BEHAVIORAL HEALTH
HEALTH SERVICES AGENCY

County of Santa Cruz
Mental Health Services Act (MHSA)
FY 2024-25 Annual Update

Issued: November 21, 2024

Mental Health Services Act (MHSA)
FY 2024-2025 Annual Update

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

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 2024-25 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 years 2023-2024. This Plan is not intended as a binding contract with any entity or provider of services. Services will be monitored on a continual base, and the County may make changes, as necessary. These changes would be presented in the required Annual Update plans during the next year.

A draft plan was posted for public comment from November 21, 2024 – December 23, 2024. A Public Hearing was held during the Mental Health Advisory Board meeting on November 21, 2024, at 3pm at the Behavioral Health Services Building at 1400 Emeline Avenue-Room 206/207, Santa Cruz, 95060. 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 Mental Health Services Oversight Accountability Commission 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 November 21, 2024
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
Sincerely,

Mental Health Services Act Coordinator

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MHSA County Fiscal Accountability Certification

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Santa Cruz County

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Tiffany Cantrell-Warren	Name: Christine Williams
Telephone Number: 831 454-4652	Telephone Number: 831 454-7341
E-mail: tiffany.cantrell-warren@santacruzcountyca.gov	E-mail: christine.williams@santacruzcountyca.gov
Local Mental Health Mailing Address: 1400 Emeline Santa Cruz, CA 95060	

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

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

Tiffany Cantrell-Warren
Local Mental Health Director (PRINT)

DocuSigned by: Karen Kern 11/20/2024
Signature 196F709E3274C2... Date

I hereby certify that for the fiscal year ended June 30, 2024, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/22/2023 for the fiscal year ended June 30, 2023. I further certify that for the fiscal year ended June 30, 2024, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

DocuSigned by: Christine M. Williams
County Auditor-Controller / City Financial Officer (PRINT)

11/20/2024
Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

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.[1]

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.[2] 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.

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[1] United States Census Bureau, 2020 population estimates. https://data.census.gov/profile/Santa_Cruz_County,_California?g=050XX00US06087

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

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 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 8, 2022, 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 3-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:

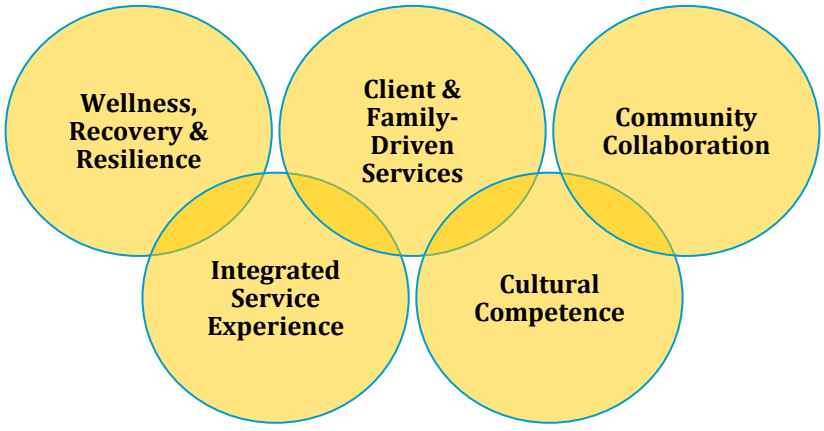
- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI); and
- Innovative Programs (INN).

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 2024-2025 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 2022-2023 as well as program plans beginning in FY 2024-2025. 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 and November, 2024.
- **Sharing of behavioral health needs identified through the CPPP** that identifies both 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 (CPPP)

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 convenes a stakeholder survey to inform program planning efforts and budget allocation. Additional information about the SCCBHD CPP process is provided in the following sections—including CPPP methodology, CPPP activities, the Annual Plan review process, and stakeholder participation. SCCBHD is delayed in completing the Annual Plan Update for the 2024-2025 year due to staffing and logistical challenges. While there were time constraints that impacted this year's community engagement efforts, SCCBHD still received a robust number of participants who provided good feedback on programs and services. We look forward to a full CPPP process in the coming months for the 2025-2026 Annual Plan Update and in preparation for upcoming years as we look forward to launching changes under BHSA and the evolution of the next Three-year Integrated Plan.

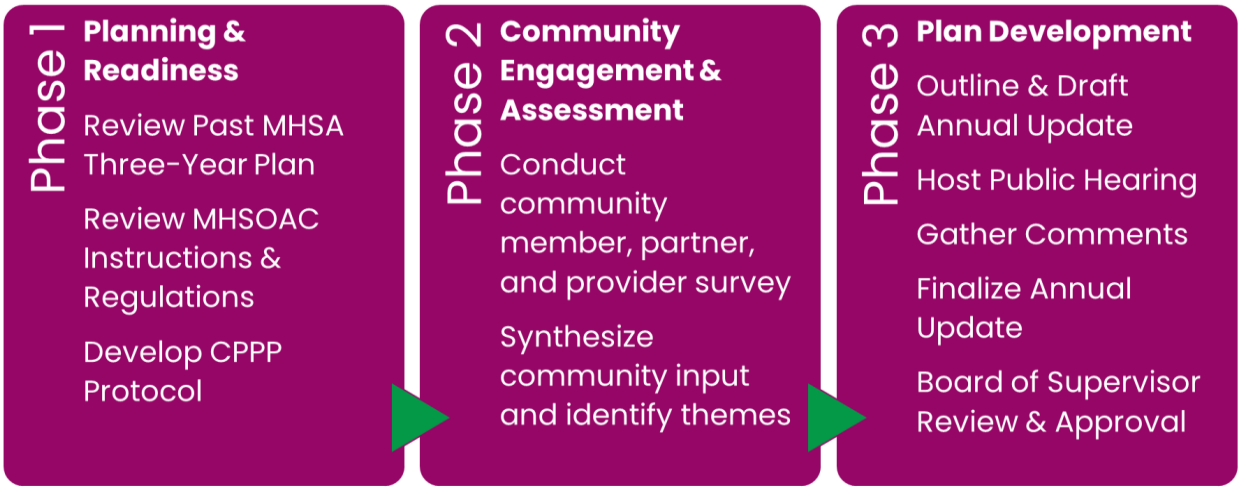
Additional Information on MHSA at SCCBHD is available on the County website, www.santacruzhealth.org/mhsa, and videos of community meetings from the FY23-26 Three Year Plan CPPP as well as program overviews created during the FY22-23 Annual Update are available on the County MHSA YouTube Channel (www.youtube.com/@santacruzcountymhsa380).

Methodology

In October 2024, SCCBHD initiated the planning process for the MHSA Annual Update for FY 2024 -2025. 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 unique phases (Figure 2) to support development of the FY 2024-2025 Annual Update Plan.

Figure 2. Community Program Planning Process (CPPP)



CPPP Engagement Activities

SCCBHD sought feedback from community members and stakeholders through a community survey, 30-day public comment period, and public hearing. These activities are outlined in Table 1 below.

Table 1. CPPP Activities, Dates & Participant Numbers

Activity	Date(s)	Participants
Community Survey	October 16th-November 1st, 2024	146
30-day Public Comment	November 21, 2024-December 23, 2024.	N/A
Public Hearing	November 21, 2024	

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. This anonymous survey included both Likert-scale and open-text questions regarding respondents' experiences with MHSA services in Santa Cruz County, particularly how well SCCBHD' MHSA-funded programs, services, and activities have been adapted to meet the community's mental health needs. 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.

Local Review Process

Public Comment Period & Public Hearing

Following the Community Program Planning Process, a draft of the Annual Plan 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 November 21, 2024 and closed on Monday December 23, 2024.

Notice of the public comment period was shared by community messaging through local newspapers (including *Good Times*, *Pajaronian*, *Watsonville*, and *Santa Cruz Sentinel*), SCCBHD social media sites, the County MHSA Website, and by email to community partners and providers. Community ads and social media posts are included in Appendix B.

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.

During the Public hearing, SCCBHD received XXX comments about the MHSA 2024-

2025 Annual Plan Update, including:

In addition to leaving a public comment, stakeholders who left comments through the county MHSA website were asked the following:
Strengths of this plan
Concerns about the plan
Whether or not they support the plan
Programs or Initiatives they would like to advocate to be funded or expanded

Public comments were made by consumers of behavioral health services, family members and caretakers of consumers, behavioral health service providers, educators, and other community members. Summaries of the key themes that emerged across public comments as well as a complete listing of all public comments received are reported in Appendix C.

The public comment period was opened at the public hearing convened by the Local Mental Health Advisory Board (MHAB) on November 21, 2024 ay 3:00PM. The public hearing was held in-person at the Santa Cruz Health Agency, 1400 Emeline Avenue, Building K, Room 207, Santa Cruz, CA 95060. Call-in and virtual options for attendance were also available.

CPPP Participation & Demographics

A total of 146 stakeholders participated in the needs assessment via the CPPP community survey. The following section describes stakeholder affiliation and demographic characteristics of survey participants.

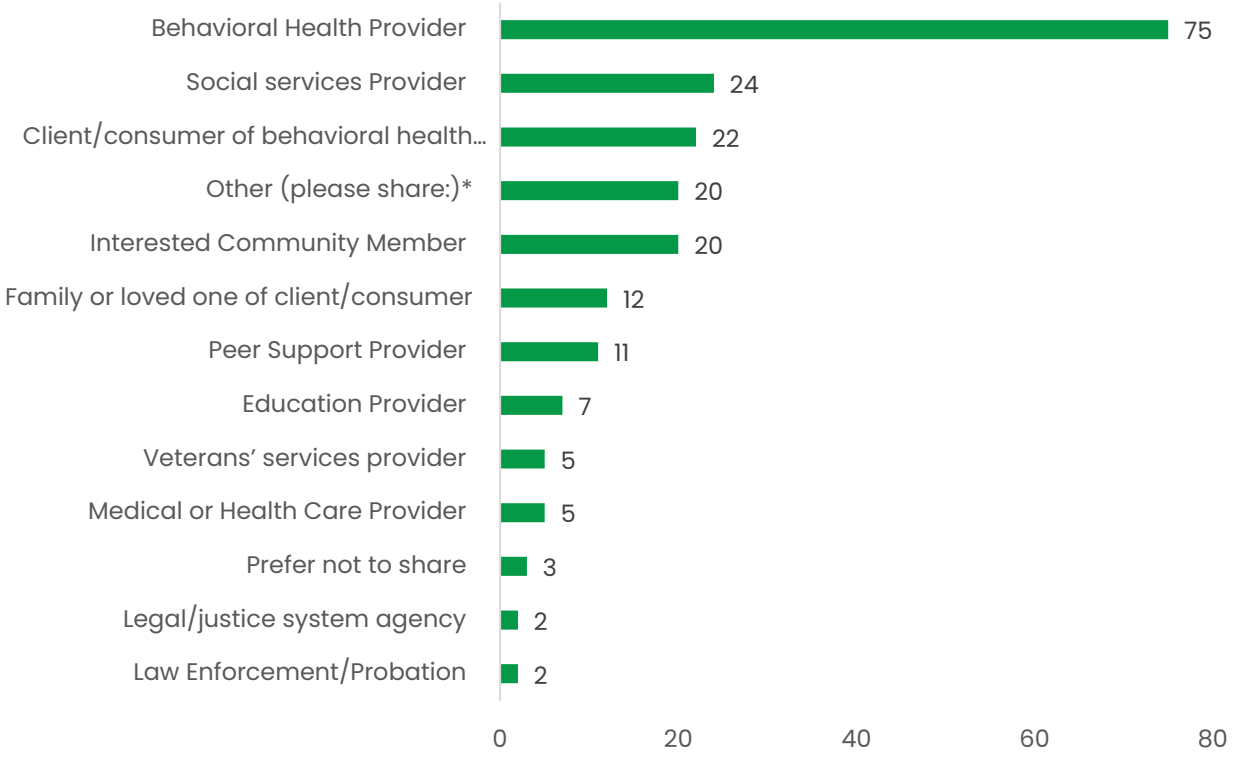
Stakeholder Affiliation of CPPP Participants

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)[1]



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

Demographic Characteristics of CPPP Participants

Community survey participants were asked to fill out an optional, anonymous demographic form. Demographic forms were partially or fully completed by the majority of survey participants (88%). Demographic characteristics collected are reported in Table 2. Most participants (70%) were adults ages 26-59, while almost one in five (19%) were adults age 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 (72%) were white. Additional demographics details can be found in Table 2 below.

