Mental Health Services Act:

Three-Year Program and Expenditure Plan FY 2017-2018 through FY 2019-2020

November 13, 2017

WELLNESS RECOVERY RESILIENCE

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County of Santa Cruz

HEALTH SERVICES AGENCY

1400 Emeline Avenue, Santa Cruz, CA 95060
(831) 454-4170 FAX: (831) 454-4663 TDD: (800) 523-1786

LETTER FROM THE MENTAL HEALTH SERVICES ACT COORDINATOR

September 18, 2017

We have completed a draft of "Three Year Program and Expenditure Plan" of the Mental Health Services Act (MHSA/Proposition 63), as required under Welfare and Institutions Code Section 5847. This Plan covers fiscal years 2017-18, 2018-2019, and 2019-2020. This Three-Year Plan is not intended as a binding contract with any entity or provider of services. Services will be monitored on a continual base, and the County may make changes, if necessary.

The report will be posted from September 18, 2017 through October 18, 2017, and a Public Hearing will be held on October 19, 2017 at 3:00. at the Watsonville Veterans Memorial building, 215 East Beach Street, Watsonville. Subsequently the Plan will be sent to the Santa Cruz County Board of Supervisors for adoption, and then to the Mental Health Services Oversight Accountability Commission and the State Department of Health Care Services.

You may provide comments about the draft plan in the following ways:

At the Public Hearing,
By fax: (831) 454-4663,
By telephone: (831) 763-8203,
By email to mhsa@co.santa-cruz.ca.us ,
Or by writing to:

Santa Cruz County Behavioral Health
Attention: Alicia Nájera, MHSA Coordinator
1430 Freedom Boulevard
Watsonville, CA 95076

Sincerely,

Alicia Nájera, LCSW
Senior Behavioral Health Program Manager
Mental Health Services Act Coordinator

I. MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Cruz

County Mental Health Director	MHSA Coordinator
Name: Erik G. Riera	Name: Alicia Nájera, LCSW
Telephone Number: 831-454-4515	Telephone Number: 831-763-8203
E-mail: erik.riera@santacruzcounty.us	E-mail: alicia.najera@santacruzcounty.us
Mailing Address: Santa Cruz County Behavioral Health 1400 Emeline Avenue Santa Cruz, CA 95060	

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

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on December 5, 2017.

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

All documents in the attached annual update are true and correct.

Mental Health Director — Signature — 9-4-17 Date

Erik G. Riera

County: Santa Cruz

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

Santa Cruz County

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

Local mental Health Director	County Auditor-Controller
Name: Erik G. Riera	Name: Michael Beaton
Telephone Number: 831-454-4515	Telephone Number: 831-454-4449
E-mail: erik.riera@santacruzcounty.us	Email: michael.beaton@santacruzcounty.us

Local Mental Health Mailing Address:

Santa Cruz County Behavioral Health
1400 Emeline Avenue
Santa Cruz, CA 95060

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

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

Erik Riera — Local Mental Health Director (Print)
Signature — Date: 10-13-17

I hereby certify that for the fiscal year ended June 30, 2017, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892f); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated December 16, 2016 for the fiscal year ended June 30, 2017. I further certify that for the fiscal year ended June 30, 2017, that State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Michael Beaton — County Auditor Controller (Print)
Signature — Date: 10-12-17

Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan Executive Summary

Welfare and Institutions Code Section 5847 states that county mental health programs shall prepare and submit a Three Year Program and Expenditure Plan and Annual Updates for the Mental Health Services Act (MHSA/Proposition 63). This year we are submitting our Three Year Plan which covers fiscal years 2017-18, 2018-2019, and 2019-2020. The State requires input from community stakeholders, and a thirty day Public Review of the draft plan. The draft plan will be available from September 18 to October 18, 2017. Following the public review we are required to have a public hearing which will be on October 19th at 3:00 at the Veterans Memorial Building, 215 East Beach Street, Watsonville.

The Three-Year Program and Expenditure Plan addresses all components of MHSA. Three programs focus on infrastructure. Counties are not allowed to use infrastructure components for direct clinical care. Note also that the State no longer provides Counties with Infrastructure funds. The three infrastructure components are: Capital Facilities, Information Technology and Workforce Education & Training. Information about how the County used these funds is described in the Plan.

Three components of MHSA focus on direct clinical services. These programs are: Community Services & Supports (CSS), Innovative Projects, and Prevention & Early Intervention (PEI). The County has eight major programs in CSS, and five major programs in PEI. The County contracts with community based agencies to enhance the services provided by County staff.

Community Services & Supports services include:

1. Community Gate
2. Probation Gate
3. Child Welfare Gate
4. Education Gate
5. Family Partnership
6. Enhanced Crisis Response
7. Consumer, Peer & Family Support Services
8. Community Support Services

The Prevention & Innovative Programs are grouped as follows:

1. Children's Services
2. Services for Diverse Communities
3. Transition Age Youth & Adult Services
4. Older Adult Services

Description of Stakeholder Process

a) Description of the local stakeholder process including date(s) of the meeting(s):
The Santa Cruz County MHSA Steering Committee oversaw the community planning process for each of the MHSA components. The MHSA Steering Committee membership was selected with the intention of having a cross section of member representatives, including mental health providers, employment, social services, law enforcement, consumers, and family members, as well as representatives from diverse geographical and ethnic/racial/cultural populations. Oversight of MHSA activities was returned to the Local Mental Health Board receiving regular updates about MHSA activities. The County works closely with the Local Mental Health Board (which includes consumers, family members and other advocates), and meets regularly with the various mental health contract agency representatives.

The County had an extensive Community Services and Supports (CSS) Planning Process, when the Act was first passed. Additionally, the County conducted planning processes for the CSS Housing component, the Workforce Education & Training Component, the Prevention & Early Intervention Component, Innovative Projects Component, and the Capital Facilities & Information Technology Components. The Community Planning Process consisted of workgroups, surveys, key informant interviews, and focus groups. A special effort was made to include consumers and family members. Focus groups were held in both North County and South County, in English and in Spanish.

The County held a Town Hall meeting on September 12, 2017 from 6 to 8 p.m. at the Aptos Village Park, Aptos (which is a central location in Santa Cruz County), specifically to obtain stakeholder input on the MHSA services. The MHSA components and their requirements were reviewed, and the County and Contractors provided an overview of the programs. We placed two ads in the Santa Cruz Sentinel (on 9/3/17 and 9/10/17) and the Watsonville Pajaronian (on 9/2/17 and 9/9/17) to inform the community at large announcing the Town Hall meeting. The response about the MHSA programs was positive. Stakeholders address the need for additional affordable housing. We noted that the new Innovative Program ("Integrated Health & Housing Supports) includes housing, as well as the fact that the County will be applying for the "No Place Like Home".

b) General description of the stakeholders who participated in the planning process and that the stakeholders who participated met the criteria established in section 3200.270:
The County works closely with the Local Mental Health Board, contract agency representatives, family members, NAMI, consumers, Mental Health Client Action Network (MHCAN), Mariposa Wellness Center, agencies representing underserved communities (the Diversity Center, Queer Youth Task Force, Migrant Head Start), community based agencies (such as Encompass, Front Street Inc., Pajaro Valley Prevention & Student Assistance, Family Services), educational institutions, social services, probation, juvenile detention, county jail, law enforcement, community resource centers, employment and health.

Approximately 45 people attended the Town Hall meeting. We asked participants to complete a demographic survey; 41 people completed and turned it in. The demographic breakdown for these participants is indicated in the tables below:

Age:		**Sexual Orientation**	#	**Primary Language**	#
0-17	1	Gay or Lesbian		English	31
18-25		Heterosexual or Straight	31	Spanish	
25-59	33	Questioning/Unsure		English and Spanish	8
60+	7	Queer	1	Other	1
		Another sexual orientation	1	**Stakeholder Affilication***	
Race/Ethnicity		Declined to state	8	Client/Consumer	12
American Indian	1			Family	4
Asian	**1**	**Gender Identity**	#	Law Enforcement/Probation	1
Black	2	Male	15	Social Service Agency	9
Latino	9	Female	21	Veteran/Veteran Advocate	1
White/Caucasian	15	Transgender Male		Education	2
More than one	7	Transgender Female		Health Care	
Declined to State	1	Genderqueer	2	Mental Health Provider	13
Other	5	Questioning or unsure		Substance Use Disorder Provider	1
		Decline to state	3	General Public	1
		Write in option:		Other:	3

*Note: some attendees indicated more than one stakeholder affiliation

c) Persons involved in writing the Three-Year Program and Expenditure Plan:
The Mental Health Services Act Coordinator facilitated the development of the Plan with key input from members of the Santa Cruz County Behavioral Services Management Team, including Erik Riera, Stan Einhorn, Pam Rogers-Wyman, Karen Anderson Grey, Adriana Bare, and Elizabeth Soria. The Staff worked with contract agencies and stakeholders to develop the programs in this plan.

d) The dates of the 30-day review process:
The draft plan of the MHSA update was available for review and comment from September 18, 2017 to October 18, 2017. Due to the fact that some members of the public wanted additional time to review the Plan (beyond the Public Hearing date), we allowed comments after the public hearing (until November 12th).

e) Methods used by the county to circulate for public comment the draft of the annual update to representatives of the stakeholder's interests, and any other interested party who requested a copy of the draft plan:
The draft plan was distributed to the Local Mental Health Board, contractors, and to other stakeholders. It was also posted on our Internet site, and made available in hard copy to anyone who requested it. We placed ads in the Santa Cruz Sentinel and the Watsonville Pajaronian to inform the community at large of its availability.

f) Date of the Public hearing held by the local Mental Health Board:
The Public Hearing was on October 19, 2017 at 3:00 p.m. at the Watsonville Veterans Memorial Building, 215 East Beach Street, Watsonville.

g) Summary and analysis of substantive recommendations received during the 30-day public comment period and description of substantive changes made to the proposed plan:

There was a request for additional information about the Suicide Prevention Services, and this information was added to the Plan. We also added language to indicate the Substance Use services are provided (in CSS work plans #6 and #8).

Additional comments about the Plan:

- Recommendation that there be at least two more peer-led drop-in centers in the City of Santa Cruz.
- Overwhelming support at the Public Hearing about MHCAN (the peer-led center in Santa Cruz).
- Request for more time to review the Plan. We allowed comments be submitted after the public hearing.
- Over 100 identical emails requesting that the Assisted Outpatient Treatment (Laura's Law) be included in the Plan, and one comment supporting Laura's Law at the Public Hearing.

There was also a proposal from the City of Santa Cruz that the County Behavioral Health staff meet with the Santa Cruz City staff to discuss programs and expenditures, in particular to address the "large percentage of mentally ill individuals who frequent our downtown and City neighborhoods, parks, beaches, and open spaces." The Behavioral Health Director met with them.

The City of Santa Cruz sent a letter dated November 12, 2018. The full letter can be seen in its entirety at the end of this Plan. The main requests in the letter are the following:

- Full funding for the mental health liaisons with the Santa Cruz City Police. (This program is not funded with MHSA dollars.)
- Have an MHSA advisory committee. (The County had an advisory committee when the MHSA components were initially rolled out, and the committee turned oversite to the Local Mental Health Board once the initial planning processes were completed.)
- Homeless mental health services need to be prioritized in future MHSA planning efforts going forward. (The County has a large percentage of consumers that receive mental health services. Additionally, the County is seeking funding under "No Place Like Home" for additional housing support.)

Mental Health Services Act (MHSA) Programs

In 2004 California passed Proposition 63, known as the Mental Health Services Act.

Three components of MHSA focus on direct clinical services:

- Community Services and Supports (CSS),
- Prevention and Early Intervention (PEI), and
- Innovative Programs (INN).

Three components focus on infrastructure:

- Workforce Education and Training (WET),
- Capital Facilities, and
- Information Technology.

MHSA funds are to be used to establish new services, or to expand services. Direct client services are not allowed in infrastructure components.

Description of county demographics such as size of the county, threshold languages, unique characteristics, etc.

The population in Santa Cruz County is 262,382 according to 2010 estimates. This is an increase of 2.7% from the 2000 census. In Santa Cruz, the breakdown of the population by race is approximately 59.6% White (Not of Latino origin), 32% Latinos, 1.1% African-Americans, .9% American Indian and Alaskan Native persons, and 4.2% Asian. Eleven percent (11.1%) of the population is over 65 years old. The primary language in Santa Cruz County is English, with 29.9% of households speaking a language other than English. The threshold language in Santa Cruz is Spanish. Half of the population (50.1%) is female.

The Santa Cruz Chamber of Commerce states that the population was 274,146 for the County in 2015. The breakdown of the population by ethnicity is 58.4% White (Not of Latino origin), 33.4% Latinos, 1.4% African-Americans, 1.8% American Indian and Alaskan Native persons, and 4.8% Asian. Santa Cruz has a higher population of white citizens than the California average of 39.2%. The primary language in Santa Cruz County is English, with 31.6% of households speaking a language other than English. Half of the population (50.4%) is female.

Cost Per Person Served:

The approximate cost for children served in the PEI prevention programs is $207 and $545 in the PEI early intervention programs. The approximate cost for children in CSS is $1,914. The approximate cost for adults served in the PEI prevention programs is $284, for PEI early intervention programs it is $334, for CSS it is $2,569, and INN is $4,043.

COMMUNITY SERVICES AND SUPPORTS (CSS)

This component is to provide services and supports for children and youth who have been diagnosed with or may have serious emotional disorders, and adults and older adults who have been diagnosed with or may have serious and persistent mental illness.

There are eight (8) program plans in this component. Five primarily serve children, and 3 serve adults and older adults. Transition age youth are served in both children and adult programs.

The Children programs are:

- Community Gate
- Probation Gate
- Child Welfare Gate
- Education Gate
- Family Partnership

The Adult programs are:

- Enhanced Crisis Response
- Consumer Support Services
- Community Support Services

Each program has a variety of community based organizations that have contracted with the County to provide services, as well as Behavioral Health programs that provide services.

CSS Program #1: Community Gate

Purpose: The services of this program are designed to create expanded community-linked screening/assessment and treatment of children/youth suspected of having serious emotional disturbances—but who are not referred from our System of Care public partner agencies (Probation, Child Welfare, Education).

The Community Gate is designed to address the mental health needs of children/youth in the Community at risk of hospitalization, placement, and related factors. These services include assessment, individual, group, collateral, case management, and family therapy with the goal of improved mental health functioning and maintaining youth in the community. This may include the provision of mental health services at various community primary care clinics.

Community Gate services focus on ensuring timely access to Medi-Cal beneficiaries of appropriate mental health services and supports, as well as other community members. This results in keeping youth hospitalization rates down, as well as helping to keep at risk youth out of deeper involvement with Probation, Child Welfare, and Special Education, including ensuring alternatives to residential care.

Target Population: Children/youth suspected of having serious emotional disturbances. Attention is paid to addressing the needs of Latino youth and families, as well as serving Transition-age youth. Services are offered to males and females, and are primarily in English and Spanish, although services are also provided to persons of other ethnicities, genders, and languages.

Providers: The staff from Encompass (Youth Services), Pajaro Valley Prevention & Student Assistant Services, and Santa Cruz County Behavioral Health provide the services in this work plan.

Number of individuals to be served each year:
The unduplicated numbers of individuals to be served by program are:
Encompass: 150
PVPSA: 70
Santa Cruz County Behavioral Health: 124

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? No.

Are there any new, changed or discontinued programs? Family Services is no longer providing services for this program. Pajaro Valley Prevention & Student Assistance Services is providing services.

Performance Outcomes (specify time):
Demographic information of unduplicated clients served, as required by the State:

Agency Reporting	Encompass				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					147
Number of individuals/families **SERVED**	110	136	141	137	221
Age Group					
• Children 0-15	75	98	94	93	93
• TAY 16-25	35	38	47	44	44
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	1	2	1	3	3
• Latino	104	129	133	130	130
• Other	5	5	7	4	4
Primary Language					
• English	67	78	88	84	84
• Spanish	42	58	53	53	53
• Other	1				
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	BEHAVIORAL HEALTH				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					140
Number of individuals/families **ACTUALLY SERVED**		137	133	141	231
Age Group					
• Children 0-15	58				135
• TAY 16-25	31				95
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	26				39
• Latino	45				129
• Other	18				63
Primary Language					
• English	73				177
• Spanish	16				38
• Other					16
Culture					
• Veterans					
• LGBTQ					

CSS Program #2: Probation Gate

Purpose: The Probation Gate is designed to address the mental health needs (including assessment, individual, collateral, group, case management, and family therapy) of youth involved with, or at risk of involvement, with the Juvenile Probation system. This program is also designed to increase dual diagnosis (mental health/substance abuse) services to these individuals. The System of Care goal (shared with Probation) is keeping youth safely at home, rather than in prolonged stays of residential placement or incarcerated in juvenile hall. We have noted that providing more access to mental health services for at-risk youth in the community via our contract providers before the youth become more deeply involved in the juvenile justice system has helped to keep juvenile rates of incarceration low.

To achieve our goal, we have increased dual diagnosis (mental health/substance abuse) services for youth that are:

- Identified by Juvenile Hall screening tools (i.e., MAYSI) with mental health and substance abuse needs that are released back into the community.
- In the community and have multiple risk factors for probation involvement (with a primary focus on Latino youth).
- Services to Transition-age youth (TAY) in the Probation population (particularly as they age out of the juvenile probation system).
- Services to Probation youth with high mental health needs, but low criminality.

These community based services help provide alternatives to residential levels of care, including minimizing lengths of stay in juvenile hall and keeping bed days low.

Target Population: Youth and families involved with the Juvenile Probation system or at risk of involvement. This includes Transition-age youth aging out of the system with particular attention paid to addressing the needs of Latino youth and families, although services are also provided to persons of other ethnicities, genders, and languages.

Providers: The staff from PajaroValley Prevention & Student Assistance (PVPSA), and Encompass provide the services in this work plan.

Number of individuals to be served each year:
The unduplicated numbers of individuals to be served by program are:
Pajaro Valley Prevention & Student Assistance: 68
Encompass: 84

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? No.

Are there any new, changed or discontinued programs? No.

Performance Outcomes: Demographic information of unduplicated clients served, as required by the State:

Agency Reporting	**PVPSA**				
System Development	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted.					**125**
Number of individuals/families **ACTUALLY SERVED**	17	25	30	28	41
• Children 0-15	14	22	29	27	38
• TAY 16-25	3	3	1	1	3
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White					
• Latino	15	21	26	25	36
• Other	2	4	4	3	5
Primary Language					
• English	13	18	21	19	28
• Spanish	4	7	9	9	13
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Encompass**				
System Development	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted.					**122**
Number of individuals/families **ACTUALLY SERVED**	44	46	49	52	94
Age Group					
• Children 0-15	25	28	29	30	57
• TAY 16-25	19	18	20	22	37
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	3	7	11	12	18
• Latino	26	26	26	27	51
• Other	15	13	12	13	25
Primary Language					
• English	37	38	42	44	79
• Spanish	7	8	7	8	15
• Other					
Culture					
• Veterans					
• LGBTQ					

CSS Program #3: Child Welfare Services Gate

Purpose: The Child Welfare Gate goals are designed to address the mental health needs of children/youth in the Child Welfare system. We have seen a significant rise in the number of younger foster children served in the 2-10-year-old range, and particularly in the targeted 0-5-age range. To address these needs, we will continue to provide:

- Consultation services for parents (with children in the CPS system) who have both mental health and substance abuse issues.
- Services to Transition age youth (18-21 years old) who are leaving foster care to live on their own (as well as other youth with SED turning 18).
- Provide increased services, including expanded services for the 0 to 5 -child populations. These services include assessment, individual, group, collateral, case management, family therapy and crisis intervention.
- Services for general foster children/youth treatment with a community-based agency, as well as county clinical capacity.

By ensuring comprehensive screening and assessment for foster children, we are assisting in family reunification and permanency planning for court dependents, helping them perform better in school, minimize hospitalization, and keep children in lowest level of care safely possible.

Target Population: Children, youth and families involved with Child Welfare Services, as well as Transition-age youth (particularly those aging out of foster care, but not limited to this population). Particular attention will be paid to addressing the needs of Latino youth and families. Services are offered to males and females, and are primarily in English and Spanish, although services are also provided to persons of other ethnicities, genders, and languages.

Providers: The staff from Parent Center, Encompass, and Santa Cruz County Behavioral Health provide the services in this work plan.

Number of individuals to be served each year:
The unduplicated numbers of individuals to be served by program are:
Parent Center: 30
Encompass Independent Living Program (ILP): 13
Santa Cruz County Behavioral Health: 122

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?

Are there any new, changed or discontinued programs? No.

Performance Outcomes: Demographic information of unduplicated clients served, as required by the State:

Agency Reporting	Parent Center				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**30**
Number of individuals/families **ACTUALLY SERVED**	86	73	28	22	
Age Group					
• Children 0-15	13	67	26	20	29
• TAY 16-25		6	2	2	16
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	5	24	10	6	17
• Latino	8	43	17	15	16
• Other		6	1	1	12
Primary Language					
• English	7	49	15	13	28
• Spanish	6	24	13	9	16
• Other					1
Culture					
• Veterans					
• LGBTQ		1	2	5	6

Agency Reporting	Encompass ILP				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**16**
Number of individuals/families **ACTUALLY SERVED**	3	3	3	3	4
Age Group					
• Children 0-15					
• TAY 16-25	3	3	3	3	4
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	1	1	1	1	1
• Latino	1	1	1	1	1
• Other	1	1	1	1	2
Primary Language					
• English	3	3	3	3	4
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ	1	1	1	1	1

Agency Reporting	**BEHAVIORAL HEALTH**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**195**
Number of individuals/families **ACTUALLY SERVED**	152	149	144	127	217
• Children 0-15					161
• TAY 16-25					56
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White					37
• Latino					120
• Other					60
Primary Language					
• English					169
• Spanish					34
• Other					
Culture					
• Veterans					
• LGBTQ					

CSS Program #4: Education Gate

Purpose: This program is designed to create school-linked screening/assessment and treatment of children/youth suspected of having serious emotional disturbances. In addition, specific dual diagnosis (mental health/substance abuse) service capacity has been created and targeted to students referred from Santa Cruz County's local schools, particularly those not referred through Special Education.

The Education Gate goal is to address the mental health needs of children/youth in Education system at risk of school failure by

- Providing mental health services to children/youth with serious emotional disturbance (SED) at school sites, particularly at-risk students referred from local School Attendance Review Board's and the county's County Office of Education's alternative schools.
- Providing assessment, individual, group, collateral, case management, and family therapy services.
- Providing consultation and training of school staff in mental health issues regarding screening and service needs of students with SED

Targeting specific referral and linkage relationships with the County Office of Education's Alternative School programs has helped target at-risk students not eligible for special education services, but still in need of mental health supports. Education Gate services are particularly helpful in reaching out to our local Alternative Schools students who don't qualify for special education services and are at risk of escalation into Probation and Child Welfare services.

Target Population: Children/youth in Education system at risk of school failure. Particular attention will be paid to addressing the needs of Latino youth and families. Transition-age youth will also be served. Services are offered to males and females, and are primarily in English and Spanish, although services are also provided to persons of other ethnicities, genders, and languages.

Providers: Santa Cruz County Behavioral Health staff provides the services in this work plan.

Number of individuals to be served each year:
The unduplicated number of individuals to be served by program is 15.

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? No.

Are there any new, changed or discontinued programs? No.

Performance Outcomes: Demographic information of unduplicated clients served, as required by the State:

Agency Reporting	**BEHAVIORAL HEALTH**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted					**38**
Number of individuals/families **ACTUALLY SERVED**	2	13	24	33	46
Age Group					
• Children 0-15					24
• TAY 16-25					22
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White					2
• Latino					34
• Other					10
Primary Language					
• English					32
• Spanish					9
• Other					5
Culture					
• Veterans					
• LGBTQ					

CSS Program #5: Special Focus: Family & Youth Partnerships

Purpose: This MHSA contract is designed to expand Family and Youth Partnership activities provided by parents, and youth, who are or have been served by our Children's Interagency System of Care, to provide support, outreach, education, and services to parent and youth services in our System of Care. Family partners have become increasingly integrated parts of our interagency Wraparound teams serving youth on probation at-risk of group home placement.

The support, outreach, education, and services include:

- Community-based agency contract to provide parent and youth services in our System of Care, and
- Capacity for youth and family advocacy by contracting for these services with a community bases agency. Emphasis is on youth-partnership activities.
- Rehabilitative evaluation, individual, collateral, case management, and family counseling.

Having family partners integrated into our Wraparound teams has provided invaluable peer resources for these families. It has helped parents navigate the juvenile justice, court, and health service systems and provided a peer-family advocacy voice.

Target Population: Families and youth involved in our Children's Mental Health System of Care in need of family and youth partnership activities. Services are offered to males and females, and are primarily Caucasian or Latino, and speak English and/or Spanish, although services are also provided to persons of other ethnicities, genders, and languages.

Providers: The staff from Volunteer Center- Family Partnerships provide the services in this work plan.

Number of individuals to be served each year:
The unduplicated numbers of individuals to be served by program are:
Volunteer Center/Family Partnerships: 6

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? No.

Are there any new, changed or discontinued programs? Yes. Encompass is no longer providing services in this program.

Performance Outcomes: Demographic information of unduplicated clients served, as required by the State:

Agency Reporting	**Volunteer Center**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					6
Number of individuals/families **ACTUALLY SERVED**	5	3	41	32	59
Age Group					
• Children 0-15	4	1	20	14	30
• TAY 16-25	1	2	21	18	26
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	1		7	2	7
• Latino	4	3	21	12	33
• Other			13	5	19
Primary Language					
• English	5	3	31	19	23
• Spanish			10		15
• Other					
Culture					
• Veterans					
• LGBTQ			4	4	8

CSS Program #6: Enhanced Crisis Response

Purpose: This work plan provides enhanced 24/7 supports to adults experiencing significant impact to their level of functioning in their home, or community placement, to maintain functioning in their living situation, or (2) in need or at risk of psychiatric hospitalization but are able to be safely treated on a voluntary basis in a lower level of care, or (3) individuals being inappropriately treated at a higher level of care or incarceration and able to step down from psychiatric hospitalization or locked skilled nursing facility to a lower level of care in the community.

