



MHSA Stakeholder Leadership Committee Innovation Meeting

FEBRUARY 10, 2016, 3:00PM-4:30PM
COUNTY OF SANTA CLARA SOCIAL SERVICES AGENCY
333 WEST JULIAN STREET, 1ST FLOOR
SAN JOSE, CA 95110

2/10/2016



SANTA CLARA COUNTY MENTAL HEALTH SERVICES ACT

MHSA Innovation Meeting Agenda

- I. Welcoming and Opening Comments
- II. Selection Process
- III. INN Project Development
- IV. Additional Areas of Need
- V. Objective
- VI. Comments/Questions



MHSA Innovation Meeting

Welcoming and Opening Comments



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Selection Process



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MHSA Innovation Meeting Selection Process

Priorities of the Behavioral Health Services Department (BHSD)

Reviewed INN Requirements*

Does the idea address one of the four primary purposes of INN?

Does the idea support one of the three innovative approaches of INN?

Is the idea consistent with MHSA general standards?

Does the proposed idea focus on mental health and mental illness?

**Welfare and Institutions Code (WIC) 5830: Innovative Programs; Title 9 California Code of Regulations (CCR) § 3910: Innovative Project General Requirements; and Title 9 CCR 3320: MHSA General Standards.*

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MHSA Innovation Meeting Selection Process

SCC Behavioral Health Guiding Principles

- Consumer and Family Member Involvement
- Culturally Responsive Approaches
- Life Span Focus (Across the Age Continuum)
- Innovative Care Practices
- Strategic Care Transitions (Between Levels of Care)
- Meaningful Outcomes

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Selection Process

Total of 16 ideas were submitted which addressed the following program areas:

- Criminal Justice / Juvenile Justice (2)
- Domestic Violence (1)
- Employment (3)
- Outreach Education and Training (3)
- Peer Support (2)
- Prevention and Early Intervention (PEI)-(2)
- Respite Services (1)
- Technology (2)



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INN Project Development



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MHSA Innovation Meeting INN Project Development

(1) INN Project Development: **Client and Consumer Employment**

- Reviewed submitted ideas received from Bill Wilson Center, Catholic Charities, and Momentum for Mental Health; considered concepts included in their submissions for one INN project regarding employment for clients and consumers
- **Target population:** TAY, Adults, and Older Adults
- **INN Purpose:** Increase the quality of services (employment), including measurable outcomes
- **INN Approach:** Makes a change to an existing mental health practice or approach, including but not limited to, adaption for a new setting or community
- **Test:** Individual Placement & Support Supported Employment (IPS/SE) model; although the model has shown to be an effective evidence-based practice (not new), it is BHSD's belief that the implementation of the model will help transform the culture of how the overall system views employment for clients/consumers which will be the innovative element of this project: employment adds to the well-being of clients/consumers

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INN Project Development

(2) INN Project Development: Outreach, Education, Training

- Considered idea submitted by Wesley Mukoyama, Behavioral Health Board (BHB) Member, to provide mental health educational training for Faith/Spiritual Leaders
- **Target population:** Across the age continuum, from children to older adults; especially in ethnically, diverse communities
- **INN Purpose:** Increase access to services
- **INN Approach:** Make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community
- **Test:** If customized behavioral health (BH) “101” training plan provided to Faith/Spiritual Leaders help them respond appropriately to individuals seeking their help and assist with linkage to County BH services thereby improving access to services for County residents

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INN Project Development

(3) INN Project Development: Peer Support and Prevention Services

- Considered ideas submitted by David DeTata of NAMI Santa Clara County (SCC) around TAY Peer Support and Evelyn Tirumalai-SCC Suicide Prevention Coordinator on Suicide Prevention
- **Target population:** TAY
- **INN Purpose:** Increase access to services
- **INN Approach:** Make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community
- **Test:** Psychiatric Emergency Response Team (PERT) model implemented by San Diego County; specifically target the Palo Alto area due to the history of suicide clusters occurring in the area and create TAY peer support post-crisis

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INN Project Development – Next Steps

- Immediate Action Plan: Hold focus group meeting in March 2016*:
 1. Client and Consumer Employment Project
 2. Faith Based Training Project
 3. Psychiatric Emergency Response Team (PERT)/Linkage Project
- *Meeting Dates/Times will be emailed to the MHSA Email Distribution Group and posted on www.sccmhd.org/mhsa; one focus group meeting per project
- BHSD will compile information from focus group meetings and finalize the three projects
- Consult/share initial draft of project concepts with the State-Mental Health Services Oversight & Accountability Commission (MHSOAC)

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INN Project Development – Next Steps *(continued 2 of 2)*

Utilize same local stakeholder process similar to the Annual Update process with one additional step:

- Hold SLC Meeting to present draft INN County Plan and announce 30-day public review and comment period;
- Post draft INN Plan for the required 30-day public review/comment period;
- Hold SLC Meeting to request SLC membership's endorsement of the County's draft INN Plan;
- Hold BHB Public Hearing on the County's draft INN Plan;
- Request County Board of Supervisors Approval of the County's draft INN Plan; and
- ***Request State-MHSOAC Approval; required before the County can expend INN funds (WIC 5830, CCR § 3905).***

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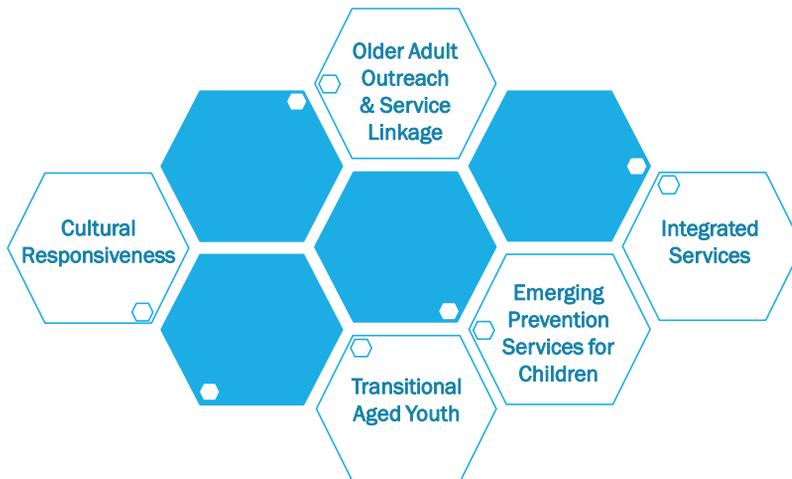
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Additional Areas of Need



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Additional Areas of Need



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Additional Areas of Need

- During BHSD's review of the submitted ideas it was determined there is a need for innovative approaches relating to the following program areas:
 1. Culturally responsive training practices for the County's diverse communities and cultures
 2. Outreach services, and linkage to behavioral health services for older adults
 3. Emerging prevention services for children
 4. Transitional aged youth supports and care transitions
 5. Integrated services: primary care and behavioral health
- Commence a 30-day window to solicit new ideas for items 1-4 as listed above from 2/17/2016 to 3/18/2016; fillable forms will be available on www.sccmhd.org/mhsa
- For item #5, BHSD will explore integrated services around primary care and behavioral health



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Ultimate Objective



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Comments and Questions



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MHSA Additional Information

- For additional questions about the planning process: please contact Jeanne Moral at 408-885-6867; jeanne.moral@hhs.sccgov.org
- MHSA Email Distribution List - If you are currently not part of the County's MHSA email distribution list and would like to be included please send email request to alexandra.weight@hhs.sccgov.org



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MHSA Stakeholder Leadership Committee (SLC) Meeting

February 10, 2016 Meeting – 3:00 PM to 4:30 PM – MHSA Innovation (INN)

County of Santa Clara Social Services Agency, 333 West Julian Street, 1st Floor,
San Jose, CA 95110

Additional Meeting Handouts

- **Listing of Submitted INN Ideas**
- **INN Requirement**
- **State-MHSOAC New Innovation Program Form**

