COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

Mental Health Services Act*:*
FY 2020-2023 Three-Year Plan
FY 2021-2022 Annual Update

WELLNESS • RECOVERY • RESILIENCE

Contents

County of Santa Cruz

HEALTH SERVICES AGENCY

1400 Emeline Avenue, Santa Cruz, CA 95060

(831) 454-4170 FAX: (831) 454-4663

LETTER FROM THE MENTAL HEALTH SERVICES ACT COORDINATOR

March 11, 2021

We have completed a draft of "Three Year Program and Expenditure Plan" of the Mental Health Services Act (MHSA/Proposition 63), as required under Welfare and Institutions Code Section 5847. This Plan covers fiscal years 2020-2021, 2021-2022, and 2022-2023. This Three-Year Plan is not intended as a binding contract with any entity or provider of services. Services will be monitored on a continual base, and the County may make changes, if necessary. We have completed a draft of the 2021-22 Annual Update Program and Expenditure Plan of the Mental Health Services Act (MHSA/Proposition 63), as required under Welfare and Institutions Code Section 5847. This Plan covers fiscal years 2021-2022. This Plan is not intended as a binding contract with any entity or provider of services. Services will be monitored on a continual base, and the County may make changes, if necessary.

The report will be posted from March 11, 2021 to April 15, 2021 and a virtual Public Hearing will be held virtually on April 15th, 2021 at 3pm at the Behavioral Health Services Building at 1400 Emeline Avenue-Room 206, Santa Cruz, 95060. . Call in information for that meeting is (916) 318-9542, Conference ID 812 691 851# . Subsequently the Plan will be sent to the Santa Cruz County Board of Supervisors for adoption, and then to the Mental Health Services Oversight Accountability Commission and the State Department of Health Care Services.

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

At the Public Hearing,
By telephone: (831) 763-8203,
By internet:
http://santacruzhealth.org/MHSA
By email to mhsa@co.santa-cruz.ca.us ,
Or by writing to:

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

Sincerely,

Cassandra Eslami

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

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Cruz County

Local Mental Health Director	Program Lead
Name: **Erik G. Riera**	Name: **Cassandra Eslami**
Telephone Number: 831-454-4515	Telephone Number: 831-763-8203
E-mail: Erik.Riera@santacruzcounty.us	E-mail: Cassandra.Eslami@santacruzcounty.us
County Mental Health Mailing Address 1400 Emeline Ave Santa Cruz, CA 95060	

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

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on May 18, 2021.

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

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

DocuSigned by:

Erik G. Riera — 4/16/2021

Local Mental Health Director/Designee (PRINT) — Signature — Date

County: Santa Cruz

Date: April 16, 2021

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: **Santa Cruz County**

- [X] Three-Year Program and Expenditure Plan
- [X] Annual Update
- [X] Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: **Erik G. Riera**	Name: Christine Williams
Telephone Number: 831-454-4515	Telephone Number: 831-454-7341
E-mail: Erik.Riera@santacruzcounty.us	E-mail: Christine.Williams@santacruzcounty.us
Local Mental Health Mailing Address: 1400 Emeline Avenue Santa Cruz, CA 95060	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations 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.

DocuSigned by:
4/16/2021

Erik G. Riera
Local Mental Health Director (PRINT)

Signature Date

I hereby certify that for the fiscal year ended June 30, 2020, 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 Dec. 23, 2020 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, 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.

Christine M. Williams Chief of Fiscal Services

DocuSigned by:
Christine M. Williams 4/16/2021

County Auditor Controller / City Financial Officer (PRINT)

Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Stakeholder Engagement
MHSA 2020-2023 three-year plan

Stakeholder engagement plan

To assist in development of the MHSA Three-Year Plan 2020-2023, Santa Cruz County Behavioral Health Services hired consultant Dr. Jerry Solomon. Dr. Solomon's vast experience with MHSA stakeholder engagement processes includes the original Santa Cruz County MHSA stakeholder process designed in 2005 for program development of initial fund allocation. Dr. Solomon's experience as a trusted and skilled facilitator was evident when the announcement of his return for MHSA stakeholder engagement facilitation was met with community enthusiasm and excitement. Dr. Solomon's skilled facilitation of the community meetings is evident by his active listening, empathetic tone, and inclusive process.

Detailed below is the list of stakeholder events held for the MHSA Three-Year Plan 2020-2023. Sadly, the remaining workgroups for Children and Adults were cancelled because of the COVID-19 pandemic. The group size was too large and not in line with County Health Officer guidance. Careful consideration was made to continue to planning process through technological means, such as Zoom, however, based on understanding of the challenges facing our population, the current crisis and available support and resources, a decision was made to move forward in the planning process with the data available based on the robust stakeholder process that had been completed to date.

Three-year plan Kickoff Events-

Two stakeholder kickoff events were held and facilitated by Dr. Solomon. The first was held in Mid-County at Simpkins Swim Center (979 17th Avenue, Santa Cruz) on Tuesday, February 11th from 5:30-7:30pm. The second was held in South County at Pajaro Valley Health Trust (85 Neilson Street, Watsonville) on Tuesday, February 18th from 5:30-7:30pm. Both meetings were held with Spanish language interpretation services available and included snacks and beverages. Meetings were held in evening hours to accommodate daytime working schedules and traditional school hours. Meetings were announced in advance in local newspapers including the Santa Cruz Sentinel and Pajaro Valley Pajaronian. Meeting flyers (attachment 1) were created in Spanish and English and disseminated via internal and external provider email listserv, in addition to posting on County MHSA website. Flyers were posted in county buildings, in addition contract providers were also asked to post flyers in publicly visible locations.

KICKOFF 02/11/20 TOTAL ON SIGN IN= 41	
AGE	
18-25	4
26-35	5
36-42	5
43-59	13
60+	7

Ethnicity	
Black/African American	3
Latino	8
White	15
American Indian	1
Asian	1
More than one	4
Other	2

Gender	
Male	11
Female	23

Primary Language	
English	26
English & Spanish	6
Other	4

Group Representing	
Client/Consumer	13
Family	2
Social Services Agency	4
Education	3
Healthcare	1
Mental Health provider	6
General Public	4
Other	8

KICKOFF 02/18/20 TOTAL ON SIGN IN= 33 AGE	
26-35	6
36-42	4
43-59	8
60+	3

Ethnicity	
Black/African American	
Latino	8
White	6
American Indian	1
More than one	3
Other	3

Gender	
Male	13
Female	8

Primary Language	
English	13
English & Spanish	8

Group Representing	
Client/Consumer	8
Family	1
Social Services Agency	3
Education	2
Mental Health provider	10
General Public	2
Other	2

The purpose of the kickoff events was to educate participants on the MHSA process, provide a background of current MHSA funded county programs, and explain the future goals of the MHSA three-year stakeholder engagement planning process by using a PowerPoint presentation. Meeting locations were identified as easily accessible via local municipal transportation, were deemed safe and welcoming (noting immigration concerns with official governmental agency sites) and provided an opportunity for engagement with our South County predominately Spanish speaking community. In each kickoff event we reviewed the timeline (attachment 3) detailing the planning process for participant understanding and encouraged participation in all upcoming MHSA stakeholder events by providing clear details and flyers. We also encourage participants to spread the word and help to recruit others into the planning process.

Focus Groups

Focus groups were held to gain specific feedback from targeted populations for inclusion in the planning process. The identified focus groups were: 1. Families of Consumers; 2. Consumers; 3. Monolingual Spanish Speakers; and 4. People experiencing serious mental illness and homelessness. The purpose of each focus group was to gain feedback and input from targeted populations within our system of care. Another goal was to focus on the strengths and needs within the current system based on their vantage point. All focus groups, except for the Monolingual Spanish Speakers group, were facilitated by Dr. Solomon.

The first focus group- Families of Consumers was held in North County Behavioral Health Services (1400 Emeline Avenue, Santa Cruz) on Monday, February 24th from 6:00-7:30pm. Participants were invited to attend this focus group in collaboration with NAMI, who sent the flyer to their listserv of over 1,000 community members. Participants then RSVP to the MHSA Coordinator to confirm attendance. Meeting notes were kept and transcribed after each focus group (attachment 2).

FOCUS GROUP #1- FAMILIES OF CONSUMERS TOTAL ON SIGN IN= 11 AGE	
43-59	1
60+	6

Ethnicity	
White	6
More than one	1

Gender	
Male	1
Female	6

Primary Language	
English	7

Group Representing	
Family	7

The second focus group- Consumers, was held in partnership with our community contracted agency services in the community. This meeting was held at MHCAN (1051 Cayuga Street, Santa Cruz) on Tuesday, February 25th from 6:00-7:30pm. Participants were invited to attend this meeting through a specialized recruitment targeting consumers. Flyers were disseminated through contract provider agencies. Participants were provided $10 gift cards to Grocery Outlet for attendance, as well as dinner. Spanish language translation was provided upon request. Meeting notes were transcribed (attachment 3).

FOCUS GROUP #2- CONSUMERS TOTAL ON SIGN IN= 12 AGE	
26-35	6
36-42	4
43-59	5
60+	1

Ethnicity	
Black/African American	1
Latino	1
White	6
More than one	1
Other	1

Gender	
Male	5
Female	5

Group Representing	
Client/Consumer	8
Mental Health provider	2
Other	1

Primary Language	
English	10

The third focus group- Monolingual Spanish Speakers, was held at Pajaro Valley Health Trust (85 Neilson Street, Santa Cruz) on Thursday, February 27th from 6:00-7:30pm. Participants were invited to attend this meeting through a specialized recruitment targeting the Spanish speaking community members. Flyers were disseminated through South County contract provider agencies. Participants were provided $10 gift cards to Grocery Outlet for attendance, as well as dinner. This meeting was held in Spanish and facilitated by Jaime Molina, a retired Santa Cruz County Behavioral Health Services employee who worked within the Culturally and Logistically Appropriate Services (CLAS) department. Mr. Molina is a native of the South County community and was able to actively outreach participants for this meeting. Meeting notes were transcribed (attachment 4).

FOCUS GROUP #3- SPANISH SPEAKERS TOTAL ON SIGN IN= 6 AGE	
18-25	1
26-35	1
43-59	3

Primary Language	
English	1
Spanish	3
English & Spanish	1

Ethnicity	
Latino	5

Group Representing	
Client/Consumer	2
Family	3
Social Services Agency	3
General Public	1

Gender	
Male	1
Female	4

The fourth focus group - people experiencing serious mental illness and homelessness - was done via face to face interviews. Santa Cruz County Behavioral Health Services Outpatient Team Case Managers identified clients on their caseloads who were experiencing homelessness. Those clients were offered a $10 gift card to Grocery Outlet for their feedback on questions surrounding MHSA programming.

Workgroups

Four Children's Workgroups were scheduled on March 4th from 10:30-noon in South County Behavioral Health Services office building (1430 Freedom Blvd, Watsonville), March 10th from 6:00-7:30pm at North County Behavioral Health Services office building (1400 Emeline Avenue, Santa Cruz), March 18th from 10:30-noon at South County Behavioral Health Services office building (1430 Freedom Blvd, Watsonville), March 24th from 6:00-7:30pm at North County Behavioral Health Services office building (1400 Emeline Avenue, Santa Cruz).

CHILDREN'S WORKGROUP #1 TOTAL ON SIGN IN= 13	
AGE	
0-17	1
18-25	2
26-35	2
36-42	2
43-59	4
60+	2

Gender	
Male	3
Female	8
Transgender Female	1
Other	1

Primary Language	
English	11
English & Spanish	2

Group Representing	
Social Services Agency	3
Education	3
Mental Health provider	6
Substance use disorder provider	1
Other	3

Ethnicity	
Latino	1
White	10
More than one	1

Four Adult Workgroups were scheduled on March 3rd from 6:00-7:30pm at North County Behavioral Health Services office building (1400 Emeline Avenue, Santa Cruz), March 11th 10:30-noon in South County Behavioral Health Services office building (1430 Freedom Blvd, Watsonville), March 19th from 6:00-7:30pm at North County Behavioral Health Services office building (1400 Emeline Avenue, Santa Cruz) and March 25th from 10:30-noon in South County Behavioral Health Services office building (1430 Freedom Blvd, Watsonville).

ADULT WORKGROUP #1 TOTAL ON SIGN IN= 51	
AGE	
18-25	3
26-35	4
36-42	3
43-59	6
60+	2

Ethnicity	
Latino	1
White	10
More than one	5
Other	1

Primary Language	
English	17
English & Spanish	1

Gender	
Male	8
Female	10

Group Representing	
Client/Consumer	7
Family	2
Veteran/veteran advocate	1
Social Services Agency	3
Education	1
Mental Health provider	10
General Public	1
Other	1

Participants were invited to workgroups from flyers disseminated via internal and external listserv; NAMI listserv; County MHSA website and provided in kickoff and focus group meetings. Participants were told they would be provided a $50 incentive gift card for participation in three of the four scheduled meetings for either Children's or Adult workgroups. Workgroups were designed with the following agenda and goals:

1. MHSA funded programs provide brief presentations on services and evaluation components for providing high quality programming:

CSS PROGRAMS	PEI PROGRAMS
• By COUNTY contract (exhibit D) any quarterly or annual program data or evaluative information you collect • Please supply any other pertinent information from other performance measures/metrics/tools you utilize to highlight your achievements	• Brief overview of your annual program evaluation report • If you are not required to provide an evaluation report, please supply other information from performance measures/metrics/tools you utilize to highlight your achievements

2. Participants use the information to give feedback on areas of identified strength and needs within the community.
3. Participants to make recommendations on MHSA programming in our community.

MHSA Coordinator worked with each contract agency to develop a brief handout to discuss with the workgroup participants. This forum provided the opportunity for participants to gain a deeper understanding of the current service spectrum and the chance to ask questions to further conceptualize the strengths and needs of programing within the community.
Children's workgroups performance outcomes:

- Encompass Children's Programs (attachment 5)
- County Office of Education (COE): The Diversity Center (attachment 6), Live Oak Resource Center (attachment 7) and Positive Behavioral Intervention Supports (PBIS) (attachment 8)
- Pajaro Valley Prevention and Student Assistance (PVPSA) (attachment 9)
- Volunteer Center (attachment 10)
- Triple P Parenting Program (attachment 11)
- Trauma Informed Systems (attachment 12)

Adult workgroups performance outcomes:

- Front Street (attachment 13)
- MHCAN (attachment 14)
- Veterans Advocate (attachment 15)
- Encompass Adult Programs (attachment 16)
- NAMI (attachment 17)
- Volunteer Center (attachment 18)
- Family Services Agency (attachment 19)
- Senior Council (attachment 20)

Community Survey

The timing of the stakeholder engagement process synchronized with NAMI strategic planning efforts. Santa Cruz County Behavioral Health Services was able to partner with NAMI and add questions specific to their community surveys and key informant interviews. NAMI provided their obtained data back to Santa Cruz County Behavioral Health Services for consideration in the planning process. The community surveys were completed by 155 participants. Of those participants 43 (27.7%) were people affiliated either as family, friends or personally served by Santa Cruz County Behavioral Health Services.

Stakeholder attachments

Attachment 1 (flyers were created in each event in English and Spanish)

Attachment 2

MHSA Focus Group – Families of Consumers

Date/Time: Monday, February 24, 2020

Location: 1400 Emeline Ave., Bldg. K, Room 206 & 207, Santa Cruz, CA 95060

Introductions

The Mental Health Services Act (MHSA) Focus Group for Families of Consumers was facilitated by Jerry Solomon, Ph.D. Dr. Jerry Solomon provided an overview of the passage of Prop. 63 by California voters in November 2004 which created the Mental Health Services Act (MHSA). The purpose of MHSA is to expand and improve mental health services and transform the mental health system. Dr. Solomon also provided the timeline for the approval process in which the 3-Year Plan report will be completed. The plan is initially compiled based on recommendations from the workgroups and is competed in the draft form. The draft is released for a thirty-day public comment, at which time it will also be reviewed by the MHSA Steering Committee. Public comment will be closed at the end of the thirty-day period at the Mental Health Advisory Board (MHAB) Meeting. At that time and with final changes based on public comment, the plan will be reviewed by County of Santa Cruz Behavioral Health Services Senior Leadership Team. The plan will then be finalized and sent to the Santa Cruz County Board of Supervisors (BOS) for final approval. Once the BOS approves the MHSA Three-year Plan the report is sent to the State for acceptance. Upon acceptance funds are dispersed to the local counties.

