BEHAVIORAL HEALTH
HEALTH SERVICES AGENCY

County of Santa Cruz
Mental Health Services Act (MHSA)
FY 2025-26 Annual Update

Draft for Public Comment
May 15, 2025

This report was developed by RDA Consulting under contract with Santa Cruz County Behavioral Health Division

RDA Consulting, 2025

About RDA Consulting
RDA Consulting (RDA) is a mission-driven, employee-owned, majority women-managed social purpose corporation. RDA is based out of Oakland, CA and operates across the United States. RDA works to help public and social sector organizations to best meet the needs of our communities and to improve equity, access, and opportunity.

Message from the Mental Health Services Act Coordinator

The Santa Cruz Behavioral Health Division (SCCBHD) has completed the FY 2025-26 Annual Update 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 year 2025-2026. This is the last year of our 2023-2025 MHSA Three-Year Plan, and the last year of working together with the community to Plan and fund services under Proposition 63 – Mental Health Services Act. In just a few months, we will embark on a new Community Program Planning Process (CPP) to collaborate on our next Three-Year Plan spanning 2026-2029, our first under Proposition 1 – Behavioral Health Services Act. The regulations for both process and content have changed significantly under Proposition 1, and instead of focusing on services funded under BHSA, which comprises between a quarter and a third of our Behavioral Health Division budget, we will work together to determine needs, gaps, strengths, and supports for our entire continuum of care and the community we serve, regardless of funding stream. This will be new to all of us, and we will learn together.

In general, tax revenue is largely volatile, meaning that our distribution can vary significantly year over year. In addition, tax revenues are generally limited to supporting specific services, and the service mix under BHSA is changing significantly, although there are no new or additional dollars to support services that we may lose in the shift. A comparison of funding categories comparing MHSA to BHSA can be found in the table below:

Current MHSA Allocation	Current % of Santa Cruz County Distribution	Future BHSA Allocation	Future % of Santa Cruz County Distribution
County Allocation	95%	County Allocation	90%
Community Support Services (CSS)	76%	Behavioral Health Support Services (BHSS), includes Early Intervention (EI)	35%
Prevention and Early Intervention (PEI)	19%	Full-Service Partnerships (FSP)	35%
Innovation Project (INN)	5%	Housing Subsidies and Support	30%
State Directed Allocation	5%	State Directed Allocation	10%
Administration	5%	Population-based Prevention	4%
		Workforce	3%
		Administration	3%

For the final Annual Update under the 2023-2026 Three-Year Plan, a draft plan was posted for public comment from May 15, 2025, to June 18, 2025. A Public Hearing was held during the Mental Health Advisory Board meeting on May 15, 2025, at 3pm during their regular session. The Public Hearing was held in-person and virtually.

Following Public Hearing, the Plan was submitted for review and approval to the Santa Cruz County Board of Supervisors for adoption, and then to the Commission for Behavioral Health and the State Department of Health Care Services.

Community members were able to review the plan and provide comments in the following ways during the public comment period:

- At the Public Hearing on May 15, 2025
- By internet: santacruzhealth.org/MHSA
- By email to: MentalHealth.ServicesAct@santacruzcountyca.gov
- By writing to:
  Santa Cruz County Behavioral Health
  Attention: MHSA Coordinator
  1400 Emeline Avenue, Building K, Santa Cruz, CA 95060

This Plan is not intended as a binding contract with any entity or provider of services. Services will be monitored on a continual basis, and the County may make changes, as necessary. These changes would be presented in the required Annual Update plans during the next year.

Sincerely,

Karen Kern, MPA
Deputy Director, County of Santa Cruz Behavioral Health Division
Mental Health Services Act Coordinator

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MHSA County Compliance Certification

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MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Cruz

☐ Three-Year Program and Expenditure Plan
☒ Annual Update

County Behavioral Health Director(acting)	**Program Lead**
Name: Karen Kern Telephone Number: 831-454-5244 Email: Karen.Kern@santacruzcountyca.gov	Name: Karen Kern Telephone Number: 831-454-5244 Email: Karen.Kern@santacruzcountyca.gov
County Behavioral Health Mailing Address: Santa Cruz Behavioral Health Division 1400 Emeline Avenue Santa Cruz, CA 95060	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the county/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and non-supplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The Annual Update and expenditure plan, attached hereto, was adopted by the county Board of Supervisors on February 11, 2025.

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

___ Karen Kern
Mental Health Director/Designee (PRINT)

[X]

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karen kern
Signature
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Date 5/8/2025

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MHSA County Fiscal Accountability Certification

Santa Cruz County Overview

The County of Santa Cruz

Santa Cruz County is located at the northern tip of Monterey Bay, approximately 65 miles south of San Francisco, 35 miles north of Monterey, and 35 miles southwest of Silicon Valley. Santa Cruz County has a population of 270,861.

Its natural beauty is present in the pristine beaches, lush redwood forests, and rich farmland. It has an ideal Mediterranean climate with low humidity and sunshine 300 days a year. There are four incorporated cities in the County.[1] The largest is the City of Santa Cruz, with a population of 61,950. Watsonville has a population of 52,067 (notably, 84.3% of Watsonville City community members identify as Hispanic/Latinx), Scotts Valley has 12,232 residents, and Capitola has 9,846 residents. Spanish is the only threshold language in Santa Cruz County.

There is a diversity of community members within the County; 56% identify as White/Caucasian, 34% Hispanic, 5% Asian, 4% Multiracial, 2% Native American, and 2% Black. Additionally, 18% of community members are foreign-born, 19.8% of residents are 65 years of age or older, and 18% of residents are under the age of 18. As of 2020, the County had a median income of $105,631, with a 13% poverty rate. 60.1% of Santa Cruz County residents own their home, and 50.8% of homes have a value of $1 million or more.

The County of Santa Cruz Behavioral Health Division

The Santa Cruz County Behavioral Health Division (SCCBHD) is situated within the Health Services Agency, along with Health Centers, Environmental Health, and Public Health, for Santa Cruz County Government. SCCBHD provides a wide range of prevention and treatment services for adults, children, and families across the County.

SCCBHD develops the Mental Health Services Act (MHSA) three-year plan and annual updates and provides program implementation and oversight. MHSA services are designed to address the most significant behavioral health needs of the county and to ensure services and access for all residents, with an emphasis and priority focus on serving individuals at highest risk for experiencing behavioral health service gaps and access

[1] County of Santa Cruz, About Santa Cruz County. https://www.santacruzcountyca.gov/AboutUs.aspx

barriers. This includes individuals who are experiencing homelessness, individuals that do not speak English as their primary language, community members of color, and low-income community members living in Santa Cruz County.

Project Overview

MHSA Background

The Mental Health Services Act (Proposition 63) was approved by California voters in 2004 to expand and transform the public mental health system. On November 5, 2024, Californians voted in Proposition 1, which will amend the current MHSA rules and update spending and service categories under the Behavioral Health Services Act (BHSA) beginning with the 2026-2029 Three-year Planning Process. The MHSA requires that every three years, the entities that receive funding under MHSA must submit a plan that details the programs that will be administered using those funds. In addition to program details, entities are required to include budget projections as well as program updates with outcome measurement reports from the previous service year.

Three components of the MHSA focus on direct services:

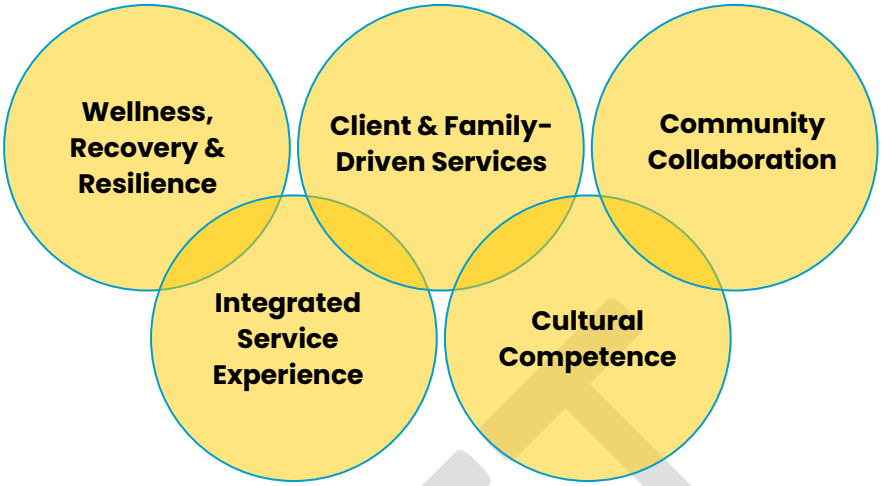
- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI); and
- Innovative Programs (INN).

The remaining two components focus on infrastructure and human resources:

- Workforce Education and Training (WET)
- Capital Facilities and Technology Needs (CFTN)

The MHSA represents a statewide movement to provide a better-coordinated and comprehensive system of care for those with serious mental illness (SMI) and to define an approach to the planning and the delivery of mental health services that are embedded in the MHSA values (Figure 1).

Figure 1. MHSA Core Values



MHSA planning and programming is funded through a 1% tax on individual annual incomes at or exceeding one million dollars.

Annual Update Plan Contents

The MHSA Annual Program and Expenditure Plan for FY 2025-2026 outlines Santa Cruz County's proposed programs and strategies to address mental health service gaps and better meet identified community needs. The purpose of the annual update is providing an opportunity for ongoing community engagement and timely identification of behavioral health needs within the County. This annual update Plan includes program status updates and accomplishments in FY 2023-2024 as well as program plans beginning in FY 2025-2026. These plans are based upon a community needs assessment and stakeholder input provided during a Community Program Planning Process (CPPP).

SCCBHD contracted with RDA Consulting (RDA) to facilitate CPPP activities and summarize information for this plan.

The Annual Update Plan includes the following sections:

- **Overview of the community program planning process** that took place in Santa Cruz County between October 2024 and April 2025.
- **Sharing of behavioral health needs identified through the CPPP** that identifies strengths, challenges, gaps, and opportunities to improve the public behavioral health service system in Santa Cruz County.
- **Description of Santa Cruz County's MHSA programs** by component, which includes an explanation of each program, its target population, the behavioral health needs it addresses, and the goals and objectives of the program. This section of the plan also

provides information on the expected number of unduplicated clients served and the program budget amount.

Community Program Planning Process (CPP)

Overview

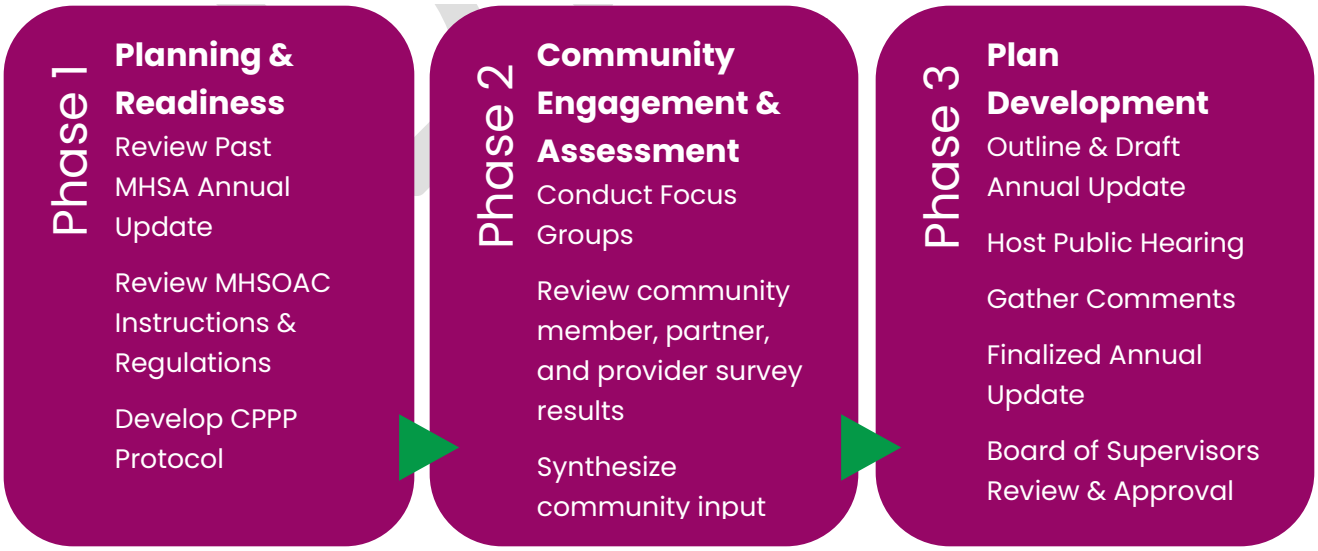
The MHSA requires counties to implement a CPPP that meaningfully engages consumers, partners, and community members to identify local needs, identify MHSA funding priorities, and guide the development of changes to MHSA-funded programs.

As a part of the annual update planning process, SCCBHD organized a series of stakeholder engagement activities to inform program planning efforts and budget allocation. Additional information about the SCCBHD CPP process is provided in the following sections: CPP methodology, CPP activities, the Annual Plan review process, and stakeholder participation. SCCBHD experienced delays in completing the Annual Update for the 2024-2025 year due to staffing and logistical challenges. Given the previous year's delay, SCCBHD has elected to utilize the recent stakeholder survey results from November 2024, prioritize community engagement events and focus groups to inform the 2025-2026 Annual Plan Update, and prepare for upcoming years as we look forward to launching changes under BHSA and the evolution of the next Three-year Integrated Plan.

Additional Information on MHSA at SCCBHD is available on the County website, www.santacruzhealth.org/mhsa.

Methodology

Figure 2: CPP Process



In January 2025, SCCBHD initiated the planning process for the MHSA Annual Update for FY 2025 -2026. The MHSA Planning Team consisted of leadership and service providers from SCCBHD and RDA Consulting. The planning team developed a community focused framework to engage with providers, consumers, and their families as well as the broader Santa Cruz community. The CPPP moved through three phases (Figure 2) to support development of the FY 2025-2026 Annual Update Plan.

CPP Process Engagement Activities

SCCBHD sought feedback from community members and stakeholders through a series of focus groups, 30-day public comment period, and public hearing. Additionally, SCCBHD utilized the information from the community survey that was completed in November 2024. These activities are outlined in Table 1 below.

Table 1. CPP Activities, Dates & Participant Numbers

Activity	Date(s)	Participants/ Comments
Community Survey	October 16-November 1, 2024	146 participants
30-day Public Comment	(May 15-June 18, 2025)	TBD
Public Hearing	June 26, 2025 (TBD)	TBD
Focus Groups	March 3- March 7, 2025	24 participants

Community Survey

RDA designed and administered a countywide survey to include input from a wide range of consumers, community members, and partners. The survey was open from October 16th through November 1st, 2024, and was available in both English and Spanish. The community survey included 12 Likert-scale questions, where participants were asked to rate the level of their agreement with various statements regarding behavioral health services in Santa Cruz County. Likert-scale responses included Strongly disagree, Somewhat disagree, Neither disagree nor agree, Somewhat agree, and Strongly agree. Two additional Likert-scale questions, using the same scale, asked participants to rate their level of agreement with statements regarding Prop 1 and the BHSA. Participants were then asked three multiple-choice questions regarding the strengths, challenges, and gaps in behavioral health services in the county. The survey also included 2 open-ended questions, which were analyzed as qualitative data for key themes. The survey also included questions regarding respondent demographic characteristics and relationship to MHSA services to track and characterize community engagement.

The survey was available online and promoted through posting to SCCBHD' website, posted on the SCCBHD Facebook page, and shared with MHSA partner listservs. Additionally, community partners including NAMI helped to further distribute the survey within the community. SCCBHD elicited feedback from consumers at three program sites across the County – South County at Mariposa Center in Watsonville, Midtown at Mental health Client Action Network (MHCAN) and North County ay Community Connection in Santa Cruz. SCCBHD sent survey links by email in English and Spanish to our provider network and community partners with a request to share widely to get a broad response.

The first 100 Santa Cruz County residents who completed the community survey were provided a $10.00 gift card as a thank you for their time and contribution to planning efforts. Survey questions can be found in Appendix A.

Focus Groups

RDA designed question protocols and administered focus groups for both care providers and members of the community. Focus group questions focused on the participants' experiences of the behavioral health system strengths, challenges, and any gaps in services. The providers' focus group also included questions about how they expect the upcoming BHSA transition to impact services.

Two of the focus groups were conducted virtually and included SCCBHD staff members and stakeholders from community-based organizations. The third focus group was conducted in-person with members of the community and a Spanish language translator for the participants. Each focus group lasted approximately one hour.

After the focus groups were completed, RDA conducted a qualitative analysis to identify major themes. Findings can be found in the Community Program Planning Process Findings section.

Local Review Process

Public Comment Period & Public Hearing

Following the Community Program Planning Process, a draft of the Annual Update was posted on the Health Services Agency website for 30 days, along with instructions for public comment, in accordance with MHSA regulations. The Public Comment period began [date] and closed on [date].

Notice of the public comment period was shared by…[placeholder].

Public comments were able to be submitted in verbal and written formats through email, website form submission, phone, and through in-person or virtual participation during the public hearing. [Placeholder – provide details for public hearing].

SCCBHD received a total of [#] public comments about the MHSA FY2025-2026 Annual Plan Update. [How were comments submitted/received?] [What stakeholder groups are represented in the comments?]. A complete listing of all public comments received as well as SCCBHD's responses are reported in [Appendix Letter].

CPP Process Participation & Demographics

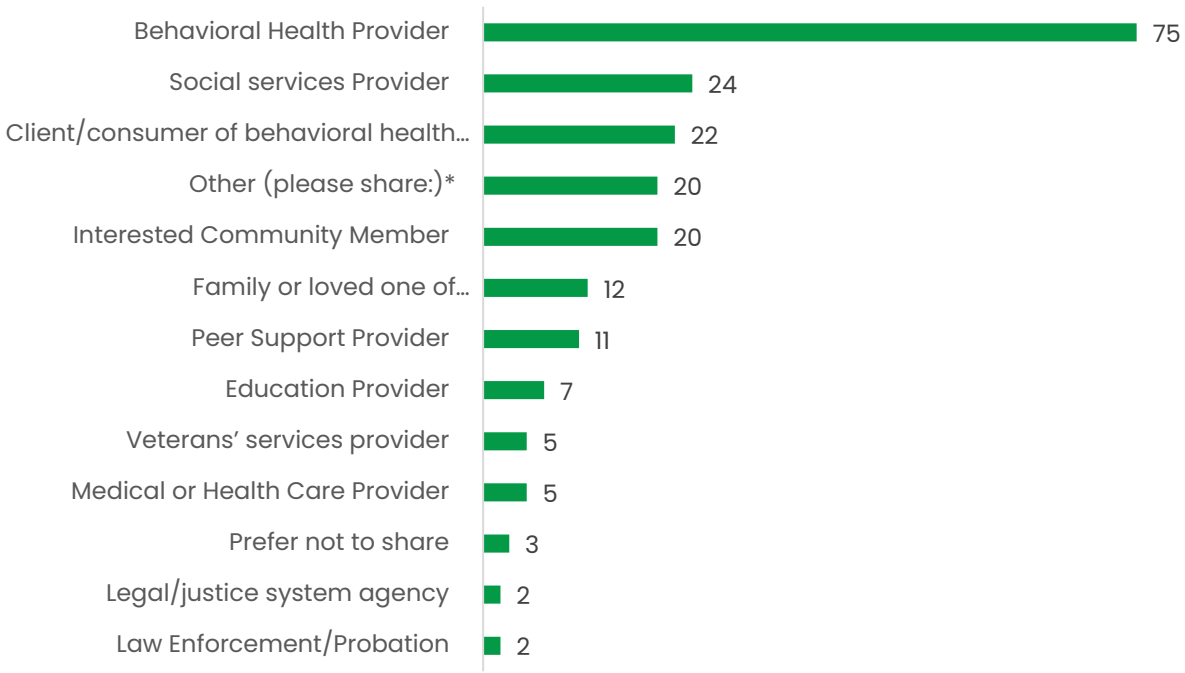
A total of 178 stakeholders participated in the CPP process, including 146 stakeholders who completed the community survey, 24 stakeholders who participated in a focus group, and

8 stakeholders who participated in the Community Program Planning meeting. The following section describes stakeholder affiliation and demographic characteristics of participants in these CPP activities. Participant reporting of affiliation and demographics was optional; therefore, these statistics will not represent all participants.

Stakeholder Affiliation of CPP Participants

As part of the community survey, participants were asked to report their relationship to SCCBHD. Stakeholder affiliation is reported below in Figure 3 for the 146 survey participants. Survey participants could self-identify with one or more affiliations. Over half of survey respondents were Behavioral Health Providers (53%). About one third (30%) identified as either a client/consumer of behavioral health services (16%) or an interested community member (14%). Almost one in ten (9%) were family or loved ones of a client/consumer. 40% of Stakeholders also represented other community service providers, including social services providers, peer support providers, medical or health care providers, education providers, legal/justice system agency members, and law enforcement/probation. 2% of survey respondents preferred not to share an affiliation. Additional details about stakeholder affiliation for community survey participants is available in the Appendix D.

Figure 3. Stakeholder Affiliation of Community Survey Participants (n=208)



*Some "other" responses include: Behavioral health administrator, substance use service provider, mental health provider, and front line worker

Focus group and community meeting participants were also asked to report their affiliation. Of participants in these qualitative data collection methods (32), the majority (19) identified as behavioral health service providers, while almost half (14) identified as a client/consumer of behavioral health services. A summary of stakeholder affiliation in focus groups and the community meeting can be found in Figure 4 below.

Table 2. Stakeholder affiliation of focus group and meeting participants (n=32)

Activity	Date(s)	Total # of Participants	Stakeholder Affiliation Breakdown
Community Focus Groups (3)	February 26 – March 7, 2025	24	• 13 clients/consumers of behavioral health services • 11 behavioral health providers
Community Program Planning Meeting	April 15, 2025	8	• 1 client/consumer of behavioral health services • 8 behavioral health service providers • 1 other social service provider

Demographic Characteristics of CPP Process Participants

Community Program Planning activity participants were asked to fill out an optional, anonymous demographic form. Demographic forms were partially or fully completed by 141 participants across all activities. Demographic characteristics collected are reported in Table 2. Most participants (71%) were adults ages 26-59, while almost one in five (19%) were adults aged 60 or older. The remaining 11% were ages 16-25 (6%) or preferred not to share (5%). Over half (56%) shared the gender identity of Woman/Female. Almost all participants (89%) speak English as their primary language, and the majority of participants (77%) were white. Additional demographics details can be found in Table 2 below.

Table 3. Selected Demographic Characteristics of CPP Activity Participants[2]

Demographic Characteristic		CPP Participants N (%)
Age Group	Transition Age Youth (16-25)	8 (6%)
	Adults (26-59)	100 (71%)
	Older Adults (60+)	26 (19%)
	Unknown / Not reported	6 (5%)
Gender Identity	Woman/Female	73 (56%)
	Man/Male	43 (33%)
	Another Gender Identity	5 (4%)
	Unknown / Not Reported	9 (7%)
Race	White	100 (77%)
	Asian	8 (6%)
	American Indian or Alaska Native	5 (4%)
	Black / African American	4 (3%)
	Another Race	17 (13%)
	Unknown / Not Reported	14 (11%)
Ethnicity	European	49 (40%)
	Mexican/Mexican American/Chicano	19 (15%)
	Eastern European	12 (8%)
	Other Hispanic or Latino	8 (7%)
	Japanese	3 (2%)
	Filipino	3 (2%)
	Chinese	3 (2%)
	Central American	3 (2%)
	Middle Eastern	2 (2%)
	Caribbean	2 (2%)
	Another Ethnicity	17 (14%)
	Unknown/ Not Reported	20 (16%)
TOTAL PARTICIPANTS		**141**

[2] Race and ethnicity data sums to greater than 100% as some participants identified multiple races or ethnicities.

Community Program Planning (CPP) Findings

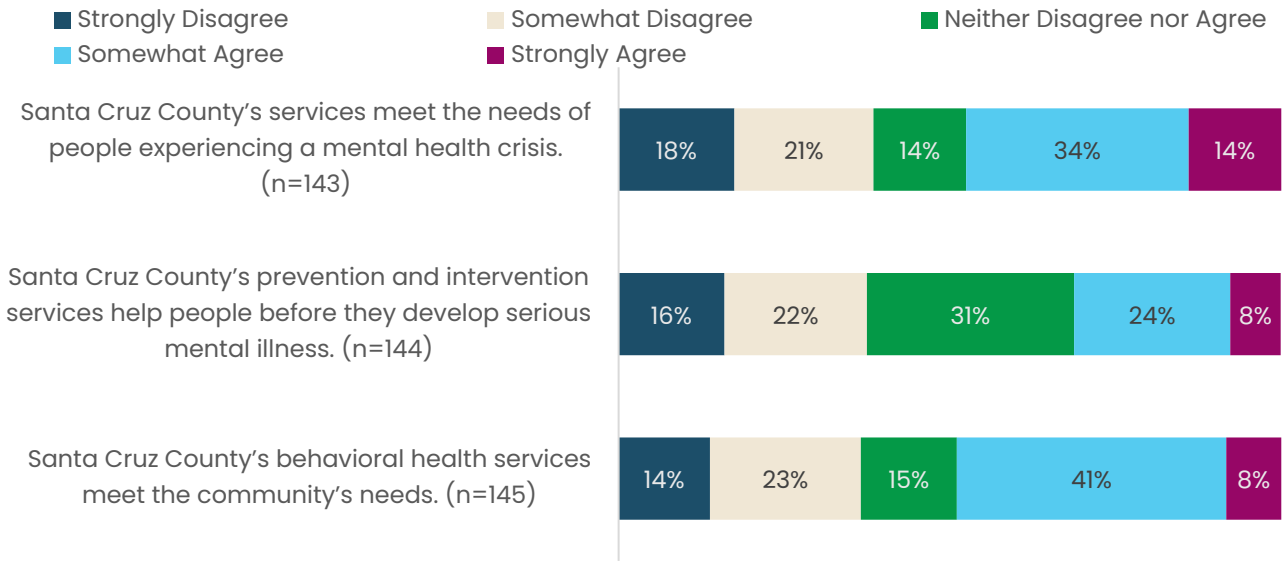
This section presents thematic findings identified through analysis of data collected throughout the Community Program Planning Process (i.e. the community survey, focus groups, and community meeting). Results combine both closed-ended, quantitative data and open-ended, qualitative data gathered across these activities. This section is divided into themes related to the following areas of focus:

- Population needs
- Access to SCCBHD services
- Experiences with SCCBHD services
- Proposition 1/BHSA awareness and perceptions
- Service gaps and persistent needs
- Stakeholder recommendations for improvement

Findings: Population needs

The community survey asked participants to rate their agreement with several statements about population needs. These prompts and participant responses are summarized in **Figure 4**. Almost half of participants (49%, n=71) felt SCCBHD services are meeting the community's needs overall. Approximately equal numbers of participants agreed (31%, n=45) as disagreed (38%, n=54) that SCCBHD's prevention and intervention services help people before they develop serious mental illness. About half of respondents (48%, n=68) agreed that SCC's services meet the needs of people experiencing a mental health crisis, while over a third (38%, n=55) disagreed.

Figure 4. Community Survey Responses about SCCBHD Services Provided



In community focus groups and the CPP meeting, stakeholders were invited to share their perspectives about population needs in Santa Cruz County. Themes from these conversations are summarized below.

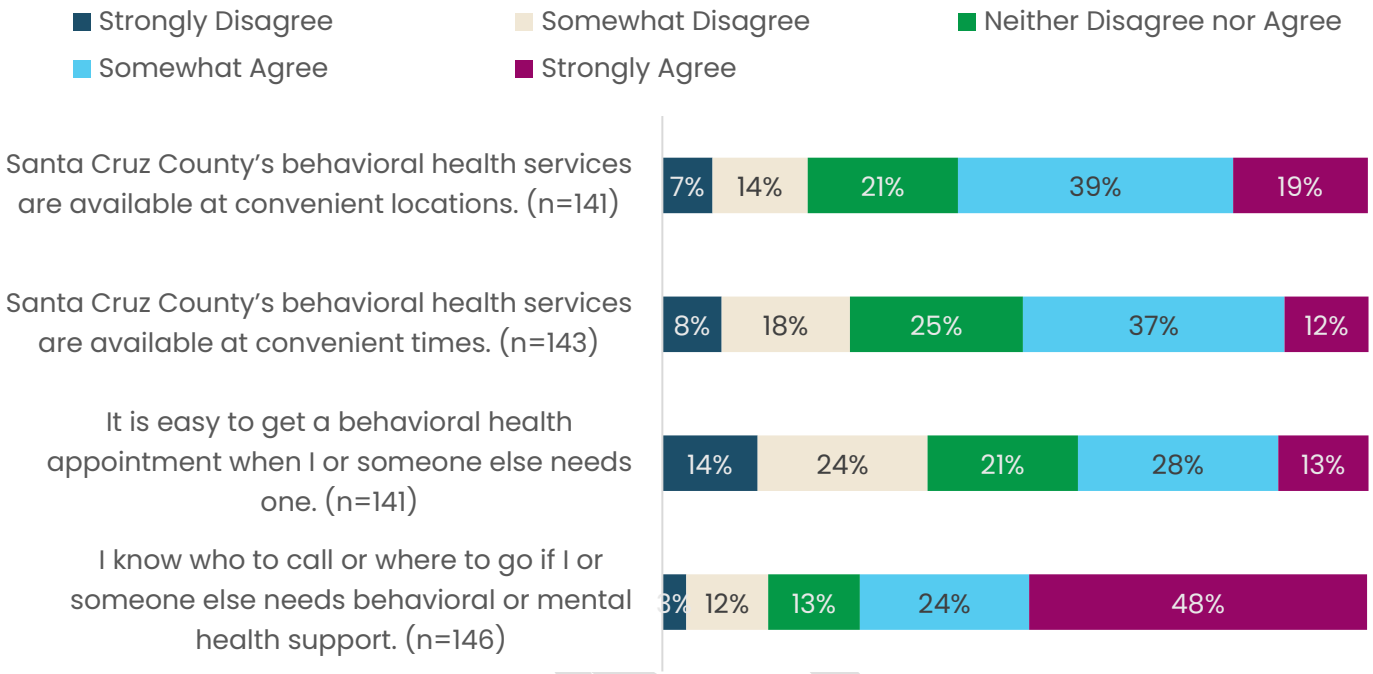
- A lot of needs are being met by existing services, but there are gaps in available services and unmet needs.
- Both consumers and providers appreciate the variety of programs and services available.
- There is a growing need for inpatient services such as crisis stabilization units.

