Let’s get connected!

Social Worker & Caregiver Resource Fair

January 21, 2021

Behavioral Health Services

9:30 am-11 am

COUNTY OF SANTA CLARA
Behavioral Health Services

THE COUNTY OF SANTA CLARA
Dept of Family & Children’s Services
AGENDA FOR TODAY

• Welcome Activity
• Housekeeping
• Agency Overview
• Q/A
• Closing/Survey
HOUSEKEEPING

✓ WEBINAR IS BEING RECORDED
✓ ALL PARTICIPANTS ARE MUTED
✓ QUESTIONS AND COMMENTS SHOULD BE TYPED IN THE Q&A BOX
✓ WE WILL ANSWER QUESTIONS AT THE END OF THE WEBINAR
✓ MATERIALS WILL BE AVAILABLE AFTER THE SESSION AND SENT VIA EMAIL
✓ YOU WILL RECEIVE A SURVEY LINK AT THE END OF THE WEBINAR, PLEASE PROVIDE FEEDBACK!
Text the #: 22333

Text the following in the textbox: **FRANKG011**

You will receive a text from Poll Everywhere. **IGNORE this message and DO NOT click the link received.**

Respond with your answer in the text box right after receiving the message!
Pathways to Well-Being

Presented by Gayle Peitso, LCSW
Behavioral Health Coordinator
All youth in open child welfare cases receive screening in collaboration with Pathways to Well-Being at intake, change of circumstance, and at regular intervals.

- May get directly referred by BHSD to Katie A intensive services program,
- May get referred by BHSD to the BH Call Center for assignment to another MH program,
- Youth living out of county will need to have Presumptive Transfer determination and documentation sent by SW when screening is completed,
- Other recommendations may be provided,
- Disposition is provided by BH Coordinators.

Youth who need immediate, intensive support to stabilize serious behavioral health concerns and preserve living situation.

- Placement Supportive Services (PSS) or Intensive Stabilization Services (ISS) may be available,
  - SW should consider interagency (IPC) referral for wraparound, specialized placement settings such as Treatment Foster Care, or Short Term Residential Therapeutic services,
  - Referrals must be made via DFCS,
  - Must have open DFCS case.

Youth who are ending child welfare involvement or for whom no case will be opened.

- Consider whether the Differential Response (DR) program would meet the needs of the child and family (cannot have open case),
- Consult DR Coordinators for assistance,
- Referrals to Differential Response program made directly via DR Coordinators,
- May not have open DFCS case when services are in place.
Therapeutic Behavioral Services (TBS) can be accessed across the continuum of care, but cannot be received as a standalone service.

Crisis Services can be accessed across the continuum of care and offers Mobile Crisis, Community Transition Service (CTS) and Crisis Stabilization Unit (CSU).
Pathways to Well-Being

**Behavioral Health Coordinators**
Gayle Peitso, LCSW
Janet Caudillo, LCSW
Marcela Sandate, LMFT

Email our team at:
BHSDPathways@hhs.sccgov.org

BHSD website: www.sccbhsd.org
## CONTACT INFORMATION AND RESOURCES

### Crisis Support Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHSD Suicide and Crisis Line</td>
<td>855-278-4204</td>
</tr>
<tr>
<td>Crisis Support via Text</td>
<td>Text RENEW to 741741</td>
</tr>
<tr>
<td>Mobile Crisis Response Teams (MCRT)</td>
<td></td>
</tr>
<tr>
<td>MCRT Adults BHSD</td>
<td>800-704-0900</td>
</tr>
<tr>
<td>MCRT Children and Youth @ Uplift Family Services</td>
<td>408-379-9085</td>
</tr>
</tbody>
</table>

### To Access Behavioral Health Services, Call:

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHSD Call Center</td>
<td>800-704-0900</td>
</tr>
<tr>
<td>BHSD Gateway Call Center for Substance Use Treatment Services</td>
<td>800-488-9919</td>
</tr>
<tr>
<td>Youth Substance Use Treatment Services (Mon-Fri 9AM – 6PM)</td>
<td>408-272-6518</td>
</tr>
<tr>
<td>Youth Substance Use Treatment Services (Afterhours)</td>
<td>800-488-9919</td>
</tr>
</tbody>
</table>

Substance Use Services: [https://www.sccgov.org/sites/bhd/info/suts-resources-info/Pages/SUTS-Info.aspx](https://www.sccgov.org/sites/bhd/info/suts-resources-info/Pages/SUTS-Info.aspx)

Alum Rock Counseling Center
Prevention & Early Intervention Program

Presented by:
Desseray Vega, AMFT
Our mission: To heal families and inspire youth to reach their full potential.

- **Program goal:**
  - Prevent, reduce, and eliminate mental health symptoms that may be negatively impacting academic success and family wellness.

- **Target population:**
  - Youth ages 5-13 years old and their caregivers/parents. Students who are experiencing behavior issues or displaying symptoms that have caused impairment in their daily activity (for example, school), social relationships, or their health. Students who have experienced trauma (grief, bullying, life changes, or experiences- COVID/distance learning can absolutely be included in this).

- **Insurance eligibility:**
  - Medi-Cal insured, Non Medi-Cal insured, or families with no insurance. No fees for services

- **Length of services:**
  - Average of 3-6 months. Our program runs year round (summer included)

- **Services:**
  - provided in-person however, during this time we have been providing presentations, individual services, family sessions via telehealth.
Different levels of care & different ways we support

Lower Needs

Family Partner
- Case Management/Linkage and Referrals
- Parent Coaching & Individual Triple P Level 4
- Community Resourcing

Family Specialist
- Behavioral Support (coaching/skill building) in the Classroom and/or at home
  - Disruptive behaviors
  - Social Skills
  - Following Directions
  - Peer Relationships

Clinician
- Individual Therapy
  - Anxiety
  - Depression
  - Trauma
  - Adjustment to life stressors
  - Interpersonal Conflicts
  - Behavioral Challenges
- Trauma Focused Therapy TF-CBT

Higher Needs

Other ways we support:
- Free parent and family workshops
- Parent support services
- Student and family therapy
- Connections/linkage to resources
- Provide staff support
Thank you so much for your time!

- Alum Rock PEI serves all schools in ARUSD, MPSD, and OGSD. Services can be requested by individual schools or directly through 408-294-0500 or info@alumrockcc.org

- Desseray Vega, AMFT #97986
  - Prevention and Early Intervention Program Manager
  - dvega@alumrockcc.org (408) 797-8875

Individually, we are one drop. Together, we are an ocean. 
Ryunosuke Satono

[BrainyQuote]
SCHOOL LINKED SERVICES
SUPPORTS AND SERVICES
CHILDREN, YOUTH, TRANSITION AGE YOUTH, AND FAMILY SYSTEM OF CARE

**Prevention and Early Intervention** (approx. 1.4 hours/month)
- School Linked Services (SLS)
- Family Engagement
- Substance Use Prevention Services (SUPS)
- Prevention and Early Intervention (FEI)

**Outpatient** (approx. 4-7 hours/month)
- Outpatient Services (Behavioral health services addressing mental health and substance use concerns provided by contracted providers and County-operated programs)
- Substance Use Treatment Services (SUTS)
- Population-Specific Outpatient Programs:
  - Ethnic Specific Outpatient Services
  - KidsConnections Network (Birth through five)
  - Integrated Outpatient Services (Co-Occurring Mental Health and Substance Use Treatment)
- Status Offender Services (SOS)
- Transition Age Youth (TAY)
- Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ)
- Young Adult Transition Team (YATT) TAY Interdisciplinary Service Team (IST)
- Independent Living Program (ILP)
- Dually Involved Youth (DIV)
- Treatment Focused Services (TFS)

**Intensive Outpatient** (approx. 8-14 hours/month)
- Intensive Outpatient (Intensive behavioral health services addressing mental health and substance use concerns provided by contracted providers)
- Differential Response
- Katie A. Services
- Eating Disorders Programs
- Cross-Systems Behavioral Health Clinic (Transformation Team and Kaihi BH)
- Therapeutic Visitation Services
- Guadalupe Behavioral Health
- Juvenile Justice Support and Enhancement Service (SES), Probation Gang Resistance and Intervention Program (Pro-Grip), Youth Therapeutic Integrated Program (yttip), Probation Continuum of Services to Reentry (Pro-CSR)

**Intensive Wraparound** (15+ hours/month)
- Full Service Partnership (Child/Transition Age Youth TAY)
- Intensive Full Service Partnership (Youth/TAY)
- Wraparound (Child Welfare and Juvenile Justice)
- Therapeutic Foster Care
- Placement Supportive Services (PSS)

**Residential**
- Substance Use Residential Treatment Program
- Short Term Residential Therapeutic Program (STRTP)

---

Therapeutic Behavioral Services (TBS/TBS-ID) can be accessed across the continuum of care, but cannot be received as a standalone service.

Crisis Services can be accessed across the continuum of care and offers Mobile Crisis, Community Transition Service (CTS), Crisis Stabilization Unit (CSU), SOS Crisis Triage.