The Santa Cruz Behavioral Health Program is committed to a person-centered recovery vision as its guiding principles and values; central to this is the notion that every individual should receive services in the least restrictive setting possible. We enable individuals to avoid or minimize the disruption and trauma of psychiatric hospitalization and/or incarceration while maintaining their safety in a supportive, safe, and comfortable environment. Additionally, we provide individualized attention and a compassionate presence for individuals in need on a 24/7 basis.

To accomplish the above, we provide the following services:

1. **Telos.** This is a licensed crisis residential program that provides voluntary alternatives to acute psychiatric hospitalization, and its primary function is hospital diversion via an intensive service model. Individuals are referred directly from the community, from the Crisis Stabilization Program at the Santa Cruz County Behavioral Health Center and as "step-down" from the Psychiatric Health Facility. The "step down" intention is to reduce the length of time an individual spends in locked care and provide a safe environment to continue to recover prior to returning to the community.
2. **Enhanced Support Service (ESS).** ESS works in conjunction with the County Full Service Partnership Team that is focused on the heavy utilizers of services. Most of the consumers on the team have a history of inpatient and locked care treatment. The team focuses care on returning these individuals from locked care setting to a community-based setting. ESS assists adult consumers maintain the least restrictive care by providing intensive wrap around services, including afterhours and on weekends.
3. **El Dorado Center (EDC).** This is a residential treatment program with capacity to provide sub-acute treatment services to individuals returning to the community from a locked care setting. The treatment is guided by recovery oriented and strength based principles. Staff collaborates with residents in identifying their strengths, skills and areas they want to improve upon as they continue the healing process in preparation for transitioning back to community living.
4. **Peer Supports at the Psychiatric Health Facility.** The focus of this program is to provide peer support to individuals receiving treatment at the County inpatient PHF, operated by Telecare Corporation. Peer lead activities include daily groups, aftercare planning and individual support.
5. **Specialty Staffing.** This is a centralized unit providing clients and providers with information and referrals to Santa Cruz County's Behavioral Health system through Access Services. Access provides walk-in crisis services, crisis intervention, intake assessments, referral and linkage to County and community-based services. One clinician will serve as the primary County-led gate to Substance Use services (SUDs).

Target Population: Individuals 18 and older diagnosed with a serious mental illness at high risk of crisis. Clients are primarily White or Latino, male or female, and speak English and/or Spanish, although services are also provided to persons of other ethnicities, genders, and languages.

Providers:

- Encompass (Telos, ESS, EDC, River Street Shelter, and Casa Pacific)
- Mental Health Client Action Network (Peer Supports)
- Santa Cruz Behavioral Health (Specialty Staffing)

Number of individuals to be served:
The unduplicated numbers of individuals to be served by program are:
Telos: 20 for outreach, and 70 FSP
ESS: 20
El Dorado Center: 60
Peer Support: 100
Specialty Staffing: 750

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
No.

Are there any new, changed or discontinued programs?
Yes, we have transitioned the ESS services to work specifically with the FSP focused on heavy utilizers of services. The ESS staff will augment the wrap-around model of intensive services to include after hours and weekend coverage to stabilize individuals in the community to live in the least restrictive setting.

Performance Outcomes: Demographic information of unduplicated clients served, as required by the State:

Agency Reporting	**Encompass: Telos**				
Outreach and Engagement	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted					**50**
Number of individuals/families **ACTUALLY SERVED**	0	0	0	0	0
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					**10**
Number Actually Served	2	3	6	3	**9**
Adults (26-59)					
Number of individuals/families targeted					**30**
Number Actually Served	16	22	17	22	**62**
Older Adults (60+)					
Number of individuals/families targeted					**10**
Number Actually Served:	4	2	2	3	9
Race/Ethnicity					
• White	17	22	20	19	65
• Latino	2	4	4	7	11
• Other	3	1	1	2	4
Primary Language					
• English	19	24	23	24	75
• Spanish	2	3	2	4	5
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Encompass: ESS Team**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**5**
Number Actually Served	5	2	2	1	**5**
Adults (26-59)					
Number of individuals/families targeted					**50**
Number Actually Served	9	14	12	5	**22**
Older Adults (60+)					
Number of individuals/families targeted					**5**
Number Actually Served:	4	3	2	2	4
Race/Ethnicity					
• White	11	15	11	6	24
• Latino	3	1	1	1	3
• Other	4	3	4	1	4
Primary Language					
• English	18	18	13	7	28
• Spanish		1	3	1	3
• Other					
Culture					
• Veterans					
• LGBTQ	2	1	1		1

Agency Reporting	Encompass: El Dorado Center				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**10**
Number Actually Served	4	3	2	3	**11**
Adults (26-59)					
Number of individuals/families targeted					**60**
Number Actually Served	9	14	12	16	**53**
Older Adults (60+)					
Number of individuals/families targeted					**10**
Number Actually Served:	1	2	2	2	6
Unduplicated Annual Target for all					
Race/Ethnicity					
• White	10	12	9	15	47
• Latino	1	3	6	5	15
• Other	3	4	1	1	8
Primary Language					
• English	13	16	13	19	63
• Spanish	1	3	3	2	7
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	MHCAN: Peer Supports at PHF				
Outreach	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**100**
Number of individuals/families **ACTUALLY SERVED**	85	72	116	94	
Age Group					
• TAY 16-25			29		
• Adults 26-59	27	23	62	19	
• Older Adults 60+	40	34	25	36	
• unknown	18	15		39	
Race/Ethnicity					
• White	47	38	38	34	
• Latino	22	18	18	35	
• Other	16	16	16	25	
Primary Language					
• English	79	60	78	59	
• Spanish	4	7	14	33	
• Other		5	6	2	
Culture					
• Veterans	8	6	7	5	
• LGBTQ	12	14	18	12	

Agency Reporting	**BEHAVIORAL HEALTH (Access)**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served					163
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served					662
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:					108
Age Group					
• Children 0-15					3
• TAY 16-25					160
• Adults 26-59					662
• Older Adults 60+					108
Race/Ethnicity					
• White					563
• Latino					216
• Other					154
Primary Language					
• English					873
• Spanish					40
• Other					6
Culture					
• Veterans					
• LGBTQ					

CSS Program #7: Consumer, Peer, & Family Services

Purpose: These services and supports are intended to provide peer support, which is empowering and instills hope as people move through their own individual recovery process. Services are available countywide and are culturally competent, recovery oriented, peer-to-peer and consumer operated. This plan includes

1. **The Wellness Center.** This is located in Santa Cruz at the Mental Health Client Action Network (MHCAN) self-help center. It is a client-owned and operated program that offers a menu of services and programming for persons with psychiatric disabilities. The programming is provided by individuals with lived-experience and trained in the Intentional Peer Support model. The TAY Academy operates out of MHCAN, as well, and is focused on transitional age youth. The TAY Academy offers prosocial and life skill development.
2. **Mariposa**. This Wellness Center is located Watsonville. Mariposa Offers a variety of activities and support services for adult mental health consumers and their families, as well as for outreach activities. Activities include employment services, therapy, groups, and medication management. Services are offered by peer staff.

Target Population: The priority population for these services includes transition age youth, adults and older adults, males and females, with serious mental illness. The target population for this program is primarily White or Latino, and speaks English and/or Spanish, although services are also provided to persons of other ethnicities, genders, and languages.

Providers:

- For North County Wellness: Mental Health Consumer Action Network
- For Mariposa: Community Connection/Volunteer Center

Number of individuals to be served each year:
The unduplicated numbers of individuals to be served by program are:

- MHCAN: 230, plus 70 outreach
- Mariposa: 100, plus 50 outreach

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
Yes. A review of MHCAN's use permit was initiated by the City of Santa Cruz. The outcome is pending at the time of this submission.

Are there any new, changed or discontinued programs?
No.

Performance Outcomes: Demographic information of unduplicated clients served, as required by the State:

Agency Reporting	**MHCAN**				
System Development	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	20	20			**105**
Number of individuals/families **ACTUALLY SERVED**	24	29	23	28	**104**
Full Service Partnerships	Q1	Q2	Q3	Q4	**Annual**
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted	70	70			**200**
Number Actually Served	119	163	124	145	**172**
Adults (26-59)					
Number of individuals/families targeted	90	90			**300**
Number Actually Served	195	207	192	166	**355**
Older Adults (60+)					
Number of individuals/families targeted	70	70			**95**
Number Actually Served:	108	123	102	119	
Age Group					
• TAY 16-25	119	163	124	145	
• Adults 26-59	195	207	192	166	
• Older Adults 60+	108	123	102	119	
• unknown					
Race/Ethnicity					
• White	216	256	201	179	
• Latino	65	98	86	168	
• Other	145	139	131	112	
Primary Language					
• English	243	268	256	273	
• Spanish	35	53	78	98	
• Other	144	172	84	59	
Culture					
• Veterans	36	33	27		
• LGBTQ	59	73	65		

Agency Reporting	**Volunteer Center/Community Connection: Mariposa**				
System development	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted	15	15	15	15	
Number of individuals/families **ACTUALLY SERVED**	34	23	34	57	39
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted	5	5	5	5	
Number Actually Served	10	4	3	3	3
Adults (26-59)					
Number of individuals/families targeted	70	70	70	70	
Number Actually Served	11	20	23	26	83
Older Adults (60+)					
Number of individuals/families targeted	10	10	10	10	
Number Actually Served:	8	5	8	7	6
Age Group					
• TAY 16-25	10	6	3		3
• Adults 26-59	45	41	23		83
• Older Adults 60+	8	5	8		6
• Unknown					
Race/Ethnicity					
• White	44	34	19		56
• Latino	15	16	10		31
• Other	4	2	5		5
Primary Language					
• English	61	49	32		90
• Spanish	2	3	2		2
• Other					
Culture					
• Veterans					
• LGBTQ					

CSS Program #8: Community Support Services

Purpose: The services and strategies in this work plan are designed to advance recovery goals for all consumers to live independently, to engage in meaningful work and learning activities that are central to enhancement of quality of life. Participants will be enrolled in Full Service Partnership (FSP) Teams. FSPs are "partnerships" between clients and clinicians that include opportunities for clinical care, housing, employment, and 24/7 service availability of staff.

To accomplish the above, we have several specialty teams:

- The Recovery Team and South County Adult Team provide intensive wrap around services to persons with chronic mental health conditions and severe functional impairments to provide support services to assist individuals to remain in the least restrictive residential setting and prevent acute hospitalizations. These teams focus on an array of recovery-oriented supports that include case management, psychiatry, psychotherapy, occupational therapy, linkage to housing, employment and education. Additional clinicians will manage the county-wide residential authorization to Substance Abuse services.

- The Maintaining Ongoing Stability through Treatment "MOST" team serves individuals that have a psychiatric disability and are involved in the criminal justice system. It is a Forensic Assertive Community Treatment (FACT) program that combines evidence-based program of wrap around mental health services inclusive of case management, psychiatry, psychotherapy, employment skill development, with additional supports specific to the criminal justice system. This program seeks to reduce jail bed days, the occurrence of new offenses and probation violations. In addition to demonstrating improved stability in the community, the program seeks to reduce psychiatric inpatient bed days, reduce days of homelessness, increase treatment compliance and increase days in pro-social activities such as employment.

- The Older Adults Team (60 and above with a complex medical condition) focuses on older adults with a major mental illness and complex medical conditions who need a FSP to maintain in the community. With the addition of the INN funding, to provide whole person care inclusive of psychiatric condition, medical condition and SUD condition, additional supports will be available to the older adult population.

The teams are supported with these ancillary services:

- Housing support to provide services and supports to adults living independently to help them maintain their housing and mental health stability. Community Connection staff offer an employment specialist and peer counselor, and Encompass provide case managers.
- Adult care facility beds provide 24/7 care, bi-lingual, bi-cultural services. The Board and Care facilities include Wheelock, and Willowbrook.
- Opal Cliffs provides an adult residential setting to provide intensive supervision and support to individuals returning from Locked Care settings to prepare to re-integrate into housing and community services.
- **River Street Shelter.** This is an emergency shelter for homeless adult men and women. The shelter is a clean and sober environment where residents can begin or continue the

process of rebuilding their lives, maintaining sobriety, and reconnecting with the community as they move towards ending homelessness. River Street Shelter staff provides expertise and specialized services for individuals with psychiatric disabilities and substance abuse challenges. Staff works individually with residents to assist them in connecting with community resources for obtaining benefits, physical health services, employment, and housing. Specialized counseling is available for those residents with mental health and substance abuse issues, to support them in maintaining psychiatric stability and achieving individualized goals.

- **Casa Pacific.** This is a 15-bed residential treatment program for those individuals with co-occurring mental health and substance use disorders. Residents are provided with specialized co-occurring treatment in a clean and sober environment that also prepares them for maintaining sobriety in the community following discharge.
- The supportive employment activities include the development of employment options for clients, competitive and non-competitive alternatives, and volunteer opportunities to help consumers in their recovery. The Cabrillo "College Connection" supports "consumer" students expressing interest in educational pursuits.

Target Population: The priority population for these services includes transition age youth, adults, and older adults with serious mental illness. The target population for this program is primarily White or Latino, and speaks English and/or Spanish, although services are also provided to persons of other ethnicities, genders, and languages.

Providers: The staff from Front Street, Encompass, Volunteer Center/Community Connection and Santa Cruz County Behavioral Health provide the services in this work plan. These providers work collaboratively and comprise a multi-disciplinary team.

- Front Street provides: Wheelock (Residential), Wheelock (Outpatient), Willowbrook, and Opal Cliffs.
- Encompass provides Housing Support (case management)
- Volunteer Center/Community Connection provides Housing Support (employment & education focus) and Opportunity Connection (pre-employment services, including peer support), Cabrillo college connection and Avenues (employment services for dual diagnosis clients).
- Santa Cruz County Behavioral Health staff provides case management services.

Number of individuals to be served each year:
The unduplicated numbers of individuals to be served by program are:
Front Street- Wheelock (Residential & Outpatient): 16
Front Street- Willowbrook: 40
Front Street- Opal Cliff: 16
Encompass- Supported Housing: 60
Volunteer Center/Community Connection-Housing Support (employment): 50
Volunteer Center/Community Connection-Opportunity Connection: 60
Volunteer Center/Community Connection Avenues: 45
Volunteer Center/Community Connection Cabrillo College Connection: 25
Santa Cruz County Behavioral Health North & South County Recovery: 600

Santa Cruz County Behavioral Health Older Adult Team: 60
Santa Cruz County Behavioral Health MOST: 100
River Street Shelter: 20 for outreach and 50 FSP
Encompass Casa Pacific: 30

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? No.

Are there any new, changed or discontinued programs? No

Performance Outcomes: Demographic information of unduplicated clients served, as required by the State:

Agency Reporting	BEHAVIORAL HEALTH: Staffing Support (North & South County Recovery)				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted	40	40	40	40	
Number Actually Served	38	42			11
Adults (26-59)					
Number of individuals/families targeted	290	290	290	290	
Number Actually Served	269	251			356
Older Adults (60+)					
Number of individuals/families targeted	5	5	5	5	
Number Actually Served:	107	101			84
Unduplicated Target for all					451
Race/Ethnicity					
• White					206
• Latino					89
• Other					156
Primary Language					
• English					400
• Spanish					39
• Other					12
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	BEHAVIORAL HEALTH: Staffing Support (MOST)				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served					
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served					
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:					
Unduplicated Target for all					
Race/Ethnicity					
• White					
• Latino					
• Other					
Primary Language					
• English					
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	BEHAVIORAL HEALTH: Staffing Support (OAS)				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served					6
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:					82
Unduplicated Target for all	64	61	57	54	88
Race/Ethnicity					
• White					37
• Latino					1
• Other/unknown					50
Primary Language					
• English					81
• Spanish					3
• Other					4
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	Community Connection: Housing Support (employment)				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	2	0	0	0	2
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	25	26	35	25	37
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:	5	5	4	1	5
Race/Ethnicity					
• White	39	23	28	19	30
• Latino	3	5	6	2	7
• Other				5	7
Primary Language					
• English	39	23	39	26	41
• Spanish	3	5			3
• Other		3			
Culture					
• Veterans	0	0			
• LGBTQ	0	2	1	1	1

Agency Reporting	Encompass: Housing Support				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					1
Number Actually Served	0	1	1		1
Adults (26-59)					
Number of individuals/families targeted					49
Number Actually Served	16	14	13		18
Older Adults (60+)					
Number of individuals/families targeted					10
Number Actually Served:	4	4	4		5
Race/Ethnicity					
• White	15	15	14		19
• Latino	3	2	2		3
• Other/Unknown	4	4	2		3
Primary Language					
• English	20	19	18		24
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	Front Street: Wheelock (outpatient & residential)				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					1
Number Actually Served	0	0	0	0	0
Adults (26-59)					
Number of individuals/families targeted					15
Number Actually Served	12	12	13	12	13
Older Adults (60+)					
Number of individuals/families targeted					4
Number Actually Served:	4	4	4	4	5
Race/Ethnicity					
• White	11	11	12	12	12
• Latino	3	3	3	3	3
• Other	2	2	3	2	3
Primary Language					
• English	15	15	15	15	15
• Spanish	1	1	1	1	1
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	Front Street: Willowbrook				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					0
Number Actually Served	0	0	0	0	0
Adults (26-59)					
Number of individuals/families targeted					25
Number Actually Served	24	24	21	25	25
Older Adults (60+)					
Number of individuals/families targeted					15
Number Actually Served:	17	17	19	20	20
Race/Ethnicity					
• White	29	29	29	31	31
• Latino	6	6	6	7	7
• Other	6	6	6	7	7
Primary Language					
• English	39	40	39	44	44
• Spanish	1	1	1	1	1
• Other					
Culture					
• Veterans	2	2	2	2	2
• LGBTQ	2	2	2	2	2

Agency Reporting	Front Street: Opal Cliffs				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					1
Number Actually Served	0	0			
Adults (26-59)					
Number of individuals/families targeted					13
Number Actually Served	12	11	10	10	12
Older Adults (60+)					
Number of individuals/families targeted					1
Number Actually Served:	3	3	3	3	4
Race/Ethnicity					
• White	13	12	11	11	14
• Latino	2	2	2	2	2
• Other					
Primary Language					
• English	14	13	12	12	15
• Spanish	1	1	1	1	1
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	Community Connection: Opportunity Connection				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	0	1	1	1	3
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	35	27	29	33	43
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	10	8	8	7	12
Race/Ethnicity					
• White	40	30	31	34	47
• Latino	4	2	2	3	5
• Other	1	4	4	4	6
Primary Language					
• English	39	36	38	39	56
• Spanish	1	0		1	1
• Other	0	0		1	1
Culture					
• Veterans	0	0			0
• LGBTQ	0	2	1	4	3

Agency Reporting	Community Connection: Avenues				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	2	3	6	8	10
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	18	18	21	21	33
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	1	2	2	1	3
Race/Ethnicity					
• White	15	12	13	12	22
• Latino	4	4	10	11	13
• Other	2	7	5	7	11
Primary Language					
• English	19	23	26	23	27
• Spanish	2	0	1	3	3
• Other			1	1	1
Culture					
• Veterans	1	0	1		
• LGBTQ	0	0	1	1	1

Agency Reporting	Community Connection: College Connection				
Outreach	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted					
Number Actually Served	25	25	30	23	34
Age Group					
• **16-25**	8	6	7	5	8
• **26-59**	16	18	22	18	25
• **60 +**	1	1	1		1
Race/Ethnicity					
• White	17	18	19	14	23
• Latino	6	5	7	6	7
• Other	2	2	4	3	4
Primary Language					
• English	24	24	30	22	33
• Spanish	1	1		1	1
• Other					
Culture					
• Veterans					
• LGBTQ	1	1	2	1	2

Agency Reporting	Encompass: Casa Pacific				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**5**
Number Actually Served	1	2	2	2	**3**
Adults (26-59)					
Number of individuals/families targeted					**20**
Number Actually Served	6	8	8	6	**18**
Older Adults (60+)					
Number of individuals/families targeted					**5**
Number Actually Served:	1	1	1	1	1
Unduplicated Annual Target for all					
Race/Ethnicity					
• White	5	6	5	2	10
• Latino	1	3	5	6	6
• Other	2	2	3	1	6
Primary Language					
• English	8	7	10	8	21
• Spanish		1	1	1	1
• Other					
Culture					
• Veterans					
• LGBTQ	2	2			

Agency Reporting	**Encompass: River Street Shelter**				
Outreach and Engagement	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted					**45**
Number of individuals/families **ACTUALLY SERVED**	11	11	13	9	**25**
Full Service Partnerships	Q1	Q2	Q3	Q4	**Annual**
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					**5**
Number Actually Served	2	1	2	2	**4**
Adults (26-59)					
Number of individuals/families targeted					**45**
Number Actually Served	15	14	15	16	**46**
Older Adults (60+)					
Number of individuals/families targeted					**5**
Number Actually Served:	4	4	3	3	11
Unduplicated Target for all					
• Children 0-15	0				
• TAY 16-25	3	1	2	2	6
• Adults 26-59	22	24	15	23	55
• Older Adults 60+	7	5	3	5	15
Race/Ethnicity					
• White	20	22	23	21	60
• Latino	5	4	4	3	9
• Other	7	4	6	6	17
Primary Language					
• English	32	30	33	30	86
• Spanish					
• Other					
Culture					
• Veterans	2	2	2	1	4
• LGBTQ			1	1	1

COMMUNITY SERVICES AND SUPPORTS: HOUSING

This component offered permanent supportive housing to the target population, with no limit on length of stay. The target population is defined as very low-income adults, 18 yrs of age and older, with serious mental illness, and who do not have stable permanent housing, have a recent history of homelessness, or are at risk for homelessness.

Nuevo Sol located in Santa Cruz has 2 units for adults 18 and over who were chronically homeless. These units are accessed through our partnership with Homeless Persons Health Project. Nuevo Sol was the first project in the State to use the Governor's Homeless Initiative funding, tied to MHSA for services and also the capitalized subsidy reserve.

The County has developed housing at Bay Avenue Apartments, Capitola. The Bay Avenue project provides five MHSA units for seniors 60 years and older, at risk of homelessness. "Aptos Blue" opened in February 2014, and it provides five MHSA for adults with mental illness who are homeless, or at risk of homelessness. County staff is developing Lotus Apartments for six transition age youth and adults located mid county. These units will be owned and operated by a local non-profit Encompass in partnership with the County MHSA and a property management agency. All referrals and supports to MHSA housing come from a FSP team.

A program requirement for these services is that persons be without stable housing or at risk of becoming homeless. The Housing Support team has worked intensively to both educate the client and mitigate any problem issues that might lead to eviction notices with the property manager.

In order to ensure that the potential tenants have appropriate skills and supports for independent housing, the County has developed these General Screening and Evaluation Requirements:

1. The applicant(s) must be able to demonstrate that his/her conduct and skills in present or prior housing has been such that the admission to the property would not negatively affect the health, safety, or welfare of other residents, or the physical environment, or financial stability of the property.
2. Positive identification with a picture will be required for all adult applicants (photocopy may be kept on file). Eligible applicants without picture identification will be supported by County Mental Health or other service providers to obtain one. For purposes of the application, a receipt from the DMV showing an application for an ID will be sufficient. If deferred, the final picture identification will be required at the time of move-in.
3. A complete and accurate Application for Housing that lists a current and at least one previous rental reference, with phone numbers will be required (incomplete applications will be returned to the applicant). Applicants must provide at least 2 years residency history. Applications must include date of birth of all applicants to be considered complete. Requests for Consideration will be considered for MHSA applicants whose disability may result in insufficient or negative references.
4. A history of good housekeeping habits.
5. A history of cooperation with management regarding house rules and regulations; abiding by lease terms; and care of property.
6. Each applicant family must agree to pay the rent required by the program under which the applicant is qualified.

7. A history of cooperation in completing or providing the appropriate information to qualify an individual/family for determining eligibility in affordable housing and to cooperate with the Community Manager.
8. Any applicant that acts inappropriately towards property management staff or is obviously impaired by alcohol or drugs, uses obscene or otherwise offensive language, or makes derogatory remarks to staff, may be disqualified
9. Applicants must agree that their rental unit will be their only residence. When applicants are undergoing income limit tests, they are required to reveal all assets they own including real estate. They are allowed to own real estate, whether they are retaining it for investment purposes as with any other asset, or have the property listed for sale. However, they may never use this real estate as a residence while they live in an affordable housing unit.

Other Screening Criteria include:
1. Income / Assets
2. Credit and Rental History
3. Criminal Background
4. Student Status

PREVENTION & EARLY INTERVENTION - PEI

On October 6, 2015, the Mental Health Services Oversight Accountability Commission (MHSOAC) changed the requirements in this MHSA component. The programmatic changes were to be reflected beginning July 1, 2016. Based on these changes, Counties are required to have PEI programs for each of these types of services:

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Examples of risk factors include, but are not limited to serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins (including in the womb), poverty, family conflict or domestic violence, experience of racism and social inequality, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

Early Intervention: Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Early intervention shall not exceed 18 months, unless the person is identified as experiencing first onset of a serious mental illness, or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years. Serious mental illness or emotional disturbance with psychotic features means schizophrenia spectrum, other psychotic disorders, and schizotypal personality disorder. These disorders include abnormalities in one of the five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia, and negative symptoms).

Outreach for Increasing Recognition of Early Signs of Mental Illness: A process of engaging, encouraging, educating, an/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. Potential responders include, but are not limited to families, employers, primary health care providers, law enforcement, and school personnel. Outreach may include reaching out to individuals with signs and symptoms of a mental illness so they can recognize and respond to their own symptoms.

Stigma and Discrimination Reduction: Activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

Access and Linkage to Treatment: A set of related activities to connect children, adults and seniors with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs. Examples include screening, assessment, referral, telephone help lines, and mobile response.

Suicide Prevention: Organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This program does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness. Programs include, but not limited to, public and targeted information campaigns, suicide prevention hotlines, training, and education. (Note: According to the new regulation, this service is optional, but Santa Cruz County does offer this service.)

We have four major PEI programs in Santa Cruz County:

- Children's Services
- Services for Diverse Communities
- Transition Age Youth & Adult Services
- Older Adult Services.

We have a variety of community based organizations that have contracted with the County to provide services, as well as Behavioral Health programs that provide services.