After the MHSA Focus Groups, we will have community wide Work Groups (Children's and Adults) that will meet to review existing funding and programs and make recommendations to the Behavioral Health Director on whether to continue, expand or discontinue. There are only four Group Works and are asking for the four-meeting commitment for attendees that sign up.

What was your first encounter with County Behavioral Health?

- Confusing
- Overwhelming (2)
- Antagonistic – Reception staff short, bureaucratic, and not user friendly.
    - County Behavioral Health is training all non-clinical staff on Trauma Informed Services to be able to work with the population we serve.
- Humbling
- 1-year ago: positive experience because both parents have many years of navigating the system of care
- Scary
- Traumatizing because parent did not understand what was going on due to child's hospitalization and being sent to another County.
- No clear navigation guides
- There is no follow-up for consumers or their families when they are sent out of County
    - Once a consumer is handed off to another County then their rules and regulations govern what happens next.
- Confidentiality and HIPPA seen as a barrier and it's difficult to help a consumer by a loved one or family members.
    - Understanding that there is a 1-year time limit per encounter when a consumer signs to allow family members access to information.
    - Family members request that it should be up to the clinician to at least present the idea to the consumer about signing the release of information to allow them to speak to their family members about their case.
    - 2011 Assembly Bill passed to allow family members to submit a form for a loved one in crisis that would allow them to provide information regarding their treatment medications or plan. Law revised in 2014 to state that clinicians and Doctors must at least consider this form if it's submitted. The treatment staff don't have to go with it but they at least have to look at it.
- Challenging
- Communication/information/handouts are not available for the family of consumers to read
    - There must be a commitment at the organizational level – a shift/change to see parents/family as partners/ally's

- Families/parents don't know what types of services are available or offered. They also need basic skills in order are to navigate the system when there is a first encounter.
- Consumer entered the system through Access and not a hospitalization – went well but nervous because no one was telling them what was going on or what would happen next. There was no map given to families about the process of entering the system.
- MERT – Mobile Emergency Response Team embedded with the police so when calls come out for Sheriff's/Police to intervene, ideally a clinician will be available to assist with a Behavioral Health crisis.

Needs

- Packet given to parents/family members
- Brochures needed
- Family Mentor/Navigator/Advocate is needed
- Family members requesting a monthly scheduled 1-day Boot Camp (whether people attend or not) around the different types of mental health illnesses to familiarize themselves with what their loved one is experiencing and to help navigate the system.
    - NAMI in collaboration with County Behavioral Health could provide this type of class because information and education is power.
    - A shift in Behavioral Health that has been happening over the last 20 years is to see Families as resources and part of the treatment process instead of being viewed as the cause of the problems.
- Inform and educate consumers and family members about all the different types of services that County Behavioral Health has to offer such as:
    - Case Managers
    - Community Connection
    - NAMI

What has worked?

- Case management – Plan designed for each consumer. Case Managers can make change happen for a consumer.
    - Doug Holmes
    - Barbara Lehman
    - Debbie Garza
    - Brian Whiteside
    - Marissa Torres
    - Nurses at Telecare
    - Dr. Freddie Weinstein at Telecare – speaks to families
    - Kurt Churchill
- Psychiatrists

Issues and gaps in services

- Psychiatrists – Transition in staffing pattern as to what the plan is once they leave. There is no continuity in services.
- Scheduling issues
- There should be a checklist given to a consumer from Psychiatrist about scheduling the consumer meds instead of waiting for them to run out.
- A difficult case conference: inclusion of family/parents
- HIPPA concerns regarding family member's input
    - Even when the consumer has not signed the Release of Information, family members can still provide the treatment staff with information (background, meds, etc.) about their loved one even though they may not get any in return due to laws governing confidentiality.
- Shortage of children's/adult beds within the County

- Burden is placed on consumer regarding scheduling of their meds. How the default is set within the system for the consumers to have the burned of responsibility instead of having staff pick up some of that.

Where would you like to see programs/funding?

- Shortage of beds
    - 55% of Santa Cruz County consumers are sent out of County (poor supportive housing)
    - Locked beds are expensive
    - IMD's in general
    - PHF/Acute
        - Conservatorship taken up (6 beds)
        - TELOS model in terms of capability so not to build more in terms of acute care in order to keep consumers in the County
        - Supported housing
        - Jail
        - Hospital
        - Out of County
        - Homeless
        - Lose Rose Acres (35 beds)

If you had unlimited funds, what would you advocate they be spent on:

- Local beds
- Dual Diagnosis (Co-Occurring Disorders) Casa Pacific as a model
- ACCESS barriers
    - 42% of outpatient services are out of network (Parity)
- Step-down capacity
- Bigger funding pot
- Special program for first break/special team (peers)
- Peers/MHCAN under-utilized
- Peer Involvement/Peer Coordinator
- More education at schools
- Videos – Platforms to chat via social media

One word about participants of the focus group and their experience today:

- Grateful (2)
- Interesting
- Hopeful
- Alignment
- Productive
- Informative
- Useful
- Educational
- Rewarding
- Heartfelt and warm

Attachment 3

MHSA Focus Group – Consumers

Date/Time: Tuesday, February 25, 2020

Location: MHCAN, 1051 Cayuga Street, Santa Cruz, CA 95062

Introductions

The Mental Health Services Act (MHSA) Focus Group for Families of Consumers was facilitated by Jerry Solomon, Ph.D. Dr. Jerry Solomon provided an overview of the passage of Prop. 63 by California voters in November 2004 which created the Mental Health Services Act (MHSA). The purpose of MHSA is to expand and improve mental health services and transform the mental health system. Dr. Solomon also provided the timeline for the approval process in which the 3-Year Plan report will be completed. The plan is initially compiled based on recommendations from the workgroups and is competed in the draft form. The draft is released for a thirty-day public comment, at which time it will also be reviewed by the MHSA Steering Committee. Public comment will be closed at the end of the thirty-day period at the Mental Health Advisory Board (MHAB) Meeting. At that time and with final changes based on public comment, the plan will be reviewed by County of Santa Cruz Behavioral Health Services Senior Leadership Team. The plan will then be finalized and sent to the Santa Cruz County Board of Supervisors (BOS) for final approval. Once the BOS approves the MHSA Three-year Plan the report is sent to the State for acceptance. Upon acceptance funds are dispersed to the local counties.

After the MHSA Focus Groups, we will have community wide Work Groups (Children's and Adults) that will meet to review existing funding and programs and make recommendations to the Behavioral Health Director on whether to continue, expand or discontinue. There are only four Group Works and we are asking for attendees that sign up to commit to the four meetings.

What has been most successful when consumers have had to deal with mental health services in Santa Cruz County? What has worked?

- Psychiatry
- Housing
    - For example, Casa Pacific and Debbie Garza
- Work/Employment
- Mariposa Center
- Peer Run Services such as:
    - Therapist
    - Safe space
    - Support
    - Peers
    - Guidance and structure
- Case Coordinators/Case Workers – guidance and structure make all the difference
- Brenda Pappas
- Chuck Estes
- Barbara Lehman
- MHCAN
- Carl Graue
- Jodie Wells/Gerardo Sandoval
- Second Story
- NAMI
- Community Connection
- Transition Age Youth (TAY) Team
- Steve Ruzicka
- Sarah Leonard
- Mandy from River Street Shelter
- Dr. Freddie Weinstein

- Telecare – Paperwork and Admin. works for consumers at Telecare
- Encompass – Housing Support Services
- Paige Smith

Where has the system not worked for the community? What hasn't worked? What are the challenges and gaps in services?

- Housing (affordable) for consumers as well as qualified Psychiatrists
- Attitude from workers due to consumer not being local
- Nurses lines – trouble/breakdown with communication within the system
- Need Peer Treatment funding – for example, Second Story
- Telecare – Psychiatric Health Facility (PHF)
    - Short staffed
    - Need to have water, tea, coffee and crackers in lobby
    - Not enough food for patients/clients
    - Need clothing and other supplies for patients/clients
    - Basic needs are not being met at PHF
- No Psychiatry Doctors continuity of care when they leave the County
- Change of treatment staff
- Medication flow plan when a Doctor leaves the County for the client to have a smooth transition
- There is no Plan B in place when consumers need help once a Psychiatrist leaves
- Paperwork and Administration of services fails
- Prevention vs. Crisis – Not only be responsive and reactive but have a proactive engagement with consumers about how to keep themselves well and a plan on what to do when they're having difficulty or experiencing a mental health challenge.
- Having On-call staff can help consumers
- No safe place for consumers in the system once released from involuntary commitment
- Case Coordinators/Workers overwhelmed with huge case loads
- Consumers need more supports at County level because paperwork has not been working
- Peer Support Specialist for 5150's to coordinate with law enforcement
- Job placement/work for consumers
- MHCAN needs a new van
- Consumers having to travel to Santa Cruz instead of being seen in South County

What are the things that are promoting your resilience and wellness?

- Honesty about medications to maintain wellness for self and family
- Community Connection (7 days/week) – Variety of classes offered for consumers
    - Dual Diagnosis classes
    - Arts Classes
    - Creative Writing classes
- Maribel @Mariposa Center
- Jodie Wells
- Friendship and support from other people
    - Feeling of connection
    - Belonging somewhere
    - Having the support of community around
- Mariposa Center

State is moving in the direction of limiting discrimination towards consumers labeled as having mental illness. What has been your experience with discrimination?

- Consumers feel they are not taken seriously, or they are told they are overreacting in situations due to their mental health status. Stigma is there. Consumers want others to see through their diagnosis.

- Discrimination of peer run programs by neighborhoods in which they are in can limit the effectiveness of those programs.
    - MHCAN with very restrictive requirements/conditions on a special use permit limiting what a program can do.
    - Second Story – neighborhood not accepting of Peer Run Program
- Be careful of discriminating against each other (other Programs up for funding)
- It's not the community that stigmatizes this population but the System itself
- Psychiatric Health Facility (PHF) – Offer more food for consumers

Is there anything else that you would like the Mental Health Services Act process to know?

- Feeding the homeless
    - Voucher for homeless on Pacific Avenue and Watsonville to eat food
- 211 (access to resources)
- Group for parents that are mentally ill raising children
- Housing supports (no adequate housing)
- Community Connection is great but relies on Intensive Peer Support (IPS) programs that may not be well received by all consumers
- Need other programs when consumers are going through crisis to help stabilize consumers
- Sensitivity among all programs regarding funding
- Services in South County – more equity around services like there is in North County (getting better/closer but not equal yet)
- More paid peer positions/involvement within the entire system to support each other
- Thank you for your support
- Family passes at the Psychiatric Health Facility (PHF)

One word to describe what this experience was like at this meeting:

- Enlightening
- Grounding
- Relief
- Satisfaction
- Informative
- Inspiring (2)
- Educating
- Caring

Attachment 4

MHSA Focus Group – Consumers

Date/Time: Thursday, February 27, 2020

Location: Pajaro Valley Community Health Trust, 85 Nielson St., Watsonville, CA 95076

Introductions

The Mental Health Services Act (MHSA) Focus Group for Monolingual Spanish Speakers was facilitated by Jaime Molina, MSW. Mr. Molina provided an overview of the passage of Prop. 63 by California voters in November 2004 which created the Mental Health Services Act (MHSA). The purpose of MHSA is to expand and improve mental health services and transform the mental health system. Mr. Molina also provided the timeline for the approval process in which the 3-Year Plan report will be completed. The plan is initially compiled based on recommendations from the workgroups and is competed in the draft form. The draft is released for a thirty-day public comment, at which time it will also be reviewed by the MHSA Steering Committee. Public comment will be closed at the end of the thirty-day period at the Mental Health Advisory Board (MHAB) Meeting. At that time and with final changes based on public comment, the plan will be reviewed by County of Santa Cruz Behavioral Health Services Senior Leadership Team. The plan will then be finalized and sent to the Santa Cruz County Board of Supervisors (BOS) for final approval. Once the BOS approves the MHSA Three-year Plan the report is sent to the State for acceptance. Upon acceptance funds are dispersed to the local counties.

After the MHSA Focus Groups, we will have community wide Work Groups (Children's and Adults) that will meet to review existing funding and programs and make recommendations to the Behavioral Health Director on whether to continue, expand or discontinue. There are only four Group Works and we are asking for attendees that sign up to commit to the four meetings.

What has been most successful from your point of view when community members have had to look for and/or receive mental health services in Santa Cruz County? What has worked and/or has been a positive experience?

- Accessible – Family members of consumer felt comfortable in obtaining/using mental health/substance use disorder services in order to help stabilize loved one. In this instance the system in place worked for this family.
- Watsonville Works Program – Helps homeless by preparing them to search, find and maintain employment (through assistance with creating/updating their resume, completing applications, employment matching/connections, and other job-related skill sets), housing, counseling, etc. The participants of this program work by helping to clean and beautify the streets of the City of Watsonville. This provides participants with job skills and prepares them for future employment.
    - 85% of homeless are afflicted by mental health/substance use disorders
    - Program listens to their needs and helps with resources for substance use disorders
- Community Action Board of Santa Cruz County, Inc. – Project Drive serves youth.
    - 82% of youth served by this program have admitted to having substance use disorders
    - This program has case managers to help the youth but no funding to provide direct services to this vulnerable population.
    - They are a bridge that can connect the youth to other resources or services
- White Heart – Serves youth 15 – 24 years old. It's a place/program where consumers feel welcome, safe and accepted. There are case workers but again there is no funding to provide direct services to the youth being served.
    - Serves youth with or without parental permission (age 16 and over) and regardless of immigration status.
- Prevention & Early Intervention (PEI) from Santa Cruz County – Fosters a bridge that provides funding for consumers as the County level and through funding sources for different programs

What have been the biggest challenges? Where has the system (programs) not worked for the community? What hasn't worked? What are the challenges and gaps in services?

- Not accessible – Consumer that was in crisis due to substance use disorder was not able to obtain services from Janus due to insurance issues/cost of obtaining treatment and was told to be on a waiting list. In this instance the system did not work for this consumer.
- Wait time for consumers to receive an appointment to see a therapist

- Stigma at the cultural level
- Taboo at the cultural level
- Religious beliefs/faith at the cultural level
- Lack of insurance
- Communication/dialogue at the cultural level. There needs to be understanding/clarification.
- Need more Bilingual/Bi-cultural therapists
- More education around mental health and substance use disorders in schools and the community
- For funding for existing programs in order to continue providing services

What are the things that are promoting consumers with resilience and wellness?

- Faith
- Mentors/peers with lived experience
- Basic needs such as rental assistance, housing
- Assistance for consumers leaving the criminal justice system
    - housing assistance
    - documentation after their release in order to find job placement
    - resources/connections for mental health/substance use disorder services
    - assistance with reconnecting with family members/loved ones after release
- HPHP
- Robert Scolds
- Presbyterian Church on East Lake (adopted families) and helped them navigate their new life in the United States
    - Learn English
    - Job search/placement
- Families Together (Marianna Juarez)
- Jesuit from Links Together

If you had a million dollars to fund/enhance services for consumers, families, and other non-profit organizations, what would it look like?