---

**County of Santa Clara Behavioral Health Services**
SLS School Districts:

The following school districts are part of the SLS initiative, on which at least one SLS District Coordinator is located to provide coordinated services and resource linkages among students and families. SLS Coordinators at the district level partner with school district administrators, community organizations and schools to ensure families and children are receiving coordinated resources and services that address their health and academic wellbeing.

- Alum Rock Union School District - Milpitas Unified School District
- Campbell Union School District - Morgan Hill Unified School District
- Campbell Union High School District - Mountain View Whisman School District
- Franklin McKinley School District - Oak Grove School District
- Fremont Union High School District - Orchard School District
- Gilroy Unified School District - San Jose Unified School District
- Luther Burbank School District
SLS SUPPORTS AND SERVICES

- SLS Service Coordination and Family Engagement
  - Home visitations
  - Referral and Linkage to resources
  - Family Engagement Activities and Workshops
    - PIQE, Parent Project, Triple P, Strengthening Families

- PEI and SLS School Based Behavioral Health Services
  - **Tier 2 services**
    - Mental health groups
    - Triple P
    - Strengthening Families
  - **Tier 3 services**
    - Individual therapy to address barriers to attending school, such as depression, anxiety, bullying, etc.
    - Home based BH services to review home structure and engage parents and families.
    - Parent coaching
SLS ACTIVITIES

- SCCOE and BHSD Collaboration
  - Student re-engagement and re-opening planning
  - Identifying resources
- Court for Achieving Reengagement in Education (CARE) Court – BHSD Collaborative Support
  - BHSD Psychiatric Social Worker attends CARE court 2x/month
  - Collaborative discussions with DA’s office, family, school district and Public Health nurse to identify school attendance barriers and how to address barriers.
  - Care coordination support to families and school administration to accessing services
- SCCOE SARB Presentations
  - Monthly presentations to families with truancy concerns
  - Collaborative effort with DA’s office
  - BHSD Psychiatric Social Worker presents on mental health behaviors and symptoms, services and programs available, and accessing services
Comments & Questions

Guadalupe Ramirez
School Linked Services
Program Mental Specialist
Guadalupe.Ramirez@hhs.sccgov.org
Supportive Therapeutic Options Program (STOP)

Presenter: Bernadette Martinez, LCSW
Program Manager
Supportive Therapeutic Options Program (STOP)

Target Population:

• Accessible to children/youth up to age 19 that are unable to access mental health services due to no coverage or under-coverage,

• Children/youth and families in need of supportive and therapeutic services to prevent entry or re-entry into out-of-home placement,

• Children/youth transitioning from out-of-home placement back to their homes.
Services:

- Individual therapy,
- Rehabilitation,
- Assessments,
- Plan development,
- Medication and medication support,
- Case management, and
- Community based,
- Languages: English, Spanish, Vietnamese
Referrals can be made by contacting us directly:

(408) 287-6200

Mike Danner, LCSW
Program Supervisor
mdanner@gfhn.org

Bernadette Martinez, LCSW
Program Manager
bmartinez@gfhn.org

Amy Rice, LMFT
Senior Program Manager
arice@gfhn.org
CHR-P Project & REACH Program

- **Psychosis**: The experience of people who have a difficult time distinguishing reality from internal experience.
  - Symptoms may include bothersome voices, intrusive thoughts, disorganization, hallucinations, delusions, or confused thinking.
  - 3 in 100 individuals develop psychosis.

- **First Episode Psychosis (FEP)**: Individuals early in the course of a psychotic illness or treatment.
  - Every year, 100,000 individuals experience FEP.

- **Clinical High Risk (CHR)**: Individuals who exhibit noticeable changes in perception, thinking, and functioning.
  - These are early warning signs that they may develop psychosis.

**Mission/Vision**: To identify youth and young adults (ages 10-25), at clinical high risk for psychosis and provide evidence-based interventions to lessen the severity of a first episode of psychosis or prolong it.
Early Warning Signs

1. Behavioral Changes:
   - Extreme fear for no apparent reason
   - Uncharacteristic, bizarre actions, statements or beliefs
   - Incoherent or bizarre writing
   - Extreme social withdrawal
   - Decline in appearance & hygiene
   - Sleep (sleep reversal, sleeping all the time, insomnia)
   - Dramatic changes in eating

2. Perceptual Changes:
   - Fear others are trying to hurt them
   - Heightened sensitivity to sights, sounds, smells or touch
   - Statements like, “My brain is playing tricks on me”
   - Hearing voices or sounds others don’t
   - Visual changes (wavy lines, distorted faces, colors more intense)
   - Feeling like someone else is putting thoughts in your brain or taking them out.

3. Reduced Performance
   - Trouble reading or understanding complex sentences
   - Trouble speaking or understanding others
   - Becoming easily confused or lost
   - Trouble in sports or other activities that used to be easy
   - Attendance problems related to sleep or fearfulness
REACH is a collaborative program developed and run by Momentum for Health and Starlight Community Services. REACH provides education, early intervention and prevention services for individuals experiencing initial symptoms related to psychosis. REACH is community-based and currently using teletherapy.

### Interdisciplinary Team

- Psychiatry
- Individual & Family Therapist
- Education and Employment Specialist
- Occupational Therapist
- Parent Partner/Family Advocate
- Family Specialist/Peer Mentor

### Program Criteria

- Ages 10-25
- Lives in Santa Clara County
- Exhibits early warning signs
- Medi-Cal eligible or uninsured/unsponsored
- Needs to be stable and able to engage in evaluation process
- Symptoms are not due to substance use or active trauma
- Stable housing / placement
Referral Process

- Call REACH hotline at 1-855-2REACHUS
- Initial phone screening
  - Within 1 business day of call
- SIPS Assessment (Structured Interview for Psychosis-Risk Syndromes)
  - Within 1 week of screening
  - Criteria met: transition/opening coordinated with client or referrer
  - Criteria not met: discuss results and set plan of action with client or referrer
Contact Information

REACH
1-855-2REACHUS
https://www.reach4scc.org/

Lisa Hameed, ASW
CHR-P Project Director
Santa Clara County Behavioral Health Services
Family & Children’s Division
C: 669-275-5125
Lisa.hameed@hhs.sccgov.org

Rick Navarro, ASW
CHR-P Clinical Coordinator
Santa Clara County Behavioral Health Services
Family & Children’s Division
C: 669-263-4735
Rick.Navarro@hhs.sccgov.org
What Does REACH Offer?

REACH services are based on the most current research from prevention of psychosis. Services include:

- Psycho-education and outreach to the community
- Consultations and individualized assessments
- Treatment and support from a team, including a psychiatrist, mental health clinicians, occupational therapist, vocational specialist, and mentors
- Family groups where families learn together how to understand the illness and how to provide the best support to their family member

Who is REACH?

Our mission is to raise awareness and understanding of mental illness within the community while offering culturally competent and evidence-informed treatment to underserved youth and their families.

REACH Partnership

REACH is a collaborative effort between Momentum for Mental Health and Starlight Community Services. Together, REACH is committed to providing early intervention and prevention services throughout Santa Clara County.

This program is one of the Early Detection models from the PIER Training Institute in Portland, Maine. This program has been funded by the Mental Health Services Act.

Serving youth ages 10-25 in Santa Clara County

At risk for developing a mental illness

For consultations, more information, or referrals

Please Call

1.855.2REACHUS [toll free]

www.Reach4SCC.org

Starlight Community Services

www.starsinc.com

Momentum for Mental Health

www.momentumformentalhealth.org
Psychosis is a brain condition which, if untreated, prevents the person from being able to know what is real and what is not real. The REACH program was created to detect early warning signs of psychosis that may pose a threat to young adults, and to provide effective support and treatment.

Early symptoms are often subtle, but can be quite disabling. They affect young people’s ability to complete schoolwork, interact socially, and accomplish daily tasks.

“3 in 100 individuals develop psychosis, and symptoms are most prominent between the ages of 10-25.”

With early, effective treatment and support, most young people will succeed in school, work, and life. Early intervention allows:
- Preservation of brain function
- Preservation of social skills
- Decreased need for intense treatment down the road

**Identify Early Warning Signs**
If a person is having **new, significant, and worsening difficulties** in any of the following areas:

**Reduced Performance**
- Trouble reading or understanding complex sentences
- Trouble speaking or understanding others
- Becoming easily confused or lost
- Trouble in sports or other activities that used to be easy
- Attendance problems related to sleep or fearfulness

**Behavior Changes**
- Extreme fear for no apparent reason
- Uncharacteristic and bizarre actions or statements
- Impulsive and reckless behavior
- Extreme social withdrawal
- Decline in appearance and hygiene
- Dramatic changes in sleep or eating

**Perceptual Changes**
- Fear that others are trying to hurt them
- Heightened sensitivity to sights, sounds, or touch
- Making statements like “my brain is playing tricks on me”
- Hearing voices or other sounds that others don’t hear
- Reporting visual changes (ex. colors are more intense, faces distorted, lines turned wavy)

- Feeling like someone else is putting thoughts into their brain or that others are reading their thoughts

**Referral Guidelines**
- Meets any of the early warning signs
- Youth is between the ages of 10-25
- Youth resides in Santa Clara County
- Youth is currently uninsured, has Medi-cal, or Healthy Families
- Youth is not currently receiving ongoing treatment for a psychotic disorder

**REACH’s mission is to promote independence and prevent onset of mental illness in the Santa Clara County youth population through early education and awareness, consistent treatment, and community support.**
Basic Info & Eligibility

Our mission is to support the LGBTQ+ community in Santa Clara County through direct services, access and linkage to community resources, and building an affirming service delivery system.