> *"I love other county programs as well; there is strength in numbers when we bring together a variety of specialty roles."*
> *- Behavioral Health Provider*

Findings: Access to SCCBHD services

Survey participants were also asked to rate their agreement with statements regarding the accessibility of SCCBHD services. These statements and participant responses are summarized in **Figure 5**. The majority of participants (72%, n=105) reported they knew where to go or who to call to access services if they or someone needs mental health support. Participants' perceptions of accessing services were more varied. About half of participants felt services were generally available at convenient locations (58%, n=82) and at convenient times (49%, n=70)). A slightly small proportion (41%, n=58) of participants (n=48) agreed that it is easy to get a behavioral health appointment when needed.

Figure 5. Community Survey Responses about Access to SCCBHD Services



In community focus groups and the CPP meeting, stakeholders were invited to share their perspectives about the accessibility of SCCBHD services. Themes from these conversations are summarized below.

- Consumer perceptions of accessibility vary significantly depending on the program.
- Several factors can determine or improve service accessibility: transportation support, flexibility in hours, timeliness of connection to care, cultural responsiveness, and offering services and service navigation in consumers' primary language.
- Providers also noted that there are fewer services available to Medi-Cal enrolled consumers in South County.

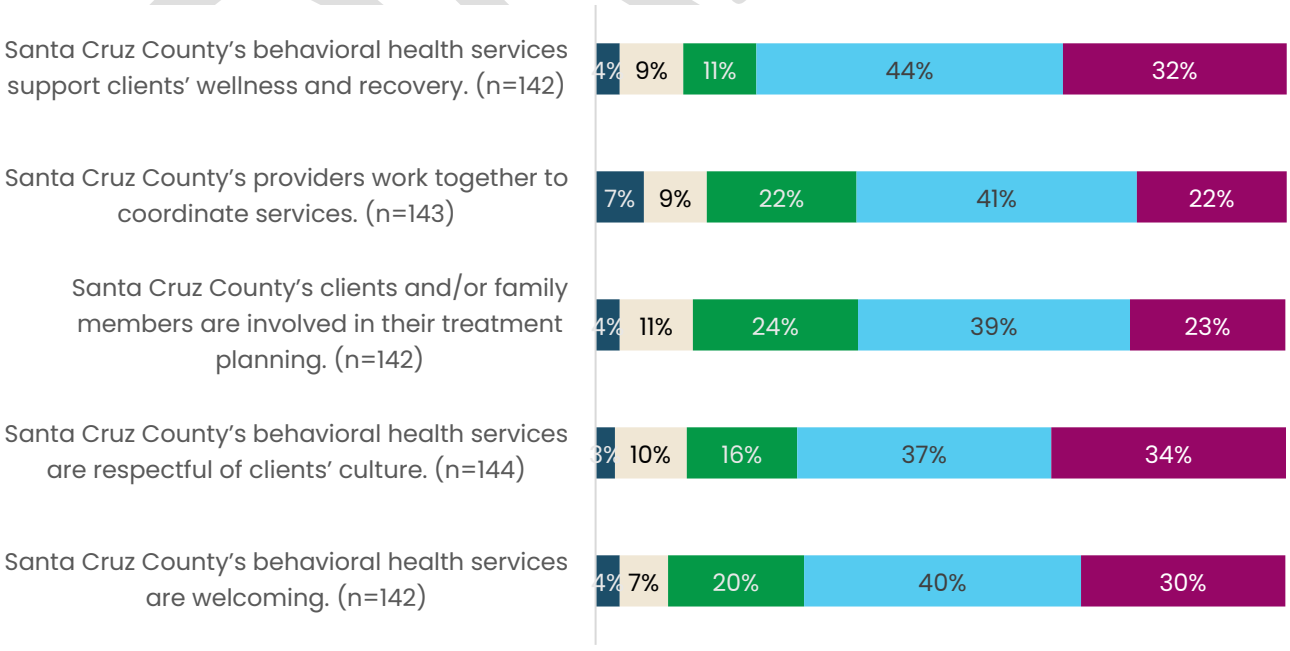
> *"I was invited to a program for summer school, but transportation was a problem; I had to go to work. [At one program] the workers though, they would actually pick my children up."*
> *– Consumer of Behavioral Health Services*

"South county has 70% of MediCal recipients, but the majority of services are in North county. There are more family supports in South county, but the question remains if we are doing enough outreach in those areas."
- Behavioral Health Provider

Findings: Experiences with SCCBHD Services

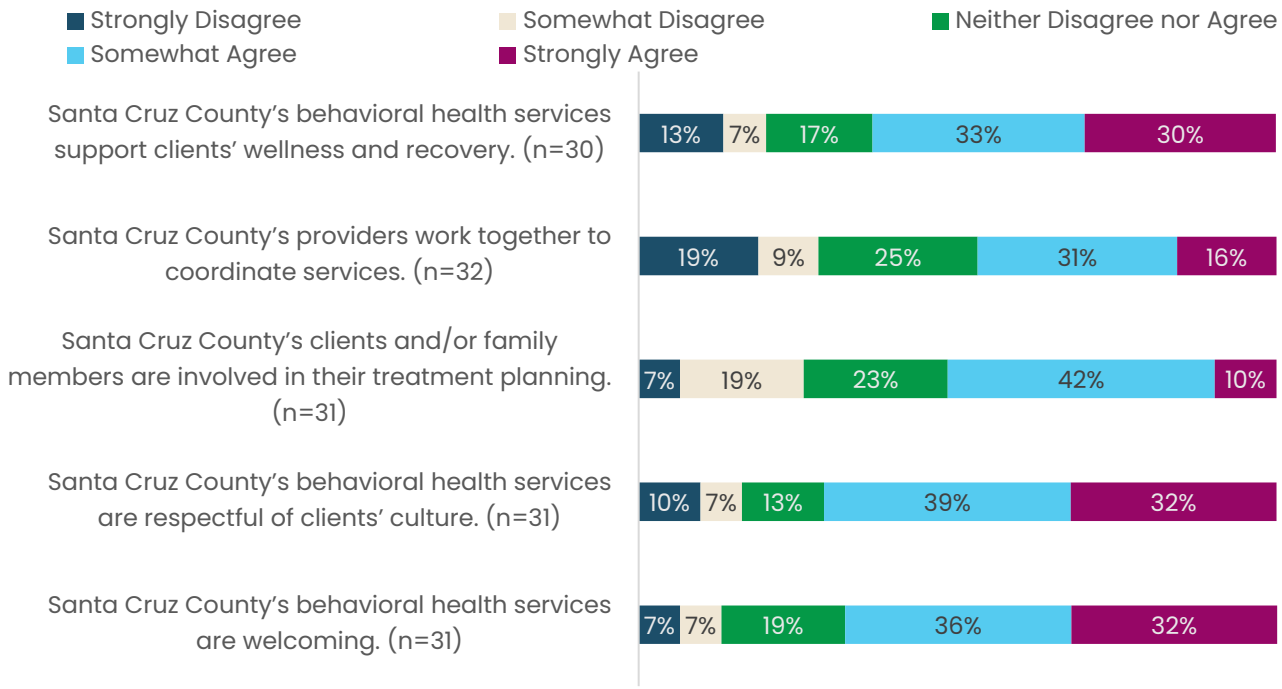
Survey participants were asked to rate their agreement with five statements about experiences with SCCBHD services. Participants' ratings about their experiences with SCCBHD services are summarized in **Figures 6 and 7**. Overall, the majority of participants felt that SCCBHD services support clients' wellness and recovery (77%, n=109), clients and/or their families are included in treatment planning (62%, n=88), services are respectful of clients' culture (71%, n=102), and services are welcoming (70%, n=99). Notably, consumers or consumers' family members and loved ones had relatively similar perceptions of SCCBHD service experiences as the full survey sample (which includes many behavioral health

Figure 6. Community Survey Responses about Experiences with SCCBHD



providers), though perceptions in these groups are slightly more mixed. In general, approximately 50-70% of consumers and family members or loved ones reported services support clients' wellness and recovery, are welcoming, respect clients' culture, and include clients in treatment planning, compared to approximately 60-80% of all survey participants. Perceptions about service coordination were also mixed, with 47% (n=15) of clients/consumers, their family members, and non-provider community members reporting that they agree that providers work together to coordinate services, while 28% (n=9) disagreed.

Figure 7. Community Survey Responses about Experiences with SCCBHD Services, Excluding Service Providers



In community focus groups and the CPP meeting, stakeholders were invited to share their perspectives about their experiences with SCCBHD services. Themes from these conversations are summarized below.

- Consumers reported that many staff are dedicated and caring
- Stakeholders perceive that direct behavioral health treatment services often take significant time to be connected to a provider.
- Providers noted that gaps in available services or service capacity can prevent continuity of care or quality of care.

"I would like to commend the staff on their welcoming attitudes and genuine interest in informing and providing services that benefit their clients"
- Community Member

"Once released from a 5150, clients can go to facilities that have 30-120 days. Then there's peer respite, but where do you go next? It just loops back around to 5150"
- Behavioral Health Provider

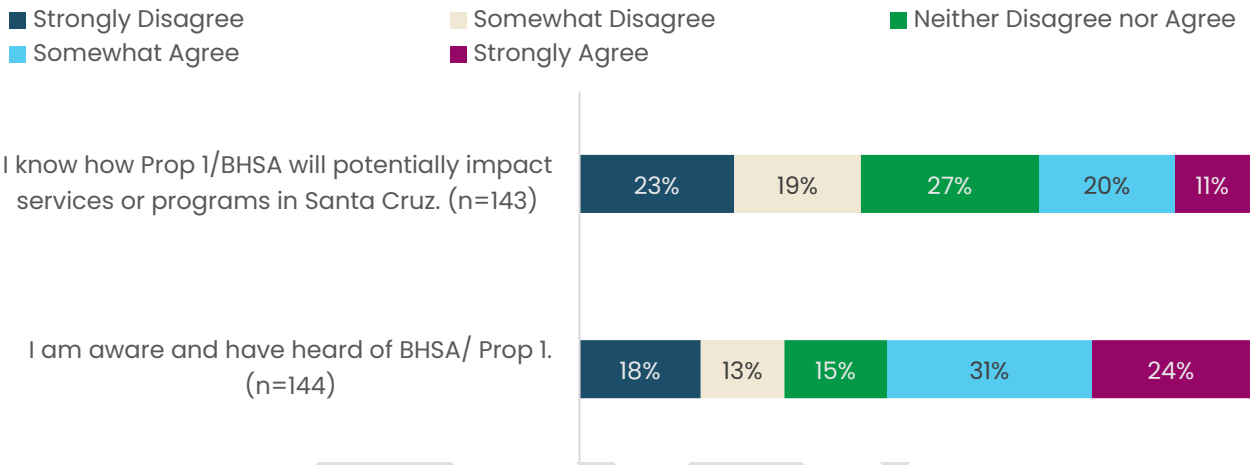
"[PVPSA] has been the fastest place – I've been looking at other places and applying and still now they haven't called me, it's been 3 years! They still haven't called me. But here it was fast."
- Community Member

Findings: BHSA/ Proposition 1 Awareness and Impacts

Survey participants were asked to rate their level of awareness of BHSA/Proposition 1 as well as the extent to which they know how the legislation will impact services or programs in SCC. Among all survey respondents, over half agreed that they are aware of the legislation

(54%, n=78) while about a third (31%, n=45) agree that they know how it will impact the services locally. Excluding service providers of any kind (i.e. among consumers/clients of behavioral health services, their family members, and interested community members only), less than half (41%, n=13) agreed that they are aware of the legislation and only 17% (n=5) agreed that they know how it will impact services locally.

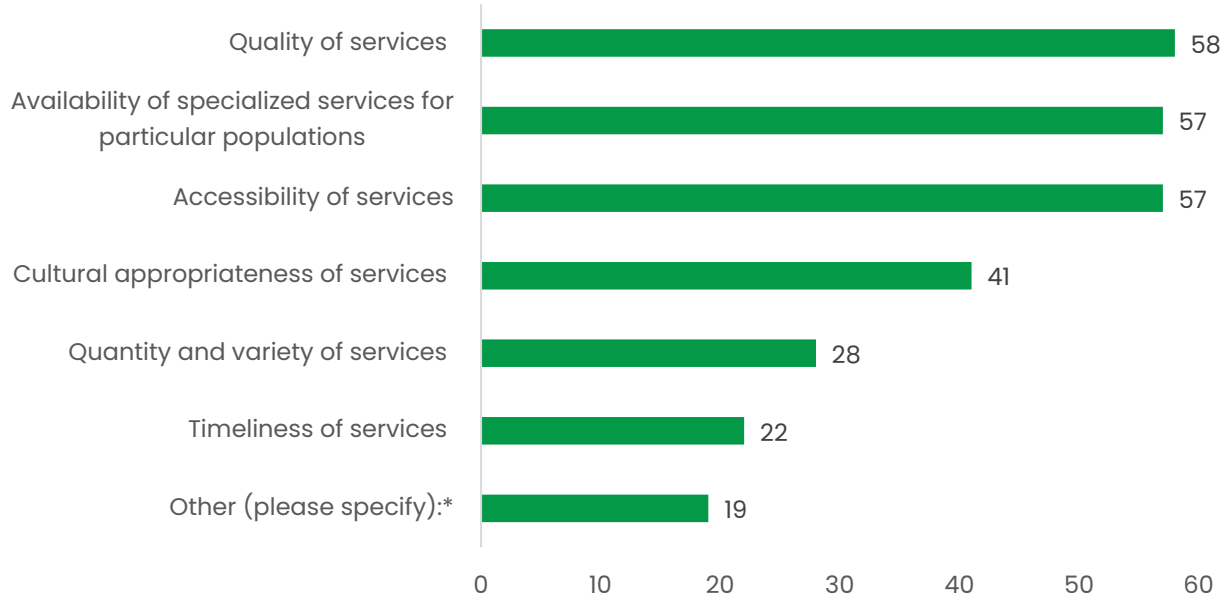
Figure 8. Community Survey Responses Regarding Awareness and Impacts of BHSA/Proposition 1.



Findings: Service Gaps and Persistent Needs

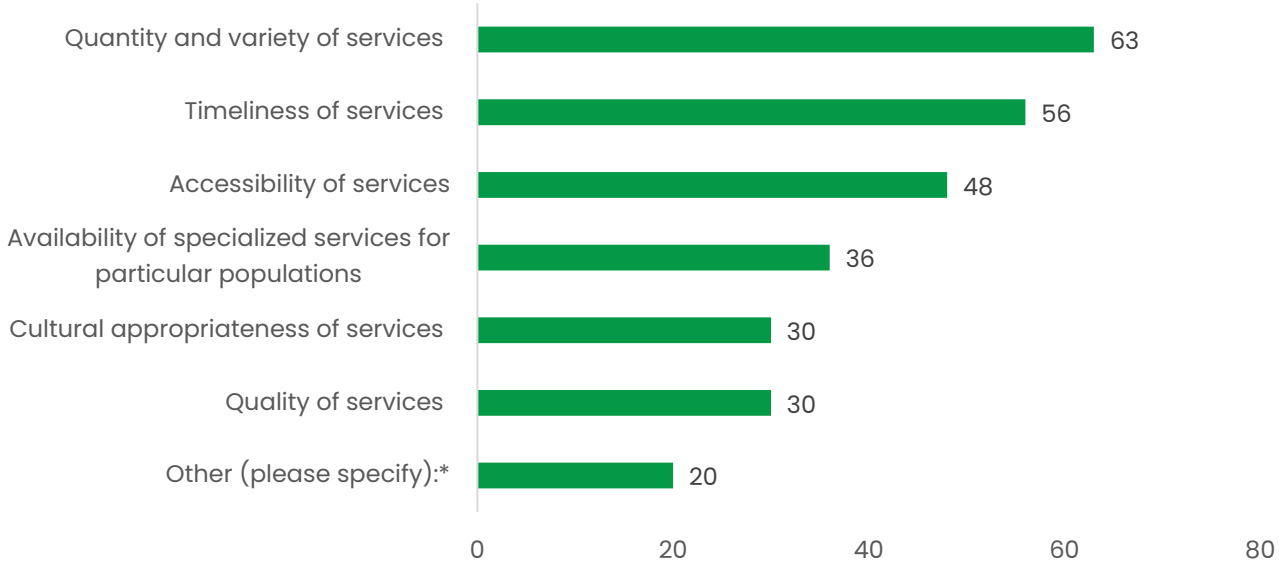
Survey respondents were asked to select up to three elements of SCC's behavioral health system that they found most helpful and most challenging respectively. Participants most commonly selected quality of services (44%, n=58), availability of specialized services for particular populations (43%, n=57), and accessibility of services (43%, n=57) as most helpful. Meanwhile, participants most commonly selected quantity and variety of services (47%, n=63), timeliness of services (42%, n=46), and accessibility of services as most challenging (36%, n=48). When asked to select up to three areas of greatest unmet behavioral health needs and/or gaps in the community, respondents most commonly selected "People experiencing homelessness and/or housing insecurity," "Youth experiencing behavioral health crises," "Individuals with early signs of behavioral health needs (i.e. early intervention services)," and "Adults experiencing behavioral health crises."

Figure 9. Community Survey Responses about SCC Behavioral Health System Strengths (n=133)



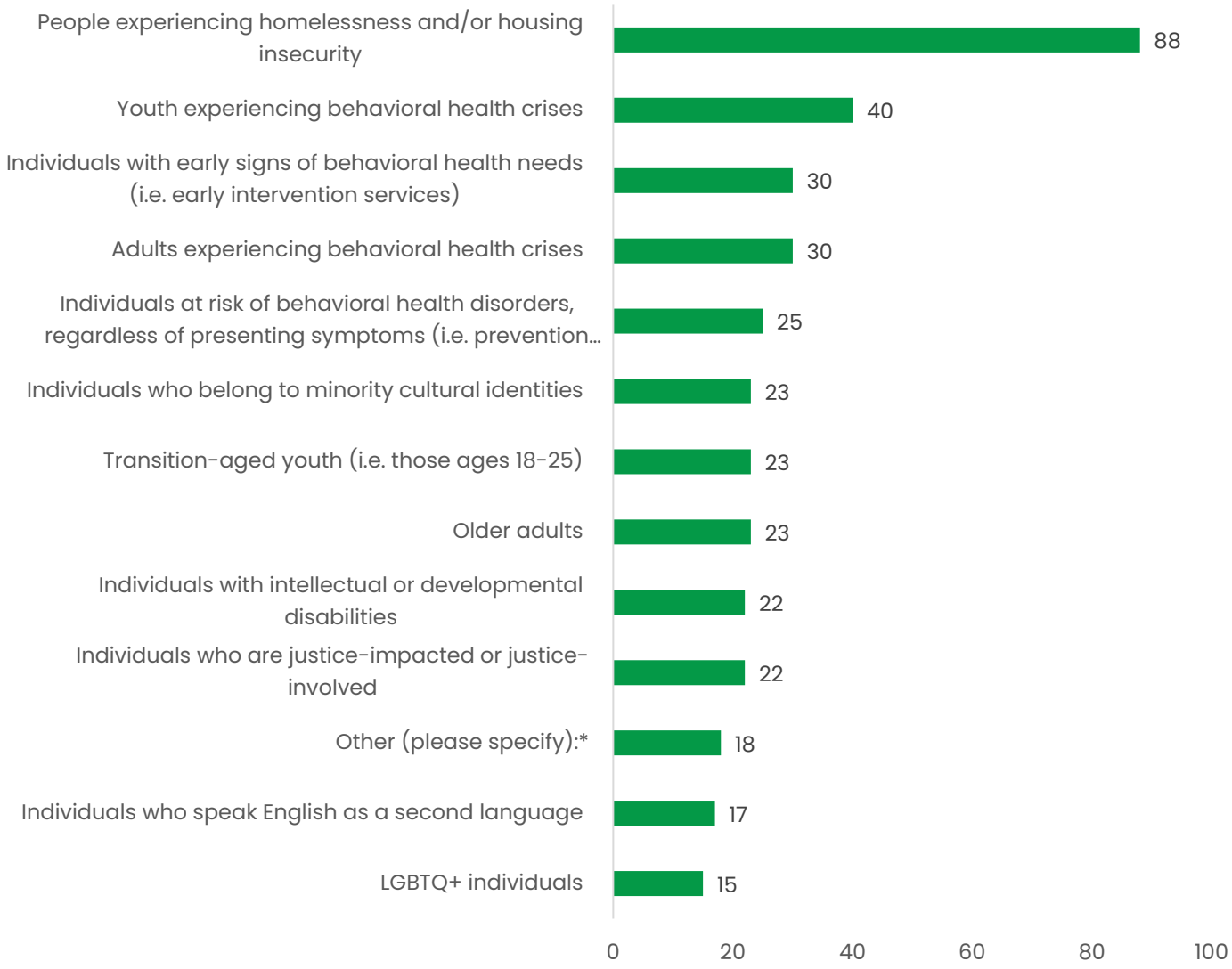
*Other responses are included in qualitative analysis

Figure 10. Community Survey Responses about SCC Behavioral Health System Challenges (N=133)



*Other responses are included in qualitative analysis

Figure 11. Community Survey Responses about Areas of Greatest Unmet Needs and/or Gaps in Behavioral Health Services (n=141)



*Other responses are included in qualitative analysis

Summary of Findings: Current Strengths in SCCBHD Services

- Overall, the majority of survey participants felt that SCCBHD services support clients' wellness and recovery (77%, n=109), clients and/or their families are included in treatment planning (62%, n=88), services are respectful of clients' culture (71%, n=102), and services are welcoming (70%, n=99).
- The majority of survey participants (72%, n=105) reported they knew where to go or who to call to access services if they or someone needs mental health support.
- Almost half of survey participants (49%, n=71) felt SCCBHD services are meeting the community's needs overall.
- Many survey participants rated the following SCCBHD system components as *most helpful*: quality of services (44%, n=58), availability of specialized services for particular populations (43%, n=57), and accessibility of services (43%, n=57).
- Qualitatively, CPP participants shared appreciation for SCCBHD service providers and staff.

"I am new to the services provided here…but I would like to commend the staff on their welcoming attitudes and genuine interest in informing and providing services that benefit their clients"
- Client/consumer of behavioral health services

"We have some of the most heart-centered people ever here in Santa Cruz. Really great people in all the teams I've been on who are truly dedicated to helping individuals."
– Behavioral health provider

"[SCCBHD Staff, names redacted] have been extremely helpful in my mental health transition. Very grateful."
- Client/consumer of behavioral health services

Summary of Findings: Current Challenges and Gaps in SCCBHD Services

- While not the majority of survey respondents, over a third of participants disagreed (38%, n=54) that SCCBHD's prevention and intervention services help people before they develop serious mental illness. Additionally, over a third of participants (38%, n=55) disagreed that SCC's services meet the needs of people experiencing a mental health crisis.
- Many survey participants most rated the following SCCBHD system components as *most challenging*: quantity and variety of services (47%, n=63), timeliness of services (42%, n=46), and accessibility of services as most challenging (36%, n=48).
- Qualitatively, CPP participants shared challenges with wait times for services, coordination of care, Medi-Cal billing constraints, and gaps in the behavioral health workforce.

> *"South county has 70% of MediCal recipients, but the majority of services are in North County. There are more family supports in South County, but the question remains if we are doing enough outreach in those areas."*
> *– Behavioral health provider*

> *"CalAIM was a huge hit for SCC, the rate is less than the counties around us, but our cost of living is higher. It impacts the rates we pass on to contractors and their sustainability."*
> *- Provider*

Summary of Findings: Current Community Needs

- Many participants rated the following as areas of *greatest unmet need and/or gaps*: "People experiencing homelessness and/or housing insecurity," "Youth experiencing behavioral health crises," "Individuals with early signs of behavioral health needs (i.e. early intervention services)," and "Adults experiencing behavioral health crises."
- Qualitatively, CPP participants reported a number of specific needs and gaps in behavioral health services, most commonly including housing support, crisis services, youth services, and older adult services.

"Youth services are often underfunded/ represented and don't get the attention or focus that adult services do." - Behavioral health provider

"I believe the homeless need more support." - Veterans services provider

"Services are not useful without adequate housing."
- Client/consumer of behavioral health services

"We need more accessible clinic areas, for those clients who are near us. Additionally, we need more crisis units, hospitalization prevention programs, SUD programs like Casa P but in Santa Cruz!"
- Behavioral health provider

"Severe lack of older adult residential housing options. County does not run an IOP program, dependent upon non-profit programs."
- Behavioral health provider and social services provider

Annual Update and Three-Year PEI Reports

Community Services and Supports

Community Services and Supports (CSS) focuses on providing services and support for children and youth who have been diagnosed with or may have serious emotional disorders, as well as adults and older adults who have been diagnosed with or may have serious and persistent mental illness.

In response to community and provider feedback, SCCBHD developed a new Full-Service Partnership Team called the Integrated Housing and Recovery Team (IHART) for people with SMI or co-occurring SMI and SUD who are experiencing homelessness. IHART comprises of an integrated process of case management, peer support, housing navigation, psychiatric provision and the provision of therapy and OT services. IHART comprises of the County Behavioral Health Full-Service Partnership Team in coordination with Housing for Health. IHART provides Enhanced Care Management (ECM) services in North and South County and also has mental health connectors.

Program demographic reports and annual service updates FY2023-2024 are Included in Appendix E.

CSS #1 Community Gate

Purpose: The services of this program are designed to create expanded community-linked screening/assessment and treatment of children/youth suspected or at risk 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 and out-of-home placement. These services include assessment, individual therapy, 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 (TAY). Services are offered to individuals of all genders, and are primarily in English and Spanish, although services are also provided to persons of other ethnicities and in other languages.

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

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

- Encompass: Percentage of MHSA CCS funding is 28%. The program is expected to serve 300 unduplicated youth for FY '23-'24 and therefore 84 of Youth Services clients will funded through the MHSA allocation. Specific % allocation for Community Gate was not made available to Encompass so we are unable to supply a Community Gate Target number.
- Pajaro Valley Prevention and Student Assistance (PVPSA): 192 individuals/families served
- Santa Cruz County Behavioral Health:

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
Our primary challenge as a program with service delivery is in hiring and retaining clinicians, especially bilingual (and bicultural) clinicians. Staff turnover this year has increased due to higher cost of living in our region and stringent Medi-Cal demands. Clinicians are leaving their positions for higher paying, non-MediCal positions. We are continuing to work with our County and community partners to address this serious issue through budgeting for salary increases for next fiscal year as well as developing more creative and proactive recruitment efforts.

CalAIMS implementation has been a barrier for families unable to receive services in our clinics. Because driving time is no longer billable, clinicians have limited time available to meet clients in the community. We attempt to assign clinicians cases looking at geographical locations.

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.

We continue to provide services to clients in home and community locations to remove barriers to access and service. CalAIM is no longer reimbursing for travel time. To mitigate, we have been doing location-based caseload assignments to reduce travel time.

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

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

- Encompass: Percentage of MHSA CCS funding is 28%. The program is expected to serve 300 unduplicated youth for FY '23-'24 and therefore 84 of Youth Services clients will be funded through the MHSA allocation. Specific % allocation for Probation Gate was not made available to Encompass so we are unable to supply a Probation Gate Target number
- Pajaro Valley Prevention & Student Assistance:

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

Our primary challenge as a program with service delivery is in hiring and retaining clinicians, especially bilingual (and bicultural) clinicians. Staff turnover this year has increased due to higher cost of living in our region and stringent Medi-Cal demands. Clinicians are leaving their positions for higher paying, non-MediCal positions. We are continuing to work with our County and community partners to address this serious issue through budgeting for salary increases for next fiscal year as well as developing more creative and proactive recruitment efforts.

CalAIMS implementation has been a barrier for families unable to receive services in our clinics. Because driving time is no longer billable, clinicians have limited time available to meet clients in the community. We attempt to assign clinicians cases looking at geographical locations.

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

CSS #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.
- Increased services, including services for the 0 to 5 child populations. These services include assessment, individual therapy, group, collateral, case management, family therapy and crisis intervention.

- Services for general children/youth In the Foster Care System treatment with a community-based agency, as well as county clinical capacity.
- IHBS – In home behavioral services to all age children and youth to support parents in coaching and managing behavioral challenges in the home.

By ensuring comprehensive screening, assessment, and treatment for children in the foster care system, we are supporting family reunification efforts and permanency planning for court dependents, helping the youth perform better in school, minimizing need for hospitalization, and supporting 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 individuals of all genders, 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, and Santa Cruz County Behavioral Health provide the services in this work plan.

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

- Parents Center: 89
- Santa Cruz County Behavioral Health: 1062

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
Santa Cruz County, like most California counties, experienced challenges and hardships related to the ongoing COVID-19 pandemic. Challenges included recruitment of staff, onsite staffing resources, client and family telehealth capabilities and issues in services related to infection prevention. While these the pandemic challenges have been recently alleviated with CDPH and CDC guidelines there are ongoing risk mitigation strategies in healthcare settings that can create lasting barriers.

The Parents Center experienced challenges this year with employing and keeping bilingual/bicultural clinicians.

Ongoing barriers include transition to CalAIM system, especially in removing the reimbursement for travel time. This prompted our services to be more office-based, which

is a barrier to clients accessing services. A mitigation strategy applied is regional case assignments.

Are there any new, changed or discontinued programs? No

CSS #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 therapy, 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:
The unduplicated number of individuals to be served by program is:

- Santa Cruz County Behavioral Health Services: 55

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

One ongoing challenge is staff recruitment, as well as securing on-site spaces for client sessions. Currently, staff must travel between school sites throughout the day rather than being stationed on-site, which results in non-reimbursable travel time and limits service accessibility. Establishing dedicated on-site workspaces would help streamline service delivery and maximize efficiency.

