COUNTY OF SANTA CLARA
Behavioral Health Services

DRAFT

Mental Health Services Act

Fiscal Year 2020 Annual Plan Update

DRAFT

WELLNESS • RECOVERY • RESILIENCE

Modifications made after the 30-Day Public Review and Comment Period appear in red.

Table of Contents

Overview and Executive Summary

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

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

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

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

The County of Santa Clara's FY2020 MHSA Annual Plan Update ("Plan Update" or "Update") to the Three-Year Program and Expenditure Plan for FY 2018-2020 marked the final year of existing approved planning. This draft plan update will be posted for the required 30-day public comment period from April 11 – May 10, 2020. It will be followed by a Public Hearing hosted by the Behavioral Health Board on May 11, 2020 and submitted for approval and adoption at the first June meeting of the Board of Supervisors in FY 2020. Considering the COVID-19 Shelter in Place order by the County of Santa Clara Public Health Department, the Behavioral Health Board Public Hearing of the draft plans will be conducted virtually via zoom in accordance with the Governor's Executive Emergency Order N-25-20.

MHSA Components and Funding Categories

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

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

Community Services and Supports Component

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

Prevention and Early Intervention Component

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

Innovation Component

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

Workforce Education and Training Component

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

Capital Facilities and Technological Needs Component

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

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

Annual Prevention and Early Intervention Report

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

Summary of Changes for Fiscal Year 2020

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

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

Increase Capacity

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

Redesign and Realign

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

Programs for Adults and Older Adults (AOA) Proposed Changes

Increase Capacity

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

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

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

Workforce Education and Training

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

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

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Clara

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

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

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____, 2020.

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

Sherri Terao _____

Mental Health Director/Designee (PRINT) Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

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

County: Santa Clara

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

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

Sherri Terao _____ _____
Mental Health Director/Designee (PRINT) Signature Date

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

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

Community Program Planning Process

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

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

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

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

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

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

Stakeholder Leadership Committee

Since 2005 the Mental Health Services Act (MHSA) Stakeholder Leadership Committee (SLC) has been in place to provide input and to advise the County Behavioral Health Services Department (BHSD) in its MHSA planning and implementation activities. The MHSA SLC serves as the BHSD's primary advisory committee for MHSA activities. The MHSA SLC consists of representatives of various stakeholder groups, including consumers, family members and underserved cultural communities. The MHSA SLC members review, comment and provide input on MHSA plans and annual updates. MHSA SLC meetings serve as a forum to assure wide-ranging representation in the MHSA community planning process. All MHSA SLC meetings are open to the public and allow for public comment. At the beginning of each MHSA planning cycle, the BHSD holds MHSA SLC meetings to discuss MHSA related business and programs. In 2018, the MHSA SLC was redesigned to include additional consumer representation by adding 5 client/consumer only additional seats to the group. The 30-member committee list of current members is listed on the Appendix.

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

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

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

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

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

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

Prevention and Early Intervention Program Summaries and Report appear in the *Prevention and Early Intervention Annual Report* Section. Use the link on the www.sccbhsd.org/mhsa.

Community Services and Supports: Full Service Partnership

Full Service Partnership

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

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

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

Description:

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

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

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

Children's Full Service Partnership

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

Summary of Achievements:

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

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

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

Community Services and Supports: General System Development (GSD)

Outpatient Services for Children and Youth

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

Description

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

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

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

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

Summary of Achievements:

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

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

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

Community Services and Supports: General System Development (GSD)

Outpatient Services for Children and Youth

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

Description:

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

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

Summary of Achievements:

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

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

Outpatient Services for Children and Youth

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

Description:

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

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

Update:

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

- Served 13 clients/consumers (youth and adult)

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

Update:

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

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

Update:

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

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

Update:

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

Community Services and Supports: General System Development (GSD)

Foster Care Development Initiative

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

Description:

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

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

Summary of Achievements:

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

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

Community Services and Supports: General System Development (GSD)

Crisis and Drop-In Services for Children and Youth

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

Description:

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

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

Crisis response includes:

- Diagnostic interview

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

Summary of Achievements:

- 68% of youth were successfully diverted from inpatient hospitalization

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

Community Services and Supports: General System Development (GSD)

School-Linked Services

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

Description:

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

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

Summary of Achievements:

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

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

Community Services and Supports: Full Service Partnership

Full Service Partnership

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

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

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

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

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

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

Summary of Achievements:

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

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

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

Community Services and Supports: General System Development (GSD)

Outpatient Services for Children and Youth

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

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

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

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

Summary of Achievements:

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

LGBTQ Outpatient

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

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

Community Services and Supports: General System Development (GSD)

Foster Care Development

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

Description:

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

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

Summary of Achievements:

- 45% successful discharge from mental health services.

