Santa Clara County Behavioral Health Services Department
Mental Health Services Act (MHSA)
Three- Year Program & Expenditure Plan Fiscal Year 2018-Fiscal Year 2020

WELLNESS • RECOVERY • RESILIENCE

Prepared by:

Resource Development Associates

June 2018

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Dear MHSA Stakeholders and Santa Clara County Community Members:

The Behavioral Health Services Department is pleased to present you with the FY18-FY20 MHSA Three-Year Program and Expenditure Plan. Highlights of the County's FY18-FY20 MHSA Three-Year Program and Expenditure Plan reflect the Department's commitment to wellness and recovery through a continuum of care that aims to meet the needs of consumers across the lifespan.

In addition to the array of ongoing services funded by MHSA, this plan represents BHSD's investment in a number of new and expanded services including:

- **Targeted and culturally responsive outreach** including a new *Promotores* program to provide culturally and linguistically targeted outreach by peer health educators and new targeted outreach and engagement teams to connect consumers with mental health needs to services;

- Increased **capacity to meet the need of people with the most serious mental health needs** including: two new Assertive Community Treatment (ACT) teams; an expansion of Full Service Partnership (FSP) services; and three new Adult Residential Treatment facilities;

- Enhanced **services and support for the County's transition age youth** including triage staff located at Emergency Psychiatric Services (EPS) and the County jail to support reentry; and new TAY interdisciplinary services teams to provide clinical and non-clinical services located at community colleges, wellness spaces, and other youth friendly spaces; and

- An **expansion of community services to meet the needs of older adults** including a new Elder Health Community Treatment services to provide outreach, assessment, and services provided by a multi-disciplinary team— including peers— in the community wherever older adults need them; and an expansion of a collaboration with senior nutrition sites to co-locate services for older adults.

This plan is the result of a collaborative effort that included the participation of multiple stakeholders. Without all of the input we have received through the Community Program Planning (CPP) process, we would not have been able to develop such a comprehensive FY18-20 MHSA Three-Year Program and Expenditure Plan. Santa Clara County Behavioral Health Services Department wishes to thank the many consumers, family members, community members, agencies, and County staff who participated and helped guide the development of this plan.

We are thankful for the vision and commitment of the BHSD Leadership Team and the Stakeholder Leadership Committee (SLC). Throughout this process, the BHSD staff and the SLC demonstrated a deep commitment to the values of the MHSA and to the communities it serves.

We also appreciate the efforts of the Resource Development Associates team of Roberta Chambers, Kira Gunther, David Klauber, Caitlin Palmer, Lupe Garcia, Lily Bonadonna, and Ardavan Davaran for their work facilitating the CPP process and developing this plan.

Our hope is that this FY18-FY20 MHSA Three-Year Program and Expenditure Plan provides a transparent look into how Santa Clara County will meet the mental health needs of its residents. Thank you for your continued support

and participation in the County's MHSA planning process. Your voice and participation are critical to our collective success in preventing serious mental illness, supporting clients/consumers, families and communities, and testing innovative ways to address the mental health needs of Santa Clara County residents.

Sincerely,

Toni Tullys, MPA
Behavioral Health Services Director

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MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Clara

Local Mental Health Director	**Program Lead**
Toni Tullys, MPA (408) 885-7581 Toni.tullys@hhs.sccgov.org	Evelyn Tirumalai, MHSA Manager (408) 885-3982 Evelyn.tirumalia@hhs.sccgov.org
Local Mental Health Mailing Address: Santa Clara County Behavioral Health Services Department Mental Health Administration 828 South Bascom Avenue, Suite 200 San Jose, CA 95128	

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

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 20, 2018.

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.

Toni Tullys
Mental Health Director/Designee (PRINT)

Toni Tullys 6.20.18
Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County: Santa Clara

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

Local Mental Health Director	**County Auditor-Controller/City Financial Officer**
Toni Tullys, MPA (408) 885-7581 Toni.tullys@hhs.sccgov.org	Alan Minato (408) 299-5236 Alan.Minato@fin.sccgov.org
Local Mental Health Mailing Address: Santa Clara County 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.

Toni Tullys — Toni Tullys 6.28.18

Mental Health Director/Designee (PRINT) — Signature — Date

I hereby certify that for the fiscal year ended June 30, 2017, 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 December 19, 2017 for the fiscal year ended June 30, 2017. I further certify that for the fiscal year ended June 30 2017, 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 — Alan Minato 6/28/18

County Auditor Controller/City Financial Officer (PRINT) — Signature — Date

Introduction

The Santa Clara County Behavioral Health Services Department (BHSD) is pleased to present the following Mental Health Services Act (MHSA) *Three-Year Program and Expenditure Plan Fiscal Year 2018 – Fiscal Year 2020 (FY18-FY20).*

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 Santa Clara County 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.

Prior plans have been organized into large initiatives offering a broad range of services and system improvements targeted to age groups across the lifespan. Most initiatives were composed of multiple programs and prior plans focused on funding, staffing, and consumers served by initiative. Recognizing the importance of a transparent plan that clearly and specifically describes the services that will be provided, and which can easily align with MHSA funding categories, this plan breaks apart the larger initiatives into their discrete programs. Each program description is designed in a standardized format to easily display the target population, key services, anticipated numbers of consumers served, funding allocation, and program goals. Discrete programs are organized by systems of care for children, youth, families, and adults/older adults. Within each system of care, programs are grouped by larger initiatives. As much as possible, we have provided descriptions to allow a reader to see how these programs relate to prior initiatives.

Background

Figure 1: MHSA Values

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

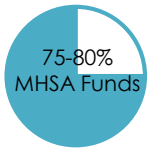
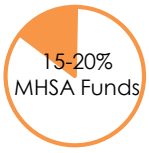
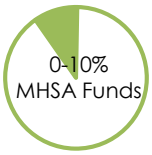
MHSA is funded through a one percent tax on individual annual income exceeding one million dollars. California counties receive MHSA allocations from the state, which typically make up about 50% of a county's

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.

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

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

Figure 2. MHSA Components

CSS	PEI	INN	WET	CFTN
Community Services & Supports	**Prevention & Early Intervention**	**Innovation**	**Workforce Education & Training**	**Capital Facilities & Technology Needs**
Outreach and direct services for children, TAY, adults and older adults with the most serious mental health needs.	Services promoting wellness and prevent the development of mental health problems. Early intervention services screen for and intervene in early signs of mental health issues.	Funding to test new approaches that may improve access, collaboration, and/or service outcomes for un-, under-, and inappropriately served populations.	Support to build, retain, and train a competent public mental health workforce.	Infrastructure development to support the implementation of an electronic health record and appropriate facilities for mental health services.
 At least 51% of **CSS** funds must be dedicated to FSP.	 At least 51% of **PEI** money must fund programs for consumers age 0-25.	 **INN** provides funding for 3-5 years per innovative practice.	Counties received a one-time allocation of **WET** funds to be spent by FY 2018.	Counties received a one-time allocation of **CFTN** funds to be spent by FY 2018.

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

Additionally, MHSA intends to serve individuals who are historically ***unserved*** or ***underserved*** by the public mental health care system.[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."*

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. One common factor that contributes to these disparities is language barriers which inhibit people from engaging in services available only in English. Cultural backgrounds also influence individuals' experiences of mental health treatment; some practices are more effective to engage people in services or provide effective treatment for one culture than for others. Additionally, individuals experiencing poverty or discrimination based on race, ethnicity, gender identity, or sexual orientation may be more likely to face mental health issues or difficulty navigating the system of care.

Santa Clara County's MHSA Plan

In the fall of 2016—approximately ten years after MHSA implementation began[2]—Santa Clara County Behavioral Health Services Department (BHSD) hired Resource Development Associates (RDA) to assess the effectiveness, structure, quality, and impact of its MHSA-funded Continuum of Care. One of the goals of this project was a retrospective exploration of what had been accomplished with regards to MHSA implementation. BHSD was also interested in documenting the current landscape of MHSA-funded services, and in exploring outstanding/unmet needs in order to target its future efforts. These efforts culminated in a comprehensive needs assessment and series of recommendations that informed the direction of this MHSA Plan.

In January 2018, BHSD— in collaboration with RDA— began the Community Program Planning (CPP) process for its MHSA *Three-Year Program and Expenditure Plan FY18 – FY20.* This process included

[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

[2] The MHSA was passed in 2004 with the first component, Community Services and Supports, implemented in 2005-2006.

presenting and validating findings and recommendations from the needs assessment, and working closely with the County's Stakeholder Leadership Committee (SLC).

The resulting Plan describes BHSD's CPP process, provides an assessment of the needs identified and prioritized via inclusive stakeholder outreach and engagement activities, and proposes programs and expenditures to support a robust mental health system based in wellness and recovery. This Plan includes the following sections:

- **Overview of the Community Program Planning (CPP) process** that took place in the County from January 2018 through May 2018. BHSD's CPP process built upon the meaningful involvement and participation of mental health consumers, family members, County staff, providers, and many other stakeholders.

- **Assessment of mental health needs** that identifies both strengths and opportunities to improve the mental health service system in Santa Clara County. The needs assessment used multiple data sources—including focus groups with community members and community-based organizations, interviews with County leadership, literature review, document review, benchmarking, site observation, surveys, and analysis of BHSD's electronic health records and financial data— to identify the service gaps which will be addressed by BHSD's proposed MHSA programs for FY18 – FY20.

- **Descriptions of Santa Clara County's 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.

After completing the needs assessment and concurrent with the CPP phase of the *Three-Year Program and Expenditure Plan FY18–FY20*, Santa Clara County stakeholders have focused their efforts on addressing gaps that have emerged and enhancing the mental health services offered by current MHSA programs. Examples of new services or enhancements made to MHSA programs during this time include:

- **New targeted outreach and engagement teams** to connect consumers with mental health needs to services;
- **Two new Assertive Community Treatment (ACT) teams** to provide intensive services to adults with the most severe mental health needs in order to decrease hospitalization, incarceration, and homelessness;
- An **expansion of Full Service Partnership (FSP)** services including 700 additional spaces and an increase in per person annual funding for transition age youth (TAY), adults, and older adults;
- **Three new Adult Residential Treatment facilities** to provide services to consumers who are stepping down from Institution of Mental Disease (IMD) placements, to divert consumers who

would otherwise be in a locked facility, and to provide treatment for individuals with serious mental health and substance abuse needs;

- **New TAY triage staff** located at Emergency Psychiatric Services (EPS) and the County jail to support reentry through peer counseling, case management, and linkage services;
- **New TAY interdisciplinary services teams** to provide clinical and non-clinical services located at community colleges, wellness spaces, and other youth friendly spaces;
- **An expansion of a collaboration with senior nutrition sites** to provide community training, workshops, and referrals to co-locate services for older adults;
- **New Elder Health Community Treatment services** to provide outreach, assessment, and services provided by a multi-disciplinary team— including peers— in the community wherever older adults need them.
- **A new *Promotores* program** to provide culturally and linguistically targeted outreach by Peer Health Educators to enhance linkage to services.

In addition to these new and modified programs, the County is also in the process of proposing three new Innovation (INN) programs, including a home matching program that connects consumers with places to stay and case management services during transitions; and a dedicated older adult in-home outreach team.

This 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.

Thank you for your interest and participation in developing Santa Clara County's *FY18 – FY20 MHSA Three-Year Program and Expenditure Plan.*

Community Program Planning (CPP)

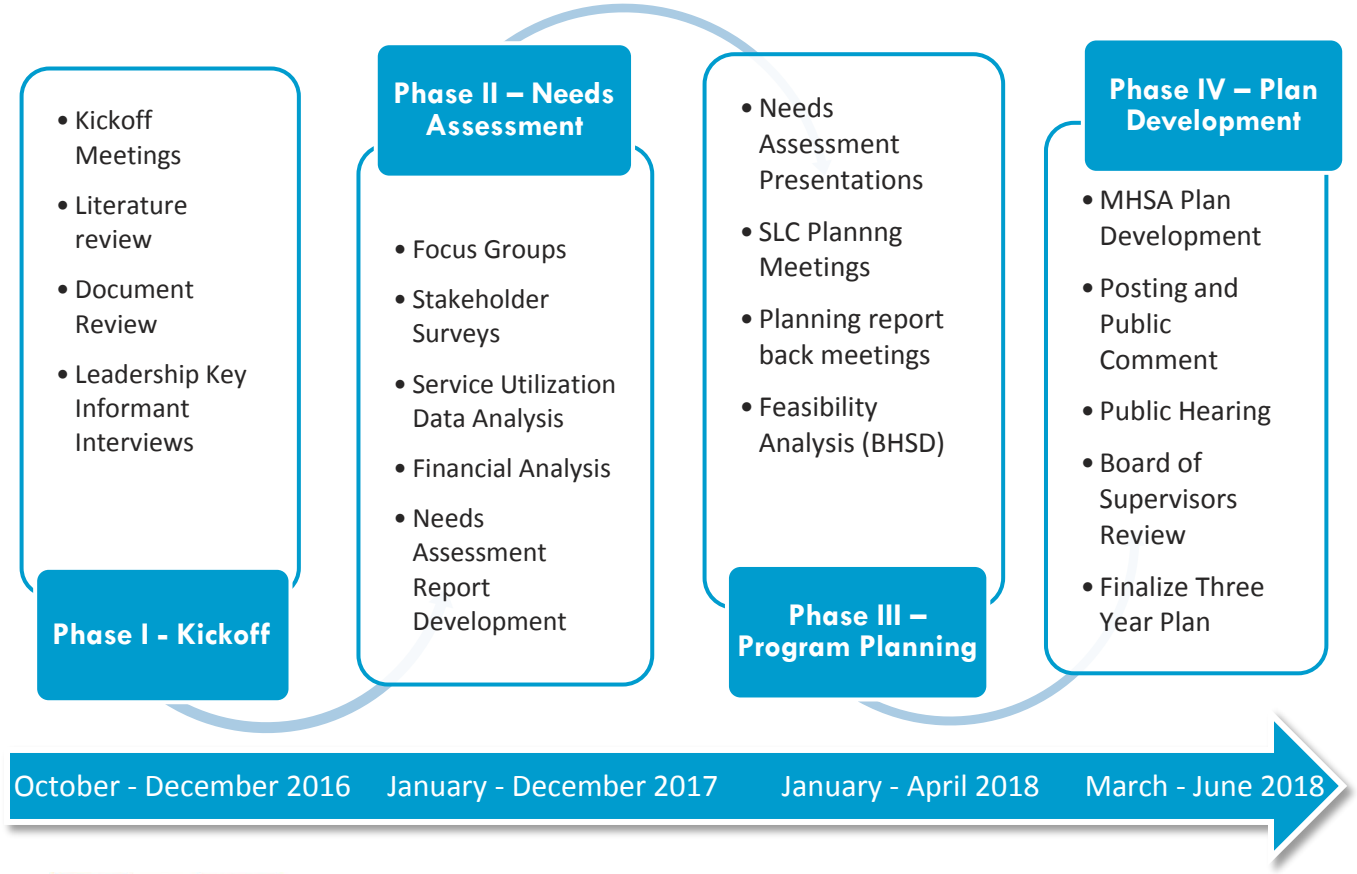
I. Description of Community Program Planning (CPP) Process

Planning Approach and Process

In January 2018, BHSD embarked on a planning process for the Mental Health Services Act (MHSA) *Three-Year Program and Expenditure Plan FY18 – FY20*. The planning team was led by Toni Tullys, Director of the Behavioral Health Department; Deane Wiley, Deputy Director; Evelyn Tirumalai, MHSA Coordinator; Lily Vu, MHSA Innovations Coordinator; and Resource Development Associates (RDA), a consulting firm with mental health planning expertise.

The planning team utilized a participatory framework to encourage buy-in and involvement from stakeholders including service providers, consumers, family members, other professionals likely to come into contact with people with mental health needs, and interested community members. The planning process was divided into four phases: 1) Kickoff, 2) Needs Assessment, 3) Program Planning, and 4) Plan Development. Figure 2 lists the activities included in each phase.

Figure 3. Needs Assessment and Community Planning Process



Community Planning Activities

The planning team carried out a set of community meetings and information-gathering activities, engaging stakeholders in all stages of the planning and strategy development process in order to ensure that the Plan reflected their experiences and suggestions. Planning activities and their corresponding dates are presented in the table below, followed by a detailed description of each activity. Materials and handouts from each meeting are included in the Appendix.

Table 1. Community Planning Activities and Dates

Activity	Date
Kickoff Meetings	
Stakeholder Leadership Kickoff Meeting	October 2016
Discussion Groups with BHSD Leadership	October 2016
Leadership Interviews	November 2016 – December 2016
Needs Assessment	
Consumer Focus Groups	May 2017 - June 2017
Provider Focus Groups	May 2017 - June 2017
Stakeholder Surveys	October 2016- November 2016
Needs Assessment Presentations	February 13, 2018 February 14, 2018 February 20, 2018
Strategy Development	
Stakeholder Leadership Committee Orientation	February 12, 2018
Stakeholder Leadership Committee Planning Meetings	February 22, 2018 March 8, 2018 March 16, 2018 March 27, 2018
Behavioral Health Board	March 12, 2018
BHSD Staff Meeting	March 20, 2018
SLC Report Back Meeting	May 8, 2018
Public Review Process	
30-Day Review Period	May 11, 2018 – June 10, 2018
Public Hearing	June 11, 2018
Board of Supervisors	June 19, 2018

Kickoff Meetings

MHSA Stakeholder Leadership Committee Kickoff Meeting

The planning process began with a kickoff presentation to the MHSA Stakeholder Leadership Committee (SLC). Since 2005, the MHSA SLC has provided input and advised BHSD in its MHSA planning and implementation activities. The MHSA SLC serves as BHSD's primary advisory committee for MHSA-related activities. Members of the MHSA SLC include:

- People with lived experience, including consumers and family;
- First responders, including law enforcement;
- Contract providers from across all age groups, geographies, and types of service;
- Representatives from un-, under-, and inappropriately served populations; and
- BHSD staff.

RDA facilitated this kickoff during a regularly scheduled MHSA SLC meeting to introduce the project, share information about the needs assessment process and its goals, and discuss the various opportunities for stakeholder engagement throughout the process.

Discussion Groups with BHSD Leadership

The planning team conducted discussion groups with Department leadership and management teams to describe behavioral health services in the County and how people accessed and moved through services. Participants were asked to reflect on what works well in the current system, the biggest challenges they face, how consumers move through system decision-making processes, and any concepts or ideas they would like the needs assessment to explore. The discussion group format allowed the planning team to learn firsthand from Department leadership and program managers how the systems of care are set up.

Key Informant Leadership Interviews

RDA staff conducted 13 interviews with key leadership staff from BHSD as well as the larger Santa Clara Valley Health & Hospital System (SCVHHS) to understand the types and levels of services provided in each system of care, access points into each system, referral pathways, and crisis services and responses in the County.[3] The purpose of these interviews was to learn about the landscape of mental health services and the ways in which other SCVHHS departments interact with BHSD services. The interviews were used to explore the strengths and challenges within BHSD services, conceptualize gaps and needs across departments within SCVHHS (i.e. Emergency Medical Services, Valley Medical Center), and inform data collection activities moving forward.

[3] For a complete list of interview questions, see Appendix.

Needs Assessment

Focus Group Discussions

RDA staff convened 20 focus groups to gather input from providers and community members about their 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, service gaps, provider competence and training, and recommendations for future directions. To better understand the differences between how consumers and providers experience the mental health system, RDA created unique focus group protocols for each of these two groups.[4] The focus group format allowed the planning team to reach a greater number of participants and gave participants the chance to discuss topics among themselves, thereby producing additional information that might not have emerged through individual interviews. BHSD leadership and staff from local community-based organizations conducted recruitment for the focus groups, making special efforts to reach target populations and communities throughout Santa Clara County. Focus groups were advertised to providers and community leaders via emails explaining the purpose of the meetings. To facilitate the participation of the County's non-English speaking populations, interpreters were provided at the Hispanic/Latino consumer focus group and the Vietnamese consumer focus group.

Stakeholder Survey

The planning team also developed a survey to collect input from stakeholders regarding their experiences with MHSA services and their perceptions of community needs. The purpose of the survey was to collect information from a wider audience beyond the focus groups. RDA administered the stakeholder survey to consumers and families through SurveyGizmo, a web-based survey instrument. SurveyGizmo was selected for its accessible user interface and its compliance with HIPAA regulations, as required for the collection of personal health information. Surveys were administered in English, Spanish, and Vietnamese. Surveys were distributed to providers, who encouraged consumers and their family members to complete the survey and provide feedback on their experience of care.

The survey included questions designed to capture experiences and perceptions of when consumers attempt to access care, are referred to services, communicate with providers, and receive services. The survey also captured perspectives and beliefs related to the cultural competency of mental health services, incorporation of recovery into mental health services, and consumers' perceptions of their own recovery process. In addition, the survey gathered input from consumers and family members on strengths and challenges of the behavioral health system. The survey included both closed- and open-ended responses, allowing respondents the opportunity to provide detailed feedback. Finally, the survey included eight questions that captured the demographic profile of the consumer or family member completing the survey. In total, 650 surveys were analyzed.

[4] See Appendix for focus group protocols.

Needs Assessment Report Back Presentations

At the conclusion of the needs assessment, the planning team presented the needs assessment at three report back meetings held in February 2018 with the MHSA SLC, the Health and Hospital Committee, and the BHSD. These report back meetings served as an opportunity to validate the findings and recommendations that came from the needs assessment, and served as a transition from the needs assessment into the community program planning (CPP) process.

Strategy Development

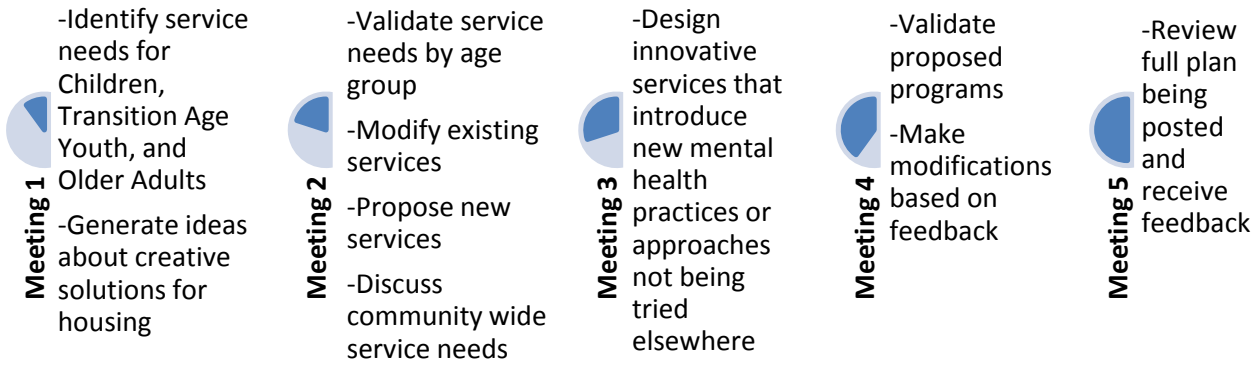
SLC Orientation

BHSD staff involved in the MHSA planning team facilitated a public application process to solicit applicants to join a new MHSA SLC, in order to ensure that all key stakeholders were represented in the planning process, including representatives from the Behavioral Health Board, the National Alliance on Mental Illness (NAMI), local law enforcement agencies, veterans, providers, consumers, and family members. After SLC members were selected, the planning team conducted an orientation for the SLC that provided an overview of MHSA, components, and regulations; a review of the CPP process; and a discussion of the SLC roles and responsibilities.

MHSA SLC Planning Meetings

The planning team facilitated four three-hour planning meetings with the MHSA SLC and one two-hour report back meeting. The planning meetings were designed to discuss and build upon the results of the needs assessment, prioritize service gaps, and identify strategies to address these gaps. As shown in Figure 4, each meeting was designed to address a specific area of the plan and build upon the ones before it.

Figure 4. SLC Activities and Timeline



MHSA SLC Meeting 1: The first MHSA SLC meeting identified the key service needs for consumers based on age group and began to generate ideas about creative housing solutions. Because the needs assessment had already resulted in a proposed redesign of the adult system– reviewed and vetted by numerous County stakeholders— the MHSA SLC therefore focused its efforts on services for children, TAY, and older adults. At the beginning of the meeting, each stakeholder was asked to join a smaller group representing children, youth, and older adults. An RDA facilitator and a County staff person knowledgeable about existing County services for that age group was stationed at each small group; each group was also given a worksheet with key findings from the needs assessment, existing programs for that age group, and a list of key discussion questions. The groups designated a note taker and representative and used the worksheet to identify which existing programs should remain, what programs should be changed, what programs should be removed, and what programs need to be added to the system. At the conclusion of the small group activity, the designated representatives reported back to the larger group. In the second half of the meeting, the MHSA SLC had a large group discussion to generate creative ideas for housing. The planning team facilitated the discussion and took notes.

MHSA SLC Meeting 2: The second MHSA SLC planning meeting built upon the discussion from the first meeting. MHSA SLC representatives returned to their small groups from the first meeting, and a facilitator from the planning team reported back to each group on key themes from the first planning meeting, in order to validate and refine them. The small groups then used a worksheet to design programs for their system of care. The groups determined whether to focus on new programs or modifying existing programs, and varied in the number of programs they discussed depending on the needs identified. For example, the needs assessment found the children's system to be more robust than either the TAY or older adult groups, so the children's group focused more on refining existing programs, while the other groups build out new services. In the second half of the meeting, the MHSA SLC broke into two larger groups, based on individual preference, and the groups discussed prevention and outreach for increasing recognition of early signs of mental illness and promoting access and linkage to treatment.

MHSA SLC Meeting 3: The third MHSA SLC meeting focused on designing Innovation (INN) programs. The planning team began by presenting an overview of the planning process to date, including a recap of the programs designed by the MHSA SLC in the prior meeting, a review of MHSA's INN requirements, and a list of ideas generated in prior MHSA SLC meetings that were likely to meet the INN criteria. Then, staff from BHSD provided an update on two new INN projects that are moving forward in the County, and solicited feedback from the group. After these presentations, the MHSA SLC broke into three small groups to design INN programming. The MHSA SLC members decided to move forward with two suggestions from the prior meetings— one focusing on housing and one on TAY— and formed a third small group to brainstorm additional ideas. MHSA SLC members self-selected into groups, each group designated a note taker and representative, and the groups worked independently to design the INN programs. Each group then presented their idea to the larger group and answered questions. At the end of the meeting, a representative from the Office of Supportive Housing spoke for a few minutes to solicit feedback from the MHSA SLC on ideas for housing options for consumers in the County.

MHSA SLC Meeting 4: The fourth and final planning meeting was a review of the programs recommended for inclusion in the Plan. The planning team presented an overview of the programs ideas generated by the MHSA SLC in the first three meetings. The MHSA SLC was asked to propose areas of refinement for County consideration. After some discussion, the MHSA SLC chose to break into four smaller groups to discuss services for children 0-5 years old, service centers for older LGBTQ adults, peer respite options for older adults, and services for commercially sexually exploited minors. Each group designated a note taker and a representative, met as a small group to generate ideas, and reported back to the larger group.

MHSA SLC Meeting 5: At the final MHSA SLC meeting, members were provided a copy of the draft Plan along with a proposed budget. The planning team solicited feedback from the MHSA SLC to validate the proposed Plan and suggest any modifications.

Report-Back Meetings

The results of the MHSA SLC planning meetings were presented to BHSD Staff and the Behavioral Health Board in two report-back meetings. The Behavioral Health Board meeting was open to the public and publicized by email to MHSA stakeholders, community providers, and other individuals who signed up for email updates throughout the planning activities and whose contact information was added to the MHSA coordinator's email list serve. Information about this meeting was also posted on the BHSD website, and a flyer was distributed at the MHSA SLC meetings with location and date.

During these meetings, stakeholders discussed their impressions of the proposed Plan and provided feedback on how well they felt the community planning process included their input.

Public Review Process

The public review process is described in Section III.

II. Stakeholder Participation

Stakeholder Engagement and Outreach for Community Planning Activities

The needs assessment and the Community Program Planning (CPP) process included a variety of stakeholder groups reflective of the geographic and cultural diversity of Santa Clara County 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
- Valley Medical Center staff, managers, and senior leadership
    - Emergency Psychiatric Services staff, including staff psychiatrist
    - Barbara Arons Pavilion staff
- Community-based providers
- Consumers of services
- Family members and other loved ones
- Law enforcement
- Emergency medical services
- County Office of Education and community college representatives
- Culture-specific providers and consumers and family of culture-specific providers
- Staff from social services
- Veterans and representatives from veterans organization

Both the needs assessment and CPP process leveraged a number of existing meetings, including meetings of the following bodies:

- Board of Supervisors Health and Hospital Sub-Committee
- Behavioral Health Advisory Board
- Stakeholder Leadership Committee
- Behavioral Health Contractor's Association

Outreach efforts were developed to ensure that the planning process reached a broad spectrum of stakeholders and that the process was driven by community input. Prior to the planning process, BHSD launched a MHSA Stakeholder Leadership Committee (SLC) recruitment search among stakeholders to form a new MHSA SLC group representative of Santa Clara County. Recruitment fliers and the final list of committee members are included in the Appendix. The CPP launch was announced via email to list serves and participants from previous meetings, as well as former SLC members, were notified. 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 Key Dates flyer that was distributed at meetings and via email. Additionally, all meetings were posted on BHSD's website.

Efforts to Include Consumers and Unserved and Underserved Populations

The needs assessment and the CPP was an inclusive process that sought to include participation of the linguistic and cultural diversity of Santa Clara County. During the needs assessment, culture-specific outreach and input gathering sessions were held across the County for the following groups:

- African and African Ancestry communities
- Latino/Hispanic communities
- Asian/Pacific Islander communities
- Reentry population
- People experiencing homelessness
- LGBT+ communities

Community members were asked to provide data through an online survey, focus groups, and interviews. They were also invited to provide input on needs assessment findings and potential recommendations. Surveys were available in English, Spanish, and Vietnamese, while focus groups were either conducted in the preferred language of participants when all participants had a shared language (i.e. Spanish), or with simultaneous interpretation when there were multiple language needs within a group.

The following providers supported culture-specific outreach to consumers and their families regarding survey and focus group participation, as well as contributed input and recommendations to the needs assessment on their own and on behalf of their communities.

- Ujiima
- Catholic Charities
- HomeFirst
- Caminar
- Mekong Community Center
- Asian Americans for Community Involvement
- Bill Wilson Center
- Alum Rock Counseling Services
- Native American Health Center

Summarized in the table below are the focus groups that included the exclusive participation of consumers:

Table 2. Community Focus Group Participants, by Focus Group Type

Agency	Focus Group Population
Community Solutions	Older adult consumers
Community Solutions	Family members
Ujima Family Recovery Services	Black/African Ancestry consumers
Catholic Charities of Santa Clara County	Older adult consumers
HomeFirst	Homeless consumers
Hope Services	Adult consumers
The LGBTQ Youth Space	LBGTQ consumers
Reentry Resource Center	Reentry consumers
Mekong Community Center	Asian adult monolingual consumers
Momentum for Mental Health	Older adult consumers
Bill Wilson Center	TAY consumers
Alum Rock Counseling Center	Hispanic/Latino consumers
National Alliance on Mental Illness	Family members
Starlight Community Services	TAY consumers
Project Safety Net	TAY consumers
Santa Clara Behavioral Health Services	Adult/older adult County providers
Rebekah Children's Services	Children/TAY contract providers
Santa Clara Behavioral Health Services	TAY County providers
Santa Clara Behavioral Health Services	County provider leadership

Summary of Stakeholder Participation

There were over 900 (n=917) community members and agency staff who participated in community planning activities. Across the needs assessment, 712 surveys were completed and 167 unduplicated individuals participated in focus groups. BHSD staff and audience members who attended public or other regularly scheduled meetings are not included in this number.

The following table presents the number of participants in each activity.

Table 3. Total Number of Participants, by Activity

Community Planning Activity	Total Count of Duplicated Participants
Focus Groups	167
Leadership Interviews	13
Stakeholder Surveys	712
Stakeholder Leadership Committee	25
Total	917

Survey Respondent Demographics

As shown in the figures below, survey participants represented a diverse cross section of Santa Clara residents. Just under half of survey respondents (49%) identified as consumers. Overall, there was a larger share of female respondents (59%) than male respondents (38%). The majority of survey respondents were adults (48%), but more than a quarter (28%) identified as TAY. Approximately one in three respondents (34%) identified as white or Caucasian, 15% identified as Asian/Pacific Islander, and 12% identified as mixed race.

Figure 5. Survey Respondents by Self-identification (n=670)

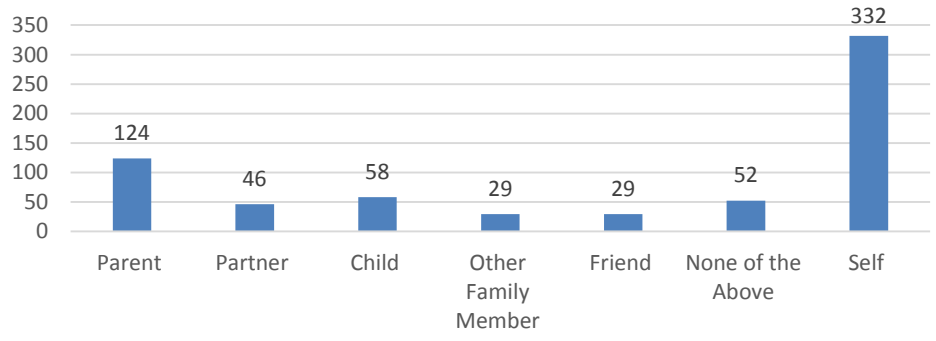


Figure 6. Survey Respondents by Gender (n= 628)

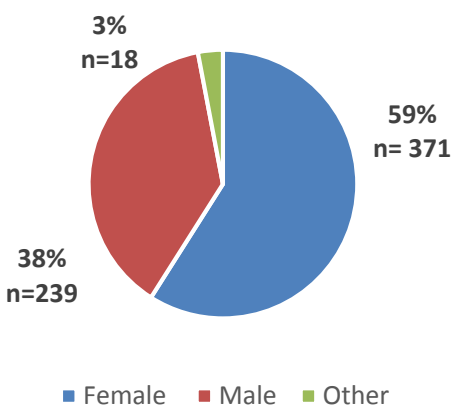


Figure 7. Survey Respondents by Age (n= 624)

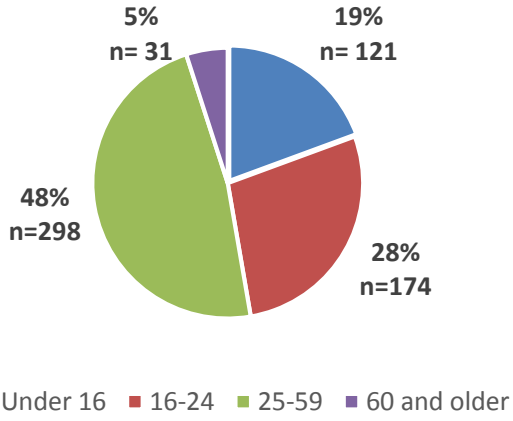
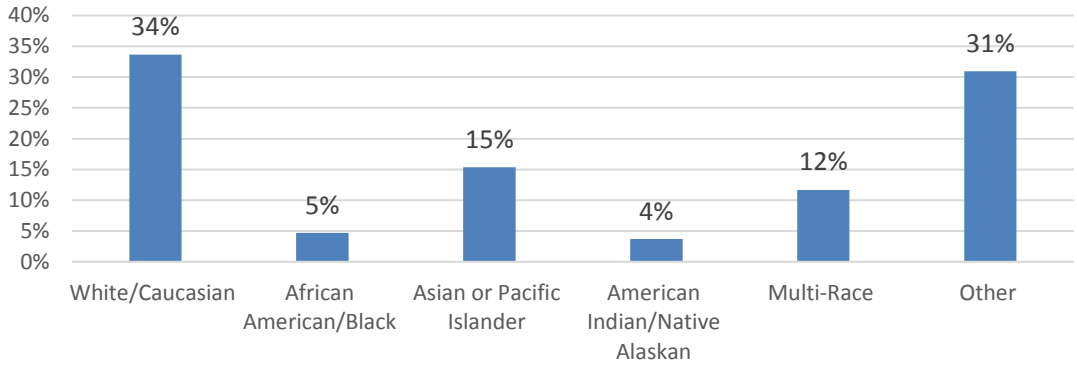


Figure 8. Survey Participants by Race (n= 514)



SLC Demographics

The Stakeholder Leadership Committee was composed of 25 stakeholders that represented the diversity of the County's residents across a range of race and ethic identities, sexual orientation, and geographic location (see Figure 9). The Committee was modeled after MHSA requirements that there be a meaningful stakeholder process to provide subject matter expertise to the development of plans focused on utilizing the MHSA funds at the local level.

Figure 9. Stakeholder Leadership Committee Representatives [5]

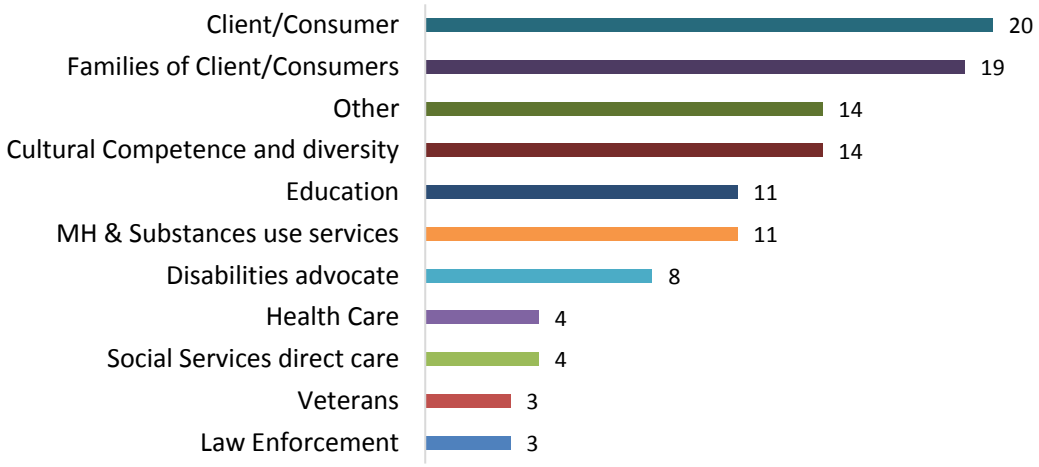


Figure 10. Race and Ethnicity of Stakeholder Leadership Committee

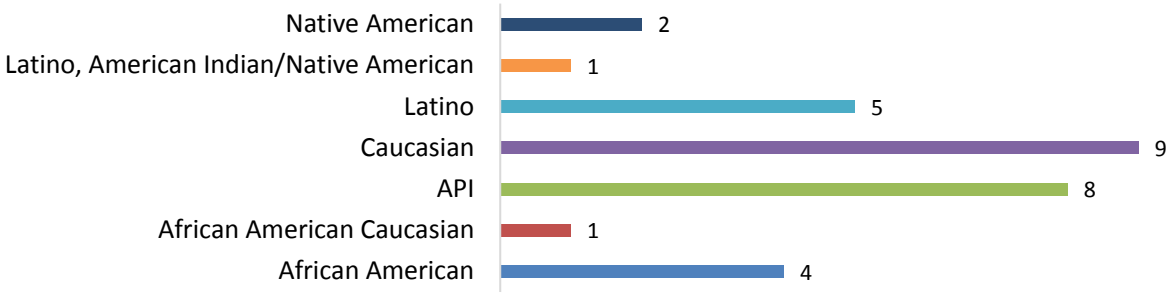
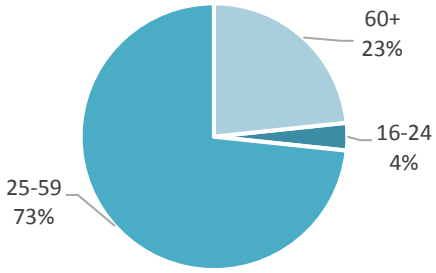


Figure 11. Age Groups of Stakeholder Leadership Committee



[5] Some stakeholders identify with several stakeholder groups. Therefore, the totals in the graph exceed the 25 committee members.

III. Public Review Process and Hearing

The 30-day public comment period opened May 11, 2018 and closed on June 10, 2018. The County announced and disseminated the draft Plan to the Board of Supervisors, Behavioral Health Advisory Board, County staff, service providers, consumers, family members, and those whose email addresses are associated with the stakeholder email list compiled throughout this planning process. A public notice was also posted on the County's MHSA website **www.sccbhsd.org/mhsa**. The draft Plan was posted to the County's website and could be downloaded electronically along with public comment forms with instructions on how to submit stakeholder input. Paper copies were also made available at BHSD offices in San Jose, as well as other locations throughout Santa Clara County such as public libraries and community centers. Any interested party could request a copy of the draft Plan by submitting a written or verbal request to the MHSA Coordinator at evelyn.tirumalai@hhs.sccgov.org or by calling (408) 885-5783.

The Behavioral Health Board hosted a public hearing on June 11, 2018, during which stakeholders were engaged to provide feedback about the Santa Clara County's *FY18-FY20 MHSA Three-Year Program and Expenditure Plan* (see Appendix for the 30-Day Public Comment form and Agenda for Public Hearing). The Behavioral Health Board unanimously recommended the Draft Plan, Reversion Plan, and new Innovations Projects to move forward. The Department is scheduled to request Board of Supervisor approval and adoption of the Draft Plan and Reversion Plan on June 19, 2018.

The Santa Clara County Board of Supervisors unanimously approved the FY18-FY20 MHSA Program and Expenditure Plan, Innovations Projects and Reversion Plan as presented at the June 19, 2018 general meeting. A presentation of the Plan Document summary is found in the Appendix section of this report.

Needs Assessment Summary

Santa Clara County Overview

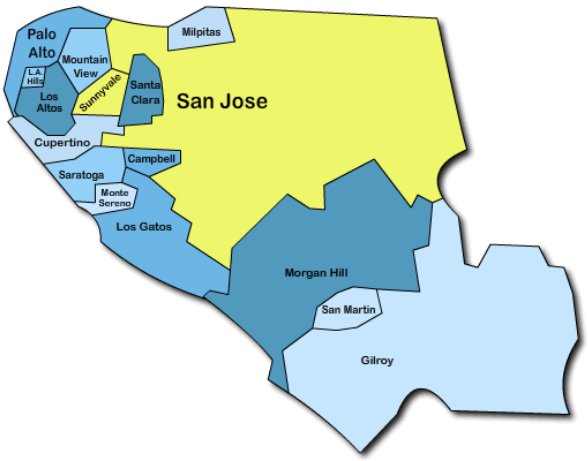
Santa Clara County, located in Northern California, is situated at the southern end of the San Francisco Bay Area. With a population estimate of approximately 1,868,000, Santa Clara County is the most populous county in the San Francisco Bay Area. Also known as Silicon Valley, Santa Clara County is a major employment center for the region, providing more than a quarter of all jobs in the Bay Area. San Jose is the largest city in the County, with a population of nearly one million, and is the administrative site of the County government, including the Behavioral Health Services Department (BHSD).[6]

Santa Clara County is home to a diverse range of races and ethnicities. The majority of residents are White (48%), followed by Asian or Pacific Islander (34%), and Hispanic or Latino (27%). The Asian population in the County is comprised of high proportions of Indian, Chinese, Vietnamese, and Filipino individuals.[7] Santa Clara County is also home to a large population of foreign-born persons, with estimates of 35% to 38% (655,000 to 704,000) of the total Santa Clara population born outside of the United States. Of the foreign-born population, approximately 64% are of Asian descent, and approximately 25% are of Latin American descent.[8] In Santa Clara County, approximately 104,000 residents are from the Philippines[9] and 106,000 from Vietnam, comprising about 11% of the total population. According to a 2017 report from the Pew Research Center, 6.5% of the total County population and 16% of the foreign-born population (n=120,000 individuals) are undocumented residents.[10] From 2011 to 2016, Santa Clara County took in approximately 1,500 refugees.

In Santa Clara County, roughly 53% of residents are speakers of a non-English language, which is higher than the national average of 21.5%. In 2015, the most common non-English language spoken in Santa Clara County was Spanish, with 17% of the overall population being native Spanish speakers. Chinese and Vietnamese were the next two most common languages, with approximately 7% of the population speaking Chinese and 6% speaking Vietnamese.[11]

[6] https://www.sccgov.org/sites/scc/pages/about-the-county.aspx
[7] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
[8] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
[9] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
[10] http://www.pewresearch.org/fact-tank/2017/02/09/us-metro-areas-unauthorized-immigrants/
[11] https://www.census.gov/programs-surveys/acs/

The County has one of the highest median family incomes in the country and is home to many extremely affluent areas, including San Jose, Palo Alto, Sunnyvale, Saratoga, and Mountain View.[12] However, 9.5% of the population lives below the poverty level, of which disproportionate amounts are Black/African Ancestry, Hispanic/Latino, and Native individuals.[13]



Map of Santa Clara County by city

There are 15 cities in the County, spanning 50 miles from Palo Alto in the north to Gilroy in the south. South Santa Clara Valley is a census county division located in southern Santa Clara County. The area covers approximately 118 square miles and includes the cities of Morgan Hill, San Martin, and Gilroy. Approximately 103,500 residents reside in South County, of whom a majority (47%) are Hispanic/Latino.[14,15]

Like many counties, Santa Clara County has a decentralized police force with 15 unique police departments each operated by its own city government and having jurisdiction covering its own municipality. While common, a decentralized police force may present challenges within a large and geographically dispersed county such as Santa Clara, as there is no leading command to resolve jurisdictional problems.

Santa Clara County is home to approximately 61,600 veterans.[16] Veterans in Santa Clara County are eligible to receive services through the Veterans Affairs Northern California Health Care System. For this reason, few veterans show up in Mental Health Service Act (MHSA)-funded public mental health services.

Santa Clara County's BHSD is part of the Santa Clara Valley Health & Hospital System (SCVHHS). SCVHHS provides comprehensive care, services, and programs to the residents of Santa Clara County. In 2014, the Santa Clara's Mental Health Department and the Department of Alcohol & Drug Services merged into the current Santa Clara BHSD. The process was conducted with the goal of fully integrating the County's behavioral health vision, values, approach, infrastructure, systems, processes, services, and supports to:

- Support SCVHHS' Vision and Strategic Priorities

[12] https://www.sccgov.org/sites/scc/pages/about-the-county.aspx
[13] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
[14] https://www2.census.gov/geo/maps/dc10map/GUBlock/st06_ca/cousub/cs0608593175_south_santa_clara_valley/DC10BLK_CS0608593175_000.pdf
[15] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
[16] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

- Recognize the frequent co-occurrence of mental health and substance use disorders
- Better meet the needs and expectations of current and future consumers and their families
- Focus on prevention and early intervention
- Prepare for Affordable Care Act implementation and full collaboration of mental health providers and primary care doctors
- Merge these perspectives into a broader model of integrated care
- Apply best practices to work with those with single and dual diagnoses

BHSD is currently set up as a "No Wrong Door" system of care intended to provide consumers with care regardless of where they go seeking mental health services. A No Wrong Door system of care is designed such that the appropriate level of care is easily accessible no matter where or how consumers present. In this access model, individuals should be able to be treated immediately and redirected to the appropriate level of care. In Santa Clara County, the Behavioral Health Services Call Center is the entry point for access to all of Santa Clara County's behavioral health services. BHSD serves a geographical region covering a total of 1,312 square miles, and provides services to Medi-Cal beneficiaries and unfunded populations in need of specialty mental health services. BHSD also serves residents in need of involuntary psychiatric evaluation and treatment, residents eligible for MHSA-funded services, students who qualify through AB 3632, residents in custody, and those with acute mental health needs who lack resources. Of the 326,311 Medi-Cal beneficiaries in the County, BHSD provided mental health services to 18,286 in FY15-16.[17] BHSD provides a full continuum of services that spans access and crisis services; outpatient, intensive, outpatient, and full service partnership (FSP) programs; and prevention, early intervention, and innovation programs. The overall system of care is organized into two sub-systems: 1) Children, Youth and Families; and 2) Adult and Older Adult.

Background Information

In the fall of 2016, BHSD hired Resource Development Associates (RDA) to assess the effectiveness, structure, quality, and impact of their MHSA-funded Continuum of Care. This MHSA Needs Assessment was commissioned by BHSD approximately ten years post MHSA implementation.[18] One of the goals of the project was to conduct a retrospective exploration to determine what had been accomplished with regards to MHSA implementation. The Department was also interested in documenting the current landscape of MHSA-funded services and what additional needs remain in order to target future efforts.

[17] Behavioral Health Concepts, Inc. FY16/17 Medi-Cal Specialty Mental Health Ext4ernal Quality Review MHP Final Report. Retrieved December 19, 2017 from https://www.sccgov.org/sites/bhd/partners/QI/EQRO/Documents/Santa%20Clara%20MHP%20EQRO%20Report%20Final%20FY16-17%20JP%20v4.pdf

[18] The MHSA was passed in 2004 with the first component, Community Services and Supports, implemented in 2005-2006.

There were a number of other intersecting County initiatives and events that preceded or were concurrently unfolding during this project. These contextual factors are discussed below, as they are likely to influence BHSD, contracted providers, consumers, and their families; how services are organized and delivered; and what future directions are most likely to be successful.

Leadership and Management

In 2014, the County appointed Toni Tullys, a seasoned healthcare leader with extensive expertise in public behavioral health and community health services, to serve as the first Behavioral Health Services Director. Additionally, new Executive Leadership and Senior Management positions were created, including:

- Deputy Director
- Administrative Services Manager III
- Children, Youth and Families Director
- Adult/Older Adult Director
- Quality Improvement Director
- Criminal Justice Division Director and Senior Health Care Program Manager

These positions were filled by both internal and external candidates between 2015 and 2017.