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

CSS #5 Special Focus: Family Partnership

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:
The unduplicated numbers of individuals to be served by program are:
Volunteer Center/Family Partnerships: 42

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? Challenges continue to be recruitment and retention of staff to return services and numbers back to what they were pre-pandemic. In addition, changes and challenges of the CalAIM implementation has led to frustrations in staff. Providing and implementing a work/life balance schedule has helped in the recruitment and retention of staff. Restructuring of the program to increase productivity, as well as attempting to allow referrals from other gateway programs, will hopefully help with service numbers as those relationships continue to develop.
Are there any new, changed or discontinued programs? No.

CSS #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:

- 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, Santa Cruz County Jail 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.

- 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.

- 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 led activities include daily groups, aftercare planning and individual support.

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

- Encompass-Telos:
- Encompass- El Dorado Center:
- MHCAN (Peer Supports at the Psychiatric Health Facility): (outreach)
- Santa Cruz County Behavioral Health:

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

Are there any new, changed or discontinued programs?

MHCAN no longer provides peer support specialists to the county inpatient PHF run by Telecare due to a breach of policy occurrence that terminated the contract.

CSS #7 Consumer, Peer, & Family Support 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:

- **The Wellness Center.** 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.
- **Mariposa Wellness Center**. This Mariposa Wellness Center is in Watsonville. Mariposa offers a variety of activities and support services for adults and their families experiencing mental health challenges, including bi-cultural outreach activities to underserved populations in south county. Activities include peer-led social integration, I-IMR and recovery support groups, work readiness and employment services, healthy lifestyle classes, connection to meaningful activities, peer groups for monolingual Spanish speaking adults and individual/group rehab counseling.

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 Wellness Center: Community Connection of the Volunteer Center

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

- MHCAN: 3403 (FSP) 533 (outreach)
- Mariposa Wellness Center: (FSP) (outreach)

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

Are there any new, changed or discontinued programs?

MHCAN is now an adult only wellness community center and no longer serves youths or transition age youths.

CSS #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 that create "partnerships" between clients and clinicians with a "whatever it takes" framework and 24/7 support through our 800-number.

To accomplish the above, we have several specialty teams:

- The Recovery Team provides 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 reduce acute hospitalizations. There is a team serving South County residents and a team serving North County residents. These teams focus on an array of recovery-oriented supports that include case management, psychiatry, psychotherapy, occupational therapy, and linkage to other needed 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 based on the Forensic Assertive Community Treatment (FACT) model that combines evidence-based program of wrap around mental health services

inclusive of case management, psychiatry, psychotherapy, and occupational therapy, with additional supports specific to the criminal justice system. This program seeks to reduce jail bed days, recidivism, 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 adherence, and support individuals as they exit probation. A probation officer is embedded with the team.

- The Older Adult Services Team (60+ years old with a complex medical condition) focuses on older adults with a major mental illness who need a coordinated care team to maintain living in the least restrictive level of care by providing mental health services inclusive of case management, psychiatry, psychotherapy and occupational therapy. Additional supports include coordinating with medical appointments, chronic disease treatment and obtaining durable medical equipment, with an occupational therapy focus on improving functioning with physical limitations.
- The Integrated Housing and Recovery Team (IHART) is a new FSP team developed in response to community input on housing and homelessness for people with SMI. Our CPP surveys for the 2023-2026 Three-year Plan and Annual Updates consistently show this as a top priority for our system of care, and this year we developed a team specifically designed to support people with SMI experiencing homelessness. This team offers more intensive case management along with outreach and engagement, street medicine services that bring the services to individuals wherever they are at and has embedded connection to housing resources and housing navigation. This team partners with connectors in our Housing Continuum of Care to assess individuals for housing needs, ensure they are entered into the Coordinated Entry system to be eligible for vouchers and housing subsidies, and provides housing navigation.

The teams are supported with these ancillary services:

- Front St. Inc. and Encompass provide additional housing support services to adults living independently, helping them maintain their housing and mental health stability. Community Connection staff offer an employment specialist and peer counselor. Licensed Adult Residential Facilities (ARF) and Residential Care Facilities for the Elderly (RCFE) operated by Front St. Inc. provide additional supervision, medication management, and pro-social activities.
- Casa Pacific is a 12-bed residential treatment program for those individuals with co-occurring mental health and substance use disorders. Residents are provided with specialized co-occurring treatment that also prepares them for maintaining sobriety in the community following discharge.

- The Volunteer Center of Santa Cruz provides supportive employment activities include the development of employment options for clients, competitive and non-competitive alternatives, and volunteer opportunities to help clients in their recovery. The Cabrillo "College Connection" supports "consumer" students expressing interest in educational pursuits.

Target Population: The priority populations are 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 St. Inc., 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 St. Inc. provides services at Wheelock, Willowbrook, Front St. Residential and Opal Cliff as well as housing support services to individuals in independent housing throughout the County.
- 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).
- Santa Cruz County Behavioral Health staff provides Full-Service Partnership Teams

Number of unduplicated individuals to be served:

Table 3. Unduplicated individuals to be served

Program	# Clients
Front St. Inc.- Wheelock (Residential & Outpatient)	16
Front St. Inc.- Willowbrook (Residential & Outpatient)	40
Front St. Inc.- Opal Cliff (Residential & Outpatient)	14
Front St. Inc.- Front St. Residential (Residential & Outpatient)	47
Front St. Inc.- Housing Support Team (Outpatient)	100
Front St. Housing Inc.- Supported Housing	61
Encompass- Supported Housing	30
Volunteer Center/Community Connection-Housing Support (employment)	20
Volunteer Center/Community Connection-Opportunity Connection	15
Volunteer Center/Community Connection Avenues	40

Volunteer Center/Community Connection Cabrillo College Connection	10
Santa Cruz County Behavioral Health Services North & South County Recovery	225
Santa Cruz County Behavioral Health Services Older Adult Team (OAS)	130
Santa Cruz County Behavioral Health Services MOST	100
Santa Cruz County Behavioral Health Services IHART	70
Encompass Casa Pacific	40

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
Challenges continue to be recruitment (and holding onto) of staff. In addition, we are seeing rapid growth in our older adult population and the Older Adult team was strained until we could add additional resources. As the older adult population and chronically unhoused population (often with co-occurring substance use d/o or history) in supported housing increases there is a correlating increase in support required to sustain housing.

Are there any new, changed or discontinued programs? Yes, we added a Full-Service Partnership team focused on individuals with SMI who are also experiencing homelessness.

Community Support Services – Housing

Purpose: This component is to offer permanent supportive housing to the target population, with no limit on length of stay.

Target Population: 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.

Providers: The Bay Avenue project provides five MHSA units for seniors 60 years and older, at risk of homelessness. "Aptos Blue" provides five MHSA for adults with mental illness who are homeless, or at risk of homelessness. Lotus Apartments provide housing for five transition age youth and adults located mid county. Santa Cruz County Behavioral Health Services FSP teams provide the initial referral for clients who enter the MHSA housing application process.

Program requirements include experiencing SMI with a lack of stable housing or at risk of becoming homeless. The Housing Support team works with clients to mitigate any problems that could result in eviction notices.

The County developed General Screening and Evaluation Requirements to ensure that the potential tenants have appropriate skills and supports for independent housing:

1. The applicant(s) must be able to demonstrate that their conduct and skills in present or prior housing did not and will not negatively affect the health, safety, or welfare of other residents, or the physical environment, or financial stability of the property.
2. Picture id is required for all adult applicants. Eligible applicants without picture ID are supported by service providers to obtain one. A receipt from the DMV showing an application for an ID will be sufficient with picture id will be required at the time of move-in.
3. A complete and accurate Application is required, incomplete applications will be returned. Applicants must provide at least 2 years residency history and birthdates of each applicant. MHSA applicants whose disability results in insufficient or negative references are provided a Request for Consideration.
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.
7. Demonstrated cooperation in completing and providing the necessary information to determine eligibility for affordable housing.
8. 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 not use this real estate as a residence while they live in an affordable housing unit.
9. An applicant may be disqualified if obviously impaired by alcohol or drugs, uses obscene or otherwise offensive language, or makes derogatory remarks.

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

Prevention & Early Intervention Three-Year Evaluation Report

Prevention & Early Intervention (PEI) programs and initiatives focus on engaging individuals before the development of a 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 transition to extended mental health treatment. MHSA-required PEI services are as follows:

1. Prevention
2. Early Intervention
3. Outreach for Increasing Recognition of Early Signs of Mental Illness
4. Stigma & Discrimination Reduction
5. Suicide Prevention
6. Access & Linkage to Treatment

Every three years, Counties must provide a Three-Year PEI Evaluation Report including information about program participation, activities, and outcomes achieved during the previous year three years. The goal of the PEI Evaluation Report is to understand the populations that key MHSA-funded services reach and the impact of services on those populations.

Per MHSA regulations, programs have different reporting and outcome requirements depending on which PEI service area they fall under; therefore, the components included in each program update in this section vary across programs. **This PEI Three-Year Evaluation report includes program participation (i.e., numbers served), target population, expected outcomes and outcomes achieved (pending data availability), alignment with PEI strategies, and information related to each PEI service area achieved during the three-year period of FY 21-22, FY 22-23, and FY 23-24.** PEI program reports are organized by the PEI service areas outlined above.

Outcome information is not available for all programs and all years. Although data collection has improved, data reporting is limited due to data capacity challenges. Complete program demographic reports and annual service updates for the three-year period from FY2021-2022 to FY 2023-24 are included in Appendix F.

SCCBHD has not proposed any changes or modifications to programming for FY 2025 - 2026. SCCBHD will continue to engage with consumers, families, providers, partners, and broader community to Identify community needs and evolve programming to meet those needs in future years.

PEI #1 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.

Program Name: Triple P Positive Parenting Program

Agency: First 5

Numbers Served FYs 2021-2024:

FY 2021-22:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY 2021-2022)?** In FY 2021-22, 193 parents/caregivers received Level 3 Individual, Level 4 Standard/Group, or Level 5 Triple P services. (Note: An additional 727 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?** 178 families (intensive services)

FY 2022-23:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)?** In FY 2022-23, 195 parents/caregivers received Level 3 Individual, Level 4 Standard/Group, or Level 5 Triple P services. (Note: An additional 792 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?** 186 families (intensive services)

FY 2023-24:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY 2021-2022)?** In FY 2023-24, 180 parents/caregivers received Level 3 Individual, Level 4 Standard/Group, or Level 5 Triple P "intensive" services. (Note: An additional 966 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?** 166 families (intensive services)

Target population:

- **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.

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:

- Improvements in child behavior and emotional regulation.
- Increased use of positive parenting styles.
- Improvements in parental emotional well-being and family relationships.
- Increased parental confidence.

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.

First 5 utilizes the following research-based assessments, administered at pre- and post-intervention, to measure changes in parenting attitudes, skills, and behaviors:

- **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. Utilized July 2018 – current.
- **Parenting and Family Adjustment Scale (PAFAS):** Measures parenting practices and parent/family adjustment. Utilized July 2018 – current.
- **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. Utilized January 2010 – current.
- **Parental Attributions for Child Behavior (Level 5 Pathways Triple P only):** Measures the degree of parents' negative attributions (beliefs) about their children's behaviors. Utilized January 2010 – current.

- **Acrimony Scale (Level 5 Family Transitions Triple P only):** Measures the degree of co-parenting conflict between divorced or separated partners. Utilized January 2010 – current.

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 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 confidential and anonymous, and informed that they may decline to participate in the evaluation but still receive Triple P services.

Data are collected by Triple P practitioners providing the services and entered into a web-based database (Vertical Change). Data are submitted monthly to First 5 Santa Cruz County's Research & Evaluation Analyst for proofing and then analyzed by First 5 annually.

All Triple P client forms and assessment measures are available in both English and Spanish. Most 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.

Assessment data are analyzed for all parents, then disaggregated by key demographics

(gender, race/ethnicity, primary language, and whether they are receiving services from the child welfare system). First 5 reviews disaggregated data to gauge whether there are significant differences in program outcomes that seem to be associated with parents' cultural identities, which would raise concerns about the cultural competence of the delivery of services and/or the evaluation methodology. However, the data have consistently shown that the degree of improvement from pre- to post-assessments reported by Latinx and Spanish-speaking parents is like, or even greater than, improvements reported by White and English-speaking parents. These local data reflect the built-in cultural flexibility of Triple P. Practitioners are trained to introduce a consistent set of positive parenting principles and strategies, then tailor the content and teaching methods to individual families so that their goals, parenting plans, and use of the parenting strategies reflect their personal and cultural values.

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?

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

a. **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 2023-24 are currently being analyzed. However, a cumulative analysis of outcomes (using the new assessment tools adopted in July 2018) demonstrates positive outcomes such as:

- **Improvements in child behavior and emotional regulation.**
    - As measured by the CAPES (July 2018 – June 2022): Overall, the majority of parents who completed intensive services demonstrated improvements in child emotional and behavioral regulation. Of the parents who began the program with more serious parenting issues, 92% reported improvements in children's challenging behaviors and 90% reported improvements in emotional difficulties.
- **Increased use of positive parenting styles.**
    - As measured by the PAFAS (July 2018 – June 2022): On average, 64% of parents reported improvements in consistent parenting, and 69% reported decreased use of coercive parenting practices after completing the program.
- **Improvements in parental emotional well-being and family relationships.**
    - As measured by the PAFAS (July 2018 – June 2023): On average, 64% of parents reported improved emotional well-being after participating in the program. In addition, 74% reported improvements in parent-child relationships, and 58% reported improvements in overall family relationships.
- **Increased parental confidence.**
    - As measured by the CAPES (July 2018 – June 2023): Overall, the majority of parents reported improvements in their confidence as a parent. Of the parents who began the program with more serious parenting issues, 95% reported increased confidence by the end of the program.

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.
First 5's Triple P Program Manager (staff) and Triple P consultant provide individualized implementation support to practitioners and their supervisors/managers and facilitates peer coaching during quarterly Triple P practitioner meetings.

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 and 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.

  All individual and group services have been offered by phone and/or video during the COVID-19 pandemic. Some Triple P practitioners are beginning to resume in-person services, but virtual services are likely to remain an integral part of the local Triple P system. While COVID-19 created significant disruptions to Triple P services, the shift to providing virtual sessions and Zoom classes has made it more feasible for some parents to participate because the usual childcare and transportation barriers have been removed.

- **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 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, mental health status, or other household challenges. First 5 Santa Cruz County disseminates bilingual messaging and materials through its countywide Level 1 social marketing campaign, which normalizes the need for parenting support and reduces the social stigma that often prevents parents from seeking help before costly treatment is required. Key social marketing and outreach activities include:

- 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.
- Coordinating outreach, classes, and other special events during the annual "Positive Parenting Awareness Month" in January, which has grown into a statewide movement.
- Distributing First 5's locally designed "parenting pocket guides" with bilingual Triple P parenting tips through schools, health care settings (clinics, pediatric offices, hospitals), childcare providers, county health and human service programs, correctional facilities, and other non-profits serving children and families.
- Utilizing bilingual "Triple P parenting strategy cards" to educate parents about positive parenting techniques during community outreach events and classes.

Program Name: Children's Services

Agency: COE: The Diversity Center

Numbers Served FYs 2021-2024:

FY 2021-22:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** 3,881
- **What is the number of families served?** 23

FY 2022-23:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)?** 1,896
- **What is the number of families served?** 56

FY 2023-24:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2023-2024)? 735**
- **What is the number of families served? 50 (Estimated)**

Target population:

- **Mental illness or illnesses for which there is early onset.**

Research shows that in addition to the destruction caused by COVID-19, the pandemic intensified preexisting health disparities that LGBTQ+ people experience. For instance, according to a 2022 Trevor Project report, 45% of LGBTQ+ youth reported having suicidal thoughts in the last year and 14% of LGBTQ youth attempted suicide in the past year including nearly 1 in 5 transgender youth. More broadly, individuals in our community are at greater risk of suicide, mood disorders, anxiety, eating disorders, alcohol and substance abuse, and tobacco use (C. Gillespie 2020). What's more, 34% of LGBTQ+ older people worry about having to hide their identity in order to access senior housing (SAGE 2021). From the "Injustice at Every Turn" Report, transgender people are four times more likely to live in poverty, 41% reported attempting suicide, and a high percentage feel oppressed.

State lawmakers have introduced more anti-LGBTQ legislation in 2024 than in the previous five years combined. With 558 anti-LGBTQ bills reaching state dockets, including over 100 specifically targeting transgender people, and 84 bills passed into law, LGBTQ people are fighting for their lives (American Civil Liberties Union 2024). This level of anti-LGBTQ+ intensity has created a ripple effect nationally and locally. The Trevor Project's Annual U.S. National Survey of LGBTQ Young People (2024) reports that 90% of young people said their well-being was negatively impacted due to recent politics. The Trevor Project also reports that 39% of LGBTQ+ young people seriously considered attempting suicide in the past year, including 46% of transgender and nonbinary young people. 50% of LGBTQ+ youth reported wanting mental health care but were not able to get it. Additionally, 66% of LGBTQ+ young people reported experiencing recent symptoms of anxiety and 53% of LGBTQ+ young people reported experiencing recent symptoms of depression.

Locally, Santa Cruz LGBTQ+ express fear and concern for their freedom and safety in response to recent anti-LGBTQ+ activity, such as the anti-trans letter in LookOut Santa Cruz, attempts to ban drag-queen shows, threats of physical violence to LGBTQ+ events, and calls for limitations on gender identity and expression in local schools.

How is the risk of a potentially serious mental illness defined and determined?
As a prevention-focused organization, our 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 significant concerns about the mental health and/or safety of a program participant, the individual was referred to an in-house

clinician or intern to receive on-site individual therapy, or a referral/warm handoff was made to appropriate behavioral health services.

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.

TDC's program addresses critical mental health and safety challenges impacting LGBTQ+ individuals, including high rates of depression, anxiety, and suicidal ideation, particularly among youth and transgender or nonbinary individuals. Many face barriers to accessing affirming mental health care due to affordability, stigma, and a shortage of LGBTQ+ providers. These challenges are compounded by systemic inequities that increase risks of school failure, unemployment, homelessness, and prolonged suffering. Our program combines trauma-informed counseling and preventative education to address these needs. Individual and family therapy sessions with TDC's licensed Clinical Program Director or supervised Mental Health Trainees provide affirming care aimed at reducing the symptoms of depression, anxiety, and suicidal ideation while promoting emotional resilience. Educational workshops like the Green Flags Workshop teach youth to identify healthy relationship behaviors and develop coping skills. Community-belonging activities, including the Queer Youth Prom and CampOUT offer safe spaces for healing and self-expression. Our program provides advocacy and support to GSAs, improving LGBTQ+ students' sense of belonging and reducing risks of school failure. Additionally, TDC facilitates in-service training with school administrators and community organizations, as well as educational LGBTQ+ speaker panels and Social Emotional Learning workshops in an effort to create welcoming school environments.

Outcomes:

Please refer to the evaluation methodology below for a detailed overview of the outcomes we assess to promote mental health. These key outcomes include:

1. Improved mental well-being.

2. Improved health coping strategies.

3. Improved sense of community belonging and connection.

These measurable outcomes reflect our commitment to fostering resilience and well-being in the individuals we serve.

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

TDC tracks satisfaction and program outcomes using both quantitative and qualitative evaluation methods, which include:

- Intake Form: Administered upon entry to everyone utilizing our services, this form collects demographic information, including gender, sexual orientation, race, income, geographical location, and school (when applicable).
- Mental Health Services Surveys: A pre-survey is administered at the initial session, followed by periodic formal check-ins to collect impact data.
- Support Group Surveys: A bi-annual check-in survey is conducted in spring and winter to assess the effectiveness of support groups.
- Training and Speaker Panel Surveys: After each training or speaker panel, a demographic/attendance and feedback survey is administered to gather participant feedback.
- Staff Observations: Ongoing staff observations provide additional insights to supplement self-reported progress and challenges.
- Narrative Feedback: Participants share specific examples of how our organization has supported their well-being.

The data collected through these methods is used to:

- Inform needed staff training.
- Identify and implement solutions to remove barriers to access.
- Adjust program modalities to better serve our community.

The entire process is supported by the dedicated TDC staff, including a Graduate Student Researcher from UCSC, who has implemented data and evaluation best practices. Survey questions are tailored as needed to ensure we capture the necessary qualitative and quantitative service information. By utilizing these comprehensive evaluation methods, we continually enhance the effectiveness of our programs and ensure we meet the needs of the LGBTQ+ community.

How is the Program likely to reduce suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes?

1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome**.
   TDC utilizes the Eight Dimensions of Wellness model, an evidence-based framework developed by Dr. Peggy Swarbrick. This model addresses holistic well-being by integrating eight interconnected dimensions: emotional, physical, social, occupational, intellectual, spiritual, environmental, and financial wellness. Research demonstrates that fostering wellness across these dimensions reduces mental health challenges, enhances coping skills, and improves overall quality of life, particularly in marginalized populations like LGBTQ+ individuals. The model's emphasis on prevention and resilience aligns with the program's goals of reducing suicidal ideation, school failure, and prolonged suffering. TDC also uses The Developmental Assets, an additional evidence based framework that identifies 41 positive traits, values, and experiences that help young people thrive. These assets include internal strengths like social-emotional skills and values, and external assets like relationships and opportunities.

2. **Explain how the practice's effectiveness has been demonstrated for the intended population**.
   The Eight Dimensions of Wellness model has been widely adopted in mental health and community-based interventions. Studies highlight its effectiveness in reducing depression and anxiety, fostering a sense of belonging, and promoting life skills, all of which are critical for LGBTQ+ populations facing systemic inequities. Our Graduate Student Researcher (GSR) has met directly with Dr. Peggy Swarbrick to assist in improving our data collection practices and ensuring we generate a baseline through approved evidence-based inventories or markers of wellness that resonate with LGBTQ+ individuals. Additionally, research suggests that LGBTQ+ youth who have high levels of Developmental Assets are less likely to engage in high-risk behaviors. These assets can also help LGBTQ+ youth develop resilience and coping strategies to help them in stressful

situations. These two frameworks have demonstrated to be effective. When surveyed, 80% of our participants reported an improvement in their mental health as a result of their time with The Diversity Center. Other key impacts include 75% learning healthy coping skills and 85% experiencing community connection and belonging. An area we continue to develop includes 65% experiencing improved relationships with family and friends.

3. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program**.
Our GSR is working directly with Dr. Swarbrick to ensure fidelity to the Eight Dimensions framework. The entire staff responsible for program development, delivery, and evaluation will have the opportunity to meet with Dr. Swarbrick in the next year. The Developmental Assets are a framework being adopted and implemented by a collaboration of local community based organizations. In 2025 the collaboration will contract with the Search Institute to provide a professional learning opportunity to strategize how this network can work together in becoming asset builders. The Executive Director and Development Director are committed to reporting out timely, accurate information to the County to keep them updated on the progress of 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 Diversity Center prioritizes access and linkage by connecting Santa Cruz County youth and adults in need of mental health care to the necessary resources and counseling as early as possible. To ensure our ability to do this, our program provides no-cost, on-site counseling services in Santa Cruz and Watsonville, and offers virtual counseling when needed. By addressing mental health concerns early, the program helps reduce the risk of more severe outcomes. Youth participating in our programs are made aware of this resource and utilize it when necessary. One participant said, "*The counseling has greatly improved my overall mental well-*

being. It is the best thing that has happened to me in a while. It is the best therapy that I have ever had."

- **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):

  TDC offers the only free and affirming LGBTQ+ mental health clinic in Santa Cruz County. Our services, including counseling, peer support groups, and well-being workshops, are designed to be culturally aware and accessible at no cost to participants. We actively pursue diverse funding streams to ensure that financial barriers never prevent LGBTQ+ individuals from receiving the care they need. Through targeted outreach efforts, we focus on high-risk populations, such as LGBTQ+ youth, transgender individuals, and those who have historically faced barriers to care, ensuring they are connected to timely and supportive mental health resources. One participant stated, *"The Diversity Center has made me feel much more comfortable in myself and has provided a place for me to be my complete self."*

- **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)*:

  Our team is dedicated to reducing stigma and discrimination within mental health services by creating programs that are welcoming, inclusive, and culturally sensitive. We offer opportunities for leadership, role modeling, and personal development, fostering safe spaces where individuals feel comfortable seeking help without fear of judgment. In addition, we engage in public education and community outreach

through our training initiatives to challenge stereotypes and misconceptions about both the LGBTQ+ community and mental health. One youth participant stated, *"It can be so relieving to be somewhere where no one is going to judge you and everyone is accepting. It is nice to have a safe space to be."*

Program Name: Live Oak Resource Center, PEI #1

Agency: COE, Live Oak Resource Center

Numbers Served FYs 2021-2024:

FY 2021-22:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** 276
- **What is the number of families served?** 219

FY 2022-23:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)? 907**
- **What is the number of families served? 627**

FY 2023-24:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2023-2024)?** 133
- **What is the number of families served?** Not specified

Target population:

- **Mental illness or illnesses for which there is early onset:** Variable
- **How is the risk of a potentially serious mental illness defined and determined?**

Each participant served at LOCR is designated a Family Advocate in their primary language and screened for support services and benefits such as Cal Fresh, Medi-Cal, CalWORKs, mental health services like Cognitive Behavioral Therapy, housing assistance, and other benefits such as energy assistance, unemployment benefits, rental and/or financial assistance and transportation. Depending on their presenting issues, they may be referred to follow-up with their designated Family Advocate for family case management services, parent education classes, and/or counseling services. As participants begin utilizing these services, more serious needs sometimes emerge. At this point, we may refer out for additional interventions with a partner such as County Mental Health Services. Whenever possible, we continue

providing support concurrently with these other services. We offer ESL classes and provide childcare. We have continued to provide advocacy support to our Live Oak families, coordinating financial/rental assistance for undocumented families and those affected by this year's floods, including a clean-up equipment loan program, support with navigating FEMA applications, and filing insurance claims. In addition, we assisted with applications for ITINS, tax preparation, education and support regarding vaccines (Flu, COVID-19, Monkey-pox), assisting with the application and appeal process for state rental assistance, continuing our parent education classes and counseling online and in person, and our parent and child playgroups at the center.

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.

This project addresses all Five Protective Factors for Strengthening Families (Center for the Study of Social Policy) as follows:

1) **Parental Resilience**— Helping families realize the importance of developing resilient coping skills and how to develop them through individual and family counseling and by case management, by working one-on-one with parents for an extended time to set realistic goals and address barriers to their accomplishment.

2) **Social Connections**— Through the Cradle to Career Parent Leadership Council, Parent Education classes parents are able to socialize, build, and connect with others in the community. Revised 12/20/16 Santa Cruz County: Mental Health Services Act PEI Report

3) **Concrete Support in Times of Need**— Provided through case management, Family Advocates connect families with twice a month food distribution, enrollment in government benefits such as Medi-Cal and CalFresh, assist in applying for unemployment benefits, vetting for counseling services, supporting with various

financial assistance programs, seasonal assistance including back-to-school supplies and holiday gifts. Advocates also encourage participation in parental support programs and refer to other agencies as needed.

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

5) **Social and Emotional Competence of Children**— Enhanced through counseling, the parent-led Cradle to Career strategies, and participation in tutoring program.

This project addresses the Five Protective Factors for Strengthening Families. Data about activities and services in alignment with the 5 Protective Factors is provided below. Information was not available for FY23-24 at the time of this report.

A. Family Case Management-

In FY21-22, provided case management to 20 unduplicated families.
In FY22-23, provided case management to 63 unduplicated families.

- Assessed family strengths and needs
- Supported family in setting and pursuing goals
- Facilitated enrollment in government benefits and/or additional financial assistance
- Referred to appropriate community resources
- Provided translation as needed

B. A LEADERSHIP ROLE IN THE LIVE OAK CRADLE TO CAREER (C2C) INITIATIVE – **In FY21-22, engaged with 21 unduplicated parents and caregivers in Cradle to Career.**
In FY22-23, engaged with 32 unduplicated parents and caregivers in Cradle to Career.

- Participated in monthly C2C steering committee meetings
- Supported monthly Parent Leadership Council meetings
- Worked with parent leaders to carry out strategies identified to improve selected data indicators in the areas of health, education, and character
- C2C parents participated in LOCR parenting classes

C. COUNSELING SERVICES –

In FY21-22, provided services to 65 unduplicated individuals.
In FY22-23, provided services to 47 unduplicated individuals.

- Coordinated on-site counseling by professionally supervised counseling interns
- Coordinate and submit referrals for families to on-site counseling services
- Counseling services are bicultural and are offered in both Spanish and English, with the option of in-person or telehealth
- Counseling is billed to Medi-Cal or offered at no charge

D. COORDINATION OF PARENT EDUCATION CLASSES –

In FY21-22, 56 unduplicated parents and caregivers participated.

In FY22-23, 39 unduplicated parents and caregivers participated.

- Scheduled and promoted classes and workshops
- Enrolled families
- Arranged childcare for in-person classes as well as provided support for those participate in classes virtually via Zoom.

E. WEEKLY PARENT/CHILD PLAYGROUPS –

In FY21-22, 57 unduplicated caregivers and their children participated.

In FY22-23, 29 unduplicated caregivers and their children participated.

- One two-hour weekly group offered in Spanish

4. Specify any negative outcomes as a consequence of untreated mental illness.

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

Outcomes:

i. **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**:

Project outcomes are measured by:

1. An annual parent survey which asks program participants how strongly they agree or disagree with the following statements:
    a. As a result of participating in this class, I have improved parenting skills
    b. The Advocate continued to work with me until my issues were resolved
2. Tracking of progress towards goals set by the family
3. Cradle to Career Initiative indicators Parent Education assessments administered before and after each training series
4. Pre and post counseling assessments (DASS and SDQ)

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

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

1. Cradle to Career Initiative indicators are collected through annual student testing and surveys at the school site and reported back to the Cradle to Career Data Committee.
2. Cradle to Career indicators measure long-term, school-wide trends. LOCR's influence on these trends is contributive, rather than attributive. An annual survey is conducted each spring, which asks program participants how strongly they agree or disagree with the following statements:
    a. LOCR staff continued to work with me and has met my needs

b. As a result of participating in this class, I have improved parenting skills

FY 21-22 Outcomes: Annual Survey results included:

- 58.6% reported an improvement in parenting skills.
- 86.2% reported feeling overall satisfaction with their needs being met by LOCR staff.

FY 22-23 Outcomes: 86.2% reported feeling overall satisfaction with their needs being met by LOCR staff. At the end of each Triple P class or end of the series parents are asked about their parenting style and they reported the following improvement in their overall parenting style

- Parental consistency: 6.2%
- Coercive parenting: 9.9%
- Positive encouragement: 10.7%
- Parent-Child relationship: 12.3%

FY 23-24 Outcomes: Outcome data was not available for FY 23-24 at the time of this report.

