mobile Crisis	314,594	220,216	94,378			
8. T02-04 TAY Outpatient Services	1,861,321	712,706	927,793		220,822	
9. Intensive Outpatient Program (IOP)	539,822	539,822				
10. C03 Independent Living Program (ILP)	55,707	20,252	35,455			
11. C02 CSEC Program	886,649	886,649				
12. C03 Services for Juvenile Justice Involved Youth	3,273,457	1,756,298	874,446		217,779	424,934
13. T02-04 TAY Triage to Support Reentry	1,648,813	898,813	750,000			
14. T02-04 TAY Crisis and Drop In Center	539,822	539,822				
15. T02-04 TAY Interdisciplinary Service Teams	1,500,000	750,000	750,000			
16. A02/A04 County Clinics	9,057,352	3,556,692	5,110,339			390,321
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18. A02 CalWORKs Community Health Alliance	2,610,386	1,223,206	705,340			681,840
19. A03 Criminal Justice Residential and Outpatient Treatment Programs	4,238,111	4,238,111				
20. A03 Criminal Justice Outpatient Services	1,724,820	871,410	853,410			
21. A03 Faith Based Resource Centers	1,848,688	450,000				1,398,688
22. A04 Mental Health Urgent Care	2,370,030	1,144,152	1,225,878			
23. A02 Crisis Stabilization Unit and Crisis Residential Treatment	20,100,396	8,586,448	11,513,948			
24. A02 Adult Residential Treatment	3,099,398	1,424,048	1,675,350			
25. OA02-04 In-Home Outreach Teams	2,260,000	2,260,000				
26. OA02-04 Outpatient Services for Older Adults	2,173,893	1,840,308	333,585			
27. OA02-04 Clinical Case Management for Older Adults	2,300,000	1,150,000	1,150,000			
28. OA02-04 Connections Program	151,000	151,000				
29. LP01 Learning Partnership	2,194,165	2,194,165				
CSS Administration	1,985,202	1,985,202				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	178,509,625	83,773,828	72,915,309	0	18,900,705	2,919,783
FSP Programs as Percent of Total	78.9%					

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Clara Date: 5/29/20

	Fiscal Year 2020/21					
	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	250,000	250,000				
3. P2 Support for Parents	660,000	660,000				
4. P9 Promotores	900,000	900,000				
PEI Programs - Early Intervention						
5. P3 Raising Early Awareness Creating Hope (REACH)	1,428,361	1,069,597	311,376		47,388	
6. P4 Integrated Prevention Services for Cultural Communities	1,098,390	1,098,390				
7. P9 Elder Story Telling	400,000	400,000				
8. P2 School Linked Services (SLS) Initiative	19,167,234	10,232,019	5,464,660		3,470,555	
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
9. P9 Older Adult In-Home Peer Respite Program	400,000	400,000				
10. P1 Community Wide Outreach and Training	150,000	150,000				
11. P9 Law Enforcement Training	304,244	304,244				
PEI Programs - Stigma and Discrimination Reduction						
12. P4 New Refugees Program	691,043	691,043				
13. P1 Cultural Communities Wellness Program	1,850,000	1,850,000				
PEI Programs - Access and Linkage to Treatment						
14. P2 Services for Children 0-5	388,527	388,527				
15. P8 Office of Consumer Affairs	580,197	580,197				
16. P8 Office of Family Affairs	773,377	773,377				
17. P6 Re-Entry	473,146	473,146				
18. P7 LGBTQ	649,500	649,500				
PEI Programs - Suicide Prevention						
19. P5 Suicide Prevention Strategic Plan	1,900,636	1,900,636				
PEI Programs - Improve Timely Access to Services for Underserved Populations						
20. P1 Culture-Specific Wellness Centers	1,454,769	1,454,769				
PEI Administration	1,464,790	1,464,790				
Total PEI Program Estimated Expenditures	35,183,234	25,889,255	5,776,036	0	3,517,943	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Clara Date: 5/29/20

	Fiscal Year 2021/22					
	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	250,000	250,000				
3. P2 Support for Parents	660,000	660,000				
4. P9 Promotores	900,000	900,000				
PEI Programs - Early Intervention						
5. P3 Raising Early Awareness Creating Hope (REACH)	1,428,361	1,069,597	311,376		47,388	
6. P4 Integrated Prevention Services for Cultural Communities	1,098,390	1,098,390				
7. P9 Elder Story Telling	400,000	400,000				
8. P2 School Linked Services (SLS) Initiative	19,167,234	10,232,019	5,464,660		3,470,555	
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
9. P9 Older Adult In-Home Peer Respite Program	400,000	400,000				
10. P1 Community Wide Outreach and Training	150,000	150,000				
11. P9 Law Enforcement Training	304,244	304,244				
PEI Programs - Stigma and Discrimination Reduction						
12. P4 New Refugees Program	691,043	691,043				
13. P1 Cultural Communities Wellness Program	1,850,000	1,850,000				
PEI Programs - Access and Linkage to Treatment						
14. P2 Services for Children 0-5	388,527	388,527				
15. P8 Office of Consumer Affairs	580,197	580,197				
16. P8 Office of Family Affairs	773,377	773,377				
17. P6 Re-Entry	473,146	473,146				
18. P7 LGBTQ	649,500	649,500				
PEI Programs - Suicide Prevention						
19. P5 Suicide Prevention Strategic Plan	1,900,636	1,900,636				
PEI Programs - Improve Timely Access to Services for Underserved Populations						
20. P1 Culture-Specific Wellness Centers	1,454,769	1,454,769				
PEI Administration	1,464,790	1,464,790				
Total PEI Program Estimated Expenditures	35,183,234	25,889,255	5,776,036	0	3,517,943	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Clara Date: 5/29/20

	Fiscal Year 2022/23					
	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	250,000	250,000				
3. P2 Support for Parents	660,000	660,000				
4. P9 Promotores	900,000	900,000				
PEI Programs - Early Intervention						
5. P3 Raising Early Awareness Creating Hope (REACH)	1,428,361	1,069,597	311,376		47,388	
6. P4 Integrated Prevention Services for Cultural Communities	1,098,390	1,098,390				
7. P9 Elder Story Telling	400,000	400,000				
8. P2 School Linked Services (SLS) Initiative	19,167,234	10,232,019	5,464,660		3,470,555	
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
9. P9 Older Adult In-Home Peer Respite Program	400,000	400,000				
10. P1 Community Wide Outreach and Training	150,000	150,000				
11. P9 Law Enforcement Training	304,244	304,244				
PEI Programs - Stigma and Discrimination Reduction						
12. P4 New Refugees Program	691,043	691,043				
13. P1 Cultural Communities Wellness Program	1,850,000	1,850,000				
PEI Programs - Access and Linkage to Treatment						
14. P2 Services for Children 0-5	388,527	388,527				
15. P8 Office of Consumer Affairs	580,197	580,197				
16. P8 Office of Family Affairs	773,377	773,377				
17. P6 Re-Entry	473,146	473,146				
18. P7 LGBTQ	649,500	649,500				
PEI Programs - Suicide Prevention						
19. P5 Suicide Prevention Strategic Plan	1,900,636	1,900,636				
PEI Programs - Improve Timely Access to Services for Underserved Populations						
20. P1 Culture-Specific Wellness Centers	1,454,769	1,454,769				
PEI Administration	1,464,790	1,464,790				
Total PEI Program Estimated Expenditures	35,183,234	25,889,255	5,776,036	0	3,517,943	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Clara Date: 5/29/20

	Fiscal Year 2020/21					
	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	818,432	818,432				
3. Psychiatric Emergency Response Team (PERT) and Peer Linkage	1,572,043	1,572,043				
4. Allcove Implementation Project	3,762,320	3,762,320				
5. Independent Living Facilities Project	330,000	330,000				
INN Administration	1,296,390	1,296,390				
Total INN Program Estimated Expenditures	8,087,736	8,087,736	0	0	0	0

	Fiscal Year 2021/22					
	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	0					
2. Client and Consumer Employment	826,146	826,146				
3. Psychiatric Emergency Response Team (PERT) and Peer Linkage	0					
4. Allcove Implementation Project	3,814,531	3,814,531				
5. Independent Living Facilities Project	330,000	330,000				
INN Administration	1,296,390	1,296,390				
Total INN Program Estimated Expenditures	6,267,067	6,267,067	0	0	0	0

	Fiscal Year 2022/23					
	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	0					
2. Client and Consumer Employment	0					
3. Psychiatric Emergency Response Team (PERT) and Peer Linkage	0					
4. Allcove Implementation Project	3,076,195	3,076,195				
5. Independent Living Facilities Project	330,000	330,000				
INN Administration	1,296,390	1,296,390				
Total INN Program Estimated Expenditures	4,702,585	4,702,585	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Clara Date: 5/29/20

	Fiscal Year 2020/21					
	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				
WET Regional Partnership Contribution						
Total WET Program Estimated Expenditures	3,129,104	3,129,104	0	0	0	0

	Fiscal Year 2021/22					
	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				
WET Regional Partnership Contribution						
Total WET Program Estimated Expenditures	3,129,104	3,129,104	0	0	0	0

	Fiscal Year 2022/23					
	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				
WET Regional Partnership Contribution						
Total WET Program Estimated Expenditures	3,129,104	3,129,104	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Clara Date: 5/29/20

	Fiscal Year 2020/21					
	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. Residential Facilities	0	4,000,000				
2.	0					
3.	0					
4.	0					
5.	0					
CFTN Programs - Technological Needs Projects						
6. CFTN Support Staff	1,241,566	1,241,566				
7.	0					
8.	0					
9.						
10.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	1,241,566	5,241,566	0	0	0	0

	Fiscal Year 2021/22					
	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. Residential Facilities	0	4,000,000				
2.	0					
3.	0					
4.	0					
5.	0					
CFTN Programs - Technological Needs Projects						
6. CFTN Support Staff	1,241,566	1,241,566				
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	1,241,566	5,241,566	0	0	0	0

	Fiscal Year 2022/23					
	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. Residential Facilities	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
6. CFTN Support Staff	1,241,566	1,241,566				
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	1,241,566	1,241,566	0	0	0	0

Appendices

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

COUNTY OF SANTA CLARA
Behavioral Health Services

Prepared by:
Palo Alto University
February 2020

Informing the 2021-23 MHSA 3-Year Plan

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

Note: Click on each item to jump to its contents

TABLE OF CONTENTS

OBJECTIVES OF THE EVALUATION

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

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

METHODOLOGY

Stakeholder input data was collected from three sources:

1. The County of Santa Clara Consumer Survey

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

2. Stakeholder Leadership Community Listening Sessions

Since 2005, the Mental Health Services Act (MHSA) Stakeholder Leadership Committee (SLC) has been in place to provide input and to advise the County Behavioral Health Services Department (BHSD) in its MHSA planning and implementation activities. The MHSA SLC serves as the BHSD's primary advisory committee for MHSA activities. The MHSA SLC consists of representatives of various stakeholder groups, including consumers, family members and underserved cultural communities. The MHSA SLC members review, comment, and provide input on MHSA plans and annual updates. MHSA SLC meetings serve as a forum to assure wide-ranging representation in the MHSA community planning process. All MHSA SLC meetings are open to the public and allow for public comment. Throughout the year, the MHD holds MHSA SLC meetings to discuss MHSA related business and programs.

Return to Table of Contents

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

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

3. MHSA Planning Forum

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

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

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

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

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

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

Structure and Schedule for Discussion Groups at the 2020 MHSA Forum

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

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

Return to Table of Contents

COUNTY OF SANTA CLARA
2020 CONSUMER SURVEY RESULTS

EXECUTIVE SUMMARY

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

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

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

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

Participants

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

Results by Consumer Survey Domain

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

Return to Table of Contents

Figure 1. Consumer Survey Respondents by Age

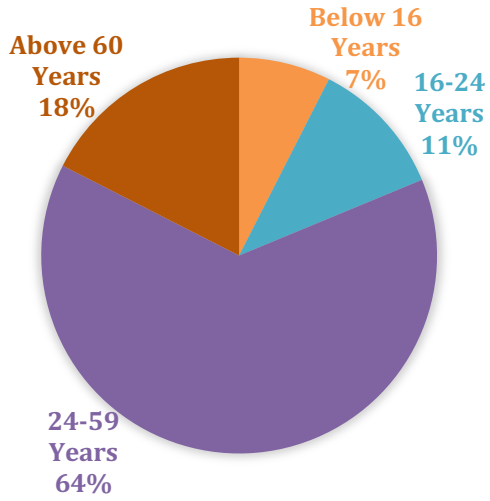


Figure 2. Consumer Survey Respondents by Relationship to Consumer

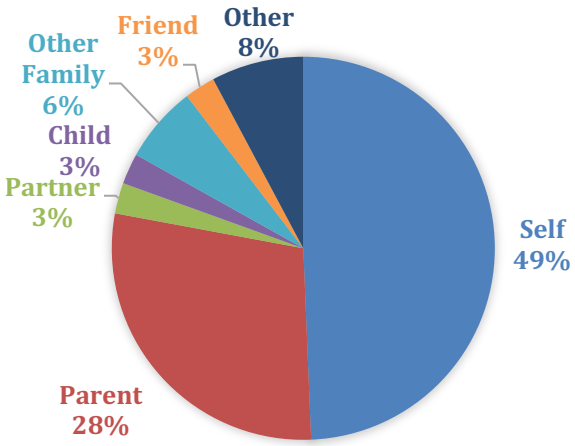


Figure 3. Consumer Survey Respondents by Gender

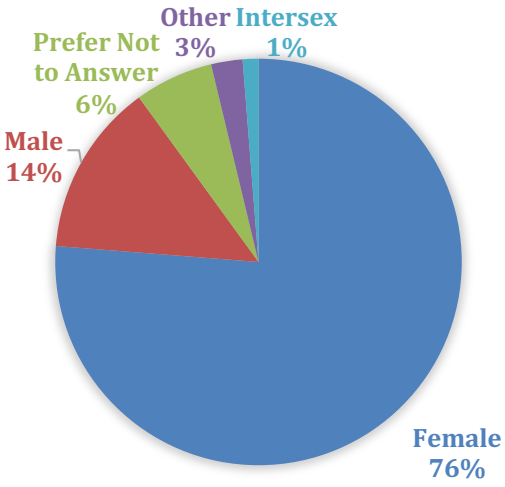
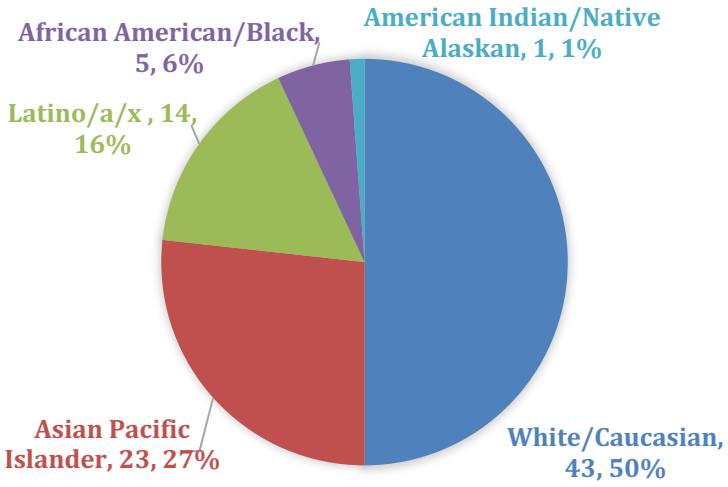


Figure 4. Consumer Survey Respondents by Race/Ethnicity



Return to Table of Contents

Figure 5. Consumer Survey Respondents by City

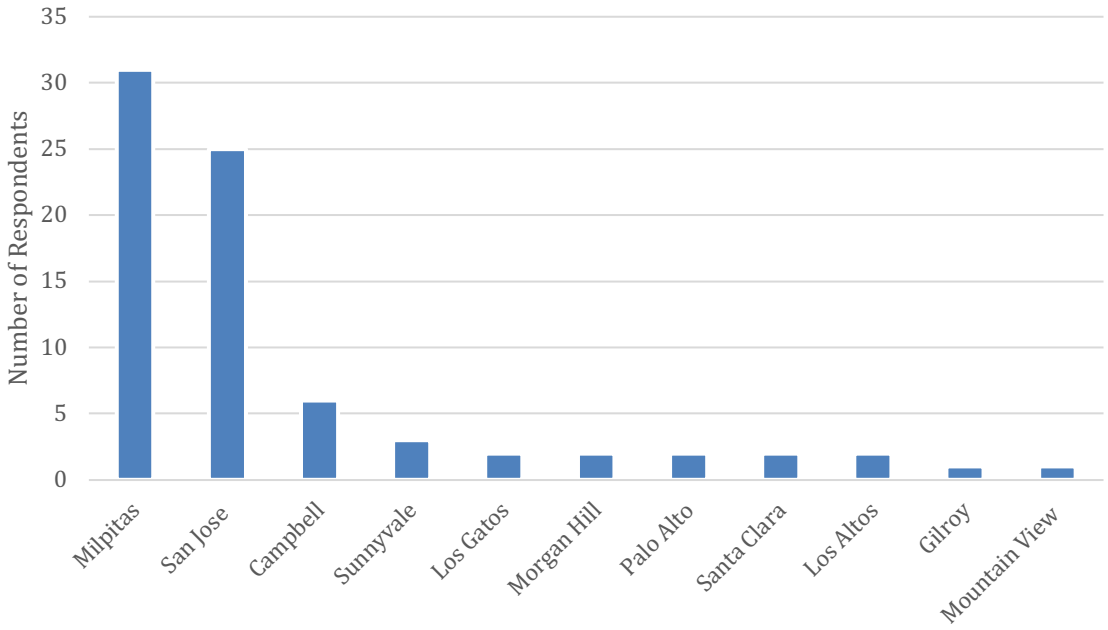
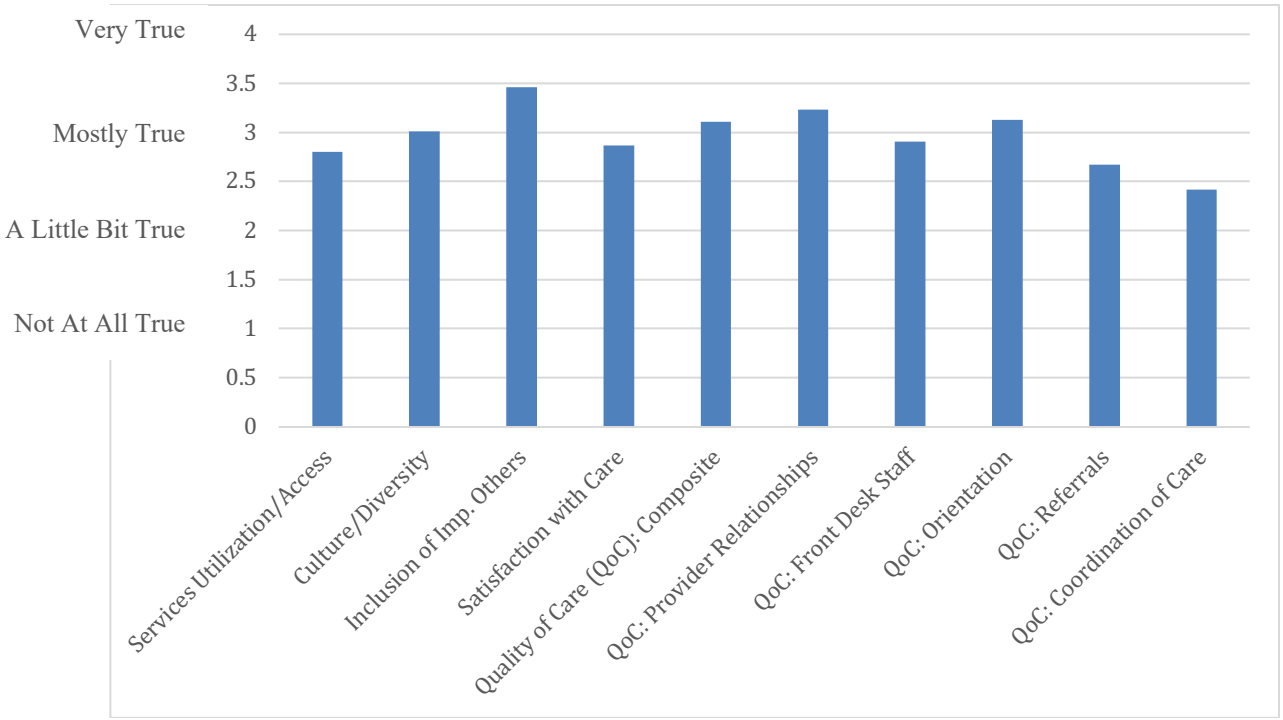


Figure 6. Summary of Survey Domain Results



Quality of Care: Consumers reported moderate-high satisfaction with quality of care; the average response in this domain was "Mostly True" (3.11). This domain included 12 questions measuring referrals, care coordination, front desk staff, provider relationship, and consumer-recovery orientation. Consumers' highest ratings came when asked how much their providers respect them (3.43 "Mostly True"), and their lowest rating came when asked how well their services fit together (2.42, "A Little Bit True"). Results for each sub-domain of Quality of Care are detailed below:

> *Quality of Care: Provider Relationships:* This sub-domain included five questions assessing providers on the following: discussing consumer rights, answering consumer questions, respecting consumers, making consumers feel respected, and making consumers feel open to discuss their problems. Consumers reported moderate-high satisfaction with their provider experience; the average response was "Mostly True" (3.23).
>
> *Quality of Care: Front Desk Staff:* This sub-domain included three questions measuring front desk staff's likelihood to ask questions and behave in a friendly, helpful manner. Consumers reported moderate-high satisfaction with front desk staff; the average response was "Mostly True" (2.91).
>
> *Quality of Care: Consumer-Recovery Service Orientation:* This sub-domain included 4 questions measuring shared decision-making, consumer-focused goal-setting, and individualized recovery goals. Consumers reported moderate-high levels of recovery-oriented service provision; the average response was "Mostly True" (3.13).
>
> *Quality of Care: Referrals:* Consumers reported that it is "Very True" (2.67) that their providers talk to them about services that may help them.
>
> *Quality of Care: Coordinated Care:* Consumers reported that it is "A Little Bit True" (2.42) that their different services fit together well.