PEI Project #1: Prevention and Early Intervention Services for Children

These projects serve children and youth from stressed families, early onset of mental illness, and trauma exposed children and their families. Of concern are families needing help with parental/supervision skills, or affected by substance use/abuse, and/or whose children/youth are exposed to violence, abuse, and /or neglect. The desire is to decrease the negative impact of these factors by offering mental health services to children/youth and their families.

PEI Project #1 has four strategies:

1. **0-5 Early Intervention Stanford Neurodevelopmental Foster Care Clinic**:
   - **Purpose**: This **Early Intervention** program provides multi-disciplinary team mental health/family assessments for foster children aged 0-5, through a multi-agency funded clinic at the Stanford Children's Health Specialty Services site, and located in Santa Cruz County. The program includes with PEI supported mental health services, as well as in-kind and contracted services for Stanford University specialist time from a developmental psychologist and a pediatrician.
   - **Target Population**: Foster children aged 0-5.
   - **Providers**: Santa Cruz County Behavioral Health
   - **Number of Individuals to be served each year**: 90
   - **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** The original site of the multidisciplinary clinic was due to be closed and re-located by Dominican Hospital. Negotiations between Dominican and Stanford yielded a new site, and enhanced programming, at the Stanford Children's Health Specialty Services clinic, located in the city of Capitola in Santa Cruz County. The new site has scheduled its open house for February 2014, and we'll continue to provide MHSA/PEI related mental health services there. The number of children seen is increasing, with the "clinic days" expanding to twice weekly.

Performance Outcomes (specify time): Demographic information of unduplicated clients served as required by the State:

Agency Reporting		BEHAVIORAL HEALTH			
Work Plan/Program/Service		0-5 Screening			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	4	2	2	1	7
Age Group					
• Children 0-15					5
• TAY 16-25					2
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White					4
• Latino					2
• Other					1
Primary Language					
• English					5
• Spanish					1
• Other					1
Culture					
• Veterans					
• LGBTQ					

Performance Outcomes (specify time): Narrative report as required by the State:

Early Intervention: Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Early intervention shall not exceed 18 months, unless the person is identified as experiencing first onset of a serious mental illness, or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years. Serious mental illness or emotional disturbance with psychotic features means schizophrenia spectrum, other psychotic disorders, and schizotypal personality disorder. These disorders include abnormalities in one of the five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia, and negative symptoms.

1. **Program Name:** PEI #1 0-5 Screening **Agency:** MHSAS

2. **Target population:**
   - **Demographics:** Children in foster care under the age of 5
   - **What is the unduplicated number of individuals served in preceding fiscal year?** 47
   - **What is the number of families served?** 41
   - **Mental illness or illnesses for which there is early onset:** adjustment disorder, PTSD, anxiety disorders, mood disorders, attachment disorders
   - **Description of how participant's early onset of a potentially serious mental illness will be determined:**

   Children are provided with a psychosocial assessment including diagnosis and mental status exam by a licensed or licensed-waivered clinician. In addition, Childhood and Adolescent Needs and Strengths Assessment Instrument (CANS) are provided. In some cases, the Child Behavior Checklist (CBCL) is also used which is a caregiver report form identifying problem behavior in children as well as the Ages and Stages Questionnaire focused on Social and Emotional health screening tool.

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3. **Identification of type(s) of problem(s) and need(s) for which program will be directed, and activities to be included in program to bring about mental health and related functional outcomes (including suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes).**

   Most of these children have been removed from the care of their biological parents and/or caregivers due to serious abuse and neglect. Many of these children have survived traumatic events (such as witnessing domestic violence, parental drug addiction and criminality) and all of them have been living in poverty. Many of these children have not received developmentally appropriate parenting and have developmental delays related to expressing feelings and needs which can result in aggression, defiance and acting out behaviors. In addition, many of these children experience challenges in sleeping, eating, toileting and social realms. Due to parental instability and challenges and then removal from family, many of these children experience attachment-challenges as well. Many of these children also have unmet needs with regards to health and education.

   Activities the program engages in include providing these children with a thorough psychosocial assessment, treatment planning and often developmental assessment with recommendations. Treatment and services provided are them tailored to the specific needs of each child to reduce frequency and severity of symptoms and functional impairments, prevent further development of mental health and developmental challenges and improve functioning. Services provided to accomplish this include individual therapy, family therapy, rehab counseling, case management to connect these children with additional needed resources and supports and frequent collateral contact with support system members to increase their ability to help the children overcome mental health and functional challenges.

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4. **Outcomes:**
   - **List the mental health indicators used to measure reduction of prolonged suffering that result from untreated mental illness as measured by reduced symptom and/or improved recovery, including mental, emotional and relational functioning:**

Mental health indicators used include the CANS assessment at intake and at 6-month intervals, caregiver, educational provider and clinician observation and reports of reduction in acting out and improved ability to regulate and express emotions, reduction in developmental delays and challenges in daily living and reduction in mental health symptoms.

- **Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects cultural competence:**
  Evaluation methodology includes the following: All clients are provided the assessment including the CANS assessment at intake and then a treatment plan is developed to target mental health challenges. Most of these children also receive a developmental assessment by Stanford psychologist Dr. Barbara Bentley. Upon completion of this assessment, CMH clinicians receive recommendations for treatment to address finding of Dr. Bentley's assessment. Another CANS is completed at 6 months at which time the treatment plan may be altered to address changing needs. In addition clinicians work with caregivers and significant support people on weekly basis evaluating progress and challenges and altering treatment when needed. All evaluation and assessment is done through a lens of understanding the different aspect of the client's culture.

5. **How is the Early Intervention Program likely to reduce suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes?** Answer questions in either A or B.

   A. If an evidence-based practice or promising practice was used to determine the program's effectiveness:

   1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

   2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

   3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

   B. If a community and/or practice-based standard was used to determine the Program's effectiveness:

   1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**
   There is much evidence about the disproportionately high rates of developmental and mental health problems among children in foster care and growing evidence pointing to the potential of early intervention for the amelioration of developmental and behavioral problems in young children. For more on this see "Addressing the Developmental and Mental Health Needs of Young Children in Foster Care" at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1519416/" Early assessment, detection and targeted treatment with follow-up interventions is likely to reduce the existing developmental and mental health problems among young children in foster care as well as serve as a preventative measure for them in having additional social, school and conduct problems as they age.

   2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

We measure success and fidelity to the practice by ensuring that each child is getting the thorough assessment and treatment when this is indicated. We work closely with all the adults in the child's support system including biological parents, foster parents, extended family members, natural supports and resource people, Court Appointed Special Advocates, child welfare social workers and public health nurses, the clinical psychologist, pediatricians and early education providers to help increase their understanding of what the child is in need of and how they can help. We measure success by the increase in these significant support people's ability to provide appropriate care and understanding in the needs of these at-risk children. In addition, getting these children connected with the additional services they may need is also how we measure success and fidelity to the model.

6. **Describe how the following strategies were used:**

   A. **Access and Linkage (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):**

Children's Mental Health has built and maintained a strong partnership with the Department of Family and Children's services. As a result, 98% of the children who come to the attention of child welfare receive an assessment (as outlined above) by Children's Mental Health. If for some reason these children do not qualify for our services, they may be referred to one of our contract agencies, like the Parent Center. In addition we provide case management services to connect these children with other needed services for physical health, education and recreation.

- **Timely Access to Mental Health Services for Underserved Populations (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):**

Due to the partnership mentioned above, 98% of the at-risk youth in this county are receiving this service. Children's Mental Health provides bilingual and bicultural clinicians whenever possible to ensure cultural and language appropriateness when needed. Clinicians are also trained in engagement and treatment with families and young children to ensure effective services are provided. Children's Mental Health provided field-based services to ensure that all children and families can participate in case transportation is a barrier. Children's Mental Health mission is to work with families and communities to help youth stay in home, in school, and out of trouble. We strive to provide strength based, culturally appropriate, comprehensive community based mental health services using flexible "whatever it takes" approach to help families achieve their own positive outcome. Clinicians also flex their work time to ensure children and families can be seen at convenient times.

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):

  - Children's Mental Health is committed to providing a safe and welcoming environment that children and families can depend on when seeking services. We pride ourselves on meeting children and caregivers where they are and working with them to help them get where they want to go. As mentioned earlier we provide field-based services when needed meeting our clients and families in the community, in their homes, or at their schools. We will happily help with transportation by picking people up providing mental health services "out of the office" if this increases the success of these services and improves the likelihood of active participation in services and reduces the stigma of receiving mental health services.

2. The Positive Parenting Program (Triple P)

- **Purpose:** Triple P is a **Prevention** Program and provides a five-tiered public health model of progressive mental health information, prevention, training, screening, and early intervention. It is an evidence-based practice increasingly deployed throughout California, addressing both prevention and early intervention needs.
- **Target Population:** All Santa Cruz County families in need of public information about parenting skills and resources, as well as families needing various levels of enhanced training supports, and brief treatment.
- **Providers:** First 5
- **Number of individuals to be served each year:** 1300
- **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** The "tier one" public information campaign has been a success, building on the earlier implementation of training modules for a wide range of community members, as well as therapists. Like other counties, we continue to assess how best to maintain a good pool of well-targeted providers for the prevention and training levels, including primary care and education providers, family resource center staff, and others.

Performance Outcomes (specify time): Demographic information of unduplicated clients served as required by the State:

Agency Reporting		First 5			
Work Plan/Program/Service		Triple P			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	132	121	140	167	431
Age Group					
• Children 0-15					
• TAY 16-25	17	14	15	18	43
• Adults 26-59	112	105	123	146	380
• Older Adults 60+	3	2		3	8
• Unknown			2		
Race/Ethnicity					
• White	32	37	44	47	102
• Latino	91	71	80	100	244
• Other	9	13	16	20	85
Primary Language					
• English	81	89	83	100	269
• Spanish	51	31	57	66	159
• Other		1		1	3
Culture					
• Veterans			2	1	2
• LGBTQ					
Other relevant data:					
Parents in level 2	19	4	59	38	171
Parents in seminars/workshops	153	262	297	83	792
Children of parents in Triple P intensive services	254	207	224	291	673
Children of parents in Triple P brief services	298	474	614	220	1,694

Performance Outcomes: Narrative report for Triple P as required by the State:

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Examples of risk factors include, but are not limited to serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins (including in the womb), poverty, family conflict or domestic violence, experience of racism and social inequality, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

1. **Program Name:** PEI #1 Triple P Agency: First 5 Santa Cruz County

2. **Target population:**
   - **Demographics:** (fill out chart)
   - **What is the unduplicated number of individuals served in preceding fiscal year?** In FY 2016-17, 431 parents/caregivers received Level 3 Individual, Level 4 Standard/Group, or Level 5 Triple P services
   - **What is the number of families served?** Approximately 373 families
   - **Participants' risk of a potentially serious mental illness?**

     Parents/caregivers who participate in Triple P parenting services often enter the program reporting high levels of depression, anxiety, stress and family conflict. This, in turn, increases the risk of parenting practices that negatively impact children's health and development. The effects of parental distress, mental illness, or family conflict often manifest as moderate to severe behavioral and emotional difficulties in children, which is often what leads parents to seek parenting support.

   - **How is the risk of a potentially serious mental illness defined and determined?**

     Triple P uses a standardized set of assessment measures to identify potential mental health concerns related to parenting, including:
     - **Eyberg Child Behavior Inventory (ECBI):** Measures the severity of child behavior issues.
     - **Depression, Anxiety, and Stress Scale (DASS - short form):** Measures three aspects of parent mental health: Depression, anxiety, and stress.
     - **Parent Problem Checklist:** Measures the degree of conflict over parenting in the family.
     - **Parenting Scale (short form):** Measures the level of three parenting traits: Laxness, Over-reactivity, and Hostility.

     Several of the assessment measures identify a "clinical cut-off score" that indicates a high level of parental distress or maladaptive parent and/or child behaviors. All assessments are administered pre- and post-intervention.

3. **Specify the type(s) of problem(s) and need(s) for which program will be directed.** What activities are included in the program to bring about mental health and related functional outcomes (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes)?

   The Triple P – Positive Parenting Program is a comprehensive, evidence-based parenting and family support system designed to strengthen parent-child relationships and prevent or decrease problematic child behaviors before costly treatment is required. Triple P is offered as a preventive measure to families seeking anticipatory guidance before the risk for mental illness is identified or elevated, as well as to families experiencing high levels of conflict and mental health concerns. The Triple P system consists of five levels of interventions of

increasing strength, ranging from a positive parenting social marketing campaign (Level 1), to brief, targeted parenting assistance (Levels 2 & 3), to in-depth parent skills training (Level 4) and intensive family interventions (Level 5). Research shows that when the comprehensive system of Triple P services is offered communitywide – as it is in Santa Cruz County – it can reduce the rate of substantiated child abuse and neglect, foster care placements, and child abuse injuries.

4. **Specify any negative outcomes as a consequence of untreated mental illness** (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes) that the Program is expected to affect, including reduction of prolonged suffering (mental, emotional and/or relational functioning).

   A. **List the mental health indicators that the Agency/County will use to measure reduction of prolonged suffering (mental, emotional and/or relational functioning):**

   Level of parental depression, anxiety and stress
   Intensity and frequency of child behavior problems

   B. **If the Agency/County intends the Program to reduce any other negative outcome as a consequence of untreated mental illness, list the indicators that the County will use to measure the intended reductions:**

   C. **Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence:**

   Although all levels of Triple P services are provided and evaluated in Santa Cruz County, the evaluation methodology described in this report pertains to the highest levels of service (Level 4), since these are frequently the parents who report moderate to severe child behavior problems and/or distress related to parenting.

   The following research-based assessments are administered at pre- and post-intervention to measure changes in parenting attitudes, skills and behaviors:

   A. **Eyberg Child Behavior Inventory (ECBI):** Measures the severity of child behavior issues from the parent's perspective
   B. **Parenting Scale (short form):** Measures the degree to which parenting practices are Lax/Permissive, Over-reactive or Hostile
   C. **Depression, Anxiety and Stress Scale (DASS – short form):** Measures parent's emotional well-being
   D. **Parenting Problem Checklist:** Measures the degree of conflict over parenting between parenting partners
   E. **Conflict Behavior Questionnaire (Teen Triple P only):** Measures the degree of conflict between parent's and adolescents

   Data is collected by Triple P practitioners providing the services, and then submitted on a monthly basis to First 5 Santa Cruz County's Research & Evaluation Analyst, in a way to ensure the anonymity of the parents. All data entry is proofed to ensure accuracy, and then analyzed by First 5 and/or Applied Survey Research annually.

   All Triple P client forms and assessment measures are available in both English and Spanish. Practitioners are trained to offer neutral assistance to clients who have difficulty reading or understanding the assessment questions (i.e. avoid conveying bias or leading parents to select a particular answer).

5. **Specify how the Prevention Program is likely to bring about reduction of suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes.**

A. If an evidence-based practice or promising practice was used to determine the program's effectiveness:

1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

Triple P is backed by over 30 years of rigorous international research. A particularly compelling study was conducted in South Carolina, funded by the Centers for Disease Control and Prevention (CDC). In this study, researchers randomly assigned nine counties to implement Triple P countywide (intervention counties) and another nine counties to provide parenting "services as usual" (control counties). Results of this study showed that compared to the control counties, the Triple P counties had significantly lower rates of substantiated child abuse reports, foster care placements, and child abuse injuries treated in hospitals and emergency rooms. The CDC Triple P study was the first of its kind to demonstrate that treating parenting as a public health issue could improve child outcomes at a countywide, population level.

The robust body of research on Triple P has led to it being designated as a highly-effective evidence-based program (EBP) by multiple established clearinghouses, including: California Clearinghouse on Evidence-Based Programs in Child Welfare; Substance Abuse & Mental Health Services Agency's National Registry of Evidence-Based Programs and Practices; Promising Practices Network; Technical Assistance Center on Social Emotional Intervention for Young Children; and the Coalition for Evidence-Based Policy.

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

First 5's rigorous evaluation of Triple P has demonstrated statistically significant improvements in child, parent and family well-being ever since its inception in Santa Cruz County. A cumulative analysis of outcomes from the past 5 years demonstrates positive outcomes such as:

- **Improvements in child behavior.** Overall, the majority of parents (80%) reported improvements in their children's behaviors after completing the Triple P program. Of the parents who began the program with more serious parenting issues, 92% reported improvements in their children's behaviors.
- **Increased use of positive parenting styles.** Overall, the majority of parents (77%) reported improvements in parenting styles, indicating they became less lax (permissive), over-reactive, or hostile through the course of the Triple P program. Of the parents who began the program with more serious parenting issues, 82% reported improvements in their parenting styles by the end of the program.
- **Increased levels of parents' emotional well-being.** On average, parents reported significantly lower levels of stress, depression and anxiety (63%, 55% and 53% of parents, respectively) after completing in-depth Triple P services. Of the parents who began the program with more serious parenting issues, 90% reported improvements in their level of stress, 87% reported improvements in anxiety, and 86% reported improvements in their level of depression.

This local data suggests that Triple P is particularly effective for a broad population of parents, particularly those who are experiencing more serious parenting challenges at the onset of the program.

3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

The local Triple P Coordinator (contractor for First 5) has developed a fidelity coaching model that involves observing selected practitioners as they conduct classes and completing a Fidelity Checklist to document adherence to both the Triple P content and teaching process. The Coordinator and practitioner meet soon afterward for a feedback and coaching session to reinforce and enhance skills.

A. If a community and/or practice-based standard was used to determine the Program's effectiveness:

3. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

N/A

4. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

N/A

6. **Describe how the following strategies were used:**

A. **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):

First 5 Santa Cruz County is implementing all five levels of Triple P interventions. Individual and group services are offered to families with children birth-16 years old, including children with special needs, in a wide variety of settings such as health clinics, schools, family resource centers, counseling centers, and other government- or community-based agencies. This means that Triple P practitioners often work with families where the parents and/or children are currently receiving or need assistance accessing medical care and/or mental health services. In many instances, Triple P practitioners make referrals, advocate for, and coordinate services with social workers, therapists, Children's Mental Health clinicians, health clinics, and other behavioral health providers.

- **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):

One of the main strengths of the Triple P program is its ability to reach families before more intensive mental health services are needed. At the same time, the higher "levels" of Triple P services are an effective method of supporting families whose children are already connected with mental health services. Increasing parents' confidence and capacity to provide safe, stable, nurturing caregiving is a critical component of promoting and restoring children's mental and emotional health.

First 5 works in close partnership with Triple P providers to ensure that services are available on a continuous basis in English and Spanish, throughout the county at different times and locations. First 5 serves as a central hub for information and referrals to Triple P services. This helps ensure that parents get connected in a timely manner to the appropriate level of Triple P parenting support. In addition, training a broad network of Triple P providers ensures that this particular evidence-based parenting intervention is accessible in places where families already go to seek support.

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):

Triple P is designed to provide parenting information and support to all parents seeking support, regardless of their socioeconomic status or risk level. In particular, First 5 Santa Cruz County disseminates bilingual messaging and materials through its countywide Level 1 social marketing campaign, which normalizes the need for parenting support and reduces the social stigma that often prevents parents from seeking help before costly treatment is required. Key social marketing and outreach activities include:

- Distributing First 5's locally-designed "parenting pocket guides" with bilingual Triple P parenting tips through schools, health care settings (clinics, pediatric offices, hospitals), child care providers, county health and human service programs, and other non-profits serving children and families.

- Disseminating a monthly article with Triple P parenting tips through print and electronic media
- Maintaining a steady social media and advertising presence in key print and electronic media outlets
- Utilizing newly-developed "Triple P parenting strategy cards" to educate parents about positive parenting techniques during community outreach events and classes

3. School Mental Health Partnership Collaborative (The County Office of Education):

- **Purpose**: Under the auspices of the Santa Cruz County Schools/Mental Health Partnership collaborative, to provide targeted **Prevention** services to local schools and in the community through a range of evidence-based and promising practices.
- **Target Population:** School sites, education personnel, and students and families throughout the county.
- **Providers:** The County Office of Education (COE) has subcontracted with the Diversity Center, the Live Oak Resource Center, and Positive Behavioral Interventions & Support.

1. The Diversity Center:
    - The Diversity Center provides support services to LGBTQ students throughout the county. Services will include support to student Gay Straight Alliance (GSA) groups and offering LGBTQ counseling and advocacy, and LGBTQ-friendly pro-social activities.
    - The Triangle Speakers program provides education and awareness about LGBTQ issues to the broader school and community population and provide identification and referral services for LGBTQ students showing early indicators of mental illness.
    - The Queer Youth Task Force's Safe School Project supports school policies, practices and trainings that make schools safer for LGBTQ youth. They also provide trainings in LGBTQ cultural issues and counseling strategies.

2. Positive Behavioral Intervention and Supports (PBIS):

    Positive Behavior Intervention and Supports (PBIS) training is a model for establishing a positive school climate and helps schools focus existing resources in a school-wide prevention model as well as designing site-relevant interventions for children showing signs of distress. Successfully implemented, PBIS establishes clear expectations, emphasizes recognition for positive behavior and creates a school culture that is stable and consistent across campus areas and grade levels.

    School-Wide PBIS Trainings is composed of Tier 1, Tier 2 and Tier 3. Tier 1 develops a framework by focusing on developing school rules and teaching expectations, developing an acknowledgement system, responding to a problem behavior and discipline referral system, and developing an implementation plan.

    Tier 2 is intervention level that serves between 15-25 students at once using a "check-in, check-out" system. This technique is an efficient use of resources rather than a one student at a time approach. Students can get support almost immediately upon referral. This level requires almost no legwork from referring staff to begin implementation of the intervention with a student. The

process being used is referred to as a "Check-in, Check-out" (CICO).

Tier 3 consists of seven training modules focused on conducting behavioral assessment and developing function-based support for students with mild to moderate challenging behaviors.

3. Live Oak Community Resources
   Support and strengthen families by providing family case management, counseling services and coordination of parent education classes.

- **Number of individuals to be served each year:**
  The Diversity Center:
  1. GSA support to a minimum of nine high schools and three middle schools, and attend a minimum of 48 GSA meetings during the year.
  2. Triangle Speakers conduct a minimum of 35 panels in Santa Cruz County Schools reaching approximately 1000 students.
  3. Safe Schools Project identify Safe School Liaisons in additional school districts; support at a minimum of 60 students, staff and parents seeking services; work with Trans students, school staff and parents on trans issues; work with K-12 school counselors in the county on LGBTIQ issues.

  PBIS
  1. CONTRACTOR will provide PBIS training to three school districts (26 schools).
  2. CONTRACTOR will provide Tier 1 training to a minimum of one school district.
  3. CONTRACTOR will provide Tier 2 training to a minimum of three school districts.
  4. CONTRACTOR will provide Tier 3 training to a minimum of two school districts.
  5. Total teachers to be trained: 60

  Live Oak Resource Center
  1. Case management services for a minimum of 20 families.
  2. Counseling services for a minimum of 20 individuals
  3. Coordinate parent education classes for a minimum of 40 parents and caregivers.
  4. Weekly parent/child playgroups for a minimum of 40 caregivers and their children, in both English and Spanish.

- **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** No.

Performance Outcomes: Demographic information of unduplicated clients served as required by the State:

Agency Reporting	Diversity Center (via COE)				
Work Plan/Program/Service	School Based PEI				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	292	1,788	1365	1,515	4,960
Age Group					
• Children 0-15	82	1116	330	143	1379
• TAY 16-25	136	955	1035	1,342	3468
• Adults 26-59	62	9		27	98
• Older Adults 60+	12			3	15
• Unknown					
Race/Ethnicity					
• White	110	631	682	612	2035
• Latino	98	383	465	557	1503
• Other/unkown	84	773	218	346	1422
Primary Language					
• English	231	195	979	1,040	2445
• Spanish	62	296	386	475	1218
• Other/declined					1297
Culture					
• Veterans					
• LGBTQ	110	94	284	258	752

Agency Reporting	Live Oak Family Resource Center (via COE)				
Work Plan/Program/Service	School Based PEI				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	62	97	48	51	196
Age Group					
• Children 0-15	4	1	5	1	11
• TAY 16-25	4	5	4	3	16
• Adults 26-59	46	74	35	43	198
• Older Adults 60+	1	7		1	9
• unknown				3	24
Race/Ethnicity					
• White	30	52	17	23	10
• Latino	32	33	29	24	118
• Other		12	2	4	68
Primary Language					
• English	28	62	23	25	1238
• Spanish	54	23	19	18	114
• Other	9	3	6	8	1
Culture					
• Veterans		2			
• LGBTQ		3	1	2	6

Agency Reporting		Positive Behavioral Intervention Program/COE			
Work Plan/Program/Service		School Based PEI			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	56	60	5+18	53	192
Age Group					
• Children 0-15					
• TAY 16-25	1		+1		2
• Adults 26-59	55	60	4+17	6	140
• Older Adults 60+			1		1
• Declined to state				47	49
Race/Ethnicity					
• White	28		4+16	19	67
• Latino			+1	2	3
• Other			1+1		1
• unknown	56	60		32	121
Primary Language					
• English	56	60	5+18	21	100
• Spanish					
• Other/unknown					92
Culture					
• Veterans					
• LGBTQ			+1		

Performance Outcomes: Narrative report for Diversity Canter as required by the State:

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Examples of risk factors include, but are not limited to serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins (including in the womb), poverty, family conflict or domestic violence, experience of racism and social inequality, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

1. **Program Name**: PEI #1: Children's Services Agency: COE: The Diversity Center
2. **Target population**:
   - **Demographics**: (fill out chart)
   - **What is the unduplicated number of individuals served in preceding fiscal year?** 925
   - **What is the number of families served?** 15
   - **Participants' risk of a potentially serious mental illness?**

     LGBTQ+ teens have a particularly high risk of mental health conditions, including depression and anxiety, and have documented higher rates of attempted and completed suicide.

   - **How is the risk of a potentially serious mental illness defined and determined?**

   As a prevention-focused organization, in our youth groups, staff are assessing for changes in functioning, indicators of abuse or neglect and signs of depression or other mental health issues that would require further intervention. When staff have concerns about the mental health and/or safety of a program participant, the concerns are brought to the Executive Director who is an LCSW to case conference and figure out a plan to best support the young person in need.

3. **Specify the type(s) of problem(s) and need(s) for which program will be directed.** What activities are included in the program to bring about mental health and related functional outcomes (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes)?

