Mental Health Services Act*:*
FY 2019-2020 Annual Update

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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

LETTER FROM THE MENTAL HEALTH SERVICES ACT COORDINATOR

January 17, 2020

We have completed a draft of the 2019-2020 Annual Update 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 2018-2019. This 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 January 17, 2020 to February 20, 2020 and a Public Hearing will be held on February 20, 2020 from 3-4 p.m. at the Behavioral Health Services Building at 1400 Emeline Avenue-Room 206, Santa Cruz, 95060. 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 telephone: (831) 763-8203,
By internet:
http://santacruzhealth.org/MHSA
By email to mhsa@co.santa-cruz.ca.us ,
Or by writing to:

Santa Cruz County Behavioral Health
Attention: Cassandra Eslami, MHSA Coordinator
1430 Freedom Boulevard, Suite F
Watsonville, CA 95076

Sincerely,

Cassandra Eslami, LMFT
Senior Behavioral Health Program Manager
Mental Health Services Act Coordinator

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<u>MHSA County Fiscal Accountability Certification</u>

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MHSA County Compliance Certification

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MHSA County Compliance Certification pg. 2

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Description of Stakeholder Process

a) **Description of the local stakeholder process including date(s) of the meeting(s):**

The Santa Cruz County MHSA Coordinator oversaw the community planning process for the MHSA Annual Update. The stakeholder/community engagement process was designed for inclusion with representation from behavioral health providers, social services, law enforcement, consumers, and family members, as well as representatives from diverse geographical and ethnic/racial/cultural populations. MHSA stakeholder engagement activities were 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.

When MHSA was initially implemented, Santa Cruz County had an extensive Community Services and Supports (CSS) Planning Process. 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. At that time focus groups were held in both North County and South County, in English and in Spanish. The County has held numerous Town Hall meetings to provide updates and hear from the community about the impact of the MHSA services.

In 2019 four stakeholder meetings were held that focused on providing information about MHSA current programming, as well as gaining community and consumer feedback on current MHSA strengths and gaps within the community. There were 57 participants (those who chose to complete sign in sheets), which represented a range of stakeholders, including consumers, family members and community providers. To ensure community inclusion the meetings times included evening hours and were offered at sites in North County, Mid County and South County. All the meetings were announced via emails, advertised in the local newspapers and listed on the county MHSA website. Spanish translation services were provided at each meeting. Refreshments and light snacks were served at the meetings. Feedback was also collected at each event on notecards, to ensure attendees who were uncomfortable speaking in a large group format would have their questions answered and feedback/comments noted.

The first stakeholder interactive event was held at Cabrillo College in Watsonville (South County) on February 13th. The purpose of this event was to promote and collaborate on MHSA PEI efforts on suicide prevention. This was done by hosting a participant table at the Cabrillo College Student Wellness Fair. The table was co-hosted by Family Services Agency-Suicide Prevention Services, a MHSA PEI funded organization. At this event we shared information on suicide prevention efforts taking place county-wide including the launch of the Suicide Prevention Task Force. The mission and goals of the Task Force were widely shared and discussed, including distribution of the Santa Cruz County Suicide Prevention Task Force Strategic Direction handout materials. Suicide Prevention Services was also able to provide information on their hotline services and training/volunteer opportunities.

The second stakeholder meeting was held May 16th in conjunction with completion of the Suicide Prevention Task Force Strategic Plan. The strategic plan was completed and open to public comment for 30 days. At closing of the public comment period, this stakeholder event was held to ensure all comments/feedback would be heard and taken into consideration for the final strategic plan. At the event, our Suicide Prevention Consultant, Noah Whitaker described the steps taken by the Task Force to design and create the plan. He shared the county-wide plan to move forward in areas of

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prevention, intervention and postvention. He also shared our next steps about the creation of sub-committees in those realms to begin launch of services.

On June 5th, Children's Behavioral Health presented on MHSA programming and on June 6th, Adult Behavioral Health presented on MHSA funded programming. The agenda for both presentations were as follows: 1. Welcome 2. Exciting announcements, including new programming based on previous stakeholder feedback 3. Current MHSA programming 4. Community feedback and Q&A. These events were widely attended by stakeholders and presentations came from a variety of staff within Behavioral Health programs. The goals of the MHSA stakeholder engagement meetings were to provide information about countywide MHSA services, gain information from the community about their views/thoughts of the current services; while also learning more about current gaps and emerging needs in the community.

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, Barrios Unidos, 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**.** The demographic breakdown below is of those who completed a demographic information sheet at the 2019 stakeholder meetings:
Note: Some people indicated they represented more than one group. Many people who attended the stakeholder engagement meetings chose not to provide attendance/demographic information.

AGE	
0-17	
18-25	6
26-35	2
36-42	1
43-59	12
60+	12

Ethnicity	
Black/African American	1
Latino	4
White	24
American Indian	
Asian	2
Middle Eastern	1
More than one	3
Other	1

Gender	
Male	13
Female	23
Transgender Female	

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Transgender Male	
Genderqueer	
Questioning/Unsure	
Other	

Primary Language	
English	32
Spanish	
English & Spanish	1
Other	

Group Representing	
Client/Consumer	7
Family	12
Law Enforcement/Probation	
Social Services Agency	4
Veteran/Vet Advocate	2
Education	8
Healthcare	
Mental Health provider	6
SUD provider	
General Public	4
Other	3

c) **The dates of the 30-day review process:**
The draft plan of the MHSA update was available for review and comment from January 17, 2020 to February 20, 2020.

d) **Methods used by the county to circulate for the purpose of 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 MHSA draft plan was distributed to the Local Mental Health Board, contractors, and to interested stakeholders. The draft plan was also posted on our county MHSA webpage and made available in hard copy to anyone who requested it. Advertisements were placed in the Santa Cruz Sentinel and Register-Pajaronian notifying people of the Annual Update and how to obtain a copy.

e) **Date of the Public hearing held by the local Mental Health Board:**
The Public Hearing will be held on February 20, 2020 from 3-4 p.m. at the County Behavioral Health Services Building at 1400 Emeline Avenue-Room 206, Santa Cruz, 95060

f) **Summary and analysis of substantive recommendations received during the 30-day public comment period and description of substantive changes made to the proposed plan:**
Public comment will be added upon closing of the public comment period

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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:
(Note: direct client services are not allowed in infrastructure components.)

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

Description of county demographics such as size of the county, threshold languages, unique characteristics, etc.
The population in Santa Cruz County is 274,255 according to 2018 estimates. In Santa Cruz, the breakdown of the population by race is 56.9% are White (Not of Latino origin), Latinos make up 34.1% of the county population, 1.4%, African American, 1.9% are American Indian and Alaskan Native persons, and 5.2% are Asian. 16.5% of the population is over 65 years old; persons under 19 years comprised 25% of the population. The primary language in Santa Cruz County is English, with 31.6% of households speaking a language other than English. The threshold language in Santa Cruz is Spanish. Slightly more than half of the population (50.5%) identify as female.

The Santa Cruz Mental Health Plan (MHP) is serving ethnic groups at comparable rates as reflected in the overall population. However, when comparing the Mental Health consumers against the Medi-Cal population the Mental Health Plan is falling short at serving Latinos. The Mental Health Plan appears to be serving Black and Asian consumers at comparable rates to their representation among Medi-Cal beneficiaries. White consumers are over-represented.

Cost Per Person Served Fiscal Year 2018-2019:
The approximate cost for children served in the CSS program is $1,932 and in the PEI programs is $88. The approximate cost for adults served in the CSS program is $1,249, in the PEI program is $127 and INN is $8,247.

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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.

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 2019-2020:
The unduplicated numbers of individuals to be served by program are:
Encompass: 150
Pajaro Valley Prevention and Student Assistance (PVPSA): 100
Santa Cruz County Behavioral Health: 175

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? Hiring and retaining bilingual (and bicultural) clinicians is a challenge. We are continually working with Santa Cruz County Personnel and community partners to address this issue. Contracts now require Licensed/Waivered/Registered clinicians, which has created a burden in staffing within county behavioral health programs and across community partner programs.

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

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/18 to 6/30/19, which is attached.

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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).
- Transition-age youth (TAY) in the Probation population (particularly as they age out of the juvenile probation system).
- 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 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 Pajaro Valley Prevention & Student Assistance (PVPSA), and Encompass provide the services in this work plan.

Number of individuals to be served 2019-2020:
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?
Encompass encountered staffing challenges. Hiring and retaining bilingual (and bicultural) clinicians is a challenge. We are continually working with Personnel and community partners to address this issue. Contracts now require L/W/R clinicians, which has created a burden in staffing across the community partner programs. In addition, in 2018-19 Encompass initiated the Fuerte Program focused on providing Wraparound services to probation youth, which was not MHSA funded. This program may have impacted the referral rates of probation youth to other programs.

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

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/18 to 6/30/19, which is attached.

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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 to 10-year-old range, and particularly in the targeted 0 to 5-age range. To address these needs, we will continue to provide:

- Consultation services for parents (with children in the Child Protective Services 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 Serious Emotional Disturbances turning 18).
- 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 the 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 Parents Center, Encompass, and Santa Cruz County Behavioral Health provide the services in this work plan.

Number of individuals to be served 2019-2020:
The unduplicated numbers of individuals to be served by program are:
Parents Center: 30
Encompass Independent Living Program (ILP): 13
Santa Cruz County Behavioral Health: 200

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
Parent Center lost funding, which resulted in a decrease in FTE staff to provide the services. 18-19 target population has been lowered to reflect the decrease in staffing. At the end of calendar year 2019 the Parents Center changed their executive leadership, by the end of the fiscal year they resolved their staffing issues and are on track to meet contract targets for 19-20.

Are there any new, changed or discontinued programs? See above.

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/18 to 6/30/19, which is attached.

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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 the 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 the 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 2019-2020:
The unduplicated number of individuals to be served by program is
Santa Cruz County Behavioral Health Services: 38

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 (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/18 to 6/30/19, which is attached.

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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
- Capacity for youth and family advocacy by contracting for these services with a community-based 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 2019-2020:
The unduplicated numbers of individuals to be served by program are:
Volunteer Center/Family Partnerships: 50

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 (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/18 to 6/30/19, which is attached.

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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. **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.
3. **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.
4. **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 and EDC)
- Mental Health Client Action Network (Peer Supports)
- Santa Cruz Behavioral Health (Specialty Staffing)

Number of individuals to be served 2019-2020:

The unduplicated numbers of individuals to be served by program are:
Encompass-Telos: 100
Encompass- El Dorado Center: 100
MHCAN (Peer Supports at the Psychiatric Health Facility): 100 (outreach)

Santa Cruz County Behavioral Health: 1000

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 (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/18 to 6/30/19, which is attached.

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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 2019-2020:

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

- MHCAN: 600 (FSP) 80 (outreach)
- Mariposa: 40 (FSP) 50 (outreach)

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

Yes. MHCAN's use permit has been modified by the City of Santa Cruz limiting daily attendance to a maximum of 50 clients to be served per day and restricting hours of operation. MHCAN requested a process though the City of Santa Cruz to allow a review of the use permit to increase capacity.

Are there any new, changed or discontinued programs?

No.

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/18 to 6/30/19, which is attached.

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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 an 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:

- Front Street: 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.

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- 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 services at Wheelock (Residential), Wheelock (Outpatient), Willowbrook, and Opal Cliffs.
- Encompass provides services at Casa Pacific
- 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).
- River Street Shelter
- Santa Cruz County Behavioral Health staff provides case management services.

Number of individuals to be served 2018-2019:
The unduplicated numbers of individuals to be served by program are:
Front Street- Wheelock (Residential & Outpatient): 16
Front Street- Willowbrook: 40
Front Street- Opal Cliffs: 14
Encompass- Supported Housing: 60
Volunteer Center/Community Connection-Housing Support (employment): 55
Volunteer Center/Community Connection-Opportunity Connection: 70
Volunteer Center/Community Connection Avenues: 45
Volunteer Center/Community Connection Cabrillo College Connection: 25
Santa Cruz County Behavioral Health Services North & South County Recovery: 450
Santa Cruz County Behavioral Health Services Older Adult Team (OAS): 60
Santa Cruz County Behavioral Health Services MOST: 100
Encompass River Street Shelter: 100 (FSP) 125 (outreach)
Encompass Casa Pacific: 40

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 (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/18 to 6/30/19, which is attached.

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COMMUNITY SERVICES AND SUPPORTS: HOUSING

This component is to offer 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 years 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.

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 also developed Lotus Apartments for five transition age youth and adults located mid county. Santa Cruz County Behavioral Health Services FSP team provides the initial referral to clients who enter the MHSA housing 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.

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

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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.

- School Mental Health Partnership Collaborative (The County Office of Education)
  The Diversity Center
  Live Oak Resource Center
  Positive Behavioral Intervention and Supports (PBIS)
- Trauma Informed Systems
- The Positive Parenting Program (Triple P)
- Veteran's Advocate Agency
- Senior Peer Companion

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).

- 0-5 Early Intervention Stanford Neurodevelopmental Foster Care Clinic
- Employment Services/Community Connection
- Santa Cruz County Behavioral Health Access

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.

- Senior Outreach-Family Service Agency of the Central Coast

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.

- NAMI
- MHCAN-Shadow Speakers

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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.)

- Suicide Prevention Service of the Central Coast
- Santa Cruz County Suicide Prevention Task Force

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.

- Second Story
- Mobile Emergency Response Team (MERT)/Mental Health Liaisons (MHL)

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

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PEI Project- 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.

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

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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.

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

2018/2019 COE Q1 Narrative Report
From: The Diversity Center
Submitted: July 2019

Program Name: PEI #1: Children's Services **Agency**: COE: The Diversity Center
Target population:

- **Demographics**: (fill out chart)
- **What is the unduplicated number of individuals served in preceding fiscal year?** 4,498
- **What is the number of families served?** 29
- **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.

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 Gender/Sexuality 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,

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).

- **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

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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.

- **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:**

  See evaluation methodology below which details the outcomes we evaluate that contribute to promoting mental health.