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

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

Return to Table of Contents

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

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

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

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

Recommendations:

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

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

Return to Table of Contents

MHSA FORUM & STAKEHOLDER LEADERSHIP COMMITTEE LISTENING SESSIONS

EXECUTIVE SUMMARIES & RECOMMENDATIONS BY AGE GROUP

CHILDREN AND FAMILIES

OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS

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

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

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

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

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

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

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

TRANSITIONAL AGE YOUTH
OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS

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

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

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

2. Provide more definitional clarity around who transitional age youth are, and what their specific services look like.

- Clarify who falls under TAY category and how they differ from child/youth or adult groups (e.g. "aged out" foster care children)
- Provide definitions for transient versus chronically homeless TAY.

3. Further develop services tailored to TAY-specific needs

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

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

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

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

ADULTS AND OLDER ADULTS

OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS

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

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

1. Culture and Diversity Needs

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

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

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

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

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

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

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

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

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

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

- Expand recruitment to include more peer support workers and others

Return to Table of Contents

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

MHSA FORUM & STAKEHOLDER LEADERSHIP COMMITTEE LISTENING SESSIONS

EXECUTIVE SUMMARIES BY TOPIC

PREVENTION AND EARLY INTERVENTION
OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS

Existing Systems are Strong

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

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

Suggestions to Improve Existing Systems

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

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

Some "Fall Through the Cracks"

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

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

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

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

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

3. **A need to address access barriers through innovative outreach and education**.

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

4. **System-oriented barriers related to gaps in linkages to and continuity of care, and communications and collaborations between care entities.**

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

HOMELESSNESS PREVENTION

OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS

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

1. Many stakeholders found it **difficult to understand the system of care** for behavioral health in homeless populations.

- Suggested ideas for improving awareness and understanding of services included: improving the referral system for homelessness prevention, disseminating list of homelessness prevention or intervention services to providers, discussing current homelessness efforts in a newsletter to county network, or offering homelessness services closer to other sources of services.

2. **More overall resources are needed to address the needs of homeless individuals and families.**

- Changes in policy (enhance regulation of board and care facilities) and definitional clarity (e.g., what counts as "permanent" supportive housing, "chronic" homelessness, and "affordable" housing) may be needed to improve services and access.

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

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

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

WORKFORCE EDUCATION AND TRAINING
OVERALL EXECUTIVE SUMMARY AND RECOMMENDATIONS

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

1. Recruitment: Implement **proactive recruitment outreach and programming** targeting youth, peer support or retired workers, and non-English speaking, marginalized, and underrepresented communities.

- Promote **outreach and programming to recruit youth** into the county workforce pipeline.

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

2. **Retention Efforts**: Retain existing employees through **incentives and reduction of burnout/stress.**

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

3. **Training**: Improve workforce competency through more **trainings and supervision.**

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

INNOVATIONS

OVERALL EXECUTIVE SUMMARY

The innovations focus groups held at the 2020 MHSA Forum served as a space for creative brainstorming around improvements to the behavioral system with regards to: Prevention and Early Intervention, Homelessness Prevention, and Workforce Education and Training.

- Stakeholders offered innovative ideas for PEI services that **increase consumer engagement and access, improve mental health screening and detection, and provide innovative prevention-oriented services.**

Return to Table of Contents

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

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

PREVENTION & EARLY INTERVENTION CHILDREN AND FAMILIES

EXECUTIVE SUMMARY

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

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

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

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

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

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

Return to Table of Contents

RESULTS

PREVENTION AND EARLY INTERVENTION: FAMILY AND CHILDREN

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

Programming and Services

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

Client Care Access

Different forms of **challenges in consumers accessing appropriate care** emerged. Some participants mentioned the direct denial of service to families (N=3). A few participants discussed the difficulties of serving children and access to mental health services of individuals belonging to private insurance (N=3). Similarly, another participant noted the denial of services to families of children who have developmental disabilities like autism and recommended more oversight within county agencies before denial of services (N=1).

Systemic barriers also emerged (N=5) including difficulty navigating the referral system to access services in an effective and timely manner (e.g. lack of easily accessible list of services for client referral [N=1], long waiting periods for mental health services [N=1], needing to call multiple entities [N=1]). Other client barriers included consumers' challenges in accessing care due to lack of transportation (N=2) and food and child-care (N=1). Reduction of stigma of mental health in the community was also recommended to encourage client care access (N=2).

Staffing

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

Culturally-Responsive Care

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

Care Triage

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

Return to Table of Contents

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

Service and Resource Awareness

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

Other Support Services

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

Structural Changes

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

Funding

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

Other Structural Changes

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

Psychoeducation & Outreach

Psychoeducation

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

Outreach

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

School Linked Services

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

What should stay the same?

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

What should be removed?

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

RECOMMENDATIONS

PREVENTION AND EARLY INTERVENTION: FAMILY AND CHILDREN

1. **Examine areas where client care can be made more accessible through the county system**

   Examples: Assist consumers with private insurance, reduce wait time for services, better triage and referral system, increase staffing, ensure cultural-responsiveness in care across agencies.
2. **Examine ways to increase accessibility of services by tending to individual client barriers**

Return to Table of Contents

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

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

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

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

   Examples: Promoting psychoeducational shows or social media accounts for youth

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

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

PREVENTION & EARLY INTERVENTION TRANSITIONAL AGE YOUTH

EXECUTIVE SUMMARY

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

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

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

Potential Solutions

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

RESULTS

PREVENTION AND EARLY INTERVENTION: TRANSITIONAL AGE YOUTH

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

Structural Changes

Return to Table of Contents

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

System Integration

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

Funding Transparency & Accountability

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

Program Outcomes & Data

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

Family Integration

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

Community/Consumer Involvement

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

Return to Table of Contents

General Services & Other

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

Outreach & Education

Trauma-Informed Care

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

Training

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

Culture & Stigma

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

Service Awareness

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

Programmatic & Interventions

Staffing

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

Centers & Programs

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

Housing

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

General & Other

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

What should stay the same?

Programmatic & Interventions

Community Involvement & Gatekeeper Trainings

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

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

Trauma-Informed Care

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

Suicide Prevention

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

General & Other Services

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

Culture & Diversity

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

What should be removed?

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

Recommendations

Prevention and Early Intervention: Transitional Age Youth

Service Connectivity and Collaboration

1. **Increase system integration and collaboration and communication between programs and appropriate care providers with special attention to services most relevant to transitional age youth (e.g. foster care system, case management, housing, employment, mental health services).**

   Examples: Transition from hospital or psychiatric inpatient back into schools or community, appropriate referral to psychiatric services instead of arrest, connection between mental health services and substance use treatment, determine ways to integrate family members into youth care

2. **Increase staffing in providers and community connectors to services.**

   Examples: More peer support, clinicians, case managers, CIT officers

Return to Table of Contents

Structural Improvements

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

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

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

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

Programming

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

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

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

   Examples: More wellness centers, substance withdrawal programs, work development programs, more transitional housing support

Return to Table of Contents

PREVENTION & EARLY INTERVENTION ADULTS AND OLDER ADULTS

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

RESULTS

PREVENTION AND EARLY INTERVENTION: ADULTS AND OLDER ADULTS

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

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

Cultural and Diversity-Related Needs

General Strategies

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

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

Specific Populations

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

Structural Changes

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

Policy and Structural Changes

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

Return to Table of Contents

Staffing

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

Coordination and Collaboration

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

Education and Outreach

Education and Training

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

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

Education Topics

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

Outreach

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

Programming and Interventions

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

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

What should stay the same?

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

What should be removed?

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

RECOMMENDATIONS

Return to Table of Contents

PREVENTION AND EARLY INTERVENTION: ADULTS AND OLDER ADULTS

1. **Increase outreach and education to culturally diverse and underserved adult and older adult communities.**
   Examples: Improve engagement of refugees and non-English speakers; resource navigation for older adults; use ethnic media sources; meet communities where they reside
2. **Focus and tailor staffing and programming towards the needs of cultural and diverse adult and older adult communities.**
   Examples: Language-matched providers and cultural brokers in community-based organizations; Pacific Islander, Korean, LGBTQ+ representation (e.g., on CCWP); Programming for mothers and LGBTQ+ older adults
3. **Consider the need for a broader offering of post-crisis intervention (tertiary prevention) options that promote recovery and prevent relapse.**
   Examples: More individual interventions, more offerings of WRAP, groups other than WRAP, modalities other than CBT
4. **Assess points of coordination and collaboration between county behavioral health and other entities.**
   Examples: VA medical centers, coordination with contracted non-English speaking clinics, custody behavioral health

HOMELESSNESS PREVENTION CHIDREN AND FAMILIES

EXECUTIVE SUMMARY

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

Clarification and Definitions

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

Removing Barriers

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

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

Improving Existing Services and Programs

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

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

Program Outcomes and Data

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

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

RESULTS

HOMELESSNESS PREVENTION: CHILDREN AND FAMILIES

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

What should be added?

Programming & Interventions

The most commonly mentioned topics on homelessness prevention services for families and children were related to programming and interventions.

Service Awareness

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

School Resources

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

Housing Services

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

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

Family Integration

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

Provider Competency

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

Care Access

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

Other

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

Program Outcomes & Data

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

System Integration

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

Return to Table of Contents

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

What should be removed?

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

Clients' Barriers to Care Access

Client Mistrust

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

Client Stress

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

Staff Stress

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

What should stay the same?

School Resources

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

Programming & Interventions

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

Return to Table of Contents

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

What should be changed?

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

RECOMMENDATIONS
HOMELESSNESS PREVENTION: CHILDREN AND FAMILIES

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

Return to Table of Contents

HOMELESSNESS PREVENTION
TRANSITIONAL AGE YOUTH

EXECUTIVE SUMMARY

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

Recommendations for expansion of services included:

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

RESULTS

PREVENTION OF HOMELESSNESS – TRANSITIONAL AGE YOUTH (TAY)

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

Need for Definitional Clarity

Defining Homelessness and Housing

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

Defining Specific Sub-populations

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

Structural Changes

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

Return to Table of Contents

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

Services, Programming and Interventions

Age Appropriate Housing

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

Financial Support

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

What should stay the same?

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

What should be removed?

Stakeholders did not provide feedback on this area.

RECOMMENDATIONS

PREVENTION OF HOMELESSNESS – TRANSITIONAL AGE YOUTH (TAY)

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

Return to Table of Contents

HOMELESSNESS PREVENTION ADULTS AND OLDER ADULTS

EXECUTIVE SUMMARY

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

Housing

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

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

Outreach

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

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

Structural/System Improvements of Services

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

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

RESULTS

HOMELESSNESS PREVENTION: ADULTS AND OLDER ADULTS

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

What should be changed?

Improve Housing Services

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

Policy and Structural Changes

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

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

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

Housing Staff

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

Improve Board and Care Facilities

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

Regulation of Board and Care

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

Additional support facilities in board and care

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

Return to Table of Contents

Awareness and Outreach

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

What should stay the same?

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

What should be removed?

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

RECOMMENDATIONS

HOMELESSNESS PREVENTION – ADULTS AND OLDER ADULTS

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

   Examples: Hire housing specialists; clarify the definition of affordable housing, provide interim housing options; provide harm-reduction housing options; clarify the roles of case managers, housing specialists and peer support workers in providing assistance to access housing; continue to assign case managers to homeless AOA; continued funding for those involved in the criminal justice system.

2. **Enhance the regulation of board and care facilities and streamline the transition of AOA to other housing options.**

   Examples: Start peer support groups; increase availability of rapid rehousing options; define the maximum length of stay at board and care sites.

3. **Increase culturally-appropriate outreach and awareness programs focused on mental health and housing resources.**

   Examples: Designing outreach events for cultural minority groups (e.g. LGBTQ+); increasing outreach events targeting the mental health stigma.

Return to Table of Contents

WORKFORCE EDUCATION AND TRAINING
CHILDREN AND FAMILIES

EXECUTIVE SUMMARY

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

High School/University

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

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

Services Post-Graduation/Currently Employed

Post-graduation, stakeholders noted the following needs:

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

RESULTS

WORKFORCE EDUCATION AND TRAINING: CHILDREN AND FAMILIES

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

High School Recruitment

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

College / Universities

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

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

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

Workforce Recruitment

Post-Education Transition to Workforce

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

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

Community Recruitment

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

Workforce Retention

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

Trainings

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

RECOMMENDATIONS
WORKFORCE EDUCATION AND TRAINING: CHILDREN AND FAMILIES

1. **Explore proactive county action to address barriers and engage high school and college students in county behavioral health**
   Examples: Scholarships, stipends, outreach to students of color, outreach at university events
2. **Assess opportunities to bridge transition periods between graduation and employment,**
   Examples: To reach bachelor and masters level graduates before they are diverted from county pathways.
3. **Attend to the need for incentives to retain county employees.**
4. **Continue trainings (e.g., for providers) that integrate community, consumer, and family perspectives.**
   Examples: Consumer culture, family perspectives, collaborative training

WORKFORCE EDUCATION AND TRAINING
TRANSITIONAL AGE YOUTH

EXECUTIVE SUMMARY

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

Outreach, Engagement, Training

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

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

Structural/System Changes

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

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

RESULTS

WORKFORCE EDUCATION AND TRAINING: TRANSITIONAL AGE YOUTH (TAY)

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

Outreach and Engagement

Workforce Recruitment

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

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

Return to Table of Contents

Marginalized Communities

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

Educational Outreach

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

Policy Change

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

Training

Education and Training

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

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

Worker Retention and Mental Health

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

What should stay the same?

Stakeholders largely supported maintaining current funds allocated to workforce education to "build upon what is currently available."

Return to Table of Contents

What should be removed?

Stakeholders did not provide feedback on this area.

RECOMMENDATIONS

WORKFORCE EDUCATION AND TRAINING: TRANSITIONAL AGE YOUTH (TAY)

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

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

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

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

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

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

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

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

WORKFORCE EDUCATION AND TRAINING ADULTS AND OLDER ADULTS

EXECUTIVE SUMMARY

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

Workforce Recruitment

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

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

Workforce Competency

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

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

Workforce Retention

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

RESULTS

WORKFORCE EDUCATION AND TRAINING: ADULTS AND OLDER ADULTS

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

Workforce Recruitment

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

Peer Support and Programs

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

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

Other Recruitment

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

Workforce Competency

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

Workforce Retention

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

Programming and Interventions

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

System Integration

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

What should stay the same?

Stakeholders recommended that stipends and scholarship opportunities for students (N=1) and warmlines should continue (N=1).

RECOMMENDATIONS

WORKFORCE EDUCATION AND TRAINING: ADULTS AND OLDER ADULTS

Workforce Education and Training for Adults and Older Adults

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

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

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

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

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

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

INNOVATIONS
PREVENTION AND EARLY INTERVENTION

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

Ideas to Increase Engagement and Access

Innovation to Increase Access to Resources

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

Family and Community Readiness for Engagement

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

Family and Parent Training & Resource Access

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

Screening and Detection

Universal Trauma and Mental Health Pediatric Screening Initiative

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

Innovative Prevention Services

Supporting the Needs of Diverse Families

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

Comprehensive Recreational Spaces/ After-school Programs

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

County-wide Mindfulness-based Stress Reduction Support Groups for Parents

A suggestion for more **support and psychoeducation** to address concerns about a family's lack of space, direction, and education about what to do when impacted by a child's mental illness.

Inclusive Community Space with Resources and Support Groups

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

INNOVATIONS
HOMELESSNESS PREVENTION

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

Outreach and Engagement of Homeless into Services

Outreach to Homeless via "Storage Connect"

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

Mental Health Outreach Events and Awareness building

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

Information Navigation Systems

Creating a Registry for Available Board and Care and Other housing

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

24/7 Navigation Center

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

Prevention of Homelessness in Justice-Involved Populations

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

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

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

Case Managers in the Criminal Justice System

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

Prevention of Homelessness in Families

Prioritizing Homeless Families with Children

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

Support Programming

Skill Training for Homeless Individuals/Homeless Ambassadors

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

Peer Support Groups in Board and Care

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

INNOVATIONS
WORKFORCE, EDUATION, AND TRAINING

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

Ideas for Recruitment

Training Youth Peer Support Providers

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

Specialized Peer and Family Partners Support Training and Placement with Incentives

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

Trainings to Facilitate Recovery and Recruitment

Leveraging Teen Centers to Provide Support/Outreach

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

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

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

Workforce Support

Additional Mental Health Services Outreach to First Respondents

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

Enhancement and Retention of Existing Workforce

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

Return to Table of Contents

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

Degrees-At-Work to Increase MH Workforce

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

Housing Incentives for Behavioral Health Providers

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

PREVENTION AND EARLY INTERVENTION DATA TABLES

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

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

Programming & Services	<u>Client Care Access</u> (N=11)
	• Denial of service to families (N=3)
	  ○ Difficulties of serving children and access to mental health services of individuals belonging to private insurance (N=3), including Kaiser (e.g. Kaiser not providing denial letters frequently enough)
	  ○ Similarly, another participant noted the denial of services to families of children who have developmental disabilities like autism and recommended more oversight within county agencies before denial of services (N=1)
	• Systemic barriers (N=5):
	  ○ Create easily accessible list of services to refer clients (N=1)
	  ○ Long waiting periods to access mental health services (N=1); "don't make parents/patients call all over – intake and match." (N=1)
	  ○ Barriers to access care like transportation, lack of food and child-care (N=1); make travel to services more possible (N=1)
	• Reduce stigma of mental health in the community (N=2)
	
	<u>Staffing (N=7)</u>
	• Need for an overall increase in providers, particularly on school grounds, including (N=6):
	  ○ Bilingual staff (e.g. interpreters, clinicians) (N=3)
	  ○ Mental health providers and school coordinators (N=5)
	  ○ Substance use specialists (N=2)
	• More training for providers (N=1)
	
	<u>Culturally-Responsive Care (N=7)</u>
	Need for more linguistically appropriate care and for more programs focused on serving the refugee population (N=5)
		41

Return to Table of Contents

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

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

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

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

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

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

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

Return to Table of Contents

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

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

Return to Table of Contents

	<u>Provider Training (N=7)</u>
	• More training should be offered regarding:
	  o Trauma-informed care (N= 4)
	  o Individual level of practitioners following best practices (N=1)
	  o DBT (N=1)
	  o Mental health training among police officers (N=1)
	• Training for clinicians should be tracked (N=1) and enforced (N=1)
	• Train primary care providers, encourage assistance from the physiological side (N=1)
	
	<u>Culture & Stigma (N=5)</u>
	Culture encouraging stigma needs to be addressed. In particular:
	• Mental health language (N=3):
	  o Attention on how mental illness and services are talked about (N=1)
	  o Changing "mental health" to "wellness" or "behavioral health' (N=1)
	  o Adjusting the use of term "peer" depending on the cultural group. (e.g. LGBTQ finds significance and trust in the term "peer" and "peer and lived experience"). Suggestion to change to "outreach" in some contexts, as a way to change the impression that these providers are "less than" other providers (N=1)
	• Veterans – Loss of job opportunities and services due to stigma, particularly among veterans with mental health disorders (N=1)
	• Youth outside of school systems should also be prioritized for concerns like homelessness, human trafficking, transition from incarceration, workers, and immigrant youth (N=1)
	
	<u>Service Awareness (N=3)</u>
	• More education and outreach to families about existing TAY services (N=2)
	• Easy access of reference list of services for clients and families (N=1)	

Programming & Interventions	<u>Staffing (N=5)</u>
	• Peer Support (N=5)
	  o Increase number of peer support workers (N=2)
	  o Expansion of peer support programs (N=1)
	  o Increase awareness and access to peer workers and groups (N=1)
	• Case management and liaisons – More case management services and providers and liaisons in the community (N=4)
	  o "*Train them better, give them smaller caseloads, and pay them higher salaries to alleviate turn-over*." (N=1)
	• More:
	  o Clinicians (N=1)
	  o CIT officers (N=1)
	  o "*Someone to listen and connect*" (N=1)
	
	<u>Centers & Programs (N=6)</u>
		18

Return to Table of Contents

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

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

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

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

Return to Table of Contents

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

Return to Table of Contents

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

HOMELESSNESS PREVENTION DATA TABLES

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

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

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

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

Return to Table of Contents

	○ Afterschool resources (N=4) ▪ Afterschool services linked to regular school services (N= 2) ○ School liaisons or cross-agency connections that link to mental health and other services (e.g. food access, childcare, etc.) (N=4) ▪ More community members to act as referral for services in schools for eviction prevention (N=1) • Free lunch in schools as a form of homelessness prevention (N=1) <u>Housing Services (N=4)</u> • New "affordable housing" does not address the homeless population's need (N=2) • More case management (N=2) ○ Increase case management support and communication with landlords so that landlords do not call law enforcement (N=1) ○ Case management regarding housing should follow the client (e.g. veterans), to prevent problems caused by changes in the housing management. (N=1) "*Veterans are on temporary housing. Problem is that after two years, they are on their own. Going from one agency to another, the way they follow-up with their clients is very different. For example, there is an apartment complex that is changing hands in management. The people who live there are very stressed out. Housing needs to follow the client or veteran, regardless of what happens to the building*." <u>Family Integration (N=2)</u> • Stakeholders encouraged more efforts in integrating more whole family care for families rather than focusing only on family members individually. • Determine how to expand Medi-Cal benefits to cover the whole family <u>Provider Competency (N=2)</u> • Better provider competency ○ Cultural-responsiveness (N=1) ○ Empathy (N=1) <u>Care Access (N=2)</u> • Consider placing resources closer together to encourage warm handoffs and easier access to care (N=1) • More family resource centers (N=1) <u>Other (N=2)</u> • County should place more efforts into policy for greater levels of change (N=1) • "*More community*" (N=1)	
Program Outcomes/Data	• Create system of outcome measures, tracking, and data collection to determine: ○ Demonstrate efficacy and outcomes (e.g. for funding purposes) (N=1) ○ Accurate rates of homelessness (N=2) ○ Ensure agencies are implementing trauma-informed care (N=1) • More staff to implement program outcome and data system. (N=2) • Implementation of anti-displacement work group report (N=1).	6