Description of Submitted Ideas

SANTA CLARA COUNTY

BEHAVIORAL HEALTH SERVICES DEPARTMENT

Idea	Submitted By:	Summary of Submitted Ideas
#1	April Kihara, Mental Health Program Specialist II, F&C Division, SCC BHSD	<p>Issue: Mental Health Stigma in families and school children - This idea involves expanding a Reach Out and Read (ROR) model of book distribution to include older children and caregivers in pediatric clinics, including titles aimed at Mental Health Concerns, trauma symptoms and preventing trauma, helping children understand parental stress and depression, and dealing with feelings. Superb and effective mental health awareness books exist for all ages, but most titles are only utilized after a trauma or problem emerges. This would take a preventative approach in a natural setting where caregivers and families have access to trusted providers. It is naturally de-stigmatizing because it occurs in a setting where everyone has access and families are not targeted based on existing problems. With an expansion of the book distribution system at Valley Health Center pediatric clinics, which builds on an existing flourishing relationship between pediatricians and the MHSA Behavioral Health funded ROR program, children who come to see pediatricians at well or sick visits would receive a book.</p> <p>In the past, stigma has been so crippling that some families report not wanting to access anti-stigma material out of shame that they will be identified as having a mental health issue. My proposed Innovation project brokers a potential solution to this barrier by distributing the books to all families in a setting with an already trusted provider.</p> <p>Pediatricians have reported that families are more likely to follow up on a suggestion if it is made by a pediatrician, in comparison to other providers or outreach specialists. The hope would be that families would be more likely to actually read and consider the mental health promotion books if they are received and recommended by their pediatrician. Another potential barrier would be engaging doctors to participate. Luckily, we already have the aforementioned long term, flourishing relationship with Valley Health Center pediatric clinics, who distribute books to children ages 0-5 who come in for well baby and well child visits. The doctors have already expressed an interest in getting books to provide to older children to help increase their at home book library and to encourage reading.</p> <p>Proposed solution: This new approach would be to supply mental health promotion books on a universal prevention basis, and to gauge the effectiveness of reaching families and decreasing stigma. This idea involves expanding a Reach Out and Read (ROR) model of book distribution to include older children and caregivers in pediatric clinics, including titles aimed at Mental Health Concerns, trauma symptoms and preventing trauma, helping children understand parental stress and depression, and dealing with feelings. Superb and effective mental health awareness books exist for all ages, but most titles are only utilized after a trauma or problem emerges. This would take a preventative approach in a natural setting where caregivers and families have access to trusted providers. It is naturally de-stigmatizing because it occurs in a setting where everyone has access and families are not targeted based on existing problems. With an expansion of the book distribution system at Valley Health Center pediatric clinics, which builds on an existing flourishing relationship between pediatricians and the MHSA Behavioral Health funded ROR program, children who come to see pediatricians at well or sick visit.</p>

Idea	Submitted By:	Summary of Submitted Ideas
		<p>For the learning/evaluation: By offering two different titles of books at each age interval, we would be able to gauge the public interest in psychoeducation materials and books that educate children on mental health concerns, preventing trauma, etc. We could also do pre and post surveys to see if receiving a book increases awareness and decreases mental health concern stigma, as well as caregiver evaluation of the project.</p> <p>Target Population: Children/Youth</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Promote interagency and community collaboration • Increase access to services <p>Approach/Practice:</p> <p>Introduce new mental health practices or approaches, including, but not limited to, prevention and early intervention.</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Culturally Responsive Approaches • Meaningful Outcomes
#2	Wesley Kazuo Mukoyama, LCSW, SCC BHB Board Member	<p>Issue: When Santa Clara County consumer and family members are in behavioral health distress, more often than not, they first seek help from their faith/spiritual communities and faith leaders before going to public or private professionals. Unfortunately, many of these faith leaders don't have the skill sets or understanding about mental health and substance abuse issues to respond appropriately and perhaps shy away discussing suicide issues. We would like to utilize our 1) ECCAC Ethnic Cultural Community Advisory Committee; 2) our ethnic contractual agency groups; our 3) Faith Collaborative Partners 4) NAMI National Alliance for the Mentally Ill and 5) the LGBTQ community to collaborate and receive the support they need to be cultural brokers so they can serve as community liaisons and engage their faith communities to set up trusting relationships. We would offer Behavioral Health "101" trainings through outreach to the Faith/Spiritual leaders who have been designated leadership roles in their faith/spiritual communities. We would include ethnically diverse consumers and family members representing our all age groups to share their stories to support their leaders to better understand what the major mental health challenges are that face their</p>

Idea	Submitted By:	Summary of Submitted Ideas
		<p>respective communities. For example, because PTSD Post Traumatic Stress Disorder is prevalent in immigrant and refugee communities from war torn countries, we would spend more time discussing the signs and symptoms of PTSD and how it is manifested in their respective communities and how it can be treated. In addition, for all groups we would educate them about the signs and symptoms of Schizophrenia, as well as other SMI disorders and Substance Abuse, dispelling myths and stereotypes, highlighting culturally responsive practices to support recovery. In tum, we would organize focus groups with F S leaders and BH providers to discuss spirituality in assisting consumers/families.</p> <p>There are many misconceptions about the role Behavioral Health staff plays in support of consumers who identify and indicate a desire to have their faith included in their treatment plans. Many believe that the subject of faith must be avoided due to the concerns of the First Amendment: Separation of Church and State. By following guidelines and principles in training sessions for faith leaders that ensure staff will not impose their own beliefs or proselytize, much support can be offered. See attached paper written by San Mateo County.</p> <p>Proposed solution: We want to build an educational training for faith leaders that will give them tools, skills and resource options to better serve those of their communities who suffer from mental health and/or substance issues. At the same time they will understand their boundaries in not providing professional treatment without the necessary credentials to practice, but be informed to make appropriate referrals. This would also help in reducing the stigma and discrimination often associated with behavioral health clients. Learning would include how to assist those individuals who may be contemplating suicide to get the help and counseling necessary for suicide prevention and assistance with substance abuse. Faith/Spiritual leaders could also be an Advisory group to the Behavioral Health Coordinator/Department to provide feedback about Behavioral Health issues and teach the role of Spirituality in recovery to BH professionals, consumers and families.</p> <p>Orange County has a Faith Based Training for Faith/Spiritual Leaders Innovation grant started in 2014, but it is our belief that no other California County has used this culturally responsive and two way approach that crosses all age groups and ethnicities and builds upon the strength of existing groups as the ECCAC Ethnic Cultural Community Advisory Committee, the Faith Collaborative Partners, the Ethnic Contract agencies, NAMI and the LGBTQ community as participants to reach out to the faith/spiritual community in Santa Clara County. And, there is no other proposal that also will utilize the faith/spiritual community to provide feedback and teach practicing mental health professionals the role of faith/spirituality in recovery.</p> <p>For the learning/evaluation: We would hold focus groups and administer a pre-test to gauge the understanding of Faith/Spiritual leaders and community groups in regards to mental health and substance issues. We would work with a Seriously Mentally Ill SMI Consultant to create a customized Behavioral Health "101" Training Plan to meet the needs determined by the pre-test. After the trainings are completed, we will offer a post-test to gauge their acquired understanding and conduct a focus group to</p>

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		<p>measure the effectiveness of the approach. In addition, stories and case studies could be presented to the Faith/Spiritual Advisory group. Feedback from the Advisory Group could lead to measured outcomes to test the effectiveness of penetrating target groups.</p> <p>Target Population: Across the Age Continuum</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Promote interagency and community collaboration • Increase the quality of services, including measurable outcomes • Increase access to services <p>Approach/Practice:</p> <p>Make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.</p> <p>Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Culturally Responsive Approaches • Life Span Focus (Across the Age Continuum) • Innovative Care Practices • Meaningful Outcomes
#3	Anupam Khandelwa, SageSurfer Company	<p>Issue: Current mental health care coordination models face the following issues:</p> <ol style="list-style-type: none"> 1. Implementations are time and labour intensive. Caseloads, fidelity and staffing costs are major obstacles. 2. Care Coordinators do not have enough face to face time with the consumer. 3. Care Coordinators are struggling in the face of client's missed appointments. 4. Consumer family and friends do not know how and/or when to help 5. Wondering how to track analytics for reporting - are things working ?

