Needs Assessment Summary

Santa Clara County Overview

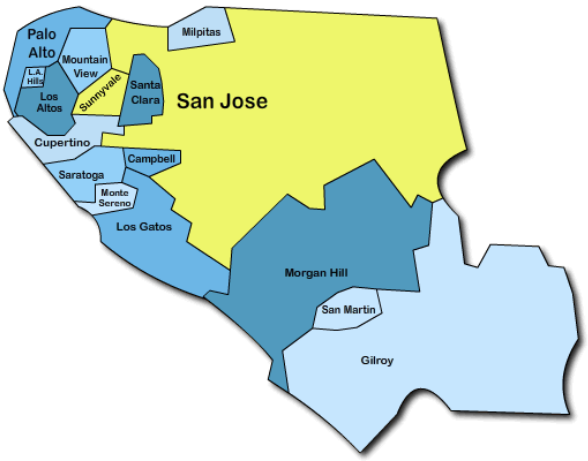
Santa Clara County, located in Northern California, is situated at the southern end of the San Francisco Bay Area. With a population estimate of approximately 1,868,000, Santa Clara County is the most populous county in the San Francisco Bay Area. Also known as Silicon Valley, Santa Clara County is a 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.

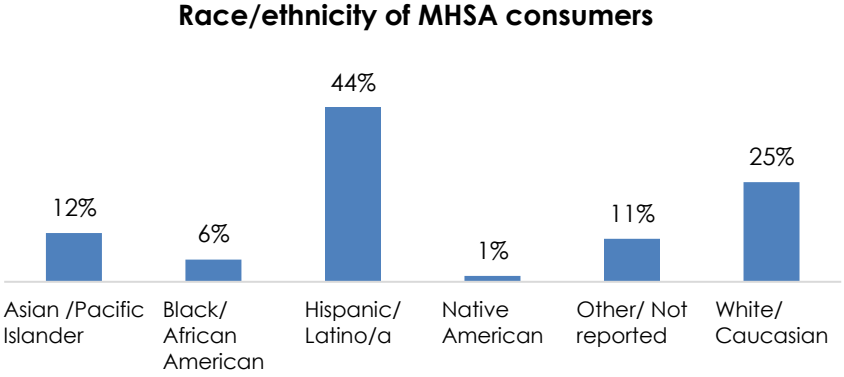
MHSA in Santa Clara County

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:

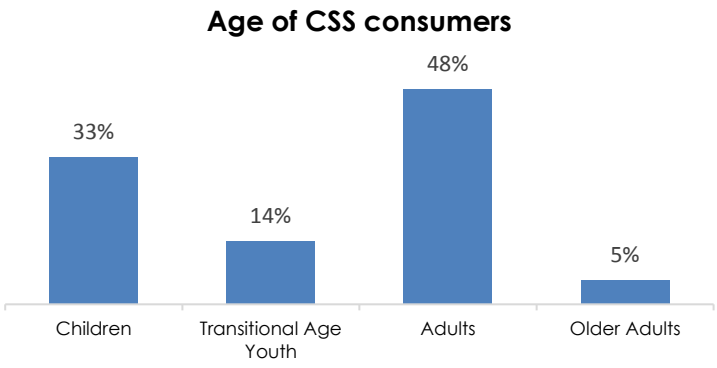
CSS in Santa Clara County

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.

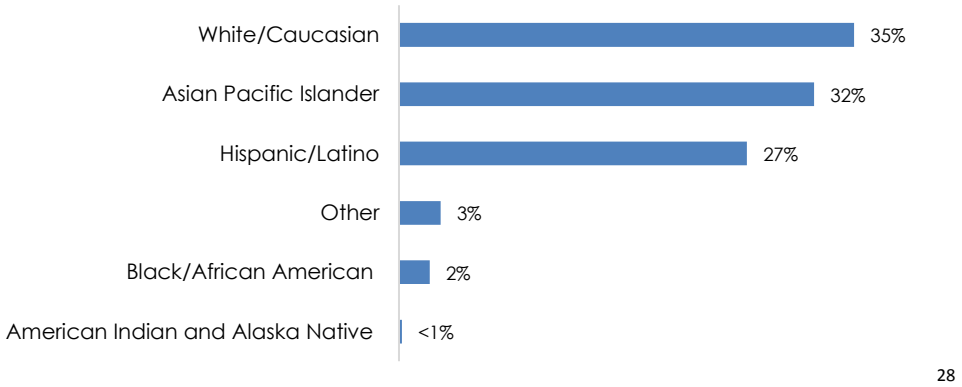
Specialty Populations

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

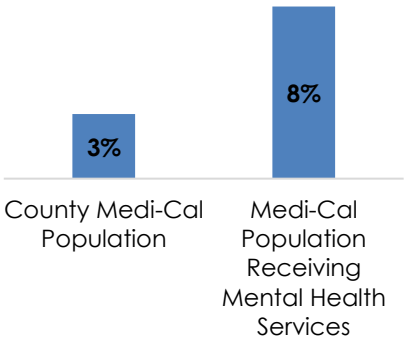
[30] Pew Research Center. 20 metro areas are home to six-in-ten unauthorized immigrants in U.S.. Retrieved from: http://www.pewresearch.org/fact-tank/2017/02/09/us-metro-areas-unauthorized-immigrants/