Technological Initiatives

HealthLink Electronic Health Record implementation

The Department recognized the need to upgrade its technology and underwent an extensive implementation project to implement EPIC (locally known as HealthLink), a nationally recognized care management system that is also implemented throughout the Health and Hospital System. HealthLink for County-operated mental health services went live in February 2018, and represents a tremendous opportunity to improve data capturing and reporting abilities as well as care coordination and communication countywide.

Call Center Redesign

BHSD also invested significant efforts into its Call Center operations to enhance timely access to care and improve consumers' engagement experience. This included technological innovations to ensure that the Call Center had access to real-time capacity of service providers, in order to connect consumers to available services.

Policy Changes

Drug Medi-Cal Organized Delivery System Waiver Implementation

In July 2017, Santa Clara implemented the Drug Medi-Cal Organized Delivery Systems Waiver (DMC Waiver), which waived specific Drug Medi-Cal rules for counties who opted in and agreed to certain

conditions. Specifically, the DMC Waiver allowed counties to bill Drug Medi-Cal for additional recovery services while requiring 1) the use of ASAM criteria to determine level of care placement and other evidence-based practices, 2) identified levels of care across the continuum of services, 3) development of network adequacy based on estimated need, and 4) integration with physical and mental health services.

Whole Person Care Pilot Project

In 2016-2017, the California Department of Health Care Services created the Whole Person Care (WPC) Pilot Program as a part of the 1115(a) Medicaid waiver, Medi-Cal 2020. SCVHHS applied for and received funding in Rounds 1 and 2 to implement a WPC pilot. SCVHHS' WPC project was a collaborative effort between Valley Medical Center and BHSD, as well as a number of other County and community-based partner organizations. The WPC pilot specifically aimed to address the needs of high users of multiple systems with new program and data infrastructure to ultimately improve health care outcomes by addressing all of a person's psychosocial and healthcare needs.

Medi-Cal Managed Care Final Rule

The Centers for Medicare and Medicaid Services (CMS) issued the Medicaid and Children's Health Insurance Program (CHIP) Final Rule in 2016, with a phased implementation starting in Fiscal Year 2017/2018. The Final Rule focuses on bringing Medicaid managed care into alignment with other health insurance coverage programs— including the mental health plan (MHP) administered by BHSD— through addressing network adequacy standards and timely access to care. This Final Rule not only applies to BHSD, but also to services contracted by BHSD as a part of MHP administration.

New MHSA Prevention and Early Intervention and Innovation Regulations

In 2017, the State of California updated the regulations for the Prevention and Early Intervention (PEI) and Innovation (INN) components of the MHSA. The PEI regulations require restructuring PEI services from Prevention and Early Intervention to include Prevention, Early Intervention, Outreach for Increasing Recognition of Early Signs of Mental Illness, Stigma and Discrimination Reduction, Suicide Prevention, and Access and Linkage to Treatment. INN regulation changes realigned the approval process for INN plans from local approval back to the California Mental Health Oversight and Accountability Commission (MHSOAC). Increased data collection and other reporting requirements were also included for both PEI and INN components.

MHSA Needs Assessment Overview

Santa Clara County's overall goal for the needs assessment was to **assess and identify opportunities to strengthen the MHSA-funded continuum of care** in order to:

- Provide services across the lifespan, in a way that is **trauma-informed, culturally responsive, recovery oriented,** and **promotes personal and public safety**;

- Ensure that people have access to **the full spectrum of mental health and co-occurring services** in the communities where they live, at the times in which they are most needed;
- Maximize every opportunity to **engage people in the appropriate level of care**, ensure **smooth transitions** for moving between levels of care, and **promote sustained participation** in mental health services;
- Promote **a culture of working together** to proactively support people who are **un-, under-, and inappropriately served** using programs and interventions that are **likely to be helpful**.
- **Align resources** and investments **to community needs and priorities** in ways that **promote accountability and sustainability** across the service continuum.

The specific purposes of the project were to determine 1) the current landscape of MHSA-funded services and what has been accomplished as a result of the MHSA, 2) how people experience MHSA-funded services, and 3) opportunities to address service gaps and remaining community needs. This report presents the MHSA needs assessment, reflecting perspectives of a variety of mental health stakeholders combined with a robust quantitative analysis of available data.

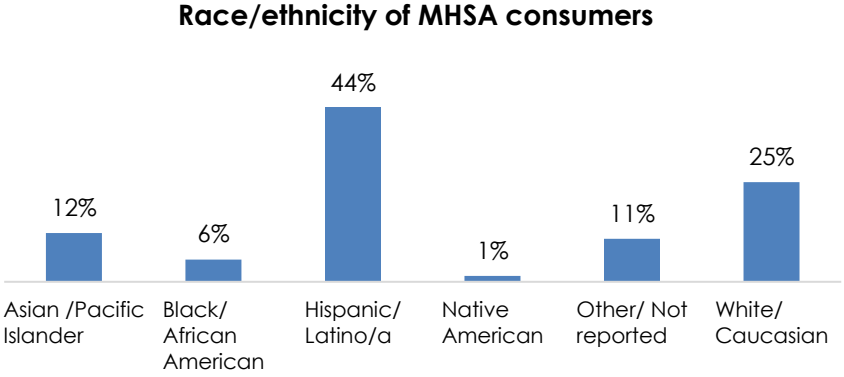
MHSA in Santa Clara County

In any given year, Santa Clara County receives approximately $80M in MHSA funds to "expand and transform" the mental health system and better respond to the mental health needs of people who are un, under, and inappropriately served. Since MHSA's inception, the County has implemented a number of new programs and services to meet the needs of residents across the lifespan throughout the County, cultivated and strengthened partnerships with additional stakeholders, and targeted funds to across the spectrum of mental health from prevention through early intervention and treatment.

Populations Served by MHSA

MHSA in Santa Clara County has prioritized serving un/under/and inappropriately served communities through culturally specific services. The majority of MHSA consumers (44%) served in FY15-16 were Hispanic/Latino, followed by White/Caucasian (25%) and Asian/Pacific Islander (10%).

Age Group	Total
Children, 0-15	8,254
Transitional Age Youth, 16-25	3,234
Adults, 26-59	8,910
Older Adults, 60+	1,008
Total	21,406



Community Services and Support

Community Services and Supports (CSS) have allowed for the provision of all necessary mental health services for children with severe emotional disturbances and adults with serious mental health challenges. CSS funds the following service categories:

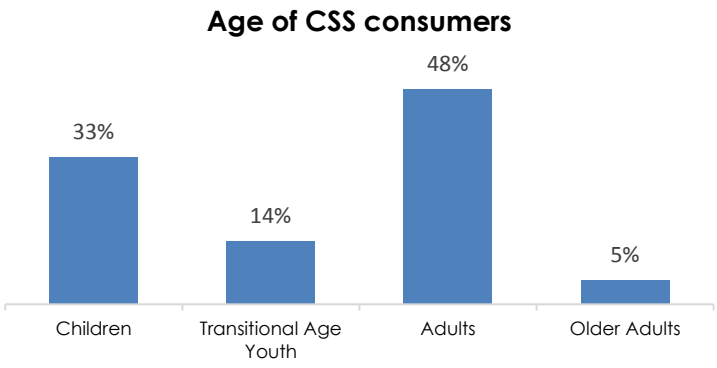
CSS in Santa Clara County

FY15-16 MHSA Expense:
$40.4 million

Consumers served in FY15-16:
15,352

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

In FY 15-16, **15,352 individuals** received CSS funded services. CSS services have allowed for **individuals of all ages** to access necessary and intensive mental health services to promote recovery and increased quality of life. The majority of MHSA consumers who engaged in CSS services were **adults between the ages of 26 to 59 years old**.



CSS-funded Programs

There are 14 CSS initiatives in Santa Clara County, organized by age group. The majority of the initiatives contain multiple programs and services, each of which are targeted to support a shared objective. Specifically, each age group has a Full Service Partnership program (FSP) as well as other initiatives that represent General Systems Development (GSD), and Outreach and Engagement (O&E). Many of these initiatives were originally developed earlier in MHSA implementation and have been refined over a series of CPP processes to continuously meet the needs of County residents with mental health issues. The purpose of the CSS-funded programs are to identify, assess, and serve individuals experiencing

mental health problems throughout the lifespan and range from 0-5 screening and assessment programs through programs and services that provide increasing levels of mental health services, including FSP programs. The following table provides an overview of the CSS-funded services.

Category	Programs	Persons Served	Budget Allocation
Children	Children's Full Service Partnership (FSP)	5,021	$3,131,024
	Child System Development		
	Children and Family Behavioral Health Service Redesign		
Youth	Transitional Aged Youth (TAY) FSP	2,166	$2,416,975
	TAY Behavioral Health Service Redesign		
Adults	Adult FSP	7,355	$29,402,714
	Adult Wellness and Recovery Services		
	Criminal Justice FSP		
	Urgent Care & Central Wellness and Benefits Center		
	Self-Help Development and Family Support		
Older Adults	Older Adult FSP	810	$1,496,234
	Older Adult Behavioral Health Services		
Housing	Housing Options Initiative	N/A	$1,888,738
Administration	Learning Partnership, Decision Support, Planning/Admin	N/A	$3,258,587

Prevention and Early Intervention

Prevention and Early Intervention (PEI) efforts in Santa Clara County were designed to introduce a continuum of services across the lifespan to prevent or intervene early in mental health issues, with particular focus on serving unserved and underserved community members. The county's PEI initiatives worked towards this goal by bringing together diverse approaches to address many facets of mental illness in the community. The primary PEI approach focuses on activities that prevent the development of mental illness or intervene during the early stages of onset. As an example, the PEI program *Strengthening Children and Families* included an initiative through which school-linked service coordinators provided over 25,500 coordinated care linkages to children and families at risk of or developing mental health problems.

PEI in Santa Clara County

FY 15-16 Budget:
$18.8 million

Consumers served since FY 11-12:
41,013

The County expanded its capacity to support PEI efforts by training thousands of community partners who may interact with people at risk of or developing mental illness to identify signs of mental illness, provide prevention and early intervention support, and connect people to services they need. These community partners include school staff, criminal and juvenile justice representatives, Mental Health Peer Support

Workers (MHPSW), case workers and government staff, and medical providers. One such program is the *Suicide Prevention Initiative* which provided suicide assessment and crisis intervention presentations to high school staff and administrators in school districts throughout the county.

Santa Clara County's PEI initiatives went beyond providing prevention and early intervention services to also make strides in influencing cultural perceptions of mental health and wellness, and reduce barriers to access. PEI programs engaged in county-wide outreach and education efforts, stigma reduction campaigns, and information sharing to increase awareness of available services. For example, the *Primary Care/Behavioral Health Integration for Adults and Older Adults* conducted outreach and culturally-responsive stigma reduction efforts to engage new refugees in mental health services. Refugees settling in the County often have a history of trauma, and as a result, are at risk of developing mental illness. PEI initiatives such as these help the County reduce the stigma and cultural perceptions that prevent people from accessing the mental health services they need to support their wellbeing.

Mental health is often influenced by a complex combination of factors such as life situation and personal history, experience of trauma, and medical conditions. In response to this dynamic, some of Santa Clara County's PEI programs address the intersection of mental health as well as other aspects of wellness that overlap with mental health. The *Strengthening Children and Families* initiative includes a Nurse Family Partnership component. This program served low-income first-time mothers involved in the mental health system, foster care, juvenile or criminal justice systems, and schools in investment communities. The program was found to improve health outcomes for mothers and babies while creating opportunities to diagnose and treat postnatal depression. Another program within *Strengthening Children and Families* that addressed an intersecting issue is the Direct Referral Program, which provided prevention and early intervention services for eligible youth arrested for a minor offense and diverted youth from the juvenile justice system and into mental health services.

Santa Clara County spent approximately **$15.5 million** in FY 2015-16 on PEI programs. In total, PEI programs served at least **41,013 individuals** since FY 2011-12, including the general public, mental health consumers, and community members who interact with people with mental illness .[19] Programs served underserved and unserved communities, and focused on the needs of special populations such as low income residents, Veterans, new refugees, the LGBTQ community, and isolated older adults. Programs that reported demographic information demonstrate that PEI programs generally served a racially and ethnically diverse population.

Table 4 summarizes BHSD's PEI programs.

[19] This estimate includes some duplicated consumers who accessed multiple services. Additionally, some programs reported consumers served over the past several years, while others reported the number of consumers served for only FY 15-16.

Table 4. Summary of Santa Clara County's PEI Programs, FY15-16

PEI Program Summaries	
PEI 1: Community Engagement and Capacity Building for Reducing Stigma and Discrimination **MHSA Expense:** $1,569,356	This program's is intended to reduce disparities in service access for unserved and underserved communities through culturally responsive community outreach and Mental Health First Aid (MHFA) trainings. This program expanded support for unserved and underserved individuals by increasing the capacity of community members to provide mental health prevention and intervention support for individuals with mental health issues.
PEI 2: Strengthening Families and Children **MHSA Expense:** $8,826,588	The purpose of this program is to: 1) 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 access to screenings; and 2) Provide services in high-need areas for children and youth 0-18 with symptoms caused by trauma or other risk factors. This program engaged in a range of activities across the continuum of care to connect people of all ages to needed services that prevent the development of mental illness and address factors that affect mental health.
PEI 3: PEI Interventions for Individuals Experiencing Onset of Serious Psychiatric Illness **MHSA Expense:** $746,675	This program provides a continuum of prevention and early intervention services for youth and TAY. The Raising Early Awareness Creating Hope (REACH) program expanded the resources available to youth and TAY at risk of or in early onset of mental illness through wide-reaching outreach and intervention efforts.
PEI 4: Primary Care/ Behavioral Health Integration for Adults and Older Adults **MHSA Expense:** $3,476,591	This program intends to: 1) Provide outreach and services to new refugees; and 2) Implement an integrated behavioral health services model within local Federally Qualified Health Centers that serve underserved ethnic minorities. This program served refugees through therapeutic services that improved consumers' wellbeing, and expanded access to behavioral health services by offering joint medical and behavioral health visits.
PEI 5: Suicide Prevention Initiative **MHSA Expense:** $911,719	This initiative seeks to reduce suicide risk among all age groups and is intended to directly support the implementation of the County's Suicide Prevention Strategic Plan (SPSP). SPSP is a multi-strategy initiative that engaged in a broad range of activities to prevent and reduce the risk of suicide and reduce the stigma around mental health.

Innovation

Innovation projects are designed to increase mental health care access for underserved groups, increase the quality of services, and promote interagency collaboration through innovative new approaches. INN programs may introduce new mental health practices that have never been done before, change an existing mental health practice, or introduce a new application of a promising practice that has been successful in non-mental health contexts. In Santa Clara County, MHSA-funded INN projects allowed the County to pilot innovative practices and learn new approaches that it can incorporate into existing programs to improve service delivery and consumer outcomes. Evaluations of each innovative program provided crucial information about the strengths and challenges of adopting innovative practices, as well as the potential impact on consumer outcomes.

INN in Santa Clara County

FY 15-16 Budget:
$2.7 million

Consumers served since FY 11-12:
19,508

INN initiatives are intended to improve mental health systems in several ways, including by increasing access to services, particularly for underserved groups. Several of the County's INN projects accomplished this by introducing new practices to engage consumers that are traditionally underserved. One example is the *Elders' Storytelling Project* which used an innovative method of paring specially trained case workers with underserved elders who primarily speak Spanish or Vietnamese in order to help them use storytelling as a way to tell their own story and connect with their families and community.

Another goal of INN programs is to improve outcomes for consumers engaged in services. An INN project that pursued this goal was the *Peer-Run TAY INN* program. TAY are a historically underrepresented in mental health services. To address this, *Peer-Run TAY INN* introduced a practice that provided training for TAY to become mentors to other TAY in residential care. This practice led to improvements in the mental health and recovery process for TAY participants and high satisfaction with the program overall.

INN programs are also designed to promote interagency collaboration. The County took a significant step in developing collaborative relationships with community partners through its *Transitional Mental Health Services for Newly Released Inmates* project. This project expanded the capacity to provide services to individuals reentering communities after incarceration by providing organizational support to the faith-based community. With this additional support, faith partners were able to provide the target population with linkages, service coordination, housing and employment support, and other services.

All together, the County's INN efforts served **19,508 people**[20] between FY11-12 and FY15-16 including diverse target populations in needed mental health services such as TAY, older adults, young children, and individuals who have been incarcerated. The program utilized **$2 million** in MHSA funding to implement the practices summarized in .

[20] Data collected from INN programs is not standardized across any fiscal year, as compared to CSS and PEI programs. As such, it is not possible to accurately estimate the number of people served in FY 15-16.

Table 5.

Table 5. Summary of Santa Clara County's INN Programs, FY15-16

INN Program Summaries	
INN 1: Early Childhood Universal Screening Project **MHSA Expense:** $38,556	The goal of this project is to link families sooner to mental health and other needed services by strengthening screening and referral process for young children with developmental and/or social-emotional concerns. An evaluation of the program found that clinic staff reported that using the *Ages and Stages Questionnaire* (ASQ) increased detection of developmental delays and more referrals to services.
INN 2: Peer-Run TAY INN **MHSA Expense:** $1,177,941	The peer-run TAY INN model equipped TAY to provide each other peer partnership that supported their recovery and contributed to improving self-sufficiency and other outcomes for program participants. This project is innovative in that Peer Partners were expected to significantly manage the day-to-day operations of the INN and have primary responsibility for developing and designing program services.
INN 4: Elders' Storytelling Project **MHSA Expense:** $220,883	This project aimed to: 1) Use the technique of life review and storytelling (reminiscence) and incorporate other innovative service components to help restore participating elders to a position of social connectedness with family, friends, caregivers and community; and 2) Improve the quality of services and outcomes for isolated older adults who are predisposed to mental health issues or have unrecognized mental health symptoms. Clients showed improvements in outcomes related to depression, loneliness, life satisfaction, and treatment satisfaction after participating in the program.
INN 5: Multi-Cultural Center Project Plan **MHSA Expense:** $499,567	This project is designed to: 1) Increase access to underserved and inappropriately served ethnic minorities by co-locating activities and service; and 2) Provide opportunities for community coordinators to collaborate in identifying and initiating multi-cultural approaches to engage individuals in mental health services and reduce stigma. This project is currently in the planning stages and is not yet implemented.
INN 6: Transitional Mental Health Services for Newly Released Inmates **MHSA Expense:** $549,852	This project aims to develop a model that provides BHSD organizational support to expand the capacity of an inter-faith collaborative to serve newly-released inmates and improve outcomes. This initiative brought the faith community into partnership with BHSD for the first time to expand supportive services through Faith Reentry Resource Centers (FBRCs) for the individuals reentering community life after incarceration.

Santa Clara County MHSA Implementation

Accomplishments

Since its 2004 passage, MHSA funds have been used to improve the type, scope and availability of services across the public mental health system. Some key MHSA achievements in Santa Clara County include the following:

- Creating ***Full Service Partnerships*** services for all ages: Full Service Partnerships (FSP) seek to engage individuals across the lifespan with serious mental illness and/or serious emotional disorder into intensive, team-based, and culturally appropriate services. FSP provides a "whatever it takes" approach to promote recovery and increased quality of life, decrease negative outcomes, and increase positive outcomes.
- Providing ***School Linked Services for children***: School-Linked Services offer on-site, school-based services to children, youth, and families. This system of coordinated health and social services on school campuses and in the community help children thrive at home, in school, and in their communities.
- Facilitating ***collaboration between mental health, faith based, and criminal justice systems***: This innovative initiative brought the faith community into partnership with BHSD for the first time to expand supportive services for individuals reentering community life after incarceration.
- Prioritizing ***serving the un/under/and inappropriately served communities*** through ***culturally specific services***: Santa Clara County offers culturally specific services for Black/African Ancestry individuals, Hispanic/Latino individuals, the Asian American community, Southeast Asian refugees/immigrants, Native Americans, and individuals experiencing homelessness.

Areas for Growth

As reflected above, the MHSA plan is primarily organized around a series of initiatives. The majority of these initiatives were originally developed as systems-level and "redesign" initiatives that included a series of programs and services custom designed to meet the needs of the County at that time. While this is a common practice in larger California counties, including the neighboring San Mateo County, it appears to have become increasingly difficult over time to describe the evolution of each of these initiatives, including the specific programs and services funded by MHSA. This creates 1) barriers for stakeholder participation as well as 2) difficulty ensuring compliance with the MHSA. The findings presented below arose from the needs assessment; BHSD has used this plan to begin the process of redesigning MHSA planning and reports to include more stakeholder participation, ensure compliance with MHSA components, and resolve any challenges with MHSA expense allocation.

Stakeholder Participation

Given that the planning, design, implementation, and evaluation are intended to be developed through a process of meaningful community engagement, the overall effect is that it results in a lack of transparency

in terms of funding allocations and expenses and makes meaningful stakeholder participation inherently challenging. Meaningful participation from the variety of stakeholders named in the MSHA requires a foundation of shared knowledge, including what's being funded, in what ways, and at what levels. In the absence of this shared information, stakeholders are limited in the kinds of input and feedback they may be able to provide and may not be able develop and subsequently share useful, relevant, or actionable counsel.

The County used information from the needs assessment to work toward increased transparency about what specific programs and services are funded through the MSHA. This will likely improve stakeholders' ability to more meaningfully contribute to subsequent plan development efforts in service of the County's diversity of communities.

Compliance with the MHSA Components

Many of these initiatives were developed over time to solve specific problems, for example the Children and Family or TAY Behavioral Health Redesign initiatives. The initiatives were originally placed in the MHSA components that were most reflective of the problem to be solved or population to be served. For example, the CSS TAY Behavioral Health Redesign is focused around serving TAY with mental health issues and the PEI Strengthening Families and Children initiative is focused on supporting children and families at risk of experiencing mental health problems. Over a decade later, the initiatives appear to have organically developed programs and/or services that would be more appropriately funded in a different component. Examples include:

- The School Linked Services program provides clinical services at schools for children experiencing mental health problems as well as a number of mental health prevention activities for children at-risk of experiencing mental health problems. The clinical services component for children experiencing mental health problems more appropriately align with CSS regulations.
- One program within the Primary Care/Behavioral Health Integration for Adults and Older Adults includes PEI-funded outpatient services for older adults with mental illness who are not yet connected to the specialty mental health system. While it is possible to fund older adult outpatient services through PEI, services that are focused on treating mental health issues for people with mental health problems is more appropriately funded under CSS. If this program were to remain a PEI program, it would likely need to adjust the target population to older adults at risk of mental health issues instead of those already experiencing mental health problems.

Given that each component has its own reporting requirements, and PEI has an updated set of data collection and reporting requirements, it is increasingly important that each of the programs and services funded under the MHSA are clearly assigned to the most accurate or appropriate component. This may also help clarify any confusion about target population, services provided, or outcomes to be expected that may be otherwise confusing for service providers, other referring parties, and those accessing services.

MHSA Expense Allocation

In other California counties, MHSA plans set forth the program and services to be funded under the plan. While it is common make adjustments over the course of the year, the plan structure and associated expense reports are relatively unclear in terms of matching initiatives in the plan to programs and services to be funded and actual expenditures. Additionally, many of the planned and actual expenditures are associated with staff positions or provider contracts rather than programs and services. While the scope of the needs assessment did not and was not intended to include a fiscal audit, it did include describing what was funded through the MHSA and what was subsequently accomplished. The plan structure around initiatives and the lack of clear alignment between MHSA plan and cost reporting further complicates ensuring compliance with the MSHA regulations as well as promoting the kind of transparency that would allow for meaningful stakeholder participation.

Santa Clara County Family and Children's Services Division

Santa Clara County's Behavioral Health Services Family and Children's Services Division (F&C) serves children, adolescents, and young adults, ages 0 – 25, who are experiencing social-emotional and behavioral concerns. Services are provided by County-operated programs and Community Based Organizations. The F&C Division provides outpatient care and programs specific to the unique needs of children and their families. Services provided are designed to respect cultural values, build off the natural support systems of youth and families, and address children and family behavioral health problems in the **least restrictive, most family-like context possible**. Services in the F&C Division include:

- **Age appropriate services** for children 0-15 and youth ages 16 -25
- **Multiple levels of care**, including prevention and early intervention, outpatient, intensive outpatient, Full Service Partnerships, and crisis services
- Services in the **places where children and families** already are
- A **spectrum of specialty services to serve the unique needs of all children and youth** in Santa Clara County

In addition to PEI and CSS programs described in the preceding section, the County provides specialized services to meet the unique, and often complex, needs of all children and youth in Santa Clara County. These include services for children and youth involved in Child Welfare, Juvenile Justice, children and youth with co-occurring disorders, and children and youth with eating disorders. Services are provided through the F&C division, community-based organizations, and the Juvenile Justice and Child Welfare systems. The proceeding section describes the children and youth served by the Family and Children's Services Division, with a particular focus on the specialty mental health system. In this section of the report, the focus transitions from services funded under the MHSA to all mental health services available to children, youth, and families from the Behavioral Health Services Department (BHSD) or their contract providers. **In FY15-16, the County provided specialty mental health services to 12,504 children and youth.**

Populations Served

In Santa Clara County, there is a complex clinical presentation among children and adolescents, and issues commonly seen in adolescence are presenting in younger children.

Adolescence is the period of developmental transition between childhood and adulthood, involving multiple physical, intellectual, personality, and social developmental changes.[21] This is a critical time of changes for how children and youth think, feel, and interact with others.[22] Further, adolescence is a critical period for young people to develop the necessary skills to move towards independence.

Children and youth in Santa Clara County are presenting with complex clinical profiles, including co-occurring substance use and behavioral health disorders, trauma-related disorders, and serious mental health challenges such as schizophrenia and bipolar disorders. Of the children and adolescents receiving mental health services, 6% had a co-occurring behavioral health and substance abuse disorder, and 16% had a trauma-related disorder.

Within this group, there is also a subset of transgender children and youth with additional, unique needs. Transgender children and youth require culturally responsive care that allows for exploration of gender identity, coming out and social transition, and common mental health challenges experienced by this group, including mood disorders, generalized anxiety, substance abuse, and post-traumatic stress disorder (PTSD).[23]

Stakeholders noted during the needs assessment that substance use and support related to sexual orientation and gender identity are presenting in younger children, and that the system needed to build capacity to address these challenges within children's services, not just in the TAY specific services. Some service providers noted that there are children presenting for support related to sexual orientation and gender identity between the ages of 12-15, with specific examples of children even younger. Given this and that the average age for a diagnosed co-occurring disorder is 15, it is important for the system to develop specialty services for children experiencing these needs.

Access and Service Participation

In the F&C Division, multiple points of entry work well to access services; however, there are challenges with mobile crisis services.

The F&C Division is set up as a "No Wrong Door" system of care that is intended to provide consumers with the appropriate level of care, regardless of where they access care. This model is successful within the F&C Division largely in part because individual service providers have multiple levels of care within their organization. For example, community-based organization Community Solutions provides

[21] https://my.clevelandclinic.org/health/articles/7060-adolescent-development
[22] https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/adolescence2.html
[23] http://transhealth.ucsf.edu/trans?page=guidelines-mental-health

outpatient, intensive outpatient, and Full Service Partnerships services. Individuals can walk into service providers and access the appropriate level of treatment quickly. Additionally, mental health services are co-located at schools and provided in partnership with the JPD and DCFS. These connections support children, youth, and families to access services wherever they are and when they are most needed.

Santa Clara County also provides mobile-crisis services for children and youth, operated by four unique service providers. To access mobile crisis, individuals must contact the respective service provider. This decentralized service can create difficulty in accessing time-sensitive crisis services, as individuals may need to contact four different organizations to connect to care. At best, this may result in frustration and confusion, and at worst, cause delay in accessing necessary care resulting in harmful consequences.

The majority of children and youth access and receive outpatient services. Only 4.4% of children and youth in the F&C system of care experience crisis and hospital services only.

In Santa Clara County, 12,504 unique children and youth participated in F&C specialty mental health services. Of the 1,595 children and youth who experienced a crisis or hospital episode, the majority (n=1,229, 77%) received crisis services that did not require hospitalization. Of these, 73% of the crisis episodes were singular, meaning that the child or youth experienced a single crisis event during the year and did not require subsequent crisis or hospital intervention. However, 90 children experienced more than one crisis episode but did not require hospitalization, and 366 required hospitalization following the crisis episode. It is likely that all of the 456 children and youth experiencing more than one crisis episode or at least one hospitalization would meet medical necessity for some sort of specialty mental health service.

As a result, the F&C division may wish to consider how to develop an ongoing practice of reviewing cases of children and youth who are experiencing more than one crisis and/or hospitalization and build mechanisms to proactively engage these children, youth, and families in ongoing mental health services. This type of follow-up support may be appropriate for the mobile crisis and crisis triage programs, if there were capacity. It is also likely that a portion of this group would meet medical necessity for FSP programs. Given that the children's FSP programs served 185 unduplicated individuals and the TAY FSP served 277 in FY 15-16, it is likely that there is a need for an additional 100 children and 100 TAY FSP spots to ensure that there would be availability at the right level of care during follow-up efforts to link children and youth to services.

There is a group of TAY ages 18+ who only participate in services associated with the Adult System of Care, including crisis and hospitalization, and do not participate in F&C services.

Emergency Psychiatric Services (EPS) is a county-operated designated 5150 receiving facility located at the Valley Medical Center (VMC) campus. This is the primary location for individuals ages 18+ who are experiencing a psychiatric crisis and require a 5150 psychiatric hold. Twenty-four percent (24%, n=1,464) of individuals admitted to EPS in FY 15-16 were ages 18-25, with an average age of 22. These 1,464 youth who went to EPS for crisis stabilization had an average of 3 encounters per year, and most did not participate in additional mental health services. This suggests that there is a need to 1) develop ways to

strengthen how TAY are linked to ongoing mental health services following a crisis, and 2) build capacity to respond to older youth. Given that youth transition out of EPSDT, special education, and foster care eligibility at the age of 21, it appears as if there is a need to strengthen services for the older TAY group, either in F&C division or within the Adult and Older Adult division.

Cultural Competency

Engagement in FSP services varies across subpopulations.

In FY15-16, 462 children and TAY received FSP services. Service engagement — measured by frequency and intensity of engagement in services — varied across FSP service recipients. When comparing service engagement, higher service engagement was measured by longer FSP episodes, a higher number of visits per month, and longer lengths of visits. Conversely, lower service engagement was measured by shorter FSP episodes, a lower number of visits per month, and shorter lengths of visits. Certain subpopulations had differing levels of FSP service engagement, including by race/ethnicity and by area of residence.

The majority of FSP children and TAY consumers were Hispanic/Latino(a) (57%) and White/Caucasian (19%). Hispanic/Latino(a) and African American children and TAY generally had higher FSP service engagement compared to other race/ethnicity groups once enrolled in FSP. Additionally, children and TAY FSP consumers living in South County were slightly more engaged with FSP services compared to those not living in South County.

Although only 5% of children engaged in FSP were American Indian/Native Alaskan or Native Hawaiian or other Pacific Islander, these groups had significantly lower FSP service engagement compared to other race/ethnicity groups. Among the 11% of children and TAY FSP consumers who did not speak English, they had higher FSP service engagement compared to English-speaking consumers. Culturally specific providers are key to providing services that engage individuals from vulnerable and marginalized groups. While the Adult Division has culturally specific FSP providers, there are no culturally specific providers for Children's and TAY FSP. Culturally specific providers are crucial to engaging and serving their communities, but require enough consumers to support the level of staffing needed for FSP.

LGBTQ+ service providers struggle to competently serve the transgender community.

The lesbian, gay, bisexual, transgender, queer, questioning, and other (LGBTQ+) community faces mental health conditions just like the rest of the population; however, members of this community may experience more negative mental health outcomes due to prejudice and other biases.[24] In Santa Clara County, there is a subset of LGBTQ+ youth with mental health challenges.

> *There needs to be people that we can identify with, a variety of counselors, including Trans men and women. We are all different and our experiences are personal and it is hard when you go and don't feel represented.*
>
> –Focus Group Participant

[24] https://www.nami.org/Find-Support/LGBTQ

While Santa Clara County provides services specifically for members of the LGBTQ+ community, LGBTQ+ mental health services should not be a "one-size-fits-all" model. Members of the LGBTQ+ community face *within group* diversity. Within the LGBTQ+ community, there are different sexual orientations, gender identities, and identity intersections — such as race, religion, language, and socioeconomic status. Stakeholders identified a need for more training for all LGBTQ+ service providers, particularly for providers serving transgender individuals. Further, stakeholders shared a desire for more diversity and representation among their providers and expressed wanting to work with providers with shared backgrounds.

Collaboration and Coordination

There is a need to maintain continuity of care across systems, levels of care, and providers.

While there are many strong standalone services in Santa Clara County, there is a need for collaboration across systems, levels of care, and providers to ensure continuity of care for children and youth. This is particularly important for children and youth from vulnerable populations and for those involved across multiple systems, such as DCFS and JPD. Many of these young people have faced systemic and structural oppression and have complex needs that require seamless coordination of care. It is important to ensure that accessing mental health services and transitioning between services is an easy and safe experience that does not re-traumatize individuals.

Stakeholders shared that youth-serving entities are not always able to provide warm-hand offs, wherein providers conduct real-time, in-person transfer of care. Warm-handoffs engage patients and families in communication and provides individuals with an opportunity to clarify or correct information and ask questions about their care.[25] Further, warm-handoffs serve a critical purpose in closing gaps in care when an individual moves from one service or system to another.

The County has a strong practice collaboration with child and youth serving organizations.

From the KidConnections and KidScope services in partnership with First5 Santa Clara County, school linked services located in 88 schools across 11 school districts, and institutionalized practices of collaboration with JPD and DCFS, the County has clearly developed strong relationships with other child and youth serving organizations. This includes placing mental health services where children and youth already are, such as schools, and supporting a shared case review for system-involved children, youth, and families. The only suggestion for improvement from stakeholders related to these types of collaboration were to expand them. This includes expanding the number of school sites and districts that have co-located school linked services. It also includes expanding the venues in which the BHSD partners with other organizations through shared referrals, collaborative case reviews, and a clear referral to mental health services.

[25] https://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions/warmhandoff.html

Santa Clara County Adult and Older Adult Services Division

Santa Clara County's Adult and Older Adult Services Division (O/OA) serves individuals eighteen and up who are experiencing serious mental illness. The Adult and Older Adult Mental Health System consists of a variety of mental health programs, including Emergency and Crisis Services, Residential Services, and Outpatient Services. There is also a collection of community education and prevention services, housing, and specialty services. In FY15-16, Santa Clara County BHSD provided specialty mental health services to 16,500 unique individuals, age 18 and over in the A/OA division. The majority of individuals were adults ages 26-59; Latino, White, or Asian; and English-speaking.

Un and Under Served Groups

MHSA intends to serve individuals, families, and communities across the lifespan who are historically ***unserved*** or ***underserved*** by the public mental health care system.[26]

- **Unserved.** 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 those "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."

There is a group of consumers who cycle in and out of EPS, hospital, and jail and do not connect to ongoing services.

Twenty five percent (n=4,104) of adults and older adults who participate in specialty mental health services only receive services in emergency and crisis settings and never connect to ongoing services likely to promote their recovery. Once people discharge from EPS services, there is little to support them in connecting to ongoing services. Without support to engage consumers in ongoing treatment, it is more likely that these individuals will experience further crises and undue suffering. Additionally, 9% of all adults and older adults in the specialty mental health system experience being served in a locked setting designed for a stay of more than 30 days. At any point in time, there are approximately 300 adults and older adults served in locked settings, many of which are located out of county and away from consumers' family and other natural supports. In FY15-16, among the 187 consumers discharged from a longer term locked setting, 37% (n=69) of consumers were readmitted within the same year; the median number of days before consumers experienced crisis and returned to MHRC was 8 days. Upon discharge from long-

[26] "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

term hospitalization back into the community, it is integral for consumers' success in recovery to have residential treatment. While the County does have a Board and Care facility co-located with a day treatment program (i.e. Crossroads) as well as a Community Placement Team to support consumers to reenter the community from locked settings, the County does not use Adult Residential Treatment facilities (aka Transitional Residential programs) to support individuals with Medi-Cal funded residential treatment in an unlocked residential environment, which is likely contributing to difficulty in transitioning individuals back to the community from locked psychiatric settings.

Community-based services are not able to adequately serve those with the highest level of need.

For those individuals who do receive ongoing mental health services, there are challenges with the efficacy of services. Community-based programs, specifically FSP, are not able to adequately serve people with the highest needs. FSP programs seek to engage people with serious mental illness into intensive, wraparound services that provide a "whatever it takes" approach to promote recovery and increased quality of life and decrease negative outcomes such as hospitalization, incarceration, and homelessness. In Santa Clara County, there are 320 FSP slots for adults and older adults. RDA's analysis suggest that there are 500 additional consumers who are likely to meet medical necessity for FSP services. In FY 15-16, 1,033 adults received FSP services. The misalignment between available spaces and consumers being served indicates that individuals may not be receiving the intensity and length of care they need to recover. Among the 1,033 adult FSP consumers, 45% received EPS services, 25% were admitted to short-term hospitalization, 22% received crisis residential treatment, and 14% were admitted to long-term hospitalization. 363 FSP consumers (35%) were hospitalized during an open FSP episode; among this group, 82% visited EPS multiple times in FY15-16. FSP consumers are continuing to experience hospitalizations and crises, despite being engaged in intensive, wraparound services. These findings indicate that FSP services may not be effectively meeting consumers' needs.

FSP programs in Santa Clara County are not funded or designed to provide the level of care typically seen in FSP programs across the state. Across the state in other counties of similar size, FSP teams are typically staffed to provide services from 50-100 consumers, where Santa Clara County has FSP teams as small as a capacity of 20 consumers. In Santa Clara County, culturally relevant FSP providers struggle to balance smaller caseloads with overhead expenses. While these teams are effective in supporting consumers in their recovery, they struggle to provide clinical services. Without community-based programs with capacity for high acuity consumers, consumers are more likely to be hospitalized rather than discharged to the community. Additionally, FSP programs in similar counties generally invest on average $30,000-35,000 per consumer per year whereas Santa Clara County reimburses approximately $15,000 per consumer per year. As a result, FSP teams are not able to provide the quantity or variety of interdisciplinary staff, including professional or licensed staff because of the small teams and lower salary scales. They are also not able to provide the frequency or intensity of services expected for an FSP program given that they are not as richly staffed, also a result of a smaller financial investment. Santa Clara should consider increasing the number of FSP spots available by 500, increase the per-consumer,

per year investment, and restructure the teams to have larger teams with richer staffing, both in quantity and diversity of professionals.

The adult and older adult mental health system should be redesigned to ensure that an appropriate level of resources are allocated to programs that serve those with the highest degree of need.

In order to support individuals to connect to and participate in community-based mental health services and interrupt the repetitive cycle of crisis and hospitalization, the County should consider developing additional programs and modifying existing programs to meet the needs of these un and under-served individuals.

Targeted Outreach and Engagement: Targeted outreach and engagement works to meet high need individuals where they are to engage them in needed services. Individuals who may benefit from targeted outreach and engagement include consumers who have been released from the inpatient setting but did not continue engaging in services at outpatient mental health clinics; consumers who refuse or struggle to access treatment; or consumers whose symptoms are so severe that they cannot leave the house or get to a clinic for assessment. Consumers who experience mental health crises need linkages to medically necessary services and treatment in the least restrictive environment possible in order to stabilize and strengthen their wellness and recovery. According to our research, there are approximately 788 people who are in need of targeted outreach and engagement services.[27]

Mental Health Urgent Care: MHUC is designed to treat individuals in crisis and provide short-term (up to 60 days) as needed services while individuals are connected to ongoing community-based services. MHUC can help relieve the burden on emergency departments and connect consumers to the appropriate level of care they need. In addition to providing crisis services and short-term care, MHUC will serve as a physical location to connect individuals to BHS programs and services.

Full Service Partnership: FSP was designed to provide intensive, wraparound, case management services to individuals with serious mental illness. They are typically organized into interdisciplinary teams that provide a high level of service. Santa Clara is not achieving the outcomes expected of an FSP program, likely a result of limited capacity as well as the structural and financial challenges discussed above. As a result, the County should consider increasing the per person per year investment, reorganizing the teams into larger programs, and increasing the total number of spots available by 500.

Assertive Community Treatment (ACT): ACT is an evidence- based service delivery model for people with serious mental illness who are at-risk of or would otherwise be served in institutional settings or experience homelessness. ACT has the strongest evidence base of any mental health practice for people

[27] The projected number of consumers estimated to benefit from targeted outreach and engagement was calculated based on their history with multiple EPS visits with no history of meaningful service engagement in fiscal year 2015-2016. This is likely an underestimate due to limited availability of incarceration history records.

with serious mental illness and, when implemented to fidelity, ACT produces reliable results for consumers. The ACT model is a comprehensive community-based model of treatment, support, and rehabilitation for individuals who have serious and persistent mental illness, and who do not seek-out support and/or have trouble engaging in traditional office-based programming. Often referred to as a "hospital without walls" in which the ACT team itself provides the community support, ACT teams are 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 his/her 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, and where at least 80% of services are provided in the community, as opposed to in the 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.

- Time-unlimited services, which allow ACT consumers to receive ACT services for as long as they are a part of their county's ACT program.

Adult Residential Treatment (ART): ARTs are a residential program designed for persons who are able to take part in programs in the general community, but who, without the support of counseling, as well as the therapeutic community, would be at risk of returning to the hospital. Without long-term unlocked residential treatment, individuals are more likely to be hospitalized more frequently and be hospitalized for longer lengths of time. ARTs provide up to 24 months of residential treatment for people at risk of or transitioning from institutional placements. ARTs are licensed, certified, and Medi-Cal billable treatment environments. The lack of ART step down option leads to people staying in locked psychiatric settings for extended periods of time and can lead to increased rates of relapse once back in the community. RDA recommends that SCC develop three residential treatment options: 2 ARTs for MHRC Step-Down/Diversion, and 1 ART with specific co-occurring capacity.

The "No Wrong Door" approach creates barriers to access, level of care determinations, and oversight.

SCC is currently set up as a "No Wrong Door" model of access to care. In its current state, the County's "No Wrong Door" approach creates barriers to access, level of care determinations, and lack of oversight. Individuals trying to access services may find themselves confronted with myriad organizational barriers. This often comes at a time of vulnerability or crisis that can result in people making decisions based on incomplete, and sometimes inaccurate, information about their options. There is no centralized mechanism in place to assess if a client needs to be stepped up or down, or if a client is in the appropriate level of care, other than an administrative authorization. If an organization is at capacity and not taking new clients, then calls and requests to get help may not result in services. This decentralized system results in limited oversight of clients' care and the County's ability to manage capacity and demand to ensure that those with the highest level of need receive service. A coordinated entry will help the County more effectively manage level of care determinations, have more visibility and transparency with authorization and re-authorization processes, and manage capacity and demand. RDA recommends that SCC develop a county-led level of care determination process. In this model, designated county staff would assess clients for level of care determination. By having a centralized intake and assessment team, it would create an "easy" and "fast" way to get clients into the appropriate level of medically necessary services.

Older adult programs should be tailored to meet the specific needs of older adults.

Older adults with mental health problems generally experience a complex set of medical and behavioral health problems that require specialized services to promote service access and engagement as well as aging in place. Given the shortage of mental health facilities and the difficulties in placing older adults with medical and mental health needs in a care facility, the County should invest resources in supporting older adults to age in place and engage in mental health services likely to preserve their independence or current home environment. This could include 1) placing mental health services where older adults already are, such as a senior center of health center, 2) providing mobile services that go out to the individual rather than requiring them to come into a clinic or office, 3) supporting caregivers and other family members to preserve the placement, and 4) staffing older adult programs with older adult specific disciplines, including nurse practitioners, social workers, and occupational therapists, as well as peer and family support.

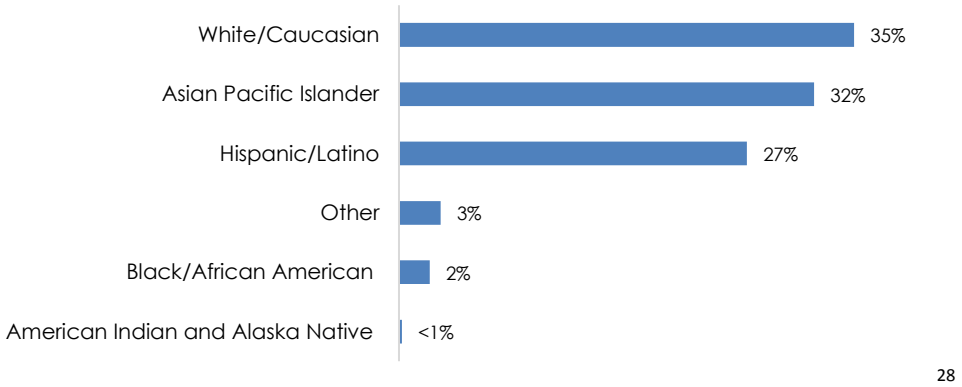
Specialty Populations

Within the County's Medi-Cal population, there are higher proportions of Hispanic/Latino and Asian and Pacific Islander individuals in the general Medi-Cal population than in the County's Medi-Cal population receiving mental health services. Within the Medi-Cal population, more white individuals are receiving mental health services than in the general Medi-Cal population. The discrepancy in representation between the general Medi-Cal population and the Medi-Cal population receiving mental health services may indicate that County mental health services are more welcoming to white individuals than to

Hispanic/Latino individuals and Asian and Pacific Islanders. This disparity may also speak to higher levels of mental health stigma within these communities.

Santa Clara County is home to a diverse range of races and ethnicities. The majority of residents are White (35%), followed by Asian or Pacific Islander (32%) and Hispanic or Latino residents (27%).

Figure 12: Santa Clara County Demographics



28

Santa Clara County is home to a large population of foreign-born persons, with estimates of 35% to 38% of the total Santa Clara population born outside of the United States. Of the foreign-born population, approximately 64% are of Asian descent and 25% of Latin American descent.[29] According to a 2017 report from the Pew Research Center, 6.5% of the total County population and 16% of the foreign-born population (n=120,000 individuals) are undocumented residents.[30]

African/African Ancestry

Santa Clara County is comprised of approximately 2% African American individuals. African Americans have faced a long history of adversity in the United States, including: slavery; systemic, race-based exclusion from health, educational, social, and economic resources; police violence and brutality; violent hate crimes; and much more. These historical and contemporary traumas have resulted in disparities experienced by African Americans, including poorer health outcomes, lower socioeconomic status, and higher incarceration rates.[31,32] Of Santa Clara County residents living below the poverty line, approximately

[28] American Fact Finder. Santa Clara County, California. Retrieved from: Retrieved from: https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

[29] American Fact Finder. Place of Birth by Nativity and Citizenship Status. Retrieved from: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

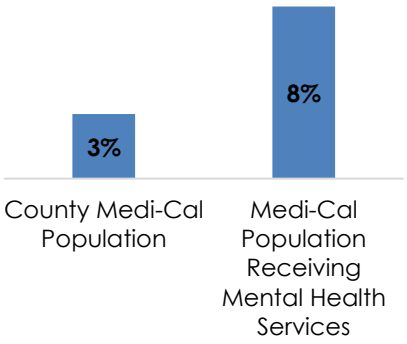
[30] Pew Research Center. 20 metro areas are home to six-in-ten unauthorized immigrants in U.S.. Retrieved from: http://www.pewresearch.org/fact-tank/2017/02/09/us-metro-areas-unauthorized-immigrants/

[31] U.S. Department of Health and Human Services Office of Minority Health. Profile: Black/African Americans. Retrieved from: https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61

[32] Prison Policy Initiative. Breaking Down Mass Incarceration in the 2010 Census: State-by-State Incarceration Rates by Race/Ethnicity. Retrieved from: https://www.prisonpolicy.org/reports/rates.html

16% are African American. This is higher than the 9% average of the entire county, and double the 8% of White individuals living below the poverty line.[33] Individuals who are impoverished, homeless, incarcerated, or have substance abuse problems are at higher risk for poor mental health.[34]

Figure 13: County Adult Medi-Cal Population and Adult Mental Health Consumers: African American



Although anyone can develop a mental health challenge, African Americans sometimes experience more severe forms of mental health challenges resulting from systemic discrimination. According to the Health and Human Services Office of Minority Health, African Americans are 20% more likely to experience serious mental health problems.[35] Another issue in the African American mental health community is over and misdiagnosis. African Americans are twice as likely as Whites to be diagnosed with schizophrenia.[36]While the County's MediCal population is comprised of approximately 3% African Americans, 8% of these MediCal recipients are engaging in mental health services. While this statistic may indicate that there is higher representation of African Americans in County mental health services, other data questions this theory. African Americans had significantly lower utilization of Emergency Psychiatric Services than their White counterparts did (7% and 38%, respectively), as well as lower engagement in Full Service Partnerships than their White counterparts (10% and 34%, respectively). Further, African Americans are overrepresented in AB 109 Full Service Partnerships (15%), which may indicate higher representation of African Americans in Santa Clara's criminal justice system.