Table 2. Selected Demographic Characteristics of CPPP Survey Participants[3]

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%)

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

Demographic Characteristic		Community Survey Participants N (%)
	Another Ethnicity	16 (13%)
	Unknown/ Not Reported	19 (15%)
TOTAL PARTICIPANTS		**128**

Community Program Planning Process (CPPP) Findings

This section presents strengths, needs, and services of Santa Cruz County's MHSA programming that were identified through the community program planning process (i.e. the Community Survey). Results combine both closed-ended, quantitative data and open-ended, qualitative data gathered from survey participation. This section is divided into themes related to the following areas of focus:

- SCCBHD Services Provided
- Access to SCCBHD services
- Experiences with SCCBHD Services
- Proposition 1/BHSA Awareness and Perceptions
- Service Gaps and Needs

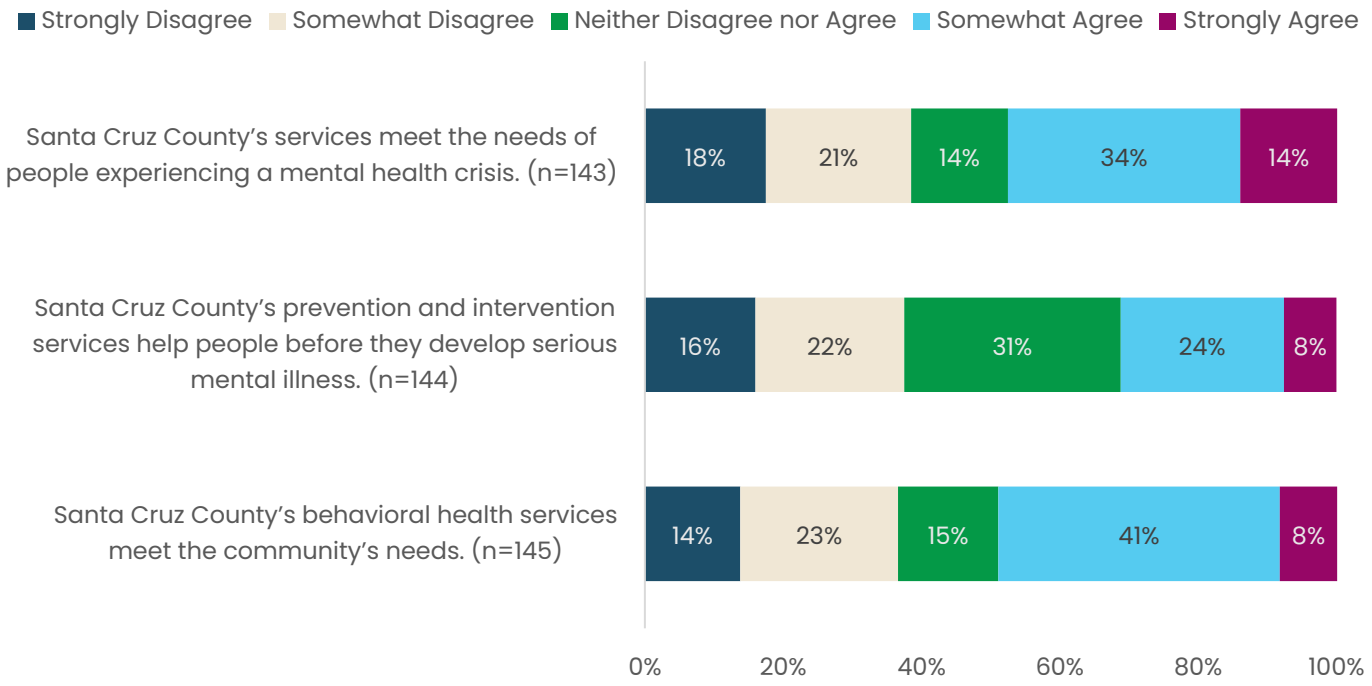
Community Survey Overview

As mentioned, 146 individuals participated in the community survey. 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.

Findings: SCCBHD Services Provided

Survey participant responses about how well SCCBHD services meet the community's needs 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



Survey participants were also provided the opportunity to expand on their reasons for the ratings they provided. A sample of comments regarding existing services is included below.

"The biggest challenge is lack of services for those with severe mental illness, which has a longer wait time than those who rule into IBH/Carelon."

- Social services provider

"There is a lack of wraparound services for youth… There is [also] a serious lack of services for families with private insurance."

- Behavioral health provider

"Mental health services everywhere are underfunded [and very costly to clients]. Human life should be worth more and with just a little help, valuable populations would be drastically affected."

- Client/consumer of behavioral health services

"Crisis services are severely lacking and there is a need for more trained, licensed clinicians to provide these services."

- Behavioral health provider

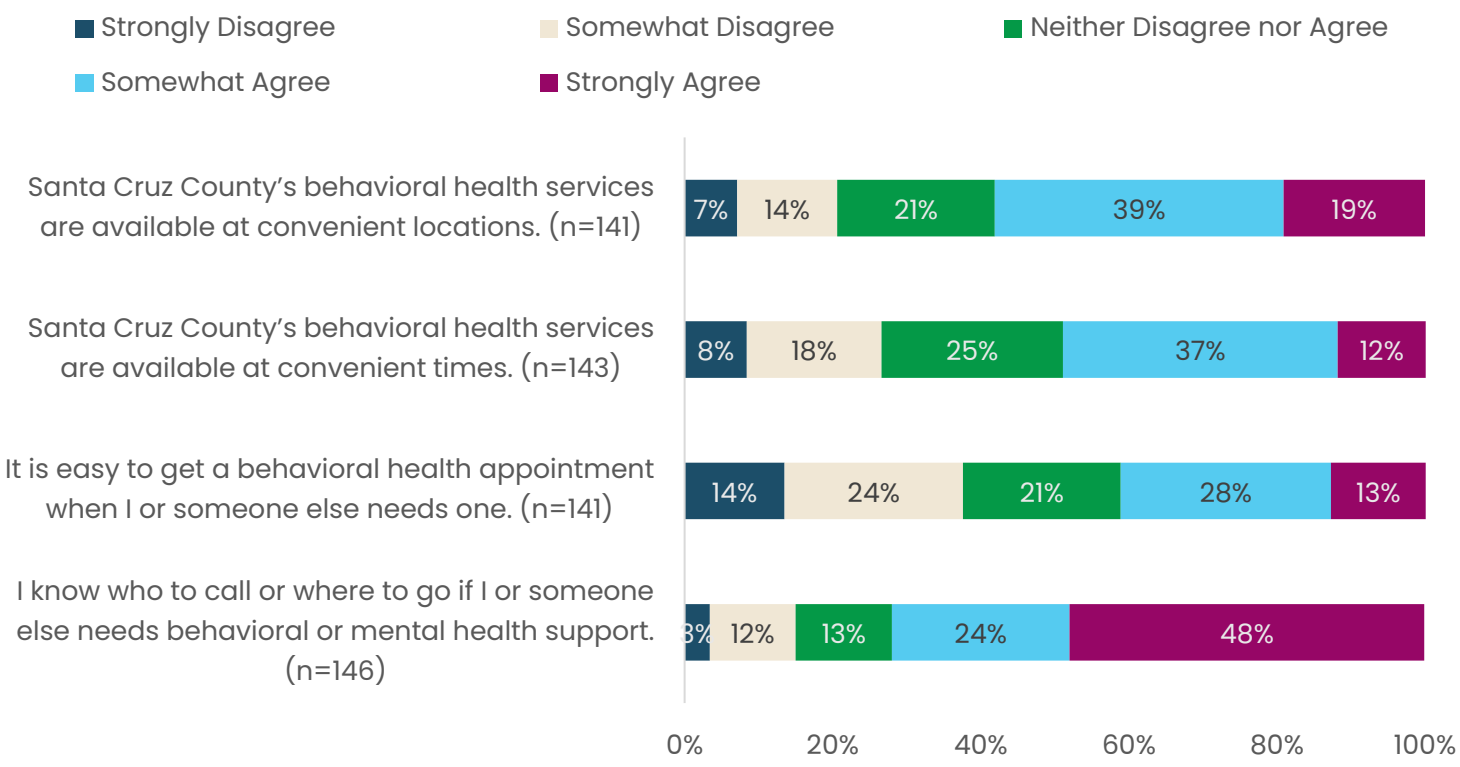
If we want to see real improvement, we need to address the housing crisis. Too many times our clients work hard to recover only to end up on the streets, where they experience more trauma."

- Behavioral health provider

Findings: Access to SCCBHD Services

Survey participants responses about ease of accessing SCCBHD services 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



Survey participants were also provided the opportunity to expand on their reasons for the ratings they provided. A sample of comments regarding access to services is included below.

"Getting an ACCESS appointment is easy and quick, but ongoing appointments are often difficult and have long wait times..."

- Behavioral health provider

"More Spanish speaking professionals are needed."

- Medical or healthcare provider

"Services are also incredibly lacking for those who make enough not to qualify for publicly funded services (around the federal poverty line, which is 1/5th of Santa Cruz's cost of living) ...[services] need to be expanded to meet the needs of this population before the lack of support leads to severe poverty."

- Social services provider and client/consumer of behavioral health services

"There are no service locations north of the Emeline Campus. The Emeline Campus is isolated from the larger community due to poor transportation infrastructure. BH does not have a presence on the West Side, Downtown Santa Cruz, Mid County."

- Behavioral health provider

Findings: Experiences with SCCBHD Services

Survey participants' responses about their overall 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 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 6. Community Survey Responses about Experiences with SCCBHD Services

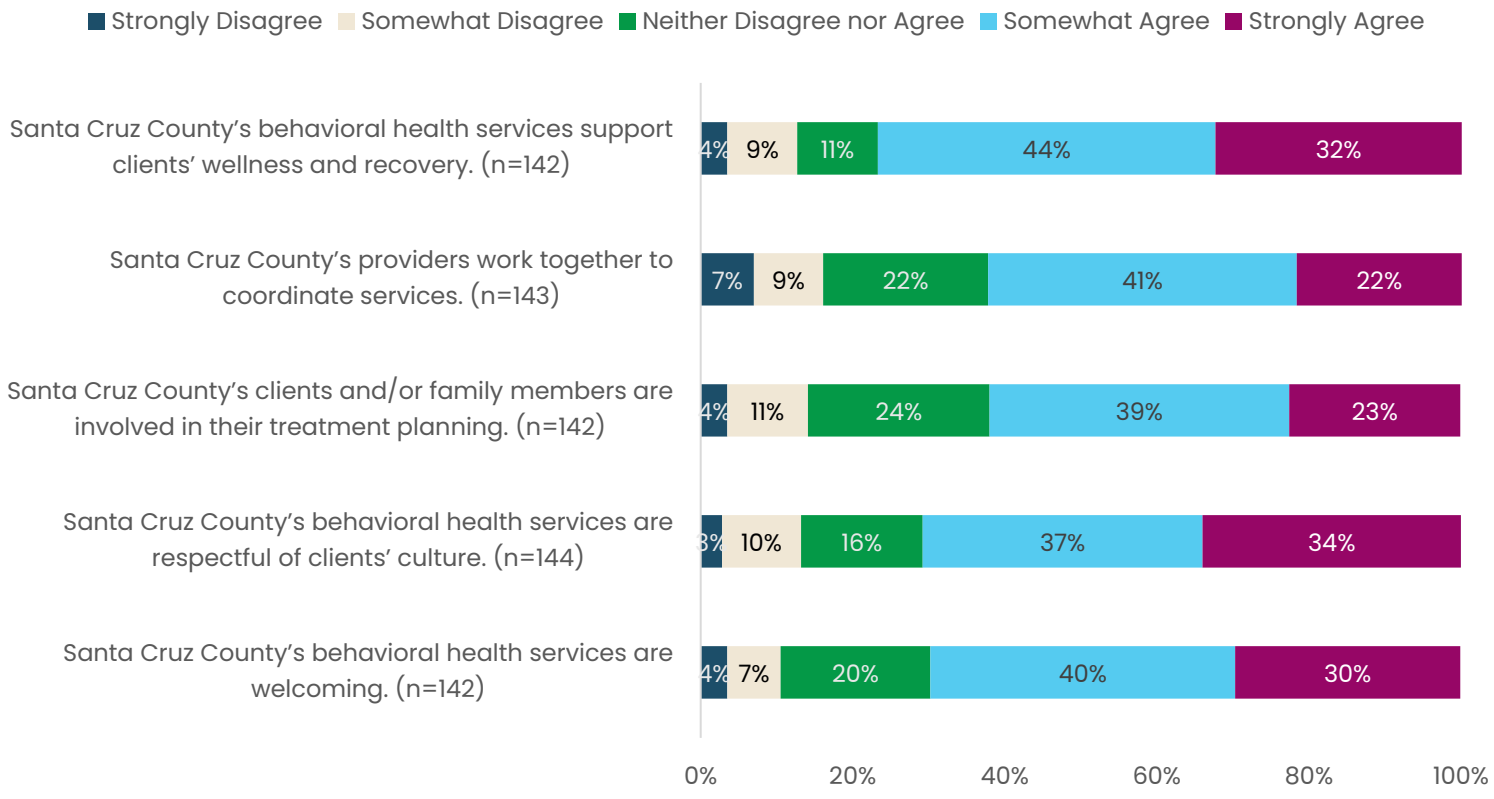
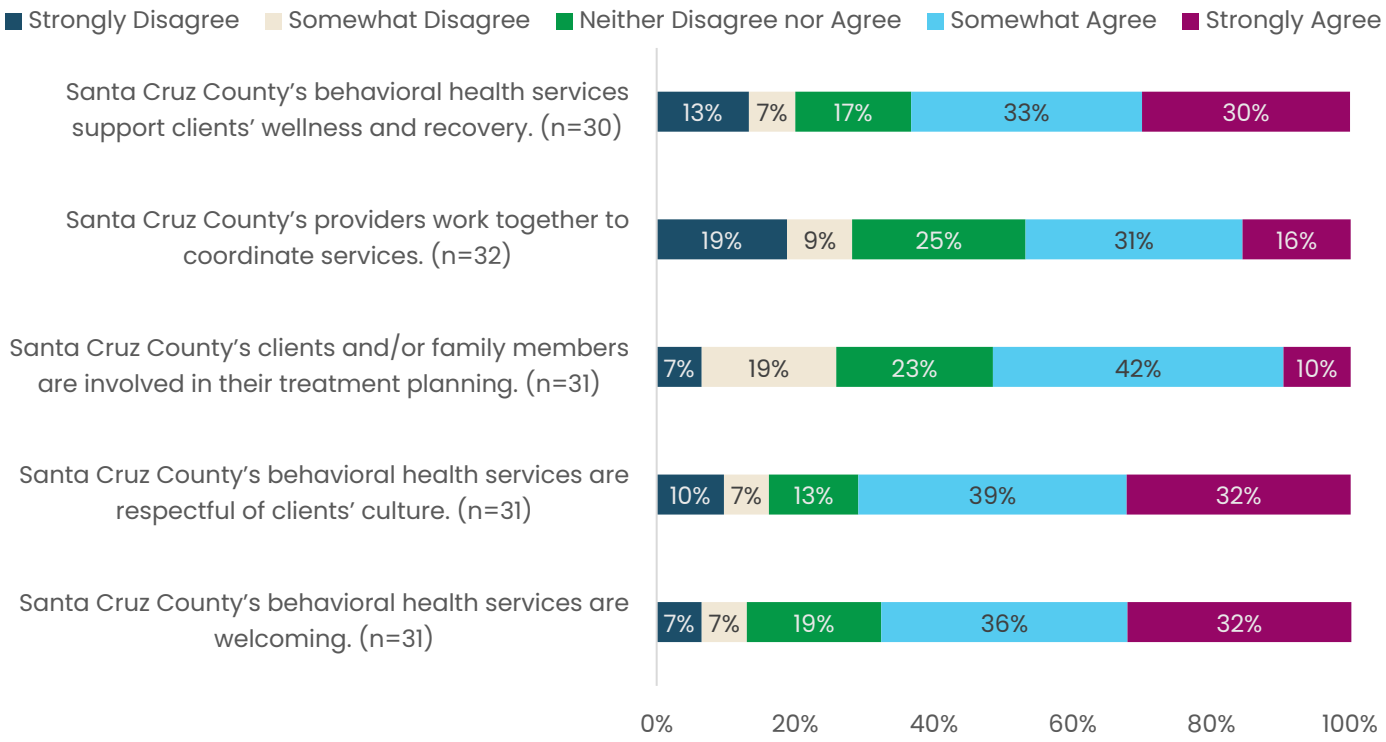