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

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

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

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

- **The Protective Factors Framework**
  Studies show that building the Five Protective Factors promotes optimal child development and reduces child abuse and neglect (Center for the Study of Social Policy). Live Oak Community Resources', Advocates are trained in Family Strengthening Case Management and use the Five Protective Factors framework at the beginning of their relationship with the family and throughout their time

together, seeking out existing strengths to build on and identifying areas for growth.

- **Motivational Interviewing**
  LOCR Advocates are trained in Motivational Interviewing (MI), which has proven effective in supporting individuals through the process of behavior change (Case Western Reserve University Center for Evidence- Based Practices). Advocates use MI by framing conversations around Case Management families' interests for positive change in their lives and in their work. Additionally, MI can help families through personal changes, such as diet, exercise, reducing and eliminating the use of alcohol, tobacco, and other drugs, managing symptoms of mental illness and chronic physical conditions such as heart disease, diabetes, and obesity, among others.
- **The Promise Neighborhoods Model**
  The Live Oak Cradle to Career Initiative is based on the Promise Neighborhoods model, which began with the Harlem Children's Zone and was then federally funded to expand to communities nationwide. This model has proven effective in improving outcomes for families in high-need areas through the collective impact of parent leaders and multiple community agencies (Promise Neighborhoods Institute). As a member of the Cradle to Career steering committee, LOCR is on the front lines of bringing this model to the Live Oak community.
- **Positive Parenting Program**
  At LOCR, we partner with Positive Discipline Community Resources (PDCR) and classes are offered to LOCR families. If a family cannot pay for the class, the parents either are offered a scholarship to qualify for free classes. Triple P is a parenting program used in communities around the world, and officially adopted by First 5 Santa Cruz County, the Santa Cruz County Health Servies Agency, and the Santa Cruz County Human Services Department. The Community Bridges Family Resource Collective employs 4 certified Triple P educators, who provide Parent Education in English and in Spanish, working both in-group and individual settings.
- **Cognitive Behavioral Therapy**
  CBT has proven effective in controlled studies to treat conditions including anxiety disorders, anger issues, and general stress (Hoffman et al. 2012). CBT is used in the early stages of traumatic response. CBT is a skills-based, present-focused,

and goal-oriented treatment approach that targets thinking styles and behavioral patterns that cause and maintain a depression-like state. At LOCR, certified Marriage and Family Therapist interns work under the licensed supervision of Community Bridges' Clinical Supervisor to provide CBT and complimentary treatment methods to adults and children undergoing events such as bullying, family violence, or sexual assault, or experiencing conditions including depression and/ or anxiety. CBT is offered in both Spanish and English. Counseling participants often come referred by community partners such as the Juvenile Probation Department, local schools or school districts, and will sometimes receive a referral from a county nurse or caseworker. Participants take pre and post DASS (Depression Anxiety Stress Scales) or SDQ (Strengths and Difficulties Questionnaire) assessments to gauge program effectiveness.

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

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

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

For over 50 years, the Family Resource Collective has been building trusting relationships with the communities the centers individually serve. The Family Advocates build trust with each participant to ensure there is clear communication, when offering mental health services and parent support groups. This is an important step to ensure that families are educated about the requirements and benefits of the program and increase the number of participants' commitment to change. During the referral process, the Advocates explain the program to families and answer any questions or concerns they may have. Clear communication addresses stigma of mental health services and allays fears participants may harbor regarding immigration status, and any financial burdens or language barriers.

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: 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)*:

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

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

  Counseling services at our site are billed to Medi-Cal, on a sliding scale fee, or provided free of charge. Counseling is offered both during and after school hours, and evenings depending on need. In response to COVID-19 we offered tele-health services to counseling participants, and this year began seeing counseling participants in person, as preferred. Currently, LOCR has a bilingual counselor and an MFT intern that are both available to serve Spanish-speaking participants (often counseling is provided for English-speaking children who have Spanish-speaking parents) under the supervision of our Clinical Supervisor. If more counseling is requested in Spanish and have a waitlist, we provide a warm handoff to a bilingual counselor either at Santa Cruz Community Health Centers or Family Service Agency, or other agencies in the county.

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

Program Name: PBIS

Agency: Santa Cruz County Office of Education

Participating Schools:

In FY 2021-22 and FY 2022-23, the program included 5 school districts representing 20 schools in Santa Cruz County. The school districts include:

Live Oak School District
- Cypress Charter High School
- Del Mar Elementary
- Green Acres Elementary
- Live Oak Elementary
- Shoreline Middle School

Scotts Valley Unified School District
- Brook Knoll Elementary
- Scotts Valley High School
- Scotts Valley Middle School
- Vine Hill Elementary

Santa Cruz City Schools
- Bayview Elementary
- Branciforte Middle School
- Delaveaga Elementary
- Gault Elementary

Westlake Elementary

Soquel Union Elementary School District

Main Street Elementary

New Brighten Middle School

Santa Cruz Gardens Elementary

Soquel Elementary

San Lorenzo Valley Unified School District

Boulder Creek Elementary

San Lorenzo Valley Elementary

In FY 2023-24, the program expanded to 6 school districts (adding Pajaro Valley Unified School District) representing 48 schools in Santa Cruz County. The participating schools in the Pajaro Valley School District include:

Alianza Charter School

Amesti Elementary

Ann Soldo Elementary

Aptos High School

Aptos Junior High School

Bradley Elementary

Calabasas Elementary

Cesar Chavez Middle School

Diamond Technology Institute

E.A. Hall Middle School

Freedom Elementary

Hyde Elementary

Lake View Elementary

Landmark Elementary

MacQuiddy Elementary

Mintie White Elementary

New School 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

Numbers Served FYs 2021-2024:

FY 2021-22:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** The 5 school districts representing 20 schools impacted more than 10,700 students.
- **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 5,138 (10,070/1.96)

FY 2022-23:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)?** The 5 school districts representing 20 schools impacted more than 17,500 students.
- **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 8,928 (17,500/1.96)

FY 2023-24:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2023-2024)?**
  The 6 school districts representing 48 schools impacted more than 34,800 students.
- **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 17,755 (34,800/1.96)

Target population:

- **Mental illness or illnesses for which there is early onset:** Varies per the usual general school aged population statistics.
- **Description of how participant's early onset of a potentially serious mental illness will be determined:** PBIS does not utilize clinicians or serious mental illness

diagnostics given that the trainings and programs are learned and implemented by school staff: janitors to teachers to principals. There are, however, 3 tiers of prevention and intervention. Tier 3 represents student referrals that need individual planning and programming. In this process of individualizing services and supports a referral can also be made to a collaborative counseling agency if the school personnel determine the needs are severe enough or needs more assessment. At this level a school team would also be convening to discuss this highest level of supportive services, hence the decision to refer would be based on multiple inputs.

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.

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).

Outcomes:

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 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**:

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

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

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

   Nothing more than mentioned in 4, part A above.

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

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

Cultural competence seems also a place for improvement, as the reporter has not seen an explicit document or process that would consider 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.

A. 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**. 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.
    - **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.

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. *Answered A*
- 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.

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

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

Supplemental Notes:

*Most youth are healthy, physically and emotionally, yet one in every four to five youth in the general population meet criteria for a lifetime mental disorder that is associated with severe role impairment and/or distress (11.2 percent with mood disorders, 8.3 percent with anxiety disorders, and 9.6 percent behavior disorders).1 A national and international literature review found that an average of 17 percent of young people experience an emotional, mental, or behavioral disorder. Substance abuse or dependence was the most commonly diagnosed group for young people, followed by anxiety disorders, depressive disorders, and attention deficit hyperactivity disorder.2 The rate of serious mental illness was higher for 18 to 25 year olds (7.4 percent) in 2008 than for any other age group over 18.3 In addition, the onset for 50 percent of adult mental health disorders occurs by age 14, and for 75 percent of adults by age 24.4(youth.gov website July, 2017: http://youth.gov/youth-topics/youth-mentalhealth/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

Program Name: Veterans Advocate Agency

Agency: Santa Cruz County Behavioral Health Services

Numbers Served FYs 2021-2024:

FY 2021-22:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** 237
  What is the number of families served? 97

FY 2022-23:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)?** 258
- **What is the number of families served?** Not specified

FY 2023-24:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2023-2024)?** 244
- **What is the number of families served?** 87

Target population:

- **Mental illness or illnesses for which there is early onset:** Not specified
- **Description of how participant's early onset of a potentially serious mental illness will be determined:**

Risk for serious mental illness is indicated by homelessness, identification of traumatic events during military service, identification of traumatic events during childhood, pervious mental health diagnosis, and substance use disorder.

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.

Veterans Advocates will work to identify veterans struggling with substance abuse, homelessness, incarceration, mental health challenges, 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 the Veterans Advocate will contribute a reduction in suicide, incarceration, school failure, unemployment, homelessness and prolonged suffering.

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:

Veterans Advocates conduct interviews with each client and screens them for placement in appropriate programs including county mental health, VA counseling programs, and VA residential programs. Veterans Advocates work to identify warning signs of PTSD, depression, and other mental health conditions. Veterans Advocates coordinate appropriate care and connection 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, and
- 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 are measured, how data is collected and analyzed, and how the evaluation reflects 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 Advocates will maintain professionalism with all clients and utilize active listening and motivational interviewing skills to identify the specific challenges of each client and create pathways to success.

[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 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 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 Veterans 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 Veterans 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.

The Veterans 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. The Veterans Advocate will work closely with the Veterans Services Office to coordinate efforts and ensure effectiveness.

Describe how the following strategies were used:

- **Access and Linkage**

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 can assess the needs of each client and make appropriate referrals based on those needs.

FY 2022-23 by the numbers:
Total Volunteer Peer Supports: 7

Incoming Referrals
Connecting with local veterans requires the Veteran Advocate to maintain working relationships with other service providers in Satna Cruz County. Through in-service trainings and consistent collaboration, the Veteran Advocate has built up report with various agencies.

FY 2022-23 by the numbers: Where Referrals come from
Veteran Services Office: 61
Vets Court/ Public Defenders office: 43
Home Health Agencies: 18
Non-profit/ Veteran Organizations: 24
Family member of Veteran: 12
Housing programs: 21
Adult Protective Services: 16
Self-referrals / Walk-ins: 15
County Jail: 7
Friend/ not related: 5
Hospice: 4
Hospital: 8
Senior Network Services: 1
Art program: 4
Assisted living facility: 2
HOPES Team: 2
VA healthcare: 3
Collages: 6
Watsonville Veteran Services Day: 6

Collaborative Meetings

Beyond direct services, the Veteran Advocate strives to open lines of communication with other service providers and community partners. The Veteran Advocate hosts a monthly Collaborative meeting with service providers working with Veterans in Santa Cruz County. These meetings are attended by 15-20 people and including service providers from veteran housing programs, the Veteran Services Office, veteran member organizations, in-home care agencies, employment services, and more.

Emergency Assistance

Many of the veterans served by the Veteran Advocate have emergency needs that are not easily met by traditional resources. Through collaboration with Vets 4 Vets Santa Cruz, Community Foundation Santa Cruz County, and the Bob Woodruff Foundation, the Veteran Advocate has been able to help veterans access emergency assistance that can be used for food, clothing, rental assistance, transportation, and other urgent needs.

FY 2022-23 by the numbers:

Total Emergency funds distributed in FY 2022-2023: $18,148
Total Veterans & families Served: 72

Santa Cruz Veterans Art Program

The Veteran Advocate coordinates the Santa Cruz Veterans Art program. Through artistic expression and community engagement, this program fosters healing, understanding, and support. By enabling veterans to share their art with the world, this program plays a significant role in breaking down barriers, building connections, and promoting overall well-being, making it an invaluable resource for the veteran community and the greater community of Santa Cruz County.

FY 2022-23 by the numbers:

Hosted 2 events that featured Veteran Artists.

Program Name: Peer Companion

Agency: Seniors Council of Santa Cruz County

Numbers Served FYs 2021-2024:

FY 2021-22:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** 14

FY 2022-23:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)?** 14

FY 2023-24:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)?** Not specified

Target population:

Description of how participant's early onset of a potentially serious mental illness will be determined:

The Senior Program Coordinator 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.

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.

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 the Senior Program Coordinator 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.

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:

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
- mood and behavior improvement
- personnel expression
- companionship

Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects 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.

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?

a. **Describe the evidence that the approach is likely to bring about applicable outcomes**: Logic Model Attached in Appendices.
b. **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 included in Appendices.

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.

Describe how the following strategies were used:

- **Access and Linkage**
  This service is provided by Susan Fisher, OTR/L with Santa Cruz County Behavioral Health Services.
- **Timely Access to Mental Health Services for Underserved Populations** 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. COVID-19 change: Senior Companions began picking up pre-ordered groceries and prescription's that are delivered to their clients (following CDE guidelines so as not to interact physically with clients).
- **Stigma and Discrimination reduction**
  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 13 years and the other for 9 years).

PEI #2 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).

Program Name: Employment (Community Connection)

Agency: Volunteer Center of Santa Cruz
Numbers Served FYs 2021-2024:
FY 2021-22:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** 42

FY 2022-23:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)?** 63

FY 2023-24:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** 137

Target population:

- **Mental illness or illnesses for which there is early onset:** Schizophrenia Spectrum Disorders, PTSD, Bipolar, Major Depression

Description of how participant's early onset of a potentially serious mental illness will be determined: Intake questionnaires, psychosocial assessments, ANSAs, interviews with individuals/mental health care professionals/school counselors/family members/other support people.
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.
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, incarceration, unstably housed, first episode of psychosis.
Activities: supported employment and education counseling (including the opportunity to volunteer and meet employers in order to better prepare to enter the workforce and opportunities to attend classes specific for mental health consumers at the college level), skill building and symptom management, opportunities to participate in groups with peers and information to find meaningful activities. Services are provided in the community, at school, and in the workplace to reduce stigma and better serve the young adult population.
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 of support services, education, employment, and

volunteerism opportunities, as well as reduced hospitalizations due to a mental health crisis, and reduction of relapse of psychosis and SUD

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

Completion of yearly ANSAs and Recovery Evaluations every 3 months. Data is collected via Google Forms. Evaluations include culturally inclusive questions including racial/ethnic/gender/LGBTQIA+ identity.

Changes in program outcomes and data collection over FYs 2021-24:

For the fiscal years indicated, our methods have remained steady but have been slightly more robust in the last 2 years. We collect more data around demographics, hospitalizations, specific age ranges, and incarcerations. Our client data tracking methods have worked well and could use more regular assessment. For instance, the Program Manager will be required to check Client Evaluation due dates for promptness of completion on a quarterly basis.

The outcomes achieved during the three-year period from FY 2021-22 – FY 2023-24 are summarized below.

Outcome Measure	FY 2021-22	FY 2022-23	FY 2023-24
Total Participants Served	42	63	137
Total number/%Hospitalized	4 (18%)	10 (16%)	15 (11%)
Total enrolled in school	9	19	17
Total engaged in volunteer/work opportunities	12	39	53
Number of TAY consumers ages 17 and under	0	5	4

FY 2021-22 Outcomes: In FY 2021-22, we served 42 people in the TAY program and only 74% (31) were in the target age range. The remaining clients were over 25 but were reaching out for services for the first time. Of the 42 clients, 18% had an inpatient hospitalization this year and 0.01% of those were hospitalized more than once. Only 16% of clients were also enrolled in SUD services, although most participants expressed substance use as an ongoing issue.

FY 2022-23 Outcomes: In FY 2022-23, we served 63 people in the TAY program and only 81% (51) were in the target age range. The remaining clients were over 25 but were reaching out for services for the first time. Of the 63 clients, 16% had an inpatient hospitalization this year and 0.01% of those were hospitalized more than once. Only 10%

of clients were also enrolled in SUD services, although most participants expressed substance use as an ongoing issue. We were able to incorporate 5 under 18 year-old individuals into TAY service delivery.

FY 2023-24 Outcomes: In FY 2023-24, we served 137 people in the TAY program and 91% (125) were in the target age range. The remaining clients were over 25 but were reaching out for services for the first time. Of the 137 clients, 11% had an inpatient hospitalization this year and 0.01% of those were hospitalized more than once. Only 12% of clients were also enrolled in SUD services, although most participants expressed substance use as an ongoing issue. We were able to incorporate four 14–17-year-old individuals into TAY service delivery.

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?

A. 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**.
  Motivational Interviewing, NAVIGATE Model SEE (Supported Employment and Education)/IRT (Individual Resiliency Training)/Family Education, and Case Management have all been shown to reduce the experience of severe mental health challenges, being unhoused, substance misuse, incarcerations, harm to self/others, and reliance on government funding for wellbeing.
- **Explain how the practice's effectiveness has been demonstrated for the intended population**.
  The above-mentioned practices have been shown to increase independence, autonomy, resilience, and grit while reducing recurrence of mental health challenges, psychosis, and dependence on substances.
- **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**
  We will ensure fidelity through ongoing supervision and trainings of staff as well as oversight and consultation from the NAVIGATE creators.

Describe how the following strategies were used:

- **Access and Linkage**
  Participants are asked if they are connected with support services (SCBH, NAMI, MediCal, etc.) upon intake and are given resources and support in coordinating services if they are not already enrolled.

- **Timely Access to Mental Health Services for Underserved Populations**
  Families and participants of underserved or marginalized populations are to be outreached at community events, schools, and through other services provider warm hand-offs. With bilingual staff who have lived experience, identify as LGBTQIA+, and also identify as coming from underserved populations available to meet participants in the community, at their homes, or anywhere all parties can be safe and available.
- **Stigma and Discrimination reduction**
  In addition to appropriate trainings and opportunities to not have to self-identify in the community as struggling with mental health challenges, we are creating social media platforms centering on mental health and how to normalize and encourage folks to seek support for mental health struggles. Staff are also taught how to provide trauma informed services in a culturally sensitive manner.

Program Name: Wellness Connect (Transition Age Youth and Adult Services)

Agency: Community Connection, a program of the Volunteer Center
Target population: Youth and Young Adults between the ages of 14-25 experiencing a serious mental illness or first episode psychosis.

- **What is the unduplicated number of individuals served in preceding fiscal year?** 51
- **What is the number of families served?** 40
- **Target population**: Youth and Young Adults between the ages of 14-25 experiencing a serious mental illness or first episode psychosis.
- **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:** Clients are assessed through the County Access Team and referred to Wellness Connect, or identified at Wellness Connect by people who self-present for services and are screened and then referred for assessment through the County Access Team. Assessments are also available as walk-in, by appointment, and via Telehealth.

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.
Early onset/first-break 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:
Reduction in hospitalizations and other higher level-of-care residential services, family report, self-report, and ability to maintain job and/or school functions.
Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects cultural competence:
CANS and ANSA assessments are administered every 6 months.
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?

- **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome**.
    - CANS and ANSA reports- determine areas of clinical concern for individuals and evaluate changes in client's current functioning and symptomology related to services utilized, housing, vocational and educational status, hospitalizations, conservatorship, etc.
- **Explain how the practice's effectiveness has been demonstrated for the intended population**.
    - CANS and ANSA reports- data used to develop treatment plan goals.
    - Review of CANS and 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.**
    - Monitoring within program and by County.

Describe how the following strategies were used:

- **Access and Linkage**
  Individuals identified as eligible for these services are screened and assessed for appropriate services. Additional supports are provided through linkages to other community services.
- **Timely Access to Mental Health Services for Underserved Populations**
  Screening and Assessment services are available as walk-in, appointment and via Telehealth. If an appointment is not available within the timely access period, individuals are encouraged to walk-in.

- **Stigma and Discrimination reduction**
  Psychoeducation for clients and their families, TAY Youth Council for social supports and normalization of the clients' experience, and Referrals to vocational, educational, and independent housing services to increase clients' quality of life.

PEI #3 Outreach

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.

Program Name: Senior Outreach

Agency: Family Services Agency
Numbers Served FYs 2021-2024:
FY 2021-22:

Number of Potential Responders served in previous fiscal year (FY2021-2022): 70
Settings in which potential responders were engaged: Agencies include Volunteer Center, Unite Us, Dignity Health, PAMF, Hospice and Senior Network Services. We also get referrals from private physician offices. This year during the pandemic, we focused on working with staff of referring agencies to make sure clients eligible for our services were sent to us for phone or telehealth individual and group services.
Types of potential responders engaged in each setting:
Social workers, physician offices, nurses, and staff at the various nonprofit agencies.

FY 2022-23:

Number of Potential Responders served in previous fiscal year (FY2022-2023):
Approximately 900
Settings in which potential responders were engaged: Senior centers, physician offices/health centers/clinics, cultural organizations and events (MAH), senior support groups, senior residences, residential care facilities, Sr. Network Services, APS, Grey Bears, dialysis clinics, Stroke Center, shelters, libraries, Louden Nelson, VNA, volunteer settings, homes of seniors, health fairs, support groups, Diversity Center, PAMF, Dignity Health, Hospice, Palliative Care, Unite Us.
Types of potential responders engaged in each setting: Social workers, medical clinics including physicians, nurses and staff, families of seniors, visiting nurses, social workers, caregivers, volunteers, mental health therapists and workers, residential care

administrators including personnel and residents, staff at various nonprofit agencies, health fair workers and attendees.

FY 2023-24:

Number of Potential Responders served in previous fiscal year (FY2023-2024): 66 (as of March 2024)

Settings in which potential responders were engaged: Senior centers, physician offices/health centers/clinics, cultural organizations and events (MAH), senior support groups, senior residences, residential care facilities, Sr. Network Services, APS, Grey Bears, dialysis clinics, Stroke Center, shelters, libraries, Louden Nelson, VNA, volunteer settings, homes of seniors, health fairs, support groups, Diversity Center, PAMF, Dignity Health, Hospice, Palliative Care, Unite Us.

Types of potential responders engaged in each setting: Social workers, medical clinics including physicians, nurses and staff, families of seniors, visiting nurses, social workers, caregivers, volunteers, mental health therapists and workers, residential care administrators including personnel and residents, staff at various nonprofit agencies, health fair workers and attendees.

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 telephone outreach, we are creating awareness of mental health issues that help responders to identify and to allow for a response to signs and symptoms. Materials, posters and handouts are distributed to clients through medical offices, health fairs, senior residential housing, senior centers, social workers, visiting nurses, other nonprofits and the general public.

Explain the utilization of the following strategies:

- **Connection and Coordination (Linking individuals with severe mental disorders to medically necessary care and treatment as promptly as possible following the onset of these conditions, encompassing care supplied by county mental health initiatives):**

  Our outreach participants consistently receive information regarding County mental health support options, like the around-the-clock multilingual suicide crisis hotline (now 988) and elderly care resources available through the local directory. Staff members and volunteers keep detailed references of community

resources that cover aspects such as housing, accessibility, crisis intervention, home health, caregiver assistance, case handling, and government services.

- **Prompt Mental Health Service Provision to Underserved Groups (Enhancing the likelihood that a person or family from a marginalized community requiring mental health care due to the risk or existence of a mental illness gains timely access to suitable services, thanks to features like cultural compatibility, transportation, accessibility, family-centric approaches, available hours, and service costs):**
  Specialized training is given to peer counselors, empowering them to guide participants in identifying issues tied to aging such as grief, loss, depression, and substance-related problems. Should additional support be needed, seniors are directed to other services like County Access, APS, Medi-Cal, IHSS, Medicare-licensed counseling, MSSP, the Stroke Center, CCCIL, Senior Network Services, Second Harvest, and Lift Line for transport. Extra attention is paid to prioritize underserved groups, including but not limited to LGBTQI individuals, veterans and their families, and seniors with histories of substance, sexual, or physical abuse, domestic violence, and loneliness.
- **Reduction of Stigma and Discrimination (Encouraging, shaping, and executing programs in manners that minimize and avoid stigma, self-stigma included, and prejudice tied to mental illness diagnoses, possession of mental illness, or seeking mental health aid, while ensuring accessible, approachable, and positive services):**
  Every facet of our volunteer peer training, one-on-one services, support groups, and outreach efforts is dedicated to enhancing understanding of senior mental health matters, debunking prevalent misconceptions, and fostering open and sincere dialogues about aging-related mental health concerns. The pandemic has further isolated seniors, intensifying the risk of illness and death. We address mental health difficulties as natural outcomes of aging's social and biological factors. Individual and group counseling is conducted in an uplifting and compassionate manner by trained volunteers who employ active listening techniques.

PEI #4 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.

Program Name: Stigma and Discrimination Reduction

Agency: NAMI-SCC

Numbers Served FYs 2021-2024:

FY 2021-22:

Number of people reached in previous fiscal year (FY2022-2023): 16,988 duplicated client count

FY 2022-23

Number of people reached in previous fiscal year (FY2022-2023):

Q1: Data not available
Q2: Unduplicated total client count 10/1/22 - 12/31/22: **673**
Q3: Unduplicated total client count 01/01/23 - 03/31/23: **1321**
Q4: Unduplicated total client count 04/01/23 - 06/30/23: **1364**

FY 2023-24

Number of people reached in previous fiscal year (FY2023-2024):

Q1: Unduplicated total client count 7/1/23 - 12/31/23: **2,961**
Q2: Unduplicated total client count 10/1/23 - 12/31/23: **3,532**
Q3: Unduplicated total client count 01/01/24 - 03/31/24: **1,961**
Q4: Unduplicated total client count 04/01/24 - 06/30/24: **2,734**

Identify who the program intends to influence:

- Education and Training Series – families, consumers, and providers.
- Presentations and Public Education – students (middle, high school, higher ed), consumers, teachers/professors, community at large
- Community Partnerships – providers, families, and consumers
- Support Programs – families and consumers

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**

  We ask participants to fill out evaluations upon participation in any of our programs to ensure we meet the stated goals. Each of our programs has a slightly different goal related to the following: reducing stigma, access to mental health care, and/or an increased understanding of mental health conditions. All of these are central themes in NAMI programming, and are interwoven throughout our classes, groups, and presentations. Our methods of delivery include psychoeducation, structured

conversations, NAMI tools and structures, and promoting a culture of sharing lived experience. We analyze our surveys monthly, and will be submitting the outcomes to County Behavioral Health on a quarterly basis starting next year.

Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:

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

- **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:

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

  Two research studies have been conducted on NAMI Basics

  1. 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.
  2. 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:

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

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

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.

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

Describe how the following strategies were used:

- **Access and Linkage:**
  Warmline/Helpline in English and Spanish- 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 in English and Spanish – Provide linkage to services and support by relying on the wisdom of the group. We also have an email group where NAMI Volunteers are kept current on resources and events that they can then

share with the attendees.
Website and Facebook – online presence distributes information on local resources and events as well as articles on current research, recordings of local meetings.
Online Chat Group Support for Parents of children ages 12 to 26. Parents share resources, opinions, and support each other. Linkage to services and supports.

- **Timely Access to Mental Health Services for Underserved Populations:**
  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, even on an emergency basis. Our classes, support groups and individual advocacy helps to address their needs and improve the outcomes of the consumer. All of our programs are free, offered on a regular basis, do not involve an extensive intake process, and many of our programs are drop-in friendly.
  We also added two new peer programs in Spanish - our Peer-to-Peer/Persona a Persona class, and our Connection/Conexion support group. In a county where a high percentage of the population speaks Spanish, language accessibility is a high priority. We are excited to be able to now offer all of our peer and family programs in Spanish!

- **Stigma and Discrimination reduction:**
  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 effect is a robust one, occurring across different presenters, across different study schools, and across the diverse populations within those schools.

NAMI Outcomes Information:

FY 2022-23: Programs surveys/outcomes
Outcome data was not available for this time period.