- Use the funding/resources to enhance South County services
- Housing (a lot more)
- Funding equity/resources for South County residents
- Create a resources bridge to support families especially undocumented residents that are part of our most vulnerable population
- Provide funding for Community Action Board (CAB) so they can have a space to offer multi-services in South County since there are some obstacles for consumers to receive funding due to their immigration status.
    - There is a lack of recognition at the Federal level about the reality of this situation.
- Funding for a center for families that are agricultural workers where they can receive wrap-around services especially in South County
- Mobile Emergency Response Team (MERT) more funding needed to expand services
- More cultural awareness training for contract providers in the County
- Cara y Corazon programs need more funding to continue
- Need a place as the bridge/connection where consumers can feel safe and welcome
- Establish a type of program for work funded by the County

Other ideas:

- Educate youth through peer counselors
- Undocumented families
- Oaxacan community
- Law enforcement training in social services (police around homelessness)
- Cultural trainings for social service providers

One word to describe what this experience was like at this meeting:

- Hope
- Unity
- Collaboration
- Grateful
- Informative
- Pleasantly surprised

Attachment 5

ENCOMPASS YOUTH SERVICES

Outpatient Mental Health Counseling

Encompass Youth Services Counseling provides quality mental health support for youth ages 3-20 and families living in Santa Cruz County. Services are designed to address the developmental and social-emotional needs of children and adolescents and are provided in a supportive, safe, and welcoming environment for qualified youth.

Our guiding philosophy emphasizes compassion, respect, and collaboration with the intention of creating conditions that allow youth and families to feel valued and engaged throughout their counseling experience. We promote the health and well-being of youth and families by offering guided opportunities to acquire the skills and resources necessary to build self-esteem, establish healthy relationships, and make positive life choices. Through exploring the strengths and struggles present in the specific life circumstances of each client and family, we are able to develop a therapeutic plan that is responsive to the client's individual needs and potentials.

We strive to provide services that promote healing and wellbeing and are dedicated to the following core values:

- ***Client-Centered –*** Collaborative and respectful of the individual preferences, needs, and values of each client.
- ***Culturally Responsive –*** Respectful, relevant, and responsive to the values, needs, and cultural framework of diverse populations.
- ***Strength-Based –*** Recognizing and building upon client strengths, resources, and resilience.
- ***Trauma-Informed –*** Understanding, recognizing, and responding to the effects of trauma and the need for safety and choice in the client's treatment.

Our team of skilled clinicians and counselors work closely with youth and families to provide a comprehensive initial assessment and assist in developing individualized, client-centered treatment plans. Services provided include individual and family counseling, crisis intervention, case management, and group counseling. The day/time and frequency of sessions and treatment approach is determined in collaboration with clients and parents/caregivers.

Services are provided at our north and south Youth Services locations and are also available in appropriate settings in the community, such as school or home, according to the clients' preference. Extended hours are also available to accommodate families' needs. We have services in both English and Spanish and welcome children and youth of all backgrounds and cultures.

Outcomes

Service Measures		YTD Actual*	YTD Goal	YTD % Of Goal
1.	100% of youth served will be Medi-Cal beneficiaries.	**98.35%**	100%	**98.35%**
2.	300 unduplicated youth and their families will be served.	**231**	175	**132%**
3.	65% of clients will reduce their severity scores on 3 or more CANS items with an original score of 2 or 3.	Of the clients who received services in FY 2019-20 and received at least two assessments between January 1, 2018 and January 31, 2020 – **64% reduced their severity score**.		

*July 2019 – January 2020

Client Satisfaction Survey – Youth Services	SEPTEMBER 2019
Results by Domain	***Strongly Agree or Agree***
Collaboration	98%
Cultural Humility & Responsiveness	100%
Quality of Services	95%

Site Safety and Accessibility	95%
Trauma-Informed Care	100%

**Results exclude clients who responded as "undecided", and includes "strongly agree/agree" or "disagree/strongly disagree"*

TRANSITION AGE YOUTH (TAY) PROGRAM

Program Description

The Transition Age Youth Program provides mental health and support services to current and former foster youth from the age of 15-25. The program provides the full array of mental health rehabilitation and case management services including assessment, individual, collateral, group, case management and crisis services to foster care and juvenile justice youth ages 15-17, and former foster care and juvenile probation youth (aftercare youth) between the ages of 18-20. Crisis intervention services, with 24-hour on-call availability, are also provided for the youth participating in our Transitional Housing Programs supportive housing program. These services include assistance in developing and maintaining educational progress, employment skills, daily living skills, social skills, financial management skills, and, if needed, medication management skills. Also included are individual counseling, assistance in complying with justice system requirements, and obtaining referrals to health, mental health, and chemical dependency resources. For youth who are not coordinated by other programs, TAY staff will serve as coordinators of clinical services. Like all Encompass programs, TAY utilizes a client-centered, trauma-informed approach.

Our guiding philosophy emphasizes compassion, respect, and collaboration with the intention of creating conditions that allow clients to feel empowered to access the on-going services they need to help them transition out of homelessness. We strive to provide services which promote healing and wellbeing and are dedicated to the following core values:

- ***Client-Centered*** – collaborative and respectful of the individual preferences, needs, and values of each client.
- ***Culturally Responsive –*** respectful, relevant, and responsive to the values, needs, and cultural framework of diverse populations.
- ***Strengths-Based –*** recognizing and building upon client strengths, resources, and resilience.
- ***Trauma-Informed –*** understanding, recognizing, and responding to the effects of trauma and the need for safety and choice in the client's own treatment.

TAY provides youth with individual and case management services that utilizing our core values as well as positive youth development. Through these approaches, several interventions are implemented during sessions with youth including teaching mindfulness strategies, providing peer support, and engaging youth in cognitive behavioral activities to help youth increase coping skills while decreasing mental health symptoms that are negatively affecting functioning. We emphasize building social and self-advocacy skills and this supports youth with developing the confidence to engage in their community and advocate for their needs in a pro-social way. These skills further support youth with reconnecting to their natural support system, empowering their voice, and engaging with their community in a pro-social manner. Through every interaction, we are also modeling healthy relationships, so youth receive the support needed to develop positive relational attachments.

Highlight Story

"Sarah", a twenty-year-old mom, has been working with our program since she was 16. Her coordinator has been supporting her to attend Cabrillo College and has struggled with determining her next steps. She has always been interested in criminal justice but has felt conflicted about what she would do with it. Through this program, she was able to connect with California Youth Connects to engage in advocating at the state level for Foster youths' rights and support. She has received support through our housing program as well as opportunities to practice self-advocacy through our Youth Advocacy Project. Sarah has found a new sense of direction as these components have all come together to empower her to discover what she thinks might be her calling.

Outcomes

Service Measures		YTD Actual*	YTD Goal	YTD % Of Goal
1.	TAY staff shall serve approximately 50 clients annually.	**49**	29	**169%**
2.	100% of youth served shall be Medi-Cal beneficiaries.	**98.72%**	100%	**98.72%**
3.	65% of clients shall reduce their severity scores on 3 or more CANS items with an original score of 2 or 3.	Of the clients who received services in FY 2019-20 and received at least two assessments between January 1, 2018 and January 31, 2020 – **61% reduced their severity score**.		

*July 2019 – January 2020

Client Satisfaction Survey – TAY	SEPTEMBER 2019
Results by Domain	***Strongly Agree or Agree***
Collaboration	100%
Cultural Humility & Responsiveness	100%
Quality of Services	97%
Site Safety and Accessibility	89%
Trauma-Informed Care	100%

**Results exclude clients who responded as "undecided", and includes "strongly agree/agree" or "disagree/strongly disagree"*

Attachment 6

SANTA CRUZ COUNTY OFFICE OF EDUCATION

MHSA (Mental Health Services Act)
PEI (Prevention and Early Intervention)
The Diversity Center
Santa Cruz County

With funding from MHSA PEI, The Santa Cruz County Office of Education is able to assist with funding for The Diversity Center to reach several thousand students by creating safer schools through building and supporting Gender/Sexuality Alliances (GSAs) and supporting their advisors, bringing Triangle Speaker presentations into schools to help promote a welcoming and accepting school climate, working with K-12 counselors on LGBTQ+ issues, identifying best practices and successful curriculum on anti-bullying programs as it relates to LGBTQ+ students and meeting the needs of individual students, staff and parents in schools who call for our help. All these activities support the health and well-being of LGBTQ+ youth who have disproportionate rates of suicide, truancy, sexual risk-taking, and experiencing bullying, family rejection, and homelessness among other challenges.

Gay Straight Alliance (GSA) Support:

- PEI funds help fund the Queer Youth Program Coordinator's time working with school-based Gay-Straight Alliance (GSA) groups, supporting a minimum of 9 high schools and at 3 middle schools across the county.

Triangle Speakers Activities:

- PEI funds help fund the Triangle Speakers Coordinator's time reaching out to teachers and school administrators, building relationships and creating opportunities for Triangle Speakers panels to conduct several dozen panels in Santa Cruz County schools reaching more than 1,000 students.

www.diversitycenter.org

Safe Schools Project Activities:

- PEI funds help fund Identifying best practices and successful curriculum on anti-bullying programs as it relates to LGBTQ+* students and safe schools to be implemented in Santa Cruz County, working with K-12 school counselors in the county on LGBTIQ issues, meeting the needs of individual students, staff and parents in SCC schools who call for our help, improving, expanding and maintaining the SSP website as a user-friendly resource for K-12 students, staff and parents on LGBTIQ issues, supporting Safe School Liaisons in school districts, working with Trans students, school staff and parents on trans issues and the implementation of AB1266, working to implement SB71, sex-ed for LGBT students and working to implement the FAIR ACT.

For more information, contact: Michael Paynter, Ed.D., LMFT
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mpaynter@santacruzcoe.org
(831) 466-5729

Attachment 7

SANTA CRUZ COUNTY OFFICE OF EDUCATION

MHSA (Mental Health Services Act)
PEI (Prevention and Early Intervention)
Live Oak Community Resources
Community Bridges

With funding from MHSA PEI, The Santa Cruz County Office of Education is able to assist with funding for the Live Oak Community Resources Strengthening Families Project, serving more than 200 families, caregivers and youth annually.

The Five Protective Factors for Strengthening Families (Center for the Study of Social Policy) are addressed to Live Oak Families 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/Child Playgroups, and Parent Education classes, parents are able to socialize, build, and connect with others in the community.*

***3) Concrete Support in Times of Need**—Provided through case management, Family Advocates connect families with monthly food distribution, enrollment in government benefits such as Medi-Cal and CalFresh, seasonal assistance including back-to-school supplies and holiday gifts. They also encourage participation in parental support programs, and refer out to other agencies.*

Live Oak COMMUNITY RESOURCES
COMMUNITY BRIDGES PUENTES DE LA COMUNIDAD

www.communitybridges.org/locr/

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

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

For more information, contact: Michael Paynter, Ed.D., LMFT
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(831) 466-5729

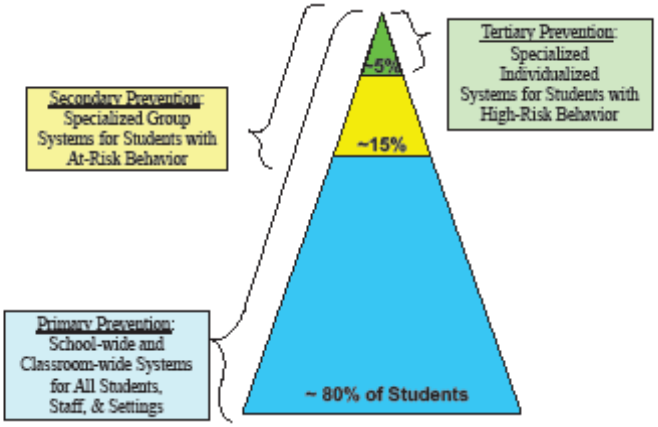
Attachment 8

SANTA CRUZ COUNTY OFFICE OF EDUCATION

MHSA (Mental Health Services Act)
PEI (Prevention and Early Intervention)
PBIS (Positive Behavioral Interventions and Supports)

PBIS is a nationally recognized model for establishing a positive school climate helps schools focus existing resources in a school-wide prevention model as well as designing site-relevant interventions for children showing signs of distress.

Successfully implemented, PBIS establishes clear expectations, emphasizes recognition for positive behavior and creates a school culture that is stable and consistent across campus areas and even grade levels. These elements are of value for all students, but critical for students experiencing mental illness. The implementation is divided into 3 tiers, often referred to as serving, "all", "some" and "few". Ideally, support is offered and helpful at the lowest intensity, most upstream moment, thereby preventing further escalation in need.



https://www.pbis.org/school

With funding from MHSA PEI, The COE is able to assist with funding in the 6 largest school districts, collectively serving 626 staff, representing 47 schools in Santa Cruz County. These in turn impact more than 27,000 students.

For more information, contact: Michael Paynter, Ed.D., LMFT
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mpaynter@santacruzcoe.org
(831) 466-5729

Attachment 9

Pajaro Valley Prevention and Student Assistance

PVPSA is a school-based community agency offering culturally relevant services to students and families of the Pajaro Valley Unified School District. We also partner with other key organizations in our region to ensure the health and safety of our youth and families.

Community Gate

During the Quarter 2 reporting period we were able to increase our evidence-based preventative mental health services for our Medi-Cal eligible children and families by extending service hours and increasing staff. We provide parenting classes to support families and increase awareness of PVPSA services.

System Development (SD)	Quarter 1	Quarter 2
Number of individuals/families targeted:		
Number Actually Served	72	106
Age Group		
• Children 0-15	65	91
• TAY 16-25	7	15
• Adults 26-59		
• Older Adults 60+		
Race/Ethnicity		
• White		3
• Latino	65	96
• Other	7	7
Primary Language		
• English	60	86
• Spanish	9	19
• Other	3	1
Culture		
• Veterans		
• LGBTQ		

Probation Gate

During the Quarter 2 reporting period we experienced an increase in at risk youth and families served due to referrals received from our community partners. The flexibility of our staff to meet the needs of our clients with flexible appointment times supports parents with scheduling challenges and safety needs.

System Development (SD)	Quarter 1	Quarter 2
Number of individuals/families targeted.		
Number Actually Served	42	44
Age Group		
• Children 0-15	33	35
• TAY 16-25	9	8
• Adults 26-59		
• Older Adults 60+		
Race/Ethnicity		
• White	1	
• Latino	38	42
• Other	3	2
Primary Language		
• English	37	39
• Spanish	4	5
• Other	1	
Culture		
• Veterans		
• LGBTQ		

We provide additional service awareness through programs such as Tobacco Use Prevention Education (TUPE) and our Alcohol and other Drugs Prevention and treatment services (ADP) . PVPSA invited community partners to share in the grand opening of our new, larger facility at 411 E. Lake Avenue.

Goals: Increasing community awareness through various mediums: marketing, increase presentation to parent groups at various school sites and community events, such as with the City of Watsonville Park and Recreation. Strengthen our referral process and our partnership with Salud Para La Gente.

Attachment 10

MHSA Program Handout (February 2020)

Program Name: Positive Parenting Program (Triple P) **Agency:** First 5 Santa Cruz County

First 5 Santa Cruz County implements Triple P (Positive Parenting Program) throughout the county as an Early Intervention program under the Mental Health Services Act. A robust body of research has led Triple P to be designated as an evidence-based parenting and family support program that can improve the emotional and behavioral health of both children and parents/caregivers. One of the main strengths of the Triple P program is its ability to reach families before more intensive behavioral health services are needed. Increasing parents' confidence and capacity to provide safe, stable, nurturing caregiving is a critical component of promoting and restoring children's behavioral and emotional health.

First 5 Santa Cruz County is implementing all five levels of Triple P interventions (from brief to in-depth services). Individual and group services are offered to families with children birth-16 years old, including children with special needs, in a wide variety of settings such as health clinics, schools, family resource centers, counseling centers, correctional facilities, and other government- or community-based agencies. This means that Triple P practitioners often work with families where the parents or children are currently receiving (or need assistance accessing) medical care 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.

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.

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. Although Triple P assessments are not diagnostic tools, they are validated measurements of parental knowledge and behavioral and emotional change. The results of two assessments currently being used for in-depth services—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 behavioral strengths and challenges. Assessment results that indicate areas of concern are discussed with parents, and parents are connected to concurrent child or adult mental health services as needed.