Asian Pacific Islander

In Santa Clara County, Asian Pacific Islander (API) residents comprise 32% of the population. The API population in Santa Clara County is composed of a diverse range of ethnicities, illustrated in the chart below. Outside of Spanish, Chinese and Vietnamese were the most common language among non-English Speakers.[37]

[33] American Fact Finder. Santa Clara County, California. Retrieved from: Retrieved from: https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

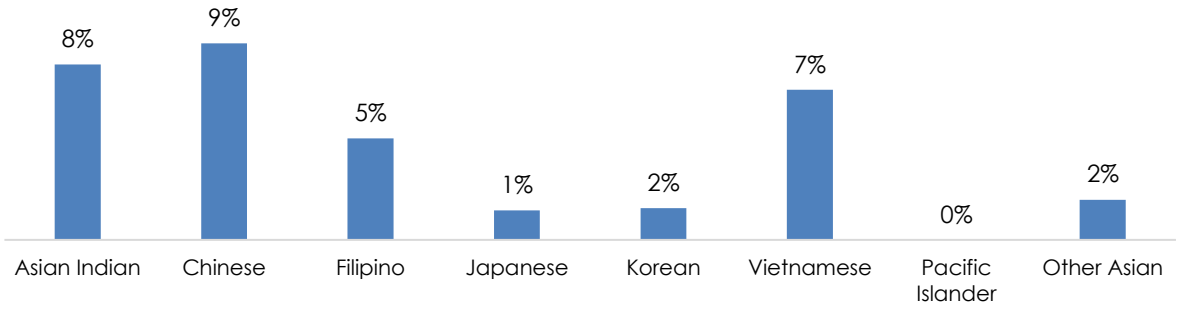
[34] Mental Health America. Black & African American Communities and Mental Health. Retrieved from: http://www.mentalhealthamerica.net/african-american-mental-health#Source

[35] U.S. Department of Health and Human Services Office of Minority Health. Mental Health and African Americans. Retrieved from: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=24

[36] American Psychological Association. African Americans Have Limited Access to Mental and Behavioral Health Care. Retrieved from: http://www.apa.org/advocacy/civil-rights/diversity/african-american-health.aspx

[37] Data USA. Santa Clara County, CA. Retrieved from: https://datausa.io/profile/geo/santa-clara-county-ca/#demographics

Figure 14. Asian Pacific Islander population in Santa Clara County



Within the API community there are high levels of stigma around mental illness. Within many Asian cultures, discussing mental health concerns is considered and as a result Asian Americans may deny or neglect their symptoms. Asian Americans are three times less likely to seek mental health services than Whites.[38]

Hispanic/Latino

In Santa Clara County, approximately 27% of the residents are Hispanic/Latino.[39] Within the larger Hispanic/Latino population, approximately 22% are of Mexican origin, followed by less than 1% Puerto Rican and Cuban. Approximately 3% of the Hispanic/Latino population are from other places.

Table 6: Hispanic/Latino population in Santa Clara County

Hispanic or Latino (of any race)	n=496,591	26.3%
Mexican	421,025	22.3%
Puerto Rican	8,111	0.4%
Cuban	2,426	0.1%
Other Hispanic or Latino	65,029	3.4%

A considerable issue within the Hispanic/Latino population, particularly in light of the current presidential administration, is around immigration. While it is difficult to know exactly how many undocumented residents live in the County, a 2017 report from the Pew Research Center estimates that there are approximately 120,000 undocumented individuals living in Santa Clara County.[40] Other sources estimate

[38] American Psychological Association. Mental Health Among Asian-Americans. http://www.apa.org/pi/oema/resources/ethnicity-health/asian-american/article-mental-health.aspx

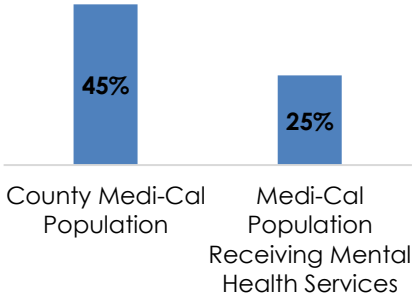
[39] Pew Research Center. Santa Clara County, California. Retrieved from: http://www.pewhispanic.org/states/county/06085/

[40] Pew Research Center. 20 metro areas are home to six-in-ten unauthorized immigrants in U.S.. Retrieved from: http://www.pewresearch.org/fact-tank/2017/02/09/us-metro-areas-unauthorized-immigrants/

that there are as many as 180,000 undocumented individuals living in the County.[41] Within Santa Clara County, 23% of all immigrants are from Mexico.[42]

Like other minority groups, Latinos face systemic barriers and lack of opportunities in education, employment, and health. Though Latinos make up 27% of Santa Clara County, fewer than 4% work in Silicon Valley's science, technology, engineering, and math sectors.[43]

Figure 15: County Adult Medi-Cal Population and Adult Mental Health Consumers: Hispanic/Latino



Within the County's Medi-Cal population, there are higher proportions of Hispanic/Latino individuals in the general Medi-Cal population than in the County's Medi-Cal population receiving mental health services. This discrepancy in representation between the general Medi-Cal population and the Medi-Cal population receiving mental health services may indicate that Hispanic/Latinos are having difficult accessing and engaging in mental health services. While Latino communities show similar susceptibility to mental illness as other groups, this community experiences disparities in access to treatment and in the quality of treatment received.[44] Like other minority groups, this puts Hispanic/Latinos at a higher risk for untreated, thus more severe, forms of mental health challenges.

This disparity may also speak to higher levels of mental health stigma within the community. As a community, Latinos are less likely to seek mental health treatment. A 2001 Surgeon General's report found that only 20% of Latinos with symptoms of a psychological disorder talk to a doctor about their concerns and only 10% seek care from a mental health specialist.[45]

Refugee Population

Santa Clara County is designated by the State of California as a "refugee-impacted county" and is home to a large population of refugees.[46] Refugees in Santa Clara County are from many regions of the world, including Europe, Africa, the Middle East, and Asia. Refugees have been forced to flee their country

[41] Public Policy Institute of California. Undocumented Immigrants in California. Retrieved from: http://www.ppic.org/publication/undocumented-immigrants-in-california/
[42] http://dornsife.usc.edu/assets/sites/731/docs/SANTACLARA_web.pdf
[43] University of Southern California. Santa Clara. Retrieved from: https://www.theatlantic.com/politics/archive/2014/11/how-california-is-making-life-easier-for-undocumented-immigrants/431721/
[44] Vega WA, Rodriguez MA, Gruskin E. Health Disparities in the Latino Population. *Epidemiologic reviews*. 2009;31:99-112. doi:10.1093/epirev/mxp008.
[45] National Alliance on Mental Illness. Latino Mental Health. Retrieved from: https://www.nami.org/Find-Support/Diverse-Communities/Latino-Mental-Health
[46] Department of Social Services. Refugee Impacted Counties. Retrieved from http://www.cdss.ca.gov/inforesources/Refugees/CRCs/Refugee-Impacted-Counties

because of persecution, war, or violence for reasons of race, religion, nationality, political opinion, or membership in a particular social group.[47]

Santa Clara County's refugee population include asylees, victims of human trafficking, survivors of torture, unaccompanied undocumented children, and victims of work slavery and sexual and gender based violence. Refugees have often been deprived of basic human rights, including housing, the freedom of movement, and access to adequate medical care.[48] These individuals are highly susceptible to mental health challenges, particularly trauma. Because of the influx of Asian refugees in the late 1970's through early 1990's — particularly from Vietnam and Cambodia — mental health providers within Santa Clara County are likely to see residual trauma within these communities.

LGBT+

It is difficult to estimate how many people identify as part of the lesbian, gay, bisexual, transgender, queer, or questioning (LGBT+) community. While a 2013 U.S. survey found that less than 3% of Americans identify as LGBT+,[49] other estimates suggest that LGBT+ individuals make up around 4% of the population of California[50] and around 4% in Santa Clara County specifically.[51]

The LGBT+ community is one that has been historically underserved by institutions and experienced overt forms of discrimination and violence. Numerous studies have discussed these discrepancies, including Santa Clara County's 2013 report on the status of health in the LGBT+ community. This health assessment concluded that the LGBT+ community experiences substantial health disparities and health inequities and a high level of need for social services. Further, the report identified a lack of awareness of available services and a shortage of LGBT competent services.[52]

The history of mental health treatment in the LGBT+ community is a problematic one. Individuals who have identified outside of gender and heteronormative standards have been diagnosed as having a mental illness. Members of the LGBT+ community have been subjected to treatment against their will including forced hospitalizations, conversion and aversion therapy, and electroshock therapy, all in an effort to

[47] The UN Refugee Agency. What is a Refugee. Retrieved from https://www.unrefugees.org/refugee-facts/what-is-a-refugee/

[48] County of Santa Clara. Santa Clara County to Celebrate 23rd Annual World Refugee Day. Retrieved from https://www.sccgov.org/sites/opa/ma/Pages/Santa-Clara-County-to-Celebrate-23rd-Annual-World-Refugee-Day.aspx

[49] Center for Disease Control. Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013. Retrieved from: https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf

[50] Gallup. LGBT Percentage Highest in D.C., Lowest in North Dakota. Retrieved from: http://news.gallup.com/poll/160517/lgbt-percentage-highest-lowest-north-dakota.aspx

[51] Santa Clara County Public Health. Status of LGBTQ Health: Santa Clara County 2013. Retrieved from: https://www.sccgov.org/sites/phd/hi/hd/Documents/LGBTQ%20Report%202012/LGBT%20Health%20Assessment.pdf

[52] Status of LGBTQ Health: Santa Clara County 2013.

forcibly change someone's sexual orientation or gender identity.[53] In 1973, the American Psychiatric Association removed "homosexuality" from the Diagnostic and Statistical Manual of Mental Disorders (DSM). However, in 1980, a new diagnosis, "ego-dystonic homosexuality," as defined as a persistent lack of heterosexual arousal, was created for the DSM's third edition. In 1986, this, too, was removed from the DSM.

According the most recent edition of the DSM, a person may be diagnosed with "Gender Dysphoria" if their gender identity does not match the sex they were assigned at birth *and* they are suffering clinically significant distress or social/occupational impairment. While a diagnosis may provide an explanation for the emotional distress an individual may experience, receiving a Gender Dysphoria diagnosis may be perceived as pathologizing.[54]

While strides have been made for some members of the LGBT+ community — particularly for white, cisgender, lesbian, and gay individuals — many members of the LGBT+ community still face varying levels of discrimination. Just like within the general population, within the LGBT+ community there is intersectionality of identities— such as age, race, religion, language, and socioeconomic status. What this mean is that LGTB+ individuals can have compounded minority status, such as being African American, transgender, and low socioeconomic status. LGBT+ youth are four times more likely to attempt suicide than their straight peers.[55] According to the County's "Status of LGBTQ Health" report, nearly half of transgender respondents in the County's health assessment seriously considered suicide or hurting themselves during the past 12 months.[56]

[53] National Alliance on Mental Illness. LGBTQ. Retrieved from: https://www.nami.org/Find-Support/LGBTQ
[54] University of California San Francisco. Mental health considerations with transgender and gender nonconforming clients. Retrieved from: http://transhealth.ucsf.edu/trans?page=guidelines-mental-health
[55] Center for Disease Control and Prevention. Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9–12. Retrieved from: https://www.cdc.gov/mmwr/pdf/ss/ss60e0606.pdf
[56] Status of LGBTQ Health: Santa Clara County 2013.

Specialty populations experience difficulty in trusting the government, resulting in treatment delay or avoidance.

Specialty populations have faced historical and contemporary traumas that result in these groups having trouble trusting authority and government. This lack of trust often results in groups delaying or avoiding accessing treatment. Providers shared that it often takes months or even years to build trust with these groups, and that service engagement must be conducted in a culturally relevant way.

> *You stay in a program for 10 months, and then I was told that I might have to leave Ujima.*
>
> ***I don't think that is fair because I am comfortable being with my culture. My depression is always going to be there and I don't want to lose my connections.***
>
> *- Focus Group Participant*

If members of specialty populations do eventually successfully engage in services, they may face risk of being dropped from services if their service authorization changes. Providers shared that it is critical to have sustained engagement to build trust over time and to not drop consumers from services. Providers also shared that while consumers may eventually get better and not need as intensive services as they initially needed, it would be detrimental to an individual's wellbeing to stop care altogether. Without step-down service and the appropriate —and culturally relevant — level of care to transfer patients to, they will get sick again, fall through the cracks, and revisit crisis services.

Providers shared that it is critical to have sustained engagement to build trust over time and to not drop consumers from services. Providers also shared that while consumers may eventually get better and not need full FSP services, it took a long time to build trust between among these groups and get them to the place they are now. Without step-down service and the appropriate —and culturally relevant — level of care to transfer patients to, they will get sick again, fall through the cracks, and revisit crisis services.

Cultural specific Wellness Centers: In order to provide a mechanism for consumers to remain engaged with services and providers with whom they have developed relationships and to avoid the disruption in relationship when services are terminated, the County should consider developing intergenerational, cultural-specific wellness centers for the African American, Latino, Asian/Pacific Islander, Native American, and LGBT+ communities. This would allow a space where traditional and culturally responsive healing could occur while providing a safe space for the transfer of cultural knowledge and healing across generations and a way to remain connected without requiring participation in and authorization of formal specialty mental health services.

In Santa Clara County, there is an overreliance on 5150 and crisis response to individuals experiencing mental health challenges.

> *When the police came they always threw me in jail; I ended up with nine misdemeanors.* ***My friends who weren't my color were sent to the hospital.*** *That's not right with what they do.* ***My therapist says that they take blacks to jail and others to the hospital.***
>
> *- Focus Group Participant*

Due to difficulty in trusting government and authority, specialty populations often delay or avoid treatment until they are in crisis. What this means is that groups who have historical trauma with institutions and authority are now engaging with services that are inherently traumatic. Being involuntarily detained, either at the hands of law enforcements or as pathway to hospitalization, removes an individual's autonomy. For groups with history of traumatic experiences with authority, this can be an incredibly re-traumatizing experience.

Additionally, In Santa Clara County there may also be discrepancy in treatment between racial and ethnic groups. African American consumers identified a disparity in the level of treatment they receive from law enforcement when experiencing crisis compared to other racial groups. One individual shared that African American consumers experiencing crises are taken to jail, whereas their White counterparts are taken to emergency care.

Individuals experiencing mental health crises often interact with police and emergency departments. Interacting with law enforcement can be a frightening and distressing experience for anyone and particularly for individuals and groups that have historical trauma at the hands of police and other authority. It is important to recognize, however, that law enforcement frequently plays a critical role as the gatekeepers of access to mental health treatment. Similarly, involuntary hospitalization can be a traumatic experience for individuals who have faced discrimination from medical professionals. In order to minimize the trauma of interacting with these systems, RDA recommends the following strategies.

Mobile crisis and triage support: In order to best respond to individuals in crisis, there should be meaningful collaborations between law enforcement and behavioral health to ensure that police have access to mental health staff as joint response. Mobile crisis services provide acute mental health crisis stabilization and psychiatric assessment and treatment outside of a hospital or health care facility.[57] The main outcome objectives of mobile crisis teams are to reduce psychiatric hospitalizations and to reduce arrests of individuals with mental illness.

Implement trauma-informed policing: Santa Clara County should consider implementing trauma-informed policing so that when law enforcement interacts with individuals in mental health crises they approach the situation with a trauma-informed lens. A trauma-informed system is one that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in individuals involved with the system; integrates knowledge about trauma into

[57] Psychiatry Online. Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction. Retrieved from: http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.51.9.1153

policies, procedures, and practices; and actively works to avoid re-traumatization. The GAINS Center— a program of the Substance Abuse and Mental Health Service Authority— has developed a training program to assist criminal justice professionals in developing trauma-informed responses to justice-involved individuals. The primary goals of the training are to increase understanding of trauma; create an awareness of the impact of trauma on behavior; and develop trauma-informed responses. Trauma-informed criminal justice responses can help to avoid re-traumatizing individuals, and thereby increase safety for all, decrease recidivism, and promote and support recovery of justice-involved women and men with serious mental illness.

MHSA Three-Year Program 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. 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 though the Uplift Mobile Crisis services and drop-in services for youth through the Youth Drop-In Centers.
- **School Linked Services**: School linked services provide outreach and clinical services to school-age children at selected school sites throughout the County.
- **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:

- **Prevention Services for Children and Youth, and Families:** Prevention services provide support for parents through a number of 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 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.
- **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	Program Status
	Community Services and Supports: Full Service Partnership		
Full Service Partnership for Children, Youth, and Families	Intensive Children's 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 living with serious mental illness to reach their wellness and recovery goals.	**Modified** Increase capacity by 100
	Maintenance Children & TAY Full Service Partnership	Continuation of the FSP model from previously approved plans. This tier of services will ensure that individuals that currently receive FSP services will continue to receive care without any reduction in service. The FSP Maintenance service is a step down from Intensive FSP for those who may still needs services, including housing support, to remain successful in the community. Maintain current number of FSP slots: Child, TAY, Adult, Older Adult, and Criminal Justice.	**Continuing**
	Intensive TAY Full Service Partnership	Full range of community and clinical services that provides a higher per person funding allocation that was not previously available to serve people with serious mental health needs. These services represent new intensive service slots for individuals and will assist youth living with serious mental illness to reach their wellness and recovery goals.	**Modified** Increase capacity by 100
	Community Services and Supports: General System Development		
Outpatient Services for Children and Youth	Children and Family Outpatient/ Intensive Outpatient Services	Counseling, case management, and medication management services for children who meet medical necessity Long-term counseling, case management, and medication management services provided at a greater frequency and intensity for intensive outpatient treatment	**Continuing**

	TAY Outpatient Services/ Intensive Outpatient Services	Outpatient programs for TAY ages 16-24 aim to prevent chronic mental illness while improving quality of life for youth; long-term clinical care and case management to youth ages 8-12 to improve quality of life for youth while preventing the later need for high intensity care *In the original Draft Plan, these services were segmented (Children/Youth and TAY). Per public comment request, these services are now combined to mirror the procurement process.*	**Continuing**
	Specialty Services: Integrated MH/SUD	Outpatient integrated behavioral health services to children and youth with co-occurring mental health and substance abuse needs	**Continuing**
	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	**New**
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**
	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	**Continuing**
	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	**New**
Juvenile Justice Development	Services for Juvenile Justice Involved Youth	Education, training, and intensive case management services for justice-involved children/youth including aftercare services to assist them and their families in developing life skills that will improve their ability to live and thrive in community	**Continuing**
	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	**New**

Crisis and Drop-In Services for Children and Youth	Uplift Mobile Crisis	Onsite rapid-response crisis assessment and intervention for children who are depressed, suicidal, or having acute psychological crisis	**Continuing**
	TAY Crisis and Drop-In Center	Safe, welcoming, and inclusive spaces for youth to receive access to behavioral health resources and overnight respite	**Continuing**
School Linked Services	School Linked Services	Screening, identification, referral, and counseling services for school age children/youth in school-based settings	**Continuing**
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	**New**
	Prevention and Early Intervention		
Prevention Services for Children, Youth, and Families	Support for Parents	An array of support initiatives that are intended to prevent or intervene early in the development of emotional and behavioral problems in young children by providing the parents with outcome-based parenting strategies, support services, and classes	**Continuing**
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	**Continuing**
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	**Continuing**

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. Santa Clara County's FSP provides intensive, comprehensive services for seriously emotionally disturbed (SED) children within a wraparound model.

FSP serves children ages six years old to 15 years old with SED, particularly African American, Native American, and Latino children and youth. Children and youth served may be at risk of or transitioning from out-of-home placement; engaged with child welfare and/or the juvenile justice system; or at risk of homelessness, incarceration or hospitalization. Santa Clara County's FSP will be expanding its capacity to an additional 100 spots.

FSP is a team-based planning process intended to provide individualized and coordinated family-driven care. FSP should increase the "natural support" available to a family—as they define it— by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships.[58] 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
- 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

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

• 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 2018:	160	**Proposed Budget FY 2018:**	$4,736,788
Cost per Person FY 2018:	$29,604	**Total Proposed Budget FY 2018-2020:**	$16,410,364

CSS: General System Development

Outpatient Services for Children and Youth

Children & Family 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. Santa Clara County contracts with various community-based organizations that provide an array of outpatient support services for children and youth. OP programs serve children and youth ages 0-16, particularly those from unserved and underserved ethnic and cultural populations. Children and youth who meet medical necessity can access outpatient services. 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 2018:	3,177	**Proposed Budget FY 2018:**	$35,063,058
Cost per Person FY 2018:	$11,036	**Total Proposed Budget FY 2018-2020:**	$104,599,979

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 2018:	156	**Proposed Budget FY 2018:**	$992,200
Cost per Person FY2018:	$6,360	**Total Proposed Budget FY 2018-2020:**	$2,976,600

Specialty and Outpatient Services- Eating Disorders for Children, Youth 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

Santa Clara County offers a continuum of care for young people and their families that provides the help and support they need in recovering from eating disorders. Service providers offer comprehensive youth-oriented programs where participants can feel safe, nurtured, and hopeful.

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.

In addition to children and youth, the Department is responsible for providing eating disorder services to adults. The Adult continuum includes medical services with mental health supports that includes outpatient and higher intensity programs. Clients/Consumers with the most intensive needs enter the continuum through the Family & Children's Division (children/youth) and 24-Hour Care Unit (adults) where a team evaluation determines the appropriate level of residential care. For the other non-residential services, clients/consumers are referred through the County's Inpatient Coordinators. Services include:

- **Unlocked Residential:** This level of care provides structured supervision and monitoring of patients' meals in a residential setting to avoid further weight loss and decompensation. This residential treatment program assists with stabilizing medical and psychological symptoms of eating disorder prior to beginning outpatient treatment. The 24-Hour-Care unit authorizes placement in this level of treatment.
- **Partial Hospitalization Program:** This is a structured and focused level of outpatient services where individuals diagnosed with eating disorders participate in personalized outpatient treatment five days a week. During this time, clients have two supervised meals and one afternoon snack. Patients also participate in two weekly individual/family therapy sessions, nutritional counseling, psychiatric evaluation, and medication management.
- **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.

Goals and Objectives

Outcome 1:	Support recovery with an age appropriate approach		
Outcome 2:	Increase self-help and consumer/family involvement		
Outcome 3:	Increase access to specialty eating disorder services in the community		
Number to be served FY 2018:	15 (includes repeat residential admissions)	**Proposed Budget FY 2018:**	$926,000
Cost per Person FY2018:	$62,000	**Total Proposed Budget FY 2018-2020:**	$5,926,000

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

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

The RAIC serves as a transition point for children and youth experiencing a removal, placement disruption, or new pending placement, while also addressing their interim needs. Children can remain at the RAIC for up to 23 hours and 59 minutes, until an appropriate and safe placement is determined. During the time that children and youth are at the RAIC, they receive assessments of their emotional, psychological, medical, and behavioral needs. BHSD 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. Upon review, the Department increased the number of youth served to 200 at a lower dosage of service.

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 2018:	200	**Proposed Budget FY 2018:**	$1,274,514
Cost per Person FY2018:	$6,373	**Total Proposed Budget FY 2018-2020:**	$4,147,288

Crisis and Drop-In Services for Children and Youth

Children's (Uplift) 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 Uplift Mobile Crisis program—also known as the EMQ Families First Child and Adolescent Crisis Program (CACP) program— 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. Upon further review based on public comment, BHSD recommends an increase to Mobile Crisis by $196,600 which would provide additional services to 200 youth in FY19-FY20.

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 2018:	200	**Proposed Budget FY 2018:**	$589,884
Cost per Person FY2018:	$2,950	**Total Proposed Budget FY 2018-2020:**	$1,769,652

School Linked Services

School Linked Services (SLS) Initiative				
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 School Linked Services (SLS) program portion that supports 11 school district partners and schools has been categorized in the Prevention and Early Intervention (PEI) component of this Draft Plan, following the PEI regulations. Only the corresponding SLS clinical services are included in this CSS section.

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

To best support children's successes in school, SLS provides services to students and families that aim to improve knowledge, attitude, and behavior relative to academic success and family wellbeing. Based

on medical necessity, children and youth are referred to SLS Prevention and Early Intervention (PEI) or SLS clinical services.

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

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 2018:	800	**Proposed Budget FY 2018:**	$8,525,666
Cost per Person FY2018:	$10,657	**Total Proposed Budget FY 2018-2020:**	$38,805,214

Prevention and Early Intervention

Prevention Services for Children, Youth, and Families

School Linked Services (SLS) PEI				
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:	PEI: Prevention			

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 through the community program planning process. 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.

- **SLS Coordinators:** SLS Coordinators engage families and service providers, manage referrals, provide consultations with school referring parties, facilitate parent-involved activities, and provide required documentation and accountability. Coordinators are responsible for convening stakeholders including services providers, community groups, and parents.

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. PEI provides services to students and their families who require a lower level of service regardless of insurance status. PEI services include enhanced behavioral support, skill building, linkage and referral services and strengthening family programs.

For students with higher needs, they are referred to SLS clinical services which provide long-term clinical services such as psychiatry, individual therapy, family therapy, and medication support

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 2018:	2,000	**Proposed Budget FY 2018:**	$7,200,894
Cost per Person FY 2018:	$3,600	**Total Proposed Budget FY 2018-2020:**	$11,516,353

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 2018:	2,000	**Proposed Budget FY 2018:**	$760,000
Cost per Person FY 2018:	$380	**Total Proposed Budget FY 2018-2020:**	$2,280,000

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			
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 2018:	1100	**Proposed Budget FY 2018:**	$321,860
Cost per Person FY 2018:	$293	**Total Proposed Budget FY 2018-2020:**	$1,685,580

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

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 2018:	240	**Proposed Budget FY 2018:**	$4,663,926
Cost per Person FY2018:	$19,433	**Total Proposed Budget FY 2018-2020:**	$16,185,525

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, and provide mental health services, promote recovery, and reduce the likelihood that youth served will later require higher levels of care such as FSP.

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

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

In the original Draft Plan, these services were segmented (Children/Youth and TAY). Per public comment request, these services are now combined to align with the procurement process.			
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 2018:	330	**Proposed Budget FY 2018:**	$2,376,381
Cost per Person FY 2018:	$7,201	**Total Proposed Budget FY 2018-2020:**	$7,301,909

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 2018:	78	**Proposed Budget FY 2018:**	$114,101
Cost per Person FY2018:	$1,462	**Total Proposed Budget FY 2018-2020:**	$342,303

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.

- This program is slated to begin in Fiscal Year 2018-2019. The project intends to serve 300 youths.

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 2018:	100	**Proposed Budget FY 2018:**	$367,000
Cost per Person FY2018:	$3,670	**Total Proposed Budget FY 2018-2020:**	$1,101,000

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 2018:	140	**Proposed Budget FY 2018:**	$1,938,196
Cost per Person FY 2018:	$13,844	**Total Proposed Budget FY 2018-2020:**	$6,288,579

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 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 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 is slated to begin in Fiscal Year 2019-2020 and it will serve 500-600 TAY.

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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-2020:**	$1,500,000

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

Specific mental health outpatient service offered include:

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

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 2018:	165	**Proposed Budget FY 2018:**	$539,822
Cost per Person FY 2018:	$3,272	**Total Proposed Budget FY 2018-2020:**	$1,619,466

Interdisciplinary Services Teams

TAY Interdisciplinary Service Teams				
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

TAY interdisciplinary service teams provide a spectrum of resources to youth, including youth who are homeless, to 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. This project is slated to begin in Fiscal Year 2019-2020 with an expected service capacity of 1,000 TAY.

Goals and Objectives			
Outcome 1:	Increase service connectedness		
Outcome 2:	Reduce later need for higher intensity of care		
Number to be served FY 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY2018:	$ 0	**Total Proposed Budget FY 2018-2020:**	$1,500,000

Prevention and Early Intervention

Prevention Services for Children and Youth, and Families

Early Intervention

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 2018:	86	**Proposed Budget FY 2018:**	$1,613,726
Cost per Person FY 2018:	$18,764	**Total Proposed Budget FY 2018-2020:**	$4,841,178

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. The adult and older adult system has 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; Adult FSP; Older Adult FSP; and a Criminal Justice FSP 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:** 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.
- **Outpatient Clinical Services for Adults and Older Adults:** The Outpatient Clinical Services Initiative provides an array of clinical and case management program 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 a new Elder Health Community Treatment Services team; a Connections Program that works with Adult Protective Services; and an expanded collaboration with Senior Nutrition Centers.
- **Criminal Justice:** As is the case across the country, in Santa Clara County 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; new Adult Residential Treatment program; Community Placement Teams, an IMD Alternative, Mobile Crisis, 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, Office of Family Affairs, and the Mental Health Advocacy Project. It also includes a new Older Adult In-home Respite program.

As with the children, youth, and family system, a crosswalk mapping each new initiative and its programs to prior plans is included in the Appendix.

Overview of Services for Adults and Older Adults

Initiative	Program	Description	Proposed Changes
	CSS: Full Service Partnership		
Full Service Partnership for Adults and Older Adults	Assertive Community Treatment	This program, not funded prior to this plan year, will provide two 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.	**New** 2 Teams; 200 slots
	Intensive Full Service Partnerships for 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 new intensive service slots for individuals and will assist consumers living with serious mental illness to reach their wellness and recovery goals.	**Modified** Additional Capacity; increase per person spending; 400 slots
	Intensive Criminal Justice FSP	Full service partnership program for consumers who are involved in the criminal justice system with a focus on returning to the community. These services provide 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 consumers living with serious mental illness to reach their wellness and recovery goals.	**Modified** Additional Capacity; increase per person spending; 100 slots
	Intensive Full Service Partnerships for 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 new intensive service slots for individuals and will assist consumers living with serious mental illness to reach their wellness and recovery goals.	**Modified** Additional Capacity; increase per person spending;

	FSP Maintenance	Continuation of the FSP model from previously approved plans. This tier of services will ensure that individuals that currently receive FSP services will continue to receive care without any reduction in service. The FSP Maintenance service is a step down from Intensive FSP for those who may still needs services, including housing support, to remain successful in the community. Maintain current number of FSP slots: Child, TAY, Adult, Older Adult, and Criminal Justice.	**Continuing**
	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	**Continuing**
Outpatient Clinical Services for Adults and Older Adults	County Clinics	An array of mental health supports including basic mental health services and medication support. The County's clinics expand access to mental health services by co-locating at health facilities people are likely to go to or be familiar with	**Continuing**
	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**
	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**
	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**
Criminal Justice Initiative	Criminal Justice Residential and Outpatient	Outpatient and residential services provided at a wellness and recovery centers for individuals who are involved in the criminal justice system to meet the needs of re-entering the community	**Continuing**

	Criminal Justice IOP/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**
	Faith-based Resource Centers	Service coordination to individuals reentering the community from jail provided by multi-agency faith-based resource centers	**Continuing**
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**
	Crisis Stabilization and Crisis Residential	Crisis support, counseling, and linkage services in up to 24-hour stabilization unit and CRT	**Continuing**
	Adult Residential Treatment	Full range of clinical and support services to consumers who need an IMD/hospital diversion or who have substance abuse and serious mental illness located at two new Institution of Mental Disease (IMD) Step-down/Diversion centers and one Co-Occurring Treatment center	**New**
	Community Placement Team	Case management, housing, and linkage support by a 24-hour case management unit that provides services to consumers returning to the community from other settings	**Continuing**
	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**
	Mobile Crisis	Immediate crisis support services including assessment, crisis support, and linkage provided by clinicians housed at Mental Health Urgent Care	**New**
Older Adult Community Services Initiative	Clinical Case Management Team for Older Adults (Elder Health)	An array of services provided to engage older adults who may be reluctant or unable to access needed mental health services due to geographic barriers, limited mobility, health issues, or stigma associated with receiving mental health services in a clinic	**New**
	Connections Program	Case management and linkage services for older adults who are at risk of abuse as part	**Continuing**

		of a collaboration with Adult Protective Services	
	Older Adult Collaboration with San Jose Nutrition Centers	Expansion of mental health outreach, awareness, and training at Senior Nutrition Sites to provide community training and workshops and referral to mental health services	**Modified:** Expansion of program
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)	**New**
Prevention and Early Intervention			
	Integrated Behavioral Health	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.	Modified
	The Re-Entry Resource Center	This 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.	**New**
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	**Continuing**

		are uniquely qualified to offer support, encouragement, and hope to consumers	
	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	**Continuing**
	Mental Health Advocacy Project	Specialized, free legal and advocacy assistance for people identified as having mental health issues or developmental disabilities	**Continuing**
	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	**New**

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. This project is slated for FY2020 to serve 200 consumers.

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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$7,000,000

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

Santa Clara County has identified the need for multiple levels of Full Service Partnership (FSP) in order to appropriately and efficiently serve individuals with varying levels of mental health needs, because the intensity and frequency of service engagement should vary considerably based on level of need. FSP programs 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).

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.[59, 60]

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.

[59] Section 5898, Welfare and Institutions Code
[60] Sections 5801, 5802, 5850 and 5866, Welfare and Institutions Code

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 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

Additional FSP Capacity

Santa Clara County estimates that approximately 500 individuals are in need of FSP services requiring high levels of intensity and frequency of services in order to maintain connection with their integrated service team. The majority of individuals currently engaged with the County's FSPs (approximately 320 individuals) need a lighter level of touch, because they have become stable through engagement with the program. Therefore, Santa Clara County plans to expand its existing FSP capacity of 320 to provide services for an additional 500 consumers, serving a total of 820 consumers. Additional service capacity is slated for Fiscal Year 2019-2020.

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		
Outcome 4:			
Number to be served FY 2018:	320	**Proposed Budget FY 2018:**	$7,529,057
Cost per Person FY 2018:	$23,528	**Total Proposed Budget FY 2018-20:**	$35,078,410

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.[61] [62]

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

[61] Section 5898, Welfare and Institutions Code
[62] Sections 5801, 5802, 5850 and 5866, Welfare and Institutions Code

- 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 increase by 100 is slated to begin in Fiscal Year 2019-2020.

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 2018:	355	**Proposed Budget FY 2018:**	$5,435,405
Cost per Person FY 2018:	$15,311	**Total Proposed Budget FY 2018-20:**	$22,806,215

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:

- Augmented staff and resources for Permanent Supportive Housing System Improvements including
- Resource to develop a coordinated outreach system to provide dedicated resources to provide housing information at the Reentry Resource Centers in San Jose and Gilroy
- Resources for Supportive Housing Programs for Transition Age Youth.

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 2018:	148	**Proposed Budget FY 2018:**	$2,818,584
Cost per Person FY 2018:	$19,044	**Total Proposed Budget FY 2018-20:**	$8,843,766

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 Santa Clara County. 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 2018:	3,800	**Proposed Budget FY 2018:**	$8,677,238
Cost per Person FY 2018:	$2,283	**Total Proposed Budget FY 2018-20:**	$28,864,700

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 2018:	260	**Proposed Budget FY 2018:**	$1,305,472
Cost per Person FY 2018:	$5,021	**Total Proposed Budget FY 2018-20:**	$3,916,416

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 Santa Clara County 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 FY 2018:	500	**Proposed Budget FY 2018:**	$2,647,627
Cost per Person FY 2018:	$5,295	**Total Proposed Budget FY 2018-20:**	$7,942,881

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 2018:	200	**Proposed Budget FY 2018:**	$4,927,134

Cost per Person FY 2018:	$24,685	**Total Proposed Budget FY 2018-20:**	$18,274,608

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 Santa Clara County that serve justice involved individuals with mental illness:

Intensive Outpatient Treatment Program – Momentum

Momentum's Intensive Outpatient Treatment Program teaches justice involved consumers how to manage stress, and better cope with emotional and behavioral issues The program provides the following services:

- Group, individual, and family therapy
- Frequent visits at home or in the community (usually 3-5 days per week), and an average of 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 Santa Clara County, 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 2018:	274	**Proposed Budget FY 2018:**	$1,546,650
Cost per Person FY 2018:	$5,644	**Total Proposed Budget FY 2018-20:**	$4,954,843

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 Santa Clara County. The FBRCs are sites where services are provided to people leaving jail or prison and returning to the Santa Clara County community. The Santa Clara County Reentry Resource Center, located in downtown San Jose, serves as the main point of entry for people leaving jail and entering the community. The Reentry Resource Center operates in collaboration with several Santa Clara County departments including the Office of the County Executive, Probation Department, Office of the Sheriff, Department of Correction, Mental Health Department, Department of Alcohol and Drugs, Custody Health, and the Social Services Agency.

Staff from 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.

The program is currently funded under INN-06, transitioning into Community Services and Supports beginning in Fiscal Year 2018-2019.

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 2018:	340	**Proposed Budget FY 2018:**	$1,848,688
Cost per Person FY 2018:	$5,437	**Total Proposed Budget FY 2018-20:**	$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 Santa Clara County 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 2018:	1,600	**Proposed Budget FY 2018:**	$3,868,946
Cost per Person FY 2018:	$2,418	**Total Proposed Budget FY 2018-20:**	$11,930,438

Crisis Stabilization Unit and Crisis 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

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.

Goals and Objectives			
Outcome 1:	Consumers experiencing crisis access the support they need to avoid unnecessary hospitalizations or incarceration as a result of crisis episodes		
Number to be served FY 2018:	500	**Proposed Budget FY 2018:**	$24,389,842
Cost per Person FY 2018:	$48,779	**Total Proposed Budget FY 2018-20:**	$73,169,526

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 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.

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.

Santa Clara County will operate three ARTs, each with a capacity of 16 beds. All will be voluntary alternatives to psychiatric hospitalization. Two of the ARTs will serve as a step-down from institutional

treatment settings back to the community. These ARTs will 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 will 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. This project is slated for Fiscal Year 2019-2020. It is estimated to serve 45 adult and older adult consumers.

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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$3,350,700

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 developing treatment plans through an equal partnership between the individual and treatment team. Services include clinical and psychosocial supports. Drake House offers quality residential programs and mental health treatment services to adults and older adults in Monterey County. Services include: 24/7 Staffing, Nursing Support Services and Medication Assistance

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 2018:	100	**Proposed Budget FY 2018:**	$5,347,120
Cost per Person FY 2018:	$53,471	**Total Proposed Budget FY 2018-20:**	$16,153,154

Technical Assistance Support for Community Based Providers

Status:	☒New	☐Continuing
Service Category	CSS: General Systems Development	

Program Description

As part of this three-year plan, BHSD has undergone a substantial investment in new programs and services including a new ACT team, substantial increases to the Full Service Partnership, and a series of new programs that aims to greatly increase the capacity of services for consumers across the system. In order to support CBOs capacity to implement new and existing programs, BHSD is allocating MHSA funding to support CBOs to receive support and technical assistance to comply with regulatory requirement and to support data and reporting that is required with MHSA.

Budget

Proposed Budget FY 2018:	$ -	**Total Proposed Budget FY 2018-20:**	$1,200,000

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: Santa Clara County'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. IHOT teams are slated for a Fiscal Year 2019-2020 start.

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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$2,260,000

Prevention and Early Intervention

Integrated Behavioral Health				
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:			

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

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. BHSD proposes six sites for this modified project with the intent to release Requests for Proposal (RFP) in September 2018. The six sites will serve the needs of individuals in the mild to moderate range.

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 2018:	1,500	**Proposed Budget FY 2018:**	$1,068,230
Cost per Person FY 2018:	$712	**Total Proposed Budget FY 2018-20:**	$7,58,690

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			

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

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 2018:	400	**Proposed Budget FY 2018:**	$669,142
Cost per Person FY 2018:	$1,672	**Total Proposed Budget FY 2018-20:**	$2,046,431

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			

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.

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 2018:	400	**Proposed Budget FY 2018:**	$320,325
Cost per Person FY 2018:	$800	**Total Proposed Budget FY 2018-20:**	$991,620

Mental Health Advocacy 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:	PEI			

Program Description

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

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

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

MHAP also provides information and referral in the areas of rehabilitation, employment, family, and criminal law. During FY2019, this project will expand to increase service capacity. Funding for MHAP increases to $150,000 in FY19-FY20.

Goals and Objectives			
Outcome 1:	Consumers are able to access legal advocacy support needed to address challenges they may face while navigating the mental health system		
Number to be served FY 2018:	150	**Proposed Budget FY 2018:**	$66,875
Cost per Person FY 2018:	$445	**Total Proposed Budget FY 2018-20:**	$366,875

Re-Entry Resource Center

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 2018:	150	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-2020:**	$926,999

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, Santa Clara County has identified the need for multiple levels of Older Adult FSP in order to appropriately and efficiently serve individuals with varying levels of mental health needs, because the intensity and frequency of service engagement should vary considerably based on level of need.

Santa Clara County estimates that approximately 500 adults and older adults are in need of FSP services and require high levels of intensity and frequency of services in order to maintain connected with their integrated service team. The County also estimates the need for a lighter level of touch for a majority of individuals who are currently engaged with the County's FPSs (approximately 320 individuals), because they have become stable through engagement with the program.

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

- Their mental disorder results in substantial functional impairments or symptoms, or they have a psychiatric history that shows that, without treatment, there is an imminent risk of decompensation with substantial impairments or symptoms;

- Due to mental functional impairment and circumstances, they are likely to become so disabled as to require public assistance, services, or entitlements; 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.

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 2018:	66	**Proposed Budget FY 2018:**	$994,925
Cost per Person FY 2018:	$15,074	**Total Proposed Budget FY 2018-20:**	$4,784,775

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. Santa Clara County's older adult outpatient programs provide a continuum of Outpatient and Intensive Outpatient services to adults age 60 and over who are often dealing with symptoms of depression, anxiety, and mental health issues due to the loss of loved ones, job loss or retirement, reduced income and status, isolation, medical issues, and changes in living situation.

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 2018:	300	**Proposed Budget FY 2018:**	$3,162,703
Cost per Person FY 2018:	$10,542	**Total Proposed Budget FY 2018-20:**	$9,530,592

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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$ 2,300,000

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 2018:	275	**Proposed Budget FY 2018:**	$151,000
Cost per Person FY 2018:	$549	**Total Proposed Budget FY 2018-20:**	$453,000

Older Adult Collaboration with Senior Nutrition 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: General System Development			

Program Description

The Older Adult Collaboration with Senior Nutrition Centers provides mental health outreach, awareness, and training to adults age 60 and older who are already receiving services at any of the 34 Senior Nutrition Centers located throughout the County, in order to improve knowledge, increase access to behavioral health services, and support wellness. This collaboration with Senior Nutrition Centers co-locates behavioral health counselors and interns to provide outreach and engagement services where older adults are already receiving services. The Senior Nutrition program, managed by the Santa Clara Department of Aging and Adult Services, aims to reduce hunger and food insecurity, increase socialization, and promote the health and wellbeing of older adults by improving access to nutritious meals and other health and wellness services.[63]

One need for older adults identified in the needs assessment and by the MHSA SLC is for more behavioral health services in locations where they are already receiving other services, which increases

[63] https://www.sccgov.org/sites/ssa/daas/snp/Documents/SNP%20Annual%20Report%202017.pdf

access and helps to reduce stigma. This program represents a substantial increase in the scope of services for older adults co-located at nutrition centers. In the prior plan, the Older Adult Collaboration was staffed exclusively by San Jose State interns, served seniors at only 14 nutrition centers in San Jose, and provided monthly education presentations at program sites relevant to senior wellness and mental health. The SLC identified the need to expand services to all nutrition centers, provide dedicated BHSD staff to oversee interns, and integrate services with other new clinical programs designed for older adults. Additionally, this expansion will meet the needs of residents outside of San Jose, and broaden the scope of services beyond monthly presentations.

Under the redesign, the collaboration will provide an assortment of outreach and education services, including:

- Culturally responsive resources and mental health trainings to the older adults at nutrition sites, with a focus on consumers who participate in the Senior Nutrition Lunch Program;
- Outreach and engagement services to older adults to provide linkage to County mental health services;
- Brief assessment, counseling, and case management support and linkage;
- Collaboration with other clinical programs that provide outreach, assessment, and linkage such as the Elder Health Program.

Additionally, BHSD is expanding the scope of support groups and trainings at nutrition sites, including wellness and grief support groups, and programs to help older adults and their loved ones address challenging issues such as end of life planning with dignity. This project will launch in Fiscal Year 2019-2020.

Goals and Objectives	
Outcome 1:	Improve wellness and quality of life for older adults who access services at Senior Nutrition Sites
Outcome 2:	Reduce the signs and symptoms of mental health needs
Outcome 3:	Increase older adults' coping abilities to deal with loss and end of life issues
Outcome 4:	Increase knowledge of behavioral health among the older adult population

Number to be served FY 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$456,000

Prevention and Early Intervention

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: Prevention			

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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$750,000

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 mid-Fiscal Year 2019.

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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$1,350,000

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 Community Wide Programs

Program	Description	Proposed Changes
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**
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 **(New)** to increase understanding and awareness of the impact of trauma and develop trauma-informed responses	**Modified:** New Trauma-Informed Policing
PEI: Prevention		
Violence Prevention Program: Intimate Partner Violence Prevention	In partnership with local communities and County Departments, expanding violence prevention efforts for youth and adults to address a growing community need regarding intimate partner violence.	Modified
PEI: Stigma and discrimination reduction		
New Refugees Program	An array of outreach, engagement, and prevention activities treatment for new refugees	**Modified:** Will begin to allow services to children and refugees who have lived in the Country for seven years or less

Ethnic and Cultural Community Advisory Committees	Peer support, outreach, engagement and educational services to underserved and unserved communities to reduce stigma and discrimination and increase access to mental health services	**Continuing**
Culture Specific Wellness Centers	A variety of healing services, community engagement activities, and health education occurs specifically designed and implemented for specific cultural communities	**New**
Culture is Prevention	Linkages to high need populations with a particular focus on American Indian/Alaska Native youth and families involved in the foster care and juvenile justice systems	**Continuing**
PEI: Access and linkage to treatment		
Promotores	Culturally and linguistically targeted outreach within communities and neighborhoods to create enhanced linkages/referrals from and to nearby clinics to community services provided by Peer Health Educators	**New**
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.	New
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	**Continuing**

Prevention and Early Intervention

Access and Linkage to Treatment

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: Access and linkage to treatment			
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. This project is slated to begin on Fiscal Year 2019-2020.

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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY2018:	$ 0	**Total Proposed Budget FY 2018-2020:**	$1,200,000

Prevention

Violence Prevention 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: 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 through community education and evidence-based strategies, which are offered through the Healthy Relationships program, described below.

1. Healthy Relationships: a program of the Public Health Department (PHD) using evidence-based strategies to increase awareness about community resources and healthy relationships among

youth. Outreach and education are a major component reducing violence in youth and younger groups. Teams work with PHD to better educate and increase the public's knowledge on healthier ways to interact with each other and when to seek help.

2. In addition to this program, BHSD will partner with the County's Office of Women's Policy to better address an alarming growing trend on intimate partner violence (IPV). The Centers for Disease Control (CDC) describes IPV as a serious, preventable public health problem that affects millions of Americans. The term "intimate partner violence" describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. The goal is to stop IPV before it begins.

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 harm		
Number to be served FY 2018:	200	**Proposed Budget FY 2018:**	$182,910
Cost per Person FY 2018:	$914	**Total Proposed Budget FY 2018-2020:**	$1,275,153

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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$300,000

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

Santa Clara County 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 crises.

Law Enforcement Liaison (LEL) Team

In Santa Clara County, mental health professionals from BHSD provide specialized training to police officers through the LEL Team to improve their responses to a person with a mental health issue. The mission of the LEL Team is to build and enhance teamwork, training, discussion, and collaboration with law enforcement agencies throughout the County. The ultimate goal of the LEL Team is to provide police officers 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 and mobile crisis staff may travel to an 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 arrange transportation for people experiencing crisis to Emergency Psychiatric Services (EPS) or Mental Health Urgent Care (MHUC) as needed. The mobile crisis team may also place 5150 involuntary holds. Mobile crisis staff are co-located with MHUC and in Gilroy and are trained to meet the specific needs of youth, adults, and older adults.

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 crises
Outcome 3:	Connect individuals experiencing mental health crisis to appropriate services
Outcome 4:	

Number to be served FY 2018:	600	**Proposed Budget FY 2018:**	$180,000
Cost per Person FY 2018:	$300	**Total Proposed Budget FY 2018-20:**	$849,000

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 2018:	350	**Proposed Budget FY 2018:**	$691,043
Cost per Person FY2018:	$1,974	**Total Proposed Budget FY 2018-2020:**	$2,073,129

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

Ethnic and Cultural Community Advisory Committees (ECCACs) 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.

Santa Clara County'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 2018:	6,000	**Proposed Budget FY 2018:**	$2,039,522
Cost per Person FY 2018:	$340	**Total Proposed Budget FY 2018-2020:**	$6,401,093

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 Santa Clara County. A team of LGBTQ+ Peer Navigators, in collaboration with the Department's Ethnic and Cultural Communities Advisory Committee (ECCAC), County Office of LGBTQ+ Affairs and community based-service providers, will conduct outreach and engagement activities to increase connectedness to behavioral health resources and services.

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

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

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, families and adults in LGBTQ+ community

Number to be served FY 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY2018:	0	**Total Proposed Budget FY 2018-2020:**	$1,326,167

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: Stigma and Discrimination Reduction			

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 2019-2020.

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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY2018:	$ 0	**Total Proposed Budget FY 2018-2020:**	$1,500,000

Culture is 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: Stigma and Discrimination Reduction			

Program Description

The Culture is Prevention program aims to ensure the survival and healing of American Indians/Alaskan Natives through culturally competent community building and mental health care. The program aims to improve service linkages for these high need communities and provide cultural and traditional education services. Understanding the importance of culture in designing behavioral health programs, this community-based program is a valued alternative to the psychiatric model. The program partners with the Indian Health Center to improve mental health outcomes for American Indian/Alaskan Native youth involved in foster care and juvenile justice systems. Outreach and engagement occurs in a variety of settings including homes, clinics, schools, and community agencies.

The Culture is Prevention program offers community gatherings and cultural meetings/events around outreach and services. Specific programs include:

- **San Jose Native Youth Empowerment Program** incorporating Native American values in case management, peer support, cultural education, and community connection to build effective social skills, respect, self-worth, responsibility, and wellness
- **Dance and Drum Classes** allowing for cultural reflection and celebration
- **Educational Support** providing tools to empower students to achieve their academic goals

Goals and Objectives

Outcome 1:	Provide space for cultural celebration community building
Outcome 2:	Empower students to achieve academic goals
Outcome 3:	Increase connectedness to culturally competent mental healthcare

Number to be served FY 2018:	500	**Proposed Budget FY 2018:**	$54,769
Cost per Person FY2018:	$109	**Total Proposed Budget FY 2018-2020:**	$164,307

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 2018:	3,000	**Proposed Budget FY 2018:**	$1,487,575
Cost per Person FY2018:	$495	**Total Proposed Budget FY 2018-2020:**	$4,683,473

Learning Partnership

Decision Support, Research and Evaluation		
Status:	☐New	☒Continuing
Program Description		
The Learning Partnership is comprised of three units: Decision Support (the department's research and evaluation unit), Cultural Competency (ensures that cultural needs of the County's ethnic and racial populations are met by the Department), and Continuous Learning (responsible for staff development and consumer and family member workforce education and training). These units are tasked with working together to aid and support the transformation of the BHSD to a client driven/family supportive, wellness and recovery system.		
Budget		
Proposed Budget FY 2018:	$ 1,805,158	**Total Proposed Budget FY 2018-20:** $ 6,295,654

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. Santa Clara County has continued to allocate funding to WET as a carve-out of CSS funding. The mission of the MHSA WET is to address community-based workforce shortages in the public mental health system. It seeks to train community members and staff to develop and maintain a culturally and linguistically competent workforce that includes consumers and family members. The WET activities include:

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 Santa Clara County 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

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.