- Population Served: LGBTQ+ community members (all ages) and their families, friends, and allies.
- Cost: free
- Services include:
  - Peer Support (individual and group)
  - Resources and referrals
  - Community building activities
  - Trainings
- Services are currently virtual, connect by phone, email, video meeting
- Office: 1075 East Santa Clara St. San Jose
Direct Support Services

- **Peer Support**
  - Listening and mentoring from peers who have “been there”

- **Resources**
  - Information about local resources specially suited for the individual’s unique needs
  - Supplying local providers with information and resources

- **Referrals**
  - Connection and referrals to programs focused and experienced in working with LGBTQ+ folks
Community Building

- **Q Corner Chats**
  Info-sessions on subjects relevant to LGBTQ+ folks, hosted in collaboration with local expert panelists

- **Peer Support Groups** for trans, non-binary, and gender expansive adults
  - English Group: 1st / 3rd Mondays
  - Spanish Groups: 2nd / 4th Mondays

- **Community Building** Events
  - Trivia or Treat Event
  - Community Hypefest
  - Virtual Pride Events
Trainings

Foundation Trainings
- RISE Core Training (SOGIE 101)
- RISE Training and Coaching Intensive

Gender Affirming Trainings
- Gender Affirming Clinical Consultation
- Gender Wheel Workshops: Overview and Implementation Sessions
- Comprehensive Care Of Gender Expansive and Transgender Youth
- Eating Disorders In Trans-Communities
- Writing the Support Letter For Gender – Affirming Health Services

Clinical Trainings
- LGBTQ+ Clinical Academy

Peer Support Trainings:
- Intentional Peer Support in LGBTQ+ Communities
- La Cultura Cura and Circle Keeping

Supporting Families
- Family Acceptance Project Practices

Supporting Education Professionals
- Step In, Speak Up! For Inclusive Schools
Contact Us!

**Email:**
theqcorner@hhs.sccgov.org

**Phone:**
408-977-8800

**Social Media:**
@theqcorner

**Website:**
www.sccbhsd.org/theqcorner
Trans | Non-Binary | GNC
Virtual Peer Support Group

This is a space for individuals who are transgender, non-binary, GNC, gender expansive, and/or questioning their gender to collectively build community in a safe, confidential space.

**FREE BI-WEEKLY GROUP | 18+ | Mondays**

Questions? Please email Wellness at: lgbtqwellness@fcservices.org

Register: bit.ly/3i5Fp9L

**SCHEDULE**
First and Third Monday of the month

**First:** 10:00-11:15am
**Third:** 6:00-7:15pm

IN PARTNERSHIP WITH

SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics
Gender Health Center
Este es un espacio para personas transgénero, no binarias, GNC, de género expansivo y/o que cuestionan su género para construir colectivamente una comunidad en un espacio seguro y confidencial.

**GRUPO QUINCENAL GRATIS | 18+ | Lunes**

Preguntas? Por favor, envíe un correo electrónico a Wellness: lgbtqwellness@fcservices.org

Regístrese: bit.ly/3cqZRAat

**ORARIO**

Segundo Y Cuarto
Lunes del mes

**Segundo:** 10:00-11:15am
**Cuarto:** 6:00-7:15pm
THE Q CORNER is a Behavioral Health Services Department program connecting with the LGBTQ+ Community in Santa Clara County through Peer Support Services. We are a safe, welcoming, and affirming team dedicated to making community services and resources available to everyone.

CONTACT US TO MEET YOU IN THE COMMUNITY

EMAIL
TheQCorner@hhs.sccgov.org

CALL
(408) 977-8800

DROP BY OUR OPEN OFFICE HOURS

WHERE
1075 E. Santa Clara St.
San Jose, CA 95112
Bus Lines: 22/522 & 23/253

WHEN
Tuesday mornings 9-11am
Wednesday afternoons 3-5pm
Thursday midday 12-2pm

The Q Corner services are FREE, and for all ages!

www.sccbhsd.org/theQCorner

RESOURCES & REFERRALS

- Behavioral Health & Healthcare Services
- Basic Needs & Public Benefits
- Legal Services, including name & gender marker change
- And so much more!
Join us for the first episode of the 2021 series "Q Corner Chats"

THE CURRENT STATE OF

LGBTQ + in the US

a conversation with

OASIS LEGAL SERVICES

MARIA ELENA PANIAGUA

RACHEL KAFELE

JANUARY 28TH | 2PM-3PM

HTTPS://TINYURL.COM/LGBTQASYLUM
SPEAKER BIOS:

MARIA ELENA PANIAGUA: OASIS CO-FOUNDER, ASYLUM PROGRAM DIRECTOR, DEPT. OF JUSTICE ACCREDITED REPRESENTATIVE

Maria Elena is a Bay Area native and has a BA in Psychology from UC Berkeley. After graduating college, she began working in legal immigration services at the East Bay Sanctuary Covenant (EBSC), where she started the organization’s LGBTQ/HIV+ Asylum Program. Since Oasis’s founding, Maria Elena has managed the asylum and naturalization programs and her clients continue to be her inspiration for doing the work she does.

RACHEL KAFELE: OASIS CO-FOUNDER, LEGAL PROGRAM DIRECTOR

Also a Bay Area native, Rachel graduated NYU School of Law in 2010 and spent her first 3 years as a lawyer working as a public defender in Miami. She began working with LGBTQ+ asylum seekers in 2013 and has helped hundreds of clients find safety in the United States. At Oasis, she heads the legal program in addition to representing clients in complex asylum cases.
Seneca Family of Agencies: Differential Response Program

Program Supervisor: Susan Smith
Support Counselor: Tiye Garrett
Seneca’s vision for service is an integrated community-engaged approach with high standards of practice. All Seneca services are designed to be flexible, individualized, trauma-informed, and culturally responsive.

- Website: https://www.senecafoa.org/
- Contact Number: (510)-317-1444
- Contact email: info@senecacenter.org
Target Population

Families that have been referred through various pathways such as Diversion, Aftercare, Prevention, Post Adoption, Guardianship, Kin Gap

- Our services via telehealth are being provided for families with youth residing in the home
- Meetings are held on a weekly & bi-weekly basis
- Eligibility requirements: Services are FREE for Medi-Cal and non Medi-Cal families
Referral Process

- CPS Report
- DFCS
- Social Worker
- Seneca DR
Service Types

- Case Management
- Mental Health Counseling
- Basic Living Needs (housing, food, clothing, utilities, etc.)
- Child Growth & Development
- Parent Education
- Domestic Violence Awareness
- Self-Sufficiency
- Substance Abuse Support
- Health & Wellness
For consultation and referral for Differential Response:

Contact the Differential Response Team:

• Bertha Reyna, DR Resource Coordinator
• Nancy Castro, DR Resource Coordinator

• Email: Differential.Respo@ssa.sccgov.org
• Phone: (408) 793-8977
Our Mission:
To improve the quality of life for individuals with developmental disabilities and mental health needs.

Presenters:
• Linda Siino, MSW
• Allison Murray
• John Robinson
TARGET POPULATION

Children, teens, and adults with developmental disabilities who also have co-occurring mental health needs.
REFERRAL PROCESS

- Self referral to Santa Clara Co. Behavioral Health Dept 800-704-0900
  or
- San Andreas Regional Center (SARC) referral

- Funding:
  - Full Scope MediCal or SARC funding with no shared cost
  - Private Pay accepted, Insurance not accepted
Eligibility

• San Andreas Regional Center (SARC)-qualifying diagnosis of a developmental disability with a concurrent qualifying mental health diagnosis

• SARC consumer who is referred by the Santa Clara County Department of Mental Health

• Live in Catchment area- San Mateo, Santa Clara, Santa Cruz, Monterey, and San Benito Counties
LOCATION AND TIME

Main Office:
- 1555 Parkmoor Avenue San Jose 95128

Satellite offices in:
- Santa Cruz
- Salinas
- Seaside
- Gilroy

Office Hours:
- 8:00AM-5:00PM
- Additional times may be available based on individual need
I. Counseling/Behavioral Health Services: May include

- Individual and group therapy
- Case management
- Rehabilitation counseling
- Psychotherapy
- Psychiatric consultation with a child psychiatrist
- Individual consultation for parents
MORE CHILDREN’S SERVICES

II. Therapeutic Behavioral Services (TBS):
- For children with extreme needs
- A history or risk of hospitalization or loss of placement
- At-risk for losing placement
- Behavioral 1:1 treatment

III. Family Support and Education:
- Services for families and others who serve people with mental health needs and developmental disabilities.
SERVICES FOR ADULTS

I. Behavioral Health may include:
   • Psychotherapy
   • Rehabilitation counseling
   • Cognitive behavior therapy
   • Supportive therapy
   • Dialectical behavior therapy
   • Play therapy
   • Other modalities to assist w/ controlling anxiety, depression, or more severe cognitive and mood disorders.
MORE ADULT SERVICES

II. Case Management
- Linkages to other community services

III. Psychiatric Services
- Physician assessments and medication

IV. Registered Nurse Services

V. Behavioral Health Management Groups-
Promoting healthy living
VI. Family Support And Education - Services for families and others who serve people with mental health needs and developmental disabilities.