Family-to-Family:
"As a result of this class, I am better able to access the care and support services that I or my family member need" **100% (15)**
"As a result of this class, I am better able to manage crises that may result from mental health conditions" **79% (14)**
"I would recommend this program to others" **100% (15)**

Peer-to-Peer:
"As a result of this class, I am better able to access the care and support I need" **92% (13)**
"As a result of this class, I am better able to manage the stresses and negative impacts of my mental health condition" **100% (13)**
"I would recommend this program to others" **100% (13)**

Mental Health Education:
"I have learned information from the Ambassadors presentation that is useful": **75% (32)**
"I would recommend this presentation to others" **85%**

School Presentations:
"As a result of this presentation, I have an understanding of how to seek help" **95% (85)**
"As a result of this presentation. I can identify a friend or trusted adult who I can talk to about mental health": **89% (84)**

Peer Support Groups:
"I feel satisfied with the support group" **96% (90)**
"This support group gives me practical information to help me deal with my problems or challenges" **99% (89)**
"I would recommend this program to others" **100% (89)**

Provider Education: n/a Q2

Community Education: n/a Q2

Family Navigation Helpline: n/a Q2

FY 2022-23 Q3: Programs surveys/outcomes

Family-to-Family:
"As a result of this class, I am better able to access the care and support services that I or my family member need" **97% (33 surveyed)**
"As a result of this class, I am better able to manage crises that may result from mental health conditions" **91% (32)**
"I would recommend this program to others" **100% (33)**

Peer-to-Peer:
"As a result of this class, I am better able to access the care and support I need" **88% (16 surveyed)**
"As a result of this class, I am better able to manage the stresses and negative impacts of my mental health condition" **88% (16)**
"I would recommend this program to others" **94% (16)**

Mental Health Education:
"I have learned information from the Ambassadors presentation that is useful": **81% (64 surveyed)**
"Overall, I feel satisfied with the Ambassadors presentation I received" **83% (64)**

School Presentations:
"As a result of this presentation, I have an understanding of how to seek help" **87% (203 surveyed)**
"As a result of this presentation. I can identify a friend or trusted adult who I can talk to about mental health": **83% (202)**

Peer Support Groups:
"I feel satisfied with the support group" **98% (62 surveyed)**
"This support group gives me practical information to help me deal with my problems or challenges" **98% (67)**
"I would recommend this program to others" **97% (66)**

Community Education:
"Because of this Speaker Meeting, I now have more information on mental health and the subject presented" **100% (13 surveyed)**

Family Navigation Helpline:

Value Based Leadership
90% (9/10) full-time staff attended value-based leadership training
75% (15/20) part-time staff attended value-based leadership training
92.5% (27 surveyed) able to define 3 characteristics of a good leader
100% (27) reported values that motivate them in their work

FY 2022-23 Q4: Programs surveys/outcomes

Family-to-Family:
"As a result of this class, I am better able to access the care and support services that I or my family member need" **98% (42 surveyed)**
"As a result of this class, I am better able to manage crises that may result from mental health conditions" **88% (41)**
"I would recommend this program to others" **100% (43)**

Peer-to-Peer:
"As a result of this class, I am better able to access the care and support I need" **83% (23 surveyed)**
"As a result of this class, I am better able to manage the stresses and negative impacts of my mental health condition" **83% (23)**
"I would recommend this program to others" **91% (23)**

Provider Education Program:
"As a result of this class, I have a better understanding of the type of intervention and support people with mental illness need" **100% (20 surveyed)**
"As a result of this class, I am better able to recognize the impact mental health conditions have on individuals and families" **100% (20)**
"I would recommend this program to others" **100% (20)**

Community Education:
"Because of this Speaker Meeting, I now have more information on mental health and the subject presented" **100% (13 surveyed)**

Mental Health Education:
"I have learned information from the Ambassadors presentation that is useful": **81% (64 surveyed)**
"Overall, I feel satisfied with the Ambassadors presentation I received" **83% (64)**

School Presentations:
"As a result of this presentation, I have an understanding of how to seek help" **87% (208 surveyed)**
"As a result of this presentation. I can identify a friend or trusted adult who I can talk to about mental health": **83% (207)**

Peer Support Groups:
"I feel satisfied with the support group" **98% (270 surveyed)**
"This support group gives me practical information to help me deal with my problems or challenges" **99% (288)**
"I would recommend this program to others" **99% (286)**

Family Navigation Helpline:

Value Based Leadership
90% (9/10) full-time staff attended value-based leadership training
75% (15/20) part-time staff attended value-based leadership training
92.5% (27 surveyed) able to define 3 characteristics of a good leader
100% (27) reported values that motivate them in their work

Crisis Response Training
95% As a result of this presentation, I now feel better equipped to support someone in a crisis situation **(41 surveyed)**
100% As a result of this training, I know when to connect someone I am supporting to 9-8-8 **(40)**

FY 2023-24: Programs surveys/outcomes

Mental Health Education:
"I have learned information from the Ambassadors presentation that is useful": **79% (48 surveyed)**
"Overall, I feel satisfied with the Ambassadors presentation I received" : **90% (48)**

School Presentations:
"As a result of this presentation, I have an understanding of how to seek help": **75% (17 surveyed)**
"As a result of this presentation. I can identify a friend or trusted adult who I can talk to about mental health": **87% (17)**

Peer Support Groups:
"I feel satisfied with the support group": **100% (6 surveyed)**
"This support group gives me practical information to help me deal with my problems or challenges": **100% (6)**
"I would recommend this program to others": **100% (6)**

FY 2023-24 Q2: Programs surveys/outcomes

Family-to-Family & Basics Education Series:
"As a result of this class, I am better able to access the care and support that I or my family member need" **85% (5 people surveyed)**
"As a result of this class, I am better able to manage crises that may result from mental health conditions" **85% (5)**
"I would recommend this program to others" **100% (5)**

Peer-to-Peer Education Program:
"Because of the Peer-to-Peer course I just attended, I am better able to access the care and support I need": **100% (4 people surveyed)**
"Because of the Peer-to-Peer course I just attended, I am better able to manage the dresses and negative impacts my condition may cause": **100% (4)**
"I would recommend this program to others": **100% (4)**

Community Education, Events, Speaker Meetings, Lectures:
"Because of this presentation, I now have more information on mental health and the subject presented": **100% (10 people surveyed)**
"This presentation was useful to myself or a loved one": **96% (10)**

School Presentations:
"As a result of this presentation, I have an understanding of how to seek help": **80% (23 surveyed)**
"As a result of this presentation. I can identify a friend or trusted adult who I can talk to about mental health": **86% (23)**

Support/Educational Groups:
"I feel satisfied with the support group": **100% (12 surveyed)**
"This support group gives me practical information to help me deal with my problems or challenges": **98% (12)**
"I would recommend this program to others": **100% (12)**

FY 2023-24 Q3: Programs surveys/outcomes

Family-to-Family & Basics Education Series:
"As a result of this class, I am better able to access the care and support that I or my family member need" 87% (7 people surveyed)
"As a result of this class, I am better able to manage crises that may result from mental health conditions" 90% (7)
"I would recommend this program to others" 100% (7)

Peer-to-Peer Education Program:
"Because of the Peer-to-Peer course I just attended, I am better able to access the care and support I need" 100% (5 people surveyed)
"Because of the Peer-to-Peer course I just attended, I am better able to manage the dresses and negative impacts my condition may cause" 100% (5)
"I would recommend this program to others" 100% (5)

Community Education, Events, Speaker Meetings, Lectures:
"Because of this presentation, I now have more information on mental health and the subject presented" 100% (14 people surveyed)
"This presentation was useful to myself or a loved one" 95% (14)

School Presentations:
"As a result of this presentation, I have an understanding of how to seek help" 85% (20 surveyed)
"As a result of this presentation. I can identify a friend or trusted adult who I can talk to about mental health": 80% (20)

FY 2023-24 Q4: Programs surveys/outcomes

Family-to-Family:
In-Person class: April 20th - June 8th
"As a result of this class, I am better able to access the care and support services that I or my family member need": **90% (9 surveyed)**
"As a result of this class, I am better able to manage crises that may result from mental health conditions": **100% (9 surveyed)**
"I would recommend this program to others": **100% (9 surveyed)**

Online class: April 17th- June 5th
"As a result of this class, I am better able to access the care and support services that I or

my family member need": **87% (14 surveyed)**
"As a result of this class, I am better able to manage crises that may result from mental health conditions": **85% (14 surveyed)**
"I would recommend this program to others": **100% (14 surveyed)**
Community Education:
"Because of this Speaker Meeting, I now have more information on mental health and the subject presented": **97% (8 surveyed)**
"This presentation was useful to myself, my loved one, my client, or my student": **95% (8 surveyed)**

Family Navigation Helpline (TRAININGS):

Value Based Leadership 12/4/23 via Zoom, 21 participants:
92% (11 full time staff) full-time staff attended value-based leadership training
83% (10 part time staff) part-time staff attended value-based leadership training
100% (21 surveyed) able to define 3 characteristics of a good leader
100% (21 surveyed) reported values that motivate them in their work

Crisis Response Training 06/24/24 via Zoom, 12 participants:
100%: As a result of this presentation, I now feel better equipped to support someone in a crisis situation (12 surveyed)
100%: As a result of this training, I know when to connect someone I am supporting to 9-8-8 (12 surveyed)

Create Welcoming and Inclusive Spaces 11/1/23 via Zoom, 45 participants:
90% (45 participants) of staff and volunteers receive this training
100% (45 surveyed) report they understand how to create an inclusive and welcoming environment

PEI #5 Suicide Prevention

Organized activities that the County undertakes to prevent suicide because 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. Please see the Suicide Prevention Strategic Plan in Appendix G for additional information. (Note: According to the new regulation, this service is optional, but Santa Cruz County does offer this service.)

Program Name: Suicide Prevention

Agency: Family Services Agency
Numbers Served FYs 2021-2024:
FY 2021-22: Target Population
What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)? *Target is 3,500*
Suicide Prevention and Crisis Lifeline
Calls to Lifeline 3,456
(Santa Cruz County location verified): 977

Number of follow-up calls: 67
(Santa Cruz County location verified)

Number of 911 calls: 27
(Santa Cruz County location verified)

Suicide Prevention and Resources Education and Outreach: 4,285

FY 2022-23: Target Population
What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)? Target is 3,500. Data regarding numbers served were not available for FY 2022-23.

FY 2023-24: Target Population
What is the unduplicated number of individuals served in preceding fiscal year (FY2023-2024)? Target is 3,500. Data regarding numbers served were not available for FY 2023-24. SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the fiscal year.

Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.
The methodology, activities and EBPs that Suicide Prevention Service (SPS) relies on and implements to help our community prevent suicide are based on the best available evidence and BPB's. Our three primary programs/strategies are; operating a Suicide Prevention and Crisis Lifeline, offering Suicide Prevention and Education classes/presentations, and organizing and managing Suicide Loss Survivor support groups.

Suicide Prevention and Crisis Lifeline
Lifeline responders will be trained, monitored, and supervised in applying evidence-based risk assessment and safety planning tools to achieve safe outcomes for callers at risk. Our

Suicide Prevention and Crisis Lifeline (988 and local #) offers real-time access to a live person every moment of every day. Responders provide free telephonic crisis intervention services to all callers. SPS Suicide Prevent and Crisis Lifeline is part of a national network of crisis call centers and operates within National Suicide Prevention Lifeline (NSPL) operational guidelines regarding suicide risk assessment and engagement and offers resource referrals.

In preparation for the launch of 988 on July 16, 2022, SPS (for the first time) hired Staff Responders to answer calls and support Volunteer Responders. SPS's Lifeline Responder training (accredited by the American Association of Suicidology) traditionally a 10-week program has been redesigned to three weeks (40hrs/week). We also required mandatory refresher trainings throughout the year focused on imminent risk protocols and resource referral and 988 updates and ongoing education opportunities for all SPS crisis line Responders and staff.

On June 31, The American Association of Suicidology re-accredited SPS (for 5 years). This rigorous accreditation process validated that our service delivery programs, policies and procedures are performing according to nationally recognized standards.

Suicide Prevention and Resources Education and Outreach
SPS conducts suicide prevention educational presentations and trainings, including ASIST, and Safe TALK for SPS staff, at-risk populations, and anyone who works with at-risk populations. We also participate at public events (in person and virtual) such as community forums. health fairs, public and private school activities, and County functions. Other outreach activities include implementing public marketing and public relation campaigns; social media postings, press conferences, participation in sector-based and general public presentations/forums (in-person and virtually).

Suicide Loss Survivor Support Groups
Research shows that there is a higher risk of suicide for individuals who have lost a loved one to suicide. SPS works closely with experienced and qualified community members and Family Service Agency volunteers to host a new group facilitator training for current clients, volunteers and staff who may be interested in becoming a facilitator for our support groups.

How will the Agency/County measure changes in attitude, knowledge and/or behavior related to reducing mental illness-related suicide?
There is very limited research available to support the efficacy of suicide prevention interventions, but some helpful data is available for a population-based program where an

intervention with very low risks, low cost and data not available, a prevention program may need to rely on best practices, expert consensus and lessons from related prevention fields and the National Suicide Lifeline is considered as a reliable source.

Suicide Prevention and Crisis Lifeline

Numerous studies of Lifeline calls have shown that a majority of callers were significantly more likely to feel depressed, less suicidal, less overwhelmed, and more hopeful after speaking with a Lifeline Responder. In accordance with NSPL best-practices/call framework protocols, SPS/SPCL (Suicide Prevention and Crisis Lifeline), Responders collect and record individual callers risk assessment and other information (when/if offered by caller) during the call. At conclusion of a Lifeline call, Responder are required to establish and a safety plan and agreement as well as regarding whether the call was helpful. The results of these questions are documented in a call report in real time (via iCarol), reviewed on a daily basis and aggregated monthly by staff for review by the Program Director.

Suicide Prevention and Resources Education and Outreach

Program staff maintained written records (database) of all outreach activities, including service utilization and impact of the activity. A written survey conducted of all youth and adult participants demonstrate
the percentage of participants who report an increase in their knowledge of suicide warning signs and of ways to get help for themselves or someone else.

Suicide Loss Survivor Support Groups

Risk of suicide and suicide risk factors has been shown to increase among people who have lost a friend/peer, family member, co-worker, or other close contact to suicide (source: Pitman A, Osborn D, King M, Erlangen A). Care and attention to the bereaved is therefore of high importance. These programs have not typically been evaluated for their impact on suicide, attempts, or ideation, but they may reduce survivors' guilt, feelings of depression, and complicated grief.[1]

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?

Suicide Prevention and Crisis Lifeline

Many paths in life can bring someone to the brink of suicide, and a shorter phone number might seem to be a naïvely simple solution. But researchers have repeatedly found that

simple works: Callers routinely credit the existing hotline, which is on track to take 2.5 million calls this year, with keeping them safe. And while the role of crisis Lifelines traditionally were limited to de-escalation and service linkage, Lifelines are increasingly moving towards providing outreach and follow-up to suicidal individuals. Hotlines have the opportunity to not just defuse current crises but also provide brief interventions to mitigate future risk including safety planning, a promising approach to reduce crisis callers' future suicide risk.

In adherence with National Suicide Prevention Lifeline protocols and policies, SPS's utilizes the Stanley and Brown's Safety Planning tool, regarded by the American Association of Suicidology, the Suicide Prevention Resource Center, and the National Suicide Prevention Lifeline as the signature tool for effectively helping suicidal individuals navigate and survive a suicidal crisis.

Suicide Prevention and Resources Education and Outreach

Additionally, SPS outreach program (ASIST and Safe TALK) follows the effective suicide prevention strategies outlined by the Suicide Prevention Resource Center (SPRC) the Substance Abuse and Mental Health Services Administration (SAMHSA). The Suicide Prevention Resource Center has verified that these strategies and trainings are demonstrated to be effective (Programs with Evidence of Effectiveness) in teaching attendees to 1) Identify and assist persons at risk of suicide 2) Increase help seeking behaviors and reduce the likelihood of suicide 3) Effectively respond to individuals in crisis and provide linkages to care and 4) Promote social connectedness, support, and resilience.

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

FY 2021-22 Outcomes:

Suicide Prevention and Crisis Lifeline

In FY21-22, 3,674 individuals made acute crisis calls to the Suicide Prevention Lifeline. Over 90% were able to agree to a safety plan (for completed calls).

Outreach and Education Activities

897 Santa Cruz County residents, healthcare professionals, educators, students, and community partners participated in 28 suicide prevention training and educational presentations. When surveyed, 97% of youth and 96% of adults reported a resultant increase in knowledge of suicide warning signs and strategies/resources to help oneself or someone else.

FY 2022-24 Outcomes:

Suicide Prevention and Crisis Lifeline: Data are not available for FYs 2022-24. Strengthening data collection and tracking will be a priority for the next fiscal year.

Outreach and Education Activities: In 2023, Suicide Prevention Service of the Central Coast had a strategy to market our services using different media outlets, social media, and community outreach to increase visibility.

In May, Mental Health Awareness month, we launched our first-ever 30-second commercial in English and in Spanish via television and radio. In addition, we used this commercial on social media, digital marketing, eblasts, and presentations. The commercial had a theme focused on 988 as a place to go for help.

During the month of September, various newspapers used our letter to the editor to bring awareness to suicide prevention. Thanks to the marketing planning, the agency has seen an increase in people seeking support, more followers on social media, more donations from private donors, and more grants from foundations and from the counties we serve. The impact is huge, and we know more lives are saved the more information we disseminate.

Our goal for creating and disseminating public health media campaign materials for suicide prevention is to reduce stigma associated with mental health and suicide and to educate the public on ways to help and the resources that exist for those experiencing thoughts of suicide.

Our framework for successful and consistent public messaging is aligned with SAMHSA, Striving for Zero, the National Alliance for Suicide Prevention, Know the Signs, the Suicide Prevention team within the Injury and Violence section at MDHHS.

Materials Disseminated: SPS designed, printed, shared artwork/printable 988 flyers/posters/wallet cards (Spanish and English) with community members, partners, schools, general public throughout the Central Coast (with help from BH Advisory Committee members).

Number of Materials Disseminated: 432 flyers, 50 Posters, over 2,000 988 stickers, 300 SPS brochures, 750 pens/pencils, 988 cards, Seeds of Hope, 988 cards, LOSS packets and magnets.

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

Staff and volunteers complete an extensive 80+ hour training before presenting/training or responding to suicidal callers on their own. Compliance with the risk assessment practices of the C-SSRS and the Safety Planning tools are monitored annually by the National Suicide Prevention Lifeline (via Vibrant Health) and the American Association of Suicidology, through which we are accredited. Volunteers and staff implement continuous quality improvement activities, including documentation of C-SSRS responses and safety plans, as well as annual refresher training and 24/7 staff supervision and monitoring of responder activity to ensure that standards are being met and to address (through additional training, supervision, etc.) any issues.

Students, stakeholders, teachers, staff and community members will personnel be provided (when appropriate) with evaluation forms to report on the effectiveness and applicability of the presentation and skill of the presenter. ASIST and Safe TALK trainers and their fidelity to the programs are routinely monitored by Living Works Education through participate evaluation forms, trainer evaluations, and onsite visitations.

Describe how the following strategies were used:

- **Access and Linkage**

  Like most public health problems, suicide is preventable and requires strategies and collaboration with our behavioral health partners and community members.

  SPS and Family Service Agency has prioritized strengthening and expanding our Suicide Prevention Lifeline, public awareness and education campaigns and community partnerships in preparation for the launch of 988, the anticipated 30-35% increase in call volume, increased caller confusion about calling 911 or 988, and working with/supporting callers who are not experiencing suicidal ideation.

  SPS staff met with and continues to work closely with Santa Cruz County Behavioral staff, Santa Cruz County 911/Emergency Serves, United Way SCC (2-1-1), NAMI Santa Cruz County, Monterey County Forensic Services and other partners in the mental health sector to further the long-term vision of 988 – to build a robust crisis care response system across the county that links callers to community-based providers who can deliver a full range of crisis care services, if needed (like mobile crisis teams or stabilization centers), in addition to connecting callers to tools and resources that will help prevent future crisis situations. This more robust system will be essential to meeting crisis care needs across our county, state and the nation. SPS Lifeline's Imminent Risk Policy outlines when call information should be shared with

emergency services. In these cases, the connections only occur when rigorous criteria for an active rescue is met – such as an ongoing suicide attempt when the caller's imminent safety is at risk. When a caller is determined to be at imminent risk, Responders are responsible for connecting with SC County public safety answering point 911 (PSAPs) to provide any available information to assist the PSAP in locating the individual and ensuring their safety.

Responders receive training and are required to demonstrate their ability to effectively utilize our resource directory (which is updated annually) in connecting callers or others at risk with appropriate resources relative to the severity of the All participants in our outreach are informed of local County mental health resources, including our 24/7 multilingual suicide crisis line. crisis and needs of the individual. SPS Lifeline Responders, program employees and volunteers are provided with a current and thorough list of local resources in accessible formats, including multilingual capabilities, hours, and locations, services offered, phone numbers.

Staff also prioritize collaborative relationships and cross-training with other service providers, both for the purpose of providing consultation and support (to avoid burnout or isolation amongst community and County service providers), as well as enhancing the ease of referrals and collaborations when supporting individuals or families at risk.

- **Timely Access to Mental Health Services for Underserved Populations**

  By framing suicide prevention and intervention as "everyone's business," Suicide Prevention Service emphasizes the provision of trainings, resources, and information to and in collaboration with a wide variety of traditional and non-traditional helpers throughout the community, thereby increasing the likelihood that an individual at risk can receive effective support at a wider variety of locations and through a range of avenues, rather than solely by calling a hotline or reaching out to a mental health provider.

  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 emphasis is given to ensure the provision of services to (and the adherence of these services to cultural and

linguistically appropriate standards) to traditionally underserved populations, such as transition-age youth and young adults, transgender individuals, veterans and their families, foster care youth, LGBTQQIA+ community members, Latinx community members, and any community members with histories of substance use, sexual or physical abuse, domestic violence, and isolation, among others.

- **Stigma and Discrimination reduction**

  All SPS outreach services promote knowledge of warning signs and community resources, and provide opportunities for participants to examine their own experiences around suicide, including the beliefs and attitudes that often result from these (as well as to gauge the impact of these on how likely we are to seek help), to help someone at risk, and other impacts of beliefs and attitudes around suicide and mental health on our intervention work as helpers.

  Program staff work with participants to examine the origins of myths around suicide and mental health, as well as to challenge these by providing factual information (both via research and through the sharing of lived experiences), and to illuminate the negative possible outcomes and impacts of these myths. All promotional materials, social media communications, website messaging, etc. reflect our program values of safety and support and adhere to effective messaging principles and safe reporting practices. We work, through digital and in-person activities, to promote honest conversations about suicide and mental health, encourage compassion, connect community members and service providers with useful content and information about mental health, suicide, reinforce the importance of self-care and connectedness over isolation, and provide up-to-date information and resources for supporting oneself or someone else.

PEI #6 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: Second Story

Agency: Encompass

Numbers Served FYs 2021-2024:

FY 2021-22: Target Population

- **Number of individuals with SMI referred to treatment and kind of treatment?** 66 unduplicated
- **Number of individuals who followed through on the referral and engaged in treatment (attended at least once)**: 66 unduplicated last fiscal year.
- **Average duration of untreated mental illness:** various
- **Average interval between referral and participation in treatment (at least once)**: Various

FY 2022-23: Target Population

- **Number of individuals with SMI referred to treatment and kind of treatment?** 63 unduplicated
- **Number of individuals who followed through on the referral and engaged in treatment (attended at least once)**: 63 unduplicated last fiscal year.
- **Average duration of untreated mental illness:** various
- **Average interval between referral and participation in treatment (at least once)**: Various

FY 2023-24: Target Population

- **Number of individuals with SMI referred to treatment and kind of treatment?** 70 unduplicated
- **Number of individuals who followed through on the referral and engaged in treatment (attended at least once)**: 70 unduplicated last fiscal year.
- **Average duration of untreated mental illness:** various
- **Average interval between referral and participation in treatment (at least once)**: Various

Explanation of how program and strategy will create Access and Linkage to Treatment for individuals with serious mental illness:

Second Story at Encompass is one of six Peer Respite operated programs in the State of California with staffing provided 24-hours a day, seven days per week. It is a voluntary program for clients of Santa Cruz County's system of care for persons served who struggle with mental health and substance use issues. One of the primary purposes of this program is to provide a person-centered alternative to psychiatric hospitalization for people who historically have had access only to acute inpatient hospital and/or sub-acute programs (e.g., Telos or the Crisis Stabilization Program/Psychiatric Health Facility at Telecare).

2nd Story assists persons served entering the program with linkage to primary care and mental health treatment appointments, recovery services for substance use disorders, and referrals to various County programs for services, including crisis response. 2nd Story also provides access and linkage to community resources, including housing, educational, and employment resources.

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?

2nd Story accepts up to 5 adults aged 18 and older, with an average length of stay of 14 days. Individuals seeking service are self-referred, screened by Second Story staff through an interview and assessment process. Peer staff utilize community-based partners (e.g., County Behavioral Health) for additional assessment information as needed. Second Story maintains connection with County Coordinators, and other contracted providers to identify individuals needing assessment, treatment, and crisis services. In crisis situations, 2nd Story engages the MERT Team and/or other liaisons for support.

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?

2nd Story works closely with Santa Cruz County Behavioral Health Services, to identify needed linkages to primary care and other mental health providers. Persons served are provided with staff support with self-referrals and linkage to resources as indicated. Santa Cruz County Behavioral Health Services continues to provide psychiatric medication support, case management and therapy services as needed. 2nd Story supports linkage to county mental health services, primary care providers and other mental health treatment services through activities such as driving guests to necessary appointments as needed.

How will referrals be followed up to support engagement in treatment?

2nd Story supports guest requests for connection to resources, and coordinates with other mental health system providers and family members. 2nd Story connects providers, guests, and families to NAMI Santa Cruz trainings which include Peer to Peer, Family to Family and Provider Training all of which happen throughout the year.

Substantial collaboration exists with Mental Health Access Team, Santa Cruz County Behavioral Health Services coordinators, NAMI, program managers, and psychiatrists. Second Story maintains regular contact with other mental health contractors and resources including, the Psychiatric Health Facility, Janus, Front Street, Homeless Persons

Health Project, and the Homeless Resource Center. 2nd Story staff promote and discuss with guests the importance of receiving ser ices to co-create stronger ties to providers and families if such discussions benefit person-centered services.

Describe how the following strategies were used:

- **Access and Linkage**
  2nd Story works in close collaboration with Santa Cruz County Behavioral Health Services to ensure guests seeking respite services are knowledgeable about the availability of services, including medical and other county offered services. The program also works with other community agency partners to ensure guests are referred and linked to the appropriate level of services and resources needed to promote healing and well-being. 2nd Story supports individuals with connecting to psychiatrists, primary care providers, surgery, and pre-planning appointments. When there is a challenge, the team connects with guests' coordinators and care teams. Further, the team provides referrals to individuals for substance use disorder treatment programs as part of discharge planning as requested by guests.
- **Timely Access to Mental Health Services for Underserved Populations**
  2nd Story promotes a welcoming environment that is accessible to guests 24/7 as a diversion to, or step-down from, sub-acute or inpatient programs. This respite housing option allows guests, 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 offering activities that include family involvement and participation in community events so that people may find support through others. All activities are directed by guests' expressed requests and needs. Forms in Spanish and English are provided, and translation services are engaged as needed for accessibility to services. 2nd Story staff builds strong relationship with families and providers in Watsonville with outreach to South County coordinators and families through NAMI.
- **Stigma and Discrimination reduction**
  2nd Story remains dedicated to serve as a respite and voluntary housing option for people by offering support and connection with a peer recovery model. Peers assist in learning with people how to be in relationship by building upon shared backgrounds and lived experiences. With the support of community partners, including NAMI, Front Street, and Housing Matters, 2nd Story has been able to reduce stigma surrounding mental illness. In addition, self-stigma has been reduced by promoting a safe place for guests to self-refer when recognizing a need for respite and connection when feeling vulnerable from mental health symptoms. 2nd Story supports an environment through which narratives about people and their

experiences are shared. Peers discuss ways of seeing beyond the diagnosis and seeing beyond the need for alienating oneself from the community.

Program Outcomes:

FY 2022-23: The following are discharge outcomes of Second Story clients (duplicated) during FY22-23.

Discharge Outcome	FY 22-23
Higher Level of Care (Telecare, Other Behavioral Health Facility)	2 (2%)
Home, Board & Care, Other Permanent Living Situation	67 (63%)
Medical Hospital	3 (3%)
Place not meant for habitation	12 (11%)
Recovery Program (including residential treatment)	8 (8%)
Shelter or Temporary Living Situation	8 (8%)
Unknown	6 (6%)
TOTAL	**106 (100%)**

FY 2023-24: The following are performance measures of the Second Story program during FY 23-24.

Area of Focus	Performance Measures	FY23-24	Target	Status
Satisfaction	70% of total guests will complete a satisfaction survey.	82%	70%	Goal Met
Outcomes	Fewer than 5% of total exits will discharge to a higher level of care.**	2%	<5%	Goal Met
Utilization	The average length of stay will be 15 days.	The average length of stay for discharges in the reporting period was 14 days.		
Capacity	Bed days will be at or above 85% of capacity.	77%	>85%	Goal not Met
Outputs	Peer support will be provided to at least 10-20 unduplicated clients quarterly.	Goal Met. On average, 12 individuals were provided peer support.		

*Calculation does not include guests who declined to complete the survey or were at the program at the end of the reporting period

**Of 27 exits in the reporting period, two (7%) went to a higher level of care

The following are outcomes from the satisfaction survey during FY23-24.

Survey Question	FY 23-24 Average Score (Out of 5)
Staff worked with me to create goals while at 2nd Story.	4.47
Staff encouraged and supported my sense of empowerment.	4.68
There are things I can do that help me deal with unwanted symptoms.	4.55
I have my own plan for how to stay or become well.	4.52
I can identify the early warning signs of becoming unwell.	4.53
Although my symptoms may get worse, I know I can handle it.	4.29
I feel like I benefitted from my time here.	4.80
I feel that groups help me with my overall wellness.	4.54
I feel that individual meetings with counselors help me with overall wellness.	4.60
When I come here I feel emotionally safe.	4.67
Average Score	**4.56**

Program Name: Mobile Emergency Response Team & Mental Health Liaison Team

Agency: Santa Cruz Behavioral Health Services
Target population: All Individuals, all ages
What is the unduplicated number of individuals to be serviced annually: In FY2021-22, the program had a target of 150 people and served 361 individuals. Data for FY 2022-23 and FY 2023-24 were unavailable. SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the next fiscal year.
This **Access & Linkage - Mobile Crisis** program 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. The youth program is called MERTY (mobile emergency response team – youth). For this plan, MERT will be used to refer to both programs. These teams provide 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.

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.

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.

MERT provides 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?
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

Describe how the following strategies were used:

Access and Linkage

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

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 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 after-hours information, consultation, and linkage to emergency services.

Stigma and Discrimination reduction

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.

[1] Szumilas M, Kutcher S. Post-suicide intervention programs: a systematic review. Can J Public Health. 2011;102(1):18-29.

Capital Facilities and Technology Needs
Funds and guidelines for Capital Facilities and Technology Needs 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, improve operational efficiency, and improve cost effectiveness.
- Increase consumer and family engagement by providing an opportunity for clients and families to provide feedback on the services they are receiving.

Funding allocated for capital facilities in the FY2022-2023 Annual Update and program expenditure period was expended to partially fund the Youth Crisis Residential, located at 5300 Soquel Avenue.

There is currently no funding projected for use in the FY2023-2026 Three-Year Plan budgets for capital facilities and technology needs.

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.

There are no activities under Workforce Education and Training in the 2023-2026 Three-year Plan.

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 training with the overarching goal of improving Cultural Competency for Behavioral Health Professionals, including Culturally and Linguistically Appropriate Interventions and Services.

Additional Assistance Needs from Education & Training Programs

An ongoing challenge is how to sustain the training and education program, given that the State has not distributed additional Workforce Education and Training (WET) funding and SCCBHD has expended designated funds in previous program years. There are no MHSA designated WET funds for FY2023-2026, 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).

Core Competencies Training

Motivational Interviewing (MI), an approach developed by William Miller, has been well established as an effective way to promote behavior change in individuals. The prerequisite 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.

Evidence Based Practices

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 amid 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.

Identification of Shortages of Personnel

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

- Psychiatrists (adult and child)
- Bilingual mental health providers (psychiatrist, therapists, case managers)
- Forensic mental health providers
- Psychiatric Nurse practitioners
- Clinical psychologists
- Skilled practitioners treating co-occurring (mental health & substance abuse) disorders

- Licensed Clinicians (LCSW, MFT, LPCC)

Innovation Projects

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.