Return to Table of Contents

System Integration	<u>System Integration (N=4)</u> • Encourage system integration through collaboration across agencies, programs, services, providers, etc. ○ Encourage increasing collaborations with "non-traditional partners in resources" (N=2) • Providing schooling services before kindergarten and schooling services that are available to children from birth to 18 years old (N=1) • Encourage creation of a universal county release of information (ROI) form to increase efficiency and ease of communication between agencies for client care. (To avoid HIPAA violations, instead of specifying "for mental health services," change language to "living services.") (N=1)	4
What should be removed?		**N**

Clients' Barriers to Care Access	<u>Client Mistrust (N=5)</u>
	• Client mistrust of institutions, agencies, and systematic care was mentioned as a difficulty for accessing care and services among consumers at risk of homelessness or homeless. Building trust through attentive, empathetic, trauma-informed care through individual provider care in the community was encouraged.
	• Mistrust of school-based services was commonly mentioned and efforts to increase trust of providers was encouraged, including in afterschool programs. (N=2)
	
	<u>Client Stress (N=4)</u>
	• Client stress was mentioned as a difficulty for accessing care and services among consumers either at risk of homelessness or homeless.
	  ○ The political climate regarding immigration causes fear among community members and prevents them from seeking services. (N=1)
	  ○ Mental health problems can make the challenges of homelessness even more overwhelming (e.g. veterans with PTSD and having problems with housing) (N=1)
	  ○ Homelessness itself can be traumatizing and prevent clients from seeking assistance (N=1)
		9

Staff Stress	Stakeholders mentioned county staff stress due to lack of resources and not enough staff members to meet client needs.	5
General	Access barriers (N=1)	1

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

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

Return to Table of Contents

What should be changed or added?		N
Definitions	Defining Homelessness and Housing Terms (N=6) • Differentiate between "chronic homelessness" versus "homelessness" (N=4) • Clarification of "permanent housing" (N=2) o "*Not really permanent given that services follow the client*" Defining Specific Subpopulation Terms (N=2) • Change acronym of "Transitional Age Youth" (TAY) to "Youth and Young Adults" (YYA) (N=1) • Defining "extended foster care" (N=1) o "*If they don't stay in foster care until the age of 18, they will not qualify for services. A lot of foster kids stay homeless*."	8
Structural Changes	• Increase connectivity with care and provider entities (N=4) o Greater continuity of care will identify barriers (N=1) • Require trauma-informed, behavioral health/mental health training for property management (N=2)	6
Programming & Interventions	• Housing services (N=4): o Increase rapid rehousing incentives from 6 to 24 months and include supportive services like vocational training and mental health services (N=3) o More housing specifically for TAY (N=1) o Differentiate assessment tools and queue between adults and TAY • Financial support (N=1): o Universal basic income for youth (N=1)	5

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

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

Return to Table of Contents

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

WORKFORCE EDUCATION AND TRAINING DATA TABLES

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

What should be added or changed?		N

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

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

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

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

Return to Table of Contents

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

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

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

Return to Table of Contents

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

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

COUNTY OF SANTA CLARA
Behavioral Health Services

Prepared by:
Palo Alto University
February 2020

Informing the FY2021-23 MHSA 3-Year Plan

Community Program Planning Process

to inform the 2021-2023 3-year plan

3 Sources of Data

- Santa Clara County Consumer Survey (Dec 2019 – Jan 2020)
- Stakeholder Leadership Committee Listening Sessions (Oct 15, 2019)
- 2020 MHSA Forum (Jan 21, 2020)

Survey Respondents (as of 1/28/20)**: 253**

166 excluded due to incomplete responses or failing to identify as a consumer/family member

Final Sample: 87 Consumers & Family Members

Santa Clara County Consumer Survey

Overview of Survey Areas

- Service Utilization and Access
- Culture and Diversity Considerations
- Inclusion of Important Others in Care
- Satisfaction with Care
- Quality of Care
  - Provider Relationships
  - Front Desk Staff
  - Consumer Recovery Service Orientation
  - Referrals
  - Coordinated Care

Consumer Survey

Strong Satisfaction with Behavioral Health Services

Areas of Strength

Positive experiences with mental health providers

Providers' abilities to include families in consumers' recovery plans

Recommendations: Potential Areas for Growth

Increase Access to Care

Inform consumers of the easiest method for accessing care

Improve coordination between services Providers' discussion of referrals with consumers

Explore consumers' strong desire for additional & more varied MH interventions / services

Increase quantity & variety of treatment options

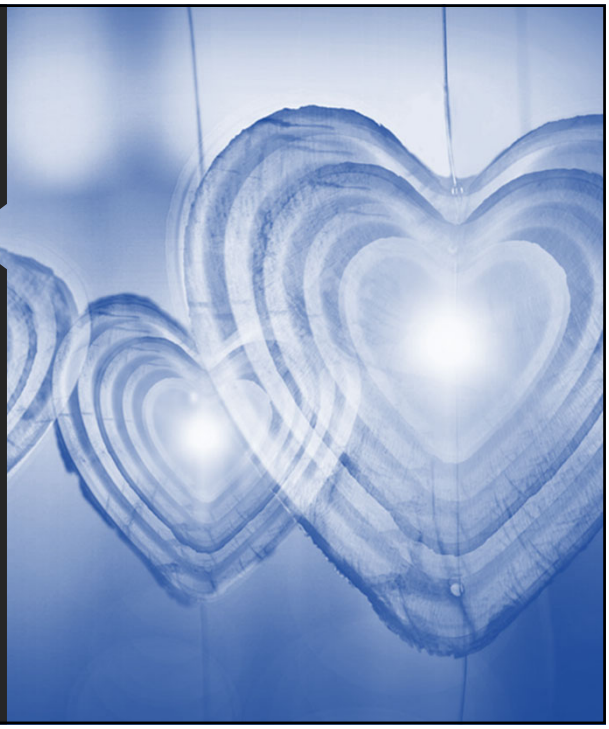
MHSA Forum & Stakeholder Leadership Committee (SLC) Listening Sessions

Children & Family System

Strengths in the quality of care

Examples

- Funding priorities
- Flexible & accessible child/ family services
- Service of refugees and children <6 yrs old
- Additional future psychiatric beds
- Student Internship Program (youth recruitment)
- Bill Willson program evaluation work
- Milpitas grassroots work on homelessness
- Mental health stability and rent stability work



Suggested strategies to prevent children & families from "falling through the cracks"

INNOVATIVE OUTREACH – clients, homeless, & workforce

Innovative methods *(e.g., social media, movie clips, mental health specialists in schools*

Decrease access barriers *(e.g., stigma, wait times, low awareness about services, unmet daily living needs)*

Reach those at-risk for homelessness

Engage workforce in high school, college, post-grad school

EXPAND SCHOOL & HOUSING SERVICES

Expand school-related services & staffing *(e.g., beyond-school hours; increase staffing in & collaboration w/ schools; improve coordination between school linked services & PEI).*

Reach children/families at risk for homelessness through schools.

LINKAGES / CONTINUITY OF CARE

Increase accessibility by addressing gaps in service linkage points between county systems *(improved triage screening, detection, referrals, school collaborations)*

CULTURAL RESPONSIVENESS

Ensure culturally-responsive access and intervention *(e.g., the working poor, homeless RV families, Latinx, immigrants, refugees, language needs)*

Transitional Age Youth

A maturing system of care that needs specific attention to the needs of TAY

TAY System: Example Areas of Strength

- Suicide prevention programming
- Trauma-informed care
- Inclusivity of the community
- Consideration of the multi-dimensionality of TAY needs
- Gatekeeper trainings
- Full Service Partnership (FSP) programs
- Efforts to integrate trauma-informed services
- Flex Funds
- Communicating through routine newsletters
- Mobile Crisis Hotline
- Institute for Local Government
- Culturally-responsive services across the lifespan
- Easily accessible self-referral process for services

Overall Recommendations for the TAY system

Budget/ Data Structures

Improve data systems for program evaluation

Continue to ensure budget transparency / RFPs for TAY programming

Overall Recommendations for the TAY system

Budget/ Data Structures

Improve data systems for program evaluation

Continue to ensure budget transparency / RFPs for TAY programming

Clarify Definitions

Definitional clarity around who TAY are, & what their specific services look like.

Overall Recommendations for the TAY system

Budget/ Data Structures

Improve data systems for program evaluation

Continue to ensure budget transparency / RFPs for TAY programming

- Trauma-informed care across the TAY system
- Integration of family members into youth care
- Train "service connectors"
- TAY-specific housing & emergency shelters
- Increased lengths of rapid TAY housing
- Assessment tools tailored to TAY
- Gaps in daily living services: Life-skill and vocational services
- Greater financial assistance (e.g. universal basic income)
- Needs of youth outside of school system

Overall Recommendations for the TAY system

TAY-Specific Services	Clarify Definitions	WET from TAY stakeholders
Further develop services tailored to TAY-specific needs.	Definitional clarity around who TAY are, & what their specific services look like.	Increase workforce recruitment, education, and training from TAY communities and for TAY-specific issues

Adults & Older Adults (AOA)

A strong system with needs for greater attention to **culture/diversity, access, collaboration, & intervention options**

Overall Recommendations for the AOA system

Interventions Options
Increase the diversity of intervention options

Overall Recommendations for the AOA system

Interventions Options	Collaborations
Increase the diversity of intervention options	Increase collaborations with other service entities to reach at-risk individuals

Overall Recommendations for the AOA system

Interventions Options	Collaborations	Workforce Recruitment / Retention
Increase the diversity of intervention options	Increase collaborations with other service entities to reach at-risk individuals	Recruit peer workforce Retain workforce by addressing burnout

Overall Recommendations for the AOA system

Interventions Options	Collaborations	Workforce Recruitment / Retention	Homeless Resources
Increase the diversity of intervention options	Increase collaborations with other service entities to reach at-risk individuals	Recruit peer workforce Retain workforce by addressing burnout	Clarity in staff & system navigation Better access / availability

Overall Recommendations for the AOA system

Interventions Options	Collaborations	Workforce Recruitment / Retention	Homeless Resources
Increase the diversity of intervention options	Increase collaborations with other service entities to reach at-risk individuals	Recruit peer workforce Retain workforce by addressing burnout	Clarity in staff & system navigation Better access / availability

Culture & Diversity: Many vulnerable populations identified
Specific outreach, staffing, and programming needed

Overall Summary

Culture and Diversity

- Increase Access: Outreach and Awareness of services, even among stakeholders
- Points of Connection and Collaboration
- Recruitment/retention amid economic challenges- diversity, TAY transitions, burnout
- Intervention options
- TAY-specific services and definitions
- Homeless system needs more resources, and is complicated

Palo Alto University Evaluation Team

Leads:

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Team:

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Leila Wallach, M.A.
Jessica Lin
Kevin Rodriguez

COMMUNITY PROGRAM PLANNING PROCESS

INTEGRATED FY20 UPDATE & FY21-23 PLAN

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

October 29, 2019 4:00pm – 6:00pm
Evergreen City College Extension - Milpitas Campus

November 6, 2019 5:30pm - 7:30pm
Milpitas Unified School District

November 12, 2019 3:00pm – 5:00pm
County Office of Education, ERC3

December 19, 2019 8:30am – 9:30am
South County Collaborative

January 21, 2020 8:30am – 2:30pm
MHSA Forum
County Office of Education

Plan Review

February 13, 2020
4:30pm - 6:30pm
MHSA SLC Validation Meeting

April 9, 2020
2:30 - 4:00pm
MHSA SLC Virtual Meeting

April 11 - May 10, 2020
30-Day Draft Plans for Public Review

May 11, 2020
2:30 - 3:30pm Virtual Meeting
Behavioral Health Board Public Hearing of Draft Plans

June 2, 2020
Request Board of Supervisor Approval

June 30, 2020
Submission of adopted and approved plans to DHCS and MHSOAC

PlanForBetterHealth

SANTA CLARA COUNTY
Behavioral Health Services
Supporting Wellness and Recovery

Santa Clara County Consumer Survey

Introduction

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

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

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

2. Which of the following best represents you as an individual?

❑ I am a consumer.
❑ I am a family member of a consumer.
❑ I am both a consumer and a family member of a consumer.

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

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

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

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

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

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

6. **The following questions are about cultural considerations in service delivery:**

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

7. The following questions are about your experiences with recovery:

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

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

☐ Yes → *IF "YES": Go to question 8a.*

☐ No → *IF "NO": Skip to question #9.*

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

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

Return to Table of Contents

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

9. How true are the following statements?

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

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

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

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

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

Return to Table of Contents

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

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

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

Please write your comments in the box below:

Demographic Form

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

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

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

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

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

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

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

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

Thank you for taking our survey!

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA Consumer Survey

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

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

- Yes
- No

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA Consumer Survey

* 2. Which of the following best represents you as an individual?

- I am a consumer.
- I am a family member of a consumer.
- I am both a consumer and a family member of a consumer.

* 3. The following questions are about your getting in **getting help**:

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

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

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

* 5. The following questions are about your experiences **talking** with providers/staff:

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

* 6. The following questions are about **cultural considerations** in service delivery:

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

* 7. The following questions are about your experiences with **recovery**:

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

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

- Yes
- No

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA Consumer Survey

* 10. How true are the following statements?

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

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA Consumer Survey

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

	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
My provider asks me who I want involved in my recovery.					
My provider includes people I've identified as important to me.					
Providers have helped my family better support me.					
Family members support my recovery.					

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

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

* 11. What are you most proud of because of mental health treatment?

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

* 12. What is the greatest accomplishment of the mental health system?

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

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA Consumer Survey
Demographic Form

* 15. How are you related to the mental health consumer in your life?

- ○ Self
- ○ Parent
- ○ Partner
- ○ Other (please specify):
- ○ Child
- ○ Other Family Member
- ○ Friend

* 16. What is your primary stakeholder affiliation?

- ○ Community member
- ○ Government agency (City or County)
- ○ Government agency (State)
- ○ Community-based organization
- ○ Other (please specify):
- ○ Law Enforcement
- ○ Education agency
- ○ Social service agency
- ○ Veteran or Veterans Organizations
- ○ Provider of mental health services
- ○ Provider of alcohol and other drug services
- ○ Medical or health care organization

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA Consumer Survey

14. Is there anything else you would like to share about your experience? Please write your comments in the box below.

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA Consumer Survey
Demographic Form

* 19. What is your race? Please select all that apply.

- ☐ White/Caucasian
- ☐ African American/Black
- ☐ Asian or Pacific Islander
- ☐ American Indian/Native Alaskan
- ☐ Multi-Race
- ☐ Other (please specify):

* 20. In which part of Santa Clara County do you live?

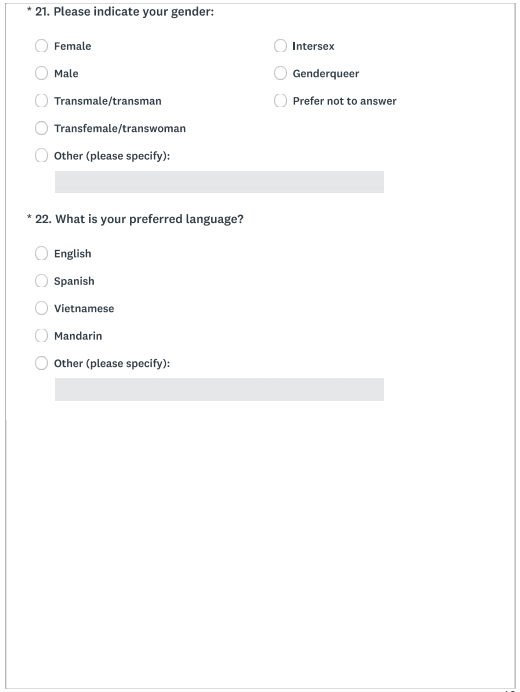
- ○ Campbell
- ○ Cupertino
- ○ Gilroy
- ○ Los Altos
- ○ Milpitas
- ○ Other (please specify):
- ○ Monte Sereno
- ○ Morgan Hill
- ○ Mountain View
- ○ Palo Alto
- ○ San Jose
- ○ Santa Clara
- ○ Saratoga
- ○ Sunnyvale

* 17. Please indicate your age range:

- ○ Under 16
- ○ 16 - 24
- ○ 25 - 59
- ○ 60 and older

* 18. What is your ethnicity?

- ○ Hispanic/Latino
- ○ Non-Hispanic/Latino


* 21. Please indicate your gender:

- Female
- Male
- Transmale/transman
- Transfemale/transwoman
- Other (please specify):
- Intersex
- Genderqueer
- Prefer not to answer

* 22. What is your preferred language?

- English
- Spanish
- Vietnamese
- Mandarin
- Other (please specify):

13

The purpose of today is to help the BHSD identify and prioritize community needs, especially around MHSA programs and services.

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?

   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?

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?

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

MHSA Listening Session- Gilroy

9/17/2019 conducted in Spanish

Background on MHSA history and local funding allocation provided.
CSS 76%, 51% for FSP (Children, TAY, AOA, Criminal Justice Involved)
PEI 19%, 51% for ages 0-25
INN 5%

EXPERIENCE	**Access:** Rebekah Children's Services, Behavioral Health Call Center, Primary Care, Pediatrician, Gilroy VMC, Kaiser, Private Insurance, Starlight Youth Services. Lack of transportation to appointments in San Jose Language barriers with provider No local mental health clinics for adults - don't have local mental health services for us (mothers of children who receive local services) - don't get call backs - I can't go to San Jose - I'm in a waiting list - I don't know where to go for mental health services Lack of appropriate care for my son with autism spectrum Pediatricians not helping access care for my children Cannot find support to get assessments for IEP or 504 plans No transportation to KidScope
NEEDS	Transportation No local mental health clinics/services for adults No language access
IMPROVEMENTS	Provide mental health services to fathers/men Open up a clinic in Gilroy for family mental health services (e.g. adult services)

MHSA Listening Session- Bill Wilson Center

9/23/2019 TAY

Background on MHSA history and local funding allocation provided.

EXPERIENCE	**Access:** Crisis hotline Bill Wilson Next door solutions There should be an App Telepsychiatry Home/grandma's Doctor Bill Wilson Downtown San Jose is where I go for services
NEEDS	Transportation More public awareness Better variety of therapists More access to resources More information about medication Better facilities for more people that need help *less hoops to jump through to access resources Open about insurances taken Better screening for therapists Ongoing education/training for therapists Increase housing programs - long term - short term - permanent facilities that cater to disabilities housing for "more functional clients" as a criterion
IMPROVEMENTS	Therapists Psychiatry meditation Make consistent case management Faith services Staff and Bill Wilson provide resources Getting a screening or diagnosis for SMI *self-motivation Affordability Transportation Working but not making enough to keep housing

	Housing access HUD Marketing of mental health services - Where to go for services? - Clarity about criteria and requirements Better staffing - Professional - More training - Take their job seriously - Shorten wait times More community outreach More rehabilitation Work training programs for re-entry individuals Create more rehabilitative services in custody, addressing youths Housing/faster application Rapid housing Subsidized, income-based first place for youth

Additional comments from comment forms:

- Today I feel was very informative and helped me realize what resources we need but don't have
- Better screening of mental health conditions
- Involve political activity to strengthen the effect of the community's cause and achieve greater goals
- Better marketing for the resources we don't have
- Better resources!!!
- To continue to consider input from clients
- Continue to strengthen outreach and marketing
- My goal is to leave California
- Good presentation (talk)
- Goals for the future: good home, a job that pays good
- Provide more public awareness/marketing of services
- Greater <acceptances> of insurance
- (smaller) waitlist
- Housing services
- Services for foster youth (current/former)
- I think it would be great for individuals who have severe anti-social behavior such as Asperger's, psychopathy to have access to housing for those who seek isolation
- I believe we need more marketing on the resources we do have, better resources

MHSA Kick Off Meeting - Stakeholder comments

10/01/2019

For meeting content, refer to PPT.

Comment #1	Need collaboration and more older adult and cultural competent programs
Comment #2	Identify current gaps in continuum of care and stabilization
Comment #3	It was a good overview. I would like to know what process/structure is in place to ensure (that) as programs are being developed, (that) there is an integrated, coordinated, systemic approach and leverage community systems and not be a silo program.
Comment #4	Thank you for including the legislative update. Toni, I appreciate the history.
Comment #5	I really wanted to see how things were progressing with the mental health services act. I've attended meetings in the past and wanted to check-in and hear how things are going.
Comment #6	Good information, I will think of the housing part to improve the mental health patient service.
Comment #7	Great updates and summary to let us know where we are. It's great to hear the legislative updates and wonderful to have Toni here also.
Comment #8	Where ever possible, please do not use (an) achronims – ex O.A.C. New here – would help to understand what is communicated.
Comment #9	Comprehensive program tracking that is accessible to programs, program managers and consumers.
Comment #10	Great to come together for this next year. Enjoy reconnecting with colleagues from last year and meeting new members. History was valuable to give context of field work on mental health by public sector. Inspired and 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 and covering key info.
Comment #11	Recovery and resilience are so important for prevention and for long-term sustainability…both for caregivers and those we serve. Can you facilitate a community meeting/outreach in Milpitas? I can find space and spread the word. (Nicole Steward 408.771.3950)

Comment #12	Can meetings take place earlier in the day? At minimum 1-3 or even on AM.
Comment #13	Page 7, slide 14: would appreciate more specific information details than what is shown under "FY18-20Plan" 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 Services Bulleting, www.sccbhsd.org "news and stories" web page, Stanford University's Center for Youth Mental Health and Wellbeing Initiatives webpage. Can you put more update content on sccbhsd.org/mhsa?
Comment #14	As a part of an innovation project, this county's BHS should develop and implement a program to improve the workplace culture of mental health agencies in the county. Some not significant support and trainings on selfcare for providers, it is not enough to counteract the malfunctioning of this community mental health workplace culture.
Comment #15	Meeting was great. Welcome by Director, history was good. How did we get where we are today? Prevention, prevention. We need to talk about innovation in future meetings, (the) homeless.
Comment #16	Can't wait to get to work. Let's start planning. Can we have more plates ha ha ha!!!!