Idea	Submitted By:	Summary of Submitted Ideas
		<p>Overall, consumers, families, physicians, behavioural health providers, community organizations, and social workers often find it difficult to collaborate and engage in the coordination or care for patients and recipients.</p> <p>Learning Goal: developing collaborative relationships and providing immediate access to information and team based processes that support best practices for mental health care.</p> <p>The main reasons are the following :</p> <ol style="list-style-type: none"> 1. Disparate agencies not working together or unable to efficiently collaborate. 2. Lack of training 3. Lack of facilitated processes 4. Lack of infrastructure - software automation and collaboration to support facilitated processes. <p>Proposed Solution: The County should pilot the Collaborative Care Connection platform to support mental health care coordination. The Platform can be customized for the county and the facilitated processes. Powerpoint attached (Attachment 1)</p> <p>The idea and the Collaborative Care Connection platform have been implemented in Loudoun County, VA. The attached document (Attachment 2) describes the main goals of the project. Department Contact Information, Joe Wilson, Director, MHSADS 906 Trailview Blvd. SE, Suite C, Mailstop #77 Leesburg, VA 20175</p> <p>For the learning/evaluation:</p> <ol style="list-style-type: none"> 1. Effectiveness of Care Coordination Teams 2. Performance Measures (see attached [Attachment 2]) <p>Target Population: Across the Age Continuum</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Promote interagency and community collaboration • Increase the quality of services, including measurable outcomes • Increase access to services

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		<p>Approach/Practice:</p> <ul style="list-style-type: none"> • Make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community. • Introduce a new application to the mental health system a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Innovative Care Practices • Strategic Care Transitions (Between Levels of Care) • Meaningful Outcomes
#4	Beth Johns, Program Manager - Employment Services, Momentum	<p>Issue: Advancing recovery for mental health consumers is a current focus of the Santa Clara County Behavioral Health Services. Having a job contributes to a person's overall sense of well-being and can be a significant contributor toward achieving and maintaining recovery from mental illness. Multiple studies have indicated that an average 2/3 of people with mental illness want to go to work, yet only 10% are employed. Until the development of the Individual Placement & Support Supported Employment (IPS/SE) model, there were no alternatives to the traditional delivery of employment supports specifically targeted for people with serious mental illness. This model is a widely-researched evidence-based practice developed to significantly increase employment outcomes. These improved outcomes have been demonstrated in community-based mental health programs across the country and in the international community utilizing a service structure similar to we currently have here in Santa Clara County.</p> <p>Since 1992, SCCMH has contracted with Department of Rehabilitation (DOR) to provide employment services utilizing providers Momentum for Mental Health and Catholic Charities, as part of a Mental Health Cooperative. The SCCMH/DOR Cooperative is the only County-funded employment program for persons with mental illness. Services funded by the DOR cooperative are based on a model of service provision structured to fit the general disability population and includes requirements that are contrary to what has been proven to be most effective for the SMI population. Locally, DOR has developed their own criteria for eligibility that screens out many SMI clients who would like to go to work and who have the ability to succeed if given the right kind of supports. As of 7/1/15, DOR has cut the Cooperative contract by 50%. Under the reduced DOR contract, the providers will only be authorized to serve 130 new consumers per year. The current MediCal funding structure restricts the type of employment</p>

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		<p>services that can be reimbursed. Employment services has historically not been a priority for the county. Implementation of an evidence-based practice requires rigorous adherence to fidelity which is challenging when attempted on a system-wide scale.</p> <p>Proposed Solution: The Individual Placement & Support / Supported Employment (IPS/SE) model of providing employment services to people with mental illness is a rigorously-tested SAMHSA evidence-based practice. Key components of the model include: 1) Zero exclusion (everyone who wants to work is eligible) 2) Employment services are integrated with mental health treatment services. 4) Competitive employment is the goal. 5) Personalized benefits counseling is provided. 6) The job search starts soon after a person expresses interest in working. 7) Employment specialists systematically develop relationships with employers based upon their client's preferences. 8) Job supports are continuous. 9) Client preferences are honored. On a pilot basis, IPS/SE can be tested at a single clinic site, allowing for full integration with the mental health team and development of the partnerships needed to ensure success.</p> <p>In 2012, the Alameda County Behavioral Health Care Services Vocational Program, in collaboration with Johnson & Johnson - Dartmouth IPS Learning Collaborative, developed a pilot program to implement the Individual Placement & Support / Supported Employment model for mental health consumers in Alameda County. The program is in its third year and has expanded to include two other service sites within the county. IPS/SE for persons with mental illness has successfully been implemented in 17 states and 3 European countries. 22 randomized studies have been conducted comparing IPS with traditional employment services. IPS participants were substantially higher in all outcomes listed below. 88 sites are participating in the Dartmouth Learning Collaborative with a goal of achieving high fidelity adherence to the IPS model. In 2013, 11,000 consumers were served; 40% obtained employment. Long-term studies show that 49% of IPS consumers maintained employment, compared to 11% receiving traditional services.</p> <p>For the learning/evaluation: Positively impacting the number of people in the county system who are currently unemployed.</p> <ul style="list-style-type: none"> -% of program participants who obtain employment -# of days to first job -Average number of hours worked per week -Total hours worked during the year -Total earnings during the year -Total months employed <p>Target Population: Transitional Aged Youth, Adult, and Older Adult</p>

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		<p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Promote interagency and community collaboration • Increase the quality of services, including measurable outcomes • Increase access to services <p>Approach/Practice:</p> <p>Make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.</p> <p>SCC’s Guiding Principle(s):</p> <ul style="list-style-type: none"> • Innovative Care Practices • Strategic Care Transitions (Between Levels of Care) • Meaningful Outcomes
#5	<p>Gabby Olivarez, A/OA Division Director, SCC BHSD; Honorable Stephen V. Manley, SCC Superior Court</p>	<p>Issue: The community conservatorship concept would target adults (ages 18-59), older adults (ages 60 and older) and criminal justice involved individuals with numerous psychiatric emergency room visits and hospitalizations who are unwilling/unable to engage in treatment resulting in significant deterioration to their overall health. These individuals are typically extremely ill, paranoid, a potential danger to self and others, and/or insight-impaired to be aware of their illness(es); past or current trauma; and/or the stigma associated with mental health impacts their inability to engage in treatment services. This innovative idea cultivates a recovery model that reduces the impact of mental illness and mandates intensive outpatient services for individuals at risk for suicide; incarceration; and emergency and psychiatric inpatient over-use. This model promotes innovative care practices; develops strategic care transitions; consumer and family involvement; has a life span focus; and utilizes culturally responsive approaches.</p> <p>This idea seeks to offer voluntary conservatorship as an assisted support during community transition by identifying and engaging people who meet LPS criteria while in an acute inpatient or sub-acute facilities. Upon discharge from an acute hospital or sub-acute facility, the person conserved will be enrolled in a Full Service Partnership program and will have access to additional services. The consumer will also be offered the opportunity to engage a family or other key support staff to serve as co-conservator in partnership with the Conservator's Office.</p>

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		<p>There hasn't been implementation of a community conservatorship program court ordered intensive outpatient services was not in place. As such, individuals were not authorized to obtain court-ordered intensive outpatient services. Since there was no mechanism in place to assist individuals with linkages to outpatient mental health treatment, seriously mentally ill individuals would not engage in treatment and/or could refuse treatment even though Providers would offer mental health services. However, these individuals are in need of assisted outpatient treatment services in order to prevent a relapse or deterioration that would likely result in grave disability or serious harm to self or others. Oftentimes, these individuals abuse emergency psychiatric services and are frequently discharged without linkages or access to Mental Health and/or Substance Abuse Services.</p> <p>Proposed Solution: The project intends to provide assisted court-ordered intensive outpatient treatment to individuals with recent histories of recurrent psychiatric emergency room visits and acute inpatient hospitalizations whose mental health condition have significantly deteriorated and are unwilling/unable to engage in voluntary services to support their recovery. Consumers who are conserved under the community conservatorship program shall be enrolled in a Full Service Partnership Program upon discharge from an acute or sub-acute facility and will have access to additional services as necessary that includes peer support services.</p> <p>This practice has been implemented in both San Francisco and San Mateo Counties.</p> <p>For the learning/evaluation: The following are measures/outcomes that that are recommended be used to analyze the effectiveness of this new idea:</p> <ol style="list-style-type: none"> 1. Did individuals who participated in the assisted outpatient treatment (AOT) program decrease the over-utilization of emergency psychiatric services and/or acute inpatient hospitalizations? 2. Is the AOT program improving consumer/family involvement and increasing the network community support services? 3. Reduction in incarcerations and /or elimination of involvement with the criminal justice system. 4. Improved coordination and access to medication evaluations and psychiatric and substance abuse services. <p>Target Population: Adult and Older Adult</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase the quality of services, including measurable outcomes • Increase access to services

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		<p>Approach/Practice:</p> <p>Make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Culturally Responsive Approaches • Life Span Focus (Across the Age Continuum) • Innovative Care Practices • Strategic Care Transitions (Between Levels of Care) • Meaningful Outcomes
#6	David DeTata, NAMI Peer Pals Coordinator, NAMI SCC	<p>Issue: YES! Youth Empowerment and Support seeks to combat the isolation and stigmatization of high school and college aged young people with a mental health diagnosis. By training student peers as youth leaders (who may or may not have a mental illness themselves) to be mentors and friends, young people with a mental health diagnosis would have greater socialization and support. The youth leaders themselves would become more knowledgeable and empathetic as they undergo intensive training on diagnoses, recovery, and coping skills; QPR suicide prevention; and learn about lower stress curriculum and career opportunities. Our vision would be that youth leaders would quality for community service hours in high school or internship hours at the college level.</p> <p>Clinical language has clearly been a barrier--with labels like "bipolar" and "anorexic" and "schizophrenic" only making young people feel different and alone. In this program, the youth with diagnoses will be called youth heroes for the courage and tenacity they exhibit in confronting their illnesses. Youth heroes who complete a pairing with a youth leader will have the option of becoming a youth leader themselves, only they would be called ambassadors as they spread the word that hope and healing are possible.</p> <p>Proposed Solution: In a word: friendship. It sounds so simple, but the power of relationship, especially for young people, should not be overlooked. An honest, caring relationship can combat all kinds of negative self-thought and provide invaluable support and inspiration. Also, by recognizing the individual as a person through the use of non-clinical, non-stigmatizing language in using ordinary language in describing their problems and symptoms, and in recognizing those struggling daily with their illness as true Youth Heroes.</p>

