### Table of Contents

#### Letter from the Director
Page 2

#### MHSA County Compliance Certification
Page 4

#### MHSA County Fiscal Accountability Certification
Page 5

#### Introduction
Page 6

**Current Programs:**

- Community Services and Supports (CSS)  Page 11
- Prevention and Early Intervention (PEI)  Page 48
- Innovative Programs (INN)  Page 69
- Workforce Education and Training (WET)  Page 80
- Capital Facilities and Technological Needs (CFTN)  Page 88

#### MHSA Community Planning Process and Local Update Public Review
Page 97

#### MHSA Funding Summary
Page 100

**Attachments:**

A. Summary of Recommended Changes

B. FY13 and FY14 Budget Summary

C. FY13 and FY14 Summary of Proposed Changes of One-Time Funded Budget Items (CSS/PEI/INN)

D. List of Acronyms

E. MHSA SLC July 29, 2013 Meeting Presentation and Documents

F. MHSA SLC September 5, 2013 Meeting Presentation and Documents

G. Santa Clara County Mental Health Board Public Hearing September 9, 2013 Presentation and Documents
LETTER FROM THE DIRECTOR

July 23, 2013

Dear Santa Clara County Community Members:

It is with great pride that the Mental Health Department (MHD) provides you with the FY12-13 MHSA Annual Report and FY13-14 Annual Update. This report marks the eighth year since the passing of this important legislation; and the MHD’s sixth year of implementation of programs intended to expand and enhance the public mental health system. The MHSA funded programs reported on here have become integral to the County Mental Health system, impacting virtually every aspect of service delivery as well as many partner systems that also touch those with or at risk of experiencing mental illness.

This past year we have seen our Community Services and Supports (CSS) programs come to full implementation; and we have also seen significant implementation of our Prevention and Early Intervention (PEI) programs and our Innovation (INN) projects. All of these new programs have been supported by an extensive array of trainings and technical assistance, and supports aimed at providing our workforce with the skills and competencies they need to achieve the desired outcomes of the MHSA through our Workforce Education and Training (WET) projects. Almost all housing projects are underway and this year we will launch significant projects of our Capital, Facilities and Technological Needs (CFTN) plan.

Key highlights of the past six years include:

- **Expansion of services to those with greatest need, including the traditionally underserved and diverse communities in the County:** Over 30,000 individuals of all ages across the lifespan have received MHSA funded direct services between June 1, 2006 and June 30, 2012, with over 3,200 clients provided intensive Full Service Partnerships that resulted in significant reductions in psychiatric emergency visits, hospitalizations, incarceration, and homelessness among those served.

- **Increased access to care by underserved and diverse populations, with 20,400 (68%) of the newly served being people of color:** 45% of those were Hispanic; 9.6% were from Asian/Pacific Islander populations; 7.6% were African American; 3.7% were of other races; 1.4% were Native American; and 3% were of Mixed Race.

- **Increased client-centered and peer support services facilitated through 496 trainings offered to consumers, families, community members and providers.**

- **Increased Collaboration with multiple system partners to address the mental health concerns of those systems’ clients:** CIT academies have trained several hundred law enforcement personnel; over 5000 patients have been provided behavioral health services in primary care clinics; 1209 individuals received services through our criminal justice continuum of services; and 535 youth involved in the juvenile justice system were provided aftercare services.

- **Expanded scope of services to include promotion, prevention and early intervention activities:** Over 117,835 well child visits have been delivered by pediatricians participating in Reach Out and Read, an initiative to help parents and pediatricians identify early developmental needs of young children; 6071 children under five have been served in the new Child System of Care, with 4988 (82.17%) of those services provided to underserved populations and 45% of the services provided in Spanish.
The above illustrates just a few accomplishments that are presented in the following report. These accomplishments have occurred despite the challenging economic downturn experienced in California over the last seven years which has had a significant impact on funding to the County Mental Health Department.

This information is shared with you, our key local stakeholders and policy makers to illustrate the impact these services are having on those in our community who face mental health challenges; and to assist the County in determining the future strategies and activities that will improve the system through the optimal utilization of MHSA resources. It is through your feedback and advocacy that we learn how we can better serve consumers and family members, and the broader community.

Thank you for another year of support and input.

Sincerely,

Nancy Dane Peña, Ph.D.
Director
MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Clara

<table>
<thead>
<tr>
<th>Local Mental Health Director</th>
<th>Program Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Nancy Dane Peña, Ph.D.</td>
<td>Name: Jeanne Moral</td>
</tr>
<tr>
<td>Telephone Number: 408-885-5782</td>
<td>Telephone Number: 408-885-6867</td>
</tr>
<tr>
<td>E-mail: <a href="mailto:nancy.pena@hhs.sccgov.org">nancy.pena@hhs.sccgov.org</a></td>
<td>E-mail: <a href="mailto:jeanne.moral@hhs.sccgov.org">jeanne.moral@hhs.sccgov.org</a></td>
</tr>
</tbody>
</table>

County Mental Health Mailing Address:
Santa Clara County - Mental Health Administration
828 South Bascom, Suite 200
San Jose, CA 95128

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and non-supplantation requirements.

This 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 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 October 22, 2013.

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.

Nancy Peña, Ph.D. ____________________
Local Mental Health Director/Designee (PRINT) 10/23/13

Signature Date

County: Santa Clara

Date: 10/23/13
MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County/City: Santa Clara

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

<table>
<thead>
<tr>
<th>Local Mental Health Director</th>
<th>County Auditor-Controller / City Financial Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Nancy Dane Peña, Ph.D.</td>
<td>Name:</td>
</tr>
<tr>
<td>Telephone Number: 408-885-5782</td>
<td>Telephone Number:</td>
</tr>
<tr>
<td>E-mail: <a href="mailto:nancy.pena@hhs.sccgov.org">nancy.pena@hhs.sccgov.org</a></td>
<td>E-mail:</td>
</tr>
<tr>
<td>Local Mental Health Mailing Address</td>
<td></td>
</tr>
<tr>
<td>Santa Clara County - Mental Health Administration</td>
<td></td>
</tr>
<tr>
<td>828 South Bascom, Suite 200, San Jose, CA 95128</td>
<td></td>
</tr>
</tbody>
</table>

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(b), shall revert to the state to be deposited into the fund and available for other counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

[Signature]
10/23/15

Local Mental Health Director/Designee (PRINT) | Date

I hereby certify that for the fiscal year ended June 30, 2013, 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 12/13 for the fiscal year ended June 30, 2012. I further certify that for the fiscal year ended June 30, 2013, 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 the attached report is true and correct to the best of my knowledge.

[Signature]
10/31/13

County Auditor Controller / City Financial Officer (PRINT) | Date

1 Welfare and Institutions Code Sections 5847(b)(9) and 5891(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (02/14/2013)
Santa Clara County Mental Health Services Act
FY2013-14 Annual Update

INTRODUCTION

The Mental Health Department is pleased to present the following MHSA Annual Update to our Mental Health Services Act (MHSA) Three-Year Plan. The MHSA requires that an Annual Update be provided each year to summarize the status of the Plan and to outline important changes proposed for the coming year. It also requires that the update be posted for public comment for 30 days followed by a hearing conducted by the Mental Health Board.

The November 2004 statewide passage of Proposition 63, now referred to as the MHSA, provided a much needed increase in revenues to support mental health programs throughout California. The MHSA became law in January of 2005; and it called on counties to transform their public mental health systems to achieve the goals of making access easier, services more effective, out-of-home and institutional care utilization reduced, and stigma toward those with severe mental illness or serious emotional disturbance eliminated. Through the provisions of the MHSA, California counties have been challenged to work with stakeholders to create comprehensive, state-of-the-art, culturally competent mental health services systems that promote recovery and wellness for adults and older adults with severe mental illness and resiliency for children and youth with serious emotional disorders and their families.

The Process of Transformation

The process of true system transformation is slow and arduous. The very things that represent strengths in the long run often create delays in the short run, such as taking the time to seek and include broad stakeholder involvement and to develop and manage a process of reaching informed consensus among large, diverse groups. However, the essence of the American ideals of government are based on the cumbersome, unwieldy, often messy, sometimes frustrating, but always important process of involving people in decision-making.

Santa Clara County is very proud of its inclusive MHSA planning. The Community Services and Supports (CSS) planning effort incorporated the concerns and desires of 10,000 stakeholders from virtually every walk of life in rigorous planning that lasted a full year. Likewise, Prevention and Early Intervention (PEI), Innovative Programs, and other components also have been developed based upon broad public input.

Today the influence of the MHSA is present throughout the public mental health system in every division of the system. Santa Clara County MHSA programs provide hundreds with Full Service Partnerships every year, programs that offer clients of all ages who are the most in need, with “wraparound” 24-hour support, treatment, peer support, and housing Support. Over 4,000 are now served through the Urgent Care program; 1,600 without insurance are served through the new Central Wellness and Benefit program; and over 4,600 are served through primary care clinics.

Today, several thousand young children are being screened for early signs of socio-emotional developmental needs and are being accessed to services that will increase their opportunity to have their needs addressed in time to optimize their resiliency through increasing their parents and other caregivers the ability to understand and better respond to their children’s needs.

Today, young people are receiving early intervention at the onset of serious psychiatric illness and young adults have access to a new residential program driven by young peers; and LGBTQ young adults have access to a specialized drop-in program designed for them.
Today hundreds of individuals with mental illness and concurrent substance abuse problems have been involved with
the criminal justice system, are being provided a continuum of services that are assisting them as they re-enter the
community and help them to avoid re-incarceration.

Today, scores of individuals from diverse cultures and ethnicities, with lived experience with mental illness as
consumers and family members, work in the system providing support, guidance, advocacy and hope to hundreds of
consumers and their families.

These examples illustrate some, but not all of the ways in which the MHSA has impacted Santa Clara County. There
are many more wonderful projects and initiatives underway or about to be launched that together are transforming
the public mental health system in Santa Clara County.

**MHSA COMPONENTS**

MHSA funds five categories of funding for direct services, outreach, education, and infrastructure development to
local public mental health systems. They are:

1. **Community Services and Supports (CSS)** is the largest component providing 80% of ongoing
annual MHSA funds. This component funds ongoing system expansion and improvement for new
and current clients and comprises the largest portion of MHSA funding.

2. **Prevention and Early Intervention (PEI)** is the second largest component providing 20% of
ongoing funds. This component funds early intervention and prevention services.

3. **Innovative Programs (INN)** is drawn from CSS and PEI funding in the amount of 5% of the
combined CSS/PEI annual pool of funds. This component is to be used for innovative projects and
programs that will test new models of service delivery or system improvement.

4. **Workforce Education and Training (WET)** - provides one-time funds from initial years of MHSA
funding which is to be spent over 10 years for consumer, family and staff training and workforce
development at the state and local levels.

5. **Capital Facilities and Technological Needs (CFTN)** - provides one-time funds from initial years of
MHSA which is to be spent over 10 years funding for facilities, and technology.

6. **State Administrative Costs** - provides funds for the costs of State implementation of the MHSA,
including support for the Oversight and Accountability Commission. Funds are to be used to assure
consumer and family participation and adequate research and evaluation regarding the
effectiveness of services. Assembly Bill (AB) 100 signed by the Governor on March 24, 2011
reduced allowable MHSA state administrative expenditures from up to 5% of total annual funds to
3.5%. Recently, Senate Bill (SB) 82: Investment in Mental Health Wellness Act of 2013, chaptered
into law June 27, 2013, restores the maximum MHSA state administrative fund percentage from
the current 3.5% to the original level of 5%.
<table>
<thead>
<tr>
<th>MHSA Key Performance Measures by Plan Component</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CSS</strong></td>
</tr>
<tr>
<td>• Reduction of subjective suffering from mental illness</td>
</tr>
<tr>
<td>• Increase meaningful use of time and capabilities in school, work, activity</td>
</tr>
<tr>
<td>• Reduce homelessness and increase safe and permanent housing</td>
</tr>
<tr>
<td>• Increase access to substance abuse treatment</td>
</tr>
<tr>
<td>• Increase natural networks of supportive relationships</td>
</tr>
<tr>
<td>• Reduction in multiple foster care placements</td>
</tr>
<tr>
<td>• Reduction in incarceration/juvenile justice involvement</td>
</tr>
<tr>
<td>• Reduction in disparities in service access</td>
</tr>
<tr>
<td>• Increase in self-help and consumer/family involvement</td>
</tr>
<tr>
<td><strong>PEI</strong></td>
</tr>
<tr>
<td>• Reduction of Stigma and Discrimination</td>
</tr>
<tr>
<td>• Reduction of Disparities in Access to Mental Health Services</td>
</tr>
<tr>
<td>• Reduction of Psycho-Social Impact of Trauma</td>
</tr>
<tr>
<td>• Prevention and Early Intervention of At-Risk Children, Youth and Young Adult Populations experiencing onset of serious Psychiatric Illness</td>
</tr>
<tr>
<td>• Reduction and Prevention of Suicide Risk</td>
</tr>
<tr>
<td><strong>INN</strong></td>
</tr>
<tr>
<td>• Increase access to underserved groups</td>
</tr>
<tr>
<td>• Increase the quality of services, including better outcomes</td>
</tr>
<tr>
<td>• Promote interagency collaboration</td>
</tr>
<tr>
<td>• Increase access to services</td>
</tr>
<tr>
<td><strong>WET</strong></td>
</tr>
<tr>
<td>• Have a workforce fully integrated and reflective of the cultural and ethnic diversity of consumers and family members at all levels of the workforce, including employees, interns, and volunteers</td>
</tr>
<tr>
<td>• Provide employment opportunities and integrated support mechanisms throughout the system</td>
</tr>
<tr>
<td>• Enhance staff training and develop opportunities and career pathways for County and Community Based Organization (CBO) staff</td>
</tr>
<tr>
<td>• Provide training and educational opportunities in the mental health system</td>
</tr>
<tr>
<td><strong>CFTN</strong></td>
</tr>
<tr>
<td>• Provide a comprehensive electronic medical record for consumers that can be shared in a secure &amp; shared across service providers (EHR Project)</td>
</tr>
<tr>
<td>• Create a single data repository for all of the MHD information (EDW Project)</td>
</tr>
<tr>
<td>• Provide computer labs and basic PC skills training for consumers in established Wellness Centers across the County (CLC Project)</td>
</tr>
<tr>
<td>• Enhance the current Mental Health Department website (WEB Project)</td>
</tr>
<tr>
<td>• Provide a housing and/or bed availability database (BHX Project)</td>
</tr>
<tr>
<td>• Create secure, real-time data system of client records accessible across agencies to provide a cross agency view of registered consumer’s demographic, service &amp; other information (CHR Project)</td>
</tr>
<tr>
<td>• Improve access to high risk populations in the downtown &amp; east San Jose service areas; areas with the highest concentration of at-risk youth (Medi-Plex Project)</td>
</tr>
<tr>
<td>• Improve the current space for Self-Help Center to have a computer training room &amp; several activity rooms which will allow multiple group activities (DTMH Project)</td>
</tr>
</tbody>
</table>
MHSA PROJECTED REVENUES

The MHSA created a 1 percent tax on income in excess of $1 million to expand mental health services. Approximately 1/10 of one percent of tax payers are impacted by the tax. MHSA funding can change from year to year. Since the last reporting update, MHSA component funding estimates have been updated. Current estimates for the next three years project MHSA Component funding to decline by 22.2 percent in FY14, to increase by 11.1 percent in FY15, and to decline by 4.3 percent in FY16.

MHSA Estimated Component Funding as of June 2013
Statewide MHSA (millions of dollars)

<table>
<thead>
<tr>
<th>Component</th>
<th>FY08</th>
<th>FY09</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSS</td>
<td>$518.2</td>
<td>$650.0</td>
<td>$900.0</td>
<td>$783.6</td>
<td>$741.0</td>
<td>$1,154.2</td>
<td>$898.5</td>
<td>$997.9</td>
<td>$954.6</td>
</tr>
<tr>
<td>PEI</td>
<td>$115.0</td>
<td>$232.6</td>
<td>$330.0</td>
<td>$216.2</td>
<td>$185.2</td>
<td>$288.5</td>
<td>$224.6</td>
<td>$249.5</td>
<td>$238.6</td>
</tr>
<tr>
<td>INN*</td>
<td>$71.0</td>
<td>$71.0</td>
<td>$119.6</td>
<td>$48.7</td>
<td>$75.9</td>
<td>$59.1</td>
<td>$65.7</td>
<td>$62.8</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$633.2</td>
<td>$953.6</td>
<td>$1,301.0</td>
<td>$974.9</td>
<td>$1,518.6</td>
<td>$1,182.2</td>
<td>$1,313.1</td>
<td>$1,256.0</td>
<td></td>
</tr>
</tbody>
</table>

% Change 50.6% 36.4% -14.0% -12.9% 55.8% -22.2% 11.1% -4.3%

*5% of the total funding must be utilized for innovative programs (W&I Code Section 5892(a)(6)).

MHSA LOCAL PERSPECTIVE AND FY2014 REVENUE ESTIMATES

Based on current statewide estimates, it is projected there will be approximately a 22.2 percent decline in MHSA component funding from FY13 to FY14. The MHD applied this percentage to the County’s FY13 estimated component funding to obtain the projected MHSA revenue estimates for the County in FY14.

MHSA Revenue Projection
Santa Clara County
as of June 2013

<table>
<thead>
<tr>
<th>Component</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSS</td>
<td>$33,536,100</td>
<td>$53,051,426</td>
<td>$41,299,483</td>
<td>$45,872,400</td>
<td>$43,877,644</td>
</tr>
<tr>
<td>PEI</td>
<td>$9,037,900</td>
<td>$13,262,856</td>
<td>$10,324,871</td>
<td>$11,468,100</td>
<td>$10,969,411</td>
</tr>
<tr>
<td>INN From CSS 80%</td>
<td>N/A</td>
<td>$2,792,180</td>
<td>$2,173,657</td>
<td>$2,414,337</td>
<td>$2,309,350</td>
</tr>
<tr>
<td>INN From PEI 20%</td>
<td>N/A</td>
<td>$698,045</td>
<td>$543,414</td>
<td>$603,584</td>
<td>$577,337</td>
</tr>
<tr>
<td>INN*</td>
<td>$2,238,600</td>
<td>$3,490,225</td>
<td>$2,717,071</td>
<td>$3,017,921</td>
<td>$2,886,687</td>
</tr>
<tr>
<td>Total</td>
<td>$44,812,600</td>
<td>$69,804,507</td>
<td>$54,341,426</td>
<td>$60,358,421</td>
<td>$57,733,743</td>
</tr>
</tbody>
</table>

% Change 55.8% -22.2% 11.1% -4.3%

*5% of the total funding must be utilized for innovative programs (W&I Code Section 5892(a)(6)).
REPORT OVERVIEW

This report summarizes Santa Clara County’s progress in implementing services funded by the Mental Health Services Act (MHSA) during the period July 1, 2012 and June 30, 2013. In addition, it provides a brief synopsis of changes, if any, recommended for the coming fiscal year, FY14, for each of the work plans (projects) in each of the five MHSA program components.

In the years since its passage, MHSA funding has enabled the Santa Clara County Mental Health Department to make significant improvements in the types, scope and availability of public mental health services. This annual update will provide an overview of the programs and expenditures that make up the collective scope of services for components 1 through 5 listed above. Number 6, State Administrative Costs, is not applicable for county reporting.

This report is being posted for public review and comment for thirty days. Following the review period, the Mental Santa Clara County Health Board will hold a public hearing where there will be an opportunity for further public input. Following the public hearing the Mental Health Director will summarize the input and will include the summary in the final update, noting where comments have resulted in modifications to the update, where they have not been incorporated into the plan, and with an explanation for the rationale for the decision to include or not include changes to the update.

The final proposed plan will be presented to the Mental Health Board seeking their recommendation of the plan. Following the MHB action, the Annual Update will be submitted to the Board of Supervisors for approval and adoption.
COMMUNITY SERVICES AND SUPPORTS (CSS) PLAN

DESCRIPTION

The first component of the Mental Health Services Act (MHSA) was the Community Services and Supports (CSS) Plan. This component includes those elements of the Act that define the requirements of service delivery to children, youth, adults and older adults with serious emotional disturbances and/or severe mental illnesses. County proposals submitted to the State Department of Mental Health as CSS Three-Year Plans were evaluated for their contribution to meeting specific outcomes for the individuals served including:

- Meaningful use of time and capabilities
- Safe housing
- A network of supportive relationships
- Access to help in a crisis
- Reduction in incarceration
- Reduction in involuntary services

Five elemental concepts were required to be embedded in County plans. These include:

- Community collaboration and stakeholder involvement
- Cultural and language competence programs and services as methods for elimination of racial and ethnic mental health disparities
- Client/family driven mental health system
- Wellness focus, which includes the concepts of recovery and resilience
- Integrated service experiences for clients and their families throughout their interactions with the mental health system

Services were defined in three categories: Full Service Partnerships, System Development and Outreach and Engagement. This component of the MHSA is the largest, with 80% of ongoing MHSA funds to be allocated to these three categories of service.

ESSENTIAL PLAN PRINCIPLES

The CSS local planning process facilitated by the Mental Health Department identified the following essential principles to guide the CSS plan:

- Lifespan approach
- Community engaged and supported
- Cultural competence
- Social ecology focus
- Connectedness emphasis
- Recovery and resiliency guided
- Consumer and family driven
- Based in system partnerships
- Emphasis on quality and continuous learning
- Grounded in respect, hope, self-help, and empowerment
The local planning process prioritized the following objectives for the initial CSS Plan. Those objectives are to achieve the:

- Reduction of subjective suffering from mental illness
- Increase meaningful use of time and capabilities in school, work, activity
- Reduce homelessness and increase safe and permanent housing
- Increase access to substance abuse treatment
- Increase natural networks of supportive relationships
- Reduction in multiple foster care placements
- Reduction in incarceration/ juvenile justice involvement
- Reduction in disparities in service access
- Increase in self-help and consumer/family involvement

There are currently 15 CSS initiatives offering a broad range of services and system improvements targeted to age groups across the lifespan. Each initiative may have multiple program components. The table below illustrates the current fiscal year budget for each initiative, along with the proposed budget for FY14, which begins July 1, 2013.

<table>
<thead>
<tr>
<th>CSS Programs</th>
<th>FY2013 Funding</th>
<th>FY2014 Recommended Funding</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>C01 Children’s Full Services Partnerships</td>
<td>$1,150,074</td>
<td>$1,150,074</td>
<td>-</td>
</tr>
<tr>
<td>C02 Child System Development</td>
<td>$290,657</td>
<td>$290,657</td>
<td>-</td>
</tr>
<tr>
<td>C03 Children/Family Behavioral Health Outpatient Systems Redesign</td>
<td>$2,679,427</td>
<td>$2,707,715</td>
<td>28,288</td>
</tr>
<tr>
<td>T01 Transition Age Youth System of Care Development</td>
<td>$1,035,965</td>
<td>$1,035,965</td>
<td>-</td>
</tr>
<tr>
<td>T02-04 Behavioral Health System Redesign/TAY Crisis and Drop-In Services</td>
<td>$1,436,289</td>
<td>$1,436,289</td>
<td>-</td>
</tr>
<tr>
<td>A01 Adult Full Service Partnerships</td>
<td>$4,545,934</td>
<td>$4,351,925</td>
<td>(194,009)</td>
</tr>
<tr>
<td>A02 Adult Behavioral Health Services Outpatient System Redesign</td>
<td>$7,589,738</td>
<td>$9,648,153</td>
<td>2,058,415</td>
</tr>
<tr>
<td>A03 Criminal Justice System Jail Aftercare Program</td>
<td>$6,680,608</td>
<td>$6,535,151</td>
<td>(145,457)</td>
</tr>
<tr>
<td>A04* Urgent Care</td>
<td>$3,523,171</td>
<td>$8,223,500</td>
<td>4,700,329</td>
</tr>
<tr>
<td>A05 Consumer and Family Wellness and Recovery Services</td>
<td>$1,059,761</td>
<td>$1,059,761</td>
<td>-</td>
</tr>
<tr>
<td>OA01 Older Adult Full Service Partnerships</td>
<td>$371,288</td>
<td>$371,288</td>
<td>-</td>
</tr>
<tr>
<td>OA02-04 Older Adult Behavioral Health Services Outpatient Redesign</td>
<td>$1,585,042</td>
<td>$1,495,042</td>
<td>(90,000)</td>
</tr>
<tr>
<td>HC01 Behavioral &amp; Primary Health Care Partnership (Merge w/A04 in FY14)</td>
<td>$5,230,979</td>
<td>-</td>
<td>($5,230,979)</td>
</tr>
<tr>
<td>HO01 Housing Options Initiative</td>
<td>$2,437,350</td>
<td>$2,424,240</td>
<td>(13,110)</td>
</tr>
<tr>
<td>LP01 Learning Partnership</td>
<td>$1,845,676</td>
<td>$1,593,772</td>
<td>(251,904)</td>
</tr>
<tr>
<td>CSS AD01 Administration</td>
<td>$1,573,287</td>
<td>$1,573,287</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total CSS</strong></td>
<td><strong>$43,035,245</strong></td>
<td><strong>$43,896,818</strong></td>
<td><strong>861,573</strong></td>
</tr>
</tbody>
</table>

*For FY14, rename A04 “Central Wellness and Urgent Care Services” to reflect the HC01 merge with A04.