Figure 7. Community Survey Responses about Experiences with SCCBHD Services, Excluding Service Providers



Survey participants were also provided the opportunity to expand on their reasons for the ratings they provided. A sample of comments regarding experiences with services is included below.

> "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

"I think the providers are doing what they can to meet the needs of the community, and I think there is a shortage of providers."

- Behavioral Health provider

"Police presence is overly utilized for de-escalation of behavioral health issues."

- Family or loved one of client/consumer of behavioral health services

"I have had a very hard time finding providers for myself, my brother, my husband, and my teenage son."

- Client/consumer of behavioral health services and family or loved one of client/consumer

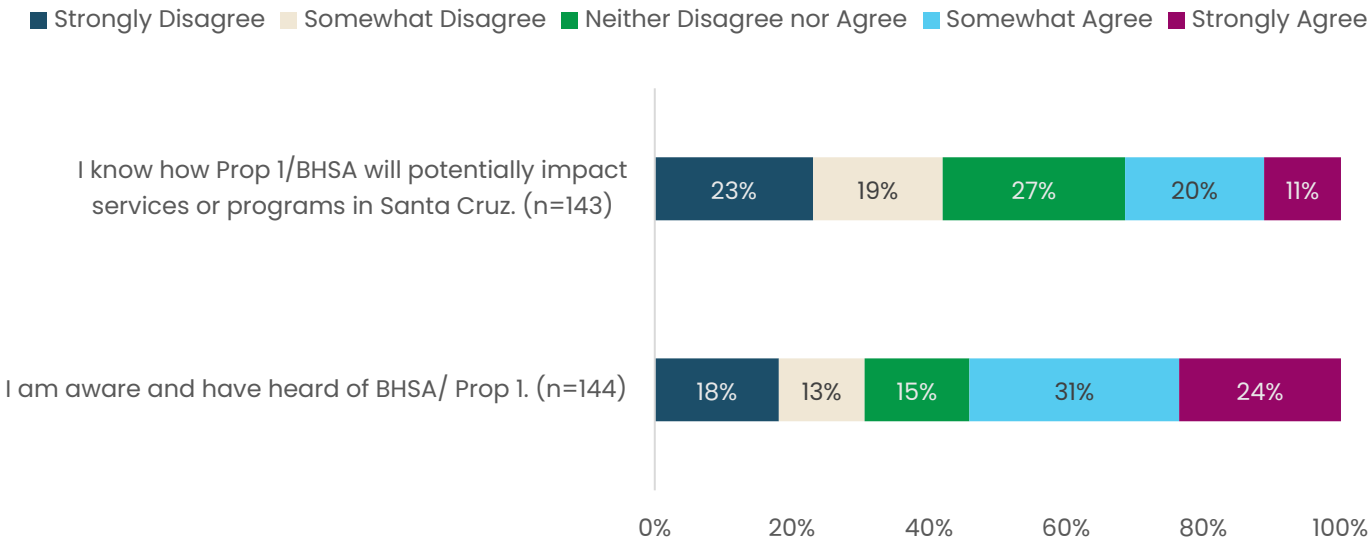
"I believe the facilities at 1400 Emeline are bleak and dreary and do not provide a warm and welcoming environment for clients."

- Interested 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.



Survey participants were also provided an opportunity to expand on their reasons for the ratings they provided. A sample of comments regarding awareness and impacts of the BHSA/Proposition 1 is included below.

"I am familiar with Prop 1 however, I don't know how well it will actually work in terms of housing people, and the impact on diverting that money away from mental health services."

- Behavioral health provider

"I believe there will be less mental health services as a result of prop 1."

- Social services provider

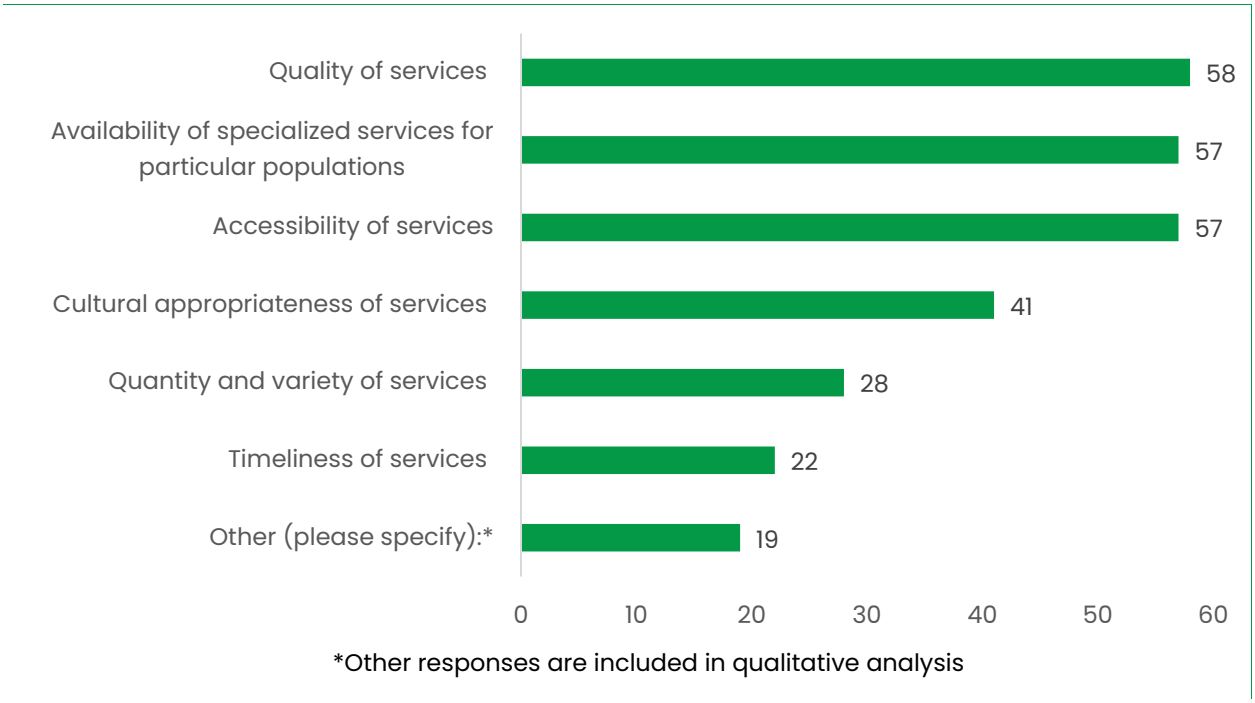
"I know nothing about Proposition 1."

- Client/consumer of behavioral health services

Findings: Service Gaps and Needs

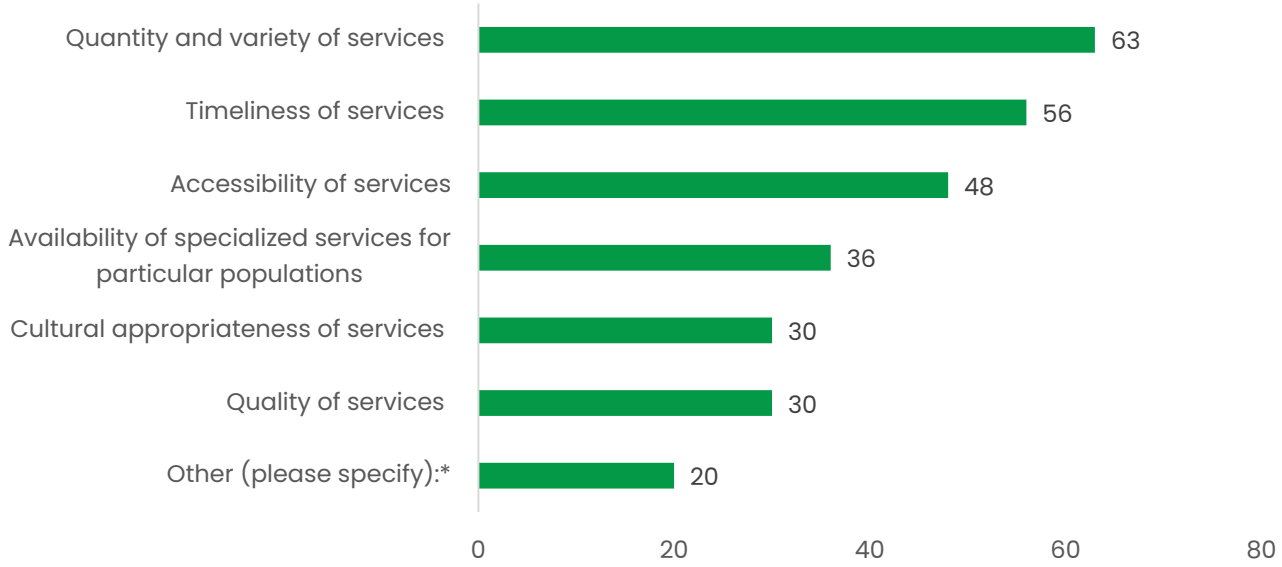
Survey respondents were asked to select up to three elements of SCC's behavioral health system that they found most helpful and most challenging respectively. Participants most commonly selected quality of services (44%, n=58), availability of specialized services for particular populations (43%, n=57), 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)