MHSA Listening Session- Mitchell Park Community Center – Palo Alto

10/09/2019

Background on MHSA history and local funding allocation provided.

EXPERIENCE	**Access:** Uplift 24-7/5150 Crisis Text Line 741-741 RENEW Alum Rock Community Solutions County Call Center MHUC Emergency Room Teachers/Schools Psychologists Police Faith Leaders Trusted adults MHACC Peer Community Groups (peer support) Cultural support groups (National Compadres Network) Outlet Youth Space **Services:** Case management Medical Management (within a service team) Family/Individual therapy Acculturation Intensive outpatient Substance use prevention Jail-diversion/ probation /re-entry Parent unification ACS crisis Residential treatment Truancy abatement Support groups for LGBTQ Parent/family support for LGBTQ (limited) Parent/teacher/professional education MHUC: fantastic, but wait times for medication relief delayed Crisis residential facilities (decrease ER visits, decreases hospitalizations) Crisis Text Line (positive/confidential/not in person circle) District partnership with CASSY MediCal: 0-6 yrs kid services Respect to community/diverse populations Suicide prevention Gatekeeper trainings/MH 101/SP 101/YMHFA

NEEDS/Challenges	Wait times Workforce - Building a pipeline - Professional/paraprofessional - Change in requirements Prevention work - Creates barriers in pulling youth out of class - Policy changes - Stigma Cultural barriers Knowledge of resources/availability Marginalized community, uphill battle Overwhelming need in community not matching existing resources Accessibility places - Location - Community venues
IMPROVEMENTS	Navigating the county/mental health services/private-public Limited funding for Social-Emotional-Learning (SB 1004) → PEI Finding providers that are understanding and supportive of LBGTQ communities Integrated community clinics – build on mental health urgent care model Beds in county for youth mental health services

Additional comments from comment forms:

- satellite MHUC primary care county clinics
- intergenerational PEI Services
- accessibility and cultural tailored gatekeeper training, intervention, peer support and prevention
- to learn what new services are being offered and what efforts are being made to improve system
- of care
- find ways to join efforts with knowledge and partnership
- To hope to have influence on where funds go
- To make sure facilitators are listening
- Very helpful, good information
- I want to continue the conversation about potential collaborations and learn how to get new projects going
- I enjoyed hearing about the different resources available as well as the various problems that face us. I'd like to be involved in helping with solutions, specially at the school sites.
- Very informative, MHSA framework, services. I was able to address major concern for our organization and receive relevant resources. Thank you.
- Find ways to access the funding.

Stakeholder Leadership Committee Planning Meetings
October 15, 2019

Children: Needs Assessment Findings

RDA's needs assessment findings revealed the children's system is robust and appears to be meeting the needs of children and families in the following areas:

- Services start in the 0-5 age range and continue throughout childhood.
- Investments begin with early identification and referrals through mental health and wraparound services.
- There are consistent uses of Evidence-Based Practices (EBPs).
- Services are throughout the County in places where children and families are mostly like to be.
- There are strong partnerships among agencies that serve children.

However, most of the data come from children who are involved in the system in some way so it can be hard to know if there are groups that are falling through the cracks.

Current Programs and Services for Children in Santa Clara County

Programs: Children and Families		
Community Services and Supports (CSS)	Full Service Partnership	❖ Children's FSP (Increase capacity by 100)
	General System Development	❖ Kid Scope/SED EPSDT Expansion Services ❖ School-Linked Services- Treatment ❖ Mobile Crisis/ Transition Services ❖ Mental Health Wellness to foster youth in the Independent Living Program (ILP) ❖ Foster Care Development Juvenile Justice Development
	Outreach and Engagement	❖ Culture is Prevention Program ❖ LGBTQ Center (drop in)
Prevention and Early Intervention (PEI)	Prevention	❖ School Linked Services- Prevention ❖ Mentor Parents Program ❖ Triple P Parenting ❖ Nurse Family Partnership ❖ Violence Reduction Program
	Access and Linkage to Treatment	❖ Kid Connection Network of Care ❖ Early Screening and Assessment ❖ Developmental Behavioral Pediatrician ❖ Early Childhood Universal Screening Project ❖ *Reach out and Read*

Group Activity Worksheet: Assessment of MHSA Services

Activity Overview: The main purpose of this exercise is to evaluate your current MHSA services to see what aspects are working and what might need to be changed.

What should stay the same?

- unsure as there are a few programs I'm familiar with within this area

What should be changed?

Groups of children (and adults) falling through cracks, yes!!

1. working poor (no MCAL, can't afford food vs. copay)
2. homeless RV population: kids get some school help, but adults?
3. Latino communities, same plus more, and other immigrant communities
4. Present a South County Plan

Publicize the MHSSA
Set up support to bill MCAL it that is a requirement to get funding
Remove the red tape and bureaucracy
What SLS (School Linked Services) pays for is not practical, sometimes funds are returned
SLS vs. MHSA PEI funding, lack of clarity, overlap?
PEI should be in ALL schools not parts of districts
Don't make parents/patients call all over: Intake and Match!
-Leverage existing resources, ie First Five FRCs to be intake hub instead of funding cuts
-Communicate MHSSA grants
- the lack of equity by meeting continually in San Jose, omitting voice of those who need additional support
- there are so many programs yet little awareness of what's available for youth
- School districts should be provided with information that directly relates to schools, school-aged youth, and families
- schools are required to notify parents 2X per year about services and MHSA funds may be used for this work

What should be added?

Need greater comprehension across county of what is available, e.g. school linked services
14 school districts have SLS coordinators, others do not
Clarification of Access, make travel possible
New comers: refuge supportive MH services, other help with navigation, regardless of ability to pay

Expand prevention
Training for providers

Groups of children and adults, falling through the cracks, Yes!

- Working poor, no MCAL, can't afford food vs copays
- Homeless RV pop kids get some school help, but the adults?

Cover gap areas, south county, mid county
Welcome/Access, dynamic database for intake and access
Newcomer programs, culture systems, better language access

Ensure that the Santa Clara County Office of Education has access to what's available for all school districts and how to access supports as the SCCOW acts as the conduit for districts
Add a direct liaison form SCC Mental Health to coordinate services for schools through the County Office of Education

What should be removed?

Remove funding silos, e.g. SLS and PEI

Remove the lack of inequitable distribution of MHSA funds to address the youth in our county who need additional support.

Older Adults: Needs Assessment Findings

Older adults face complex needs, which makes it difficult to provide services and supports.

- Intersections between **depression, early dementia, and physical health concerns** require specialized expertise and service environments.
- There is an important need for services to support aging in place that addresses emerging mental health and physical health issues and the complexity of mental health, substance abuse, and suicidality.
- Additionally, a key component of supporting aging in place is to provide needed services and support to caregivers.

Older adults experience isolation and may have difficulty accessing services outside of their home.

- Services may be more accessible when provided where seniors already are (i.e. nutrition centers, home)
- Services may be more inviting if paired with an activity-based program.
- Services may be more effective with a senior-specific interdisciplinary team.

Current Programs and Services for Older Adults in Santa Clara County

		Programs: Older Adults
Community Services and Supports (CSS)	Full Service Partnership	❖ Older Adult Full Service Partnership (FSP)
		❖
	General System Development	❖ Connections Program ❖ Outpatient/Intensive Outpatient Services ❖ Older Adult Collaboration with Senior Nutrition Centers Expansion ❖ NEW: Clinical Case Management Team for Older Adults (in development)
	Outreach and Engagement	❖ Golden Gateway Comprehensive Older Adult Program
Prevention and Early Intervention	Prevention	❖ NEW: Older Adult In-Home Peer Respite Program ❖ MODIFIED: Elders' Story Telling Program

Group Activity Worksheet: Assessment of MHSA Services

Activity Overview: The main purpose of this exercise is to evaluate your current MHSA services to see what aspects are working and what might need to be changed

What should stay the same?

- FSP eligibility: 1 hospitalization, outpatient, housing flex funds

What should be changed?

- Neighborhood housing option? Room match pending, case manager
- AOA foster families

What should be added?

- Add services for developmentally disabled elderly adults that treat them in an age appropriate manner. Not as "young" needing to learn basic skills already have or can't develop.
- Housing
- Mental health
- Supervision (meds and food)
- share collaborative housing
- club house model
- training for managing life skills (budget/cooking)
- volunteer programs, earning points (e.g. Sunday Friends model)

What should be removed?

<< no input provided here >>

Stakeholder Leadership Committee Planning Meeting
October 15, 2019

Transition Age Youth (TAY): Needs Assessment Findings

Overall, the TAY system of care for TAY is less developed than other areas.

- Many of the TAY-specific services are centralized, which can be a challenge if a youth lives in certain geographic areas or has needs outside the scope of existing services.
- Some children's services go up to 18 and some to 21, and TAY who have been involved with the children's system more easily transition into the TAY system.
- Where the children's system ends or for TAY who are just becoming involved with mental health services, the system is less able to identify and provide for their needs.

The TAY system should consider how to best support TAY to launch into adulthood, and for those who need it, how to transition into the adult system.

Current Programs and Services for TAY in Santa Clara County

Programs: TAY		
Community Services and Supports (CSS)	Full Service Partnership	❖ TAY Full Service Partnership
	General System Development	❖ TAY Outpatient/Intensive Outpatient Services ❖ Community-Based Drop-in Centers (Bill Wilson) ❖ Overnight Respite Care (Bill Wilson) ❖ Workforce Development and Peer Support (Bill Wilson)
		❖ Mental Health Wellness to foster youth in the Independent Living Program (ILP) ❖ Foster Care Development ❖ Commercially Sexually Exploited Children (CSEC) ❖ Services for Juvenile Justice Involved Youth ❖ New: TAY Interdisciplinary Service Teams
	Outreach and Engagement	❖ New: Multi-generational culture-specific wellness centers (Latinos, API, African American, Native American, and LGBT+ communities) ❖ New: TAY Triage to Support Re-Entry
Prevention and Early Intervention (PEI)	Prevention	❖ Violence Reduction Program
	Early Intervention	❖ Direct Referral Program Commercially Sexually Exploited Children (CSEC) ❖ Raising Early Awareness Creating Hope (REACH)

Group Activity Worksheet: Assessment of MHSA Services

Activity Overview: The main purpose of this exercise is to evaluate your current MHSA services to see what aspects are working and what might need to be changed.

What should stay the same?

- Multigenerational cultural wellness centers
- Drop-in centers

What should be changed?

- In the future consider expanding the cultural wellness centers to beyond current populations/groups, like Allcove
- Workforce development and peer support, look more like innovation
- Respite program is not an actual shelter.
- Need a TAY emergency shelter (environment) that preserves the dignity and ensures wellbeing. Links them to long term sustainable housing and mental health services

What should be added?

- Add Substance withdrawal program for young adults on ADHD meds who want to stop them. Dealing with the world off meds, physical and mental dealing with withdrawal issues.
- Educate PCPs on this issue they know nothing about. This and how to help patients through the physical side.
- BWC programs/add more providers and more locations beyond San Jose (no South County)
- Create more long-term supportive housing for TAY (years vs days) to prevent trauma.
- Prioritize wellness centers in South County and East County
- Add commercial insurance for REACH program
- Parent involvement/education of TAY
- Partnership with colleges (counseling centers)
- Youth outside of school systems are also prioritized (homeless, human trafficking, transition from incarceration, working, immigrant youth)
- Stress management, social-emotional learning/resilience programs
- PTSD support
- Coordinated substance use prevention services ($, programs, staff)

What should be removed?

- Dissolve silo-ing of funds

MHSA SLC Planning Meeting - Stakeholder comments

Valley Specialty Center, San Jose, CA

10/15/2019

For meeting content, refer to PPT.

Comment #1	Good work from all involved!
Comment #2	Some people were a little confused about use of MHSA – maybe a quick refresher next time.
Comment #3	How about including a target population on maternal mental health for expectant mothers and post-partum mothers.
Comment #4	Thank you!
Comment #5	Anything on gang violence and services for older LGBT?
Comment #6	Overview of current programs and ask??s to evaluate
Comment #7	Will flesh out and comment later.
Comment #8	A bit long but worth it.
Comment #9	More outcomes data on specific TAY programs. We want to make our recommendations more educated and based on data from current programs.
Comment #10	Small groups is good, but it is kind of hard to gather all the comments.
Comment #11	It felt like I needed more people who were boots on the ground – people who try to connect people to services and 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?
Comment #12	Intervention support for providers/teachers. Workplace safety/supportive places of work.
Comment #13	Very good meeting, productive, good discussion, a lot of ideas. Thank you.
Comment #14	Good meeting to share thoughts!

MHSA Listening Session- Milpitas

10/29/19

Background on MHSA history and local funding allocation provided.

EXPERIENCE	**Access:** Case manager/office number, no direct line Primary care doctor Mental health urgent care At school: uplift, alum rock Call center (first intake/non-specific) Crisis hotline Crisis textline Milpitas residents cannot easily go to San Jose Kaiser Milpitas PD CASSY, but only for >18+ year olds at few schools CASSY teen center Church Senior center (Milpitas) Rec center (gym) Received festival information Domestic violence info Offer materials at events HOPE: Milpitas SP efforts MPD has been supportive/responsive/gender-appropriate officer MHUC: Thursday AM around 10-11am, one receptionist, zero customer service - 20 minute wait without waiting clients - 40 minutes without contact - Zero de-escalation, no separate provider - 3-4 hours without being seen, - The look and feel is not welcoming Uplift/ARCC: busy Waiting for help to arrive Zip codes: Bill Wilson -> from police or dropped off Catholic charities Sacred heart **Services:** Drop in center/youth safe home/crisis center (eg Bill Wilson) Providers, locally, right now: San Jose - Resource center/community wide e.g. city hall - More active NAMI presence County training first responders

NEEDS/Challenges	Isolated individuals Support for parents Youth (6-week services, increase level or care) What happens when kids turn 18yrs? Life skills training Referral out into higher level of care, they fall off at step 1 level of care
IMPROVEMENTS	Transportation Language Vietnamese, Chinese, Punjabi, tagalog Cultural barriers, decrease stigma - AACI More services, whole range of ages More training available to general population - MH 101 (1-2 hours) - Understanding MH - Language appropriate More crisis to home/family **Create IHOT for school-aged kids - More CASSY counselors - Increase SLS Make own decisions (consumer lens) Increase support Increase family support

Additional comments from comment forms:
Appreciated the meeting. It was great to be in Milpitas and hear from our community. I'd love to have more opportunities to share the needs. Thank you!
We need services in Milpitas, please!!
I think small group meeting is good. Very productive. A lot of information.
City (of Milpitas) is supportive and has space for meetings and trainings. Contact me if you need room space. tmclane@ci.milpitas.ca.gov

MHSA Listening Session 11/12/2019

Santa Clara County Office of Education

2004 voters approved Prop. 63
Designated tax, 1% tax on incomes of greater than $1 mil,
Amount of people in a county, number identified as SMD, and number of millionaires = 4.5-6.3%
We collect 60-90 million annually in SCC to fund mental health services
2006-2009 revised to include

CSS- direct services (76% total expenses). Clinical services, counseling
FSP = 51% out of the 76% (housing, physical health, food for children, TAY, older adults, re-entry programs)

PEI= 19% in SCC for upstream intervention. Early years, 0-5 young children.
51% of the 19% should be used for 0-5 aged children
Early intervention is up to 18months.

Innovation- 5% on innovative ideas. One is the client and consumer employment program is one of the MHSA Innovation projects.

Fiscal year 2021-23. Finalizing fiscal year 18-20. Finalizing the 2020 FY plan and planning the 2021-2023 plan simultaneously. We're behind two years because we completed the county needs assessment.

Experience	**Access:** call center, EAP call line for employees, First 5, RCS, Bill Wilson, CHAC, Community Solutions, Discovery Counseling, Alum Rock, ACCI, Uplift, Momentum, Primary Care, Pediatrician, Kaiser, Private Insurance, on-line, Zephyr, Seneca, Starlight, **Call center-** usually takes an hour to an hour and a half / 911/ School Linked Services supports families with linking through the call center. If the support from SLS did not exist, it would be very difficult for families to navigate. It almost takes a professional to support a family. It takes approximately a month an a half with a personal experience shared in the room.Multiple tests are required prior to getting support. It depends also on the time of the year the referral is given. Language is a challenge. Foster youth are still waiting for referrals. **What Services Are Available?**: Classes. Workshops, psychiatric, counseling, TBS, FSP, **I don't know what else exists. Gap between medical and private. Middle population is those that can't pay out of pocket, yet have insurance and can't find a provider (Cupertino and everywhere) Not many places to send folks unless they can pay out of pocket- clinical services, medication, support.** Acuity level is also an issue, higher need for advanced level support. Huge uptick in high needs, high risk in PEI and SLS. We're going to be looking at the classification of PEI. ~~PEI requires that they meet medical necessity~~. Services can be provided for more than

	three sessions. Three to six months of services. SLS will have a public forum to revisit the program. Most helpful: stress management classes. Non public agencies pick up services of those they serve transitioning from a school-based referral. For the most part in house services has been beneficial (Cupertino) especially for students with IEPs. Agreement that working with in-house with one mental health provider per school (Rocketship) . Partnerships with First 5's is essential. For those providing within , funded by grants, LEA, LCAP, ERMHS, etc. **Challenges:** No access to clinics during the holidays. More upstream services that are truly preventative, help for depression and support for those to take the first step to seek help. Are there laws asking for Tier 1 supports. PEI manager: Roshni SB 1004: State has defined x areas of focus and build outcomes for early intervention, suicide prevention and childhood trauma. Early prevention and intervention should be available to all. State will release to all counties what they're looking for to prevent suicide and childhood trauma. Funding is available through MHSA. From a Tier 1 lens, from a school perspective, are we looking at what a school can provide? How can we align multiple protective factors addressing (violence prevention, suicide prevention, bullying prevention, CSEC, SEL, TUPE, etc.) SKY teaches breathing techniques to youth to support their behavioral health. SPED from County Office of Education: Extreme anxiety and perfectionism. Do not get support until there are high needs of care. Having all the care in each community so they can get what they need. Every community needs to full service support. Sometimes we send students out of state. Highly aggressive/assaultive/emotional needs students in NPS who need support. Out of school because no one will take them. **January 21st: MHSA Forum for the Public at the SCCOE to come in and have workshops to discuss issues.**
Needs	Foster youth, homeless youth, LGBTQ, refugee, juvenile justice youth, asylum seeking students, undocumented, CSEC, native american population, culturally responsive services (african american youth, suicide rates for asian americans, certain areas based on data points) students with disabilities, those who are resistant to support, reducing stigma of mental health supports, normalizing self-care, mothers, single parent, care- providers, service-providers, educators
Improvements	**Improvements:** Inventory, align, and share resources to critical stakeholders. In large urban city, there was cross team work to reduce overlap and inefficiency. CAST is working on the integration and network adequacy= not enough providers. Ensure that MHSA is represented at CAST. Promote connectedness. Social Thinking for students on the spectrum. More communication about what's available and knowledge being

	shared. Invest in a media campaign. Is there extra money? Because there is need and unspent funds, we using unspent funds but there will be a limited amount of time to do that. Healthy communities and healthy schools. Tier 1 school climate work. Integrated systems of support. We support PBIS. Restore music, art, health, Shifting towards an outcome based system for accountability, data, evidence-based programs to support. Whole child and whole family. Define prevention and intervention. First 5s , Family Resource Centers, pull together all the services and have them funded in a way that supports alignment. Learn how to “package” programs to serve youth and families. **Create:** Prevention education for youth and parents that supports all Paradigm shift that health and wellness for all without having to be in trouble to use it. Is there a needs assessment that identifies the barriers? What action is being taken to ensure that the action suggested are taken? Regular feedback loop with schools/districts MHSSA Act grant in the spring PEI funds are restricted and difficult. Funds will go through a long, public process.

South County Suicide Prevention Workgroup Listening Session
Morgan Hill
Date: December 19, 2019

Notes:

(pre MHSA discussion)
Open acceptance of all members at local churches is a challenge and tricky conversation
Individuals from LGBTQ community do not feel welcome at some churches
Need to make sure that the County and City, as a public entity, is messaging clearly when working with faith community

MHSA Staff:
- provided overview of MHSA to the group (Prop 63 and MHSA components)
- shared about open South County seat on SLC
- shared survey information to the group
- shared CPPP timeline

Question asked about how South County can utilize Innovations funding

South county wants to understand what are the services available (and what's missing) in South County -- a comprehensive list would be helpful

→ define south county, Gilroy and MH are so far from each other -- look at MH and Gilroy and not look at it as one entity because of geographic barriers (transportation is an issue between these cities)

How does this translate into human beings on the street? Map out what actually is in south county
Sheet of services needs updating (workgroup has)
-- there was some funding, but the dollars sunsetted
-- need a dedicated person to continue updating this

San Martin is so isolated
Group wanted to make sure that SC was getting its fair share of dollars → figuring out the solution to this is
Interest in knowing what projects were funded through INN funding in last 3 year plan

Brief discussion about previous listening session in Gilroy - have services for kids, but moms felt they did not have a place to go when they needed help → there was some agreement from the group

Who do we call when we need services?
-- call center needs improvement, 90 minute time for call center (12/18/19), mom was in tears
-- average time is 60 - 90 minutes per call
-- sometimes they get disconnected, sometimes language is rough
-- families hand up and staff has to make calls with them (not best use of time)
-- how can we improve call center timing? Families just give up
-- SC needs a location that is not the call center (call center is a barrier)
-- can we put an emergency place to get support/connection to resources in between MH and Gilroy?