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		<p>As far as we know, a program like YES! Youth Empowerment and Support incorporating trained fellow students for peer support and companionship hasn't been done in the schools before, but there is documented evidence to show that peer-run programming is highly effective.</p> <p>For the learning/evaluation: The best outcome will be youth heroes who go on to become youth ambassadors. They can only benefit as they move from being care receivers to care givers themselves. But other outcomes will be extremely positive as well, most notably the large number of young people who will be educated about mental illnesses and the possibility for early diagnosis and intervention as young people become less afraid to admit they have a problem.</p> <p>Target Population: Transitional Aged Youth</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Promote interagency and community collaboration • Increase access to services <p>Approach/Practice:</p> <p>Introduce new mental health practices or approaches, including, but not limited to, prevention and early intervention.</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Innovative Care Practices • Meaningful Outcomes
#7	Eila Latif, Deputy Division Director - Economic Development Services, Catholic	<p>Issue: Employment brings stability as well as tools for managing life circumstances and symptoms. It also leads to systemic change. Individuals becoming self-reliant reduce the burden on our public Social and Mental Health services systems. Employment provides income necessary to live, a social structure, a means to develop self-worth, meaning, a sense of accomplishment, social assets. Employed individuals create abundance for themselves, their families and their communities. Santa Clara County has documented 8000 individuals' severe mental illness. The County Mental Health and Vocational Rehabilitation collaboration allows for a very limited number of individuals with mental illness to access employment Center. This project will pilot the introduction of Individual Placement and Support (IPS) employment model based on actual data gathered</p>

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	Charities of SCC	<p>from Dartmouth Psychiatry Research which has proved to be 61% successful Vs. 23% with the traditional Vocational Rehabilitation method, currently used in Santa Clara County.</p> <p>Department of Rehabilitation funded employment programs have been a stable but the sole option for individuals with serious mental illness seeking employment. This employment resource is not inclusive to all but a small number who make it through the state's lengthy process of eligibility. This may take up to 5 months before a consumer gets employment support. The IPS model resolves this lag for services and focuses on each person's strength and motivation.</p> <p>Proposed Solution: IPS supported employment helps people with severe mental illness work at regular jobs of their choosing. It is an evidenced-based practice with practitioners focus on each person's strengths. This model support that work is therapeutic and promotes recovery and wellness. IPS works in collaboration with state rehabilitation counselors and uses a multi-disciplinary team approach. Services are individualized and long lasting.</p> <p>Principles of IPS Supported employment: 1. Focus on Competitive Employment 2. Eligibility Based on Client Choice 3. Integration of Rehabilitation and Mental Health Services 4. Attention to Worker Preferences 5. Personalized Benefits Counseling 6. Rapid Job Search 7. Systematic Job Development 8. Time-Unlimited and Individualized Support.</p> <p>Alameda County Mental Health. Currently, ten states and the District of Columbia are working with the Dartmouth Psychiatric Research Center on supported employment for people with serious mental illness. Each state has multiple supported employment programs and reports program outcomes on a regular basis. At any given time, about 50% of the people in those supported employment programs have competitive jobs.</p> <p>For the learning/evaluation: The efficiency and length of time it takes for individual placement vs. traditional VR services. 2. The number of people placed to jobs and the length of time it requires to secure their employment.</p> <p>Target Population: Transitional Aged Youth, Adult, and Older Adult</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Promote interagency and community collaboration • Increase the quality of services, including measurable outcomes • Increase access to services

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		<p>Approach/Practice:</p> <p>Make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Culturally Responsive Approaches • Life Span Focus (Across the Age Continuum) • Innovative Care Practices • Strategic Care Transitions (Between Levels of Care) • Meaningful Outcomes
#8	April Kihara, Mental Health Program Specialist II, F&C Division, SCC BHSD	<p>Issue: The issue is that some extremely poor and unserved/underserved children and families live in relatively well-off neighborhoods in Santa Clara County. In some cases, the children are being bused to schools in nicer areas, and then are not eligible for our school based programs in high risk areas. In other cases, the families may live in a low income housing complex that happens to be in a more affluent neighborhood, but they have very limited resources and are suffering from a myriad of problems.</p> <p>Another problem is that some people can't afford their copays, despite having health care coverage.</p> <p>My learning goal is to see if there is a way to outreach to these families and get them the prevention and early intervention services they would significantly benefit from. Instead of waiting until their child has a severe problem, they could be captured on the precipice with strategic outreach.</p> <p>In the past, the strategy has been to identify high risk areas and blanket them with services. It has not been economical to seek out especially needy families in other non HRAs for prevention and early intervention services. If the child has Medi-Cal and seeks help, they would then be served, but there isn't a preventative approach or the same kind of outreach that families in identified HRA schools receive.</p> <p>Proposed Solution: It would be great if the County could create an Innovation mini grant program, similar to other counties that would provide funds to agencies to outreach to the aforementioned families. This could even be accomplished using schools as a natural access point.</p>

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		<p>For the learning/evaluation: I think we could measure the outcomes of the program by doing pre and post assessments with the families identified. We could also do qualitative data collection with focus groups or a survey to see how likely the families would have been to receive preventative services if not outreached to.</p> <p>Target Population: Children/Youth</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Increase access to services <p>Approach/Practice:</p> <p>Introduce new mental health practices or approaches, including, but not limited to, prevention and early intervention.</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Culturally Responsive Approaches • Meaningful Outcomes
#9	Jo Caffaro, Regional Vice President, Hospital Council of Northern and Central California	<p>Issue:</p> <p>Idea: Web-based Bed Board for Mental Health Treatment.</p> <p>Persons suffering a mental health crises are in need of timely access to treatment services. A community-wide “bed board” would provide hospitals and other providers with real-time bed availability to expedite referrals, a valuable tool to reduce wait times for those in crisis, increase access to services & maximize the sure of available resources in our community.</p> <p>This cooperative program could build bridges between organizations caring for persons with mental illness in our community.</p> <p>Proposed Solution: The Bed Board would be a real-time web-based application. Facilities would use the tool to do simple real-time data updates as bed becomes available, and hospitals and other providers would use the tool to more quickly identify appropriate mental health treatment beds and make referrals.</p>

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		<p>The goal would be to reduce wait times for person in crisis, increase access to services, and maximize the use of available resources in our community.</p> <p>Other entities have successfully implemented Bed Boards, including Vermont (Department of Mental Health), North Carolina (Department of of Health and Human Services), and Virginia (Department of Behavioral Health and Development Services).</p> <p>For the learning/evaluation: The pilot program could</p> <ul style="list-style-type: none"> • Promote interagency and community collaboration • Expedite the referral process • Improve timely access to appropriate services for persons in crisis <p>Target Population: Adult and Older Adult</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Promote interagency and community collaboration • Increase access to services <p>Approach/Practice:</p> <p>Introduce a new application to the mental health system a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Strategic Care Transitions (Between Levels of Care)
#10	Jo Caffaro, Regional Vice President, Hospital Council of Northern and Central California	<p>Issue: Idea: Behavioral Health Respite Program</p> <p>Persons suffering from mental illness and homelessness (or lack of a stable home environment) often remain in a hospital inpatient unit longer than necessary rather than being discharged to a less restrictive environment due to limited placement options in our community. A respite program with housing, food, transportation to a hospital’s partial hospitalization program, family involvement, and intensive case management could prove to be a viable alternative for persons actively engage in their</p>