- **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 and Development Director (who has 15 years of evaluation expertise) in collaboration with program coordinators. 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.

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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.

- **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 Gender and Sexuality Alliances (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 shows the impact our program has on local youth.

  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.

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

Oversight by the Executive Director and Program Director ensures fidelity to the program design and practice model.

- **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 are 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.

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

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

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):

  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):

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Many teens 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 Youth Gender Expansive support group is a safe place 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.

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

2018/2019 COE Q1 Narrative Report
From: The Diversity Center
Submitted: July 2019

Program Name: PEI #1: Children's Services **Agency**: COE: The Diversity Center
Target population:

- **Demographics**: (See 2018-19 Demographics Report)
- **What is the unduplicated number of individuals served in preceding fiscal year?** 4,498
- **What is the number of families served?** 29
- **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.

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 Gender/Sexuality 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,

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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).

- **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.

- **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:**

  See evaluation methodology below which details the outcomes we evaluate that contribute to promoting mental health.

- **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:

  6. Increased sense of self-confidence
  7. Improved relationships with peers, family, and teachers
  8. Increased sense of community
  9. Increased positive coping strategies to stress
  10. Increased sense of safety

  Data is then analyzed by the Executive Director and Development Director (who has 15 years of evaluation expertise) in collaboration with program coordinators. 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.

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.

- **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 Gender and Sexuality Alliances (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 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.

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

Oversight by the Executive Director and Program Director ensures fidelity to the program design and practice model.

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

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

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

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):

  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 teens 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 Youth Gender Expansive support group is a safe place 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.

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

Program Name: PBIS **Agency**: Santa Cruz County Office of Education

Target population:

- **Demographics**: (See 2018-2019 Demographics Report)
- **What is the unduplicated number of individuals served in preceding fiscal year?**

  - 626 staff in 6 school districts representing 47 schools in Santa Cruz County. These in turn impacted more than 27,000 students.

    Live Oak School District *1,949 Students*
    - Cypress Charter High School
    - Del Mar Elementary
    - Green Acres Elementary
    - Live Oak Elementary
    - Shoreline Middle School

    Scotts Valley Unified School District *2,502 Students*
    - Brook Knoll Elementary
    - Scotts Valley High School
    - Scotts Valley Middle School
    - Vine Hill Elementary

    Santa Cruz City Schools *2,590 Students*
    - Bayview Elementary
    - Branciforte Middle School
    - Delaveaga Elementary
    - Gault Elementary
    - Westlake Elementary

    Soquel Union Elementary School District *1,934 Students*
    - Main Street Elementary
    - New Brighten Middle School
    - Santa Cruz Gardens Elementary
    - Soquel Elementary

    San Lorenzo Valley Unified School District *2,502 Students*
    - Boulder Creek Elementary
    - San Lorenzo Valley Elementary

    Pajaro Valley Unified School District *17,394 Students*
    - Alianza Charter School
    - Amesti Elementary
    - Ann Soldo Elementary
    - Aptos High School
    - Aptos Junior High School
    - Bradley Elementary
    - Calabasas Elementary
    - Ceasar Chavez Middle School
    - Diamond Technology Institute
    - E.A. Hall Middle School
    - Freedom Elementary
    - Hyde Elementary
    - Lake View Elementary
    - Landmark Elementary

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MacQuiddy Elementary
Mintie White Elementary
Ohlone Elementary
Pajaro High School
Pajaro Middle School
Radcliff Elementary
Renaissance High School
Rio Del Mar Elementary
Rolling Hills Middle School
Starlight Elementary
Valencia Elementary
Watsonville Charter School of the Arts
Watsonville High School

- **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 14,072 (27,583/1.96)

- **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 determines 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.

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)."

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

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number of students with too few protective factors and therefore at risk of institutional involvement and decreased emotional and/or relational functioning.

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.

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.

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.

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.

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.

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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 (from CSUMB & Santa Clara County Office of Education), using the Tiered Fidelity Inventory Tool. It has not been universally utilized, but will be highly encouraged this fiscal/school year.

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

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):

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.

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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):

  PBIS promotes a positive school culture and climate as it's 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*

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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? No

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

TRAUMA TRANSFORMED

Program Name: Trauma Informed Systems, **Agency**: Santa Cruz County Behavioral Health

Target population:

- **Demographics**: (fill out chart) Please see attached
- **What is the unduplicated number of individuals served in preceding fiscal year?** ___433____
- **What is the number of families served?** ___0______
- **Participants' risk of a potentially serious mental illness?** ___0___
- **How is the risk of a potentially serious mental illness defined and determined?**

n/a

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)?

Early Childhood Care and Education Cohort:
Children benefit from being surrounded by calm and attuned caregivers, whether in the home or in childcare. Having an attuned adult in their life is a protective factor for any Adverse Childhood Experiences they may have. This year the program focused on providing mental health consultation, trainings, and technical assistance in English and in Spanish to Early Childhood Education sites throughout Santa Cruz County to increase their ability to be calm and attuned for the children in their care, provide trauma-informed early childhood care in order to increase protective factors for children.
Activities included:

- 6 Early Childhood Leadership Learning Community Meetings
- 6 Early Childhood Educator Learning Community Meetings
- 2 joint ECE Leadership and Educator Learning Communities
- Visiting 7 different ECE school sites; providing early childhood trauma-informed mental health consultation to ECE Educators and Leadership at each site and observing classroom and environmental practices to support learning

Santa Cruz County Trauma-informed Systems (TIS) Collaboration:
Trauma is a pervasive, long-lasting public health issue that affects our health delivery systems and workforce. In order to effectively deliver trauma-informed care to impacted communities served by behavioral health and human services, our workforce and policies must also align to trauma-informed care practices and principles. In order to sustain progress in the adoption of TIS across Santa Cruz child-serving systems and organizations and to create more trustworthy, coordinated, and culturally responsive systems of care, Trauma Transformed provided the following activities to a cohort of Santa Cruz child-serving agencies including behavioral health, human services, encompass, probation, education, and others. Activities included:

- 15 TIS 101 trainings for 406 participants
- Maintained Santa Cruz embedded and certified TIS Trainers with 5 trainer learning communities to coach and improve ability of trainers to disseminate knowledge and practice change. We certified 11 trainers this year.
- Build capacity for organizational leaders and champions to apply learning and TIS principles to practices and policies by facilitating 9 learning sessions with champions across 8 agencies, 5 leadership learning communities with leaders across 8 agencies, and one joint champions / leadership meeting
- 4 targeted presentations to H.S.A and other agencies to enhance and advance implementation and knowledge dissemination
- Participated in planning and facilitating monthly Behavioral Health Leadership TIS meetings.

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).

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

For the purposes of this contract, the above-mentioned specific outcomes are not measured.

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:
For the purposes of this contract, the above-mentioned specific indicators are not measured.

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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:

After each TIS 101 training, all attendees are given a training evaluation that is then collected and aggregated. Data is then shared with Trauma Transformed who creates reports of the demographic data and has provided summaries of data in the past. The TIS 101 training evaluation includes a question that asks participants to rate how much the trainer "Demonstrated ability to apply material to culturally diverse population". If concerns were to arise in this category, they would be discussed with trainers.

Additional evaluation was done through participant questionnaires given to people who attended the various activities including early education, champions, leadership learning communities, etc. Please see below for qualitative highlights of each activity that were mentioned in evaluations:

EARLY CHILDHOOD EDUCATION

ECE Educator Group:

What about this training was most useful in supporting your work responsibilities?

- The techniques and self-care
- The handouts and tools provided to take back to the center to use with the children
- The games learned, breathing exercises, ways to speak with parents, strategies on a day to day basis
- Thank you for help in understanding development and expressing emotions

What is one thing you learned:

- How to better connect and re-direct; use the PEARLS practice
- It's okay to make mistakes, to love myself
- That we need to feel well ourselves to be able to help others
- Keep practicing breathing when the kids are out of control
- How to interact with parents when there has been a difficult day with their kids

ECE Leadership Group:

Please let us know one thing you learned over the course of our work together:

- So much. I don't know if I could have made it personally and professionally without this training.
- I learned the relationship building tool, to connect, more empathy and respect more
- I learned that I'm not the only one who has stress at work and that I feel I have too much work. I learned that trauma/stress is part of our lives and I learned things that I can do to feel less stress
- Take time to appreciate the staff (new and senior) for the work they do on a daily basis

Please let us know any feedback you have on our work together:

- Super supportive environment and followed groups interests. Constantly applied what was said into how it fits with TIS
- Thank you for modeling how to be with teachers, each other, and clients. I want to share the impact of stress on our work with ED staff and share the importance of self-care.
- Thanks, because after our meeting I feel that what I'm doing is great and I feel value. I enjoy the way you present the workshop. Thanks for the time to listen to us. I love it and I really enjoy. Please do it again.

TIS LEADERSHIP AND CHAMPION GROUPS

Please let us know one thing that you learned over the course of our work together

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- I learned that several agencies both county and non-county are experiencing trauma in a number of ways and I also learned that there are a lot of different strategies to consider when trying to implement trauma informed practices.

Please let us know one thing you are doing differently after learning more about Trauma Informed Systems

- I am really encouraging our trainers who have done some training previously to become re-engaged and serve as trainers and champions in our county and department so as not to let the training and opportunities escape us. We need to continue to move forward with our efforts and take advantage of the inroads, which have already been created.

Please let us know any feedback you have on our work together

- I enjoyed working with Cathy immensely in her role as advocate and facilitator for change around the trauma informed work. Along the same lines I truly enjoyed the cohesiveness and camaraderie that our leadership cohort shared in the journey. It was very valuable time and time well spent!

<u>TIS TRAININGS</u>

- The training was well received by staff, and lots of positive comments were heard. I know I learned some new things, and it was also a poignant reminder that we all have histories and experiences.
- I wanted to take a moment and say thank you for your energy to share this important topic. Parks has a vital role in providing outdoor spaces for all persons to renew and enliven themselves and connecting with the employees who make that happen was a wonderful partnership.
- It was a positive low stress experience with tools I can bring back to my classroom
- I liked the message of compassion and building resiliency
- Well presented with clear vision and provided good tools
- Very pertinent information – helping to transform mental health

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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. <u>Answer questions in either A **or** B.</u>

B. 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**.

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

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

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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**:

The TIS model is designated as a promising practice by SAMHSA and has been used across the Bay Area and nationally where champions, leaders and training participants have reported positive changes in the way they lead others, the practices they use in public system settings, and increased understanding of the effects of trauma, stress and racial oppression on people's behavior and brains functioning.

Using the Trauma-Informed Agency Assessment (TIAA), we hope to quantify outcomes for system transformation and trauma-informed care learning and practices during the next FY. In FY 18-19, we established a baseline using the TIAA and the Tool for a Trauma-Informed Worklife (TTIW) as part of the champions learning community and will follow up to capture metrics to measure adoption, efficacy, and impact in Q2.

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

With regards to the TIS model, Santa Cruz County Behavioral Health currently has approximately 14 active certified TIS trainers, as well as two certified lead trainers who present all TIS trainings. One of the certified lead trainers has also been responsible for co-facilitating the trainer, champions and leadership learning communities with technical assistance from Trauma Transformed, who implements this model in other counties. Trainers and lead trainers receive ongoing technical assistance as needed in order to maintain fidelity to the model.

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):

This is not a direct service model. However, our TIS consultant did advocate and support the coordination of care and access to services in the following ways**:** 1 – Worked with Children's Behavioral Health Management and Access to ensure that referrals coming in from Early Childhood Education as well as families of young children who are experiencing behavioral health challenges, would be thoroughly assessed and referred appropriately. 2. Met with Early Childhood Educators and Leadership providing education on how and where to refer families for behavioral health services and providing contact numbers and information on intake procedures. 3. Providing education to Early Childhood Educators on ways to support families in accessing behavioral 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 features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):

While the activities from this year do not include direct services, training county staff to use trauma-informed approaches increases likelihood that they will understand the impact of trauma and stress and how that can contribute to mental health challenges, and therefore be better equipped to recognize the true depth of impact that children and families carry, and then more willing to provide services.

Our TIS Leadership and Champion groups worked to apply TIS principles to initiate Trauma Informed Practices in their different agencies. As an example, one of the Behavioral Health clinicians in our Champion groups described how she utilized the support and education she received from our Champion Learning Community to a need she identified in her position. She recognized that the transportation protocol in place for transporting individuals who were being held on a 51.50 hold was causing additional stress and trauma to an already stressful situation. This protocol had individuals being held sometimes for hours while waiting for appropriate transportation to the holding facility. This excessive wait time caused many challenges for both the individuals in need as well as the behavioral health staff working to support those individuals – (patients would sometimes become increasingly dysregulated, have an increase in suicidal ideation, would leave the facility, etc.). This TIS Champion was able to effectively advocate for and effect change in the transportation protocol resulting in a more effective and timely process for transporting individuals on 51.50 hold to the holding facility.

- **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):
  One of the main goals of the TIS model is to increase understanding of stress and trauma and how it impacts people individually and organizationally. In doing so, people are better able to view colleagues and those they serve from a lens that incorporates "what has happened" to them, rather than "what is wrong with them". In this way, providers are better able to see past potentially frustrating behaviors to recognize the needs and wounds of those they serve. Providers are also less likely to contribute to negative perceptions of those they serve and decrease discrimination by seeking to collaborate with and empower those they serve rather than making unilateral and potentially harmful decisions about the care of those they serve. Additionally, the curriculum includes didactic, experiential, and coaching to identify implicit bias and implement de-biasing strategies shown to reduce stigma and discrimination. Furthermore, the champions and leadership communities began to utilize the Trauma Transformed Policy Audit tool intended to reduce or mitigate the ways in which bias is embedded into structures and policies towards creating more accessible, culturally-rooted and responsive and effective services in their design as well as their delivery.