During the FY2023-2026 MHSA Three-year Plan period, Santa Cruz County Behavioral Health (SCCBHD) will utilize Innovation funding to support participation in the Crisis Now model.

The Crisis Now model focuses efforts toward four pillars of crisis service:

- Call Center (someone to call)
- Mobile Crisis Teams (someone to respond)
- Receiving (somewhere to go)
- Use of Evidence-based practices

MHSA INN funds Recovery Innovations International (RI) as a consulting team to guide this project and Research Development Associates (RDA) as evaluators of the project, as well as operation of the services.

The project plan is in the implementation stage. RI is supporting policy development. RDA is supporting the evaluation plan, metrics and data analysis. We continue to assess current mobile crisis services to understand which Crisis Now principles are already in use and where we need to add resources to address gaps. Progress during this Annual Plan Update includes:

- Call Center (someone to call) – Our local 988 Call Center is beginning to integrate with our current crisis dispatch and is adding additional FTE to manage the increase in volume. We were required to shift the timeline for this work due to the policy requirements of BH 23-025, the DHCS mandate for 24/7/365 crisis response services, and we are currently using an 800 number for calls to maintain compliance with that BHIN. Eventually we will have one call center.
- Mobile Crisis Teams (someone to respond) – we contracted with a community-based organization, Family Services Agency, to provide additional mobile crisis teams to get to 24/7/365 response and are currently operating from 8AM to 12AM 7 days a week. We expect to add an additional overnight shift by the next Annual Plan Update. We also added additional on-call support.

- Receiving (somewhere to go) – While our children and youth Crisis Receiving Unit and Crisis Residential services facility is being built, we developed an interim solution for youth in partnership with Watsonville Community Hospital Emergency Department and Pacific Clinics to provide youth in our County with one place to go and receive additional crisis support and services.
- Use of Evidence-based practices – This includes identification of evidence-based practices to continue training staff in mobile crisis response and de-escalation and a process to monitor and reinforce the use of those practices. Staff completed training through M-TAC, contracted for the Mobile Crisis Services mandated in BHIN 23-025 by DHCS.

Fiscal Year 2023-2024 Expenditure Plan & Funding Summary

Mental Health Services Act Three-Year Plan
2023-24 to 2025-26 Funding Summary

County: Santa Cruz Date: 3/15/23

	MHSA Funding			
	A	B	C	D
	Community Services and Supports	Prevention and Early Intervention	Innovation	Prudent Reserve
A. Estimated FY 2023/24 Funding				
1. Estimated Unspent Funds from Prior Fiscal Years	5,354,796	3,492,859	2,084,580	
2. Estimated New FY2023/24 Funding	22,049,529	5,512,382	1,450,627	
3. Transfer in FY2023/24a/	-			-
4. Access Local Prudent Reserve in FY2023/24	-	-		-
5. Estimated Available Funding for FY2023/24	27,404,325	9,005,241	3,535,207	
B. Estimated FY2023/24 MHSA Expenditures	**19,793,687**	**5,006,972**	**1,800,000**	-
C. Estimated FY2024/25 Funding				
1. Estimated Unspent Funds from Prior Fiscal Years	7,610,638	3,998,269	1,735,207	
2. Estimated New FY2024/25 Funding	20,777,624	5,194,406	1,366,949	
3. Transfer in FY2024/25a/				-
4. Access Local Prudent Reserve in FY2024/25				-
5. Estimated Available Funding for FY2024/25	28,388,262	9,192,675	3,102,156	
D. Estimated FY2024/25 Expenditures	**20,783,370**	**5,257,319**	**1,890,000**	**-**
E. Estimated FY2025/26 Funding				
1. Estimated Unspent Funds from Prior Fiscal Years	7,604,892	3,935,356	1,212,156	
2. Estimated New FY2025/26 Funding	15,980,005	3,995,001	1,051,316	
3. Transfer in FY2025/26a/				-
4. Access Local Prudent Reserve in FY2025/26				-
5. Estimated Available Funding for FY2025/26	23,584,897	7,930,357	2,263,472	
F. Estimated FY2025/26 Expenditures	**21,822,538**	**5,520,185**	**2,079,000**	**-**
G. Estimated FY2025/26 Unspent Fund Balance	1,762,359	2,410,172	184,472	

**Estimates are subject to change based on projected statewide distributions, actual revenues received and actual expenditures reported on the MHSA Revenue and Expenditure Report.*

H. Estimated Local Prudent Reserve Balance	Amount
1. Estimated Local Prudent Reserve Balance on June 30, 2022	2,997,367
2. Contributions to the Local Prudent Reserve in FY 2022/23	-
3. Distributions from the Local Prudent Reserve in FY 2022/23	-
4. Estimated Local Prudent Reserve Balance on June 30, 2023	2,997,367

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.

Community Services and Supports (CSS) Component

Mental Health Services Act Three-Year Plan
Community Services and Supports (CSS) Funding

County: Santa Cruz Date: 3/15/2023

	Fiscal Year 2023/24			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated Other Funding
FSP Programs				
1. Community Gate	-			
2. Probation Gate	-			
3. Child Welfare Gate	-			
4. Education Gate	-			
5. Family Partnerships	-			
6. Enhanced Crisis Response	2,128,664	1,080,408	866,081	182,175
7. Consumer, Peer, and Family Services	569,029	437,716	131,313	-
8. Community Support Services	13,267,045	9,419,363	3,629,714	217,968
9.	-			
10.	-			
11.	-			
Non-FSP Programs				
1. Community Gate	5,456,886	2,945,069	1,943,325	568,492
2. Probation Gate	562,621	292,398	270,223	-
3. Child Welfare Gate	2,624,876	898,229	1,190,778	535,869
4. Education Gate	339,960	134,851	159,188	45,921
5. Family Partnerships	321,905	74,649	158,122	89,134
6. Enhanced Crisis Response	2,976,585	1,726,559	1,190,845	59,181
7. Consumer, Peer, and Family Services	62,893	59,002	-	3,891
8. Community Support Services	2,505,793	1,870,788	437,955	197,050
9.	-			
10.	-			
11.	-			
CSS Administration	1,166,574	840,255	326,319	-
CSS MHSA Housing Program Assigned Funds	-			
Community Program Planning	14,400	14,400	-	-
Total CSS Program Estimated Expenditures	31,997,231	19,793,687	10,303,863	1,899,681
FSP Programs as Percent of Total	80.7%			

	Fiscal Year 2024/25			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated Other Funding
FSP Programs				
1. Community Gate	-	-	-	-
2. Probation Gate	-	-	-	-
3. Child Welfare Gate	-	-	-	-
4. Education Gate	-	-	-	-
5. Family Partnerships	-	-	-	-
6. Enhanced Crisis Response	2,225,988	1,134,428	909,385	182,175
7. Consumer, Peer, and Family Services	597,481	459,602	137,879	-
8. Community Support Services	13,919,499	9,890,331	3,811,200	217,968
9.	-			
10.	-			
11.	-			
Non-FSP Programs				
1. Community Gate	5,701,305	3,092,322	2,040,491	568,492
2. Probation Gate	590,752	307,018	283,734	-
3. Child Welfare Gate	2,729,326	943,140	1,250,317	535,869
4. Education Gate	354,662	141,594	167,147	45,921
5. Family Partnerships	333,543	78,381	166,028	89,134
6. Enhanced Crisis Response	3,122,455	1,812,887	1,250,387	59,181
7. Consumer, Peer, and Family Services	65,843	61,952	-	3,891
8. Community Support Services	2,621,230	1,964,327	459,853	197,050
9.	-			
10.	-			
11.	-			
CSS Administration	1,183,201	882,268	300,933	-
CSS MHSA Housing Program Assigned Funds	-			
Community Program Planning	15,120	15,120	-	
Total CSS Program Estimated Expenditures	33,460,405	20,783,370	10,777,354	1,899,681
FSP Programs as Percent of Total	80.6%			

	Fiscal Year 2025/26			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated Other Funding
FSP Programs				
1. Community Gate	-	-	-	-
2. Probation Gate	-	-	-	-
3. Child Welfare Gate	-	-	-	-
4. Education Gate	-	-	-	-
5. Family Partnerships	-	-	-	-
6. Enhanced Crisis Response	2,328,178	1,191,149	954,854	182,175
7. Consumer, Peer, and Family Services	627,355	482,582	144,773	-
8. Community Support Services	14,604,576	10,384,848	4,001,760	217,968
9.	-			
10.	-			
11.	-			
Non-FSP Programs				
1. Community Gate	5,957,946	3,246,938	2,142,516	568,492
2. Probation Gate	620,290	322,369	297,921	-
3. Child Welfare Gate	2,838,999	990,297	1,312,833	535,869
4. Education Gate	370,099	148,674	175,504	45,921
5. Family Partnerships	345,763	82,300	174,329	89,134
6. Enhanced Crisis Response	3,275,618	1,903,531	1,312,906	59,181
7. Consumer, Peer, and Family Services	68,941	65,050	-	3,891
8. Community Support Services	2,742,439	2,062,543	482,846	197,050
9.	-			
10.	-			
11.	-			
CSS Administration	1,242,361	926,381	315,980	-
CSS MHSA Housing Program Assigned Funds	-			
Community Program Planning	15,876	15,876	-	-
Total CSS Program Estimated Expenditures	35,038,441	21,822,538	11,316,222	1,899,681
FSP Programs as Percent of Total	80.5%			

Prevention and Early Intervention (PEI) Component

Mental Health Services Act Three-Year Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Cruz Date: 3/15/23

	Fiscal Year 2023/24			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs - Prevention				
1. Children's Services	1,117,317	679,227	355,905	82,185
2. Services for Diverse Communities	352,454	320,469	31,985	-
3. Transition Age Youth and Adult Services	4,080,697	3,571,120	509,577	-
4. Older Adult Services	56,328	56,328	-	-
5.	-			
6.	-			
7.	-			
8.	-			
9.	-			
10.	-			
PEI Administration	467,475	379,828	87,647	-
PEI Assigned Funds	-			
Total PEI Program Estimated Expenditures	6,074,271	5,006,972	985,114	82,185

	Fiscal Year 2024/25			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs				
1. Children's Services	1,169,073	713,188	373,700	82,185
2. Services for Diverse Communities	370,076	336,492	33,584	-
3. Transition Age Youth and Adult Services	4,284,732	3,749,676	535,056	-
4. Older Adult Services	59,144	59,144	-	-
5.	-			
6.	-			
7.	-			
8.	-			
9.	-			
10.	-			
PEI Administration	490,848	398,819	92,029	-
PEI Assigned Funds	0			
Total PEI Program Estimated Expenditures	6,373,873	5,257,319	1,034,369	82,185

	Fiscal Year 2025/26			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs - Prevention				
1. Children's Services	1,223,417	748,847	392,385	82,185
2. Services for Diverse Communities	388,580	353,317	35,263	-
3. Transition Age Youth and Adult Services	4,498,969	3,937,160	561,809	-
4. Older Adult Services	62,101	62,101	-	-
5.	-			
6.	-			
7.	-			
8.	-			
9.	-			
10.	-			
PEI Administration	515,390	418,760	96,630	-
PEI Assigned Funds	-			
Total PEI Program Estimated Expenditures	6,688,457	5,520,185	1,086,087	82,185

Innovation (INN) Component

Mental Health Services Act Three-Year Plan
Innovations (INN) Component Worksheet

County: Santa Cruz Date: 3/15/23

	Fiscal Year 2023/24			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Crisis Now	1,565,217	1,565,217	0	0
2.	-			
3.	-			
INN Administration	234,783	234,783	0	0
Total INN Program Estimated Expenditures	1,800,000	1,800,000	0	0

	Fiscal Year 2024/25			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Crisis Now	1,643,478	1,643,478		
2.				
3.	-			
INN Administration	246,522	246,522		
Total INN Program Estimated Expenditures	1,890,000	1,890,000	0	0

	Fiscal Year 2025/26			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Crisis Now	1,807,826	1,807,826		
2.	-			
3.	-			
INN Administration	271,174	271,174		
Total INN Program Estimated Expenditures	2,079,000	2,079,000	0	0

Appendix A. CPP Activity Outreach & Promotion Materials

CPP Website Promotion

The flyer below was posted to the County's MHSA webpage:
https://www.santacruzhealth.org/HSAHome/HSADivisions/BehavioralHealth/MHSA.aspx

Survey Promotional Materials

Survey Outreach language

Community Survey Sharing Messages

PRE-SURVEY LAUNCH MESSAGE (EMAIL/WEBSITE) by 10/14

Santa Cruz County Behavioral Health Services Community & Partner Feedback Survey

Santa Cruz County Behavioral Health Division (SCBHD) has partnered with RDA Consulting (RDA) to help prepare the 2024-2025 Annual Update under the Mental Health Services Act (MHSA).

As a part of the community program planning process, RDA will be launching a survey to collect community thoughts, opinions, and feedback on the current behavioral health

system as well as other unmet needs within Santa Cruz County. The behavioral health system includes broader mental health and substance use disorder services. The survey is open to all SCBHD service providers as well as consumers of behavioral health services.

The survey will take approximately 10-15 minutes to complete and first 100 people to complete this survey, will have the opportunity to receive a $10 gift card. The survey will go live on October 16th and will remain open until October 30th, 2024. We look forward to your participation as your feedback is essential to inform SCBHD's MHSA Annual Update.

SURVEY LAUNCH MESSAGE (EMAIL/WEBSITE) by 10/16

Santa Cruz County Behavioral Health Services Community & Partner Feedback Survey

Santa Cruz County Behavioral Health Division (SCBHD) has partnered with RDA Consulting (RDA) to help prepare the 2024-2025 Annual Update under the Mental Health Services Act (MHSA).

This survey will collect community thoughts, opinions, and feedback on the current behavioral health system as well as other unmet needs within Santa Cruz County. The behavioral health system includes broader mental health and substance use disorder services.

This survey is voluntary and confidential, and only RDA will see your responses. This survey will take 10-15 minutes to complete. When the results of this survey are reported, your answers will not be tied to you.

If you are among the first 100 people to complete this survey, you will have the opportunity to receive a $10 gift card to thank you for your time. If you would like to receive this gift card, you may provide contact information at the end of the survey. Your contact information will **not** be tied to your answers or shared with anyone else.
Thank you for taking the time to complete this survey and help guide decision-making on MHSA-funded programming for Santa Cruz County!

SURVEY LAUNCH MESSAGE REMINDER (EMAIL/WEBSITE) by 10/25

Santa Cruz County Behavioral Health Services Community & Partner Feedback Survey

This is the final reminder to complete the Santa Cruz County Behavioral Health Division

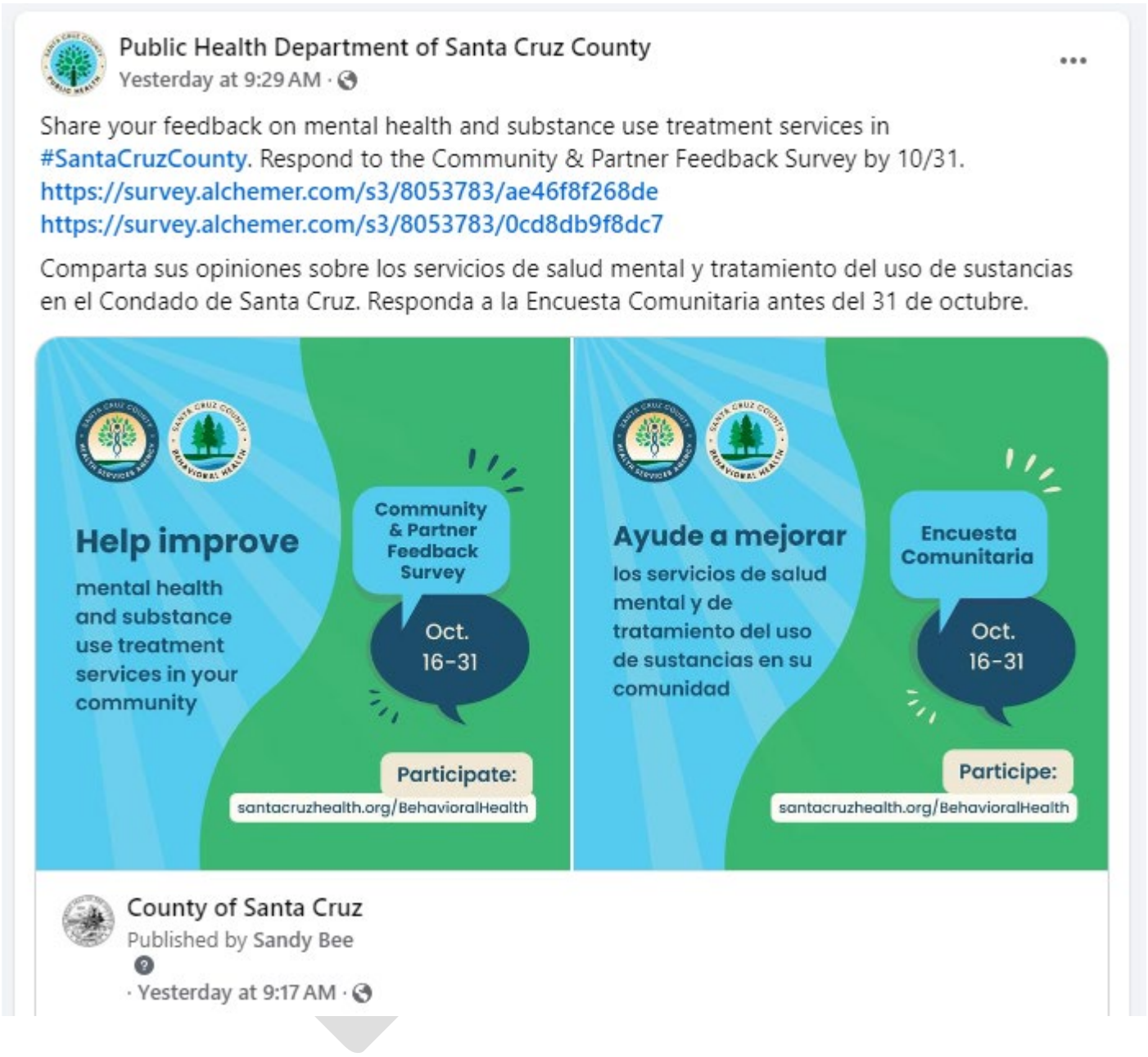
(SCBHD) Community and Partner Feedback Survey as your feedback is essential to inform SCBHS' MHSA Annual Update.

This survey will collect community thoughts, opinions, and feedback on the current behavioral health system as well as other unmet needs within Santa Cruz County. The behavioral health system includes broader mental health and substance use disorder services.

This survey is voluntary and confidential, and only RDA will see your responses. This survey will take 10-15 minutes to complete. When the results of this survey are reported, your answers will not be tied to you.

If you are among the first 100 people to complete this survey, you will have the opportunity to receive a $10 gift card to thank you for your time. If you would like to receive this gift card, you may provide contact information at the end of the survey. Your contact information will **not** be tied to your answers or shared with anyone else.
Thank you for taking the time to complete this survey and help guide decision-making on MHSA-funded programming for Santa Cruz County!

Survey Social Media Promotions

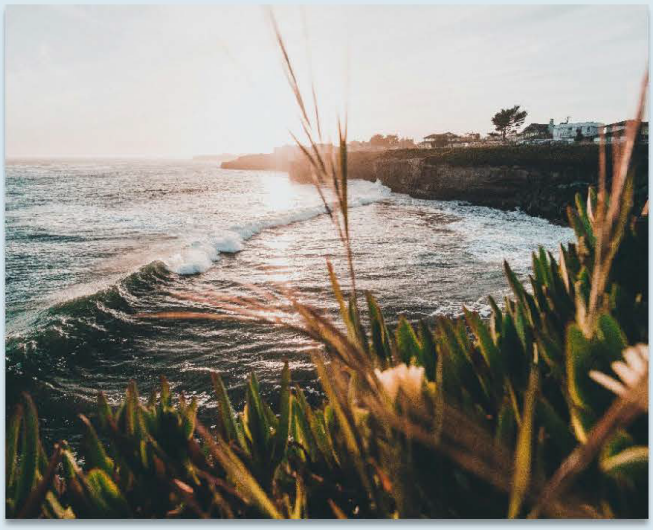


County of Santa Cruz
Published by Sandy Bee
· a day ago ·

#SantaCruzCounty: We invite you to share your feedback on mental health and substance use treatment services in our community to help plan for the 2024-2025 Mental Health Services Act (MHSA) Annual Update. In partnership with RDA Consulting, Behavioral Health Division invites you to complete the community and partner feedback survey by October 31st. ⌛
➡️ https://survey.alchemer.com/s3/8053783/0cd8db9f8dc7

✅The survey is voluntary, confidential, and takes about 10-15 minutes... See more

CPP Meeting Promotional Flyers



Tuesday, April 15, 2025

Mental Health Services Act FY25-26 Annual Update Community Program Planning Meeting

Are you a provider or community member interested in the Mental Health Services Act (Prop.63)? Or a behavioral health services participant, family member, or friend?

Please join us for the upcoming MHSA Community Program Planning Meeting! We will be discussing MHSA behavioral health programs and services for the Annual Update. All are welcome to attend. Your input is essential!

Salud Mental y Tratamiento del Uso de Sustancias

Community Program Planning Meeting

Date: Tuesday, April 15, 2025

Time: 1:00 – 3:00pm PST

The meeting will be held using the Zoom video Conferencing platform. You can join through a computer or dial -in by phone.

Web link:
https://us06web.zoom.us/j/88421174172
Meeting ID: 884 2117 4172
Phone Number: +1 301-715-8592

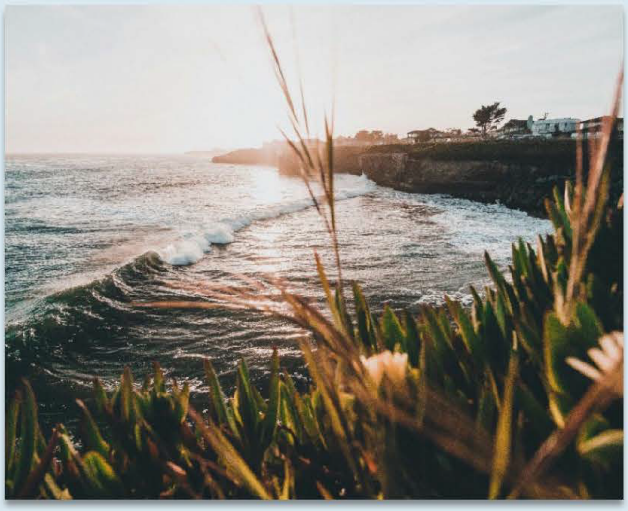
You can also attend in person at:
1400 Emeline Ave. Bldg. K
Room 207
Santa Cruz, CA

Spanish interpretation will be available for this meeting via Zoom

Questions or concerns?
Please contact:

Santa Cruz County MHSA Coordinator
mentalhealth.servicesact@santacruzcountyca.gov

Christy Spees, RDA Consulting
cspees@rdaconsulting.com



Martes 15 de abril de 2025.

Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) Actualización Anual del año fiscal 2025-2026

Reunión de planeación del Programa Comunitario

¿Eres un proveedor o miembro de la comunidad interesado en la Ley de Servicios de Salud Mental (Prop. 63)? ¿O un participante de servicios de salud conductual, familiar o amigo?

¡Únete a la próxima Reunión de planeación del Programa Comunitario MHSA! Hablaremos sobre los programas de salud conductual y los servicios de la Actualización Anual de la MHSA. Todos son bienvenidos a asistir. ¡Tu opinión esesencial!

Salud Mental y Tratamiento del Uso de Sustancias

Reunión de planeación del Programa Comunitario

Fecha: **Martes 15 de abril de 2025.**

Hora: **1:00 – 3:00pm PST**

La reunión se llevará a cabo por medio de la plataforma de Zoom Video Conferencing. Puedes unirte a través de una computadora o llamar por teléfono.

Liga web:
https://us06web.zoom.us/j/88421174172
ID de la reunión: 884 2117 4172
Número de teléfono: +1 301-715-8592

También puedes asistir presencialmente en:
1400 Emeline Ave. Bldg. K
Room 207
Santa Cruz, CA

Habrá interpretación al español disponible para esta reunión a través de Zoom.

¿Dudas o preguntas?
Favor de contactar a:

Coordinador de la MHSA del Condado de Santa Cruz
mentalhealth.servicesact@santacruzcountyca.gov

Christy Spees, RDA Consulting
cspees@rdaconsulting.com

Appendix B. CPP Data Collection Tools

Santa Cruz County Behavioral Health Services

Community & Partner Feedback Survey

Santa Cruz County Behavioral Health Services (SCBHS) has partnered with RDA Consulting (RDA) to help prepare the 2024-2025 Annual Update under the Mental Health Services Act (MHSA).

This survey will collect community experiences, opinions, and feedback on the current behavioral health system to inform the annual assessment of behavioral health needs within Santa Cruz County. Santa Cruz's behavioral health system includes broader mental health and substance use disorder services. Your feedback is essential to inform Santa Cruz County's 2024-2025 MHSA Annual Update.

This survey is voluntary and confidential, and will take approximately 10-15 minutes to complete. You may choose to skip any questions you do not feel comfortable answering. RDA Consulting will combine your individual responses with feedback from all survey participants to inform the Annual Update**. When the results of this survey are reported, your answers will not be tied to you and your identity will not be shared.**

If you are among the first 100 people to complete this survey, you will have the opportunity to receive a $10 gift card to thank you for your time. If you would like to receive this gift card, you may provide contact information at the end of the survey. Your contact information will **not** be tied to your survey answers or shared with anyone else.

Thank you for taking the time to complete this survey and for helping guide decision-making on MHSA-funded programming for Santa Cruz County!

1. **Which of the following best describes your connection to Santa Cruz County Behavioral Health Services:**
   - ☐ Behavioral Health Provider
   - ☐ Medical or Health Care Provider
   - ☐ Education Provider
   - ☐ Social services Provider
   - ☐ Peer Support Provider
   - ☐ Client/consumer of behavioral health services
   - ☐ Family or loved one of client/consumer of behavioral health services
   - ☐ Interested Community Member
   - ☐ Law Enforcement/Probation
   - ☐ Legal/justice system agency
   - ☐ Veterans' services provider
   - ☐ Other (please share: _____)
   - ☐ Prefer not to share

1. **Please indicate your level of agreement to each of the following statements about the overall behavioral health system in Santa Cruz County.**

Behavioral Health System	Strongly Disagree	Somewhat Disagree	Neither Disagree	Somewhat Agree	Strongly Agree

			nor Agree		
Services Provided					
Santa Cruz County's behavioral health services meet the community's needs.	☐	☐	☐	☐	☐
Santa Cruz County's prevention and intervention services help people before they develop serious mental illness.	☐	☐	☐	☐	☐
Santa Cruz County's services meet the needs of people experiencing a mental health crisis.	☐	☐	☐	☐	☐
Access to Services					
I know who to call or where to go if I or someone else needs behavioral or mental health support.	☐	☐	☐	☐	☐
It is easy to get a behavioral health appointment when I or someone else needs one.	☐	☐	☐	☐	☐
Santa Cruz County's behavioral health services are available at convenient times.	☐	☐	☐	☐	☐
Santa Cruz County's behavioral health services are available at convenient locations.	☐	☐	☐	☐	☐
Experience with Services					
Santa Cruz County's behavioral health services are welcoming.	☐	☐	☐	☐	☐
Santa Cruz County's behavioral health services are respectful of clients' culture.	☐	☐	☐	☐	☐
Santa Cruz County's clients and/or family members are involved in their treatment planning.	☐	☐	☐	☐	☐
Santa Cruz County's providers work together to coordinate services.	☐	☐	☐	☐	☐
Santa Cruz County's behavioral health services support clients' wellness and recovery.	☐	☐	☐	☐	☐
Californians recently voted to pass Proposition 1 to modernize the behavioral health delivery system, improve accountability and increase transparency, and expand the capacity of behavioral health care facilities for Californians.					
I am aware and have heard of BHSA/ Prop 1.	☐	☐	☐	☐	☐
I know how Prop 1/BHSA will potentially impact services or programs in Santa Cruz.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above (optional):					

2. **What are one or two things that are <u>most helpful</u> about Santa Cruz County's behavioral health system (e.g., accessing services, specific programs offered, specific services received, etc.)?**

3. **What are one or two things that have been <u>most challenging</u> about Santa Cruz County's behavioral health system (e.g., accessing services, providing services, specific services received, etc.)?**

4. **In your experience, what are the <u>greatest unmet behavioral health needs and/or gaps</u> in the community? What <u>populations</u> are most in need?**

5. **Please share any additional comments that you would like to add.**

Thank you for taking the time to complete this survey! You will be prompted to kindly complete an optional demographics form that would help us in our planning. We will ensure confidentiality of your responses.

If you are among the first 100 respondents to complete the survey, you may choose to accept a $10 gift card to thank you for your time. If you would like to receive this emailed gift card, please check the box below marked "Yes" and share your contact information. Your name and contact information will <u>not</u> be linked to your survey responses or shared with anyone else.

Gift cards will be sent by email after the survey closes on October 30th, 2024.

Would you like to receive a $10 gift card if you are among one of the first 100 respondents to complete this survey?

☐ Yes, I would like to receive a $10 gift card if I am among the first 100 respondents to complete this survey.

☐ No, I do not want to receive a $10 gift card.

Please provide your contact information to receive the $10 gift card if you are among one of the first 100 respondents to complete this survey.