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		<p>treatment and needing short term structure care to achieve meaningful outcomes and avoid crises in the future. “No Wrong Door” approach – a person eligible for respite program would not be turned away because of payer source or lack of insurance.</p> <p>Communities throughout California are faced with limited placement options for person suffering from mental illness and homelessness.</p> <p>Proposed Solution: Behavioral Health Respite Program – Three hospitals (El Camino, Good Samaritan, and Stanford Health Care) have expressed interest in exploring a possible partnership with the County and a community-based nonprofit organization to pilot a 15 bed respite program. The program’s cost would be shared by the hospitals and the County. Participants in the respite program would have a clean and safe bed in the community (motels), healthy meals, and transportation to the referring hospital’s partial hospitalization program, for up to 90 days. Participants would receive intensive case management and wrap-around services with a focus on family involvement, support services (benefit enrollment, support networks, housing, and homeless services), and a solid aftercare plan (follow-up appointments, medication information, outpatient programs, strategies to help the person avoid crises in the future). In recognition of the Community Plan to End Homelessness in Santa Clara County, the goal would be to identify stable housing or permanent supportive housing for these individuals.</p> <p>The Santa Clara County Medical Respite Program is a successful collaborative partnership between the Hospital County and seven participating hospitals, the County’s Valley Homeless Healthcare Program, and a local shelter provider. The planning for the MRP was coordinated by the Hospital Council during a county-wide initiative to end homelessness that was initiated by Supervisor Don Gage and San Jose Mayor Chuck Reed. The program services homeless adults with acute medical conditions who are medically stable, independent in activities of daily living, and able to care for themselves. The program provides a clean, safe and healthy living environment for patients to continue their recuperation and linkages to needed support services (benefit enrollment, employment assistance, and housing and homeless services) to achieve better health outcomes and sable housing. The Behavioral Health Respite Program could be a similar partnership, but on a much smaller scale.</p> <p>For the learning/evaluation: Possible measurements could include:</p> <ul style="list-style-type: none"> • Successful transition from partial hospitalization program to coordinated outpatient treatment and support services • Stable housing • Reduction in future crises • Reduction in emergency department utilization <p>Target Population: Adult and Older Adult</p>

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		<p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Promote interagency and community collaboration • Increase the quality of services, including measurable outcomes • Increase access to services <p>Approach/Practice:</p> <p>Introduce a new application to the mental health system a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Strategic Care Transitions (Between Levels of Care) • Meaningful Outcomes
#11	Lorraine Zeller, Mental Health Peer Support Worker, SCC BHSD Consumer Affairs	<p>Issue: Hopelessness, “learned helplessness” and lack of meaningful activities are common challenges that most individuals living in licensed or unlicensed board and care homes share. Additionally, residents lack knowledge and understanding of the potential for recovery as well as their housing rights. For many residents, the board and care environment is the "end of the road" and many settle to live in environments that don’t promote wellness and recovery or a healthy life style. Some of the homeless population have stated that they prefer to live in the streets rather than continuing to stay in their board and care home while others who remain are stagnant in their recovery for decades. The issue is now a top priority for the department’s Behavioral Health Board, administration, family members, providers, and the consumers who live in these conditions.</p> <p>LEARNING GOAL: The main learning goal of this program is to use intensive peer support services to improve the health and quality of life for residents, promote hope, self-advocacy, readiness for independent living, and decrease the learned helplessness of residents. Another learning goal for this program is to successfully build a collaboration between peer support providers, board and care operators, and other behavioral health providers.</p>

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		<p>What has prevented solutions from solving the issue:</p> <ol style="list-style-type: none"> 1) The traditional perspective of the "medical" model of care does not support the possibility of recovery. As a result there has been a minimal funding and expressed interest to improve the quality of life for board and care residents and the promotion of recovery oriented services. 2) The business model for some of the board and care operators prioritizes "meeting the bottom line" rather than the promoting the care of the residents. 3) Residents who may have lost their sense of hope and motivation to accept recovery-oriented services could present another barrier. <p>Proposed Solution: To have peer support specialists provide outreach, support, education, and advocacy to improve the health, welfare, quality of life, and recovery of people living in board and care homes. Outreach will take place in board and care residences as well as hospitals, IMDs, and crisis residential sites where mental health consumers will be transitioning from a higher level of care to living in board and care. Transitional support will include peer counseling, education, and encouragement to become involved in the larger community. Resources to be provided include: self-help centers, NAMI, spiritual support, and other community programs. Peer support specialists will provide WRAP groups on-site or at near-by locations, residents' rights workshops (open to everyone), teach independent living skills, and teach self-advocacy skills such as setting appropriate boundaries, communication skills, and how to develop resident councils. These peer support specialists will work closely with the 24 Hour Care program, Office of Supportive Housing, and the Community Living Coalition to ensure that services are coordinated.</p> <p>For the learning/evaluation: We plan to have a test group and a control group measuring rates of re-hospitalization. We hope to see a decrease in re-hospitalization rates for those provided peer support services. We also plan to administer satisfaction surveys and to measure outcomes regarding independent living skills. We will research existing survey instruments from the fields of psychiatric rehabilitation, occupational therapy, or other resources.</p> <p>Target Population: Adult</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Promote interagency and community collaboration • Increase the quality of services, including measurable outcomes • Increase access to services

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		<p>Approach/Practice:</p> <p>Introduce new mental health practices or approaches, including, but not limited to, prevention and early intervention.</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Innovative Care Practices • Strategic Care Transitions (Between Levels of Care) • Meaningful Outcomes
#12	Héctor Sánchez-Flores, Executive Director, National Latino Father and Family Institute, National Compadres Network	<p>Issue: People of color, especially the children and youth of Latino families in Santa Clara County continue to be disproportionately impacted by the effects of poverty, drugs, alcohol, and violence. While these conditions manifest themselves in many ways, mental health is a common and expensive problem. According to the Mental Health Care in California; Painting a Picture, 2013 Report, the prevalence of serious mental illness among children varied by income, with much higher rates of mental illness at lower income levels. The report also noted significant racial and ethnic disparities for the incidence of serious mental illness among adults: Communities of Color experienced the highest rates. About half of adults and two-thirds of adolescents with mental health needs don't get treatment. According to the Santa Clara County Suicide Prevention Advisory Committee 2008 Report, fewer than 30% seeking MHD services are actually treated. The same report noted that an estimated 51,144 students (20%) have mental health needs. Despite growing evidence of ineffectiveness, community-based organizations and local institutions have continued to provide services based on an individualistic, and symptom-based understanding of mental health and healing. Recent researches such as Foxen (2015) note that Latino youth need involvement from parents, cultural values and inter-connection with their extended families. In A Brown Paper; Lifting Latinos up by their Root-straps (2012), NCN argues that programs need to "develop pathways to health and well-being for Latino and Native males through culturally grounded and responsive physical, emotional, mental and spiritual development". (Executive Summary attached) Changing the existing approach requires training, ongoing technical assistance and support at all levels of service delivery. Our primary learning goal is to implement and assess the effectiveness of such a technical assistance program.</p> <p>Santa Clara County traditional intervention programs tend to have symptom-based one-dimensional approaches and individualistic structures that do not address the root causes of mental disorders. Existing practices and models lack the necessary cultural competency needed to build strong connections and buy in from clients. Organizations many times lack bilingual and bicultural staff that represents the community they are servicing. Organizations and institutions have worked in silos applying different models of service that tend to isolate families and continue to disconnect them from their own internal and external resources, their communities and their sacredness. The focus has been on "fixing" symptoms rather than helping</p>

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		<p>people rediscover their place and purpose. Primarily because of a unifying conceptual model, there is a lack of cross-agency communication and increasing disconnection from a continuum of services and neglecting the need to build a web of community for the individuals and families receiving services.</p> <p>Proposed Solution: The National Compadres Network, a national training and capacity building institute, believes that county wide supporting systems, local organizations, and institutions are in place to heal people and communities, that they have a curative function—to guide individuals and families that have become disconnected. This work can be better supported with the building of a countywide network of healing informed providers and stakeholders. This Network can provide the means of support and accountability to ensure collaboration, provide continued capacity building & technical assistance, and design & maintain the documentation and assessment systems to monitor the progress and consistent quality improvement needs. The La Cultura Cura Network approach will focus on the transformation of the community from one in which people seeking mental health services are marginalized and under-served into one that in which they are actively engaged, connected and self-sustaining. Working toward the development of local community defined practices; another expected outcome is increased collaboration between participating entities. Through this outcome of network building NCN will work with local service providers and institutions to identify key community workers that will participate in La Cultura Cura philosophy and curriculum trainings. (See attachment LCC Overview Services and Curriculums).</p> <p>NCN has been providing LCC training and technical assistance since 1987. In that time, we have provided services to a wide spectrum of organizations. Between 2012 and 2014, NCN implemented a training and technical assistance program for the Family Strengthening Innovation Project in Merced County. The goal of the program was to develop a culturally competent model through which Mental Health staff could help families tap into and develop community-based interventions. As part of this work, NCN led in an assessment and work-plan development for five communities in the county. The work-plan included training in the LCC model for staff involved in the implementation of the program. This included staff from the Mental Health and Probation Departments. Through NCN guidance, a cadre of community “partners” were hired and trained to serve as liaisons/advocates that delivered the services identified in the work-plan. Outcomes from this project included successful implementation of LCC Curriculums at various locations, the development and implementation of an ongoing community assessment, and the Merced County Probation Department requesting LCC technical assistance for their staff.</p> <p>For the learning/evaluation: The project goal is to introduce and implement La Cultural Cura principles, as an innovative, culturally competent and effective model for meeting the mental health needs of Santa Clara County residents. This entails LCC overview training for personnel of participating organization, instruction in specific LCC curricula, as well as ongoing technical assistance and support. Primary outcomes would therefore include an assessment of the training and technical assistance. NCN is very interested in program fidelity as well as issues that arise in the application of principles. Assessing relevant objectives and</p>