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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?
No

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

Program Name: Positive Parenting Program (Triple P) **Agency**: First 5/United Way

Target population:

- **Demographics**: (see Annual 2018-19 chart)
- **What is the unduplicated number of individuals served in preceding fiscal year?** In FY 2018-19, 276 parents/caregivers received Level 3 Individual, Level 4 Standard/Group, or Level 5 Triple P services. (Note: An additional 1,113 parents/caregivers participated in brief Level 2 Individual consultations, Level 2 Seminars or Level 3 Workshops, but this figure is likely to include some duplicate clients.)
- **What is the number of families served?** 224 families (intensive services)
- **Mental illness or illnesses for which there is early onset:** Depression or anxiety (parents), Oppositional Defiant Disorder, Conduct Disorder (children)
- **Description of how participant's early onset of a potentially serious mental illness will be determined:**

1) Parents are often referred to Triple P by social workers, licensed clinicians or medical professionals with knowledge of the parents' and/or children's mental health risks and needs
2) Although Triple P assessments are not diagnostic tools, the results of the Child Adjustment and Parent Efficacy Scales (CAPES) and the Parenting and Family Adjustment Scales (PAFAS) provide helpful information about parents' emotional well-being and children's social, emotional, and behavior challenges. Assessment results that indicate areas of concern are discussed with parents, and parents are connected to concurrent child and/or adult mental health services as needed.

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).

Triple P practitioners conduct an initial intake interview with parents receiving intensive individual or group services. During the intake or initial session, the practitioner obtains background information about the family composition, children's behaviors, children's health and development (including medical/behavioral health/educational needs and services), and other family dynamics that may be causing or contributing to the current child or family challenges. At the end of the initial intake/session, parents complete the Triple P pre-assessment packet containing questionnaires about their parenting practices, child behaviors, parent-child relationship, parental well-being, family relationships, and parental teamwork.

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Most parents sign up or are referred for specific services (brief or in-depth, individual or group), but the initial intake provides an opportunity to confirm that a) the parents are interested and committed to participating in Triple P services, and b) the practitioner is offering the appropriate level and type of Triple P service to the parent.

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 child behaviors.
  - Improved parenting practices.
  - Decreased level of parental stress.
  - Increased confidence in parenting abilities.

- **Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects 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 most intensive levels of service (Levels 4 & 5), since these are frequently the parents who report moderate to severe child behavior problems and/or distress related to parenting.

  Effective July 1, 2018, First 5 began utilizing a new set of research-based assessments, administered at pre- and post-intervention, to measure changes in parenting attitudes, skills and behaviors:
  - **New:** Child Adjustment and Parental Efficacy Scale (CAPES): Measure of child behavioral and emotional adjustment in children aged 2 to 12 years old, and parental self-efficacy.
  - **New:** Parenting and Family Adjustment Scale (PAFAS): Measures parenting practices and parent/family adjustment.
  - Lifestyle Behavior Checklist (Level 5 Lifestyle Triple P only): Measures parents' perception of children's health- and weight-related behavior challenges (nutrition, physical activity) and parents' confidence in handling the behaviors.
  - Parental Attributions for Child Behavior (Level 5 Pathways Triple P only): Measures the degree of parents' negative attributions (beliefs) about their children's behaviors.
  - Acrimony Scale (Level 5 Family Transitions Triple P only): Measures the degree of co-parenting conflict between divorced or separated partners

  The CAPES and PAFAS were developed and tested by the University of Queensland Parenting and Family Support Centre, under the direction of Professor Matt Sanders, the founder of the Triple P program. Triple P America now recommends all practitioners use the CAPES and PAFAS in place of the previously recommended assessments (Eyberg Child Behavior Inventory, Parenting Scale, Depression-Anxiety-Stress Scale, and Parent Problem Checklist), as they measure similar parenting domains and outcomes and are more user-friendly for both families and practitioners.

  Parents are always asked to sign a Consent to Participate in the Evaluation of Triple P, prior to completing the pre-assessments. They are informed of the purpose of the evaluation, given assurance that their personal information and responses to the questionnaires will remain anonymous and de-identified, and informed that they may decline to participate in the evaluation but still receive Triple P services.

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Data is collected by Triple P practitioners providing the services, then data for clients who have provided consent is submitted on a monthly basis to First 5 Santa Cruz County's Research & Evaluation Analyst. Procedures have been established to ensure that First 5 receives de-identified data. All data entry is proofed to ensure accuracy, and then analyzed by First 5 annually.

All Triple P client forms and assessment measures are available in both English and Spanish. The majority of Triple P program materials are also available in English and Spanish. If program materials are not yet available in Spanish through Triple P International (parent company), then First 5 develops Spanish-language teaching aids in accordance with Triple P's policies. Bilingual 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). If parents have low literacy levels, then practitioners assist parents by reading the assessment questions and responses options, and marking off parents' verbal responses on the assessments.

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.

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

4. **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.

More recently, some longitudinal studies have demonstrated the long-term benefits of Triple P services:

- Results from a follow-up study of Group Triple P in Germany (Heinrichs, N., Kliem, S., & Hahlweg, K. 2014) found that a reduction in mothers' dysfunctional parenting behavior was maintained up to 4 years after the intervention. Results indicate that positive parenting practices may decrease with time, if no further intervention is provided – i.e. parents may stop using some strategies as children grow older, suggesting the need for continued encouragement to use positive parenting strategies.
- Results from a 15-year follow-up study of Western Australia's Triple P trial (Smith, G. 2015) indicate that participation in an 8-week group for parents of children 3-5 years old was associated with higher reading and numeracy achievement, fewer absences from school, and reductions in emergency department visits. Triple P was also associated with an increased use of community mental health services, which the researchers hypothesize may be a positive sign that Triple P helped encourage and normalize help-seeking behavior.

The robust body of research has led Triple P to be 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.

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. Outcome data from FY 2018-19 is currently being analyzed. However, a cumulative analysis of outcomes from January 2010 – June 2018 demonstrates positive outcomes such as:

- **Improvements in child behavior.** Overall, the majority of parents (79%) 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, 91% reported improvements in their children's behaviors.
- **Increased use of positive parenting styles.** Overall, 67% of parents reported they were less over-reactive, 66% reported they were less permissive, and 50% reported they had a less hostile parenting style after completing intensive Triple P services. Of the parents who began the program with more serious parenting issues, 83% reported they were less over-reactive, 81% were less permissive, and 89% were had less hostile 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 (64%, 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, 84% reported improvements in anxiety, and 84% 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.

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) observes selected practitioners as they conduct classes and completes 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. The Coordinator also provides implementation support and facilitates peer coaching during the quarterly Triple P practitioner meetings and agency-specific meetings.

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

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

NA

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

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):

  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, correctional facilities, 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. First 5 Santa Cruz County disseminates bilingual messaging and materials through its countywide Level 1 social marketing campaign,

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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, correctional facilities, and other non-profits serving children and families.
- Disseminating a monthly article with Triple P parenting tips through print and electronic media
- Posting on social media and maintaining an advertising presence in key print and electronic media outlets
- Utilizing “Triple P parenting strategy cards” to educate parents about positive parenting techniques during community outreach events and classes
- Coordinating outreach, classes, and other special events during the annual “Positive Parenting Awareness Month” in January.

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

Target population:

- **Demographics**: (fill out chart)
- **What is the unduplicated number of individuals served in preceding fiscal year?** 250
- **What is the number of families served?** 250
- **Participants' risk of a potentially serious mental illness?** 134
- **How is the risk of a potentially serious mental illness defined and determined?**

Homelessness, incarceration, identification of traumatic events during military service, identification of traumatic events during childhood, previous mental health diagnosis, Substance Use Disorder

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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 conditions. 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.

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).

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 and connect to available resources.

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.

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 an motivational interviewing skills to identify the specific challenges of each client and create pathways to success.

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.

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

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

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

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

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

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

Through interviews the Veterans Advocate will use direct questions and active listening to identify challenges that the 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. The Veteran Advocate will produce evidence of the success this program by tracking referrals made and conduct follow up phone calls/ visits to track outcomes. The Veteran Advocate will work directly with the Veteran Services Office, which has long been a source of support for Veterans in Santa Cruz County. The efforts of the Veteran Advocate will increase the effectiveness of the Veteran Services Office and increase the accessibility of benefits available to the Veterans of Santa Cruz County.

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

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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.

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):
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, regardless of type of discharge or length of service. One on one confidential interviews allow 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 is positive and will help to reduce the suffering each client is facing.

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

Program Name: PEI #4 Peer Companion **Agency**: Senor Council

Target population:

- **Demographics**: (fill out chart)
- **What is the unduplicated number of individuals served in preceding fiscal year?** ___14_____
- **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.

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 term 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.

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).

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 MHSA clients participating will show improvement on at least one of the following quality of life indicators:

- social ties/social support

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- mood and behavior improvement
- personnel expression
- companionship

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
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.

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.

If an evidence-based practice or promising practice was used to determine the program's effectiveness:
Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.
N/A
Explain how the practice's effectiveness has been demonstrated for the intended population.

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

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

5. **Describe the evidence that the approach is likely to bring about applicable outcomes**:
   See Logic Model Attached

6. **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 logic model for both clients served and Senior Companions who serve those clients.

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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):

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 features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):
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 10 years and the other for 6 years).

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PEI Project- 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. **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?** There were problems with getting the referral forms completed and processed smoothly between all agencies. There has been a high level of turnover of staffing from Social Services which has made the process of referrals challenging.

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

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

Target population:

Demographics: Children in foster care under the age of 5

What is the unduplicated number of individuals served in preceding fiscal year? 23 in 2018-19

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.

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

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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.

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.

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.

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

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

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

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

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

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.

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.

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):

Children's Mental Health has built and maintained a strong partnership with the Department of Family and Children's services. As a result, 95% 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, 95% 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

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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.

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A. **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:

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?** _____49_____
   - **What is the number of families served?** ____n/a______
   - **Mental illness or illnesses for which there is early onset:** ___schizophrenia, bipolar dx, depression, PTSD, GAD
   - **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, school counselors 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, prolonged suffering, isolation, lack of support system, lack of knowledge of services. Activities will include academic and employment counseling, skill building and symptom management. Opportunities to participate in groups with peers and information to find meaningful activities. 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 young adult 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 and volunteerism. ANSA assessment at intake and at 6-month intervals to assess for reduction in isolation and prolonged suffering.

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- **List the indicators used to measure the intended reductions**:
  School attendance, employment, volunteerism, ANSA assessment and connection and attendance to support groups/activities.

- **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 and Recovery Evaluation 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, support group, training program, volunteer opportunities, or by becoming employed in part-time or full-time 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?**

   . **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**.

   Utilization of Evidenced Based SAMHSA Supported Employment and Education models, as well as WRAP (Wellness Recovery Action Plan), will reduce risk of homelessness, incarcerations, hospitalization for risk to self, as well as prolonged suffering.

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

   Supported Employment and education models increase self-esteem and self- worth, which reduces risk of suicide, prolonged suffering potential hospitalizations. Employment and education reduce risks of incarceration and homelessness due to access to higher wages and financial security.

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

   Ongoing trainings and supervision will ensure fidelity.

- **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 Evidence Based Practices 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 and Recovery Evaluation to determine particular aspects of mental health recovery and community involvement.

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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):
     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, TAY team and other community resources 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.

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Program Name: Adult & TAY clinical services **Agency**: Santa Cruz County Behavioral Health Services

Target population:

Demographics: See MHSA 18-19 report attached

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.

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.

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

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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

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.

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

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.

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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.

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:

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

N/A

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

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

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Referrals to vocational, educational and independent housing services in order to increase clients' quality of life

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<u>PEI Project-Outreach for Increasing Recognition of Early Signs of Mental Illness</u>: 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) **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: See the MHSA PEI Annual Report for 7/1/18 to 6/30/19, which is attached.

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

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

2. **Number of potential responders:** __1511__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, health fairs, senior housing, MAH and Diversity Center.

4. T**ypes of potential responders engaged in each setting** (e.g. nurses, principles, parents):
   Responders included nonprofit staff, general public, facility residents, MAH and health fair attendees.

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 medical offices, a health fair, residential care facilities, art exhibit, senior centers and nonprofit agencies including the Grey Bears and Diversity Center.

7. **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):

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, housing, caregiver resources, home health, crisis intervention, case management and government 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):

  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 are in need of additional support are identified that might include APS, County Access, Medi-Cal, Medicare licensed counseling, IHSS, MSSP, Stroke Center, CCCIL, Senior Network Services, Second Harvest 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 volunteer peer trainings, support groups, individual services and 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..

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PEI Project-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.

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:

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

2. **Number of people reached**: <u>3134 unduplicated count (For Q1 Q2, Q3, Q4) 2018/19</u>

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

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 from participants. In addition, NAMI has thriving support groups, presentations, and classes due to a stellar reputation.

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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:

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- **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 a 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. Our trained speakers tell how different treatments helped them recover. School presentations (Ending the Silence) normalize mental health challenges and encourage students to talk to someone they trust.

  A recent research study by NAMI National of 932 students compared students who had seen the ETs presentation to a control group who did not see the presentation, and concluded that NAMI Ending the Silence is effective in changing high school students' knowledge and attitudes toward mental health conditions and toward help-seeking. The

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effect is a robust one, occurring across different presenters, across different study schools, and across the diverse populations within those schools.

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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

1. **Program Name**: Shadow Speakers **Agency**: MHCAN

2. **Number of people reached**: ___3,345________ Target #: 2,500

3. **Identify who the program intends to influence:**
The entire community through the people we do reach. This year we have reached an entirely new audience, some of the religious communities of Santa Cruz which previously had refused us. We have had a special audience in a Christian group in the mountains who has a monthly potluck for over a hundred Christian identified people. Two other church groups have been engaged besides them and one is now making monthly donations of used clothing and used shoes, which our members appreciate.

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
     People often have a disconnect between the mass mainstream media portrayal of people with mental health diagnoses and the real life people with mental health diagnoses. The Shadow Speakers enable
     People to meet people in person who have severe mental health diagnoses and to acknowledge their charm, wit, candor, poignant life stories and humanity.
   - **Changes in attitude, knowledge, and/or behavior related to seeking mental health services that are applicable to the specific program**.
     We also get new members from people who hear about MHCAN from hearing speakers or from people they knew who heard speakers. We get a lot of feedback that the speakers bureau is very helpful in changing people's attitudes toward themselves and others with severe mental health diagnoses.
5. Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:
   B. 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 CalMHSA Promising Practices Program identifies speakers bureaus themselves as a promising best practice.