VII. WRAP (Wellness and Recovery Action Plan) Services - Group experiences to prevent crises, promote adaptive behaviors, and develop skills to maintain mental health stability.

VIII. Autism and Co-occurring Disorders - Mental health treatment for people with autism and co-existing behavioral health problems.
Hope Mental Health Services follows all County, State and CDC guidelines. During the pandemic services are as follows:

I. Clinical services including Counseling, TBS, and WRAP groups provided by:
   - Telehealth
   - Phone

II. Case Management:
   - Telehealth
   - Zoom
   - Phone
   - In person, as needed Staff must take their temperature BEFORE contact with clients and document any COVID related symptoms. Masks and social distancing must be a consistent practice.
• Anna Fernandez, LMFT, Director,  408 282-0402  
afernandez@hopeservices.org

• Hope Services 408 284-2850  www.hopeservices.org

• Hope Counselling Center 408-282-0402

• Santa Clara County Behavioral Health Dept.-  
  800-704-0900

• San Andreas Regional Center- 408-374-9960, sarc.org

THANK YOU
Mental Health Services
Serving the unique needs of people with developmental disabilities and co-occurring mental health issues

Hope’s Mental Health Services is the largest outpatient facility in the Bay Area dedicated to helping children, teens, and adults with developmental disabilities who also have co-occurring mental health needs. Hope’s Mental Health Services enjoys an international reputation for excellence in helping people with developmental disabilities learn how to manage mental health issues while integrating into the community. Our skilled staff have extensive training, and are linguistically and culturally fluent in many languages including Spanish, Vietnamese, Mandarin, and Tagalog. We provide a variety of evidence-based treatment modalities, including cognitive behavioral therapy, dialectical behavior therapy, art therapy, play therapy, and positive behavior interventions.

Services for Children & Teens Include:

• **Counseling/Behavioral Health Services:** May include individual and group therapy, case management, rehabilitation counseling, psychotherapy, psychiatric consultation with a child psychiatrist, and individual consultation for parents to aid them in supporting their children, teens and transition age adolescents/young adults.

• **Therapeutic Behavioral Services (TBS):** Available for children with intense needs who required recent hospitalization, are at-risk for hospitalization, or are at-risk of losing placement. They may qualify for behavioral 1:1 treatment with parental consultation in the home, school, or community.

• **Family Support and Education:** Educational and support meetings for families, significant others, and providers from residential care homes who serve people with mental health needs and developmental disabilities.

Services for Adults Include:

• **Behavioral Health:** May include psychotherapy, rehabilitation counseling, cognitive behavior therapy, supportive therapy, dialectical behavior therapy, play therapy, and other modalities as necessary to assist the individual in controlling troubling symptoms such as anxiety, depression, or more severe cognitive and mood disorders.

• **Case Management Services:** May involve assistance in linking the individual to other community services to improve quality of life.

• **Psychiatric Services:** Includes assessment by a physician and medication if needed.

• **Registered Nurse Services:** Available to clients.

(continued on back)
Services for Adults, Continued:

- **Behavioral Health Management Groups:** Available to assist clients with management of health behaviors to promote healthy living.

- **Family Support and Education:** Educational and support meetings for families, significant others, and providers from Board & Care homes who serve people with mental health needs and developmental disabilities.

- **WRAP (Wellness and Recovery Action Plan) Services:** Group experiences to prevent crises, promote adaptive behaviors, and develop skills to maintain mental health stability.

- **Autism and Co-Occurring Disorders:** Mental health treatment for people with autism and co-existing behavioral health problems.

Service Eligibility

Prospective clients must meet the following eligibility requirements:

- San Andreas Regional Center (SARC)-qualifying diagnosis of a developmental disability with a concurrent qualifying mental health diagnosis

- Consumer of a State Regional Center who is referred by the Regional Center or a SARC consumer who is referred by the Santa Clara County Department of Mental Health

- Live in a geographical area served by our programs

Referral Process

- Ask your Regional Center Service Coordinator to refer you to Hope Services' Mental Health Services.

or:

- Call the Santa Clara County Behavioral Health Department at 1-800-704-0900 for a referral if you have Medi-Cal and no private insurance, and are a SARC consumer.

For More Information

Anna Fernandez, LMFT — Director, Mental Health Services  
Hope Services, 1555 Parkmoor Ave., San Jose, CA 95128  
afernandez@hopesservices.org or 408-282-0402

**HOPE SERVICES' MISSION:** Our mission is to improve the quality of life for individuals with developmental disabilities, as measured by eight indicators: personal development, self-determination, interpersonal relations, social inclusion, rights, emotional well-being, physical well-being, and material well-being.

**DONATE TO HOPE:** Hope is only partially funded by the State and relies on donations to fund its services for individuals with developmental disabilities. If you’d like to donate to Hope and help fill the funding gap, visit www.HopeServices.org or call 408-284-2862.
Rebekah Children’s Services
Katie A. Services
Justin Wirth, LMFT, Clinical Program Manager
Mission: We are committed to seeing our community flourish by building pathways to hope, happiness, and well-being.

Vision: To be the best agency for quality care, education, and employment.

Rebekah Children’s Services
Katie A.

Community Based Mental Health Services

Coordination

Team Oriented

Client Centered

Strength Based
Target Population

- Youth ages Birth to 21 years
- Youth involved in or at risk of child welfare involvement with significant mental health concerns
- Youth with complex care coordination needs across child-serving systems
Eligibility and Access

- Youth must meet Medical Necessity and have a qualifying mental health diagnosis
- Child welfare and Social Services involvement is not necessary to receive services
- Common Referral sources: DFCS, schools, medical doctors, other mental health providers, and self referred through the Santa Clara County Call Center
- Katie A. referrals are screened by Santa Clara County Behavioral Health by submitting to BHSDPathways@hhs.sccgov.org
- Medi-Cal is required
- Youth ages Birth-21 years of age
- Youth resides within Santa Clara County
Services Offered

Intensive Care Coordination (ICC)
- Coordinates with service providers
- Facilitates Child and Family Team meetings

Intensive Home Based Services (IHBS)
- Direct 1:1 work with youth and families (if needed)
- Based upon treatment plan goals set by youth and family

Individual/Family Therapy, Therapeutic Behavioral Services, Psychiatry, Family support
- As needed adjunctive services
- Can be coordinated through other agencies
## Overall Objectives of Katie A. Services

<table>
<thead>
<tr>
<th>Restore</th>
<th>Improve</th>
<th>Support</th>
<th>Coordinate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restore/Improve</td>
<td>Improve youth’s mental health and emotional</td>
<td>Support caregivers in keeping youth safe,</td>
<td>Coordination and collaboration across systems of care for the youth</td>
</tr>
<tr>
<td>child/youth’s</td>
<td>well-being</td>
<td>supported, and healthy</td>
<td></td>
</tr>
<tr>
<td>ability to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>function</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>effectively in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>home, school,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and community</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Service Delivery

Community Based Services
• Meet youth in their homes, communities, and where they are comfortable

Strength Based and Client Centered
• Youth and family are valued members of the treatment team

Telehealth
• Available to all youth/families
• Increases availability to reach more clients and promote social distancing (if necessary)

Team Based
• Collaborative services based on the Integrated Core Practice Model
Contact Information:

- Gilroy Area: 408.846.2100
- Campbell Area: 408.871.4900
- Salinas Area: 831.287.3870
- Toll-free: 888.225.4663
- Email: info@rcskids.org

For consultation and/or referral, email: BHSDpathways@hhs.sccgov.org

Santa Clara County Behavioral Health Call Center:

**Mental Health Services**
1 (800) 704-0900

**Hours:** 24-hours, 7 days a week

**Languages Spoken:** English, Mandarin, Spanish, Tagalog, Vietnamese
What is Intensive Care Coordination? (ICC)

ICC starts with a team, called the Child and Family Team (CFT), made up of youth, family and/or caregivers, and mental health professionals, as well as other people whom you identify to be on your team (e.g. coach, teacher, relative, family friend, pastor or priest, others).