   Through this funding, The Diversity Center is supporting and creating safer schools through building and supporting Gay/Straight Alliances (GSAs) and supporting their advisors, bringing Triangle Speaker presentations into schools to help promote a welcoming and accepting school climate, working with K-12 counselors on LGBTQ+ issues, identifying best practices and successful curriculum on anti-bullying programs as it relates to LGBTQ+ students and meeting the needs of individual students, staff and parents in SCC schools who call for our help. All of our activities support the health and well-being of LGBTQ+ youth who have disproportionate rates of suicide, truancy, sexual risk-taking, and experiencing bullying, family rejection, and homelessness among other challenges,

4. **Specify any negative outcomes as a consequence of untreated mental illness** (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes) that the Program is expected to affect, including reduction of prolonged suffering (mental, emotional and/or relational functioning).
   A. **List the mental health indicators that the Agency/County will use to measure reduction of prolonged suffering (mental, emotional and/or relational functioning):**

   Our youth programs reduce social isolation and create a pro-social peer network. We help youth stay in school and obtain education. We provide early assessment and intervention for mental health issues. We support

positive peer networks and provide resources for young people experiencing bullying and provide early assessment and resources around intimate partner violence and sexual health issues.

B. **If the Agency/County intends the Program to reduce any other negative outcome as a consequence of untreated mental illness, list the indicators that the County will use to measure the intended reductions:**
NA

C. **Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence:**
We conduct an annual evaluation of our youth program. We use a survey as our evaluation instrument. We are evaluating if program participants report the following outcomes:

1. Increased sense of self-confidence
2. Improved relationships with peers, family, and teachers
3. Increased sense of community
4. Increased positive coping strategies to stress
5. Increased sense of safety

Data is then analyzed by the Executive Director in collaboration with program coordinators and the MSW intern. While our evaluations have been overwhelmingly positive, if we find we are not meeting program outcomes, the program implementation will be revisited and additional training will be identified for staff.

2017 Youth Program evaluation results:
Youth self-reported the following in our annual evaluation as a result of their participation in our youth program:
94% of youth feel better about themselves (eval goal #1)
91% report feeling proud of who I am (eval goal #1)
98% have made new friends (eval goal #2/3)
42% have better relationships with teachers (eval goal #2)
42% have better relationships with some of their family members (eval goal #2)
98% feel like they belong to the LGBT community (eval goal #3)
46% are better at dealing with stress (eval goal #4)
92% feel more connected to other LGBT youth (eval goal #2/3)
83% know a person or hotline they can call in tough times (eval goal #4/5)
71% know who or where to go to if they feel unsafe at school (eval goal #5)
74% feel safer in their lives overall (eval goal #5)

5. **Specify how the Prevention Program is likely to bring about reduction of suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes.**
   A. **If an evidence-based practice or promising practice was used to determine the program's effectiveness:**
      1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

This funding supports prevention on multiple levels. The Diversity Center's youth program is on the ground in schools supporting and building GSAs. Having a safe place for youth to connect and know they will be accepted can literally be a lifeline for youth (and a reason to go to school). Our Triangle Speakers Program brings trained community speakers into schools to promote "lived equality" and to destigmatize

being LGBTQ+ and to help school climates become more welcoming. The Safe School Project works with administrators to problem-solve issues as they arise, and to recommend and implement anti-bullying curriculum. Additionally, our youth program evaluation (above) shows the impact our program has on local youth.

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

We evaluate effectiveness from our annual youth program evaluation and Triangle Speakers has a post-panel survey. We have not had the capacity to do additional evaluation to study the long-term impact we have on the schools we work with.

3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

NA

B. If a community and/or practice-based standard was used to determine the Program's effectiveness:

1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

We have a community based standard. The youth program's peer support groups is a community based standard, but it is based off of the evidence based practice that peer support groups for marginalized communities provide a platform for participants to feel less isolated, gives them a safe place, allows them to have adults in their life who are supportive and gets them connected to community resources. We have an annual evaluation to help us determine the program's effectiveness.

2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

The Executive Director has regular supervision meetings with program coordinators to ensure fidelity to the program design and to trouble shoot any issues that arise.

6. **Describe how the following strategies were used:**

A. **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):

The Diversity Center regularly makes referrals to school and community therapists. We commonly see youth who are struggling as they come to terms with the sexual and gender identity We commonly refer youth who are struggling (or their families are struggling) with their gender identity to The Santa Cruz Transgender Therapist Team.

- **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):

The Diversity Center does not provide on-site therapy, but we do work with youth (and their parents when appropriate) to make referrals to therapists and other local support resources.

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):

  Many youth in The Diversity Center's programs are struggling with mental health issues and suicidal ideation. We strive to create a warm and welcoming space for all. Our Trans teen support groups are safe places for teens to share their struggles. Support groups are a way for teens to support and learn from each other and it helps break the social isolation that many feel.

Performance Outcomes: Narrative report for Live Oak Resource Center as required by the State:

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Examples of risk factors include, but are not limited to serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins (including in the womb), poverty, family conflict or domestic violence, experience of racism and social inequality, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

1. **Program Name**: PEI #1: Children's Services **Agency**: COE: Live Oak Resource Center

2. **Target population**:
   - **Demographics**: Chart attached
   - **What is the unduplicated number of individuals served in preceding fiscal year?** 196
   - **What is the number of families served?** 185
   - **Participants' risk of a potentially serious mental illness?** Varies
   - **How is the risk of a potentially serious mental illness defined and determined?**

   When new program participants walk in or are referred, we assess them both on basic needs (food, housing, and healthcare) as well as fit in one or more of our programs. Depending on their presenting issues, they may be referred to follow-up with an advocate for family case management services, parent education classes, and/or counseling services. As participants begin utilizing these services, more serious needs sometimes emerge. At that point, we may refer for additional interventions with a partner such as County Mental Health. Whenever possible, we continue providing support concurrently with these other services.

3. **Specify the type(s) of problem(s) and need(s) for which program will be directed.** What activities are included in the program to bring about mental health and related functional outcomes (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes)?

   The Five Protective Factors for Strengthening Families (Center for the Study of Social Policy) are:

   1) Parental Resilience

   2) Social Connections

   3) Concrete Support in Times of Need

   4) Knowledge of Parenting and Child Development

   5) Social and Emotional Competence of Children

   This project addresses all five factors as follows:

   1) Parental Resilience—Addressed through individual and family Counseling and by Case Management, working one-on-one with parents for an extended time to set realistic goals and address barriers to their accomplishment.

   2) Social Connections—Built as families get to know one another through the Cradle to Career Parent Leadership Council, Parent/Child Playgroups, and Parent Education classes.

   3) Concrete Support in Times of Need—Provided through Case Management, as Advocates connect families with monthly food distribution, enrollment in government benefit programs such as Medi-Cal and CalFresh, seasonal assistance including back-to-school supplies and holiday gifts, and referral to community agencies.

4) Knowledge of Parenting and Child Development—Increased at Parent Education Classes and Parent/Child Play Groups, and reinforced by interaction with peers also enrolled in these programs.

5) Social and Emotional Competence of Children—Enhanced through Counseling, the parent-led Cradle to Career strategies, and interaction with other children and families at the Parent/Child Playgroups.

This project addresses the Five Protective Factors for Strengthening Families with services including:

A. FAMILY CASE MANAGEMENT for 29 unduplicated families
- Assessed family strengths and needs
- Supported family in setting and pursuing goals
- Facilitated enrollment in government benefits
- Referred to appropriate community resources
- Met in LOCR office or conducted home visits as needed
- Provided translation as needed
- Conducted Multi-Disciplinary Team meetings to assess progress

B. A LEADERSHIP ROLE IN THE LIVE OAK CRADLE TO CAREER (C2C) INITIATIVE, engaging 95 unduplicated parents and caregivers
- Participated in monthly C2C steering committee meetings
- Supported monthly Parent Leadership Council meetings
- Worked with parent leaders to carry out strategies identified to improve selected data indicators in the areas of health, education, and character
- Provided supports including refreshments and childcare for parent meetings
- Provided translation of written materials

C. COUNSELING SERVICES for 14 unduplicated individuals
- Coordinated on-site counseling by professionally supervised MFT interns
- Referred families to on-site counseling services

D. COORDINATION OF PARENT EDUCATION CLASSES for 112 unduplicated parents and caregivers
- Scheduled and promoted classes
- Enrolled families
- Arranged childcare

E. WEEKLY PARENT/CHILD PLAYGROUPS for 55 unduplicated caregivers and their children
- One two-hour weekly group offered in English
- One two-hour weekly group offered in Spanish

4. **Specify any negative outcomes as a consequence of untreated mental illness** (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes) that the Program is expected to affect, including reduction of prolonged suffering (mental, emotional and/or relational functioning).

   Those who lack access to the Five Factors for Strengthening Families are at increased risk of isolation, untreated mental illness, and child abuse or neglect. Families with unaddressed chronic school attendance issues risk school failure, removal of children from the home, and even the criminal prosecution of parents.

   A. **List the mental health indicators that the Agency/County will use to measure reduction of prolonged suffering (mental, emotional and/or relational functioning)**:

Project outcomes are measured by:

- An annual parent survey which asks program participants how strongly they agree or disagree with the following statements:
  - As a result of participating in this class, I have improved parenting skills
  - The Advocate continued to work with me until my issues were resolved
- School attendance data provided by Live Oak School District
- Tracking of progress towards goals set by the family (see attached form)
- Cradle to Career Initiative indicators (see attached)
- Parent Education assessments administered before and after each training series

B. If the Agency/County intends the Program to reduce any other negative outcome as a consequence of untreated mental illness, list the indicators that the County will use to measure the intended reductions:

NA

C. Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence:

- School attendance data is provided on an ongoing basis by Live Oak School District comparing attendance before and after the family began receiving services
  - After several years of attempting different strategies to increase referrals from the school district for students with attendance issues, we have stepped away from this performance measure.

- Cradle to Career Initiative indicators are collected through annual student testing and surveys at the school site and reported back to the Cradle to Career Data Committee
  - Cradle to Career indicators measure long-term, school-wide trends. LOCR's influence on these trends is contributive, rather than attributive. The most recent indicators, along with successes from this year, are attached here.

- An annual parent telephone survey is conducted each spring which asks program participants how strongly they agree or disagree with the following statements:
  - As a result of participating in this class, I have improved parenting skills
    - 100% of respondents in 2016-2017 agreed with this statement
  - The Advocate continued to work with me until my issues were resolved
    - 84% of respondents agreed with this statement

5. **Specify how the Prevention Program is likely to bring about reduction of suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes.** Answer questions in either A **or** B.

A. If an evidence-based practice or promising practice was used to determine the program's effectiveness:

1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

This project makes use of a number of evidence-based approaches, including:

The Protective Factors framework

Studies show that building the Five Protective Factors promotes optimal child development and reduces child abuse and neglect (Center for the Study of Social Policy). Live Oak Community Resources Advocates

are trained in Family Strengthening Case Management and use the Five Protective Factors framework at the beginning of their relationship with the family and throughout their time together, seeking out existing strengths to build on and identifying areas for growth. See attached overview of the Protective Factors framework for more information.

Motivational Interviewing
LOCR Advocates are also trained in Motivational Interviewing (MI), which has proven effective in supporting individuals through the process of behavior change (Case Western Reserve University Center for Evidence-Based Practices). Advocates use MI with Case Management families to help them identify areas in their lives they would like to change and assess their readiness to pursue these changes.

The Promise Neighborhoods model
The Live Oak Cradle to Career Initiative is based on the Promise Neighborhoods model, which began with the Harlem Children's Zone and was then federally funded to expand to communities nationwide. This model has proven effective in improving outcomes for families in high-need areas through the collective impact of parent leaders and multiple community agencies (Promise Neighborhoods Institute). As a member of the Cradle to Career steering committee, LOCR is on the front lines of bringing this model to the Live Oak community.

Positive Parenting Program
Triple P is a parenting program used in communities around the world, and officially adopted by First 5 Santa Cruz County, the Santa Cruz County Health Services Agency, and the Santa Cruz County Human Services Department. The Community Bridges Family Resource Collective employs six certified Triple P educators who provide Parent Education in English and Spanish, working both in group and individual settings.

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

All of the evidence-based practices listed above have been successful in diverse settings, including low-income minority populations that resemble the core population we serve.

B. If a community and/or practice-based standard was used to determine the Program's effectiveness:

3. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

NA

4. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

NA

6. **Describe how the following strategies were used:**

A. **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practical to medically necessary care and treatment, including but not limited to care provided by county mental health programs):

Individuals identified as needing mental health services are connected with on-site counseling from our MFT interns. Those needing services beyond our scope—such as psychiatric services or residential treatment—are referred to the appropriate entities, normally County Mental Health. When we have a counseling waiting list we also refer to Santa Cruz Community Health Centers and Family Service Agency.

- **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through

program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):

Counseling services at our site are billed to Medi-Cal or provided free of charge. Triple P parent education classes are free of charge. Counseling is offered both after school and evenings, depending on need. Parent Education classes are evenings and weekends. In terms of language access, if a bilingual MFT intern is not available to serve a Spanish-speaking participant, we either provide staff to translate in the session (often we are providing counseling for English-speaking kids who have Spanish-speaking parents, so we only need occasional translation). If more intensive counseling is required in Spanish, we provide a warm handoff to a bilingual counselor either at Santa Cruz Community Health Centers or Family Service Agency.

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):

All of our services are provided in a warm, welcoming, neighborhood-based environment, which is comfortable and familiar to our participants. When we refer someone to parent education classes or counseling, we do so in a neutral, non-judgmental way, mentioning it as just one in our range of services. Parent education is offered as a way to connect with other parents who may be facing the same challenges. Confidentiality is respected across all our programs.

Performance Outcomes: Narrative report for PBIS as required by the State:

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Examples of risk factors include, but are not limited to serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins (including in the womb), poverty, family conflict or domestic violence, experience of racism and social inequality, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

1. **Program Name**: PEI #1: Children's Services **Agency**: COE: PBIS

2. **Target population**:
   - **Demographics**: (See Year End Chart)
   - **What is the unduplicated number of individuals served in preceding fiscal year?**
     - 53 staff received assistance or training in 2016-17. These were broken down into 2 distinct categories:
     - 41 school staff in 3 districts (13 Schools). All schools together impacted approximately 5,465 Students via implementation of programming from training and supporting:

Live Oak School District	1,706 Students
Del Mar Elementary	
Green Acres Elementary	
Live Oak Elementary	
Ocean Alternative	
Tierra Pacifica Charter	
Shoreline Middle School	
Scotts Valley Unified School District	1,702 Students
Brook Knoll Elementary	
Vine Hill Elementary	
Scotts Valley Middle School	
Santa Cruz City Schools	2,082 Students
Bayview Elementary	
Westlake Elementary	
Gault Elementary	
Delaveaga Elementary	

     - 12 staff were also trained in May from 5 school other school districts as an introductory course for planning purposes for 2017-18 with a potential impact of an additional 5,000+ students if implemented at those school sites next school year.

   - **What is the number of families served?**
     Using 1.96 as an average per family child number in California from census data, the approximate of families served was 2,788 (5,465 X 1.96 – and excludes May's training)

   - **Participants' risk of a potentially serious mental illness?**
     Varies per the usual general school aged population statistics*

   - **How is the risk of a potentially serious mental illness defined and determined?**

PBIS does not utilize clinicians or serious mental illness diagnostics given that the trainings and programs are learned and implemented by school staff: janitors to teachers to principals. There are, however, 3 tiers of prevention and intervention. Tier 3 represents student referrals that need individual planning and programming. In this process of individualizing services and supports a referral can also be made to a collaborative counseling agency if the school personnel determine the needs are severe enough or needs more assessment. At this level, a school team would also be convening to discuss this highest level of supportive services, hence the decision to refer would be based on multiple inputs.

3. **Specify the type(s) of problem(s) and need(s) for which program will be directed.** What activities are included in the program to bring about mental health and related functional outcomes (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes)?

PBIS is aimed at keeping students in school and engaged with the educational community at the specific school site and learning and growing that can occur when this happens. It is the hope that many students who may have higher risk factors for institutional involvement (CPS, Probation), suicidal ideation and/or mental health disorders will receive enough support and protective factors to reduce the percent of school going youth who experience these outcomes.

Taken from: Horner, Sugai & Lewis, 2015 - "Is School-Wide Support Positive Behavior Support an Evidence Based Practice?"**:
"School-wide Positive Behavior Interventions and Supports is a systems approach to establishing the social culture and behavioral supports needed for all children in a school to achieve both social and academic success. PBIS is not a packaged curriculum, but an approach that defines core elements that can be achieved through a variety of strategies. The core elements at each of the three tiers in the prevention model are defined below:

Prevention Tier	Core Elements
Primary	Behavioral Expectations Defined Behavioral Expectations Taught Reward system for appropriate behavior Clearly defined consequences for problem behavior Differentiated instruction for behavior Continuous collection and use of data for decision-making Universal screening for behavior support
Secondary	Progress monitoring for at risk students System for increasing structure and predictability System for increasing contingent adult feedback System for linking academic and behavioral performance System for increasing home/school communication Collection and use of data for decision-making Basic-level function-based support
Tertiary	Functional Behavioral Assessment (full, complex) Team-based comprehensive assessment Linking of academic and behavior supports Individualized intervention based on assessment information focusing on (a) prevention of problem contexts, (b) instruction on functionally equivalent skills, and instruction on desired performance skills, (c) strategies for placing problem behavior on extinction, (d) strategies for enhancing contingence reward of desired behavior, and (e) use of negative or safety consequences if needed. Collection and use of data for decision-making

The core elements of PBIS are integrated within organizational systems in which teams, working with administrators and behavior specialists, provide the training, policy support and organizational supports needed for (a) initial implementation, (b) active application, and (c) sustained use of the core elements (Sugai & Horner, 2010)."

4. **Specify any negative outcomes as a consequence of untreated mental illness** (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes) that the Program is expected to affect, including reduction of prolonged suffering (mental, emotional and/or relational functioning).
   A. **List the mental health indicators that the Agency/County will use to measure reduction of prolonged suffering (mental, emotional and/or relational functioning):**

      There is research that shows the most at risk youth in schools tend to have increased rates of office referrals, discipline, suspensions, expulsions and school failure and this in turn correlates with increased involvement with the criminal justice system, less protective factors and poorer social-emotional functioning (Baglivio, Epps, Swartz, Huq, Sheer & Hardt, 2014; Bridgeland, Dilulio, Morrison, Civic & Peter, 2006; Boyd, 2009; Gonzales, 2012).

      PBIS uses rates of suspension/expulsion along with office discipline referrals (ODRs) to monitor and evaluate the effectiveness of the program and ultimately by correlation a reduction in the number of students with too few protective factors and therefore at risk of institutional involvement and decreased emotional and/or relational functioning.

   B. **If the Agency/County intends the Program to reduce any other negative outcome as a consequence of untreated mental illness, list the indicators that the County will use to measure the intended reductions:**
      Nothing more than mentioned in 4, part A above.

   C. **Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence:**
      ODRs (Office Discipline Referrals) are reviewed monthly by school leadership teams. Some schools used the database system known as SWIS to aggregate and analyze this data as well. Other schools augmented their existing data systems to generate similar reports. Each has used this data internal to their district for improving supportive services and PBIS implementation, but it has not been recorded well for external reporting. This is something that can be improved in coming years, both on an individual school or district level and a combined countywide (for those that participate) level.

      Cultural competence seems also a place for improvement, as the reporter has not seen an explicit document or process that would take into account varying cultural differences and needs and understand behavior, histories and supports in this context. Using this critical lens seems crucial so as to avoid unintended cultural bias or blind spots.

5. **Specify how the Prevention Program is likely to bring about reduction of suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes.** Answer questions in either A **or** B.
   A. **If an evidence-based practice or promising practice was used to determine the program's effectiveness:**
      1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

      The article mentioned above, Horner, Sugai & Lewis, 2015 - "Is School-Wide Support Positive Behavior Support an Evidence Based Practice?" has an extensive listing of the most relevant research to date that shows the effectiveness of PBIS to reduce problem behaviors, increase a positive school culture and

climate and by correlation help reduce negative outcomes such as those listed in the question: suicide, incarceration, school failure, prolonged suffering, etc.

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**
PBIS was developed specifically for schools and school aged youth to increase a supportive and healthy school culture and climate, reduce office referrals and school failure and increase relational and social-emotional functioning. The Journal of Positive Behavior Interventions, along with the Horner, Sugai & Lewis, 2015 article outline numerous elements of the program, target populations and effectiveness.

3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**
Districts assess themselves for fidelity with the assistance of the official trainer (Transitioning from CSUMB to Santa Clara County Office of Education), using the Tiered Fidelity Inventory Tool.

C. **If a community and/or practice-based standard was used to determine the Program's effectiveness:**
1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**
Answered A

2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**
Answered A

6. **Describe how the following strategies were used:**
A. **Access and Linkage (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):**
PBIS regularly notes students who may need increased tiered services or outside referrals to collaborative agencies for additional support, especially around mental health concerns. This can happen from an individual evaluation or from a school team convened for Tier 2 and 3 supportive services.

- **Timely Access to Mental Health Services for Underserved Populations (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):**
Analysis of discipline data allows schools to address patterns of disproportionality to ensure appropriate behavior supports are provided equitably to students from diverse backgrounds. Additionally, PBIS acts as a large net, first addressing all students with creating positive norms in a school's functioning, then taking note of and supporting small groups of students needing targeted responses and finally individualizing services for the most at-risk population in the school. At each level PBIS aims to use culturally relevant language, varied supports and services and referrals for more severe mental health concerns.

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):

PBIS promotes a positive school culture and climate as its prime directive and in that pursuit is included being supportive of differences, reducing stigma and bullying around multiple factors, including mental health diagnoses, and creating supports system-wide, in groups and individually to address issues which may arise that inhibit the desired school climate.

Supplemental Notes:

***Most youth are healthy, physically and emotionally, yet one in every four to five youth in the general population meet criteria for a lifetime mental disorder that is associated with severe role impairment and/or distress (11.2 percent with mood disorders, 8.3 percent with anxiety disorders, and 9.6 percent behavior disorders).[1] A national and international literature review found that an average of 17 percent of young people experience an emotional, mental, or behavioral disorder. Substance abuse or dependence was the most commonly diagnosed group for young people, followed by anxiety disorders, depressive disorders, and attention deficit hyperactivity disorder.[2] The rate of serious mental illness was higher for 18 to 25 year olds (7.4 percent) in 2008 than for any other age group over 18.[3] In addition, the onset for 50 percent of adult mental health disorders occurs by age 14, and for 75 percent of adults by age 24.[4](youth.gov website July, 2017: http://youth.gov/youth-topics/youth-mental-health/prevalance-mental-health-disorders-among-youth)**

**** Horner, R., Sugai, G., & Lewis, T. (2015). Is school-wide positive behavior support an evidence-based practice. *Retrieved May 10*, 2017. *https://www.pbis.org/research***

3. **Trauma Informed Systems**:
   - **Purpose**: Trauma is a pervasive, long-lasting public health issue that affects the workforce and system. Like people, organizations are susceptible to trauma in ways that contribute to fragmentation, numbing, reactivity and depersonalization. When systems are traumatized, it prevents staff members from responding effectively to each other and the people served by the system.

     Trauma informed Systems (TIS) is an organizational change model to support organization in creating contexts that nurture and sustain trauma-informed practices. The model has multiple components, including:
     - Trauma 101 foundational training to create a shared language and understanding of trauma
     - Train the trainer program to harness trauma expertise within the workforce
     - TIS Champions embedded in the workforce to spearhead TIS change efforts
     - Leadership engagement and promotion of system change at the program and policy level

     TIS 101 is a foundational 3.5-hour training which will be provided for mental health providers, pre-school teachers, childcare workers, family advocates, and other staff in the prevention workforce. The training content explores the application of six principles of trauma-informed systems: Trauma Understanding, Safety & Stability, Cultural Humility & Responsiveness, Compassion ^ Dependability, Resilience & Recovery, and Empowerment & Collaboration.

     This is a Prevention Program.

   - **Target Population:** Mental health providers, pre-school teachers, childcare workers, family advocates, and other staff in the prevention workforce.
   - **Providers:** East Bay Agency for Children
   - **Number of individuals to be served each year:** 675
   - **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** N/A This is a new program.

PEI Project #2: Services for Diverse Communities

These projects help decrease the risk of violence, suicide, and other traumas individuals may be exposed to by providing education, skills-based training, early intervention and treatment referrals to parents, families, and children. We also provide stigma and discrimination reduction services.

1. **Cara y Córazon**
    - **Purpose**: Cara Y Corazón is a culturally based family strengthening and community mobilization approach that assists parents and other members of the extended family to raise and educate their children from a positive bicultural base.
    - **Target Population:** parents, adults/caretakers, service providers, educators working with youth and/or children
    - **Providers:** Santa Cruz County Behavioral Health oversees and coordinates the implementation of this program, and contracts with individual facilitators to carry out the groups.
    - **Number of individuals to be served each year:** 175 adults
    - **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** We spent time with the evaluators revising and modifying the evaluation tools and this temporarily caused a pause in our groups. We are working with several School Districts, which require facilitators to go through the background check and clearance protocols. Our facilitator's team was not allowed on school campuses until they were notified of their clearance. This process took several months, which temporarily delayed our ability to serve more families. We provided all the documentation related to the curriculums (as required by school districts) filled the paperwork, followed the fingerprint protocol process, and utilized this situation as an opportunity to get our facilitators cleared to avoid this delay from happening again.