*In CalMHSA's "**Stigma and Discrimination Reduction Projects Funded by the Mental Health Services Act: California, 2011–2014" Networking, Social Marketing, Capacity Building, Resource Development, Standards and Guidelines for Accurate Portrayals and are all seen as components of S&DR, and a speakers bureau has all of those components as active parts.***

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

The practice has resulted in jobs training and in a cohort of people being able to eventually mainstream. The practice has resulted in income for food and clothing and self care. The practice has resulted in greater self esteem on a widespread level. The whole community feels those differences.

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

We were trained by The Diversity Center Triangle Speakers in a very standard speakers bureau format almost indistinguishable except by our folks themselves.

4. **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**:

Just as with all the other speakers bureaus I know of, people are really able to change and grow when exploring their own lives, frames of reference and stories within a supportive, positive group of peers.

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

Experientially. We are pretty standard although different places for presentation will sometimes bring about changes in the way people present.

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): *As the Shadows Speakers reach across the entire county with various places to speak, we are able to connect with people's families, allies and themselves to help them get resources and referrals. We get a lot of email and a lot of phone calls from family members after Shadow Speakers- and a lot of people reach out to us from the inpatient settings as well.*
   - **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 Shadow Speakers enables us to reach people in communities where we may not already have anchored members. We are able to appear before different communities and make bridges for service and referral. We are able to communicate quickly to large, varied groups of people in different communities. For example, we now have a group of MHCANers in the local Baptist church community who outreach to people there in need of services.*
   - **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to

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being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):

*People are proud to be Shadow Speakers. The group that goes once monthly to the huge Christian meeting even designed and printed up their own team T shirts for when they go as a sign of their value for the occasion. People not only display that they are proud- by being proud of being speakers they encourage others to be proud. Years ago, when we first started, only the most "highly functional" people would speak. It was in the second and third year that people who were conserved began to speak. After them, our feral folk joined in. Now everyone at MHCAN speaks except for our folks with mutism. One of our most feral members who used to get called out for profanity every time, and got asked to step down half the time in our MHCAN centered training, whose speech used to be half un-understandable mumbles and half growling swear words, just spoke last week standing proud, tall and utterly perfect in enunciation, in projection and in presentation. When he was done, there were literally a lot of non dry eyes "in the house". Someone said: "He has *changed*" and that is what the speakers bureau does, it leads to gradual positive changes through encouraging, positive based feedback and peer support. The best example we ever had of how it can affect isolated peers was at Watsonville High School. We had a young Latina speaker and a classroom full of almost entirely Latino teens. Everyone spoke and the kids were polite, but when our young Latina speaker went on the whole room went electric. And afterwards, this young man in the farthest backroom raised his hand and said, "I'm bipolar too!" And suddenly, just like that, he was not alone- and the whole room asked questions of both of them in a very respectful way-*

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PEI Project- Suicide Prevention: Organized activities that the County undertakes to prevent suicide connected with 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.)

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

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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: Narrative report for Family Service Agency-Suicide Prevention 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 Service, a program of Family Service Agency

2. **Number of people reached:**
   Number of calls to the suicide crisis line:
   (Santa Cruz location verified) 937
   (Location unknown) 1172
   Number of follow-up calls:
   (Santa Cruz location verified) 39
   (Location unknown) 27
   Number of 911 calls:
   (Santa Cruz location verified) 17
   (Location unknown) 17
   Outreach Participants: 6,483

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, 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**

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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.**

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

5. **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".

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6. **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,

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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.

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Program Name: Suicide Prevention Task Force **Agency**: Santa Cruz County Behavioral Health Services

Number of people reached: 60

Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.

A consultant, Noah Whitaker, was hired to help guide the county of Santa Cruz in conjunction with a newly created Suicide Prevention Task Force to design and complete a county wide plan for suicide reduction. The Task Force worked throughout FY18-19 initially to develop a strategic direction to further guide the creation and board of supervisors approved strategic plan. Santa Cruz County has a higher than average rate of completed suicides in comparison to the state of California. By securing the assistance of the consultant the county can move forward in creating a high quality, comprehensive plan geared toward prevention, intervention and postvention.

How will the Agency/County measure changes in attitude, knowledge and/or behavior related to reducing mental illness-related suicide?

As the strategic plan has been completed, we are now in the process of developing sub-committees focused within the realms of prevention, intervention and postvention. As these sub-committees investigate the models for community implementation, metrics will be developed to capture data on suicide reduction; increased access to behavioral health services and decrease in stigma surrounding suicide. Community engagement work geared toward education, stigma reduction and understanding signs and symptoms of mental health issues that could lead to suicidal ideation are planned during the implementation of the plan (FY19-20). Pre and post measures will be utilized to gain information on changes in attitude and knowledge surrounding suicide awareness.

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? Answer questions in either A **or** B**.**

B. 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:

Describe the evidence that the approach is likely to bring about applicable outcomes:
With the assistance of the consultant, Santa Cruz County is able to gain expertise from prior plans implemented in Tulare/Kings County and Fresno County and implement current best practices that are effective, sustainable and accessible in a community setting.

Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.
The Suicide Prevention Task Force is utilizing the consultant during the 19-20 fiscal year to assist the facilitation of the county wide strategic plan sub-committee work within prevention,

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intervention and postvention models. The Suicide Prevention Task Force based on the guidance of the Consultant will remain in link with the Statewide Suicide Prevention Plan and local Schoolwide Suicide Prevention Plan efforts (AB2246) to ensure a collaborative planning process. During the Task Force work in FY18-19 the group reviewed ongoing monthly meetings task force members participated in detailed and thorough conversations on evidence-based practices in suicide prevention, including current trainings and models. In total we reviewed over thirty-five models to vote on the "best fit" for our county, given strengths and needs of our community

Santa Cruz County Suicide Prevention Task Force

Collective foundation of values in how we want to approach practices/interventions and ensure they work in the Santa Cruz County suicide prevention plan:

1. CLAS; cultural sensitivity
2. Investigate and understand existing resource or similar resource in community
3. Fills a gap/need (general population vs. targeted services); prioritizing population to serve
4. Accessibility; ease of linking to services
5. Cost effective
6. Seek subsidies/leveraging other resources
7. Long term sustainability or with understood launching strategy
8. Operationally effective & yield future data
9. Broad based community representation
10. Broad based community input
11. Supports infrastructure development- Senior management buy-in

a. Identify hubs (e.g. Law Enforement-->CIT training, NAMI, Education, Service Clubs, Community Based Clubs/Organizations)

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):

  The Suicide Prevention Task Force is made up of a multidisciplinary collaborative of community stakeholders from throughout the county. The goal of the Task Force was to recognize and respond with an integrated service plan to the entire community, providing a network of suicide prevention services clearly defined for access at any time. By creating a Task Force inclusive of the community, we have a large network to share the plan and assist in educating on access and linkage for services.
  In FY18-19 key informant interviews were conducting with 111 community members to gain information on current ideas, thoughts and feelings about suicide within Santa Cruz County. The interviews also sought information on knowledge of current programming to gain understanding of community knowledge on strengths and identified gaps.

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 Suicide Prevention Task Force will create a plan inclusive of a robust model of interventions, which will assist in providing accessible and culturally competent services to those in need. Current service models, which will be expanded or enhanced in the plan include county wide suicide prevention programs, crisis hotlines and Behavioral Health Access services. In addition, the plan will outline crisis

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service availability during non-business hours including MERT, Mental Health Liaisons, Crisis Stabilization Program and Psychiatric Health Facility.

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):
An overarching goal of the Suicide Prevention Task Force is to decrease stigma associated with mental illness and suicide in the community. By educating and informing our community about behavioral health issues, treatment accessibility and options, recovery and healing we create a safer community for people experiencing these issues. Overarching community education on risk and protective factors as well as direct information on services will be a focus of stigma reduction.

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<u>PEI Project- Access and Linkage to Treatment</u>: 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.

Program Name: Second Story **Agency**: Encompass

Explanation of how program and strategy will create Access and Linkage to Treatment for individuals with serious mental illness:
The Second Story Peer Respite House is a peer operated program through Encompass Community Services with staffing provided 24-hours a day, seven days per week. It is a voluntary program for clients of Santa Cruz County's specialty mental health service system. The primary purpose is to provide an alternative to sub-acute psychiatric care and ultimately divert people who historically, without this type of early support, would often end up using the acute inpatient hospital and/or sub-acute programs, El Dorado Center or Telos. 2nd Story also assists guests with connecting to physical health appointments, and with smoking cessation.

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?
The program will accept up to six (6) adults age 18 and older, with an average length of stay of seven days. The focus of treatment is on providing Recovery-based support by peer staff through a mutual understanding of mental health challenges based on the staff's "lived experiences" using the evidence-based practice called "Intentional Peer Support or IPS". Through the interview process and assessment peer staff will utilize community-based partners for referrals to ensure client connectedness. Second Story will maintain connection with coordinated care in the county or other contract providers to identify individual needing assessment or treatment.

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?
Santa Cruz County Behavioral Health Services will augment services as needed. Santa Cruz County Behavioral Health Services will continue to make available psychiatric medication supports, case management and therapy services. Clients may "self-refer" to the program, with the support of the case manager. 2nd Story will drive people to appointments as needed to link individuals to services. In crisis situations, 2nd Story will engage MERT Team and the liaisons for resident support.

How will referrals be followed up to support engagement in treatment?
Second Story will coordinate with all other mental health system providers. Substantial collaboration exists with Mental Health Access Team, Housing Council, Santa Cruz County Behavioral Health Services coordinators, program managers, and psychiatrists. Second Story will maintain regular contact with other mental health contractors, Homeless Persons Health Project, and the Homeless Resource Center.
Demographic information. (fill out chart)

Outcomes: New program (FY19-20)

- **Number of individuals with SMI referred to treatment and kind of treatment?** 150 unduplicated
- **Number of individuals who followed through on the referral and engaged in treatment (attended at least once)**: 150 unduplicated per year
- **Average duration of untreated mental illness:** various
- **Average interval between referral and participation in treatment (at least once)**: various

6. **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**.
______ No ____X__ Yes
If yes indicate outcomes, measurement and time frames for measurement:

A. A guest satisfaction survey will be conducted upon exit with at least 70% of guests. A survey summary will be submitted to the County no later than one month following the close of the contract year.
B. Less than 5% will exit to higher level of care.
C. The program will operate at an average of 85% or above of capacity.

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):
Second Story works in close collaboration with Santa Cruz County Behavioral Health Services to ensure clients seeking respite services are knowledgeable about availability of services, including medical and other county offered services. Second Story also works with other community agency partners to ensure people are referred and linked to the appropriate level of services and resources needed to promote healing and wellbeing. Second Story supports individuals with connecting to psychiatrist, primary care, surgery, and pre-planning appointments. When there is a challenge, we connect with people's coordinators and care team. Further, staff connects individuals to substance use programs as part of discharge planning as needed.
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):
Second Story promotes a welcoming environment that is accessible to clients 24/7 as a diversion to a sub-acute or inpatient program. This respite housing option allows clients, who might otherwise end up in an inpatient setting, a safe alternative for connection and relationship building that can assist in their recovery and wellness. We assist underserved populations by having family involvement, church, and community events so that people may find support through others on-site. We have forms in Spanish and English. On staff there are several people who speak some or fluent Spanish connect with people

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):
Second Story remains dedicated to serve as a respite and voluntary housing option for people by offering support and connection with a peer recovery model. These peers assist in helping people by providing relationship building based in shared backgrounds and lived experience. With the support of community partners, including NAMI, Second Story has been able to reduce stigma surrounding mental illness. In addition, self-stigma has been reduced by promoting a safe place for people to self-refer when recognizing a need for respite and connection when feeling vulnerable from mental health symptoms. Second Story supports an environment through which narratives about people and their experiences are shared. Peers discuss ways of seeing beyond the diagnosis, seeing beyond the need for alienating ourselves from our community.

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Mobile Crisis

Purpose: This **Access & Linkage** program is also referred to as the Mobile Emergency Response Team (MERT) & Mental Health Liaison (MHL) Team. MERT and MHL 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. These teams 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. Mental Health Liaisons provide similar crisis assessment and intervention and disposition planning in collaboration with law enforcement for field based crisis response model. MERT's and Mental Health Liaisons 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. 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.

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

Performance Outcomes: See the MHSA PEI Annual Report for 7/1/18 to 6/30/19, which is attached.

Performance Outcomes: Narrative report for MERT/MHL 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.

Program Name: Mobile Crisis MERT (mobile emergency response team)/Mental Health Liaisons (MHL) **Agency**: Santa Cruz Behavioral Health Services

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/MHL has field-based services and the ability to respond in the community.

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/MHL 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 Santa Cruz County Behavioral Health Services Psychiatrist for med-evaluation and ACCESS intake clinician to initiate higher level of care.

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?

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MERT/MHL 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/MHL clinicians will encourage consumers to utilize family support and resources.

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.

Demographic information. See the MHSA PEI Annual Report for 7/1/18 to 6/30/19, which is attached.

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______

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:

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/MHL 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/MHL 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

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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. MHL are available 7 days a week from 8am-7pm. 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 /MHL values and provides in team training/discussions regarding establishing good rapport through welcoming practices. Clinicians also are provided time to attend the 15-hour NAMI Provider Education Training.
MHL are actively involved with development and training for the local county CIT trainings for law enforcement officials, focused on stigma reduction.
Santa Cruz County Behavioral Health also provides various training including consumer panels to increase empathy, awareness, sensitivity, and general welcoming skills.

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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.

During 2018/2019, the IHHS INN project made progress in the following areas:

- In March 2019, 20 peer workers from the community were trained in the evidence-informed curriculum Intentional Peer Support (IPS), including the peers from the IHHS team.
- In November 2018, five clients enrolled in the initial pilot group of the telehealth monitoring devices.
- An additional 40+ consumers have been identified for launch of telehealth devices in Fall 2019.