-- sometimes barrier is insurance -- some services only for Medi-Cal, but what about people who have private insurance?
-- need a mental health urgent care in south county for connections and support
-- getting access to MH services "is a job" -- people who really need the support don't have the patience to do this
-- what about the families who don't come to us? They say the call center hangs up on them or they don't understand the folks at the call center; often discouraging to many people
-- schools and communities find call center very difficult
-- families who need monolingual language ask for "Spanish" and do not get someone who speaks Spanish -- need someone there who will translate, which is also a huge cost for the center, non-profit, etc.
-- question asked if MHSA dollars fund call center → No
-- are there resources around providing outreach funds? Those can't be medi-cal billed
-- positive response to Promotores contracts from group
-- interest in wellness centers as well -- want to make sure the centers are talking with the family resource centers → this is across the lifespan

ADDITIONAL COMMENTS FROM STAKEHOLDER COMMENT FORMS:
1. We need more comprehensive services in South County (Morgan Hill and Gilroy) or just one city. Call Center needs to be easier to access/use (average time to b e referred in 90 minutes). We need psychiatric services in Morgan Hill and Gilroy (med management).

2. Morgan Hill and Gilroy communities need a one stop "shop" for mental health services, one on one, family, group therapy, support groups, medication support, crisis intervention.

3. Process for obtaining project-specific/program-specific funds from MHSA.

4. We need more services/outreach in Morgan Hill/Gilroy. We need call center process to get better. Very difficult process – long, sometimes disconnected, etc.

5. We need more services in Morgan Hill: WRAP, transition, high level.

6. Today's meeting was very informative to better understand the MHSA and how it affects South County.

Mental Health Services Act Planning Forum

Please join the Behavioral Health Services Department for the Mental Health Services Act (MHSA) planning forum open to the County of Santa Clara community. The forum will provide a venue for consumers/clients, families and other community supports to discuss, inform and prioritize program and innovations planning for Fiscal Years 2021-2023 addressing the following three key areas:

- **prevention and early intervention with a focus on children and youth**
- **prevention of homelessness**
- **workforce education and training**

Join Us

2020 MHSA Forum
Tuesday January 21, 2020
8:30 AM-4:30 PM
Santa Clara County Office of Education
1290 Ridder Park Drive, San Jose, CA

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA
WELLNESS · RECOVERY · RESILIENCE

Breakfast and lunch will be served. REGISTER via our Eventbrite link:

https://2020mhsaforum.eventbrite.com

Need special accommodations, translation services and/or transportation to and from the event? Please indicate it on the sign up link. To reach someone right away, please call (408) 885-5785 or email: mhsa@hhs.sccgov.org

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.

Santa Clara County Office of Education

COUNTY OF SANTA CLARA
Behavioral Health Services

2020 MHSA Planning Forum
January 21, 2020, 8 a.m. – 2 p.m.
Santa Clara County Office of Education
1290 Ridder Park Drive, San Jose, CA

8:00 – 8:30	**Breakfast, Registration & Resource Tables**	San Jose Room
8:30 – 8:50	**Welcome and Opening from Behavioral Health Services Director** *Toni Tullys, MPA* *Director, Behavioral Health Services*	San Jose Room
8:50 – 9:00	**Address from County Superintendent of Schools** *Mary Ann Dewan, Ph.D.*	San Jose Room
9:00 – 9:20	***Mental Health Services Act (MHSA) Overview and the Sessions of the Day*** *Evelyn Castillo Tirumalai, MPH, Mental Health Services Act (MHSA) Coordinator*	San Jose Room
9:20 – 9:30	**Break & Stretch**	--
9:30 – 10:30	**Breakout Group #1: Overview, Input & Sharing by System of Care** *Session A: Prevention & Early Intervention, Roshni Shah, MPH* *Session B: Prevention of Homelessness, Evelyn Castillo Tirumalai, MPH*	San Jose Room Educator Resource Center – Room 1 & 2
10:30 – 10:40	**Break & Stretch**	--
10:40 – 11:40	**Breakout Group #2: Overview, Input & Sharing by System of Care** *Session C: Prevention & Early Intervention, Roshni Shah, MPH* *Session D: Workforce Education & Training, Jeannette Ferris, MPH*	San Jose Room Educator Resource Center – Room 1 & 2
11:40 – 12:30	**Lunch, Networking & Resource Tables**	
12:30 – 1:30	**Breakout Group #3** *Session E: Innovations, Gina Vittori, MPH: Overview of Innovations, Current Innovative Projects, Innovations Submission Process, Breakouts by Topic: Prevention & Early Intervention, Prevention of Homelessness, Workforce Education & Training*	San Jose Room
1:30 – 2:00	**Closing & Next Steps with Stakeholder Leadership Committee** *Open to all*	San Jose Room

WELLNESS • RECOVERY • RESILIENCE

OVERVIEW OF THE
MENTAL HEALTH SERVICES ACT (MHSA)
PLANNING FORUM
JANUARY 21, 2020

COUNTY OF SANTA CLARA
Behavioral Health Services

1

WHAT IS THE MENTAL HEALTH SERVICES ACT (MHSA)?

The Mental Health Services Act (MHSA) s a ballot measure passed by California voters in November 2004 that provides new funding for *public mental health services*. The Act imposed a 1% taxation on personal income exceeding $1 million.

Question on the ballot:
"Should a 1% tax on taxable personal income above $1 million to fund expanded health services for mentally ill children, adults, seniors be established?"

Prop. 63 passed with 6.2 million 'Yes' votes (53.8%)

2

2

NOTABLE RESTRICTIONS IN THE ACT

- No supplantation of state or local funds for mental health
- Maintenance of effort in state spending on mental health
- Target population limited: serious mental illness/serious emotional disturbance
- State parolees excluded

Acknowledgement: County Behavioral Health Directors Association of California (CBHDA)

3

3

REGULATIONS AND OVERSIGHT

State Governance:
Department of Health Care Services (DHCS)
https://www.dhcs.ca.gov/formsandpubs/Pages/Letters.aspx

Mental Health Services Oversight and Accountability Commission (MHSOAC)
https://www.mhsoac.ca.gov/

4

4

LEGISLATION AMENDMENTS AND CHANGE*

AB 43 (Gloria)
AB 480 (Salas)
AB 306 (Ramos)
AB 563 (Quirk Silva)
AB 480 (Salas)
AB 713 (Mullin)
AB 1126 (O'Donnell)
AB 1443 (Maienschein)
SB 192 (Beall)
SB 582 (Beall)
SB 604 (Bates)
SB 688 (Moorlach)
SB 539 (Caballero)
SB 1004 (Wiener)

- Listed to depict bills brought forth by Sacramento law makers with potential changes to MHSA implementation. Not all bills were approved, others will be reviewed in 2020.

5

5

COMMUNITY PROGRAM PLANNING PROCESS

- MHSA CPP processes, per regulation must include:
  - **Stakeholder input**
    - Training (CCR, 9 CA §3300).
    - Outreach to clients with serious mental illness (SMI) and/or serious emotional disturbance (SED), and their family members, to ensure the opportunity to participate (CCR, 9 CA §3300).
  - **A local review process** prior to submitting the Three-Year Program and Expenditure Plans or Annual Updates that includes a 30-day public comment period (CCR, 9 CA § 3315).
    - Behavioral Health Board Public Hearing
    - BOS Approval and Adoption
- MHSOAC Approval (for Innovations Projects)

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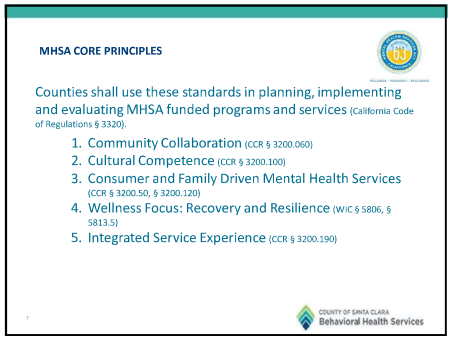
MHSA CORE PRINCIPLES
Counties shall use these standards in planning, implementing and evaluating MHSA funded programs and services (California Code of Regulations § 3320).
1. Community Collaboration (CCR § 3200.060)
2. Cultural Competence (CCR § 3200.100)
3. Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120)
4. Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5)
5. Integrated Service Experience (CCR § 3200.190)
COUNTY OF SANTA CLARA
Behavioral Health Services

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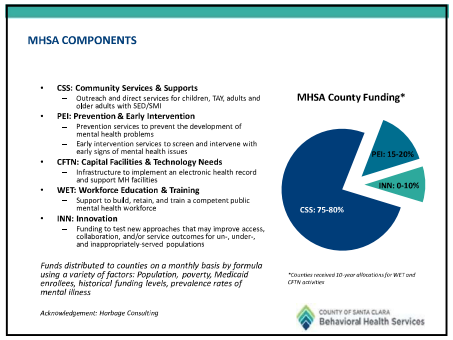
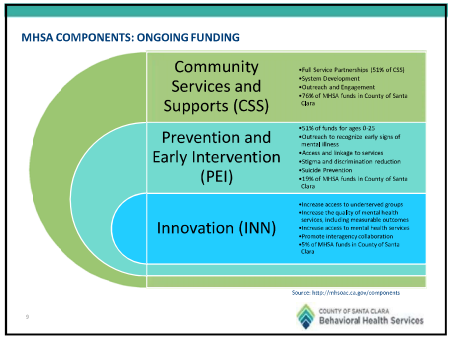
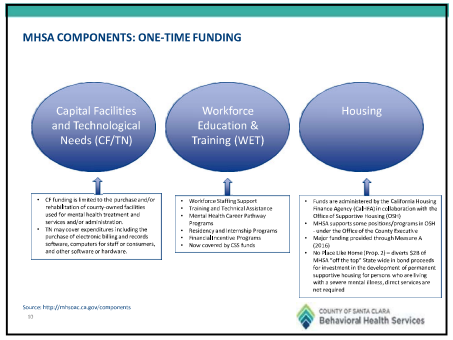

MHSA COMPONENTS
CSS: Community Services & Supports
Outreach and direct services for children, TAY, adults and older adults with SED/SMI
PEI: Prevention & Early Intervention
Prevention services to prevent the development of mental health problems
Early intervention services to screen and intervene with early signs of mental health issues
CFTN: Capital Facilities & Technology Needs
Infrastructure to implement an electronic health record and support MH facilities
WET: Workforce Education & Training
Support to build, retain, and train a competent public mental health workforce
INN: Innovation
Funding to test new approaches that may improve access, collaboration, and/or service outcomes for un-, under-, and inappropriately-served populations
Funds distributed to counties on a monthly basis by formula using a variety of factors: Population, poverty, Medicaid enrollees, historical funding levels, prevalence rates of mental illness
Acknowledgement: Harbage Consulting
MHSA County Funding*
PEI: 15-20%
INN: 0-10%
CSS: 75-80%
*Counties received 10-year allocations for WET and CFTN activities
COUNTY OF SANTA CLARA
Behavioral Health Services

8


MHSA COMPONENTS: ONGOING FUNDING
Community Services and Supports (CSS)
Full Service Partnerships (51% of CSS)
System Development
Outreach and Engagement
76% of MHSA funds in County of Santa Clara
Prevention and Early Intervention (PEI)
51% of funds for ages 0-25
Outreach to recognize early signs of mental illness
Access and linkage to services
Stigma and discrimination reduction
Suicide Prevention
17% of MHSA funds in County of Santa Clara
Innovation (INN)
Increase access to underserved groups
Increase the quality of mental health services, including measurable outcomes
Increase access to mental health services
Promote interagency collaboration
5% of MHSA funds in County of Santa Clara
Source: http://mhsoac.ca.gov/components
COUNTY OF SANTA CLARA
Behavioral Health Services

9


MHSA COMPONENTS: ONE-TIME FUNDING
Capital Facilities and Technological Needs (CF/TN)
CF funding is limited to the purchase and/or rehabilitation of county-owned facilities used for mental health treatment and services and/or administration.
TN may cover expenditures including the purchase of electronic billing and records software, computers for staff or consumers, and other software or hardware.
Workforce Education & Training (WET)
Workforce Staffing Support
Training and Technical Assistance
Mental Health Career Pathway Programs
Residency and internship Programs
Loan/Incentive Programs
Now covered by CSS funds
Housing
Funds are administered by the California Housing Finance Agency (CalHFA) in collaboration with the Office of Supportive Housing (OSH)
MHSA supports some positions/programs in OSH under the Office of the County Executive
Major funding provided through Measure A (2016)
No Place Like Home (Prop. 2) – diverts $2B of MHSA "off the top" State-wide in bond proceeds for investment in the development of permanent supportive housing for persons who are living with a severe mental illness, direct services are not required
Source: http://mhsoac.ca.gov/components
COUNTY OF SANTA CLARA
Behavioral Health Services

10


MHSA COMMUNITY PLANNING PROCESS
Results
What we have
Remaining Needs
Evaluate
COUNTY OF SANTA CLARA
Behavioral Health Services

11


REPRESENTATIVE STAKEHOLDER LEADERSHIP COMMITTEE
MHSA SLC is to assure that the recommended MHSA Plan:
Reflects local needs and priorities
Contains the appropriate balance of services within available resources
Addresses the criteria and goals established by the State Mental Health Services Oversight and Accountability Commission (MHSOAC)
COUNTY OF SANTA CLARA
Behavioral Health Services

12

ROLES AND RESPONSIBILITIES

- **Community Stakeholders**
  - Contribute insight, share experiences, provide recommendations
- **Stakeholder Leadership Committee**
  - Validate proposed programs and services for the 3-year MHSA plan
- **County Behavioral Health**
  - Implement Three Year MHSA Plan and Annual Updates
- **Behavioral Health Board**
  - Conduct public hearing of draft plans and validate recommendations
- **Board of Supervisors**
  - Approve Three Year MHSA Plan and Annual Updates
- **Mental Health Services Oversight and Accountability Commission (MHSOAC)**
  - Approve INN Project funding
- **Department of Health Care Services (DHCS)**
  - Conduct MHSA county plan reviews

COUNTY OF SANTA CLARA Behavioral Health Services

13

COMMUNITY PROGRAM PLANNING PROCESS INTEGRATED FY20 UPDATE & FY21-23 PLAN

14

MHSA Planning Forum Objectives

Provide a venue for consumers/clients, families and other community supports to discuss MHSA programs and services	**Address** key priority areas of need in County of Santa Clara's public mental health system	**Inform** and **prioritize** program and innovations planning for Fiscal Years 2021-2023

COUNTY OF SANTA CLARA Behavioral Health Services

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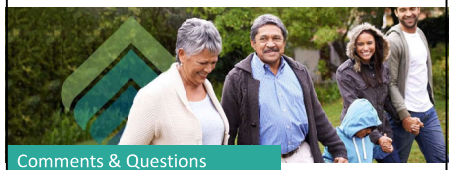


Comments & Questions

16

THANK YOU !

For more information:

408-885-5785 office

MHSA@hhs.sccgov.org

www.sccbhsd.org/mhsa

17

Mental Health Services Act (MHSA) Planning Forum

Prevention & Early Intervention (PEI)

Roshni Shah, MPH
County of Santa Clara
Behavioral Health Services Department
January 21, 2020

COUNTY OF SANTA CLARA
Behavioral Health Services

WELLNESS · RECOVERY · RESILIENCE

MHSA PEI
FAST FACTS

WHAT IS PREVENTION & EARLY INTERVENTION (PEI)?

- Prevention services to promote wellness and prevent the development of mental health problems
- Early intervention services to screen and intervene in early signs of mental health issues

PURPOSE OF PEI

- **Engage** persons prior to development of serious mental illness or emotional disturbance
- **Alleviate** the need for additional mental health treatment
- **Transition** those with identifiable need to extended mental health treatment

MHSA FUNDING FOR PEI

- 19% of County MHSA Funding
- **At least 51%** of PEI budget must be dedicated to individuals who are between the ages of 0 and 25

POPULATIONS SERVED

Persons **prior to onset or development OR at risk of developing serious mental illness or severe emotional disturbance** including:

- Underserved cultural populations
- Individuals experiencing onset of serious psychiatric illness
- Children/youth in stressed families
- Trauma-exposed individuals
- Children/youth at risk for school failure
- Children/youth at risk of or experiencing juvenile justice involvement
- Parents, caregivers, and other family members of the person with early onset of a mental illness

[1]Senate Bill 1004 – Standardizing MHSA-PEI Programs Fact Sheet. https://www.calhospital.org/sites/main/files/file-attachments/ab_1004_fact_sheet.pdf

PEI FUNDING CATEGORIES & CURRENT PROGRAMS (FY 2018 – 2020)

PEI FUNDING CATEGORY	DEFINITION OF CATEGORY	CURRENT PROGRAMS IN CATEGORY
Prevention	Programs to prevent the occurrence, severity, and consequences of serious mental illness for individuals with identified risk factors or for members of a group with demonstrated greater average vulnerability to mental illness	• Violence Prevention Program • Intimate Partner Violence Prevention • Support for Parents • Promotores
Early Intervention	Time-limited services for individuals with early onset of serious mental illness to promote mental health outcomes including recovery, wellness, and resilience, and to assist people in quickly regaining productive lives	• Raising Early Awareness Creating Hope (REACH) • Elders' Story Telling • School Linked Services (SLS) Initiative
Outreach for increasing recognition of early signs of mental illness	Conduct outreach to families, employers, primary care health care providers, and others to recognize early signs of potentially severe and disabling mental illness	• Older Adult In-Home Peer Respite Program • Community Wide Outreach and Training • Law Enforcement Training
Stigma and discrimination reduction	Activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families	• New Refugees Program • Ethnic and Cultural Communities Advisory Committees (ECCACs) • Culture is Prevention
Access and linkage to treatment	Create access and linkage to medically necessary care provided by county mental health programs	• Services for Children 0-5 • Office of Consumer Affairs • Office of Family Affairs • Mental Health Advocacy Project • Re-entry Resource Center • LGBTQ
Suicide Prevention		• Suicide Prevention Strategic Plan
Improve Timely Access to Services for Underserved Populations		• Culture-Specific Wellness Centers
Administration		

[1]Senate Bill 1004 – Standardizing MHSA-PEI Programs Fact Sheet. https://www.calhospital.org/sites/main/files/file-attachments/ab_1004_fact_sheet.pdf

SENATE BILL 1004
STANDARDIZING MHSA-PEI PROGRAMS

Senate Bill 1004 will standardize Prevention & Early Intervention (PEI) programs funded by the Mental Health Services Act (MHSA). Statewide standards for PEI programs will ensure that all children, transition age youth (TAY), and young adults have access to effective, research-based treatment that can stem the progression of serious mental illness and pave the way for a stable and successful life.[1]

Priorities for Senate Bill 1004:

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

[1]Senate Bill 1004 – Standardizing MHSA-PEI Programs Fact Sheet. https://www.calhospital.org/sites/main/files/file-attachments/ab_1004_fact_sheet.pdf

Group Activity Worksheet: Assessment of MHSA PEI Services

Activity Overview: The main purpose of this exercise is to evaluate the current MHSA PEI services to see what aspects are working and what might need to be changed.

What should stay the same?

What should be changed?

What should be added?

What should be removed?

[1]Senate Bill 1004 – Standardizing MHSA-PEI Programs Fact Sheet. https://www.calhospital.org/sites/main/files/file-attachments/ab_1004_fact_sheet.pdf

Breakout Groups
Discussion Guiding Questions

- What needs are most important to the group of people you represent?
- What do you see happening in your community because of these needs? (what problems are occurring?)
- What prevention services or resources are needed?
- What early intervention services or resources are needed?
- What keeps people from getting the prevention and/or early intervention services they need?
- What types of things or strategies would help people get the services they need?
- What recommendations do you have for how to let people know about prevention and early intervention services?

[1]Senate Bill 1004 – Standardizing MHSA-PEI Programs Fact Sheet. https://www.calhospital.org/sites/main/files/file-attachments/ab_1004_fact_sheet.pdf

1

PREVENTION

- Financial assistance/supportive services to stabilize at-risk households

Acknowledgment: SAMHSA

2

PREVENTION CHALLENGES

- Targeting
- Rapid re-housing placement
- Transitioning to stability
- Performance measurement

Acknowledgment: SAMHSA

3

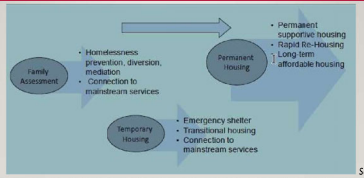
LESSONS FROM THE FIELD

- Need unified definition of "homeless" and "at-risk"
- Targeting assistance to the right people makes a difference
- Local context matters; learn from successful local, innovative models
- Focus on at-risk and homeless children

Source: SAMHSA

4

EMERGING MODEL



Source: SAMHSA

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MODEL ASSUMPTIONS

- Most families who receive an eviction notice do not become homeless
- Most families living in poverty do not become homeless
- Most families who *do* become homeless exit shelter and never return a second time
- Families who stay in shelter longer generally regress in the following areas: mental health, substance use, domestic violence, and children's performance in school

Source: SAMHSA

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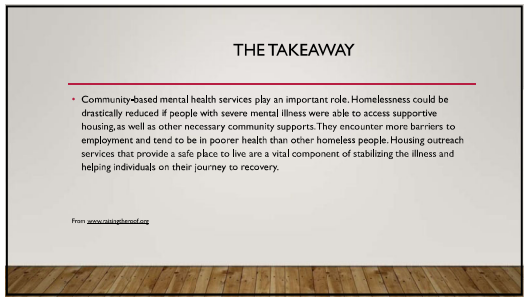
THE TAKEAWAY
• Community-based mental health services play an important role. Homelessness could be drastically reduced if people with severe mental illness were able to access supportive housing, as well as other necessary community supports. They encounter more barriers to employment and tend to be in poorer health than other homeless people. Housing outreach services that provide a safe place to live are a vital component of stabilizing the illness and helping individuals on their journey to recovery.
From www.raisingthehood.org

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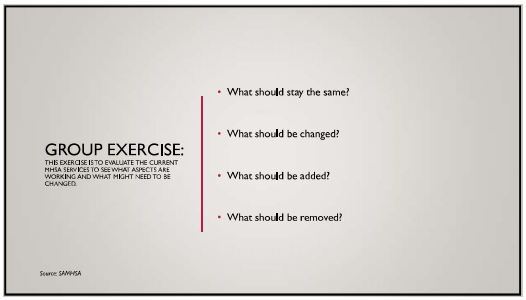

GROUP EXERCISE:
THIS EXERCISE IS TO EVALUATE THE CURRENT MHSA SERVICES TO SEE WHAT ASPECTS ARE WORKING AND WHAT MIGHT NEED TO BE CHANGED.
• What should stay the same?
• What should be changed?
• What should be added?
• What should be removed?
Source: SAMHSA

8

MHSA Planning Forum 2020
Workforce Education & Training

January 21, 2020

Jeannette Ferris, MPH
WET Coordinator
Alexis Horozan, LMFT
Intern & Career Pathways Manager

COUNTY OF SANTA CLARA
Behavioral Health Services

WET Statewide Initiative

- OSHPD Allocations
- Regional Partnership Grants – Greater Bay Area Region – 13 counties
- Toni Tullys Regional Partnership Lead for Greater Bay Area
- Local matching requirement – 33%
- Outcome requirements
- Additional direction forthcoming from the State

COUNTY OF SANTA CLARA
Behavioral Health Services

Regional Partnership Grant Program Components

- Pipeline Development
- Undergraduate College & University Scholarships
- Clinical Master & Doctoral Graduate Education Stipends
- Loan Repayment Program
- Retention

COUNTY OF SANTA CLARA
Behavioral Health Services

County of Santa Clara's Workforce Education & Training WET Plan FY 18-20

COUNTY OF SANTA CLARA
Behavioral Health Services

History

- Starting in 2008
- Stakeholder Meetings - 350 individuals attended one or more planning meetings, focus group, and community Town Hall meetings
- Staff and Community WET Surveys - 1355 respondents
- WET Workgroup
- Planning Process
  - Engagement & Commitment
  - Learning & Assessment
  - Prioritization & Planning – WET Action Items Emerged
  - Implementation & Evaluation – Steering Committees

COUNTY OF SANTA CLARA
Behavioral Health Services

WET Funding

- WET funds were exhausted 2016
- CSS is current funding source for WET activities per MHSA regulation and as requested by stakeholders

COUNTY OF SANTA CLARA
Behavioral Health Services

Staff Development & Support

- Develop and offer training on a wide range of subjects aimed at increasing staff competencies in a transformed system.
- Make trainings available to consumer and family providers.