- This team meets and works together to help you identify your family’s strengths, needs, and goals. Together you will come up with a plan to help meet your needs, achieve your goals and support your strengths.

- The team will help to coordinate the care that the youth receives from all areas such as mental health, education, child welfare, and physical health care.

- Where the team meets and how often the team meets is guided by you and your family’s wishes.

- The team meeting is led by a facilitator whose role is to ensure that your voice and choice are heard during the meetings.

What are Intensive Home Based Services (IHBS)?

- IHBS are provided by a behavioral coach/family specialist, therapist, peer mentor, or parent partner.

- IHBS services help your child develop skills to succeed at home and in the community.

- IHBS providers work with you and/or your family in your home, school, or other community settings.

- IHBS services help your child connect to community services that support their healthy development.

- Therapy provided if agreed as a need in CFT.

Katie A. Core Values and Principles

- Services are needs driven and strength based.

- Services are individualized for each child and family.

- Parent/family voice and choice are valued and acknowledged.

- Your family’s own natural supports and connections to your community are valued and utilized.

- Services are respectful of the child and family’s culture, language and beliefs.

- Services are provided in your family’s community.

- Families are supported to help maintain or build children’s permanency and stability.

Elements of a Successful Team

- A process of a group of people coming together who are committed to a common purpose

- Mutual respect between team members and recognizing their value to the team

- Meeting schedules and locations are guided by the family’s needs and preferences

- Membership must include child and family, mental health provider, and others identified by the family
What is Katie A.?

- Katie A. is a class action settlement agreement which seeks to improve the behavioral health of children and families.

- Katie A. Program provides needed behavioral health services in your own home and/or community in order to meet the child’s needs for safety, stability, and well-being.

- Katie A. services are strength based, individualized to your child and family, and respectful of your family’s values and culture.

- The settlement agreement created two new services: Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS).

- Youth ages 0-21 with full-scope Medi-Cal and medical necessity qualify for services.

Katie A. Coordinators
Behavioral Health Services Department
408-501-6793 or 408-501-6768
Full Service Partnership (FSP)- Child Program
Presenter: Bernadette Martinez, LCSW Program Manager
Gardner: FSP Child Program

Target Population:
- Ages 6-15
- Medi-cal eligible
- May have a history or current Child Welfare or Juvenile Justice involvement
- May have one to two hospitalizations or incarcerations in the last year
- Homeless or at high risk for becoming homeless due to the severe mental illness
- Child/youth benefits from service two to five times a week
- Child/youth need is greater than 8 hours of service a month
Services:

- Individual therapy,
- Rehabilitation,
- Assessments,
- Plan development,
- Medication and medication support,
- Peer support,
- Interdisciplinary team approach,
- Case management, and
- Community based.

12-15 hours a month of services which may include telehealth when appropriate

30-50% Community base

24/7 hour support

9 months length of stay
1 to 13 staff to consumer ratio

Clinical Team may include:

- Clinician
- Peer Partner
- Family Partner
- Psychiatrist
- Rehabilitation Counselor
Referrals can be made by calling the BHSD Call Center or contact directly:

(408) 287-6200

Marcela Pallais, LCSW
Program Supervisor
mpallais@gfhn.org

Bernadette Martinez, LCSW
Program Manager
bmartinez@gfhn.org

Amy Rice, LMFT
Senior Program Manager
arice@gfhn.org
Placement Supportive Services (PSS)

MAE SAMPANI, CLINICAL DIRECTOR
Service Delivery Expertise

PSS1 has the ability to respond within 30 minutes of receiving a referral activation call, and 24 hours (PSS2) response time after receiving a referral
Assessment and safety planning
Immediate support and stabilization to potential placement disruption to

60 day Professional Parent placement (up to 10 Professional Parent beds). No eject, no reject. Individualized community-based mental health services, with up to 24/7 in-placement supportive services (PSS1)
Collateral support for caregivers/parents/significant support people
Child & Family Team meeting, plans to address crisis & Placement Stabilization
“Do what it takes” philosophy with expertise in engaging youth to reduce AWOL’ing behaviors, while taking a trauma informed approach to meet the individual needs of the youth we serve
Linkage to community resources related to youth and family strengths and needs
Development of natural support network which may including Family Finding
After-hours On-Call Network (SBQR)
Support with referrals and recommendations to appropriate level of service for continuity of care
Eligibility

Referrals come exclusively from DFCS Placement Unit

PSS serves youths ages 0-21, in need of placement stabilization.

PSS1 typical referrals include high acuity youth who are likely to experience chronic AWOL, substance use, multiple 5150 hospitalizations, as well as Commercially Sexually Exploited Youth, placement disruptions.

PSS2 typical referrals include lower acuity youth, at risk of losing their placement or needing support in re-entering home placement after having been removed, for placement stabilization.

Capacity to serve 62 youth

Youth referred to PSS must meet medical necessity.
PSS 1 track

30-minute response time after receiving a referral

High acuity youths

Individual community-based mental health services, with up to 24/7 in-placement support services

Potential Professional Parent placement
PSS 2

- 24-hour response time after receiving a referral, to contact family and schedule intake within the week
- Lower acuity youths
- Approximately 1-3 times per week supportive services
PSS team

• 7 Facilitators
• 4 Family Partners
• 18 Family Specialists
• 2 Program Supervisor
• 2 Clinical Program Managers
• 73% of staff speak other languages:
  • Spanish, Tagalog, Vietnamese, German, French, Farsi, Cambodian, Hindi, and Punjabi
2020 Outcome Data

- 87% of all discharges achieved treatment goals
- 70.1% Maintained In Home or in family setting
- 94.2% Maintained their educational placement
- 96.6% Stayed out of trouble
- 29.9% Receiving intensive services to support towards in home placement
Placement Supportive Services (PSS) merged two of Uplift’s 60-day programs, PSCSRT and FFSS into one. PSS partners with the Department of Family and Children Services, Placement Unit, and the Receiving Center, to provide stabilization services, by offering individual, intensive, brief therapeutic treatment and crisis stabilization, to children, youths, and non-minor depends (ages 0-21,) who are either at the RAIC or at risk of entering the RAIC, at risk of losing their home placement, or who are difficult to find placement for.

**About Us**

**Mission Statement**
We do whatever it takes to strengthen and advocate for children, families, adults, and communities to realize their hopes for behavioral health and well-being.

**For More Information about PSS**
Client Services Center
(408) 379-3796

**Our Headquarters:**
251 Llewellyn Avenue
Campbell, CA 95008
Tel (408) 379-3790

**Management Contact Information:**
Jennifer Chandler, LMFT
Clinical Program Manager
408-335-9771

Laura Plottier-Ramirez, AMFT
Program Manager
408-431-8591
Eligibility

- Referrals come exclusively from DFCS or the Receiving Center. PSS serves youths ages 0-21, in need of placement stabilization.
- Capacity to serve up to 90 youth
- Youth referred to PSS must meet medical necessity.

Service Delivery Components

- 60-day program (extensions beyond 60 days, granted as needed by the Placement Unit)
- Capacity to respond to referrals within 30 minutes or 24 hours, depending on need
- Team based and strength-based approach; assessment and safety planning
- Collateral support for caregivers/parents/significant support, related to youth’s treatment needs
- Child & Family Team meeting, plans to address crisis & placement stabilization
- “Do what it takes” philosophy
- Linkage to community resources related to youth and family strengths and needs
- Development of natural support network which may include family finding
- After-hours on-call network (Stand by Quick Response) 24/7 access
- Support with referrals and recommendations to appropriate level of services for continuity of care
- Potential Professional Parent placement for high acuity youth to support in stabilizing behaviors

Our Agency Values

Family Input
Your needs and ideas are given top priority in planning success

Focus on Strengths
Your knowledge and strengths are brought out to create the best possible plan

Individualized
The team creates a plan that works for your family, based on what you need

Team Based
We work with a diverse team of people committed to your family that includes extended family and friends

Respect for all Families, Cultures, and Differences
However you define your family, we will respect and celebrat who you are

Community Based
We work within your community to help you get support from your community