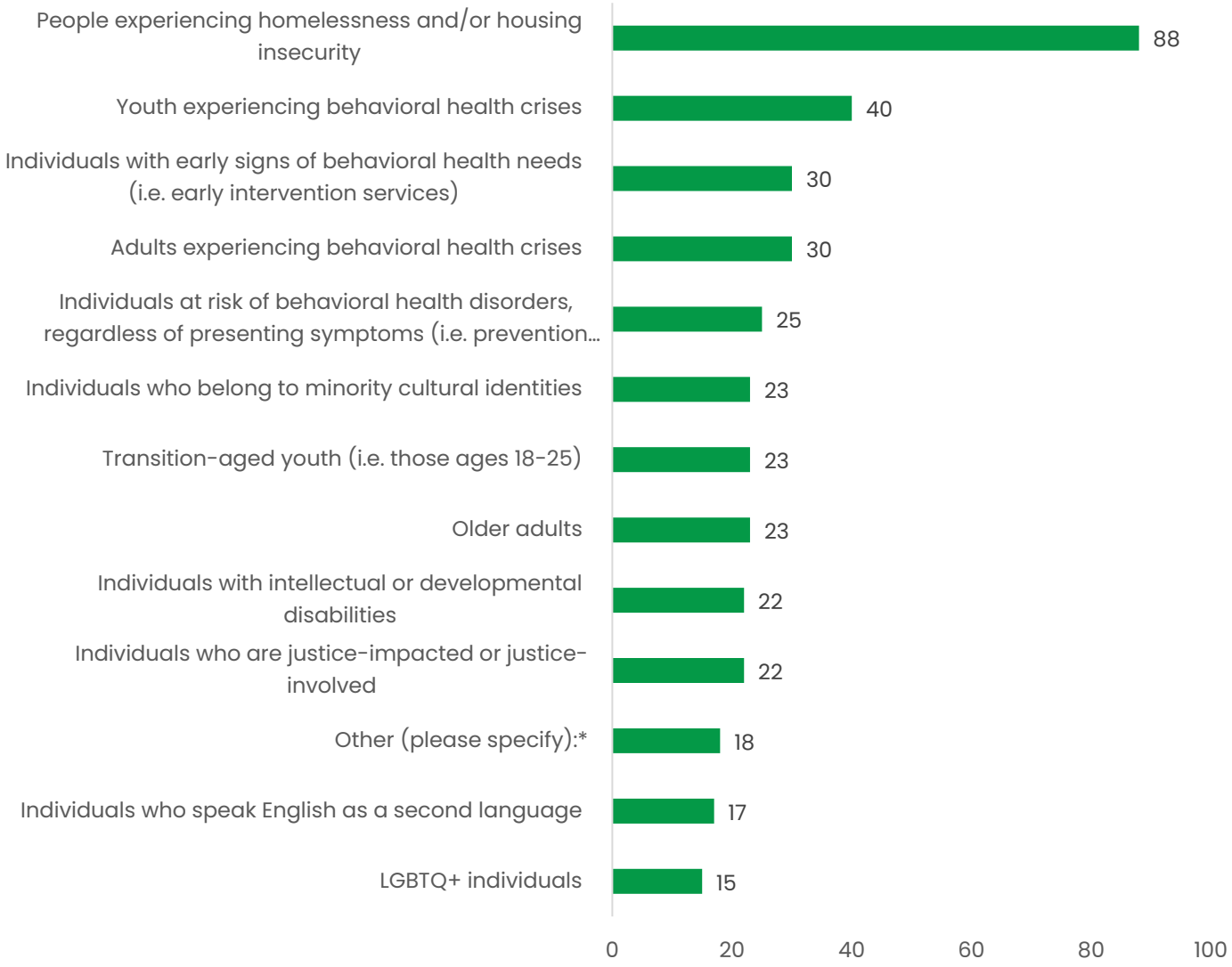
*Other responses are included in qualitative analysis

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 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 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 participants (49%, n=71) felt SCCBHD services are meeting the community's needs overall.
- Many 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, survey respondents 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

"Great folks at Access and Santa Cruz Health Services." - Social services 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, survey respondents shared challenges with wait times for services, coordination of care, and gaps in the behavioral health workforce.

> *"Currently the coordination between services is poor, and our crisis services feel non-existent-- both as a member of County BH and from my perspective as a long-time community member." - Behavioral health provider*

> *"The biggest challenge is lack of services for those with severe mental illness, which has a longer wait time than those who rule into IBH/Carelon." - Social services 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, survey respondents 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 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 FY2022-2023 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 (through our Children's Behavioral Health Clinic in Santa Cruz and Watsonville) provide the services in this work plan. Encompass served 150 unduplicated youth through Community Gate services.

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
Hiring and retaining bilingual (and bicultural) clinicians is a challenge. We are continually working with Santa Cruz County Personnel and community partners to address this issue. There is a workforce shortage nationally, however in Santa Cruz County the cost of living is so high that it's difficult to attract people to work here.

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. Encompass served 84 unduplicated youth through this program.

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. As stated above, staff turnover this year has increased due to higher cost of living in our region and stringent Medi-Cal demands. We are continuing to work with our County and community partners to address this serious issue through budgeting for significant salary increases for next fiscal year as well as developing more creative and proactive recruitment efforts.

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.

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 Encompass, Parents Center, and Santa Cruz County Behavioral Health provide the services in this work plan. Encompass served 13 unduplicated youth through this program.

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

Maintaining bilingual/bicultural staff remains a barrier as noted above.

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. Clinicians work closely with the County Office of Education (COE), Pajaro Valley Unified School District and Santa Cruz Unified School District to provide services through this program.

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
Maintaining bilingual/bicultural staff remains a barrier as noted above.

Are there any new, changed or discontinued programs? With the increase in school-based mental health services through new funding opportunities, many schools have grown their wellness programs to include mental health and wellbeing services for students. This has led to additional collaboration -with school mental health practitioners and programs

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.

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? None for this program.

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 or transitioning from Telos. 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. Peer support services are provided via a subcontract with NAMI.

- 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)
- NAMI (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: 20 (Outreach); 100 (FSP)
- Encompass- El Dorado Center: 100

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? Challenges continue to be recruitment of staff and onsite staffing resources

Are there any new, changed or discontinued programs? No

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.
- **Mariposa Wellness Center**. Located in Watsonville, the Mariposa Wellness Center 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 South County: Mariposa Wellness Center, a program of Community Connection of the Volunteer Center

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

Yes. MHCAN's use permit has been modified by the City of Santa Cruz limiting daily attendance to a maximum of 50 clients to be served per day and restricting hours of operation. MHCAN requested a process though the City of Santa Cruz to allow a review of the use permit to increase capacity, and has adjusted their hours and limited the number of participants at the center at and given time. MHCAN also hired a new Executive Director, who will be reviewing programming, groups and activities and working with center members to add additional offerings.

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

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 CPPP 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 Street, 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. Adult Residential Facilities (ARF) and Residential Care for the Elderly (RCFE) licensed facilities 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 Street, Encompass, Volunteer Center/Community Connection and Santa Cruz County Behavioral Health provide the services in this work plan. These providers work collaboratively and comprise a multi-disciplinary team.

- Front St, Inc provides services at Wheelock, Willow brook, Front Street and Opal Cliffs as well as housing support 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 Street- Wheelock (Residential & Outpatient)	16
Front Street- Willow brook	40
Front Street- Opal Cliffs	16
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 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.

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

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.

SCCBHD has not proposed any changes or modifications to programming for FY 2023 - 2024. 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 and to be reported in the next MHSA Annual Update during the FY2023-2026 period.

The program overviews and service numbers reported in this section are anticipated and planned to be the target for services provided Into FY2023-2024.

Complete program demographic reports and annual service updates for FY2022-2023 are Included in Appendix F.

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

Target population:

- **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)
- **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 2022-23 is 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, 75% of parents reported improvements in their children's challenging behaviors, and 59% reported improvements in their children's emotional difficulties. Of the parents who began the program with more serious parenting issues, 90% reported improvements in children's challenging behaviors and 91% reported improvements in emotional difficulties.
- **Increased use of positive parenting styles.**
  - As measured by the PAFAS (July 2018 – June 2022): On average, 65% of parents reported improvements in consistent parenting, and 70% 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 2022): On average, 63% of parents reported improved emotional well-being after participating in the program. In addition, 73% reported improvements in parent-child relationships, and 56% reported improvements in overall family relationships.
- **Increased parental confidence.**
  - As measured by the CAPES (July 2018 – June 2022): Overall, 77% of parents reported improvements in their confidence as a parent. Of the parents who began the program with more serious parenting issues, 93% 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.

The local Triple P Coordinator (contractor for First 5) provides 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

Target population:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)?** 1896
- **What is the number of families served? 56**
- **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.

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.

All of our activities support the health and well-being of LGBTQ+ individuals who have disproportionate rates of suicide, truancy, sexual risk-taking, and experiencing bullying, family rejection, and homelessness among other challenges. We do this by holding weekly and monthly support groups, meetups, and connecting events that celebrate and educate. Our 60+ community is supported with free lunches 5 times a year, social groups to combat isolation, and weekly drop in to get information, resources and support. We offer free mental health services to the community and have a walk-in center where individuals can get information they need in a safe space.

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**:

  Our programs reduce social isolation and create a prosocial peer network. We help youth stay in school and obtain education. We provide early assessment and intervention for mental health issues. We support positive peer networks and provide resources for young people experiencing bullying and provide early assessment and resources around intimate partner violence and sexual health issues.

- **Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects cultural competence**:
  For any new mental health client or participant in a program, we conduct an intake. Mental health also does a pretreatment test and a post services test. We conduct an annual evaluation of our youth program in programs. We use a survey as our evaluation instrument. We are evaluating if program participants report the following outcomes:
    1. Increased sense of self-confidence
    2. Improved relationships with peers, family, and teachers
    3. Increased sense of community
    4. Increased positive coping strategies to stress
    5. Increased sense of safety

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

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**.
   This funding supports prevention on multiple levels. The Diversity Center's youth program is on the ground in schools supporting and establishing GSAs. Having a safe place for youth to connect and know they will be accepted can literally be a lifeline for youth (and a reason to go to school). We work with partners like the Safe School Project works with administrators to problem-solve issues as they arise, and to recommend and implement anti-bullying curriculum.

We have a community-based standard. The youth program's peer support groups is a community-based standard, but it is based off of the evidence based practice that peer support groups for marginalized communities

provide a platform for participants to feel less isolated, gives them a safe place, allows them to have adults in their life who are supportive and gets them connected to community resources. We have an annual evaluation to help us determine the program's effectiveness.

2. **Explain how the practice's effectiveness has been demonstrated for the intended population**.
   We evaluate effectiveness from our annual youth program evaluation and Triangle Speakers has a post-panel survey. We have not had the capacity to do additional evaluation to study the long-term impact we have on the schools we work with.

1. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program**.
   Oversight by the Executive Director, along with the Manager of Programs and Impact and the Director of Development ensures fidelity to the program design and practice model.

Describe how the following strategies were used:

- **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs): The Diversity Center regularly makes referrals to our onsite therapist, as well as our intern/associate and school and community therapists. We regularly see youth who are struggling as they come to terms with the sexual and gender identity as well as their families if they are struggling and need support.
- **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services): The Diversity Center provides no-cost on-site and virtual therapy in both Santa Cruz and Watsonville. We also work with youth (and

their parents when appropriate) to make referrals to community therapists and other local support resources.

- **Stigma and Discrimination reduction (**Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive): Many youth in The Diversity Center's programs are struggling with mental health issues and suicidal ideation. We strive to create a warm and welcoming space for all. Our trans teen support groups are safe places for teens to share their struggles. Support groups are a way for teens to support and learn from each other and it helps break the social isolation that many feel.

Program Name: Live Oak Resource Center, PEI #1

Agency: COE, Live Oak Resource Center
Target population:

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

A. Family Case Management- **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 – **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 – **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 –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 – 29 **unduplicated caregivers and their children**
    - 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:

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

ii. 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:
    1. LOCR staff continued to work with me and has met my needs
iii. 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
    1. Parental consistency: 6.2%
    2. Coercive parenting: 9.9%
    3. Positive encouragement: 10.7%
    4. Parent-Child relationship: 12.3%
    *Statistically significant improvement between pre-post

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.
- **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

Target population:

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

  5 school districts representing 20 schools in Santa Cruz County. These in turn impacted more than 17,500 students.

  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

- **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)
- **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 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
Target population:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)?** 258
- **What is the number of families served?** Not specified
- **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.
- **Timely Access to Mental Health Services for Underserved Populations**
  The Veterans Advocate will do extensive outreach to the veteran community. The veteran population has a high risk of mental health challenges based on the nature of military service. The Veterans Advocate is able to assist low income and homeless veterans by providing access to benefits earned during service. Through identification and early intervention, the Veterans

Advocate is able to assist veterans with all of their needs. The Veteran Advocate has the ability visit veterans who are otherwise not able to find transportation to an office.

- **Stigma and Discrimination reduction**
  The Veterans Advocate can reduce stigma by addressing veterans in a respectful way and providing support for their needs, regardless of type of discharge or length of service. One on one confidential interviews allow each client the opportunity to be honest about their needs. Through compassion and active listening, the Veterans Advocate can present mental health services in a positive way and will help to reduce the suffering of the client.

Additional information about the Veteran Advocate Program Direct Services
The Veteran Advocate provides direct services that include helping veterans to enroll/ re-enroll in VA healthcare, help veterans get connected to housing resources, connect veterans with mental health support through the VA and/or County services, assist veterans to file for VA disability claims, assist low-income veterans to file for the VA pension, make connections to employment services, and assist veterans to access their education benefits.

By the numbers
Total Veterans assisted: 258
VA Health Care enrollments: 34
Housing assistance: 33
Mental Health connections: 52
Assistance with VA Disability: 35
Assistance with VA pension: 8
Employment referrals: 6
Education benefits: 5

Veterans Court
The Veterans Court program is a collaborative court designed to help veterans who are suffering from Post-Traumatic Stress Disorder, Traumatic Brian-Injury, Military Sexual Trauma, Substance Use Disorder, or other mental health condition related to their service. The Veteran Advocate helps veterans to apply for Veteran Court by assisting them in gathering the necessary documentation (discharge papers, evidence of qualifying condition, etc.) and submitting it the information Vet Court

team. The Veteran advocate also screens veterans for relevant benefits and resources.