Budget			
Proposed Budget FY 2018:	$3,714,038	**Total Proposed Budget FY 2018-20:**	$11,312,160

Capital Facilities and Technological Needs

General Feasibility for Acquisitions and HealthLink Upgrades		
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 upgrades to community-based facilities which support integrated service experiences that are culturally and linguistically appropriate.

1. ***headspace* Sites Renovation:** As part of an Innovations project currently underway, BHSD will be renovating two clinic sites to provide comprehensive services to youth participating in the *headspace* project. It is estimated that facility improvements in the amount of $470,000 per site would be required to upgrade existing clinic spaces to promote health and wellness for *headspace* participants. This is expected to be an 18 months project for a total of $940,000.
2. **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 $1,711,566 annually during Fiscal Years 2019 and 2020. Staffing costs in FY18 will amount to $537,622.

Budget			
Proposed Budget FY 2018:	$ 537,622	**Total Proposed Budget FY 2018-20:**	$ 3,960,754

Innovation

Programs in Progress

headspace Ramp-up 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 ***headspace*** 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. ***headspace*** 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 ***headspace*** centers located in the intended service areas of Central San Jose and North County (Palo Alto/Mountain View). ***headspace*** was approved by MHSOAC on November 16, 2017 and the County is currently in progress of implementing.

The ***headspace*** treatment model was developed in Australia and is designed to create an innovative culture of youth health that reduces the burden of mental illness through early detection and treatment. Santa Clara County partnered with the Stanford Psychiatry Center for Youth Mental Health and Wellbeing to conduct a feasibility study for introducing the ***headspace*** model in the U.S. and to design a framework to ramp up ***headspace*** implementation over an eight month period.

Goals and Objectives

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

Number to be served FY 2018:	0	**Proposed Budget FY 2018:**	$572,273
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$572,273

Approved and Beginning Implementation

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

The Faith Based Training and Supports Project aims to provide the necessary tools and information to faith and spiritual leaders so that they are able to serve their congregants appropriately and make necessary referrals to BHSD services as needed. Research shows that Santa Clara County is home to many who are part of a faith community. Some of those individuals may be more likely to seek guidance from a faith or spiritual leader than to access mental health services through the County or other mental health professionals. The Faith Based Training and Supports Project has been approved by MHSOAC and the County is preparing for implementation. The County has selected a contracted evaluator and has issued an RFP to run the project.

The Faith Based Training and Supports Project will develop a customized educational training program tailored and implemented for use by faith and spiritual leaders in Santa Clara County. The program will be designed to provide them the necessary tools, skills, and resources to better serve those in their communities who suffer from mental health issues and co-occurring diagnoses. Specifically, the project will teach faith and spiritual leaders how to provide appropriate behavioral health referrals to their congregants and how to directly link them to needed mental health and/or substance use treatment services. The project will also give faith and spiritual leaders a better understanding of safe boundaries between their role and professional/clinical treatment without the necessary credentials to practice.

Goals and Objectives

Outcome 1:	This project will expand referrals and linkages to services for faith community members seeking mental health services

Number to be served FY 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$608,964

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 the County is preparing for implementation. The County has issued an RFP for a contractor to provide these services.

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.[64] 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
- **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

[64] 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

- **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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$1,659,919

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 Santa Clara County 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 Santa Clara County 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.[65]

A study conducted by the Centers for Disease Control and Prevention found that 62% of suicide deaths in Santa Clara County 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 Santa Clara County 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. .

[65] 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

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 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$3,688,511

Multi-Cultural Center

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 Multi-Cultural Center (MCC) project is designed to increase access to housing activities and services for underserved and inappropriately served ethnic minorities in Santa Clara County. The MCC will provide an opportunity for ethnic minority community coordinators to collaborate in identifying and initiating multi-cultural approaches to successfully engage individuals in mental health services in a culturally sensitive manner, and to find appropriate ways to combat stigma and internalized oppression. The project has yet to start, as an appropriate space has not been identified, however, BHSD is looking for a space that will meet the needs of the MCC project. Currently, BHSD is proposing the second floor of the Downtown Mental Health (DTMH) Center for the project.

Goals and Objectives			
Outcome 1:	Consumers from underserved and unserved ethnic groups will have increased access to culturally responsive services through the Multi-Cultural Center		
Number to be served FY 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$499,567

Proposed Programs

headspace 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 ***headspace*** 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. ***headspace*** 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 ***headspace*** centers located in the intended service areas of Central San Jose and North County (Palo Alto/Mountain View).

The ***headspace*** treatment model was developed in Australia and is designed to create an innovative culture of youth health that reduces the burden of mental illness through early detection and treatment. Santa Clara County partnered with the Stanford Psychiatry Center for Youth Mental Health and Wellbeing to conduct a feasibility study for introducing the ***headspace*** model in the U.S. and to design a framework to ramp up ***headspace*** implementation over an eight month period.

The County has completed its ramp up phase and implementation will begin in the third year of this Plan following MHSOAC approval and an RFP process that will begin in August 2018. During the ramp up phase, the County designed a framework to adapt and implement ***headspace*** in Santa Clara County. 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 ***headspace*** 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 ***headspace*** 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:	***headspace*** increases youth connection to needed mental health services and provides support during the early stages of mental health issues		
Number to be served FY 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$5,469,635

Technology Suite for Community Mental Health

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

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

The goals of this project include:

- Increase access to care needed and desired
- Reduce time to recognition and acknowledgment that a symptom needs to be addressed and reduce time to receiving appropriate level of care.
- Increase ability to analyze and collect data from a variety of sources to improve mental health needs assessment and delivery of services
- Increase purpose, belonging and social connectedness for users
- Reduce stigma associated with "mental illness" by promoting mental optimization

Goals and Objectives

Outcome 1:	Consumers will have expanded options to access mental health support from peers		
Number to be served FY 2018:	0	**Proposed Budget FY 2018:**	$ 0
Cost per Person FY 2018:	$ 0	**Total Proposed Budget FY 2018-20:**	$3,749,566

Room Match				
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

Santa Clara County has identified insecure housing as a barrier to mental health care access and consistent utilization of mental health services. The goal of Room Match is to support the housing needs of consumers receiving or in need of mental health services through systemized connections to available rooms within the community. Meeting housing needs and incorporating choice for both consumers and renters aims to reduce the risk of homeless, relapse, hospitalization, and arrest for individuals with mental health needs. This proposed housing project seeks out available bedrooms in homes that might be used for both short- and long-term housing.

Given the current housing crisis, homeless youth and young adult consumers who have serious mental health issues, including hospitalizations, are increasingly vulnerable to housing insecurity that can result in their cycling through institutionalizations without consistent long term care. The program targets these individuals, as well as older adults, for services that will link them to individuals and families within the community that have rooms available for rent.

Housing will include both short-term 3-6 months "bridge" housing and long-term rentals. Bridge housing will be for renters who only need a brief respite before reuniting with family, or for consumers who may be eligible for rapid rehousing or other affordable housing placements but are placed on a waiting list. The program will match housing insecure participants with community members who have available rooms for rent in their homes through a user-friendly matching application, accessible by smart phone and computer. Before gaining access to the app, home owners will go through a background check and screening, and renters will be screened by case managers. Case managers will work with residents to assure the placements are successful. Participants and those renting rooms will be able to communicate through the "Match App" before being officially paired to determine compatibility. The official matching will be coordinated and overseen by an assigned caseworker. Once a participant is paired with a renter, they will move in for a three-month trial period to ensure the match is effective and sustainable for both parties. The ability to match with different renters and rentees, combined with the live-in trial period, allows each party to have increased control in establishing a successful match.

A key component of the program is a Concierge position that serves as an on-call support to renters. The Concierge will work with both rentees and renters to establish healthy communication pathways and respond quickly in the event that extra support, mediation, or crisis support is required. Case

managers will assist short-term renters to reunite with family or find long-term permanent supportive affordable housing.

The County will pay for 3-6 months rents for short-term rentees. Long-term renters will need a stable funding source to pay for their room. Case managers will work to assure that renters maintain funds to pay rent and that the match remains viable.

The Department will meet with the MHSA SLC to discuss and strategize on the functionality of a proposed application and will work closely with the County Office of Supportive Housing to develop a custom solution to serve populations in Santa Clara County that could benefit from this program. The amount on this proposed project was increased, based on the potential to work with a web developer and to adjust for the cost of housing in the Bay Area.

Goals and Objectives

Outcome 1:	Consumers with housing needs will have increased access to temporary respite housing while they transition to permanent housing
Outcome 2:	Consumers will experience decreased jail, hospitalization, or homelessness until they find permanent housing

Number to be served FY 2018:	TBD	**Proposed Budget FY 2018:**	$ TBD
Cost per Person FY 2018:	$ TBD	**Total Proposed Budget FY 2018-20:**	$1,200,000

Older Adult In-Home Outreach Team

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 Friendly Calling Older Adult In-Home Outreach Team is a proposed project that will provide culturally responsive mental health services for isolated adults over 60 in Santa Clara County via a multilingual phone line. This project will target underserved or unserved older adults who experience isolation and/or depression and who may be homebound. For this population, isolation may be the result of many factors such as the loss of a life-long partner or other loved ones, medical problems, financial constraints, unstable housing, and caregiving responsibilities. Mental health resources that could benefit isolated older adults tend to be inaccessible to them due to a lack of information and support in accessing services. Friendly Calling is designed to connect isolated older adults to supportive services they would otherwise have difficulty accessing.

The program will be widely publicized and referrals will come from consumers' family, faith-based community resources, senior community centers, senior housing programs, and the medical community. The service will be staffed with Elder Peer staff, who have been trained in this specialized service and who will serve as Navigators or *Promotores* to help consumers navigate the system of care. The staff will call and engage each consumer, establish and build trust, provide understanding and a sense of connection, and help to address the individualized needs of each consumer. Elder Peers will visit consumers in their homes as necessary, and make "warm handoff" referrals to mental health and community services that meet each consumer's needs.

Homeless isolated older adults will be served through personal contacts by the Elder Peer staff, who will also help provide cell phones to these individuals so they have a means to communicate with service providers.

Elder Peer staff will make home visits to elders who do not respond to phone calls or who do not have a phone. Staff will refer them to outreach visiting programs. When there is a concern for consumers' safety, staff will conduct a "welfare check" and refer consumers to Adult Protective Services and/or law enforcement for follow-up if needed.

The Department will meet with the MHSA SLC to discuss and strategize on the recommended approach to implement this innovative program, while also identifying interventions that have a positive impact on the elder community.

The proposed amount for this project has been reduced upon further study of the scope of services and staffing required, and may be modified based on guidance and experience gleaned from similar programs.

Goals and Objectives			
Outcome 1:	Isolated older adults will experience increased access to services to support their wellbeing and recovery		
Number to be served FY 2018:	TBD	**Proposed Budget FY 2018:**	$ TBD
Cost per Person FY 2018:	$ TBD	**Total Proposed Budget FY 2018-20:**	$850,000

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) *FY2018 Through FY2020 MHSA Three-Year Program and Expenditure Plan Submittals* (www.mhsoac.ca.gov) instructions for documenting the expenditure of the proposed MHSA programs.

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Santa Clara Date: 6/13/18

	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 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	83,782,568	15,256,867	16,160,579	0	3,960,754	
2. Estimated New FY2017/18 Funding	68,521,964	17,130,491	4,507,069			
3. Transfer in FY2017/18[a/]	(3,714,038)			3,714,038		
4. Access Local Prudent Reserve in FY2017/18						0
5. Estimated Available Funding for FY2017/18	148,590,494	32,387,358	20,667,648	3,714,038	3,960,754	
B. Estimated FY2017/18 MHSA Expenditures	73,337,451	18,439,230	1,844,694	3,714,038	537,622	
C. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	75,253,043	13,948,128	18,822,954	0	3,423,132	
2. Estimated New FY2018/19 Funding	61,221,781	15,307,712	4,026,436			
3. Transfer in FY2018/19[a/]	(3,779,056)			3,779,056		
4. Access Local Prudent Reserve in FY2018/19						0
5. Estimated Available Funding for FY2018/19	132,695,768	29,255,840	22,849,390	3,779,056	3,423,132	
D. Estimated FY2018/19 Expenditures	75,618,066	20,220,229	8,594,188	3,779,056	1,711,566	
E. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	57,077,702	9,035,611	14,255,202	0	1,711,566	
2. Estimated New FY2019/20 Funding	65,502,137	16,373,267	4,307,561			
3. Transfer in FY2019/20[a/]	(3,819,066)			3,819,066		
4. Access Local Prudent Reserve in FY2019/20						0
5. Estimated Available Funding for FY2019/20	118,760,773	25,408,878	18,562,763	3,819,066	1,711,566	
F. Estimated FY2019/20 Expenditures	105,005,756	21,739,647	12,562,343	3,819,066	1,711,566	
G. Estimated FY2019/20 Unspent Fund Balance	13,755,017	3,669,232	6,000,420	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	20,462,002
2. Contributions to the Local Prudent Reserve in FY 2017/18	0
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	20,462,002
5. Contributions to the Local Prudent Reserve in FY 2018/19	0
6. Distributions from the Local Prudent Reserve in FY 2018/19	0
7. Estimated Local Prudent Reserve Balance on June 30, 2019	20,462,002
8. Contributions to the Local Prudent Reserve in FY 2019/20	0
9. Distributions from the Local Prudent Reserve in FY 2019/20	0
10. Estimated Local Prudent Reserve Balance on June 30, 2020	20,462,002

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 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2017/18					
	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	4,736,788	1,117,406	1,907,580		1,711,802	
2. T01 Transitional Age Youth FSP	4,663,926	1,145,431	2,005,586		1,512,909	
3. A01 Adult Full Service Partnership	7,529,057	5,309,366	2,219,691			
4. A03 Criminal Justice FSP	5,435,405	3,234,234	2,201,171			
5. OA01 Older Adult Full Service Partnership	994,925	640,820	354,105			
6. A02 Adult Assertive Community Treatment	Estimated to Start in FY 2020					
7. A02 Community Placement Team Services and IMD Alternative Program	1,604,136	1,604,136				
8. A02 Crisis Stabilization Unit and Crisis Residential Treatment	7,316,953	3,514,970	3,801,983			
9. A03 Criminal Justice Residential and Outpatient Treatment Programs	1,970,854	1,970,854				
10. A04 Mental Health Urgent Care	1,160,684	464,274	696,410			
11. C02 Children's (Uplift) Mobile Crisis	353,930	353,930				
12. C02 CSEC Program	220,200	220,200				
13. C02 Specialty Services - Integrated MH/SUD	595,320	595,320				
14. C03 Foster Care Development	382,354	382,354				
15. C03 Independent Living Program (ILP)	34,231	8,216	26,015			
16. C03 Services for Juvenile Justice Involved Youth	581,459	443,533	72,593		65,334	
17. HO01 Permanent Supportive Housing	2,818,584	1,876,897	917,687			24,000
18. Specialty Services- Eating Disorders --- Child/Adult/Other combined	277,800	277,800				
19. T02-04 TAY Crisis and Drop In Center	269,911	269,911				
Non-FSP Programs						
1. C03 Children & Family Behavioral Health Outpatient/IOP Services	35,063,058	6,909,426	16,639,103		11,514,529	
2. Specialty Services- Eating Disorders --- Child/Adult/Other combined	648,200	648,200				
3. C02 Specialty Services - Integrated MH/SUD	396,880	396,880				
4. C03 Foster Care Development	892,160	892,160				
5. A02 Community Placement Team Services and IMD Alternative Program	3,742,984	3,742,984				
6. C02 Children's (Uplift) Mobile Crisis	235,954	235,954				
7. C02 School Linked Services (SLS) Initiative	8,525,666	2,135,840	3,362,853		3,026,973	
8. T02-04 TAY Outpatient Services	1,836,559	1,236,777	337,743		262,039	
9. Intensive Outpatient Program (IOP)	539,822	539,822				
10. C03 Independent Living Program (ILP)	79,871	19,170	60,701			
11. C02 CSEC Program	146,800	146,800				
12. C03 Services for Juvenile Justice Involved Youth	1,356,737	1,034,909	169,383		152,445	
13. T02-04 TAY Triage to Support Reentry	Estimated to Start in FY 2020					
14. T02-04 TAY Crisis and Drop In Center	269,911	269,911				
15. T02-04 TAY Interdisciplinary Service Teams	Estimated to Start in FY 2020					
16. A02/A04 County Clinics	8,677,238	8,313,620				363,618
17. A02 Hope Services: Integrated Mental Health and Autism Services	1,305,472	806,773	498,699			
18. A02 CalWORKs Community Health Alliance	2,647,627	1,204,000	761,787			681,840
19. A03 Criminal Justice Residential and Outpatient Treatment Programs	2,956,280	2,956,280				
20. A03 Criminal Justice Outpatient Services	1,546,650	930,203	616,447			
21. A03 Faith Based Resource Centers	1,848,688	450,000				1,398,688
22. A04 Mental Health Urgent Care	2,708,263	1,083,305	1,624,958			
23. A02 Crisis Stabilization Unit and Crisis Residential Treatment	17,072,889	8,201,596	8,871,293			
24. A02 Adult Residential Treatment	Estimated to Start in FY 2020					
25. OA02-04 In-Home Outreach Teams	Estimated to Start in FY 2019					
26. OA02-04 Outpatient Services for Older Adults	2,094,473	1,741,671	352,802			
27. OA02-04 Connections Program	151,000	151,000				
28. LP01 Learning Partnership	1,805,158	1,805,158				
CSS Administration	4,055,360	4,055,360				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	141,550,217	73,337,451	47,498,589	0	18,246,031	2,468,146
FSP Programs as Percent of Total	55.8%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2018/19					
	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	4,736,788	1,117,406	1,907,580		1,711,802	
2. T01 Transitional Age Youth FSP	4,663,926	1,145,431	2,005,586		1,512,909	
3. A01 Adult Full Service Partnership	7,529,057	4,517,434	3,011,623			
4. A03 Criminal Justice FSP	5,435,405	3,234,234	2,201,171			
5. OA01 Older Adult Full Service Partnership	994,925	640,820	354,105			
6. A02 Adult Assertive Community Treatment	Estimated to Start in FY 2020					
7. A02 Community Placement Team Services and IMD Alternative Program	1,614,037	1,614,037				
8. A02 Crisis Stabilization Unit and Crisis Residential Treatment	7,316,953	3,514,970	3,801,983			
9. A03 Criminal Justice Residential and Outpatient Treatment Programs	1,888,415	1,888,415				
10. A04 Mental Health Urgent Care	1,192,570	477,028	715,542			
11. C02 Children's (Uplift) Mobile Crisis	471,890	471,890				
12. C02 CSEC Program	390,200	390,200				
13. C02 Specialty Services - Integrated MH/SUD	545,710	297,660	248,050			
14. C03 Foster Care Development	427,853	427,853				
15. C03 Independent Living Program (ILP)	51,574	8,216	43,358			
16. C03 Services for Juvenile Justice Involved Youth	692,836	511,354	72,593		108,890	
17. HO01 Permanent Supportive Housing	3,002,341	2,060,654	917,687			24,000
18. Specialty Services- Eating Disorders --- Child/Adult/Other combined	750,000	750,000				
19. T02-04 TAY Crisis and Drop In Center	269,911	269,911				
Non-FSP Programs						
1. C03 Children & Family Behavioral Health Outpatient/IOP Services	34,714,286	5,802,614	17,397,143		11,514,529	
2. Specialty Services- Eating Disorders --- Child/Adult/Other combined	1,750,000	1,750,000				
3. C02 Specialty Services - Integrated MH/SUD	446,490	198,440	248,050			
4. C03 Foster Care Development	998,325	998,325				
5. A02 Community Placement Team Services and IMD Alternative Program	3,766,087	3,766,087				
6. C02 Children's (Uplift) Mobile Crisis	314,594	314,594				
7. C02 School Linked Services (SLS) Initiative	13,533,179	7,143,353	3,362,853		3,026,973	
8. T02-04 TAY Outpatient Services	1,880,707	667,481	951,187		262,039	
9. Intensive Outpatient Program (IOP)	539,822	539,822				
10. C03 Independent Living Program (ILP)	62,528	19,170	43,358			
11. C02 CSEC Program	260,133	260,133				
12. C03 Services for Juvenile Justice Involved Youth	1,471,432	1,193,160	169,383		108,890	
13. T02-04 TAY Triage to Support Reentry	Estimated to Start in FY 2020					
14. T02-04 TAY Crisis and Drop In Center	269,911	269,911				
15. T02-04 TAY Interdisciplinary Service Teams	Estimated to Start in FY 2020					
16. A02/A04 County Clinics	9,526,784	4,164,440	4,983,392			378,952
17. A02 Hope Services: Integrated Mental Health and Autism Services	1,305,472	806,773	498,699			
18. A02 CalWORKs Community Health Alliance	2,647,627	1,204,000	761,787			681,840
19. A03 Criminal Justice Residential and Outpatient Treatment Programs	2,832,623	2,832,623				
20. A03 Criminal Justice Outpatient Services	1,658,041	892,423	765,618			
21. A03 Faith Based Resource Centers	1,848,688	450,000				1,398,688
22. A04 Mental Health Urgent Care	2,782,664	1,113,066	1,669,598			
23. A02 Crisis Stabilization Unit and Crisis Residential Treatment	17,072,889	8,201,596	8,871,293			
24. A02 Adult Residential Treatment	Estimated to Start in FY 2020					
25. OA02-04 In-Home Outreach Teams	413,333	413,333				
26. OA02-04 Outpatient Services for Older Adults	2,103,284	1,051,642	1,051,642			
27. OA02-04 Connections Program	151,000	151,000				
28. OA02-04 Older Adult Collaboration with Senior Nutrition Centers	152,000	152,000				
29. Technical Assistance Support for Community Based Providers	1,200,000	1,200,000				
30. LP01 Learning Partnership	2,158,115	2,158,115				
CSS Administration	4,566,452	4,566,452				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	152,400,857	75,618,066	56,053,280	0	18,246,031	2,483,480
FSP Programs as Percent of Total	55.5%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. C01 Child Full Service Partnership	6,936,788	2,450,271	2,774,715		1,711,802	
2. T01 Transitional Age Youth FSP	6,857,676	2,601,697	2,743,070		1,512,909	
3. A01 Adult Full Service Partnership	20,020,296	11,429,366	8,590,930			
4. A03 Criminal Justice FSP	11,935,405	7,134,234	4,801,171			
5. OA01 Older Adult Full Service Partnership	2,794,925	1,720,820	1,074,105			
6. A02 Community Placement Team Services and IMD Alternative Program	1,627,773	1,627,773				
7. A02 Crisis Stabilization Unit and Crisis Residential Treatment	7,316,953	3,514,970	3,801,983			
8. A03 Criminal Justice Residential and Outpatient Treatment Programs	3,131,974	3,131,974				
9. A04 Mental Health Urgent Care	1,716,229	490,351	1,225,878			
10. C02 Children's (Uplift) Mobile Crisis	471,890	330,323	141,567			
11. C02 CSEC Program	470,700	470,700				
12. C02 Specialty Services - Integrated MH/SUD	545,710	297,660	248,050			
13. C03 Foster Care Development	433,979	303,785	130,194			
14. C03 Independent Living Program (ILP)	34,231	8,216	26,015			
15. C03 Services for Juvenile Justice Involved Youth	655,835	328,167	262,334		65,334	
16. HO01 Permanent Supportive Housing	3,022,841	2,081,154	917,687			24,000
17. Specialty Services- Eating Disorders --- Child/Adult/Other combined	750,000	750,000				
18. T02-04 TAY Crisis and Drop In Center	269,911	269,911				
19. A02 Assertive Community Treatment	7,000,000	4,200,000	2,800,000			
Non-FSP Programs						
1. C03 Children & Family Behavioral Health Outpatient/IOP Services	34,822,635	5,908,538	17,399,568		11,514,529	
2. Specialty Services- Eating Disorders --- Child/Adult/Other combined	1,750,000	1,750,000				
3. C02 Specialty Services - Integrated MH/SUD	446,490	198,440	248,050			
4. C03 Foster Care Development	1,012,617	708,832	303,785			
5. A02 Community Placement Team Services and IMD Alternative Program	3,798,137	3,798,137				
6. C02 Children's (Uplift) Mobile Crisis	314,594	220,216	94,378			
7. C02 School Linked Services (SLS) Initiative	16,746,369	8,747,610	4,971,786		3,026,973	
8. T02-04 TAY Outpatient Services	1,965,177	729,549	973,589		262,039	
9. Intensive Outpatient Program (IOP)	539,822	539,822				
10. C03 Independent Living Program (ILP)	79,871	19,170	60,701			
11. C02 CSEC Program	313,800	313,800				
12. C03 Services for Juvenile Justice Involved Youth	1,530,281	765,723	612,112		152,445	
13. T02-04 TAY Triage to Support Reentry	1,500,000	750,000	750,000			
14. T02-04 TAY Crisis and Drop In Center	269,911	269,911				
15. T02-04 TAY Interdisciplinary Service Teams	1,500,000	750,000	750,000			
16. A02/A04 County Clinics	9,987,678	4,487,018	5,110,339			390,321
17. A02 Hope Services: Integrated Mental Health and Autism Services	1,305,472	806,773	498,699			
18. A02 CalWORKs Community Health Alliance	2,647,627	1,204,000	761,787			681,840
19. A03 Criminal Justice Residential and Outpatient Treatment Programs	4,697,962	4,697,962				
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	17,072,889	8,201,596	8,871,293			
24. A02 Adult Residential Treatment	3,350,700	1,675,350	1,675,350			
25. OA02-04 In-Home Outreach Teams	2,260,000	2,260,000				
26. OA02-04 Outpatient Services for Older Adults	2,130,145	1,796,560	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. OA02-04 Older Adult Collaboration with Senior Nutrition Centers	304,000	304,000				
30. LP01 Learning Partnership	2,373,464	2,373,464				
CSS Administration	4,821,351	4,821,351				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	201,928,644	105,005,756	76,182,008	0	18,246,031	2,494,849
FSP Programs as Percent of Total	72.4%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2017/18					
	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	182,910	182,910				
2. P2 Support for Parents	760,000	760,000				
3. P1 Promotores	Estimated to Start in FY 2020					
PEI Programs - Early Intervention						
4. P3 Raising Early Awareness Creating Hope (REACH)	1,613,726	1,279,276	287,062		47,388	
5. P4 Integrated Behavioral Health	1,068,230	1,068,230				
6. P2 School Linked Services (SLS) Initiative	7,200,894	7,200,894				
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
7. P1 Community Wide Outreach and Training	Estimated to Start in FY 2019					
8. P1 Law Enforcement Training	180,000	180,000				
PEI Programs - Stigma and Discrimination Reduction						
9. P4 New Refugees Program	691,043	691,043				
10. P1 Ethnic and Cultural Communities Advisory Committees (ECCACs)	2,039,522	2,039,522				
11. P1 Culture is Prevention	54,769	54,769				
PEI Programs - Access and Linkage to Treatment						
12. P2 Services for Children 0-5	321,860	321,860				
13. P1 Office of Consumer Affairs	669,142	669,142				
14. P1 Office of Family Affairs	320,325	320,325				
15. P1 Mental Health Advocacy Project	66,875	66,875				
PEI Programs - Suicide Prevention						
16. P5 Suicide Prevention Strategic Plan	1,487,575	1,487,575				
PEI Programs - Improve Timely Access to Services for Underserved Populations						
17. P1 Culture-Specific Wellness Centers	Estimated to Start in FY 2020					
PEI Administration	1,866,809	1,866,809				
PEI Assigned Funds- CalMHSA	250,000	250,000				
Total PEI Program Estimated Expenditures	18,773,680	18,439,230	287,062	0	47,388	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2018/19					
	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	193,223	193,223				
2. P2 Intimate Partner Violence Prevention	350,000	350,000				
3. P2 Support for Parents	760,000	760,000				
4. P1 Promotores	Estimated to Start in FY 2020					
PEI Programs - Early Intervention						
5. P3 Raising Early Awareness Creating Hope (REACH)	1,613,726	1,279,276	287,062		47,388	
6. P4 Integrated Behavioral Health	3,258,230	3,258,230				
7. P1 Elder Story Telling	450,000	450,000				
8. P2 School Linked Services (SLS) Initiative	3,645,828	3,645,828				
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
9. P1 Community Wide Outreach and Training	150,000	150,000				
10. P1 Law Enforcement Training	300,000	300,000				
PEI Programs - Stigma and Discrimination Reduction						
11. P4 New Refugees Program	691,043	691,043				
12. P1 Ethnic and Cultural Communities Advisory Committees (ECCACs)	2,154,210	2,154,210				
13. P1 Culture is Prevention	54,769	54,769				
PEI Programs - Access and Linkage to Treatment						
14. P2 Services for Children 0-5	588,527	588,527				
15. P1 Office of Consumer Affairs	679,030	679,030				
16. P1 Office of Family Affairs	331,106	331,106				
17. P1 Mental Health Advocacy Project	150,000	150,000				
18. P1 Re-Entry	359,999	359,999				
19. P1 LGBTQ	626,667	626,667				
PEI Programs - Suicide Prevention						
20. P5 Suicide Prevention Strategic Plan	1,580,828	1,580,828				
PEI Programs - Improve Timely Access to Services for Underserved Populations						
21. P1 Culture-Specific Wellness Centers	Estimated to Start in FY 2020					
PEI Administration	2,367,493	2,367,493				
PEI Assigned Funds- CalMHSA	250,000	250,000				
Total PEI Program Estimated Expenditures	20,554,679	20,220,229	287,062	0	47,388	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. P2 Violence Prevention Program	199,020	199,020				
2. P2 Intimate Partner Violence Prevention	350,000	350,000				
3. P2 Support for Parents	760,000	760,000				
4. P1 Promotores	1,200,000	1,200,000				
PEI Programs - Early Intervention						
5. P3 Raising Early Awareness Creating Hope (REACH)	1,613,726	1,279,276	287,062		47,388	
6. P4 Integrated Behavioral Health	3,258,230	3,258,230				
7. P1 Elder Story Telling	900,000	900,000				
8. P2 School Linked Services (SLS) Initiative	669,631	669,631				
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
9. P1 Older Adult In-Home Peer Respite Program	750,000	750,000				
10. P1 Community Wide Outreach and Training	150,000	150,000				
11. P1 Law Enforcement Training	369,000	369,000				
PEI Programs - Stigma and Discrimination Reduction						
12. P4 New Refugees Program	691,043	691,043				
13. P1 Ethnic and Cultural Communities Advisory Committees (ECCACs)	2,207,361	2,207,361				
14. P1 Culture is Prevention	54,769	54,769				
PEI Programs - Access and Linkage to Treatment						
15. P2 Services for Children 0-5	588,527	588,527				
16. P1 Office of Consumer Affairs	698,259	698,259				
17. P1 Office of Family Affairs	340,189	340,189				
18. P1 Mental Health Advocacy Project	150,000	150,000				
19. P1 Re-Entry	567,000	567,000				
20. P1 LGBTQ	699,500	699,500				
PEI Programs - Suicide Prevention						
21. P5 Suicide Prevention Strategic Plan	1,615,070	1,615,070				
PEI Programs - Improve Timely Access to Services for Underserved Populations						
22. P1 Culture-Specific Wellness Centers	1,500,000	1,500,000				
PEI Administration	2,492,772	2,492,772				
PEI Assigned Funds- CalMHSA	250,000	250,000				
Total PEI Program Estimated Expenditures	22,074,097	21,739,647	287,062	0	47,388	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Clara

Date: 6/13/18

	Fiscal Year 2017/18					
	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. Headspace Ramp-up Project	572,273	572,273				
2. Multi-Cultural Center	424,567	424,567				
3. Tech Suite	Estimated to Start in FY 2019					
4. Psychiatric Emergency Response Team (PERT) and Peer Linkage	Estimated to Start in FY 2019					
5. Older Adult In-Home Outreach Team	Estimated to Start in FY 2020					
INN Administration	847,854	847,854				
Total INN Program Estimated Expenditures	1,844,694	1,844,694	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Clara

Date: 6/13/18

	Fiscal Year 2018/19					
	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	300,413	300,413				
2. Client and Consumer Employment	818,433	818,433				
3. Psychiatric Emergency Response Team (PERT) and Peer Linkage	2,116,468	2,116,468				
4. Headspace Implementation Project	1,802,691	1,802,691				
5. Tech Suite	1,651,108	1,651,108				
6. Multi-Cultural Center	424,567	424,567				
8. Older Adult In-Home Outreach Team	Estimated to Start in FY 2020					
INN Administration	1,480,508	1,480,508				
Total INN Program Estimated Expenditures	8,594,188	8,594,188	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Faith Based Training and Supports Project	308,551	308,551				
2. Client and Consumer Employment	841,486	841,486				
3. Psychiatric Emergency Response Team (PERT) and Peer Linkage	1,572,043	1,572,043				
4. Headspace Implementation Project	3,666,944	3,666,944				
5. Tech Suite	2,098,458	2,098,458				
6. Room Match	850,000	850,000				
7. Multi-Cultural Center	424,567	424,567				
8. Older Adult In-Home Outreach Team	1,200,000	1,200,000				
INN Administration	1,600,294	1,600,294				
Total INN Program Estimated Expenditures	12,562,343	12,562,343	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2017/18					
	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	310,293	310,293				
2. W2 Promising Practice Based Training	803,375	803,375				
3. W3: Improved Svcs/Outreach to Unserved/Underserved Populations	451,939	451,939				
4. W4: Welcoming Consumers and Family Members	622,042	622,042				
5. W5: WET Collaboration with Key System Partners	25,000	25,000				
6. W6: Mental Health Career Pathway	183,963	183,963				
7. W7: Stipends and Incentive to Support MH Career Pathways	954,000	954,000				
WET Administration	363,426	363,426				
Total WET Program Estimated Expenditures	3,714,038	3,714,038	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2018/19					
	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	806,474	806,474				
3. W3: Improved Svcs/Outreach to Unserved/Underserved Populations	474,040	474,040				
4. W4: Welcoming Consumers and Family Members	646,041	646,041				
5. W5: WET Collaboration with Key System Partners	25,000	25,000				
6. W6: Mental Health Career Pathway	190,161	190,161				
7. W7: Stipends and Incentive to Support MH Career Pathways	954,000	954,000				
WET Administration	363,426	363,426				
Total WET Program Estimated Expenditures	3,779,056	3,779,056	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. W1 WET Coordination	319,914	319,914				
2. W2 Promising Practice Based Training	809,120	809,120				
3. W3: Improved Svcs/Outreach to Unserved/Underserved Populations	487,142	487,142				
5. W4: Welcoming Consumers and Family Members	665,010	665,010				
6. W5: WET Collaboration with Key System Partners	25,000	25,000				
7. W6: Mental Health Career Pathway	195,454	195,454				
8. W7: Stipends and Incentive to Support MH Career Pathways	954,000	954,000				
WET Administration	363,426	363,426				
Total WET Program Estimated Expenditures	3,819,066	3,819,066	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2017/18					
	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.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. CFTN Support Staff	537,622	537,622				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	537,622	537,622	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Clara Date: 6/13/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. headspace Sites	470,000	470,000				
2.						
3.						
4.						
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. CFTN Support Staff	1,241,566	1,241,566				
12.						
13.						
14.						
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	1,711,566	1,711,566	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Clara Date: 6/13/18

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

Spending Plan for Funding Subject to AB 114 – Department of Health Care Services
Info Notice 17-059

Pursuant to AB 114 (Chapter 38, Statues of 2017) and the Department of Health Care Services (DHCS) Information Notice 17-059, each County must prepare and publically post a plan for MHSA funding subject to reversion from Fiscal Years 2005 - 06 through 2014 - 15. Counties must develop a plan to spend these MHSA funds by June 30, 2020.

On April 24, 2018 the DHCS provided Santa Clara County Behavioral Health Services Department (BHSD) with the latest diversion funds as shown in the table below. DHCS identified $2.8 million of Prevention and Early Intervention (PEI), $8.3 million of Innovation (INN), and $3,423,132 of Capital Facilities and Technological Needs (CFTN) funds that were subject to reversion as of July 1, 2017. The following is the two year spending plan for the MHSA reversion funds:

Department of Health Care Services
MHSA Funds Subject to Reversion by Fiscal Year by Component
4/24/2018

Santa Clara	CSS	PEI	INN	WET	CFTN	Total
FY06	$ -					$ -
FY07	$ -			$ -		$ -
FY08	$ -	$ -			$ 3,423,132	$ 3,423,132
FY09	$ -	$ -	$ 2,609,677			$ 2,609,677
FY10	$ -	$ 2,854,964	$ 710,660			$ 3,565,624
FY11	$ -	$ -	$ 1,763,381			$ 1,763,381
FY12	$ -	$ -	$ -			$ -
FY13	$ -	$ -	$ -			$ -
FY14	$ -	$ -	$ 280,357			$ 280,357
FY15	$ -	$ -	$ 2,988,364			$ 2,988,364
Total	**$ -**	**$ 2,854,964**	**$ 8,352,439**	**$ -**	**$ 3,423,132**	**$ 14,630,535**

Prevention and Early Intervention

The following programs from approved MHSA Prevention and Early Intervention (PEI) plans have been identified to draw down the funding for the PEI amount subject to reversion. These projects are described below:

1. **Strengthening Children and Families (East/South)** is divided into two components; component one is 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 access to screenings to identify developmental delays; and component two builds upon the first by implementing a continuum of services targeting four geographic areas of high need (Investment Communities) for children and youth ages 0-18 who may be experiencing symptoms ranging from behavioral/emotional distress to depression and anxiety caused by trauma or other risk factors. BHSD will apply $2,043,906 in Fiscal Year 2018 to these programs and services.

2. **The Raising Early Awareness Creating Hope (REACH)** project implements a continuum of services targeting youth and transition age youth (TAY), ages 11 to 25, who are experiencing At Risk Mental States (ARMS) or prodromal symptoms. The service model is based on the PIER-Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, which is a replication study which occurred at six sites nationwide to build research evidence on the effectiveness of preventing the onset and severity of serious mental illness with psychosis. BHSD will apply $396,065 in Fiscal Year 2018 to these programs and Services.

3. **LGBTQ Ethnic Cultural Communities Advisory Committee (ECCAC)** The ECCACs originally included seven groups providing peer support, outreach, engagement and educational services to nine underserved and unserved communities to reduce stigma and discrimination and increase access to mental health services. The County approved the LGBTQ group to provide services to LGBTQ community throughout the lifespan. Family Children Services (FCS) operates this project after a thorough selection process to support the needs and services for LGBTQ communities. BHSD will apply $164,993 in Fiscal Year 2018 to these programs and Services.

4. **California Mental Health Services Authority (CalMHSA)** The Statewide PEI Project is publicly known as *Each Mind Matters: California's Mental Health Movement*, which represents an umbrella name and vision to amplify individual efforts from the county and other organizations that are taking place across California under a united movement to reduce stigma and discrimination and prevent suicides. This project is operated by CalMHSA. Santa Clara County has contributed to these statewide efforts since its inception in 2009. In FY 2016-2017, there were a total of 17 local agencies, schools and organizations that received outreach materials, a training, technical assistance or a presentation about stigma reduction, suicide prevention and/or student mental health through the collective efforts of all programs implemented under the Statewide PEI Project. These include:
    - **County Agencies**: Santa Clara County Behavioral Health Services
    - **K-12 Schools**: Evergreen Valley High School; Leland High School; Redwood Middle School
    - **Colleges & Universities**: San Jose State University, Evergreen Community College, De Anza Community College, Gavilan College, Foothill Community College, Mission College, San Jose City College, West Valley College
    - **Community Based Organizations**: Learning Partnership, Momentum for Mental Health, Grail Family Services; NAMI Santa Clara County; Stanford Center for Youth Mental Health Well Being

   The County contribution to CalMHSA is $250,000 for Fiscal Year 2018.

Summary of PEI Reversion Fund Allocation	**FY2018**
Strengthening Families (East/South)	$ 2,043,906
REACH	$ 396,065
LBGTQ ECCAC	$ 164,993
CalMHSA	$ 250,000
Total PEI	**$ 2,854,964**

Capital Facilities and Technological Needs (CFTN)

The MHSA provides funding for services and resources that promote wellness, recovery, and resiliency for adults and older adults with severe mental illness and for children and youth with serious emotional disturbances and their family members. Capital Facilities and Technological Needs (CFTN), a portion of MHSA Funds, were set aside pursuant to Welfare and Institutions Code (WIC) Section 5892(a)(2) to promote the efficient implementation of the MHSA. Santa Clara County's CFTN project proposal supports the goals of the MHSA and the provision of MHSA services.

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 upgrades to community-based facilities which support integrated service experiences that are culturally and linguistically appropriate.

1. ***headspace* Sites Renovation:** As part of an Innovations project currently underway, BHSD will be renovating two clinic sites to provide comprehensive services to youth participating in the *headspace* project. It is estimated that facility improvements in the amount of $470,000 per site would be required to upgrade existing clinic spaces to promote health and wellness for *headspace* participants. This is expected to be an 18 months project for a total of $940,000.

2. **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 $1,711,566 annually during Fiscal Years 2019 and 2020.

Summary of CFTN Reversion Fund Allocation		**FY2019**	**FY2020**
headspace Sites		$470,000	$470,000
CFTN Support Staff		$1,241,566	$1,241,566
	Total Annual	$1,711,566	$1,711,566
TOTAL CFTN		**$3,423,132**	

Innovation

The new MHSA Stakeholder Leadership Committee was established in February 2018 December to develop and refine project proposals for the FY18-20 MHSA Program and Expenditure Plan. Additionally, the SLC reviewed, recommended, refined and validated programs that meet the criteria for Innovation. To date there have been five workgroup meetings, one serving as an orientation and training to MHSA for the new MHSA SLC, along with weekly updates and individual contacts made between meetings. Each meeting has averaged 25 individuals in attendance. While the *headspace* Implementation project continues to receive input and will be prepared and presented for approval

at the Mental Health Oversight and Accountability Commission (MHSOAC), it has met initial qualification as an Innovation project as validated by the MHSA Stakeholder Leadership Committee. BHSD would like to seek broader public input on the Implementation Phase during this 30-Day public comment process. The following approved Innovations projects (*headspace* Implementation approval pending) have been identified to fulfill the requirements of AB114:

1. **INN-10: Faith Based Training and Supports Project**
   The MHSOAC approved this project on November 16, 2017. The primary goal of the Faith-Based Training and Supports Project is to increase access to services by implementing customized faith-based behavioral health training plans that would provide faith community leaders with skills for appropriate, supportive responses to those seeking their help due to behavioral health challenges. Additionally, the project would develop faith-informed behavioral health workshops for behavioral health direct care providers. The dual benefit would be to further decrease stigma about help-seeking behaviors by normalizing behavioral health linkages and referrals to County services. The approved total budgeted amount of $608,964 will be utilized during Fiscal Years 2019-2020. This is a two year project.

2. **INN-11: The Client and Consumer Individual Placement & Support (IPS) Employment Project**
   The MHSOAC approved this project on November 16, 2017. This project aims to engage clients and consumers to identify their employment goal(s) as part of their treatment plan. The project will adapt the IPS Supported Employment (IPS/SE) model to a new setting, Santa Clara County, with the intention of transforming how the overall system views employment and start recognizing employment as a wellness goal for behavioral health consumers and an element of their treatment. 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 (SMI). This model is an evidence-based practice developed to significantly increase employment outcomes. The IPS/SE model reflects zero exclusion in the employment program model. The project will create the foundation for Santa Clara County's employment based programming for SMI clients/consumers by including employment as a component of their treatment plan. The approved three-year project budget is $2,525,148. However, the Department will only utilize $1,659,919 during Fiscal Years 2019 through 2020. The remaining amount of $865,229 will be applied to FY2021.

3. **INN-12: Psychiatric Emergency Response Team (PERT) and Peer Linkage**
   This project seeks to decrease EPS admits by law enforcement (20%) and create a distinctive warm handoff, peer linkage structure after PERT encounter for individuals ages 18-25. In maintaining the primary objective of the PERT model, the project would provide effective crisis intervention to individuals in mental health crises, de-escalate crisis situations, provide the appropriate behavioral health service referrals when necessary and avoid hospitalizations. The Santa Clara County PERT and Peer Linkage Project's linkage component would provide peer support services post-crisis to assist client/consumers with their recovery and prevent future suicide attempts. The budget for this two-year project is $3,688,511 and will be utilized by the end of Fiscal Year 2020.

4. **INN 13: *headspace* Ramp Up (Phase 1)**
   headspace would be rolled out in two phases: Ramp Up (8 months, approved by MHSOAC on November 16, 2017) and Implementation (48 months). The primary aim of the ramp up phase is to design a framework for the implementation plan and sustainability components to adapt and replicate *headspace* in Santa Clara County. This new framework would provide an innovative approach to mental health services and supports for young people ages 12-25. The framework will also provide guidance on the complicated financial modeling required in a system that is not a national healthcare model, as it exists in Australia, Canada and some countries in Europe. This adaptation would address issues related to the multi-service components of two centers, as well as the need for a public/private insurance structure to support all youth regardless of their insurance coverage. BHSD intends to follow a "no wrong door approach" without exclusion, supporting youth needs and limiting interruptions to care in the *headspace* centers. The budget for the Ramp Up phase is $572,273. This amount will be applied in Fiscal Year 2018.

5. **INN 13: *headspace* Implementation (Phase 2) – pending MHSOAC approval**
   The implementation phase of *headspace* has undergone stakeholder input and will be posted for 30-public comment from May 11-June10. This phase will provide an opportunity to explore the advantages and challenges of integrating behavioral health, physical health, and social support; develop and test a new financial model and serve a broad age range within the two centers. *headspace* will provide peer leadership and peer-to-peer mentorship opportunities for older youth to serve as mentors and role models for their younger peers; continuity of care for youth throughout adolescence, allowing them to work with their service providers over a long period of time; and opportunities for tracking longitudinal data and a longer term impact evaluation across the years a young person participates in services. The *headspace* project will also explore the unique needs of 18-25 year olds, which are distinct from 12-17 year olds, and the service/workflow components related to treating minors and involving parents/guardians. The target population for *headspace* is 12-25 year olds in Santa Clara County.

   The estimated costs for the four-year *headspace* implementation project is $15,875,675. Pending MHSOAC approval, the Department will apply $1,822,772 over the next 24 months to prepare and equip the centers with the required clinical and management staff and set up initial service contract agreements.

   INN Purpose: Increase access to services

   INN Approach: Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community.

   Goals/Objectives: BHSD seeks to achieve the following learning goals:
   1) Understand the efficacy of integrating multiple service components to increase youth access and engagement in behavioral health services;

2) Distinguish the barriers and facilitators to access headspace sites among youth who are currently engaged and not engaged in the integrated care model;
3) Understand how to effectively and successfully adopt a financial model that allows all youth to access integrated care services regardless of their ability to pay and insurance coverage;
4) Identify best approaches to include youth, family members, and community stakeholders in the development, implementation and evaluation of an integrated care model intended for young people; and
5) Learn the effects of the integrated model on clients' social-emotional and physical wellbeing, as well as life functioning.

The Department has identified an independent evaluator to conduct an evaluation plan to achieve the desired objectives and long-term measures.

Summary of INN Reversion Fund Allocation

		FY2018	FY2019	FY20
INN 10	Faith Based (2 years)		$300,413.00	$308,551.00
INN 11	Client Consumer (3 years)		$818,433.00	$841,486.00
INN 12	PERT (2 years)		$2,116,468.00	$1,572,043.00
INN 13	*headspace* Ramp Up*(8 months)*	$572,273.00		
	headspace Implementation*		$1,810,387.00	$12,385.00
	Total Annual	$572,273.00	$5,045,701.00	$2,734,465.00
		Total INN	**$8,352,439.00**	

**pending MHSOAC approval*

Appendices

Appendix A. Kickoff Meetings

Discussion Groups with BHSD Leadership

Santa Clara County MHSA Evaluation/Needs Assessment Focus Group Protocol (Professional Relationship)

Date	
FG Type/Size	
Location	
Facilitator	

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. We are with a consulting firm called Resource Development Associates and we are here to help the Santa Clara Behavioral Health Services Department with several projects that take a look at its MHSA-funded system, identify gaps and opportunities around crisis services, and seeks ways to both reduce locked psychiatric care and improve it for people who are there. I will be facilitating our talk today and _____ will take notes, but we won't use your name unless we specifically ask if we can use your comment as a quote.

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

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

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

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

Interview Guide

Introductions

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

Service Provider Experience

1. Tell us about your/your agency's role in mental health services or working with people with mental health needs.

   Mental Health Providers:

   a. How do people access your services?
   b. What services do you provide?
   c. How do you include the consumer's perspective?
   d. How do you include the input of family members?
   e. How do you know if your services are working?

   First Responders/Other Professionals:

   a. How do you become aware that a consumer has a mental health need?
   b. What services do you provide?
   c. What services or supports do you have access to?

2. What promotes collaboration between providers and agencies?
   a. What are the barriers to working to working together?

3. What works well in Santa Clara County's mental health system?
   Prompt: Crisis services and locked inpatient facilities

4. What challenges do you encounter when treating consumers?
   Prompt: Crisis services and locked inpatient facilities

Needs

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

Improvements

6. 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?