Please note: Adjustments to the MHD MHSA County personnel budget resulting from Board of Supervisor (BOS) approval for: 1) Increased contributions to the California Employers Retiree Benefit Trust (CERBT) and 2) Salary and benefit adjustments based on contract negotiations with labor unions is still pending and not reflected in the table above. The proposed plan is to spread the budget adjustments across the five MHSA components (See pages 98-99).
### C01 PLAN - CHILDREN'S FULL SERVICE PARTNERSHIP (FSP)

**Description**
Intensive, comprehensive age-appropriate project for as many as 60 seriously emotionally disturbed children ages 0-15 that combines critical core services within a wraparound model. The targeted population is juvenile justice-involved and SED African American, Native American and Latino youth at risk of, or returning from, out-of-home placement.

**Progress Update**
The MHSA FSP programs are a compliment to the County’s wraparound programs providing a total capacity of close to 280 slots for children from the foster care, juvenile justice and mental health systems. The MHSA FSP cost per client is $5,286.

The Children’s FSP program has served 454 children from FY07 to FY12 (Source Data: Unicare):

- 67.2% (N=305) Latino
- 11.2% (N=51) African American
- 3.3% (N=15) Native American
- 4.8% (N=22) Asian/Pacific Islander
- 1.5% (N=7) Other Ethnicity
- 10.1% (N=46) Caucasian/White
- 1.8% (N=8) Unknown Ethnicity

In addition, 86.5% (N=393) were from the Underserved Population:

- 67.2% (N=305) Latino
- 11.2% (N=51) African American
- 3.3% (N=15) Native American
- 4.8% (N=22) Asian/Pacific Islander

![Pie Chart](image)

**Total Number Served**
- Latino: 67.2%
- African American: 11.2%
- Native American: 3.3%
- Asian/Pacific Islander: 4.8%
- Caucasian/White: 10.1%
- Other Ethnicity: 1.5%
- Unknown Ethnicity: 1.8%
CO2 PLAN – CHILD SYSTEM DEVELOPMENT

**C01 Proposed FY14 Changes**

There are no proposed changes for FY14.

**CO2 Description**

This plan establishes systems of care for at-risk young children and families through key Santa Clara County child-serving agencies involved in 0 to 5-age services. The objectives are to establish quality screening, assessment, service linkages and parent support models that achieve the outcomes of increased school readiness and success among at-risk young children through early identification, treatment and support interventions for children with significant developmental, behavioral and emotional challenges.

**CO2 Progress Update**

In October 2006, a multi-agency collaborative, KidConnections Provider Network (KCN), was established through the leadership of FIRST 5 Santa Clara County in partnership with the MHD. KCN is a coordinated system that identifies children ages 0-5 with suspected developmental delays and provides screening, assessments, family consultations, and connections to behavioral health and social services. FIRST 5 is both a funder and a sponsor of children and family services, investing more than $30 million each year to support critical issues such as children’s health insurance, infant and early childhood mental health, early care and education, and health promotion. KCN is an innovative funding model, utilizing two California ballot initiatives, tobacco tax for early childhood programs (FIRST 5/Proposition 10) and MHSA, County general funds, Medi-Cal, and the State’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) reimbursement. Utilizing FIRST 5 funds as match, KCN providers leverage Medi-Cal and EPSDT, ensuring KidConnections is sustainable. KidConnections functions seamlessly with KidScope, operated by the MHD in conjunction with Valley Medical Center developmental behavioral pediatricians. KidScope is one of the KCN providers to

<table>
<thead>
<tr>
<th>Year</th>
<th>Child Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY07</td>
<td>18</td>
</tr>
<tr>
<td>FY08</td>
<td>38</td>
</tr>
<tr>
<td>FY09</td>
<td>78</td>
</tr>
<tr>
<td>FY10</td>
<td>94</td>
</tr>
<tr>
<td>FY11</td>
<td>110</td>
</tr>
<tr>
<td>FY12</td>
<td>116</td>
</tr>
</tbody>
</table>

**Number Served Per Fiscal Year**

![Graph showing the number of children served per fiscal year from FY07 to FY12.](image-url)
which children and families may be referred for further evaluation and the only provider equipped
to perform complex medical and developmental assessments. More children than ever before are
being screened early for developmental delays to ensure they receive coordinated intervention and
treatment services. Thousands of children now have a better chance to begin their school and family
lives with the support they need to succeed.

From FY07 to FY12, the **MHD and First 5 Collaboration** has served 6,071 Children (Source Data:
Unicare):

- 72.5% (N=4,400) Latino
- 3.7% (N=225) African American
- 0.6% (N=34) Native American
- 5.4% (N=329) Asian/Pacific Islander
- 0.2% (N=11) Mixed Race
- 3.6% (N=219) Other Ethnicity
- 8.3% (N=501) Caucasian/White
- 5.8% (N=352) Unknown Ethnicity

In addition, 82.17% (N=4,988) were from the Underserved Population:

- 72.5% (N=4,400) Latino
- 3.7% (N=225) African American
- 0.6% (N=34) Native American
- 5.4% (N=329) Asian/Pacific Islander

**Total Number Served**

- Latino 72.5%
- African American 3.7%
- Native American 0.6%
- Asian/Pacific Islander 5.4%
- Mixed Race 0.2%
- Other Ethnicity 3.6%
- Caucasian/White 8.3%
- Unknown Ethnicity 5.8%
CO3 PLAN - CHILDREN AND FAMILY BEHAVIORAL HEALTH OUTPATIENT SERVICES REDESIGN

C03 Description
This project involves the research, design and implementation of system-wide level-of-care screening, assessment, practice guidelines, and treatment services to improve the system of care for children and youth, particularly those from un-served and underserved ethnic and cultural populations. Services include screening, assessment and service linkages for young children; services for SED youth involved in the juvenile justice system; service system redesign for foster care youth; partial funding for independent living programs that provide services to TAY foster youth; Services to Uninsured Youth; the Juvenile Competency Restoration program; funding for one Family Affairs Coordinator and approximately 4 FTE Family Partners.

C03 Progress Update
The MHD initiated a system redesign planning process to increase the effectiveness of services as a means to improve quality and maximize resources. A multi-agency project team, appointed to carry out this redesign, initially convened in October 2009. The goals of the redesign were to:

- Identify the strengths and weaknesses of the current service continuum.
- Identify gaps in the continuum of services that impact effectiveness, with specific focus on juvenile justice and social services-referred youth.
- Compare SCC’s current system of care with peer counties, with specific focus on range of services, interagency collaboration, and authorization/quality improvement systems.
- Develop an integrated continuum of care.
- Implement measurement and outcome measures that provide continuous quality improvement
and efficiency to the system of care.

To date, a draft of F&C System standards has been developed along with identification of a system-wide assessment tool (Child Adolescent Needs and Strengths -- CANS) implemented in July 2012, as well as implementation of Transformational Care Planning (TCP), a person-centered approach to treatment/care planning. As the F&C redesign work is still in progress, some of the following critical next steps will occur over the next several months:

- Identification of a set of standardized assessment tools that will assist in determining the appropriate dosage and duration of services that should be developed for use with children, youth and their families.
- Examination of the Family and Children’s Gap Analysis data to inform the development of treatment manuals to be utilized with children, youth and their families.
- Development of an articulated level of care system and stepped approach to care with clearly defined interventions, timeframes, and expected outcomes.
- Enhancement of performance outcome measurement tools and data systems in order to examine service-related outcomes for children, youth and their families.

From FY08 to FY12 The Juvenile Probation Department (JPD) Aftercare program served 854 Juvenile Probation Involved youth (Source: Unicare):

- 73.8% (N=630) Latino
- 5.2% (N=44) African American
- 1.1% (N=9) Native American
- 4.3% (N=37) Asian/Pacific Islander
- 0.4% (N=3) Mixed Race
- 3.7% (N=32) Other Ethnicity
- 10.5% (N=90) Caucasian/White
- 1.1% (N=9) Unknown Ethnicity

In addition, 84.4% (N=720) were from the Underserved Population:

- 73.8% (N=630) Latino
- 5.2% (N=44) African American
- 1.1% (N=9) Native American
- 4.3% (N=37) Asian/Pacific Islander

![Pie chart showing the distribution of ethnicities among served individuals.](chart.png)
In 2012, the Muriel Wright Center was closed and all youth were consolidated to one Ranch program, William F. James Ranch. This resulted in a decreased census of youth. Due to the consolidation to one Ranch program, Starlight was retained as the agency providing mental health services at William F. James Ranch and Community Solutions (formerly providing services at Muriel Wright Center) was transitioned to provide aftercare services through the JPD Peak and Edge Programs. These changes in programming resulted in a slight decrease in the number of youth served during FY12.

From FY08 to FY12, the OPD F&C Redesign served 11,614 (Source: Unicare):

- 52.9% (N=6,145) Latino
- 6.1% (N=708) African American
- 1.1% (N=131) Native American
- 8.0% (N=925) Asian/Pacific Islander
- 0.2% (N=29) Mixed Race
- 3.8% (N=444) Other Ethnicity
- 22.5% (N=2612) Caucasian/White
- 5.3% (N=620) Unknown Ethnicity

In addition, 68.1% (N=7,909) were from the Underserved Population:

- 52.9% (N=6,145) Latino
- 6.1% (N=708) African American
- 1.1% (N=131) Native American
- 8.0% (N=925) Asian/Pacific Islander
Several changes are recommended to for FY14, totaling $28,288:

1. For FY14, Child and Adolescent Needs and Strengths (CANS) Training to be provided to the MHD Staff and Community Based Organizations (CBOs) will be funded under existing ongoing "Triple P" budget item in PEI Project 2 therefore the one-time FY13 budget allocation of $13,250 in C03 will no longer be needed;

2. As a result of the settlement agreement in Katie A v. Bonta lawsuit, the State of California has agreed to take a series of actions that are intended to transform the way California children/youth who are in foster care, or who are at imminent risk of foster care placement receive access to mental health services including assessment and individualized treatment. As a result of this settlement, the MHD is requiring mental health screening for all children in foster care. As such, a 0.5 FTE Health Services Representative (HSR) is needed to provide clerical support in registering and opening clients in the Unicare system. One-time funding of $41,538 for the HSR position is proposed for FY14;

3. The MHD is responsible for the oversight of the FIRST 5 System of Care (KidConnections) program. This program offers families with children ages zero to five, access to screening, targeted diagnostic assessments, home visitation and therapeutic services; referrals are made through the MHD Call Center (Call Center), creating a seamless access point for mental health
service delivery. The number of calls and referrals to KidConnections has increased since April 2011 (Call Center Data indicates 212 referrals between April 2011-June 2011, 1,574 referrals between July 2011 to June 2012 and 999 referrals between July 2012 to January 2013). Given the increase in the number of referrals to the Call Center, KidScope has seen an increase in the number of children requiring targeted diagnostic assessments. The current plan is to add one clinic day per week in order to increase the capacity for targeted diagnostic assessments. For FY14 it is proposed to fund 0.50 FTE Developmental Behavioral Pediatrician for KidScope through a redirection of existing ongoing funds from program services budget line item. No additional funds are needed for this item.

4. The Juvenile Competency Restoration Program has served 25 youth since the program was implemented. Given the increase in number of youth being served, it is recommended that a contract be developed with a Psychologist/Evaluator for the purpose of conducting independent competency evaluations. The MHD proposes to redirect a portion of the ongoing $133,190 funds set aside for the University of Virginia’s training contract to cover the $74,000 expense related to independent competency evaluations. No additional funding is required.

Total proposed budget change: an increase of $28,288 in the C03 budget.

<table>
<thead>
<tr>
<th>T01 Description</th>
<th>This is an intensive, comprehensive, age-appropriate project for as many as 100 TAY consumers with high levels of need. The project targets youth “aging out” of other child-serving systems.</th>
</tr>
</thead>
<tbody>
<tr>
<td>T01 Progress Update</td>
<td>According to Unicare data, the Transition Age Youth (TAY) FSP program has yielded positive outcomes in terms of number served from FY07 to FY12. For FSP consumers with psychiatric hospital admissions, the unduplicated consumer number of psychiatric admissions a year before FSP enrollment, compared with the unduplicated consumer number of psychiatric admissions a year after FSP enrollment, show that the rate of admissions declined for TAY FSP consumers. Among TAY consumers who received at least one year of FSP services, the data show that the number of arrests declined. Data also suggest the total duplicate consumer arrests a year before FSP enrollment, compared with those a year after FSP enrollment, show a lower number after one year of enrollment in FSP services for TAY consumers. For those TAY discharged from FSP, EPS readmission was lowest for those in the Children/Youth FSP (14%). In examination of data on inpatient hospital readmission among FSP clients, there was a significant decrease in inpatient readmission for TAY FSP consumers. The MHSA FSP cost per client is $8,961. The TAY FSP program has served 488 TAY from FY07 to FY12 (Source Data: Unicare):</td>
</tr>
<tr>
<td></td>
<td>• 50.2% (N=245) Latino</td>
</tr>
<tr>
<td></td>
<td>• 15.0% (N=73) African American</td>
</tr>
<tr>
<td></td>
<td>• 2.7% (N=13) Native American</td>
</tr>
<tr>
<td></td>
<td>• 4.7% (N=23) Asian/Pacific Islander</td>
</tr>
<tr>
<td></td>
<td>• 0.8% (N=4) Mixed Race</td>
</tr>
</tbody>
</table>
• 2.5% (N=12) Other Ethnicity
• 18.6% (N=91) Caucasian/White
• 5.5% (N=27) Unknown Ethnicity

In addition, 72.6% (N=354) were from the Underserved Population:

• 50.2% (N=245) Latino
• 15.0% (N=73) African American
• 2.7% (N=13) Native American
• 4.7% (N=23) Asian/Pacific Islander

Proposed FY14 Changes

During FY14 contracts negotiations the three FSP-TAY Community Based Organizations (CBOs) reported the ability for expansion of available slots within their programming. CBOs will be able to adjust existing budgets to support expansion of slots to meet the high demand of FSP-TAY services for this vulnerable population. For FY14, increase TAY slots from 70 to 119.

Proposed change: Increase the number of TAY FSP slots with no change in the MHSA budget allocation for the program; current funding allocation will be able to support the TAY FSP expansion.
**TO2-04 BEHAVIORAL HEALTH SERVICES OUTPATIENT SYSTEM REDESIGN / TAY CRISIS AND DROP-IN SERVICES**

<table>
<thead>
<tr>
<th>TO2-04 Description</th>
<th>This expands the system of care for TAY youth through a continuum of services that include specialized outreach, crisis intervention, linkages, self-help, peer support and case management. The project includes a 24-hour Drop-In Center and a community center serving the LGBTQ community (500 served).</th>
</tr>
</thead>
</table>
| TO2-04 Progress Update | Bill Wilson Center (BWC) and Family & Children’s Services (FCS) provide services under this initiative. BWC provides outpatient mental health services to TAY through a drop-in center. In addition, BWC is able to offer services to unsponsored/uninsured youth which ensure that these youth do not fall through the cracks with untreated mental health conditions. In FY10, BWC served 186 youth and in FY11 served 207 youth. FCS provides outpatient mental health services at the Billy de Frank Center focused on LGBTQ TAY. FCS’ provision of services through a drop-in center model and ability to serve unsponsored/uninsured youth ensure that access to mental health services is available for TAY. In FY10, FCS served 68 youth and in FY11 served 80 youth. Please note, in November 2012 FCS moved their outpatient mental health services into their own Youth Space drop-in center for LGBTQ TAY program. The TO2-04 CBO operated programs served 944 TAY from FY09 to FY12 (Source Data: Unicare):  
  - 33.5% (N=316) Latino  
  - 12.6% (N=119) African American  
  - 2.9% (N=27) Native American  
  - 9.9% (N=93) Asian/Pacific Islander  
  - 0.4% (N=4) Mixed Race  
  - 4.6% (N=43) Other Ethnicity  
  - 33.7% (N=318) Caucasian/White  
  - 2.5% (N=24) Unknown Ethnicity  
In addition, 58.9% (N=555) were from the Underserved Population:  
  - 33.5% (N=316) Latino  
  - 12.6% (N=119) African American  
  - 2.9% (N=27) Native American  
  - 9.9% (N=93) Asian/Pacific Islander |
Other news: FCS received a Speakers’ Bureau mini-grant from CalMHSA to conduct more Outreach panels in FY14 for audiences throughout Santa Clara County. Their Speakers Bureau is comprised of LGBTQ and all identified youth and young adults ages 13-25. Speakers will talk about their experiences as members of the LGBTQ and all community as well as share their experiences receiving mental health services when applicable.

<table>
<thead>
<tr>
<th></th>
<th>78</th>
<th>252</th>
<th>277</th>
<th>337</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAY</td>
<td>FY09</td>
<td>FY10</td>
<td>FY11</td>
<td>FY12</td>
</tr>
</tbody>
</table>

There are no proposed changes for FY14.
### A01 - ADULT FULL SERVICE PARTNERSHIPS (FSP)

#### Description
This is an intensive, comprehensive program for 175 highest risk SMI adults who are frequent users of involuntary care and/or underserved homeless consumers with high levels of need. Based on the AB2034 philosophy, the project provides treatment, case management and community resources necessary to meet the needs of each individual’s life circumstances.

#### Progress Update
According to FY12 FSP data, adult FSP client utilization of Emergency Psychiatric Services (EPS) decreased by 12% compared to FY11. Hospital admissions increased by 30% while adult arrests decreased by 8% compared to FY11. In terms of capacity, the number of Adult FSP consumers served in 2012 was 222. The MHSA FSP cost per client is $9,971.

The Adult FSP program served 974 Adults from FY07 to FY12 (Source Data: Unicare):

- 18.4% (N=179) Latino
- 7.2% (N=70) African American
- 2.8% (N=27) Native American
- 14.9% (N=145) Asian/Pacific Islander
- 3.0% (N=29) Other Ethnicity
- 45.8% (N=446) Caucasian/White
- 8.0% (N=78) Unknown Ethnicity

In addition, 43.3% (N=421) were from the Underserved Population:

- 18.4% (N=179) Latino
- 7.2% (N=70) African American
- 2.8% (N=27) Native American
- 14.9% (N=145) Asian/Pacific Islander
The Adult FSP IMD Diversion program served 246 Adults from FY11 to FY12 (Source Data: Unicare):

- 21.1% (N=52) Latino
- 10.2% (N=25) African American
- 0.8% (N=2) Native American
- 14.6% (N=36) Asian/Pacific Islander
- 2.8% (N=7) Other Ethnicity
- 43.5% (N=107) Caucasian/White
- 6.9% (N=17) Unknown Ethnicity

In addition, 46.7% (N=115) were from the Underserved Population:

- 21.1% (N=52) Latino
- 10.2% (N=25) African American
- 0.8% (N=2) Native American
- 14.6% (N=36) Asian/Pacific Islander
Two changes are proposed for FY14:

1. Adjust Adult FSP budget since Indian Health Center (IHC) will be using/redirecting a portion of their Adult FSP allocation for their new “Culture is Prevention Program” under PEI project 2.

2. For the Enhanced Residential Recovery Services program it is recommended to adjust the program’s budget based on actual experience. In FY12, actual expenses were approximately $806,000 while the current FY13 yearend expense estimates are projected at about $883,000. For FY14, the MHD proposes to adjust the ongoing budget from $1,000,000 to $900,000.

Total proposed budget change: the two adjustments results in a decrease of $194,009 in the A01 budget.
Services provided through this plan include:

- **Community Placement Team and 24-Hour Alternatives**: One of the primary goals of this program is to reduce utilization of high end services by ensuring the consumers who are leaving acute settings receive adequate aftercare. MHSA funds currently support a County team that is entrusted with coordinating care and services for consumers being discharged from EPS and/or BAP. To avoid institutions and to avoid discharging clients onto the streets, the Community Placement Team has access to residential and temporary housing programs that are also funded by the MHSA.

- **The goal of the MHSA Crisis Residential** is to assist individuals to return to the community from acute psychiatric units and locked psychiatric treatment facilities and to provide diversion of individuals from admission to acute psychiatric hospitalization and emergency psychiatric services.

- **Downtown Mental Health Clinic** has three full-time service teams operating Monday through Friday. The aim of the service teams is to work with clients suffering from serious mental illness who exhibit severe problems in normal daily functioning. Likewise, the goal is to assist individuals within the context of a mutual partnership effort to achieve higher levels functioning, to develop community and/or family support systems wherever possible. All three teams are comprised of case managers and a psychiatrist that offer a full array of mental health services, including case management services, crisis intervention, and medication support services.

- **Injection/Medication/Case Management Support to Outpatient Clinics & FQHC Staffing**: There are six FTEs under the “Injection/Medication/Case Management Support to Outpatient Clinics & FQHC staffing; four are located at East Valley FQHC, while two FTE’s are located at Fairoaks FQHC site. The Rehabilitation Counselors are under the Outpatient Specialty Services.

- **MHSA Adult Redesign program** is a Contract Based Organization (CBO) operated program designed to provide services to seriously mentally ill clients whose level of functioning, symptoms and psychiatric history necessitate service intervention to maintain the individual in community settings.

- **The goal of the Institution for Mental Disease (IMD) Alternative program** is to transition patients from a higher level of care to the most appropriate residential type of facility based on their ability to function independently. This model allows clients to transition to an environment that is less restrictive. Additionally, the goal is to reduce readmission of clients into emergency treatment and acute inpatient hospital settings, preventing homelessness of Serious Mental Illness (SMI) clients, providing patients with stability and a home-like setting and reducing the cost of patient care.

- **The Services for Developmentally Disabled Consumers Program** is a CBO-operated program that provides developmentally disabled consumers with integrated treatment and support services.

Additional progress updates:

The redesign has resulted in a new measurement system currently being implemented to assess stages of recovery, level of functioning/impairment and level of risk: A client assessment filled out
by a clinician, Milestones of Recovery Score (MORS), is currently being utilized to assist in
determining service level and type for clients. A second self-assessment, a Client Informed Outcome
Measure (CIOM), is slated for pilot testing in Fall 2013. The measurement system is intended to
assist in providing clients services targeted to their stage of recovery, enabling the system of care
to provide highly efficient, person-centered and culturally competent services.

Training is also a critical part of the A02 plan. For example, the Department of Alcohol and Drug
Services (DADS) is providing Mental Health staff training in Substance Use Disorders and
interventions, enhancing the MHD staff competency to address both mental health and substance
use issues experienced by their clients. The training series focuses on evidence-based foundational
information and knowledge necessary for practical application in real-world settings.

Another example of collaboration underway is the Mental Health partnership with Public Health to
provide Smoking Cessation courses for clients that want to quit smoking allowing mental health
clinicians to have a significant impact on their clients’ physical health. This intervention is expected
to improve our clients’ physical health by reducing health risks that include heart disease, cancer,
emphysema and chronic bronchitis.

Additionally, the MHD is partnering with multiple law enforcement jurisdictions to improve the
“mental health competency” of law enforcement personnel who respond to community crises that
involve individuals with mental health concerns and needs. This effort through Crisis Intervention
Team (CIT) Academies, Innovation strategies and Law Enforcement Liaisons, aims to successfully
engage individuals and families in effective mental health treatment services and supports
immediately after a mental health-related crisis event.

The A02 plan is also enhancing existing services and supports. Peer Mentors have been stationed at
all the County Mental Health Clinics and most of the contract agencies are also employing peers
and family members. They provide outreach, life coach support in one-on-one and group settings,
and team up with consumers as peer mentors.

<table>
<thead>
<tr>
<th>A02 Proposed FY14 Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Several changes are proposed for FY14:</td>
</tr>
<tr>
<td>1. County MHD position moves between work plans A02, A04 and HC01 are needed. No additional funding is required since the positions being moved are currently funded with existing ongoing funds. The position moves will result in a budget decrease of $35,700 in work plan A02.</td>
</tr>
<tr>
<td>2. Create a new 1.0 FTE Health Services Office Supervisor (HSOS) to support Downtown Mental Health Clinic, one-time funding of $98,334 is needed for FY14.</td>
</tr>
<tr>
<td>3. In FY13, the INN-03 Adult with Autism and Co-occurring Mental Health Disorders Project, funded with INN funds, ended on June 30, 2013. It is proposed to sustain and integrate the INN-03 project into the A02 work plan due to the positive results of the two-year project. The data derived from the Adult with Autism and Co-occurring Mental Health Disorders Project has demonstrated that the use of the Schedule for the Assessment of Psychiatric Problems Associated with Autism (SAPPA) tool has been able to more precisely identify co-occurring mental health disorder(s) at a faster rate. 80 new consumers were assessed using the SAPPA, a supportive diagnostic assessment tool, which was tested through the project</td>
</tr>
</tbody>
</table>
with positive results. Please note that if an INN project has proven to be successful and the County chooses to continue it, the project must transition to a different MHSA funding source (as determined by the County), for example the CSS component, the PEI component, or another source of funding. Ongoing funding for the Community Based Organization (CBO) operated program is proposed at $350,324 for FY14.

4. Propose new A02 program called “Intensive Transition Services” (ITS) Program which is based on the premise that every individual possesses an inherent ability to access personal strengths and attributes in order to self-govern his/her own recovery. Through the program, the participant’s inherent ability will be awakened and fueled by mutual collaboration to increase the participant’s overall understanding of mindfulness practice, to learn and incorporate health and wellness tools, to foster an atmosphere of individual emancipation, and to overtly confront both societal and internalized stigma. In addition, to create an environment that focuses on wellness and recovery, the new program’s weekly schedule will be based on a “wellness wheel” and offer skills-building within the facets of life that are critical for anyone’s successful navigation in the life process, emotional growth and regulation, effective social engagement and interaction, spiritual balance, healthy living and exercise, and community/environmental stewardship. ITS program participants, in collaboration with their assigned ITS program staff member, will select from an array of “groups” built specifically for each facet of the wellness wheel. ITS participants may pick and choose groups based on their identified needs for improvement in major life areas. Additionally, each ITS participant will be encouraged to explore how best (s)he learns and incorporates information by taking advantage of the different group modalities offered. These modalities may range from facilitated discussion, to activity based, to client led. As each participant gains skill mastery in identified areas, ongoing collaboration with his/her assigned ITS staff member enables each participant to gauge his/her progress and to identify new areas for growth and recovery. The participant’s new group selections, then, becomes based on these new areas for growth and is participant-driven. Ongoing group relevancy and adaptation will be based on continual participant evaluation and feedback to ITS staff members. The proposed new A02 program will need new one-time funding of $1,500,000 in FY14.