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		<p>indicators would include interviews, focus groups or self-reports from participating staff and management. Secondly, the project seeks to create a more interactive health-care delivery system; we would therefore pay attention to indicators of inter-agency communication and collaboration. Finally, NCN would also provide training and support in culture-based evaluation to help organizations assess the effectiveness of their LCC based services. We would collaborate with organizational partners, relevant stakeholders and external evaluators in the data collection and assessment of client outcomes. This includes an assessment of variables such client satisfaction, access and utilization of care. As part of learning and evaluation, we would also collaborate with partners in the development of system to assess specific behavior and attitude changes. This would levels of stress, indicators of anxiety, depression and other similar conditions.</p> <p>Target Population: Children/Youth, Transitional Aged Youth and Adult</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Promote interagency and community collaboration <p>Approach/Practice:</p> <p>Introduce a new application to the mental health system a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Culturally Responsive Approaches • Innovative Care Practices • Meaningful Outcomes
#13	Kathy Martinez, Deputy Chief, SCC Juvenile Probation Dept	<p>Issue: Youth who have experienced maltreatment are more likely to become involved in the Juvenile Justice System. Dually Involved Youth (DIY) is defined as a youth who has either past experiences of abuse or neglect, or who has current involvement with DFCS and who are engaging in delinquent activity. Recent research on youth that touch both the child welfare and the juvenile justice system demonstrate that these “dually-involved” youth have worse outcomes than youth served only in one system. In addition, this population has higher rates of recidivism, greater dependence on service systems such as public welfare, and diminished opportunities for gainful employment. Once a youth becomes “dually involved,” their chances for successful life outcomes plummet. This population represents some of society’s most vulnerable youth and SCC’s DIY unit is one of the most exciting and progressive innovations nationally to address the unique needs presented by these families. With expert technical</p>

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		<p>assistance, true community and consumer inclusion and full stakeholder participation, SCC has launched a truly promising program. At this stage of evolution, expansion is required due to the economy of scale and the unfairness of only serving a fraction of our families with this integrated approach. With a lengthy waiting list and early successes in the unit, expansion will allow SCC to fully test and evaluate this integrated approach to improve the outcomes of the systems most vulnerable youth and families. The following staff are necessary for successful expansion: One Program Manager (PM) to oversee the unit, maintain momentum, expand our local DIY Initiative, facilitate the leadership and provider meetings, develop and refine the units policy and protocols and lead us to sustainability; One additional Peer Youth Advocate to prepare youth and their families for participation in Youth Family Team Meetings, explain Court processes and assists the youth in identifying their strengths and needs and having their voice heard; and two new DFCS Social Workers who will team with two reallocated PO's and bring the unit to four teams to serve waiting families.</p> <p>In July 2014, two (2) JPD Dually-Involved Youth Probation Officers were assigned to the Departments Family Preservation Unit with two (2) additional positions forthcoming. These two current positions are housed at the DFCS's Family Resource Center and carry caseloads with a maximum of 24 dually involved youth combined at any given time. Those 24 families are case managed by the two teams of a Social Worker and Probation Officers. Since inception, these case management teams (SW, Probation, Peer Advocate & MH) continue to meet regularly to refine policy and procedures associated with the Unit with the best interest of the youth and families in the forefront. The Initiative and Leadership teams lack capacity and bandwidth to attend to the development and refinement of policies to expand this successful model and to continue with policy and practice research. County Agencies and a myriad of community and systems stakeholders have invested significant time in launching a successful dually involved youth practice model through eighteen months of technical assistance (competitively granted) from the MacArthur Foundation. The County Initiative has taken what they learned and would like to continue evolving it to create a local practice model that can be replicated nationally. Currently the demand for this unit is significantly more than the current capacity of the unit. This funding would allow us to double our existing capacity to a total of 48 families served concurrently.</p> <p>Proposed Solution: The County's Dually Involved Youth (DIY) Initiative is a new coordinated systems approach where Social Workers, Probation Officers and Peer Advocates are co-located and teamed for a united case management approach with youth and families. In the past, coordinated efforts have been tested, however, due to issues related to changes in staff as youth move through the system and fundamental differences in long ingrained departmental cultures, these methods have proven unsuccessful. This model has high potential for success with a unique, partnered approach with a fully integrated, culturally responsive cross systems team providing intensive services for youth and their families. Primary goals are: seamless service delivery for families, for youth to not escalate in either system and to exit DFCS and Probation systems successfully. With added components of a Project Director, two additional Social Workers and an additional Peer Youth Advocate, the Initiative has a great potential for long term success. This Initiative is an opportunity to test a new model that can be replicated within the state and</p>

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		<p>nationally. The uniqueness of an integrated model is an opportunity to develop a systems approach that is responsive to the individualistic needs of dual systems youth in the least restrictive environments. Youth are able to stay connected to positive caring adults and their own community. The partnerships with Mental Health, DFCS and Probation also contribute to achieving the same goal of having youth exit the systems with lasting linkages to their communities. A sophisticated and comprehensive evaluation process is already developed and being used and provides a means for continuous quality improvement for a sustainable systems approach. The cost of these positions total \$535,000 annually. Additional costs are being requested for the purchase of laptops for the added staff, yielding a total request of \$550,000.</p> <p>Often youth engaged in delinquency exhibit behaviors that are a manifestation of unresolved trauma and presents as increased risk. It is the understanding of the collaborative that this increased risk does not imply that future involvement with the juvenile justice system is inevitable or the solution. With appropriate identification, coordination and intervention, penetration into the juvenile justice system can be minimized and possibly avoided altogether. This is a unique coordinated and integrated model that is currently being implemented and tested. There have been other efforts at coordination among system partners and agencies; however, previous practices and approaches remained siloed and disconnected. The current model being tested was based on initial baseline data and results from several focus groups conducted with agency staff, stakeholders, parents and system involved youth. There are currently other models targeting DIY and are being piloted nationally with mixed results - the primary criticism of these models are that they are "system-focused" and not inclusive of community and consumer voice; which has actually resulted in net-widening in some jurisdictions. Our model has placed community and consumer voice at the center of the design and oversight team. Practices and policies remain in need of further development and refinement in this recently launched pilot. Various domain data indicators have been identified and initial data collection started.</p> <p>For the learning/evaluation: The County's DIY Initiative has developed a state of the art tracking system of DIY Unit outcomes that measure changes in risk related behaviors and protective factors as primary indicators of success of the model and its interventions and services. A Project Director will be able to provide critical assistance with monitoring in this area. Current data being tracked, outside of demographic information, includes indicators of court process, youth living situation, engagement in wraparound services, youth well-being, educational attendance and achievement, youth needs and services received, family finding efforts and placement history and type, restorative justice indicators, faith based connections, connections to pro-social peers and activities, amounts and types of substances used and closure/outcomes reasons. This data being collected will be evaluated for continuous quality improvement and to prove success for replication as a model for other jurisdictions. A robust analysis of these data points, will allow us to review success in various domains and as a program model. The Leadership involved with the initiative seek to evaluate services provided to youth including dosage and frequency, crossed with system outcome data for deeper understanding of effectiveness of services.</p>

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		<p>Target Population: Children/Youth and Transitional Aged Youth</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Promote interagency and community collaboration • Increase the quality of services, including measurable outcomes <p>Approach/Practice:</p> <p>Make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Culturally Responsive Approaches • Innovative Care Practices • Meaningful Outcomes
#14	<p>Evelyn C. Tirumalai, MPH, Suicide Prevention Coordinator, SCC IBH Division and Lauren Olaiz, MPH, HEARD Alliance</p>	<p>Issue: According to SAMHSA, a student is at increased risk of attempting suicide in the days and weeks immediately following discharge from the ER, hospital or care facility. Through a county-wide effort, most of the school districts in Santa Clara County have adopted a suicide prevention policy (N=26), many with administrative regulations for prevention, intervention and post-vention guidelines. The Suicide Prevention and Intervention Workgroup of the Santa Clara County Behavioral Health Services Department in partnership with the HEARD Alliance (Health Care Alliance for Response to Adolescent Depression), propose a "warm hand-off " approach to address the transition period between mental health service treatment into school life among youth 18 and younger. The County's School-Linked Services (SLS) initiative has created a network of care in which children and youth are screened and referred to mental health services. They are connected to systems of care through contracted agencies in high-risk communities. However, upon their release from either an Emergency Department, a Crisis Stabilization Unit or Mental Health Urgent Care, appropriate transition or recommendations for school officials regarding the need to provide a modified school day, or assist a student with administration of medications is not initiated or coordinated in many cases. This leaves schools in the dark about the appropriate care plan for the student, the family and the classroom teacher, often times triggering another cycle of crisis for the student, family and school. It also creates an opportunity for information to be missed and opportunities for intervention to be overlooked. In addition, SLS is a program that is not available in every district and only</p>