Target Population: Program participants will be consumers who (1) have co-occurring psychiatric and physical health conditions, and (2) have a primary care physician in a 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?
Challenges in securing and retaining Peers for employment opportunities. Challenges with telehealth implementation and consumer adherence to the intervention, which are being mitigated through a continuous process improvement project to improve enrollment and utilization of the devices. In addition, challenges with finding appropriate facilities for supportive housing model. Once the housing opportunities were found the contract process has taken months to finalize and secure housing.

Performance Outcomes: Demographic information of unduplicated clients:

Annual Target: 60

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	Quarter 1 Jul. to Sept. 2018		Quarter 2 Oct. to Dec. 2018		Quarter 3 Jan. to Mar. 2019		Quarter 4 Apr. to Jun. 2019		Annual Unduplicated	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Unduplicated Client Count	105		104		115		118		141	
Gender Assigned at Birth										
Male	59	56%	56	54%	61	53%	65	55%	80	57%
Female	46	44%	48	46%	54	47%	53	45%	61	43%
Declined to State	0	0%	0	0%	0	0%	0	0%	0	0%
Sexual Orientation										
Heterosexual or Straight	20	19%	21	20%	29	25%	34	29%	40	28%
Gay or Lesbian	1	1%	1	1%	2	2%	2	2%	2	1%
Bisexual	0	0%	1	1%	1	1%	2	2%	2	1%
Queer	0	0%	0	0%	0	0%	0	0%	0	0%
Questioning or Unsuare of Sexual Orientation	1	1%	1	1%	0	0%	0	0%	1	1%
Another Sexual Orientation	0	0%	0	0%	0	0%	0	0%	0	0%
Declined to State	83	79%	81	78%	83	72%	80	68%	96	68%
Age										
0 Years to 5 Years	0	0%	0	0%	0	0%	0	0%	0	0%
16 Years to 25 Years	5	5%	3	3%	3	3%	3	3%	5	4%
26 Years to 59 Years	58	55%	59	57%	60	52%	65	55%	79	56%
60 Years and Older	42	40%	42	40%	52	45%	50	42%	57	40%
Declined to State	0	0%	0	0%	0	0%	0	0%	0	0%
Ethnicity										
Hispanic or Latino	13	12%	12	12%	13	11%	14	12%	20	14%
Not Hispanic or Latino	73	70%	75	72%	82	71%	84	71%	97	69%
Declined to State	19	18%	17	16%	20	17%	20	17%	24	17%
Race										
White	80	76%	78	75%	87	76%	90	76%	105	74%
Hispanic or Latino	11	10%	12	12%	13	11%	13	11%	18	13%
Black or African American	2	2%	2	2%	3	3%	3	3%	3	2%
American Indian and Alaskan Native	0	0%	0	0%	0	0%	0	0%	0	0%
Asian	9	9%	7	7%	8	7%	8	7%	10	7%
Native Hawaiian and Other Pacific Islander	0	0%	0	0%	0	0%	0	0%	0	0%
Other	2	2%	4	4%	3	3%	3	3%	4	3%
Two or more Races	1	1%	1	1%	1	1%	1	1%	1	1%
Declined to State	0	0%	0	0%	0	0%	0	0%	0	0%
Language										
English	99	94%	98	94%	109	95%	112	95%	131	93%
Spanish	3	3%	4	4%	4	3%	3	3%	5	4%
Other	3	3%	2	2%	2	2%	3	3%	5	4%
Veteran Status										
Yes	1	1%	1	1%	1	1%	1	1%	1	1%
No	31	30%	30	29%	33	29%	35	30%	42	30%
Declined to State	73	70%	73	70%	81	70%	82	69%	98	70%

B. New Innovative Project Budget By FISCAL YEAR (FY)*							
EXPENDITURES	Beg: April 2017					Ends: March 2022	
NON RECURRING COSTS (equipment, technology)	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Contractor: Telehealth Devices @ $1,000/each x 60 devices	60,000	-	-	-	-	-	60,000
Contractor: Telehealth Integration Fees @ $30,000	30,000	-	-	-	-	-	30,000
Iphone (for Medical Assistant @ approx. $200/each)	200						200
Total Non-recurring costs	90,200	-	-	-	-	-	90,200
Personnel	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Medical Assistant (Salaries & Benefits)	21,509	90,924	96,099	96,099	98,489	75,719	478,839
Medical Assistant (Operational Costs)	1,549	4,192	4,217	4,217	4,229	3,030	21,434
Total Personnel	23,058	95,116	100,316	100,316	102,718	78,749	500,273
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Contractor: Integrated Health Housing Support Team	162,718	671,346	684,773	698,468	712,436	545,013	3,474,754
Contractor: Master Lease & Rent Subsidies	95,000	380,000	391,400	410,970	431,519	339,821	2,048,710
Total Contract Operating Costs	257,718	1,051,346	1,076,173	1,109,438	1,143,955	884,834	5,523,464
OTHER EXPENDITURES (please explain in budget narrative)	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Contractor: Telehealth Connection/Software Fees (60 devices)	12,420	49,680	50,400	51,120	51,840	39,420	254,880
Contractor: Program Evaluation	50,000	25,000	25,000	50,000	50,000	25,000	225,000
Total Other Expenditures	62,420	74,680	75,400	101,120	101,840	64,420	479,880
BUDGET TOTALS	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Non-recurring costs	90,200	-	-	-	-	-	90,200
Personnel	23,058	95,116	100,316	100,316	102,718	78,749	500,273
Contract Operation Costs	257,718	1,051,346	1,076,173	1,109,438	1,143,955	884,834	5,523,464
Other Expenditures	62,420	74,680	75,400	101,120	101,840	64,420	479,880
Total Gross Budget	**433,396**	**1,221,142**	**1,251,889**	**1,310,874**	**1,348,513**	**1,028,003**	**6,593,817**
Administrative Cost @ 15% Net of INN Funds	45,408	103,162	106,666	114,702	119,375	91,288	580,602
Grand Total	**478,804**	**1,324,304**	**1,358,555**	**1,425,576**	**1,467,888**	**1,119,291**	**7,174,419**

C. Expenditures By Funding Source and FISCAL YEAR (FY)							
Estimated total mental health expenditures for the entire duration of this INN Pro	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Innovative MHSA Funds	348,128	790,911	817,774	879,381	915,210	699,875	4,451,280
Federal Financial Participation	73,188	303,440	310,828	316,242	322,725	246,951	1,573,374
Behavioral Health Subaccount	19,988	79,953	79,953	79,953	79,953	59,965	399,765
Other funding* - MHSA CSS	37,500	150,000	150,000	150,000	150,000	112,500	750,000
Total Proposed Administration	478,804	1,324,304	1,358,555	1,425,576	1,467,888	1,119,291	7,174,419
*If "Other funding" is included, please explain.							

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WORKFORCE EDUCATION & TRAINING

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 & LINGUISTICALLY APPROPRIATE SERVICES

The County of Santa Cruz has designated a person who is identified as the Culturally and Linguistically Appropriate Services ("CLAS") Coordinator. The CLAS Coordinator collaborates with other department staff and assigned managers to assure that the appropriate mental health services, staff development trainings are provided so that the diverse needs of the county's racial, ethnic, cultural, and linguistic populations are being met. However, the responsibility for ensuring the provision of culturally and linguistically appropriate services is not the sole responsibility of one person. We believe that CLAS standards need to be infused throughout our division, and therefore is the responsibility of every staff person.

Santa Cruz County Behavioral Health staff and contractors are required to complete CLAS training, which encourages employees to respect and better respond to the health needs and preferences of consumers. We offer trainings with the overarching goal of improving Cultural Competency for Behavioral Health Professionals, including Culturally and Linguistically Appropriate Interventions and Services.

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 Workforce Education and Training (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 three national Evidence Based Practices: Integrated Illness Management and Recovery (I-IMR), Evidence Based Supported Employment (EBSE), and Integrated Dual Disorders Treatment (IDDT).

Outcomes and the effectiveness of services, as well as the promotion of a transformational system of care as opposed to a service-oriented system of care, will be supported through the adoption of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

Finally, the County seeks to improve its own internal operations and programs utilizing the LEAN Performance Improvement model, by initially working with a certified LEAN facilitator, and then training staff to conduct their own LEAN projects within Behavioral Health and the Health Services Administration.

1. Core Competencies Training

a. Motivational Interviewing (MI), an approach developed by William Miller, has been well established as an effective way to promote behavior change in individuals. The pre-requisite to participating in the face-to-face MI training, is currently available. Individuals first need to complete a free, four-hour, self-paced online course entitled the Tour of Motivational Interviewing: An Interprofessional Road Map for Behavior Change http://healtheknowledge.org/course/index.php?categoryid=53#TourOfMI.

   We are hopeful that we will be embarking on a MI skill development training that will focus on helping individuals to engage in change talk, and then make commitments to make behavioral changes based on goals that they have identified. Ample time will be devoted to role play practice to enable training participants to gain skills necessary to elicit change talk from individuals with low levels of readiness for change, thereby increasing levels of motivation and moving them toward action to address their substance use issues.

2. Evidence Based Practices
   a. Integrated Illness Management and Recovery (I-IMR): I-IMR is an Evidence Based Practice that has been proven effective to assist consumers in more effectively managing their psychiatric illness, promoting recovery, independent living and physical illness self-management. Thus, reducing the need for long-term intensive services in the community. The County is working to train and establish an I-IMR program, with fidelity to the model, in the County Mental Health System- both North and South County.

   b. Evidence Based Supported Employment (EBSE): EBSE provides for the skill building and on the job supports in order to provide access to and success in obtaining and maintaining competitive employment for adults who have a severe mental illness. The only criteria for consumers to access an EBSE program is a desire to work. There are no assessments or readiness criteria established, or any barriers placed in the way of an individual seeking to work. The focus is on competitive employment- jobs that provide for a living wage in the community that any member of the public would have access to. Competitive employment does not include a sheltered workshop program, or jobs created exclusively for consumers. EBSE has been proven highly effective at supporting recovery and reducing the long-term need for services as well as enhancing the quality of life for individuals. The County is proposing to establish one Evidence Based Supported Employment Team through a contracted provider in the community.

   c. Integrated Dual Disorders Treatment (IDDT): IDDT is an integrated approach to providing supports and services to individuals who have both a severe mental illness and a substance abuse problem. The majority of individuals served in the public mental health system have a co-occurring disorder. The traditional approaches of parallel treatment models or sequential treatment models are ineffective at supporting positive outcomes for this population. IDDT, offering an integrated approach, provides training to clinicians to support both an individual's mental health needs and effectively address their substance abuse issues, at the same time. IDDT has as its foundation, motivational interviewing, cognitive behavioral therapy, and IMR. It also relies on EBSE and other supported services particularly Evidence Based Supported Housing. The County is proposing to transform 2 Full Service Partnership Teams (1 in North County, 1 in South County) to IDDT teams in year 1 and establish similar models with its contracted providers in the community.

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d. Mental Health First Aid (MHFA) is an 8-hour course that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training helps participants identify, understand and respond to signs of addictions and mental illnesses. Mental Health First Aid is a research-based approach that provides skills-based training and teaches participants about mental health and substance-use issues. In 2019, we had five individuals from Behavioral Health complete the rigorous application process and get approved for the MHFA Facilitator training.

Child and Adolescent Needs and Strengths Assessment (CANS), and the Adult Needs and Strengths Assessment (ANSA): Santa Cruz County Behavioral Health is invested in providing data supported, evidence based best practice interventions to consumers in a collaborative and comprehensive manner. To this end, we are in the midst of a system wide engagement effort with our CANSA Project. The CANSA project combines the workforce and efforts of both the Child and Adolescent Needs and Strengths Assessment (CANS), and the Adult Needs and Strengths Assessment (ANSA). The CANS and ANSA are tools designed to serve as opportunities for communication and collaboration by engaging consumers in treatment discussions, which focus on identifying strengths and actionable needs. The result is a comprehensive assessment and treatment plan that reflects clients voice and choice. The CANS and ANSA also serve as a foundation for collaboration within the treatment system by facilitating shared knowledge without consumer having to retell their story to each provider. The CANS and ANSA also provide important feedback and data to program managers and administrators to better understand system needs, service delivery, outcomes and trends.

C. County Behavioral Health Services Program Improvement: LEAN Performance Improvement Model. As part of the County's ongoing efforts to improve services and operations within the County operated community mental health center, we are utilizing LEAN as a performance improvement tool to focus on the County's front door Access process- and adopting changes in that process to ensure individuals and families can rapidly access services and treatment, that the process is easy to navigate and supportive of an individual's need for the right level of care at the right time, and that the County has a process that is both effective and efficient.

In 2019, Whole Person Care – Cruz to Health (WPC - C2H) sponsored a Lean Six Sigma Green Belt Training, in alignment with the Process Improvement initiative. The cohort was made up of 23 County employees within Behavioral Health and Health Services and 12 participants from outside partner agencies. All in the cohort are trained in the DMAIC methodology and learn about specific tools to aid in leading process improvement projects. DMAIC (an acronym for Define, Measure, Analyze, Improve and Control) refers to a methodology used for improving, optimizing and stabilizing processes. Like in martial arts, belt levels include white, yellow, green, and black. White belt training provides a basic understanding of LeanSix Sigma concepts. The pilot projects involve improving care coordination across sectors:

Improved Information Sharing for Care Coordination
Improving Care Coordination
Track and Share Whole Person Care-Cruz to Health Outcomes
TeleFriend Onboarding
SSP Linking to Services & Treatment
Improving Whole Person Care-Cruz to Health Referral Process
Client-centered Coordinated CARE to improve engagement, Collaboration, and Treatment

D. IDENTIFICATION OF SHORTAGES IN PERSONNEL

Santa Cruz County has identified the following as hard-to-fill and/or hard-to retain positions:

1. Psychiatrists (adult and child)
2. Bilingual mental health providers (psychiatrist, therapists, case managers)
3. Forensic mental health providers
4. Psychiatric Nurse practitioners
5. Clinical psychologists
6. Highly skilled practitioners treating co-occurring (mental health & substance abuse) disorders
7. Data Processing Programmer Analyst
8. Licensed Clinicians (LCSW, MFT, PhD)

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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 also 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 Medi-Cal, the challenge is staying current with changes and doing new implementation at the same time.