COUNTY OF SANTA CLARA
Behavioral Health Services

Promising Practice-Based Training

- These trainings will be developed annually and be open to the entire lifespan training needs.
- They will include both Wellness and Recovery methods and address child, adolescent and family treatment models.
- Align themselves with the Learning Partnership's Five Learning Paths:
  - Consumer and Family Driven
  - Strengths and resiliency-based practice
  - System Partnerships
  - Cultural competence practice
  - Quality practice and accountability

COUNTY OF SANTA CLARA
Behavioral Health Services

Improved Services & Outreach to Unserved and Underserved Populations

Cultural Humility Training

- Training needed on culturally appropriate programs for consumers and family members and strategies for effective *engagement*.
- Training for all staff to improve *services* to ethnic and cultural populations

COUNTY OF SANTA CLARA
Behavioral Health Services

Welcoming Consumers and Family Members

Stigma and discrimination are underlying barriers to accepting and welcoming consumers into the workforce

- Implement training, workshops and consultations that create an environment that welcomes consumers and family members as contributing members of the public mental health system.

COUNTY OF SANTA CLARA
Behavioral Health Services

Collaboration with Key System Partners

- Collaboration between the Behavioral Health Services Department and key system partners to develop and share training and education programs
- Implement a training plan that brings Behavioral Health training to system partners and vice versa, emphasizing system wide collaboration with law enforcement, probation department, child protective services department, and community agencies

COUNTY OF SANTA CLARA
Behavioral Health Services

Mental Health Career Pathways

- Develop consumer career pathways, certification programs, and volunteer, stipend and internship opportunities.
- Financial stipends and incentives are needed to support a mental health Career Pathways
- Stipends are needed to provide financial incentives for bilingual and bicultural student interns and needed supervision

COUNTY OF SANTA CLARA
Behavioral Health Services

Stipends and Incentives

- **Consumer & family member Stipends**
  - For individuals who are not yet be ready to enroll in formal educational programs, but are interested in improving their skills in volunteering and exploring further mental health career opportunities
- **Scholarship Program for Bachelor Degrees in Social Work at SJSU**
- **Stipends for graduate level students – MSW students**

COUNTY OF SANTA CLARA
Behavioral Health Services

Group Activity

Break out into 3 groups:

- Children & Family Focused
- Adult Focused
- Special Population Focused

Assessment of WET Plan

- What should stay the same?
- What should be changed?
- What should be added?
- What should be removed?

COUNTY OF SANTA CLARA
Behavioral Health Services

COUNTY OF SANTA CLARA
Behavioral Health Services

WELLNESS • RECOVERY • RESILIENCE

INNOVATIONS BREAKOUT SESSION
JANUARY 21, 2020
MHSA FORUM 2020
GINA VITTORI, MPH, INNOVATIONS MANAGER AND PLANNER

1

MENTAL HEALTH SERVICES ACT (MHSA) INNOVATION FUNDING

5% of MHSA revenues to support innovative ideas.

Innovation projects ***test out*** novel, creative and/or original mental health practices/approaches that contribute to learning.

Projects must be developed within communities through the MHSA ***community program planning process***, inclusive and representative of underserved or inappropriately served individuals.

SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

2

INNOVATION PROJECTS

Innovation projects may affect any aspect of mental health practices with a promising approach to solving mental health challenges. The project **contributes to learning** rather than a primary focus on providing a service.

- ❑ The project introduces a **new mental health practice or approach** that is new to the mental health system, including but not limited to prevention and early intervention.
- ❑ The project makes a change to an existing practice or approach, including but not limited to application to a different population.
- ❑ The project introduces a **new application** to the mental health system of a promising community-driven practice or approach that has been successful in a non-mental health context.

SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

3

INNOVATION PROJECTS IN CURRENT MHSA PLANS

Approved	Faith Based Training and Support Project	Vendors secured, implementation under way
	Client and Consumer Employment	Vendors secured, implementation under way
	Psychiatric Emergency Response Team and Peer Linkage	Evaluation vendor secured, project in development
	Allcove Youth and Young Adult Health Centers Implementation	Evaluation vendor secured, CBO partner secured, Two sites secured
Pending Approval	Technology Suite for Mental Health	Proposal submitted, Awaiting guidance from MHSOAC
	Reach Out, Engage, and Connect for Older Adults	In planning process
	Room Match	Reviewing implementation feasibility

SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

4

CRITERIA FOR FUNDING APPROVAL

Does the proposed project meet any of the following four criteria under state regulations for Innovations funding?

- Increase access to underserved groups
- Increase the quality of mental health services, including measurable outcomes
- Promote interagency and community collaboration to mental health services or supports or outcomes
- Increase access to mental health services

SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

5

MHSA CORE PRINCIPLES

Counties shall use these standards in planning, implementing and evaluating MHSA funded programs and services (California Code of Regulations § 3320).

1. Community Collaboration (CCR § 3200.060)
2. Cultural Competence (CCR § 3200.100)
3. Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120)
4. Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5)
5. Integrated Service Experience (CCR § 3200.190)

SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

6

ADDITIONAL CRITERIA FOR FUNDING APPROVAL

Is there a strong need for the Innovation idea? Are there clear data available supporting this need?

Is the proposed project a time-limited study that would bring about learning which could be applied within the community of providers/systems of care? Is the Innovation idea centered around a strong learning question?

Is there potential for buy-in with necessary systems/providers for the project to be successful? Is there readiness and/or support for this idea among relevant stakeholders?

Is the proposed project in alignment with strategic goals and priorities of Behavioral Health Services Department (BHSD), County Board of Supervisors, relevant/community stakeholders, and the Mental Health Services Oversight and Accountability Commission (MHSOAC)?

SANTA CLARA COUNTY Behavioral Health Services

7

FOCUS AREAS

- Prevention for Youth and Children
- Homelessness Prevention
- Workforce Education and Training

SANTA CLARA COUNTY Behavioral Health Services

8

PROJECT IDEA PHASE, COUNTY LEVEL

- New Idea Submission
  - Complete the MHSA INN Proposal Form by Feb 4, 2020
- Vetting Process
  - Internal Review with BHSD
  - Review and Validation with Stakeholder Leadership Committee
- MHSA Three Year Plan/Plan Update
  - 30-Day Public Posting
  - BMB Public Hearing
  - BOS Approval

SANTA CLARA COUNTY Behavioral Health Services

9

PROJECT IDEA PHASE, STATE LEVEL

Submit idea to MHSOAC → MHSOAC review and staff input → Three Options for Approval:
1. Presentation at Commission Meeting
2. Placed Consent Calendar
3. If under $1 million, MHSOAC Executive Director Approval

SANTA CLARA COUNTY Behavioral Health Services

10

BREAKOUT TABLES BY TOPIC

- Prevention for Youth and Children
- Homelessness Prevention
- Workforce Education and Training

SANTA CLARA COUNTY Behavioral Health Services

11

DISCUSSION QUESTIONS

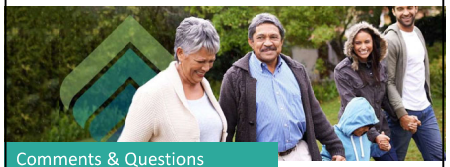
What is your innovative project idea?

How is this project innovative? What will change or be different if your project is successful?

What is the need that your project idea addresses? Whom does your project serve?

SANTA CLARA COUNTY Behavioral Health Services

12



Comments & Questions

Gina Vittori, MPH
Innovations Projects Manager and Planner
TEL: (408) 885-3983
EMAIL: mhsa@hhs.sccgov.org

13

APPENDIX – CURRENT INNOVATIVE PROJECTS

14

FAITH-BASED TRAINING AND SUPPORTS

- Develop customized faith-based behavioral health training for faith community leaders to enhance knowledge, skills, responses to individuals seeking their help
- Design and implement faith-informed workshop series for behavioral health direct care providers to learn about the role of spirituality in wellness/recovery
- Amount: $608,964; Project Length: 24 months

15

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

16

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

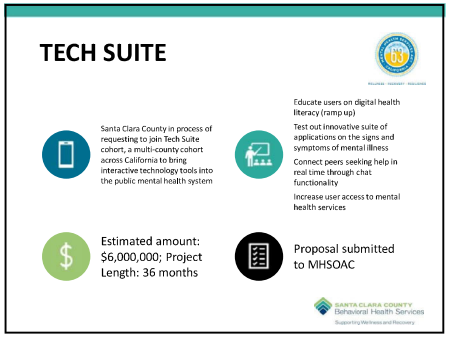
17

allcove

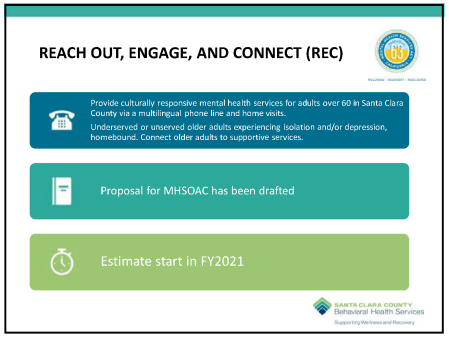
Stanford Medicine Center for Youth Mental Health & Wellbeing

- 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)

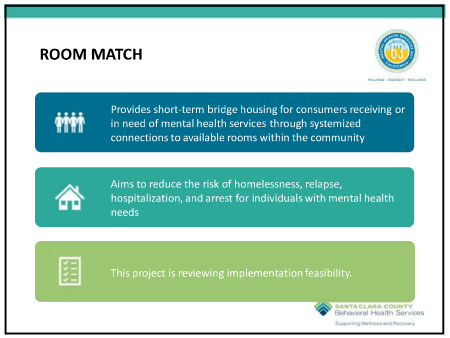
18


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
Educate users on digital health literacy (ramp up)
Test out innovative suite of applications on the signs and symptoms of mental illness
Connect peers seeking help in real time through chat functionality
Increase user access to mental health services
Estimated amount: $6,000,000; Project Length: 36 months
Proposal submitted to MHSOAC
SANTA CLARA COUNTY Behavioral Health Services

19


REACH OUT, ENGAGE, AND CONNECT (REC)
Provide culturally responsive mental health services for adults over 60 in Santa Clara County via a multilingual phone line and home visits.
Underserved or unserved older adults experiencing isolation and/or depression, homebound. Connect older adults to supportive services.
Proposal for MHSOAC has been drafted
Estimate start in FY2021
SANTA CLARA COUNTY Behavioral Health Services

20


ROOM MATCH
Provides short-term bridge housing for consumers receiving or in need of mental health services through systemized connections to available rooms within the community
Aims to reduce the risk of homelessness, relapse, hospitalization, and arrest for individuals with mental health needs
This project is reviewing implementation feasibility.
SANTA CLARA COUNTY Behavioral Health Services

21

COUNTY OF SANTA CLARA
Behavioral Health Services

2020 MHSA Planning Forum Stakeholder Comment Form

Thank you for attending the 2020 MHSA Planning Forum! We ask that you complete this short survey, for us to further improve events like these in the future. All responses will be anonymous and confidential. Please contact the MHSA Team at the event or via email at mhsa@hhs.sccgov.org if you have any questions. Thank you!

COUNTY OF SANTA CLARA
Behavioral Health Services

2020 MHSA Planning Forum Stakeholder Comment Form
Demographic Form

* 1. How are you related to the mental health consumer in your life? Please select one.

- ○ Self
- ○ Parent
- ○ Partner
- ○ Other (please specify):
- ○ Child
- ○ Other Family Member
- ○ Friend

* 2. What is your stakeholder affiliation? Please select one.

- ○ Community member
- ○ Government agency (City or County)
- ○ Government agency (State)
- ○ Community-based organization
- ○ Other (please specify):
- ○ Law Enforcement
- ○ Education agency
- ○ Social service agency
- ○ Veteran or Veterans Organizations
- ○ Provider of mental health services
- ○ Provider of alcohol and other drug services
- ○ Medical or health care organization

* 3. Please indicate your age range:

- Under 16
- 16 - 24
- 25 - 59
- 60 and older

* 4. What is your ethnicity?

- Hispanic/Latino
- Non-Hispanic/Latino

COUNTY OF SANTA CLARA
Behavioral Health Services

2020 MHSA Planning Forum Stakeholder Comment Form
Demographic Form

* 5. What is your race? Please select all that apply.

- [ ] White/Caucasian
- [ ] African American/Black
- [ ] Asian or Pacific Islander
- [ ] American Indian/Native Alaskan
- [ ] Multi-Race
- [ ] Other (please specify):

* 6. In which part of Santa Clara County do you live?

○ Campbell	○ Milpitas	○ San Jose
○ Cupertino	○ Monte Sereno	○ Santa Clara
○ Gilroy	○ Morgan Hill	○ Saratoga
○ Los Altos	○ Mountain View	○ Sunnyvale
○ Los Gatos	○ Palo Alto	

○ Other (please specify):

* 7. Please indicate your gender:

- Female
- Male
- Transmale/transman
- Transfemale/transwoman
- Other (please specify):
- Intersex
- Genderqueer
- Prefer not to answer

* 8. What is your preferred language?

- English
- Spanish
- Vietnamese
- Mandarin
- Tagalog
- Other (please specify):

COUNTY OF SANTA CLARA
Behavioral Health Services

2020 MHSA Planning Forum Stakeholder Comment Form

* 9. Please rate your overall satisfaction with the MHSA Forum today.

- ○ Poor
- ○ Average
- ○ Very Good
- ○ Excellent

10. Please share any comments about **strengths** of the MHSA Forum today.

11. Please share any comments about **areas of improvement** for the MHSA Forum.

Public Review Process

COUNTY OF SANTA CLARA
Behavioral Health Services

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

PlanForBetterHealth

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

3
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3

4
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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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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

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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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

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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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

8

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

9

MHSA PROGRAM UPDATES

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SANTA CLARA COUNTY Behavioral Health Services Supporting Wellness and Recovery

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
	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

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		
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

13

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

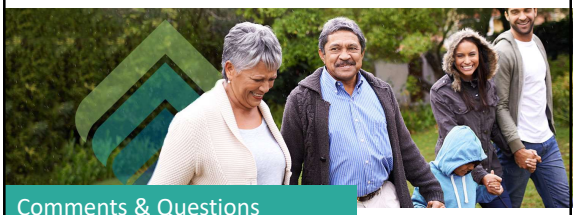
Transfers from Community Services and Supports to Capital Facilities and Technological Needs:
*Pursuant to the **Welfare and Institutions Code Section 5892(b)**, Counties may use a portion of their CSS funds for WET, CFTN and the Local Prudent Reserve. It is further specified that the total amount of 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.

14

NEXT STEPS

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

15



Comments & Questions

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

17

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA Stakeholder Leadership Committee Validation Meeting
Valley Specialty Center, San Jose, CA
February 13, 2020 4:30pm – 6:30pm

MHSA SLC VALIDATION MEETING

FEBRUARY 13, 2020
VALLEY SPECIALTY CENTER

TOPIC	TIME
Welcome and Introductions	4:30 – 4:40
MHSA Fiscal Update, Q & A	4:40 – 5:00
CPP Process Findings (Listening Sessions, Forum)	5:00 – 5:35
Proposed Recommendations to MHSA Programs and Services	5:35 – 6:20
Next Steps/Comment Form/Adjourn	6:20 – 6:30

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FY20 & FY21-FY23
MHSA FISCAL UPDATE

MHSA OVERVIEW

- California voters passed Proposition 63, also known as the Mental Health Services Act (MHSA) in November 2004 to expand and improve public mental health services
- 1% income tax on income above $1 million

4

MHSA CONSISTS OF FIVE COMPONENTS AND EACH HAS ITS DISTINCT REQUIREMENTS

Ongoing Funding

- **Community Services and Supports (CSS)—**provides funds for direct services to individuals with severe mental illness. Full Service Partnerships (FSP) are in this category; FSPs provide wrap-around services or "whatever it takes" services to consumers.
- **Prevention and Early Intervention (PEI)—**provides funds to recognize early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination.
- **Innovation (INN) –** provides funds to evaluate new approaches that increase access to the unserved and/or underserved communities. This component requires State approval (MHSOAC).

One Time Funding (Counties may continue to fund from CSS distribution)

- **Capital Facilities and Technological Needs (CFTN)—**provides funds for building projects and increasing technological capacity to improve mental illness service delivery.
- **Workforce, Education and Training (WET)—**provides funds to improve and build the capacity of the mental health workforce.

5

STATEWIDE MHSA APPORTIONMENTS

(in millions of dollars)

	FY16	FY17	FY18	FY19	FY20 Estimate
CSS	$1,077.4	$1,389.9	$1,503.9	$1,483.2	$1,606.8
PEI	$269.4	$347.5	$376.0	$370.8	$401.7
INN	$70.9	$91.4	$98.9	$97.6	$105.7
Total[1]	$1,417.7	$1,828.8	$1,978.9	$1,951.6	$2,114.2
% Change		29%	8%	-1%	8%

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

1 https://sco.ca.gov/ard_payments_mentalhealthservicefund.html
2 Apportionment does not account for interest accrued during the year
3 The fiscal impact of the voter-approved Proposition 2 (No Place Like Home) has not been applied to the FY20 Estimate

6

SANTA CLARA COUNTY MHSA APPORTIONMENTS

(in millions of dollars)

	FY16	FY17	FY18	FY19	FY20 Estimate
CSS	$49.9	$63.4	$68.2	$69.3	$73.8
PEI	$12.5	$15.8	$17.1	$17.1	$18.5
INN	$3.3	$4.2	$4.5	$4.5	$4.9
Total[1]	$65.7	$83.4	$89.8	$89.9	$97.2
% Change		27%	8%	-1%	8%
% Share of State	4.6%	4.6%	4.5%	4.6%	4.6%

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

1 https://sco.ca.gov/ard_payments_mentalhealthservicefund.html
2 The fiscal impact of the voter-approved Proposition 2 (No Place Like Home) has not been applied to the FY20 Estimate

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

SANTA CLARA COUNTY MHSA EXPENSE ESTIMATES

As of January 2020:
(in millions of dollars)

	FY16	FY17	FY18	FY19	FY20 Estimate
CSS	$42.6	$59.2	$63.8	$89.5	$114.7
PEI	$16.4	$16.1	$15.5	$12.3	$32.8
INN	$2.3	$1.0	$0.6	$1.1	$12.6
WET	$0	$2.2	$2.3	$2.3	$3.8
CFTN	$3.2	$2.4	$1.9	$1.6	$4.7
Total	$64.5	$80.9	$84.1	$106.8	$168.6
Prudent Reserve	$20.3	$20.5	$20.7	$20.7	
Unspent Balance[1]	$106.4	$110.4	$118.7	$100.8[2]	

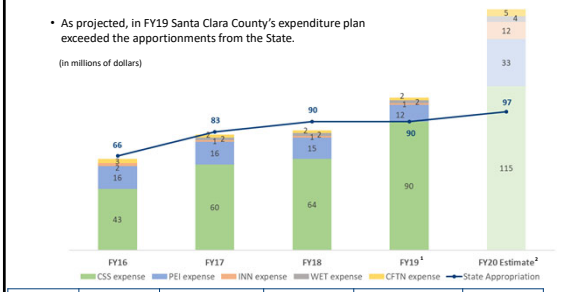
1 Unspent balance excludes Prudent Reserve.
2 FY19 unspent balance incorporates interest revenue of $3M from the year and a one-time claim of $4M for denied MHSA funded mental health services claims in FY14 related to the OIG audit.

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

SANTA CLARA COUNTY MHSA FUNDING AND EXPENSE

- As projected, in FY19 Santa Clara County's expenditure plan exceeded the apportionments from the State.

(in millions of dollars)



Total Expenses	64	81	84	107	169

1 FY19 RER was submitted to the State on December 13, 2019.
2 The fiscal impact of the voter-approved Proposition 2 (No Place Like Home) has not been applied to the FY20 estimate.