By the numbers
Total Participants: 35
New Admits: 20
Graduates: 17

A key aspect of Veterans Court is the peer support team. The Veteran Advocate supervises the peer support team and ensures that each veteran is assigned a peer support. The Veteran Advocate also ensures peers are properly trained to support the veterans in Veterans Court and recruits new volunteers to serve on the peer support team.

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.

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.

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. This program hosted 2 events in the last year that featured Veteran Artists. 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.

Program Name: Peer Companion

Agency: Seniors Council of Santa Cruz County

Target population:

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

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

Target population:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2022-2023)?** 50
- **What is the number of families served?** 12
- **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.

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

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
- **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

Number of Potential Responders served in previous fiscal year (FY2022-2023):
Approximately 900

Settings in which potential responders were engaged (family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement, residences, shelters, etc.):
Settings and agencies 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 (e.g. nurses, principles, parents):
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
Number of people reached in previous fiscal year (FY2022-2023):
Unduplicated total client count 10/1/22 - 12/31/22: **673**
Unduplicated total client count 01/01/23 - 03/31/23: **1321**
Unduplicated total client count 04/01/23 - 06/30/23: **1364**

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

  Two research studies have been conducted on NAMI Basics
  i. 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.

ii. 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:

i. Felt less alone.
ii. Learned new relapse prevention skills.
iii. Reported more acceptance towards their illness.
iv. Embraced advocacy and used the class to help others.
v. 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.

Additional NAMI Outcomes Information

Unduplicated total client count 10/1/22 - 12/31/22: 673

Programs surveys/outcomes

<u>Family-to-Family:</u>
"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

Unduplicated total client count 01/01/23 - 03/31/23: 1321

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

Crisis Response Training

Unduplicated total client count 04/01/23 - 06/30/23: 1364

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)**

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
Target population:

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

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.[4]

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

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

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.

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.

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
Target Population:

- **Number of individuals with SMI referred to treatment and kind of treatment?** 60 unduplicated
- **Number of individuals who followed through on the referral and engaged in treatment (attended at least once)**: 60 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 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:** 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

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.

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. CPPP Outreach & Promotion Materials

CPPP Website Promotion

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

Public Health Department of Santa Cruz County
Yesterday at 9:29 AM ·

Share your feedback on mental health and substance use treatment services in #SantaCruzCounty. Respond to the Community & Partner Feedback Survey by 10/31.
https://survey.alchemer.com/s3/8053783/ae46f8f268de
https://survey.alchemer.com/s3/8053783/0cd8db9f8dc7

Comparta sus opiniones sobre los servicios de salud mental y tratamiento del uso de sustancias en el Condado de Santa Cruz. Responda a la Encuesta Comunitaria antes del 31 de octubre.

County of Santa Cruz
Published by Sandy Bee
· Yesterday at 9:17 AM ·


Instagram
Home
Search
Explore
Reels
Messages
Notifications
Create
Profile
AI Studio
Threads
More
Help improve
mental health and substance use treatment services in your community
Community & Partner Feedback Survey
Oct. 16-31
Participate:
santacruzhealth.org/BehavioralHealth
countyofsantacruz
countyofsantacruz #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 to complete.
Responses are anonymous, and only RDA will review them.
The first 100 participants can opt to receive a $10 gift card by providing contact details, which will remain separate from survey answers.
Help shape future MHSA-funded programs in the County!
Los invitamos a compartir sus comentarios sobre los servicios de tratamiento de salud mental y tratamiento del uso de sustancias en nuestra comunidad para ayudar a planificar la Actualización Anual de la Ley de Servicios de Salud Mental (MHSA) 2024-2025. En asociación con RDA Consulting, la División de Salud Mental y Tratamiento del Uso de Sustancias lo invita a completar la Encuesta Comunitaria antes del 31 de octubre.
https://survey.alchemer.com/s3/8053783/ae46f8f268de
La encuesta es voluntaria, confidencial y toma entre 10 a 15 minutos en completarse.
Las respuestas son anónimas y solo RDA las revisará.
Los primeros 100 participantes pueden optar por recibir una tarjeta de regalo de $10 si brindan sus datos de contacto, que permanecerán separados de las respuestas de la encuesta.
¡Ayúdenos a dar forma a los futuros programas financiados por la MHSA en el Condado!
1d
4 likes
1 day ago
Add a comment...
Post

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 nor Agree	Somewhat Agree	Strongly 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):
     _____
   - ☐ Prefer not to 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

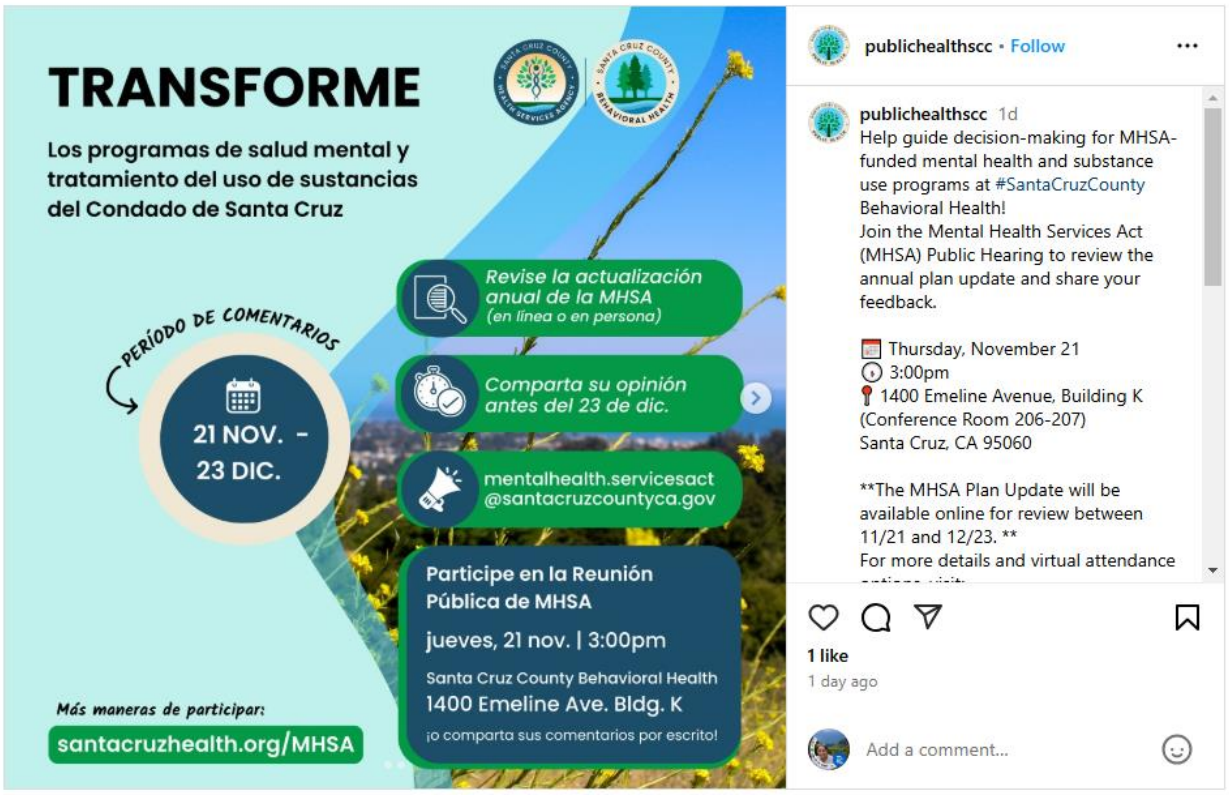
8. Are you a veteran of the United States military?
   - ☐ Yes
   - ☐ No
   - ☐ Prefer not to share

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

10. What is your zip code? _____

Appendix B. Public Comment & Public Hearing Notice

Public Comment Promotion – *Social Media*



Public Health Department of Santa Cruz County
Yesterday at 12:56 PM ·

Help guide decision-making for MHSA-funded mental health and substance use programs at #SantaCruzCounty Behavioral Health!
Join the Mental Health Services Act (MHSA) Public Hearing to review the annual plan update and share your feedback.
📅 Thursday, November 21
🕒 3:00pm
📍 1400 Emeline Avenue, Building K (Conference Room 206-207)
Santa Cruz, CA 95060

**The MHSA Plan Update will be available online for review between 11/21 and 12/23. **
For more details and virtual attendance options, visit: santacruzhealth.org/MHSA

¡Ayude a orientar la toma de decisiones para los programas de salud mental y consumo de sustancias financiados por la MHSA en la División de Salud Mental y Tratamiento del Uso de Sustancias del Condado de Santa Cruz!
Acompáñenos a la Reunión Pública de la Ley de Servicios de Salud Mental (MHSA) para revisar la actualización del plan anual y compartir sus comentarios.

📅 Jueves 21 de noviembre
🕒 3:00 p.m.
📍 1400 Emeline Avenue, Edificio K (sala de conferencias 206-207) Santa Cruz, CA 95060

**La actualización del plan de la MHSA estará disponible en línea para su revisión entre el 21 de noviembre y el 23 de diciembre. **
Para obtener más detalles y opciones de asistencia virtual, visite: santacruzhealth.org/MHSA

See Translation

1

Like Comment Send Share

County of Santa Cruz
7,463 followers
1d •

+ Follow ···

Help guide decision-making for MHSA-funded mental health and substance use programs at #SantaCruzCounty Behavioral Health!
Join the Mental Health Services Act (MHSA) Public Hearing to review the annual plan update and share your feedback.

Thursday, November 21 | 3:00pm
1400 Emeline Avenue, Building K (Conference Room 206-207)
Santa Cruz, CA 95060

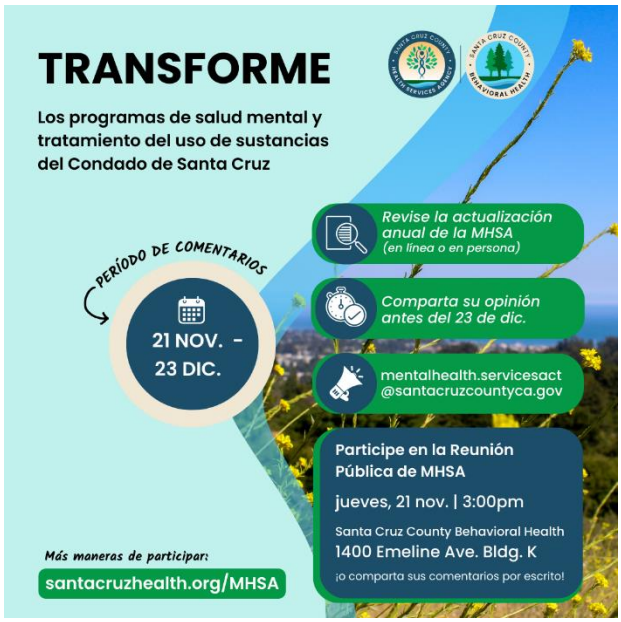
**The MHSA Plan Update will be available online for review between 11/21 and 12/23. **

For more details and virtual attendance options, visit:
santacruzhealth.org/MHSA


TRANSFORM
Santa Cruz County
mental health + substance use
treatment programs
PUBLIC COMMENT PERIOD
NOV. 21 -
DEC. 23
Review the MHSA
Annual Update
(online or in-person)
Share your feedback
by 12/23/24
mentalhealth.servicesact
@santacruzcountyca.gov
Join the MHSA Public Hearing:
Thursday, 11/21 | 3:00pm
Santa Cruz County Behavioral Health
1400 Emeline Ave. Bldg. K
More ways to participate:
santacruzhealth.org/MHSA
countyofsantacruz • Follow
countyofsantacruz 1d
Help guide decision-making for MHSA-funded mental health and substance use programs at #SantaCruzCounty Behavioral Health!
Join the Mental Health Services Act (MHSA) Public Hearing to review the annual plan update and share your feedback.
Thursday, November 21
3:00pm
1400 Emeline Avenue, Building K (Conference Room 206-207)
Santa Cruz, CA 95060
**The MHSA Plan Update will be available online for review between 11/21 and 12/23. **
For more details and virtual attendance options, visit:
santacruzhealth.org/MHSA
Liked by aleshirewynder
1 day ago
Add a comment...

Public Comment Promotion – Newspaper

- *Pajaronian – Quarter Page*
- *Good Times – Quarter Page*
- *Sentinel- Quarter Page*



Public Hearing – Mental Health Advisory Board Agenda

County of Santa Cruz

HEALTH SERVICES AGENCY
Behavioral Health Division

Salud Mental y Tratamiento del Uso de Sustancias

NOTICE OF PUBLIC MEETING
MENTAL HEALTH ADVISORY BOARD
NOVEMBER 21, 2024, 3:00 PM-5:00 PM
HEALTH SERVICES AGENCY, 1400 EMELINE, ROOMS 206-207, SANTA CRUZ, CA 95060
THE PUBLIC MAY JOIN THE MEETING ON MICROSOFT TEAMS (LINK BELOW) OR
CALL (831)454-2222, CONFERENCE ID 994 864 032#

Xaloc Cabanes Chair 1st District	Valerie Webb Member 2nd District	Michael Neidig Co-Chair 3rd District	Antonio Rivas Member 4th District	Jennifer Wells Kaupp Member 5th District
Kaelin Wagnermarsh Member 1st District	Dean Shoji Kashino Member 2nd District	Hugh McCormick Member 3rd District	Celeste Gutierrez Member 4th District	Jeffrey Arlt Secretary 5th District

Felipe Hernandez Board of Supervisor Member	
Tiffany Cantrell-Warren Director, County Behavioral Health	Karen Kern Deputy Director, County Behavioral Health

Information regarding participation in the Mental Health Advisory Board Meeting

The public may attend the meeting at the Health Services Agency, 1400 Emeline, Rooms 206-207, Santa Cruz. Individuals may click here to Join the meeting now or may participate by telephone by calling (831)454-2222, Conference ID 994 864 032#. All participants are muted upon entry to prevent echoing and minimize any unintended disruption of background sounds. This meeting will be recorded and posted on the Mental Health Advisory Board website.