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		<p>contracts with certain agencies, thus leaving too many students and schools without the care coordination needed to promote the health and safety of all students in Santa Clara County.</p> <p>Community providers and hospitals have privacy regulations that prohibit communication with schools which is compounded by the fact that each school and school district have different treatment models and available services. School Linked Services is not a program that is available in every school district and is only contracted with certain agencies as service providers. An identified failure point of that model is that the SLS Coordinators also do not have a mental health background thus limiting their ability to appropriately support a student in crisis or need. This creates an enormous gap which leaves too many students and schools without the care coordination needed to promote the health and safety off all students in Santa Clara County. From the consumer and family standpoint, there is concern about how health information is shared and the potential stigma that ensue if that information is mishandled. When there is not a streamlined any systematic approach to address warm hand-offs, the potential for a negative outcome is too high to risk.</p> <p>There have been community organizations and individual workgroups that have tried to address this issue in the past. The challenge has been that the ideas or plans are never fully adopted and implemented. Schools, hospitals, community organizations all have different ideas and needs and without leadership to organize they fail to make impact.</p> <p>Proposed Solution: We propose bridging the established screening, referral and treatment systems already in place at many of our County schools and community settings with a "warm hand-off" step. The warm hand-off will complete a full service wraparound care for students seen at a mental health services facility (e.g. ED, EMQ, etc). This is a transitional period necessary to provide additional support to students and families entering back into their daily routines, i.e. school life. Many times, parents and educators alike may not know the next steps in helping a student transition into school life. The proposed grant funding would support the creation of a community task force that would research, analyze, and design a warm hand-off system for students with mental health needs in Santa Clara County. The funding would support the position of a task force leader who, with the support of the HEARD Alliance and Santa Clara County Suicide Prevention, would engage community leaders, hospitals in both the private and County system, physicians, community based organizations, and families. The ultimate design and recommendations of the task force would be reviewed by the County for consideration of County-wide implementation. This process would occur in phases. Phase I (assessment and planning); Phase II (design); Phase III (Adoption of plan by local schools, providers, and County); Phase IV (roll out of plan/implementation) with evaluation markers along the process. We expect this to be a 2-3 year planning and implementation timeline.</p> <p>This approach has been proposed before at some degree (Kataoka S, Stein BD, Lieberman R, Wong M. Suicide Prevention in Schools: Are We Reaching Minority Youths? Psychiatric Services, 2003;54:1444.) and applied at the Palo Alto Unified School</p>

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		<p>District to some extent. However, it has not been consistent and in some cases, the student is not identified early enough to be assessed and placed in a modified school day if warranted. In some cases, families tend to "watch" their student at home without appropriate follow up care. Currently, only EMQ First Families is doing follow up care with those recently leaving their 24-care facility. This may be one of the models we can modify or enhance to serve all students throughout Santa Clara County.</p> <p>For the learning/evaluation: In 2013, over 370 youth ages 10-19 were treated at Emergency Rooms in our county for self-inflicted/suicide attempts (CA Department of Public Health, 2013). The primary objective of a “warm handoff” is to provide accurate information about a student’s care, treatment, and services, current condition and any recent or anticipated changes after treatment from a suicide attempt. Additionally, it will assist schools on what would be an appropriate re-entry plan for the student. This initiative would support 4 of the 9 desired outcomes from Strategy One of the countywide Suicide Prevention Strategic Plan: Strategy One – Implement Suicide Intervention Programs and Services for Targeted High Risk Populations: Improve referral relationships to access appropriate care; Increase help-seeking behavior from individuals with mental illness and from those who are connected to individuals with mental illness; Increase support services to the family members and social network of individuals with mental health issues; and, Improve quality of life for individuals and their loved ones who are dealing with mental illness. In conclusion, straightforward, often simple, and relatively inexpensive suicide prevention strategies such as connecting and coordinating a student's care may work by giving students coming out of a crisis a sense of connectedness to caregivers and by providing concrete evidence of empathic concern from a compassionate human being (SPRC, Continuity of Care for Suicide Prevention, 2011).</p> <p>Target Population: Children/Youth and Transitional Aged Youth</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Promote interagency and community collaboration • Increase the quality of services, including measurable outcomes • Increase access to services <p>Approach/Practice:</p> <p>Introduce new mental health practices or approaches, including, but not limited to, prevention and early intervention.</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Strategic Care Transitions (Between Levels of Care)

Idea	Submitted By:	Summary of Submitted Ideas
		<ul style="list-style-type: none"> • Meaningful Outcomes
#15	Lorraine Flores, Associate Director, Bill Wilson Center (BWC) and Pilar Furlong, Director of Community Resources, BWC	<p>Issue: Obtaining meaningful and stable employment is an important part of transitioning to adulthood. Typical pathways include graduating from high school, completing postsecondary education and training, and obtaining work experience that leads to progressively higher paying positions. Many transition-age youth with emotional/behavioral challenges often find themselves unemployed, unemployable, discriminated against, and disconnected from their community due to their lack of a skill-set. What the "YouthWorks Training Academy" hopes to offer is a range of employment training options for these youth in order to assist them in not only getting employment, but sustaining their employment. YouthWorks Training Academy will provide time-limited paying jobs and work experience in career-oriented opportunities. The core of this service is work in the community. We will help transition-age youth locate jobs, help them get hired, and coach them on and off the work site. Employment services will provide a range of services including employment readiness, on-site supportive employment, employment placement assistance, connection to the California Department of Rehabilitation, job training and community-based employment. A key aspect of recovery is helping these youthful consumers identify ways to live a full life, which often includes re-entry into the workforce. Unique to this model are two significant support systems: 1) a safety-net of professional mental health specialists available for immediate support if needed; and, 2) the majority of YouthWorks staff will be peers with "lived experience", who have been trained to provide employment readiness and recovery training. A paying job is a major indicator of self-reliance and a measure of worth, to self and to society. Learning Goal: to determine if peer-led employment/recovery services improves the employability & recovery of transition age youth with emotional and behavioral challenges.</p> <p>A potential barrier has been the lack of identifying "transition age youth" as a separate category of consumers. This age group does not fall in the children's realm of services, and does not quite fit in with the adult system of care. Movement in this direction is relatively new, and there is much to be developed for this growing consumer population. There are minimal services for this age group in Santa Clara County, and no comprehensive employment / recovery assistance program available. What does exist are job placements in non-career positions (fast food, retail, etc.), with little or no career opportunities.</p> <p>Proposed Solution: Our recommendation is that the County develop a structured, peer-led training academy for transition-age youth with mental health challenges. The training program would focus on career-type opportunities for young consumers. Integrated into the employment training program would be a safety net of mental health specialists available for support and stabilization (as needed). This two-fold approach provides growth, recovery and opportunity to both the peers who run the program and to the consumers who are participating in the academy.</p> <p>Yes, this approach has been attempted elsewhere. Yes, the Village in Long Beach has an employment training program (TAY Academy) designed specifically for transition age youth with emotional and behavioral challenges. At a recent Recovery-oriented</p>

Idea	Submitted By:	Summary of Submitted Ideas
		<p>meeting at San Diego University, I had an opportunity to discuss this concept with Village psychiatrist Mark Ragins, M.D., the co-founder of the Village's youth employment service. Dr. Ragins' research indicated that transition age consumers experienced better recovery outcomes when given the opportunity to participate in a structured, employment program that offered choice and support services.</p> <p>The peer-led aspect of what is being proposed comes from the current experience of Bill Wilson Center's TAY Inn, a peer led supportive residential program, and a previous innovative project. The outcomes indicate that having a peer led program is beneficial to not only the consumers, but also the peer staff.</p> <p>For the learning/evaluation:</p> <ol style="list-style-type: none"> 1. Employment status - 70% of the transitional age youth participating in Youth Works Academy will gain employment. 30% may choose to pursue educational goals or volunteer work in the community. 2. Length of employment - 60% of the transitional age youth gaining employment through Youth Works Academy will maintain employment for 6 months or longer. 3. Quality of life - Utilizing the Milestones of Recovery Scale (MORS) assessment, and a self-sufficiency matrix, peer staff will determine changes in attitude behavior for participating transitional age youth. <p>Target Population: Transitional Aged Youth</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved groups • Increase the quality of services, including measurable outcomes <p>Approach/Practice:</p> <p>Introduce a new application to the mental health system a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.</p> <p>SCC Guiding Principle(s):</p> <ul style="list-style-type: none"> • Consumer & Family Member Involvement • Innovative Care Practices • Strategic Care Transitions (Between Levels of Care) • Meaningful Outcomes