5. The MHD proposes to add a new 1.0 FTE Health Care Program Manager (HCPM) II. The DTMH is in need of a HCPM II to manage daily clinic operations and oversee Specialty Mental Health services to some of the County’s most high risk and severely mentally ill consumers. The mode of service provided at DTMH includes case management, medication support, mental health services, and crisis intervention. The annual cost of the new positions is $145,457 and will be fully funded through the deletion of a vacant 1.0 FTE Program Manager II currently budgeted in work plan A03 (Please refer to A03 section for more details). No additional funding is required for the new position.

Total proposed budget change: an increase of $2,058,415 in the A02 budget.
### A03 PLAN - CRIMINAL JUSTICE SYSTEM JAIL AFTERCARE FULL SERVICE PARTNERSHIP

<table>
<thead>
<tr>
<th>A03 Description</th>
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<tbody>
<tr>
<td>This project currently serves 486 adults 18 to 59 years old with concurrent mental health and substance abuse problems who also are involved in the criminal justice system. A continuum of intensive, comprehensive services, including residential, outpatient, and aftercare linkage and case management, is offered to clients based on individual need.</td>
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<thead>
<tr>
<th>A03 Progress Update</th>
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<tbody>
<tr>
<td>Consumers enrolled in the Criminal Justice FSP program have seen an 11% increase in arrests compared to FY11. However, there was a 118% decrease in Emergency Psychiatric Services (EPS) admissions, and a 92% decrease in the number of admissions to inpatient hospitals. The MHSA FSP cost per client is $7,145.</td>
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</table>

The Criminal Justice System FSP program served 1,209 from FY07 to FY12 (Source Data: Unicare):

- 28.0% (N=338) Latino
- 16.5% (N=200) African American
- 4.5% (N=55) Native American
- 9.8% (N=118) Asian/Pacific Islander
- 0.6% (N=7) Mixed Race
- 4.1% (N=50) Other Ethnicity
- 32.4% (N=392) Caucasian/White
- 4.1% (N=49) Unknown Ethnicity

In addition, 58.8% (N=711) were from the Underserved Population:

- 28.0% (N=338) Latino
- 16.5% (N=200) African American
- 4.5% (N=55) Native American
- 9.8% (N=118) Asian/Pacific Islander

![Total Number Served](chart.png)
The Criminal Justice System Aftercare program served 773 from FY07 to FY12 (Source Data: Unicare):

- 31.3% (N=242) Latino
- 9.1% (N=70) African American
- 2.7% (N=21) Native American
- 3.6% (N=28) Asian/Pacific Islander
- 0.8% (N=6) Mixed Race
- 3.9% (N=30) Other Ethnicity
- 44.0% (N=340) Caucasian/White
- 4.7% (N=36) Unknown Ethnicity

In addition, 46.7% (N=361) were from the Underserved Population:

- 31.3% (N=242) Latino
- 9.1% (N=70) African American
- 2.7% (N=21) Native American
- 3.6% (N=28) Asian/Pacific Islander
The MHD proposes the deletion of the vacant 1.0 FTE Program Manager II to fund new position proposed for DTMH in work plan A02. Presently, there is a filled Health Care Program Manager II position at the Evans Lane Outpatient Clinic funded in part by both AB109 and MHSA funds. Given that Evans Lane Outpatient now has a manager in place there is no longer a need for the vacant Program Manager II position at the site.

Total proposed budget change: a decrease of $145,457 in the A03 budget.

A04 PLAN – URGENT CARE

This project provides consumers and individuals with emergent needs with critical services and is an alternative to Emergency Psychiatric Services (EPS). Mental Health Urgent Care (MHUC) services include crisis counseling, referrals, education, medications, as well as intensive follow-up in the community for a short period of time. This service is available to individuals who walk in for assistance. The project is open from 8 AM to 10 PM each day, 7 days a week, and works closely with EPS staff. On a limited basis, the staff provides mobile crisis response and telephone consultation to the police as they are called to highly emotionally charged situations.

Mental Health Urgent Care (MHUC) opened in 2008 and provides emergent care to consumers and families. Many consumers are in urgent need of medication or bridge medication for continuity of care. Consumers are initially assessed for crisis and clinical needs. If consumers meet criteria for hospitalization, a MHUC clinician completes the 5150 hold and admits the individual to Emergency Psychiatric Services (EPS). Consumers who do not meet 5150 criteria get immediate mental health services such as crisis intervention and/or medication evaluation. Consumers also get linked to an ongoing outpatient service provider. MHUC serves an adjunctive function to EPS as MHUC lobby is being used as a visitor area for families of EPS consumers. The clinic provides services to a wide variety of languages, ethnicity groups and age groups. The clinic serves un-insured clients and staff assists them to obtain benefits. Community resource information is available in the MHUC lobby.
through NAMI and Family Affairs. Program evaluations are undertaken on a regular basis to ensure
that MHUC meets the needs of consumers, families, and the community. Ongoing service
improvements are implemented to address consumers and families needs, improvements to customer
service, and strengthen relationships with EPS, law enforcement and our community partners. In the
past year, MHUC created additional walk-in slots to insure that clients in crisis who need medications
can immediately be linked to psychiatrists. A transfer process was implemented to provide more
efficient access to ongoing outpatient services which increases available walk-in slots for new in-
coming clients.

Urgent Care program served 7,133 from FY09 to FY12 (Source Data: Unicare):

- 29.4% (N=2,096) Latino
- 7.1% (N=503) African American
- 1.3% (N=96) Native American
- 10.3% (N=738) Asian/Pacific Islander
- 0.3% (N=21) Mixed Race
- 3.3% (N=235) Other Ethnicity
- 38.9% (N=2,775) Caucasian/White
- 9.4% (N=669) Unknown Ethnicity

In addition, 48.1% (N=3,433) were from the Underserved Population:

- 29.4% (N=2,096) Latino
- 7.1% (N=503) African American
- 1.3% (N=96) Native American
- 10.3% (N=738) Asian/Pacific Islander

Of the 7,133 clients serves from FY09-12, there were more than 31 different languages served. The
most common languages served were English, Spanish, Vietnamese and Tagalog.
Several changes are proposed for FY14:

1. Merge work plan HC01 to A04 in FY14. The HC01 work plan was designed to improve the interface between behavioral health and primary healthcare in collaboration with mental health and substance abuse providers. The Mental Health Specialty Assessment Center (MHSAC), part of HC01, was implemented to offer mental health assessments and assistance in linkages with needed services, in particular enrollment in the VMC primary care system and assist unsponsored mental health consumers in applying for entitlements such as Ability to Pay Determination (APD), Medicare, Medi-Cal, and Social Security Insurance (SSI) programs. With the opening of the Central Wellness and Benefits Center (CWBC) and the addition of the FQHC behavioral health services in 2009, there has been a significant increase in service capacity within the system. Given the goal of the programs mentioned above are to assist consumers with benefits at the same time they begin services it is proposed to integrate all the services under the Urgent Care work plan A04. The integration will move the HC01 budget of $5,230,979 to A04. In addition, propose to rename work plan A04 to “Central Wellness and Urgent Care Services” to reflect the A04/HC01 merge.

2. County MHD position moves between work plans A02, A04 and HC01 are needed. Position moves of three Rehabilitation Counselors to work plan A02 and the addition of 1.0 P49 Psychiatrist in CWBC are required. The adjustments results in a decrease of the ongoing budget by $107,450.

3. Adjust Urgent Care Medical staff budget based on current staffing, a decrease of $350,000 of ongoing funds.

4. Redirect a portion of ongoing program services and supplies budget of $314,441 to support the Law Enforcement Liaisons (LELs), Urgent Care MOU with Protective Services, and portion to offset cost relating to Psychiatrist costs. Overall there will be no budget change due to redirection of funds. Below are the details of the redirection:

   a. Law Enforcement Liaisons (LELs): There is a continued need for LELs to support Urgent Care as the MHD continues to work on field assessments and consultations in collaboration with police and the Sheriff. In addition, the MHD plans to
AO5 - CONSUMER AND FAMILY WELLNESS AND RECOVERY SERVICES

<table>
<thead>
<tr>
<th>A05</th>
<th>Description</th>
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<tbody>
<tr>
<td></td>
<td>This is an initiative to transform the outpatient services of County and CBO-operated clinics. The initiative provides clinic staff with the training and practical skills to move toward a recovery and wellness-oriented service model, which emphasizes the consumer’s principal role in his or her own recovery, appropriate levels of care, and infuses and expands the role of peer mentors, peer-directed services and self-help programs throughout the system.</td>
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<table>
<thead>
<tr>
<th>A05</th>
<th>Progress Update</th>
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<tbody>
<tr>
<td></td>
<td>In the FY12, the Board of Supervisors approved the creation of 3.0 FTE and 13 (0.5) FTE Mental Health Peer Support Worker positions. As a result of this action, the program supporting this initiative experienced a major staffing redesign in order to accommodate this new classification code. This code was specifically created to hire consumers and family members into the workforce. The Mental Health Peer Support Work functions as an entry-level position that provides peer support services. The increased cost for these new permanent coded positions reduced the number of available positions. Staffing for the Consumer Affairs program went from 36 staff to 12 staff (2.0 FTE Mental Health Peer Support Worker Leads, 1.0 FTE Community Worker and 9 (0.5 FTE) Mental Health Peer Support Workers). The program is supervised by 1.0 FTE Health Care Program Manager II. As a result of the decrease of staff, programmatic changes occurred. Currently the Consumer Affairs program offers peer support services in two distinct settings: Clinic setting and Self-Help Centers. Mental Health Peer Support Workers in the clinic setting provide WRAP (Wellness and Recovery Action Plan) groups, tobaccocessations groups and one on one support. The Self-Help Centers are drop in centers that also provides WRAP groups, social and recreational activities, and one on one support as needed. Consumer Affairs staff use several approaches to support and validate consumers in their recovery process. A new program geared towards family members was also created, Office of Family Affair.</td>
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integrate INN-08 Interactive Video Simulation Training (IVST) into the A04 work plan. Redirect $87,000 to fund LEL contracts;

b. Adjust budget for the Urgent Care MOU with Protective Services based on actual expenses. Current budget allocation is $303,831. However, FY12 actual expense was approximately $368,000 and FY13 yearend expense estimates are currently projected at $355,000. Need to redirect $51,169;

c. Redirect funds to offset cost relating to Psychiatrist salary/benefit costs in HC01, $22,324.

For item 4, overall there is no budget change due to redirection of existing ongoing funds.

5. Remove one-time budget of $73,200 set aside for Law Enforcement Liaisons (LELs) in FY13. Ongoing funding for the LELs will be provided through redirection of ongoing program services and supplies as described in item #4 above.

Total proposed budget change: an increase of $4,700,329 in the A04 budget.
Staffing for Family Affairs includes 1.0 FTE and 4 (0.5) FTE Mental Health Peer Support Workers. They provide peer support services to family members in clinics, at Urgent Care and inpatient hospitals.

FY12 to FY13 Number of Contacts:

<table>
<thead>
<tr>
<th>Number of Contacts</th>
<th>FY12</th>
<th>FY13</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Self-Help Center</td>
<td>7,182</td>
<td>6,174</td>
<td>13,356</td>
</tr>
<tr>
<td>Clinical Peer Support</td>
<td></td>
<td>142</td>
<td>142</td>
</tr>
<tr>
<td>Family Affairs</td>
<td>717</td>
<td>717</td>
<td>717</td>
</tr>
<tr>
<td>Total</td>
<td>7,182</td>
<td>7,033</td>
<td>14,215</td>
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</table>

Eight programs designed and implemented by consumer staff are currently supporting this initiative: three Self Help Drop In Centers; Meeting Participants program; Newsletter; Project T.E.A.M. (Teaching, Empowerment, Advocacy and Mentoring); Peer Mentors; W.R.A.P. (Wellness and Recovery Action Plan); Older Adult Peer Support (OAPS); and Transitional Age Youth (TAY). These programs use several approaches to support and validate consumers in their recovery process.

Attendance at the North County Self Help Center (Phoenix) has been steadily declining over the past year. The centers hours have been reduced to adjust for the loss of clientele. Currently only two individuals use the center regularly and drop-in groups are largely unattended. As a result, the MHD recommends closing the site and reallocating the resources to other Office of Consumer Affairs activities. Consumers who have continued to use the center will be connected with other local resources. Proposed change does not result in a budget change in work plan A05.

OA01 PLAN - OLDER ADULT FULL SERVICES PARTNERSHIPS (FSP)

| OA01 Description | This project offers intensive wraparound services for up to 25 older adults. FSPs for older adults are designed to meet the comprehensive needs of seriously mentally ill older adults 60+ years of age that include psychiatric needs, homelessness or the risk of homelessness, hospitalization or other institutionalization, and the risk of being harmed physically, financially or psychologically. |

| OA01 Progress Update | In FY12, the number of EPS admissions decreased by 3% for older adults enrolled in Older Adult FSP compared to FY11. Likewise, the number of hospitalizations decreased by 66% compared to FY11 while the number of arrests remained at zero for both FY11 and FY12. The number of older adults served in FY12 increased by 19.7% from FY11 and consumers were served beyond targeted capacity. In terms of race and ethnicity, the data reflects a 4.9% increase in White, 40% increase in African-American, 22.2% increase in Hispanic and a 32.9% increase in Asian/Pacific Islander consumers while there were no Native American consumers served in either FY11 or FY12. MHSA cost per client is $11,259. In terms of capacity, the number of Older Adult FSP consumers served in FY12 was 39. |
The Older Adult FSP program served 162 from FY07 to FY12 (Source Data: Unicare):

- 13.0% (N=21) Latino
- 3.1% (N=5) African American
- 6.2% (N=10) Asian/Pacific Islander
- 7.4% (N=12) Other Ethnicity
- 61.1% (N=99) Caucasian/White
- 9.3% (N=15) Unknown Ethnicity

In addition, 22.3% (N=36) were from the Underserved Population:

- 13.0% (N=21) Latino
- 3.1% (N=5) African American
- 6.2% (N=10) Asian/Pacific Islander

<table>
<thead>
<tr>
<th>Total Number Served</th>
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</thead>
<tbody>
<tr>
<td>Latino: 13.0% (N=21)</td>
</tr>
<tr>
<td>African American: 3.1% (N=5)</td>
</tr>
<tr>
<td>Asian/Pacific Islander: 6.2% (N=10)</td>
</tr>
<tr>
<td>Other Ethnicity: 7.4% (N=12)</td>
</tr>
<tr>
<td>Caucasian/White: 61.1% (N=99)</td>
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<tr>
<td>Unknown Ethnicity: 9.3% (N=15)</td>
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<thead>
<tr>
<th>Number Served Per Fiscal Year</th>
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<tbody>
<tr>
<td>FY07</td>
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<td>OA01</td>
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There are no proposed changes for FY14.
OA02-04 PLAN - OLDER ADULT BEHAVIORAL HEALTH SERVICES OUTPATIENT REDESIGN

<table>
<thead>
<tr>
<th>OA02-04 Description</th>
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<tbody>
<tr>
<td>This initiative is intended to result in improved design for age-appropriate access, engagement, screening, assessment, and level of care system assignment for outpatient services; and training and staff development plans to ensure incorporation of core transformation principles and new intervention models throughout the system, including recovery-focused services, consumer/family member involvement, and cultural competency.</td>
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<tr>
<th>OA02-04 Progress Update</th>
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<td>On June 1, 2011, 348 members of the community, including seniors and their families, caregivers, advocates, service providers, community leaders and government officials from throughout Santa Clara County, attended the Santa Clara County Older Adult Summit. It was a great success and provided an excellent forum for input on problems facing seniors with mental health and related critical needs. Subsequently, the Mental Health Department outlined a three year implementation process to address the concerns and recommendations that resulted from the Summit. This effort is expected to significantly improve the quality of life and wellbeing of the County’s senior population. Participants for the Partners Implementation Task Force will be recruited from the agencies that participated in the Older Adult Summit. New partners who had not previously participated in this process but who are key contributors to the strategies will be identified and invited to participate. The Seniors’ Advisory Council will be formed by inviting persons over the age of 60 who are committed to effectively carrying out the strategies in the report. The Mental Health Department, through collaboration with the Aging Services Collaborative, will ensure that the recommendation from the Summit and the subsequent strategies being implemented are shared with key leaders and organizations in the senior-serving community.</td>
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Training for geriatric care is critical---clinicians and therapists participated in a new training opportunity that allowed them to improve their therapeutic skills in helping older adults dealing with depression. This project provides training and evaluation to participating clinicians in a well-established clinical intervention skill set called Cognitive Behavioral Therapy. Designated provider sites will utilize the PHQ9 depression screening tool as part of their individual projects, and the resultant data will help track the rates of depression in their systems by reporting the number of individual patients screened for depression. Two long-term goals for this project group will be to develop a process for utilizing the PHQ9 as a monitoring tool across the various settings and to ensure organizations involved in this project have a mechanism in place to address positive responses to screening questions. |

Golden Gateway Comprehensive Older Adult program is intended to provide comprehensive services to SMI Older Adults (60+), who may be physically; linguistically or culturally isolated; or homebound with primary health and other age-related conditions through the following: |

- Comprehensive Outreach & Education, which includes extensive outreach to diverse communities, and ongoing education at senior centers, housing communities and faith communities |
- Engagement |
- Assessment and Referral |
- Treatment and Support Services |

Additionally, the program has been established to address the following: |

- The needs of unserved and underserved older adults diagnosed with SMI and age-related conditions.
• Cultural and linguistic needs of seniors with mental illness who are monolingual, and are culturally or physically isolated.

• To provide older adults support through outreach and in-home services at their personal residence or out-of-home placements.

• To provide social and other needed support services to this population.

• To employ peer mentors and family members as part of the outreach, engagement, treatment and support team process.

• To provide full scope of services through the use of a multidisciplinary team which includes psychiatry, case managers, family and peer partners, nursing and other clinical staff.

The Older Adult Golden Gateway program served 355 from FY09 to FY12 (Source Data: Unicare):

- 18.0% (N=64) Latino
- 1.4% (N=5) African American
- 0.6% (N=2) Native American
- 14.1% (N=50) Asian/Pacific Islander
- 6.5% (N=23) Other Ethnicity
- 18.0% (N=64) Caucasian/White
- 41.4% (N=147) Unknown Ethnicity

In addition, 34.1% (N=121) were from the Underserved Population:

- 18.0% (N=64) Latino
- 1.4% (N=5) African American
- 0.6% (N=2) Native American
- 14.1% (N=50) Asian/Pacific Islander

### Total Number Served

- Latino: 41.4%
- African American: 18.0%
- Native American: 6.5%
- Asian/Pacific Islander: 14.1%
- Other Ethnicity: 1.4%
- Caucasian/White: 18.0%
- Unknown Ethnicity: 0.6%
In FY13, the budget included one-time funds to support a collaboration with the City of San Jose. The expected outcomes of the project include:

- Geriatric Specialists employed by the City of San José to work at the community centers will be better able to identify key mental health issues faced by the senior participants at their center and as requested by senior participants, link individuals to mental health interventions.

- Senior participants of the community centers will be more knowledgeable about mental health issues and services, in addition, more senior participants will be better able to address mental health related issues they personally experience.

Project activities to-date include:

- The training of 14 City of San Jose Community Center staff on Mental Health First Aid (MHFA) provided by SCCMHD. The training participants included one program manager, and Community Center Geriatric Specialist staff members. Additionally, City of San Jose staff will continue to receive ongoing training on various mental health topics which will be sponsored by the SCCMHD Learning Partnership.

- March 2013 was the first month of a 12 month community education program for senior participants at 14 City of San Jose Community Centers. In total 737 individuals attended the “Close Friendships and Relationships” presentation presented by a MHD Licensed Marriage and Family Therapist County Staff. Future presentations will cover topics such as “Understanding our Losses”, etc.

- Assigned a Sr. Mental Health Program Specialist and Health Care Program Analyst to manage the weekly capacity of FSP providers. The open capacity is communicated to the Mental Health Call Center.

The Older Adult collaboration with City of San Jose was initially slated to start July 2012. However, actual start of the program occurred in March 2013. The project is funded on a one-time basis at $280,000. Due to delay start of the program, the expenses projected for FY13 is approximately $90,000 and the remaining balance projected to be spent in FY14. The one-time amount slated for FY14 will be $190,000, the remaining amount of the contract. Total proposed budget change: a decrease of $90,000 in one-time funding in the OA02-04 budget.
HC01 PLAN - BEHAVIORAL AND PRIMARY HEALTH CARE PARTNERSHIP

HC01
Description
This is an initiative designed to improve the interface between behavioral health and primary healthcare in collaboration with mental health and substance abuse providers. The project incorporates key evidenced-based administrative and direct service strategies that will improve service access, care coordination and care delivery across healthcare systems. A Mental Health Specialty Assessment Center (MHSAC) was implemented to offer mental health assessments and assistance in linkages with needed services, enrollment in the VMC primary care system, annual health screenings with pharmacy education for enrolled consumers, and increased pharmacy consultation to improve primary care with psychiatric medication management.

HC01
Progress
Update
The MHSAC program was designed to assist unsponsored mental health consumers in applying for entitlements such as Valley Care, Ability to Pay Determination (APD), Medi-Cal, Medicare, and Social Security Insurance (SSI) Programs. With the opening of the Central Wellness and Benefits Center (CWBC) and the addition of the Federally Qualified Health Clinic (FQHC) behavioral health services in 2009, there has been a significant increase in service capacity within the system.

The MHSAC program served 3,789 from FY07 to FY12 (Source Data: Unicare):
- 24.4% (N=926) Latino
- 5.9% (N=222) African American
- 0.9% (N=34) Native American
- 19.7% (N=748) Asian/Pacific Islander
- 0.3% (N=10) Mixed Race
- 3.9% (N=147) Other Ethnicity
- 37.5% (N=1,420) Caucasian/White
- 7.4% (N=282) Unknown Ethnicity

In addition, 50.9% (N=1,930) were from the Underserved Population:
- 24.4% (N=926) Latino
- 5.9% (N=222) African American
- 0.9% (N=34) Native American
- 19.7% (N=748) Asian/Pacific Islander

Total Number Served

- Latino
- African American
- Native American
- Asian/Pacific Islander
- Mixed Race
- Other Ethnicity
- Caucasian/White
- Unknown Ethnicity
From FY11 to FY12 there was a decrease in numbers served at MHSAC from 900 consumers to 49 consumers as MHSAC staff was consolidated into the Central Wellness Benefit Center (CWBC) program. Given the goal of the CWBC program is also to assist consumers with benefits at the same time they begin services, it was determined that there was no longer a need to have two programs providing the same service and that staff would be better utilized by consolidating the two programs into one.

The CWBC moved into the HC01 work plan effective FY13. CWBC continues to provide needed mental health services to underserved and uninsured individuals. Individuals receive an assessment, medication management, minimal time limited case management, and crisis intervention services. Additionally, clients receive access to a Financial Counselor to assist with eligibility for benefits, i.e., APD, Valley Care II (The Valley Care II program serves individuals who will be eligible for Medi-Cal in 2014 and is part of the new Health Care Reform legislation), Medi-Cal, SSI, Medicare, Medicare Part-D, Minor Consent Medi-Cal, and Low Income Subsidy (LIS).

The volume of referrals on a monthly basis is the highest of any outpatient county or contract provider with CWBC receiving at minimum 50% total of all referrals in any given month and at least 50% of all Level I referrals a month.

Working in close collaboration with MHUC, CWBC implemented a streamlined process to eliminate the number of new referrals coming from MHUC via the Call Center. As a result, all new clients referred to CWBC from MHUC are considered a transfer and are no longer directed to Call Center for referral to CWBC. These individuals have received a psychosocial assessment and medication evaluation by a Psychiatrist at MHUC thereby not needing a new full psychosocial assessment or full medication evaluation. At MHUC, clients receive a prescription for 30 days of medication plus two refills. This new workflow has resulted in a quicker ability for "new" referrals coming directly from Call Center to CWBC, to be seen sooner - within 14 days – as medication evaluation time slots are freed up due to the transfer cases needing less time for the MD to see the transferred client. This change has resulted in a positive, timely access to services at CWBC for clients. It has also decreased the number of referrals needing to be processed at the Call Center.

On a quarterly basis, CWBC closes approximately 150 to 200 inactive cases a quarter. This quarterly process has been in effect for three years and provides a close, real time ability to manage current caseloads and an overview of the total clinic caseload.