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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 the majority of 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.

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ATTACHMENTS-
MHSA Quarterly and Annual Reports

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COMMUNITY SERVICES AND SUPPORTS (CSS) **Intent**: 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.

CSS Program #1: Community Gate:

- **Purpose**: 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, and family therapy with the goal of improved mental health functioning and maintaining youth in the community.

Agency Reporting	**Encompass**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					150
Number of individuals/families **ACTUALLY SERVED**	195	203	127	192	343
Age Group					
• Children 0-15	146	148	135	145	269
• TAY 16-25	49	55	52	47	74
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	36	2	40	44	69
• Latino	145	146	133	134	248
• Other	14	15	14	14	26
Primary Language					
• English	131	137	131	132	232
• Spanish	64	66	56	60	111
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**PVPSA**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					100
Number of individuals/families **ACTUALLY SERVED**	56	62	52	59	101
Age Group					
• Children 0-15	50	55	46	51	83
• TAY 16-25	6	7	6	6	18
• Adults 26-59					
• Older Adults 60+					

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Race/Ethnicity					
• White	1	0	0	0	1
• Latino	49	57	47	54	94
• Other	6	5	5	5	6
Primary Language					
• English	42	50	43	7	85
• Spanish	11	9	6	49	13
• Other	3	3	3	3	3
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					175
Number of individuals/families **ACTUALLY SERVED**	132	131	145	168	258
Age Group					
• Children 0-15	83	83	73	73	
• TAY 16-25	49	47	71	71	
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	49	44	55	53	
• Latino	71	77	80	80	
• Other	12	10	10	10	
Primary Language					
• English	118	119	128	128	
• Spanish	13	12	17	17	
• Other	1	0	0	0	
Culture					
• Veterans					
• LGBTQ					

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CSS Program #2: Probation Gate

- **Purpose**: To address the mental health needs (including assessment, individual, group, and family therapy) of youth involved with, or at risk of involvement, with the Juvenile Probation system. 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.

Agency Reporting	**PVPSA**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					68
Number of individuals/families **ACTUALLY SERVED**	36	24	16	22	47
• Children 0-15	31	23	15	19	39
• TAY 16-25	5	1	1	3	8
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	0	0	0	1	1
• Latino	21	11	14	19	42
• Other	4	2	2	2	4
Primary Language					
• English	23	15	11	18	34
• Spanish	12	8	4	3	12
• Other	1	1	1	1	1
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Encompass**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					84
Number of individuals/families **ACTUALLY SERVED**	5	6	6	2	8
Age Group					
• Children 0-15	2	2	2	2	3
• TAY 16-25	3	4	4	0	5
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White					
• Latino	5	6	6	2	8
• Other					
Primary Language					
• English	2	2	2	1	4
• Spanish	3	4	4	1	4
• Other					

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Culture					
• Veterans					
• LGBTQ					

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CSS Program #3: Child Welfare Services Gate

- **Purpose**: The Child Welfare Gate goals were designed to address the mental health needs of children/youth in the Child Welfare system.

Agency Reporting	Parent Center				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					30
Number of individuals/families **ACTUALLY SERVED**	3	7	9	7	26
Age Group					
• Children 0-15	3	7	8	7	25
• TAY 16-25	0	0	1	0	1
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	3	1	8	3	
• Latino	0	6	1	4	
• Other					
Primary Language					
• English	3	7	8	5	
• Spanish	0	0	1	2	
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	Encompass ILP				
System Development:	Q!	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					13
Number of individuals/families **ACTUALLY SERVED**	45	47	48	48	59
Age Group					
• Children 0-15					
• TAY 16-25	11	12	12	12	15
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	3	3	4	3	4
• Latino	5	5	6	6	7
• Other	3	4	2	3	4
Primary Language					
• English	10	9	8	9	11
• Spanish	1	3	4	3	4
• Other					

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Culture					
• Veterans					
• LGBTQ	3	3	3	4	4
•					

Agency Reporting	Santa Cruz County Behavioral Health Services				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					200
Number of individuals/families **ACTUALLY SERVED**	84	83	109	129	171
• Children 0-15	58	57	60	71	100
• TAY 16-25	26	26	49	58	71
• 71					
• Older Adults 60+					
Race/Ethnicity					
• White	28	26	36	37	52
• Latino	44	46	55	68	86
• Other	47	48	60	76	99
Primary Language					
• English	72	73	97	115	148
• Spanish	11	10	11	13	20
• Other	1	0	1	1	3
Culture					
• Veterans					
• LGBTQ					

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CSS Program #4: Education Gate

- Purpose: The Education Gate program is designed to create new school-linked screening/assessment and treatment of children/youth suspected of having serious emotional disturbances.

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					38
Number of individuals/families **ACTUALLY SERVED**	20	33	42	39	65
Age Group					
• Children 0-15	12	14	15	12	
• TAY 16-25	8	19	27	27	
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	5	9	7	9	
• Latino	13	22	32	29	
• Other	2	2	3	1	
Primary Language					
• English	19	29	36	30	
• Spanish	1	4	6	9	
• Other					
Culture					
• Veterans					
• LGBTQ					

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CSS Program #5: Special Focus: Family Partnerships

- **Purpose**: 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 support, outreach, education, and services to parent and youth services in our System of Care.

Agency Reporting	**Volunteer Center-Family Partnerships**				
Outreach & Engagement	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					50
Number of individuals/families **ACTUALLY SERVED**	17	30	37	46	57
Age Group					
• Children 0-15	12	20	27	38	41
• TAY 16-25	5	10	10	8	16
• Adults 26-59					
• Older Adults 60+	0	0	0	8	8
Race/Ethnicity					
• White	6	9	10	12	15
• Latino	7	15	19	23	29
• Other	4	6	5	11	13
Primary Language					
• English	13	21	25	32	38
• Spanish	4	9	12	14	19
• Other					
Culture					
• Veterans					
• LGBTQ	5	9	9	9	14

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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.

Agency Reporting	**Encompass: El Dorado Center**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					15
Number Actually Served	13	13	15	7	27
Adults (26-59)					
Number of individuals/families targeted					70
Number Actually Served	28	32	42	42	104
Older Adults (60+)					
Number of individuals/families targeted					15
Number Actually Served:	9	8	6	6	19
Unduplicated Annual Target for all					100
Race/Ethnicity					
• White	33	39	37	33	94
• Latino	11	11	17	14	36
• Other	6	3	9	8	20
Primary Language					
• English	47	48	58	52	138
• Spanish	2	5	5	3	11
• Other	1	0	0	0	1
Culture					
• Veterans					
• LGBTQ					

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Agency Reporting	**Encompass: Telos**				
Outreach and Engagement	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					20
Number of individuals/families **ACTUALLY SERVED**					
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					20
Number Actually Served	11	13	9	9	35

Adults (26-59)					
• Number of individuals/families targeted					65
• Number Actually Served	36	44	52	45	139
• **Older Adults (60+)**					
• Number of individuals/families targeted					15
• Number Actually Served	7	6	10	11	27
Race/Ethnicity					
• White	40	43	48	42	137
• Latino	10	14	8	16	41
• Other	4	6	15	7	23
Primary Language					
• English	51	59	64	59	188
• Spanish	3	3	6	4	10
• Other	0	1	1	2	3
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Santa Cruz County Behavioral Health Services-Access**				
Number of individuals/families **ACTUALLY SERVED**	297	317	298	320	1074
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	45	56	45	46	
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	205	220	223	237	
Older Adults (60+)					
Number of individuals/families targeted					1000
Number Actually Served	46	41	29	37	
Race/Ethnicity					
• White	212	210	198	214	
• Latino	58	80	69	75	
• Other	27	27	31	28	
Primary Language					
• English	275	300	281	298	
• Spanish	14	9	11	12	
• Other	8	8	6	10	

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Culture					
• Veterans					
• LGBTQ					

Agency Reporting	MHCAN @ PHF				
Outreach	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:	25	25	25	25	100
Number of individuals/families **ACTUALLY SERVED**	95	88	91	79	113
Outreach	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	19	18	16	9	
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	48	44	47	54	
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	28	25	28	16	
Race/Ethnicity					
• White	43	56	48	41	
• Latino	27	24	19	15	
• Other	21	20	24	23	
Primary Language					
• English	56	73	62	59	
• Spanish	9	9	2	8	
• Other	0	6	6	12	
Culture					
• Veterans	35	8	9	8	
• LGBTQ	1450	13	18	17	

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

- **Purpose** This plan provides expanded countywide access to culturally competent, recovery-oriented, peer-to-peer, community mentoring, and consumer-operated services.

Agency Reporting	**MHCAN**				
System Development	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:	20	20	20	20	80
Number of individuals/families **ACTUALLY SERVED**	44	132	137	122	216
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted	50	50	50	50	200
Number Actually Served	94	104	111	129	328
Adults (26-59)					
Number of individuals/families targeted	88	87	88	87	350
Number Actually Served	213	241	233	287	1783
Older Adults (60+)					
Number of individuals/families targeted	12	13	12	13	50
Number Actually Served:	116	189	101	303	1039
Race/Ethnicity					
• White	179	179	165	28	287
• Latino	122	122	134	234	234
• Other	80	80	146	198	198
Primary Language					
• English	252	398	340	459	459
• Spanish	67	149	78	89	89
• Other	104	31	27	24	24
Culture					
• Veterans	24	29	28	37	37
• LGBTQ	86	123	132	188	188

Agency Reporting	**Volunteer Center/Community Connection: Mariposa**				
Outreach	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**50**

Number of individuals/families **ACTUALLY SERVED**	27	28	37	47	53
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					8
Number Actually Served	2	2	1	2	5
Adults (26-59)					
Number of individuals/families targeted					25
Number Actually Served	33	26	27	33	52
Older Adults (60+)					
Number of individuals/families targeted					7
Number Actually Served:	9	8	9	9	12
Age Group					
• TAY 16-25	2	2	1	2	5
• Adults 26-59	33	26	27	33	52
• Older Adults 60+	9	8	9	9	12
• Unknown					
Race/Ethnicity					
• White	25	21	23	24	32
• Latino	15	12	11	15	26
• Other	4	3	0	5	11
Primary Language					
• English	38	31	32	37	57
• Spanish	6	5	5	7	12
• Other					
Culture					
• Veterans	1	1	2	4	4
• LGBTQ	1	1	1	2	2

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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 and to be engaged in meaningful work and learning activities. Participants will be enrolled in Full Service Partnership (FSP) Teams. FSP's are "partnerships" between clients and clinicians that include opportunities for clinical care, housing, employment, and 24/7 service availability of staff. County staff in collaboration with community partners (Community Connection, Front Street, and Wheelock) provides the services for this project.

Agency Reporting	**Santa Cruz County Behavioral Health Services MOST**				
Number of individuals/families **ACTUALLY SERVED**	81	85	112	111	147
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	8	10	16	16	
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	70	72	93	90	
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	3	3	2	5	
Unduplicated Annual Target for All					100
Race/Ethnicity					
• White	56	59	74	76	
• Latino	19	20	27	25	
• Other	6	6	11	10	
Primary Language					
• English	76	81	108	106	
• Spanish	4	4	4	5	
• Other	1	0	0	0	
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Santa Cruz County Behavioral Health Services OAS**				
Number of individuals/families **ACTUALLY SERVED**	30	42	53	51	70
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	4	1	0	0	
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	26	41	53	51	
Unduplicated Annual Target for All					60
Race/Ethnicity					
• White	23	36	45	43	
• Latino	5	2	2	2	
• Other	2	4	6	6	
Primary Language					
• English	29	41	51	149	
• Spanish	1	0	0	0	
• Other	0	1	2	2	
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Santa Cruz County Behavioral Health Services-RECOVERY**				
Number of individuals/families **ACTUALLY SERVED**	305	312	312	309	494
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	3	3	3	4	
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	237	237	237	233	
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	64	71	72	72	
Unduplicated Annual Target for All					450
Number Actually Served:					
Race/Ethnicity					
• White	224	224	231	224	
• Latino	53	61	57	60	
• Other	28	27	24	25	
Primary Language					
• English	276	279	287	282	
• Spanish	22	28	22	23	
• Other	7	5	3	4	

Culture					
• Veterans					
• LGBTQ					

Agency Reporting	Front Street: Housing Support				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					15
Number Actually Served					
Adults (26-59)					
Number of individuals/families targeted					60
Number Actually Served					
Older Adults (60+)					
Number of individuals/families targeted					15
Number Actually Served:	23	24	25	22	26
Race/Ethnicity					
• White	78	81	81	74	85
• Latino	9	9	8	9	12
• Other	6	6	7	7	8
Primary Language					
• English	93	96	96	90	105
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ	1	1	2	2	4

Agency Reporting	Front Street: Wheelock				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					2
Number Actually Served	0	0	0	0	0
Adults (26-59)					
Number of individuals/families targeted					12
Number Actually Served	11	11	13	13	14
Older Adults (60+)					

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Number of individuals/families targeted					2
Number Actually Served:	5	6	5	5	6
Race/Ethnicity					
• White	10	11	12	13	14
• Latino	3	3	3	3	3
• Other	5	6	5	5	6
Primary Language					
• English	15	16	17	17	19
• 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					
Number Actually Served					
Adults (26-59)					
Number of individuals/families targeted					23
Number Actually Served	21	22	21	22	23
Older Adults (60+)					
Number of individuals/families targeted					22
Number Actually Served:	20	20	20	20	22
Race/Ethnicity					
• White	28	29	28	30	32
• Latino	5	5	5	4	5
• Other	8	8	8	8	8
Primary Language					
• English	1	42	41	40	42
• Spanish	0	0	0	2	3
• Other	0	0	0	0	0
Culture					
• Veterans	0	0	0	0	0
• LGBTQ	1	1	1	2	2
•					