Performance Outcomes: Demographic information of unduplicated clients served as required by the State:

Agency Reporting		BEHAVIORAL HEALTH			
Work Plan/Program/Service		Cara y Corazón			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	48	50	37	45	141
Age Group					
• Children 0-15					
• TAY 16-25	5	6	6	10	18
• Adults 26-59	40	29	38	30	110
• Older Adults 60+	3	15	3	5	13
Race/Ethnicity					
• White	5	17			45
• Latino	20	28	37	35	77
• Other	23	5		10	25
Primary Language					
• English	23	17	15	10	53
• Spanish	23	32	22	35	88
• Other	2	1			
Culture					
• Veterans	5	2			12
• LGBTQ	3	3			

Performance Outcomes: Narrative report for Cara y Corazón as required by the State:

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Examples of risk factors include, but are not limited to serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins (including in the womb), poverty, family conflict or domestic violence, experience of racism and social inequality, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

1. **Program Name:** PEI #2: Cara y Corazón **Agency:** BEHAVIORAL HEALTH
2. **Target population:**
   - **Demographics:** (fill out chart)
   - **What is the unduplicated number of individuals served in preceding fiscal year?** __141_____
   - **What is the number of families served?** _____178_____
   - **Participants' risk of a potentially serious mental illness?** _____moderate to serious_____
   - **How is the risk of a potentially serious mental illness defined and determined?**

   Emotional decompensation, chronic depression, history of depression, out of home placement, removal of children from the home, individual/family/environmental trauma. Domestic violence, adverse childhood experiences

3. **Specify the type(s) of problem(s) and need(s) for which program will be directed.** What activities are included in the program to bring about mental health and related functional outcomes (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes)?

   Diffuse myths about MH, create awareness/education, and process past or existing trauma, develop healthier relationships, re-establish structure, family values, safety and security

4. **Specify any negative outcomes as a consequence of untreated mental illness** (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes) that the Program is expected to affect, including reduction of prolonged suffering (mental, emotional and/or relational functioning). Mental health related symptoms and/or episode, unhealthy coping strategies (substance abuse, alcohol abuse, domestic violence, homelessness, potential law-enforcement involvement, stigma, discriminations
   A. **List the mental health indicators that the Agency/County will use to measure reduction of prolonged suffering (mental, emotional and/or relational functioning):**

      Positive awareness of personal emotional needs, healthier relationships, awareness of own emotional challenges and local resources, programs and support systems. Family communication, increased trust among family members

   B. **If the Agency/County intends the Program to reduce any other negative outcome as a consequence of untreated mental illness, list the indicators that the County will use to measure the intended reductions:**

      Physical health, wellness, relationships, family communication, housing, socio-economic resources, cultural pride in their ethnicity, positive outlook on education and emotional wellness

   C. **Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence:**

Pre-survey questions to measure baseline attitude and perspective to family relationship, family and cultural values, discipline styles, parenting skills, pride in cultural traditions and practices, 8 week intervention to reconnect with personal, family and cultural values, awareness and education about acceptance character development, recognizing personal and family emotional baggage, reestablishing structure, recognizing that every person in the family has something to contribute and is part of the family. Post evaluation survey to measure changes in attitudes about the same baseline variables to see what changed and in what way it's contributing to the family physical and emotional health

5. **Specify how the Prevention Program is likely to bring about reduction of suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes.**
   A. **If an evidence-based practice or promising practice was used to determine the program's effectiveness:**
      1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

The evidence is the participant's engagement, trust, participation, awareness of changes that might be needed to build stronger relationship with family members. Parent's commitment to be more connected to family and cultural values that had been suspended. Parent's willingness to open up about individual and family challenges. Stronger commitment to family and cultural values, discipline and commitment to be more consistent to the family dynamics and structure for everyone in the family

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

Participants do not want to stop meeting and want to continue meeting, they offer testimony of what they are learning or willing to do more to restore family and cultural values in the families. Feedback from participants, organizations, schools, who report positive attitudes, behaviors, positive parenting styles

3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

The structured trainings, coaching, support and fidelity measures and certification process to support facilitators who have the skills to provide these teachings. Group facilitators must be certified before they are allowed to facilitate groups.

   B. **If a community and/or practice-based standard was used to determine the Program's effectiveness:**
      1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

The participants who attend the series are referring other individuals, families, schools to bring these teachings to their schools, the community is voicing their support for this approach, families relate to the curriculum model and agree that his approach is more in line with their daily experiences, challenges and healing practices

2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

The county has a practice model coordinator, who is also the trainer and fidelity enforcer of this practice model, who trains, coaches and provide technical support to ensure that the model is carried out with

fidelity. We have post intervention surveys to analyze participant responses, attitudes, parenting practice changes, trust, respect and relationship strength

6. **Describe how the following strategies were used:**
   A. **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):
   We provide a safe and comfortable setting through engagement, trust building activities, welcoming environment. Sharing of personal, family experiences and participants who are struggling with more serious MH challenges are able to open up and ask for help or guidance. Whenever appropriate we offer county MH or local agency referrals for services

   - **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):
   Whenever appropriate and necessary we provide support, referrals, for individuals who may have language barriers, dealing with stigma about MH, lack of economic resources, immigration challenges, we work with local agencies to access every possible service that may help the person and/or family who needs services

   - **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):
   We provide awareness, education, and stigma reduction activities, clarify what MH is and offer referrals to agencies who are able to provide guidance in how to navigate the system, access resources, support from community partners and culturally appropriate agencies and local support groups

2. Jóven Noble

- **Purpose**: Jóven Noble is a youth leadership development program for boys. This 10-week rite of passage curriculum focuses on the process of reconnecting and maintaining a true essence of being a young person. Participants will be empowered through reflection, teachings and personal experiences to develop the interpersonal skills needed to maintain a true sense of purpose and direction in their lives. This program incorporates an approach and curriculum that is based on the philosophy that young men need other men, their family and community to care for, assist, heal, guide and successfully prepare them for true manhood.
- **Target Population:** Teen boys
- **Providers:** Santa Cruz County Behavioral Health oversees and coordinates the implementation of this program, and contracts with individual facilitators to carry out the groups.
- **Number of individuals to be served each year:** 80
- **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** Our facilitator's team was not able to facilitate the Jóven Noble groups until they were notified of their clearance. This process took several months, which temporarily delayed our ability to serve more youths. We provided all the documentation related to the curriculums (as required by school districts) filled the paperwork, followed the fingerprint protocol process, and utilized this situation as an opportunity to get our facilitators cleared to avoid this delay from happening again.

Performance Outcomes: Demographic information of unduplicated clients served, and narrative report, as required by the State:

Agency Reporting		BEHAVIORAL HEALTH			
Work Plan/Program/Service		Jóven Noble			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	34	47	32	44	157
Age Group					
• Children 0-15	26		18	16	78
• TAY 16-25	8	29	14	28	79
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	4	5	5	6	120
• Latino	30	42	27	38	137
• Other					
Primary Language					
• English	28	5	20	6	20
• Spanish	6	42	12	38	137
• Other					
Culture					
• Veterans					
• LGBTQ					

Performance Outcomes: Narrative report for Jóven Noble as required by the State:

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Examples of risk factors include, but are not limited to serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins (including in the womb), poverty, family conflict or domestic violence, experience of racism and social inequality, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

1. **Program Name:** PEI #2: Jóven Noble **Agency:** BEHAVIORAL HEALTH
2. **Target population:**
   - **Demographics:** (fill out chart)
   - **What is the unduplicated number of individuals served in preceding fiscal year?** ___157_____
   - **What is the number of families served?** _____157_____
   - **Participants' risk of a potentially serious mental illness?** _____moderate to serious risk_____
   - **How is the risk of a potentially serious mental illness defined and determined?**

   Serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins (including in the womb), poverty, family conflict or domestic violence, experience of racism and social inequality, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

3. **Specify the type(s) of problem(s) and need(s) for which program will be directed.** What activities are included in the program to bring about mental health and related functional outcomes (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes)?

   Restoring dignity, respect, trust, love, integrity, prevention of school failure, depression, substance abuse, suicide, domestic violence, gang involvement, homelessness, sexual abuse

   Specify any negative outcomes as a consequence of untreated mental illness (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes) that the Program is expected to affect, including reduction of prolonged suffering (mental, emotional and/or relational functioning). Diffuse myths about MH, create awareness/education, and process past or existing trauma, develop healthier relationships, re-establish structure, family values, safety and security.

4.
   A. **List the mental health indicators that the Agency/County will use to measure reduction of prolonged suffering (mental, emotional and/or relational functioning):**
   engagement, participation, positive communication, reduction in delinquent behavior, family connectedness, self-respect, respect for others, school, law enforcement, women, individual/family/ and cultural values.

   B. **If the Agency/County intends the Program to reduce any other negative outcome as a consequence of untreated mental illness, list the indicators that the County will use to measure the intended reductions:**
   Self-esteem, school attendance, positive attitude toward life, supportive friends and family, positive school effort, integrity, outlook on life, traditions, family and cultural values

   C. **Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence:**

Screening process to ask to be part of group, **Pre-test** to establish a baseline about how they feel about life, school, relationships, cultural reference- **Intervention:** attendance and group participation, attitude towards concepts and cultural values, connection to family and extended family Post-**test**: Survey to measure behavior and attitude changes in how they see the same concepts introduced in pre-test

5. **Specify how the Prevention Program is likely to bring about reduction of suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes.**
   A. **If an evidence-based practice or promising practice was used to determine the program's effectiveness:**
      1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

The intended outcome for this Prevention and Early Intervention project is to engage with youth who may be at risk of school failure, poverty, discrimination, mental health challenges, and abandonment, suicide, substance abuse. This model creates awareness, education and guidance in how to begin to understand how personal, family and cultural values, traditional healing practices, and supportive relationships may provide the healing and medicine to prevent this risk factors from affecting youth in our community

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

Youth express more positive outlook to life, school attendance, wanting to know more about their cultural values, practices, and traditions and how they have endured throughout the times. Positive communication with family members, stronger relationship and appreciation with parents' role

3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

Only certified facilitators are allowed to implement this model. A training coordinator is assigned to train, coach and provide technical assistance to ensure fidelity to the model

   B. **If a community and/or practice-based standard was used to determine the Program's effectiveness:**
      1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

School attendance, manners, self-respect, respect for others, respect for parents and teachers, attitudes about MH, substance abuse, violence, and integrity, positive school and community involvement

2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

Only certified facilitators are allowed to implement this model. A training coordinator is assigned to train, coach and provide technical assistance to ensure fidelity to the model

6. **Describe how the following strategies were used:**

A. **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):

We provide a safe and comfortable setting through engagement, trust building activities, welcoming environment. Sharing of personal, family experiences and participants who are struggling with more serious MH challenges are able to open up and ask for help or guidance. Whenever appropriate we offer county MH or local agency referrals for services

- **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):

  Whenever appropriate and necessary we provide support, referrals, for individuals who may have language barriers, dealing with stigma about MH, lack of economic resources, immigration challenges, we work with local agencies to access every possible service that may help the person and/or family who needs services

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):

  We provide awareness, education, and stigma reduction activities, clarify what MH is and offer referrals to agencies who are able to provide guidance in how to navigate the system, access resources, support from community partners and culturally appropriate agencies and local support groups

3. **Xinatchli**
   - **Purpose**: Xinatchli is a youth leadership development program for girls (Bill: say more here...). "Xinatchli" (Germinating Seed Curriculum) is a comprehensive bilingual/bicultural youth development process designed to provide adolescent female youth the guidance for healthy development into adulthood. Based on indigenous principles of the individual's interconnectedness to the family and the community, this curriculum provides a dialectic process of Reflexión (reflection), Creación (creation), Concientización (Awareness), and Acción (action) while supporting and building on the strengths of the individual.
   - **Target Population:** Teen girls
   - **Providers:** Santa Cruz County Behavioral Health oversees and coordinates the implementation of this program, and contracts with individual facilitators to carry out the groups.
   - **Number of individuals to be served each year:** 80 Teen girls
   - **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** Our facilitator's team was not able to facilitate the Xinatchli groups until they were notified of their clearance. This process took several months, which temporarily delayed our ability to serve more youths. We provided all the documentation related to the curriculums (as required by school districts) filled the paperwork, followed the fingerprint protocol process, and utilized this situation as an opportunity to get our facilitators cleared to avoid this delay from happening again.

Performance Outcomes: Demographic information of unduplicated clients served, and narrative report, as required by the State:

Agency Reporting		BEHAVIORAL HEALTH			
Work Plan/Program/Service		Xínatchli			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	21	30	24	12	66
Age Group					
• Children 0-15	0	30	20	12	62
• TAY 16-25	17		4		4
• Adults 26-59	4				
• Older Adults 60+					
Race/Ethnicity					
• White	11		4	6	7
• Latino	4	30	20	9	59
• Other	6				
Primary Language					
• English	20		4	3	7
• Spanish	1	30	20	9	59
• Other					
Culture					
• Veterans					
• LGBTQ	1				

Performance Outcomes: Narrative report for Xinachtli as required by the State:

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Examples of risk factors include, but are not limited to serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins (including in the womb), poverty, family conflict or domestic violence, experience of racism and social inequality, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

1. **Program Name:** PEI #2: Xinachtli **Agency:** BEHAVIORAL HEALTH
2. **Target population:**

- **Demographics:** (fill out chart)
- **What is the unduplicated number of individuals served in preceding fiscal year?** ___66_____
- **What is the number of families served?** ____66_____
- **Participants' risk of a potentially serious mental illness?** ____moderate to serious_____
- **How is the risk of a potentially serious mental illness defined and determined?**
- Emotional decompensation, chronic depression, history of depression, out of home placement, removal of children from the home, individual/family/environmental trauma. Domestic violence, adverse childhood experiences.

3. **Specify the type(s) of problem(s) and need(s) for which program will be directed.** What activities are included in the program to bring about mental health and related functional outcomes (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes)? Restoring dignity, respect, trust, love, integrity, prevention of school failure, depression, substance abuse, suicide, domestic violence, gang involvement, homelessness, sexual abuse.

4. **Specify any negative outcomes as a consequence of untreated mental illness** (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes) that the Program is expected to affect, including reduction of prolonged suffering (mental, emotional and/or relational functioning).). Diffuse myths about MH, create awareness/education, and process past or existing trauma, develop healthier relationships, re-establish structure, family values, safety and security.

A. **List the mental health indicators that the Agency/County will use to measure reduction of prolonged suffering (mental, emotional and/or relational functioning)**:
Engagement, participation, positive communication, reduction in delinquent behavior, family connectedness, self-respect, respect for others, school, law enforcement, women, individual/family/ and cultural values.

B. **If the Agency/County intends the Program to reduce any other negative outcome as a consequence of untreated mental illness, list the indicators that the County will use to measure the intended reductions:**
Self-esteem, school attendance, positive attitude toward life, supportive friends and family, positive school effort, integrity, outlook on life, traditions, family and cultural values.

C. **Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence:** Screening process to ask to be part of group, **Pre-test** to establish a baseline about

how they feel about life, school, relationships, cultural reference- **Intervention:** attendance and group participation, attitude towards concepts and cultural values, connection to family and extended family **Post-test:** Survey to measure behavior and attitude changes in how they see the same concepts introduced in pre test

5. **Specify how the Prevention Program is likely to bring about reduction of suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes.** The intended outcome for this Prevention and Early Intervention project is to engage with youth who may be at risk of school failure, poverty, discrimination, mental health challenges, and abandonment, suicide, substance abuse. This model creates awareness, education and guidance in how to begin to understand how personal, family and cultural values, traditional healing practices, and supportive relationships may provide the healing and medicine to prevent this risk factors from affecting youth in our community

A. If an evidence-based practice or promising practice was used to determine the program's effectiveness:

1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**
   The intended outcome for this Prevention and Early Intervention project is to engage with youth who may be at risk of school failure, poverty, discrimination, mental health challenges, and abandonment, suicide, substance abuse. This model creates awareness, education and guidance in how to begin to understand how personal, family and cultural values, traditional healing practices, and supportive relationships may provide the healing and medicine to prevent this risk factors from affecting youth in our community

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**
   Youth express more positive outlook to life, school attendance, wanting to know more about their cultural values, practices, and traditions and how they have endured throughout the times. Positive communication with family members, stronger relationship and appreciation with parents' role.

3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**
   Only certified facilitators are allowed to implement this model. A training coordinator is assigned to train, coach and provide technical assistance to ensure fidelity to the model

B. If a community and/or practice-based standard was used to determine the Program's effectiveness:

1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**
   School attendance, manners, self-respect, respect for others, respect for parents and teachers, attitudes about MH, substance abuse, violence, and integrity, positive school and community involvement

2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**
   Only certified facilitators are allowed to implement this model. A training coordinator is assigned to train, coach and provide technical assistance to ensure fidelity to the model

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6. **Describe how the following strategies were used:**

Access and Linkage (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):
We provide a safe and comfortable setting through engagement, trust building activities, welcoming environment. Sharing of personal, family experiences and participants who are struggling with more serious MH challenges are able to open up and ask for help or guidance. Whenever appropriate we offer county MH or local agency referrals for services

- **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):
  - Whenever appropriate and necessary we provide support, referrals, for individuals who may have language barriers, dealing with stigma about MH, lack of economic resources, immigration challenges, we work with local agencies to access every possible service that may help the person and/or family who needs services

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- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):
  - We provide awareness, education, and stigma reduction activities, clarify what MH is and offer referrals to agencies who are able to provide guidance in how to navigate the system, access resources, support from community partners and culturally appropriate agencies and local support groups

4. NAMI

- Purpose: The local Santa Cruz County Chapter of the National Alliance for Mental Illness provides extensive classes, support groups and mental health awareness events. The focus of the MHSA funded services is to reduce stigma and discrimination through community-wide education presentations, a quarterly speaker series, and community and mental health awareness events. This is a Stigma and Discrimination Reduction program.
- **Target Population:** Families, consumers, schools, providers, and the public at large
- **Provider:** NAMI
- **Number of Individuals to be served each year:** 2,500
- **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** No.

Performance Outcomes: Unduplicated number of served as required by the State:

Agency Reporting		NAMI			
Work Plan/Program/Service		Stigma & Discrimination Reduction			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Count
Total Served (Unduplicated)	1694	1676		2007	2627

No demographic information required by State for this program.

Performance Outcomes: Narrative report for NAMI as required by the State:

Stigma and Discrimination Reduction: Activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

1. **Program Name:** Stigma and Discrimination Reduction **Agency:** NAMI

2. **Number of people reached:** 2627 unduplicated count (For Q2, Q3, Q4)

3. **Identify who the program intends to influence:**
   - Education and Training Series – families, consumers and providers
   - Presentations and Public Education – students (middle, high school, higher ed), consumers, teachers/professors, community at large
   - Community Partnerships – providers, families and consumers
   - Support Programs – families and consumers

4. **Specify methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness, and/or seeking mental health services, and indicate timeframes for measurement of:**
   - **Changes in attitudes, knowledge and/or behavior related to seeking mental health services that are applicable to the specific program.**

     By educating not only the clients, but also the family members, the providers, schools, and the community at large, the stigma against mental illnesses and the fear of seeking treatment is reduced for all.

     Education and Training Series – Training for Providers, Consumers and Families includes multi-week curriculum covering information about mental illness, how to work toward wellness and to communicate well with natural and professional supports. Post evaluations are given at the end of each class series.

     Family Class Series: Increased confidence in working with mentally ill family members, less fear and stigma related to mental illness, more understanding of needs and triggers that are important for wellness of their loved one's health, and more understanding of resources available.

     Peer to Peer Education Series: increased wellness for the consumer, new tools to help with wellness/recovery, and an ability to understand some of the triggers environmental and physiological that contribute to stress and periods of emotional crisis. Wellness plans are part of the program and support of each other in a peer-based community is an important part of not feeling alone.

     Provider Education Series: reducing stigma and increased knowledge of mental illness and linkage to care. Encourages therapists to consider serving persons with serious mental health needs.

     Presentations and Public Education – Provides improved knowledge of mental illness, recovery and services available, engagement of stakeholders in understanding services and getting involved, reduction of stigma and education on new treatments and efforts of system improvement. Student presentations also include information on how to help a friend. In parent presentations, we also explore the stages of emotional recovery and for teachers we include information on how to support behaviors in a classroom. Post evaluations are given at the end of selected presentations.

Community Partnerships – Participation in various key collaboratives – Integrated Behavioral Health Action Coalition of HIP working of improving services community wide (NAMI and MHCAN are only consumer voices in coalition), Criminal Justice Council, School Mental Health Partnership, all housing activities to support access for those with mental illness and co-occurring disorders to live in the community. Bringing a voice of the family and peer perspective. Measurement: Attendance and participation at 30 meetings per year with the current commitments of 9-40 people in the events.

Support Programs: Improved confidence and mental wellness in addressing symptoms in themselves and others, development of support systems to call upon for assistance and socialization, better understanding of what is available in the community, and improved understanding of mental health and mental wellness. We will keep a record of attendance.

5. Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:
   A. If an evidence-based practice or promising practice was used to determine the program's effectiveness:
      1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

NAMI Family-to-Family Education Program has been added to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP).

The research found that the family members who participated in Family-to- Family classes showed:

- Significantly greater overall empowerment as well as empowerment within their family, the service system and their community
- greater knowledge of mental illness
- a higher rating of coping skills
- lower ratings of anxiety related to being able to control conditions
- higher reported levels of problem- solving skills related to family functioning.

Two research studies have been conducted on NAMI Basics

- A 2008 study conducted by Missouri State University psychologist Dr. Paul Deal found that parents/caregivers who took the NAMI Basics course reported knowing more about the symptoms, assessment and treatment of mental illness than they did before taking the course. The study also found that these parents felt better about themselves as caregivers after taking the course.
- A 2009-2010 study conducted by Dr. Kimberly Hoagwood of Columbia University and Dr. Barbara Burns of Duke Medical Center found that parents who took the NAMI Basics course reported taking better care of themselves, feeling more capable of advocating for their children and being able to communicate more effectively with their children after taking the course. The results of this study were published on May 6, 2011 in the Journal of Child and Family Studies.

An evaluation of participants of the **NAMI Peer-to-Peer** by the University of Maryland found that taking the course improved self-image, increased self-motivation and willingness to help others with mental health challenges. In addition, participants:

- Felt less alone.
- Learned new relapse prevention skills.
- Reported more acceptance towards their illness.
- Embraced advocacy and used the class to help others.
- Experienced improved relationships with loved ones.

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.** (See above)

3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

Our volunteers are trained in accordance with NAMI National Guidelines and by certified NAMI trainers. We maintain fidelity by listening to quarterly national teleconferencing calls and also by meeting quarterly to discuss successes and challenges in delivering the programs.

B. If a community and/or practice-based standard was used to determine the Program's effectiveness:

1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

Evidence that our approach is providing applicable outcomes include positive post evaluation reports. Thriving support groups, presentations and classes due to a stellar reputation.

2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

Our volunteers are trained in accordance with NAMI National Guidelines and by certified NAMI trainers. We maintain fidelity by listening to quarterly national teleconferencing calls and also by meeting quarterly to discuss successes and challenges in delivering the programs.

6. **Describe how the following strategies were used:**

- **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):

  Warmline - is supervised by experienced volunteer and staff with linkage to MH as needed for acute calls. Many families and the general public use the warm line for information on access to care, rehab, housing, case management, medications etc. Primary function is linkage to care and help in a crisis to offer support and some assistance. It is not always answered immediately but usually within 24 hours. Many are linked to support groups and classes.

  Support Groups and Classes – Provide linkage to services and support by relying on the wisdom of the group. We also have an email group where NAMI Volunteers are kept current on resources and events that they can then share with the attendees.

  Website and Facebook – online presence distributes information on local resources and events as well as articles on current research, recordings of local meetings.

  Online Chat Group Support for Parents of children ages 12 to 26. Parents share resources, opinions, and support each other. Linkage to services and supports.

- **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):

Traditionally family members of individuals living with mental illness have been underserved; even in provider organizations who have served families in the past, budget cuts and staffing shortages have decreased that ability to work with families on anything other than an emergency basis. Our classes, support groups and individual advocacy helps to address their needs and improve the outcomes of the consumer.

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):

  All of our programming includes stories of recovery by a trained speaker. The information in the classes, materials used in the Support Groups, and presentations allow for dignity and acceptance of individuals with disability to live successfully in the community. We reduce self-stigma by providing a safe place to share with other of similar lived experience. Community stigma reduction is provided through our educational presentations, brochures, events and newsletters. School presentations normalize mental health challenges and encourage students to talk to someone they trust. Our trained speakers tell how different treatments helped them recover.

5. **Shadow Speakers.**
   - **Purpose:** The Shadow Speakers program is operated by MHCAN. The program trains peers to "tell their story" and experience of lived experience. The experience empowers other peers to develop similar skills and share strategies for living with a psychiatric condition. Shadow Speakers provides classes and mental health awareness events; reduces stigma and discrimination through community-wide education presentations, a quarterly speaker series, and community and mental health awareness events to help reduce **Stigma and Discrimination** against people with serious mental illness.
   - **Target Population:** community at large
   - **Provider:** MHCAN
   - **Number of Individuals to be served each year:** 2,500
   - **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** No

Performance Outcomes: Unduplicated number of served as required by the State:

Agency Reporting		MHCAN shadow speakers			
Work Plan/Program/Service		Stigma & Discrimination Reduction			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Count
Total Served (Unduplicated)	1242				3530

No demographic information required by State for this program.

Performance Outcomes: Narrative report for Shadow Speakers as required by the State:

Stigma and Discrimination Reduction: Activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

1. **Program Name**: Shadow Speakers **Agency**: MHCAN
2. **Number of people reached**: 3530
3. **Identify who the program intends to influence:**
   The program intends to influence all people in the Santa Cruz community through doing speaking arrangements for people in locked facilities, schools, businesses, churches, other nonprofits. The program intends to alleviate the very real stigmatization of people with severe mental health diagnoses as violent, bad, defective individuals and to share our diverse experiences as people of wisdom, character and experience.
4. **Specify methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness, and/or seeking mental health services, and indicate timeframes for measurement of:**
   - **Changes in attitudes, knowledge and/or behavior related to seeking mental health services that are applicable to the specific program**, or
     Using common themes that are universal in non-mental health environments, average people are able to identify and have an empathetic response with those of us who are often put on a spectrum or continuum as lower functioning or lower value human beings. The otherization of us is impaired by connection. The Speakers Bureau is an effort to connect into the wider community.
   - **Changes in attitude, knowledge, and/or behavior related to seeking mental health services that are applicable to the specific program.**
     The amount of other peoples and organizations that wish to bridge with MHCAN are directly attributable to Shadow Speaking encounters in which people have perhaps heard of us for the first time. New people are referred by relatives or friends who hear the speakers' bureau panels as well as resources for our program and quality volunteers.
5. Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:
   A. **If an evidence-based practice or promising practice was used to determine the program's effectiveness:**
   1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

   Peer Run Drop In Centers have been found to be evidence based practices. We have had a very interesting timeline with doing Shadow Speaking for years. The first years only the most outgoing people did it, but as time passed the more withdrawn among us felt comfortable to speak. All of a sudden people who were conserved discovered their voices for speaking. After 3 years! After 3 years all of a sudden one after another folks who were conserved felt comfortable enough to speak- and we had a flood of people who were conserved all wanting to speak at once. In general the conserved folks are a little more difficult to understand and being involved in Shadow Speakers has literally improved people's abilities to speak and to be understood, to speak in intelligibly more consensual reality style. SO we have been a part of this greater participation to the point where people who I would have considered absolutely

unemployable at the beginning of Shadow Speaking have grown and changed and adapted in ways that have made them very able to be hired and to work in other regards as well.