The CWBC served 5,011 from FY09 to FY12 (Source Data: Unicare):
• 31.7% (N=1,589) Latino
• 5.3% (N=266) African American
• 0.9% (N=44) Native American
• 16.3% (N=816) Asian/Pacific Islander
• 0.1% (N=6) Mixed Race
• 4.4% (N=218) Other Ethnicity
• 35.7% (N=1,788) Caucasian/White
• 5.6% (N=283) Unknown Ethnicity

In addition, 54.2% (N=2,715) were from the Underserved Population:

• 31.7% (N=1,589) Latino
• 5.3% (N=266) African American
• 0.9% (N=44) Native American
• 16.3% (N=816) Asian/Pacific Islander

Please note, prior to FY12 the CWBC was in work plan A02 and in FY13 HC01.
Merge HC01 work plan into Urgent Care, work plan A04. The HC01 work plan was designed to improve the interface between behavioral health and primary healthcare in collaboration with mental health and substance abuse providers. Given the goal of HC01 is to assist consumers with benefits at the same time they begin services it is proposed to integrate all the services currently in HC01 to A04. In addition, the MHD proposes to rename work plan A04 to “Central Wellness and Urgent Care Services” to reflect the A04/HC01 merge, refer to A04 section.

Total proposed budget change: Move HC01 ongoing budget of $5,230,979 to A04.

HO01 PLAN - HOUSING OPTIONS INITIATIVE

HC01 Proposed FY14 Changes

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>This plan was established to help the MHD and the County directly address the housing needs of consumers through housing development, services, and interagency collaboration. The Office of Housing and Homeless Support Services (OHHSS) was created to oversee the MHD’s housing development, programs, and services for un-served and underserved consumers of all age groups and their families, particularly those who are homeless or are at-risk of homelessness, have co-occurring disorders, suffer from abuse or are involved in the criminal justice system. Using County General Funds, the OHHSS supports the County’s effort to address homelessness throughout the County. The goals and strategies of this initiative intersect and are coordinated with those of agencies addressing homelessness throughout Santa Clara County.</td>
</tr>
</tbody>
</table>

HO01 Progress Update

All programs under this work plan are fully implemented. The Office of Housing and Homeless Support Services (OHHSS) major responsibilities include the following:

- The OHHSS develops, implements, and/or manages permanent supportive housing programs.
  - In partnership with the Office of Affordable Housing, the Housing Plus Fund led to the development of 37 units of housing affordable to households earning 30% or less of the area median income.
  - MHSA Housing Program: As of June 30, 2013, the County had allocated funds to develop 113 new rental units that are affordable to households earning 15% of area median income. Approximately $1.18 million remains to be allocated.
  - Housing 1000 Campaign (H1K): In 2011, the community launched an effort to house 1,000 of the most vulnerable, chronically homeless individuals and families in Santa Clara County. Since the campaign’s inception, the County and its partners have funded or obtained direct access to nearly 620 units or permanent subsidies (including 63 funded by the MHSA Housing Program). Some of the units will not be available until 2015. Under H1K, permanent housing is coupled with Intensive Case Management (ICM) services, which are critical for assisting chronically homeless individuals and families obtain and maintain permanent housing. Since the inception of H1K, the County and its partners have funded 15 new intensive case managers, with a total capacity of serving 300 households at any one time. Over half of the ICM capacity is overseen by the MHD or other County departments. From July 11, 2011 through June 30, 2013, 354 chronically homeless
households (421 people) have moved into permanent supportive housing. Of these 354 households, 129 were served by the H1K Coordination Care Project (CCP). The CCP was established by the County, Destination: Home, the City of San Jose, and partners to streamline services and meet the needs of clients with the highest levels of need.

- The MHD is the recipient of four HUD-funded permanent supportive housing programs. Together, the programs serve 125 chronically homeless individuals with serious mental illness and/or addiction disorders. For two programs over 88% of clients maintained their housing, and over 76% of clients increased or maintained their income. The remaining two programs were just starting at the end of FY13.

- The OHHSS develops, implements, and/or manages transitional supportive housing programs, which provide housing stability to enable households to become economically self-sufficient. In FY13, the OHHSS administered, managed or supported more than 100 units of transitional supportive housing on behalf of various divisions, departments and programs including:
  - 42 units for the Criminal Justice Services program
  - 15 units for the Department of Alcohol and Drug Services (St. James Park Pilot)
  - Approximately 30 units under the “San Jose Tenant-Based Rental Assistance (TBRA)” program
  - 35 units for individuals under mandatory community supervision pursuant to AB109

- The OHHSS develops, implements, and/or manages rapid re-housing, homeless prevention, and homeless service programs, including the Cold Weather Shelter Program and the UPLIFT transit pass program.

- In partnership with the other stakeholders, the OHHSS assists in planning for, assessing, developing, resourcing, and improving programs to end and prevent homelessness.

- Major accomplishments for FY13 include:
  - Launched a community-wide planning effort to implement a new governance structure for the Continuum of Care.
  - Launched the Homeless Cost Study to understand the cost profiles of homeless populations, determine the efficacy of permanent supportive housing, and to develop a tool to identify high users of safety net services.
  - Developed and implementing a framework for meeting the needs of homeless households centered on housing need rather than household composition.
  - Developed and implementing a community-wide framework for addressing the needs of and issues associated with unsheltered populations especially those residing in homeless encampments.
  - Completed the 2013 Biennial Homeless Census and Survey.
  - Finalized contract with HUD to implement 63 units of permanent supportive housing for the
highest users of SCVHHS services.

- Applied for approximately $900,000 in new funding from HUD.

<table>
<thead>
<tr>
<th>HO01 Proposed FY14 Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are few recommended changes proposed for FY14:</td>
</tr>
<tr>
<td>1. Propose to add new Mental Health Community Worker. One of the Office of Housing and Homeless Support Services (OHHSS) key tasks is to assist high needs clients with obtaining and maintaining permanent supportive housing. The Mental Health Community Worker will work closely with the MHSA Housing Support Liaison to form the OHHSS Housing Support and Engagement Team (Team). The cost of the new position is $66,658 based on ten months. Funding will come from the deletion of Management Aide/Management Analyst A/B position in HO01.</td>
</tr>
<tr>
<td>2. Deletion of vacant Management Aide/Management Analyst A/B position in HO01 to fund new Mental Health Community Worker. Please refer to the item above for details. Reduction of $53,460.</td>
</tr>
<tr>
<td>3. The Temporary Housing Subsidy Program (THSP) MHSA portion adjusted based on FY13 Community Based Organization (CBO) Exhibit B. MHSA amount changed from $638,719 to $612,411; a reduction of $26,308.</td>
</tr>
<tr>
<td>4. Housing for Homeless Addicted to Alcohol (HHAA) HUD Grant. Propose to continue program but reduce MHSA funding by $100,000 which will be replaced with County General Funds. Change MHSA funding from $198,413 to $98,413.</td>
</tr>
<tr>
<td>5. Propose to fund Intensive Case Management (ICM) South County program with MHSA funds. The MHD intends to increase ICM services for the southern region of the County. Add $100,000 MHSA funding through redirection of funds from item #4.</td>
</tr>
</tbody>
</table>

Total proposed budget change: a decrease of $13,110 in one-time funding in the HO01 budget.

LP01 PLAN – LEARNING PARTNERSHIP

<table>
<thead>
<tr>
<th>LP01 Progress Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a Division of the SCCMHD comprised of three units, Decision Support (the Department’s research and evaluation unit), Cultural Competency (ensures that cultural needs of the County’s ethnic and racial populations are met by the Department), and Continuous Learning (responsible for staff development and consumer and family member workforce education and training). These units are tasked with working together to aid and support the transformation of the Department to a client driven/family supportive wellness and recovery system.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LP01 Progress Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>In addition, to the above mentioned units, the Learning Partnership also has incorporated Consumer Affairs and Family Affairs. Fully staffed, the units are operating as planned and continually work to expand their ability to support the quality improvement efforts of the Department.</td>
</tr>
<tr>
<td>CSS AD01 Administration</td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LP01 Proposed FY14 Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The new 2.0 FTEs licensed Mental Health Program Specialists added in FY13 will be funded with existing MHSA WET funds. Remove $251,904 from LP01 budget.</td>
</tr>
</tbody>
</table>

### CSS AD01 Description

This includes support staff positions and contracts for Administration, Contracts, Finance and Quality Improvement.

### CSSAD01 Progress Update

In FY12, administration/contracts unit staff members were responsible for executing 360 standard/non-standard contracts (Contracts); 58 memorandums of understanding (MOU)/operational agreements (OA); 22 Board of Supervisors transmittals; and 35 Health and Hospital Committee pending board items (PBIs); and conducting 12 requests for proposals (RFPs) and 10 informal competitive process (ICPs) solicitations. RFPs included Adult Transitional Housing and Crisis programs, Adult/Older Adult Storytelling, and Innovation 4.

The MHD’s FY13 CSS component budget includes $1,573,287 for Administrative costs. These funds are supporting managerial and clerical positions in Mental Health Administration, Contracts, Finance, Information Systems, Quality Assurance and other system-wide administrative functions. For FY14, the MHD proposes to maintain the same amount with no additional funding needed.

### CSS AD01 Proposed FY14 Changes

For FY14, the MHD proposes to swap existing Management Analyst Program Mgr (MAPM) I/II position with a new Sr. Mental Health Program Specialist (MHPS) position code for the MHSA Coordination Role/Position. The requested proposal will require an add/delete action but will not require additional funds. The MHD will need to add new 1.0 FTE Sr. MHPS position and delete existing MAPM I/II position. The proposed change will have no impact on the AD01 budget.
PREVENTION AND EARLY INTERVENTION (PEI) PLAN

DESCRIPTION

The PEI component includes strategies to help prevent and address the early symptoms of mental disorders regardless of their etiology. Many of the PEI strategies are being implemented countywide. Others are focused in high risk areas in which overburdened and underserved families face multiple stressors. There is particular emphasis on reaching and serving individuals and families who are subject to cumulative risk factors and on reducing disparities in access to help.

Consistent with the County’s CSS Plan, the PEI Plan continues the emphasis on a lifespan approach, based on strong system partnerships, rooted in cultural competency throughout, and with an emphasis on connectedness. We expect to create improvements in a range of life stages and domains by preventing and reducing the incidence, prevalence and severity of mental illness.

KEY COMMUNITY NEEDS

1. Stigma and Discrimination
2. Disparities in Access to Mental Health Services
3. Psycho-Social Impact of Trauma
4. At-Risk Children, Youth and Young Adult Populations
5. Suicide Risk

PRIORITY POPULATIONS

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

<table>
<thead>
<tr>
<th>PEI Programs</th>
<th>FY2013 Funding</th>
<th>FY2014 Recommended Funding</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 Community Engagement/Capacity Building for Reducing Stigma and Discrimination</td>
<td>$1,742,278</td>
<td>$1,701,278</td>
<td>$(41,000)</td>
</tr>
<tr>
<td>P2 Strengthening Families and Children</td>
<td>$10,041,626</td>
<td>$9,845,983</td>
<td>$(195,643)</td>
</tr>
<tr>
<td>P3 PEI Interventions for Individuals Experiencing Onset of Serious Psychiatric Illness</td>
<td>$2,780,999</td>
<td>$2,472,002</td>
<td>$(308,997)</td>
</tr>
<tr>
<td>P4 Primary Care/Behavioral Health Integration for Adults and Older Adults</td>
<td>$2,817,357</td>
<td>$5,000,781</td>
<td>$2,183,424</td>
</tr>
<tr>
<td>P5 Suicide Prevention Strategic Plan</td>
<td>$1,010,125</td>
<td>$1,283,500</td>
<td>$273,375</td>
</tr>
<tr>
<td>PEI Administration</td>
<td>$1,819,254</td>
<td>$1,819,254</td>
<td>-</td>
</tr>
<tr>
<td>Total PEI</td>
<td>$20,211,639</td>
<td>$22,122,798</td>
<td>$1,911,159</td>
</tr>
</tbody>
</table>

Please note: Adjustments to the MHD MHSA County personnel budget resulting from Board of Supervisor (BOS) approval for: 1) Increased contributions to the California Employers Retiree Benefit Trust (CERBT) and 2) Salary and benefit adjustments based on contract negotiations with labor unions is still pending and not reflected in the table above. The proposed plan is to spread the budget adjustments across the five MHSA components (See pages 98-99).
P1 PLAN – COMMUNITY ENGAGEMENT AND CAPACITY BUILDING FOR REDUCING STIGMA AND DISCRIMINATION

This is an initiative to improve the interface between behavioral health and local medical primary care in collaboration with mental health and substance abuse providers. The program incorporates key evidenced-based administrative and direct service strategies that will improve service access, care coordination and care delivery across healthcare systems.

In January 2012, the MHD started hiring for seven full-time and 14 half-time Mental Health Peer Support Worker (MHPSW) positions. Currently, six full-time and four half-time positions are filled. The MHD is actively recruiting for the vacant positions.

Seven groups are providing peer support, outreach, engagement and educational services to nine underserved and unserved communities to reduce stigma and discrimination and increase access to mental health services.

The Ethnic and Cultural Communities Advisory Committees (ECCACs) is creating an access database that tracks numbers for one-to-one outreach and support, ECCAC support groups and events, and community events. The database will also track demographics, service type, frequency of services, collaborations with CBOs, and outcomes. In the first to third quarter of FY13, the ECCACs served 454 individuals (unduplicated), had 2,657 contacts in ECCAC groups and events (duplicated), and provided information to an estimated 6,792 contacts at community events.

In recent years, the ECCACs focused on providing Mental Health First Aid (MHFA) trainings to ethnic communities. From January 2011 to March 2013, ECCAC staff provided 68 trainings, and 706 community members had completed the two-day training. The ECCAC has the capacity to provide MHFA trainings in Amharic, Cantonese, English, Mandarin, Somali, Spanish, Tagalog, Tigrinya, and Vietnamese.

Additional Updates:

- Number of individuals and families served from underserved populations has steadily increased since the program began in 2008.

- In FY08 quarterly contacts averaged 591. The average number of contacts per quarter in FY12 is 1,673. (Source: ECCAC Consumer and Family Served Table)

- The number of benefited individuals from underserved populations has improved in many communities.
  - The number of African-Americans with benefits has increased from 890 in FY08 to 979 in FY11.
  - The number of Latino/Hispanic consumers with benefits has increased from 4,421 in FY08
to 6,140 in FY11 (Source: Cultural Competency Dashboard).

### P1 Proposed FY14 Changes

There are few recommended changes proposed for FY14:

1. For the FY13 annual update, there were one-time funds set aside for the ECCAC and Self-Help services agreements. Initially, it was thought service agreement funding was needed but during FY13 as the MHPSW positions were getting filled there was actually no need to access the one-time funds. For FY14, it proposed not to continue the $206,000 one-time funds for ECCAC services agreements and one-time funds of $200,000 for Self-Help service agreements; a decrease of one-time funding totaling $406,000.

2. The MHD program staff and ECCAC members expressed the need for program supplies funding for each ECCAC group at $5,000 per group. Currently there are seven groups. Propose one-time funds of $35,000 for program supplies in FY14.

3. Add two new groups: 1) a Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) group, and 2) a Veterans’ group. Allocate $160,000 per group which is closely equivalent to 1.5 FTE Mental Health Peer Support Worker (MHPSW) allocated per ECCAC group. In addition, allocate $5,000 per group for program supplies. Propose new one-time funding of $330,000 in FY14. Once new one-time funding request is approved, the MHD plans to release a Request for Proposal (RFP) for the two new groups sometime in FY14.

Total proposed PEI P1 budget change: a decrease in budget by $41,000 based on the changes noted above of one-time funds.

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### P2 PLAN – STRENGTHENING FAMILIES AND CHILDREN

#### P2 Description

This initiative is divided into two components; component one is intended to prevent or intervene early in the development of emotional and behavioral problems in young children by providing the parents with outcome-based parenting strategies, support services, and access to screenings to identify developmental delays; and component two builds upon the first by implementing a continuum of services targeting four geographic areas of high need (Investment Communities) for children and youth ages 0-18 who may be experiencing symptoms ranging from behavioral/emotional distress to depression and anxiety caused by trauma or other risk factors.

#### P2 Progress Update

Strengthening Families and Children in Investment Communities throughout four regions in Santa Clara County began FY13. The County PEI Plan served as a blueprint for the Strengthening Families and Children Project, informed by more than two years of extensive research and collaborative development by a diverse group of stakeholders.

In order to ensure that direct services met the unique needs of each identified high risk region, local planning teams were formed in four geographical areas of the County: East, Central, South, and North County. These planning teams met for six months, reviewing data on census tracts, school performance, demographics, and other key factors in determining the target populations and appropriate service strategies. Each team ultimately selected schools as the hub for service delivery,
while expanding eligibility to all family members of students attending the identified schools.

The planning teams also opted to recommend those strategies promoted by the PEI plan, while suggesting additional evidence-based practices in each specialized regional Investment Community Plan. The recommended practices included Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Strengthening Families Program, Triple P Levels 4 and 5, and a brief family therapy model.

The MHD conducted outreach to the eleven school districts selected by the regional planning teams. Simultaneously, a competitive procurement process was underway that resulted in the selection of five community based organizations to deliver the services. In FY13, operational agreements outlining the responsibilities of each party were developed and executed between the MHD and each of the 11 school districts. Contracts were negotiated and executed with each of the five CBOs to deliver direct services utilizing the evidence-based practices recommended through the planning processes. The program was integrated into the MHD’s broader School Linked Services program, which includes 13 school district partners and over 15 government entities and other organizations providing a continuum of services to local families.

New systems were developed for processing the unique requirements of this novel project, including methods for outcome evaluation and seamless integration of non-medical necessity clients with the standard Medi-Cal eligible services. Processes were developed to streamline the prevention oriented services to minimize paperwork requirements and make services easier to access for families. Multiple advisory meetings were held on an ongoing basis to ensure continuous quality improvement and the incorporation of school recommendations. Hundreds of staff from Strengthening Families and Children Project, the MHD clinics, and other system of care providers were trained in the evidence-based practices identified for the program.

Program implementation began on a wide scale in January 2013. More than 50 new clinicians, family partners, behavioral specialists, and supporting staff were brought on to launch the Strengthening Families and Children Project in the 53 targeted schools. Over 600 students and their families were served through this program in its inaugural three months, with capacity created to serve many more. Preliminary data from the program indicates success in reducing office referrals for discipline, improving attendance rates, and improving the academic performance of students in the schools receiving Strengthening Families and Children Project services. Outcome data utilizing assessment tools for evaluating changes in the status of mental health is being collected and will be available for analysis in FY14.

School Linked Services (SLS) Coordinators: This PEI project provides ten School Linked Services partner school districts support for service coordination. These school districts include Alum Rock Union School District, Campbell Unified School District, Franklin McKinley School District, Gilroy Unified School District, Luther Burbank School District, Morgan Hill Unified School District, Mt. Pleasant Elementary School District, Mountain View Whisman School District, Oak Grove School District and San Jose Unified School District. Selected schools from each of these districts were identified for receipt of Prevention and Early Intervention mental health services through countywide and regional Prevention and Early Intervention planning processes. Additionally, these districts are committed to the School Linked Services initiative and are participating in the initiative as funding partners.

Through engagement with school districts over the course of the Strengthening Families and Children Project’s planning and implementation processes, as well as through the development of the School Linked Services strategic plan, the need for enhanced services coordination at the district and
campus levels emerged as a strategic priority.

During the School Linked Services strategic planning process, research informed models utilized throughout the nation were combed for critical elements applicable to local needs. Models reviewed included the Community Schools model, Coordinated School Health model and UCLA Center for Mental Health in Schools model. These approaches all recognize that when utilizing school campuses as a hub for services, improved coordination through dedicated personnel improves appropriate service utilization by maximizing efficiency and reach of available resources.

The School Linked Services Implementation and Oversight Task Force determined that a full time, campus based School Linked Services Coordinator would perform the following duties: Provide oversight and coordination of campus-based services and service providers; actively engage families, caregivers and the community; grow and manage a campus collaborative consisting of service providers, community members and families and caregivers; identify campus resources and gaps in service areas; diffuse and triage student crisis situations and connect students to appropriate services; address school climate and safety needs; support training needs of teachers and school staff in the areas of school climate, safety and health; develop and/or support data collection infrastructure to assist with data driven decision making and determination of program effectiveness; function as a compliment to or part of school’s multidisciplinary team or equivalent; and coordinate linkage of identified students to appropriate services.

The ten districts funded through this program each prioritized functional areas consistent with the School Linked Services coordinator description. The districts considered these areas to be of critical need and not currently addressed by existing staff.

Over the past fiscal year, contract development, approval through district management and school boards and hiring, have progressed. Coordinators have attended orientation training and have been provided with additional support opportunities. Coordinators are working directly with district and school personnel, community based organizations, and students and their families. Coordinators are supporting existing and new programs, including initial ramp up of the Strengthening Families and Children Project, and are poised to offer enhanced support for schools, families and services providers as the scope of recently launched programs increases.

School Linked Services (Provided by Community Based Organizations) and County Mental Health Clinical Staff: In an effort to develop and offer a full continuum of services ranging from promotion, prevention, early intervention and intervention, funds that were formerly allocated to AB114 (Transition of Special Education and Related Services Formerly Provided by County Mental Health Agencies) were transitioned to support Medi-Cal eligible mental health services at the intervention level. These services are currently being offered by Children’s Health Council, Community Solutions, EMQFF, Rebekah Children’s Services, Starlight, and three County Clinics (KidScope, Las Plumas, and Sunnyvale) to support children and youth identified by schools to have mental health needs.

Mobile Crisis/Transition Services also known as EMQFF’s Child and Adolescent Crisis Program: The EMQFF Child and Adolescent Crisis Program (CACP) provide onsite, rapid-response crisis assessment and intervention to children and families who are depressed, suicidal. A potential danger to themselves, others or are in some other form of acute psychological crisis. CACP utilizes a family-centered, strengths based approach. Children and families are viewed as living within many interrelated systems, including extended families, schools and communities as well as professional external resources. Opportunities to involve and draw support from these systems are incorporated with the intervention. 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 for emergency
hospitalization when needed.

During FY12, 700 clients were served by CACP, 347 females and 353 males; 656 (94%) of those served spoke English and 26 (4%) spoke Spanish.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>FY12</th>
<th>as % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 0 - 5</td>
<td>5</td>
<td>0.7%</td>
</tr>
<tr>
<td>Ages 6 - 10</td>
<td>97</td>
<td>13.9%</td>
</tr>
<tr>
<td>Ages 11 - 13</td>
<td>222</td>
<td>31.7%</td>
</tr>
<tr>
<td>Ages 14-17</td>
<td>375</td>
<td>53.6%</td>
</tr>
<tr>
<td>Age 18</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total</td>
<td>700</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The following is a breakdown of the unduplicated number (N=588) of children and families served by ethnicity:

- 38% (N=232) Latino
- 5% (N=29) African American
- 1% (N=3) Native American
- 16% (N=92) Asian/Pacific Islander
- 4% (N=22) Other Ethnicity
- 35% (N=206) Caucasian/White
- 1% (N=4) Unknown Ethnicity

**Total Number Served**

- Latino: 38.0%
- African American: 4.0%
- Native American: 1.0%
- Asian/Pacific Islander: 16.0%
- Other Ethnicity: 1.0%
- Caucasian/White: 35.0%
- Unknown Ethnicity: 5.0%

Direct Referral Program (DRP) is a diversion program that serves youth ages 15 years of age and younger, who are arrested for the first time by the San Jose Police Department on a minor offense. The citations are diverted from the regular court process and youth are referred to community based services in lieu of an official arrest record. The goal of this program is to provide an immediate intervention to address the youth’s behavior while positively impacting the overrepresentation of minority youth in the juvenile justice system. In FY13, 477 youth were screened for the DRP with the vast majority of the youth screened were identified as Hispanic/Latino (71.5%), see below for details:

- 71.5% (N=341) Latino
- 7.8% (N=37) African American
- 0.4% (N=2) Native American
- 5.9% (N=28) Asian/Pacific Islander
• 2.5% (N=12) Other Ethnicity
• 11.3% (N=54) Caucasian/White
• 0.6% (N=3) Unknown Ethnicity

In addition, 73.4% of the youth screened were 13 to 15 years old and 26.7% were 12 and younger, see table below for details.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>FY13</th>
<th>as % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 8</td>
<td>2</td>
<td>0.4%</td>
</tr>
<tr>
<td>Age 9</td>
<td>6</td>
<td>1.3%</td>
</tr>
<tr>
<td>Age 10</td>
<td>4</td>
<td>0.8%</td>
</tr>
<tr>
<td>Age 11</td>
<td>37</td>
<td>7.8%</td>
</tr>
<tr>
<td>Age 12</td>
<td>78</td>
<td>16.4%</td>
</tr>
<tr>
<td>Age 13</td>
<td>134</td>
<td>28.1%</td>
</tr>
<tr>
<td>Age 14</td>
<td>204</td>
<td>42.8%</td>
</tr>
<tr>
<td>Age 15</td>
<td>12</td>
<td>2.5%</td>
</tr>
<tr>
<td>Total</td>
<td>477</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Male and female youth were screened for the program with the boys representing a higher percent at 64.6% to the girls at 35.4%.

<table>
<thead>
<tr>
<th>Gender</th>
<th>FY13</th>
<th>as % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>169</td>
<td>35.4%</td>
</tr>
<tr>
<td>Male</td>
<td>308</td>
<td>64.6%</td>
</tr>
<tr>
<td>Total</td>
<td>477</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Of the 477 youth screened during the FY13 period, 241 youth were found eligible and referred for services. Hispanic youth consistently represented the 72% of the youth in the program.