Collaborative
The team works together to meet needs and share responsibility
Annual Report for FY20
Santa Clara County
Placement Supportive Services (PSS)
<table>
<thead>
<tr>
<th>Target Population/Customers</th>
<th>Core Practices</th>
<th>Key Activities/Processes</th>
<th>Goals/Outcomes (Measurement)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Children, youth, and non-minor dependents at risk of losing current approved DFCS placement</td>
<td><strong>Intake and Assessment (Day 1)</strong></td>
<td>- Triage Level of Care&lt;br&gt;- Planned Intake – Engagement&lt;br&gt;- Crisis Intake – Crisis stabilization</td>
<td>1.1) 75%; 87% of youth will meet their treatment goals <em>(Source: Reason for Discharge: Planned Discharge; Exclude reasons categorized as “Neutral”)</em></td>
</tr>
<tr>
<td>• Youth with parents, foster parents, relative or non-related extended family members (NREFM) needing stabilization and transition services.</td>
<td></td>
<td>- Medication support&lt;br&gt;- CEDE&lt;br&gt;- Referral through DFCS placement unit.&lt;br&gt;- Reach out to Caregiver within 30 minutes of receiving referral (PSS1) and 24 hours (PSS2)</td>
<td>2.1) 100%; 100% of youth will be responded to within 30 minutes of referral. <em>(Source: Internal spreadsheet.)</em> 2.2) 90%; 100% of youth identified by DFCS requiring 1:1 24/7 care shall receive this service. <em>(Source: Internal spreadsheet.)</em></td>
</tr>
<tr>
<td><strong>Ages:</strong> 0-21 years old</td>
<td><strong>Risk Assessment and Safety Planning</strong></td>
<td>- Risk Assessment&lt;br&gt;- Crisis Intervention&lt;br&gt;- Pro-Active/Reactive Safety Plans</td>
<td>3.1) 80%; 70% of youth will maintain or improve their living placement. <em>(Source: CEDE – Current living situation)</em> **</td>
</tr>
<tr>
<td><strong>Payor:</strong> MediCal &amp; DSS</td>
<td></td>
<td></td>
<td><strong>Satisfaction Outcomes</strong></td>
</tr>
<tr>
<td><strong>Referral Source:</strong></td>
<td></td>
<td>Comprehensive planning process&lt;br&gt;Mental health assessment, if LOS is greater than 30 days&lt;br&gt;EPSDT Services (e.g. therapy, plan development, collateral, rehabilitation, case management)</td>
<td>5.1) 80% 75% (YSSF), 92% (YSS), % (CSQ-3) of youth and families will be satisfied with services. <em>(Source: CSQ-3; Satisfaction is defined by a score of 3.5 on item #2. YSS, YSS-F, AS; % Satisfied=Mean score of 4 or higher on Total Satisfaction)</em></td>
</tr>
<tr>
<td>• SCC DFCS Placement Unit</td>
<td></td>
<td>Medication support&lt;br&gt;Weekly CFT meetings&lt;br&gt;Continuous safety planning&lt;br&gt;24/7 crisis intervention and management&lt;br&gt;EBPs: Motivational Interviewing, PBIS, &amp; Stages of Change, Core Elements FSE and Connectedness Maps&lt;br&gt;Whole Person Care integration</td>
<td></td>
</tr>
<tr>
<td><strong>Criteria for Entry:</strong></td>
<td></td>
<td></td>
<td><strong>Notes:</strong> (1) CEDE Paired data with 30 days difference between admit and discharge timeframes. (2) In <strong>RED</strong>: per contract, in <strong>GREEN</strong>: per desired target goal, and in <strong>BLUE</strong>: per program baseline or KPI standard. (3) <strong>FSE data collection and analysis will begin in FY16. (4)</strong> CEDE: Current Living Situation Improvement is defined by youth in an out-of-home placement at Admit and in an in-home placement at Discharge. Improvement is also defined as a youth moving to less restrictive level of care from Admit to Discharge. Maintained is defined as youth maintaining level of care or maintaining in an in-home placement. <strong>Date Revised:</strong> 2020-02-28 O&amp;E Contact: Martha Njie, Research Specialist Program Contact: Sheena Mae Sampani, Clinical Director and Jennifer Chandler and Laura Plottier-Ramirez, Clinical Program Managers</td>
</tr>
</tbody>
</table>
Program Mission Statement

Description
Placement Supportive Services (PSS) partners closely with the Department of Family and Children Services (DFCS,) Placement Unit and Keiki Center to stabilize placement by providing individual, intensive, brief therapeutic treatment and crisis stabilization. PSS provides stabilization services, to children, youth, and non-minor dependents (0-21) who are at the Keiki Center or at risk of entering the Keiki Center, and/or for whom are difficult to find placement.

Service Delivery Expertise
- PSS1 has the ability to respond within 30 minutes of receiving a referral activation call, and 24 hours (PSS2) response time after receiving a referral
- Assessment and safety planning
- 60 day Professional Parent placement (up to 10 Professional Parent beds). No eject, no reject.
- Individualized community-based mental health services, with up to 24/7 in-placement supportive services (PSS1)
- Collateral support for caregivers/parents/significant support people
- Child & Family Team meeting, plans to address crisis & Placement Stabilization
- “Do what it takes” philosophy with expertise in engaging youth to reduce AWOL’ing behaviors, while taking a trauma informed approach to meet the individual needs of the youth we serve
- Linkage to community resources related to youth and family strengths and needs
- Development of natural support network which may including Family Finding
- After-hours On-Call Network (SBQR)
- Support with referrals and recommendations to appropriate level of service for continuity of care

Eligibility and referral process
Referral exclusively come from DFCS Placement Unit. PSS serves children, youth, and non-minor dependents who are in need of placement stabilization. Typical referrals include high acuity youth who are likely to experience chronic AWOL’ing, substance use, multiple 5150 hospitalizations, as well as Commercially Sexually Exploited Youth (CSEC).

Capacity
90 youth

Contact Information

Mae Sampani  
Clinical Director  
(408) 335-9130  
mae.sampani@upliftfs.org

Jennifer Chandler  
Clinical Program Manager  
(408) 335-9771  
jennifer.chandler@upliftfs.org

Laura Plottier-Ramirez  
Clinical Program Manager  
(408) 431-8591  
laura.plottier@upliftfs.org
Executive Summary

Demographic Data On The 257 Youth We Served From July 1, 2019 Through June 30, 2020

Gender

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>48%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Ethnicity

<table>
<thead>
<tr>
<th>Hispanic/Latino</th>
<th>Caucasian</th>
<th>African American</th>
<th>Native American</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>54%</td>
<td>21%</td>
<td>13%</td>
<td>1%</td>
<td>5%</td>
</tr>
</tbody>
</table>

41% are aged 14-17 years old

Mostly affected by Trauma-Stressor Related (68%) and Mood Disorder (22%)

PSS is able to stabilize and transition youth to ongoing supportive services within 60 days

Our Excellent Discharge Outcomes Include

<table>
<thead>
<tr>
<th>Outcome Objective</th>
<th>Target</th>
<th>Actual</th>
<th>Achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth are satisfied with services</td>
<td>4</td>
<td>4.42</td>
<td>✓</td>
</tr>
<tr>
<td>Families are satisfied with services</td>
<td>4</td>
<td>4.36</td>
<td>✓</td>
</tr>
</tbody>
</table>

94% of youth attend school

97% of youth are out of trouble

70.1% of our youth live in home settings, with the remainder 29.9% of our youth residing in intensive treatment settings.

PSS supports these youth towards stabilizing in order to move towards placement in a home-like setting.
Part I: Descriptive Data

Our Referral Sources
Trust Uplift Family Services

Our referral sources trust us to provide quality services. All PSS referrals come exclusively from the Placement Unit at the Department of Family and Children Services. PSS received 257 referrals.

We Served 257 Youth From July 1, 2019 Through June 30, 2020

Our youth are split almost evenly between male and female and the majority of our youth are Hispanic or Latino/a.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female 48%</th>
<th>Male 52%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td>Hispanic/Latino 54%</td>
<td>Caucasian 21%</td>
</tr>
</tbody>
</table>

School-aged Youth (6-17 Years) Make Up 88% Of Our Capacity

Most of the youth participating in our programs are school-aged. Here is a breakdown of their ages at start of the program.

- Ages 14-17: 89 youth
- Ages 6-10: 46 youth
- Ages 11-13: 57 youth
- Ages 0-5: 23 youth
- Ages 18-25: 1 youth
Part II: Outcome Data

87% Of All Discharges Achieved Treatment Goals

There are 5 main reasons why youth would be discharged from our services. Here is the breakdown by number of youth.

- Treatment Goals Met: 183 Youth
- AWOL: 0 youth
- Other/Administrative: 13 Youth
- Treatment Goals Not Met: 0 Youth
- More Restrictive LOC: 4 Youth

Reason For Youth Discharges In FY 20

Part III: CEDE Data

Core Evaluation Data Elements

Uplift Family Services look to these three items as indicators of how well our services are received by the 143 youth that were in our program.

70.1%
Maintained In Home Or In A Family Setting

96.6%
Stayed Out Of Trouble

94.2%
Maintained Their Educational Placement

29.9%
Receiving Intensive Services to Support Towards in Home Placement
Part IV: Satisfaction and Staff Data

Youth, Families, and Adults Report Their Satisfaction Levels

Youth, families, and adults report their satisfaction level with services on a scale from 0 to 5, where 5 indicate highest satisfaction. There were 14 Youth and 43 Families that completed the survey.

Youth 4.60
Families 4.70

Legend

4.60
4.70
4.40
4.20
4.10

Access to services
Family involvement
Cultural Sensitivity
Satisfaction
Outcomes

Staff Information on Language, Ethnicity, and Retention

Our program is composed of 26 dedicated staff who support and celebrate the milestones with each youth and family.