In FY 2018-19, 276 parents/caregivers (approximately 224 families) received in-depth services (8+ group classes or 10+ individual sessions). Positive outcomes included:

- **Improvements in child behavior.** Overall, the majority of parents reported improvements in their children's challenging behaviors (78%) and emotional difficulties (62%) after completing the Triple P program. Of the parents who began the program reporting more serious parenting issues, 100% reported improvements in their children's challenging behaviors (N=11), and 89% reported improvements in their children's emotional difficulties (N=9).[1]
- **Increased use of positive parenting styles.** Overall, 65% of parents reported they were less coercive, 65% reported their parenting was more consistent, and 52% reported they used more positive encouragement after completing intensive Triple P services.
- **Increased levels of parents' emotional well-being.** On average, the majority of parents reported higher levels of confidence (73%) and emotional well-being (61%) after completing in-depth Triple P services. Of the parents who began the program reporting more serious parenting issues (N=9), 100% reported improvements in their confidence.[1]

- These local results suggest that Triple P is effective for a broad population of parents, particularly those who report experiencing more serious parenting challenges at the onset of the program.

[1] Results for parents with more serious parenting issues should be interpreted with caution due to low sample sizes in this first year of implementing these two new assessments.

Attachment 11-

TRAUMA TRANSFORMED - TRAUMA INFORMED SYSTEMS INITIATIVE

Santa Cruz County Trauma-Informed Systems (TIS) Collaboration

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

Activities included: FY 2018/2019:

- 15 TIS 101 trainings for 406 participants
- Maintained Santa Cruz embedded and certified TIS Trainers with 5 trainer learning communities to coach and improve ability of trainers to disseminate knowledge and practice change. We certified 11 trainers this year.
- Building capacity for organizational leaders and champions to apply learning and TIS principles to practices and policies by facilitating 9 learning sessions with champions across 8 agencies, 5 leadership learning communities with leaders across 8 agencies, and one joint champions / leadership meeting

So far in FY 2019/2020:

- 5 TIS 101 trainings for approximately 180 participants
- Trained 13 Santa Cruz embedded and certified TIS Trainers on updated TIS 101 curriculum and held 2 additional trainer learning community meetings.
- Assisted in the development of a Behavioral Health TIS Steering Committee, and are facilitating monthly meetings
- Facilitated 2 Leadership Learning Communities
- Facilitated 2 Trauma-Informed Parenting Workshops in Spanish
- Facilitated a Community Trauma Healing Circle

Feedback from community:

On Leadership Learning Community: "I really appreciated this group and the wealth of wisdom and experience shared. The networking opportunity was great as well. I learned a lot and I really hope the County continues to invest resources in Trauma Informed Systems. The group facilitators were great, very knowledgeable on the subject and they really modeled the work throughout the process."

TIS 101 Trainings: What did you like best about the training?

- It was a positive low stress experience with tools I can bring back to my classroom
- Learning more about triggers and how to handle stressful situations
- Being reminded that treating myself well is not selfish

Learning about transforming our organization

Attachment 12

Front St. Inc.

Front St. Inc. is a behavioral health organization that provides residential and community housing with treatment services for over 300 individuals in Santa Cruz County and Monterey County. Front St. provides most of the County of Santa Cruz's permanent housing for individuals with serious mental health diagnoses. The agency operates a variety of residential mental health programs in addition to providing supported housing services to individuals living independently. Our treatment philosophy focuses on strengths, resiliency and inherent worth enabling consumers to develop independent living skills.

Front St. Inc.'s mission is to provide residential services and person-centered mental health treatment that promote recovery and wellness is focused by our Guiding Principles: Person-Centered Practices, Wellness, Relational Integrity, Diversity, Innovation and Fiscal Responsibility.

In 2019, Front St. Inc MHSA-funded residential programs helped clients manage their mental health symptoms through person-centered services resulting in a low acute hospitalization rate of 5% (31 incidences). The Supported Housing program had an acute hospitalization rate of 6% (7 incidences).

By helping individuals succeed in their current placement, Front St. Inc. helps minimize the cost of higher-level placements and provide a stable housing environment for individuals to meet their goals.

Front St. Inc. Programs

Front St. Residential Care **Location: Downtown Santa Cruz**
Front St. Residential Care is a 47-bed adult residential care facility (ARF). Front St. Residential Care is in an ideal location near downtown Santa Cruz between the beach and the Pacific Garden Mall.

Willowbrook Residential Center **Location: Set in the redwoods in Ben Lomond**
Located in the Santa Cruz hills of Ben Lomond, Front St. operates two separate residential facilities. WRC-1 is a 34-bed Adult Residential Program serving adults from 18 through 59 years of age. WRC-2 is a six-bed Residential Care Facility for the Elderly with six residents.

Wheelock Residential Care **Location: Watsonville**
Wheelock Residential Care provides sixteen adults with residential and mental health services. Located in the beautiful hills of Watsonville, residents enjoy a country setting with easy access to buses and local shopping.

Opal Cliff Residential Center **Location: Santa Cruz (near Capitola Village)**
Opal Cliff Residential Center, serving 15 adults, is beautifully perched over the ocean cliffs of Capitola beach.

Supported Housing Program **Location: Scattered-Site Independing Living**
Front St. provides housing for up to 60 individuals in the Supported Housing Program. Our Supported Housing case management team provides mental health services to around 120 individuals living independently, including the 60 individuals in Front St. housing. These services including Occupational Therapy, medication support provided by nurses, and case management services. Our Housing Management staff assist with securing new units and assisting tenants maintain their independent housing.

Attachment 13

MHCAN
Mental Health Client Action Network

Prioritizes Services to People with Serious Mental Health Diagnoses

- A Safe Space for Connection, Support, Challenges and Community
- The Only Peer Run Mental Health Organization in Santa Cruz County
- Support Groups for Anxiety, Depression, PTSD, Eating and Body Image Issues, Schizophrenia and Bipolar Disorder
- Recovery Meetings- Alcoholics Anonymous, SMART Recovery, DRA, AnyA, Recovery Dharma, NA, Sex Abuse Survivors
- Groups- Chess, Karate, Art, Scrabble, Dungeons & Dragons, Music, Watercoloring, Gaming, Puzzles, etc
- Employment Opportunities and Workforce Education Training
- A Mental Health Speaker's Bureau, The Shadow Speakers
- Food Box Deliveries to Vulnerable Members of Our Community
- Coffee, Daily Breakfast and Lunch When Drop In Center is Open
- Hygiene Assistance for Our 40% of Members who are Unhoused
- Hygiene Supplies- Shampoo, Conditioner, Razors, Soap, Feminine Products, Adult Diapers
- Laundry Capabilities for Hygiene Assistance Individuals
- Transport to MD Appointments, Social Occasions and Field Trips
- A Computer Room and Phone, Fax Usage
- A Gate and Referrals for County Mental Health Services
- Provide 1/1 and Group Peer Support As Needed Daily

In 2018-2019 MHCAN…

- Referred 122 people to the county Access team
- Served 934 Unduplicated Individuals through our Drop In Center
- With the help of a state grant, provided 3 drivers and over 11,032 rides
- Supported the Transition Age Youth group
- Employed 32 Regular Workers and over 97 Stipend Workers
- Provided Between 36-57 Weekly Groups, Events and Classes

Attachment 14-

Veterans Advocate
Prevention and Early Intervention

Travis Deyoung

The annual program evaluation report for the Veterans Advocate consists of an evaluation of the number of individuals served, demographics of that population, and assessment of the risk of serious mental illness. The Veterans Advocate evaluates the risk of serious mental health illness based on several factors including homelessness, incarceration, identification of traumatic events during military services, previous mental health diagnosis, and substance use disorder.

Through one-on-one interviews with veterans the Veterans Advocate assess potential risks and identifies benefits, resources, and support. The Veterans Advocate assists veterans and their families to access resources available through the Veterans Affairs, State programs, County programs, and other local resources. The identification of veteran needs and connection to applicable resources results in the reduction of homelessness, incarceration, financial instability, and prolonged suffering.

Data is collected in real time using an excel spreadsheet and the online tool: VetPro. The Veterans Advocate measures reduction in homelessness by tracking referrals to housing programs and the result. Reduction to incarceration is measured by the number of veterans that successfully complete veteran's treatment court. Reduction to financial instability is measured by claims awarded by the Veterans Affairs. Increase to availability of medical treatment is measured by enrollment in the VA health care system. Reduction in mental illness is measured by referrals made to VA counseling, substance abuse groups, and County mental health.

Through extensive coordination and collaboration with community partners the Veterans Advocate is able to increase access to needed medical and mental health services, housing, employment, and community support for the veteran population in Santa Cruz County. The Veteran Advocate serves as a connection point and support for navigating the various resources that are available to veterans in our community.

Veteran Advocate
Quantitative Data Fiscal Year 2018-2019

Total Veterans Served: 250
Those at Risk for Serious Mental Illness: 134 (53%)
Referrals made for Mental Health treatment (VA or County): 51 (20%)
Housing referrals made for unstably housed/homeless veterans: 45 (18%)
--Of Veterans referred, those now known to be housed: 12
Healthcare enrollments: 28 (11%)
New Admins into Veterans court: 22
Graduated: 16
VA Disability and Pension claims filed: 62

Attachment 15

ENOMPASS ADULT PROGRAMS
CASA PACIFIC

Program Description

Casa Pacific is a 12-bed residential program located in Watsonville, the treatment focus of Casa Pacific is helping individuals struggling with mental illness and substance use disorders to build resilience, develop coping skills, and to successfully graduate to independent living. Casa Pacific is part of an innovative project centered on supporting client work goals and participation in meaningful daily activities, as the core of a co-occurring disorders treatment approach. Our program works to assist residents in maintaining sobriety, reaching their personal goals, and transitioning to independent community living. Services are provided in a supportive, safe, and welcoming environment.

Our guiding philosophy emphasizes compassion, respect, and collaboration with the intention of creating conditions that allow clients to remain engaged throughout their counseling experience.
We strive to provide services which promote healing and wellbeing and are dedicated to the following core values:

- ***Client-Centered*** – collaborative and respectful of the individual preferences, needs, and values of each client.
- ***Culturally Responsive –*** respectful, relevant, and responsive to the values, needs, and cultural framework of diverse populations.
- ***Strengths-Based –*** recognizing and building upon client strengths, resources, and resilience.
- ***Trauma-Informed –*** understanding, recognizing, and responding to the effects of trauma and the need for safety and choice in the client's own treatment.

Our team of skilled clinicians and counselors works closely with clients in providing a comprehensive initial assessment and assistance in developing individualized client-centered treatment plans. Our approach is based in building resiliency and reducing harm. We help clients identify and address internal and external stressors, establish healthy and supportive relationships, and develop more effective coping strategies. The program provides a healing environment where residents receive the treatment, support and caring they need to stabilize and move out of their crisis state. Our counselors utilize evidence-based treatment approaches including Mindfulness based practices, Motivational Interviewing, Seeking Safety, and Wellness Recovery Action Plan (WRAP).

Client services include daily groups that facilitate stabilization, build coping skills, and prepare clients for the next step in their mental health recovery. Additionally, each client has a counselor assigned who will collaborate on goals and treatment. Through our model of client-centered care, we individualize case management and resource linkages to support each client with preparing for independent living and engaging in continued supportive services upon completion of the program.

Outcomes

Casa Pacific	July 2019 – January 2020
All Clients Served (Duplicated)	**45**
Unduplicated Clients Served	**42**
Average Length of Stay (Days)	**66**
Bed Utilization Rate	**91.43%**

	Service Measures	YTD Actual*	YTD Goal	YTD % Of Goal
1.	No more than 12% of clients will be hospitalized during the year.	**6%**	≤ 12%	**Goal met**
2.	50% of residents will have stayed 45 or more days at time of discharge.	**68%**	50%	**136%**
3.	60% of residents who received a planned discharge will report improvement on the Recovery Assessment Scale – Domains and Stages.	**100%**	60%	**Goal met**
4.	60% of residents who receive a planned discharge will be referred to an appropriate level of care.	**62%**	60%	**103%**

*July 2019 – January 2020

Client Satisfaction Survey – Casa Pacific	SEPTEMBER 2019
Results by Domain	***Strongly Agree or Agree***
Collaboration	87%
Cultural Humility & Responsiveness	93%
Quality of Services	93%
Site Safety and Accessibility	87%
Trauma-Informed Care	88%

**Results exclude clients who responded as "undecided", and includes "strongly agree/agree" or "disagree/strongly disagree"*

DOWNTOWN OUTREACH WORKER (DOW)

Program Description

The Downtown Outreach program (DOW) assists people located in the downtown corridor experiencing homelessness access services and support toward health and wellness. The DOW team provides street outreach and prevention services to individuals with psychiatric disabilities who have had contact with law enforcement and/or are at risk of becoming involved in the criminal justice system. DOW serves as a diversion program for our community's most vulnerable population and outreach services are centralized in the downtown area. Like all Encompass programs, DOW utilizes a client-centered, trauma-informed approach.

Our guiding philosophy emphasizes compassion, respect, and collaboration with the intention of creating conditions that allow clients to feel empowered to access the on-going services they need to help them transition out of homelessness. We strive to provide services which promote healing and wellbeing and are dedicated to the following core values:

- ***Client-Centered*** – collaborative and respectful of the individual preferences, needs, and values of each client.
- ***Culturally Responsive –*** respectful, relevant, and responsive to the values, needs, and cultural framework of diverse populations.
- ***Strengths-Based –*** recognizing and building upon client strengths, resources, and resilience.
- ***Trauma-Informed –*** understanding, recognizing, and responding to the effects of trauma and the need for safety and choice in the client's own treatment.

DOW services include homeless outreach, linkage to ongoing services, street intervention, crisis services, and targeted case management. DOW workers address basic needs such as food, clothing, shelter and safety. In addition, DOW provides linkages with other community resources addressing long-term needs such as primary healthcare, mental health treatment, substance use disorder treatment, and access to permanent housing. Targeted case management is available to ten highly vulnerable individuals per month, with the goal of accessing long term services and supports, including housing. As illustrated by our outcomes, the DOW program has a significant impact in supporting individuals experiencing homelessness in the downtown Santa Cruz region.

Highlight Story

"Bill", a chronically homeless veteran, was a frequent visitor of downtown Santa Cruz. The downtown outreach worker team was able to engage with Bill and connect him to Supportive Services for Veteran Families. Through this program, they were able to support Bill with securing an apartment and provided initial funding for this apartment. When the initial funding ended, Bill was unable to afford his apartment at market rates and was again facing homelessness. Through the Downtown Outreach Worker program, Bill was connected to a specialized housing voucher allowing him to pay an affordable monthly housing rate and retain his apartment. Bill, who had experienced chronic homelessness for 40 years has now been stably housed for two years.