• 72.2% (N=174) Latino
• 7.5% (N=18) African American
• 0.8% (N=2) Native American
• 5.0% (N=12) Asian/Pacific Islander
• 2.5% (N=6) Other Ethnicity
• 12.0% (N=29) Caucasian/White
Of the 241 youth eligible for services, about 81.3% were 13 to 15 years old and 18.7% were 12 and younger, see table below for details.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>FY13</th>
<th>as % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 8</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Age 9</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Age 10</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Age 11</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Age 12</td>
<td>33</td>
<td>13.7%</td>
</tr>
<tr>
<td>Age 13</td>
<td>64</td>
<td>26.6%</td>
</tr>
<tr>
<td>Age 14</td>
<td>123</td>
<td>51.0%</td>
</tr>
<tr>
<td>Age 15</td>
<td>9</td>
<td>3.7%</td>
</tr>
<tr>
<td>Total</td>
<td>241</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Of the male and female 241 youth eligible for the program, boys represented a slightly higher percent at 59.3% to the girls 40.7%.

<table>
<thead>
<tr>
<th>Gender</th>
<th>FY13</th>
<th>as % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>98</td>
<td>40.7%</td>
</tr>
<tr>
<td>Male</td>
<td>143</td>
<td>59.3%</td>
</tr>
<tr>
<td>Total</td>
<td>241</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Violence Reduction Program (VRP) provides services in the community to and addresses prevention, early intervention, intervention, and intensive intervention in the spectrum of service level need. The VRP is based on the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Comprehensive Gang Program, designed to reduce violence by implementing five core strategies: community mobilization, organizational change and development of local agencies and groups, provision of social opportunities, social intervention team and suppression team.

The Probation Department is in the process of developing a pilot project that would provide targeted services to the youth being served through the gang unit. The Mental Health Peer Support Worker (MHPSW) will provide support to the unit by assisting with youth outreach in gang impacted neighborhoods, act as a “violence interrupter”, recognize and identify youth needs such as mental health, substance abuse and pro-social activities, and work to develop a service response if one does not already exist. The MHPSW should provide linkages to community based services. The MHPSW may also serve to engage and retain youth in therapeutic pro-social athletic activities such
as sports leagues by helping youth navigate the system and provide transportation.

Mentor Parents Program with Dependency Advocacy Center provides early intervention supports to a selective population of substance dependent parents whose children have been or are currently at risk of being removed from their care. The program is a public-private collaboration funded by grants from three different agencies; the Mental Health Department (MHD), the Department of Alcohol and Drug Services (DADS) and the Social Services Agency (SSA).

Dependency Advocacy Center (DAC) administers the program and is a non-profit law firm which represents indigent parents involved in the Santa Clara County Dependency system. DAC hires, trains and supervises Mentor Parents to provide outreach and supports to those parents who may be resistance to engage in formal treatment as ordered by the Dependency Court.

Mentor Parents work in conjunction with DAC attorneys to encourage early engagement in recovery-oriented services and guidance to parents by addressing barriers impacting recovery and reunification efforts. Mentor Parents, because of their own previous involvement with the Child Welfare system, can provide lived experiences to those parents currently entering the Dependency system.

Participation in Family Wellness Court (FWC) enhances protective factors and contributes to positive outcomes for families. Per SRI International’s (Evaluation Firm) Final Report, FWC families experienced the following results:

- Custody rights returned to at least one parent (74% vs. 44% in the comparison group)
- Children spent less time in foster care (186 days vs. 429 days in the comparison group)
- Connections made with supportive services, including a developmental assessment (for children), home visitation, therapeutic services and health insurance
- Timely access to substance abuse treatment (65 days vs. 245 days in the comparison group)
- Increased housing status at program entry (55%) to the most recent follow up (75%)
- Increased employment status at program entry (16%) to the most recent follow up (25%)
- Increased access to health insurance at program entry (51%) to the most recent follow up (69%)

Culture is Prevention Program with Indian Health Center (IHC) is a one-time funded program developed to improve linkages to high need populations with a particular focus on American Indian/Alaska Native youth and families involved in the foster care and juvenile justice systems. For FY14 propose to continue one-time funding of $50,000 for the program.

Triple P Positive Parenting Program: Triple P training and implementation began in April 2011. Triple P draws on social learning, cognitive-behavioral and developmental theory, as well as research into risk and protective factors associated with the development of social and behavioral problems in children. The program’s multi-level framework aims to tailor information, advice and professional support to the needs of individual families. It recognizes that parents have differing needs and desires regarding the type, intensity and mode of assistance they may require.

Triple P interventions range from the provision of media message on positive parenting, through to
brief information resources such as tip sheets and videos, and brief targeted interventions (for specific behavior problems) offered by primary care practitioners at Levels 2 and 3, to more intensive parent training at Level 4 and Level 5 programs targeting broader family issues such as relationship conflict and parental depression, anger and stress. Training workshops with 308 clinicians and supervisors have been provided to participants between April 2011 and June 2012.

Nurse Family Partnership (NFP) initiative is a joint effort between the MHD and the County’s Public Health Department and funds a team of five Public Health nurses who provide intensive case management and service support to first-time, low-income pregnant women. To date, NFP has enrolled 154 clients, and 88 babies have been born since program inception in October 2010. Clients are primarily teen mothers, with 43% between the ages of 15 to 17 years old and 27% between the ages of 18 to 19 years old.

In partnership with VMC Pediatric Clinics, Reach Out and Read is a literacy and education program. The mission is to make literacy promotion a standard part of pediatric health care. At every well-child check-up, Santa Clara Valley Medical Center’s pediatric providers give each child a new, developmentally appropriate book to take home and read with parents. Volunteers read the same books with children in waiting rooms, so they are familiar with the material and model for parents the techniques of reading aloud to their young children. Physician screening for developmental delays is part of the program, and children with identified developmental delays are referred to specialists for further services, ensuring that problems are addressed quickly before adverse effects are fully realized in a school setting. In FY12, 34,712 books were distributed to young children through this program.

<table>
<thead>
<tr>
<th>P2 Proposed FY14 Changes</th>
<th>There are few recommended changes proposed for FY14:</th>
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</thead>
<tbody>
<tr>
<td>1. For FY13, one time funds were set aside for training related to the Strengthening SFP project for practitioners. The one-time budget of $150,000 is not needed going forward as future PEI P2 related trainings will come from the “Triple P” ongoing budget line item. Propose to remove $150,000 one-time funding.</td>
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<tr>
<td>2. The School Linked Services (SLS) Pilot / Planning phase of the project has ended. One-time allocation of $40,000 does not need to continue in FY14.</td>
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<tr>
<td>3. Below are the recommendations for the School Linked Services Match (Provided by Community Based Organizations) and County Mental Health Clinical Staff) budget:</td>
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<tr>
<td>a. The MHSA SLS match total for the CBO provider contracts actually comes out to $296,785 based on CBOs’ Exhibit Bs. Continue but adjust one-time funding from $323,119 to $296,785 based on current budget contracts;</td>
<td></td>
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<tr>
<td>b. In addition, the MHD proposes redistribution of SLS CBO funds from North County to high needs area in the County, Central Region and East San Jose. The MHD recommends redistribution of funds and releasing an RFP in fall 2013 based on new distribution. No budget change is required at this time;</td>
<td></td>
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<tr>
<td>c. Add one-time budget for SLS County Mental Health Clinical Staff of $58,445.</td>
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For item 3, overall there is a budget change of $32,111.
4. The one-time budget set aside for Mobile Crisis/Transition Services program was $128,954 in FY13 however the one-time funds is no longer needed since the program will be incorporated into the one-time budget of $512,582 set aside for F&C PEI services which will remain the same for FY14.

5. One-time funds set aside for CEUS Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Training will not need to continue as future PEI P2 related trainings will come from the “Triple P” ongoing budget line item. Propose to remove $18,800 one-time funding.

6. Propose new one-time $20,000 funding for Social Marketing Plan for Violence Prevention Campaign, a Santa Clara County Public Health Department initiative. Injury and violence constitute a significant health and safety priority for many stakeholders in Santa Clara County. Bullying, domestic violence and gang activity are significant issues for youth in Santa Clara County. To address desired changes in knowledge, attitudes and behaviors related to violence, the Public Health Department intends to develop a social marketing campaign to reach targeted audiences based on a social marketing plan. Populations most at risk of violence are youth of color particularly those who are Latino and African-American. Areas of San Jose, Milpitas and Gilroy are where communities with the highest risk factors for violence and where the greatest health disparities exist.

The social marketing plan will include market research, stakeholder engagement, assessment of local, State and National efforts, identification of appropriate methods and interventions and a final incremental plan to reach target audiences. Upon completion of the social marketing plan for a violence prevention campaign, partners associated with the initiative will help determine the implementation strategies and priorities. The Mental Health Department is proposing to allocate $20,000 in one-time funding toward this effort as it aligns with our School Linked Services initiative focused on improving outcomes for children and youth in our community as it relates to bullying prevention and gang violence prevention.

7. In an effort to inform Santa Clara County residents, schools and communities about the resources available through School Linked Services (SLS), the MHD is proposing to allocate $60,000 in one-time funds toward website development and the production of resource materials. The website and resource materials will help inform the community about the SLS initiative as well as what services and resources are available to children, youth and families.

8. Increase one-time funding amount for the School Linked Services (SLS) Coordinator program budget from $532,000 to $562,000. Currently there is need to increase budget allocation for South County as there are four more South County schools slated to be added in FY14. The change increases the budget allocation for this particular budget item by $30,000.

Total proposed PEI P2 budget change: a decrease in budget by $195,643 based on the changes noted above of one-time funds.
The REACH (Raising Early Awareness Creating Hope) project implements a continuum of services targeting youth and transition age youth (TAY), ages 11 to 25, who are experiencing At Risk Mental States (ARMS) or prodromal symptoms. The service model is based on the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, which is currently a replication study occurring at six sites nationwide to build research evidence on the effectiveness of preventing the onset and severity of serious mental illness with psychosis.

Starlight and Momentum have provided services for the REACH program. Since the inception of the program through February 2012, both agencies have conducted 264 outreach and education presentations to the community and provider agencies. The Structured Interview for Prodromal Syndromes (SIPS) assessment has been conducted with 67 youth; and of those assessed, 22 were not qualified for services based on the results of the assessment. Of the 45 youth qualified for services, 37 enrolled in the program.

- 46 youth enrolled in the program, 20 (43.5%) were female and 26 (56.5%) were male:
  - 41.3% (N=19) Latino
  - 6.5% (N=3) African American
  - 8.7% (N=4) Asian/Pacific Islander
  - 34.8% (N=16) Caucasian/White
  - 8.7% (N=4) Other/Unknown Ethnicity

- Change in Global Assessment of Functioning (GAF) from baseline to six month assessment went from average GAF 47.2 to 50.5 at six months (7% improvement). Of the 8 youth who discharged from the program, 3 (37.5%) moved out of the area, 2 (35%) were discharged to home/self care, and 3 (37.5%) had missing data.

The CalWORKS Health Alliance provides behavioral health services to adult clients enrolled in the Welfare-to-Work (WTW) Program to help them deal with mental health and substance abuse issues. The funding for this program comes from the Department of Social Services, Employment Services Division but the program is managed by the Mental Health Department. Services consist of
culturally diverse outpatient counseling and a small number of transitional housing beds. All of the 4,000 clients entering the WTW Program are screened for behavioral health issues. Additionally, the Health Alliance partners with community college and adult education programs to provide onsite individual counseling, support groups, and educational forums for CalWORKs clients.

<table>
<thead>
<tr>
<th>P3 Proposed FY14 Changes</th>
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<tbody>
<tr>
<td>Below are the recommended changes proposed for FY14:</td>
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<tr>
<td>1. Overall, the REACH Community Based Organization (CBO) contracts with Momentum and Starlight remain at $1,350,000; $675,000 per CBO. However, the MHSA portion has decreased since the CBOs are able to leverage Medi-Cal funding. For FY14, adjust MHSA funding based on current contract budgets totaling $1,136,003. The adjustment will result in a decrease of MHSA funding for the program by $213,997.</td>
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<tr>
<td>2. The Family Consumer Driven Project with Starlight has ended; one-time funds of $95,000 set aside for the project is no longer needed.</td>
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<tr>
<td>Total proposed PEI P3 budget change: a decrease in budget by $308,997 based on the changes noted above.</td>
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<tr>
<th>P4 Description</th>
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<tr>
<td>This project has two major components: 1) services to new refugees drawing upon outreach and focus groups with refugees and organizations serving refugees; and 2) implementation of integrated behavioral health services within local non-profit Federally Qualified Health Centers (FQHCs) that serve underserved ethnic communities.</td>
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<tr>
<th>P4 Progress Update</th>
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<tr>
<td><strong>New Refugees Program:</strong> In July 2011, Asian Americans for Community Involvement (AACI) was awarded the contract for New Refugees program. AACI was responsible for finding multiple community partners serving the refugee population, fostering collaboration, coordinating a system of referrals, providing and coordinating numerous culturally &amp; linguistically appropriate outreach activities. Ultimately, AACI reached a total of 1,956 individuals. A total of 290 new refugee clients were referred to AACI and were provided some degree of engagement and intervention, up to and including torture survivor support services. For those who engaged in services, significant and measureable improvements in their mental health were achieved (Data Source: PEI P4- Refugees Monthly Status Report_Cumulative 2012_Final). AACI also worked with the MHD’s new Refugees video production contractor to create new refugees outreach videos to help address stigma and mental health needs.</td>
</tr>
<tr>
<td>• The 229 refugees who received prevention and early intervention services represented 32 countries.</td>
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</table>
Primary diagnoses for those individuals receiving intervention services reveal that Post-Traumatic Stress Disorder (PTSD) is the primary issue, with Major Depressive Disorder being a close second.

- Of those referred refugees who engaged in treatment/services, 57% demonstrated improvement in functioning as demonstrated through Global Assessment of Functioning (GAF) Score.
- The following improvements were all measured by the Current Adaptive Functioning Index: Cross-Cultural Version (CAFI XC) tool:
  - 62% had improved their access to basic resources;
  - 58% had demonstrated improvement in their MH functioning or daily functioning;
  - 42% improvement in Family relations;
  - 69% improvement in social connections and
  - 54% reported a feeling of reduction external risk, feeling safer going to work/school.

Adult/Older Adult PEI Outpatient Services: In FY12, as a one-time measure, $200,000 of PEI funds were distributed across eight different community mental health service providers to provide outpatient Prevention and Early Intervention (PEI) services to individuals who had been involved with the specialty mental health system for less than 12 months. It is proposed to continue one-time funding at the same level for FY14.

Primary Care Behavioral Health (PCBH) Contracts: In November 2011, the community-based organizations (CBOs) were awarded a contract to implement the Technical Assistance and training called “Improving Mood-Providing Access to Collaborative Treatment” (IMPACT) that is offered by the University of Washington’s AIMS center. These four community clinics are Asian Americans for Community Involvement (AACI), MayView Community Health Center, and two of Gardner Family Health Network’s clinics (South County and St. James). These clinics completed the various tasks of
the preparation and pre-implementation phase, which concluded by the end of May 2012 with a three-day training workshop. Those clinics that have satisfactorily met all the contractual requirements and demonstrated a commitment to collaborative care between the Behavioral Health Clinicians (BHC) and PCPs will be funded for the next phase of the project: launch and implementation of services beginning June 1, 2012. IMPACT Technical Assistance contract was finalized in November 2011. This contract was implemented to support both the community-based integration effort described above, as well as four of Valley Health Center’s FQHCs. The four Valley Health Center clinics selected as pilot sites are Milpitas, Gilroy, Sunnyvale and Alexian Homeless Clinic.

Providing accurate data for the first six months of the integrated behavioral health services provided was challenging for all contracted clinics due to the multiple challenges they all faced: 1) overlap of the implementation of their new Electronic Medical Records (EMR) system one month prior to launching these integrated behavioral health services; 2) lack of any staff with prior experience of creating a primary care based behavioral health practice; and 3) normal workflow challenges in validating that the templates adequately support the workflow.

Roughly six months were required to refine the data entry process and refine the needed EMR BH templates, as well as trouble-shooting the practical work flow issues that occur with an implementation effort of this nature. Two common issues experienced in this effort include increasing the number of referrals to the program by primary care physicians, and trouble-shooting the rate of patients not showing up for scheduled appointments for behavioral health services.

Reasons these are common challenges with implementing this new service are that 1) primary care providers have a learning curve of how to introduce these additional treatment services in a non-stigmatizing manner, and one that ensures the patient that the doctor will still be closely involved with their treatment; 2) behavioral health providers have to learn how to tailor their services to a brief and episodic model when their professional training was focused on deep and sustained interventions; 3) providers developing a habit of consulting with each other; and 4) addressing and reducing stigma. With that in mind, initial data from launch (June/July 2012-December 2012) provided by the various contractors indicate that through funding 4.5 FTE licensed mental professionals in each of these primary care clinics:

- Of the approximately 700+ patients screened for depression using the Patient Health Questionnaire 9-item screening tool, approximately 43% were referred to Behavioral Health Services; and 323 patients were provided some behavioral health services: psycho-educational information; assessment/screening; and/or individual treatment.

- The language diversity of the patient population served (roughly) breaks out to the majority of patients served speak either Spanish (46%) or English (44%); 8% Asian language speaking (primarily from AACI), and the remainder speaking some other language.

- Initial reports demonstrate that those patients receiving BH services for depression realize a significant (60%) reduction in symptoms from their initial severity, as rated on the PHQ-9. The second twelve months of data will be instrumental in learning better the impact of these interventions on depression.

The four community-based FQHC clinics launched operations (one on June 25, 2012 and the other three clinics launching services in July 2013). Given the delay in launching, there is no reportable data on direct patient services available for FY13. All three vendors will be funded for the next phase of the contract.

**IMPACT Technical Assistance Training:** In November 2011, the University of Washington’s IMPACT
(Improving Mood-Promoting Access to Collaborative Treatment) was awarded the contract to provide all needed technical assistance and core trainings to implement the recommended collaborative care framework recommended by the community in developing the PEI Plan for PEI Project 4. All training and technical assistance was leveraged across both implementation efforts, the community contracted providers and six of SCC Valley Medical Center’s (VMC) FQHCs, (four in FY11-12, and two more due FY12-13). Various training elements were contracted for: Introduction to IMPACT model on-site training, Peer Partner on-site training- tailored made to meet SCC’s needs; and staff training in Problem Solving Training for all behavioral health providers across both systems- 23.5 FTE LCSWs and Licensed Clinical Psychologists. Many of these trainings were recorded for future use.

Trainings across both systems have received strong marks from the participating staff, including a two-day on-site introductory training provided to the community-based contractors’ staff in May 2012 to roughly 150 primary care staff (executive management, front desk receptionists, medical assistants, licensed mental health professionals- both therapists and consulting psychiatrists, and peer partners). The two-day training was modified to incorporate the various recommendations made by the community clinic staff for the VMC integration effort’s training of its 179 staff of three clinics which trained in September 2012.

Significantly, technical assistance webinars have been provided on issues such as Problem Solving Therapy (PST) and Axis II disorders; and PST en Español, in addition to maintaining a tailored IMPACT and PST training web portal for our clinicians.

P4 Proposed FY14 Changes

There are few recommended changes proposed for FY14:

1. Primary Care Behavioral Health (PCBH) Contracts - For FY13, PCBH CBOs MHSA amount reflects a partial year. For FY14, the PCBH MHSA amount needs to be annualized and the necessary adjustment reflects an increase of $780,100.

2. In FY13 the MHD recommended use of one-time MHSA funding to support FQHC clinic implementation of behavioral health services. The MHD proposes to continue funding in FY14 increasing the amount from $1,000,000 to up to $2,500,000. This funding will address a projected revenue shortfall in this service. The FQHC clinic-based behavioral health implementation was implemented in FY10. At the time the program was planned to be exclusively financed through Medi-Cal and/or Medicare reimbursement. No new funds were committed to support the program. Given that the MDs and Clinicians are serving over 5,000 clients, fulfilling a critical service need for the Health and Hospital System, it is important to consider further commitment of MHSA to this valuable service. Over the FY14 the MHD will track the impact of Health Care Reform, and particularly Medi-Cal expansion, on the financial model that was designed for this program. This analysis, along with outcome data on client outcomes will be an important service model to raise during the FY15 MHSA Three-Year Planning process to be initiated in the coming year.

3. IMPACT training (with University of Washington) needs to be extended into FY14 to accommodate the training needs of those Clinicians who will need to finish their PST training after June 30, 2013; as well as to extend the opportunity for the psychiatry consultation model technical assistance to continue into FY14, allowing SCCVMC more time to consolidate its own model of psychiatric consultation, which will not be identified by June 30, 2013. This contract extension also hopes to realize additional PST training opportunities for any new hires who may join the VMC FQHC behavioral health clinics should funding allow. In FY13, the MHD allocated $198,676 for “IMPACT training to
Practitioners’ however all of the trainings slated during FY13 has not been completed. There is approximately $102,000 balance left in the University of Washington contract which the MHD proposes to continue to fund on a one-time basis in FY14 to be able to complete the training activities mentioned above.

Total proposed PEI P4 budget change: an overall increase in budget by $2,183,424 based on the changes noted above.

<table>
<thead>
<tr>
<th>P5 Description</th>
<th>This project initiated a countywide strategic planning process to develop a strategic action plan to prevent suicide. The plan was completed in August 2010 and is now in the implementation stages.</th>
</tr>
</thead>
<tbody>
<tr>
<td>P5 Progress Update</td>
<td>Suicide Prevention Activities-to-Date:</td>
</tr>
</tbody>
</table>
| January 2012 | • A first Annual Report was approved by the Board of Supervisors.  
• Five Media outlets educated to implement Suicide Prevention Resource Center (SPRC) Safe Reporting Guidelines. | |
| February 2012 | • Customization and testing phase of the online community suicide prevention module called Question-Persuade-Refer (QPR) was finalized.  
• Santa Clara County hosted the first State Suicide Prevention Network’s Regional Workshop. The theme was Strengthen Your Role in Suicide Prevention. | |
| March 2012 | • A new Suicide Prevention Associate was hired. | |
| Fall 2012 | • The first Data Report was completed in October 2012, which analyzed the suicide deaths in Santa Clara County from 2009-2011. | |
| December 2012 | • New Suicide Prevention Coordinator was hired in mid-December 2012.  
• In December 2012, the MHD was awarded a one-year $15,000 mini-grant by CalMHSA to form a speakers bureau to achieve three goals:  
  o Incorporate Stigma and Discrimination Reduction (SDR) messages into speaker presentations;  
  o Increase the number of speaking placements on a quarterly basis; and  
  o Provide stipend funds to individuals speaking about mental illness and SDR. | |
<p>| March 2013 | • The first Suicide Prevention Speaker’s Bureau is formed and convened to promote Stigma and Discrimination Reduction messages. Eleven | |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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</table>
| April 2013| • Suicide Prevention Team was able to bring on board a volunteer to help enter the 2012 death data for a 2012 Executive Summary report. The report has an expected dissemination date on Suicide Prevention Week 2013, September 9-13, 2013.  
• The first QPR (suicide prevention training) of CIT officers is launched at the CIT training workshop in Morgan Hill. |
| May 2013  | • The first Suicide Prevention Communications Workgroup, tasked with implementing a Suicide Prevention public awareness and promotion campaign, among other functions was formed. This body will be overseen by the Suicide Prevention Oversight Committee (SPOC). |
| June 2013 | • The Intervention Workgroup finalized the first Suicide Prevention and Crisis brochure with contact information for prevention, intervention and post-intervention resources in Santa Clara County. Dissemination is on-going.  
• 54 new QPR Instructors were trained in three separate instructor trainings (Palo Alto, San Jose, and Morgan Hill) to implement QPR classes in their communities, agencies and general public. This was part of the Suicide Prevention Program's community capacity building focus to expand and provide Suicide Prevention tools throughout Santa Clara County.  
• The Suicide Prevention Team gained a Health Careers Connection intern to help with various implementation strategies (10-week assignment).  
• In late summer, the MHD will issue an Informal Competitive Procurement (ICP) process to implement key suicide prevention strategies in high-risk and at-risk communities based on a community capacity building/public health approach. |
| Fall 2013 Plans | • The Suicide Prevention Team will provide QPR Instructor trainings to school staff and teachers for up to 36 participants.  
• The Suicide Prevention Team will provide Applied Suicide Intervention Skills Training to Clinicians, Social Workers and other Mental Health Advocates throughout the county for up to 90 individuals.  
• In September-November 2013 the Suicide Prevention Team will launch its first public awareness and promotion campaign by increasing crisis line awareness and knowledge through digital mall advertisements, buses and increasing SACS ethnic print media and radio promotion. |
| Additional Updates: | • To date more than 928 individuals have been trained as community gatekeepers through face-to-face trainings.  
• 1,200 QPR Online training codes Assigned (includes those assigned, not started, started and completed).  
• 765 individuals participated in the Community Education Campaign (CEC), increasing knowledge that suicide is preventable.  
• There are seven school districts/cities/organizations with Suicide Prevention Policies to date.  
• Data on Suicide- Baseline data report pulled from redacted suicide death reports provided by the SCC Coroner’s Office of all recorded suicide deaths for FY09-11.  
• The Intervention Workgroup, which tries to recruit more individuals to weave suicide prevention into their existing activities, was launched, adding to the pre-existing Suicide Prevention Oversight Committee and Data Workgroup, which were convened last fiscal year. |
### Suicide and Crisis Services of Santa Clara County (SACS) Activities-To-Date:

<table>
<thead>
<tr>
<th>Date</th>
<th>Activities</th>
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<tbody>
<tr>
<td>August 2011</td>
<td>- The MHD was awarded a three-year, $302,520 grant by CalMHSA to enhance Suicide and Crisis Services of Santa Clara County (SACS) hotline and enhance regional suicide prevention capacity through three core functions: targeted outreach of the Hotline services to core demographic groups of county residents, ensure that SACS meets American Association of Suicidology (AAS) accreditation standards (FY13 activity), and offer technical assistance to other hotlines.</td>
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| April 2012 | - SACS became an active partner of the Bay Area Suicide and Crisis Intervention Alliance (BASCIA). The MHD has been collaborating, supporting, and attending quarterly training/conferences held by BASCIA.  
  - A full-time classified SACS Manager was hired. |
| Fall 2012  | - SACS received AAS accreditation as Lifeline Hotline in October 2012.                           |
| December 2012 | SACS, in collaboration with the Suicide Prevention Coordinator, launched a collaborative effort to aggressively recruit bilingual SACS volunteers to better serve the entire community. |
| April 2013 | - SACS’s accreditation award was recognized at AAS’s 46th Annual Conference, which was held April 24 – 27, 2013, in Austin, Texas. SACS hotline clinical supervisor and the Suicide Prevention associate attended the conference. |
| May 2013   | - SACS implemented the ACCESS database system. This database system enables the MHD to gather caller’s demographic information, document/record types, track the number of calls received and generate statistical reports.  
  - The MHD’s CalMHSA grant funding was augmented in the amount of $39,500. The augmentation is for the implementation of a bilingual outreach program to the local Latino community and to expand services to increase follow up calls to individuals who are at high risk for suicide. The plans for these funds are described below under “Fall 2013 Plans”. |
| Fall 2013 Plans | - The MHD will be launching an ethnic media campaign. Starting July 2013, the MHD will promote SACS hotline and its services on six ethnic community newspapers including the El Observador and La-Oferta bilingual Spanish newspapers, Vietnam Daily News and Cali Today of the Vietnamese newspapers, Sing Tao Daily Chinese newspaper, and the Asian Journal that focus on the Filipino community. SACS hotline promotion will occur from July 2013 to June 2014. A total of $38,000 from the CalMHSA augmentation will be used to fund the newspaper advertisements.  
  - To bring SACS operation in line with current technology, SACS has been working on a RFP to procure a web-based software solutions that has the capacity to manage SACS hotline’s caller data, comply with AAS accreditation’s technology requirements, provides the ability to generate data and reports to predict trends and support best practices, and ability to enhance features such as Live-Chat and Text.  
  - SACS is in the process of hiring an extra-help, part-time Community... |
Worker – bilingual Spanish position. The hired individual will provide community outreach services to the Latino community. The goal is to increase the number of calls from Latino residents to the crisis line. This position is a 14 month funded position from May 2013 to June 30, 2014.