73% speak an additional language
• 11 staff speak Spanish
• Other language
  • Tagalog
  • Vietnamese
  • German
  • Farsi
  • French
  • Cambodian
  • Hindi
  • Panjabi

23 hours of annual training* per person on average

*Trainings include: Art Therapy, Positive Discipline, PBIS, Trauma-Focused CBT

Our Staff Stay With Us Year After Year

White, 19%
Hispanic or Latino, 40%
Asian, 19%
2 or more races, 19%

Black, 3%
Part V: Monica and Christina’s Success Stories

Monica
Monica is a 7-year old girl who recently came into the foster care system due to unmanageable behaviors including physically aggressive outbursts that would last for hours at time. These outbursts would often lead to property destruction and physical assault toward others. Monica had experienced a lot of loss in the last 6 months, including her father passing away, losing contact with her siblings, and being removed from her mother’s care by DFCS. Monica had also been removed from 3 different foster homes due to unmanageable behavior within 10 days upon PSS referral. Monica was placed in PSS Professional Parent home where she would experience the “no eject, no reject” philosophy to provide unconditional support to help stabilize her behaviors and symptoms.

PSS partnered closely with DFCS to meet her complex needs, some of which included DFCS Social Workers with whom she had a positive relationship coming to the Professional Parent home to provide additional support and unconditional care. PSS provided support all waking hours to promote structure in the home environment, especially around bedtime and bath time, in order to increase her sense of safety in the home. PSS team also utilized creative and individualized approaches, one of which was creating a book of Monica’s character which detailed individualized social stories to address her unique challenges.

Within a 3 week period at the Professional Parent home, her team saw a huge decrease in property destruction and in intensity of physical aggression. Through collaboration with DFCS partners, PSS successfully transitioned her to Chamberlains, where youth could continue to receive intensive treatment. PSS also partnered closely with Chamberlains staff during a 2 week warm hand off period to review safety plans and treatment approaches that were found to be successful. Monica had a successful transition to Chamberlains where her social stories are still read to her every night before bed and she is thriving in her new placement.

Christina
Christina was referred to PSS when she transitioned into a new foster placement. She was struggling with low mood, low self-esteem, a sense of hopelessness and some anxiety that clouded her days. Christina would stay in bed most of the day, pained by the tumultuous relationship between herself and her biological mother. She felt alone, unseen, and hurt during this adjustment in her life, which negatively impacted her daily structure and social relationships. Christina was also struggling with the fact that she would turn 18 years old soon, and that additional pressure to be an “adult” weighed heavily on her.

In identifying strengths of Christina’s, the PSS team utilized her artistic inclinations to engage her and create individualized interventions to her specific needs. In the short amount of time Christina had been with PSS, she was open and curious to the various creative activities and interventions PSS presented to her. There was a spark that ignited within Christina when she was able to engage in art therapeutic activities. From crafting paper boxes to creating her own decorative cards to send to her loved ones, she was able to express herself through art-making in a way that traditional words could not. Christina shared that through sending her cards to her mother and younger brothers, they were able to begin repairing their relationships. Learning how to design paper boxes allowed her to gift homemade cookies to essential workers during the current pandemic as well. Christina saw the value of how the creative process can be healing for her.

Nearing the end of her time with PSS, Christina and her PSS team had created artistic emotions and needs cards, which helped Christina learn to identify her multiple emotions and needs more effectively. Christina had also increased her ability to advocate for herself, create healthier boundaries with others, and cultivate a stronger level of respect for herself. At discharge, Christina had been able to communicate with her biological mother on positive terms, to begin healing their relationship.
FAMILY AND CHILDREN’S SERVICES
YOUTH SUBSTANCE USE TREATMENT SERVICES
YOUTH OUTPATIENT SUBSTANCE USE TREATMENT SERVICES

Target Population
• Youth up to the age of 21 in need of substance use or co-occurring services

Referrals
• Referrals are made by probation, medical clinics, schools, community providers, family or self

Behavioral Health Services
• Integrated Assessment
• ASAM Level I Clinical Treatment
• Recovery Services
• Individual/Family/Group Therapy
• Medication Management & Medication Assisted Treatment (MAT)
• Utilization of Evidence-Based Practices

Guiding Principles
• Individualized Care
• Strength-based,
• Culturally responsive & developmentally appropriate
• Developmentally appropriate

Insurance
• Eligible youth receive services with primary focus on Medical beneficiaries and uninsured youth
OTHER SUPPORTS

- Wrap Consultative Partnership
- Warm Handoff MDT’s
- Outreach Presentations on Drug Trends 2020
| **Asian Americans for Community Involvement (AACI)**  
| **Main Clinic**  
| **2400 Moorpark Ave.**  
| **San Jose, CA 95128**  
| | **Asian American Recovery Services / HealthRIGHT360**  
| **AARS Tully Office**  
| **1340 Tully Rd, Suite 304**  
| **San Jose, CA 95122-3055**  
| | **Advent Group Ministries**  
| **Advent Main Clinic**  
| **90 Great Oaks Blvd, #108**  
| **San Jose, CA 95119**  
| | **Santa Clara County Behavioral Health Services**  
| **Children, Family & Community Services (CFCS)**  
| **2101 Alexian Dr. Suite 110**  
| **San Jose, CA 95116**  
| **School Sites**  
| **Yerba Buena High School**  
| **Overfelt High School**  
| **Andrew Hill High School**  
| **Evergreen High School**  
| **Independence High School**  
| **James Lick High School**  
| | **Advent Friendly Inn Clinic**  
| **17666 Crest Ave.**  
| **Morgan Hill, CA 95037**  
| **School Sites**  
| **Fremont Union High School**  
| **Cupertino High School**  
| **Homestead High School**  
| **Alta Vista High School**  
| **Mountain View High School**  
| **Los Altos High School**  
| | **Sunnyvale Health Center Clinic**  
| **660 S Fair Oaks Ave**  
| **Sunnyvale, CA 94086**  
| **Esperanza Self-Help Center**  
| **1235 First Street**  
| **Gilroy, CA 95020**  
| **School Sites**  
| **Gilroy High School**  
| **Christopher High School**  
| **Mt. Madonna High School**  
| **Sunol Community School**  
| **Apollo High School**  
| **Broadway High School**  
| **Lincoln High School**  
| **Foothill Community School**  
| **Gateway School**  
| **Escuela Popular**  

**COUNTY OF SANTA CLARA Behavioral Health Services**
YOUTH RESIDENTIAL SUBSTANCE USE TREATMENT SERVICES

Target Population
- Youth up to age 18 with Medi-Cal who have been assessed as requiring residential treatment to address their substance use and/or co-occurring disorders until they are stabilized.

Referrals
- Referrals are made via the SUTS Quality Improvement Coordinator with submission of an ALOC

Services
- ASAM Level of Care 3.1 & 3.5
- Addresses multidimensional needs
- Individual Therapy
- Family Therapy
- Group Therapy
- Case Management
- Medication Management
- Psychoeducation
- Treatment community serves as a therapeutic agent

Length of Services
- Up to 30 days
CONTACT US

☐ Contact Lia Avila, YSOC Referral Coordinator at:
  • Lia.avila@hhs.sccgov.org
  • Main # (408) 272-6518
  • Direct # (408) 272-6594

☐ Or Send Referral to:
  • YSOCSUTSReferral@hhs.sccgo.org
Santa Clara County First Stop
Therapeutic Visitation Services

Presented by Kelsey Rowland, Program Supervisor
Seneca Visitation Services

01 Supervised
- 1:1 Supervision by counselor
- Parent is the client
- Counselor Careful to not over intervene

02 Enhanced I
- 1:1 Supervision by counselor
- Clinician creates goals for parent
- Parent is client

03 Therapeutic (Enhanced II)
- 1:1 Supervision by clinician
- Youth has medical necessity
- Youth is client
Supervised
• 1:1 Supervision by counselor
• Parent is the client
• Counselor Careful to not over intervene

Enhanced I
• 1:1 Supervision by counselor
• Clinician creates goals for parent
• Parent is client

Therapeutic (Enhanced II)
• 1:1 Supervision by clinician
• Youth has medical necessity
• Youth is client
Therapeutic Visitation

- **Target population:** Dependents of Santa Clara Department of Child and Family Services and Behavioral Health Services; ages 0 to 18 and their families, primarily in Family Reunification Services
- **Insurance requirements:** Medi-cal (if youth does not have Medi-cal they can be enrolled in Enhanced II)
- **What is the service:**
  - A safe setting for parent-child visits
  - Opportunity to address feelings of trauma and loss through strength-based, family focused intervention to improve communication and interactions
  - The clinician facilitates developmentally appropriate communication and verbal interventions between the child(ren) and the parent(s)
- **Where:** Seneca Visitation Office in San Jose and Gilroy
- **Eligibility requirements:** Child (ren) meet medical necessity & family is entitled to visitation services
- **Services during COVID-19:** Offer virtual and in person visits
Referral Process

- Referral made by the Social Worker via Therapeutic Visitation referral form
- DFCS Visitation Schedulers will send the referral to our Visitation Coordinator

Please note that referrals will not be processed, and coordination of visits will not begin without the required forms completed.