7. What do staff providers and programs need to improve their services?

Prompt: More culturally relevant training, staff training, recovery oriented services, and increasing service providers

8. What kind of training or technical assistance would be most helpful to meet the needs of consumers?

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

Thank you! Please remember to fill out the anonymous demographic survey!

Leadership Interviews

Santa Clara County Leadership KII Protocol

Date	
Name	
Role/Org	
Telephone #	
Interviewer	

Introduction

Hello, my name is _____, calling from Resource Development Associates for our scheduled interview. Is now still a good time to talk? Thank you for taking the time to talk with me today.

Santa Clara County Behavioral Health seeks to conduct an assessment where department staff and stakeholders – including consumers, family members, staff, contract providers, and emergency and medical personnel – come together to discover ways in which the existing mental health system could be strengthened. The purpose of this planning process is to strengthen crisis and community-based services in order to:

- Provide crisis services in the communities in which people live, at the time in which they are most needed, in a way that ensures personal and public safety.
- Ensure that people have access to the appropriate level of care, reserving locked and emergency settings for those who need it most while providing community-based alternatives that promote recovery.
- Maximize the opportunity to engage people in services before and after crises, ensuring smooth transitions for people to move between levels of care, and reduce the likelihood of future crisis events.

Resource Development Associates (RDA) is working with BHSD to facilitate their efforts to redesign their system of care. Today, we will be asking questions about the process of how consumers move through the mental health system, and then discuss what's working and what isn't: the strengths, needs, barriers, and gaps in service. Please feel free to ask for clarification about any questions I ask, or to add information you believe is relevant.

The information gathered from today – along with information collected from focus groups, key informant interviews, and quantitative data – will be used to assist in planning efforts.

Are there any questions before we get started?

General (All)

1. Please describe your position at your [dept/org].
2. Can you describe your [dept/org's] overall role providing care for people with serious mental illness?
3. Can you describe the specific ways in which your organization supports people with the highest levels of mental health need?

   Facilitator's note: Focus on the specific ways in which the interviewee's staff interacts with consumers in and out of crisis and/or hospital.

Crisis/Emergency System (All EXCEPT Margaret Obilor and Gabby Olivarez)

4. Please walk me through the process of how a consumer moves through your program/service, and what happens at each step.

   Prompts/areas for follow-up:
   - *a. How are staff **alerted** about incoming consumers?*
   - *b. What **information** are they given beforehand?*
   - *c. What do your staff do in **preparation** for attending to a mental health crisis?*
     - *i. If different, how does your staff work with someone **just stabilized** from a crisis?*
   - *d. What is involved in the **intake** process?*
   - *e. How do individuals experiencing crises (or just stabilized from one) **respond to your staff**?*
     - *i. What **de-escalation or further stabilization** techniques do your staff utilize?*
   - *f. How are **family members/loved ones** of individuals in crisis included in your process?*
     - *i. How do family members/loved ones **respond** to your staff?*
     - *ii. **How do family/loved ones help** (or not) when you are working with the client?*
   - *g. Where do you **refer or transport** individuals in/recently stabilized from MH crisis?*
     - *i. Under what **circumstances** do you refer or transport?*
     - *ii. What **considerations** do you make when making these referrals/transports?*
5. What training(s) do your staff currently receive for dealing with mental health crises?
   a. Is this training adequate?
   b. How prepared do you feel staff are to deal with mental health crises?
6. What are your experiences when billing for the mental health crises services your [org/dept] provides?

Long Term Placement (Margaret Obilor)

4. How is a consumer's level of care determined?
5. Please explain the process for placement in a long-term facility.

   Prompts/areas for follow-up:
   - *a. How is an initial **determination** made for placement?*
   - *b. **Whose input** is sought in the process?*
   - *c. How is a **facility identified** and what factors go into that identification?*
   - *d. What is the **process** for making the placement?*
6. What factors keep a consumer from being considered for transition out of a long-term facility?
7. Please explain the process for moving a consumer to a lower level of care from a long-term facility.

***Prompts/areas for follow-up**:*

a. *What indicates a consumer is **ready** to transition to a lower level of care?*
b. ***Whose input** is sought in the process?*
    i. *How are **families/loved ones** involved?*
c. *How is a transition **plan** formulated?*
d. *Who is responsible for ensuring that the transition plan is followed?*
e. *What **services** are needed for people to leave a long-term facility?*
    i. *How **available** are the services?*
f. *What are the **options** for a lower level of care from a long-term facility?*
g. *What **support** does your team provide in the transition?*
h. *Are there situations in which a transition to a lower level of care is **abandoned**?*
i. *How do you measure transition **success**?*

8. What training(s) have your staff had for transitioning individuals to a lower level of care?
    a. Is this training adequate?
    b. How prepared do you feel they are to deal with all aspects of a transition?

Crisis Residential (Gabby Olivarez)

4. Please walk me through the process of how a consumer moves through your program, and what happens at each step.

***Prompts/areas for follow-up**:*

a. *How are staff **alerted** about individuals in crisis in the ED/jail?*
b. *What **information** are you given beforehand?*
c. *What do your staff do in **preparation** for attending to a mental health crisis?*
    i. *If different, how does your staff work with someone **just stabilized** from a crisis?*
d. *How does your staff address/intervene an individual in crisis in the **ED**?*
e. *How does your staff address/intervene with an individual in crisis in **jail**?*
f. *What specific special considerations apply to consumers in the **ED vs. jail**?*
g. *How do individuals experiencing crises (or just stabilized from one) **respond to your staff**?*
    i. *What **de-escalation or further stabilization** techniques do your staff utilize?*
h. *How are **family members/loved ones** of individuals in crisis included in your process?*
    i. *How do family members/loved ones **respond** to your staff?*
    ii. ***How do family/loved ones help** (or not) when you are working with the client?*
i. *Where do you **refer or transport** individuals in/recently stabilized from MH crisis?*
    i. *Under what **circumstances** do you refer or transport?*
    ii. *What **considerations** do you make when making these referrals/transports?*

5. How is a consumer's level of care and the services they receive determined?
6. Please explain the process for addressing a repetitive crisis/jail cycle.
    a. What factors contribute to ending this cycle?
    b. What factors contribute to the cycle continuing?
7. What training(s) have your staff had for transitioning individuals to a lower level of care?
    a. Is this training adequate?
    b. How prepared do you feel they are to deal with all aspects of a transition?

Conclusion (All)

8. What are the strengths of the mental health system, particularly around crisis and those with the highest levels of need?
    a. What are the challenges?
    b. What's the most important problem to address?
    c. What ideas should be considered to solve these?
    d. What has already been tried, or should be avoided?
9. Do you have any additional comments or questions?

Thank you!

Appendix B. Needs Assessment

Consumer Focus Group Protocol

Santa Clara County MHSA Evaluation/Needs Assessment Focus Group Protocol (Consumer Experience)

Date	
FG Type/Size	
Location	
Facilitator	

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. We are with a consulting firm called Resource Development Associates and we are here to help the Santa Clara Behavioral Health Services Department with several projects that take a look at its MHSA-funded system, identify gaps and opportunities around crisis services, and seeks ways to both reduce locked psychiatric care and improve it for people who are there. I will be facilitating our talk today and _____ will take notes, but we won't use your name unless we specifically ask if we can use your comment as a quote.

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Interview Guide

Introductions

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

Experience

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

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

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

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

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

Needs

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

Improvements

12. 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?

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

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

Thank you! Please remember to fill out the anonymous demographic survey!

Provider Focus Groups

Santa Clara County MHSA Evaluation/Needs Assessment Focus Group Protocol (Consumer Experience)

Date	
FG Type/Size	
Location	
Facilitator	

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. We are with a consulting firm called Resource Development Associates and we are here to help the Santa Clara Behavioral Health Services Department with several projects that take a look at its MHSA-funded system, identify gaps and opportunities around crisis services, and seeks ways to both reduce locked psychiatric care and improve it for people who are there. I will be facilitating our talk today and _____ will take notes, but we won't use your name unless we specifically ask if we can use your comment as a quote.

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

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

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

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

Interview Guide

Introductions

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

Experience

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

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

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

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

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

Needs

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

Improvements

17. How could the County improve its mental health services?
    h. What should there be more of?
    i. What should be fixed?
    j. What should be created?

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

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

Thank you! Please remember to fill out the anonymous demographic survey!

Stakeholder Surveys: Consumers

Santa Clara County Consumer Survey

In the questions below, "Provider" means: doctor, psychiatrist, psychologist, therapist, counselor, case manager, practitioner, or any professional that provides mental health services.

1. The following questions are about your experience in getting help:

Obtaining Services	**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 in an accessible location.	❑	❑	❑	❑	❑
I get appointments in a reasonable period of time.	❑	❑	❑	❑	❑
I am seen by providers in a reasonable period of time.	❑	❑	❑	❑	❑

The following questions are about your experiences getting referred to other services:

Referrals	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Not Applicable**
Providers suggest services to me that may be helpful.	❑	❑	❑	❑	❑
The different services offered to me work together.	❑	❑	❑	❑	❑

The following questions are about your experiences communicating with providers/staff:

Communication	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Not Applicable**
The provider's customer service/reception staff are friendly.	❑	❑	❑	❑	❑
The provider's customer service/reception staff ask questions.	❑	❑	❑	❑	❑
The provider's customer service/reception staff are helpful.	❑	❑	❑	❑	❑
The provider advised me about consumer rights.	❑	❑	❑	❑	❑
I can complain to the provider without worry.	❑	❑	❑	❑	❑
The provider answers my questions.	❑	❑	❑	❑	❑
The provider explains my treatment options.	❑	❑	❑	❑	❑
The provider asks for my opinion.	❑	❑	❑	❑	❑
I, not the provider, decides treatment goals.	❑	❑	❑	❑	❑
I feel accepted by providers.	❑	❑	❑	❑	❑
I feel respected by providers.	❑	❑	❑	❑	❑

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**
Services are sensitive to my cultural background.	❑	❑	❑	❑	❑
Services are available in my preferred language.	❑	❑	❑	❑	❑
There are service providers that reflect my cultural/ethnic background.	❑	❑	❑	❑	❑

The following questions are about your experiences with recovery:

Collaboration	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Not Applicable**
The providers are responsive to my needs.	❑	❑	❑	❑	❑
The mental health services provided meet my needs.	❑	❑	❑	❑	❑
Services I receive are recovery focused.	❑	❑	❑	❑	❑
I have made progress because of services.	❑	❑	❑	❑	❑

2. LOGIC -- Were you asked if you wanted family to be part of your recovery plan?

☐ Yes → *IF "YES": Proceed to question 6a.*

☐ No → *IF "NO": Skip to question #7.*

6a. 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**
There are mental health educational resources for my family and friends.	❑	❑	❑	❑	❑
Providers answer questions from my family/friends.	❑	❑	❑	❑	❑
My family and friends feel comfortable interacting with mental health providers.	❑	❑	❑	❑	❑
With help from providers, I am better supported by my family and friends.	❑	❑	❑	❑	❑
Family members are meaningfully included in my recovery.	❑	❑	❑	❑	❑

3. How true are the following statements?

Satisfaction	**Not at all true**	**A little bit true**	**Mostly true**	**Very True**	**Not Applicable**
The mental health team provides me with **whatever** type of help needed.	❑	❑	❑	❑	❑
The mental health team provides as much help as needed, **when** I need it.	❑	❑	❑	❑	❑
Things the mental health team does for me are useful.	❑	❑	❑	❑	❑
The mental health team acts professionally.	❑	❑	❑	❑	❑
I'm satisfied with my mental health team.	❑	❑	❑	❑	❑

4. What are your greatest accomplishments as a result of mental health treatment?

- ☐ I have better relationships with family, children, friends, and others
- ☐ I can articulate thoughts, opinions, and needs better
- ☐ I feel more confident
- ☐ I have more control over my life
- ☐ I can make better decisions
- ☐ I can hold a job or go to school
- ☐ I can better take care of daily needs (e.g., clothing, bathing, eating, etc.)
- ☐ I can get and keep stable housing
- ☐ I can resolve existing legal problems and stay out of the legal system
- ☐ I am seeing a provider more regularly
- ☐ I have more control my treatment
- ☐ I take medication that works
- ☐ I am not a risk to myself or others
- ☐ I no longer have a substance abuse problem

5. What is the greatest accomplishment of the mental health system?

- ☐ Services work well together across providers and programs
- ☐ Services are coordinated with other systems (e.g., justice, child welfare, etc.)
- ☐ Services are driven by consumers and their families
- ☐ Diversity and language of providers/staff reflect the diversity of the population they serve
- ☐ Services are wellness, recovery, and resiliency focused
- ☐ Services engage and educate the community
- ☐ Services utilize a peer workforce in a meaningful way
- ☐ Service providers understand consumer needs
- ☐ Services and referrals are right for consumer needs
- ☐ Services are easy to access (e.g., easy to get appointments, convenient locations/times)
- ☐ Services have improved in quality over time
- ☐ Services help the people with the greatest needs
- ☐ People with less severe needs can get services quickly
- ☐ Crisis services are available to everyone who needs them
- ☐ Mobile crisis services are available to meet consumers where they are
- ☐ Residential facilities meet the needs of consumers

6. What are the greatest needs of the mental health system?

- ☐ Services do not work well together across providers and programs
- ☐ Services are not coordinated with other systems (e.g., justice, child welfare)
- ☐ Services are not driven by the consumers and their families
- ☐ Diversity and language of providers/staff does not reflect diversity of the population served
- ☐ Services not are wellness, recovery, and resiliency focused
- ☐ Services do not engage and educate the community
- ☐ Services do not utilize a peer workforce in a meaningful way
- ☐ Service providers do not understand consumer needs
- ☐ Services and referrals are not right for consumer needs
- ☐ Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours)
- ☐ Services have decreased in quality over time

What are the greatest needs of the mental health system? (continued from previous page)

- ☐ Services do not help the people with the greatest needs

- ☐ People with less severe needs cannot get services quickly
- ☐ Crisis services are not available to everyone who needs them
- ☐ Mobile crisis services are not available to meet consumers where they are
- ☐ Residential facilities do not meet the needs of consumers

7. LOGIC - While living in Santa Clara County, has your loved one received any mental health services in another county?

- ☐ Yes → *IF "YES": Proceed to questions 11a, 11b, and 11c.*
- ☐ No → *IF "NO": Skip to question #12.*

11a. While living in Santa Clara County, what crisis/hospital mental health services did you use <u>in other counties</u>?

- ☐ Did not use these services
- ☐ Hospital Emergency Room (ER)
- ☐ Psychiatric Emergency Services (PES)
- ☐ Urgent Care
- ☐ Mobile crisis unit
- ☐ Psychiatric health facility (e.g., Crestwood, Fremont Hospital)
- ☐ Other: _____

11b. While living in Santa Clara County, what mental health residential services did you use <u>in other counties</u>?

- ☐ Did not use these services
- ☐ Unlocked inpatient hospital
- ☐ Locked inpatient hospital
- ☐ Mental health rehabilitation center
- ☐ Crisis residential treatment
- ☐ Adult residential treatment/transitional residential treatment
- ☐ Substance Use Treatment Program
- ☐ Jail/Juvenile Hall
- ☐ Other: _____

11c. While living in Santa Clara County, what mental health outpatient services have you used <u>in other counties</u>?

- ☐ Did not use these services
- ☐ Other county Social Services clinics
- ☐ Other county CalWorks clinics
- ☐ Day program
- ☐ Wellness Center
- ☐ Primary Care Behavioral Health
- ☐ Private Practitioner Office
- ☐ Full Service Partnership
- ☐ Full Service Partnership Assertive Community Treatment

While living in Santa Clara County, what mental health outpatient services have you used in other counties? (continued from previous page)

- ☐ Intensive Case Management

- ☐ College/University Counseling Center
- ☐ Tele-services (i.e., services over the internet)
- ☐ Faith-based organization
- ☐ Community-based organization (e.g., nonprofit organization)
- ☐ Other: _____

8. Where have you been seen for crisis/hospital mental health services in Santa Clara County?

- ☐ Did not use these services
- ☐ Hospital Emergency Room (ER)
- ☐ Psychiatric Emergency Services (PES)
- ☐ Urgent Care
- ☐ Mobile crisis unit
- ☐ Psychiatric health facility (e.g., Crestwood, Fremont Hospital)
- ☐ Other: _____

9. Where have you gone for mental health residential services in Santa Clara County?

- ☐ Did not use these services
- ☐ Unlocked inpatient hospital
- ☐ Locked inpatient hospital
- ☐ Mental health rehabilitation center
- ☐ Crisis residential treatment
- ☐ Adult residential treatment/transitional residential treatment
- ☐ Substance Use Treatment Program
- ☐ Jail/Juvenile Hall
- ☐ Other: _____

10. Where have you gone for mental health outpatient services in Santa Clara County?

- ☐ Did not use these services
- ☐ County Social Services clinics (e.g., Downtown, Narvaez, Central Wellness, Evans Ln.)
- ☐ CalWorks clinics (e.g., Gardner, AACI, Unity Care, Catholic Charities)
- ☐ Day program
- ☐ Wellness Center
- ☐ Primary Care Behavioral Health
- ☐ Private Practitioner Office
- ☐ Full Service Partnership
- ☐ Full Service Partnership Assertive Community Treatment
- ☐ Intensive Case Management
- ☐ College/University Counseling Center
- ☐ Tele-services (i.e., services over the internet)
- ☐ Faith-based organization
- ☐ Community-based organization (e.g., nonprofit organization)
- ☐ Other: _____

11. 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?
   - ☐ Parent
   - ☐ Partner
   - ☐ Child
   - ☐ Other Family Member
   - ☐ Friend
   - ☐ None of the Above

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
   - ☐ Veterans 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
   - ☐ Milpitas
   - ☐ Monte Sereno
   - ☐ Morgan Hill
   - ☐ Mountain View
   - ☐ Palo Alto
   - ☐ San Jose
   - ☐ Santa Clara
   - ☐ Saratoga
   - ☐ Sunnyvale

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

8. Is English your preferred language?
   ☐ Yes ☐ No
   If "no," what is your preferred language?
   _____

Thank you for taking our survey!

Stakeholder Surveys: Family Members and Loved Ones

Santa Clara County Family/Loved One Survey

In the questions below, "Provider" means: doctor, psychiatrist, psychologist, therapist, counselor, case manager, practitioner, or any professional that provides mental health services.

12. The following questions are about your loved one's experience in getting help:

Obtaining Services	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Not Applicable**
I know where to **go** if my loved one needs mental health services.	❑	❑	❑	❑	❑
I know who to **call** if my loved one needs mental health services.	❑	❑	❑	❑	❑
Mental health services are in an accessible location for my loved one.	❑	❑	❑	❑	❑
My loved one was able get an appointment in a reasonable period of time.	❑	❑	❑	❑	❑
My loved one was seen by a provider in a reasonable period of time.	❑	❑	❑	❑	❑

The following questions are about your loved one's experiences getting referred to other services:

Referrals	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Not Applicable**
Providers suggest services to my loved one that may be helpful.	❑	❑	❑	❑	❑
The different services offered to my loved one work together.	❑	❑	❑	❑	❑

The following questions are about your loved one's experiences communicating with providers/staff:

Communication	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Not Applicable**
The provider's customer service/reception staff are friendly.	❑	❑	❑	❑	❑
The provider's customer service/reception staff ask questions.	❑	❑	❑	❑	❑
The provider's customer service/reception staff are helpful.	❑	❑	❑	❑	❑
The provider advised my loved one about consumer rights.	❑	❑	❑	❑	❑
My loved one can complain to the provider without worry.	❑	❑	❑	❑	❑

Communication	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
The provider answers my loved one's questions.	❑	❑	❑	❑	❑
The provider explains my loved one's treatment options.	❑	❑	❑	❑	❑
The provider asks for my loved one's opinion.	❑	❑	❑	❑	❑
My loved one, not the provider, decides treatment goals.	❑	❑	❑	❑	❑
My loved one feels accepted by providers.	❑	❑	❑	❑	❑
My loved one feels respected by providers.	❑	❑	❑	❑	❑

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
Services are sensitive to my loved one's cultural background.	❑	❑	❑	❑	❑
Services are available in my loved one's preferred language.	❑	❑	❑	❑	❑
There are service providers that reflect my loved one's cultural/ethnic background.	❑	❑	❑	❑	❑

The following questions are about your loved one's experiences with recovery:

Collaboration	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
Providers are responsive to my loved one's needs.	❑	❑	❑	❑	❑
The mental health services provided meet my loved one's needs.	❑	❑	❑	❑	❑
Services my loved one receives are recovery focused.	❑	❑	❑	❑	❑
My loved one has made progress because of services.	❑	❑	❑	❑	❑

13. LOGIC - Were you asked if you wanted to be part of your loved one's recovery plan?

☐ Yes → *IF "YES": Proceed to questions 6a.*

☐ No → *IF "NO": Skip to question #7.*

6a. Please describe how you are part of your loved one's mental health care.

Family/Relationships	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
There are mental health educational resources for me and my loved one's family and friends.	❑	❑	❑	❑	❑
Providers answer questions from me and my loved one's family and friends.	❑	❑	❑	❑	❑
I and my loved one's family and friends feel comfortable interacting with mental health providers.	❑	❑	❑	❑	❑

Family/Relationships	Not at all true	A little bit true	Mostly true	Very true	Not Applicable
With help from providers, my loved one is better supported by me, family, and friends.	❑	❑	❑	❑	❑
Family members are meaningfully included in my loved one's recovery.	❑	❑	❑	❑	❑

14. How true are the following statements?

Satisfaction	Not at all true	A little bit true	Mostly true	Very True	Not Applicable
The mental health team provides my loved one with **whatever** type of help needed.	❑	❑	❑	❑	❑
The mental health team provides as much help as needed, **when** my loved one needs it.	❑	❑	❑	❑	❑
The things the mental health team does for my loved one are useful.	❑	❑	❑	❑	❑
The mental health team acts professionally.	❑	❑	❑	❑	❑
I'm satisfied with my loved one's mental health team.	❑	❑	❑	❑	❑

15. What are your loved one's greatest accomplishments as a result of mental health treatment?

- ☐ My loved one has better relationships with family, friends, children, and others
- ☐ My loved one can articulate thoughts, opinions, and needs better
- ☐ My loved one feels more confident
- ☐ My loved one has more control over his/her/their life
- ☐ My loved one can make better decisions
- ☐ My loved one can hold a job or go to school
- ☐ My loved one can better take care of daily needs (e.g., clothing, bathing, eating, etc.)
- ☐ My loved one can get and keep stable housing
- ☐ My loved one can resolve existing legal problems and stay out of the legal system
- ☐ My loved one is seeing a provider more regularly
- ☐ My loved one has more control over his/her/their treatment
- ☐ My loved one takes medication that works
- ☐ My loved one is not a risk to themselves or others
- ☐ My loved one no longer has a substance abuse problem

16. What is the greatest accomplishment of the mental health system?

- ☐ Services work well together across providers and programs
- ☐ Services are coordinated with other systems (e.g., justice, child welfare, etc.)
- ☐ Services are driven by consumers and their families
- ☐ Diversity and language of providers/staff reflect the diversity of the population they serve
- ☐ Services are wellness, recovery, and resiliency focused
- ☐ Services engage and educate the community
- ☐ Services utilize a peer workforce in a meaningful way
- ☐ Service providers understand consumer needs
- ☐ Services and referrals are right for consumer needs

- ☐ Services are easy to access (e.g., ease of getting appointments, convenient locations/times)
- ☐ Services have improved in quality over time
- ☐ Services help the people with the greatest needs
- ☐ People with less severe needs can get services quickly
- ☐ Crisis services are available to everyone who needs them
- ☐ Mobile crisis services are available to meet consumers where they are
- ☐ Residential facilities meet the needs of consumers

17. What are the greatest needs of the mental health system?

- ☐ Services do not work well together across providers and programs
- ☐ Services are not coordinated with other systems (e.g., justice, child welfare)
- ☐ Services are not driven by the consumers and their families
- ☐ Diversity and language of providers/staff does not reflect the diversity of population served
- ☐ Services not are wellness, recovery, and resiliency focused
- ☐ Services do not engage and educate the community
- ☐ Services do not utilize a peer workforce in a meaningful way
- ☐ Service providers do not understand consumer needs
- ☐ Services and referrals are not right for consumer needs
- ☐ Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours)
- ☐ Services have decreased in quality over time
- ☐ Services do not help the people with the greatest needs
- ☐ People with less severe needs cannot get services quickly
- ☐ Crisis services are not available to everyone who needs them
- ☐ Mobile crisis services are not available to meet consumers where they are
- ☐ Residential facilities do not meet the needs of consumers

18. LOGIC - While living in Santa Clara, has your loved one received any mental health services in another county?

- ☐ Yes → *IF "YES": Proceed to questions 11a, 11b, and 11c.*
- ☐ No → *IF "NO": Skip to question #12.*

11a. While living in Santa Clara County, what crisis/hospital mental health services did your loved one receive <u>in another county</u>?

- ☐ Did not use these services
- ☐ Hospital Emergency Room (ER)
- ☐ Psychiatric Emergency Services (PES)
- ☐ Urgent Care
- ☐ Mobile crisis unit
- ☐ Psychiatric health facility (e.g., Crestwood, Fremont Hospital)
- ☐ Other: _____
- ☐ I know my loved one used these services, but not which ones

11b. While living in Santa Clara County, what mental health residential services did your loved one receive <u>in another county</u>?

- ☐ Did not use these services
- ☐ Unlocked inpatient hospital
- ☐ Locked inpatient hospital

11b. While living in Santa Clara County, what mental health residential services did your loved one receive <u>in another county</u>?

- ☐ Mental health rehabilitation center
- ☐ Crisis residential treatment
- ☐ Adult residential treatment/transitional residential treatment
- ☐ Substance Use Treatment Program
- ☐ Jail/Juvenile Hall
- ☐ Other: _____
- ☐ I know my loved one used these services, but not which ones

11c. While living in Santa Clara County, what mental health outpatient services has your loved one received <u>in another county</u>?

- ☐ Did not use these services
- ☐ Other county Social Services clinics
- ☐ Other county CalWorks clinics
- ☐ Day program
- ☐ Wellness Center
- ☐ Primary Care Behavioral Health
- ☐ Private Practitioner Office
- ☐ Full Service Partnership
- ☐ Full Service Partnership Assertive Community Treatment
- ☐ Intensive Case Management
- ☐ College/University Counseling Center
- ☐ Tele-services (i.e., services over the internet)
- ☐ Faith-based organization
- ☐ Community-based organization (e.g., nonprofit organization)
- ☐ Other: _____
- ☐ I know my loved one used these services, but not which ones

19. Where has your loved one been seen for crisis/hospital mental health services <u>in</u> Santa Clara County?

- ☐ Did not use these services
- ☐ Hospital Emergency Room (ER)
- ☐ Psychiatric Emergency Services (PES)
- ☐ Urgent Care
- ☐ Mobile crisis unit
- ☐ Psychiatric health facility (Crestwood, Fremont Hospital)
- ☐ Other: _____
- ☐ I know my loved one used these services, but not which ones

20. Where has your loved one gone for mental health residential services in Santa Clara County?

- ☐ Did not use these services
- ☐ Unlocked inpatient hospital
- ☐ Locked inpatient hospital
- ☐ Mental health rehabilitation center
- ☐ Crisis residential treatment
- ☐ Adult residential treatment/transitional residential treatment
- ☐ Substance Use Treatment Program
- ☐ Jail/Juvenile Hall
- ☐ Other: _____
- ☐ I know my loved one used these services, but not which ones

21. Where has your loved one gone for mental health outpatient services in Santa Clara County?

- ☐ Did not use these services
- ☐ County Social Services clinics (e.g., downtown clinic, Narvaez, Central Wellness, Evans Ln)
- ☐ CalWorks clinics (e.g., Gardner, AACI, Unity Care, Catholic Charities)
- ☐ Day program
- ☐ Wellness Center
- ☐ Primary Care Behavioral Health
- ☐ Private Practitioner Office
- ☐ Full Service Partnership
- ☐ Full Service Partnership Assertive Community Treatment
- ☐ Intensive Case Management
- ☐ College/University Counseling Center
- ☐ Tele-services (i.e., services over the internet)
- ☐ Faith-based organization
- ☐ Community-based organization (e.g., nonprofit organization)
- ☐ Other: _____
- ☐ I know my loved one used these services, but not which ones

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

Please write your comments in the box below:

Demographic Form

9. Do you identify as (select all that apply):
   - ☐ Parent of consumer
   - ☐ Partner of consumer
   - ☐ Child of consumer
   - ☐ Other Family Member of consumer
   - ☐ Friend of consumer
   - ☐ Service Provider
   - ☐ Consumer

10. 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
   - ☐ Veterans or Veterans Organizations
   - ☐ Provider of mental health services
   - ☐ Provider of alcohol and other drug services
   - ☐ Medical or health care organization
   - ☐ Other:_____

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

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

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

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

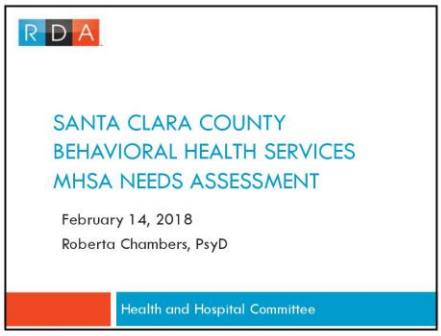
15. Please indicate your gender:
   - ☐ Female
   - ☐ Male
   - ☐ Transmale/transman
   - ☐ Transfemale/transwoman
   - ☐ Intersex
   - ☐ Genderqueer
   - ☐ Prefer not to answer
   - ☐ Other: _____

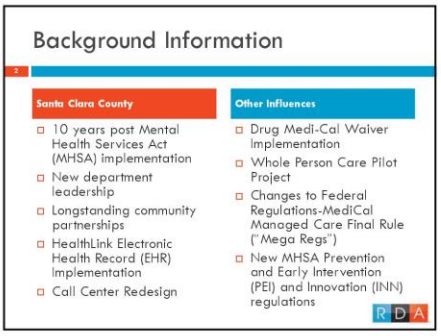
16. Is English your preferred language?
   ☐ Yes ☐ No
   If "no," what is your preferred language?
   _____

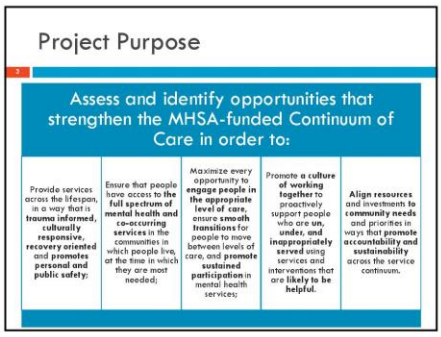
Thank you for taking our survey!

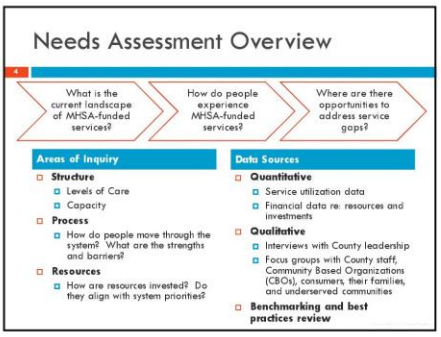
Needs Assessment Presentations

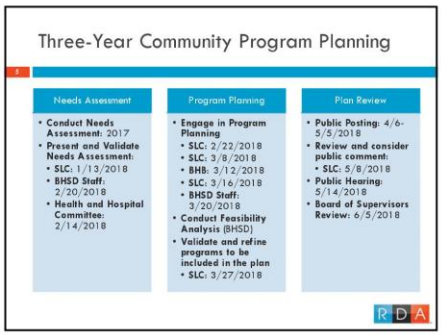
5/4/2018

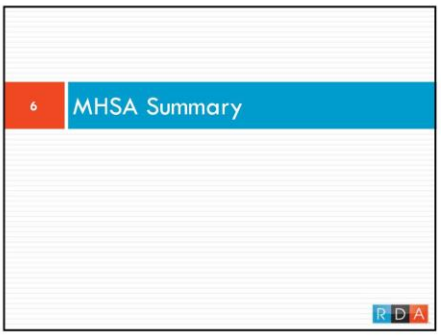












Community Services and Supports (CSS)

	Category	Programs	Persons Served	Budget Allocation
CSS in Santa Clara County FY15-16 MHSA Expense: $41.6 million Consumers served in FY15-16: 15,352	Children	Children's Full Service Partnership (FSP)	5021	$3,131,024
		Child System Development		
		Children and Family Behavioral Health Service Redesign		
	Youth	Transitional Aged Youth (TAY) FSP	2166	$2,416,975
		TAY Behavioral Health Service Redesign		
	Adults	Adult FSP	7355	$29,402,714
		Adult Wellness and Recovery Services		
		Criminal Justice FSP		
		Urgent Care & Central Wellness and Benefits Center		
		Self-Help Development and Family Support		
	Older Adults	Older Adult FSP	810	$1,496,234
		Older Adult Behavioral Health Services		
	Housing	Housing Options Initiative	N/A	$1,888,738
	Other	Learning Partnership, Decision Support, Planning/Admin	N/A	$3,258,587

Prevention and Early Intervention (PEI)

PEI Categories
- Prevention
- Early Intervention
- Access and Linkage to Treatment
- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Stigma and Discrimination Program
- Suicide Prevention

PEI in Santa Clara County FY15-16 MHSA Expense: $15.5 million Consumers served since FY11-12: 41,013	Category	Programs	Budget Allocation
	Stigma Discrimination and Reduction (SDR)	Community Engagement and Capacity Building for Reducing Stigma and Discrimination	$1,569,356
	Prevention	Strengthening Families and Children	$8,826,588
	Early Intervention	Interventions for Individuals Experiencing the Onset of Serious Psychiatric Illness (REACH)	$746,675
	Prevention	Primary Care/Behavioral Health Integration (PCBHI) for Adults and Older Adults	$3,476,591
	Suicide Prevention	Suicide Prevention Initiative	$911,719

MHSA Implementation

MHSA Accomplishments
- Created **Full Service Partnerships** for children, youth, adults, and older adults with intensive mental health (MH) issues
- Placed **mental health services where children already are** through school-linked services
- Strengthened partnerships with the **faith-based, physical health, and justice communities**
- Prioritized **un, under, and inappropriately served** consumers and families

Areas for Growth
- Aligning **capacity to demand**
- Prioritizing those with the **highest level of need** and determining **appropriate level of care and care transitions**
- Working to **promote and sustain service engagement**
- Responding to **new PEI regulations**
- Improving **coordination, collaboration, and accountability**

10 Children, Youth, and Families

Children's Service Landscape

Children's services exist in a complex set of legislation with a variety of stakeholders

- SCC BHSD provided services for **11,950 children and youth**, including:
  - Kid Connections 0-5
  - School-Linked Services
  - Katie A. and Juvenile Justice MH services
  - FSP and other outpatient mental health services
  - Crisis and emergency services

Level of Care Analysis

- Children's FSP
  - 185 children served
  - $22,162 annual cost per child
- TAY FSP
  - 277 youth served
  - $15,700 annual cost per youth

Crisis and Emergency Services	Individuals Served	Total Service Encounters
Emergency Psychiatric Services	816	1,052
Mental Health Urgent Care	33	76
Crisis Stabilization Unit	380	557
Inpatient Hospitalization	363	557

- Children's FSP could benefit from ~100 additional spots.
  - Annual investments and service provision are in alignment with other jurisdictions.
- TAY FSP could benefit from additional capacity and resources.
  - There is a need for ~100 additional TAY spots.
  - Per person investments should be approximately ~ 22-25K.
  - There is a need to clarify the service model for TAY FSP.

Children's Findings and Recommendations

13

- There's a **variety of specialized services** available for child welfare and justice-involved youth as well as co-occurring and eating disorder-specific services.
- In light of unfolding policy changes, it may be important to **ensure that children and families are able to easily access timely services** that are likely to be helpful, such as school-linked services.
- Where there are a lot of quality services, there is a need to **strengthen care coordination and maintain continuity of care** across providers and systems.

RDA

14 Adults and Older Adults

RDA

Adult/Older Adult System of Care (SOC) Findings

15

SCC BHSD serves approximately 16,500 adults and older adults annually across a variety of levels of care. Approximately 25% of adults and older adults only access crisis services.	Key Findings	Recommendations
	There is a group of consumers who **cycle in and out of Emergency Psychiatric Services (EPS), hospital, and jail** and do not connect to ongoing services. Community-based programs, specifically FSP, are not able to adequately **serve people with the highest needs.** The "No Wrong Door" approach creates **barriers to access, level of care determinations, and oversight.**	Targeted Outreach and Engagement Teams MH Urgent Care /MHUC) Redesign Full Service Partnership Build FSP capacity (500 additional consumers) Increase per person funding ($25-30,000/year) Implement 2 Assertive Community Treatment (ACT) Teams (200 consumers) Adult Residential Treatment 2 Institution of Mental Disease (IMD) Step-down/Diversion 1 Co-Occurring Treatment

Older Adult Issues

16

Findings	Recommendations
Isolation continues to be a primary issue for older adults as well as **caregiver fatigue.**	Strengthen capacity to provide services in the home that focus on **preserving independence and supporting caregivers.**
Intersections between **depression, early dementia, and physical health concerns** make serving older adults more challenging, specifically in residential environments.	Develop additional capacity for **integrated health and behavioral health care** specifically for older adults.
Many older adults are **seeking services in culture-specific settings.**	Include older adult **socialization and home visiting programs** in PEI component and culture-specific services.

RDA

17 Specialty Populations

RDA

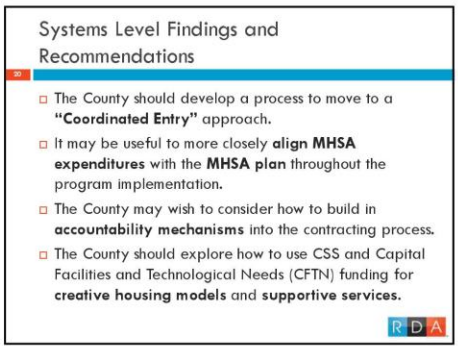
Specialty Populations

18

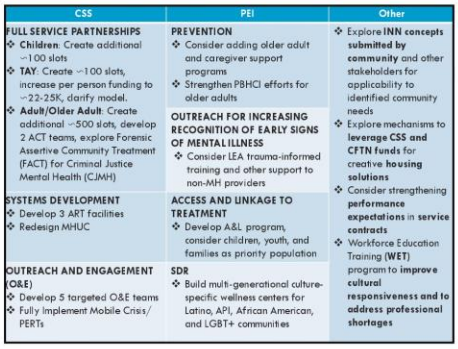
Overreliance on 5150 and crisis response
+
Access and service authorization processes
+
Stigma, discrimination, current events and political climate
↓
Reasonable mistrust in government
↓
Reduced service access and increased likelihood of crisis

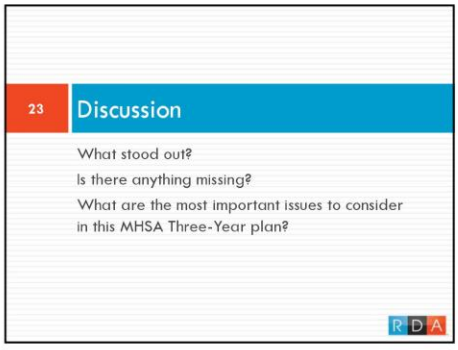
- **Promote safe and sustained engagement amongst un, under, and inappropriately served groups**
  - Develop culture-specific Wellness Centers for Latino, African American, Asian/Pacific Islander (API), and LGBT communities
- **Consider ways to minimize trauma related to crisis response**
  - Trauma-informed police training for law enforcement agency (LEA) partners
  - Mobile crisis/psychiatric emergency response teams (PERTs)
  - LEA support for differential response
  - Trans-positive protocols in gendered settings
- **Increase cultural competency throughout system**
  - Provide culture-specific training throughout system
  - Identify experts to receive referrals and provide consultation, including services that are trans-positive and available to LGBT adults and older adults


19
Other Recommendations
RDA


Systems Level Findings and Recommendations
20
The County should develop a process to move to a "Coordinated Entry" approach.
It may be useful to more closely align MHSA expenditures with the MHSA plan throughout the program implementation.
The County may wish to consider how to build in accountability mechanisms into the contracting process.
The County should explore how to use CSS and Capital Facilities and Technological Needs (CFTN) funding for creative housing models and supportive services.
RDA


21
Consolidated Recommendations
RDA


CSS
FULL SERVICE PARTNERSHIPS
Children: Create additional ~100 slots
TAY: Create ~100 slots, increase per person funding to ~22-25K, clarify model.
Adult/Older Adult: Create additional ~500 slots, develop 2 ACT teams, explore Forensic Assertive Community Treatment (FACT) for Criminal Justice Mental Health (CJMH)
SYSTEMS DEVELOPMENT
Develop 3 ART facilities
Redesign MHUC
OUTREACH AND ENGAGEMENT (O&E)
Develop 5 targeted O&E teams
Fully implement Mobile Crisis/ PERTs
PEI
PREVENTION
Consider adding older adult and caregiver support programs
Strengthen PBHCI efforts for older adults
OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS
Consider LEA trauma-informed training and other support to non-MH providers
ACCESS AND LINKAGE TO TREATMENT
Develop A&L program, consider children, youth, and families as priority population
SDR
Build multi-generational culture-specific wellness centers for Latino, API, African American, and LGBT+ communities
Other
Explore INN concepts submitted by community and other stakeholders for applicability to identified community needs
Explore mechanisms to leverage CSS and CFTN funds for creative housing solutions
Consider strengthening performance expectations in service contracts
Workforce Education Training (WET) program to improve cultural responsiveness and to address professional shortages


23
Discussion
What stood out?
Is there anything missing?
What are the most important issues to consider in this MHSA Three-Year plan?
RDA

Appendix C. Strategy Development

Stakeholder Leadership Committee Outreach and Orientation

FY18-FY20 MHSA Three-Year Draft Plan:
Community Planning Process
BHB Meeting: June 11, 2018
BOS Meeting: June 19, 2018

SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

Needs Assessment Presentations	Community Program Planning (CPP)	Plan Review *Revised*
New 2018 MHSA SLC Orientation **Monday, February 12, 2018 3:00pm – 5:00pm COMPLETED** Santa Clara Valley Medical Center Valley Specialty Center Conference Room BQ160 751 S Bascom Ave, San Jose, CA 95128 • Overview of CPPP and Timeline • Review MHSA Components • Roles and Responsibilities • Develop Member Agreements	**MHSA SLC Planning Meeting** **Thursday, February 22, 2018 2:00pm – 5:00pm COMPLETED** BHSD Administration 828 S. Bascom Avenue, Suite 200, Large Conference Room, San Jose, CA 95128 • Program development • MHSA funding categories	**MHSA SLC Plan Review** **Tuesday, May 8, 2018 3:00pm – 5:00pm** Learning Partnership, TR 3 1075 E. Santa Clara Street, 2nd Floor San José, CA 95116 • FY18-20 MHSA Program and Expenditure DRAFT Plan high level review in preparation for 30-day public posting
MHSA SLC launches FY18-20 MHSA Three-Year Planning Process **Tuesday, February 13, 2018 3:00pm – 5:00pm COMPLETED** Learning Partnership, TR 4 1075 E. Santa Clara Street, 2nd Floor San José, CA 95116 • MHSA needs assessment (RDA) • Gaps analysis and program needs review • Recommendations	**MHSA SLC Planning Meeting COMPLETED** **Thursday, March 8, 2018 2:00pm – 5:00pm** Charcot, 2310 North 1st St. San Jose, Ca 95131 (Room 1) • Program development and refinement • MHSA Budget forecast	**30-Day Draft Plan Public Review** **Friday, May 11 – Sunday, June 10** • Copies will be distributed at Community Centers, County Office of Education, Learning Partnership, and County Public Libraries for stakeholder review and input. • Offers an opportunity for public review and community input. • Utilize comment form found at: www.sccbhsd.org/mhsa and email completed form to: evelyn.tirumalai@hhs.sccgov.org
****MHSA Needs Assessment presentation to the Health and Hospital Committee**	****Behavioral Health Board Presentation of Preliminary Plan (RDA) COMPLETED** **Monday, March 12, 2018**	**BHB Public Hearing of the Draft Plan as required by MHSA Regulations** **Monday, June 11, 2018 10:45am – 11:45am** *Lunch Provided*

<table>
<tr>
<td rowspan="2">February 14, 2018 10:00am
COMPLETED
70 W Hedding St., San Jose
• Abbreviated presentation to the BOS – HCC of MHSA findings and recommendations
• Community Program Planning process and next steps
• Conducted by Roberta Chambers, PsyD</td>
<td>12:00pm – 12:45/1:00pm
Learning Partnership, TR 4
1075 E. Santa Clara Street, 2nd Floor
San José, CA 95116
• Presentation on preliminary F&C/AOA Programs and Services
• Public input</td>
<td>Learning Partnership, TR 4
1075 E. Santa Clara Street, 2nd Floor
San José, CA 95116
• Request BHB to take a motion to approve the FY18-20 MHSA Three-Year Draft Plan</td>
</tr>
<tr>
<td>MHSA SLC Planning Meeting
COMPLETED
Friday, March 16, 2018 2:00pm – 5:00pm
Santa Clara Valley Medical Center
Valley Specialty Center
Conference Room BQ160
751 S Bascom Ave, San Jose, CA 95128
• Program development and refinement
• Innovations/Housing presentation</td>
<td rowspan="2">Request Board of Supervisor (BOS) approval of the Draft Plan
Tuesday, June 19, 2018
70 W. Hedding Street
San Jose, CA 95110
• Request BOS to approve/adopt FY18-20 MHSA Three-Year Draft Plan and authorize BHSD to submit plan to spend MHSA funds subject to reversion in accordance with WIC Section 5847 (a)

For more information contact:
Evelyn Castillo Tirumalai, MPH
Mental Health Services Act (MHSA) Coordinator
408-885-5785 office
evelyn.tirumalai@hhs.sccgov.org

Rev 3.28.18</td>
</tr>
<tr>
<td>**All Managers Meeting (BHSD staff)
Tuesday, February 20, 2018 1:00pm – 2:00pm COMPLETED
• Needs assessment presentation to county leadership (executives/managers)

**SLC member attendance not required</td>
<td>**All Managers Meeting (BHSD staff)
Tuesday, March 20, 2018 1:00pm – 3:00pm COMPLETED
• Programs and Services follow-up (executives/managers)

MHSA SLC Planning Meeting
COMPLETED
Tuesday, March 27, 2018 2:00pm – 5:00pm
Learning Partnership, TR 3
1075 E. Santa Clara Street, 2nd Floor
San José, CA 95116
• Present all programs/services included in the MHSA Three Year Plan
• Program validation meeting</td>
</tr>
</table>

WELLNESS • RECOVERY • RESILIENCE

MENTAL HEALTH SERVICES ACT (MHSA)
STAKEHOLDER LEADERSHIP COMMITTEE (SLC) ORIENTATION
FEBRUARY 12, 2018

SANTA CLARA COUNTY
Behavioral Health Services

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
- Meets the criteria and goals established by the State Mental Health Services Oversight and Accountability Commission (MHSOAC)

AGENDA

I. Welcome & Introductions
II. What is MHSA?
III. MHSA Components
IV. Review of Community Program Planning (CPP) Process
V. Roles and Responsibilities
VI. Other

Refer to pre-orientation survey

CHECK-IN QUESTION

Please share:

- Name
- What is something you hope to learn during this planning process?
- What is something you hope to contribute to this planning process?

WHAT IS THE MENTAL HEALTH SERVICES ACT (MHSA)?

The Mental Health Services Act (MHSA) is 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.