Outcomes

DOW	July – December 2019
Individuals Contacted per Month (Duplicated)	**105**
Individuals Contacted per Month (Unduplicated)	**63**

	Service Measures	YTD Actual*	YTD Goal	YTD % Of Goal
1.	Will outreach a minimum of 60 unduplicated individuals per month.	**63**	60	**105%**
2.	Will provide a minimum of 1,200 service referrals annually.	**1,382**	1,200	**115%**
3.	Will link 75% of individuals with housing/shelter resources annually.	**40%**	75%	**53%**
4.	Will provide targeted case management to ten clients, including HOPES participants, per month.	**9.33**	10	**93%**
4a.	50% of the case managed individuals will be linked with housing/shelter resources.	**87%**	50%	**174%**
4b.	50% of the case managed individuals will have applied for benefits.**	**100%**	50%	**200%**
4c.	50% of the case managed individuals will have accessed medical and/or behavioral health resources.	**80%**	50%	**160%**

*July 2019 – January 2020

**The majority of case managed clients are connected to benefits before they begin receiving case management.

Referral Type	# Referrals	% of individuals referred to service	# Service Obtained	% Obtained
Housing/Shelter	255	40%	99	39%
Transportation	188	30%	165	88%
Food/Meals	160	25%	140	88%
Substance Use Disorder Treatment	119	19%	7	6%
Medical Care (HSA Clinic, Safety Net Clinic, PCP, ER, Hospice)	118	19%	96	81%
Medical Benefits (MediCal, MediCruz, MediCruz Adv, Medicare)	116	18%	88	76%
Crisis Intervention	114	18%	111	97%
Mental Health Treatment	105	17%	48	46%
Homeward Bound	90	14%	39	43%
Disability Benefits	79	13%	2	3%
Veteran's Services	9	1%	2	22%
Employment	8	1%	2	25%
Criminal Justice System	7	1%	5	71%
5150 Hold	6	1%	6	100%
Education	4	1%	1	25%
TAY	4	1%	1	25%

EL DORADO CENTER

Program Description

El Dorado Center (EDC) is a 16-bed, licensed and certified short-term treatment program for individuals stepping down from locked psychiatric care, jail, homelessness, or for individuals in the community who need support to avoid psychiatric hospitalization. EDC provides a client-centered therapeutic atmosphere that includes individual and group counseling, crisis intervention, medication support, and support with independent living skills to facilitate individuals returning to the community. Using a strength-based perspective, counselors work to encourage clients to give a voice to their experience to increase their self- care, coping skills, autonomy, independence, and community involvement. Services are provided in a supportive, safe, and welcoming environment.

Our guiding philosophy emphasizes compassion, respect, and collaboration with the intention of creating conditions that allow clients to remain engaged throughout their counseling experience. We strive to provide services which promote healing and wellbeing and are dedicated to the following core values:

- ***Client-Centered*** – collaborative and respectful of the individual preferences, needs, and values of each client.
- ***Culturally Responsive –*** respectful, relevant, and responsive to the values, needs, and cultural framework of diverse populations.
- ***Strengths-Based –*** recognizing and building upon client strengths, resources, and resilience.
- ***Trauma-Informed –*** understanding, recognizing, and responding to the effects of trauma and the need for safety and choice in the client's own treatment.

Our team of skilled clinicians and counselors works closely with clients in providing a comprehensive initial assessment and assistance in developing individualized client-centered treatment plans. Our approach is based in building resiliency and reducing harm. We help clients identify and address internal and external stressors, establish healthy and supportive relationships, and develop more effective coping strategies. The program provides a healing environment where clients receive the treatment, support and caring they need to stabilize and move out of their crisis state. Our counselors utilize evidence-based treatment approaches including Mindfulness based practices, Motivational Interviewing, Seeking Safety, and Wellness Recovery Action Plan (WRAP).

Services at El Dorado Center include an in-house County psychiatrist and a nurse who are available for medication monitoring and management as well as nursing screenings and care. In addition there are daily groups to facilitate stabilization, build coping skills, and prepare clients for the next step in their mental health recovery. Each client has a counselor assigned who will collaborate on goals and treatment. In addition, a fulltime cook provides healthy and delicious meals. Our staff assists clients in scheduling appointments and transportation as needed throughout the client's stay. As clients prepare to exit the El Dorado Center program, staff work closely with other agencies to provide uninterrupted care, and support clients with accessing continued services. The ultimate goal is to create a seamless transition as clients stabilize and prepare to move to a lower level of care or back into their community.

Outcomes

El Dorado Center	July 2019 – January 2020
All Clients Served (Duplicated)	**113**
Unduplicated Clients Served	**96**
Average Length of Stay (Days)	**29**
Bed Utilization Rate	**84.74%**

	Service Measures	YTD Actual*	YTD Goal	YTD % Of Goal
1.	Fewer than 15% of residents will discharge to a higher level of care.	**14%**	< 15%	**Goal met**
2.	25% of residents who have an identified co-occurring disorder and receive a planned discharge will be linked to the appropriate substance use disorder treatment level of care.	**100%**	25%	**Goal met**

3.	60% of residents who receive a planned discharge will report improvement on the *Looking Forward* and *Mastering My Illness* domains of the Recovery Assessment scale.	**N/A**	60%	**N/A**

*July 2019 – December 2019

Client Satisfaction Survey – El Dorado Center	**SEPTEMBER 2019**
Results by Domain	***Strongly Agree or Agree***
Collaboration	94%
Cultural Humility & Responsiveness	100%
Quality of Services	81%
Site Safety and Accessibility	93%
Trauma-Informed Care	94%

**Results exclude clients who responded as "undecided", and includes "strongly agree/agree" or "disagree/strongly disagree."*

RIVER STREET SHELTER

Program Description

River Street Shelter is a 32-bed shelter that provides specialized services to individuals experiencing homelessness who are struggling with mental health, substance use, and other co-morbidities that contribute to chronic homelessness. Services are provided in a supportive, safe, and welcoming environment for all qualified clients irrespective of race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, and sexual orientation.

Our guiding philosophy emphasizes compassion, respect, and collaboration with the intention of creating conditions that allow clients to remain engaged throughout their counseling experience.
We strive to provide services which promote healing and wellbeing and are dedicated to the following core values:

- ***Client-Centered*** – collaborative and respectful of the individual preferences, needs, and values of each client.
- ***Culturally Responsive –*** respectful, relevant, and responsive to the values, needs, and cultural framework of diverse populations.
- ***Strengths-Based –*** recognizing and building upon client strengths, resources, and resilience.
- ***Trauma-Informed –*** understanding, recognizing, and responding to the effects of trauma and the need for safety and choice in the client's own treatment.

Our team of skilled clinicians and counselors works closely with clients in providing a comprehensive initial assessment and assistance in developing individualized client-centered treatment plans. Our approach is based in building resiliency and reducing harm. We help clients identify and address internal and external stressors, establish healthy and supportive relationships, and develop more effective coping strategies. The program provides a healing environment where residents receive the treatment, support and caring they need to stabilize and transition out of homelessness. Our counselors utilize evidence-based treatment approaches including Mindfulness based practices, Motivational Interviewing, Seeking Safety, and Cognitive Behavioral Therapy.

The services at River Street Shelter emphasize supporting residents with improving quality of life and re-engaging in the community as they transition out of homelessness and into independent housing. Residents stay at the shelter for three to six months, and during that time program staff assist them with obtaining permanent housing, a particular challenge in our region. In addition to housing, we support residents with achieving their sobriety goals, obtaining employment, completing education goals, and improving physical and behavioral health. Progress toward these goals is supported through individual counseling and daily groups that connect residents with one another, facilitate stabilization, build coping skills, and prepare clients for the next step in their mental health recovery. Through our model of client-centered care, we individualize case management

support to each client and provide linkages to housing, employment, primary healthcare, mental health support and socialization activities. Additionally, residents have access to two healthy meals per day, laundry facilities, medication assistance, and on-site nursing support.

Outcomes

River Street Shelter (All Contracts)	July 2019 – January 2020
All Clients Served (Duplicated)	**175**
Unduplicated Clients Served	**147**
Average Length of Stay (Days)	**40**

	Service Measures	YTD Actual*	YTD Goal	YTD % Of Goal
1.	70% of total intakes will be provided to people living with mental illness.	**62%**	70%	**88%**
2.	50% of long-term (30 days or more) County-contracted placements will be discharged to appropriate transitional housing, residential treatment options, or appropriate community placement.	**70%**	50%	**140%**
3.	90% of County-contracted clients will receive a Smart Path assessment.	**28%**	90%	**31%**

*July 2019 – January 2020

Client Satisfaction Survey – River Street Shelter	SEPTEMBER 2019
Results by Domain	***Strongly Agree or Agree***
Collaboration	86%
Cultural Humility & Responsiveness	92%
Quality of Services	100%
Site Safety and Accessibility	100%
Trauma-Informed Care	100%

**Results exclude clients who responded as "undecided", and includes "strongly agree/agree" or "disagree/strongly disagree"*

TELOS

Program Description

Telos is a short-term subacute mental health facility that provides quality mental health services for adults ages 18 and older living in Santa Cruz County. Telos serves as a diversion to psychiatric hospitalization for individuals in crisis. The average stay for clients is 10 days and all referrals are made through Santa Cruz County Mental Health Services. Services are provided in a supportive, safe, and welcoming environment.

Our guiding philosophy emphasizes compassion, respect, and collaboration with the intention of creating conditions that allow clients to remain engaged throughout their counseling experience. We strive to provide services which promote healing and wellbeing and are dedicated to the following core values:

- ***Client-Centered*** – collaborative and respectful of the individual preferences, needs, and values of each client.
- ***Culturally Responsive –*** respectful, relevant, and responsive to the values, needs, and cultural framework of diverse populations.
- ***Strengths-Based –*** recognizing and building upon client strengths, resources, and resilience.
- ***Trauma-Informed –*** understanding, recognizing, and responding to the effects of trauma and the need for safety and choice in the client's own treatment.

Our team of skilled clinicians and counselors works closely with clients in providing a comprehensive initial assessment and assistance in developing individualized client-centered treatment plans. Our approach is based in building resiliency and reducing harm. We help clients identify and address internal and external stressors, establish healthy and supportive relationships, and develop more effective coping strategies. The program provides a healing environment where residents receive the treatment, support and caring they need to stabilize and move out of their crisis state. Our counselors utilize evidence-based treatment approaches including Mindfulness based practices, Motivational Interviewing, Seeking Safety, and Wellness Recovery Action Plan (WRAP).

Services at Telos include an in-house County psychiatrist and a nurse who are available for medication monitoring and management as well as nursing screenings and care. In addition there are daily groups to facilitate stabilization, build coping skills, and prepare clients for the next step in their mental health recovery. Each client has a counselor assigned who will collaborate on goals and treatment. In addition, a fulltime cook provides healthy and delicious meals. Our staff assists clients in scheduling appointments and transportation as needed throughout the clients stay. Through our model of client-centered care, staff assist clients in creating individualized discharge plans that identify lower level of care options that will support clients with achieving further stability prior to returning to independent living. As clients prepare to exit the Telos program, staff work closely with other agencies to provide uninterrupted care to ensure clients remain engaged in supportive services as they take the next step in their recovery journey.

Outcomes

Telos	July 2019 – January 2020
All Clients Served (Duplicated)	**127**
Unduplicated Clients Served	**114**
Average Length of Stay (Days)	**14**
Bed Utilization Rate	**80.56%**

	Service Measures	YTD Actual*	YTD Goal	YTD % Of Goal
1.	Fewer than 15% of residents will discharge to a higher level of care.	**12%**	< 15%	**Goal met**
2.	The average length of stay will be 15 days (of all discharges in the reporting period).	**14.4**	15	**96%**
3.	25% of residents who have an identified co-occurring disorder and receive a planned discharge will be linked to the appropriate substance use disorder treatment level of care.	**73%**	25%	**Goal met**
4.	60% of residents who receive a planned discharge will report improvement on the *Mastering My Illness* domain of the Recovery Assessment Scale.	**N/A**	60%	**N/A**

*July 2019 – December 2019

Client Satisfaction Survey – Telos	SEPTEMBER 2019
Results by Domain	***Strongly Agree or Agree***
Collaboration	91%
Cultural Humility & Responsiveness	91%
Quality of Services	91%
Site Safety and Accessibility	91%
Trauma-Informed Care	91%

**Results exclude clients who responded as "undecided", and includes "strongly agree/agree" or "disagree/strongly disagree"*

SECOND STORY – RESPITE HOUSE

Program Description

Second Story is a six-bed, peer respite house which serves as a voluntary program for consumers of Santa Cruz County's specialty mental health service system. The primary purpose of Second Story is to provide an alternative to sub-acute psychiatric care and ultimately divert individuals who historically, without this type of early support, would need to utilize acute inpatient hospital and/or sub-acute programs.

The heart of the Second Story program is the peer run model of care. Second Story staff are all "peers" or people with lived experience who have learned to be with some discomfort and can provide guests with the support needed to experience what change feels like and learn new responses through relationships with each other. Utilizing Intentional Peer Support (IPC) staff support guests to establish peer connections and learn to use relationships to move out of old roles and patterns.

Our guiding philosophy emphasizes compassion, respect, and collaboration with the intention of creating conditions that allow guests to work toward their own recovery goals. We strive to provide services which promote healing and wellbeing and are dedicated to the following core values:

- ***Client-Centered*** – collaborative and respectful of the individual preferences, needs, and values of each client.
- ***Culturally Responsive –*** respectful, relevant, and responsive to the values, needs, and cultural framework of diverse populations.
- ***Strengths-Based –*** recognizing and building upon client strengths, resources, and resilience.
- ***Trauma-Informed –*** understanding, recognizing, and responding to the effects of trauma and the need for safety and choice in the client's own treatment.

Second Story services include daily peer counseling, case management, and an optional peer group. During their stay, Second Story guests develop a collaborative and individualized plan for managing feelings and behaviors that, in the past, have led to inpatient stays. The first contact with staff is the beginning of using different views, working together to figure out what might be different. Each guest's plan is updated and used as a guide to get good results from the time together at Second Story.

With the expectation that everyone is capable and inherently knows what they need, both staff and guests create a space for those qualities to surface. Along with creating a home, staff and guests share stories to connect and understand each other's experiences, gently challenging themselves to listen to the untold story. The hope is not to rebuild a culture of illness, but instead generate some sparkling moments of connection and trust; lessons which will spill over into the future.

Outcomes

Second Story – Respite House	July 2019 – January 2020
All Clients Served (Duplicated)	**89**
Unduplicated Clients Served	**50**
Average Length of Stay (Days)	**13.13**
Bed Utilization	**85.35%**

2nd Story - Respite House	July 2019 – January 2020			
Diversion Data	**Intakes**		**Discharges**	
Higher Level of Care (Telecare - CSP, Telecare - PHF, other Behavioral Health Facility)	0	*0%*	**1**	*1%*
Home, Board & Care, Other Permanent Living Situation	**55**	*65%*	**54**	*65%*
Place Not Meant for Habitation	**3**	*4%*	**2**	*2%*

Recovery Program (incl. Residential Treatment)	**6**	*7%*	**2**	*2%*
Shelter or Transitional Housing for the Homeless	**16**	*19%*	**15**	*18%*
Temporary Living Situation	**5**	*6%*	**5**	*6%*
Unknown	0	*0%*	**4**	*5%*

Client Satisfaction Survey – 2nd Story	**SEPTEMBER 2019**
Results by Domain	***Strongly Agree or Agree***
Collaboration	100%
Cultural Humility & Responsiveness	100%
Quality of Services	100%
Site Safety and Accessibility	92%
Trauma-Informed Care	100%

**Results exclude clients who responded as "undecided", and includes "strongly agree/agree" or "disagree/strongly disagree"*

Attachment 16

NAMI Santa Cruz County

NAMI-SCC builds a community where families and peers go from isolation to belonging, where people break the silence and feel empowered. We provide essential support and education to people with mental health conditions, youth, families, and law enforcement through classes, support groups, presentations, a Help Line, and advocacy. We are the **only** organization that offers unique educational curriculums for individuals with mental health conditions AND their loved ones. *We help approximately 7,000 people a year through our ten programs.* Following are programs which are funded by MHSA and serve over 3,000 people.

Educational Programs: Consumers, Providers & Families			Educational Programs Performance Outcome
1) **Family Education** *. Family to Family 10-week class for family members of individual with mental illness. Basics 6wk class for parents of youth (English & Spanish)	2) **Consumer Education** **8 wk class series -Peer to Peer for those with mental health conditions	3) **Support groups** for families/friends of adults, families of youth and consumers (5 types of groups) Spanish Family group	Outcomes: Evaluations from participants 1.Received practical information to help support self , client or a family member: **80%** 2. Improved ability to access and advocate for mental health services for self or family member: **90%** 3. Would recommend: **90%** *People attending our classes and support groups also find hope, friendship and often see for a path of recovery.*
	4)**Provider Education** for mental health professionals (15 hrs.)	5) **Consumer led presentations** (In Our Own Voice) in mental health facilities and community	

6.Community Education Event: NAMI holds six Speaker Meetings a year to improve the knowledge of mental illness and services available to stakeholders, seek reduction of stigma, information on new treatments and efforts of mental health care system improvement. In addition, we do mental health education presentations to community groups on mental health.