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

DRAFT BUDGET FOR FY20 ANNUAL UPDATE

MHSA Component	FY20 Budget in FY18-20 Plan	FY19 Annual Update	FY20 Annual Update	FY20 Budget
CSS	105,005,756	1,032,075	8,671,045	114,708,876
PEI	21,739,647	2,221,324	8,797,610	32,758,581
INN	12,562,343			12,562,343
WET	3,819,066			3,819,066
CFTN	1,711,566	11,000,000	(8,000,000)	4,711,566
Total	**$ 144,838,378**	**$ 14,253,399**	**$ 9,468,655**	**$ 168,560,432**

Changes		
CCP	955,405	17,468,655
County	2,297,994	-
Facility	11,000,000	(8,000,000)
Total	**$ 14,253,399**	**$ 9,468,655**

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

DRAFT BUDGET FOR FY21-23 PLAN

MHSA Component	FY20 Budget	FY21 Annual Update	FY21 Budget	FY22 Budget	FY23 Budget
CSS	114,708,876	19,284,765	133,993,641	133,993,641	133,993,641
PEI	32,758,581	861,751	33,620,332	33,620,332	33,620,332
INN	12,562,343		12,562,343	12,562,343	12,562,343
WET	3,819,066		3,819,066	3,819,066	3,819,066
CFTN	4,711,566	1,000,000	5,711,566	5,711,566	1,711,566
Total	**$ 168,560,432**	**$ 21,146,516**	**$ 189,706,948**	**$ 189,706,948**	**$ 185,706,948**

Changes	
CCP	18,022,400
County	2,124,116
Facility	1,000,000
Total	**$ 21,146,516**

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

SANTA CLARA COUNTY MHSA PRUDENT RESERVE

- DHCS IN 19-017 states that the Prudent Reserve cannot exceed 33% of the average CSS revenue received in the preceding five years.
- Calculation must be submitted by June 30, 2019
  - Done.
- Transfer of funds must occur by June 30, 2020.
- Santa Clara's Prudent Reserve maximum threshold is $18,703,636. The excess will be transferred to CSS and PEI, based on the percentage allocation of prior transfers into the Prudent Reserve.
  - This will be reflected on the FY20 Annual Update submission.

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

LISTENING SESSIONS AND MHSA FORUM

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

COUNTY OF SANTA CLARA Behavioral Health Services

Prepared by:
Palo Alto University
February 2020

Informing the 2021-23 MHSA 3-Year Plan

PROPOSED CHANGES

FY20 MHSA ANNUAL PLAN UPDATE
PROPOSED CHANGES: PROGRAMS FOR CHILDREN, YOUTH, AND FAMILIES

Increase Capacity
- Increased capacity and allocation 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

COUNTY OF SANTA CLARA Behavioral Health Services

FY20 MHSA ANNUAL PLAN UPDATE
PROPOSED CHANGES: PROGRAMS FOR ADULT/OLDER ADULT SYSTEM OF CARE

Increase Capacity
- Increased capacity and allocation 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
- 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)

COUNTY OF SANTA CLARA Behavioral Health Services

FY21-23 MHSA PROGRAM AND EXPENDITURE PLAN
ONGOING IMPLEMENTATION: ADULT/OLDER ADULT SYSTEM OF CARE

Older Adult Collaboration with Senior Nutrition Centers: Currently in planning status

Elders' Storytelling and Older Adult In-Home Peer Respite: RFP issued and in development

Clinical Case Management Team for Older Adults – Currently in planning status

COUNTY OF SANTA CLARA Behavioral Health Services

FY21-23 MHSA PROGRAM AND EXPENDITURE PLAN
PROPOSED CHANGES: PROGRAMS FOR ADULT/OLDER ADULT SYSTEM OF CARE

Modification
- Enhance supplemental health care beds for clients/consumers stepping down from IMD (AOA) and released from jail (CJS) with length of stay for two years or more

Addition
- Add a Homeless Engagement Access Team (HEAT) to include ongoing street-based outreach, engagement and mental health treatment for mentally ill homeless individuals who have been difficult to engage and linking them to appropriate treatment and stabilizing services which may include interim housing (MHSA Housing)
- Add 10 Mental Health Triage beds at the Sobering Station for homeless consumers exhibiting mental health symptoms that do not meet 5150 requirements

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

FY21-23 MHSA PROGRAM AND EXPENDITURE PLAN
STATEWIDE MODIFICATIONS: WORKFORCE EDUCATION AND TRAINING

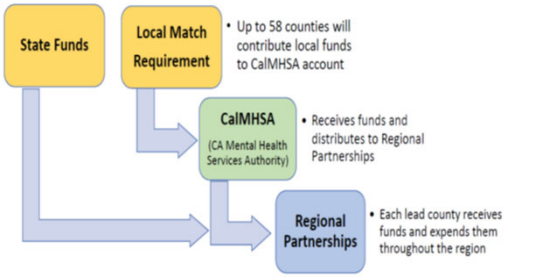
WET programs will be implemented by Regional Partnerships:

- Pipeline Development
- Undergraduate College & University Scholarships
- Clinical Master & Doctoral Graduate Education Stipends
- Loan Repayment Program
- Retention Activities

WET Funding Placeholder for Regional Partnerships:
- Counties anticipate providing MHSA funding to support ongoing WET programs beyond 2020/2021

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

State and Local Matching Funds: Collection and Distribution Process



COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

INNOVATIONS PROJECTS AND NEW SUBMISSIONS

- ❑ MHSOAC approved no-cost extensions of all approved BHSD INN Projects:
- ❑ BHSD released request for new INN submissions (N=22 ideas submitted)
- ❑ Compile/summarized new INN submissions
- ❑ Review all submissions and convene an SLC and stakeholders meeting in July 2020

23

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

General Discussion

1. What stood out?
2. Is there anything missing?
3. What are the most important issues to consider in these recommendations?

COMMUNITY PROGRAM PLANNING PROCESS
INTEGRATED FY20 UPDATE & FY21-23 PLAN

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, B2160

October 29, 2019 4:00pm – 6:00pm
Evergreen City College Extension - Milpitas Campus

November 6, 2019 5:30pm - 7:30pm
Milpitas Unified School District

November 12, 2019 3:00pm – 5:00pm
County Office of Education, ERC3

December 19, 2019 8:30am – 9:30am
South County Collaborative briefing

January 23, 2020 8:30am – 2:00pm
MHSA Forum
County Office of Education

Plan Review

February 13, 2020
4:30pm - 6:30pm
MHSA SLC Validation Meeting

March 13 - April 12
30-Day Draft Plans for Public Review

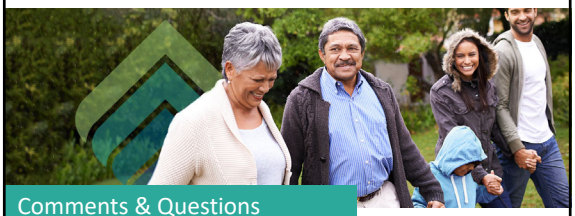
April 13, 2020
10:45 am-11:45am
Behavioral Health Board
Public Hearing of Draft Plans

June 2, 2020
Request Board of Supervisor Approval

June 30, 2020
Submission of adopted and approved plans to DHCS and MHSOAC

PlanForBetterHealth

SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery



Comments & Questions

SANTA CLARA COUNTY Behavioral Health Services

THANK YOU

Toni Tullys, MPA
Director, Behavioral Health Services

Sherri Terao, EdD
Deputy Director, Behavioral Health Services

Todd Landreneau, PhD, CHC, CPHQ
Director, Adult/Older Adult System of Care

Virginia Chen, MBA
Senior Departmental Fiscal Officer

For questions, additional information or other concerns, contact:
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27

COUNTY OF SANTA CLARA Behavioral Health Services
Supporting Wellness and Recovery

WELLNESS · RECOVERY · RESILIENCE

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA Stakeholder Leadership Committee Review of Programs
Virtual Zoom Meeting
April 9, 2020 2:30-4:00pm

MHSA SLC REVIEW OF PROGRAMS VIRTUAL MEETING

APRIL 9, 2020

TOPIC	TIME
Virtual Meeting Opens to Accommodate for Technical Difficulties *MHSA Staff*	1:30 pm
Welcome and Introductions *Toni Tullys, MPA, BHSD Director*	2:30 pm
MHSA Fiscal Update *Virginia Chen, MBA, Senior Departmental Fiscal Officer*	2:40 pm
Proposed Program Recommendations *Sherri Terao, EdD, BHSD Systems of Care Deputy Director*	3:00 pm
Q&A	3:30 pm
Next Steps/Comment Form/Adjourn	4:00 pm

PlanForBetterHealth

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

COVID-19 PANDEMIC & IMPACTS ON BEHAVIORAL HEALTH

- The pandemic has stretched all counties to address multiple and critical client/consumer needs.
- There is an immediate need to provide direct services and funding during the crisis.
- Based on discussions with behavioral health stakeholders, Department of Health Care Services plans to provide an official response/Frequently Asked Questions addressing COVID-19 and the MHSA.
    - *This could include greater flexibility with MHSA funding and timelines.*

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

COVID-19 IMPACT ON MHSA FUNDING

- State revenues decreased in March 2020.
- The delay in State Income Tax payments will likely impact MHSA funding in Fiscal Year (FY) 2022.
- The financial impact of COVID-19 may result in additional decreases to MHSA funding.
- BHSD expected an over expenditure of MHSA funding in FY22 & FY23, as a result of expanding services and utilizing unspent MHSA funds.
- In early FY21, BHSD planned to launch a stakeholder process to review and prioritize MHSA services and programs and to balance expenses with funding allocations. These changes would be included in the FY21 MHSA Plan Update.
- In the current environment, a planning process is essential.

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

GOALS FOR TODAY'S MEETING

- Review program modifications to Fiscal Year (FY) 2020 MHSA Annual Plan Update (Draft)
- Review proposed program modifications to FY21-23 Three-Year Plan (Draft) with focus on FY21
- Share the proposed FY21-23 Expenditure Plan
- Provide update on current Innovations Projects
- Discuss DRAFT MHSA Three Year Plan and next steps

MHSA CONSISTS OF FIVE COMPONENTS AND EACH HAS ITS DISTINCT REQUIREMENTS

Ongoing Funding

- **Community Services and Supports (CSS)**—provides funds for direct services to individuals with severe mental illness. Full Service Partnerships (FSP) are in this category; FSPs provide wrap-around services or "whatever it takes" services to consumers.
- **Prevention and Early Intervention (PEI)**—provides funds to recognize early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination.
- **Innovation (INN)** – provides funds to evaluate new approaches that increase access to the unserved and/or underserved communities. This component requires State approval (MHSOAC).

One Time Funding (Counties may continue to fund from CSS distribution)

- **Capital Facilities and Technological Needs (CFTN)**—provides funds for building projects and increasing technological capacity to improve mental illness service delivery.
- **Workforce, Education and Training (WET)**—provides funds to improve and build the capacity of the mental health workforce.

FINANCIALS FOR FY20 ANNUAL UPDATE AND FY21-23 PLAN

FY19-20	CSS	PEI	INN	WET	CFTN	TOTAL
Unspent from FY19	43,590,751	21,265,183	24,061,454	0	11,642,662	100,560,050
Revenue	73,854,244	18,463,561	4,858,832	0	0	97,176,637
Expenditure	(82,592,455)	(21,388,741)	(11,714,914)	(3,129,104)	(4,711,566)	(123,536,780)
Transfer from CSS	(3,129,104)			3,129,104		0
Prudent Reserve Transfer (req)	1,547,519	498,320				2,045,839
Unspent Balance	33,270,955	18,838,323	17,205,372	0	6,931,096	76,245,746
FY20-21						
Revenue	77,201,068	19,300,267	5,079,018	0	0	101,580,352
Expenditure	(83,773,828)	(25,839,255)	(7,757,736)	(3,129,104)	(5,241,566)	(125,741,489)
Transfer from CSS	(3,129,104)			3,129,104		0
Unspent Balance	23,569,091	12,299,335	14,526,653	0	1,689,530	52,084,609
FY21-22						
Revenue	78,248,204	19,562,051	5,147,908	0	0	102,958,163
Expenditure	(83,773,828)	(25,839,255)	(5,937,067)	(3,129,104)	(5,241,566)	(123,920,820)
Transfer from CSS	(6,681,140)			3,129,104	3,552,036	0
Unspent Balance	11,362,327	6,022,131	13,737,495	0	0	31,121,952
FY22-23						
Revenue	80,138,540	20,034,635	5,272,272			105,445,448
Expenditure	(83,773,828)	(25,839,255)	(4,372,585)	(3,129,104)	(1,241,566)	(118,356,338)
Transfer from CSS	(4,370,670)			3,129,104	1,241,566	0
Unspent Balance	3,356,369	217,511	14,637,182	0	0	18,211,062

* FY20 includes the transfer in excess of the PR maximum threshold to CSS and PEI

FY20 MHSA ANNUAL PLAN UPDATE
CHANGES: PROGRAMS FOR CHILDREN, YOUTH, AND FAMILIES

Increase Capacity

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FY20 MHSA ANNUAL PLAN UPDATE
CHANGES: PROGRAMS FOR ADULT/OLDER ADULT SYSTEM OF CARE

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- Increased allocation for the Transitional Housing Unit (Rainbow) for 15 women coming out of custody and receiving mental health services (expansion of services).

FY21-23 MHSA PROGRAM AND EXPENDITURE PLAN
PROGRAM UPDATES: ADULT/OLDER ADULT SYSTEM OF CARE

Older Adult Collaboration with Senior Nutrition Centers: discontinued

Independent Living Facilities Project: discontinued

Voluntary County Contribution to CalMHSA for PEI: discontinued

Elders' Storytelling and Older Adult In-Home Peer Respite: RFP issued and award in process, reduced allocation

Clinical Case Management Team for Older Adults: Currently in planning status, county-operated

Intensive FSP Services for Older Adults: in place

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

FY21-23 MHSA PROGRAM AND EXPENDITURE PLAN
PROPOSED CHANGES: PROGRAMS FOR ADULT/OLDER ADULT SYSTEM OF CARE

Modification

- Enhance supplemental health care beds for clients/consumers stepping down from IMD (AOA) and released from jail (CJS) with length of stay for two years or more.

Addition

- Add a Homeless Engagement Access Team (HEAT) to include ongoing street-based outreach, engagement and mental health treatment for mentally ill homeless individuals who have been difficult to engage and linking them to appropriate treatment and stabilizing services which may include interim housing (MHSA Housing)
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COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

FY21-23 MHSA PROGRAM AND EXPENDITURE PLAN
STATEWIDE MODIFICATIONS: WORKFORCE EDUCATION AND TRAINING

WET programs will be implemented by Regional Partnerships:

- Pipeline Development
- Undergraduate College & University Scholarships
- Clinical Master & Doctoral Graduate Education Stipends
- Loan Repayment Program
- Retention Activities

WET Funding for Regional Partnerships:

- County of Santa Clara will send matching contribution during FY2022 in order to participate in regional WET partnership

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

INNOVATION PROJECTS

Project	Description	Status
Client and Consumer Employment	Implements Individual Placement & Support/Supported Employment (IPS/SE) model, views employment as a critical element to recovery and wellness	*Continuing - Project extended to 2/1/2023*
Faith-Based Training and Supports	Develops customized behavioral health training plans for faith/spiritual leaders and behavioral health providers, goal to increase knowledge, skills of faith leaders and increases behavioral health services providers' understanding of the role of spirituality in client/consumer wellness/recovery	*Continuing - Project extended to 10/1/2022*
Psychiatric Emergency Response Team (PERT) and Peer Linkage	Reduces utilization of EPS and acute psychiatric hospitalization services for County of Santa Clara residents experiencing acute mental health crises. Pairs law enforcement officer with clinician and connects to post crisis peer support services	*Continuing - Project extended to 6/1/2022*
Allcove (Ramp up and Implementation)	Integrated center with health and mental health care, on-site psychiatric services, alcohol and drug treatment, education, employment, peer support services to meet the needs of youth ages 12-25 with emerging mental health issues	*Ramp up and Implementation Continuing – Ramp up budget extended to 11/15/20*

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

INNOVATION PROJECTS

Project	Update	Status
Multicultural Community Center	• Challenges finding a site for community center	***MCC INN project discontinued*** *Using PEI funding to establish 5 Cultural Wellness Centers with co-located services*
Tech Suite Cohort	• CalMHSA Tech Suite cohort has experienced challenges addressing liability, privacy, online trolls, lack of training of peer listeners, lack of connection to local crisis support services, counties in cohort have not implemented any apps to date	***Tech Suite Cohort INN discontinued*** *BHSD independently exploring technology apps*
Reach Out, Engage, and Connect	• Friendly calling outreach program to engage isolated older adults in behavioral health services will be incorporated into an existing program/older adult system of care	***REC INN discontinued*** *Incorporated into existing program*
Room Match	• Partnership explored with Office of Supportive Housing (OSH) and did not move forward	***Room Match INN discontinued*** *OSH currently funding similar Room Match project in Santa Clara County*

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

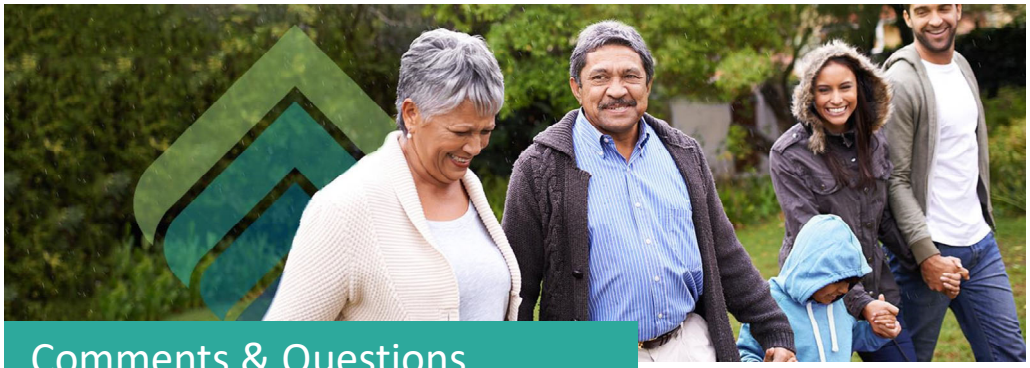
INNOVATION PROJECTS AND NEW SUBMISSIONS

- ❑ MHSOAC approved no-cost extensions of approved BHSD INN Projects
- ❑ BHSD released request for new INN submissions (N=23 ideas submitted)
- ❑ Compile/summarized new INN submissions
- ❑ Review all submissions and convene an SLC and stakeholders meeting as part of the MHSA Planning Process in July or August 2020

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

Current Timeline

Date	Activity	Goals
April 9, 2020 2:30pm – 4:00pm	**Virtual MHSA SLC Meeting** BHSD is inviting you to a scheduled Zoom meeting. https://zoom.us/j/946132517 Meeting ID: 946 132 517 +16699006833,,946132517# US (San Jose) +14086380968,,946132517# US (San Jose)	Review of Programs and Recommendations
April 11 – May 10, 2020	**30-Day Public Comment Period**	Review of MHSA Draft Plans, submit public comments: https://www.surveymonkey.com/r/2020MHSA_PublicCommentForm **or** Email Comments Directly to: MHSA@hhs.sccgov.org
May 11, 2020 2:30-3:30pm	**Virtual Public Hearing** *hosted by* Behavioral Health Board (depending on Governor's executive order and County's Health Officer order of shelter in place)	Request approval of Draft Plans by Behavioral Health Board
June 2, 2020	**Request Board of Supervisor Approval/Adoption** of MHSA Draft Plans	Required by MHSA regulations
June 30, 2020	**Submission of Adopted/Approved Plans to DHCS and MHSOAC**	In accordance with state regulations



Comments & Questions

SANTA CLARA COUNTY
Behavioral Health Services

THANK YOU

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Director, Behavioral Health Services

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Deputy Director, BHSD Systems of Care

Todd Landreneau, PhD, CHC, CPHQ
Deputy Director, BHSD Managed Care Services

Virginia Chen, MBA
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MHSA@hhs.sccgov.org
1-408-401-6117 Mobile

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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**

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.

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**
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.

Received From	Comment
	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.

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**
	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.

Received From	Comment
	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.

Received From	Comment
	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.

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**

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

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**
	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*	
Received From	**Comment**
	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*	
Received From	**Comment**
	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*	
Received From	**Comment**
	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

Received From	Comment
	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.

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**
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*	
Received From	**Comment**
	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*	
Received From	**Comment**
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*	
Received From	**Comment**

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.

Behavioral Health Board Public Hearing

Pursuant to the provisions of California Governor's Executive Order N-29-20, issued on March 17, 2020, the Public Hearing of the Behavioral Health Board (BHB) was held by teleconference on Monday, May 11, 2020. The Three-Year Plan was recommended 7 to 1 by the Behavioral Health Board.

WELLNESS • RECOVERY • RESILIENCE

COUNTY OF SANTA CLARA
Behavioral Health Services

PUBLIC HEARING HOSTED BY THE BEHAVIORAL HEALTH BOARD
FY20 MHSA ANNUAL PLAN UPDATE AND FY21-23 MHSA PROGRAM AND EXPENDITURE PLAN
VIRTUAL ZOOM MEETING
MONDAY, MAY 11, 2020 – 2:30PM -3:30PM

GOALS FOR TODAY'S MEETING

- Share the proposed Fiscal Year (FY) 2020 & FY2021-2023 Expenditure Plan Summary.
- Review of County of Santa Clara's Community Program Planning Process.
- Review program modifications and proposed recommendations to:
  - FY2020 MHSA Annual Plan Update (Draft Plan).
  - FY2021-2023 MHSA Program and Expenditure Plan (Draft Three-Year Plan) with a focus on sustaining and maintaining existing programs and services.
- Provide update on current Innovations Projects.
- Review MHSA Plan adoption process and next steps.
- Request the BHB to take action on the Draft Plans.