The purpose and intent of the MHSA is to emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

1. Suicide
2. Incarcerations
3. School failure or dropout
4. Unemployment
5. Prolonged suffering
6. Homelessness
7. Removal of children from their homes

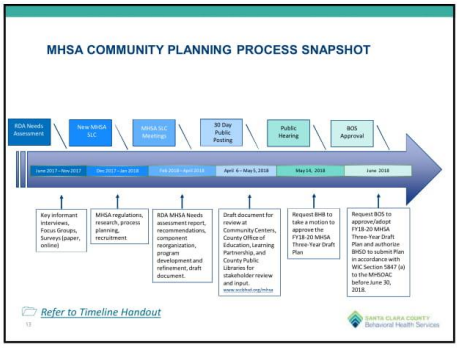
Source: California Welfare and Institutions Code (WIC) § 5840 (d)

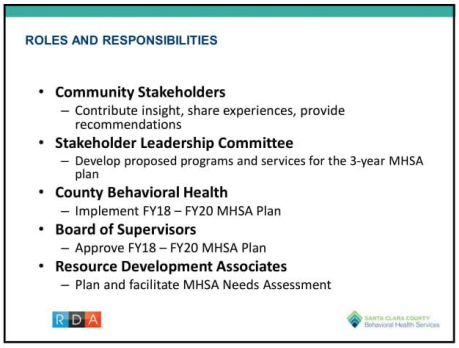
MHSA CORE PRINCIPLES

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)

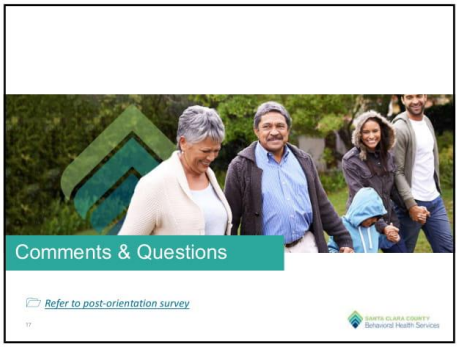
Refer to RDA Handout


MHSA COMMUNITY PLANNING PROCESS SNAPSHOT
RDA Needs Assessment
New MHSA SLC
MHSA SLC Meetings
30 Day Public Posting
Public Hearing
BOS Approval
Key informant interviews, Focus Groups, Surveys (paper, online)
MHSA regulations, research, process planning, recruitment.
RDA MHSA Needs assessment report, recommendations, component reorganization, program development and refinement, draft document.
Draft document for review at Community Centers, County Office of Education, Learning Partnership, and County Public Libraries for stakeholder review and input.
Request BHB to take a motion to approve the FY18-20 MHSA Three-Year Draft Plan
Request BOS to approve/adopt FY18-20 MHSA Three-Year Draft Plan and authorize BHSD to submit Plan in accordance with WIC Section 5847 (a) to the MHSOAC before June 30, 2018.
Refer to Timeline Handout

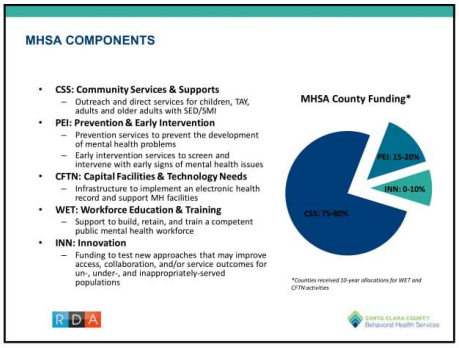

ROLES AND RESPONSIBILITIES
Community Stakeholders
– Contribute insight, share experiences, provide recommendations
Stakeholder Leadership Committee
– Develop proposed programs and services for the 3-year MHSA plan
County Behavioral Health
– Implement FY18 – FY20 MHSA Plan
Board of Supervisors
– Approve FY18 – FY20 MHSA Plan
Resource Development Associates
– Plan and facilitate MHSA Needs Assessment
RDA

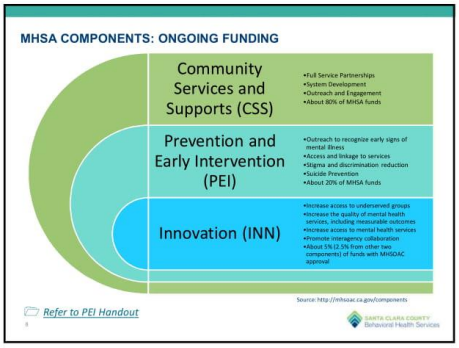

REPRESENTATIVE STAKEHOLDER LEADERSHIP COMMITTEE
Foundational Agreements for Planning
a group activity

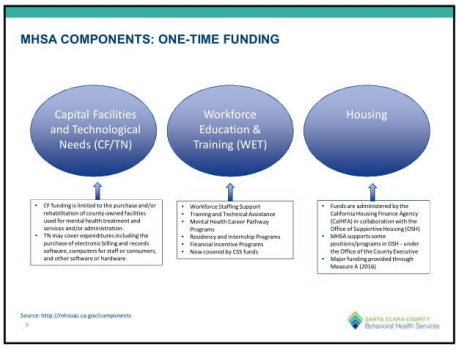

TOMORROW'S MEETING OBJECTIVES
The MHSA SLC will:
Develop a deeper understanding of the strengths and needs in the County.
Identify and prioritize the most important problems to solve.
Create goals and objectives for the 2017-2020 MHSA plan.
RDA

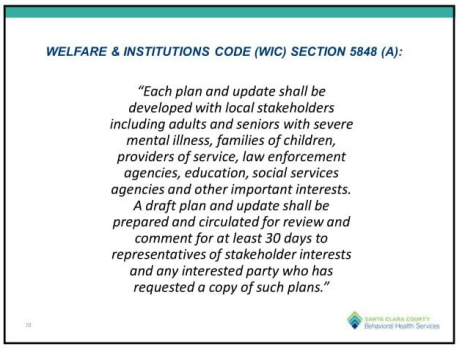

Comments & Questions
Refer to post-orientation survey

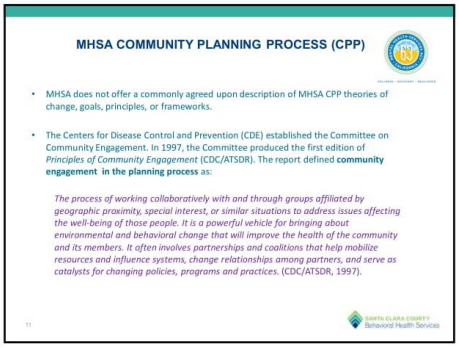

THANK YOU !
Evelyn Tirumalai, MPH – MHSA Coordinator
408-885-5785 office
408-401-6117 mobile
evelyn.tirumalai@hhs.sccgov.org
Lily Vu, MSW – MHSA INN Coordinator
(408) 885-3983
Lily.Vu@hhs.sccgov.org
www.sccbhsd.org/mhsa


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
MHSA County Funding*
PEI: 15-20%
INN: 0-10%
CSS: 75-80%
*Counties received 10-year allocations for WET and CFTN activities
R D A
SANTA CLARA COUNTY Behavioral Health Services


MHSA COMPONENTS: ONGOING FUNDING
Community Services and Supports (CSS)
•Full Service Partnerships
•System Development
•Outreach and Engagement
•About 80% of MHSA funds
Prevention and Early Intervention (PEI)
•Outreach to recognize early signs of mental illness
•Access and linkage to services
•Stigma and discrimination reduction
•Suicide Prevention
•About 20% of MHSA funds
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
•About 5% (2.5% from other two components) of funds with MHSOAC approval
Source: http://mhsoac.ca.gov/components
Refer to PEI Handout
SANTA CLARA COUNTY Behavioral Health Services

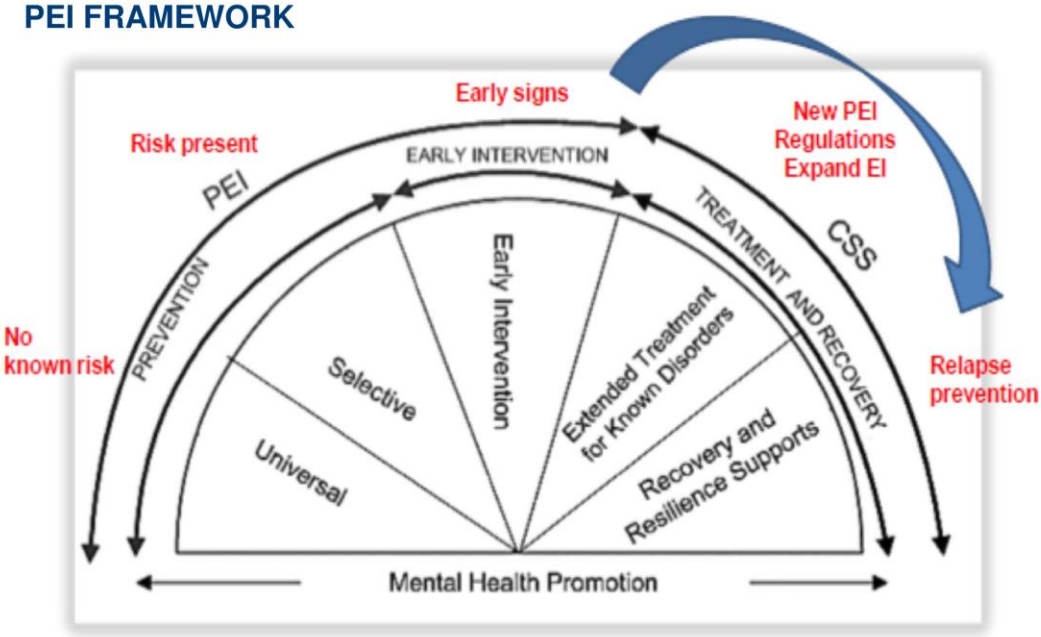

MHSA COMPONENTS: ONE-TIME FUNDING
Capital Facilities and Technological Needs (CF/TN)
CF funding is limited to the purchase and/or rehabilitation of county-owned facilities used for mental health treatment and services and/or administration.
TN may cover expenditures including the purchase of electronic 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
Financial 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)
Source: http://mhsoac.ca.gov/components
SANTA CLARA COUNTY Behavioral Health Services


WELFARE & INSTITUTIONS CODE (WIC) SECTION 5848 (A):
"Each plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, providers of service, law enforcement agencies, education, social services agencies and other important interests. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of such plans."
SANTA CLARA COUNTY Behavioral Health Services


MHSA COMMUNITY PLANNING PROCESS (CPP)
MHSA does not offer a commonly agreed upon description of MHSA CPP theories of change, goals, principles, or frameworks.
The Centers for Disease Control and Prevention (CDE) established the Committee on Community Engagement. In 1997, the Committee produced the first edition of Principles of Community Engagement (CDC/ATSDR). The report defined community engagement in the planning process as:
The process of working collaboratively with and through groups affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral change that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs and practices. (CDC/ATSDR, 1997).
SANTA CLARA COUNTY Behavioral Health Services


MHSA COMMUNITY PLANNING PROCESS
Results
What we have
Remaining Needs
Evaluate
SANTA CLARA COUNTY Behavioral Health Services

PEI FRAMEWORK



Source: Adapted from Mrazek and Haggerty (1994) and Commonwealth of Australia (2000)

SANTA CLARA COUNTY Behavioral Health Services

MHSA SLC Orientation and Training

Valley Specialty Center

Please check all box (es) that apply to you:

❑ Consumer ❑ Family Member ❑ Parent ❑ Professional

1. I understand the following MHSA Components:

	Agree	Not Sure	Disagree
CSS	❍	❍	❍
PEI	❍	❍	❍
Innovations	❍	❍	❍
WET	❍	❍	❍
CFTN	❍	❍	❍

2. The Principles guiding MHSA Planning include (check all that apply):

❍ Cultural Competence

❍ Community Collaboration

❍ Consumer and Family Driven Mental Health Services

❍ Focus on Wellness and Resilience

❍ Integrated Service Experience

3. The purpose and intent of the MHSA is to emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness, except:

❍ removal of children from their homes

❍ remove mental health related offenses

❍ homelessness

- ❍ prolonged suffering
- ❍ unemployment
- ❍ school failure or dropout
- ❍ incarcerations
- ❍ suicide

4. **What is the correct funding ratio according to the MHSA regulations?**
   - ❍ CSS (75%-80%); PEI (15%-20%); INN (0%-10%)
   - ❍ CSS (55%-60%); PEI (35%-40%); INN (0%-10%)
   - ❍ CSS (0-10%); PEI (15%-20&); INN (75%-80%)

5. **Which components of MHSA are ongoing (check all that apply), as opposed to one-time allocation?**
   - ❍ CSS
   - ❍ PEI
   - ❍ INN
   - ❍ Capital Facilities (CF)/Technology Needs (TN)
   - ❍ Workforce Education and Training (WET)

PLEASE COMPLETE AFTER THE ORIENTATION:

1. **I understand the following MHSA Components:**

	Agree	Not Sure	Disagree
CSS	❍	❍	❍
PEI	❍	❍	❍
Innovations	❍	❍	❍
WET	❍	❍	❍
CFTN	❍	❍	❍

2. **The Principles guiding MHSA Planning include (check all that apply):**

   ❍ Cultural Competence

   ❍ Community Collaboration

   ❍ Consumer and Family Driven Mental Health Services

   ❍ Focus on Wellness and Resilience

   ❍ Integrated Service Experience

3. **The purpose and intent of the MHSA is to emphasize strategies to reduce the following negative**

   outcomes that may result from untreated mental illness, except:

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   ❍ remove mental health related offenses

   ❍ homelessness

   ❍ prolonged suffering

   ❍ unemployment

   ❍ school failure or dropout

   ❍ incarcerations

❍ suicide

4. **What is the correct funding ratio according to the MHSA regulations?**

   ❍ CSS (75%-80%); PEI (15%-20%); INN (0%-10%)

   ❍ CSS (55%-60%); PEI (35%-40%); INN (0%-10%)

   ❍ CSS (0-10%); PEI (15%-20&); INN (75%-80%)

5. **Which components of MHSA are ongoing (check all that apply), as opposed to one-time allocation?**

   ❍ CSS

   ❍ PEI

   ❍ INN

   ❍ Capital Facilities (CF)/Technology Needs (TN)

   ❍ Workforce Education and Training (WET)

6. **Thoughts and comments about today's orientation:** _____

Mental Health Services Act (MHSA)
MHSA Component Funding Guidelines and Decision Tree

Mental Health Services Act

Mental Health Services Act (MHSA) Purpose

*The MHSA is intended to **expand** and **transform** mental health services in California to provide a better coordinated and more comprehensive system of care for those with serious mental illness, and to define an approach to the planning and the delivery of mental health services that are embedded in the MHSA Values.*

MHSA History

More than 2 million people in California are affected by potentially disabling mental illnesses every year. Thirty years ago, the State cut back on services in state hospitals for people with serious mental illnesses but did not provide adequate funding for community-based mental health services. Cuts to federal Medicaid (Medi-Cal) during the 1980s further devastated the public mental health system. These cuts prevented tens of thousands of Californians from accessing much-needed mental health care, which led to increased homelessness, hospitalizations, and incarceration. To address the gap in services, voters passed the Mental Health Services Act (MHSA) in 2004. The MHSA places a 1% tax on personal income above $1 million. Since then, it has generated approximately $8 billion for the public mental health care system.

MHSA Components

Community Services & Supports (CSS)
Outreach and direct services for children, transition age youth (TAY), adults and older adults with the most serious mental health needs

Prevention & Early Intervention (PEI)
Prevention services to promote wellness and prevent the development of mental health problems, and early intervention services to screen and intervene in early signs of mental health issues

Capital Facilities & Technology Needs (CFTN)
Infrastructure development to support the implementation of the technological infrastructure and appropriate facilities to provide mental health services

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

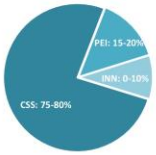
Innovation (INN)
New approaches that may improve access, collaboration, and/or service outcomes for all mental health consumers, with a focus on unserved, underserved, and inappropriately served populations

Meaningful Stakeholder Involvement[1]

The MHSA intends that there be "**meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocation.**" MHSA-funded initiatives should engage the following community members:

- Adults and seniors with serious mental illness
- Families of children, adults, and seniors with severe emotional disturbance or serious mental illness
- Providers of mental health services
- Law enforcement agencies
- Education agencies Social services agencies
- Veterans and representatives from veterans organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests

MHSA Funding to Counties



Counties may use up to 20 percent of the average amount of funds allocated to the county for the previous five years to fund **WET and CFTN** expenses and a prudent reserve.[2] Counties received 10-year allocations for **WET and CFTN** activities and the most recent MHSA Expenditure Report states that they have until the end of FY 2018-19 to spend them.

County Boards of Supervisors are the approval body for MHSA funding, except for INN, which is approved by the **Mental Health Services Oversight & Accountability Committee**

MHSA Populations

MHSA is intended to increase access and services for **underserved, unserved,** and **inappropriately served** populations in the following age groups:

Children and youth: 0-15
Transitional age youth: 16-25
Adults: 26-59
Older adults: 60+

MHSA Funding Rules

The MHSA specifies that MHSA funds **cannot be used to supplant existing state or county funds** for mental health services.

The state **cannot decrease its level of financial support** for mental health programs.

MHSA funds **cannot be used to pay for services in long-term hospital and/or institutional settings**.

[1] Welfare and Institutions Code Section 5848(a)
[2] Welfare and Institutions Code Section 5892(b)

Prepared by RESOURCE DEVELOPMENT ASSOCIATES

February 2018 | 1

Mental Health Services Act (MHSA)
MHSA Component Funding Guidelines and Decision Tree

Community Services & Support (CSS)[3]

Purpose

Provide all necessary mental health services to seriously mentally ill children, adults, and seniors for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable.

MHSA Funding for CSS

- **At least 51%** of MHSA allocations to counties must be dedicated to Full Service Partnerships (FSP).
- Many CSS services are also eligible to bill to Medi-Cal.
- MHSA funds can also be used for non-Medi-Cal eligible expenses such as non-mental health services.

Populations Served

- **Children** with severe emotional disturbance and their **families**
- **Transitional age youth, adults,** and **older adults** with serious mental illness

CSS Funding Categories	DIRECT SERVICES COSTS Eligible for CSS Funding[4]		NON-DIRECT SERVICES COSTS Eligible for CSS Funding	Activities NOT Eligible for CSS Funding
Full Service Partnerships (FSP) Individuals (and sometimes their families) enroll in a voluntary program that provides a broad range of supports to accelerate their recovery. FSP includes a "whatever-it-takes" commitment to progress on concrete recovery goals. *Serves clients that meet System Development (SD) criteria AND are un- or underserved and at risk of homelessness, incarceration, or hospitalization*[5] *NOTE: Some FSP-funded costs overlap with SD costs, but are distinct from SD in the population served and in funding non-mental health services*	**Full spectrum of community services including, but not limited to:** • Mental health treatment, including alternative and culturally specific treatments • Peer support • Supportive services to assist the client, and when appropriate the client'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 client, and when appropriate the client'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 within the full spectrum of community services 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 • Wrap-around services to children	• Needs assessment • Efforts to improve the county mental health service delivery system for all clients and their families • Developing strategies to reduce ethnic/racial disparities.	• Mental health programs and/or services that were in existence on November 2, 2004, **except** to expand services or program capacity beyond what was previously provided. • To replace state or county funding for programs that were already in existence as of FY 2004-05 • Long-term hospitalizations or institutionalization • Building and acquisition of housing
System Development (SD) Develop and operate programs to provide mental health services to 1) severely emotionally disturbed children or adolescents, 2) adults and older adults who have a serious mental disorder, 3) adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence	**Mental health treatment, including alternative and culturally specific treatments:** • Peer support • Supportive services to assist the client, and when appropriate the client's family, in obtaining employment, housing, and/or education • Wellness centers • Personal service coordination/case management/personal service coordination to assist the client, and when appropriate the client's family, to access needed medical, educational, social, vocational rehabilitative or other community services	• Needs assessment • Individual Services and Supports Plan development • Crisis intervention/stabilization services • Family education services • Improve the county mental health service delivery system for all clients and their families • Develop and implement strategies for reducing ethnic/racial disparities		
Outreach and Engagement (OE) Identifying those in need, reaching out to target populations, and connecting those in need to appropriate treatment	• Reaching out to target populations or community-based partners • Food, clothing, and shelter, but only when the purpose is to engage unserved individuals (and their families when appropriate) in the mental health system • If in collaboration with other non-mental health community programs, only the costs directly associated with providing the mental health services and supports			
Administrative	N/A		Costs or consulting fees related to conducting a needs assessment or evaluation, and facilitating the Community Planning Process	

[3] Adapted from the following sources: Mental Health Services Act as Revised September 2016; California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3620 - 3650; Fresno County MHSA 101: http://www.co.fresno.ca.us/uploadedFiles/Departments/Behavioral_Health/MHSA/Mental%20Health%20Services%20Act%20101%20revised%20-%208-2-13.pdf
[4] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3620
[5] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3620.05

Stakeholder Leadership Committee Planning Meetings

Children: Needs Assessment Findings

Overall, the children's system is robust and appears to be meeting the needs of children and families.

- 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 our 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

		Program: Children
Community Services and Supports (CSS)	Full Service Partnership	❖ Children's FSP (Increase capacity by 100)
	General Systems Development	❖ Kid Scope/SED EPSDT Expansion Services ❖ School-Linked Services- Treatment ❖ Mobile Crisis/ Transition Services
		❖ Mental Health Wellness to foster you in the Independent Living Program (ILP) ❖ Foster Care Development Juvenile Justice Development
	Outreach and Engagement	❖ Culture is Prevention Program ❖ LGBTQ Center
		❖ New: Multi-generational culture-specific wellness centers
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?
What should be changed?
What should be added?
What should be removed?

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 Systems Development	❖ TAY 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 ❖ Juvenile Justice Development
	Outreach and Engagement	❖ Culture is Prevention Program ❖ LGBTQ Center
		❖ New: Multi-generational culture-specific wellness centers (Latinos, API, African American, Native American, and LGBT+ communities)
Prevention and Early Intervention (PEI)	Prevention	❖ Violence Reduction Program
	Early Intervention	❖ REACH
	Outreach for Increasing Recognition of Early Signs of Mental Illness	❖ Direct Referral Program Commercially Sexually Exploited Children (CSEC)

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?
What should be changed?
What should be added?
What should be removed?

What should stay the same?
What should be changed?
What should be added?
What should be removed?

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

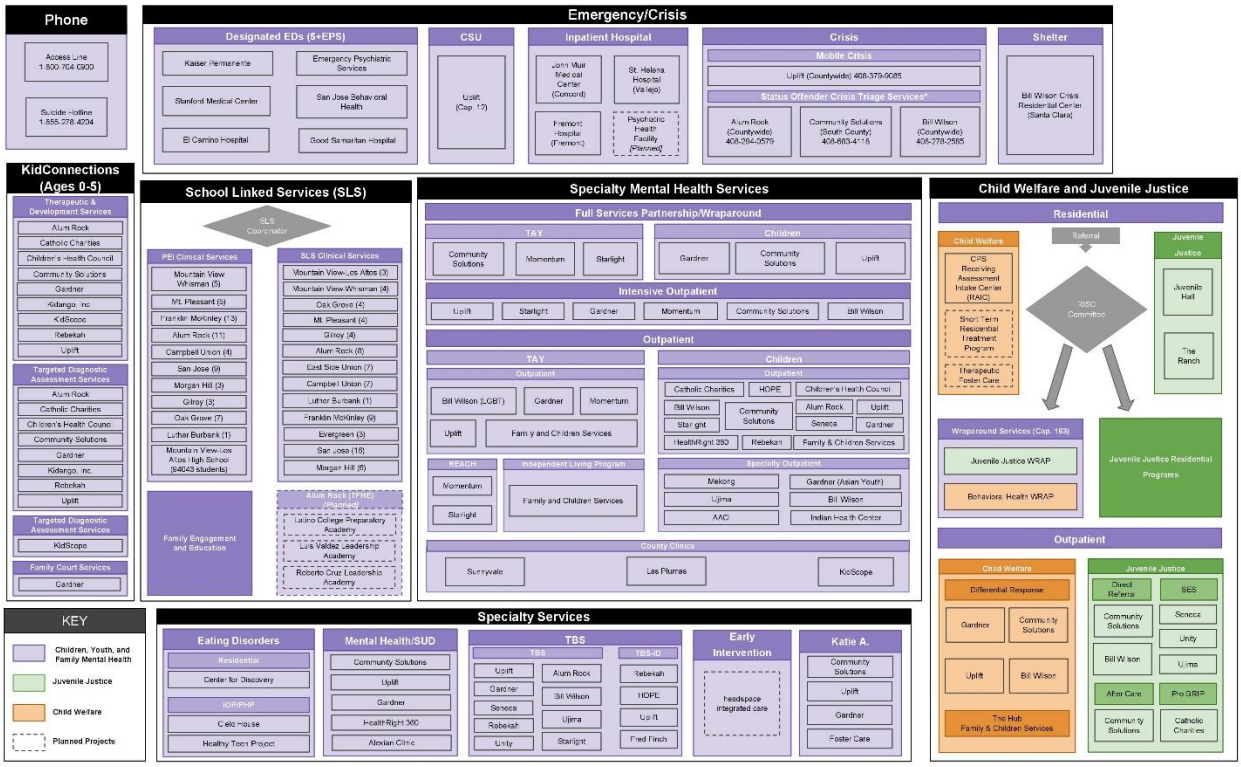
		Programs: Older Adults
Community Services and Supports (CSS)	Full Service Partnership	❖ Older Adult Full Service Partnership
	General Systems Development	❖ Connections Program ❖ Outpatient Services ❖ Older Adult Collaboration with San Jose Senior Nutrition Centers
	Outreach and Engagement	❖ Golden Gateway Comprehensive Older Adult Program
		❖ New: Multi-generational culture-specific wellness centers (Latinos, API, African American, Native American, and LGBT+ communities)

Group Activity Worksheet: Assessment of MHSA Services

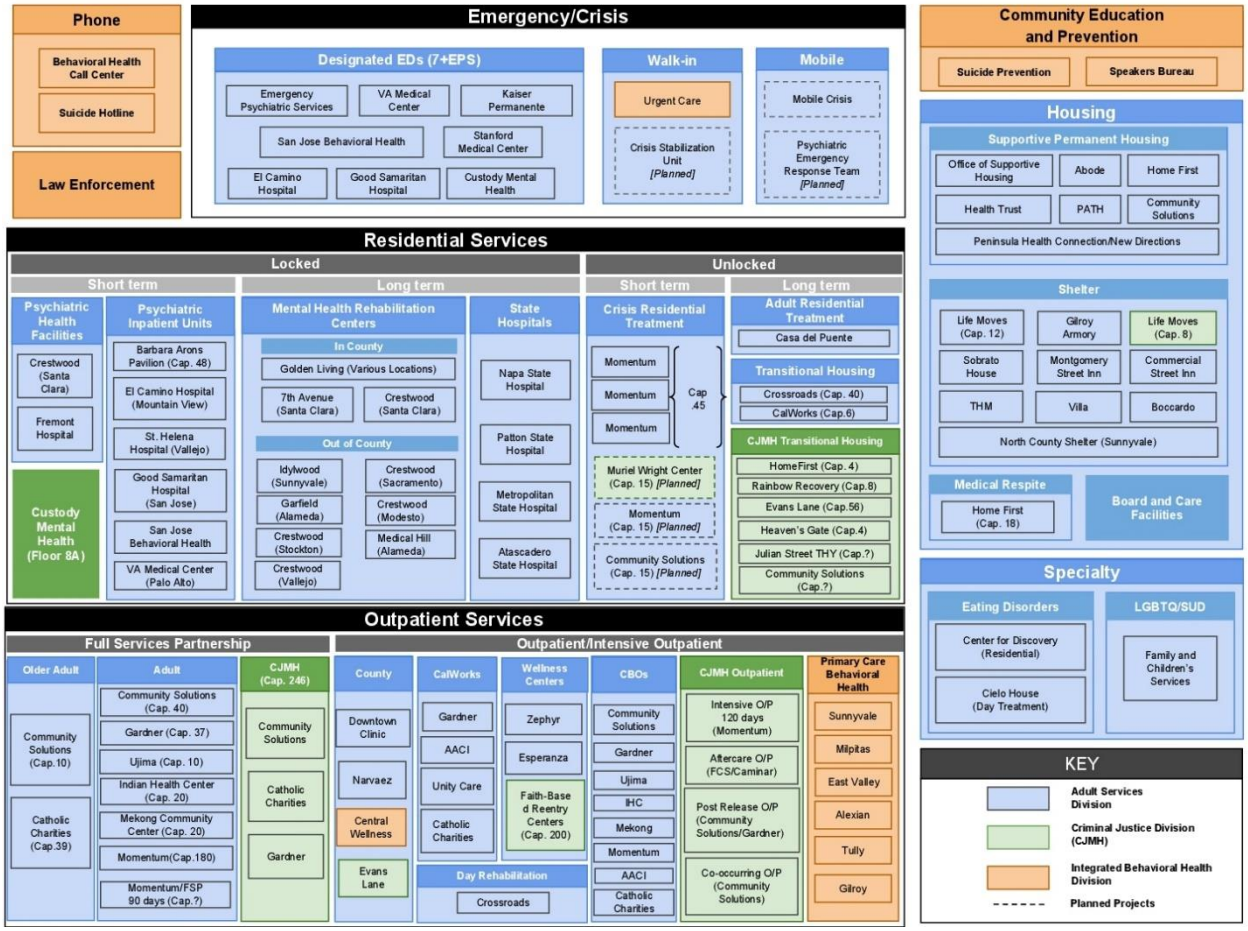
Activity Overview: The main purpose of this exercise is to evaluate your current MHSA services to see what aspects are working and what might need to be changed

What should stay the same?
What should be changed?
What should be added?
What should be removed?

Children, Youth, and Family System Map



Adult and Older/Adult System Map



RDA

SANTA CLARA COUNTY BEHAVIORAL HEALTH SERVICES: SLC MEETING

March 16, 2018
Roberta Chambers, PsyD
Kira Gunther, MSW

SLC Planning Meeting

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2 MHSA Planning Process

RDA

Three-Year Community Program Planning

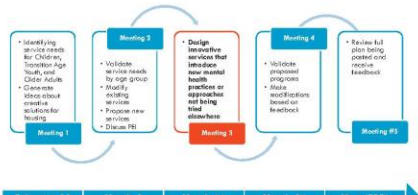
3

Needs Assessment	Program Planning	Plan Review

• **Conduct Needs Assessment:** 2017
• **Present and Validate Needs Assessment:**
  • **SLC:** 2/13/2018
  • **BHSD Staff:** 2/20/2018
  • **Health and Hospital Committee:** 2/14/2018
	• **Engage in Program Planning**
	  • **SLC:** 2/22/2018
	  • **SLC:** 3/8/2018
	  • **BHB:** 3/12/2018
	  • **SLC:** 3/16/2018
	  • **BHSD Staff:** 3/20/2018
	• **Conduct Feasibility Analysis** (BHSD)
	• **Validate and refine programs to be included in the plan**
	  • **SLC:** 3/27/2018
		• **Public Posting:** 5/11-6/10/2018
		• **Public Hearing:** 6/11/2018
		• **Board of Supervisors Review:** 6/19/2018

RDA

SLC Activities and Timeline



RDA

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5 Recommendations

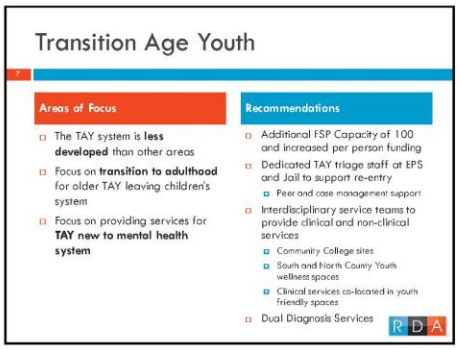
RDA

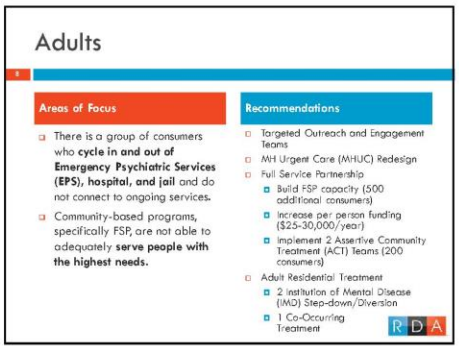
Children and Families

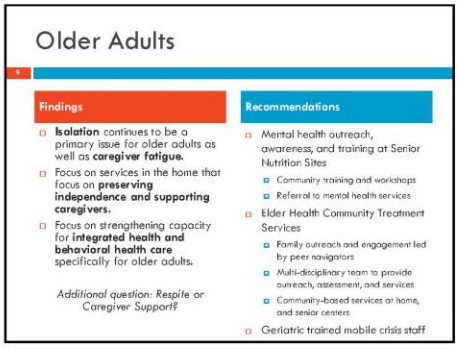
4

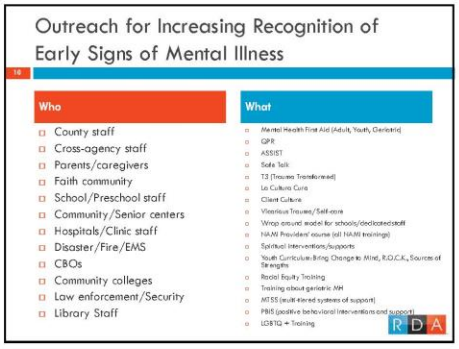
Areas of Focus	Recommendations
▫ Overall system is **robust** and meeting the needs of children and families ▫ The Needs Assessment data tend to include children and families already involved in the system ▫ Focus on groups that might be **falling though the cracks**	▫ Additional FSP Capacity of 100 ▫ Additional support and services for undocumented/ unaccompanied children ▫ Promotores program focused on East San Jose ▫ School-linked services in expanded locations ▫ More LGBT services and building professional capacity ▫ Dual Diagnosis Services

RDA

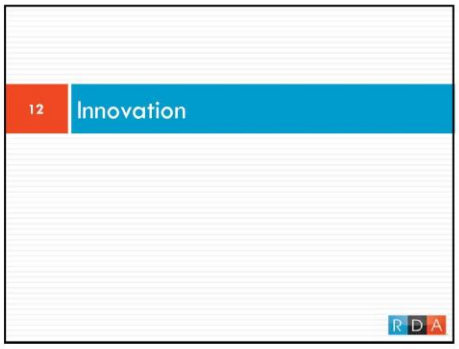

Transition Age Youth
7
Areas of Focus
The TAY system is less developed than other areas
Focus on transition to adulthood for older TAY leaving children's system
Focus on providing services for TAY new to mental health system
Recommendations
Additional FSP Capacity of 100 and increased per person funding
Dedicated TAY triage staff at EPS and Jail to support re-entry
Peer and case management support
Interdisciplinary service teams to provide clinical and non-clinical services
Community College sites
South and North County Youth wellness spaces
Clinical services co-located in youth friendly spaces
Dual Diagnosis Services
RDA

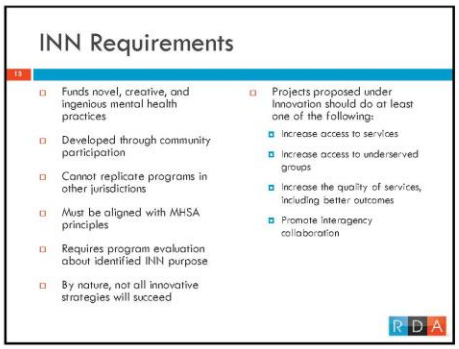

Adults
8
Areas of Focus
There is a group of consumers who cycle in and out of Emergency Psychiatric Services (EPS), hospital, and jail and do not connect to ongoing services.
Community-based programs, specifically FSP, are not able to adequately serve people with the highest needs.
Recommendations
Targeted Outreach and Engagement Teams
MH Urgent Care (MHUC) Redesign
Full Service Partnership
Build FSP capacity (500 additional consumers)
Increase per person funding ($25-30,000/year)
Implement 2 Assertive Community Treatment (ACT) Teams (200 consumers)
Adult Residential Treatment
2 institution of Mental Disease (IMD) Step-down/Diversion
1 Co-Occurring Treatment
RDA

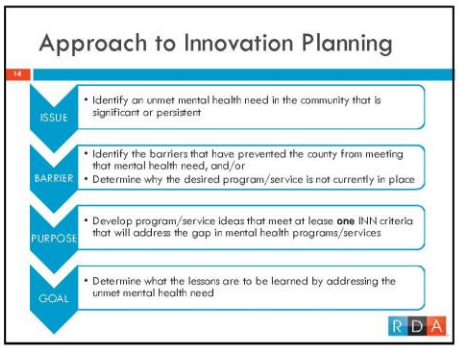

Older Adults
9
Findings
Isolation continues to be a primary issue for older adults as well as caregiver fatigue.
Focus on services in the home that focus on preserving independence and supporting caregivers.
Focus on strengthening capacity for integrated health and behavioral health care specifically for older adults.
Additional question: Respite or Caregiver Support?
Recommendations
Mental health outreach, awareness, and training at Senior Nutrition Sites
Community training and workshops
Referral to mental health services
Elder Health Community Treatment Services
Family outreach and engagement led by peer navigators
Multi-disciplinary team to provide outreach, assessment, and services
Community-based services at home, and senior centers
Geriatric trained mobile crisis staff


Outreach for Increasing Recognition of Early Signs of Mental Illness
10
Who
County staff
Cross-agency staff
Parents/caregivers
Faith community
School/Preschool staff
Community/Senior centers
Hospitals/Clinic staff
Disaster/Fire/EMS
CBOs
Community colleges
Law enforcement/Security
Library Staff
What
Mental Health First Aid (Adult, Youth, Geriatric)
QPR
ASIST
Safe Talk
TSI (Trauma Transformed)
La Cultura Cura
Client Culture
Vicarious Trauma/Self-care
Wrap around model for schools/dedicated staff
NAMI Providers' course (all NAMI trainings)
Spiritual interventions/supports
Youth Curriculum: Bring Change to Mind, R.O.C.K., Sources of Strengths
Racial Equity Training
Training about geriatric MH
MTSS (multi-tiered systems of support)
PBIS (positive behavioral interventions and support)
LGBTQ + Training
RDA


Other Community Wide Programs
11
Multi-generational culture-specific wellness centers (Latinos, API, African American, Native American, and LGBT+ communities)
Promotores program
Redesign of call center
Triage staff at emergency departments
Outreach and Access services for those in crisis (IHOTT teams as part of adult redesign)
RDA

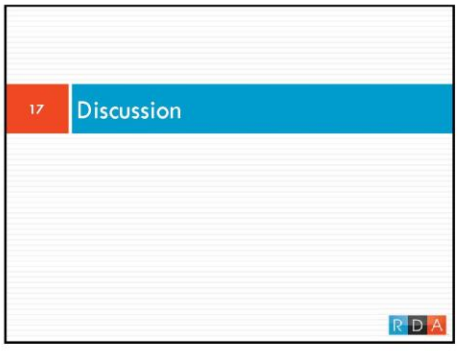

12
Innovation
RDA


INN Requirements
13
Funds novel, creative, and ingenious mental health practices
Developed through community participation
Cannot replicate programs in other jurisdictions
Must be aligned with MHSA principles
Requires program evaluation about identified INN purpose
By nature, not all innovative strategies will succeed
Projects proposed under Innovation should do at least one of the following:
Increase access to services
Increase access to underserved groups
Increase the quality of services, including better outcomes
Promote interagency collaboration
R D A


Approach to Innovation Planning
14
ISSUE
• Identify an unmet mental health need in the community that is significant or persistent
BARRIER
• Identify the barriers that have prevented the county from meeting that mental health need, and/or
• Determine why the desired program/service is not currently in place
PURPOSE
• Develop program/service ideas that meet at lease one INN criteria that will address the gap in mental health programs/services
GOAL
• Determine what the lessons are to be learned by addressing the unmet mental health need
R D A


Current Innovation Programs
15
Faith Based Training and Supports Project
Client and Consumer Employment
Psychiatric Emergency Response Team (PERT) and Peer Linkage Project
Headspace Project
Multi-Cultural Center Project
R D A


Recommendations
16
Innovation Programs for Transition Age Youth
Entrepreneurial services/support
Parenting support for TAY
Creative Housing Solutions
Utilizing available rooms in community (private home owners share space)
Maximizing existing facility space to serve mental health consumers
Leveraging community assets to add housing
R D A


17
Discussion
R D A

Community Engagement Feedback Form

Thank you for your involvement in the Community Program Planning (CPP) Process for Santa Clara County's Mental Health Services Act *Three-Year Program & Expenditure Plan*. We would like to hear about your experience with the CPP process. Your feedback will help us understand what we did well and what we can improve upon in the future. Please help us by taking a few minutes to fill out this anonymous feedback form.

Based on your experience with the MHSA Community Program Planning Process, please check how much you agree with the following statements.

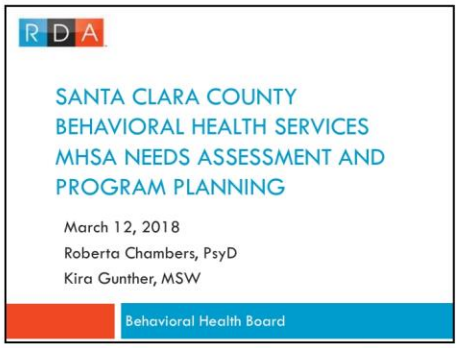
	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The discussion reflected my ideas and perspectives about how to strengthen mental health services in our County.				
2. There was adequate time for discussion and questions.				
3. The information and activities in this meeting allowed us to move forward in the planning process.				
4. The community planning process is in alignment with MHSA values.				

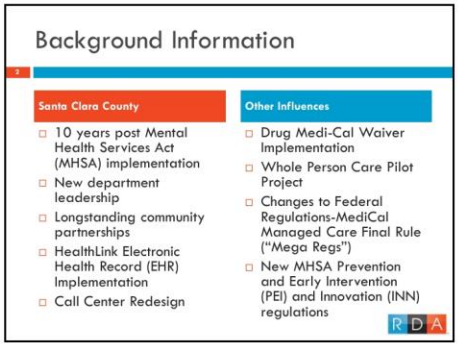
5. Are there specific issues or topics that are important to consider?

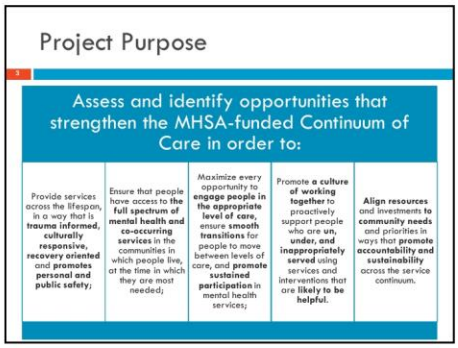
Thank you!

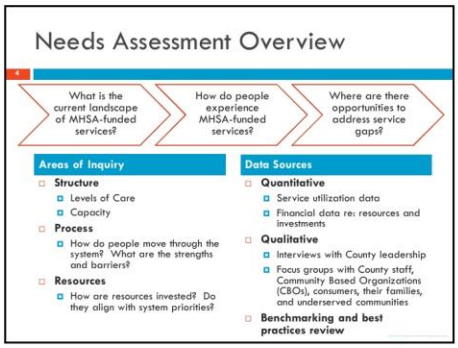
Behavioral Health Board

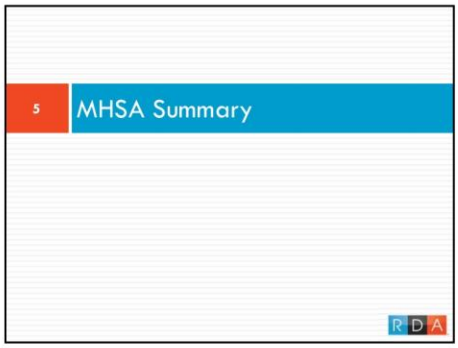
4/28/2018

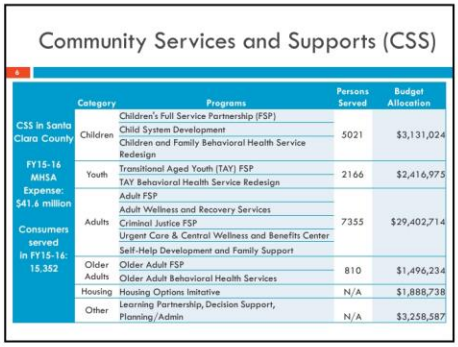












Prevention and Early Intervention (PEI)

7

PEI Categories
- Prevention
- Early Intervention
- Access and Linkage to Treatment
- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Stigma and Discrimination Program
- Suicide Prevention

PEI in Santa Clara County	Category	Programs	Budget Allocation
FY15-16 MHSA Expense: $15.5 million Consumers served since FY11-12: 41,013	Stigma Discrimination and Reduction (SDR)	Community Engagement and Capacity Building for Reducing Stigma and Discrimination	$1,569,356
	Prevention	Strengthening Families and Children	$8,826,588
	Early Intervention	Interventions for Individuals Experiencing the Onset of Serious Psychiatric Illness (REACH)	$746,675
	Prevention	Primary Care/Behavioral Health Integration (PCBHI) for Adults and Older Adults	$3,476,591
	Suicide Prevention	Suicide Prevention Initiative	$911,719

MHSA Implementation

8

MHSA Accomplishments
- Created **Full Service Partnerships** for children, youth, adults, and older adults with intensive mental health (MH) issues
- Placed **mental health services where children already are** through school-linked services
- Strengthened partnerships with the **faith-based, physical health, and justice communities**
- Prioritized **un, under, and inappropriately served** consumers and families

Areas for Growth
- Aligning **capacity to demand**
- Prioritizing those with the **highest level of need** and determining **appropriate level of care and care transitions**
- Working to **promote and sustain service engagement**
- Responding to **new PEI regulations**
- Improving **coordination, collaboration, and accountability**

9 Children, Youth, and Families

Children's Service Landscape

10

Children's services exist in a complex set of legislation with a variety of stakeholders

- SCC BHSD provided services for **11,950 children and youth,** including:
  - Kid Connections 0-5
  - School-Linked Services
  - Katie A. and Juvenile Justice MH services
  - FSP and other outpatient mental health services
  - Crisis and emergency services

Level of Care Analysis

11

- Children's FSP
  - 185 children served
  - $22,162 annual cost per child
- TAY FSP
  - 277 youth served
  - $15,700 annual cost per youth

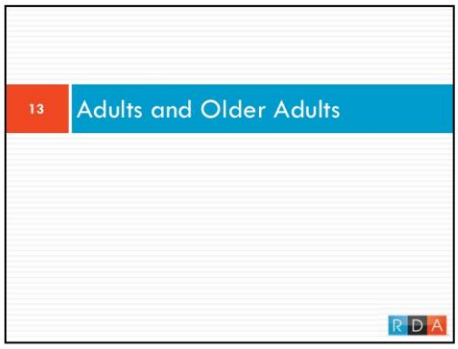
Crisis and Emergency Services	Individuals Served	Total Service Encounters
Emergency Psychiatric Services	816	1,052
Mental Health Urgent Care	33	76
Crisis Stabilization Unit	380	557
Inpatient Hospitalization	363	557

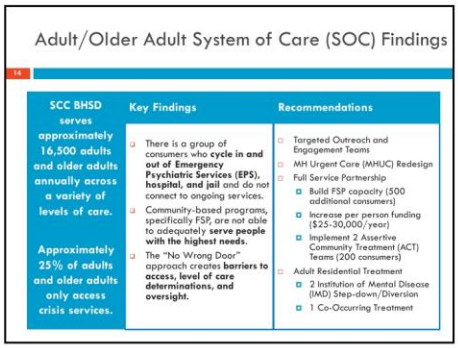
- Children's FSP could benefit from ~100 additional spots.
  - Annual investments and service provision are in alignment with other jurisdictions.
- TAY FSP could benefit from additional capacity and resources.
  - There is a need for ~100 additional TAY spots.
  - Per person investments should be approximately ~ 22-25K.
  - There is a need to clarify the service model for TAY FSP.

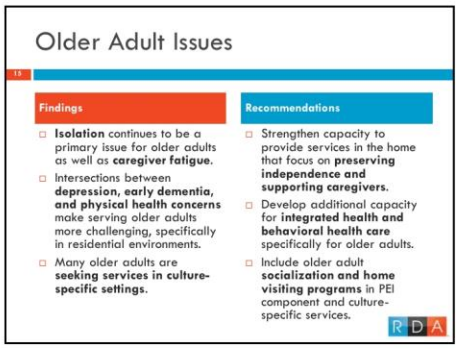
Children's Findings and Recommendations

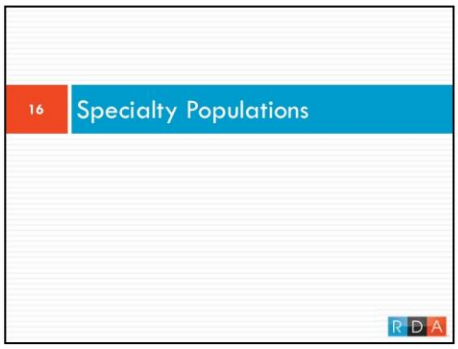
12

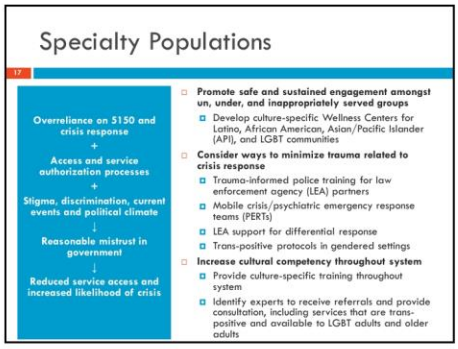
- There's a **variety of specialized services** available for child welfare and justice-involved youth as well as co-occurring and eating disorder-specific services.
- In light of unfolding policy changes, it may be important to **ensure that children and families are able to easily access timely services** that are likely to be helpful, such as school-linked services.
- Where there are a lot of quality services, there is a need to **strengthen care coordination and maintain continuity of care** across providers and systems.