- 96,260 Individuals were served by SACS Hotline in Calendar Year (CY) 2010 to 2012.
- SACS has reached out to other warm line agencies in the County to provide cross-training and referral services. The MHD also established partnership with these agencies through a Memorandum of Understandings (MOUs).
- SACS has been providing Suicide Assessment/Crisis Intervention presentations to raise awareness in ethnic communities including the Latino, Asian, and African American community. Since July 1, 2012, SACS provided a total of 11 presentations to these ethnic communities.
- SACS has conducted outreach activities to rural communities including the unincorporated areas throughout the County as well as the Southern part of the County, such as Morgan Hill and Gilroy areas.
- SACS expands its outreach services to specific communities including LGBTQ community, seniors, as well as Transitional Age Youth population. Since July 1, 2012, the MHD provided a total of nine presentations to these specific communities.
- In addition, SACS has also been providing Suicide Assessment/Crisis Intervention presentations to high school teachers and staff as well as self care presentations for students. Presentations were conducted to teachers, staff, and students at James Lick High School, Yerba Buena High School, Oak Grove High School, Andrew Hill High School, and Independence High School.
- 94 Individuals received support from Survivors of Suicide (SOS) Support Group.
- The Santa Clara County Suicide and Crisis Services (SACS) hotline receives 27,000 – 36,000 calls per year during 2010 – 2012. Currently, SACS has a total of 95 active volunteers that handles the 24-hour crisis hotline. Out of the total, 16 of the volunteers have master’s degree in either social work or counseling psychology. It is essential to the hotline and to the Santa Clara County residents that we are able to retain these highly qualified volunteers who can provide great quality services to our callers.

In May 2013, the Suicide Prevention Oversight Committee (SPOC) met and discussed the County’s Suicide Prevention plan and future plans which resulted in the following proposed one-time additions to the following budget line items:

1. Propose additional one-time funds of $213,000 to the Community Education and Information program budget line item in FY14 to:
   a. Carry out public awareness campaign of county crisis line through buses, digital mall advertisement, and expansion of ethnic media outreach;
   b. Develop and implement a long-term media plan that includes a sub-brand (SCC Suicide Prevention) and marketing tools in multiple languages (Spanish, Vietnamese, Tagalog, Chinese and English);
   c. Mini-grants to fund suicide prevention in high risk communities;
   d. Non-profit agency to administer and manager the over 50 trained QPR instructor pool.
2. Propose additional one-time funds of $58,375 to the Evaluation program budget line item in FY14 to:
   a. To develop an evaluation dashboard;
   b. To conduct a sampling survey on awareness, knowledge and attitudes regarding suicide prevention and crisis

3. Propose additional one-time funds of $2,000 to the Evaluation program budget line item in FY14. Additional funds are needed for strategies four and five of PEI P5. Strategy four is to implement policy and governance advocacy to promote systems change in suicide awareness while strategy five addresses data collection.

Total proposed PEI P5 budget change: an overall increase of $273,375 in one-time funds based on the changes noted above.

<table>
<thead>
<tr>
<th>PAD1 Description</th>
<th>Represents the indirect administrative overhead costs for Mental Health Administration, County’s Health &amp; Hospital System Overhead (e.g. Information Systems, Patient Business Services, Finance), County Overhead, and other Mental Health-wide administrative functions (e.g. Quality Improvement).</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAD1 Progress Update</td>
<td>The MHD’s FY13 PEI component budget includes $1,819,524 for Administrative costs. These funds are supporting managerial and clerical positions in Mental Health Administration, Contracts, Finance, Information Systems, Quality Assurance and other system-wide administrative functions.</td>
</tr>
<tr>
<td>PAD1 Proposed FY14 Changes</td>
<td>There are no proposed changes for FY14.</td>
</tr>
</tbody>
</table>
INNOVATION PLAN PROJECTS (INN)

DESCRIPTION

Mental Health Services Act (MHSA) Innovation funds provide exciting opportunities to learn something new that has the potential to transform the mental health system. An Innovation program is defined as one that contributes to learning and one that tries out new approaches that can inform current and future practices.

There are various types of Innovation programs:

- programs that introduce new practices/approaches that have never been done before anywhere
- programs that make a new change that has never been done before to an existing practice/approach, including adaptations for a new setting or community
- programs that introduce a new application to the mental health system (never done before) of a practice/approach that has been successful in non-mental health settings

Essential Purpose of MHSA Innovation Programs

- To increase access to underserved groups.
- To increase the quality of services, including better outcomes.
- To promote interagency collaboration.
- To increase access to services.

In general, INN projects are time-limited projects. The MHD's Current Innovative Projects Plan consists of nine distinct work plans ranging in duration from 24 to 36 months.

<table>
<thead>
<tr>
<th>INN Programs</th>
<th>FY2013 Funding</th>
<th>FY2014 Recommended Funding</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>INN01 Early Childhood Universal Screening Project</td>
<td>$727,364</td>
<td>$727,364</td>
<td>-</td>
</tr>
<tr>
<td>INN02 Peer-run TAY Inn</td>
<td>$1,356,053</td>
<td>$1,320,858</td>
<td>$(35,195)</td>
</tr>
<tr>
<td>INN03 Co-Occurring MH Disorders in Adults with Autism and Dev Disabilities</td>
<td>$411,282</td>
<td>$-</td>
<td>$(411,282)</td>
</tr>
<tr>
<td>INN04 Elders’ Storytelling Project (Prior Name: Merging the Old with the New)</td>
<td>$428,042</td>
<td>$388,042</td>
<td>$(40,000)</td>
</tr>
<tr>
<td>INN05 Multi-Cultural Center (MCC)</td>
<td>$799,567</td>
<td>$499,567</td>
<td>$(300,000)</td>
</tr>
<tr>
<td>INN06 Transitional Mental Health Services for Newly Released Inmates</td>
<td>$492,264</td>
<td>$742,264</td>
<td>$250,000</td>
</tr>
<tr>
<td>INN07 Mental Health/Law Enforcement Post Crisis Intervention</td>
<td>$625,420</td>
<td>$-</td>
<td>$(625,420)</td>
</tr>
<tr>
<td>INN08 Interactive Videos Scenarios Training</td>
<td>$251,400</td>
<td>$14,400</td>
<td>$(237,000)</td>
</tr>
<tr>
<td>INN09 AB109/117 Re-Entry Multi-Agency Pilot aka &quot;Re-Entry MAP&quot;</td>
<td>$1,029,890</td>
<td>$523,680</td>
<td>$(506,210)</td>
</tr>
<tr>
<td>INN Administration</td>
<td>$600,832</td>
<td>$600,832</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total INN</strong></td>
<td><strong>$6,722,113</strong></td>
<td><strong>$4,817,007</strong></td>
<td><strong>$(1,905,106)</strong></td>
</tr>
</tbody>
</table>

Please note: Adjustments to the MHD MHSA County personnel budget resulting from Board of Supervisor (BOS) approval for: 1) Increased contributions to the California Employers Retiree Benefit Trust (CERBT) and 2) Salary and benefit adjustments based on contract negotiations with labor unions is still pending and not reflected in the table above. The proposed plan is to spread the budget adjustments across the five MHSA components (See pages 98-99).
## INN01 PLAN - EARLY CHILDHOOD UNIVERSAL SCREENING PROJECT

### INN01 Description
The aim of this 24 month project is to develop a model to increase access to services and improve outcomes by strengthening the screening and referral process for young children with developmental concerns and social-emotional delays. This project will test whether the implementation of multi-language electronic developmental screening tools and audio/visual components in a pediatric clinic provides an economic, low cost, and effective method for linking parents and their children to mental health and other indicated services.

### INN01 Progress Update
This innovation project offers a vital opportunity to screen children for developmental concerns during well-baby/well-child pediatric visits. It examines the utility of electronic developmental screening as a way to identify a greater number of children and to increase bilingual capacity of screening, as well as an audio component to support caregivers with limited literacy. The utilization of a standardized screening tool enhances the traditional developmental surveillance conducted by the Pediatrician.

A dual phased implementation approach was selected. The first phase embeds a full time screener at a County pediatric clinic to perform paper based ASQ-3 and ASQ-SE (Ages and Stages Questionnaire and Ages and Stages Questionnaire – Social Emotional) screenings at well-baby/well-child pediatric visits. In addition to providing screenings and integrating the screening process into the clinical flow, data collection during this phase of implementation will establish baseline productivity rates and identification rates of children whose screenings indicate recommended follow-up screening or assessment. Phase two will utilize an off-network electronic application. Data collection during this phase will determine whether use of this electronic tool impacts the screener’s productivity and the identification rates of children who require additional follow-up.

In January 2013, a full time bilingual and bi-literate developmental screener was stationed at a County pediatric clinic and screening protocols were established. Since January 2013, over 800 children have been screened. Approval of the independent evaluator’s research plan was granted by the Institutional Review Board (IRB) in May 2013. Training for the screener on evaluation protocol will be completed by August 2013, with data collection slated to commence immediately following. The implementation start date coincides with the launch of the formal evaluation protocol, currently scheduled for August 2013.

### INN01 Proposed FY14 Changes
There are one-time funds set aside for Extra-Help at $192,694 and RFP application costs at $250,000, with a combined total of $442,694. The MHD recommends redirecting portion of the funds set aside for the RFP application to cover expenses related to Extra-Help. For FY14, Extra-Help will be $264,117 and the RFP application one-time budget at $178,577. The project requires use of 2.5 FTEs Extra-Help Rehabilitation Counselors (RC) to support parents within pediatric clinic settings to utilize developmental screening tools. The RC staff will assist parents/guardians in completing the screening tools prior to their child’s well-check appointments. These staff will also participate in the project evaluation process. **Redirection of one-time funds will not change the overall program budget allocation.**
**INN02 Peer-run TAY Inn** - The aim of this 36-month project is to increase access to services and improve outcomes for high-risk, transition age youth in a voluntary 24-hour care setting. The project model proposes the implementation of an innovative 24-hour service that involves a significant expansion of the role of TAY employees in decision-making and provision of program services.

**INN02 Progress Update**

This innovation project expands a promising new peer mentoring approach into a 24-hour care setting designed to promote wellness and recovery for Transition Age Youth (TAY). Peer-led staff with support from professional staff will assume the lead responsibility for decision-making to run the facility and the program services. The programs offered will be informed by wellness and recovery approaches that are effective in helping TAY develop skills and increase capacity to achieve life goals. In addition to helping TAY stabilize and gain self-awareness and skills within a safe environment, the program also will serve as a bridge for access into appropriate ongoing services and supports in the broader system of care within the County. Bill Wilson Center (BWC) was the community based organization (CBO) selected to implement this project and began providing services in December 2011. Since the program’s inception, 67 TAY between the ages of 18-24 have been served within the project.

- Self-Sufficiency outcomes have demonstrated that at discharge residents had increased in the domains of employment, housing, interpersonal relations and access to services.
- 89% of residents reported satisfaction with the services they received.
- 64% of Peer staffing reported “Strongly Agree” that they are learning valuable skills, obtaining good experience for the future and enjoy their job.
- 54% of residents reported their ability to choose their own treatment goals as the service received with the highest satisfaction.
- 44% of residents reported “Strongly Agree” that Peer staff communicated in a way they understood.
- TAY (underserved population) within the county was able to access services and shelter in a safe supportive environment.
- Homeless TAY was able to acquire services which linked them to housing opportunities at discharge demonstrating functional change within this life domain.
- 55% of Peer staffing (most with the same lived experience as the residents) feels they are making a difference in the life of the TAY residents they are serving.

**INN02 Proposed FY14 Changes**

There are few recommended changes proposed for FY14:

1. Adjust INN-02 CBO contract with BWC from $1,159,995 to $1,179,800 based on their approved three-year project budget proposal during the RFP process, an increase of $19,805. The three-year project began October 2011 and set to end September 2014.

2. For FY14, the one-time allocation for the Department of Family and Children’s Services (DFCS) HUB initiative will be adjusted from $75,000 to $50,000.

3. One-time funds of $30,000 set aside for VOICES Training Consultation was not utilized and is not needed going forward. 

Based on the changes noted above, the overall INN-02 budget will decrease by $35,195.
This project will test an assessment model for determining the extent of concurrent psychiatric and developmental disabilities and will explore models of effective treatment for individuals challenged by these dual conditions.

The study period for this project began on July 1, 2011, and ended on June 30, 2013. Please note the program began to assess clients beginning January 1, 2012 as the instrument was adjusted to meet DSM-IV criteria and staff was trained on the use of this new tool. As of March 31, 2013, the project has assessed 80 new clients as well as the 10 existing clients through the MHD's contract with HOPE Services. Utilization of the Schedule for the Assessment of Psychiatric Problems Associated with Autism (SAPPA) tool as a support diagnostic assessment tool indicated that significantly more individuals with autism had one or more lifetime episodic disorders. Consumers with intellectual disabilities and autism interviewed using the SAPPA tool show higher rates of episodic psychiatric disorders than the control group assessed with the standard approach. These preliminary results indicated that the use of the SAPPA instrument assist clinicians to identify more precisely the specific co-occurring mental illnesses, and supports consumers and caregivers in choosing the most appropriate treatment modalities that fit their specific diagnoses. Almost two in three of the individuals with autism had suffered episodic psychiatric disorders, compared to one in five of the clients in the random control group from FY12 and diagnoses were determined at a faster rate. Further, there has been no crisis related events involving any of this project's consumers to date.

This study suggest that the use of the semi-structured interview, integrated with the clinical experience matured in years of experience in the field, may help in closing the gap in our lack of understanding and awareness regarding individuals with classic autism and co-occurring mental disorders. Closing the gap is the first step to build a spirit of collaboration between the County and families and caregivers of consumers with autism and co-occurring mental disorders. This collaboration will help the MHD to build a clear protocol for referral and remove this existing huge obstruction to treatment existing for clients and their families.

On the outcome rating scale (ORS), social setting is the area where clients face the stronger challenge (average satisfaction in their interaction with the therapist with average scoring between 8.9 and 8.5, approximately 56% of the clients gave the therapist the highest scoring of 40/40). Evaluation report from the second ORS survey of a sample population of 17 consumers involved in the project show a general improvement in the well-being of the consumers. Final Evaluation Report by HOPE expected in July 2013.

The INN-03 project ended on June 30, 2013 but will be sustained and integrated into the A02 work plan due to the positive results of the two year project. The data derived from the Adult with Autism and Co-Occurring Mental Health Disorders project has demonstrated that the use of the SAPPA tool has more precisely identified the co-occurring mental health disorder at a faster rate. The FY14 proposed provider contract amount allocation in CSS work plan A02 for the program will be $350,324, at the same level as FY13. While the remaining balance of $61,158 will not continue as the County MHD personnel costs associated with the INN project will not continue.

Please note if an INN project has proven to be successful and a county chooses to continue it, the work plan must transition to a different MHSA funding source (as determined by the county), for example the CSS component, the PEI component, (i.e., a new work plan) or another source of funding.
### INN04 PLAN – ELDERS’ STORYTELLING PROJECT (PRIOR NAME: MERGING THE OLD WITH THE NEW)

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>This project develops a model to increase the quality of services for isolated older adults by adapting a culturally-based “story-telling” approach that capitalizes on the traditional role of older adults as transmitters of cultural wisdom and values. The core service will be provided by community workers through a 12-week curriculum where the older adult, in the company of family members and caregivers, is encouraged to reminisce about his/her life and express and capture significant memories and personal accomplishments.</td>
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<thead>
<tr>
<th>Progress Update</th>
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<tbody>
<tr>
<td>In FY13, Asian Americans for Community Involvement (AACI) and Gardner Family Care Corporation (GFCC) were awarded a contract to implement the INN04 “Story-Telling” project. Following the hiring of a bilingual clinical and peer mentor/specialist staff, both AACI and GFCC began their community outreach and engagement efforts by reaching out to Latino and Vietnamese communities within Santa Clara County. In most cases, community outreach took place in non-mental health settings such as community centers, public libraries and health fairs. To date, a total of 39 Spanish and Vietnamese Speaking Seniors have participated in the project. Of these 39 participants, 15 seniors completed the program while 24 individuals are currently active participants. All participants reported experiencing symptoms associated with mild to moderate depression. Additionally, thus far, both AACI and GFCC have held memorable community celebrations to honor the lives of the participants who have completed the program.</td>
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<thead>
<tr>
<th>Proposed FY14 Changes</th>
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<tbody>
<tr>
<td>One-time start-up funding of $20,000 for the project allocated to each CBO, totaling $40,000 combined, will not continue in FY14.</td>
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### INN05 PLAN - MULTI-CULTURAL CENTER (MCC)

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<tr>
<th>Description</th>
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<tr>
<td>This project is designed to increase access to underserved and inappropriately served ethnic minorities by housing activities and services for multiple ethnic communities in Santa Clara County. MCC will provide an opportunity for ethnic minority community coordinators to collaborate in identifying and initiating multi-cultural approaches to successfully engage individuals in mental health services in a culturally sensitive manner and find sensitive ways to combat stigma and internalized oppression.</td>
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<tr>
<th>Progress</th>
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<tr>
<td>The MHD is actively looking for potential buildings/space that will meet the needs of this project. The MHD currently has identified a potential site and is coordinating a walk-through with Building Owner/Property Manager, which will involve ECCAC members.</td>
</tr>
</tbody>
</table>
### INN05 Proposed FY14 Changes

Due to high cost related to MCC facility/renovation, the MHD finds it is more appropriate to fund cost related to the facility/renovation using CFTN funds and not INN funds. An estimate of the cost of the renovation is being completed.

Current proposed change is to remove $300,000 set aside for facility costs in INN05 and fund facility renovation costs related to the project using unspent funds from the CFTN component.

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### INN06 PLAN - TRANSITIONAL MENTAL HEALTH SERVICES FOR NEWLY RELEASED INMATES

#### INN06 Description

The aim of this 36-month project is to develop a model that examines whether the organizational support of the Mental Health Department provided to an inter-faith collaborative, and coordination and collaboration with other service providers/advocacy groups increases the capacity of faith organizations to serve newly-released inmates and improve outcomes (symptom management, relationships, work/meaningful activities, and satisfaction with service).

#### INN06 Progress Update

The MHD has worked over the past several months with local faith organizations to develop a strategic plan for the faith collaborative. The vision, mission, and values of the collaborative have been defined and approved by the initial group of approximately 20 faith organization members. The collaborative have agreed to include a 24/7 warm line and resource directory; housing support; service coordination; peer/family support; and connection to friendly “faith homes.” The partners have agreed on a structure and co-chairs. In FY13, work groups were launched to outline specific deliverables.

Activities to-date include:

- In FY13, three vendors were selected for the three faith-based resource centers located in different geographic areas of the County.
- Over 15 Faith entities engaged.
- Organizational structure and leadership formed.
- Three resource centers implemented: Destiny Center, Good Samaritan and Mission Possible.
- A Faith Based mentor program has been initiated among the faith collaborative partners, including the three faith based resource centers, over 30 individuals are registered and trained.

The following data was reported as of April 2013:

- Total number of individuals served at the Faith Based Resource Center (FBRC): 89
- Average Age: 39
- Race/Ethnicity:
- Hispanic/Latino: 43%
- African American: 29%
- White/Caucasian: 23%

- Housing Status
  - Homeless: 27%
  - Living with Friends/Family: 27%
  - Transitional Housing: 26%
  - Renting & Stable Housing: 20%

- Past Release Status
  - Probation: 62%
  - Parole: 26%
  - Community Supervision/AB109: 7%

- Current and Past Church Affiliation
  - Current Affiliation: 46% yes, 43% no
  - Past Affiliation: 45% yes, 42% no

- 10 Most Immediate Needs as reported by program participants:
  - Housing: 52
  - Employment: 51
  - Transportation: 45
  - Food: 36
  - Legal Assistance: 33
  - Clothing: 32
  - Counseling Services: 21
  - Health Care Services: 19
  - Self-care (i.e. hygiene or grooming supplies): 19
  - Financial Support: 16

<table>
<thead>
<tr>
<th>INN06 Proposed FY14 Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Propose to move funding for Three Faith-Based Resource Centers (FBRCs) in INN-09 project to INN-06. The FBRC program budget item is more in line with the INN-06 project. The FBRC budget line item is funded with $250,000 MHSA funds and $350,000 AB109 funds.</td>
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**INN07 PLAN - MENTAL HEALTH / LAW ENFORCEMENT POST CRISIS INTERVENTION**

<table>
<thead>
<tr>
<th>INN07 Description</th>
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<tbody>
<tr>
<td>This 24-month project is designed to develop a model to improve mental health crisis resolution and engagement in services for individuals and their families who experience law enforcement-involved acute mental health crises. This involves the provision of compassionate and timely post-crisis services that include post-event visits (within 24-hours) from a team that includes a peer/family mentor and mental health clinician, follow-up support and linkage services, and de-briefing with law enforcement liaisons, consumer/family mentors and clinical staff to continually inform the effectiveness of service.</td>
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<thead>
<tr>
<th>INN07</th>
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<tbody>
<tr>
<td>From September 1, 2011 through May 31, 2013 there were 3,844 mental health calls to San Jose Police Department; 2,145 calls in the first year and 1,699 calls during the second year up to May 31, 2013 have been received. A total of 339 Informed Consent and Referrals (ICAR’s) were received</td>
</tr>
</tbody>
</table>
by the Post-Crisis Intervention Team (PCIT) from which 284 individuals accepted follow-up services and 55 refused services. Of the 284 who agreed to services, a total of 113 consumers were linked to ongoing mental health services and 171 opted out; 118 of the 171 consumers indicated that services were no longer needed; PCIT staff were unable to contact 53 consumers.

According to the evaluation contract between San Jose State University (SJSU) and Santa Clara County Mental Health Department (SCCMHD) deliverables regarding the draft of the Final Evaluation report will be due by July 2013; then SCCMHD has thirty days in which to review, comment and submit input to SJSU by August 31, 2013. A final report from SJSU will be due in November 2013, 90 days after SJSU receives input from SCCMHD.

This project ended on June 30, 2013 and will not continue in FY14. The project encountered several challenges, the first of which was a procedural change involving placing individuals on a 5150 Hold when appropriate and having them transported to Emergency Psychiatric Services (EPS) for an evaluation. It was later decided that the consumers would be taken to Mental Health Urgent Care (MHUC) where they would wait to be assessed. This created a certain amount of resistance among staff, some of whom were unable to adapt to this project as a learning and development model. Moreover, the timing of the project's implementation coincided with many changes occurring within the San Jose Police Department that included staff reduction of officers and change in leadership which made it difficult to achieve “buy in” to the project. One of the original project goals was to decrease the number of repeat callers. As it turned out that type of information is not tracked by San Jose Police Department and it could not be measured. Additionally, 71 of the 113 consumers who received the PCIT services were either already connected to mental health or had prior involvement with mental health. The total number of crisis calls received by the SJPD compared to the total number of referrals received during the two year project does not support the continuation of this project.

This project will conclude its operation on June 30, 2013 and will not continue.

This is a new application of Interactive Video Simulation Training (IVST) to teach police officers to recognize mental illness, de-escalate mentally ill people in crisis, and increase access for these people to services. In IVST applications, students interact with a life-sized video projection that actually changes based on the students statements and decisions. Project 8 will produce six interactive video simulations depicting mentally ill people in crisis. The IVST will be used in conjunction with lectures and discussions to increase the awareness and proficiency of police officers encountering people with mental illness.
## INN08 Progress Update

Six interactive video simulations depicting mentally ill people in crisis have been completed. A comprehensive lesson plan and PowerPoint presentation also have been completed, and a portable projection system has been acquired.