COVID-19 PANDEMIC & IMPACTS ON BEHAVIORAL HEALTH

- The pandemic has stretched all counties to address multiple and critical client/consumer needs.
- There is an immediate need to provide direct services and funding during the crisis.
- Based on discussions with behavioral health stakeholders, Department of Health Care Services plans to provide an official response/Frequently Asked Questions addressing COVID-19 and the MHSA.
  - *This could include greater flexibility with MHSA funding and timelines.*
  - *To date, DHCS has not provided flexibilities to the MHSA timelines and counties continue to complete their MHSA plans by the June 30, 2020 deadline following current legislation.*

COVID-19 IMPACT ON MHSA FUNDING

- The delay in State Income Tax payments will likely impact MHSA funding in Fiscal Year (FY) 2022.
- The financial impact of COVID-19 may result in additional decreases to MHSA funding.
- BHSD expected an over expenditure of MHSA funding in FY22 & FY23, as a result of expanding services and utilizing unspent MHSA funds.
- In early FY21, BHSD will launch a stakeholder process to review and prioritize MHSA services and programs and to balance expenses with funding allocations. These changes would be included in the FY22 MHSA Plan Update.
- In the current environment, a planning process is essential.

MHSA CONSISTS OF FIVE COMPONENTS AND EACH HAS ITS DISTINCT REQUIREMENTS

Ongoing Funding

- **Community Services and Supports (CSS)—**provides funds for direct services to individuals with severe mental illness. Full Service Partnerships (FSP) are in this category; FSPs provide wrap-around services or "whatever it takes" services to consumers. Allocation is 76% of MHSA funds per regulations.
- **Prevention and Early Intervention (PEI)—**provides funds to recognize early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination. Allocation is 19% of MHSA funds per regulations.
- **Innovation (INN) –** provides funds to evaluate new approaches that increase access to the unserved and/or underserved communities. This component requires State approval (MHSOAC). Allocation is 5% of MHSA funds per regulations.

One Time Funding (Counties may continue to fund from CSS distribution)

- **Capital Facilities and Technological Needs (CFTN)—**provides funds for building projects and increasing technological capacity to improve mental illness service delivery.
- **Workforce, Education and Training (WET)—**provides funds to improve and build the capacity of the mental health workforce.

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

FINANCIALS FOR FY20 ANNUAL UPDATE AND FY21-23 PLAN

FY19-20	CSS	PEI	INN	WET	CFTN	TOTAL
Unspent from FY19	43,590,751	21,265,183	24,061,454	0	11,642,662	100,560,050
Revenue	73,854,244	18,463,561	4,858,832	0	0	97,176,637
Expenditure	(82,592,455)	(21,388,741)	(11,714,914)	(3,129,104)	(4,711,566)	(123,536,780)
Transfer from CSS	(3,129,104)			3,129,104		0
Prudent Reserve Transfer (req)	1,547,519	498,320				2,045,839
Unspent Balance	33,270,955	18,838,323	17,205,372	0	6,931,096	76,245,746
FY20-21						
Revenue	77,201,068	19,300,267	5,079,018	0	0	101,580,352
Expenditure	(83,773,828)	(25,839,255)	(7,757,736)	(3,129,104)	(5,241,566)	(125,741,489)
Transfer from CSS	(3,129,104)			3,129,104		0
Unspent Balance	23,569,091	12,299,335	14,526,653	0	1,689,530	52,084,609
FY21-22						
Revenue	78,248,204	19,562,051	5,147,908	0	0	102,958,163
Expenditure	(83,773,828)	(25,839,255)	(5,937,067)	(3,129,104)	(5,241,566)	(123,920,820)
Transfer from CSS	(6,681,140)			3,129,104	3,552,036	0
Unspent Balance	11,362,327	6,022,131	13,737,495	0	0	31,121,952
FY22-23						
Revenue	80,138,540	20,034,635	5,272,272			105,445,448
Expenditure	(83,773,828)	(25,839,255)	(4,372,585)	(3,129,104)	(1,241,566)	(118,356,338)
Transfer from CSS	(4,370,670)			3,129,104	1,241,566	0
Unspent Balance	3,356,369	217,511	14,637,182	0	0	18,211,062

* FY20 includes the transfer in excess of the PR maximum threshold to CSS and PEI

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Community Program Planning Process

SANTA CLARA COUNTY
Behavioral Health Services

COMMUNITY PROGRAM PLANNING PROCESS

- Mental Health Services Act (MHSA) Stakeholder Leadership Committee Kick Off Event
  - clients/consumers
  - family members of consumers
  - community partners and service providers
  - law enforcement and probation
  - County Office of Education
  - ethnic and culturally diverse group
- Staff and SLC members conducted 13 listening sessions across the county. One session was limited to South County Collaborative members only at the request of the Chair. But two SLC members attended the event.
- Administered surveys for clients/consumers and family members of consumers in all threshold languages.
- Conducted the first Annual MHSA Planning Forum.
- Partnered with Palo Alto University's Office of Diversity and Community Mental Health to conduct an intensive analysis and report of the qualitative and quantitative elements of the community input across the county to help inform the plan and create direction for future planning.

FY20 MHSA ANNUAL PLAN UPDATE
CHANGES: PROGRAMS FOR CHILDREN, YOUTH, AND FAMILIES

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.

FY20 MHSA ANNUAL PLAN UPDATE
CHANGES: PROGRAMS FOR ADULT/OLDER ADULT SYSTEM OF CARE

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.
- 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).

FY21-23 MHSA PROGRAM AND EXPENDITURE PLAN
PROPOSED PROGRAM RECOMMENDATIONS:
PROGRAMS FOR ADULT/OLDER ADULT SYSTEM OF CARE

Modification

- Enhance supplemental health care beds for clients/consumers stepping down from IMD (AOA) and released from jail (CJS) with length of stay for two years or more.

Addition

- Add a Homeless Engagement Access Team (HEAT) to include ongoing street-based outreach, engagement and mental health treatment for mentally ill homeless individuals who have been difficult to engage and linking them to appropriate treatment and stabilizing services which may include interim housing (MHSA Housing). This would modify the existing Permanent Supportive Housing efforts funded by BHSD-MHSA.
- Add 10 Mental Health Triage beds at the Sobering Station for homeless consumers exhibiting mental health symptoms that do not meet 5150 requirements. This would enhance existing Crisis Treatment and Stabilization Programs.

FY21-23 MHSA PROGRAM AND EXPENDITURE PLAN
PROPOSED PROGRAM RECOMMENDATIONS:
ADULT/OLDER ADULT SYSTEM OF CARE

In planning for an estimated loss of revenue in FY2022, the Department is recommending suspension of MHSA allocation to the following planned, undeployed program ideas and the voluntary county contribution to statewide prevention:

***Older Adult Collaboration with Senior Nutrition Centers*:**
BHSD explored this potential opportunity, however the plan is to consolidate older adult outreach efforts across the system. This is an estimated $304,000 per year x 3 yrs.

Independent Living Facilities Project:
BHSD is exploring this recommendation in conjunction with other residential programs. This is an estimated $500,000 per year x 3 yrs.

Voluntary County Contribution to CalMHSA for Statewide Prevention:
This is a voluntary county contribution to statewide prevention efforts. County of Santa Clara is continuing contract with CalMHSA for out of county hospitalizations for children and youth. This is an estimated $250,000 per year x 3 years.

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

FY21-23 MHSA PROGRAM AND EXPENDITURE PLAN
STATEWIDE MODIFICATIONS: WORKFORCE EDUCATION AND TRAINING

WET programs will be implemented by Regional Partnerships:
- Pipeline Development
- Undergraduate College & University Scholarships
- Clinical Master & Doctoral Graduate Education Stipends
- Loan Repayment Program
- Retention Activities

WET Funding for Regional Partnerships:
- County of Santa Clara will send matching contribution during FY2022 in order to participate in regional WET partnership

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

INNOVATION PROJECTS: PROJECT UPDATES

Project	Description	Status
Client and Consumer Employment	Implements Individual Placement & Support/Supported Employment (IPS/SE) model, views employment as a critical element to recovery and wellness	*Continuing - Project extended to 2/1/2023*
Faith-Based Training and Supports	Develops customized behavioral health training plans for faith/spiritual leaders and behavioral health providers, goal to increase knowledge, skills of faith leaders and increases behavioral health services providers' understanding of the role of spirituality in client/consumer wellness/recovery	*Continuing - Project extended to 10/1/2022*
Psychiatric Emergency Response Team (PERT) and Peer Linkage	Reduces utilization of EPS and acute psychiatric hospitalization services for County of Santa Clara residents experiencing acute mental health crises. Pairs law enforcement officer with clinician and connects to post crisis peer support services	*Continuing - Project extended to 6/1/2022*
Allcove (Ramp up and Implementation)	Integrated center with health and mental health care, on-site psychiatric services, alcohol and drug treatment, education, employment, peer support services to meet the needs of youth ages 12-25 with emerging mental health issues	*Ramp up and Implementation Continuing – Ramp up budget extended to 11/15/20*

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

INNOVATION PROJECTS: PROPOSED RECOMMENDATIONS

Project	Update	Status
Multicultural Community Center	• Challenges finding a site for community center	***MCC INN project idea modified*** *The Department has allocated PEI funding to establish 5 Cultural Wellness Centers with co-located services.*
Tech Suite Cohort	• CalMHSA Tech Suite cohort has experienced challenges addressing liability, privacy, online trolls, lack of training of peer listeners, lack of connection to local crisis support services, counties in cohort have not implemented any apps to date	***Tech Suite Cohort INN discontinued*** *BHSD independently exploring technology apps*
Reach Out, Engage, and Connect	• Friendly calling outreach program to engage isolated older adults in behavioral health services will be incorporated into an existing program/older adult system of care	***Incorporated into an existing program*** *in CSS, will not be pursued as an independent INN Project*
Room Match	• Partnership explored with Office of Supportive Housing (OSH) and did not move forward	***Room Match INN idea will not be pursued*** *as OSH currently funding similar Room Match project in Santa Clara County*

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

INNOVATION PROJECTS AND NEW SUBMISSIONS

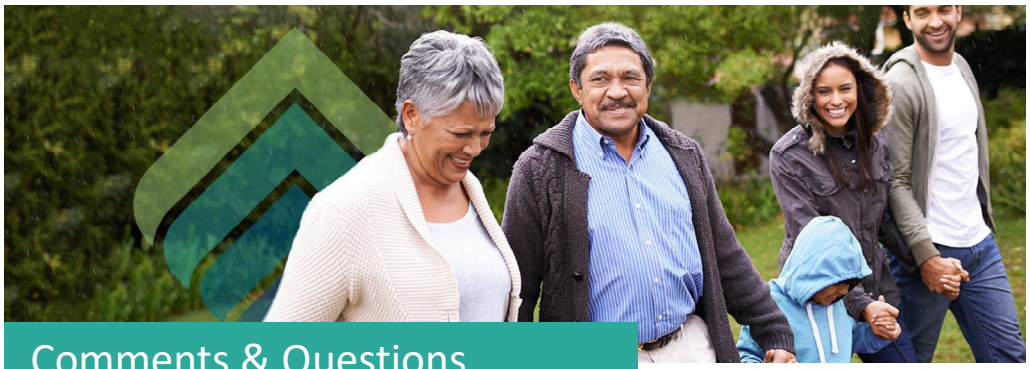
- ❑ MHSOAC granted no-cost extensions of approved BHSD INN Projects
- ❑ BHSD released request for new INN submissions (N=23 ideas submitted)
- ❑ Compile/summarized new INN submissions
- ❑ Review all submissions and convene an SLC and stakeholders meeting as part of the MHSA Planning Process in July or August 2020

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Current Timeline

Date	Activity	Objective
April 11 – May 10, 2020	**30-Day Public Comment Period**	Review of MHSA Draft Plans, submit public comments: https://www.surveymonkey.com/r/2020MHSA_PublicCommentForm **or** Email Comments Directly to: MHSA@hhs.sccgov.org
May 11, 2020 2:30-3:30pm	**Virtual Public Hearing** *hosted by* Behavioral Health Board (depending on Governor's executive order and County's Health Officer order of shelter in place)	Request Behavioral Health Board to take action on the plans, i.e. recommend the plan.
June 2, 2020	**Request Board of Supervisor Approval/Adoption** of MHSA Draft Plans	Required by MHSA regulations
June 30, 2020	**Submission of Adopted/Approved Plans to DHCS and MHSOAC**	In accordance with state regulations

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery



Comments & Questions

SANTA CLARA COUNTY
Behavioral Health Services

REQUEST BHB TO TAKE ACTION ON THE PLANS

Potential Action: Take motion to recommend the Draft Plans

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

THANK YOU

For questions, additional information or other concerns, contact:

The MHSA Team at

MHSA@hhs.sccgov.org

1-408-401-6117 Mobile

www.sccbhsd.org/mhsa

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

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

Board of Supervisors

FY21 - FY23 MHSA Three-Year Plan, unanimously approved by the Board of Supervisor and adopted at the meeting held on June 2, 2020.

Revamped Stakeholder Involvement:

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. As adopted in the FY19 MHSA Annual Plan Update, the revamped Stakeholder Leadership Committee (SLC) with the added five (5) additional client/consumer only seats, provided an increased client/consumer lens in the development and validation of these services. This brought the Client/Consumer representation to 50% compared to other representative groups in the committee (education, law enforcement, service providers, etc). An additional four seats are held by three Behavioral Health Board members, the Chair of the BHB Co-Chairs the SLC along with the BHSD Director. The additional BHB members serve as alternates.

The following are the newly added consumer/client committee representatives:

1. Lorraine Zeller, BHSD Mental Health Peer Support Worker (retired May, 2020), ACCESS CA Ambassador, Adult/Older Adult, Caucasian.
2. Colette Hill, Consumer/Client, Adult/Older Adult, Caucasian.
3. Peggy Cho, BHSD Mental Health Peer Support Worker, Adult, Asian American.
4. Terri Cheng, Consumer/Client, Adult, Asian American.
5. Eduardo Alvarez, BHSD Associate Training and Staff Development Specialist, LGBTQ+ Adult/Older Adult, Asian/Pacific Islander.

The Co-Chairs of the SLC:

June Klein, Co-Chair of SLC, Chair of the BHB
Toni Tullys, Co-Chair of SLC, Director of BHSD (until May 7, 2020)
Sherri Terao, Co-Chair of SLC, Acting Director of BHSD (Since May 11, 2020)
Charles Pontious, Co-Chair Alternate (BHB Member)
Gary Miles, Co-Chair Alternate (BHB Member)

FY20 Stakeholder Process

In consultation with the Mental Health Services Oversight and Accountability Commission (MHSOAC), County of Santa Clara was approved in September of 2019 to conduct a combined community program planning process that would inform both 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) were sectioned separately to provide clarity and transparency. This combined approach would allow the County of Santa Clara to align all MHSA reporting requirements with the State's deadlines and expectations and keep the County updated with all reporting requirements related to MHSA.

The FY 2020 MHSA Annual Plan Update represents a summary of planned and stakeholder-approved ***program implementation, outcomes, service expansions, and modifications of previously, Board of Supervisors' adopted MHSA Plans***. The majority of the implementation work described in the FY18-20 MHSA Three Year Plan started implementation during FY2020.

Stakeholder Engagement and Outreach for Community Planning Activities:

The Community Program Planning (CPP) process included a variety of stakeholder activities reflective of the geographic and cultural diversity of County of Santa Clara as well as the affiliations listed in the MHSA for CPP processes. This included representatives from the following groups: clients/consumers, family members of consumers, community partners and service providers, law enforcement and probation, County Office of Education, ethnic and culturally diverse groups.

The CPP process leveraged several existing meetings, including meetings of the following bodies:

- Behavioral Health Board
- Stakeholder Leadership Committee Member Organizations/Affiliation (Bill Wilson, Rebekah Children's Services, South County Collaborative, Milpitas Unified School District, County Office of Education, Project SafetyNet, etc).
- Community partners

Outreach efforts were developed to ensure that the planning process reached a broad spectrum of stakeholders and the process was driven by community input. The CPP launch was announced via email to list-serves and participants from previous meetings, as well as current and former SLC members and in collaboration with the Behavioral Health Board leadership. The

announcement was also sent to all BHSD staff and Department Managers were asked to share broadly with community service providers and the public. All community-planning activities were included in a timeline flyer that was distributed at meetings and via email. Additionally, all meetings were posted on BHSD's website on a timely manner.

Efforts to Include Consumers and Unserved and Underserved Populations

The CPP was an inclusive process that sought to include participation of the linguistic and cultural diversity of Santa Clara County. During the community input phase, culture-specific outreach and input gathering sessions were held across the County reaching the following communities: African and African Ancestry, Latino/Hispanic, Asian/Pacific Islander, the Reentry, post custody population, people experiencing homelessness, and LGBTQ+ communities. Community members were asked to provide data through an online survey, listening sessions and to attend an MHSA Planning Forum. Surveys were available in English, Spanish, Chinese, Tagalog and Vietnamese, while listening sessions were either conducted in Spanish (with translator present) or asked to request translation services. Transportation needs were also assessed and provided when needed. For all meetings conducted after 4:00pm, food and/or refreshments were offered to participants.

9 CCR § 3300(c) states that involvement of clients and their family members be in all aspects of the community planning process and that training shall be offered, as needed, to stakeholders, clients, and client's family who are participating in the process.

Throughout July and September, the MHSA Coordinator offered and trained all new MHSA SLC members. This training provided an overview of the MHSA components, the programs and services provided in County of Santa Clara a legislation update affecting MHSA planning, implementation, and evaluation.

Community input was collected from three venues (Figure 1):

1. A **consumer survey** created by Resource Development Associates in 2018 was distributed across the county to get an understanding of how County behavioral health services are doing. A total of 253 participants initiated the consumer survey. Of these survey responses, 167 were excluded from the analysis because they didn't identify as a consumer or family member, or they didn't actually fill out the survey items. The final sample included 87 mental health consumers in County of Santa Clara – these individuals gave feedback about areas of strength and improvement for the county.

2. **Listening sessions**/discussion groups with the MHSA Stakeholder Leadership Committee member organizations and affiliations, which includes consumers, family members, and underserved community representatives. Thirteen separate sessions were conducted across the county which included Gilroy and Morgan Hill communities, Transitional Age Youth, North County (Palo Alto) and central San Jose. A total of 156 participants attended the Listening Sessions across the county.

3. First Annual **MHSA Community Planning Forum** on January 21, 2020 that included 115 consumers, providers, community members, and stakeholders. Palo Alto University research and evaluation team was present in each breakout group to record qualitative data, summarize a prepare an evaluation report of the community planning process. Use the following link to retrieve:

   https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Documents/2020/MHSA-Community-Planning-Process-Evaluation-Report-FY20_FY21-23.pdf

   A full presentation of the findings was presented at the February 13, 2020 MHSA meeting of the SLC. This is the link to the presentation:

   https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Documents/2020/MHSA-Planning-Forum-Evaluation-Results-Presentation2.13.20.pdf

Combined FY2020 MHSA Annual Plan Update and FY2021-FY2023 MHSA Program and Expenditure Report (Draft Plans)

Figure 1. Community Program Planning Timeline for FY20 & FY21-23 MHSA Plans.

Stakeholder Trainings and Kick Off	Community Planning Process	Plan Review
July – September 2019 MHSA SLC new member recruitment and training N= 10 participants **October 1, 2019** 3:00pm – 5:00pm Overview of CPPP and Timeline Review of MHSA Components Legislative Update N=35 participants	**September 17, 2019 6:00pm – 8:00pm** Rebekah Children's Services (Gilroy, session conducted in Spanish) N=10 participants **September 23, 2019 1:00pm – 3:00pm** Bill Wilson Center (session with TAY) N= 17 participants **October 4, 2019 9:00am – 11:00am** Behavioral Health Board N=8 participants **October 9, 2019 3:30pm – 5:30pm** Mitchell Park Community Center (Palo Alto) N= 15 participants **October 15, 2019 3:30pm – 6:30pm** Santa Clara Valley Specialty Center N= 30 participants **October 29, 2019 4:00pm – 6:00pm** Evergreen City College Extension – Milpitas Campus N= 3 participants **November 6, 2019 5:30pm – 7:30pm** Milpitas Unified School District *(due to a MUSD Board emergency the District provided input via survey)* **November 12, 2019 3:00pm – 5:00pm** County Office of Education, ERC3 N= 17 participants **December 19, 2019 8:30 am – 9:30am** South County Collaborative Briefing (Morgan Hill) N= 21 participants **January 21, 2020 8:00am – 2:00pm** MHSA Community Planning Forum County Office of Education N= 115 participants	**February 13, 2020 4:30-pm – 6:30pm** MHSA SLC Validation Meeting N= 25 participants **April 9, 2020 2:30pm – 4:00pm** MHSA SLC Review of Programs Virtual Meeting via Zoom https://zoom.us/j/946132517 N=70 participants **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 N=66 participants **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

30-Day Public Comment Period (April 11 – May 10, 2020) and Public Hearing

WIC § 5848 states that an Annual Update or Three Year Plan shall be prepared and circulated for review and comment for at least 30 days to representative of stakeholder interests and any interested party who has requested a copy. Additionally the mental health board shall conduct a public hearing on the draft Annual Update or a Three Year Plan at the close of the 30 day comment period.

Nineteen public comments were submitted by stakeholders. BHSD reviewed and provided responses to these comments and questions. The Department modified and edited the documents based on public input as appropriate. The full response report is accessible at the following link:

https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Documents/2020/30-Day-PublicComments-and-BHSD-Response.pdf

The revised documents were reposted for public review and found at the MHSA website: www.sccbhsd.org/mhsa

At the end of the 30-Day Public Comment period, the Behavioral Health Board held a Public Hearing on May 11, 2020 virtually[1]. By a motion and a second, followed by 7 (yes) and 1 (no), roll call, the BHB affirmed that the Department had adhered to the MHSA CPP process and supported the submission of the MHSA Draft Plans for Fiscal Year 2020 and FY21-23 to the County of Santa Clara Board of Supervisors for approval at the June 2, 2020 meeting and the subsequent submission to the Mental Health Services Oversight and Accountability Commission and the California Department of Health Care Services.

[1]Executive Order 29-20 issued on March 17, 2020. https://www.gov.ca.gov/wp-content/uploads/2020/03/3.17.20-N-29-20-EO.pdf

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 is will continue to 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