13
Adults and Older Adults
RDA


Adult/Older Adult System of Care (SOC) Findings
14
SCC BHSD serves approximately 16,500 adults and older adults annually across a variety of levels of care.
Approximately 25% of adults and older adults only access crisis services.
Key Findings
There is a group of consumers who cycle in and out of Emergency Psychiatric Services (EPS), hospital, and jail and do not connect to ongoing services.
Community-based programs, specifically FSP, are not able to adequately serve people with the highest needs.
The "No Wrong Door" approach creates barriers to access, level of care determinations, and oversight.
Recommendations
Targeted Outreach and Engagement Teams
MH Urgent Care (MHUC) Redesign
Full Service Partnership
Build FSP capacity (500 additional consumers)
Increase per person funding ($25-30,000/year)
Implement 2 Assertive Community Treatment (ACT) Teams (200 consumers)
Adult Residential Treatment
2 Institution of Mental Disease (IMD) Step-down/Diversion
1 Co-Occurring Treatment


Older Adult Issues
15
Findings
Isolation continues to be a primary issue for older adults as well as caregiver fatigue.
Intersections between depression, early dementia, and physical health concerns make serving older adults more challenging, specifically in residential environments.
Many older adults are seeking services in culture-specific settings.
Recommendations
Strengthen capacity to provide services in the home that focus on preserving independence and supporting caregivers.
Develop additional capacity for integrated health and behavioral health care specifically for older adults.
Include older adult socialization and home visiting programs in PEI component and culture-specific services.
RDA


16
Specialty Populations
RDA


Specialty Populations
17
Overreliance on 5150 and crisis response
+
Access and service authorization processes
+
Stigma, discrimination, current events and political climate
↓
Reasonable mistrust in government
↓
Reduced service access and increased likelihood of crisis
Promote safe and sustained engagement amongst un, under, and inappropriately served groups
Develop culture-specific Wellness Centers for Latino, African American, Asian/Pacific Islander (API), and LGBT communities
Consider ways to minimize trauma related to crisis response
Trauma-informed police training for law enforcement agency (LEA) partners
Mobile crisis/psychiatric emergency response teams (PERTs)
LEA support for differential response
Trans-positive protocols in gendered settings
Increase cultural competency throughout system
Provide culture-specific training throughout system
Identify experts to receive referrals and provide consultation, including services that are trans-positive and available to LGBT adults and older adults


18
Other Recommendations
RDA

Systems Level Findings and Recommendations

19

- The County should develop a process to move to a **"Coordinated Entry"** approach.
- It may be useful to more closely **align MHSA expenditures** with the **MHSA plan** throughout the program implementation.
- The County may wish to consider how to build in **accountability mechanisms** into the contracting process.
- The County should explore how to use CSS and Capital Facilities and Technological Needs (CFTN) funding for **creative housing models** and **supportive services.**

RDA

20 Consolidated Recommendations

RDA

CSS	PEI	Other
FULL SERVICE PARTNERSHIPS ❖ **Children:** Create additional ~100 slots ❖ **TAY:** Create ~100 slots, increase per person funding to ~22-25K, clarify model. ❖ **Adult/Older Adult:** Create additional ~500 slots, develop 2 ACT teams, explore Forensic Assertive Community Treatment (FACT) for Criminal Justice Mental Health (CJMH)	**PREVENTION** ❖ Consider adding older adult and caregiver support programs ❖ Strengthen PBHCI efforts for older adults **OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS** ❖ Consider LEA trauma-informed training and other support to non-MH providers	❖ Explore **INN concepts submitted by community** and other stakeholders for applicability to identified community needs ❖ Explore mechanisms to **leverage CSS and CFTN funds** for creative **housing solutions** ❖ Consider strengthening **performance expectations** in **service contracts** ❖ Workforce Education Training (**WET**) program to **improve cultural responsiveness and to address professional shortages**
SYSTEMS DEVELOPMENT ❖ Develop 3 ART facilities ❖ Redesign MHUC	**ACCESS AND LINKAGE TO TREATMENT** ❖ Develop A&L program, consider children, youth, and families as priority population	
OUTREACH AND ENGAGEMENT (O&E) ❖ Develop 5 targeted O&E teams ❖ Fully Implement Mobile Crisis/ PERTs	**SDR** ❖ Build multi-generational culture-specific wellness centers for Latino, API, African American, and LGBT+ communities	

22 MHSA Planning Process

RDA

Three-Year Community Program Planning

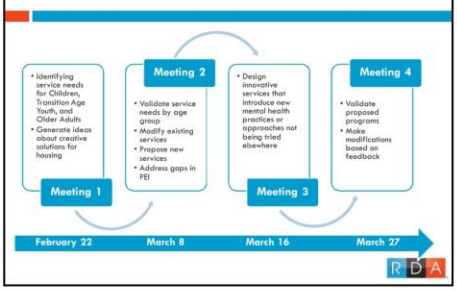
23

Needs Assessment	Program Planning	Plan Review

• **Conduct Needs Assessment:** 2017
• **Present and Validate Needs Assessment:**
  • **SLC:** 1/13/2018
  • **BHSD Staff:** 2/20/2018
  • **Health and Hospital Committee:** 2/14/2018
	• **Engage in Program Planning**
	  • **SLC:** 2/22/2018
	  • **SLC:** 3/8/2018
	  • **BHB:** 3/12/2018
	  • **SLC:** 3/16/2018
	  • **BHSD Staff:** 3/20/2018
	• **Conduct Feasibility Analysis** (BHSD)
	• **Validate and refine programs to be included in the plan**
	  • **SLC:** 3/27/2018
		• **Public Posting:** 4/6-5/5/2018
		• **Review and consider public comment:**
		  • **SLC:** 5/8/2018
		• **Public Hearing:** 5/14/2018
		• **Board of Supervisors Review:** 6/5/2018

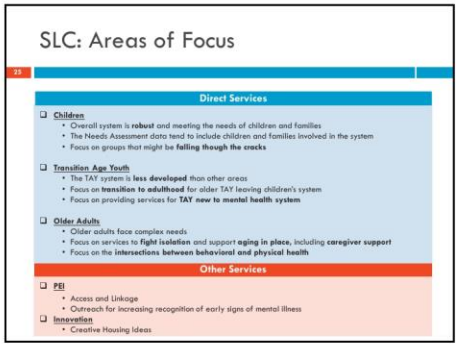
RDA

SLC Activities and Timeline

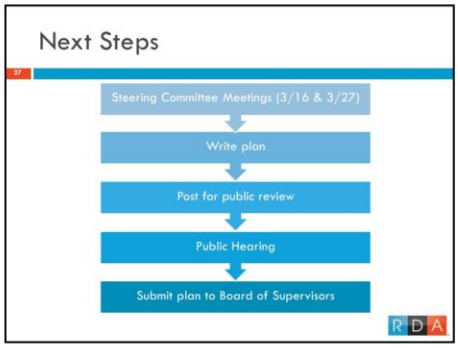


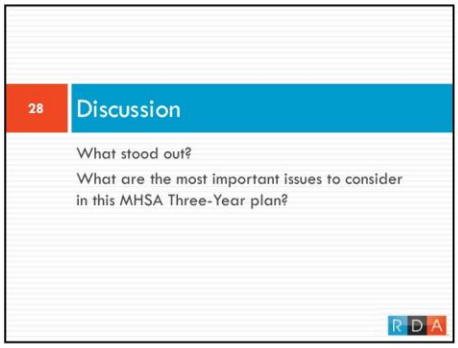
RDA

4/28/2018


SLC: Areas of Focus
25
Direct Services
Children
Overall system is robust and meeting the needs of children and families
The Needs Assessment data tend to include children and families involved in the system
Focus on groups that might be falling though the cracks
Transition Age Youth
The TAY system is less developed than other areas
Focus on transition to adulthood for older TAY leaving children's system
Focus on providing services for TAY new to mental health system
Older Adults
Older adults face complex needs
Focus on services to fight isolation and support aging in place, including caregiver support
Focus on the intersections between behavioral and physical health
Other Services
PEI
Access and Linkage
Outreach for increasing recognition of early signs of mental illness
Innovation
Creative Housing Ideas

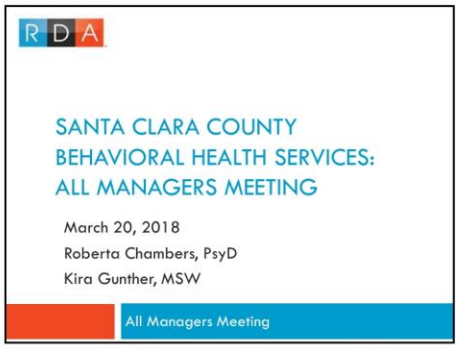

26
Next Steps
R D A

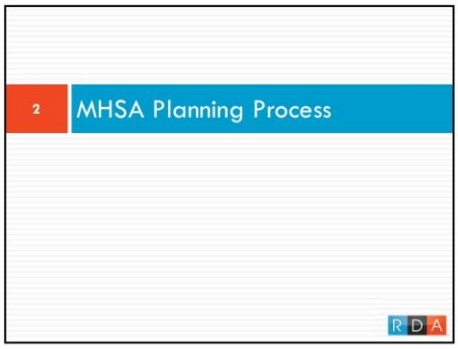

Next Steps
27
Steering Committee Meetings (3/16 & 3/27)
Write plan
Post for public review
Public Hearing
Submit plan to Board of Supervisors
R D A

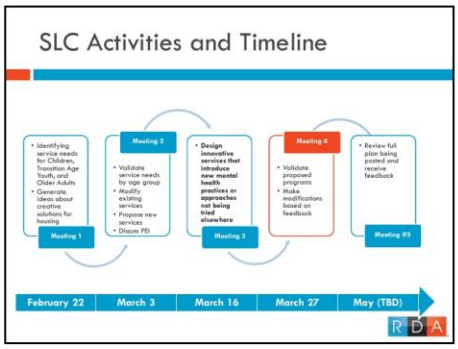

28
Discussion
What stood out?
What are the most important issues to consider in this MHSA Three-Year plan?
R D A

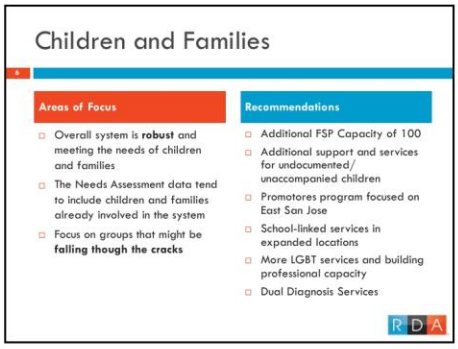
BHSD Staff Meeting

4/28/2018









Transition Age Youth

7

Areas of Focus

- The TAY system is **less developed** than other areas
- Focus on **transition to adulthood** for older TAY leaving children's system
- Focus on providing services for **TAY new to mental health system**

Recommendations

- Additional FSP Capacity of 100 and increased per person funding
- Dedicated TAY triage staff at EPS and Jail to support re-entry
  - Peer and case management support
- Interdisciplinary service teams to provide clinical and non-clinical services
  - Community College sites
  - South and North County Youth wellness spaces
  - Clinical services co-located in youth friendly spaces
- Dual Diagnosis Services

Adults

8

Areas of Focus

- There is a group of consumers who **cycle in and out of Emergency Psychiatric Services (EPS), hospital, and jail** and do not connect to ongoing services.
- Community-based programs, specifically FSP, are not able to adequately **serve people with the highest needs.**

Recommendations

- Targeted Outreach and Engagement Teams
- MH Urgent Care (MHUC) Redesign
- Full Service Partnership
  - Build FSP capacity (500 additional consumers)
  - Increase per person funding ($25-30,000/year)
  - Implement 2 Assertive Community Treatment (ACT) Teams (200 consumers)
- Adult Residential Treatment
  - 2 Institution of Mental Disease (IMD) Step-down/Diversion
  - 1 Co-Occurring Treatment

Older Adults

9

Findings

- **Isolation** continues to be a primary issue for older adults as well as **caregiver fatigue.**
- Focus on services in the home that focus on **preserving independence and supporting caregivers.**
- Focus on strengthening capacity for **integrated health and behavioral health care** specifically for older adults.

Additional question: Respite or Caregiver Support?

Recommendations

- Mental health outreach, awareness, and training at Senior Nutrition Sites
  - Community training and workshops
  - Referral to mental health services
- Elder Health Community Treatment Services
  - Family outreach and engagement led by peer navigators
  - Multi-disciplinary team to provide outreach, assessment, and services
  - Community-based services at home, and senior centers
- Geriatric trained mobile crisis staff

Outreach for Increasing Recognition of Early Signs of Mental Illness

10

Who

- County staff
- Cross-agency staff
- Parents/caregivers
- Faith community
- School/Preschool staff
- Community/Senior centers
- Hospitals/Clinic staff
- Disaster/Fire/EMS
- CBOs
- Community colleges
- Law enforcement/Security
- Library Staff
- Elected officials
- Transportation opperators

What

- Mental Health First Aid (Adult, Youth, Geriatric)
- QPR
- ASSIST
- Safe Talk
- T3 (Trauma Transformed)
- La Cultura Cura
- Client Culture
- Vicarious Trauma/Self-care
- Wrap around model for schools/dedicated staff
- NAMI Providers' course (all NAMI trainings)
- Spiritual interventions/supports
- Youth Curriculum: Bring Change to Mind, R.O.C.K., Sources of Strengths
- Racial Equity Training
- Training about geriatric MH
- MTSS (multi-tiered systems of support)
- PBIS (positive behavioral interventions and support)
- LGBTQ + Training

Other Community Wide Programs

11

- Multi-generational culture-specific wellness centers (Latinos, API, African American, Native American, and LGBT+ communities)
- Promotores program
- Redesign of call center

12 Innovation

4/28/2018

INN Requirements

13

- Funds novel, creative, and ingenious mental health practices
- Developed through community participation
- Cannot replicate programs in other jurisdictions
- Must be aligned with MHSA principles
- Requires program evaluation about identified INN purpose
- By nature, not all innovative strategies will succeed
- Projects proposed under Innovation should do at least one of the following:
  - Increase access to services
  - Increase access to underserved groups
  - Increase the quality of services, including better outcomes
  - Promote interagency collaboration

Current/New Innovation Programs

14

- Faith Based Training and Supports Project
- Client and Consumer Employment
- Psychiatric Emergency Response Team (PERT) and Peer Linkage Project
- Headspace Project
- Multi-Cultural Center Project
- Techsuite: 7 Cups of Tea (New)

SLC Innovation Recommendations

15

- **Entrepreneurial Jumpstart for Transition Age Youth**
  - An incubator space to gain business/entrepreneurial skills
  - On-site mental health services/support
- **Project Match for people with mental health needs to available housing in the community**
  - New phone application to maximize available rooms in community by matching people in need with short-term housing and case management services
- **Dedicated older adult in-home outreach team**
  - Outreach, engagement, and linkage to isolated older adults in need of mental health services

16 Discussion

SLC Report Back Meeting

This meeting was held on May 8, 2018 primarily to review the Draft Plan with all members of the MHSA SLC and the public. A printed Draft Plan for stakeholder review and immediate feedback was facilitated to all present. At this meeting, the Elder Story Telling was put back on the plan per BHDS Director's recommendation. Additionally, members shared their thoughts and comments about the process which was generally collaborative and enthusiastic for the potential to continue to better serve Santa Clara County consumers and their families. In general, the SLS provided validation to the Draft Plan before commencing the 30-Day Public Comment and Review period from May 11 through June10, 2018, and in preparation for the June 11, 2018 Behavioral Health Board Public Hearing.

Appendix D. Public Review Process

30-Day Review Period

Starting May 11 – June 10, 2018, the Department completed the 30-Day Public Review and Comment process. Seventy-six (76) comments were received during this time period. The Comments/Feedback summaries and BHSD Response are provided below.

FY18-FY20 MHSA Three-Year Program and Expenditure Plan (Draft Plan)
30-Day Public Review and Comment Period: May 11 – June 10, 2018

SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

Comment from	Comment/Feedback
Behavioral Health Contractors' Association (BHCA)	1. Leveraging Funds – Page Number: Component Worksheets Feedback: In several programs, the component worksheet of the expenditure plan does not reflect expectations for leveraging of MediCal funds. For example, in the CSS Component Worksheet that details the funding, the non FSP Programs line 19, Criminal Justice Residential and Outpatient Treatment Programs (Evans Lane) does not show any MediCal leverage funding. Budgeting for FFP that is appropriate and currently being used will free up some of the allocated MHSA funds for additional needed services. We recommend this be done in all programs for which it is allowable.
	BHSD RESPONSE: The Criminal Justice Residential program is primarily a residential treatment program and therefore cannot leverage MediCal.
	2. Accounting for Cost of Doing Business Page Number: Component Worksheets Feedback: There appears to be consistent increases built into allocation for County provided programs with no changes in deliverables over 3 years but the same is not built into contracted programs. Given that the cost of doing business escalates, why is this not included on a system-wide basis? We recommend that it should be adequately funded on a system-wide basis so that funding is available to support whatever increases are negotiated in County employee union contracts or services contracts.
	BHSD RESPONSE: It is Santa Clara County policy to build in these increases for County-operated services. Increases for contract service providers would be based on the County's direction.
	3. Program Name: FSP Page Number in Document: Component Worksheets Feedback: A great deal of programs appear to now be funded in the FSP category. In these 12 programs that are funded both as FSP and non-FSP, how will providers differentiate FSP and non-FSP clients?
	BHSD RESPONSE: MHSA requires that the majority of CSS funds be spent on Full Service Partnerships (FSPs). While the FSP programs are intended to provide "whatever it takes," there are other services that people enrolled in an FSP may also need. In these instances, the FSP program would be responsible for meeting the FSP service and data collection requirements; other service providers wouldn't have any additional responsibility for a consumer enrolled in FSP other than to provide the services within that program as they would for any consumer, regardless of FSP enrollment status. In terms of service coordination, FSP and non-FSP providers would continue to coordinate services in the same manner as they currently do.
	4. Program Name: Reentry Page Number in Document: Component Worksheets Feedback: Funding for Re-entry is shown in the PEI Component Worksheet as starting in FY19 and increasing in FY20, but it is unclear how this funding is being spent as there does not appear to be a related description in the plan narrative.
	BHSD RESPONSE: As part of a Prevention and Early Intervention (PEI) program enhancement, Peer Navigators will be embedded in the Re-Entry Centers to provide instrumental assistance and interpersonal support. A vast amount of evidence shows that those working with peer navigators are significantly more engaged in services than participants who were randomly assigned to integrated care. In addition, peer navigators support show significant improvements in health, recovery, and quality of life compared to those navigating the system alone. Using a multi-disciplinary team approach, these services offer linkage to: mental health outpatient services; alcohol and drug treatment and

Comment from	Comment/Feedback
	care; resources to the faith communities; peer mentoring; housing; general assistance benefits; health referrals; transitional case management; and a clothes closet.
	5. Program Name: LGBTQ Page Number in Document: Component Worksheets Feedback: Funding for LGBTQ is shown in the PEI Component Worksheet as starting in FY19 and increasing in FY20, but it is unclear how this funding is being spent as there does not appear to be a related description in the plan narrative.
	BHSD RESPONSE: Peer Navigators will specifically address the disparities in access to mental health services for the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ+) population of Santa Clara County. During the 30-day public comment period, there was a recommendation to expand services to LGBTQ+ TAY. In reviewing this response, BHSD identified a greater need for training and technical assistance for clients, consumers, families, and providers. BHSD has provided additional funds to fully support the LGBTQ+ community, families and the providers who serve them. This information has been added to the Plan's LGBTQ+ program description.
	6. Program Name: PEI Administration Page Number in Document: Component Worksheets Feedback: Funding for PEI Administration grows by 33.53% over the course of the plan but actual spending for PEI services only grows 1.47%. What is driving this disproportionate and significant cost in administration?
	BHSD RESPONSE: BHSD added four (4) new positions to support the increased need for greater oversight and support of PEI programs and services, meet the State's PEI requirements and support the array of PEI programs. The positions are: Associate Training and Staff Development Specialist I (1 FTE) to provide training and technical assistance to MHSA programs, conduct training workshops and support community based organizations tasked with the implementation of PEI projects. Program Manager II (1 FTE) to support new regulatory and data collection requirements in the MHSA PEI component and provide project management related to implementing and supporting PEI programs. Health Care Program Manager II (1 FTE) to support the Criminal Justice Re-Entry Center PEI component. Prevention Program Analyst II (1 FTE) to conduct PEI data analytics and contract monitoring in prevention efforts within the Adult/Older Adult System of Care.
	7. Program Name: Primary Care/Behavioral Health Integration for Adults and Older Adults Feedback: The Primary Care/Behavioral Health Integration for Adults and Older Adults is described as an existing PEI program in the narrative/needs assessment but is not included in either the narrative program descriptions or component worksheets. Will MHSA funds no longer be used for these services? BHCA recommends these services that are being utilized by those seeking services in FQHCs continue.
	BHSD RESPONSE: BHSD appreciates the recommendation and plans to continue to fund these services. The Department will release a Request for Proposals (RFP) in first quarter of FY19. The amount allocated for this PEI initiative is $7,584,690 for FY18-FY20. This program description will be added to the Draft Plan.
	8. Cost per Client by Category - Page Number in Document: page 27 • Child (app. $624/client) total $3,131,024 • Youth (app. $1,117/client) total $2,416,975

Comment from	Comment/Feedback
	• *Adult (app. $3,997/client) total $29,402,714* • Older Adult (app. $1,852/client) total $1,496,234 Feedback: These numbers don't match the data elsewhere in the document if they represent FY15-16 (number of persons served matches that year), the budget allocations don't match the total on page 26. What drives the significant variance in cost per client?
	BHSD RESPONSE: Under the Adult/Older Adult redesign, there are now three tiers of services to meet the needs of adults and older adults with the most serious mental health needs. 1) Assertive Community Treatment: This program, not funded prior to this plan year, will provide 2 new ACT teams with a total capacity of 200 slots for individuals with the highest needs. ACT is a 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 2) The second level is a new Intensive Full-Service Partnership (FSP) program that provides a higher per person funding allocation that was not previously available to serve people with serious mental health needs. These represent new intensive service slots for individuals. 3) The third level, FSP Maintenance, is a continuation of the FSP model from previous plans. This tier of services will ensure that individuals that currently receive FSP services will continue to receive care without any reduction in service. The FSP maintenance service is a step down from intensive FSP for those who may still need services, including housing support, to remain successful in the community. The updated program descriptions include the FSP Intensive budgets.
	9. No Wrong door Page Number in Document: 43 Feedback: The proposal to develop a county led Level of Care LOC determination process where a county team of staff intake and assess to determine medical necessity and level of care before triaging to the agencies needs to be balanced with the need for clients to experience a seamless and positive engagement and treatment process. While providers have experienced early drop-outs among those referred but not meeting medical necessity, the process developed needs to consider the following challenges a rigid process would create: 1) A comprehensive intake/assess followed by handover to another staff to create a treatment plan and provide services forces the client to tell and retell their story to multiple providers, which can be both re-traumatizing at worst and very frustrating at best 2) Providers already working with individuals and families need a way of in taking and assessing clients without having to refer them to a centralized intake and assessment team. Often, we engage with populations who may need additional services (ex: a kid gets opened in F&C but parent needs substance abuse services.). Providers experience has been that clients are more likely to engage with additional services when they are provided by the same organization, when possible. If providers are going into the homes and identify a need that can be addressed, they need a mechanism to do so without referral to centralized intake.
	BHSD RESPONSE: The needs assessment summary recommends moving from a "no wrong door" approach to one of "coordinated entry." A system of coordinated entry, as described in the plan, differs from a system that uses a "single point of entry." The County does not plan

Comment from	Comment/Feedback
	to create a single point of entry where all consumers would be assessed by a County staff before being referred to a mental health service. We agree that this would create the types of barriers and difficulties that this question suggests. The intention of this recommendation is to build the structure and processes that allow for a more seamless service authorization and level of care determination experience that promotes increased coordination amongst all providers, both County and contracted providers, as well as allows the County to more effectively align available capacity with demand. While this recommendation does suggest that there be a centralized intake and assessment team, this team will likely be more focused in the service authorization process and less focused on direct interaction with consumers. The intention is to create a more seamless experience of service access, authorization, and level of care determination throughout the person's involvement in specialty mental health services than what was reported by consumers and families, providers, and County staff during the needs assessment. It is also important to note that the specific structure and processes to support coordinated entry have not yet been developed, and BHSD intends to collaborate with County and contracted providers to design a coordinated entry process that is beneficial for consumers, feasible for providers, and better allows the County to serve in the capacity of the mental health plan and align capacity to demand across programs.
	10. Specialty Populations Page Number in Document: page 50 Feedback: Specialty populations should include the additional population of persons who don't have or are at-risk of losing documentation to be in the United States. The plan should address how we as a system may outreach to this population and identify how our cultural specific Wellness Centers can support this population.
	BHSD RESPONSE: Thank you for your feedback. Specialty populations have faced historical and contemporary traumas that result in these groups having trouble trusting authority and government. This lack of trust often results in groups delaying or avoiding accessing treatment. In response, BHSD will develop intergenerational, cultural-specific wellness centers for the African American, Latino, Asian/Pacific Islander, Native American, LGBTQ+ communities, immigrant and refugee communities. This would allow a space where traditional and culturally responsive healing can occur while providing a safe space for the transfer of cultural knowledge and healing across generations and a way to remain connected without requiring participation in and authorization of formal specialty mental health services.
	11. Program Name: Headspace Page Number in Document: 135- 136; 143-144, Section on AB114 Plan Feedback: This program appears in several places throughout document making it difficult to comprehensively understand the proposal. We recommend a summary that pulls together all the relevant sections and provides details on the model, staffing and how services will be provided on site as well as how the additional services not covered by MHSA (primary care, drug and alcohol treatment, education and employment services) will be paid for. MHSA spending includes the following which should be included in the above detailed description: Renovation of sites: $ 940,000 (paid for using funding to be subject to AB114) Ramp-Up: $572, 273 (this is listed in plan and paid for using funding to be subject to AB114) Implementation: The document states the FY17-20 Implementation budget is $5,388,913. It appears that $1,822,772 of funds subject to AB114 will be applied to this. The plan states the estimated cost for four-year implementation is $15,875,675. We recommend a plan for the use and source of funds be included.

Comment from	Comment/Feedback
	BHSD RESPONSE: The *headspace* Innovation project will provide an integrated, youth-informed service settings for youth ages 12-25 that render equitable access regardless of ability to pay or type of healthcare coverage in a "one-stop shop" setting. *headspace* services will include 1) Behavioral health care (i.e., mental health services and alcohol and drug treatment), 2) Primary care wellness and preventative services, 3) Educational support, and 4) Employment services. These integrated services will meet the overlapping needs of youth with mental health issues. The services will be integrated, not just co-located, in partnership with Community-Based Organizations (CBO; 4.0 FTE), BHSD staff (3.40 FTE), and Stanford Medicine (2.80 FTE). Services will be provided equitably to all youth at the center regardless of their health insurance status in a seamlessly coordinated fashion. The services will be based on the youth's need and be facilitated by the peer partners hired by the CBO. The integrated and youth-informed services distinguish 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 headspace centers located in the intended service areas of Central San Jose and North County (Palo Alto/Mountain View). The first phase of the *headspace* project is the ramp-up to plan the program framework (i.e., page 136; estimated cost of $572, 273), which is followed by the implementation phase (i.e., pages 143-144; estimated cost of $5,388,913). One of the innovative parts of headspace is the core value of youth partnership and empowerment. The Youth Advisory Group will inform the one-stop shop clinics to eliminate stigma related to mental health and help to increase service access. To this end, the site will be youth-friendly, non-stigmatizing, and easily accessible (i.e., page 135; estimated cost of $ 940,000). The four-year implementation cost is estimated at $15,875,675, which includes salary for the CBOs, BHSD Staff, and Stanford Medicine, as well as technical assistance from Stanford and the required evaluation.
	12. Program Name: CSS: FSP Page Number in Document: 56 Feedback: The increase of an additional 100 slots is positive, however, results in decline in per client funding. We recommend a significant increase in funding as at its highest of $29,604/annually which is only about 2,500/mo., the stated outcomes are not likely to be delivered. Further, over 3 years, per client funding drops 9.88% to $26,680 per client/slot. Also, in FY19/20, leveraging is increased by 8%. Why is this?
	BHSD RESPONSE: The Draft Plan does not eliminate or replace existing services. BHSD does not plan to change the FSP service models currently in place. For all new FSP intensive services (the additional slots), the Department will conduct a procurement process in FY19 with the higher rates.
	13. Program Name: Outpatient/Intensive Outpatient Page Number in Document: 58 Feedback: Over 3 years, overall funding drops slightly (.75%). Given the high number of Level One referrals that hit OP, this program should have increased funding to ensure comprehensive care and crisis stabilization. The current IOP contracts require large caseloads per clinician. The program should have been updated to include increase flexible funding to assist with basic needs for comprehensive care models.
	BHSD RESPONSE: The Department believes they have allocated adequate capacity to outpatient and intensive outpatient programs (IOP). The caseload as documented in these contracts is between 8-12 for IOP and 16-24 for Outpatient clients per full-time clinician (an

Comment from	Comment/Feedback
	appropriate case load). There is allocated case management time within the program to allow for the treatment team to link the client with other resources in lieu of flex funds which are generally allocated for youth with more intensive behavioral health needs (FSP and Wraparound).
	14. Program Name: Specialty Services – Integrated MH/SUD Page Number in Document: 59-60 Note any questions for concerns: This program is experience a lack of referrals from call center. Given all the indications that there is a high number of people with co-occurring needs, adjustments need to be made to ensure they are receiving services. While the stated age range is 6-24 but experience has been 12-24.
	BHSD RESPONSE: We appreciate your comment and will be working with our Call Center to improve screening processes for youth with co-occurring conditions and will work to more closely align these services for youth involved in the juvenile justice and child welfare systems with co-occurring conditions.
	15. Program Name: Specialty Services – Eating Disorders Page Number in Document: 60 Feedback: The budgeted 3-year amount ($7.5M) is significantly greater than the amount described in the narrative ($1.389M)
	BHSD RESPONSE: This program has been combined with Outpatient Services – Eating Disorders. The County Mental Health Plan (MHP) is now required to provide these services to both children and adults. There are very few providers in our community and across the State that can provide these services. The County is creating a continuum of care for these services.
	16. Program Name: Foster Care Development Page Number in Document: 62 New, Continuing or Modified: Continuing Feedback: Given that this is a 23-hour program, it seems unlikely that it will be possible to earn 30% FFP in FY20, which would require 25 hours of MediCal billable services per client.
	BHSD RESPONSE: We appreciate your comment and upon review have increased the number of youth served to 200 at a lower dosage of service. The Department will review the budget in the FY19 Annual Update.
	17. Program Name: Uplift Mobile Crisis Page Number in Document: 63 Feedback: This program averages 300 calls each month and averages 80 evaluations/month. The mobile team is available 24/7, 365 - 5150-5585 evaluations for any SCC child who is suicidal or homicidal. 1.7mil only covers 7.5 FTE, On Call and the response call line. The budget shows no increase over three years while the County recently applied for a State grant noting that current services were insufficient. We recommend an increase in funding to adequately support our County's population as this program, even while underfunded, still divert from hospitalization 70% of the time.
	BHSD RESPONSE: We appreciate your comment and upon further review recommend to increase Uplift Mobile Crisis by $196,600 which would provide additional services to 200 youth. This has been added to the Program Narrative and budget.
	18. Program Name: School Linked Services Page Number in Document: 64 Feedback: We recommend this program be modified to address the referral flow bottle neck and to address concerns with restrictive EBP, training, measurement tools and documentation requirements. School personnel continually complain to providers about how inflexible this SLS model is. The percentage of funds that are FFP varies significantly over 3 years. What is the reason for this?

Comment from	Comment/Feedback
	BHSD RESPONSE: BHSD meets on a quarterly basis with School Linked Services (SLS) School District Superintendents and on a monthly basis with SLS school staff through collaborative meetings to discuss issues and do collaborative problem solving. BHSD also conducts an annual satisfaction survey with SLS School District administrators and school staff. The issue of a "referral flow bottleneck" has not been raised when opportunities for feedback have been provided. Within most SLS School Districts, referrals from school personnel are triaged by the SLS Coordinator and then referred to providers. With regards to Evidenced Based Practices (EBP). Trainings, measurement tools, and documentation, these components help develop practitioner competency, ensure quality of treatment practice, measures progress and improvement on client level, and adhere to state and federal requirements related to Medi-Cal/Early, Periodic Screening, Dianostic and Treatment (EPSDT) reimbursable services. To provide flexibility, BHSD may review and accept an alternate practice by a provider if proposed. With the new PEI regulations, BHSD shifted the required programs to the appropriate MHSA component. In this case, from PEI to CSS for all SLS Clinical Services. The PEI component of SLS (SLS Coordinators) is in the PEI section.
	19. Program Name: PEI Support for Parents Page Number in Document: 65 Feedback: Over 3 years, there is no increase in funding. Is Triple P sustainability in this program and for PEI in general? Triple P is a very expensive EBP and should it continue to be required, funding needs to increase to cover costs of trainings.
	BHSD RESPONSE: The initial investment to building personnel competency in Triple P was approximately $400,000 annually. There is significant research on this evidence-based practice to reduce the incidence of child maltreatment. In partnership with FIRST 5 Santa Clara County, BHSD has provided this EBP to providers for the past four years. Since the initial roll out of trainings, investment costs have been incrementally reduced to current investment of $130,000 annually. BHSD continues its investment in Triple P because of its commitment to provide quality behavioral health services. Of note, the ongoing training has, in part, been in response to continued staff turnover among contract service provider agencies.
	20. Program Name: KCN Access and Linkage Page Number in Document: 67 Feedback: Over 3 years, funding for this program more than doubles (from $321,680 Year 1 to $588,527 in Years 2 & 3. How will this significant increase of funding be utilized? The narrative describes that MHSA funds 2 County staff who are managers.
	BHSD RESPONSE: KCN is a comprehensive system of care for children ages birth to 5 and their families. MHSA funds 25% of a Mental Health Program Specialist II whose primary responsibilities are to oversee this system of care and work collaboratively with FIRST 5 Santa Clara County. MHSA also funds a full time Health Care Program Manager II at KidScope, a specialty mental health services clinic which offers comprehensive assessments for children with complex developmental delays and serious behavioral problems. Effective July 1, 2018, the Managed Care Final Rule requirement states 10 business days from request to appointment constitutes timely access to outpatient mental health services. The results of the KCN Pan Do Study Act (PDSA) data demonstrate that our system of care is not meeting the State requirement of network adequacy for timely access therefore not meeting the needs of the family in providing appropriate clinical care. MHSA offers the ability to address and meet this State requirement by utilizing additional funding to support four (4) Community Workers stationed in high referral settings, SCVHHS Pediatric primary care clinics, to engage with families on site when a referral to KCN services has been initiated by a pediatrician. The role of the Community Worker, as part of BHSD's Community Access Referral and Engagement (CARE) team, would be to assist the family in contacting the BHSD Call Center for same day access, triage and linkage to an available KCN provider. With knowledge of where the referral is to be directed, the CARE team member would support the family in contacting that KCN provider to obtain an appointment and act as a liaison between the referral source and KCN provider.
	21. Program Name: TAY FSP Page Number in Document: 68

Comment from	Comment/Feedback
	Feedback: At the SLC meetings and in the needs assessment, the need for a higher per person investment was highlighted but the funding for the TAY FSP is flat in FY18 to FY 19 and only rises from $19, 433 to $ 20,170 in FY20, a 4 percent increase and less than the per person investment for Intensive Outpatient. As there is currently a great deal of demand for intensive Outpatient for this population, we recommend some of the funding for expansion in slots (100) be utilized to increase the availability of intensive outpatient component of the continuum in care.
	BHSD RESPONSE: The Draft Plan does not eliminate or replace existing services. BHSD does not plan to change the FSP service models currently in place. For all new FSP intensive services (the additional slots), the Department will conduct a procurement process in FY19 with the higher rates.
	22. Program Name: TAY Outpatient Page Number in Document: 69 Feedback: Some providers are seeing a need for more of this service. We recommend examining the need across the continuum of care for TAY (FSP, Outpatient, Intensive Outpatient) and increasing in all areas, not just focus on FSP. In the budget, the amount of FFP utilized more than doubles (FY17=18.39, FY19=50.58, FY 20=49.54%). What is driving this difference?
	BHSD RESPONSE: BHSD recognizes that an increase in TAY Outpatient slots is needed and plans to address this need through funding reallocation. The budget difference is related to properly recognizing the match ratio.
	23. Program Name: TAY Intensive Outpatient Page Number in Document: 70 Feedback: Currently there is a long waiting list for this service and clients are being referred to Adult IOP to reduce backlog of clients. We recommend increasing funding for expansion of number of clients served (see comment above at TAY FSP). Also, the budget does not show any leveraging of MediCal which is currently being done by CBO providers of this service.
	BHSD RESPONSE: This program recognizes that these services are managed by the Children, Youth and Families (CYF) System of Care (SOC) and will continue to be procured in the same manner. The CYF SOC serves both Children and TAY as stated. The Department will revise the Draft Plan and consolidate the programs into the SYS SOC. Budgets are included in the narrative descriptions.
	24. Program Name: CSEC Page Number in Document: 72 Feedback: The description indicates the project will begin in FY18-19 and serve 300 youths. In goals and objectives has funding in FY17-18 and indicates 175 youth. Providers experience with this population suggests that the goal of serving 300 may not be realistic as the number of identified youth is not that high. The funding in the narrative does not match the funding in the budget (difference of $700,000). Why is there no FFP in this program?
	BHSD RESPONSE: The proposed plan is to serve 300 youth over 3 years; which equates to 100 youth served per year. The 175 youth in FY 17-18 is an error and has been corrected in the Draft Plan. Medi-Cal leveraging may be adjusted in the future, depending on the insurance status of the youth served in the program.
	25. Program Name: Services for Juvenile Justice Involved Youth Page Number in Document: 73 Feedback: The percent of FFP changes significantly from 12.48% to 10.99% to 40%. Why is there a decrease in the second year and such a dramatic increase in the last year?
	BHSD RESPONSE: There is a decrease in the second year due to an increase in program costs and the MediCal billable portion remaining at the same rate for FY19. There is an increase in FY20 due to an updated rate to the MediCal billable portion for this program.

Comment from	Comment/Feedback
	26. Program Name: TAY Triage to Support Re-entry Page Number in Document: 74 Feedback: We do NOT support creation of this new program as written. It is duplication of existing services. There are providers currently conducting intakes and providing services at the Re-Entry Center that are under capacity (adult contracts) and already serve TAY. TAY also make up a small number of youth in jail. We recommend this funding earmarked for services on the jail population be redirected to creation of new program in the Pretrial Office where TAY could use support before court. Should there be no re-direction to pre-trial, the estimation of serving 500-600 youth seems high based on number of TAY at jail and EPS. The budget indicates 50% FFP. How will MediCal be billed for additional service provision at EPS or Jail? Jail is a lock-out and EPS is limited to EPS billing.
	BHSD RESPONSE: We appreciate your thoughtful comments and will consider them when we procure these services in the near future.
	27. Program Name: TAY Crisis and Drop-In Center Page Number in Document: 75 Feedback: We recommend adding homeless outreach to homeless TAY
	BHSD RESPONSE: We will modify the sixth bullet under specific mental health outpatient service offered include: • Outreach and engagement activities for homeless TAY
	28. Program Name: TAY Interdisciplinary Service Teams Page Number in Document: 76 Feedback: If the goal is to serve 1,000 clients, $1.5 million seems like not enough funding MediCal reimbursable services are to be provided. FFP is budgeted at 50% which is high given the robust variety of non-MediCal billable services described.
	BHSD RESPONSE: Thank you for your comment. The Department will review the budget in the FY19 Annual Update.
	29. Program Name: Violence Reduction Page Number in Document: 77 Feedback: The description indicates this is a continuing program, but other service providers are unfamiliar with it existing. Is it being done by County staff?
	BHSD RESPONSE: This funding has supported the County's Public Health Department's Healthy Relationships program for youth and will continue as an intimate partner violence (IPV) prevention program. The Department has added funding to the County's IPV initiative and will work with the County's Women Policy team and other partners to support this effort.
	30. Program Name: REACH Page Number in Document: 78-79 Feedback: The age bracket is incorrect. Providers currently serve 10-25, not 16-25, and span both F&C and TAY systems. We recommend including the community educational outreach portion of program in the description. This is a very large aspect of the program, covering the "prevention" piece. The outcomes should include the educational aspect as data exists on this, separate from the number of clients served
	BHSD RESPONSE: Thank you for bringing this to our attention. The age bracket is 10-25 and we will make this change in the Draft Plan. We will also add your recommendation to include the community educational outreach in the program narrative, as well as the educational aspect of the outcomes, such as an increase in school attendance.
	31. Program Name: ACT Page Number in Document: 84-85

Comment from	Comment/Feedback
	Feedback: Does the funding include Flex or Housing funds? The leveraging ratio is at 40% which seems high (FSP Adult is at 29.48%) for program description. How was this determined? What is the different referral criteria for ACT versus FSP and is this seen as a continuum of care where someone will progress from ACT to FSP?
	BHSD RESPONSE: The total budget does include flex and housing funds for consumers who do not have access to other types of housing subsidies. The 40% leveraging ratio for Medi-Cal is based on ratios from other counties who have maximized Medi-Cal revenue within FSP. We know that this represents a change from the current Medi-Cal billing, and we are committed to supporting FSP providers to maximize the Medi-Cal revenue available. In terms of ACT and FSP, the specific referral and eligibility criteria for the two levels of service have not yet been established. However, ACT and FSP are intended to be a part of continuum where enrolled consumers could step up or step down based on need.. The Department will review the budget in the FY19 Annual Update.
	32. Program Name: FSP Adult Page Number in Document: 86-87 The description references a "lighter touch" for current FSP clients. What does this mean? Will there be a continuum within FSP? FY 17-18 cost per slot goes from $23,528 per client to $24,415 in FY 2020, a 3.77% increase over 3 years. Discussions have indicated that the investment per slot was going up, but this doesn't even keep up with CPI, or any needed rate increases. FY 19-20 FFP leveraging goes up significantly (FY 18 at 29.48% to FY 20 at 42.91%). Why?
	BHSD RESPONSE: FSP Maintenance, is a continuation of the FSP model from previous plans. This tier of services will ensure that individuals that currently receive FSP services will continue to receive care without any reduction in service. The FSP maintenance service is a step down from intensive FSP for those who may still need services, including housing support, to remain successful in the community.
	33. Program Name: FSP Criminal Justice Page Number in Document: 88-90 Feedback: Program description virtually identical to FSP Adult, with added CJ involvement and incarceration, with big variance in cost per slot (almost $10K less that Adult FSP) in FY18, FY19 and then in FY20 when cost goes up 119% and then is $10K more than adult FSP (even with increase of 100 slots).
	BHSD RESPONSE: To support increased demand, FSP services have been expanded and include ACT, Adult FSP, and Criminal Justice FSP. Within CJS, these FSP services provide 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 consumers living with a serious mental illness to reach their wellness and recovery goals. Furthermore, in FY18 and based on recent assessment needs, additional funding was added to assist individuals with their housing assistance which would follow the client throughout their involvement in the Criminal Justice Systems Division.
	34. Program Name: Permanent Supportive Housing Page Number in Document: 90-91 Feedback: Over 3 years, funding increases 7.25%, does this include the proposed expansion to include TAY detailed in the proposed budget agenda item at the Health and Hospital Committee meeting in April? If so, we recommend a Request for Proposal be issued for this service.
	BHSD RESPONSE: Thank you for your comment. The Department will be working closely with the Office of Supportive Housing on their MHSA-funded programs, including the TAY program.
	35. Program Name: CalWORKs Community Health Alliance Page Number in Document: 93-94 Feedback: Why is funding flat over the 3 years? The program description makes distinction that CBOs leverage Medi-CAL to fund services, while County staff is funded entirely by CalWORKs funds. Why is the County not leveraging MediCAL?

Comment from	Comment/Feedback
	BHSD RESPONSE: Funding for the program has recently decreased due to the change in volume of CalWorks clients.
	36. Program Name: Criminal Justice Residential and Outpatient Treatment Programs Page Number 95-96 Feedback: Budget is $4,927,134 for FY 17-18. Overall proposed budget for FY17-20 is $18,274,610. This suggests here would be an increase to this budget of 64.12% ($3,493,208) across FY18-19 and FY19-20. What justifies this increase? There is no indication of more people served. Further, why is there no FFP in this program?
	BHSD RESPONSE: The Criminal Justice Residential and Outpatient Treatment Program (Evans Lane) narrative and budget have been updated in the Draft Plan and should address your questions.
	37. Program Name: Criminal Justice Outpatient Services Page Number in Document: 97-98 Feedback: Over 3 years funding increases 10.36%, but the description does not say why? Also, why does the FFP not increase at all?
	BHSD RESPONSE: During FY2019, the program adds a new Senior Health Care Program Analysts (1 FTE) to support data capture and analytics requirements for MHSA-funded programs and provide project management oversight in the Criminal Justice System.
	38. Program Name: MHUC Page Number in Document: 100 Feedback: Over 3 years funding increases 5.62%. Does this mean MHUC will be expanding hours? Are a large portion of clients seen here the newly eligible? That appears to be the only way that leveraging of 60% plus FFP can be achieved.
	BHSD RESPONSE: The Draft Plan does not include funding for expanded hours at MHUC. The 60% leveraging ratio is based on current MHUC billing data.
	39. Program Name: Crisis Stabilization Unit & Crisis Residential Treatment Page Number: 100 Feedback: The description is incorrect in stating this is an involuntary service. The providers have been very clear that it is not involuntary. *The l*everaging is at 51.96%, which seems high. It states the per client cost is $48,779.68 which is much higher than the experienced cost of providers.
	BHSD RESPONSE: Thanks for bringing this to our attention. This program description has been updated as a voluntary program in the Draft Plan.
	40. Program Name: Community Placement Teams Page Number in Document: 102 Feedback: The 3-year amount is $4.5M but number served is TBD. Please provide more detail on how this program is currently structured. How does it differ from the Pay for Success Program?
	BHSD RESPONSE: This is a not a Pay for Success Program. Individuals receiving Community Placement Team services typically have failed in traditional treatment models. Based on existing models in other California counties, the overall goal of these services is to assist in the stabilization of the individual and the transition to less intensive levels of service. The County's 24 Hour Care team monitors and authorizes placement into acute hospitals, if necessary, and residential programs, such as IMDs, Crisis Residential, Crisis Stabilization and Supplemental Services. All placements for the system are managed by 24 Hour Care and the budget is based on the full spectrum of these services.

Comment from	Comment/Feedback
	41. Program Name: IMD Alternative Page Number in Document: 103 Feedback: The numbers in the narrative appear too high.
	BHSD RESPONSE: Thank you for the feedback. The numbers served per year have been adjusted. The current service capacity is N=17.
	42. Program Name: Mobile Crisis Page Number in Document: 104 Feedback: The numbers in the narrative don't make sense and there is no line-item for Mobile Crisis in the budget.
	BHSD RESPONSE: The narrative and budget for the law enforcement and mobile crisis team partnership has been updated in the Draft Plan.
	43. Program Name: In-Home Outreach Page Number in Document: 105 Feedback: Will this program be provided by the County staff or Community-Based Providers?
	BHSD RESPONSE: One In Home Outreach Team (IHOT) will be County-operated and serve as the link between Emergency Psychiatric Services, Mental Health Urgent Care and the IHOT teams. The additional IHOT teams will be contracted out via an RFP process in FY19.
	44. Program Name: Older Adult Full Service Partnership (CSS) Page Number in Document: 110-112 Feedback: Funding amount is increasing by 180% between Year 2 and Year 3. Will there be additional number of clients served? If so, how many? If not, based on current number of 66 clients, cost would be $42K annually.
	BHSD RESPONSE: With the Intensive Full-Service Partnership for Older Adults, the program will provide 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 consumers living with a serious mental illness to reach their wellness and recovery goals. Additional capacity is planned with an increase per person spending.
	45. Program Name: Outpatient Services for Older Adults (CSS- System Development) Page Number: 112-114 Feedback: Why is there so much variation in the percentage of FFP used (11 % to 50% back to 10 ½)?
	BHSD RESPONSE: The variation noted above is due to a change in fiscal allocations and does not affect the overall service delivery for this program. In FY20 there was not a 50%-50% split in FFP as in FY19. The total remains the same, it was a minor change in the proposed allocation for the year.
	46. Program Name: Older Adult Community Services Initiative (Clinical Case Management Team for Older Adults) Page Number in Document: 114-115 Feedback: Is this new program connected to Whole Person Care? Will it be provided by County staff or Community Based Providers? Why does it not leverage FFP?
	BHSD RESPONSE: This is a new program to expand the continuum of care specifically for the older adult community. This program is slated to begin in FY20. An Older Adult Committee will be established in target communities to shape engagement activities and ensure they are culturally and linguistically responsive.

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	47. Program Name: Promotores Page Number in Document: 122 Feedback: We support the Promotores approach but do not believe it should be limited to Eastside of San Jose. We recommend that it target the disenfranchised and marginalized communities that exist throughout Santa Clara County especially in the central/downtown region and Gilroy by changing the description to *adults and teens living within zip codes where significant need has been demonstrated.* Limiting this service to Eastside San Jose fails to address the other regions where the need is just as necessary
	BHSD RESPONSE: The Department will correct the language as suggested in the Draft Plan.
	48. Program Name: Learning Partnership Page Number in Document: 132 Feedback: The funding listed in the narrative for FY18 is twice that listed in the budget ($1.8M vs. $900K). If the narrative is accurate, there will be a 163% increase for the next two years. How will the increase be utilized?
	BHSD RESPONSE: The funding listed in the budget is incorrect. The budget in the Draft Plan will be updated to the correct figure for FY18, $1,805,158.
	49. Program Name: WET: Workforce Education and Training Page Number in Document: page 132 Feedback: The Plan indicates that WET funding was exhausted in 2016 and in SCC it is now carved out of CSS. If State WET funding continues through FY18 (and there is legislative proposal to extend one more year), why is it not being used in FY18. How much of the total funding and related FTEs are allocated to each of these components? • 5 training initiatives (Training Coordination, Promising Practice, Improved Services and Outreach to Unserved and Underserved, Welcoming Consumers and Family Members, WET Collaboration with Key System Partners) • 1 initiative to support a model to develop workforce with people with "lived experience" (Mental Health Career Path) • 1 initiative: (Stipends and Incentives to Support Mental Health Career Pathways)
	BHSD RESPONSE: Santa Clara County, as did all counties, received a one-time allocation of WET funds. Santa Clara County has utilized all of this funding and leverages service continuation with annual transfers from the CSS component, as allowed by MHSA regulation. The WET funding amount has been maintained over the years and staffing has not changed since implementation.
	50. Program Name: Capitol Facilities and Technology Needs Page Number in Document: 135 Feedback: The feedback specific to requesting more detail on the headspace Renovation is included in Headspace feedback above. We support the use of funds to upgrade existing facilities to promote health and wellness but recommend that in addition to focusing on the new Headspace program, Capitol Facilities funds also be directed to the dire need for work on facilities beyond Headspace, where community-based providers have long been serving the vast majority of clients in the system and have not received support to improve the physical environment so that it promotes health and wellness In regard to Technology needs, the plan indicates $1.7M annually for a total of $3.4M over 2 years to pay for line staff and mid-managers for EPIC/HealthLink and Netsmart/Practice Management implementation. Unless Contract provider costs will be fully captured by increasing rates, the contract provider costs associated with electronic health record and practice management/billing changes require

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	these funds. Even when rates cover on-going costs, we recommend targeting some of these funds for one-time expenses such as required custom interfaces.
	BHSD RESPONSE: The Department will provide funding when there is an approved ISD plan in place with identified technology to adequately support the contract service providers for the Netsmart/MyAvatar implementation.
	51. Program Name: PERT Page Number in Document: 140 Feedback: The plan indicates the County is piloting two teams. It also refers to additional teams. How are these being implemented?
	BHSD RESPONSE: BHSD will roll out four teams in total, starting with two teams in the first year. The Office of the Sheriff and four law enforcement agencies have asked to participate in this program. BHSD leadership, managers and staff are working with the law enforcement agencies to develop policies and processes for the PERT teams.
	52. Program Name: Technology Suite for Community Mental Health Page Number in Document: 144 Feedback: We recommend more detail on how the large amount of $4.37 million will be spent (what applications) and how this initiative will connect with other services as it describes connecting individuals seeking help in real time. Also, the population targeted indicates adult and older adult. It seems that it would make sense to include TAY as on the whole, they are more likely to turn to technology, especially if compared to older adults.
	BHSD RESPONSE: We appreciate your comment and will consider the proposed expansion as we move forward in the future with any procurement efforts for these services.
	53. Program Name: Older Adult In-Home Outreach Team Page Number in Document: 146 Feedback: Will this service be provided by County staff or community-based organizations and how will it connect with existing in-person engagement and outreach such as Elder Storytelling. The cost seems very high for a primarily phone-based system when compared to budget of existing in-person services for older adults.
	BHSD RESPONSE: The intent is to provide this service via County staff. We appreciate your input on the proposed programming aspects and will consider them as we move forward in the planning and implementation of the initiative near term. Thank you for highlighting this budget issue, which we will review before moving forward.
*related to AB114	54. Program Name: Prevention and Early Intervention: Strengthening Children and Families (East/South) Page Number in Document: Section on AB114 Plan, Page 1 Feedback: Feedback is provided in relevant sections of 3-year plan.
	BHSD RESPONSE: Per regulations, SCC must indicate how funds subject to AB114 would be spent by June 30, 2020.
	55. Program Name: REACH Page Number in Document: Section on AB114, page 2 Feedback: The age bracket listed is incorrect. REACH serves ages 10-25, not 11-25, spanning both F&C and TAY systems. Related comments are in the feedback on REACH in the 3-year plan.
	BHSD RESPONSE: The Department will make this correction in the Draft Plan.