Name: _____

Email Address: _____

OPTIONAL DEMOGRAPHICS FORM

1. What is your age range?
   - ☐ Under 16
   - ☐ 16-25
   - ☐ 26-59
   - ☐ 60 and older
   - ☐ Prefer not to share

2. What is your race? (Check all that apply)
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White
   - ☐ Other (please share):
   - ☐ Prefer not to share

3. What is your ethnicity? (Check all that apply)
   - ☐ Caribbean
   - ☐ Central American
   - ☐ Mexican/Mexican-American/Chicano
   - ☐ Puerto Rican
   - ☐ South American
   - ☐ Other Hispanic or Latino
   - ☐ African
   - ☐ Asian Indian/South Asian
   - ☐ Cambodian
   - ☐ Chinese
   - ☐ Eastern European
   - ☐ European
   - ☐ Filipino
   - ☐ Japanese
   - ☐ Korean
   - ☐ Middle Eastern
   - ☐ Vietnamese
   - ☐ Other Non-Hispanic or Non-Latino
   - ☐ Other (please share):
   - ☐ Prefer not to share

4. What is your primary language?
   - ☐ English
   - ☐ Spanish
   - ☐ Other (please share):
     _____

5. What was your sex assigned at birth?
   - ☐ Female
   - ☐ Male
   - ☐ Intersex
   - ☐ Other (please share):
   - ☐ Prefer not to share

6. What is your current gender identity?
   - ☐ Woman/Female
   - ☐ Man/Male
   - ☐ Non-Binary
   - ☐ Agender
   - ☐ Another gender (please share):
   - ☐ Prefer not to share

7. How do you describe your sexual orientation?
   - ☐ Gay or Lesbian
   - ☐ Heterosexual or Straight
   - ☐ Bisexual
   - ☐ Pansexual
   - ☐ Asexual
   - ☐ Queer
   - ☐ Questioning
   - ☐ Don't know
   - ☐ Another sexual orientation (please share):
   - ☐ Prefer not to share

8. Are you a veteran of the United States military?
   - ☐ Yes
   - ☐ No
   - ☐ Prefer not to share

9. Do you experience any disabilities? (Check all that apply).
   - ☐ Difficulty seeing
   - ☐ Difficulty hearing, or having speech understood
   - ☐ Mental disability (i.e., learning disability, developmental disability, dementia)
   - ☐ Impaired physical mobility
   - ☐ Chronic health condition
   - ☐ No disability
   - ☐ Other disability (please share):
   - ☐ Prefer not to share

☐ Prefer not to share

10. What is your zip code? _____

SCBHS MHSA Annual Update FY 25-26
Community Member Focus Group Protocol

Focus Group Details

Date	
Group	
Interviewer	
Note Taker	

Introduction

Hello, my name is _____ and this is _____. Thank you very much for taking time to talk with us today. We are with RDA Consulting, a consulting firm in the Bay Area. We are working with Santa Cruz County's Behavioral Health Division to develop their FY25-26 Annual Update to the FY23-26 3-Year Plan for Mental Health Services Act (MHSA) Programs and Services. As a part of the needs assessment for this project, we are conducting focus groups with behavioral health consumers, providers, and other community members to understand system strengths and how MHSA programs can be improved to better meet community needs.

During this focus group, we want to learn about your experiences accessing and participating in services, helping friends and family to access services, and/or your experiences with behavioral health care and needs in Santa Cruz County overall. We will not ask you to share your personal history, such as any diagnoses. You do not have to answer any questions or share any information you feel uncomfortable discussing. This discussion is meant to focus on your experience engaging with Santa Cruz mental health programs and services. The feedback you share about your experiences will help inform work on the Mental Health Services Act Annual Update for 2025-2026 for program and service delivery.

We do want to also note that beginning this year, all California counties will be required to shift to a new model of systems planning and funding. The Behavioral Health Services Act (BHSA) replaces the MHSA and requires changes to how counties allocate and plan for funding that currently funds MHSA programs. This means there were likely to be some changes to behavioral health programs in Santa Cruz beginning in 2026. If you'd like to learn more about the BHSA transition, you can visit the county's BHSA webpage.

This focus group will take approximately 1 hour. Please note that everything shared here today will be anonymous - no names or identifying information will be paired with what you share. We really want to hear from all of you, so please give everyone the opportunity to share. And

we want to be sure everyone feels comfortable sharing honestly, so please keep what is said here confidential to the group.

Do we have your permission to record? Do you have any questions before we begin?

Introductions

To get started, we would like to learn a little more about you. Could you share:

- Your name
- How you are involved with the Santa Cruz mental health system (e.g., consumer, family member, behavioral health provider, advocate, community partner, etc.).
- How did you first learn about or begin participating / working with Santa Cruz behavioral health programs?

System Strengths

- From your experience, what has been working well with the behavioral health system of care in Santa Cruz County? What are some of the key strengths?
  Prompts: timely appointments, staffing, program capacity, program availability/ continuum of care, quality of services, language/ cultural sensitivity, service coordination/ communication within SCCBHD, service coordination/ communication across partner agencies, etc.)
- What has been working well in helping community members access behavioral health services? In helping community members to keep participating in services? *(location, hours of operation, etc.)*
- What is working well in terms of reaching and serving community members with unique needs (*Spanish-speaking or other non- English communities, individuals experiencing homelessness, individuals with disabilities, etc.*)?
- Could you share an example about a time you had a positive experience with behavioral health programs in Santa Cruz County? What about that experience made it positive or was helpful?

System Challenges

- What have been some of the biggest challenges with behavioral health care in Santa Cruz County? Where has the system not worked for the community overall? For the community members with unique needs (*e.g Spanish-speaking community in particular*)?

Prompts: timely appointments, staffing, program capacity, program availability/ continuum of care, quality of services, language/ cultural sensitivity, service coordination/ communication within SCCBHD, service coordination/ communication across partner agencies, etc.)

- What, if any, challenges have you experienced or witnessed in terms of accessing behavioral health services in the county? *(location, language, hours of operation, etc)*
- What kinds of things do you recommend to address these challenges?
    - What would be needed to bring about these changes?

System Gaps

- What behavioral health programs or services do you wish Santa Cruz County provided? What behavioral health services or programs are so full you need more of them?
- What populations are underserved or need more mental health support? Who may be falling through the cracks?
  Prompts: unhoused individuals, racial/ethnic groups, LGBTQ+ individuals, youth/TAY, older adults, rural or outlying areas, etc.
- What would be needed to better serve these populations?

Check-Out:

- If you had unlimited funds for mental health services, what would you want them to be spent on?

Thank you for your participation! We genuinely appreciate the time you took to speak with us today! We will be following up to share a $40 gift card with you to thank you for your participation. If you haven't already, please provide your name and email address so we can send you the gift card (your contact information will not be associated with your responses today).

If you have any other comments or feedback you would like to share, feel free to email us. You can email me at cspees@rdaconsulting.com.

We also request that you take a minute to complete the MHSA stakeholder demographic form. The form is anonymous, and just helps us understand who has participated in MHSA community engagement events.

Demographic Survey Link (English):

Demographic Survey Link (Spanish):

SCBHS MHSA Annual Update FY 25-26
Community Member Focus Group Protocol

Introduction

Hello, my name is _____ and this is _____. Thank you very much for taking time to talk with us today. We are with RDA Consulting, a consulting firm in the Bay Area. We are working with Santa Cruz County's Behavioral Health Division to develop their FY25-26 Annual Update to the FY23-26 3-Year Plan for Mental Health Services Act (MHSA) Programs and Services. As a part of the needs assessment for this project, we are conducting focus groups with behavioral health consumers, providers, and other community members to understand system strengths and how MHSA programs can be improved to better meet community needs.

During this focus group, we want to learn about your experiences providing MHSA services, working with the County, and engaging with community members, and/or your experiences with behavioral health care and needs in Santa Cruz County overall. The feedback you share about your experiences will help inform work on the Mental Health Services Act Annual Update for 2025-2026 for program and service delivery.

We do want to also note that beginning this year, all California counties will be required to shift to a new model of systems planning and funding. The Behavioral Health Services Act (BHSA) replaces the MHSA, and requires changes to how counties allocate and plan for funding that currently funds MHSA programs. This means there will likely be some changes to behavioral health programs in Santa Cruz beginning in 2026. If you'd like to learn more about the BHSA transition, you can visit the CA dept of Health Care Services (DHCS) website.

This focus group will take approximately 90 minutes. Please note that everything shared here today will be anonymous - no names or identifying information will be paired with what you share. We really want to hear from all of you, so please give everyone the opportunity to share. And we want to be sure everyone feels comfortable sharing honestly, so please keep what is said here confidential to the group.

Do we have your permission to record? Do you have any questions before we begin?

Introductions

To get started, we would like to learn a little more about you. Could you share:

- Your name
- Your role and affiliation and time in that role

System Strengths

- From your experience, what has been working well with the behavioral health system of care in Santa Cruz County? What are some of the key strengths?

Prompts: timely appointments, staffing, program capacity, program availability/ continuum of care, quality of services, language/ cultural sensitivity, service coordination/ communication within SCCBHD, service coordination/ communication across partner agencies, etc.)

- What has been working well in helping community members access behavioral health services? In helping community members continue participating in services? *(location, hours of operation, etc.)*
- What is working well in terms of reaching and serving community members with unique needs (*Spanish-speaking or other non- English communities, individuals experiencing homelessness, individuals with disabilities, etc.*)?

System Challenges

- What have been some of the biggest challenges with behavioral health care in Santa Cruz County? Where has the system not worked for the community overall? For the community members with unique needs (*e.g. Spanish-speaking community in particular*)?

Prompts: *timely appointments, staffing, program capacity, program availability/ continuum of care, quality of services, language/ cultural sensitivity, service coordination/ communication within SCCBHD, service coordination/ communication across partner agencies, etc.)*

- What, if any, challenges have you experienced or witnessed in terms of accessing behavioral health services in the county? *(location, language, hours of operation, etc)*
- What are some of your recommendations to potentially address these challenges?
    - What would be needed to bring about these changes?

System Gaps

- What behavioral health programs or services do you wish Santa Cruz County provided? What behavioral health services or programs are so full you need more of them?
- What populations are underserved or need more mental health support? Who may be falling through the cracks?

Prompts: *unhoused individuals, racial/ethnic groups, LGBTQ+ individuals, youth/TAY, older adults, rural or outlying areas, etc.*

- What would be needed to better serve these populations?

BHSA Transition

- How, if at all, do you expect that the transition to BHSA will impact the services you provide?
- What questions or concerns do you have, if any, regarding these upcoming changes?

Check-Out:

- If you had unlimited funds for behavioral health services, what would you want them to be spent on?

Thank you for your participation! We genuinely appreciate the time you took to speak with us today! If you have any other comments or feedback you would like to share, feel free to email us. You can email me at cspees@rdaconsulting.com.

We also request that you take a minute to complete the MHSA stakeholder demographic form. The form is anonymous, and just helps us understand who has participated in MHSA community engagement events.
Demographic Survey Link (English):
Demographic Survey Link (Spanish):

Appendix C. Public Comment & Public Hearing Notice

Public Comment Promotion – *Social Media*

Public Comment Promotion – Newspaper

Public Hearing – Mental Health Advisory Board Agenda

Public Comments

The following comments were received either at or after the public hearing and during the 30-day public comment period.

Public Comments: from Public Hearing

Verbal comments received during the Public Hearing were slightly edited for clarity, length, and to omit any identifying information.

Public Comment:
SCCBHD Response:

Public Comment:
SCCBHD Response:

Public Comment:
SCCBHD Response:

Public Comment:
SCCBHD Response:

Public Comment:
SCCBHD Response:

Public Comment:
SCCBHD Response:

Public Comments: from Email & Website Submission

Public Comment:
SCCBHD Response:

Appendix D. Complete CPPP Stakeholder Affiliation & Demographic Data

Table 4. Complete Stakeholder Affiliation of Survey Participants

Stakeholder Affiliation	N	%
Behavioral Health Provider	75	53%
Medical or Health Care Provider	5	4%
Education Provider	7	5%
Social services Provider	24	17%
Peer Support Provider	11	8%
Client/consumer of behavioral health services	22	16%
Family or loved one of client/consumer of behavioral health division	12	9%
Interested Community Member	20	14%
Law Enforcement/Probation	2	1%
Legal/justice system agency	2	1%
Veterans' services provider	5	4%
Other	20	14%
Prefer not to share	3	2%
TOTAL PARTICIPANTS	**208**	

Data Note: Stakeholder affiliation sums to greater than 100% as some participants identified with multiple stakeholder groups.

Table 5. Complete Demographic Characteristics of Survey Participants

Demographic Characteristic		Community Survey Participants N (%)
Age Group	Transition Age Youth (16-25)	8 (6%)
	Adults (26-59)	92 (70%)
	Older Adults (60+)	25 (19%)
	Unknown / Not reported	6 (5%)
Gender Identity	Woman/Female	73 (56%)
	Man/Male	43 (33%)
	Another Gender Identity	5 (4%)
	Unknown / Not Reported	9 (7%)
Race	White	92 (72%)
	Asian	7 (6%)
	American Indian or Alaska Native	5 (4%)
	Black / African American	4 (3%)
	Another Race	17 (13%)
	Unknown / Not Reported	14 (11%)
Ethnicity	European	48 (39%)
	Mexican/Mexican-American/Chicano	19 (15%)
	Eastern European	10 (8%)
	Other Hispanic or Latino	8 (7%)
	Japanese	3 (2%)
	Filipino	3 (2%)
	Chinese	3 (2%)
	Central American	3 (2%)
	Middle Eastern	2 (2%)
	Caribbean	2 (2%)
	Another Ethnicity	16 (13%)
	Unknown/ Not Reported	19 (15%)
TOTAL PARTICIPANTS		**128**

Data Notes:

1) Primary language, sexual orientation, veteran status, and disability status were not included in the MHCAN demographic form.
2) Race and ethnicity data sums to greater than 100% as some participants identified with multiple races and ethnicities. Another race/ethnicity includes Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, or Other race.
3) Percentages for other demographic characteristics may not sum exactly to 100% due to rounding.
4) The most reported disabilities were a chronic health condition or a mental disability (i.e., learning disability, developmental disability, dementia). Other reported disabilities included difficulty seeing, difficulty hearing or having speech understood, impaired physical mobility, or another disability.

Appendix E. Community Services and Supports (CSS), FY2022-2023 Annual Reports

CSS #1 Community Gate

Community Gate addresses the mental health needs of children and youth in the community who are 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 you in the community.

Encompass Youth Services – Community Gate (CSS #1)

Community Supports & Services: 2023-2024

Agency Reporting	***Santa Cruz County Behavioral Health Services***				
System Development:	*Q1*	*Q2*	*Q3*	*Q4*	***Annual***
Number of individuals/families targeted:					*150*
Number of individuals/families ***ACTUALLY SERVED***	*46*	*49*	*47*	*39*	*77*
Age Group					
• *Children 0-15*	*29*	*32*	*30*	*26*	*51*
• *TAY 16-25*	*17*	*17*	*17*	*13*	*26*
• *Adults 26-59*	-	-	-	-	-
• *Older Adults 60+*	-	-	-	-	-
Race/Ethnicity					
• *White*	*11*	*12*	*10*	*9*	*18*
• *Latino*	*31*	*32*	*32*	*26*	*52*
• *Other*	*4*	*5*	*5*	*4*	*7*
Primary Language					
• *English*	*36*	*40*	*38*	*32*	*64*
• *Spanish*	*10*	*9*	*9*	*7*	*13*
• *Other*	-	-	-	-	-
Culture					
• *Veterans*	*Not tracked*	*Not tracked*	*Not tracked*	*Not tracked*	*Not tracked*
• *LGBTQ*	*7*	*9*	*10*	*10*	*16*

Pajaro Valley Prevention and Student Assistance (PVPSA) – Community Gate (CSS #1)

Community Supports & Services: 2023-2024

Agency Reporting	***Santa Cruz County Behavioral Health Services***				
System Development:	*Q1*	*Q2*	*Q3*	*Q4*	***Annual***
Number of individuals/families targeted:					
Number of individuals/families ***ACTUALLY SERVED***	*94*	*107*	*110*	*118*	*192*
Age Group					
• *Children 0-15*	*80*	*91*	*96*	*107*	*160*
• *TAY 16-25*	*14*	*16*	*14*	*11*	*32*
• *Adults 26-59*	*0*	*0*	*0*	*0*	*0*
• *Older Adults 60+*	*0*	*0*	*0*	*0*	*0*
Race/Ethnicity					
• *White*	*0*	*3*	*5*	*8*	*9*
• *Latino*	*74*	*81*	*79*	*79*	*134*
• *Other*	*20*	*23*	*26*	*31*	*49*
Primary Language					
• *English*	*76*	*79*	*80*	*91*	*144*
• *Spanish*	*18*	*28*	*30*	*27*	*48*
• *Other*	*0*	*0*	*0*	*0*	*0*
Culture					
• *Veterans*	*0*	*0*	*0*	*0*	*0*
• *LGBTQ*	*1*	*2*	*2*	*2*	*2*

Santa Cruz County Behavioral Health Services – Community Gate (CSS #1)

Community Supports & Services: 2023-2024

SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the next FY 25-26 Annual Update

Agency Reporting	***Santa Cruz County Behavioral Health Services***				
System Development:	*Q1*	*Q2*	*Q3*	*Q4*	***Annual***

Number of individuals/families targeted:					
*Number of individuals/families **ACTUALLY SERVED***					
Age Group	*204*	*264*	*278*	*362*	*1108*
• *Children 0-15*	*107*	*151*	*138*	*196*	*592*
• *TAY 16-25*	*97*	*113*	*140*	*166*	*516*
• *Adults 26-59*	*0*	*0*	*0*	*0*	*0*
• *Older Adults 60+*	*0*	*0*	*0*	*0*	*0*
Race/Ethnicity					
• *White*	*64*	*69*	*81*	*85*	*299*
• *Latino*	*121*	*133*	*159*	*173*	*586*
• *Other*	*19*	*20*	*38*	*32*	*109*
Primary Language	*204*	*264*	*278*		
• *English*	*174*	*219*	*214*	*228*	*835*
• *Spanish*	*30*	*44*	*52*	*58*	*184*
• *Other*	*0*	*1*	*12*	*4*	*17*
Culture					
• *Veterans*	*NA*	*NA*	*NA*	*NA*	
• *LGBTQ*	*NA*	*NA*	*NA*	*NA*	

CSS #2 Probation Gate

Probation Gate addresses 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 (as shared with Probation) is to keep youth safely at home rather than in prolonged stays of residential placement or incarcerated in a juvenile hall.

Encompass– Probation Gate (CSS #2)

Community Supports & Services: 2023-2024

Showing an unduplicated client count for the reporting period. As of time of reporting, the percentage of MHSA funding for Youth Services-Probation Gate was not made available to Encompass.

Agency Reporting	**Encompass**				
System Development:	Q1	Q2	Q3	Q4	**Annual**

Number of individuals/families targeted:					
Number of individuals/families **ACTUALLY SERVED**					
Age Group					
· Children 0-15					
· TAY 16-25					
· Adults 26-59					
· Older Adults 60+					
Race/Ethnicity					
· White					
· Latino					
· Other					
Primary Language					
· English					
· Spanish					
· Other					
Culture					
· Veterans					
· LGBTQ					

Pajaro Valley Prevention and Student Assistance (PVPSA) – Probation Gate (CSS #2)

Community Supports & Services: 2023-2024

SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the next FY 25-26 Annual Update

Agency Reporting	***Santa Cruz County Behavioral Health Services***				
System Development:	*Q1*	*Q2*	*Q3*	*Q4*	***Annual***
Number of individuals/families targeted:					
*Number of individuals/families **ACTUALLY SERVED***	*1*	*2*	*3*	*3*	*3*
Age Group					
• *Children 0-15*	*1*	*1*	*2*	*2*	*2*

• *TAY 16-25*	*0*	*1*	*1*	*1*	*1*
• *Adults 26-59*	*0*	*0*	*0*	*0*	*0*
• *Older Adults 60+*	*0*	*0*	*0*	*0*	*0*
Race/Ethnicity					
• *White*	*0*	*0*	*1*	*1*	*1*
• *Latino*	*1*	*2*	*2*	*2*	*2*
• *Other*	*0*	*0*	*0*	*0*	*0*
Primary Language					
• *English*	*1*	*2*	*3*	*3*	*3*
• *Spanish*	*0*	*0*	*0*	*0*	*0*
• *Other*	*0*	*0*	*0*	*0*	*0*
Culture					
• *Veterans*	*0*	*0*	*0*	*0*	*0*
• *LGBTQ*	*0*	*0*	*0*	*0*	*0*

CSS #3 Child Welfare Services Gate

Child Welfare Services Gate focuses on addressing the mental health needs of children and youth who are involved with the child welfare system.

Parent Center– Child Welfare Gate (CSS #3)

Community Supports & Services: 2023-2024

Agency Reporting	***Parent Center***				
System Development:	*Q1*	*Q2*	*Q3*	*Q4*	***Annual***
Number of individuals/families targeted:					
Number of individuals/families ***ACTUALLY SERVED***					*89*
Age Group					
• *Children 0-15*					*70*
• *TAY 16-25*					*19*
• *Adults 26-59*					*N/A*
• *Older Adults 60+*					*N/A*
Race/Ethnicity					
• *White*					*37*

• *Latino*					*47*
• *Other*					*5*
Primary Language					
• *English*					*57*
• *Spanish*					*32*
• *Other*					*0*
Culture					
• *Veterans*					*N/A*
• *LGBTQ*					*6*

Encompass– Child Welfare Gate (CSS #3)

Community Supports & Services: 2023-2024

Santa Cruz County Behavioral Health Services – Child Welfare Services Gate (CSS #3)

Community Supports & Services: 2023-2024

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					
Number of individuals/families **ACTUALLY SERVED**					
Age Group	85	74	68	63	266
• Children 0-15	66	58	47	46	199
• TAY 16-25	19	16	21	18	67
• Adults 26-59	0	0	0	0	0
• Older Adults 60+	0	0	0	0	0
Race/Ethnicity					
• White	30	29	20	16	87
• Latino	42	35	36	36	141
• Other	8	7	12	11	36
Primary Language					
• English	81	68	55	54	223
• Spanish	4	6	12	8	40
• Other	0	0	1	1	3

Culture					
• Veterans	NA	-	-	-	-
• LGBTQ	NA	-	-	-	-

CSS #4 Education Gate

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

Santa Cruz County Behavioral Health Services – Education Gate (CSS #4)

Community Supports & Services: 2022-2023

SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the next update.

CSS #5 Special Focus: Family Partnership

Family Partnerships is focused on the provision of activities to support parents and youth who are currently or have in the past been served by the Children's Interagency System of Care. Outreach, education, support, and services are coordinated for parents and youth.

Volunteer Center / Community Connect– Family Partnership (CSS #5)

Community Supports & Services: 2023-2024

Agency Reporting	**Volunteer Center / Community Connect**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					
Number of individuals/families **ACTUALLY SERVED**	27	29	26	24	42
Age Group					
· Children 0-15	15	17	16	16	25
· TAY 16-25	10	12	10	8	16
· Adults 26-59	1	0	0	0	1
· Older Adults 60+	1	0	0	0	1
Race/Ethnicity					
· White	7	7	7	6	8

· Latino	14	17	14	13	28
· Other	4	4	5	5	6
Primary Language					
· English	16	17	17	18	24
· Spanish	11	12	9	6	18
· Other	0	0	0	0	0
Culture					
· Veterans	0	0	0	0	0
· LGBTQ	1	1	1	2	2

CSS #6 Enhanced Crisis Response

Enhanced Crisis Response provides enhanced 24/7 support to adults who are:

a) experiencing significant impact to their level of functioning that is impacting their ability to independently maintain their living situation either in their own home or community placement site.
b) in need of or at risk of psychiatric hospitalization but can be safely treated, on a voluntary basis, in a lower level of care setting; or
c) being inappropriately treated at a higher level of care or incarceration and can step down from psychiatric hospitalization or a locked skilled nursing facility to a lower level of community-based care.

El Dorado Center (Encompass)– Enhanced Crisis Response (CSS #6)

Community Supports & Services: 2022-2023

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted					**100**
Number Actually Served:	22	23	16	26	60
Age Group					
• Children 0-15					
• TAY 16-25	2	2	3	5	8
• Adults 26-59	18	19	11	19	45
• Older Adults 60+	2	2	2	2	7
Race/Ethnicity					
• White	14	15	11	19	41
• Latino	6	4	3	6	14
• Other	2	4	2	1	5
Primary Language					
• English	22	22	16	25	58

• Spanish		1		1	2
• Other					
Culture					
• Veterans	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected
• LGBTQ	2	2	2	2	4

The numbers represent a percentage of unduplicated clients served during this period, or the percentage of clients funded by MHSA. For FY 22-23, the percentage for El Dorado Center is 44%.

Telos (Encompass)– Enhanced Crisis Response (CSS #6)

Community Supports & Services: 2022-2023

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted					20
Number Actually Served	N/A	N/A	N/A	N/A	**N/A**
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					**20**
Number Actually Served	2	3	3	2	**6**
Adults (26-59)					
Number of individuals/families targeted					**65**
Number Actually Served	19	14	17	19	**57**
Older Adults (60+)					
Number of individuals/families targeted					**15**
Number Actually Served:	2	3	2	1	6
Age Group					
• Children 0-15					
• TAY 16-25	2	3	3	2	6
• Adults 26-59	19	14	17	19	57
• Older Adults 60+	2	3	2	1	6
Race/Ethnicity					
• White	12	13	13	14	41
• Latino	8	4	7	6	21
• Other	3	3	2	2	7

Primary Language					
• English	21	18	20	20	65
• Spanish	2	1	2	1	3
• Other		1		1	1
Culture					
• Veterans	Data not tracked	Data not tracked	Data not tracked	Data not tracked	Data not tracked
• LGBTQ	1	1	2	1	4

The numbers represent a percentage of unduplicated clients served during this period, or the percentage of clients funded by MHSA. For FY 23-24, the percentage for Telos is 52%.

Peer Supports at PHF (MHCAN) – Enhanced Crisis Response (CSS #6)

Community Supports & Services: 2022-2023

SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the next Update.

Demographic breakdown not required for Outreach & Engagement

Santa Cruz County Behavioral Health Services – Enhanced Crisis Response (CSS #6)

Community Supports & Services: 2022-2023

SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the next Update.

CSS #7 Consumer, Peer, & Family Support Services

Consumer, Peer, & Family Services provided expanded countywide access to culturally competent, recovery-oriented, peer-to-peer, community mentoring, and consumer-operated services.

North County Wellness Center (MHCAN) – Consumer, Peer & Family Support Services (CSS #7)

Community Supports & Services: 2023-2024

Community Supports & Services: 2023-2024

Agency Reporting	**MHCAN, Outreach Reporting**				
System Development:	Q1	Q2	Q3	Q4	**Annual**

Number of individuals/families targeted:	20	20	20	20	**80**
Number of individuals/families **ACTUALLY SERVED**	283	104	50	96	533

Demographic breakdown not required for Outreach & Engagement

Community Supports & Services: 2023-2024

Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted	-	-	-	-	**200**
Number Actually Served	-	-	-	-	**-**
Adults (26-59)					
Number of individuals/families targeted					**350**
Number Actually Served	539	512	456	466	**1973**
Older Adults (60+)					
Number of individuals/families targeted					**50**
Number Actually Served:	450	410	260	310	1430
Age Group					
• Children 0-15	-	-	-	-	-
• TAY 16-25	-	-	-	-	-
• Adults 26-59	439	512	456	466	1973
• Older Adults 60+	350	410	260	310	1430
Race/Ethnicity					
• White	419	411	366	372	1568
• 519	150	151	108	110	519
• Other	420	360	242	294	1316
Primary Language					
• English	498	472	372	386	1728
• Spanish	49	46	36	39	170
• Uknown/other	442	404	308	351	1505
Culture					
• Veterans	-	-	-	-	-
• LGBTQ	-	-	-	-	-

Volunteer Center / Community Connection (Mariposa)– Consumer, Peer, & Family Support Services (CSS #7)

Community Supports & Services: 2023-2024

SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the future.

CSS #8 Community Support Services

Community Support Services are designed to advance recovery goals for all consumers to live independently and to be engaged in meaningful work and learning activities. Individual participants are enrolled in Full-Service Partnerships (FSP) Teams. These FSP Teams are partnerships between clients and clinicians that include opportunities for clinical care, housing, employment, and 24/7 service availability from staff. Services in this project are provided through a collaboration of County staff and community partner agencies (Community Connection, Front Street, and Wheelock).