Speaking and in particular the in-house trainings has given value to our histories, to us, to our stories. Many people have been discriminated against so chronically that they have come to believe they are of little value. The self-esteem that comes from appreciation for their speaking is absolutely incalculable.

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

Shadow Speakers is every effective as Workforce Education Training. We have many people who have never had a job who work for the first time by doing Shadow Speaking. We do gentle feedback in trainings where we let people know that different ways of speaking can be less understood- and this understanding can transfer to the rest of their deportment where we have seen time and time again dramatic changes in presentation. The main way we see the effectiveness, however, is in the changing attitudes of people towards anyone who speaks. People reveal a lot of their personalized trauma in speaking and we often see someone who had a harder time with others before they began speaking- because now everyone understands that if they are wearing green not to go near them, for example. SO the speaker's bureau has led to greater connection and improved relationships with each other as MHCANers. The most dramatic way for society however, would be in Workforce Education Training.

3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

The Shadow Speakers actually adapted their speaker's bureau from the Santa Cruz Diversity Center's Triangle Speakers. We met with Shawn Ordinario several times and he went over the way they did their bureau and we had multiple trainings with the initial participants who passed it on ever since. It is a standard model of a speaker's bureau with no innovative elements to lead it off track. We have only had 4 children participate over time. At one point 4 years ago, we had a great panel going which consisted of a grandmother, one of her daughters and one of her seven granddaughters, then 14 years old. 4 years later all three are still involved in the speakers' bureau although to differing degrees of participation. Being part of the speakers' bureau was her granddaughter's first job. (We rarely have children participate but this last year we had a very memorable Shadow Speakers participation by a 9 year old boy with extreme social anxiety and ADD who finally felt enough at home at MHCAN to do an unforgettable presentation on "How to Escape the Zombie Apocalypse".)

B. If a community and/or practice-based standard was used to determine the Program's effectiveness:

1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

The amount of people who had never been employed in regular work before Shadow Speakers and then afterward went out and got some kind of paid work is really astounding. Being shown how to do a time card, experientially working for pay, is a very positive reward model with great efficacy. We literally could hire dozens of people if we only had more work- because people want to work- and Shadow Speakers has been a big part in changing the feelings around work at MHCAN.

The amount of people who came to MHCAN after listening to a speakers bureau or hearing from a friend or family member who attended one is really remarkable and literally evidentiary.

2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

We are always willing to have anyone come and attend any speaker's bureau. We have a speakers bureau coordinator who also works on call for MHCAN, Ms. Helen B, who attends many of the events herself and helps guide new people. She has been of inestimable boon to us and to MHCAN. She makes sure the speakings stay on course. We have only had one big disaster in years of the speakers bureau. Whenever we go into clean & sober places, we also have purely clean & sober panels scheduled. One time, someone had relapsed and not been honest with us about it. At a Janus of Santa Cruz Shadows Speakers presentation, she took a bottle of vodka out of her backpack to show everyone when talking about her recent relapse- and gave a speech as to why drugs were great for mental health. Unfortunately, she has remained non sober and not part of the bureau ever since. Other than that, we have not once had an ugliness involved.

6. **Describe how the following strategies were used:**
   - **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):
     In the speakers' bureau, people talk about accessing resources experientially and in that way, it is much more accessible to people who may be having issues but are shy about self-disclosure or seeking help.
   - **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):
     As we not only speak outwardly in the greater community but inwardly in our own, in the PHF, in the locked places, in the step downs, in the housing- we are able to share methods of accessing resources one on one in questions during the question and answer part of the speaking as well as sharing our own paths with resources in the main speaking portion.
   - **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):
     In many ways, the speaker's bureau relieves stigma and discrimination as humans tend to relate to others and when given the opportunity to hear another's story there is almost always a sympathetic response, as we are mammalian creatures who tend toward that. However, especially when dealing with people who are mental health and criminal justice, we have ignored the societal barriers about talking frankly about some things with great response. When we began the speaker bureau, whenever I spoke, the early other speakers would ask me NOT to speak as honestly as I did and do about my mental health pathology. They were afraid that I would scare people and further stigma. I am one of those lucky people who has in my life had to deal with repetitive urges to self-harm and harm others although thank goodness due to sobriety and an earnest effort to balance every day, I have never once acted on them. So, whenever we spoke at SCCR, the old Sunflower House, in the beginning, I had some of the most dramatic responses personally that I have ever had in my entire life. SCCR is a criminal justice linked population in general. AT one meeting alone, there were 4 people who all said that they had NEVER heard anyone talk honestly about that subject and that they ALL suffered with the same trauma-induced pathology- and some of them had acted on it, some had not. People were VERY RELIEVED to hear that HAVING such thoughts does NOT mean that ultimately one MUST or WILL act on them- and people were visibly and eloquently relieved. After that one meeting with four people in the audience expressing great appreciation for my candor, no one ever suggested I shut up again. This is only my experience in one regard- of how believing things about ourselves can affect our future and our actions. I do not tend to talk about that subject when we go to schools or places in the community, but on the rare times now when I get asked to go along to SCCR I always do- and inevitably there has always been at least one other person with the same pathology.

     Just as with me, almost every speaker who speaks has a story of such a shared connection where someone really needed to hear exactly what they had to say- and which leads to greater closeness as a community able to help each other through times of intensity.

PEI Project #3: Services for Transition Age Youth & Adults

These projects provide intensive treatment and education for family members when individuals are developing early signs of possible serious mental illness. Through consultation, training and direct service delivery, a broad menu of services will be offered by Peer Counselors and Licensed counselors and psychiatrists to transition age youth and their families.

PEI Project #4 has three proposed strategies:

1. **Employment Services:**
   - **Purpose**: To offer support for person's experiencing early signs and symptoms of mental illness, by meeting individual goals to improve quality of life, and integrate in a meaningful way into the community.
   - **Target Population:** Transition age youth and adults with early signs and symptoms of mental illness.
   - **Providers:** Volunteer Center/Community Connection
   - **Number of individuals to be served each year:** 40
   - **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** It is difficult to find employment opportunities in the community. A new job developer was hired to help address this issue.

Performance Outcomes: Demographic information of unduplicated clients served as required by the State:

Agency Reporting	Volunteer Center (Community Connection)				
Work Plan/Program/Service					
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	21	18	25		36
Age Group					
• Children 0-15					
• TAY 16-25	17	16	22		32
• Adults 26-59	4	2	3		4
• Older Adults 60+					
Race/Ethnicity					
• White	11	11	14		18
• Latino	4	4	6		10
• Other	6	3	5		8
Primary Language					
• English	20	17	18		14
• Spanish	1	1	2		2
• Other			5		
Culture					
• Veterans					
• LGBTQ	1	2	3		4

Performance Outcomes: Narrative report for Employment Services as required by the State:

Early Intervention: Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Early intervention shall not exceed 18 months, unless the person is identified as experiencing first onset of a serious mental illness, or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years. Serious mental illness or emotional disturbance with psychotic features means schizophrenia spectrum, other psychotic disorders, and schizotypal personality disorder. These disorders include abnormalities in one of the five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia, and negative symptoms.

1. **Program Name:** PEI #3 Employment Services **Agency:** Volunteer Center/Community Connection

2. **Target population:**
   - **Demographics:** (fill out chart)
   - **What is the unduplicated number of individuals served in preceding fiscal year?** _____45_____
   - **What is the number of families served?** ____n/a_____
   - **Mental illness or illnesses for which there is early onset:** ___schizophrenia, bipolar dx, depression, PTSD,
   - **Description of how participant's early onset of a potentially serious mental illness will be determined:**

   Through intake questionnaires, ANSA measures and interviews with individuals, mental health care professionals and family members.

3. **Identification of type(s) of problem(s) and need(s) for which program will be directed, and activities to be included in program to bring about mental health and related functional outcomes** (including suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes).

   Primary types of needs/problems: School failure, lack of education and skills, unemployment, underemployment. Activities will include academic and employment counseling and skill building. Clients will have an opportunity to volunteer and meet employers in order to better prepare to enter the workforce. Clients are given opportunities to attend classes specific for mental health consumers at the college level. Services are provided in the community, at school, and in the workplace to reduce stigma and better serve the youth population.

4. Outcomes:
   - **List the mental health indicators used to measure reduction of prolonged suffering that result from untreated mental illness as measured by reduced symptom and/or improved recovery, including mental, emotional and relational functioning:**

     Improved access and retention in education, employment. ANSA assessment at intake and at 6-month intervals.

   - **List the indicators used to measure the intended reductions:**

     School attendance, employment, volunteerism and ANSA assessment.

   - **Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects cultural competence:**

     Each consumer is given an ANSA assessment upon intake and at 6-month intervals to measure recovery outcomes. In addition, each consumer is encouraged to participate in Meaningful Activity including attending school, training program, volunteer opportunities, or by becoming employed in part-time or fulltime work. Data are collected on all activities performed by each consumer.

5. **How is the Early Intervention Program likely to reduce suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes? Answer either A or B.**

   A. If an evidence-based practice or promising practice was used to determine the program's effectiveness:

   1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

   2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

   3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

   B. If a community and/or practice-based standard was used to determine the Program's effectiveness:

   1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

      Because Community Connection is a para-professional organization, we provide practice-based tools to meet program effectiveness. We base these tools on EBPs including supported employment, supported education, and Motivational Interviewing.

   2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

      We measure success by monitoring the meaningful activities in which each consumer is involved. We also use a modified ANSA measure to determine particular aspects of mental health recovery and community involvement.

6. **Describe how the following strategies were used:**

   - **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):

     All consumers are asked at intake to discuss their medical history and any health care practitioners currently involved in their care. Each consumer is encouraged to seek medical/mental health treatment and is given resources to access this care if no providers are listed. Staff members at Community Connection are in regular contact with SC Mental Health and the TAY team in order to ensure that all consumers are able to access services.

   - **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):

     Community Connection is composed of a diverse employee pool including employees with lived experience, gender fluidity and those who are bilingual/bicultural. Our team is available to meet consumers anywhere in the community and to provide transportation to needed appointments and health/mental health care issues. Our services are payer blind and free to consumers.

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):
  All services are welcoming and designed to reduce stigma and discrimination. We meet persons where they are, literally. We meet them in the community, in their homes, or at their schools. We employ persons with lived experience to further reduce the impact of receiving mental health services. We pick people up and encourage all interaction be "out of the office" to increase the likelihood of retention in services and to reduce the "self-stigma" of receiving mental health services.

2. Clinical Services:

- **Purpose**: To provide information, referrals, clinical assessments, and short-term therapy and case management for persons showing signs and symptoms of serious mental illness.
- **Target Population:** Transition age youth and adults with early signs and symptoms of mental illness.
- **Providers:** Santa Cruz County Behavioral Health
- **Number of individuals to be served each year:** 100
- **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** Methamphetamine abuse has increased in our community, which makes it has been difficult to differentiate mental illness and substance abuse.

Performance Outcomes: Demographic information of unduplicated clients served, and narrative report, as required by the State:

Agency Reporting		BEHAVIORAL HEALTH			
Work Plan/Program/Service		Early Intervention Services			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)		18			60
Age Group					
• Children 0-15					
• TAY 16-25		18			86
• Adults 26-59					21
• Older Adults 60+					
Race/Ethnicity					
• White		10			29
• Latino		6			31
• Other		2			
Primary Language					
• English		18			96
• Spanish					9
• Other					2
Culture					
• Veterans					
• LGBTQ					

Performance Outcomes: Narrative report for Clinical Services as required by the State:

Early Intervention: Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Early intervention shall not exceed 18 months, unless the person is identified as experiencing first onset of a serious mental illness, or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years. Serious mental illness or emotional disturbance with psychotic features means schizophrenia spectrum, other psychotic disorders, and schizotypal personality disorder. These disorders include abnormalities in one of the five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia, and negative symptoms.

1. **Program Name:** Adult & TAY clinical services **Agency:** BEHAVIORAL HEALTH

2. **Target population**:
   - **Demographics:** (fill out chart)
   - **What is the unduplicated number of individuals served in preceding fiscal year?** 51 TAY
   - **What is the number of families served?** ____40_____
   - **Mental illness or illnesses for which there is early onset:** ___Psychosis NOS, schizophrenia, bipolar disorder, PTSD, Anxiety Disorder, OCD, Eating Disorders, Major Depression, Mood Disorder NOS, Substance-induced psychotic disorder_____
   - **Description of how participant's early onset of a potentially serious mental illness will be determined:**

   If PEI staff determine that a PEI client meets system-of-care criteria for County MH services, the individual will be referred to ACCESS for an ACCESS Assessment.

3. **Identification of type(s) of problem(s) and need(s) for which program will be directed, and activities to be included in program to bring about mental health and related functional outcomes** (including suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes).

   Early onset psychosis, depression and other mood disorders, extreme anxiety, symptoms of trauma that result in suicide attempts, failures at work or school, homelessness and/or removal of children from their homes.

4. **Outcomes:**
   - **List the mental health indicators used to measure reduction of prolonged suffering that result from untreated mental illness as measured by reduced symptom and/or improved recovery, including mental, emotional and relational functioning:**

     ANSA, reduction in hospitalizations and other higher level-of-care residential services, family report, self- report and ability to maintain job and/or school functions

   - **Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects cultural competence:**

     ANSA reports- collected every 6 months
     FSP Reports- collected continually

5. **How is the Early Intervention Program likely to reduce suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes?** Answer questions in either A or B.
   - **A. If an evidence-based practice or promising practice was used to determine the program's effectiveness:**

1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

ANSA reports- determine areas of clinical concern for individuals

FSP reports- evaluate changes in client's current functioning related to services utilized, housing, vocational and educational status, incarcerations, hospitalizations, conservatorship, etc.

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

ANSA reports- data used to develop treatment plan goals

Review of ANSA scores in weekly supervision sessions with clinical staff used to determine focus of treatment interventions, level-of-care services and goal setting.

2. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

FSP data reports
ANSA data reports

- **If a community and/or practice-based standard was used to determine the Program's effectiveness:**

1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

N/A

2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

N/A

6. **Describe how the following strategies were used:**
   - **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):

Referrals to ACCESS if deemed client meets system-of-care criteria for County MH services, referrals to vocational, educational and housing programs. Psycho-education for clients and their families

- **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):

Referrals to ACCESS for Assessments if deemed to meet system-of-care criteria for County MH services

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):

Psycho-education for clients and their families
TAY Youth Council for social supports and normalization of the clients' experience Referrals to vocational, educational and independent housing services in order to increase clients' quality of life

3. **Veterans' Advocacy and Service Coordination:**

- **Purpose**: The Veteran Advocate services veterans and their families throughout the County. The Veteran Advocate is responsible for brokering federal, state, and local programs to the veterans in the community. The focus is on providing needed services regardless of the veteran's discharge or benefit status. Individual case management, brokering of services and interface with the community-based organizations to assist with benefits, housing, health care, mental health and substance abuse treatment for veterans are developed and referred. The position also provides a vital community-organizing role linking various veteran service providers in efforts of service collaboration and education to the veteran community regarding available services. The Veteran Advocate provides both prevention and early intervention services.
- **Target Population:** Veterans and their families
- **Providers:** Santa Cruz County Behavioral Health
- **Number of individuals to be served each year:** 250
- **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** The Veteran Advocate for the last six years left the position to assume a Veterans Service Officer position. A new individual was hired to assume the Veteran Advocate role. The position was vacant for several months.

- **Performance Outcomes:** Demographic information of unduplicated clients served, and narrative report, as required by the State:

Agency Reporting		BEHAVIORAL HEALTH			
Work Plan/Program/Service		Veteran Advocate			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)				44	44
Age Group					
• Children 0-15	**Position was vacant.**				
• TAY 16-25				2	2
• Adults 26-59				12	12
• Older Adults 60+				30	30
Race/Ethnicity					
• White				38	38
• Latino				3	3
• Other				1	1
Primary Language					
• English				44	44
• Spanish					
• Other					
Culture					
• Veterans				41	41
• LGBTQ				1	1

Performance Outcomes: Narrative report for Veterans' Advocate as required by the State:

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Examples of risk factors include, but are not limited to serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins (including in the womb), poverty, family conflict or domestic violence, experience of racism and social inequality, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

1. **Program Name**: Veterans Advocate **Agency**: MHSA contract

2. **Target population:**

- **Demographics:** (fill out chart)
- **What is the unduplicated number of individuals served in preceding fiscal year?** 44
- **What is the number of families served?** 44
- **Participants' risk of a potentially serious mental illness?** 25
- **How is the risk of a potentially serious mental illness defined and determined?**

Homelessness, incarceration, identification of traumatic events during service, previous mental health diagnosis

3. **Specify the type(s) of problem(s) and need(s) for which program will be directed.** What activities are included in the program to bring about mental health and related functional outcomes (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes)?

Veterans Advocate will work to identify veterans struggling with substance abuse, homelessness, incarceration, mental health challenges (PTSD, TBI, depression, bi-polar, etc.), and other health problems. Veterans Advocate will assist veterans to access assistance through the Veterans Affairs programs, State programs, County programs and other local resources. Through identification of resources and support available this program will reduce suicide, incarceration, school failure, unemployment, homelessness and prolonged suffering.

4. **Specify any negative outcomes as a consequence of untreated mental illness** (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes) that the Program is expected to affect, including reduction of prolonged suffering (mental, emotional and/or relational functioning).

   A. **List the mental health indicators that the Agency/County will use to measure reduction of prolonged suffering (mental, emotional and/or relational functioning):**

Veterans Advocate interviews each client and screens them for placement in appropriate programs including county mental health, VA counseling programs, and VA residential programs. Veterans Advocate works to identify warning signs of PTSD, depression, and other mental health illnesses and assists to coordinate appropriate care.

   B. **If the Agency/County intends the Program to reduce any other negative outcome as a consequence of untreated mental illness, list the indicators that the County will use to measure the intended reductions:**

Reduction in homelessness-measured by referrals to housing programs and the result, reduction to incarceration measured by veterans that successfully complete veteran's treatment court, Reduction to financial instability measured by claims awarded by the Veterans Affairs, Reduction to availability of medical treatment measured by enrollment in the VA health care system, reduction in mental health challenges measured by referrals to VA counseling, substance abuse groups, and County mental health.

C. **Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence:**

Data will be gathered in real time and tracked via excel spreadsheet and online tool: VetPro. Outcomes will be measured each quarter and analyzed to determine successfulness of efforts. Veterans Advocate will maintain professionalism with all clients and utilize active listening skills to identify the specific challenges of each client.

5. **Specify how the Prevention Program is likely to bring about reduction of suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes. Answer either A or B.**

A. **If an evidence-based practice or promising practice was used to determine the program's effectiveness:**

1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

Through interviews the Veterans Advocate will use direct questions and active listening to identify challenges that each client is facing. By identifying these challenges and making the appropriate referrals, this program will assist clients by identifying support systems available. The Veterans Advocate will reduce incarceration by assisting veterans who are part of the Veterans treatment court to coordinate care with the Veterans Justice Outreach Program. The Veterans Advocate will work closely with the Housing and Urban Development Veterans Affairs Supportive Housing Program to assist veterans to find long term housing options. The Veterans Advocate will also work with Supportive Services for Veteran Families, Transitional and Emergency Housing programs to reduce homelessness among Veterans. The Veterans advocate will also enroll veterans in the VA health care system, make referrals to mental health programs, make referrals to employment assistance programs, and assist with education programs and professional development.

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

The Veterans Advocate works closely with the Veteran Services Office of Santa Cruz County and has assisted many veterans to find housing, increase financial stability, access health care, complete education, and find employment.

3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

The Veteran Advocate will track progress and outcomes through follow ups to ensure the client has been able to access the resources available and their needs are being met. The Veteran Advocate will report to the director of County mental health to review outcomes and develop strategies to improve the program.

B. **If a community and/or practice-based standard was used to determine the Program's effectiveness:**

1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

6. **Describe how the following strategies were used:**

A. **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):
The Veterans Advocate has the opportunity to reach out to veterans in the community and identify their needs through face to face interviews. The Veterans Advocate is able to assess the needs of each client and make appropriate referrals based on those needs.

- **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):
The Veterans Advocate will do extensive outreach to the veteran community. The veteran population has a high risk of mental health challenges based on the nature of military service. The Veteran Advocate is able to assist low income and homeless veterans by providing access to benefits earned during service. Through identification and early intervention, the Veterans Advocate is able to assist veterans with all of their needs. The Veteran Advocate has the ability visit veterans who are otherwise not able to find transportation to an office.

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):
The Veterans Advocate is able to reduce stigma by addressing veterans in a respectful way and providing support for their needs. One on one confidential interview allows each client the opportunity to be honest about their needs. Through compassion and active listening the Veterans Advocate is able to present mental health services in way that positive and will help to reduce suffering each client is facing.

4. **Suicide Prevention services:**

- **Purpose**: to provide educational presentations, grief support, and the suicide hotline. The Suicide Crisis Line is available 24 hours, 7 days per week for those who are suicidal or in crisis, as well as for community members who are grieving the loss of a loved one to suicide, are concerned about the safety of another person, or are looking for assistance with finding community resources. Outreach presentations and trainings (which help to reduce stigma, raise awareness, and promote help seeking) are provided regularly throughout the County to a range of different at-risk groups, stakeholders, and service providers for various populations (including domestic violence prevention, professional and peer mental health support organizations, etc.). One focus of community outreach activities continues to be reaching groups who are higher at risk than in the general population – for example, survivors of suicide loss are up to forty times more likely to die of suicide than others. Suicide Prevention provides prevention and early intervention services.
- **Target Population:** Everyone in Santa Cruz County.
  As of October 2017, Suicide Prevention Service staff has provided 62 presentations to 5,650 individuals at: Vet-Net, Pajaro Valley Children, Cabrillo College, Santa Cruz High School, Watsonville High School, Soquel High School, QPR training, Trauma Training, Calciano Symposium, Pacific Coast Charter, CIBHS/CSUMB, Alternative Family Solutions, Santa Cruz Mental Health Advisory Board, Walk a Mile, Denim Day, Sons In Retirement, CalFRESH, QYLA, DeWitt Anderson, Tierra Pacifica Charter School, Santa Cruz PRIDE, Scotts Valley Unified School District, Behavioral Health Department, Cabrillo College, California Institute for Behavioral Health, Solutions, Pajaro Valley PRIDE, Salud Para la Gente, Santa Cruz Connect, St. Patrick's Church, Twin Lakes Church-Mental Health Conference, and Watsonville High School.

  Program staff has also provided 11 trainings to 290 individuals at Sobriety Works, Walnut Ave Family & Women's Center, Pacific Collegiate School, Linscott Charter School, Santa Cruz County Community Health Education, Santa Cruz CIT training, Walton Warriors, and Santa Cruz Human Services Agency.

  Furthermore, in June 2017, staff conducted two Mental Health First Aid trainings in Santa Cruz County for 50 individuals at Santa Cruz Health Services Agency. Three additional will be held in November for Santa Cruz County's Health Services Agency and for the Pajaro Valley Unified School District. In addition, staff will be conducting an ASIST training in December for the Scotts Valley Unified School District staff. The training schedule for 2018 has not been finalized.

  Suicide Prevention Service of the Central Coast trainings and presentations are advertised via the Livingworks website and via e-mail sent out by the Assistant Director for Community Outreach, that are then further distributed by community collaborators. Additional methods of information distribution and enrollment for trainings open to the public are currently being developed by program staff.

Currently, program services focused on postvention within Santa Cruz County include our WINGS support group (for anyone who's lost a loved one to suicide) and the 24-HR multilingual suicide crisis line. Suicide Prevention closely collaborates with the local chapters of Hospice, SERP, schools, and other local entities to provide further individualized services around grief and loss following a suicide. LOSS (Loving Outreach for Survivors of Suicide) is our bereavement support group held in Pacific Grove. Additional program services are developed and implemented based on need, sustainability and funding availability

- **Providers:** Family Services of the Central Coast
- **Number of individuals to be served each year:** 2,500
- **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** No

Performance Outcomes: Unduplicated number of served as required by the State:

Agency Reporting		Family Services Agency			
Work Plan/Program/Service		Suicide Prevention Services			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Count
Total Served (Unduplicated)	401	1,088		2701	5673

No demographic information required by State for this program.

Performance Outcomes: Narrative report for Shadow Speakers as required by the State:

Suicide Prevention: Organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This program does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness. Programs include, but not limited to, public and targeted information campaigns, suicide prevention hotlines, training, and education.

1. **Program Name:** PEI #3 Suicide Prevention **Agency:** Family Services Agency

2. **Number of people reached:**
   Number of calls to the suicide crisis line:
   (Santa Cruz location verified) 1,221
   (Location unknown) 1,734
   Number of follow-up calls:
   (Santa Cruz location verified) 28
   (Location unknown) 27
   Number of 911 calls:
   (Santa Cruz location verified) 31
   (Location unknown) 16
   Outreach Participants: 5,673

3. **Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.**
   We will conduct suicide prevention educational presentations and trainings, including offering ASIST and SafeTALK, for County residents, at-risk populations, and anyone who works with at-risk populations. We will also participate at public events such as health fairs, public and private school activities, and County functions.

4. **How will the Agency/County measure changes in attitude, knowledge and/or behavior related to reducing mental illness-related suicide?**
   Program staff will maintain records of all outreach activities. A written survey conducted of all youth and adult participants will demonstrate that 90% of participants have increased their knowledge of suicide warning signs and of ways to get help for themselves or someone else. Teachers and agency personnel will also be provided with evaluation forms to report on the effectiveness and applicability of the presentation and skill of the presenter.