7. Ending the Silence YOUTH PROGRAM Presentations designed for middle and high school students that includes information on warning signs and symptoms, facts and statistics, and how to get help for themselves and a friend. Presented by trained peers who share their own journey with mental illness and recovery. Includes videos and slides using NAMI National curriculum. Other versions are for school staff and for parents.	1.Presentation was helpful to me: **92%** 2. Know the early warning signs of mental illness: **92%** 3.Now know how to help myself or a friend if I notice any warning signs: **92%** Quotes from **Ending the Silence** students: "It made me speak up and my whole true self shined again." "The stories made me realize I am not alone."

Other programs (not in contract) include the Crisis Intervention Training for law enforcement, and the NAMI Help Line which offers navigation assistance and support to the entire mental health community.

Further information on Performance Outcomes:

***EVIDENCE BASED PRACTICE** **NAMI Family-to-Family Education Program** has been added to the U.S. SAMHSA National Registry of Evidence-based Programs and Practices. Family members who participated in Family-to- Family classes showed: 1)Significantly greater overall empowerment as well as empowerment within their family, the service system and their community 2)greater knowledge of mental illness 3) a higher rating of coping skills 4)lower ratings of anxiety related to being able to control conditions 5)higher reported levels of problem- solving skills related to family functioning.

****NAMI Peer-to-Peer:** Evidence has found that taking the course improved self-image and increased self-motivation. Participants: felt less alone, learned new relapse prevention skills, reported more acceptance towards their illness, embraced advocacy and used the class to help others with mental health challenges. Experience improved relationships with loved ones.

Ending the Silence Presentations in middle and high schools. In a recent research study by NAMI National concluded that NAMI's 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 Outcome: Stigma Reduction

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. We also reduce stigma 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.

We also evaluate our program success by the popularity of our programs. There is often a waitlist for our classes. People often describe the information they receive as life-changing.

Attachment 17

Community Connection

Volunteer Center
Really Connect • Really Connected

Mental Health Services (MHS) & Housing

Opportunity Connection

Outpatient mental health program for adults that provides meaningful activity through supported employment, work-training positions, skill building, mental health education, recovery, wellness, socialization, peer support & community integration.

- 70 Consumers
- 21 Completed Work-Training Positions
- 8 Consumers Received Employment
- 100% reduction in incarceration
- 92% reduction in hospitalization

College Connection

Educational support services for adults with mental health challenges entering or re-entering Cabrillo College including enrollment in classes, finanical aid support, accessing campus resources, individual counseling, stress management, work skills training, socialization, and teaching of the Transition to College class for students who identify as having mental illness.

- 38 Consumers
- 27 completed at least one course
- 100% completed educational benchmarks
- 6 Consumers Received Employment
- 100% Reduction in Hospitalization & Incarceration

Housing Support

Employment, educational, & volunteerism support for adults with mental health challenges who live independently or in supported housing.

- 55 Consumers
- 13 Completed Work Training Positions
- 15 Received Employement
- 11 Enrolled or Finished Education Program
- 100% Reduction in Hospitalization & Incarceration

Total Consumers Served by MHS & Housing Programs: 163

Evaluation Method

Community Connection Recovery Evaluation adminstered via Google Forms during admission, every 6-months, and upon discharge to collect outcome data for FY 18-19.

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Attachment 18

Family Service Agency of the Central Coast - Suicide Prevention Program

Suicide Prevention Service, a program Family Service Agency of the Central Coast, has been operational in the community since 1957, is accredited by the American Association of Suicidology (AAS), and is a member center of the National Suicide Prevention Lifeline (NSPL). In our most recently completed fiscal year, over 6,750 community members received services from the program, including 3,850 youth. 11,830 bilingual materials were distributed throughout the community, to challenge myths around suicide, reduce stigma, and enhance familiarity with and access to services.

The program provides a 24/7/365 suicide crisis line. Local community members, under the supervision of experienced staff members, receive evidence-based training to provide emotional support, conduct risk assessments, assist in crisis de-escalation, coordinate safety planning, and provide consultation and support for service providers and family members concerned about someone else or grieving a loss. Individuals need not be suicidal to call and are offered referrals to other community resources where appropriate. Responders provide, with consent, follow-up services for those at-risk or needing additional support. Services are free, available to all Santa Cruz County residents, and are provided in 140+ languages. In our most recent fiscal year, trained responders answered 3,490 calls from local community members; 96% of these callers were able to agree to a mutually-developed safety plan—those in emergencies were connected with help and offered follow-up care. 95% of callers, when asked, rated the call as helpful or very helpful. Call volume has doubled over the last 10 years and is projected to continue increasing nationally over the next several years.

Program activities also include raising awareness, reducing stigma, and promoting help-seeking through community education presentations (such as safeTALK), as well as age-appropriate and culturally-relevant presentations for youth and other high risk groups. Certified staff trainers provide evidence-based outreach trainings (including the 2-day Applied Suicide Intervention Skills Training—ASIST) for first responders, medical personnel, service providers, peers, family members, and a wide variety of helpers. The demand for general and targeted outreach and education services has skyrocketed in recent years; staff is working with local organizations to build capacity and embed education and training where appropriate and possible, in an effort to meet this growing need. In the most recent fiscal year, staff provided 76 trainings & presentations, including 6 ASIST workshops. 96% of participants responded positively that their knowledge of warning signs and ability to respond and seek help for themselves or someone else had increased as a result of participating in the activity. 100% of educators polled recommended the training. Additionally, staff provided support, consultation, and training to local educational institutions and providers implementing the School Suicide Prevention Plan in accordance with AB2246. Staff and trained peer facilitators also provide information, referral, 24/7 support, and bereavement support counseling groups and services to those experiencing complicated grief after the loss of a loved one to suicide. As a high risk group for suicide, survivors of loss deserve and need additional support navigating the healing process after such a loss.

In the past year, program staff have also partnered with Santa Cruz Behavioral Health and a variety of key stakeholders to launch and support the Suicide Prevention Task Force, a data-driven effort that has culminated in the County's first Suicide Prevention Strategic Plan. This ongoing process will ensure that prevention, intervention, and postvention services are designed, selected, and provided to those most at-risk or in need of help and in alignment with both the current suicidology research, local data, and the needs and priorities of the Santa Cruz community.

Attachment 19

Seniors Companion Program

During FY 18-19 a total of 2 Senior Companions who serve the County of Santa Cruz Behavioral Health Department provided 1,967 hours of peer support services to 12 clients, of whom 100% percent are seniors. The services provided by our Senior Companion volunteers improved our client's performance on key quality of life indicators including socialization, mood, and level of activity. The result is an enhanced ability of our clients to continue to live independently in the County of Santa Cruz.

Each year in the spring, Senior Companion Volunteers complete a survey developed with assistance by Applied Survey Research and through collaboration with Dr. Peter Haas, Ph.D. at San Jose State University. The survey is designed to evaluate seniors' ability to continue to live independently as measured by five key indicators: Feelings of Depression, Status of Health, Level of Activity, Experience of Loneliness and Perception of Quality of Life. Volunteers are asked to respond to survey questions based on their experience over the past year or since becoming a Senior Companion volunteer. Surveys were completed by 8 (100% of those who served) Senior Companions who serve in various organizations within the County of Santa Cruz in FY 18-19 and revealed the following outcomes on the five key indicators.

1) Change in the Senior Companion's Experience of Depression:

Much Less Depressed 56%	Somewhat Less Depressed 22%	No Change 22%

2) Change in the Senior Companion's Health:

Much Better Health 37%	Somewhat Better Health 31%	No Change 26%	Somewhat Worse Health 6%

3) Change in the Senior Companion's Level of Activity:

Increased Activity 71%	Activity About the Same 29%

4) Change in the Senior Companion's Feelings of Loneliness:

Much Less Lonely 56%	Somewhat Less Lonely 28%	No Change 16%

5) Change in the Senior Companion's Quality of Life:

Much Better 63%	Somewhat Better 26%	No Change 11%

To measure our quality-of-life outcomes, the Supervisor completes an Assignment Plan (AP's) for each individual client assigned to a Senior Companion volunteer. The AP measures the client's quality of life improvement on five specific indicators: socialization skills, participation in activities, personal expression, mood & behavior and companionship. 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 challenge(s) of each client that will be targeted by the Senior Companion, the specific activities the Senior Companion will engage in with the client to tackle the challenge and the anticipated level of improvement on the five quality of life 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. Program staff then gather the completed AP's and tabulate the outcomes. Assignment Plans were competed by 98% of Supervisors on a total of 12 clients in May of the 2018-2019 fiscal year with the following results.

Clients' Social Ties/ Social Support showed:

Some Improvement 30%	Moderate Improvement 39%	Significant Improvement 29%

Total % of Clients Improved 98%

Clients' Activities participation showed:

Some Improvement 21%	Moderate Improvement 50%	Significant Improvement 26%

Total % of Clients Improved 97%

Clients' Personal Expression showed:

Some Improvement 31%	Moderate Improvement 42%	Significant Improvement 25%

Total % of Clients Improved 98%

Clients' Mood & Behavior showed:

Some Improvement 29%	Moderate Improvement 44%	Significant Improvement 26%

Total % of Clients Improved 99%

Clients' Companionship skills showed:

Some Improvement 25%	Moderate Improvement 42%	Significant Improvement 33%

Community Survey planning for MHSA 2021-2022 Annual Update

Considering the ongoing COVID-19 pandemic and to safely gain as much stakeholder feedback as possible Santa Cruz County released a brief 10–15-minute electronic survey via Survey Monkey. The purpose of this survey was to gain current thoughts and opinions on programming, including areas of needs and gaps based on an eight-question response ranking. The survey also allowed stakeholders to leave comments on current programming and concerns. The survey opened on 12/06/2020 and closed on 01/04/2021 and was widely completed with 103 participants. Feedback was crucial as we developed our 2021-2022 annual update considering the continued pandemic and crises from wildfires and concern of landslides/flooding.

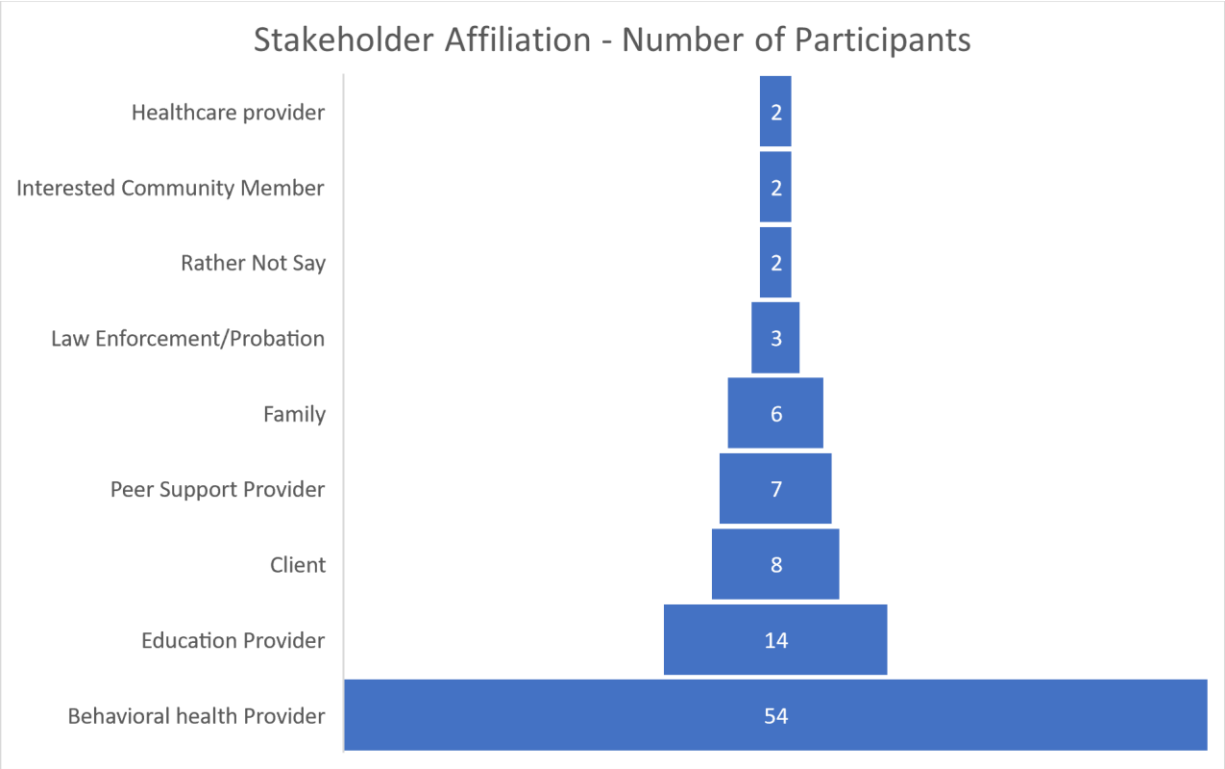
The survey opened with the following information to provide information to assist the participant in completion of the survey:

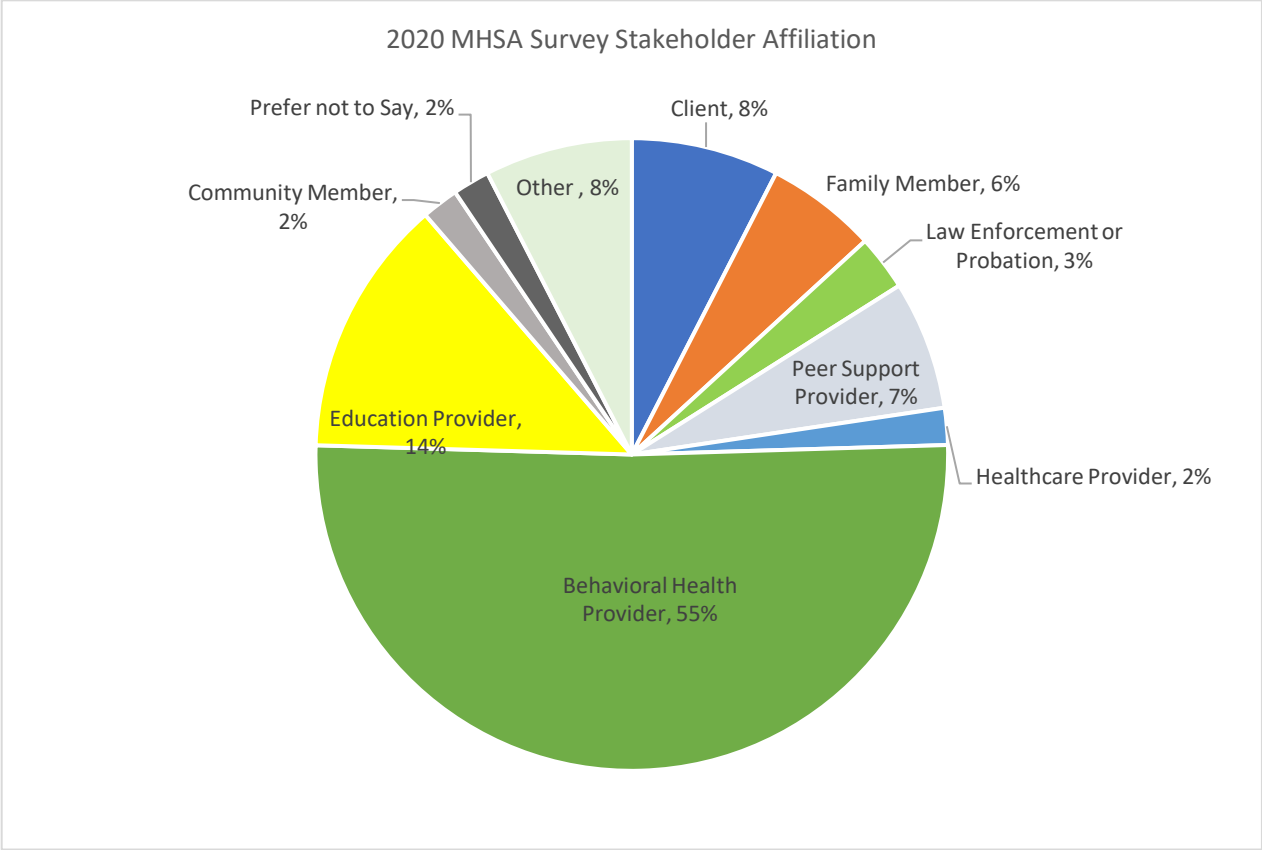
Thank you for taking the time to complete the anonymous MHSA survey below to guide decision making on MHSA funded community mental health programming. In this unprecedented year we are grateful for your willingness to help shape high quality, consumer driven services. With the pandemic and the financial ramifications over the next few years we anticipate dramatic reductions in MHSA funds. This year County Behavioral Health was fortunate enough to have community providers seek and obtain CARES Paycheck Protection Program (PPP) funds, which were used to offset the assumed reductions from MHSA. This is a one-time financial boost, which will not sustain in our next few years. Below we are asking that you prioritize and rank your preference of program type. This information will help us establish priorities for funding levels over the next three-year plan as we anticipate less MHSA funding.