[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

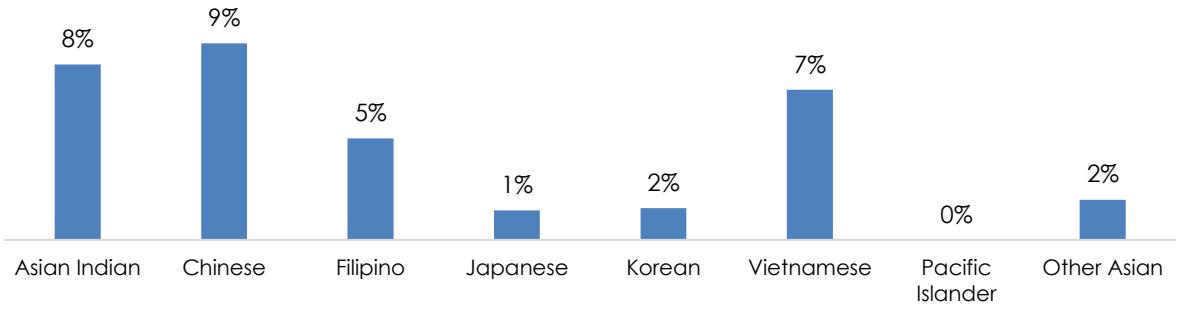
[34] Mental Health America. Black & African American Communities and Mental Health. Retrieved from: http://www.mentalhealthamerica.net/african-american-mental-health#Source

[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

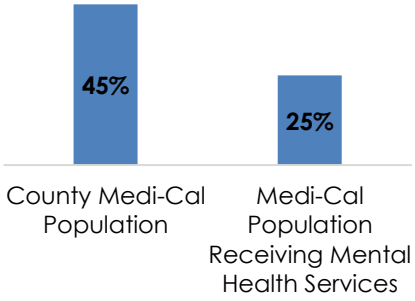
[39] Pew Research Center. Santa Clara County, California. Retrieved from: http://www.pewhispanic.org/states/county/06085/

[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.

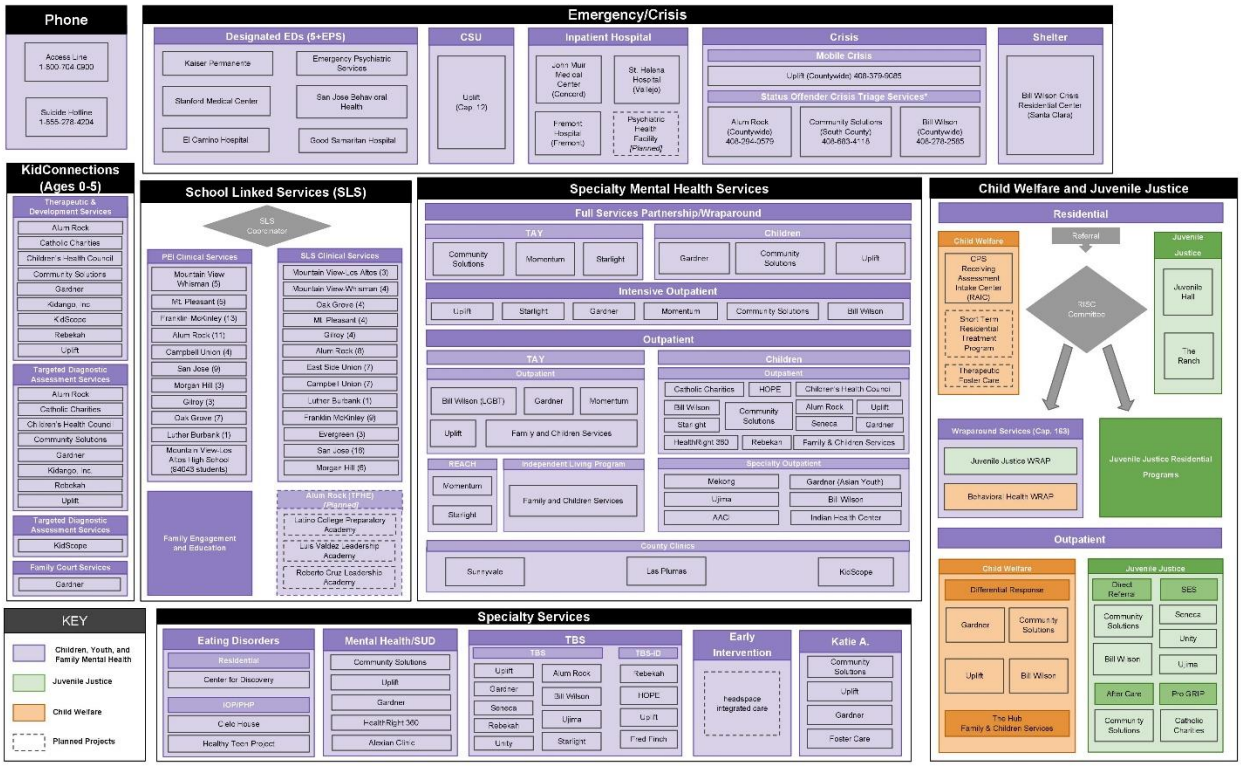
Mobile crisis and triage support: In order to best respond to individuals in crisis, there should be meaningful collaborations between law enforcement and behavioral health to ensure that police have access to mental health staff as joint response. Mobile crisis services provide acute mental health crisis 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.

Children, Youth, and Family System Map



Adult and Older/Adult System Map