5. **How is the selected method likely to bring about the selected outcomes by indicating how evidence-based standard or promising practice standard has demonstrated the practice's effectiveness, or if using a community and/or practice-based standard indication how the Agency/County will ensure fidelity to determine the program's effectiveness?**
   A. **If an evidence-based practice or promising practice was used to determine the program's effectiveness:**
   1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

B. If a community and/or practice-based standard was used to determine the Program's effectiveness:

1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

Our outreach program follows the effective suicide prevention strategies outlined by the Suicide Prevention Resource Center in that our presentations and trainings teach people to: identify and assist persons at risk, increase help-seeking behavior, ensure access to suicide care and support, effectively respond to individuals in crisis, and promote social connectedness, support, and resilience. We also offer ASIST and SafeTALK, both designated as "Programs with Evidence of Effectiveness".

2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

Staff and volunteers complete an extensive 40+ hour training before presenting/training on their own. Teachers and agency personnel will also be provided with evaluation forms to report on the effectiveness and applicability of the presentation and skill of the presenter. ASIST and SafeTALK trainers and their fidelity to the programs are routinely monitored by LivingWorks Education through participate evaluation forms, trainer evaluations, and onsite visitations.

5. **Describe how the following strategies were used:**

- **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):
  All participants in our outreach are informed of local County mental health resources, including our 24/7 multilingual suicide crisis line. Program employees and volunteers are provided with thorough lists of local resources in accessible formats, including multilingual capabilities, hours, and locations.

- **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):
  Program presentations and trainings teach participants how to recognize suicide warning signs, the various ways to support anyone experiencing a suicidal crisis (including encouraging the individual to seek further medical/mental health support), and the local available resources available to County residents in need of additional resources and support. Outreach services are available to all County residents, agencies, and organizations; however, special effort is used to prioritize underserved populations, such as transition-age youth and young adults, transgender individuals, veterans and their families, women, foster care youth, LGB community members, and any community members with histories of substance use, sexual or physical abuse, domestic violence, and isolation, among others.

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):
  All outreach services promote knowledge of warning signs and community resources, the negation of common myths, and the increase of open and honest conversation around suicide thoughts and behaviors. All promotional materials and giveaway items reflect our program values of safety and support, and offer a variety of visibility depending on the needs of each individual. Online materials, including our

website and FB page (suicide.prevention.cc), provide open dialog, useful articles about mental health, suicide, and the importance of self-care, and links for all of our followers to access up-to-date information and resources for support.

5. **Mobile Crisis**

- **Purpose**: This **Access & Linkage** program is also referred to as the Mobile Emergency Response Team (MERT). MERT's purpose is to provide crisis intervention and stabilization services for children, adolescents, and adults of Santa Cruz County who are experiencing an urgent or emergent mental health related crisis. The team provides crisis intervention services at different locations in the community, including office based visits for walk-ins and appointments, evaluations with law enforcement in the community, local hospital emergency rooms, and individual homes. MERT's focus is to provide alternatives to psychiatric hospitalization by working with consumers to find the least restrictive treatment setting that ensures safety and an appropriate level of care. The goal is to stabilize the crisis situation, determine whether or not there is a need for psychiatric hospitalization, and develop an appropriate plan for that individual which would include follow-up with the Mobile Crisis Team until the individual or the family can be connected with ongoing services. The services are available to any resident of the County regardless of ability to pay, and type of insurance they may or may not have.

  The success of the program led to a Board of Supervisor request to expand the program. With the addition of County General Fund money to this program, it will be expanded to 7-day per week service coverage. The service is provide in collaboration with county Behavioral Health's Mental Health Liaisons to Law Enforcement (co-responder with law enforcement), and the community based-sub-acute programs.

- **Target Population:** All ages
- **Providers:** Behavioral Health
- **Number of individuals to be served each year:** 150

Performance Outcomes: Demographic information of unduplicated clients served, and narrative report, as required by the State:

Agency Reporting		BEHAVIORAL HEALTH			
Work Plan/Program/Service		Mobile Crisis			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	21	45	52	67	163
Age Group					
• Children 0-15	10				67
• TAY 16-25	6				66
• Adults 26-59	5				18
• Older Adults 60+					12
Race/Ethnicity					
• White	11				76
• Latino	4				43
• Other	7				50
Primary Language					
• English					145
• Spanish					12
• Other					6
Culture					
• Veterans					
• LGBTQ					

Performance Outcomes: Narrative report for MERT as required by the State:

Access and Linkage to Treatment: A set of related activities to connect children, adults and seniors with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs. Examples include screening, assessment, referral, telephone help lines, and mobile response.

1. **Program Name**: Mobile Crisis MERT (mobile emergency response team) **Agency**: BEHAVIORAL HEALTH

2. **Explanation of how program and strategy will create Access and Linkage to Treatment for individuals with serious mental illness:**
   MERT provide additional outreach and walk-in availability for initial contact and needs assessment to link consumers to appropriate level of care. MERT has field-based services and the ability to respond in the community.

3. **How will individuals be identified as needing assessment or treatment for serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention Program?**
   MERT clinicians will conduct a brief comprehensive assessment to determine level of care. If consumer meets mild to moderate criteria they will be referred appropriately. If they merit specialty mental health criteria, they will be linked to MERT Psychiatrist for med-evaluation and ACCESS intake clinician to initiate higher level of care.

4. **How will individuals, and, as applicable, their parents, caregivers, or other family members be linked to county mental health services, a primary care provider, or other mental health treatment?**
   MERT clinician will always review appropriate resources including all available treatment options to meet consumer's needs. Parents and other natural supports will be welcomed and included in this process with appropriate consent. MERT clinicians will encourage consumers to utilize family support and resources.

5. **How will referrals be followed up to support engagement in treatment?**
   MERT clinicians will follow up a couple days after initial contact with consumers to ensure follow through. The MERT clinician sometimes meets with the consumer 2-3 times in make sure they are appropriately linked. MERT will also attempt make direct contact with all appropriate providers with the permission of the consumer. MERT wants to provide true "warm hand-off" approach with follow up.

6. **Demographic information. (fill out chart)**

7. **Outcomes:**
   - **Number of individuals with SMI referred to treatment and kind of treatment?** ____45____
   - **Number of individuals who followed through on the referral and engaged in treatment (attended at least once):** _42_____
   - **Average duration of untreated mental illness: Haven't known to track this, we will start asking this question**_____
   - **Average interval between referral and participation in treatment (at least once):** ____3 days_____

8. **Indicate if the Agency/County intends to measure outcomes in addition to those required (listed in #7 above), and if so, what outcome(s) and how will it be measured? Include timeframes for measurement.**
   ____x__ No _____ Yes

If yes indicate outcomes, measurement and time frames for measurement:

9. **Describe how the following strategies were used:**
   - **Access and Linkage (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):**
     Consumers were seen in crisis (including first break) and there was direct follow up, including a med-eval and intake assessment into SMI care as needed. MERT clinicians contacted consumers within 24 hours of initial contact to address any linkage concerns. MERT clinicians directly assist with linkage and access.

   - **Timely Access to Mental Health Services for Underserved Populations (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):**
     MERT services are payer source blind. We will assess anyone in crisis regardless of their benefits or insurance coverage. If they need help with benefits we link them to an eligibility worker. We will make the referral call with the consumer when possible to help them address any roadblocks. We have the ability through the ATT language line to communicate in any language. We hold a high value in providing a welcoming approach to all served. Working in conjunction with community agencies, we are able to reach out in ways that previously were more difficult to do. Family and other natural supports are seen as valuable assets for consumers and we encourage the active utilization of all helpful assets. Currently, we have MERT clinicians available during regular Monday through Friday business hours. There is a 24-hour 800 number available for providing after-hours information, consultation, and linkage to emergency services.

   - **Stigma and Discrimination reduction (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive)**
     MERT values and provides in team training/discussions in regard to establishing good rapport through welcoming practices. Clinicians also are provided time to attend the15 hour NAMI Provider Education Training.
     Santa Cruz County Behavioral Health also provides various training including consumer panels to increase empathy, awareness, sensitivity, and general welcoming skills.

PEI Project #4: Services for Older Adults

These strategies address the high rates of depression, isolation and suicides of Older Adults in Santa Cruz County. Strategies are aimed at identifying older adults at risk of trauma-induced mental illness, depression, anxiety, suicidal ideation, and late onset mental illness, as well as undiagnosed and misdiagnosed seniors. This group has been identified as an underserved population, often due to senior's isolation and challenges in accessing appropriate care.

PEI Project #4 has two proposed strategies:

1. **Senior outreach:**
   - **Purpose**: Outreach for isolated seniors. This is both an early intervention and prevention program.
   - **Target Population:** Older adults (age 60 and above) at risk.
   - **Providers:** Family Services Agency
   - **Number of individuals to be served each year:** 18
   - **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** No

Performance Outcomes: Demographic information of unduplicated clients served as required by the State:

Agency Reporting	Family Services Agency				
Work Plan/Program/Service	Senior Outreach Program				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	6	12	10	24	40
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59	1	1		2	4
• Older Adults 60+	5	10	10	21	34
Race/Ethnicity					
• White		1	6	15	8
• Latino	1	0	3	2	4
• Other	5	10	1	2	
Primary Language					
• English	5	11	9	21	34
• Spanish	1	1	1	1	
• Other					
Culture					
• Veterans			1		
• LGBTQ					

Performance Outcomes: Narrative report for Senior Outreach as required by the State:

Outreach for Increasing Recognition of Early Signs of Mental Illness: A process of engaging, encouraging, educating, an/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. Potential responders include, but are not limited to families, employers, primary health care providers, law enforcement, and school personnel. Outreach may include reaching out to individuals with signs and symptoms of a mental illness so they can recognize and respond to their own symptoms.

1. **Program Name:** Senior Outreach **Agency:** Family Services Agency

2. **Number of potential responders:** __400__annual_____

3. **Settings in which potential responders were engaged** (family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement, residences, shelters, etc.):
   Nonprofit agencies, residential care settings, law enforcement and clinics.

4. **Types of potential responders engaged in each setting** (e.g. nurses, principles, parents):
   Responders included nonprofit staff, facility residents, law enforcement personnel and social workers.

5. **Demographic information** (fill out chart).

6. **Specify the methods to be used to reach out and engage potential responders and the methods to be used for potential responders and public mental health services providers to learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness:**
   By reaching out to different disciplines engaged with at risk seniors through visits and phone outreach, we are creating awareness of mental health issues that help responders to identify and allow for a response to signs and symptoms. In addition to program materials to staff, materials were distributed to clients through Meals on Wheels, a program at the Sheriff's office, health fair, residential care, and Grey Bears.

7. **Describe how the following strategies were used:**
   - **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):

     All participants in our outreach are informed of local County mental health resources, including the 24/7 multilingual suicide crisis line and resources for seniors through the local directory. Program staff and volunteers have lists of local resources that include information on accessibility, multilingual capabilities, hours, and locations.

   - **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):

     Program presentations and informational trainings teach participants how to recognize problems associated with aging including depression, drug and alcohol issues, loss, grief and suicidal ideation. In addition to the service provided by senior peer counselors, resources available to seniors who need

additional support are identified that might include APS, County Access, Medicare licensed counseling and Liftline for transportation. Outreach services are available to all County residents, agencies, and organizations; however, special effort is used to prioritize underserved populations, such as LGBTQI, veterans and their families and any seniors with histories of substance use, sexual or physical abuse, domestic violence, and isolation.

- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):

  All outreach services promote understanding of mental health issues affecting seniors, the negation of common myths and the promotion of open and honest conversation around issues of aging relating to mental health. Mental health challenges are framed as an understandable consequence of the social and biological issues related to aging. Individual and group counseling is done in a positive and supportive way by trained volunteers using active listening skills.

2. **Peer Companion:**
   - **Purpose**: provides outreach and peer support to reduce isolation and increase socialization. This is an early intervention service.
   - **Target Population:** Older adults (age 60 and above) at risk.
   - **Providers:** Senior Council
   - **Number of individuals to be served each year: 35**
   - **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** No

Performance Outcomes: Demographic information of unduplicated clients served, and narrative report, as required by the State:

Agency Reporting	Senior Council				
Work Plan/Program/Service					
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	15	6	1	1	23
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59					
• Older Adults 60+	15	6	1	1	23
Race/Ethnicity					
• White	13	6	1	1	21
• Latino	1				1
• Other	1				1
Primary Language					
• English	13	6	1	1	21
• Spanish	1				1
• Other	1				1
Culture					
• Veterans				1	2
• LGBTQ					

Performance Outcomes: Narrative report for Senior Council as required by the State:

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Examples of risk factors include, but are not limited to serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins (including in the womb), poverty, family conflict or domestic violence, experience of racism and social inequality, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

1. **Program Name**: Peer Counselor/Companion **Agency**: Senior Council

2. **Target population**:
   - **Demographics**: (fill out chart)
   - **What is the unduplicated number of individuals served in preceding fiscal year?** ____15_____
   - **What is the number of families served?** ____0_____
   - **Participants' risk of a potentially serious mental illness?** _____
   - **How is the risk of a potentially serious mental illness defined and determined?**
     Susan Fisher will assess risk and assign older adult MHSA clients to the Senior Companions and monitor their activities. Adjustments to planned activities will occur throughout the contract period based on the assessment of MHSA staff in collaboration with the Senior Companion Program Coordinator.

3. **Specify the type(s) of problem(s) and need(s) for which program will be directed. What activities are included in the program to bring about mental health and related functional outcomes (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes)?**
   MHSA clients who are referred will be older adults at risk of elder abuse, trauma induced mental illness, depression, anxiety, suicidal ideation and late onset mental illness. Senior Companions will provide peer support services to MHSA older adult clients selected for participation by Susan to help reduce psychiatric hospitalization and promote long tem stability and an increased quality of life. To accomplish our goals Senior Companions use a variety of strategies including: encouraging social interaction; promoting physical activities & exercise; promoting activities that enhance emotional and mental health; assisting with arts & craft activities; assisting in reality orientation, encouraging socially appropriate behavior and providing transportation to socialization events and treatment appointments.

4. **Specify any negative outcomes as a consequence of untreated mental illness (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes) that the Program is expected to affect, including reduction of prolonged suffering (mental, emotional and/or relational functioning).**
   A. **List the mental health indicators that the Agency/County will use to measure reduction of prolonged suffering (mental, emotional and/or relational functioning):**
      A minimum of 70% of those MHAS clients participating will show improvement on at least one of the following quality of life indicators:
      - social ties/social support
      - mood and behavior improvement
      - personnel expression
      - companionship

   B. **If the Agency/County intends the Program to reduce any other negative outcome as a consequence of untreated mental illness, list the indicators that the County will use to measure the intended reductions:**

N/A

C. **Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence:**

To measure these outcomes an Assignment Plan (AP) (a client directed treatment plan) is completed by the MHSA Supervisor (Susan Fisher) at the time the client is referred to a Senior Companion. An AP is completed for each individual client assigned to a Senior Companion volunteer. The AP measures the client's quality of life improvement on the four specific indicators identified above. The AP is completed at the beginning of a relationship between a client and a Senior Companion and annually thereafter in September. The AP identifies the client needs that will be targeted by the Senior Companion, the specific activities the Senior Companion will engage in with the client to address the need and the anticipated level of improvement on the indicators being targeted. Then each year in May the Supervisor completes the AP by assessing the actual improvement the client has achieved and recording those findings on the AP.

5. **Specify how the Prevention Program is likely to bring about reduction of suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes.**
   A. **If an evidence-based practice or promising practice was used to determine the program's effectiveness:**
      1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.**

_____

_____

_____

      2. **Explain how the practice's effectiveness has been demonstrated for the intended population.**

_____

_____

      3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**

_____

_____

B. **If a community and/or practice-based standard was used to determine the Program's effectiveness:**
   1. **Describe the evidence that the approach is likely to bring about applicable outcomes:**

See Logic Model Attached

   2. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.**

See Assignment Plan and Senior Companion Eval Tool attached. These are the tools used to measure the outcomes targeted in the lotic model for both clients served and Senior Companions who serve those clients.

6. **Describe how the following strategies were used:**
   A. **Access and** Linkage (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):

This service is provided by Susan Fisher, OTR/L with Santa Cruz County Mental Health Services.

- **Timely Access to Mental Health Services for Underserved Populations (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program**
  Susan Fisher manages the timing of assignment of her clients to our Senior Companions. Senior Companions flex their schedule to the needs/schedules of their assigned clients including evenings and weekends. They provide transportation to various psychiatric and medical treatment providers and socialization activities.

- **Stigma and Discrimination reduction (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):**
  Susan Fisher provides training and collateral information to Senior Companion assigned to her clients. In addition Senior Companions attend monthly training through the Seniors Council. Current Senior Companions have been volunteering under Susan's supervision for many years (one volunteer for 7 years and the other for 4 years).

INNOVATIVE PROJECTS- "INN"

Purpose: The intent of this component is to increase access to underserved groups; to increase the quality of services, including better outcomes; to promote interagency collaboration; and/or to increase access to services. The County's work plan name is **Integrated Health and Housing Supports (IHHS).**

With the IHHS program, Santa Cruz County is seeking to combine a number of approaches to assist consumers in succeeding in community-based independent housing. First is utilizing the Permanent Supported Housing model, but adding an integrated health model that would allow home-based telehealth monitoring and care for consumers with health conditions such as diabetes, obesity, hypertension and COPD. By providing an electronic telehealth monitoring device in the home, the consumer could monitor specific health conditions, linked to a confidential and HIPAA compliant web-based program to communicate with nursing staff. In person nursing and case management staff would be part of the Integrated Health Supported Housing Team. Finally, the Integrated Health Supported Housing team would include peers trained in Intentional Peer Support (IPS) to provide skills building, social engagement and modeling for community integration.

Target Population: Program participants will be consumers who (1) have co-occurring psychiatric and other health conditions, and (2) have a primary care physician in the County operated Federally Qualified Health Clinic and (3) require housing supports to live in the community due to their mental illness and/or substance use disorder and (4) are interested in participating in the program voluntarily.

Providers: Front Street

Number of individuals to be served each year: 60

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? No

NOTE: This is a new project approved by the Mental Health Oversight & Accountability Commission. It is not fully implemented yet.

WORKFORCE EDUCATION & TRAINING – "WET"

This infrastructure component was designed to strengthen the public mental health workforce both by training and educating current staff (including concepts of recovery and resiliency), and to address occupation shortages in the public mental health profession by a variety of means.

A. Culturally and Linguistically Appropriate Services

Santa Cruz County had a committee and several ad hoc workgroups, which worked to establish a solid foundation for integrating "Culturally and Linguistically Appropriate Services" (CLAS) principals and standards throughout the County Mental Health System. The Mental Health Director works closely with the Mental Health Services Act (MHSA) Coordinator, and the CLAS Coordinator to ensure that all services/programs continue to integrate the values and standards of providing culturally and linguistically appropriate services throughout the County Mental Health System. We review CLAS issues as part of our quarterly Quality Improvement Committee meeting. Our CLAS coordinator organizes monthly trainings for the staff and community.

B. ADDITIONAL ASSISTANCE NEEDS FROM EDUCATION & TRAINING PROGRAMS

A challenge we face is how to sustain our training and education program, given that the State does not distribute additional WET funds. However, the County of Santa Cruz recognizes that we still need work in our efforts to transform our service delivery system to one which is more client and family centered, recovery oriented, fosters an environment of enhanced communication and collaboration while promoting self-directed care, utilizes Evidenced Based Practices which have been demonstrated most effective at supporting recovery and independence in the community, and measures outcomes on a client, program and system level.

The proposed training over the next three years is based on 3 different need areas: Core Competencies which will serve as the foundation to support the effective implementation and sustainability of Evidence Based Practices, the adoption of a national Evidence Based Practices: Illness Management and Recovery (IMR) ., and the adoption of evidence based clinical assessment tools such as the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

1. Core Competencies Training
    a. Motivational Interviewing
    b. Cognitive Behavioral Therapy and Cognitive Behavioral Therapy for Psychosis

2. Evidence Based Practices
    a. Illness Management and Recovery (IMR): IMR is an Evidence Based Practice that has been proven effective to assist consumers in more effectively managing their mental illness, promoting recovery and independent living, reducing the need for hospitalizations and emergency department visits, and reducing the need for long-term intensive services in the community. The County is training staff and establish an IMR program, with fidelity to the model, in the County Mental

Health System- first in North County, and then in the future in South County. The County has contracted with CIBHS and the University of Kansas for this training and consultation.

3. Child and Adolescent Needs and Strengths Assessment (CANS), and the Adult Needs and Strengths Assessment (ANSA): As part of a new approach within the framework of Total Clinical Outcomes Measurement (TCOM), the County is adopting the use of two client level outcomes tools, which also and most importantly serve as communication collaboration tools to improve services for children and adults, and transform the service delivery system from a service oriented approach to one which is transformational- in the daily lives of the people and families served, and the approach we as clinicians use in supporting recovery and resiliency in the our clients and families. The County is seeking funding to support the ongoing training and certification of clinicians, and support the effective implementation of the CANS and ANSA across all County mental health programs and services for a 3-year period. The County will be working with Dr. John Lyons from the University of Ottowa to support this initiative.

C. IDENTIFICATION OF SHORTAGES IN PERSONNEL

Santa Cruz County has identified the following as existing mental/behavioral work shortages:

1. Bilingual (Spanish) Psychiatrists Bilingual child psychiatrists;
2. Bilingual Licensed Clinical Social Workers and Marriage & Family Therapists;
3. Clinicians that have an alcohol & drug counselor certification, as well as mental health experience and/or license.

The following are hard-to-fill and/or hard-to retain positions:

1. Psychiatrists
2. Bilingual psychiatrists
3. Child psychiatrist
4. Bilingual mental health providers

INFORMATION TECHNOLOGY

Funds and guidelines for Capital Facilities and Information Technology were packaged together by the State Department of Mental Health. (Note: Infrastructure programs do not allow the County to hire staff to provide services.)

The **Information Technology** funds are to be used to:

- Modernize and transform clinical and administrative information systems to improve quality of care, operational efficiency and cost effectiveness, and
- Increase consumer and family empowerment by providing the tools for secure consumer and family access to health information within a wide variety of public and private settings.

We have two primary information technology needs:

1. To increase consumer and family empowerment. Access to knowledge is a human right. Every client will be tech literate and have Internet access to increase communication between each other and all the supports that promote recovery, wellness, resiliency, and social inclusion. Our goal is to have computer access for consumers in housing and kiosks at existing clinic sites, and to provide technical support and training (for consumers and staff). We will begin with the addition of six terminals at sites in both Santa Cruz and Watsonville, and available to both children, adult and family members. Security issues will be addressed by posting signs in English and Spanish stating:

   "This is a public computer. For your security, we advise that you take these steps: 1. Do not save your logon information. 2.Do not leave the computer unattended with sensitive information on the screen. 3. Delete your temporary files and your history. 4. Do not enter sensitive information on public computers."

2. To modernize and transform clinical administrative systems. Our goal is to improve overall functionality and user-friendliness for both clinical and administrative work processes. We need to have one cohesive system with intuitive functionality where it would only be necessary to enter information one time and have that information populate fields as needed. The system must support fiscal, billing, administrative work processes, and include an electronic health record. Ideally a patient portal is needed as well. Strong billing processes, including automated eligibility and exception reports, are needed to effectively manage accounts payable and accounts receivable, and provide necessary reporting tools for cost reports and budgeting activities. It also needs to include robust caseload and clinical management tools, as well as encourage and allow client access, interaction and participation. It should facilitate person-centered treatment planning, and ease of information sharing of documentation across service providers in the system of care.

We completed the first phase of this project and upgraded our Practice Management to Share Care. We had an RFP process this year to investigate best options in moving forward regarding the electronic health record. Official results have not been published, but we are considering two vendors. With either option we feel that there are significant administrative changes, as well as the way we deliver our direct clinical care. Another consideration is our need to extract data and information to be able to see the impact and outcomes of our services plans and look at overall

system of care trends. We know we make a difference, as can be seen with the "Community Impact" statements. However, we want the ability to quantify this data.
One of the challenges we found in implementing the first and second phases is that we lack the administrative capacity to both negotiate and implement at the same time. Our administrative have diligently set priorities and we are reaching our benchmarks. As you know with health reform and changes to MediCal, the challenge is staying current with changes and doing new implementation at the same time.

CAPITAL FACILITIES

Funds and guidelines for Capital Facilities and Information Technology were packaged together by the State Department of Mental Health. (Note: Infrastructure programs do not allow the County to hire staff to provide services.) Our stakeholders chose to spend most funds in the Information Technology projects.

The purpose of Capital Facilities is to acquire, develop or renovate buildings for service delivery for mental health clients or their families, and/or for MHSA administrative offices. Capital Facilities funds cannot be used for housing.

Projects that have yet to be completed in South County include the installation of two counters outside the reception windows for a horizontal barrier for client use. One counter will be at the American Disabilities Act height requirement and the other counter at a higher height. In the North County renovation includes upgrading existing reception by expanding existing window opening on existing wall, installing secure fire rated, electronically operated secure window (door) system, and installing new counters. Additionally, the County buildings have poor ventilation, so we will also be modifying to improve air quality and circulation. The challenge to completing these upgrades has been due to a number of other Health Service Agencies projects.