If you are a person with a special need, or if interpreting services (English/Spanish or sign language) are needed, please call 454-4611 (Hearing Impaired TDD/TTY: 711) at least 72 hours in advance of the meeting in order to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format.
Si usted es una persona con una discapacidad o necesita servicios de interpretación (inglés/español o Lenguaje de señas), por favor llame al (831) 454-4611 (Personas con Discapacidad Auditiva TDD/TTY: 711) con 72 horas de anticipación a la junta para hacer arreglos. Personas con discapacidades pueden pedir una copia de la agenda en una forma alternativa.

MENTAL HEALTH ADVISORY BOARD AGENDA

Time	Regular Business
3:00 - 3:15	• Roll Call • Public Comment (No action or discussion will be undertaken today on any item raised during Public Comment period except that Mental Health Board Members may briefly respond to statements made or questions posed. Limited to 3 minutes each) • Board Member Announcements • *Approval of October 17, 2024 minutes** • Secretary's Report
	Standing Reports
3:15 - 3:25	September and October Patients' Rights Report – George Carvalho, Patients' Rights Advocate for Advocacy, Inc.
3:25 - 3:40	Board of Supervisors Report – Supervisor Felipe Hernandez
3:40 - 4:05	Presentation: MHSA 2024-2025 Annual Plan Update and Public Comment Karen Kern, Behavioral Health Deputy Director
	Presentation
4:05 – 4:30	Medication Use in Mental Health – Mike Neidig and Dean Kashino, MHAB Members
	New Agenda Items
4:30 - 4:55	*Vote on revised Santa Cruz County Code 2.104 and revised Bylaws**
4:55 - 5:00	**Future Agenda Items**
5:00	**Adjourn**

*Italicized items with * indicate action items for board approval.*

NEXT MENTAL HEALTH ADVISORY BOARD MEETING IS ON:
JANUARY 16, 2025, 3:00 PM – 5:00 PM
LOCATION TO BE ANNOUNCED

Appendix C. Public Comments

Public comments were made by consumers of behavioral health services, family members and caretakers of consumers, behavioral health service providers, educators, and other community members. Key themes that emerged across public comments are summarized below, while all public comments received are reported in the following section.

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 CPPP Participants, by CPPP Activities

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: 2022-2023

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**	151	201	183	194	335
Age Group					
· Children 0-15	103	143	126	135	231
· TAY 16-25	48	58	57	59	104
· Adults 26-59					
· Older Adults 60+					
Race/Ethnicity					
· White	28	50	40	31	50
· Latino	111	136	124	152	248
· Other	12	15	19	11	37
Primary Language					
· English	111	155	142*	151	258
· Spanish	39	44	40*	42	75
· Other	1	2	1*	1	2
Culture					

· Veterans	N/A	N/A	N/A	N/A	N/A
· LGBTQ	12	18	21	22	29

These numbers represent the total unduplicated client count for each period.
**Updated to reflect updated data entry for primary language*

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

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 FY 25-26 Annual Update

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

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 FY 25-26 Annual Update

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.

Agency Reporting	**Encompass**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**84**
Number of individuals/families **ACTUALLY SERVED**	151	201	183	194	335
Age Group					
· Children 0-15	103	143	126	135	231
· TAY 16-25	48	58	57	59	104
· Adults 26-59					

·	Older Adults 60+					
Race/Ethnicity						
·	White	28	50	40	31	50
·	Latino	111	136	124	152	248
·	Other	12	15	19	11	37
Primary Language						
·	English	111	155	142*	151	258
·	Spanish	39	44	40*	42	75
·	Other	1	2	1*	1	2
Culture						
·	Veterans	N/A	N/A	N/A	N/A	N/A
·	LGBTQ	12	18	21	22	29

Encompass– Probation Gate (CSS #2)

Community Supports & Services: 2022-2023

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.

**Updated to reflect updated data entry for primary language*

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

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 FY 25-26 Annual Update

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: 2022-2023

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.

Encompass– Child Welfare Gate (CSS #3)

Community Supports & Services: 2022-2023

Agency Reporting	**Encompass**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**13**
Number of individuals/families **ACTUALLY SERVED**	2	2	2	2	2
Age Group					
· Children 0-15					
· TAY 16-25	2	2	2	2	2
· Adults 26-59					
· Older Adults 60+					
Race/Ethnicity					
· White	1	1	1	1	1
· Latino	1	1	1	1	1
· Other					
Primary Language					
· English	2	2	2	2	2
· Spanish					
· Other					
Culture					
· Veterans	*Data not tracked*				
· LGBTQ	1	1	1	1	1

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 is 13%.

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

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 FY 25-26 Annual Update.

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 FY 25-26 Annual 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: 2022-2023
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.

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	6	3	2	2	**9**
Adults (26-59)					
Number of individuals/families targeted					**65**
Number Actually Served	19	19	18	21	**64**
Older Adults (60+)					
Number of individuals/families targeted					**15**
Number Actually Served:	1	2	2	1	6
Age Group					
• Children 0-15					
• TAY 16-25	6	3	2	2	9
• Adults 26-59	19	19	18	21	64
• Older Adults 60+	1	2	2	1	6
Race/Ethnicity					
• White	18	14	15	17	53
• Latino	3	7	4	6	18
• Other	5	3	3	1	8
Primary Language					
• English	25	24	22	22	77

• Spanish	1			2	2
• Other					
Culture					
• Veterans	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected
• LGBTQ	3	2	1	3	5

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 Telos is 56%.

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 FY 25-26 Annual 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 FY 25-26 Annual 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.

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

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 FY 25-26 Annual Update.
Demographic breakdown not required for Outreach & Engagement

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

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 FY 25-26 Annual Update.

Annual Outreach Target: 50 - No outreach numbers reported.

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).

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

Community Supports & Services: 2022-2023

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted					40
Number Actually Served	9	10	10	11	24
Age Group					
• Children 0-15					
• TAY 16-25	1	1	1	1	2
• Adults 26-59	7	8	7	9	20
• Older Adults 60+	1	1	2	1	2
Race/Ethnicity					
• White	7	6	7	7	16
• Latino	1	3	3	3	5
• Other	1	1		1	3
Primary Language					
• English	9	10	10	11	24

• Spanish					
• Other					
Culture					
• Veterans	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected
• LGBTQ	1	1	2	2	3

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 Casa Pacific is 52%.

Housing Support (Encompass)– Community Support Services (CSS #8)

Community Supports & Services: 2022-2023

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1 Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served				1	**1**
Adults (26-59)					
Number of individuals/families targeted					**60**
Number Actually Served	5	7	9	15	**16**
Older Adults (60+)					
Number of individuals/families targeted					**0**
Number Actually Served:	5	6	8	12	12
Age Group					
• Children 0-15					
• TAY 16-25				1	1
• Adults 26-59	5	7	9	15	16
• Older Adults 60+	5	6	8	12	12
Race/Ethnicity					
• White	8	11	15	24	25

• Latino	1	1	1	2	2
• Other	1	1	1	2	2
Primary Language					
• English	10	13	15	28	29
• Spanish					
• Other					
Culture					
• Veterans	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected
• LGBTQ	2	2	2	2	2

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 Supported Housing is 51%.

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

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 FY 25-26 Annual Update.

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

Community Supports & Services: 2022-2023

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	0	0	0		
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	13	13	15		
Older Adults (60+)					
Number of individuals/families targeted					**2**
Number Actually Served:	2	2	3		

Age Group					
• Children 0-15	0	0	0		
• TAY 16-25	0	0	0		
• Adults 26-59	13	13	15		
• Older Adults 60+	2	2	2		
Race/Ethnicity					
• White	13	13	15		
• Latino	0	0	1		
• Other	2	2	2		
Primary Language					
• English	15	15	18		
• Spanish	0	0	0		
• Other	0	0	0		
Culture					
• Veterans	0	0	0		
• LGBTQ	0	0	0		

Willow brook (Front Street)– Community Support Services (CSS #8)

Community Supports & Services: 2022-2023

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	1	1	1		
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	21	22	25		
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:	18	18	16		
Age Group					
• Children 0-15	0	0	0		
• TAY 16-25	1	1	1		
• Adults 26-59	21	22	25		

• Older Adults 60+	18	18	16		
Race/Ethnicity					
• White	34	35	35		
• Latino	5	5	6		
• Other	1	1	1		
Primary Language					
• English	40	41	42		
• Spanish	0	0	0		
• Other	0	0	0		
Culture					
• Veterans	0	0			
• LGBTQ	1	1	1		

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

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 FY 25-26 Annual Update.

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

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 FY 25-26 Annual Update.

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

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 FY 25-26 Annual Update.

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

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 FY 25-26 Annual Update.

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

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 FY 25-26 Annual Update.

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

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 FY 25-26 Annual Update.

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

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 FY 25-26 Annual Update.

Demographic breakdown not required for Outreach & Engagement.

Appendix F. Prevention & Early Intervention (PEI), FY2022-2023 Annual Reports

PEI #1 Prevention

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

Prevention & Early Intervention Report: 2022-2023 Annual Target #: 1,300

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Unduplicated Client Count	55	49	29	130	195
Age:					
0-15					
16-25	5	4	4	7	9
26-59	48	43	23	121	182
60 +	2	2	2	2	4
Declined to State					
Language:					
English	40	39	20	47	93
Spanish	15	10	9	11	30
Other					
Declined to State				72	72
Race:					
American Indian	2	1		2	5
Black				1	1
White	48	41	23	46	98
Other	1	2	2	4	6
More than one	3	4	2	2	7
Declined to State	1	1	2	75	78
Ethnicity					
Latino	37	28	20	41	82
African					
Asian Indian/South Asian					
Filipino					
Other (e.g., Asian)	1	1	1	1	1
More than One					
Declined to State	17	20	8	88	112
Veteran					
Yes	1	1		1	2
No	52	47	27	54	115
Declined to State	2	1	2	75	78
Unknown**	1	1			1

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Sexual Orientation					
Gay or Lesbian					
Heterosexual or Straight	44	45	20	44	98
Questioning or Unsure					
Queer					
Another Sexual Orientation (e.g., bisexual)	2	1	2	5	8
Declined to State	9	3	7	81	89
Unknown**					
Gender Assigned at birth					
Male	15	17	7	13	15
Female	39	32	4	31	34
Declined to State	1		18	86	146
Unknown**					
Current Gender Identity					
Male	15	17	13	18	38
Female	40	32	16	40	85
Transgender Male					
Transgender Female					
Gender Queer					
Questioning or Unsure					
Declined to State				72	72
Write in Option					
Disability					
Yes***(total unique clients with disability)*	5	3	1	4	9
• Communication Domain					
Difficulty Seeing	3	1			3
Difficulty Hearing					
Difficulty Having Speech Understood					
• Mental Domain					
(mental illness, learning disability, developmental disability, dementia)	1			3	4
• Physical/mobility	1	1	1	1	1
• Chronic health condition	1		1		1
• Other (Specify)		1 (drug addiction)			1 (drug addiction)
No	49	46	26	51	109

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Declined to State	1		2	75	77
Unknown**					
Other Relevant Data					
Children of parents receiving intensive services *(unduplicated)*	110	90	48	197	323
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: 19 Seminars: 27 Workshops: 94 Inmate: 31 **Total: 163** *(unique across all brief services)*	L2 Indiv: 58 Seminars: 0 Workshops: 85 Inmate: 33 **Total: 176** *(unique across all brief services)*	L2 Indiv: 1 Seminars: 20 Workshops: 56 Inmate: 24 **Total: 97** *(unique across all brief services)*	L2 Indiv: 189 Seminars: 26 Workshops: 41 Inmate: 38 **Total: 291** *(unique across all brief services)*	L2 Indiv: 357 Seminars: 73 Workshops: 282 Inmate: 101 **Total: 792** *(unique across all brief services)*
Children of parents in brief services (L2 Individual, Seminars, Workshops, Inmate Program) *(estimated; includes duplicates)*	L2 Indiv: 39 Seminars: 57 Workshops: 160 Inmate: 43 **Total: 299**	L2 Indiv: 89 Seminars: 0 Workshops: 164 Inmate: 60 **Total: 313**	L2 Indiv: 2 Seminars: 34 Workshops: 126 Inmate: 44 **Total: 206**	L2 Indiv: 320 Seminars: 56 Workshops: 105 Inmate: 60 **Total: 541**	L2 Indiv: 592 Seminars: 147 Workshops: 512 Inmate: 170 **Total: 1,421**

* 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.