INN08 has garnered both statewide and national attention. The INN08 project team was invited to present the project at the 2011 International CIT Conference. Additionally, the California Police Officer Standard Training (POST) Commission has invited the project team to present at two separate POST workshops, and has invited the team, as well as MHD Division Director Sandra Hernandez, to participate in the statewide update for Basic Academy Learning Domain 37, which includes mental health.

Current activities/achievements to date:

- Presentation of the IVST at 11 of the County’s 13 police agencies.
- Preliminary project evaluation, based on 325 initial surveys completed by officers at the conclusion of the training, shows IVST has been highly successful in increasing the knowledge and skill levels of officers responding to the needs of mentally ill people in crisis. Following the training, 94% of officers feel “well-prepared” to address mental health related calls.
- It is significant to note that due to the innovative nature of the training, and the project’s initial success, IVST is being adopted in at least six other counties, and by the California State University System. The project has been presented at two CIT International (CITI) Conferences and also at last year’s California CIT Association Conference.

Based on preliminary data, the County proposes to continue IVST and have it be integrated to the CSS and WET component of MHSA. Final Evaluation by Resource Development Associates (RDA) estimated to be completed by December 2013.

### INN08 Proposed FY14 Changes

Current proposal is to Integrate IVST to the CSS and WET component in FY14. Law Enforcement Liaisons will be assisting in the completion of the INN-08 final evaluation report by RDA and one-time funds are needed for the LEL contracts, $14,400.
**INN09 Progress Update**

Work is under way to design and test an outcomes “dashboard” to track pilot progress in addressing client needs in multiple functional domains (health, mental health, substance abuse, housing benefits, employment/education, benefit assistance, & social network).

The re-entry index is designed to evaluate risk in eight domains: housing, income and benefits, physical health, substance abuse, mental health, family, faith and community, peers and associates. The re-entry MAP team will track services provided and progress over time, including recidivism rate.

MAP Results October 2011 to March 2013:
- Re-Entry individuals estimated released - 1,527
- Assessed by the MAP Team - 834 (54.6%)
- Connected to MHD services - 262 clients; 17.2% of total 1,527 released

In addition, of the 1,105 Correction Assessment and Intervention System (CAIS) assessments, 834 MAP assessments were completed. The majority of respondents were between the ages of 18 and 45.

Further, of these 834 MAP assessment completed, a total of 204 AB109 consumers have received services through Evans Lane Outpatient Program, Community Solutions, Gardner and Catholic Charities FSP. An additional, 65 clients have utilized Evans Lane Residential Program, of which 14 clients are currently residing at Evans Lane.

The MAP Team has worked with evaluation staff from all participating departments, the Department of Alcohol & Drug Services (DADS), Custody, SSA benefits, housing and probation, to identify a set of achievements for this population to be tracked as part of a broader Re-Entry Initiative. Currently, two tools are used in order to track pilot progress in addressing client needs in multiple functional domains: one tool to assess risk utilized by the Probation and the Sheriff Department to determine supervision plans, and one tool used by the MAP Team to assess and address service needs.

The MAP Team and the Probation Department have developed a new referral form which is ready for implementation. Once the referral form has been implemented, probation officers will utilize this form to make referrals to the MAP Team.

**INN09 Proposed FY14 Changes**

The MHD recommends discontinuation of one-time funding for one Clinical Nurse from Custody and one Eligibility Worker from Social Services Agency (SSA) and request participating agency to fund their positions. This will result in a reduction of $256,210. In addition, the MHD proposes to move funding for the Faith-Based Resource Centers (FBRCs) in the INN-09 project to the INN-06 project. The FBRC program budget item is more in line with the INN-06 project. The FBRC budget line item is funded with $250,000 MHSA funds and $350,000 AB109 funds. Total proposed budget change: an overall decrease of $506,210 in one-time funds based on the changes noted above.

**INN ADMINISTRATION**

**INNAD01 Administration** – This includes the indirect administrative overhead costs for Mental Health Administration, the County’s Health & Hospital System Overhead (e.g. Information Systems, Patient Business Services, Finance), County Overhead, and other Mental Health wide administrative functions (e.g. Quality Improvement).
<table>
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<tr>
<th>INNAD01 Progress Update</th>
<th>The MHD’s FY13 INN budget includes $600,832 for Administrative costs which the MHD proposes to maintain for FY14. These funds are supporting managerial and clerical positions in Mental Health Administration, Contracts, Finance, Information Systems, Quality Assurance and other system-wide administrative functions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>INNAD01 Proposed FY14 Changes</td>
<td>There are no proposed changes for FY14.</td>
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WORKFORCE EDUCATION AND TRAINING (WET) PLAN

DESCRIPTION

The Mental Health Department (MHD) has had a strong commitment to the involvement of a broad-based stakeholder and advisory participation in all of its MHSA planning processes. The MHD’s Workforce Education and Training component were developed with stakeholders and public participation. Throughout the stakeholder process input were considered, with adjustments made to the plan as appropriate. The MHD’s WET plan was submitted and approved by the State in 2009. The goals of the Workforce Education and Training (WET) have been:

- To have a workforce that is fully integrated and reflective of the cultural and ethnic diversity of consumers and family members at all levels of the workforce, including employees, interns, and volunteers;

- To provide employment opportunities and integrated support mechanisms throughout the system to enhance employment and retention of consumers and family members;

- To enhance staff training and develop opportunities and career pathways for county and CBO staff, including management development opportunities;

- To provide training and educational opportunities in the mental health system, with local educational institutions and the community at large.

<table>
<thead>
<tr>
<th>WET Programs</th>
<th>FY2013 Funding</th>
<th>FY2014 Recommended Funding</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>W1 Workforce Education and Training Coordination</td>
<td>$253,414</td>
<td>$253,414</td>
<td>-</td>
</tr>
<tr>
<td>W2 Promising Practice-Based Training</td>
<td>$1,075,577</td>
<td>$1,075,577</td>
<td>-</td>
</tr>
<tr>
<td>W3 Improved Services and Outreach to Un-served and Underserved Populations</td>
<td>$605,577</td>
<td>$605,577</td>
<td>-</td>
</tr>
<tr>
<td>W4 Welcoming Consumers and Family Members</td>
<td>$536,153</td>
<td>$536,153</td>
<td>-</td>
</tr>
<tr>
<td>W5 WET Collaboration with Key System Partners</td>
<td>$100,000</td>
<td>$100,000</td>
<td>-</td>
</tr>
<tr>
<td>W6 A Comprehensive Mental Health Career Pathway Model</td>
<td>$181,153</td>
<td>$181,153</td>
<td>-</td>
</tr>
<tr>
<td>W7 Stipends and Incentives to Support Mental Health Career Pathway</td>
<td>$954,000</td>
<td>$954,000</td>
<td>-</td>
</tr>
<tr>
<td>WET Administration</td>
<td>$411,858</td>
<td>$411,858</td>
<td>-</td>
</tr>
<tr>
<td>Total WET</td>
<td>$4,117,732</td>
<td>$4,117,732</td>
<td>-</td>
</tr>
</tbody>
</table>

Please note: Adjustments to the MHD MHSA County personnel budget resulting from Board of Supervisor (BOS) approval for: 1) Increased contributions to the California Employers Retiree Benefit Trust (CERBT) and 2) Salary and benefit adjustments based on contract negotiations with labor unions is still pending and not reflected in the table above. The proposed plan is to spread the budget adjustments across the five MHSA components (See pages 98-99).
**WORK PLANS, PROGRESS UPDATES AND PROPOSED FY13 CHANGES**

### W1 - WORKFORCE EDUCATION AND 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. |
| W1 | Staff has been hired to provide support for the implementation of the WET plan. |
| W1 | • W1: 2.0 FTEs hired: - WET Coordinator and Office Specialist III  
• W2 and W3: 1.0 FTE - Training Coordinator  
• W4: 1.0 FTE - Welcoming Coordinator  
• W6: 1.0 FTE - MH Career Pathways and Internship Coordinator |
| W1 | There are no proposed changes. |

### W2 - PROMISING PRACTICE-BASED TRAINING IN ADULT RECOVERY PRINCIPLES AND CHILD, ADOLESCENT AND FAMILY SERVICE MODELS

| W2 | This project expands training for SCCMHD 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. |
| W2 | • From FY09-12 provided 358 trainings.  
• From FY12-13 provided 92 trainings  
• Number of Training Participants:  
  o FY09-10: 2,250 participants attended 88 trainings.  
  o FY10-11: 3,634 participants attended 150 trainings.  
  o FY11-12: 3,474 participants attended 120 trainings. |
<table>
<thead>
<tr>
<th>W2 Proposed FY14 Changes</th>
<th>There are no proposed changes.</th>
</tr>
</thead>
</table>

- FY12-13: 2,792 participants attended 92 trainings.

- **Trainings Provided:**
  - NAMI Provider Education Course, Peer to Peer, Family to Family & Basics
  - Wellness Recovery Action Plan (WRAP)
  - Veterans: Post Traumatic Stress Disorder PTSD and TBI
  - Returning Veterans: Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI)
  - Ground Rounds: Cross Cultural Psychiatry: Diagnosing and Treating Bipolar Disorder in Children and Adolescents; Overlap in ADHD;
  - Recovery Rally
  - Clinical Aspects of 5150
  - Milestone of Recovery Scale (MORS)
  - Motivational Interviewing: Train the Trainer
  - Motivational Interviewing – Basic to Advanced
  - Co-Occurring Disorders
  - Cross System Issues for Adult Clients with Co-Occurring Disorders
  - Why Integrating MH and Substance Abuse is Hard to Do and What to Do about it
  - Law and Ethics
  - Clinical Supervision
  - SSI Benefits Training
  - Transition to Independence Process (TIP) Training
  - Bridges Out of Poverty
  - Laugh Yourself Safe
  - TCP – Adult System of Care Staff and Managers
  - TCP – F&C System of Care Staff and Managers
  - Managing Challenging Behavior in the Workplace, A Basic Behavioral Health Guide
  - Peer Run Start Up 101
  - CANS Peer Mentor/Super User Training
  - CANS – Train the Trainer
  - CANS & TCP Clinical Supervisor Training
  - Reflective Practice – Basic course one-day training
  - Reflective Practice – Facilitating Reflective Practice two-day training for mentors, facilitators and supervisors
  - Trauma Focused Cognitive Behavioral Therapy
  - Mental Health First Aid
  - Eating Disorders, Co-Morbidity and Early Life Trauma
  - The Shaken Tree: Train the Trainer and Families living with mental illness
### W3 - IMPROVED SERVICES AND OUTREACH TO UNSERVED AND UNDERSERVED POPULATIONS

<table>
<thead>
<tr>
<th>W3 Description</th>
<th>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.</th>
</tr>
</thead>
</table>

| W3 Progress Update | • FY09-12 provided 68 trainings.  
• FY12-13 provided 10 trainings  
• With a total of 1,704 Training Participants:  
  o FY09-10: 518 participants attended 17 Cultural Competency trainings  
  o FY10-11: 781 participants attended 29 Cultural Competency trainings  
  o FY11-12: 405 participants attended 22 Cultural Competency trainings  
  o FY12-13: 162 participants attended 10 Cultural Competency trainings  
• Training provided in the following topics areas:  
  -Cultural Competence - Core Foundation  
  -Cultural Complexities in Assessment, Diagnosis & Engagement  
  -Cultural Competence for Bilingual Staff & Interpreters  
  -Advancing Cultural Complexities in Assessment Engagement and Successful Working - Relationships  
  -Advancing Cultural Competence: Inclusion in the Context of MHSA  
  -Working Effectively with Bi-Lingual Staff & Interpreters  
  -Culturally Competent Practices: Working Effectively with Immigrants & Refugees  
  -Asian Americans: Culturally Responsive Services for Our Diverse and Complex  
  -The Imperatives of Effective Partnerships with Cultural and Ethnic Communities  
  -Military Culture 101: Basics of Military Culture  
  -LGBTQ Youth Space  
  -Understanding Strength & Support for Multicultural Elders and Older Adults  
  -Native American Mental Health Needs and Community Strengths  
  -History, Culture, Immigration & Implications for Health & Well-Being in the Southeast Asian American Communities  
  -Asian American & Pacific Islander: Leaders in the Workplace  
  -Culturally Competent Interventions with Asian Americans  
  -Culturally Relevant Assessments with Asian Americans  

Additional updates: The two new positions, Mental Health Program Specialist II positions, proposed and approved during the FY12-13 annual update process were added in FY13. The positions were created to work on ensuring that clinical services are provided in client-centered approach and with cultural competence. These positions will work on implementing TCP throughout the system. Both positions were filled effective May 2013. Note: initially the positions were placed in LP01 but were moved to WET component since the positions will be funded with WET funds. |

| W3 Proposed FY14 Changes | There are no proposed changes. |

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83
This project 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.

A Welcoming Committee was developed to address the welcoming needs of the MHD. Members of the committee include both contract agencies and County staff members. The Committee worked together to develop welcoming policies and procedures. The Committee also is recommending that the MHD collect qualitative and quantitative data in order to effectively address welcoming concerns for the MHD’s newly created Mental Health Peer Support Worker (a code specifically designated for consumers and family members) and consumer and family member positions throughout the system.

- Welcoming Manager was hired in 2010.
- FY09-10: 331 participants attended Welcoming specific trainings
- FY10-11: 519 participants attended 43 Welcoming specific trainings
- FY11-12: WET staff created and implemented a training course on Client Culture that went into effect in June 2012.
- FY12-13 Provided 10 Client Culture Trainings to 292 participants.
- Recruited and trained consumer and family members to participate on a panel to share their perspectives on client culture. Two trainings were conducted with 47 participants.
- New positions were added in FY13 to provide training for the MHD and its Office of Family Affairs, Office of Consumer Affairs, and Ethnic and Cultural Communities Advisory Committees (ECCACs). The MHD added 1.0 FTE Associate Training/Staff Development Specialist and 2.0 half-time Mental Health Peer Support Workers. The MHD proposed to reallocate current funds set aside for training to offset cost of new positions. Persons in these positions will be trained to provide instruction and support for Mental Health Peer Support Workers, Consumer and Family Member Interns and other MHD staff. Ongoing training and support is necessary for successful integration of consumer and family members entering into the workforce. Below is a list of trainings that are anticipated:
  - Wellness Recovery Action Plan
  - Client Culture
  - Peer to Peer Training – Boundaries, Active Listening, Dual Relationship and etc.
  - Family Member Certificate Program
  - Safety Training
  - Group Facilitation
  - Digital Storytelling
  - Effective Communication Customer Service

Staffing Update: Associate Training Staff Development Specialist I hire date is 06/24/13 and currently recruiting for 0.5 FTE Mental Health Peer Support Worker Position.

| W4 Description | A Welcoming Committee was developed to address the welcoming needs of the MHD. Members of the committee include both contract agencies and County staff members. The Committee worked together to develop welcoming policies and procedures. The Committee also is recommending that the MHD collect qualitative and quantitative data in order to effectively address welcoming concerns for the MHD’s newly created Mental Health Peer Support Worker (a code specifically designated for consumers and family members) and consumer and family member positions throughout the system. |
| W4 Progress Update | Welcoming Manager was hired in 2010. FY09-10: 331 participants attended Welcoming specific trainings FY10-11: 519 participants attended 43 Welcoming specific trainings FY11-12: WET staff created and implemented a training course on Client Culture that went into effect in June 2012. FY12-13 Provided 10 Client Culture Trainings to 292 participants. Recruited and trained consumer and family members to participate on a panel to share their perspectives on client culture. Two trainings were conducted with 47 participants. New positions were added in FY13 to provide training for the MHD and its Office of Family Affairs, Office of Consumer Affairs, and Ethnic and Cultural Communities Advisory Committees (ECCACs). The MHD added 1.0 FTE Associate Training/Staff Development Specialist and 2.0 half-time Mental Health Peer Support Workers. The MHD proposed to reallocate current funds set aside for training to offset cost of new positions. Persons in these positions will be trained to provide instruction and support for Mental Health Peer Support Workers, Consumer and Family Member Interns and other MHD staff. Ongoing training and support is necessary for successful integration of consumer and family members entering into the workforce. Below is a list of trainings that are anticipated: Wellness Recovery Action Plan Client Culture Peer to Peer Training – Boundaries, Active Listening, Dual Relationship and etc. Family Member Certificate Program Safety Training Group Facilitation Digital Storytelling Effective Communication Customer Service |
| W4 Proposed FY14 Changes | There are no proposed changes. |
## W5 - WET COLLABORATION WITH KEY SYSTEM PARTNERS

<table>
<thead>
<tr>
<th><strong>W5</strong> Description</th>
<th>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.</th>
</tr>
</thead>
</table>
| **W5** Progress Update | The MHD sponsored and hosted the Collaborating and Networking for Solutions Conference in October 2011 at the Santa Clara Convention Center. One hundred forty-two community members and mental health staff attended the event. The goal of the conference was to create opportunities and identify strategies for networking and collaborating with other service providers and to increase awareness of resources countywide. Additionally, the conference provided a linkage for service providers, consumers and family members, and community partners across sectors and enhanced the collaborative and networking opportunities that support effective partnerships in the community. Keynote speakers identified strategies and provided participants with useful resources. In February 2012, there was a follow up collaborative meeting on how to further work in partnership with the Social Services Agency. Crisis Intervention Team (CIT) Trainings:  
• FY09-10: 95 participants attended 3 CIT trainings  
• FY10-11: 120 participants attended 4 CIT trainings  
• FY11-12: 142 participants attended 4 CIT trainings  
• FY12-13: 98 participants attended 4 CIT trainings |
| **W5 Proposed FY14 Changes** | There are no proposed changes. |

## W6 - A COMPREHENSIVE MENTAL HEALTH CAREER PATHWAY MODEL

| **W6** Description | This includes a position and overhead budgeted to support the development of a model that supports SCCMHD’s commitment to developing a workforce that can meet the needs of its diverse population. The person in this position 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 un-served communities that the SCCMHD seeks to serve. |
W6 Progress Update

In order to develop a Career Pathway model, WET staff created a Peer Intern program for consumers and family members. Consumer and Family Member Interns have received training, education and coaching to develop and increase their skills in a variety of settings: office setting, computer lab, self-help centers, veteran outreach, and with the CBOs. The training that the Interns received has helped them increase their skills and experience so that they meet requirements for employment.

Partial list of training topics include the following: Resilience, Effective Communication and Listening skills, Managing Stress, Conflict Skills, Understanding Difficult People, Personal Empowerment, and Boundaries.

W6 Proposed FY14 Changes

There are no proposed changes.

W7 - STIPENDS AND INCENTIVES TO SUPPORT MENTAL HEALTH CAREER PATHWAYS

W7 Description

This project 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.

W7 Progress Update

Internships were provided to 43 students (37 students received WET stipends). WET stipends were furnished to 24 consumer and family members. Consumer and family member interns also received ongoing training and weekly group supervision. Implementation of a scholarship program is still in progress. Work is underway on developing a MHD intern position.

Consumer and Family Member (Peer) Interns – Stipend Program:

• FY09-10: County Peer Intern 2 & CBO Peer Interns 18
• FY10-11: County Peer Intern 2 & CBO Peer Interns 20
• FY11-12: County Peer Intern 7 & CBO Peer Interns 16

Graduate Student Interns – Stipend Program:

• FY09-10: County Student Interns 12 & CBO Student Interns 30
• FY10-11: County Student Interns 12 & CBO Student Interns 30
• FY11-12: County Student Interns 13 & CBO Student Interns 30

Both Peer and Student interns receive ongoing training and weekly group supervision.
W7 Proposed FY14 Changes
There are no proposed changes.

### WET ADMINISTRATION

<table>
<thead>
<tr>
<th>WAD1 Description</th>
<th>This includes the indirect administrative overhead costs for Mental Health Administration, the County’s Health and Hospital System Overhead (e.g. Information Systems, Patient Business Services, Finance), County Overhead, and other Mental Health-wide administrative functions (e.g. Quality Improvement).</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAD1 Progress Update</td>
<td>The MHD’s FY13 WET component budget includes $411,858 for Administrative costs. The MHD proposes to maintain the same budget in FY14. These funds are supporting managerial and clerical positions in Mental Health Administration, Contracts, Finance, Information Systems, Quality Assurance and other system-wide administrative functions.</td>
</tr>
<tr>
<td>WAD1 Proposed FY14 Changes</td>
<td>There are no proposed changes.</td>
</tr>
</tbody>
</table>
CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) PLAN

As one of the five components of MHSA, the Capital Facilities and Technological Needs (CFTN) component provides resources for the implementation of the SCVHHS Mental Health Department’s MHSA goals through projects that improve capital facilities and support the development of five technology initiatives. Projects under the CFTN component are considered single, time-limited projects. The projects were developed with contributions from stakeholders, the public, and our contract service providers. The projects were circulated for 30 days to stakeholders for review and comment. Stakeholder inputs were considered with adjustments made to the plan as appropriate. The following projects, Electronic Health Record, Enterprise Data Warehouse, Computer Learning Centers, Consumer Portal and Web Redesign, Mental Health Bed and Housing Exchange Database, were submitted and approved by the State in 2009. While County Health Record Integration Initiative, MediPlex F&C Screening, Assessment & Tx Center and Downtown Mental Health Renovation were approved as part of the MHD’s FY12 MHSA plan update. The specific projects and initiatives are listed in the Work Plans below.

<table>
<thead>
<tr>
<th>CFTN Programs</th>
<th>One-Time Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR      Electronic Health Record</td>
<td>$ 15,601,000</td>
</tr>
<tr>
<td>EDW      Enterprise Data Warehouse</td>
<td>$ 2,644,000</td>
</tr>
<tr>
<td>CLC      Consumer Learning Centers</td>
<td>$ 572,000</td>
</tr>
<tr>
<td>WEB      Consumer Portal and Web Redesign</td>
<td>$ 319,000</td>
</tr>
<tr>
<td>BHX      Bed and Housing Exchange</td>
<td>$ 200,000</td>
</tr>
<tr>
<td>CHR      County Health Record</td>
<td>$ 1,148,000</td>
</tr>
<tr>
<td>MediPlex Relocation of Family &amp; Children's Services (Kidscope, Las Plumas)</td>
<td>$ 500,000</td>
</tr>
<tr>
<td>DTMH     Renovation of Downtown Mental Health Self Help and Lobby areas</td>
<td>$ 313,000</td>
</tr>
<tr>
<td>MCC      Multi-Cultural Center (MCC) Renovation Project</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Total CFTN</strong></td>
<td><strong>$ 21,297,000</strong></td>
</tr>
</tbody>
</table>

*Redirect unspent funds in the CFTN component to fund the new MCC facility renovation project.

Please note: Adjustments to the MHD MHSA County personnel budget resulting from Board of Supervisor (BOS) approval for: 1) Increased contributions to the California Employers Retiree Benefit Trust (CERBT) and 2) Salary and benefit adjustments based on contract negotiations with labor unions is still pending and not reflected in the table above. The proposed plan is to spread the budget adjustments across the five MHSA components (See pages 98-99).
**WORK PLANS, PROGRESS UPDATES AND PROPOSED FY13 CHANGES**

**EHR – ELECTRONIC HEALTH RECORD**

<table>
<thead>
<tr>
<th>Purpose</th>
<th>To provide a comprehensive electronic medical record for consumers that can be shared in a secure and integrated environment across service providers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need</td>
<td>The EHR is mandated by Federal, State and Local initiatives. The Federal Executive Order requires everyone to have an electronic health record by 2014. The Governor of California has backed this deadline with an Executive Order. SCVHHS has set a goal of switching to EHRs by 2013.</td>
</tr>
<tr>
<td>Project Overview</td>
<td>Reduce paper medical charts and provide an electronic mechanism to securely share critical client treatment data with all providers in the network; Improve coordination of care between providers of services through integration of data; Provide opportunities to reduce costs by streamlining and automation of clinic operations; Produce better treatment outcomes because of better coordination of care and integrated treatment protocols.</td>
</tr>
<tr>
<td>Once completed, the EHR project will provide an integrated system for all administrative and clinical consumer information. Treatment plans, assessments and progress notes will be recorded and securely maintained electronically. Appointment scheduling, lab orders and medication prescribing will be done online. Client registration and all forms normally completed during intake, including medical histories, will be attached to the electronic medical record and will facilitate coordinated treatment.</td>
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</tbody>
</table>

| Progress Update | The EHR project is currently following two paths: 1) emergency, inpatient and ambulatory mental health services provided in FQHCs are transitioning to the VMC HealthLink EHR system, and 2) all other services, including specialty outpatient, contract acute care, IMDs and residential care will continue to use Unicare/Co-Centrix. Unicare/Co-Centrix will be upgraded to 1) provide a better clinical data capture system for county-operated specialty mental health services, and 2) receive information from contract inpatient and outpatient specialty mental health providers for processing billing, state reports and performance measures. The County’s network of contract outpatient specialty mental health providers has nearly completed the implementation of their own EHR capability with financial assistance from MHSA TN funding. The County is working with Unicare/Co-Centrix to complete the scope of work and timeline to configure the existing County system to receive an electronic transfer of information from outpatient contract agencies. In the interim, contractors will upload a data extract to the Unicare/Co-Centrix system for billing and reporting purposes. |

| Proposed FY14 Changes | There are no proposed program changes. |
EDW - ENTERPRISE-WIDE DATA WAREHOUSE

**Purpose:** To create a single data repository for all Mental Health Department service, administrative, financial and provider information. The data warehouse will integrate information to improve the ability of SCVHHS to measure key clinical and administrative metrics through enhanced business intelligence reporting capabilities. The data warehouse will directly support treatment decisions, new program design and management decision-making activities.