Wheelock-Front Street– Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	0	1	1	2	**2**
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	11	14	12	12	**15**
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:	5	5	3	4	5

Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	0	1	1	2	2
• Adults 26-59	11	14	12	12	15
• Older Adults 60+	5	5	3	4	5
Race/Ethnicity					
• White	7	9	5	8	9
• Latino	8	10	10	8	11
• Other	1	1	1	2	2
Primary Language					
• English	13	17	13	14	18
• Spanish	3	3	3	4	4
• Other	0	0	0	0	0
Culture					
• Veterans	0	0	0	0	0
• LGBTQ	0	0	0	0	0

Opal Cliffs-Front Street– Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	0	0	0	0	**0**
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	13	12	11	11	**12**
Older Adults (60+)					
Number of individuals/families targeted					

Number Actually Served:	2	3	4	4	4
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	0	0	0	0	0
• Adults 26-59	13	12	11	11	12
• Older Adults 60+	2	3	4	4	4
Race/Ethnicity					
• White	12	12	12	12	13
• Latino	1	1	1	1	1
• Other	2	2	2	2	2
Primary Language					
• English	15	15	15	15	16
• Spanish	0	0	0	0	0
• Other	0	0	0	0	0
Culture					
• Veterans	0	0	0	0	0
• LGBTQ	0	0	0	0	0

Willowbrook-Front Street– Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	1	1	1	1	**1**
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	25	28	26	23	**29**
Older Adults (60+)					

Number of individuals/families targeted					
Number Actually Served:	14	14	15	15	19
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	1	1	1	1	1
• Adults 26-59	25	28	26	23	29
• Older Adults 60+	14	14	15	15	19
Race/Ethnicity					
• White	35	37	35	31	39
• Latino	3	5	6	6	8
• Other	2	1	1	2	2
Primary Language					
• English	40	43	42	39	49
• Spanish	0	0	0	0	0
• Other	0	0	0	0	0
Culture					
• Veterans	1	1	1	1	1
• LGBTQ	1	1	1	1	1

Casa Pacific (Encompass)– Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual*
Number of individuals/families targeted					40
Number Actually Served	9	10	10	10	22
Age Group					
• Children 0-15					
• TAY 16-25	1	1	1	1	1
• Adults 26-59	7	8	8	9	20
• Older Adults 60+	1	1	1		1
Race/Ethnicity					
• White	7	8	6	7	15
• Latino	2	1	3	2	6
• Other		1	1	1	1

Primary Language					
• English	9	10	9**	9	21
• Spanish					0**
• Other			1	1	1
Culture					
• Veterans	Data not tracked	Data not tracked	Data not tracked	Data not tracked	Data not tracked
• LGBTQ	1	1	1	1	2

**The Annual Target is from the FY 2022-23 report template provided by County. **Client served in third quarter's primary language changed in source data from Spanish to English. Updating Q3 column to reflect this change. The numbers represent a percentage of unduplicated clients served during this period, or the percentage of clients funded by MHSA. For FY 23-24, the percentage for Casa Pacific is 46%.*

Supported Housing– Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	0	0	0	0	**0**
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	17	15	15	15	**17**
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:	10	12	12	13	14
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	0	0	0	0	0
• Adults 26-59	17	15	15	15	17

• Older Adults 60+	10	12	12	13	14
Race/Ethnicity					
• White	20	20	20	21	24
• Latino	3	3	3	3	3
• Other	4	4	4	4	4
Primary Language					
• English	27	27	27	28	31
• Spanish	0	0	0	0	0
• Other	0	0	0	0	0
Culture					
• Veterans	1	1	1	1	1
• LGBTQ	0	0	0	0	0

Santa Cruz County Behavioral Health Services – Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					
Number of individuals/families **ACTUALLY SERVED**	947	880	984	990	3801
Age Group					
· Children 0-15					
· TAY 16-25	57	54	54	37	202
· Adults 26-59	667	622	666	677	2632
· Older Adults 60+	223	207	270	280	980
Race/Ethnicity					
· White	562	553	609	638	2362
· Latino	206	215	239	223	883
· Other	179	112	137	129	557
Primary Language					
· English	883	813	918	925	3539
· Spanish	43	51	52	49	195

· Other	18	16	15	16	65
Culture					
· Veterans					
· LGBTQ					

Adult: CREST,FIT, MOST, OAS, Recov. N&S, FQHC Ther. N&S

SCCBHD – Services for Older Adults. Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					
Number of individuals/families **ACTUALLY SERVED**					
Age Group					
· Children 0-15					
· TAY 16-25		1		1	2
· Adults 26-59	4	5	1	4	12
· Older Adults 60+	94	76	122	141	172
Race/Ethnicity					
· White	79	63	98	111	142
· Latino	7	7	9	12	19
· Other	12	12	16	23	24
Primary Language					
· English	94	79	118	141	180
· Spanish	1	1	2	2	2
· Other	3	2	3	3	3
Culture					
· Veterans					
· LGBTQ					

SCCBHD – MOST Team. Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					
Number of individuals/families **ACTUALLY SERVED**					
Age Group					
· Children 0-15					
· TAY 16-25	6	7	6	4	8
· Adults 26-59	108	99	87	82	143
· Older Adults 60+	4	7	4	7	9
Race/Ethnicity					
· White	74	70	59	62	98
· Latino	27	29	27	23	37
· Other	17	13	10	8	21
Primary Language					
· English	111	105	90	89	148
· Spanish	5	5	5	3	6
· Other	2	2	1	1	2
Culture					
· Veterans					
· LGBTQ					

Avenues Employments Services (Volunteer Center/Community Connection)– Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	0	1	0	1	**2**

Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	30	34	36	39	**56**
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:	4	5	4	3	5
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	0	1	0	1	2
• Adults 26-59	30	34	36	39	56
• Older Adults 60+	4	5	4	3	5
Race/Ethnicity					
• White	17	22	21	21	31
• Latino	9	8	12	11	15
• Other	8	10	7	11	17
Primary Language					
• English	33	39	38	41	59
• Spanish	1	1	2	1	3
• Other	0	0	0	1	1
Culture					
• Veterans	2	2	1	2	2
• LGBTQ	9	9	8	9	11

Housing Support (Volunteer Center/Community Connection)– Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	2	1	1	1	**2**
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	13	14	17	20	**20**
Older Adults (60+)					

Number of individuals/families targeted					
Number Actually Served:	2	3	4	5	5
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	2	1	1	1	2
• Adults 26-59	13	14	17	20	20
• Older Adults 60+	2	3	4	5	5
Race/Ethnicity					
• White	11	12	16	18	18
• Latino	3	3	3	4	4
• Other	3	3	3	4	5
Primary Language					
• English	17	18	22	26	27
• Spanish	0	0	0	0	0
• Other	0	0	0	0	0
Culture					
• Veterans	1	1	1	1	1
• LGBTQ	3	2	3	3	4

Opportunity Connection (Volunteer Center/Community Connection)– Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	2	3	4	4	**5**
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	34	39	41	44	**50**
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:	8	6	6	7	10
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	2	3	4	4	5

• Adults 26-59	34	39	41	44	10
• Older Adults 60+	8	6	6	7	50
Race/Ethnicity					
• White	29	31	33	30	36
• Latino	4	4	4	7	8
• Other	11	13	14	18	20
Primary Language					
• English	42	47	50	54	62
• Spanish	2	1	1	0	2
• Other	0	0	0	1	1
Culture					
• Veterans	2	3	3	3	4
• LGBTQ	5	5	4	4	7

College Connection (Volunteer Center/ Community Connection) – Community Support Services (CSS #8)

Community Supports & Services: 2023-2024

Community Supports & Services: 2023-2024

Agency Reporting	**Volunteer Center/ Community Connection**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					
Number of individuals/families **ACTUALLY SERVED**	23	27	36	30	44

Demographic breakdown not required for Outreach & Engagement

Appendix F. Prevention & Early Intervention (PEI), FYs 2021-2024 Three-Year Demographic Reports

PEI #1 Prevention

Triple P (First 5) - Prevention Program (PEI #1)

Prevention & Early Intervention Report: FYs 2021-2024

	FY 2021-22	FY 2022-23	FY 2023-24
Unduplicated Client Count	193	195	180
Age			
0-15			
16-25	10	9	8
26-59	177	182	126
60 +	1	4	1
Declined to State	5		45
Language			
English	113	93	90
Spanish	74	30	45
Other	1		
Declined to State	5	72	45
Race			
American Indian	4	5	5
Black	1	1	1
White	163	98	84
Other	6	6	26
More than one	9	7	9
Declined to State	10	78	55
Ethnicity			
Latino	136	82	91
African			
Asian Indian/South Asian			
Filipino			
Other (e.g., Asian)	1	1	2
More than One			
Declined to State	56	112	87

Veteran			
Yes	3	2	3
No	180	115	123
Declined to State	9	78	54
Unknown**	1	1	
Sexual Orientation			
Gay or Lesbian			1
Heterosexual or Straight	148	98	95
Questioning or Unsure			
Queer			
Another Sexual Orientation (e.g., bisexual)	6	8	8
Declined to State	38	89	76
Unknown**	1		
Gender Assigned at birth			
Male	43	15	44
Female	130	34	89
Declined to State	19	146	47
Unknown**	1		
Current Gender Identity			
Male	45	38	45
Female	141	85	89
Transgender Male	1		1
Transgender Female	1		
Gender Queer			
Questioning or Unsure			
Declined to State	5	72	45
Write in Option			
Disability			
Yes	14	9	16
• Communication Domain			
Difficulty Seeing	2	3	1
Difficulty Hearing	3		
Difficulty Having Speech Understood	1		

• Mental Domain			
(mental illness, learning disability, developmental disability, dementia)	6	4	10
• Physical/mobility	2	1	2
• Chronic health condition	1	1	4
• Other (Specify)	2 ("nerves," ADHD)	1 (drug addiction)	1 (severe insomnia)
No	168	109	109
Declined to State	10	77	55
Unknown**	1		
Other Relevant Data			
Children of parents receiving intensive services *(unduplicated)*	329	323	292
Parents in brief services (L2 Individual, Seminars, Workshops, Inmate Program) *(unique within each brief service, and overall; may duplicate Intensive Service clients in this report)*	L2 Indiv: 488 Seminars: 39 Workshops: 160 Inmate: 55 **Total: 727** *(unique across all brief services)*	L2 Indiv: 357 Seminars: 73 Workshops: 282 Inmate: 101 **Total: 792** *(unique across all brief services)*	L2 Indiv: 550 Seminars: 102 Workshops: 254 Inmate: 65 **Total: 966** *(unique across all brief services)*
Children of parents in brief services (L2 Individual, Seminars, Workshops, Inmate Program) *(estimated; includes duplicates)*	L2 Indiv: 893 Seminars: 77 Workshops: 343 Inmate: 42 **Total: 1,355**	L2 Indiv: 592 Seminars: 147 Workshops: 512 Inmate: 170 **Total: 1,421**	L2 Indiv: 1,058 Seminars: 153 Workshops: 411 Inmate: 107 **Total: 1,729**

* Clients in intensive services who did not consent to have their data included in the program evaluation ("non-consenters") were reported by participating partner agencies to First 5 at the end of the fiscal year, which increased the client numbers—specifically the "Declined to State" numbers—in the Q4 and Annual columns, for both Parents and Children.

** "Unknown" - These clients were using older program forms that did not yet include all options for this demographic question.

*** Some clients had multiple disabilities, so the total number of specific disabilities may be greater than the unduplicated number of clients with disabilities.

Children's Services: The Diversity Center (COE) - Prevention Program (PEI #1)

Prevention & Early Intervention Report: FYs 2021-2024

	FY 2021-22	FY 2022-23	FY 2023-24
Unduplicated Client Count	3,881	1,896	735
Age			
0-15	1,784	1,641	242
16-25	2,097	400	200
26-59	-	276	206
60 +	-	239	87
Language			
English	2,576	1,499	-
Spanish	1,305	382	-
Other	-	19	-
Unknown	-	-	735
Race			
American Indian	2	5	29
Black	8	26	23
White	3,751	1,739	505
Other	100	10	75
More than one	20	10	9
Declined to State	-	19	50
Ethnicity			
Latino	1,321	353	143
African	-	4	-
Asian Indian/South Asian	10	5	-
Filipino	2	1	-
Other (e.g., Asian)	2,548	1,502	174
More than One	-	11	9
Declined to State	-	20	17
Veteran			
Yes	-	0	-
No	3,881	492	-

Declined to State	-	800	-
Unknown	-	-	735
Sexual Orientation			
Gay or Lesbian	1,807	893	180
Heterosexual or Straight	1,032	330	134
Questioning or Unsure	140	97	39
Queer	502	286	119
Another Sexual Orientation (e.g., bisexual)	400	284	301
Declined to State	-	6	69
Unknown	-	-	-
Gender Assigned at birth			
Male	1,067	380	-
Female	1,620	420	-
Declined to State	1,194	492	-
Unknown	-	-	735
Current Gender Identity			
Male	1,143	491	99
Female	1,681	691	270
Transgender Male	191	162	32
Transgender Female	125	60	62
Gender Queer	306	244	55
Questioning or Unsure	415	167	29
Declined to State	20	81	36
Write in Option	-	-	246
Disability			
Yes			
• Communication Domain			
Difficulty Seeing	350	112	-
Difficulty Hearing	40	-	-
Difficulty Having Speech Understood	-	-	-
• Mental Domain (mental illness, learning	565	232	-

disability, developmental disability, dementia)			
• Physical/mobility	15	7	-
• Chronic health condition	25	19	-
• Other (Specify)	-	0	-
No	2,886	129	-
Declined to State	-	800	-
Unknown	-	-	735
Other Relevant Data	None	None	None

Live Oak Community Resource Center (COE) - Prevention Program (PEI #1)

Prevention & Early Intervention Report: FYs 2021-2024

	FY 2021-22	FY 2022-23	FY 2023-24
Unduplicated Client Count	219	906	133
Age			
0-15	35	29	27
16-25	16	103	15
26-59	154	656	-
60 +	14	90	-
Declined to State	-	-	-
Language			
English	54	175	66
Spanish	151	627	46
Other	14	104	9
Declined to State	-	-	5
Race			
American Indian	1	4	1
Black	0	11	2
White	41	132	57
Other	12	149	11
More than one	162	560	62
Declined to State	3	2	-

Ethnicity			
Latino	171	740	66
African	0	11	1
Asian Indian/South Asian	3	8	2
Filipino	1	0	-
Other	6	0	42
More than One	36	25	5
Declined to State	2	2	-
Veteran			
Yes	1	1	-
No	89	288	39
Declined to State	129	617	81
Unknown**	-	-	-
Sexual Orientation			
Gay or Lesbian	-	-	-
Heterosexual or Straight	81	-	-
Questioning or Unsure	-	-	-
Queer	-	-	-
Another Sexual Orientation (e.g., bisexual)	-	-	-
Declined to State	138	-	94
Unknown**	-	906	-
Gender Assigned at birth			
Male	61	314	47
Female	158	592	86
Declined to State	0	-	-
Unknown**	-	-	-
Current Gender Identity			
Male	61	61	47
Female	158	158	86
Transgender Male	-	-	-
Transgender Female	-	-	-
Gender Queer	-	-	-
Questioning or Unsure	-	-	-
Declined to State	-	-	-

Write in Option	-	-	-
Disability			
Yes	8	55	3
• Communication Domain			
Difficulty Seeing	-	-	-
Difficulty Hearing	-	-	-
Difficulty Having Speech Understood	-	-	-
• Mental Domain (mental illness, learning disability, developmental disability, dementia)	3	-	-
• Physical/mobility	1	-	1
• Chronic health condition	4	-	3
• Other (Specify)		-	
No	109	444	68
Declined to State	100	407	60
Other Relevant Data	None	None	None

PBIS (COE) - Prevention Program (PEI #1)

Data from FY 2023-24 represents numbers served across all 6 school districts, while numbers served in previous fiscal years do not represent all school districts.

Prevention & Early Intervention Report: FYs 2021-2024

	FY 2021-22	FY 2022-23	FY 2023-24
Unduplicated Client Count	10,070	4,394	34,822
Age			
0-15	9,087	-	21,986
16-25	983	4,394	12,836
26-59	-	-	-
60 +	-	-	-
Declined to State	-	-	-
Language			
English	7,910	1,258	25,848
Spanish	1,164	336	8,974
Other	-	130	-

Declined to State	-	-	-
Race			
American Indian	39	10	47
Black	97	69	231
White	4,834	2,110	11,654
Other	1,238	7	20,703
More than one	534	250	1,625
Declined to State	-	41	562
Ethnicity			
Latino	3,051	1,773	21,819
African	96	69	231
Asian Indian/South Asian	320	102	832
Filipino	66	32	225
Other (e.g., Asian)	4,080	7	9,348
More than One	538	250	1,788
Declined to State	-	41	579
Veteran			
Yes	-	-	-
No	-	-	-
Declined to State	10,070	4,394	34,822
Sexual Orientation			
Gay or Lesbian	-	-	-
Heterosexual or Straight	-	-	-
Questioning or Unsure	-	-	-
Queer	-	-	-
Another Sexual Orientation (e.g., bisexual)	-	-	-
Declined to State	10,070	4,394	34,822
Unknown**	-	-	-
Gender Assigned at birth			
Male	-	2,280	17,660
Female	-	2,109	17,281
Declined to State	10,070	-	38
Current Gender Identity			
Male	-	-	-

Female	-	-	-
Transgender Male	-	-	-
Transgender Female	-	-	-
Gender Queer	-	-	-
Questioning or Unsure	-	-	-
Declined to State	10,070	4,394	34,822
Write in Option	-	-	-
Disability			
Yes			
• Communication Domain	-	-	-
Difficulty Seeing	-	-	-
Difficulty Hearing	-	-	-
Difficulty Having Speech Understood	-	-	-
• Mental Domain (mental illness, learning disability, developmental disability, dementia)	-	253	-
• Physical/mobility	-	12	-
• Chronic health condition	-	-	-
• Other (Specify)	598	-	2,191
No	-	-	-
Declined to State	-	-	3,424
Other Relevant Data	None	None	None

Veterans Advocate / Veteran's Advocacy Agency - Prevention Program (PEI #1)

Prevention & Early Intervention Report: FYs 2021-2024

	FY 2021-22	FY 2022-23	FY 2023-24
Unduplicated Client Count	237	258	244
Age			
0-15	-	-	-
16-25	1	4	7
26-59	76	92	91

60 +	160	162	146
Declined to answer	-	-	-
Language			
English	237	258	244
Spanish	24	19	16
Other	2	1	2
Race			
American Indian or Alaskan Native	1	3	1
Black	15	14	14
White	177	182	162
Other	15	32	29
More than one	-	5	1
Declined to answer	28	22	37
Ethnicity			
Hispanic or Latino	35	44	27
African	-	13	14
Asian Indian/South Asian	-	3	3
Filipino	-	1	1
Other	174	168	163
More than One	-	4	1
Declined to State	28	24	35
Veteran			
Yes	230	250	216
No	7	8	8
Declined to State	-	-	-
Sexual Orientation			
Gay or Lesbian	3	5	5
Heterosexual or Straight	158	169	168
Questioning or Unsure	-	1	-
Queer	-	3	1
Another Sexual Orientation	1	0	-
Declined to State	74	80	70
Gender Assigned at birth			
Male	198	226	216

Female	18	24	25
Declined to State	21	8	3
Current Gender Identity			
Male	198	225	215
Female	18	23	25
Transgender Male	-	-	1
Transgender Female	-	1	-
Genderqueer	-	1	-
Questioning or Unsure	-	-	-
Declined to State	21	8	3
Write in Option	-	-	-
Disability	Not reported		
Yes:	-	-	-
• Communication Domain			
Difficulty Seeing	-	28	53
Difficulty Hearing	-	50	65
Difficulty Having Speech Understood	-	4	4
• Mental Domain (mental illness, learning disability, developmental disability, dementia)	-	143	158
• Physical mobility	-	47	73
• Chronic health condition	-	59	72
• Other (Specify)	-	-	-
No	-	-	-
Declined to State	-	-	-
Other Relevant Data	None	None	None

Peer Counselor/Companion, Seniors Council - Prevention Program (PEI #1)

Demographic data are limited for the Peer Counselor/Companion Program. Limited demographic data are available for FY 21-22, and are unavailable for FYs 22-23 and 23-24. SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the next fiscal year.

Prevention & Early Intervention Report: FYs 2021-2024

	FY 2021-22	FY 2022-23	FY 2023-24
Unduplicated Client Count	12	-	-
Age			
0-15	-	-	-
16-25	-	-	-
26-59	-	-	-
60+	12	-	-
Decline to answer	-	-	-
Language			
English	10	-	-
Spanish	1	-	-
Other	1	-	-
Race			
American Indian or Alaskan Native	1	-	-
Black	-	-	-
White	10	-	-
Asian	-	-	-
Native Hawaiian or Other Pacific Islander	-	-	-
Declined to answer	-	-	-
Other	1	-	-
Ethnicity			
Hispanic or Latino	1	-	-
Not Hispanic or Latino	11	-	-
Declined to answer	-	-	-
Other	-	-	-
Veteran			
Yes	2	-	-
No	10	-	-
Declined to State	-	-	-
Sexual Orientation			
Gay or Lesbian	-	-	-

Heterosexual or Straight	11	-	-
Bisexual	-	-	-
Queer	-	-	-
Another Sexual Orientation	-	-	-
Declined to answer	1	-	-
Gender Assigned at birth			
Male	7	-	-
Female	5	-	-
Declined to answer	-	-	-
Current Gender Identity			
Male	7	-	-
Female	5	-	-
Transgender	-	-	-
Genderqueer	-	-	-
Questioning or Unsure	-	-	-
Another gender identity	-	-	-
Declined to answer	-	-	-
Disability			
Yes:	-	-	-
• Communication Domain			
Difficulty Seeing	3	-	-
Difficulty Hearing	3	-	-
Difficulty Having Speech Understood	-	-	-
• Mental Domain (mental illness, learning disability, developmental disability, dementia)	12	-	-
• Physical mobility	1	-	-
• Chronic health condition	10	-	-
• Other (Specify)	-	-	-
No	-	-	-
Declined to State	-	-	-
Unknown	-	-	-
Other Relevant Data	None	None	None

PEI #2 Early Intervention

Community Connection, Wellness Connect – Early Intervention Program (PEI #2)

Prevention & Early Intervention Report: FYs 2021-2024

	FY 2021-22	FY 2022-23	FY 2023-24
Unduplicated Client Count	42	63	137
Age			
0-15	-	1	4
16-25	31	50	121
26-59	11	12	12
60+	-	-	-
Decline to answer	-	-	-
Language			
English	35	55	120
Spanish	5	8	17
Other	2	-	-
Race			
American Indian or Alaskan Native	1	1	4
Black	1	2	4
White	18	26	50
Asian	2	-	5
Native Hawaiian or Other Pacific Islander	-	-	1
Declined to answer	-	-	3
Other	5	6	9
Ethnicity			
Hispanic or Latino	15	28	61
Not Hispanic or Latino	22	31	64
Declined to answer	-	-	3
Other	5	4	9
Veteran			
Yes	-	-	-
No	42	63	137
Declined to State	-	-	-

Sexual Orientation			
Gay or Lesbian	1	1	3
Heterosexual or Straight	22	33	76
Bisexual	2	9	0
Queer	-	1	4
Another Sexual Orientation	9	10	25
Declined to answer	8	9	29
Gender Assigned at birth			
Male	21	34	72
Female	21	27	60
Declined to answer	-	2	5
Current Gender Identity			
Male	21	35	71
Female	16	19	49
Transgender	1	1	1
Genderqueer	-	-	-
Questioning or Unsure	-	-	6
Another gender identity	2	4	-
Declined to answer	2	4	10
Disability	Not reported	Not reported	Not reported
Yes:	-	-	-
• Communication Domain			
Difficulty Seeing	-	-	-
Difficulty Hearing	-	-	-
Difficulty Having Speech Understood	-	-	-
• Mental Domain (mental illness, learning disability, developmental disability, dementia)	-	-	-
• Physical/mobility	-	-	-
• Chronic health condition	-	-	-
• Other (Specify)	-	-	-
No	-	-	-

Declined to State	-	-	-
Unknown	-	-	-
Other Relevant Data	None	None	None

Santa Cruz Behavioral Health Access – Early Intervention Program (PEI #2)

Demographic data are limited for the Santa Cruz Behavioral Health . Limited demographic data are available for FY 21-22, and are unavailable for FYs 22-23 and 23-24. SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the next fiscal year.

Prevention & Early Intervention Report: FYs 2021-2024

	FY 2021-22	FY 2022-23	FY 2023-24
Unduplicated Client Count	3	-	-
Age			
0-15	3	-	-
16-25	-	-	-
26-59	-	-	-
60 +	-	-	-
Language			
English	3	-	-
Spanish	-	-	-
Other	-	-	-
Race			
White	3	-	-
Hispanic or Latino	-	-	-
Other	-	-	-
Culture			
Veteran	-	-	-
LGBTQ+	-	-	-

PEI #3 Outreach

Senior Outreach, Family Services Agency - Outreach Program (PEI #3)

Prevention & Early Intervention Report: FY 2021-2024

*Demographic data for FY2021-22 represent only individuals served in Q4.

**Demographic data for FY 2023-24 was only available through Q3 (March 2024). Data are duplicated and do not represent unduplicated clients.

	FY 2021-22*	FY 2022-23	FY 2023-24**
Unduplicated Client Count	21	42	66
Age			
Unknown	-	4	-
16-25	-	-	-
26-59	1	2	7
60 +	19	36	59
Language			
English	19	31	50
Spanish	1	9	15
Other	1	-	-
Race			
American Indian or Alaskan Native	-	2	1
Black	1	-	-
White	15	36	59
Other	1	1	2
More than one	-	-	-
Declined to answer	3	3	4
Ethnicity			
Hispanic or Latino	2	14	17
African	1	-	-
Asian Indian/South Asian	1	1	-
Filipino	-	-	-
Other	2	3	42
More than One	-	-	3
Declined to State	14	3	4
Veteran			
Yes	1	1	7
No	20	41	59
Declined to State	-	-	-
Sexual Orientation			
Gay or Lesbian	-	1	2

Heterosexual or Straight	-	33	51
Questioning or Unsure	-	-	-
Queer	-	-	-
Another Sexual Orientation	-	1	-
Declined to State	20	7	13
Gender Assigned at birth			
Male	3	7	18
Female	17	34	44
Declined to State	1	1	4
Current Gender Identity			
Male	-	7	18
Female	2	34	44
Transgender Male	-	-	-
Transgender Female	-	-	-
Genderqueer	-	-	-
Questioning or Unsure	-	-	-
Declined to State	18	-	4
Write in Option	-	1	-
Disability			
Yes:	-	8	29
• Communication Domain			
Difficulty Seeing	-	-	2
Difficulty Hearing	-	-	8
Difficulty Having Speech Understood	-	-	-
• Mental Domain • (mental illness, learning disability, developmental disability, dementia)	-	-	-
• Physical mobility	-	6	12
• Chronic health condition	-	2	14
• Other (Specify)	-	-	-
No	-	31	18
Declined to State	7	3	10
Other Relevant Data		None	None

Clients seen at home	3	-	-

PEI #4 Stigma and Discrimination Reduction

No demographic reporting required for Outreach & Engagement activities.

PEI #5 Suicide Prevention

Suicide Prevention, FSA – Suicide Prevention Program (PEI #5)

Demographic data are limited for the Suicide Prevention Program. Limited demographic data are available for FY 21-22, and are unavailable for FYs 22-23 and 23-24. SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the next fiscal year.

Prevention & Early Intervention Report: FYs 2021-2024

	FY 2021-22	FY 2022-23	FY 2023-24
Unduplicated Client Count	58	-	-
Age			
0-15	-	-	-
16-25	37	-	-
26-59	18	-	-
60 +	3	-	-
Language			
English	22	-	-
Spanish	4	-	-
Other	2	-	-
Race			
White	24	-	-
Hispanic or Latino	26	-	-
Other	8	-	-
Culture			
Veteran	-	-	-
LGBTQ+	5	-	-

MERT & MERTY/ MHL, SCCBHD – Access & Linkage to Treatment Program (PEI #6)

Demographic data are limited for the MERT & MERTY/MHL Program. Limited demographic data are available for FY 21-22, and are unavailable for FYs 22-23 and 23-24. SCCBHD will continue to improve program and service data reporting and will make this a priority and goal for the next fiscal year.

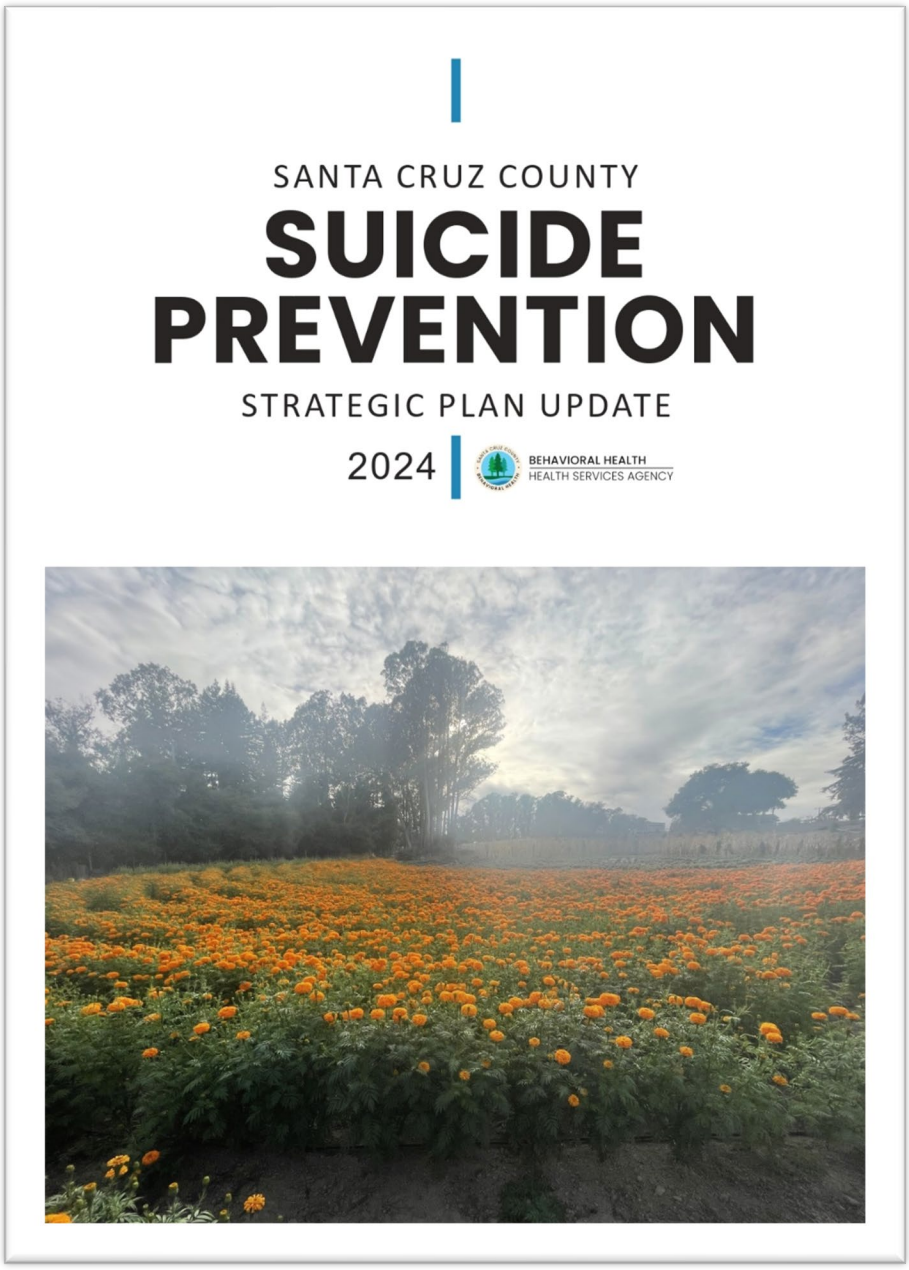
Prevention & Early Intervention Report: FYs 2021-2024

	FY 2021-22	FY 2022-23	FY 2023-24
Unduplicated Client Count	361	-	-
Age			
0-15	65	-	-
16-25	79	-	-
26-59	171	-	-
60 +	46	-	-
Language			
English	177	-	-
Spanish	112	-	-
Other	72	-	-
Race			
White	311	-	-
Hispanic or Latino	16	-	-
Other	34	-	-
Culture			
Veteran	-	-	-
LGBTQ+	12	-	-

Appendix G. Suicide Prevention Strategic Plan

2024 Suicide Prevention Strategic Plan Update (English)

Prevención del Suicidio | Actualización Del Plan Estratégico 2024



Appendix H. Prudent Reserve Assessment/Reassessment

Appendix I. Board of Supervisors Approval of Plan

[Submitted with Final Plan]