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

Prevention & Early Intervention Report: 2022-2023

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Unduplicated Client Count	292	208	387	204	906
Age:					
0-15	12	6	9	5	29
16-25	31	25	51	23	103

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
26-59	208	142	295	148	656
60 +	30	27	24	23	90
Declined to State	-	-	-	-	-
Language:					
English	54	43	61	31	175
Spanish	211	142	281	146	627
Other	27	23	13	27	104
Declined to State	-	-	-	-	-
Race:					
American Indian		2	2		4
Black	5	4	2	2	11
White	58	43	33	19	132
Other	65	167	46	179	149
More than one	162	120	11	2	560
Declined to State	2	0	1	2	2
Ethnicity					
Latino	236	160	334	178	740
African	5	4	2	2	11
Asian Indian/South Asian	4	5	1	1	8
Filipino	0	0	0	0	0
Other	61	31			0
More than One	1	8	0	0	25
Declined to State	0	0	0	2	2
Veteran					
Yes	1	1	0	0	1
No	119	82	109	75	288
Declined to State		125	278	129	617
Unknown**	-	-	-	-	-
Sexual Orientation					
Gay or Lesbian					
Heterosexual or Straight					
Questioning or Unsure	-	-	-	-	-
Queer	-	-	-	-	-
Another Sexual Orientation (e.g., bisexual)	-	-	-	-	-
Declined to State					
Unknown**	-	-	-	-	-
Gender Assigned at birth					
Male	78	58	155	59	314
Female	214	150	232	145	592

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Declined to State					
Unknown**	-	-	-	-	-
Current Gender Identity					
Male	12	11	15	23	61
Female	46	23	45	44	158
Transgender Male	-	-	-	-	-
Transgender Female	-	-	-	-	-
Gender Queer	-	-	-	-	-
Questioning or Unsure	-	-	-	-	-
Declined to State	-	-	-	-	-
Write in Option					
Disability					
Yes***(total unique clients with disability)*	20	16	16	15	55
• 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	147	97	203	114	444
Declined to State	175	95	168	75	407

The Diversity Center (COE) - Prevention Program (PEI #1)

Prevention & Early Intervention Report: 2022-2023

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Unduplicated Client Count	1292	928	1292	604	1896
Age:					
0-15	908	685	908	73	1641
16-25	234	243	234	166	400
26-59	150		150	126	276
60 +			0	239	239
Language:					
English	1010	710	1010	489	1499

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Spanish	282	218	282	96	382
Other			0	19	19
Race:					
American Indian	4	2	4	1	5
Black	18	7	18	8	26
White	1183	846	1183	556	1739
Other	87	73	87	10	10
More than one			0	10	10
Declined to State			0	19	19
Ethnicity					
Latino	264	335	264	89	353
African		7	0	4	4
Asian Indian/South Asian	2	2	2	3	5
Filipino	1	1	1	0	1
Other (e.g., Asian)	1025	505	1025	477	1502
More than One		78	0	11	11
Declined to State			0	20	20
Veteran					
Yes		-	0	0	0
No	492	928	492	0	492
Declined to State	800	-	800	0	800
Unknown**	-	-	-	-	-
Sexual Orientation					
Gay or Lesbian	625	218	625	268	893
Heterosexual or Straight	252	335	252	78	330
Questioning or Unsure	51	50	51	46	97
Queer	178	205	178	108	286
Another Sexual Orientation (e.g., bisexual)	186	120	186	98	284
Declined to State		-	0	6	6
Unknown**		-	-	-	-
Gender Assigned at birth					
Male	380	155	380	0	380
Female	420	395	420	0	420
Declined to State	492	378	492	0	492
Unknown**		-	-	-	-
Current Gender Identity					
Male	415	190	415	76	491
Female		430	473	218	691
Transgender Male	119	113	119	43	162

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Transgender Female	32	27	32	28	60
Gender Queer	142	168	142	102	244
Questioning or Unsure	111		111	56	167
Declined to State			0	81	81
Write in Option		-	0	0	0
Disability					
Yes***(total unique clients with disability)*					
• Communication Domain					
Difficulty Seeing	112	50	112	0	112
Difficulty Hearing			0	0	0
Difficulty Having Speech Understood			0	0	0
• Mental Domain			0	0	0
(mental illness, learning disability, developmental disability, dementia)	226	200	226	6	232
• Physical/mobility	6	20	6	1	7
• Chronic health condition	6	50	19	0	19
• Other (Specify)	19		0	0	0
No	129	58	129	0	129
Declined to State	800	550	800	0	800

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

Prevention & Early Intervention Report: 2022-2023

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Unduplicated Client Count	4,394	4,394	4,394	4,394	4,394
Age:					
0-15					
16-25	4,394	4,394	4,394	4,394	4,394
26-59	-	-	-	-	-
60 +	-	-	-	-	-
Declined to State	-	-	-	-	-
Language:					
English	1,258	1,258	1,258	1,258	1,258
Spanish	336	336	336	336	336
Other	130	130	130	130	130

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Declined to State					
Race:					
American Indian	10	10	10	10	10
Black	69	69	69	69	69
White	2,110	2,110	2,110	2,110	2,110
Other	7	7	7	7	7
More than one	250	250	250	250	250
Declined to State	41	41	41	41	41
Ethnicity					
Latino	1,773	1,773	1,773	1,773	1,773
African	69	69	69	69	69
Asian Indian/South Asian	102	102	102	102	102
Filipino	32	32	32	32	32
Other (e.g., Asian)	7	7	7	7	7
More than One	250	250	250	250	250
Declined to State	41	41	41	41	41
Veteran					
Yes					
No					
Declined to State	4,394	4,394	4,394	4,394	4,394
Unknown**					
Sexual Orientation					
Gay or Lesbian					
Heterosexual or Straight					
Questioning or Unsure					
Queer					
Another Sexual Orientation (e.g., bisexual)					
Declined to State					
Unknown**					
Gender Assigned at birth					
Male	2,280	2,280	2,280	2,280	2,280
Female	2,109	2,109	2,109	2,109	2,109
Declined to State					
Unknown**					

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Current Gender Identity					
Male					
Female					
Transgender Male					
Transgender Female					
Gender Queer					
Questioning or Unsure					
Declined to State					
Write in Option					
Disability					
Yes***(total unique clients with disability)*					
• Communication Domain					
Difficulty Seeing					
Difficulty Hearing					
Difficulty Having Speech Understood					
• Mental Domain					
(mental illness, learning disability, developmental disability, dementia)	253	253	253	253	253
• Physical/mobility	12	12	12	12	12
• Chronic health condition					
• Other (Specify)					
No					
Declined to State					
Unknown**					

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

Prevention & Early Intervention Report: 2022-2023

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	78	58	67	55	258

Age:					
0-15	0	0	0	0	0
16-25	0	1	1	1	4
26-59	23	25	23	21	92
60 +	54	32	43	33	162
Declined to answer	0	0	0	0	0
Language:					
English	78	58	67	55	258
Spanish	7	4	4	4	19
Other	0	1	0	0	1
Race:					
American Indian or Alaskan Native	0	1	1	1	3
Black	5	5	1	3	14
White	59	39	46	38	182
Other	4	5	12	11	32
More than one	2	1	2	0	5
Declined to answer	8	7	5	2	22
Ethnicity					
Hipanic or Latino	12	9	12	11	44
African	5	4	1	3	13
Asian Indian/South Asian	2	1	0	0	3
Filipino	1	0	0	0	1
Other	48	36	46	38	168
More than One	2	1	1	0	4
Declined to State	8	7	7	2	24
Veteran					
Yes	76	56	66	52	250
No	2	2	1	3	8
Declined to State	0	0	0	0	0
Sexual Orientation					
Gay or Lesbian	2	1	1	1	5
Heterosexual or Straight	52	35	47	35	169
Questioning or Unsure	0	0	0	1	1
Queer	1	1	0	1	3
Another Sexual Orientation	0	0	0	0	0
Declined to State	23	21	19	17	80
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	70	51	59	46	226
Female	4	7	6	7	24
Declined to State	4	0	2	2	8

Current Gender Identity					
Male	70	50	59	46	225
Female	4	7	6	6	23
Transgender Male	0	0	0	0	0
Transgender Female	0	1	0	0	1
Genderqueer	0	0	0	1	1
Questioning or Unsure	0	0	0	0	0
Declined to State	4	0	2	2	8
Write in Option	0	0	0	0	0
Disability					
Yes:					
• Communication Domain					
Difficulty Seeing	17	4	2	5	28
Difficulty Hearing	21	9	11	9	50
Difficulty Having Speech Understood	1	1	0	2	4
• Mental Domain					0
(mental illness, learning disability, developmental disability, dementia)	34	29	45	35	143
• Physical mobility	18	8	12	9	47
• Chronic health condition	22	11	14	12	59
• Other (Specify)	0	0	0	0	0
No	0	0	0	0	0
Declined to State	0	0	0	0	
Other Relevant Data					

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

Prevention & Early Intervention Report: 2022-2023

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.

Companionship/Respite — Senior Companion Assignment Plan — FY 21-22

It is a federal requirement that all Senior Companions have an Assignment Plan (AP) for the clients with whom they are assigned to work. The clients they are assigned to must have a documented special need-defined as a person who is homebound (a person unable to leave their residence due to disability, injury or age for the short or long term), an older adult (65+) and/or has one or more physical, emotional, or mental limitations-and be in need of assistance to maintain their highest level of independent living. Respite services are available for a caregiver of a person with these special needs. The Senior Companion is assigned to provide direct services to one or more eligible clients that result in increased social ties/perceived social support. Respite services are available for a caregiver of a person with these special needs. The signature of the supervisor below signifies acceptance and approval of this AP.

Senior Companion (print) _____

Senior Companion Signature _____

Coordinator Signature _____

Volunteer Site _____

Client Name (or number) _____

Client Date of Birth _____ Client Age _____

Check Service Being Provided (choose only one)

☐ **Companionship** OR ☐ **Caregiver Respite**

CONFIDENTIALITY: The Senior Companion Program recognizes and respects the confidentiality of all the clients involved in the progeam. Please be assured that all the information that you provide will only be used in aggregate and no specific client will be identified.

Supervisor (print) _____

Supervisor Signature _____ Date: _____

Section 1 Select the needs below that best describe the reasons this client has been assigned to a Senior Companion.
YOU MAY CHECK MORE THAN ONE BOX.
(If the client is receiving Respite services check the needs related to person receiving care.)

- ☐ Homebound
- ☐ Chronic Disability/Disease
- ☐ Alzheimer's
- ☐ Visually Impaired
- ☐ Hearing Impaired
- ☐ Mental Helath Related
- ☐ Terminal Illness
- ☐ Substance Abuse
- ☐ Social Isolation
- ☐ Older Adult Age 65+
- ☐ Relief From Stress (Respite Caregiver Only)
- ☐ Other Special Needs _____

Section 2 ACTIVITIES PLANNED WITH ASSIGNED CLIENT.
Mark those activities that apply with an "X"

	N/A	Weekly	2-3 times per week	Daily
Encourage social interaction				
Promote Physical activities & exercise				
Promote mental activities (games, ect.)				
Assist with arts and crafts activities				
Promote self-esteem				
Improve morale and outlook on life				
Assist in reality orientation				
Provide grief support				
Provide peer support				
Encourage socially appropriate behavior				

Companionship/Respite — Senior Companion Assignment Plan — FY 21-22

Section 3 **This section to be completed in the Fall or within 30 days of assignment to a Senior Companion.**

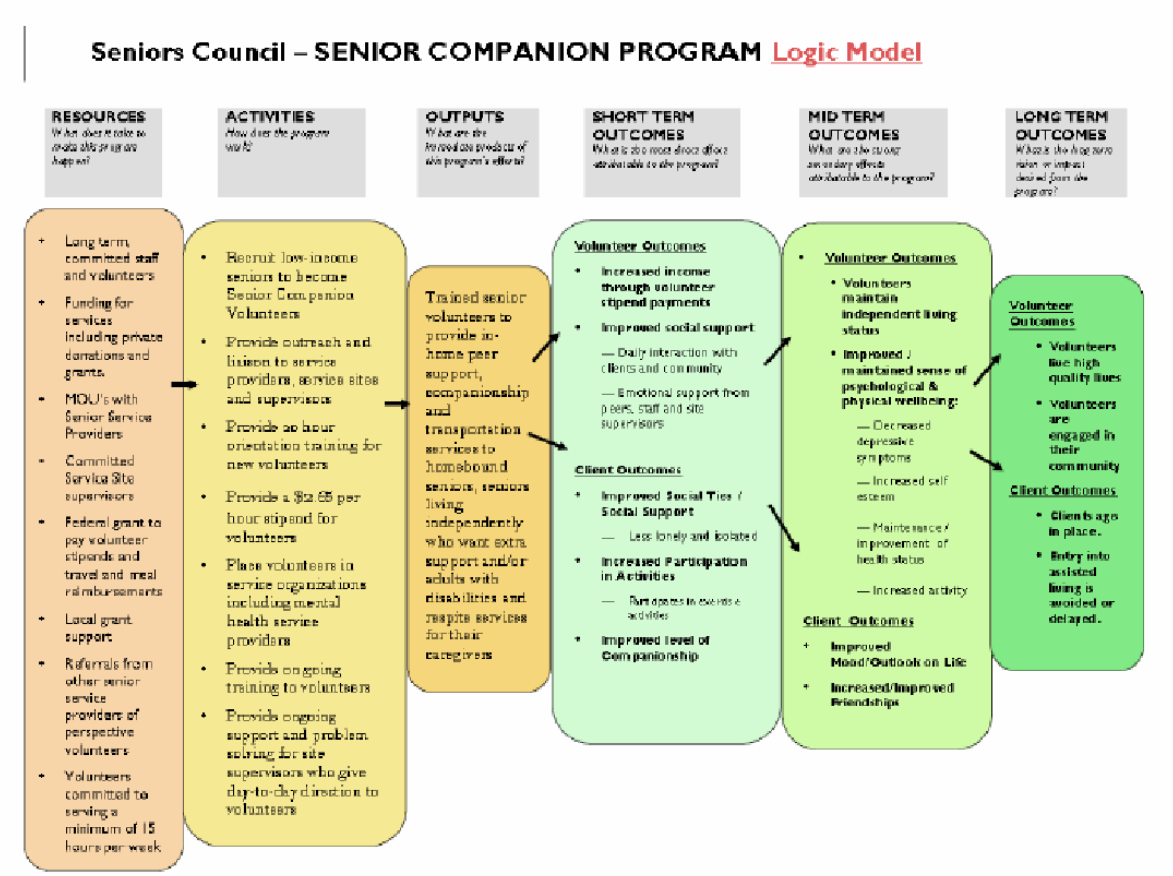
Check the boxe(s) next to the indicator(s) you expect the client to improve.