The compiled data and public comment from the survey is attached below.

Q1 Please share your stakeholder affiliation:

Answered: 98 Skipped: 5

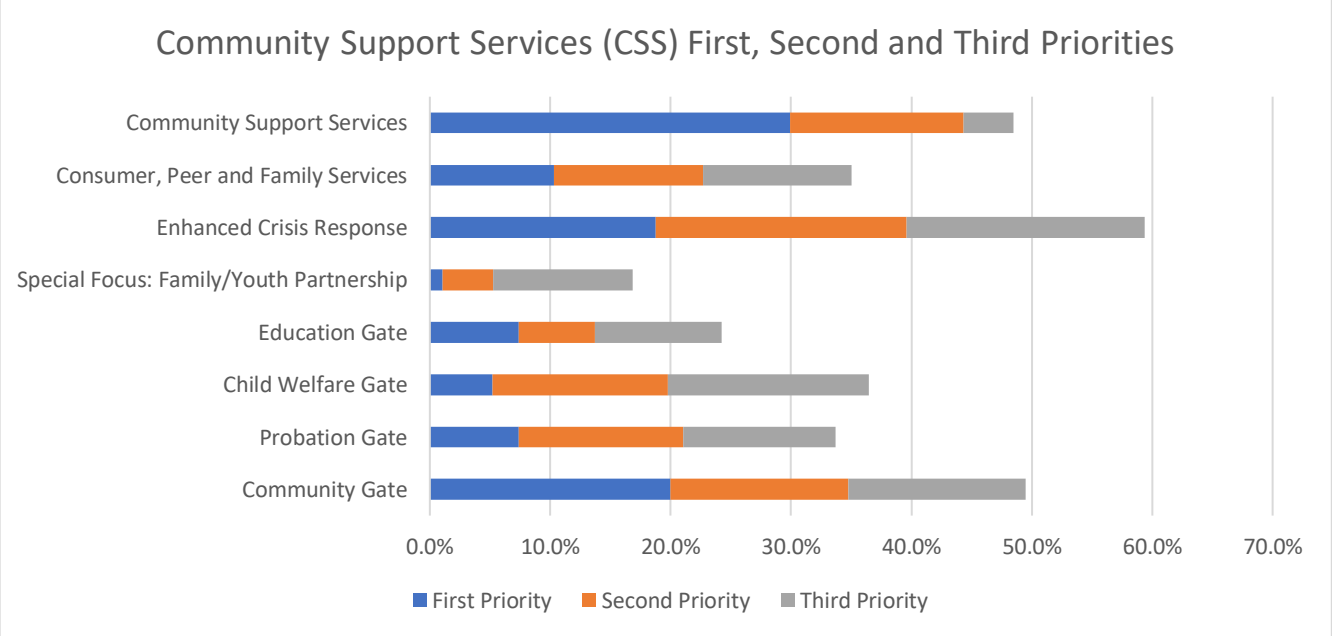




Q2 COMMUNITY SERVICES AND SUPPORTS (CSS)

This component is to provide services and supports for children and youth who have been diagnosed with or may have serious emotional disorders, and adults andolder adults who have been diagnosed with or may have serious and persistent mental illness. The total amount of MHSA dollars used toward CSS spending in fiscal year 2020-2021 is approximately $11,266,753. The chart below represents the first, second and third priorities in each category.

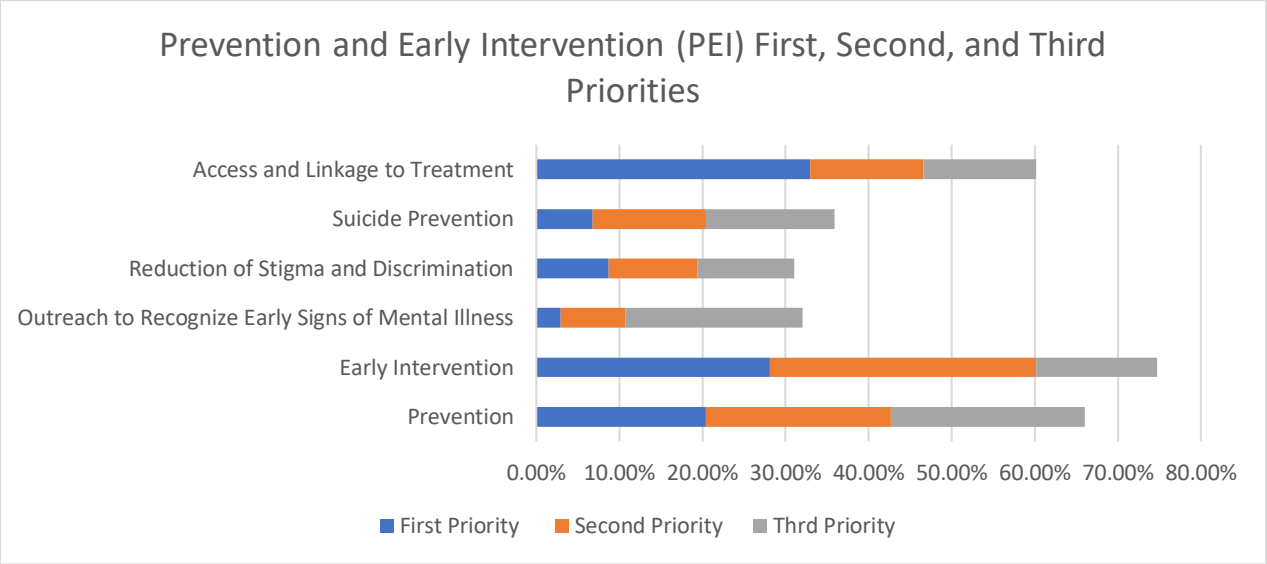
Answered: 98 Skipped: 5



Q3 PREVENTION & EARLY INTERVENTION – PEI

On October 6, 2015, the Mental Health Services Oversight Accountability Commission (MHSOAC) changed the requirements in this MHSA component. The programmatic changes were to be reflected beginning July 1, 2016. Based on these changes, Counties are required to have PEI programs for each ofthese types of services: Prevention, Early Intervention, Outreach for Increasing Recognition of Early Signs of Mental Illness, Stigma and Discrimination Reduction, Suicide Prevention, and Access and Linkage to Treatment. The total amount of MHSA dollars used toward PEI spending in fiscal year 2020-2021 is approximately $3,381,778. The chart below represents the first, second and third priorities in each category.

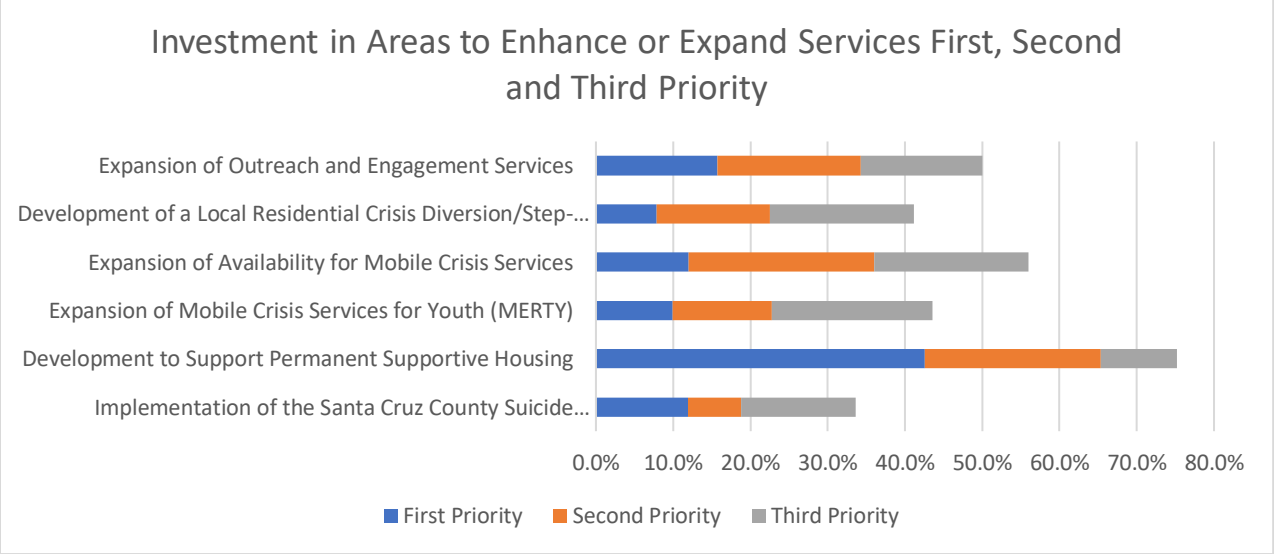
Answered: 103 Skipped: 0



Q4 FURTHER EXPLORATION, ENHAMCEMENT AND FUNDING OPPORTUITIES

In the section below we are asking you to rank areas for further exploration, enhancement, and funding opportunities. Below are currently identified areas based on stakeholder feedback. If you have an idea or area that is not listed, please use the comment box after this section to include that information. The chart below represents the first, second and third priorities in each category.

Answered: 102 Skipped: 1



Q5 COMMENTS ON UNMET NEEDS OR DISCOVERY

The table below reflects thoughts and opinions on an area of unmet need or discovery as well as other stakeholder comments.

Answered: 37 Skipped: 66

Response #	Comments	Date/Time
1	Coordination of mental health services between County, Schools, hospitals, clinics and non- profits. Also, to reach the immigrant that need mental health support and services. Provide more mental health services to our Senior population that is increasing in Santa Cruz Countyspecially our Latino/Spanish/Chicano population.	1/3/2021 9:11 AM
2	Second Story is a valuable asset in addressing mental health issues and should be prioritized	12/19/2020 9:39 AM
3	Housing with support services is a must. Housing alone will not lead strategically to solving the mental health trauma of the homeless.	12/18/2020 11:56 PM
4	The most pressing need in our behavioral health system is reducing the cost and reliance on out-of-state psychiatric hospitalization stays for SCC consumers. Our county invests hundreds of thousands of dollars to pay for out-of-county hospitalizations rather than investing that funding into community-based services that are proven to reduce the rate of hospitalization for consumers. I recommend a strategic approach to reducing out-of-county costs that drain the behavioral health budget; invest in an additional hospital diversion program that works, increase local beds with a combined FSP approach to prevent re-hospitalization and/or incarceration, and invest in recovery-based outpatient models that are proven to reduce hospitalization and incarceration rates.	12/18/2020 4:50 PM
5	Expanding Spanish outpatient services for our Latino community. In Watsonville, services in Spanish continue to be very limited to those individuals suffering from mental health challenges. Expand engagement and outpatient services for the elderly suffering from mental health challenges.	12/18/2020 10:13 AM
6	Support for navigating services	12/18/2020 9:48 AM
7	1. I believe there is a profound lack of outreach and engagement of adults with serious mental illness who are also homeless. In my experience,	12/18/2020 1:29 AM

	these individuals are often lumped in with the larger homeless population and left to compete for the same meager resources. Even when individuals are technically connected to care, there appears to be little effort by mental health staff to engage clients outside of Bldg K., to follow up on missed appointments, or to alert collaborative partners of any concern for missing and vulnerable individuals. For clients who are not on medication and not well established, this lack of basic engagement and rapport decreases the likelihood that a client will engage in treatment, in my opinion. 2.There don't appear to be options for people who aren't yet ready or willing to take medication. There is seemingly no effort at progressive engagement with these individuals, and service is eventually discontinued. Much in the same way we now take a harm reduction approach to those who use alcohol and other drugs, we could make similar efforts to meet needs, to actively engage and to help ensure the safety of individuals who have SMI, are homeless and not ready to take meds. 3. The housing outlook for homeless individuals with SMI is abysmal. Adult Behavioral Health seems to have divorced itself entirely from any meaningful effort to develop and expand independent and supported housing options. In addition, Adult Behavioral Health has failed to embrace a housing-first approach. It often feels as though higher functioning individuals (or those without SMI) are afforded housing opportunities when they become available, which lends to the appearance that housing is used as a reward for good behavior and not as the life-saving and stabilizing resource that it actually is. 4. I've observed that our mental health system seems to function in an almost mechanistic way, with involuntary holds being the primary tool. In many cases, this may be appropriate. In other cases, it seems like an invasive, costly and ineffective approach to a complex and multifaceted array of physical, mental health and SUD symptoms. 5. It is disappointing that CMH does not fill vacancies. An example is one of our SCPD liaison's is out on leave without an expectation that the position will be filled temporarily. This means that police are	

	far more likely to respond to mental health crises which greatly increases the risk of trauma, serious injury and possible death (as evidenced by the event in which an individual wielding a rake was shot and killed). I would like to see Adult Behavioral Health commit to filling these positions when they become vacant for any length of time, especially in the city of Santa Cruz, which has such a high percentage of homeless people with SMI compared to other parts of the county. Thank you for the opportunity to share these observations.	
8	None	12/17/2020 9:09 PM
9	Be honest this was confusing and way too much for me right now but I'm trying my hardestwith it	12/17/2020 3:23 PM
10	- Transitional housing, for helping people gain skills needed to succeed in independent living. - Evidence-based, outcome-driven trauma treatment for individuals with severe mental illness (such as EMDR, trauma-focused CBT, Prolonged Exposure Therapy, Stress Innoculation Therapy, etc.)	12/17/2020 11:19 AM
11	Development of a local hospital program with diversion for youth in crisis in the county.	12/16/2020 3:42 PM
12	More Mobil crisis units with trained mental health professionals to accompany law enforcement, More education from agencies like NAMI Santa Cruz and more low in comehousing for people with serious mental illness	12/16/2020 1:34 PM
13	Na	12/16/2020 9:18 AM
14	All of the above important. Very difficult to choose.	12/16/2020 8:21 AM
15	We need to reduce police power and presence in our communities whilst investing in these new programs so as to ensure equity is being delivered to vulnerable POC communities andthe poor. We also need to ensure that people currently held at the county jail are released during COVID to ensure their basic human right to not be unjustly forced to die behind bars.	12/15/2020 4:38 PM
16	NA	12/15/2020 3:25 PM