BUDGET

FY 2017/18 Mental Health Services Act Three-Year Plan
Community Services and Supports (CSS) Funding

County: Santa Cruz Date: 12/5/17

	Fiscal Year 2017/18			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated Other Funding
FSP Programs				
1. Community Gate	0	0	0	0
2. Probation Gate	0	0	0	0
3. Child Welfare Gate	0	0	0	0
4. Education Gate	0	0	0	0
5. Family Partnerships	0	0	0	0
6. Enhanced Crisis Response	1,157,098	519,681	564,487	72,930
7. Consumer, Peer, and Family Services	450,900	337,023	95,001	18,876
8. Community Support Services	6,025,986	3,330,421	1,492,127	1,203,438
9.	0			
10.	0			
11.	0			
Non-FSP Programs				
1. Community Gate	1,857,979	1,043,780	634,420	179,779
2. Probation Gate	149,954	149,954	0	0
3. Child Welfare Gate	885,933	350,472	535,461	0
4. Education Gate	246,456	141,662	104,794	0
5. Family Partnerships	10,452	10,452	0	0
6. Enhanced Crisis Response	1,309,993	757,950	529,667	22,376
7. Consumer, Peer, and Family Services	25,300	25,300	0	0
8. Community Support Services	2,776,960	1,881,580	745,258	170,122
9.	0			
10.	0			
11.	0			
CSS Administration	1,561,744	1,200,058	361,686	0
CSS MHSA Housing Program Assigned Funds	0			
Total CSS Program Estimated Expenditures	16,458,755	9,728,333	5,062,901	1,667,521
FSP Programs as Percent of Total	78.5%			

FY 2018/19 Mental Health Services Act Three-Year Plan
Community Services and Supports (CSS) Funding

County: Santa Cruz Date: 12/5/17

	Fiscal Year 2018/19			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated Other Funding
FSP Programs				
1. Community Gate	0	0	0	0
2. Probation Gate	0	0	0	0
3. Child Welfare Gate	0	0	0	0
4. Education Gate	0	0	0	0
5. Family Partnerships	0	0	0	0
6. Enhanced Crisis Response	1,196,765	542,636	581,199	72,930
7. Consumer, Peer, and Family Services	464,427	347,699	97,852	18,876
8. Community Support Services	6,101,254	3,423,554	1,474,262	1,203,438
9.	0			
10.	0			
11.	0			
Non-FSP Programs				
1. Community Gate	1,905,656	1,070,378	650,106	185,173
2. Probation Gate	154,453	154,453	0	0
3. Child Welfare Gate	916,748	365,439	551,309	0
4. Education Gate	253,538	145,707	107,831	0
5. Family Partnerships	10,766	10,766	0	0
6. Enhanced Crisis Response	1,350,759	782,954	545,429	22,376
7. Consumer, Peer, and Family Services	26,059	26,059	0	0
8. Community Support Services	2,859,571	1,919,839	769,610	170,122
9.	0			
10.	0			
11.	0			
CSS Administration	1,607,560	1,235,090	372,470	0
CSS MHSA Housing Program Assigned Funds	0			
Total CSS Program Estimated Expenditures	16,847,556	10,024,574	5,150,068	1,672,915
FSP Programs as Percent of Total	77.4%			

FY 2019/20 Mental Health Services Act Three-Year Plan
Community Services and Supports (CSS) Funding

County: Santa Cruz Date: 12/5/17

	Fiscal Year 2019/20			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi Cal FFP	Estimated Other Funding
FSP Programs				
1. Community Gate	0	0	0	0
2. Probation Gate	0	0	0	0
3. Child Welfare Gate	0	0	0	0
4. Education Gate	0	0	0	0
5. Family Partnerships	0	0	0	0
6. Enhanced Crisis Response	1,196,765	542,636	581,199	72,930
7. Consumer, Peer, and Family Services	464,427	347,699	97,852	18,876
8. Community Support Services	6,101,254	3,423,554	1,474,262	1,203,438
9.	0			
10.	0			
11.	0			
Non-FSP Programs				
1. Community Gate	1,905,656	1,070,378	650,106	185,173
2. Probation Gate	154,453	154,453	0	0
3. Child Welfare Gate	916,748	365,439	551,309	0
4. Education Gate	253,538	145,707	107,831	0
5. Family Partnerships	10,766	10,766	0	0
6. Enhanced Crisis Response	1,350,759	782,954	545,429	22,376
7. Consumer, Peer, and Family Services	26,059	26,059	0	0
8. Community Support Services	2,859,571	1,919,839	769,610	170,122
9.	0			
10.	0			
11.	0			
CSS Administration	1,607,560	1,235,090	372,470	0
CSS MHSA Housing Program Assigned Funds	0			
Total CSS Program Estimated Expenditures	16,847,556	10,024,574	5,150,068	1,672,915
FSP Programs as Percent of Total	77.4%			

County: Santa Cruz County Date: 12/5/17

	Fiscal Year 2017/18			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs - Prevention				
1. Prevention & Early Intervention Services for	327,617	304,529	12,044	11,044
2. Culture Specific Parent Education & Suppo	292,181	260,983	31,198	
3. Services for TAY & Adults	65,308	65,308	0	
4. Services for Older Adults	83,099	46,393	36,706	
5.	0			
6.	0			
7.	0			
8.	0			
9.	0			
10.	0			
PEI Programs - Early Intervention				
11. 1 - Prevention & Early Intervention Services	629,289	296,547	252,392	80,351
12. 2 - Culture Specific Parent Education & Sup	0	0	0	
13. 3 - Services for TAY & Adults	1,320,273	1,135,567	184,706	
14. 4 - Services for Older Adults	103,207	69,035	34,172	
15.	0			
16.	0			
17.	0			
18.	0			
19.	0			
20.	0			
PEI Administration	567,210	424,880	142,330	
PEI Assigned Funds	0			
Total PEI Program Estimated Expenditures	3,388,183	2,603,241	693,548	91,394

FY 2018/19 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Santa Cruz County Date: 12/5/17

	Fiscal Year 2018/19			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs - Prevention				
1. Prevention & Early Intervention Services for	244,762	221,211	12,409	11,142
2. Culture Specific Parent Education & Suppor	312,530	280,393	32,137	0
3. Services for TAY & Adults	65,791	65,791	0	0
4. Services for Older Adults	85,614	47,796	37,818	0
5.	0			
6.	0			
7.	0			
8.	0			
9.	0			
10.	0			
PEI Programs - Early Intervention				
11. 1 - Prevention & Early Intervention Services	720,339	377,810	260,000	82,529
12. 2 - Culture Specific Parent Education & Sup	0	0	0	0
13. 3 - Services for TAY & Adults	1,359,921	1,169,666	190,254	0
14. 4 - Services for Older Adults	106,303	71,106	35,197	0
15.	0			
16.	0			
17.	0			
18.	0			
19.	0			
20.	0			
PEI Administration	582,695	436,485	146,210	0
PEI Assigned Funds	0			
Total PEI Program Estimated Expenditures	3,477,955	2,670,259	714,025	93,671

FY 2019/20 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Santa Cruz County Date: 12/5/17

	Fiscal Year 2019/20			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs - Prevention				
1. Prevention & Early Intervention Services for	244,762	221,211	12,409	11,142
2. Culture Specific Parent Education & Suppo	312,530	280,393	32,137	0
3. Services for TAY & Adults	65,791	65,791	0	0
4. Services for Older Adults	85,614	47,796	37,818	0
5.	0			
6.	0			
7.	0			
8.	0			
9.	0			
10.	0			
PEI Programs - Early Intervention				
11. 1 - Prevention & Early Intervention Services	720,339	377,810	260,000	82,529
12. 2 - Culture Specific Parent Education & Sup	0	0	0	0
13. 3 - Services for TAY & Adults	1,359,921	1,169,666	190,254	0
14. 4 - Services for Older Adults	106,303	71,106	35,197	0
15.	0			
16.	0			
17.	0			
18.	0			
19.	0			
20.	0			
PEI Administration	582,695	436,485	146,210	0
PEI Assigned Funds	0			
Total PEI Program Estimated Expenditures	3,477,956	2,670,259	714,025	93,671

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Cruz 9/15/17

	Fiscal Year 2017/18			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Integrated Health and Housing Supports	1,221,142	687,749	303,440	229,953
2.	0			
3.	0			
4.	0			
INN Administration	103,162	103,162	0	0
Total INN Program Estimated Expenditures	1,324,304	790,911	303,440	229,953

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Cruz 9/15/17

	Fiscal Year 2018/19			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Integrated Health and Housing Supports	1,251,889	711,108	310,828	229,953
2.	0			
3.	0			
4.	0			
INN Administration	106,666	106,666	0	0
Total INN Program Estimated Expenditures	1,358,555	817,774	310,828	229,953

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Cruz 9/15/17

	Fiscal Year 2019/20			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Integrated Health and Housing Supports	1,310,874	764,679	316,242	229,953
2.	0			
3.	0			
4.	0			
INN Administration	114,702	114,702	0	0
Total INN Program Estimated Expenditures	1,425,576	879,381	316,242	229,953

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Cruz Date: 9/15/17

	Fiscal Year 2017/18			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated Other Funding
WET Programs				
1. A-Administration	0	0	0	0
2. B-Training & Technical Assistance	56,032	56,032	0	0
3. C-Mental Health Career Pathways	0	0	0	0
4. D-Residency & Intership Programs	0	0	0	0
5.	0			
WET Administration	0	0	0	0
Total WET Program Estimated Expenditures	56,032	56,032	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Cruz Date: 9/15/17

	Fiscal Year 2018/19			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated Other Funding
WET Programs				
1. N/A	0	0	0	0
2.	0	0	0	0
3.	0	0	0	0
4.	0	0	0	0
5.	0			
WET Administration	0	0	0	0
Total WET Program Estimated Expenditures	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Cruz Date: 9/15/17

	Fiscal Year 2019/20			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated Other Funding
WET Programs				
1. N/A	0	0	0	0
2.	0	0	0	0
3.	0	0	0	0
4.	0	0	0	0
5.	0			
WET Administration	0	0	0	0
Total WET Program Estimated Expenditures	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Cruz Date: 9/15/17

	Fiscal Year 2017/18			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
CFTN Programs - Capital Facilities Projects				
1. Capital Facilities	85,000	85,000	0	0
2.	0			
3.	0			
4.	0			
5.	0			
6.	0			
7.	0			
8.	0			
9.	0			
10.	0			
CFTN Programs - Technological Needs Projects				
11. Information Technology	0	0	0	0
12.	0			
13.	0			
14.	0			
15.	0			
16.	0			
17.	0			
18.	0			
19.	0			
20.	0			
CFTN Administration	0			
Total CFTN Program Estimated Expenditures	85,000	85,000	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Cruz Date: 9/15/17

	Fiscal Year 2018/19			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
CFTN Programs - Capital Facilities Projects				
1. N/A	0			
2.	0			
3.	0			
4.	0			
5.	0			
6.	0			
7.	0			
8.	0			
9.	0			
10.	0			
CFTN Programs - Technological Needs Projects				
11. N/A	0			
12.	0			
13.	0			
14.	0			
15.	0			
16.	0			
17.	0			
18.	0			
19.	0			
20.	0			
CFTN Administration	0			
Total CFTN Program Estimated Expenditures	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Cruz Date: 9/15/17

	Fiscal Year 2019/20			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
CFTN Programs - Capital Facilities Projects				
1. N/A	0			
2.	0			
3.	0			
4.	0			
5.	0			
6.	0			
7.	0			
8.	0			
9.	0			
10.	0			
CFTN Programs - Technological Needs Projects				
11. N/A	0			
12.	0			
13.	0			
14.	0			
15.	0			
16.	0			
17.	0			
18.	0			
19.	0			
20.	0			
CFTN Administration	0			
Total CFTN Program Estimated Expenditures	0	0	0	0

Attachment

CITY OF SANTA CRUZ

809 Center Street, Room 10, Santa Cruz, CA 95060 • (831) 420-5020 • Fax: (831) 420-5011 • city.council@cityofsantacruz.com

November 12, 2017

Mr. Erik G. Riera, County Mental Health Director
Mental Health Services Act Coordinator
Santa Cruz County Behavioral Health
1400 Emeline Avenue
Santa Cruz, CA 95060

Re: MHSA Draft 2017-2020 Program and Expenditure Plan Comments

Dear Mr. Riera:

This letter is in response to your request for public comments regarding the Santa Cruz County (County) Three Year Mental Health Services Act (MHSA) 2017-2020 Draft Program and Expenditure Plan.

It is in our mutual interest to establish goals which increase funding towards the mentally ill. More specifically we believe that significant MHSA funding be directed to those who are homeless in our community or at risk of becoming homeless, and who are predominantly represented in the City. Our review of available resources indicates that County funding from unspent MHSA dollars from prior years may accommodate a limited initial City funding request as well as encourage future collaboration which supports the prioritization of mental health services within the City. Additionally, it is our hope that we can establish a mutual goal during the Three Year MHSA Program period that increases engagement between the City and County to appropriately develop and support successful mental health programs in our shared community.

Section 5848 of the MHSA specifies that Counties shall demonstrate a partnership with constituents and stakeholders as they develop the Three Year MHSA Program and Expenditure Plan. This effort should include a "meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations." Given the issues of mental health facing our community we are surprised that this year's County stakeholder process did not include early and meaningful participation by the City and its representatives. Moving forward we would like to see increased stakeholder engagement and be considered a full partner in the process.

The City and other local jurisdictions are experiencing a regional mental health crisis. At this time we cannot support the MHSA plan as it is currently presented without a commitment by the County for an improved process of collaboration in determining how MHSA resources are utilized to address the significant concerns which exist in our City.

Pursuant to your request for public stakeholder comment, we recommend the following be incorporated in the 2017-2020 MHSA Plan for consideration by the County Board of Supervisors in the approval process:

1. Full funding for the mental health clinician ride-along for the Santa Cruz City Police Department and program expansion to two (2) shifts daily.

2. That beginning in January of 2018, an MHSA advisory committee be formed which includes membership that is representative of the County municipalities and associated public safety representatives, and that said committee be empowered and supplied with necessary resources and accountability for high-level review and deliberation.

3. That homeless mental health services be prioritized in future MHSA planning efforts going forward, inclusive of not only MHSA funding but also leveraging funding from other sources including the County Health Department, Social Service Agencies, and others through a coordinated planning process. This effort should include a comprehensive assessment of the availability of mental health facilities and services in our community.; and

4. That the County identify, and issue a report detailing, all unspent MHSA resources from prior years including MHSA Prudent Reserve Funds, for purposes of greater transparency and to use in accommodating City MHSA funding needs.

The supporting rationale for each of these requests is set forth below:

1. Full funding for the mental health clinician ride along for the Santa Cruz City Police Department and program expansion to two (2) shifts daily.

The rationale for this request is as follows:

a. The City does not receive any MHSA funding except as allocated by the County. Our City is dependent on the stakeholder relationship which as noted above was not followed in this funding cycle as regulated by the State;

b. The clinician ride along enables the County to conserve funding in mental health resources through the re-direction of individuals with mental health conditions to less-expensive services;

c. Our City's public safety staff support mental health consumers who are released by County facilities who are still experiencing mental health issues and require City public safety assistance in the absence of other mental health services;

d. Repeated requests for anticipated itemized mental health funding allocations contained in the MHSA proposal were not available at the time of the public comment deadline. Although we are unable to weigh the benefit to fully fund this service in lieu of others based on the information available we believe this is a crucial service for the mentally ill, and provides the mental health consumer with a trained mental health professional intervention in the field;

e. The Sean Arlt tragedy occurred after he was released by the CSP despite a very serious mental health episode. The system of placing individuals at significant risk back into the community without additional support services forces additional mental health interventions by City public safety personnel;

f. The City currently contributes 50% of the cost for the mental health clinician from its general fund; and

g. A review of a nearby California Coastal Community with a similar homeless and mental health issue population revealed a more robust engagement process that included City and public safety staff. The San Luis Obispo (SLO) MHSA plan included an advisory committee (MAC) which consisted of specific stakeholders that met on June 15, 2017 to hear a proposal that supported the addition of a therapist to be embedded with the SLO Police. There is no evidence that this program required municipal funding. We believe that a similar process here would have had a similar result. In fact two (2) shifts are needed in our city given the substantial homeless mentally ill issues which exist in the City of Santa Cruz for those that are either not receiving or who are discharged prematurely from County services.

2. Beginning in January of 2018, an MHSA advisory committee be formed which includes membership that is representative of the municipalities in the County and associated public safety representatives, and that said committee be empowered and supplied with necessary resources and accountability for high-level review and deliberation.

The rationale for this request is as follows:

a. There is a necessity for a highly functional local mental health board (LMHB);

b. Other counties reviewed, including San Luis Obispo County as noted above, have a specific funding committee along with the presence of a high-functioning LMHB. The funding amounts are highly significant and designed for the needs of the serious mentally ill as required under applicable regulations;

c. Many funded services (focused on education, stigma awareness, etc) are likely valuable but are not designed specifically for those with severe mental illnesses;

d. In the present situation the lack of an engagement committee of this type prevents the public to determine why the County chose the planned funded services instead of others. For example, there was one single MHSA meeting in the County prior to the comment period (not several, over a period of time as what occurred in other Counties). There was no explanation or information provided as to which stakeholders supported which proposed solutions, or information describing which stakeholders participated in scheduled discussions or public decisions. It is unclear whether proposals were presented to the community for comments or that information was collected from stakeholders and weighed in the planning process. The Draft MHSA Plan states that staff "heard from stakeholders" that an electronic medical record was a priority over capital funding. However, it is apparent that a deficiency of mental health facilities exists in our community. We would have appreciated more discussion on this topic and an opportunity for greater input to determine planned funded services.

e. In past funding cycles, a committee of this type existed in Santa Cruz. It is apparent from reports submitted to the State that a higher level of engagement previously existed.

3. Homeless mental health services need to be prioritized in future MHSA planning efforts going forward, inclusive of not only MHSA funding but also leveraging funding from other sources including the County Health Department, Social Service Agencies, and others through a coordinated planning process. This effort should include a comprehensive assessment of the availability of mental health facilities and services in our community.

The rationale for this request is as follows:

a. Those that have co-occurring substance abuse conditions should not be made ineligible to receive services though the County mental health system. As was discussed with you in a meeting with the City on November 3, 2017, the position of the County mental health is that a small percentage of the homeless are severally mentally ill and that the majority of the mentally ill have a mild to moderate mental illness and a primary substance abuse condition. However this information appears to be in conflict with available data. The July 1, 2017 Santa Cruz County Homeless Census and Survey prepared by Applied Survey Research reported that "60% of those who are chronically homeless report having a mental health condition. Yet only 17% report having accessed mental health services.";

b. In the November 3, 2017 meeting with the City, you also referred to the strategic plan for Santa Cruz County Behavioral Health. The strategic plan addressed past practices "where a client with a co-occurring disorder is not eligible for treatment in one part of a system until the other problem is resolved or suitably stabilized. For example, someone with Schizophrenia and a severe alcohol dependence would be required to receive mental health services first prior to having access to

substance use disorder services." However it appears that information supports that this is an ineffective model, particularly as psychiatric disorders become more severe, and clients experience greater amounts of distress, their substance abuse often worsens, leading to more substance abuse and even worse consequences. *Santa Cruz County Behavioral Health Strategic Plan.*; and

c. The "mild to moderate" mental health population served by the Central Coast Alliance for Health which was referenced in the November 3, 2017 meeting, is not structured to meet the needs of co-occurring homeless individuals who are highly symptomatic of mental health conditions. For example, they cannot make or keep appointments; there is no field support or other necessary support systems which are available through the County Behavioral Health Department.

4. That the County identify, and issue a report detailing, all unspent MHSA resources from prior years including MHSA Prudent Reserve Funds, for purposes of greater transparency and to use in accommodating City MHSA funding needs.

The rationale for this request is as follows:

a. According to County information available at this time the last revenue and expenditure report which has been completed and submitted to the State shows an unspent balance $8,058,924 for 2013/2014, which you stated includes Community Service and Support (CSS) and Prudent Reserve funds;

b. The present amount of unspent funds as of September 12, 2017 has not yet been calculated;

c. The use of unspent MHSA resources from prior years or from reserves to fund City requests will not impact funding for existing programs and services; and

d. Other Counties, such as San Diego County and Sacramento County have identified available unspent MHSA funding and reserves which are currently being programmed and prioritized to address the needs of homeless in the Cities of San Diego and Sacramento.

Thank you for extending the comment period through the present date and for the opportunity to provide comment for inclusion in the Santa Cruz County (County) Three Year Mental Health Services Act (MHSA) 2017-2020 Draft Program and Expenditure Plan. As noted above, we anticipate an increased opportunity to engage with the County to provide City specific perspectives. Furthermore, during the three year program period we hope to support a process by which Mental Health programs are developed and associated funds are allocated to address city needs. Our city is deeply impacted by individuals with severe mental health conditions and those with co-occurring conditions. The County receives funding resources to provide service

programs which should be appropriately prioritized in the city. Unlike the two (2) California Cities which have direct MHSA resource capability the City of Santa Cruz is entirely dependent on the County to engage with the City to prioritize programs and funding which address impacts disproportionately felt here.

Thank you for your consideration of these requests.

Sincerely,

David J. Terrazas
Vice Mayor

Sandy Brown
Councilmember

Richelle Noroyan
Councilmember

cc: Santa Cruz City Council
Martín Bernal, Santa Cruz City Manager
Andy Mills, Santa Cruz City Police Chief
Jim Frawley, Santa Cruz City Fire Chief
Giang Nguyen, Director, County Health Services Agency (HSA)

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

July 18, 2005

DMH LETTER NO.: 05-04

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: MENTAL HEALTH SERVICES ACT—NON-SUPPLANTATION

REFERENCE: Implementation of MHSA, Welfare and Institutions Code (WIC) Sections 5847, 5848, 5891 and 5892

The purpose of this letter is to transmit the County Non-Supplantation policy under the Mental Health Services Act. This policy applies to all components of the Mental Health Services Act and shall be used to guide the interpretation of the Act with regard to local funding issues.

For reference, Welfare and Institutions (W&I) Code Section 5891 implemented as part of the MSHA:

> "The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892."

The Department's policy related to county non-supplanting under the MHSA consists of three requirements, all of which must be met in order for an expenditure to be eligible for reimbursement under the MHSA:

1. Funds must be used for programs authorized in Section 5892 of the W&I Code
2. Funds cannot be used to replace other state or county funds required to be used to provide mental health services in fiscal year 2004-05 (the time of enactment of the MHSA)
3. Funds must be used on programs that were not in existence in the county at the time of enactment of the MHSA (new programs) or to expand the capacity of existing services that were being provided at the time of enactment of the MHSA (11/02/04).

Further detail regarding these requirements follows:

1. Programs Authorized in Section 5892 of the W&I Code

Section 5892 of the W&I Code requires that funds under the MHSA must be used for the following programs:

- ❒ Education and Training
- ❒ Capital Facilities and Technological Needs
- ❒ Prevention and Early Intervention
- ❒ Services for Children (including Transition Age Youth) and Adults and Older Adults (defined as Community Services and Supports by the Department)
- ❒ Innovative Programs
- ❒ Local Planning
- ❒ State Administration

Services that do not fall under one of the above programs and do not meet DMH MHSA requirements cannot be funded through the MHSA.

2. Replacement of Other State and/or County Funds

Counties cannot use MHSA funds to replace other state and county funds required to be used by the county mental health department to provide mental health services in fiscal year 2004-05 (the time of enactment of the MHSA). Funds required to be used by the county mental health department include all allocations either from or through the State Department of Mental Health, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State General Fund, and realignment funds allocated for mental health services (excluding

allowable 10 percent realignment transfers). The Department will provide each county with a listing of their fiscal year 2004-05 allocations required to be used for mental health services along with an estimate of fiscal year 2004-05 EPSDT State General Fund based on settled fiscal year 2002-03 EPSDT State general funds. County expenditures will be evaluated against the fiscal year 2004-05 aggregate spending amount net of allowable realignment transfers and county overmatch, which are not required to be used on mental health services.

This does not preclude a county from ceasing to fund programs that no longer meet the needs of the county and its stakeholders as long as the aggregate state and county funds required to be used to provide mental health services are used for such purpose. This also does not preclude a county from using MHSA funds to expand the capacity of an existing program beyond the levels funded in fiscal year 2004-05.

Note that counties are still required to comply with existing statutes and regulations regarding the use of funds for mental health services. The Department does not intend to change the structure of mental health financing which would increase a county's share of cost or financial risk for mental health services. Thus, counties are required to use the following funds consistent with current statute, regulations and contracts: realignment funds allocated to the Mental Health Account (excluding the ten percent allowable transfer) for mental health services, the county maintenance of effort on realignment funds for mental health services, managed care State General Fund for mental health services, other Department of Mental Health Local Assistance State General Fund for mental health services, and any other state or county funding sources that are statutorily required to be used for mental health services. (State General Fund for EPSDT specialty mental health services are reimbursements for prior expenditures.) Counties are not required to use county realignment funds that are legally transferred to the Health or Social Services accounts in accordance with W&I Code 17600.20 for mental health services. Counties also are not required to provide county overmatch for mental health services even if this funding was previously provided by the county.

If a county transfers up to 10 percent of realignment funding out of mental health in accordance with requirements in W&I Code 17600.20, documentation of compliance with that statute must be submitted to the Department.

> "A county or city or city and county shall, at a regularly scheduled public hearing of its governing body, document that any decision to make any substantial change in its allocation of mental health, social services, or health trust fund moneys among services, facilities, programs, or providers as a result of reallocating funds pursuant to subdivision (a), (b), or (d) was based on the most cost-effective use of available resources to maximize client outcomes."

A county wishing to transfer 10 percent of realignment funding out of mental health must provide notice to the Department and the required amount will be adjusted accordingly. Annual expenditures of state and county funds must be documented as part of the cost report process to ensure compliance with this requirement.

3. Expansion of Mental Health Services

In accordance with Section 5891 of the W&I Code, MHSA funds must be used to expand mental health services beyond services that were provided or funded at the time of enactment of the MHSA, which was November 2, 2004. The Department has interpreted expansion to represent services not provided or funded in the county at the time of enactment of the MHSA (new services) or expansion of program capacity beyond what existed at the time of enactment of the MHSA (expansion of existing services). Inflationary increases in costs associated with programs in existence at the time of enactment of the MHSA are not eligible for MHSA funding because they do not represent an expansion of services through new services or increased program capacity. Increases in program costs due to expansion of existing services to a larger population are eligible for MHSA funding because they represent an expansion of services through an increase in program capacity.

Compliance

The Department will monitor county compliance with the non-supplanting requirements through the following activities:

1. The Department will provide each county with a listing of their fiscal year 2004-05 allocations required to be used for mental health services (excluding allowable 10 percent realignment transfers if the required documentation is submitted to the Department by the county).
2. The county is responsible for documenting the expenditure of these funds on mental health services through the cost report.
3. The county mental health director is responsible for certifying that the MHSA funding is to be used solely to expand services and that fiscal year 2004-05 funds required to be used for mental health services will be used in providing such services.
4. The county mental health director is responsible for certifying on the annual cost report that funding was actually used solely to expand services and that state and county funds required to be used for mental health services were used in providing such services.

If you have questions or need additional information, please contact the County Operations staff assigned to your county.

Sincerely,

Original signed by:
Robert Garcia
for

STEPHEN W. MAYBERG. Ph.D.
Director

Enclosures

cc: California Mental Health Planning Council
Chiefs, County Operations Sections