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

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

Community Services and Supports: General System Development (GSD)

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

Description:

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

Summary of Achievements:

- 20% successful discharge from mental health services.

Program Improvements:

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

Community Services and Supports: General System Development (GSD)

Juvenile Justice Development

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

Description:

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

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

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

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

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

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

Summary of Achievements:

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

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

Community Services and Supports: General System Development (GSD)

Crisis and Drop-In Services for Children and Youth

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

Description:

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

Summary of Achievements:

- 66% successful discharges from mental health services

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

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

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

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

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

Prevention and Early Intervention Program Summaries and Report appear in the *Prevention and Early Intervention Annual Report* Section. Use the link on the www.sccbhsd.org/mhsa.

Community Services and Supports: Full Service Partnership

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

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

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

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

Program Update:

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

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

Description

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

Program Update:

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

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

Description:

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

Summary of Achievements:

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

Program Improvements:

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

Proposed Program Changes to Improve Consumer Impact:

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

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

Adult Full Service Partnership

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

Community Services and Supports: Full Service Partnership

Justice Involved FSP

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

Description

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

Program Update:

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

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

Description:

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

Summary of Achievements:

- 461 consumers enrolled in an FSP in FY2019.

Program Improvements:

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

Criminal Justice FSP

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

Community Services and Supports: General System Development (GSD)

Permanent Supportive Housing

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

Description:

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

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

Summary of Achievements:

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

Program Improvements:

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

Community Services and Supports: General System Development (GSD)

Outpatient Services for Adults and Older Adults

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

Description:

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

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

Summary of Achievements:

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

Program Improvements:

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

Community Services and Supports: General System Development (GSD)

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

Description:

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

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

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

Summary of Achievements:

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

Program Improvements:

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

Community Services and Supports: General System Development (GSD)

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

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

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

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

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

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

Justice Services Initiative

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

Description:

Evans Lane Wellness and Recovery Center

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

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

Evans Lane – Residential Treatment Program

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

Evans Lane – Outpatient Treatment Program

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

Success Story:

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

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

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

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

Description:

Outpatient Treatment Programs

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

Intensive Outpatient Treatment Program – Momentum

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

Proposed Program Changes and Consumer Impact:

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

Aftercare Outpatient Treatment Program – Caminar

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

Proposed Program Changes and Consumer Impact:

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

Co-Occurring Outpatient Treatment – Community Solutions

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

Proposed Program Changes and Consumer Impact:

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

Success Story:

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

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

Community Services and Supports: General System Development (GSD)

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

Description:

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

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

Summary of Achievements:

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

Success Story:

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

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

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

Community Services and Supports: General System Development (GSD)

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

Description:

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

Summary of Achievements:

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

Program Improvements:

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

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

Community Services and Supports: General System Development (GSD)

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

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

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

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

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

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

Success Story

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

Community Services and Supports: General System Development (GSD)

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

Description:

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

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

Summary of Achievements:

- 77 consumers served in FY2019.

Older Adult System of Care (60 and older)

Community Services and Supports: Full Service Partnership

Full Service Partnership

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

Description:

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

They are unserved and experience one of the following:

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

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

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

Summary of Achievements:

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

Older Adult Full Service Partnership (FSP)

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

Community Services and Supports: General System Development

Outpatient Clinical Services for Adults and Older Adults

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

Description:

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

Summary of Achievements:

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

Community Services and Supports: General System Development

Older Adult Community Services Initiative

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

Description:

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

Summary of Achievements:

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

Workforce Education and Training (WET)

Program Status: Continuing

Description:

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

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

County BHSD seeks to serve.

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

Achievements:

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

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

Capital Facilities and Technological Needs (CFTN)

Program Status: Continuing

Description:

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

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

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

Innovations Projects (INN) Report Update

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

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

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

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

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

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

Learning goals include:

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

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

Innovations Projects: Discontinued

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

Multi-Cultural Center

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

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

Room Match

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

rentals and provided detailed recommendations for the project.

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

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

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

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

Technology Suite for Community Mental Health

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

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

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