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Agency Reporting	**Front Street: Housing Property Management**				
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	50	50	52	58	65
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:					
Race/Ethnicity					
• White					
• Latino					
• Other	50	50	52	58	65
Primary Language					
• English	48	48	50	56	63
• Spanish	2	2	2	2	2
• Unknown					
Culture					
• Veterans					
• LGBTQ					

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	2	2	2	2	2
Adults (26-59)					
Number of individuals/families targeted					12
Number Actually Served	11	11	10	10	18
Older Adults (60+)					
Number of individuals/families targeted					1
Number Actually Served:	3	3	3	3	3
Race/Ethnicity					
• White	14	13	13	13	20
• Latino	1	2	1	1	2
• Other	1	1	1	1	1
Primary Language					
• English	16	16	15	15	23
• Spanish					
• Other					
Culture					
• Veterans					

• LGBTQ					

Agency Reporting	Encompass: Supported Housing				
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					60
Number Actually Served	24	23	25	27	28
Older Adults (60+)					
Number of individuals/families targeted					0
Number Actually Served:	11	11	10	14	14
Race/Ethnicity					
• White	29	29	29	34	34
• Latino	2	1	3	3	3
• Other/Unknown	4	4	4	4	5
Primary Language					
• English	33	34	34	40	40
• Spanish	1	0	1	1	1
• Other	1	0	0	0	1
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					10
Number Actually Served	1	0	0	0	1
Adults (26-59)					
Number of individuals/families targeted					35
Number Actually Served	15	10	15	15	21
Older Adults (60+)					
Number of individuals/families targeted					5
Number Actually Served:	2	2	2	1	2

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Race/Ethnicity					
• White	13	10	14	13	18
• Latino	3	2	2	2	5
• Other	2	0	1	1	2
Primary Language					
• English	16	12	16	15	22
• Spanish	2	0	0	0	2
• Other	0	0	1	1	1
Culture					
• Veterans	1	1	1	0	1
• LGBTQ	1	1	0	3	3

Agency Reporting	Community Connection: College Connection				
Outreach	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted					25
Number Actually Served	28	26	23	21	37

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Agency Reporting	Community Connection: Opportunity Connection				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					10
Number Actually Served	3	3	4	2	6
Adults (26-59)					
Number of individuals/families targeted					45
Number Actually Served	27	32	31	28	55
Older Adults (60+)					
Number of individuals/families targeted					5
Number Actually Served	6	10	11	10	14
Race/Ethnicity					
• White	27	35	35	29	53
• Latino	2	4	4	3	8
• Other	7	6	3	8	14
Primary Language					
• English	35	44	46	39	72
• Spanish	1	1	0	0	1
• Other	0	0	0	1	1
Culture					
• Veterans	1	0	0	0	1
• LGBTQ	5	10	0	6	10

Agency Reporting	Community Connection: Avenues Employment Services				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					25
Number Actually Served	6	9	7	9	12
Adults (26-59)					
Number of individuals/families targeted					10
Number Actually Served	31	22	15	12	44
Older Adults (60+)					
Number of individuals/families targeted					10
Number Actually Served					0
Race/Ethnicity					
• White	20	12	8	6	26
• Latino	7	8	7	5	10
• Other	10	11	0	10	18
Primary Language					
• English	34	27	18	18	14
• Spanish	3	4	4	3	2
• Other	0	0	0	0	0
Culture					
• Veterans	3	2	2	1	3
• LGBTQ	3	2	0	4	6

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Agency Reporting	**Encompass: River Street Shelter**				
Outreach and Engagement	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					125
Number of individuals/families **ACTUALLY SERVED**	34	19	25	26	75
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					5
Number Actually Served	4	4	5	5	11
Adults (26-59)					
Number of individuals/families targeted					80
Number Actually Served	36	40	44	47	120
Older Adults (60+)					
Number of individuals/families targeted					15
Number Actually Served:	12	8	5	5	22
Unduplicated Target for all					150

• Children 0-15					
• TAY 16-25	4	4	5	5	11
• Adults 26-59	36	40	44	47	120
• Older Adults 60+	12	8	5	5	22
Race/Ethnicity					
• White	34	32	34	33	96
• Latino	10	5	6	8	18
• Other	8	15	14	16	39
Primary Language					
• English					
• Spanish					
• Other					
Culture					
• Veterans	2	2	2	4	8
• LGBTQ					

Agency Reporting	**Encompass: Casa Pacific**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					6
Number Actually Served	4	3	5	6	10
Adults (26-59)					
Number of individuals/families targeted					28
Number Actually Served	22	21	20	16	49
Older Adults (60+)					
Number of individuals/families targeted					6
Number Actually Served	0	1	1	2	2
Race/Ethnicity					
• White	20	15	16	15	40
• Latino	6	9	10	9	20
• Other	0	1	0	0	1
Primary Language					
• English	24	21	23	22	56
• Spanish	2	4	3	2	5
• Other					
Culture					
• Veterans					
• LGBTQ					

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PREVENTION & EARLY INTERVENTION (PEI)

Intent: To engage persons prior to the development of serious mental illness or serious emotional disturbances, or in the case of early intervention, to alleviate the need for additional mental health treatment and/or to transition to extended mental health treatment.

Agency Reporting-		Santa Cruz County Behavioral Health Services			
EARLY INTERVENTION		0-5 Screening			
July 1, 2018 to June 30, 2019	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	24	26	23	17	44

Agency Reporting: Triple P
PREVENTION

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Unduplicated Client Count	88	95	115	96
Age:				
0-15				
16-25	10	15	18	13
26-59	75	79	95	79
60 +	3	1	2	4
Declined to answer				
Language:				
English	49	67	69	68
Spanish	36	28	46	28
Other	3			
Race:				
American Indian or Alaskan Native			2	3
Black	1	1	1	1
White	82	89	106	86
Asian		1	1	1
Native Hawaiian or Other Pacific Islander			1	
Declined to answer		1	1	3
Other				
More than one	5	3	3	2
Ethnicity				
Hipanic or Latino	61	61	78	61
Not Hispanic or Latino	27	33	35	32
Declined to answer		1	2	3
Other				

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	Quarter 1	Quarter 2	Quarter 3	Quarter
Veteran				
Yes	1		1	2
No	78	82	106	91
Declined to State	2	3	1	
Unknown*	7	10	7	3
Sexual Orientation				
Gay or Lesbian			2	
Heterosexual or Straight	67	69	81	78
Bisexual	1	1		
Queer	1	1	1	
Another Sexual Orientation				2
Declined to answer	12	14	24	13
Unknown*	7	10	7	3
Gender Assigned at birth				
Male	29	28	38	30
Female	52	57	70	63
Declined to amswer				
Unknown*	7	10	7	3
Current Gender Identity				
Male	31	30	39	31
Female	56	64	75	65
Transgender				
Gender Queer	1	1	1	
Questioning or Unsure				
Another gender idenity				
Declined to answer				
Other Relevant Data				
Parents in brief Level 2 Individual services *(unique within L2 Individual services, but may duplicate Intensive Service clients in this report)*	25	40	35	103
Parents in brief Seminars & Workshops *(may include duplicates, and may also duplicate Intensive Service clients in this report)*	Seminars: 27 Workshops: 55 **Total: 82**	Seminars: 174 Workshops: 246 **Total: 420**	Seminars: 50 Workshops: 227 Inmate *(unique)*: 82 **Total: 359**	Seminars: Workshops Inmate *(unic* 78 **Total: 14**
Children of parents receiving intensive services *(unduplicated)*	151	158	186	172
Children of parents in brief services (L2 Individual, Seminars, Workshops) *(may include duplicates)*	L2 Indiv: 47 Seminars***: 91 Workshops***: 127 **Total: 265**	L2 Indiv: 73 Seminars***: 387 Workshops***: 434 **Total: 894**	L2 Indiv: 58 Seminars: 92 Workshops: 440 Inmate *(unique)*: 144 **Total: 734**	L2 Indiv: 1 Seminars: Workshops: Inmate *(unic* 139 **Total: 43**

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Agency Reporting: Live Oak Family Resource Center (COE)
Prevention

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	62	90	79	57	174
Age:					
0-15	0	3	1	0	4
16-25	1	5	4	2	9
26-59	48	58	55	49	123
60 +	13	24	19	14	38
Declined to answer	0	0	0	0	0
Language:					
English	20	24	19	16	44
Spanish	41	65	53	41	129
Other	1	1	0	0	1
Race:					
American Indian or Alaskan Native	0	0	0	1	1
Black	0	2	2	0	2
White	15	19	16	17	40
Asian	3	2	2	2	3
Native Hawaiian or Other Pacific Islander	0	0	0	0	0
Declined to answer	0	0	0	0	0
Other	44	67	59	38	128
Ethnicity					
Hipanic or Latino	44	67	63	42	138
Not hispanic or Latino	18	23	16	15	36
Declined to answer	0	0	0	0	0
Other	0	0	0	0	0
Veteran					
Yes	0	0	0	0	0
No	30	39	39	28	77
Declined to State	32	51	40	29	97
Sexual Orientation					
Gay or Lesbian	1	0	0	0	1
Heterosexual or Straight	23	32	33	24	67
Bisexual	0	0	0	0	0
Queer	0	0	0	0	0
Another Sexual Orientation	0	0	0	0	0
Declined to answer	38	58	46	33	106
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	52	22	18	8	44
Female	10	68	61	49	130
Declined to amswer	0	0	0	0	0
Current Gender Identity					
Male	52	22	18	8	44
Female	10	68	61	49	130
Transgendergender	0	0	0	0	0
Gemderqueer	0	0	0	0	0
Questioning or Unsure	0	0	0	0	0
Another gender idenity	0	0	0	0	0
Declined to answer	0	0	0	0	0

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Agency Reporting: The Diversity Center (COE)
Prevention

	Q1: July, Aug, Sept	Q2: Oct, Nov, Dec	Q3:Jan, Feb, March	Q4: April, May, Jun
Unduplicated Client Count	1282	886	258	2072
Age:				
0-15	484	593	67	334
16-25	787	278	188	1653
26-59	11	14	3	45
60 +	-	1	-	27
Declined to answer	-	-	-	13
Language:				
English	972	651	181	1213
Spanish	303	235	77	798
Other	7	-	-	61
Race:				
American Indian or Alaskan Native	6	21	4	69
Black	19	32	6	59
White	1204	641	220	1422
Asian	20	19	10	50
Native Hawaiian or Other Pacific Islander	24	-	-	-
Declined to answer	9	39	18	299
Other	-	134	-	173
Ethnicity				
Hispanic or Latino	686	475	85	992
Not hispanic or Latino	560	315	161	394
Declined to answer	10	44	12	458
Other	26	52	-	228
Veteran				
Yes	N/A	N/A	N/A	N/A
No	N/A	N/A	N/A	N/A
Declined to State	N/A	N/A	N/A	N/A
Sexual Orientation				
Gay or Lesbian	80	79	29	194
Heterosexual or Straight	814	611	167	1654
Bisexual	103	32	33	128
Queer	149	49	-	69
Another Sexual Orientation	93	73	12	27
Declined to answer	43	42	17	-
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Male				
Female				
Declined to answer	1282			
Current Gender Identity				
Male	464	317	80	870
Female	623	498	149	1051

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Transgender	67	40	12	18
Genderqueer	66	10	5	21
Questioning or Unsure	31	2	3	22
Another gender identity	19	13	3	58
Declined to answer	12	6	6	32

Agency Reporting: PBIS (COE)
Prevention

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count				28137	
Age:					
0-15				25262	
16-25				2875	
26-59					
60 +					
Declined to answer					
Language:					
English				18141	
Spanish				9597	
Other				399	
Race:					
American Indian or Alaskan Native				73	
Black				154	
White				7992	
Asian					
Native Hawaiian or Other Pacific Islander					
Declined to answer				19742	
Other				176	
Ethnicity					
Hipanic or Latino				18487	
Not hispanic or Latino					
Declined to answer				9650	
Other					
Veteran					
Yes					
No					
Declined to State				28137	
Sexual Orientation					
Gay or Lesbian					
Heterosexual or Straight					
Bisexual					
Queer					

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Another Sexual Orientation					
Declined to answer				28137	
Gender Assigned at birth	Quarter 1	Quarter 2		Quarter 2	Annual
Male				14394	
Female				13743	
Declined to amswer					
Current Gender Identity					
Male					
Female					
Transgendergender					
Gemderqueer					
Questioning or Unsure					
Another gender idenity					
Declined to answer				28137	

Agency Reporting: Trauma Informed Systems Prevention

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	Training (T): 126	Training (T): 124 Training=104 ECE=20	Training (T): 120 Training=114, LLC=1 ECE=5	Training (T): 63 Training=62, ECE=1	Training (T)= 433
Age:					
0-15	0	0	0	0	0
16-25	12	4	6	11	33
26-59	66	68	80	40	254
60 +	7	4	5	8	24
Declined to answer	41	48	29	4	122
Language:					
English	56	46	73	35	210
English/Spanish	41	2	16	23	82
Spanish	3	27	0	2	32
Missig Info	24	48	24	3	99
Other	2	1	7	0	10
Race:					
American Indian or Alaskan Native	0	3	0	2	5
Black	1	0	0	1	2
White	40	52	63	16	171
Other	25	11	10	19	65
More than one	4	2	9	5	20
Declined to answer	56	56	38	20	170

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Ethnicity					
Hipanic or Latino	46	17	12	36	111
African	0	0	0	1	1
Asian Indian/South Asian	5	2	0	0	7
Filipino	0	0	1	0	1
Other	17	33	41	13	104
More than one	6	9	8	2	25
Declined to state	52	63	58	11	184
Veteran					
Yes					
No					
Declined to State	126	124	120	63	433
Sexual Orientation					
Gay or Lesbian					
Heterosexual or Straight					
Bisexual					
Queer					
Another Sexual Orientation					
Declined to answer	126	124	120	63	433
Gender Assigned at birth	Quarter 1	Quarter 2		Quarter 2	Annual
Male					
Female					
Declined to amswer	126	12	120	63	433
Current Gender Identity					
Male	13	15	28	13	69
Female	82	62	67	46	257
Transgendergender					
Gemderqueer					
Questioning or Unsure					
Another gender idenity					
Declined to answer	31	47	23	4	105