Comment from	Comment/Feedback
	56. Program Name: LGBTQ Wellness Page Number in Document: Section on AB114 Plan, Page 2 Feedback: The LGBTQ Wellness program would benefit from additional support and streamlined communication from the remainder of the ECCACs. Further, the ECCACs could benefit from system-wide LGBTQ+ inclusivity training.
	BHSD RESPONSE: Thank you for your comments; the Department supports your recommendation. Please refer to the response for comment #5 for details.
	57. Program Name: CFTN Page Number in Document: Section on AB114 Plan, Page 3 Feedback: Our concerns are noted in discussion of CFTN spending in 3- Year Plan.
	BHSD RESPONSE: Per regulations, the County must indicate how funds subject to AB114 would be spent by June 30, 2020.
The Judge David L. Bazelon Center for Mental Health Law (Bazelon Center) and the American Civil Liberties Union (ACLU)	58. *Coordination between Criminal, Legal and Mental Health Systems.* At the outset, the County needs to ensure that there will be systemic, ongoing coordination between the County's corrections/criminal justice officials and the County's mental health system. These partnerships are vital to ensuring that there is long-term alignment of service needs for people with significant mental health disabilities. Without such coordination, the County is likely to face similar situations in the future, with hundreds of individuals with SMI cycling between emergency rooms, hospitals, jails, and shelters. As part of this effort, the County should regularly assess the needs for the community services described in the Plan, as well as those set forth below. These ongoing assessments will help the County comply with the ADA and *Olmstead*.
	BHSD RESPONSE: Thank you for your comment and suggestion. At present, the Department maintains staff in the County's Court system to facilitate linkages to support services.
	59. *Provide Scattered Site Supportive Housing Units.* We strongly urge the County to consider alternatives to the proposed new residential programs, and in particular to increase the amount of Permanent Supportive Housing (PSH) and accompanying housing subsidies and flexible services. PSH is a critical service that not only has substantial social and economic benefits, but also would further the County's efforts to comply with the ADA and Olmstead by affording individuals with SMI the chance to live in what is the most integrated setting appropriate for virtually all: their own apartments or homes. Supportive housing units are typically scattered in mainstream buildings throughout the community—a practice that promotes greater integration than housing in developments exclusively or primarily designated for individuals with disabilities. In addition, supportive housing provides the individual with a flexible array of services, such as case management, life skills training, homemaker services, substance abuse treatment, and employment supports. Supportive housing recipients can also receive ACT or other team-based services if they need them.

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	Studies have shown that supportive housing has substantial benefits because it "leads to more housing stability, improvement in mental health symptoms, reduced hospitalization and increased satisfaction with quality of life, including for participants with significant impairments, when compared to other types of housing for people with mental illnesses." Supportive housing is also significantly less expensive than institutional care. States that reallocate funds from institutional settings to supported housing as they downsize or close institutions have been able to realize substantial cost savings. A large study in New York City of homeless individuals with SMI receiving supportive housing services demonstrated that these individuals experienced significant reductions in shelter use, hospitalizations, duration of hospital stays, and incarceration. A pilot project involving the Pathways to Housing program in Philadelphia, which provides supportive housing to formerly homeless individuals with SMI and substance abuse disorders, found that the program reduced participants' prison system episodes by 50 percent. In Delaware, a study found that when individuals with SMI who had protracted stays in the state hospital (some dating back to the 1960s) were moved to scattered site supportive housing with a state housing subsidy and ACT or similar services, there was a net annual savings per person of somewhere between $96,000 to $276,000. In addition, the hospital readmission rate for this high-risk group was found to be less than half that of the general SMI population in the state.
	BHSD RESPONSE: The Draft Plan shows an increased allocation for supportive housing. The Department works in collaboration with the County's Office of Supportive Housing to facilitate clinical staff availability in support of the behavioral health needs of clients.
	60. *Expand Mobile Crisis Capacity, Separate From Law Enforcement.* The County should implement mobile crisis and PERT teams that include clinicians and peers instead of—not in addition to—law enforcement officers. Law enforcement officers lack the expertise required to respond to individuals experiencing a mental health crisis. At the same time, the County should ensure training for 911 dispatchers, as well as robust coordination between mobile crisis teams, 911 dispatchers, and other officials responsible for responding to individuals in crisis. Mobile crisis and PERT should also be more explicitly coupled with community-based mental health and addiction services that help individuals with SMI avoid police encounters in the first place and help reduce the risk of recidivism upon release from police custody or incarceration. Finally, the County should ensure 24/7 access to mobile and walk-in crisis services and consider increasing the capacity of these programs.
	BHSD RESPONSE: Both Mobile Crisis and PERT are comprised of interdisciplinary teams; for example, licensed and licensed-waivered MFT and/or PSWs on each team. The Department has dedicated law enforcement liaisons and the teams work in tandem with local law enforcement agencies.
	61. *Revisit the Need for a New Jail.* The County is poised to spend millions of dollars on building new jail beds specifically to house people with significant mental health disabilities. While we recognize this effort may arise out of concern for the conditions currently in place, we urge you to reconsider committing both the capital dollars and the operating funds to a setting that, even if better than the current jail, is still among the most expensive—and least suited—options to house people with SMI. Incarceration generally exacerbates mental health conditions and precipitates mental health crises.33 Corrections officers are not trained or equipped to work with people who have significant mental health disabilities. Placing people with significant mental disabilities in jail will only perpetuate and increase the very problems the MHSA programs are trying to address.

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	Indeed, if the above community services are properly implemented, the County should have no need for most of these beds. Using services like FSPs, ACT, peer services, and supportive housing programs to divert people from jail has shown great promise in other jurisdictions. In Miami-Dade County, a jail diversion program focusing on people with SMI reduced rates of recidivism from 72 percent to 20 percent. The program was so successful that Miami-Dade was able to close an entire jail, saving taxpayers $12 million a year in operating expenses. In Johnson County, Kansas, the mental health co-responder program, working with other diversion programs, left the county with 300 empty jail beds. In a different Johnson County in Iowa, a diversion program has left them with half the previous jail population, and saved the county $2.7 million. In short, continuing with plans to build hundreds of jail beds specifically to house people with mental health disabilities ignores the substantial benefits you should see from the community services you are putting in place, and wastes important resources.
	BHSD RESPONSE: Thank for your comment. This is a County Leadership decision.
Asian Americans for Community Involvement (AACI)	62. I am noticing that the PEI program of Integrated Behavioral Health in Primary Care Clinics is no longer included in the 3-year plan. This program is critical to providing mental health care in a non-stigmatizing environment, in particularly to ethnic populations who would rather seek out a physician than a mental health services provider. This has been a highly successful program for the last five years and completes the continuum of services from high intensity to step down care for clients that can be maintained in primary care settings. It would be a travesty to eliminate such a valuable program, which is also in keeping with the 1115 waiver and the Whole Person Care principles. I am strongly urging the department to add back this program, which is critical to providing integrated care. Having BH within primary care supports care coordination and will be instrumental in reducing clients needing to access higher levels of care.
	BHSD RESPONSE: Thank you for your comment. Please refer to response in comment #7.
Gardner Family Care Corporation	63. I noticed that the PEI program of Integrated Behavioral Health in Primary Care Clinics is no longer included in the 3 year plan. This program is critical to providing mental health care in a non-stigmatizing environment, particularly to ethnic populations who would rather seek out a physician than a mental health service provider. This has been a highly successful program for the last five years and completes the continuum of services from high intensity to step down care for clients that can be maintained in primary care setting. Eliminating this program from the continuum of care would be inconsistent with the Whole Person Care principles, and 1115 waiver. We are strongly urging the Department to add back this program, which is critical to providing integrated care. Having BH within primary care supports care coordination and will be instrumental in reducing clients needing to access higher levels of care.
	BHSD RESPONSE: Thank you for your comment. Please refer to response in comment #7.
Community Health Partnership Community Health Partnership	64. I am concerned that Integrated Behavioral Healthcare service (IBH) is not specifically named in the plan. IBH service is not only a "best practice" in the field of community health, but also yet another avenue to reach the most vulnerable who may not be able to access county services in a timely manner. Most importantly, however, IBH is a very effective way for families who already receive other services at their local community health center to access short term counseling without necessarily having to impact the county system. Supporting and enhancing community-based IBH services enhances the county's system of care by providing prevention & early intervention (P&I) in context of a primary care treatment plan, thus increasing your ability to serve a wider population at a lower cost and in a culturally sensitive manner. Now, more than ever, it is important to acknowledge that specific populations are shying away from

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	government services - providing care at a trusted agency and via a trusted primary care system is paramount. Finally, taking the opportunity with MHSA funding to develop and support IBH services will further complement and strengthen the MediCal Waiver 1115 (Whole Person Care) programmatic objectives. Thank you for considering this request.
	BHSD RESPONSE: Thank you for your comment. Please refer to response in comment #7.
Student Intern (Health Career Connections)	65. As a prospective public health professional whose interests reside in behavioral health and mental health, I would like to thank all the progressive efforts that have been made towards improving services related to the prevention, intervention, postvention, and destigmatization of mental illness. Although I am still familiarizing myself with healthcare policy — it's structure and rhetoric — as well as the fiscal matters that follow it, there are a few comments I would like to provide with regards to the MHSA Three-Year Program and Expenditure Plan considering what I've learned from my experiences as a community member and healthcare student. Through looking through the various programs included in the three year plan and its respective budgets, I've noticed that although there are upwards of a million dollars allocated towards TAY services, the collective amount is still low compared to the rest of the allocated funds. Based off of the Santa Clara County Public Health Department Coroner's death data from 2009-2014, high suicide rates occur between the transitional ages of 15-24 and even higher rates of suicide occur after the age of 45. Given these rates, it's apparent that attention must be given to these age groups. The name, "transitional aged youth", suggests that those within this group are in a stage of transition. While not always the case, a lot of detrimental factors that lead to mental health issues tend to follow the notion of transition. Those who are in this critical age group usually undergo a lot of flux and uncertainty because of the state of transitioning from one stage of their life to the next. What occurs within this age is critical to their life outcome and subsequently the rates of suicide. More of the budget could be apportioned services that help guide these TAY into adulthood, such as the TAY Full Service Partnership, the TAY Outpatient Services, and the Intensive Outpatient Program should receive more funding as it would help guide their path and foster sustainable sufficiency and stability. With increased funding for such services, not only can we reduce the suicide rates within this age group but also beyond this age group. The higher rates of confident and stable TAY, the lower rates of middle-older adults facing uncertain and insecurity. Beyond a general increase in TAY services, I think including some services to the programs involving juvenile justice may be necessary. Because penal institutions are hostile and aggressive environments, it's just as easy for an individual's mental health to deteriorate during their sentence as it is once they are released. Besides just providing services for the recovery and reentry of juveniles, resources and services linking these individuals to sponsored attorneys or lawyers may store hope and faith to these individuals. Lastly, I think there should an increased spending for the community-wide initiatives and moreover the cultural and ethnic services. Because the community is where these stigmas and culture of negativity is manifested, it takes the effort of the community — community-based providers, community members, caregivers, law enforcement, and victims alike — to form a coalition that promotes personal well-being. With that being said, all these initiatives would be ineffective if there were a cultural divide between provider and service receivers. Increasing and providing more funding to services catered specifically towards certain ethnic groups will increase clarity and comfortability for these service receivers, thereby increasing the number of people seeking these services and further preventing the cultivation of mental health issues. Overall, I've never fully delved into a plan that was as extensive and comprehensive as the 2017-2020 MHSA Three Year Program and Expenditure Plan. I like to emphasize prevention and am impressed by all the ways this plan manages to incorporate preventative measures as well as services from all other facets of the public mental health system. As a mental health advocate, I'm pleased by the progress made towards preventing, reducing, and destigmatizing mental health.

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	BHSD RESPONSE: Through the needs assessment and gap analysis conducted by Resource Development Associates, the consultant for this initiative, and described in detail in the Draft Plan), most of the gaps in services were found in the Adult/Older Adult System of Care and that is reflected in the Plan. The increased TAY FSP slots were a recommendation from the needs assessment and is being addressed in this Draft Plan.
Bill Wilson Center	65. Children's System of Care (0-15) CSS: Full Service Partnership (page 56) In paragraph three of the program description, the inclusion of increased natural supports is extremely important - especially for those youth who may be homeless. Bill Wilson Center has Included in its core values Families Matter - recognizing that many "families" are non-traditional and consist of individuals who may not be biologically related. It is our experience that integrating a system of natural supports into a youth's care plan is advantageous to their success.
	BHSD RESPONSE: Thank you for your comment, we concur with the importance of highlighting natural supports.
	66. CSS: General System Development (page 58) (Children & Family Outpatient/Intensive Outpatient Services -page 58) This current program provides much needed behavioral health services for youth and families in Santa Clara County. A youth population that BWC serves on a regular basis is homeless youth - or those youth staying in our residential shelter. The inclusion of the homeless youth population category in the program's description of unserved and underserved children and youth will further call out the need for services to this growing population. It will also show that BHSD recognizes the growing number of homeless youth in our County and is being proactive in providing them mental health services.
	BHSD RESPONSE: We appreciate your comment and agree that this is an important population to serve. We will add "homeless youth" to the unserved and underserved population.
	67. Eating Disorders -page 60 We suggest calling out in the program description that services will be gender responsive. In addition, it there a provider located in Santa Clara County that provides unlocked residential treatment for these clients? Center for Discovery does not have a location in Santa Clara County and our MHSI\ money should fund organizations headquartered in Santa Clara County.
	BHSD RESPONSE: We appreciate your comments. The services available for youth and young adults with eating disorders is severely limited in our county, the Bay Area and across California. We continue to seek qualified providers within Santa Clara County to provide these services.
	68. Crisis and Drop-In Services for Children and Youth - Page 63 While Uplift's Mobile Crisis program is included for renewal, we do not see the SOS mobile crisis programs from Alum Rock Counseling Center, Bill Wilson Center and Community Solutions listed in this document. Please add those programs to the plan.
	BHSD RESPONSE: At this time, we are proposing to increase Uplift Mobile Crisis services. We will continue to assess the utilization of other crisis services and will make future recommendations should we determine the need for additional capacity.
	69. TAY System of Core (16-25) CSS: General System Development (TAY Full Service Partnership - page 68) In the modifications of this program, we support the proposed increase in number of slots to 240 (as shown on page 69). This is in alignment with the increased

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	number of TAY accessing care through Bill Wilson Center's FSP. In addition, we support the BHSD's suggested increase in reimbursement rate/time.
	BHSD RESPONSE: Thank you for your support.
	70. Intensive Outpatient Program -page 70 The renewal of this program is a commitment to serving the mental health needs of an often overlooked and underfunded age group. Bill Wilson Center's TAY Intensive Outpatient program is currently over capacity. Any increases in funding that can be allocated to this program to meet the increased need would be an asset to our County. In the first paragraph of the program description we suggest adding the following wording: 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. A large segment of the youth BWC serves In this program are homeless, and by including the population in the program description you acknowledge the growing number of homeless youth in our County - 2530 according to the County's 2017 Homeless Census and Survey and the high number who have a psychiatric or emotional condition (557), suffer from PTSD (506), or experience drug or alcohol abuse (177).
	BHSD RESPONSE: Refer to response for comment #23.
	71. Foster Care Development - page 71 It is good to see the continuation of the Independent Living Program (ILP) mental health services in this document. However, we recommend you reduce the annual number to be served to SO. The majority of these foster youth receive similar services through other programs.
	BHSD RESPONSE: We will continue to evaluate the need for ILP mental health services in partnership with the Department of Family and Children's Services (DFCS).
	72. CSEC Program - page 72 We are extremely pleased to see the creation of a CSEC program for youth up to age 21. However, in the Goals and Objectives section, the number (175) to be served in FY18 is extremely high - especially in light of the fact that the project intends to serve a total of 300 youth over a three year period. We recommend reducing the FY18 number to 90 since this will be the first year of the project.
	BHSD RESPONSE: The proposed plan is to serve 300 youth over 3 years; which equates to 100 youth served per year. The 175 youth in FY 17-18 is an error and we made this change to the program narrative in the Draft Plan.
	73. TAY Interdisciplinary Service Teams -page 76

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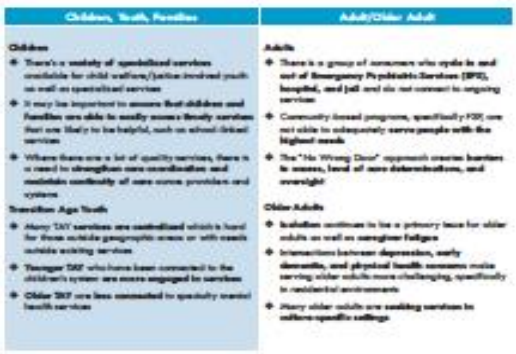
	The creation of this new service model for TAY is exciting and addresses an unmet need in our County. Bill Wilson Center has a long history of working with this young adult population -providing them with a continuum of care to ensure they have the skills they need to be self-sufficient adults. In paragraph one of the Program Description we suggest amending the language to read: TAY interdisciplinary service teams provide a spectrum of resources to youth, including those who are homeless that support their mental health and help launch them into adulthood. Again, with the increased number of homeless youth in our County, funding for a full spectrum of service for this population is critical to getting them off the street, into stable housing, and providing them the skill set they need to be successful.
	BHSD RESPONSE: We appreciate your comment and agree that this is an important population to serve. We will add "homeless youth" to service population in the narrative.
	74. SCC currently has a gap in services for youth under 18 who are insured through Kaiser Medi-Cal. Bill Wilson Center serves a great many of these youth in our current Crisis Residential Center and we anticipate serving them through our STRTP program as well. Kaiser Medi-Cal does not cover placement in STRTP so the ability to access MHSA funding to serve this population in STRTP would be a huge asset. This is a model that is currently being used for youth participating in the Innovation *headspace* initiative and we would like to see it replicated for STRTP youth.
	BHSD Response: At this time, Short Term Residential Therapeutic Program (STRTP) services are prioritized for youth in foster care and the juvenile justice system with full-scope Medi-Cal. Given the ramp up of this service for foster and juvenile justice involved youth, we are unable to currently prioritize this level of care for other youth populations.
National Alliance on Mental Illness (NAMI), BHB Public Hearing, June 11, 2018	75. NAMI encourages the County to consider adopting Ending the Silence, a school presentation designed to teach about the signs and symptoms of mental illness, as one of its PEI programs.
	BHSD RESPONSE: The Department will consult with the County's Suicide Prevention Oversight Committee to review and consider this training for possible funding.
Momentum for Mental Health, BHB Public Hearing, June 11, 2018	76. County should consider rate increases and cost per client costs should all be aligned.
	BHSD RESPONSE: The County Executive Office (CEO), in conjunction with BHSD and other County Departments, is currently evaluating existing service provider rates.

Public Hearing

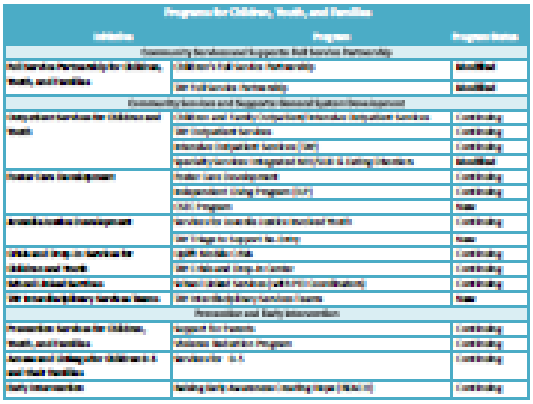
On June 11, 2018, the BHB unanimously recommended the Draft Plan to move forward.

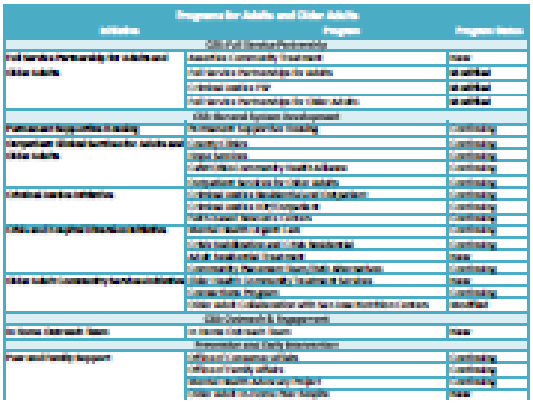
6/13/2018

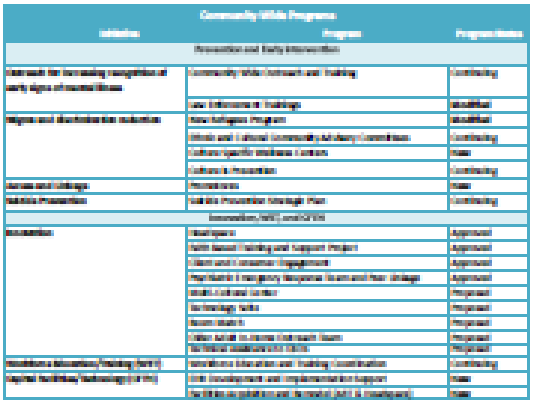


1

7 **MHSA Programs**



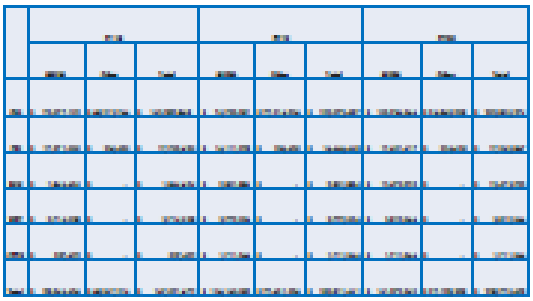




MHSA Expenditure Principles

- Maintain level of effort and ensure non-supplantation of funds
- Minimize general fund spending and maximize MediCal revenue generation
- Invest in services that minimize need for higher-end services
- Spend down unallocated and unspent funds, including funds at risk of reversion, without creating an unsustainable system on an ongoing basis

MHSA Funding by Fiscal Year



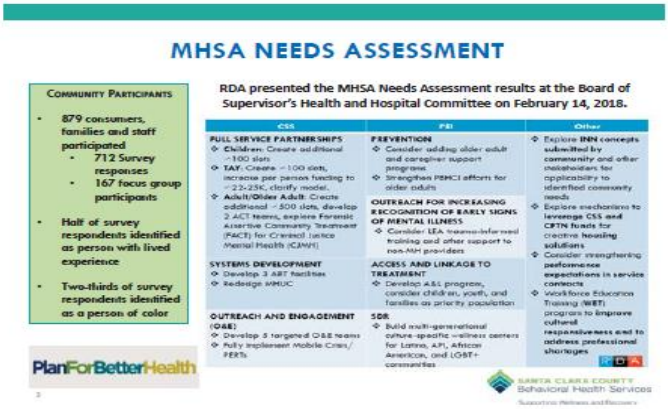
MHSA Unspent Funds

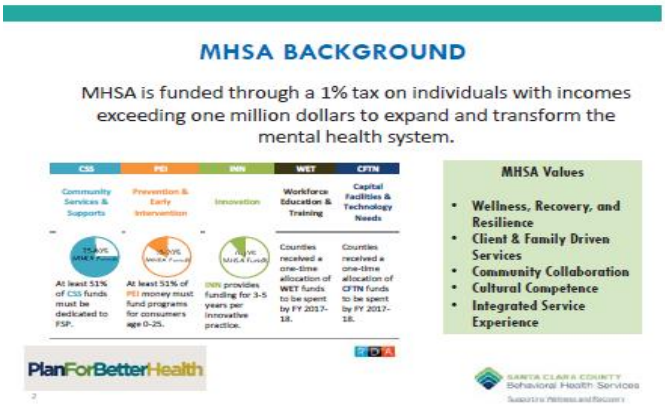
Component	Balance FY17	Projected Balance FY20
CSS	[illegible]	[illegible]
PEI	[illegible]	[illegible]
INN	[illegible]	[illegible]
WET	-	-
CFTN	[illegible]	-

14 Questions and Comments

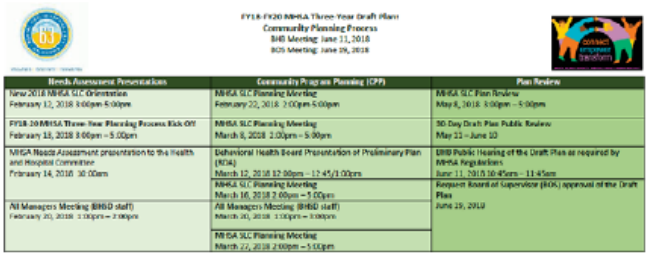
Board of Supervisors

The Santa Clara County Board of Supervisors unanimously approved the FY18-FY20 MHSA Program and Expenditure Plan, Innovations Projects and Reversion Plan as presented at the June 19, 2018 general meeting. Below is the presentation provided at the meeting. For a complete transcript of this meeting, use this link: http://sccgov.iqm2.com/Citizens/Detail_LegiFile.aspx?Frame=SplitView&MeetingID=9958&MediaPosition=4995.000&ID=91647&CssClass=





COMMUNITY PROGRAM PLANNING (CPP) PROCESS



FY18-FY20 MHSA Three-Year Draft Plan
Community Planning Process
BHB Meeting: June 11, 2018
BOS Meeting: June 19, 2018

Needs Assessment Presentation	Community Program Planning (CPP)	Plan Review
New 2018 MHSA SLC Orientation February 12, 2018 3:00pm-5:00pm	MHSA SLC Planning Meeting February 22, 2018 2:00pm-5:00pm	MHSA SLC Plan Review May 8, 2018 3:00pm – 5:00pm
FY18-20 MHSA Three-Year Planning Process Kick Off February 13, 2018 3:00pm – 5:00pm	MHSA SLC Planning Meeting March 8, 2018 2:00pm – 5:00pm	30-Day Draft Plan Public Review May 21 – June 19
MHSA Needs Assessment presentation to the Health and Hospital Committee February 14, 2018 10:00am	Behavioral Health Board Presentation of Preliminary Plan (RDA) March 12, 2018 12:00pm – 12:45/1:00pm	BHB Public Hearing of the Draft Plan as required by MHSA Regulations June 11, 2018 10:45am – 11:45am
	MHSA SLC Planning Meeting March 16, 2018 2:00pm – 5:00pm	Request Board of Supervisor (BOS) approval of the Draft Plan June 19, 2018
All Managers Meeting (BHSD staff) February 20, 2018 1:00pm – 2:00pm	All Managers Meeting (BHSD staff) March 20, 2018 1:00pm – 3:00pm	
	MHSA SLC Planning Meeting March 22, 2018 2:00pm – 5:00pm	

SANTA CLARA COUNTY Behavioral Health Services
Supporting Wellness and Recovery

5

MHSA PROGRAMS

SANTA CLARA COUNTY Behavioral Health Services

MHSA PLAN SUMMARY

- FY17-18: Used for System Assessment and Planning, which identified service gaps and needs
- MHSA Plan Budget Total is $352,634,518, with new program expenditures of $64,557,143 for contract agencies and county-operated programs
- Incorporates MHSA Reversion funding, which will be spent by June 2020 per regulations; no funds at risk for reversion
- Expands Department's infrastructure to support MHSA Plan, new MediCal regulations and County direct services

RDA

SANTA CLARA COUNTY Behavioral Health Services

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Initiative	Program	Program Status
Community Services and Supports: Full Service Partnership		
Full Service Partnership for Children, Youth, and Families	Full Service Partnership for Children	Modified
	Full Service Partnership for Transition Age Youth (TAY)	Modified
Community Services and Supports: General System Development		
Outpatient Services for Children and Youth	Children and Family Outpatient/Intensive Outpatient Services	Continuing
	TAY Outpatient Services/Intensive Outpatient Services	Continuing
	Specialty Services: Integrated MH/SUD	Modified
	Specialty and Outpatient Services: Eating Disorders for Children, Youth and Adults*	New
Foster Care Development	Foster Care Development	Modified
	Independent Living Program (ILP)	Continuing
	CSEC Program	New
Juvenile Justice Development	Services for Juvenile Justice Involved Youth	Continuing
	TAY Triage to Support Re-Entry	New
Crisis and Drop-In Services for Children and Youth	Uplift Mobile Crisis*	Modified
	TAY Crisis and Drop-In Center	Continuing
School Linked Services	School Linked Services (with PEI Coordinators)	Continuing
TAY Interdisciplinary Services Teams	TAY Interdisciplinary Services Teams	New
System Enhancement	Technical Assistance to Community Based Organizations	New
Prevention and Early Intervention		
Prevention Services for Children, Youth, and Families	Support for Parents	Continuing
Access and Linkage for Children 0-5 and their Families	Services for 0-5	Continuing
Early Intervention	Raising Early Awareness Creating Hope (REACH)	Continuing

**Modified after 30-day Public Comment/Review*

8

Programs for Adults and Older Adults		
Initiative	**Program**	**Program Status**
CSS: Full Service Partnership		
Full Service Partnership for Adults, Older Adults and Criminal Justice Adults	Assertive Community Treatment	**New**
	Full Service Partnerships for Adults	**Modified**
	Full Service Partnerships for Older Adults	**Modified**
	Full Service Partnerships for Criminal Justice Adults	**Modified**
CSS: General System Development		
Permanent Supportive Housing	Permanent Supportive Housing	Continuing
Outpatient Clinical Services for Adults and Older Adults	County Clinics	Continuing
	HOPE Services	Continuing
	CalWORKs Community Health Alliance	Continuing
	Outpatient Services for Older Adults	Continuing
Criminal Justice Initiative	Criminal Justice Residential and Outpatient	Continuing
	Criminal Justice IOP/Outpatient	Continuing
	Faith-based Resource Centers	Continuing
Crisis and Hospital Diversion Initiative	Mental Health Urgent Care	Continuing
	Crisis Stabilization and Crisis Residential	Continuing
	Adult Residential Treatment	**New**
	Community Placement Team/IMD Alternatives	Continuing
Older Adult Community Services Initiative	Clinical Case Management for Older Adults (Elder Health Community Treatment Services)	**New**
	Connections Program	Continuing
	Older Adult Collaboration with San Jose Nutrition Centers	**Modified**
CSS: Outreach & Engagement		
In Home Outreach Team	In Home Outreach Teams	**New**
Prevention and Early Intervention		
Primary Care Integration	Integrated Behavioral Health*	**Modified**
Criminal Justice System PEI Enhancement	Re-Entry Resource Center Peer Navigators – PEI enhancement*	**New**
Peer and Family Support	Office of Consumer Affairs	Continuing
	Office of Family Affairs	Continuing
	Mental Health Advocacy Project	Continuing
	Older Adult In-Home Peer Respite	**New**

**Modified after 30-day Public Comment/Review*

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EXPENDITURE PLAN

SANTA CLARA COUNTY Behavioral Health Services

Community-Wide Programs		
Initiative	**Program**	**Program Status**
Prevention and Early Intervention		
Outreach for increasing recognition of early signs of mental illness	Community Wide Outreach and Training	Continuing
	Law Enforcement Trainings and De-Escalation Mobile Response*	**Modified**
Stigma and discrimination reduction	New Refugees Program	**Modified**
	Ethnic and Cultural Community Advisory Committees	Continuing
	Culture Specific Wellness Centers	**New**
	Culture is Prevention	Continuing
Prevention	Violence Prevention*	**Modified**
Access and Linkage	Promotores	**New**
	LGBTQ+ Access & Linkage and Training & Technical Assistance*	**New**
Suicide Prevention	Suicide Prevention Strategic Plan	Continuing
Innovation, WET, and CFTN		
Innovation	*headspace* Ramp Up	Approved
	Faith Based Training and Support Project	Approved
	Client and Consumer Engagement	Approved
	Psychiatric Emergency Response Team and Peer Linkage	Approved
	Multi-Cultural Center	Approved
	headspace Implementation	*Proposed*
	Technology Suite	*Proposed*
	Room Match	*Proposed*
	Older Adult In-Home Outreach Team	*Proposed*
Workforce Education/Training (WET)	Workforce Education and Training Coordination	Continuing
Capital Facilities/Technology (CFTN)	EHR Development and Implementation Support	**New**
	Treatment Facilities Renovation (*headspace and Adult Residential Treatment*)	**New**

**Modified after 30-day Public Comment/Review*

10

MHSA EXPENDITURE PRINCIPLES

- Maintain level of effort and ensure non-supplantation of funds
- Minimize general fund spending and maximize MediCal revenue generation
- Invest in services that minimize need for higher-end services
- Spend down unallocated, unspent funds and identified reversion funds by June 2020
- Create a sustainable system on an ongoing basis

12

RDA

SANTA CLARA COUNTY Behavioral Health Services

TOTAL MHSA BUDGET
INCLUDING OTHER FUNDING SOURCES

	FY2018-20		
	MHSA	Other Funding Sources*	Grand Total
CSS	$253,961,273	$241,918,445	$495,879,718
PEI	$60,399,106	$1,003,350	$61,402,456
INN	$23,001,225	$0	$23,001,225
WET	$11,312,160	$0	$11,312,160
CFTN	$3,960,754	$0	$3,960,754
Total	$352,634,518	$242,921,795	$595,556,313

*Other Funding Sources: MediCal, EPSDT, AB109, CalWorks, HUD, CDCR, First 5, Grants, etc.

SANTA CLARA COUNTY Behavioral Health Services

NEXT STEPS

- Align MHSA Plan expenditures with the County budget through an appropriation modification and salary ordinance amendment for Board approval in August 2018.
- Send DHCS the County's MHSA Reversion Funding Plan by June 30, 2018.
- Send Mental Health Services Oversight and Accountability Commission the County's MHSA Three Year Plan and request approval for new Innovation projects (August 2018).
- Develop a project timeline for procurement of services for FY19-20.

MHSA UNSPENT FUNDS

Unspent Funds in Balance as of FY 17 and FY20		
Component	Balance FY17	Expected Balance FY20
CSS	$83,782,568	$13,755,017
PEI	$15,256,867	$ 3,669,232
INN	$16,160,579	$ 6,000,420
WET	$ 0	$ 0
CFTN	$ 3,960,754	$ 0

SANTA CLARA COUNTY Behavioral Health Services

Comments & Questions

SANTA CLARA COUNTY Behavioral Health Services

The County of Santa Clara
California

Report
91647

Approved
Jun 19, 2018 9:30 AM

Consider recommendations relating to the Adoption of the Fiscal Years 2018-2020 Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan and New Innovations (INN) Projects.

Information

Department: Mental Health Services (Santa Clara Valley Health and Hospital System) **Sponsors:**

Category: Report

Links

Link 89922 : Receive Report from Behavioral Health Services Department relating to the County's Mental Health Services Act (MHSA) System Evaluation and Needs Assessment Report.

Link 80029 : Approve Agreement with Resource Development Associates relating to providing grant writing services in an amount not to exceed $200,000 for period January 14, 2016 through January 13, 2017, that has been reviewed and approved by County Counsel as to form and legality. A single source exception to competitive procurement has been approved by the Office of Countywide Contracting Management pursuant to Board of Supervisors Policy 5.6.5.1(D)(2)(a).

Attachments

Printout
Santa Clara County Reversion Spending Plan for AB114
SCCMHSA FY18-FY20 Program Descriptions Summary
MHSA CPP Timeline FY18- FY20 Planning
New MHSA Stakeholder Leadership Committee Members 2018
DHCS Info_Notice_17-059_MHSA
SCC-Draft-MHSA-Three-Year-Plan_FY18-FY20 6.14.18
FY17-18Through19-20-3YrProgExpendPlan State_FiscalForms 6.13.18
FY18-FY20 MHSA Draft Plan 30-day public review_comments input 6.13.18
Item 12 public comment

Multiple Recommendations

Possible action:
a. Adopt the Fiscal Year 2018-2020 MHSA Three-Year Program and Expenditure Plan and New Innovation (INN) Projects.
b. Authorize the Behavioral Health Services Department (BHSD) to submit Santa Clara County's budget request to the Mental Health Services Oversight and Accountability Commission (MHSOAC) regarding the new MHSA INN Projects: INN-13 headspace Implementation; INN-14 Technology Suite; INN-15 New Housing Match; and INN-16 Dedicated Older Adult In-Home Outreach Team.
c. Authorize BHSD to submit Santa Clara County's MHSA Reversion Spending Plan to the Department of Health Care Services (DHCS) and MHSOAC subject to Assembly Bill (AB) 114.

Body

FISCAL IMPLICATIONS

Approval of the recommended actions would allow BHSD to implement the County's MHSA Plan which includes new Innovation (INN) projects that must be submitted to the MHSOAC for final approval after the adoption of the Fiscal Year (FY) 2018-2020 MHSA Three-Year Program and Expenditure Plan (Draft Plan) by the Board of Supervisors (Board). Per California Code of Regulations (CCR) Title 9, Division 1, Chapter 14, Article 9 (a), County mental health programs shall expend funds for their new INN programs upon approval by the MHSOAC. In addition, as required by AB114, the County must submit to DHCS the County's MHSA Reversion Spending Plan as adopted by the Board. This plan utilizes all prior year fund balances that are subject to reversion under AB114. In August 2018, BHSD would bring a budget modification and Salary Ordinance to the Board, to align the BHSD budget with the expenditure plan and new positions. Overall, the Three-Year Plan includes MHSA funding totaling $346,276,880 through fiscal year 2020.

Fiscal Year	2018	2019	2020	Total
Estimated Funding Plan	$98,544,456	$106,160,085	$141,572,340	$346,276,880

Through the development of this Three-Year Plan, BHSD worked to ensure MHSA programming, existing and newly proposed, are funded with MHSA funds to its full extent when appropriate, especially for programs with mixed funding. During the planning process, one of the goals was to develop a budget plan that maximizes on the MHSA funding and minimizes use of County General Funds when applicable.

REASONS FOR RECOMMENDATION

MHSA Needs Assessment

In February 2016, BHSD engaged Resource Development Associates (RDA) to conduct a needs assessment of the County's MHSA programs for the development of the MHSA Fiscal Year (FY) 2018-2020 MHSA Three-Year Plan (ID# 80029). The MHSA Needs Assessment project was commissioned by BHSD approximately 10 years after MHSA implementation. The project's aim was to conduct an MHSA system level evaluation of current programs, determine the impact of current MHSA funding and provide recommendations to address service gaps and emerging client needs. The MHSA Needs Assessment project involved the following activities:

1. Focus Group Meetings: RDA convened 20 focus groups to gather input from providers and community members. Participants were asked to reflect on what worked well within the current mental health system, identify service gaps, describe provider competence and training, and provide recommendations for future direction. An estimated 167 unduplicated individuals participated in the focus groups.
2. Conducting Surveys: RDA developed a survey to collect input from stakeholders regarding their experiences with MHSA services and perceptions of community needs. The purpose of the survey was to collect information from a wider audience beyond the focus groups. An estimated 712 surveys were completed. Half of the survey respondents identified as a person with lived experience. Two-thirds of the survey respondents identified as a person of color.

An estimated 917 community members and agency staff participated in overall community planning activities. At the conclusion of the MHSA Needs Assessment project in February 2018, RDA presented results to the MHSA Stakeholder Leadership Committee (SLC) at the

Health and Hospital Committee (ID# 89922) and BHSD staff (Refer to the Community Program Planning Timeline Attachment). This served as an opportunity to provide input on the recommendations and proposals generated by the needs assessment process.

MHSA Needs and Service Gaps

As part of the MHSA Needs Assessment project, RDA addressed needs, gaps and areas of growth. The Draft Plan includes programs and services that address the following key priorities:

1. Align capacity to demand.
2. Prioritize those with the highest level of need.
3. Improve coordination, collaboration, and accountability in all the systems of care.
4. Promote safe and sustained engagement amongst unserved and underserved groups.
5. Increase cultural competency throughout the system by identifying experts to receive referrals and provide consultation.

To support these priorities, the Draft Plan includes the following key recommendations (Refer to SCCMHSA FY18-FY20 Programs Description Summary Attachment):

1. New targeted outreach and engagement teams to connect consumers with mental health needs to services also known as In Home Outreach Teams (IHOT).
2. New mobile crisis capacity through clinicians housed at Mental Health Urgent Care (MHUC) and in Gilroy to provide assessment, crisis support, and linkages.
3. Two new Assertive Community Treatment (ACT) teams to provide intensive services to adults with the most severe mental health needs to decrease hospitalization, incarceration, and homelessness.
4. FSP services expansion for youth, transition age youth (TAY), adults, older adults and in the Criminal Justice System for a total of 700 new FSP slots.
5. Three new Adult Residential Treatment facilities to provide services to consumers who are stepping down from Institution of Medical Disease (IMD) placements, to divert consumers who would otherwise be in a locked facility.
6. New TAY triage staff located at Emergency Psychiatric Services (EPS) and the County jail to support reentry through peer counseling, case management, and linkages.
7. An expansion of a collaboration with senior nutrition sites to provide community training, workshops, and referrals to co-locate services for older adults.
8. A new Clinical Case Management Team for Older Adults (Elder Health Community Treatment) to provide outreach, assessment, and services provided by a multi-disciplinary team, including peers in the community.
9. A new Promotores program to provide culturally and linguistically targeted outreach services by Peer Health Educators to enhance linkages to services.
10. Enhanced program oversight and administration in the MHSA components and data requirements.
11. New Innovation (INN) projects to pilot innovative practices and learn new approaches that can be incorporated into County programs to improve service delivery and consumer outcomes. More information about the new INN projects are described in the next section.

The expansion of existing services, such as FSPs, and development of new services and new INN projects, represent $56,812,578 of the County's MHSA Three-Year Expenditure Funding Plan of $346,276,880.

Innovation (INN) Projects

BHSD is in the planning and implementation stages of four (4) previously approved MHSOAC INN projects (described in detail in the Draft Plan). In addition, the Draft Plan includes new INN projects listed below that were generated through the CPP/local stakeholder process which will also require approval by the State through the MHSOAC after the local CPP review/approval process is completed:

1. ***headspace* Implementation (INN-13)** seeks to change existing mental health practices that have not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population, or community to serve 1,000 youths ages 12-25 annually. Pending Board approval, the BHSD would seek MHSOAC approval for the implementation phase in August 2018 or as scheduled by the MHSOAC.
2. **Technology Suite for Community Mental Health (INN-14)** would bring interactive technology tools into the public mental health system through a highly innovative suite of applications designed to educate users on the signs and symptoms of mental illness, improve early identification of emotional/behavioral destabilization and connect individuals seeking help in real time. Pending Board approval, the BHSD would seek MHSOAC approval
3. **Room Match (INN-15)** would support the housing needs of consumers receiving or in need of mental health services through systemized connections to available rooms within the community. Pending the Board's approval, BHSD would seek MHSOAC approval for this project in October 2018.
4. **Older Adult In-Home Outreach Team (INN-16)** would provide culturally responsive mental health services for isolated adults over age 60 via a multilingual phone line. Pending the Board's approval, BHSD would seek MHSOAC approval for this project in October 2018.

INN projects are funded for a limited time (two to five years) to develop, pilot and evaluate innovative programs and services. Following the completion of each INN project, the Department will review the evaluation and outcomes and determine if the project should be continued, which would require ongoing funding from the MHSA Community Services and Supports or Prevention and Early Intervention components.

MHSA Reversion Spending Plan

Pursuant to AB 114 (Chapter 38, Statues of 2017) and DHCS Information Notice 17-059 (see DHCS Info_Notice_17-059_MHSA), each county must prepare and publically post a plan for MHSA funding subject to reversion from FY2005-2006 through FY 2014-2015 allocations. Only a specific percentage of previously allocated and unspent funds are subject to reversion. Counties must develop a plan to spend these MHSA funds by June 30, 2020. The County's Reversion Spending Plan has been finalized and includes a total of $14,630,535 of PEI, Innovations and CFTN funding (refer to Santa Clara County Reversion Spending Plan for AB114). Should the BHSD not spend

these funds in the timeframe described in the attached Santa Clara County Reversion Spending Plan, the funds would revert back to the State.

Next Steps

Following the Board's approval of the Draft Plan, BHSD will submit the INN projects to the MHSOAC and send the Reversion Plan to DHCS and MHSOAC per the DHCS Information Notice 17-059. Assuming acceptance of the Draft Plan, new INN projects and approval of the Reversion and INN plan, a County budget modification to increase the revenue and expenditures and salary ordinance amendment to implement the plans will be prepared and submitted for Board consideration in August 2018.

The Draft Plan supports the supports the Santa Clara Valley Health & Hospital System's Strategic Road Map as it relates to reducing the burden of illness and injury, through the delivery of MHSA funded services and interventions that improve client/consumer experience and outcomes.

CHILD IMPACT

The recommended action would have a positive impact on children and their families by providing prevention, early intervention and direct services to support their emotional/mental health and wellbeing and ensuring the appropriate implementation of MHSA programs that provide mental health services to children in Santa Clara County.

SENIOR IMPACT

The recommended action would have a positive impact on seniors by expanding access to services that would address their mental and physical health needs and ensuring the appropriate implementation of MHSA programs that provide mental health services to seniors in Santa Clara County.

SUSTAINABILITY IMPLICATIONS

The recommended action balances policy and program interests and enhances the Board's sustainability goal of social equity and safety by developing and providing MHSA funded mental health programs and services to address needs in the community.

BACKGROUND

Welfare and Institutions Code Section (WIC) §5847 states that County Mental Health Plans shall prepare and submit an MHSA three-year program, expenditure plan and annual updates to be adopted by the Board and submitted to the MHSOAC within 30 days after adoption. Per WIC §5848 each three-year program and expenditure plan and update shall 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, and other stakeholders.

Stakeholder Leadership Committee (SLC) and the County's Community Program Planning Process (CPP)

In early February 2018, a new MHSA stakeholder committee was formed that includes 25 new community members whose primary role is to provide input on community needs and priorities (Please refer to New MHSA Stakeholder Leadership Committee Members 2018 Attachment). A total of eight community meetings were conducted to address the MHSA components of CSS, PEI, and INN in which members of the public participated in meetings or joined roundtable discussions. All MHSA SLC meetings were open to the public and their attendance provided additional insight and direction for the Draft Plan. The 30-day public comment period took place from May 11 to June 10, 2018. This was followed by a Behavioral Health Board (BHB) public hearing on June 11, 2018 for review and recommendation to submit the Draft Plan to the Board of Supervisors (the Board). The BHB monthly meeting followed the public hearing, and the BHB members unanimously recommended that the Draft Plan be sent to the Board. Following the public comment period, the Department will respond in writing to the comments and post these responses on the BHSD MHSA website.

The Draft Plan represents BHSD's investment in a number of new and expanded services in behavioral health's systems of care. This effort reflects the deep commitment of BHSD leadership and staff, consumers, family members, providers, partners and community stakeholders to develop 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 impact BHSD's ability to implement the County's MHSA programs.

Meeting History

Jun 19, 2018 9:30 AM Video **Board of Supervisors** **Regular Meeting** **Draft**

Six individuals addressed the Board.

In response to inquiries by Supervisor Cortese, Toni Tullys, Director, Behavioral Health Services, Santa Clara Valley Health and Hospital System, advised that Administration will provide an off-agenda report to the Board on date uncertain relating to a formalized process for school districts within the County to apply for the School Linked Services program, and a report to the Board on date uncertain relating to mobile crisis and triage support efforts.

Supervisor Yeager requested that Administration ensure adequate time between the end of the comment period and the approval of future MHSA updates in order to fully integrate community input, and requested that Administration provide an off-agenda report to the Board on date uncertain relating to providing existing service partners with MHSA capital funding in Fiscal Year 2019.

In response to an inquiry by Vice President Chavez, Ms. Tullys advised that Administration intends to provide recommendations for Board consideration in the fall of 2018 relating to linkages and support services for arrested individuals with mental health issues, including recruitment and planning efforts, prioritization and demand, and leveraged funding and investment strategies.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Dave Cortese, Supervisor
SECONDER:	Ken Yeager, Supervisor
AYES:	Mike Wasserman, Cindy Chavez, Dave Cortese, Ken Yeager, S. Joseph Simitian