- A clinician will complete a full CANS (if one has not been completed) for families referred to therapeutic visitation services to determine the length and frequency of the therapeutic visits.
Contact Info

For Further Information
Email: sccvisitation@senecacenter.org

Kelsey Rowland
Seneca Family of Agencies
Program Manager
Kelsey_Rowland@senecacenter.org
669.288.0071

Tamara McClain
Seneca Family of Agencies
Division Director of Visitation
Tamara_Inman@senecacenter.org
415.760.0825
Seneca Visitation Services

Service Overview

Seneca Family of Agencies Integrated Visitation Services Program is a service dedicated to providing comprehensive visitation services for families referred by Santa Clara County (Social Services Agency and Behavioral Health Services Department). The purpose of this service is to address the unmet visitation needs, utilize visitation as an opportunity to build parental capacity and strengthen family relationships, attunement, attachment opportunities to better achieve reunification, and permanency (family finding) outcomes. Seneca Visitation Services will include an array of services, all housed in one location and visitation/permanency team to allow continuum of care, collaboration and effectiveness.

Hours of Operation

Monday-Friday: 9:00am-8:00pm
Saturday-Sunday: 9:00am-5:00p
*hours can be flexible dependent and family needs

Population

Seneca Visitation Services receives referrals from Santa Clara Department of Child and Family Services and Behavioral Health Services including dependents ages 0 to 18 and their families. Visitation is primarily for parents who are entitled reunification services with their children but is not limited due to such cases may involve siblings, parents and other family members.

Staff

Seneca Visitation Services staffing structure consist of 5 distinct positions. The first is a master’s level or bachelor’s level (3 years of related experience) Program Manager who provides case management, creation of protocols, management of referrals (setting and scheduling visits), implementation of improved services and Quality Assurance. The Program Manager also maintains working relationships and coordinates closely with Santa Clara Department of Child and Family Services. The second is a master’s level Clinician who completes the assessment that determines the level of visitation services. The Clinicians also creates the treatment goals and planning for each family. The third is a bachelor’s level Visitation Coordinator who serves as the liaison between Department of Child and Family Services, Behavioral Human Services, and Seneca Visitation Services with setting up and scheduling visits. The fourth is a bachelor’s level Visitation Counselor that is assigned to each family to supervise visits, model behaviors and coach parents. The fifth is a bachelor’s level Permanency Specialist that could be assigned to parent(s) that assist in exploring connections and identify possible support. The sixth is a Family Partner that could be assigned to parent(s) to provide emotional support, resource knowledge, psychoeducation, and coaching to parent(s).
Program Manager is supervised by the Program Director. Visitation Counselors, Coordinator and Clinicians are supervised by the Program Manager. Family Partners will consult and collaborate with the Program Manager and Clinicians. Clinicians also receives clinical supervision weekly as they are responsible for the strength and needs assessment and treatment planning that is completed for each family. The Clinical Supervisor provides supervision to the Clinicians in order to ensure high quality services and promote on-going professional development.

**Referral Process**

Referrals to Seneca Visitation Services are made by the Social Worker via Visitation Plan referral, which should include the visitation logistics, the reason for removal, a harm and danger statement, other relevant information and all contact information. The Visitation Plan referral should be accompanied by the completion of the Case Screening CANS questionnaire from the Social Worker. The Visitation Coordinator should receive the completed Visitation Plan referral and Case Screening CANS questionnaire from Social Worker via email @ sccfirststop@senecacenter.org. Please note that referrals will not be processed, and coordination of visits will not begin until the required forms are completed.

For all families referred to Seneca Visitation Services, a clinician will complete the abbreviated CANS with the family to determine whether Supervised or Enhanced Visitation services are needed. All families referred to Seneca will begin visits within 5-10 calendar days of receiving the completed visitation referral.

The abbreviated CANs assessment will be completed every 60 or 90 days (depending on the level of visitation service) and at the end of service to measure change and progression. We work with the child (ren), the parent (s) and social worker and their needs to change over time. Needs may change in response to many factors including quality of service and support provided. One way the visitation program determines how our service and support are helping alleviate needs and restore functioning is by re-assessing needs, adjusting service plan, tracking change and progression, as well as allows us to make recommendations for future service and support.

**Discharge Planning**

1. Families may discharge from Seneca’s Visitation Services when the Social Worker has determined that services are no longer needed for the family. This may be due to the Social Worker approving family members to continue the supervised visits or approval for unsupervised visits.
2. Families may also discharge due to 3 consecutive missed visits from the parents.
3. Families may also discharge if Social Worker and Court have determined reunification services will be terminated.
**Visitation Services**

**Supervised Visitation**

A Visitation Counselor and Clinician will be assigned to provide 1:1 supervision, structure, interventions, and safety support to promote safe parenting interactions during the visit. Visitation objectives may include age-appropriate interactions between the parent(s) and the child(ren) or a parent(s) demonstrating that he/she can see, understand, and respond immediately and effectively to the child(ren) verbal and nonverbal signals. Visitation Counselors are careful to not to over-intervene when providing Supervised Visitation services, with understanding that their role is to support the deepening and strengthening of the parent(s) and child(ren) relationship. The child welfare worker will receive regular updates regarding a family’s visits including progress made toward meeting their reunification case plan requirements and goals.

**Enhanced Visitation**

A Visitation Counselor and Clinician will be assigned to provide 1:1 supervision, to observe family interactions and provide role-modeling, coaching and verbal communication to ensure a safe and successful visit. Interventions will be based on child(ren) developmental needs, as well as, the specific needs of each family situation. The Visitation Counselor or Clinician will implement interventions that will help families identify, develop and utilize skills that lead to successful interactions, build connectedness, improve relationships and overall functioning. The child welfare worker will receive regular updates regarding a family’s visits including progress made toward meeting their reunification case plan requirements and goals.

If additional therapeutic interventions are deemed necessary, staff will relay this information to the Child Welfare worker to refer the family to additional therapeutic service visits.

**Enhanced II/Therapeutic Visitation**

Therapeutic Visitation services are provided when the family is entitled to visitation services and a child(ren) meet medical necessity. Enhanced II/Therapeutic visitation offers both a safe setting for parent-child visits to occur and the opportunity to address feelings of trauma and loss through strength-based, family focused and tailored therapeutic intervention to improve the parent(s) and child(ren) communication and interactions. The clinician facilitates developmentally appropriate communication and verbal interventions between the child(ren) and the parent(s) within a supportive environment. In this setting, the clinician can support difficult discussions including allegations, betrayal of child(ren) trust caused by emotional or physical abuse, the altered relationship between parent(s) and child(ren), as well as, other topics impacting the family dynamic and communication.

Referrals to Seneca Enhanced II/Therapeutic Visitation should be made by the Visitation Team of families receiving Enhanced Visitation through Seneca or directly from the Social Worker via Therapeutic Visitation referral, which
should include visitation logistics, reason for therapeutic visitation services, other relevant information and all contact information. The Visitation Coordinator should receive the completed Therapeutic Visitation referral from the Social Worker via email @ sccfirststop@senecacenter.org. Please note that referrals will not be processed, and coordination of visits will not begin without the required forms completed.

A clinician will complete a full CANS (if one has not been completed) for families referred to therapeutic visitation services to determine the length and frequency of the therapeutic visits, consistent with court orders. The Therapeutic Visitation Clinician can also assess for additional needs and make referrals for individual or family therapy as appropriate at Seneca’s existing outpatient clinic.

*See attachment of full outline referral process document for Visitation Services

**Family Finding and Engagement Services**

Family Finding services are provided when a family has been identified as needing engagement services in addition to visitation services. Family Finding/Engagement component offers a service that allows an assigned Permanency Specialist to explore and identify connections and to increase the network of natural supports. Family Finding/Engagement services will be based on the need of additional efforts for successful connections and support. The Permanency Specialist will apply the principles and stages of Family Finding from discovery to engagement, to planning, to implementation, and follow up of supports. Engagement shall be integrated into all the other stages while the discovery stage shall be an ongoing process. The Permanency Specialist shall conduct this service guided by the core belief that (I) every child has a family and they can be found if we try, (2) loneliness can be devastating and is experienced by most children in out-of-home care, (3) meaningful connections to family or natural supports help a child develop a sense of belonging, and (4) positive outcomes for children are significantly increased by meaningful connections and lifelong relationships with family and natural supports.

The Permanency Specialist facilitates all linkage and connections in a therapeutic, supportive manner.
For Further Information

Kelsey Rowland
Seneca Family of Agencies
Program Manager
Kelsey_Rowland@senecacenter.org
669.288.0071

Tamara McClain
Seneca Family of Agencies
Division Director of Visitation
Tamara_Inman@senecacenter.org
415.760.0825
WE WANT TO HEAR FROM YOU

Please complete our survey.
Thank you for your support

- Please join us in honoring this special day together with youth, social justice leaders, and community
- January 21, 2021
- 3:30-5pm
THANK YOU