At least one SOCIAL TIES/SOCIAL SUPPORT must be checked.

Section 4 **What level of improvement was ACTUALLY achieved from those you checked in section 3.**

THIS SECTION TO BE COMPLETED IN THE SPRING.

	No Improvement	Some Improvement	Moderate Improvement	Significant Improvement	N/A
SOCIAL TIES/SOCIAL SUPPORT					
☐ Less lonely and isolated	☐	☐	☐	☐	☐
☐ Relationships with other people	☐	☐	☐	☐	☐
☐ Relationship with people who will help in time of need	☐	☐	☐	☐	☐
ACTIVITIES					
☐ Participates in arts and crafts	☐	☐	☐	☐	☐
☐ Plays games with others	☐	☐	☐	☐	☐
☐ Participates in exercise activities	☐	☐	☐	☐	☐
PERSONAL EXPRESSION					
☐ Improve Self-esteem	☐	☐	☐	☐	☐
☐ Engages in conversation about life and memories	☐	☐	☐	☐	☐
☐ Writes letters	☐	☐	☐	☐	☐
MOOD & BEHAVIOR IMPROVEMENT					
☐ Improved socially appropriate behaviors	☐	☐	☐	☐	☐
☐ Improved morale and outlook in life	☐	☐	☐	☐	☐
☐ Improve reality orientation	☐	☐	☐	☐	☐
COMPANIONSHIP					
☐ Develops one-on-one friendships	☐	☐	☐	☐	☐
☐ Improved contact with family	☐	☐	☐	☐	☐
☐ Improved contact with peers	☐	☐	☐	☐	☐



PEI #2 Early Intervention

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

Prevention & Early Intervention Report: 2022-2023

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count					122
Age:					
0-5	0	0	0	0	0
6-17	4	1	0	0	5
18-20	38	1	1	7	47
21-24	50	0	3	6	59
25-44	30	1	3	5	39
45-64	0	0	0	0	0
65-74	0	0	0	0	0
75+	0	0	0	0	0

Age not available	0	0	0	0	0
Language:					
English	7	12	23	25	31
Spanish	1	3	4	4	4
Other	0	2	2	0	2
Race:					
American Indian or Alaskan Native	0	0	0	0	0
Black	0	0	1	1	1
White	4	5	12	12	17
Asian	0	1	2	0	2
Native Hawaiian or Other Pacific Islander	0	0	0	0	0
Declined to answer	0	0	0	0	0
Other	0	0	0	0	0
Ethnicity					
Hispanic or Latino	3	9	12	13	14
Not Hispanic or Latino	0	0	0	0	0
Declined to answer	0	0	0	0	0
Other	1	2	2	3	3
Veteran					
Yes	0	0	0	0	0
No	8	17	29	29	37
Declined to State	0	0	0	0	0
Sexual Orientation					
Gay or Lesbian	0	0	1	1	1
Heterosexual or Straight	12	12	18	17	22
Bisexual	0	0	0	0	0
Queer	0	0	0	0	0
Another Sexual Orientation	2	2	5	5	6
Declined to answer	3	3	5	6	8
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	4	12	17	18	20
Female	4	5	12	11	17
Declined to answer	0	0	0	0	0
Current Gender Identity					
Male	3	12	17	18	20
Female	4	3	10	10	15
Transgender	0	1	1	1	1
Genderqueer	0	0	0	0	0
Questioning or Unsure	1	0	0	0	0

Another gender identity	0	0	0	0	0
Declined to answer	0	1	1	0	1

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

Prevention & Early Intervention Report: 2022-2023

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.

PEI #3 Outreach

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

Prevention & Early Intervention Report: 2022-2023

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	22	10	7	3	42
Age:					
Unknown	4				4
16-25					
26-59	0	2			2
60 +	18	8	7	3	36
Language:					
English	17	7	6	1	31
Spanish	4	2	1	2	9
Other	1(unknown)	1			
Race:					
American Indian or Alaskan Native	2				2
Black					
White	19	8	6	3	36
Other			1		1
More than one					
Declined to answer	1	2			3
Ethnicity					
Hispanic or Latino	6	4	2	2	14
African					
Asian Indian/South Asian			1		1
Filipino					
Other	3				3
More than One					
Declined to State	1	2			3

Veteran					
Yes	1				1
No	21	10	7	3	41
Declined to State					
Sexual Orientation					
Gay or Lesbian	1				1
Heterosexual or Straight	16	10	4	3	33
Questioning or Unsure					
Queer					
Another Sexual Orientation	1(unknown)				1
Declined to State	4		3		7
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	4	1	2		7
Female	17	9	5	3	34
Declined to State	1(unknown)				1
Current Gender Identity					
Male	4	1	2		7
Female	17	9	5	3	34
Transgender Male					
Transgender Female					
Genderqueer					
Questioning or Unsure					
Declined to State					
Write in Option	1(unknown)				
Disability					
Yes:	6	1	1	0	8
• Communication Domain					
Difficulty Seeing					
Difficulty Hearing					
Difficulty Having Speech Understood					
• Mental Domain					
(mental illness, learning disability, developmental disability, dementia)					
• Physical mobility	4	1	1		6
• Chronic health condition	2				2
• Other (Specify)					
No	13	9	6	3	31

Declined to State	3				3
Other Relevant Data					

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)

Prevention & Early Intervention Report: 2022-2023

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.

PEI #6 Access and Linkage to Treatment

Second Story, Encompass – Access & Linkage Program (PEI #6)

Prevention & Early Intervention Report: 2022-2023

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	31	21	18	22	63
Age:					
0-15					
16-25	3	3	0	2	6
26-59	23	15	14	17	49
60 +	5	3	4	3	8
Language:					
English	31	21	18	22	63
Spanish					
Other					
Race:					
American Indian or Alaskan Native					
Black	2				2
White	20	13	12	17	43
Other	8	6	4	4	15
More than one	1	2	2	1	3
Declined to answer					
Ethnicity					
Hispanic or Latino	7	5	3	3	11

African					
Asian Indian/South Asian					
Filipino					
Other	24	17	15	19	52
More than One					
Declined to State					
Veteran					
Yes	Data not tracked	Data not tracked	Data not tracked	Data not tracked	Data not tracked
No	Data not tracked	Data not tracked	Data not tracked	Data not tracked	Data not tracked
Declined to State					
Sexual Orientation					
Gay or Lesbian					
Heterosexual or Straight	28	18	16	20	56
Questioning or Unsure					
Queer	1	2			2
Another Sexual Orientation	1				1
Declined to State	1	1	1	2	4
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	18	11	8	15	35
Female	13	10	10	7	28
Declined to State					
Current Gender Identity					
Male	18	11	8	13	33
Female	13	10	10	9	30
Transgender Male					
Transgender Female					
Genderqueer					
Questioning or Unsure					
Declined to State					
Write in Option					
Disability					
Yes:	Data not tracked	Data not tracked	Data not tracked	Data not tracked	Data not tracked
• 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					
Other Relevant Data					

Second Story is 100% funded by PEISSS

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

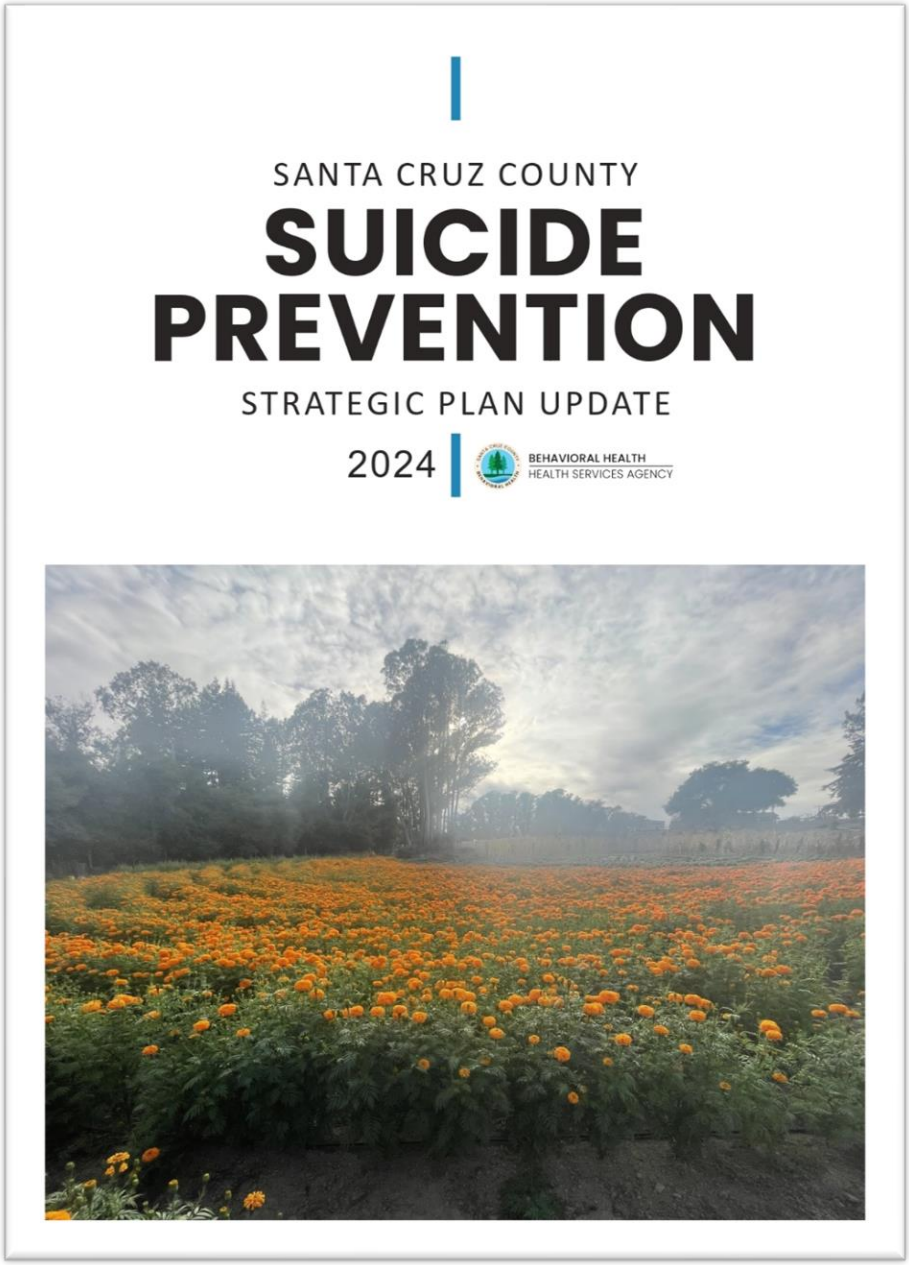
Prevention & Early Intervention Report: 2022-2023

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.

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

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State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: Santa Cruz County

Fiscal Year: 2023-24

Local Mental Health Director

Name: Tiffany Cantrell-Warren

Telephone: (831) 454-4767

Email: tiffany.cantrell-warren@santacruzcountyca.gov

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Tiffany Cantrell-Warren	Signed by: Tiffany Cantrell-Warren	10/22/2024
Local Mental Health Director (PRINT NAME)	Signature	Date

[1] Welfare and Institutions Code section 5892 (b)(2)

DHCS 1819 (02/19)

Appendix I. Board of Supervisors Approval of Plan

[Submitted with Final Draft]