**Need:** The Enterprise Data Warehouse (EDW) will address an on-going need to improve clinical and administrative reporting capabilities for SCVHHS. The need for improving access to data and reporting was the number one issue identified during an information system assessment conducted in the summer of 2008. A single system that contains easily accessible, clean and reliable data, combined with robust reporting and business intelligence tool sets will significantly improve report generation and support active decision-making processes focused on supportable data related analysis and eliminate redundant databases and reports that have been created as temporary solutions to fill the gap.

**Project Overview**

- This project will build an EDW that is capable of integrating data from the primary transaction system (EHR) and all other data sources that SCVHHS MHD uses, such as financial data, eligibility data from various payers and client care data from County and Contract Programs.
- The EDW will support interoperability across systems.
- The EDW will provide opportunities for development of data marts that can be tailored for specific management and operational reporting needs.
- The EDW Project will include the following major components:
  - Identify all data sources to be included in the data repository
  - Design of data warehouse, update processes and reporting requirements.
  - Obtain necessary hardware and software.
  - Install products and train staff.
  - Develop data maps, implement and test update processes.
  - Identify pilot project and develop work plan.
  - Develop Data Quality program and monitor data.
  - Develop reporting strategy and process
  - Develop end-user products such as dashboards and performance indicators.

**EDW Progress Update**

The County is in discussion with Unicare/Co-Centrix to install, train and support a data warehouse and companion decision support tools that will make data easily accessible at the desktop of any user. Pre-designed reports and graphs will be available along with the ability to prepare ad hoc reports to meet the needs of a variety of audiences. The EDW Scope of Work (SOW) and timeline will be developed in conjunction with the SOW and timeline for the EHR project.
<table>
<thead>
<tr>
<th>CLC – CONSUMER LEARNING CENTER</th>
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</table>
| **CLC** | Purpose: To provide additional support for consumers in MHSA recovery programs and living in the community by setting up supervised computer labs and basic PC skills training in established Wellness Centers across the County.  

Need: The need for this project was identified during meetings with consumers and staff. There is currently one consumer PC lab located in one facility. That lab has outdated equipment and is not staffed appropriately. Consumers and staff see great potential in a well-planned and modernized lab environment.  

Project Overview:  
This project will establish computer labs in up to four Wellness Centers for consumer use.  
- Each lab will have up to 10 PCs available for consumer use and training seminars.  
- The labs will offer consumers:  
  - Broadband Internet access;  
  - Basic training in PC skills and MS-Office applications;  
  - Assistance with job search techniques;  
  - Assistance with resume building;  
  - Training in Internet search techniques for health, housing and other resource information; and  
  - Training in online business transactions such as banking and bill paying.  

**CLC Progress Update**  
The first CLC will open in Summer 2013 at the self-help center co-located with the County’s Downtown Mental Health Center. This site was chosen because of the high client volume and easy access to the location. Policies and procedures have been written to guide the use of the computers and define the staff’s responsibilities. Technical work has been completed. Quantitative and qualitative measures are being finalized to determine the success of this CLC so that the findings can be applied to the next sites to be opened. The MHD has tentatively selected the Evans Lane residential facility as the second site.  

| CLC Proposed FY14 Changes | There are no proposed program changes. |
| WEB | Purpose: To provide additional services for consumers and their families by enhancing the current MH website and developing a secure consume portal. The WEB focuses on developing a set of Internet applications that provide real-time, secure behavioral health and medical treatment services and outcomes information to consumers and the public in general. These revisions will make it easier for consumers and family members to obtain mental health services, treatment, and other information.

Need: The need for this project was identified during meetings with consumers and staff. The need to provide more access to information via the website that supports consumers and their families continues to grow and must be part of a continuous and on-going plan for SCVHHS.

Project Overview: Santa Clara County recognizes that the intelligence and technological capabilities of the consumers and their families continues to grow and that the website needs to grow with their expertise. By 2014, the County will be offering more online services and consumers and their families will want more opportunities for online information. The WEB is an opportunity to provide real-time, secure information and functionality as well as health-related information to consumers and the public in general that enhance the ability of consumers to obtain mental health services, treatment, and other information.

The intent is to provide a consumer focused website that can grow with the consumer interests. Some of the ideas include:

- Housing information
- Health information to support wellness activities
- Personal Health Record (PHR) access which may include updates, such as, updates to consent forms, adding notes to the medical record or history via the portal
- Access to appointment scheduling and available services and providers
- Links to other consumer sites of interest, including NAMI
- Blogs and chat room for consumers and families to share information.

This project will also complete the State DMH IISI infrastructure requirement that all consumers have access to a secure PHR. Once the EHR is fully operational, portals will be implemented to allow consumer access to not only PHRs but other areas of the system such as appointment scheduling online.

The focus of this initiative is to improve access to health and treatment information for consumers and the general public. |

<p>| WEB Progress Update | The web redesign, with improved visual presentation, content and accessibility, is being coordinated with the County’s Information Systems Department. The first phase was completed Spring 2013 and contains information of general interest and links to helpful resources. The web redesign second phase will include a web portal to facilitate consumer access to health information to support wellness activities and eventually to personal health records, blogs and chat rooms. |</p>
<table>
<thead>
<tr>
<th>BHX – BED AND HOUSING EXCHANGE</th>
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</thead>
<tbody>
<tr>
<td><strong>BHX Description</strong></td>
</tr>
<tr>
<td>Purpose: To provide a database with posting and query tools that will allow operators of inpatient/residential Mental Health facilities services to post their open beds whenever they become available so that case managers, clinicians and others authorized to act on behalf of MH clients can quickly see what is available in housing and/or beds. The current approach is by word of mouth or having to call every facility on a rotating basis to learn of vacancies.</td>
</tr>
<tr>
<td>Need: The need for this project was identified during special needs assessment meetings with HHS MHD staff that work in the area of placement of clients in residential or inpatient beds. In other open meetings with contractors and then again with consumer and family members this need was further validated. The specific need is that there is no organized way for case managers or clinicians to determine bed availability for their clients without making calls to every facility each time the need arises. This causes delays in appropriate services delivery as well as missed opportunities for operators to get their open beds filled.</td>
</tr>
<tr>
<td>Project Overview:</td>
</tr>
<tr>
<td>- This project will obtain/build and implement database that will contain up to date postings for available inpatient/residential resources</td>
</tr>
<tr>
<td>- Postings will be organized by levels of care (e.g. IMD, Residential Care Facility, Board and Care, Board and Care with Services, Temporary Shelter, Emergency Housing and Permanent Housing)</td>
</tr>
<tr>
<td>- This database will be a secure site accessible via the internet, hosted by the MHD.</td>
</tr>
<tr>
<td>- Facility operators and/or housing specialists will be able to post their beds on a 24 x 7 basis using an e-form with a secure transaction. Each facility will maintain an up to date profile of their organization, services offered and other essential parameters.</td>
</tr>
<tr>
<td>- Mental Health 24 Hour care and other case managers and clinicians who place clients in beds will be able to query for specific types of beds on a 24 x 7 basis.</td>
</tr>
<tr>
<td>- Build a reporting capability to allow analysis of bed availability and request patterns</td>
</tr>
<tr>
<td><strong>BHX Progress Update</strong></td>
</tr>
<tr>
<td>An RFP will be issued this year for a vendor to provide a web-based inventory of short and long-term housing available to mental health clients. The service will be used by case managers to locate affordable housing in a timely manner. The County’s Information Systems Department is reviewing and assisting in the preparation of the RFP.</td>
</tr>
</tbody>
</table>
### CHR – COUNTY HEALTH RECORD INTEGRATION INITIATIVE

| CHR Description | Purpose: To create a system focused on providing secure, real-time combined wide client records that can be accessed across various service providing agencies and provide a collaborative cross agency view of registered consumer’s demographic, services and care, medications, physical health services, insurance, employment, housing and other information.  

Need: Many consumers utilize services across multiple agencies both within the SCVHHS umbrella and outside of it. The ability of many of those agencies to obtain information about the range of services a consumer is accessing is currently limited and prohibits effective coordination of care and funding. The CHR supports development of a cross agency view of services, opportunities to identify gaps and measure outcomes through shared information. This need was identified during meetings with consumers, County Health, County Social Service, and County Juvenile Justice and County Criminal Justice liaisons.  

Project Overview:  
- This project will be initiated in a series of small phased-in projects that will enable multiple County agencies to share information about common clients in order to coordinate care and other County services.  
- The first phase of the project is to develop a Master Patient Index (MPI) that can be used to capture consumer information within the broader SCVHHS system.  
- The CHR objectives include:  
  - Improved coordination of care between agencies providing services through integration of data;  
  - Opportunities to reduce costs by eliminating duplicative or, ineffective services and possibly eliminate some multi-agency case management;  
  - Easier navigation through service agencies across the County for consumers with more shared information, such as, demographics;  
  - Better treatment outcomes because of better coordination of care and integrated treatment protocols.  

| CHR Progress Update | The County Health Record is being implemented in conjunction with the HHS health record project. This is on hold during the implementation of Epic. |
| Medi-Plex Description | The renovation will relocate the existing KidScope program that specializes in diagnostic and treatment services for 0-8 year olds performed by developmental pediatricians and therapy staff, and the County teams that work with children and transition age youth. The new location will improve access to high risk populations in the downtown and east San Jose service area, the areas with the highest concentration of at-risk youth. Current services are in small quarters that inhibit the number of clients who can be seen daily. The new space will add enough square footage to allow for some growth in both programs.

The renovation will consist of redesigning and reconstructing the space formerly used for medical office suites into space appropriate for individual and group counseling with separate reception and waiting areas for young children and TAY. MD offices will exist within the suite along with rooms for individual counseling and group work. Counseling rooms will be large enough for the client and family members as appropriate. |
| MediPlex Progress Update | Renovation planning and consolidation of services to the MediPlex is in progress. The MHD initially coordinated a walk-through with Las Plumas and KidScope staff along with staff from the Juvenile Probation Department, so they could assess the new space as well as provide suggestions or ideas for the offices, meeting rooms, etc., since these programs will be moving to this new location. The MHD is currently in the planning stages and is working with the County’s Facilities Department to have plans drawn to reconfigure the entire floor. The MHD will continue to work with staff and address any specific questions or concerns they may have, as well as schedule additional walk-through dates/times throughout the renovation process. |
| MediPlex Proposed FY14 Changes | There are no proposed program changes. |
### DTMH – DOWNTOWN MENTAL HEALTH RENOVATION

<table>
<thead>
<tr>
<th>DTMH Description</th>
<th>The renovation will consist of improving the Self-Help Center by designing activity and training rooms. The current space consists of one large activity room and a coordinator’s office. The remodeled space will have a computer training room and several activity rooms to allow multiple groups to the space simultaneously.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DTMH Progress Update</th>
<th>Funds have been allocated for the renovation of the Self-Help Center located in the Downtown Mental Health Building. Meetings are being scheduled with appropriate Managers and Facility liaison in order to move forward with this project.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DTMH Proposed FY14 Changes</th>
<th>The DTMH renovation has a one-time budget allocation of $313,000. Currently the DTMH project only covers the Self-Help Center training area/activity rooms however there is current need to also renovate the lobby area of the facility. The MHD proposes to use the current $313,000 budget to expand the DTMH project to include renovation of the DTMH’s main lobby. The renovated area will provide a welcoming, comfortable wellness center environment for the clinic, self-help consumers, and family members.</th>
</tr>
</thead>
</table>

### MCC – MULTI-CULTURAL CENTER

<table>
<thead>
<tr>
<th>MCC Description</th>
<th>The renovation will consist of improving the space for the Multi-Cultural Center (MCC). The MCC will offer a welcoming, accessible and safe place where members of all ethnic communities can find a sense of cultural resonance, belonging and support. The MCC will be open to ethnic events and celebrations, creating a natural place for community members to congregate, and where conversations about mental well-being can be inserted and approached within appropriate cultural contexts and languages.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MCC Progress Update</th>
<th>Due to high cost projected for the MCC site renovation the MHD finds it more appropriate to fund the MCC renovation costs using CFTN funds rather than INN funds. The MCC, the County’s INN05 project, is designed to increase access to underserved and inappropriately served ethnic minorities by housing activities and services for multiple ethnic communities in Santa Clara County.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MCC Proposed FY14 Changes</th>
<th>The MHD recommends redirecting unspent funds in the CFTN component to fund the MCC site renovation costs. A potential site has been identified however cost estimates are still being determined by the County’s Facility and Fleet Department.</th>
</tr>
</thead>
</table>
COMMUNITY PLANNING / LOCAL UPDATE REVIEW PROCESS

In FY12-13, the Mental Health Department (MHD) continued to implement the County’s MHSA programs. Currently, 15 CSS initiatives have been fully implemented offering a broad range of services and system improvements targeted to age groups across lifespan. Full implementation of the five PEI programs, various INN projects and CFTN projects are currently underway. In addition, the WET funded programs have been fully implemented and close to 500 trainings have been provided to consumers, families, community members and providers since FY09. Primarily, the FY13-14 MHSA Annual Update Draft reflects continuation of previously approved programs for all five MHSA components and the proposed changes to those previously approved programs. This annual update also includes a recommendation to redistribute existing unspent CFTN funds to fund a new facility renovation project for the Multi-Cultural Center (MCC) site. The MCC site will be the location for the INN-05 project.

MHSA Stakeholder Leadership Committee

Since 2005 the MHSA Stakeholder Leadership Committee (SLC) has been in place to provide input and to advise the MHD in its MHSA planning and implementation activities. The MHSA SLC serves as the MHD’s primary advisory committee for MHSA activities. The MHSA SLC members review, comment and provide input on MHSA plans and annual updates. MHSA SLC meetings serve as a forum to assure wide-ranging representation in the MHSA community planning process. All MHSA SLC meetings are open to the public and allow for public comment. Throughout the year, the MHD holds MHSA SLC meetings to discuss MHSA related business and programs.

The MHSA SLC consists of representatives of various stakeholder groups as listed below, including consumers, family members and underserved cultural communities.

Association of Mental Health Contract Agencies (AMHCA) Parents Helping Parents  
City of San Jose Housing Department San Jose City College  
Coalition for Justice & Accountability Santa Clara County Mental Health Department Staff  
Community Health Partnership Santa Clara County Department of Alcohol and Drug Services  
County Office of Consumer Affairs Santa Clara County Office of Affordable Housing  
ECCAC - African Heritage Santa Clara County Office of the Public Guardian  
ECCAC - African Immigrant Santa Clara County Pre-Trial Services  
ECCAC - Chinese Santa Clara County Probation Department  
ECCAC - Filipino Santa Clara County Public Defender’s Office  
ECCAC - Latino Santa Clara County Sheriff’s Department  
ECCAC - Native American Santa Clara County Social Services Agency  
ECCAC - Vietnamese Santa Clara County Superior Court  
Family Partnership Council Santa Clara County Mental Health Board Members  
First 5 Santa Clara County Santa Clara County Office of District Attorney  
Grace Baptist SCVHHS - Main Jail  
Immigrant & Refugee Forum Silicon Valley De-Bug  
Kids in Common Health Partnership Silicon Valley Council of Non-profits  
Mental Health Client Association of SJCC South East Consortium for Special Ed AH  
National Alliance on Mental Illness (NAMI) TAY Consumers  
Palo Alto Police Department Voices United

FY13-14 MHSA Annual Update Local Review Process

In July 2013, the MHD participated in various Mental Health Board (MHB) Committee meetings to provide progress updates of the various MHSA work plans and programs as well as share with the MHB Committees the MHD’s preliminary recommendations for the FY13-14 MHSA Annual Update Draft. The MHB of Santa Clara County is composed of members of the community at large, clients and family members of clients of the mental health system. The MHD solicited feedback and input from committee members at the meetings. Below is a list of the July 2013 MHB Committee meetings and the topics discussed at specific committees:
<table>
<thead>
<tr>
<th>MHB Committee</th>
<th>Topic</th>
<th>Meeting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Adult</td>
<td>MHSA Older Adult Programs</td>
<td>July 8, 2013</td>
</tr>
<tr>
<td>Family, Adolescent and Children’s</td>
<td>MHSA Family, Children and TAY Programs</td>
<td>July 11, 2013</td>
</tr>
<tr>
<td>System Planning and Fiscal</td>
<td>Overview of the County’s MHSA Plan Components</td>
<td>July 12, 2013</td>
</tr>
<tr>
<td>Minority Advisory</td>
<td>MHSA Consumer and Family Programs</td>
<td>July 16, 2013</td>
</tr>
<tr>
<td>Adult System of Care</td>
<td>MHSA Adult Programs</td>
<td>July 18, 2013</td>
</tr>
</tbody>
</table>

On July 29, 2013, the MHD held a MHSA SLC meeting, following the informal process described above, to present the MHD’s recommended plans for the FY13-14 MHSA Annual Update Draft. The meeting was held at the MHD Learning Partnership located at 1075 E. Santa Clara Street, San Jose, CA 95128, 2nd Floor, Training Room #4. Email notifications about the meeting were sent out to a broad network of contacts including SLC members, consumers and family members, consumer and advocacy organizations, contract provider and County agencies’ representatives, other human service and justice organization representatives, and other interested stakeholders. Meeting materials/handouts included a copy of the MHD’s preliminary working draft of the FY13-14 MHSA Annual Update Draft document and a summary of the recommended changes. The MHD also distributed comment forms at the meeting to obtain additional input/feedback regarding the MHD’s recommended plans.

The FY13-14 MHSA Annual Update Draft document was posted from August 2, 2013 through September 1, 2013, for the required 30 day public review/comment period, on the County’s MHD MHSA website [http://www.sccgov.org/sites/mhd/MHSA/Pages/default.aspx](http://www.sccgov.org/sites/mhd/MHSA/Pages/default.aspx). Email notifications about the posting of the MHSA Annual Update Draft document on the MHD MHSA website, along with all other MHSA-related information about the annual update process, were sent to the same broad network of contacts as previously described above. In addition, a comment form was available on the MHD MHSA website for individuals to use to provide their input on the MHSA Annual Update Draft plan.

During the public review period, the MHD did not receive any comment or input from the public and stakeholders. At the end of the 30 day period, the MHD held another MHSA SLC meeting on September 5, 2013 to request committee members’ endorsement of the FY13-14 MHSA Annual Update Draft. The meeting was held at 1555 Berger Drive, San Jose, CA 95112, Building #2, 1st Floor Auditorium, from 9:00 AM to 10:30 AM. At the meeting, the MHD also presented substantive changes made to the proposed FY13-14 MHSA Annual Update Draft that was circulated for 30 days for public review and comment. The changes are summarized in the next section below, Public Review/Comment. The vote reached consensus and the FY13-14 MHSA Annual Update Draft was endorsed by the MHSA SLC.

On September 9, 2013, the MHD held a Mental Health Board (MHB) Public Hearing on the FY13-14 MHSA Annual Update Draft. The public hearing was at the MHD Learning Partnership location, 2nd Floor, Training Room #3, from 10:45 AM to 11:45 AM. According to the MHSA, the MHB shall review and provide recommendations on the MHSA Annual Update Draft plan. At the MHB public hearing, a motion was taken to approve the proposed FY13-14 MHSA Annual Update Draft; the action passed unanimously. On October 22, 2013, the County Board of Supervisors (BOS) approved and adopted the FY13-14 MHSA Annual Update Draft as endorsed by the MHSA SLC and approved by the MHB. Within 30 days after BOS adoption, the MHD will submit a copy of the MHSA Annual Update document to the Mental Health Oversight and Accountability Commission (MHSOAC).

### Public Review/Comment

Substantive comments received during the stakeholder review and public hearing process, responses to those comments, and a description of any substantive changes made to the proposed annual update are summarized below:

The County’s MHD did not receive comments or input from stakeholders and public during the 30 day public review and comment period of the County’s MHSA Annual Update Draft from August 2, 2013 through September 1, 2013.
However, there are four proposed changes to the Annual Update Draft posted on August 2, 2013. The table below summarizes the changes and they are also incorporated in their appropriate section in this document (reflected in red font). Items one to three do not result in additional funding. However, item four will result in an increase; the amount is pending.

### Proposed Changes to Annual Update Draft Posted on August 2, 2013:

<table>
<thead>
<tr>
<th>#</th>
<th>Component and Work Plan</th>
<th>Project</th>
<th>Amount</th>
<th>Type</th>
<th>Proposal / Change Submitted:</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>CSS - A02</td>
<td>MHSA</td>
<td>Downtown Mental Health</td>
<td>$145,457</td>
<td>Ongoing</td>
<td>By MHD Staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The MHD proposes to add a new 1.0 FTE Health Care Program Manager (HCPM) II. The DTMH is in need of a HCPM II to manage daily clinic operations and oversee Specialty Mental Health services to some of the County’s most high risk and severely mentally ill consumers. The modes of service provided at DTMH include case management, medication support, mental health services, and crisis intervention. The annual cost of the new positions is $145,457 and will be fully funded through the deletion of a vacant 1.0 FTE Program Manager II currently budgeted in work plan A03 (see item #2 below).</td>
</tr>
<tr>
<td>(2)</td>
<td>CSS - A02</td>
<td>MHSA</td>
<td>Evans Lane</td>
<td>($145,457)</td>
<td>Ongoing</td>
<td>By MHD Staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The MHD proposes the deletion of a vacant 1.0 FTE Program Manager II to fund a new position proposed for DTMH. Please see item #1 for details. Presently there is a filled Health Care Program Manager II position at the Evans Lane Outpatient Clinic funded in part by both AB109 and MHSA funds. Given that Evans Lane Outpatient now has a manager in place there is no longer a need for the vacant Program Manager II position at the site.</td>
</tr>
<tr>
<td>(3)</td>
<td>CFTN - DTMH</td>
<td>Downtown Mental Health Renovation Project</td>
<td>$0</td>
<td>One-time</td>
<td>By MHD Staff</td>
<td>The DTMH renovation has a one-time budget allocation of $313,000. Currently the DTMH project only covers the Self-Help Center training area/activity rooms however there is current need to also renovate the lobby area of the facility. The MHD proposes to use the current $313,000 budget to expand the DTMH project to include the renovation of the DTMH’s main lobby. The renovated area will provide a welcoming, comfortable wellness center environment for the clinic, self-help consumers, and family members.</td>
</tr>
<tr>
<td>(4)</td>
<td>CSS / PEI / INN / WET / CFTN</td>
<td>Various work plans</td>
<td>Pending - To Be Determined (TBD)</td>
<td>One-time</td>
<td>Resulting from BOS Approval related to: 1) County Retiree Program and 2) Labor Contract Adjustments from Recent Contract Negotiations</td>
<td>Adjust the MHD budget for the impact of: 1) Increased contributions to the California Employers Retiree Benefit Trust (CERBT). 2) Salary and benefit adjustments based on contract negotiations with labor unions. Budget items resulting from Board of Supervisor (BOS) approval will be spread across the five components.</td>
</tr>
</tbody>
</table>

Total Items 1 - 4 Pending (TBD) Proposed Changes to the Annual Update Draft posted on 8/2/2013
## FY 2013/14
### MHSA Funding Summary

**County:** Santa Clara  
**Date:** 8/2/2013

<table>
<thead>
<tr>
<th>MHSA Funding</th>
<th>CSS</th>
<th>WET</th>
<th>CFTN</th>
<th>PEI</th>
<th>INN</th>
<th>Local Prudent Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Estimated FY 2013/14 Funding</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Estimated Unspent Funds from Prior Fiscal Years</td>
<td>$41,005,456</td>
<td>$2,995,795</td>
<td>$12,584,580</td>
<td>$17,928,446</td>
<td>$10,987,690</td>
<td></td>
</tr>
<tr>
<td>2. Estimated New FY 2013/14 Funding</td>
<td>$41,299,483</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Transfer in FY 2013/14</td>
<td>($1,121,937)</td>
<td>$1,121,937</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Access Local Prudent Reserve in FY 2013/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Estimated Available Funding for FY 2013/14</td>
<td>$81,183,002</td>
<td>$4,117,732</td>
<td>$12,584,580</td>
<td>$28,253,317</td>
<td>$13,704,761</td>
<td></td>
</tr>
<tr>
<td><strong>B. Estimated FY 2013/14 Expenditures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$43,896,818</td>
<td>$4,117,732</td>
<td>$8,030,316</td>
<td>$22,122,798</td>
<td>$4,817,007</td>
<td></td>
</tr>
<tr>
<td><strong>C. Estimated FY 2013/14 Contingency Funding</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$37,286,184</td>
<td>$0</td>
<td>$4,554,264</td>
<td>$6,130,519</td>
<td>$8,887,754</td>
<td></td>
</tr>
</tbody>
</table>

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

### D. Estimated Local Prudent Reserve Balance

<table>
<thead>
<tr>
<th>Estimated Local Prudent Reserve Balance</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Estimated Local Prudent Reserve Balance on June 30, 2013</td>
<td>$19,933,202</td>
</tr>
<tr>
<td>2. Contributions to the Local Prudent Reserve in FY 2013/14</td>
<td>$0</td>
</tr>
<tr>
<td>3. Distributions from Local Prudent Reserve in FY 2013/14</td>
<td>$0</td>
</tr>
<tr>
<td>4. Estimated Local Prudent Reserve Balance on June 30, 2014</td>
<td>$19,933,202</td>
</tr>
</tbody>
</table>