Idea	Submitted By:	Summary of Submitted Ideas
#16	Melissa Luke, Domestic Violence Program Manager - Asian Women's Home, AACI	<p>Issue: There are few interventions in this county that address the intersection of domestic violence and mental health, and even fewer that meet the cultural and linguistic needs of our Asian immigrant community. Survivors of domestic violence often have PTSD, depressive symptoms, and adjustment disorders, and many are also suffering from complex trauma including childhood trauma and trauma caused by intimate partner violence. Our proposed idea fills this gap by offering survivors a new intervention - in a culturally competent setting - that prioritizes self-discovery and self-empowerment over traditional therapist-leading models.</p> <p>Traditional interventions treating complex trauma are mostly are still therapist leading, focusing on talk therapy and structured therapeutic tools. Our proposed idea will give survivors an opportunity to choose their own focus, methods, format, and time line to create a "self-discovery" project. Through this project, clients will self-identify areas of interest and strengths and, though the process of working on their project, experience healing as they regain their power, their lost self, and their disconnected strengths. A potential barrier is having enough resources to support each client's unique project. For example, if a client wants to create a short film but does not have a computer at home to do editing.</p> <p>Proposed Solution: Our proposed approach will empower the client to work on a “self-discovery” project to find their lost selves (whether in the past, future, or both). The project will be named and defined by the client, and may include anything from creating a photo album to writing a biography to making a film about her past life and/or future plans. Throughout the process of creating and implementing the project, the therapist will work with the client to emphasize the awakening of sleeping strengths, talents, skills, potentials and hope that will ultimately lead to healing and recovery.</p> <p>This approach can work in both an individual and group setting. The benefit of a group setting is the creation of a safe environment to share with peers, which will help break isolation, foster additional learning, and encourage empowerment.</p> <p>For the learning/evaluation: Effectiveness should be measured by evaluating what strengths have been discovered, what skills have been learned, what meaningful relationships have been built, what problems have been solved and how much the client's functioning level have been increased.</p> <p>Target Population: Transitional Aged Youth, Adult, and Older Adult</p> <p>Purpose(s):</p> <ul style="list-style-type: none"> • Increase access to underserved group

Description of Submitted Ideas

Idea	Submitted By:	Summary of Submitted Ideas
		<p data-bbox="415 233 659 261">Approach/Practice:</p> <p data-bbox="415 282 1919 347">Make a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.</p> <p data-bbox="415 386 716 414">SCC Guiding Principle(s):</p> <ul data-bbox="415 440 936 542" style="list-style-type: none"><li data-bbox="415 440 936 467">• Consumer & Family Member Involvement<li data-bbox="415 477 842 505">• Culturally Responsive Approaches<li data-bbox="415 514 737 542">• Innovative Care Practices

Note: Information about each submitted idea listed in this document were extracted from the form submitted by the individual(s) noted for each idea as shown in the table.

MHSA Innovation Requirements

1. Address one of the following purposes as its **primary purpose**:
- a) Increase access to underserved groups.
 - b) Increase the quality of services including measurable outcomes.
 - c) Promote interagency and community collaboration.
 - d) Increase access to services.

MHSA Innovation Requirements

2. Support **innovative approaches** by doing one of the following:
- a) **Introduces new mental health practices or approaches**, including but not limited to prevention and early intervention.
 - b) **Makes a change to an existing mental health practice or approach**, including, but not limited to, adaptation for a new setting or community.
 - c) **Introduces to the mental health system of a promising community-driven practice or approach** or a practice/approach that has been successful in non-mental health contexts or settings.

MHSA Innovation Requirements

MHSA INN requirement information available on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website: www.mhsoac.ca.gov

- MHSOAC INN Letter and Review Tool
- New MHSA INN regulations adopted October 2015



NEW/REVISED PROGRAM DESCRIPTION
Innovation

County: _____

Program Number/Name: _____

Date: _____

Complete this form for each new Innovation Program.

<p>1. Select one of the following purposes that most closely corresponds to the Innovation Program's learning goal and that will be a key focus of your evaluation.</p> <p><input type="checkbox"/> Increase access to underserved groups</p> <p><input type="checkbox"/> Increase the quality of services, including better outcomes</p> <p><input type="checkbox"/> Promote interagency collaboration</p> <p><input type="checkbox"/> Increase access to services</p>
<p>2. Describe the reasons that your selected primary purpose is a priority for your county for which there is a need to design, develop, pilot, and evaluate approaches not already demonstrated as successful within the mental health system. If your Innovation Program reflects more than one primary purpose in addition to the one you have selected, you may explain how and why each also applies.</p>
<p>3. Which MHSa definition of an Innovation Program applies to your new program, i.e. how does the Innovation Program a) introduce a new mental health practice or approach; or b) make a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community; or c) introduce a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting? How do you expect your Innovation Program to contribute to the development and evaluation of a new or changed practice within the field of mental health?</p>
<p>4. Describe the new or changed mental health approach you will develop, pilot, and evaluate. Differentiate the elements that are new or changed from existing practices in the field of mental health already known to be effective.</p>
<p>4a. If applicable, describe the population to be served, including demographic information relevant to the specific Innovation Program such as age, gender identify, race, ethnicity, sexual orientation, and language used to communicate</p>
<p>4b. If applicable, describe the estimated number of clients expected to be served annually</p>
<p>4c. Describe briefly, with specific examples, how the Innovation Program will reflect and be consistent with all relevant (potentially applicable) Mental Health Services Act General Standards set forth in Title 9 California Code of Regulations, Section 3320. If a General Standard does not apply to your Innovation Program, explain why.</p>
<p>4d. If applicable, describe how you plan to protect and provide continuity for individuals with serious mental illness who are receiving services from the Innovative Project after the end of implementation with Innovation funds</p>
<p>5. Specify the total timeframe of the Innovation program. Provide a brief explanation of how this timeframe will allow sufficient time for the development, time-limited implementation, evaluation, decision-making, and communication of results and lessons learned. Include a timeline that specifies key milestones for all of the above, including meaningful stakeholder involvement.</p>

NEW/REVISED PROGRAM DESCRIPTION
Innovation

6. Describe how you plan to measure the results, impact, and lessons learned from your Innovation Program. Specify your intended outcomes, including at least one outcome relevant to the selected primary purpose, and explain how you will measure those outcomes, including specific indicators for each intended outcome. Explain the methods you will use to assess the elements that contributed to outcomes. Explain how the evaluation will assess the effectiveness of the element(s) of the Innovative Project that are new or changed compared to relevant existing mental health practices. Describe how stakeholders' perspectives will be included in the evaluation and in communicating results. Explain how your evaluation will be culturally competent.
7. Describe how the County will decide whether and how to continue the Innovative Project, or elements of the Project, without Innovation Funds. Specify how stakeholders will contribute to this decision.
8. If applicable, provide a list of resources to be leveraged.
9. Provide an estimated annual and total budget for this Innovation Program, utilizing the following line items. Please include information for each fiscal year or partial fiscal year for the Innovation Program.

**NEW/REVISED PROGRAM DESCRIPTION
Innovation**

NEW ANNUAL PROGRAM BUDGET							
A. EXPENDITURES							
	Type of Expenditure	FY xxxx	Total				
1.	Personnel expenditures, including salaries, wages, and benefits						
2.	Operating expenditures						
3.	Non-recurring expenditures, such as cost of equipping new employees with technology necessary to perform MHSAs duties to conduct the Innovation Program						
4.	Contracts (Training Consultant Contracts)						
6.	Other expenditures projected to be incurred on items not listed above and provide a justification for the expenditures in the budget narrative						
	Total Proposed Expenditures						
B. REVENUES							
1.	MHSA Innovation Funds						
2.	Medi-Cal Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Any other funding (specify)						
	Total Revenues						
C. TOTAL FUNDING REQUESTED (total amount of MHSA Innovation funds you are requesting that MHSOAC approve)							

D. Budget Narrative

1. Include a brief narrative to explain how the estimated total budget is consistent with the requirements in Section 3920. The narrative should explain costs allocated for evaluation, if this information is not explicit in the budget