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Agency Reporting		NAMI			
STIGMA & DISCRIMINATION REDUCTION					
July 1, 2018 to June 30, 2019	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)					3134

*NO ANNUAL DEMOGRAPHIC REPORTING REQUIREMENTS ON SUICIDE PREVENTION AND STIGMA REDUCTION

Agency Reporting		MHCAN-Shadow Speakers			
STIGMA & DISCRIMINATION REDUCTION					
July 1, 2018 to June 30, 2019	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	95	88	91	79	113

*NO ANNUAL DEMOGRAPHIC REPORTING REQUIREMENTS ON SUICIDE PREVENTION AND STIGMA REDUCTION

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Agency Reporting: Employment (Community Connection)
Early Intervention Program

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	25	25	30	35	49
Age:					
0-15	0	0	0	0	0
16-25	22	23	26	30	42
26-59	3	2	4	5	7
60 +	0	0	0	0	0
Language:					
English	24	24	29	33	46
Spanish	1	1	1	1	2
Other	0	0	0	1	1
Race:					
American Indian	0	0	0	0	0
Black	0	1	2	0	2
White	13	12	16	18	25
Other	0	3	2	0	3
More than one	0	0	0	0	0
Declined to State	0	0	0	0	0
Ethnicity					
Latino	6	8	8	10	12
African	0	0	2	2	2
Asian Indian/South Asian	0	0	1	2	2
Filipino	0	0	0	0	0
Other	0	0	2	2	2
More than One	0	0	0	0	0
Declined to State	0	1	0	1	1
Veteran					
Yes	0	1	2	1	2
No	25	24	0	34	47
Declined to State	0	0	0	0	0
Sexual Orientation					
Gay or Lesbian	0	0	0	0	0
Heterosexual or Straight	14	15	17	16	25
Questioning or Unsure	3	4	3	3	4
Queer	0	0	1	1	1
Another Sexual Orientation	6	6	8	7	10
Declined to State	2		2	8	9
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	15	13	14	14	23
Female	10	12	15	14	18
Declined to State	0	0	1	7	7

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Current Gender Identity					
Male	13	11	13	14	22
Female	8	11	12	13	16
Transgender Male	1	0	0	0	0
Transgender Female	0	0	0	0	0
Gender Queer	0	0	1	2	2
Questioning or Unsure	2	2	2	1	3
Declined to State	1	1	1	5	6
Write in Option	0	0	0	0	0
Disability					
Yes:					
• Communication Domain	0	0	0	0	0
Difficulty Seeing	0	0	0	0	0
Difficulty Hearing	0	0	0	0	0
Difficulty Having Speech Understood	0	0	0	0	0
• Mental Domain	0	0	4	4	4
(mental illness, learning disability, developmental disability, dementia)	25	21	8	5	25
• Physical/mobility	0	0	1	1	1
• Chronic health condition	0	0			0
• Other (Specify)	0	4	2	2	4
No	0	0	23	23	23
Declined to State	0	0	0	0	0
Other Relevant Data					

Work Plan #3: Veterans Advocate Prevention

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	63	65	61	61	250
Age:					
0-15	0	0	0	0	0
16-25	3	0	1	2	6
26-59	25	25	27	20	97
60 +	35	40	33	39	147
Language:					
English	63	65	61	61	250
Spanish	0	4	3	2	9
Other	0	0	0	0	0
Race:					
American Indian	1	1	0	0	2
Black	2	4	5	2	13

White	53	43	51	52	199
Other	5	9	3	3	20
More than one	0	2	0	0	2
Declined to State	2	0	2	4	8
Ethnicity					
Latino	8	4	3	3	18
African	2	4	4	2	12
Asian Indian/South Asian	1	4	0	0	5
Filipino	0	0	0	0	0
Other	50	53	52	52	207
More than One	0	0	0	0	0
Declined to State	2	2	2	4	10
Veteran					
Yes	60	63	60	59	242
No	3	2	1	2	8
Declined to State	0	0	0	0	0
Sexual Orientation					
Gay or Lesbian	0	1	0	1	2
Heterosexual or Straight	49	50	44	47	190
Questioning or Unsure	0	0	0	0	0
Queer	0	1	0	0	1
Another Sexual Orientation	0	0	0	0	0
Declined to State	14	13	17	13	57
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	55	57	56	55	223
Female	7	8	4	6	25
Declined to State	1	0	1	0	2
Current Gender Identity					
Male	55	57	56	55	223
Female	7	7	4	6	24
Transgender Male	0	0	0	0	0
Transgender Female	0	0	0	0	0
Gemder Queer	0	0	0	0	0
Questioning or Unsure	0	0	0	0	0
Declined to State	1	0	1	0	2
Write in Option	0	0	0	0	0
Disability					
Yes:					
• Communication Domain					
Difficulty Seeing	2	1	5	2	10
Difficulty Hearing	4	5	9	11	29
Difficulty Having Speech Understood	1	0	1	0	2

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• Mental Domain					
(mental illness, learning disability, developmental disability, dementia)	32	36	35	31	134
• Physical/mobility	13	13	19	24	69
• Chronic health condition	13	20	11	9	53
• Other (Specify)					
No	7	10	6	5	28
Declined to State	4	8	5	3	20
Other Relevant Data					

Agency Reporting	Santa Cruz County Behavioral Health Services				
EARLY INTERVENTION	Services for Transition Age Youth and Adult				
July 1, 2018 to June 30, 2019	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	69	69	78	75	113
Age Group					
• Children 0-15					
• TAY 16-25	59	58	57	54	
• Adults 26-59	10	11	20	21	
• Older Adults 60+			1		
Race/Ethnicity					
• White	29	25	35	31	
• Latino	34	39	38	39	
• Other	6	5	5	5	
Primary Language					
• English	61	61	68	66	
• Spanish	8	8	10	9	
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	Santa Cruz County Behavioral Health Services				
ACCESS AND LINKAGE TO TREATMENT	MERT				
July 1, 2018 to June 30, 2019	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	70	97	85	70	291
Age Group					
• Children 0-15	15	37	36	20	
• TAY 16-25	16	21	20	18	
• Adults 26-59	29	30	23	24	
• Older Adults 60+	10	9	6	8	

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Race/Ethnicity					
• White	51	59	46	30	
• Latino	11	17	24	18	
• Other	8	21	15	22	
Primary Language					
• English	63	59	72	56	
• Spanish	5	5	11	10	
• Other	2	3	2	4	
Culture					
• Veterans					
• LGBTQ					

Agency Reporting: Senior Outreach (FSA)
Outreach and Increasing Early Signs of Mental Illness Program

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	10	16	18	14	25
Age:					
0-15					
16-25					
26-59	1	2	1	1	2
60 +	9	14	17	13	23
Declined to answer					
Language:					
English	9	13	17	13	22
Spanish		3	1	1	3
Other					
Race:					
American Indian or Alaskan Native		1	1		1
Black	1	1	1	1	1
White	5	11	12	8	15
Asian		1	1	1	1
Native Hawaiian or Other Pacific Islander					
Declined to answer	4	2	3	4	7
Other					
Ethnicity					
Hipanic or Latino		3	1	1	3
Not hispanic or Latino	1	1	2	1	2
Declined to answer	3	6	6	5	9
Other	5	6	9	7	11
Veteran					
Yes					
No	10	16	18	14	25
Declined to State					
Sexual Orientation					

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Gay or Lesbian					
Heterosexual or Straight			1		1
Bisexual					
Queer					
Another Sexual Orientation					
Declined to answer	10	16	17	14	24
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male				1	1
Female	16	16	18	13	24
Declined to amswer					
Current Gender Identity					
Male					
Female	3	3	5	3	5
Transgendergender					
Gemderqueer					
Questioning or Unsure					
Another gender idenity					
Declined to answer	7	13	13	11	20

Agency Reporting		Senior Council			
PREVENTION					
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	10	14	15	15	54
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59					
• Older Adults 60+	10	14	15	15	54
Race/Ethnicity					
• White	10	12	13	13	48
• Latino		1	1	1	3
• Other		1	1	1	3
Primary Language					
• English	10	12	13	13	48
• Spanish		1	1	1	3
• Other		1	1	1	3
Culture					
• Veterans	1	1	2	2	6
• LGBTQ					

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FY 2019-20 Mental Health Services Act Annual Update Expenditure Plan

Community Services and Supports (CSS) Component Worksheet

County: Santa Cruz 01/07/2020

	Fiscal Year 2019/20			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated Other Funding
FSP Programs				
1. Community Gate	0			
2. Probation Gate	0			
3. Child Welfare Gate	0			
4. Education Gate	0			
5. Family Partnerships	0			
6. Enhanced Crisis Response	1,369,121	517,718	610,917	240,486
7. Consumer, Peer, and Family Services	463,196	358,70	104,487	0
8. Community Support Services	7,298,305	4,829,626	2,432,231	36,448
9.	0			
10.	0			
Non-FSP Programs				
1. Community Gate	2,083,298	1,121,213	809,617	152,468
2. Probation Gate	238,440	119,220	119,220	0
3. Child Welfare Gate	1,303,894	402,476	623,500	277,918
4. Education Gate	350,409	162,069	146,763	41,577

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5.	Family Partnerships	10,452	10,452	0	0
6.	Enhanced Crisis Response	1,529,174	833,599	614,018	81,557
7.	Consumer, Peer, and Family Services	25,300	25,300	0	0
8.	Community Support Services	2,336,697	1,647,891	410,494	278,312
9.		0			
10.		0			
11.		0			
12.		0			
13.		0			
14.		0			
15.		0			
16.		0			
17.		0			
18.		0			
19.		0			
CSS Administration		1,251,116	898,379	352,737	0
CSS MHSA Housing Program Assigned Funds		0	0	0	0
Community Planning Process		14,400	14,400	0	0
Total CSS Program Estimated Expenditures		18,273,802	10,941,052	6,223,983	1,108,766
FSP Programs as Percent of Total		83.5%			

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FY 2019-20 Mental Health Services Act Annual Update Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Cruz

Date: 01/07/2020

	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				
1. Access & Linkage	1,778,943	1,522,460	256,483	0
2. Early Intervention	2,033,443	1,207,729	746,367	79,347
3. Outreach	5,000	5,000	0	0
4. Prevention	444,569	391,418	53,151	0
5. Stigma & Discrimination Reduction	122,309	122,309	0	0
6. Suicide Prevention	202,442	202,442	0	0
7.	0			
8.	0			
9.	0			
10.	0			
PEI Administration	694,886	524,140	170,746	0
PEI Assigned Funds	0	0	0	0
Total PEI Program Estimated Expenditures	5,281,592	3,975,498	1,226,747	79,347

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FY 2019-20 Mental Health Services Act Annual Update Expenditure Plan

Innovations (INN) Component Worksheet

County: Santa Cruz | 01/07/2020

	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 & Supported Housing	1,955,932	781,070	374,851	800,011
INN Administration	117,161	117,161		
Total INN Program Estimated Expenditures	2,073,093	898,231	374,851	800,011

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FY 2019-20 Mental Health Services Act Annual Update Expenditure Plan

Funding Summary

County: Santa Cruz

Date: 01/07/2020

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,587,243	3,533,289	390,533	0	0	
2. Estimated New FY2018/19 Funding	11,095,148	2,773,787	729,944			
3. Transfer in FY2019/20[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY2019/20	297,997	92,192	0			(390,189)
5. Estimated Available Funding for FY2019/20	13,980,388	6,399,268	1,120,477	0	0	
B. Estimated FY2018/19 Expenditures	10,941,052	3,975,498	898,231	**0**	**0**	
C. Estimated Unspent Fund Balance	3,039,336	2,423,771	222,246	0	0	

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

FY 2019-20 Mental Health Services Act Annual Update Expenditure Plan

2017-18 to 2019-20 Funding Summary

County: Santa Cruz

Date: 01/07/2020

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	631,370	3,920,422	744,053	16,233	98,137	
2. Estimated New FY2017/18 Funding	11,060,865	2,765,216	727,688			
3. Transfer in FY2017/18[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY2017/18	0	0				0
5. Estimated Available Funding for FY2017/18	11,692,235	6,685,640	1,471,741	16,233	98,137	
B. Estimated FY2017/18 MHSA Expenditures	9,824,242	2,540,655	634,761	16,233	98,137	
C. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,867,993	4,144,985	836,980	0	0	
2. Estimated New FY2018/19 Funding	10,888,228	2,722,057	716,331			
3. Transfer in FY2018/19[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY2018/19	0	0				0
5. Estimated Available Funding for FY2018/19	12,756,221	6,867,042	1,553,311	0	0	

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D. Estimated FY2018/19 Expenditures	10,168,977	3,333,753	1,162,778	**0**	**0**	
E. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,587,243	3,533,289	390,533	0	0	
2. Estimated New FY2019/20 Funding	11,095,148	2,733,787	729,944			
3. Transfer in FY2019/20[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY2019/20	297,997	92,192				(390,189)
5. Estimated Available Funding for FY2019/20	13,980,388	6,399,268	1,120,477	0	0	
F. Estimated FY2019/20 Expenditures	10,941,052	3,975,494	898,231	**0**	**0**	
G. Estimated FY2019/20 Unspent Fund Balance	3,039,336	2,423,770	222,246	**0**	**0**	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	3,387,556.00
2. Contributions to the Local Prudent Reserve in FY 2019/20	0
3. Distributions from the Local Prudent Reserve in FY 2019/20	(390,189.00)
4. Estimated Local Prudent Reserve Balance on June 30, 2020	2,997,367.00
5.Interest Earned from the Local Prudent Reserve through June 30, 2018	151,149.88

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

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