17	Active Tech support for clients/parents esp Spanish Speaking, low income families to teach, and help set them up to increase capacity and ability to access online svcs such as online group support through zoom that various agencies offer. Tech support can be via telephone and they can do an initial home visit or FtF appt to actively coach setting up technology for use, then phone support thereafter.	12/15/2020 12:48 PM
18	Technology to assist the less fortunate during this pandemic with phones, tablets and hotspots.	12/14/2020 9:56 AM
19	We need qualified bilingual staff and POC not only in service delivery but in the leadership and decision making positions. This County has gotten away with it's lack of diversity in staffing for a long time, it is time for a change.	12/11/2020 4:56 PM
20	Mert in South County - need timely and full day support. Currently, unless we call before 12pm they will not come. Homeless support/housing and mental health services for youth 18 to 25 Homeless support for youth under 18 Therapy support for non-psychotic youth 18+ that are in high need of mental health services - Those who don't qualify for TAY and can't get into CMH due to being full or not 'severe' enough. These young adults will become severe or end up in the legal system if not able to continue with good treatment.	12/11/2020 3:53 PM
21	More mobile crisis interventions for youth in Santa Cruz City.	12/11/2020 3:08 PM
22	Support for mental health services for Students during distant learning . Increase screening and treatment capacity for youth	12/11/2020 2:49 PM
23	There are many unmet needs in the county including lack of residential treatment beds for dual diagnosis individuals, those engaged in the criminal justice system with major mental illness as well as those homeless individuals in the community. The Psychiatric Health Facility is in need of expansion or added services due to limited capacity and many individuals are released back into the community too soon only to return within a short period of time. There should also be a step down process not simply a return to the	12/10/2020 9:55 AM

	street for those homeless individuals. Also access to ongoing mental health support for those with a diagnosis is lacking.	
24	More availability for counseling services for acute mh clients while in incarcerated in county jail	12/9/2020 12:51 PM
25	Low to no cost Community prevention programs for youth such as art programs, sports, andmore across the county.	12/9/2020 11:02 AM
26	Family support for school or childcare support during covid.	12/9/2020 10:51 AM
27	So many of the funded services are downstream and without a committed effort to fund primary prevention and early intervention with youth, we will continue to have high levels of unmet, unfunded needs. It would be great to fund Primary Intervention Programs at Elementaryschools along with the 0-5 focus. Building services in populations 6-18 will decrease the need for services among the adult population as we move forward.	12/7/2020 6:58 PM
28	dual diagnosis programs, longer residential substance abuse treatment programs, sober living environments that can accommodate children and families, increased funding to support mental health clinicians with training in evidence based interventions that help to heal trauma such asEMDR and IFS.	28
29	24/7 mobile crisis response for youth-right now it's limited and doesn't include an in-person response. Childcare support to help parents participate in their services, including parenting groups and collateral services. Increased accessibility to MH services after-hours and on weekends-this lack of accessibility on weekends particularly creates barriers and hardships to families and youth participating in services. Our county doesn't have a formal Wraparound program for youth in foster-care or on probation/in Juvenile Hall. This would include para- professional staff, available after-hours and on weekends to provide community based Individual/Family Rehab services. Right now the therapist is expected to provide this range of services, and staff availability to work in an IHBS role is very limited.	12/7/2020 1:38 PM

30	Housing is the biggest problem. We need transitional and permanent housing for mental healthconsumers	12/7/2020 1:19 PM
31	Development and staffing of a program that supports people staying on LPS conservatorship while outside of locked care.	12/7/2020 1:04 PM
32	substance use disorder services which often co-exists	12/7/2020 12:10 PM
33	There are far too many case managers in our system of care with no new dual diagnosis beds or facilities to place people that need help. Clients need immediate access to services or get lost in the streets. We need new providers that work hard to keep contracts with the county instead of status quo. We need more intervention programs for clients that aren't necessarily ready to admit they have a MH problem or are our more difficult MH clients. MH is VERY quick to rule people out of our system of care that are the most frequent fliers and highly in need. Weneed substantially more school counselors in all ages to help early identify clients in trauma and in need and provide early intervention/prevention so more damage is not done. We need more school anxiety CBT classes and management strategies for kids in school. The mental health system of care in this county is broken and poorly managed. You need drastic changes to improve increased bed space, immediate access to bed space for clients in need of residential care. Far too many clients are sitting in county jail and accessing hospital emergency rooms that should be in residential treatment beds.	12/7/2020 11:49 AM
34	A lot of people in the criminal justice system are "ruled out of MH services" yet still need MH support. We need more dual-diagnosis treatment programs and SLEs. We need services for adults diagnosed with personality disorders and drug-induced psychosis (large percentage of criminal justice population). There is never enough bed space at Telecare/PHF and people arereleased before they are stable and straight back to the street where they quickly destabilize again. Revolving door. Need more resources and	12/7/2020 10:57 AM

	collaboration to conserve adults who are hospitalized over and over and over....	
35	--Long-term staffed residences for Adult MH clients (model is Davis Guest Home in the Central Valley --LOCAL Children's In-patient psychiatric unit --A 'sobering/psychosis center' to cope with people presenting with psychosis that may or may not have a mental illness as a third option to the 1st (jail) 2nd Psych Facility-	12/7/2020 10:38 AM
36	expanded SUD withdrawal management beds and services.	12/7/2020 10:18 AM
37	We need a bigger psychiatric hospital. We need a bigger focus on pre/post hospitalization support/services.	12/7/2020 10:12 AM

Q6 Please use this comment box to provide any feedback on the survey-

Answered: 24 Skipped: 79

Response #	Comments	Date/Time
1	It would be helpful in the ranking process to list some of the support/intervention strategiesbeing implemented under some of these programs.	12/28/2020 10:48 AM
2	Dissemination of this survey was not widespread	12/19/2020 9:39 AM
3	This survey is very helpful in understanding the funding components and agency's under eachcomponent. It would be helpful to add an option that allows stakeholders to prioritize the services under each funding category. For example, I believe the category of "Access and Linkage to Treatment" is a high priority for our county, however I disagree with having a large portion of that funding allocated to Second Story. Re-investing that funding into a program thatcan impact a larger number of consumers would be in our communities best interest.	12/18/2020 4:50 PM
4	I appreciate the opportunity to provide my input. It's practically impossible to rank all of theseincredibly important services, we need them all.	12/18/2020 9:48 AM
5	This survey will definitely help all who depend on such services and are unable to do it on theirown. Many people are unaware what to do because of their situations and even just helping a little can help them in some way, whether it's help for housing, medical (mental and psychological), or suicide awareness. These are more	12/17/2020 9:09 PM

	rampant today and getting more funding will help not only myself telling you this, but also those who really rely on your help to get the means to survive. Mariposa Wellness Center and Second Story has helped me in so many ways and I hope you can help others like me in the process. Thank you!	
6	I was very confused and I probably filled it out very wrong sorry about that I didn't really get	12/17/2020 3:23 PM
7	It was hard to rank as so many are critical!	12/16/2020 3:42 PM
8	Na	12/16/2020 9:18 AM
9	For a healthy community we need to work on all of the strategies listed above simultaneously.It would be short sited to work on one of the areas list above and not the others.	12/16/2020 8:21 AM
10	NA	12/15/2020 3:25 PM
11	I find it really difficult to rank these services because they are all important.	12/15/2020 1:56 PM
12	N/A	12/15/2020 12:48 PM
13	N/A Thank you for asking.	12/14/2020 9:56 AM
14	very hard to rank without more info. perhaps spend on the low hanging fruit with best predictionfor good results	12/11/2020 3:21 PM
15	It would be great to find a way to quickly connect youth to therapy and better access for thosewith private insurance	12/11/2020 3:08 PM
16	Thanks for all you do, we are having an increased mental health crisis in now and schoolsneed help meeting these needs	12/11/2020 2:49 PM
17	I find early intervention services in high need in our North and South communities in allsystems that serve SC County	12/8/2020 9:23 PM
18	I think the survey was done very thoughtfully and you did a great job creating it. Thank you foradding the % instead of $$ amounts, easier to understand. For me at least :-)	12/7/2020 9:32 PM
19	Survey was well written and provided adequate information to inform selection decisions.	12/7/2020 6:58 PM
20	Though the mental health staff is highly trained and exceptional, our county is behind in offering comprehensive, Wraparound services for high-risk youth	12/7/2020 1:38 PM

	and families. Though technically we may be or at least appear to be in compliance, in practice we are not following the spirit of Wraparound or Katie A due to lack of comprehensive services and providers available.	
21	Glad this was short.	12/7/2020 1:04 PM
22	Very informative	12/7/2020 10:57 AM
23	I am a glad they are happening.	12/7/2020 10:38 AM
24	All Managers - including the Personnel Officer absolutely NEED to complete the trauma-informed training.	12/7/2020 10:12AM

Dates and Methods for MHSA Plan

a) The dates of the 30-day review process:
The draft plan of the MHSA update was available for review and comment from March 11, 2021-April 15, 2021.

b) Methods used by the county to circulate for the purpose of public comment the draft of the annual update to representatives of the stakeholder's interests, and any other interested party who requested a copy of the draft plan:
The MHSA draft plan was distributed to the Local Mental Health Board, contractors, and to interested stakeholders. The draft plan was also posted on our county MHSA webpage and made available in hard copy to anyone who requested it. Advertisements were placed in the Santa Cruz Sentinel and Register-Pajaronian notifying people of this MHSA plan and how to obtain a copy.

c) Date of the Public hearing held by the local Mental Health Board:
A virtual Public Hearing will be held virtually on April 15th, 2021 at 3pm at the Behavioral Health Services Building at 1400 Emeline Avenue-Room 206, Santa Cruz, 95060. Call in information for that meeting is (916) 318-9542, Conference ID 812 691 851# .

By telephone: (831) 763-8203,
By weblink: http://santacruzhealth.org/MHSA
By email: mhsa@co.santa-cruz.ca.us ,

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

Comment-
People with mental health challenges are 16 times more likely to be killed in encounters with police. Locally, in 2016, an SCPD officer shot and killed Seam Arlt, a 32 year old man known to police to suffer from mental illness, as he was holding a rake and moving toward them. In the same year, the SC County Sheriff's Office and other agencies shot and killed Luke Smith when he was high on LSD, because he supposedly tried to stab a police dog that was attacking him. Both of these deaths were entirely avoidable with a different type of response.

At least 20% of those killed by police have a mental illness. (Some research suggests as high as 50%.)

The presence of police officers often further alarms people in a mental health crisis. Common sense teaches that the mere existence of the uniform, handcuffs, gun, and flashing lights can make someone in a mental-health crisis.

In 2018, in Eugene/Springfield OR area, similar in population to our County, CAHOOTS responded to 20% of 911 calls and saved the medical system $4 million, money that could be spent on mental health services. These 24/7 teams of a medic and crisis counselor address and de-escalate non-violent mental health and social service related calls, resolving issues with immediate de-escalation, evaluation, care and connection to services, bypassing the criminal justice system, ambulances, and emergency rooms. Mobile crisis intervention teams operate at about 1/3 the cost of police dispatch, saving millions of dollars to invest in services.

The federal government has mandated creation of a 988 phone/text number for mental health emergency calls, to be in place by July 2022, and AB 988 and AB 270 are currently being debated in the California legislature to implement the new 988 system. This is a perfect opportunity to create CAHOOTS-style mobile crisis support teams. Callers who call 988 would be connected with counselors and could be assisted by mobile crisis support teams staffed with mental health professionals.

I have a great deal of additional information on this topic amd would be happy to share and discuss it with you.

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of individuals in crisis. We support legislation being considered in California to establish a study committee to look carefully at how mental health crises are responded to within each of our local communities in strengthening our crisis response system.

Comment-
There is an active discussion being held on the use of a CAHOOTS model for response to non critical responses instead of dispatching police. There appears to be many positives to this approach which should be understood and evaluated. I am on the Board of NAMI Santa Cruz and have the following thoughts as an individual but not speaking for the Board. I strongly recommend that this approach not be funded with MHSA funds. If it is determined that this approach is to be implemented the funds should be transferred for the department currently providing this activity.
Following is my personal thoughts:

1. *We (NAMI) support the possibility of a alternative response team for non justice system related needs.*

2. *Past implementations suggest not only a more personal and less traumatic engagement but also a reduction in cost for the responses.*

3. *Implementation of this and allocation of the resources must include a shift of existing budget between departments currently providing the response and the new organization.*

A model on how to consider and plan the shifts may be the HiAP (Health in All Policies) approach which is a framework for addressing issues across multiple agencies and which foster discussions on how they can share resources, reduce redundancies, decrease cost and improve performance and outcomes.

4. Use of any MHSA funds for the purpose of this new model will only dilute funds needed for existing programs.

5. One of the issues about a CAHOOTS model its that effective interventions in many cases rely on resources for referral such as shelter beds, crisis beds, housing, residential treatment, substance use treatment, etc. Therefore it would be necessary to also increase the capacity of the current system in order for the CAHOOTS program to be effective and create long-term change.

6. NAMI Santa Cruz is willing to partner with other organizations in the activities needed to consider this alternative.

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of individuals in crisis. We support legislation being considered in California to establish a study committee to look carefully at how mental health crises are responded to within each of our local communities in strengthening our crisis response system.

Comment-
I reviewed the current fiscal year MHSA 20-23 Plan and found some interesting changes from the previous fiscal year.
I found 2 points of interest :
Funding differences in Access & Linkages (A&L) and Early Intervention (EI) from FY 20 to 21anf FY 21 to 22. The A&I "Expenditures" increased by 25 % in FY 21-22 from FY 20-21. The "Expenditures" for EI decreased by 19% for that same FY comparison. The overall "Expenditures increased by 7% for that same FY comparison

The Innovative programs, INN, typically had a budget of $500k/yr or so.
For FY 20, 21 and 22, the INN "Expenditures" averages $1.5 M. The funds perhaps are going to Front St Inc for the Whole Person Care (WPC) contract and IPS training. The INN "Expenditures summary table is the only program set of CSS, PEI and INN that has a budget listing by individual programs. There are no budget details for the CSS and PEI programs by name.
Conclusions
With the increases in A&I budgets, it appears that Second Story is potentially funded through July 2023. There appears to be an opening for an "Innovative" program such as Peer Support for the Housing Matters 120 unit Permanent Supportive Housing Project through a staffing sponsor and SB 803.

Questions for SCCBH
What was the driver(s) for defunding the River St Shelter, given a 25% increase in A&I budget from FY 21 to FY 22?
Where are the budget details for the CSS and PEI programs for FY 22?
Who or what group of individuals makes the decisions to defund and fund MHSA programs?
Please comment on this interpretation and questions on the MHSA budget.

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of our community.

More information on financials can be found at Fiscal Reporting Tool | Mental Health Services

Regarding River Street Shelter, this was a difficult decision to make and there were a number of factors that went into moving forward with this decision. Part of these factors come from funding reductions that are beyond our control due to the Pandemic, other factors relate specifically to development that is happening on the property, state mandates for BH to utilize our funding for state mandated BH services first and foremost, the need to move another critical program for homeless adults who are recuperating from major surgery, and leases that expire in June.

The money directed to River Street Shelter is used for supportive services. The money will be redirected back into MHSA programming based on stakeholder feedback upon closure.

Comment-
Mhcan yes

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of our community.

Comment-
Closing of River Street Shelter 32 beds is shocking and a tremendous loss to people in greatest need. Where was stakeholder input on this decision? We cannot lose beds, there is a terrible shortage of options.
MHSA funding should be prioritized for serving people with Serious Mental Illnesses.
The multitude of Stakeholders comments need response

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of our community.
This was a difficult decision to make and there were a number of factors that went into moving forward with this decision. Part of these factors come from funding reductions that are beyond our control due to the Pandemic, other factors relate specifically to development that is happening on the property, state mandates for BH to utilize our funding for state mandated BH services first and foremost, the need to move another critical program for homeless adults who are recuperating from major surgery, and leases that expire in June.

Comment-
People with mental health challenges are 16x more likely to be killed in encounters with police. ***Locally, in 2016, police shot and killed Shawn Arlt, a 32 year old man known to police to suffer from mental illness, as he was holding a rake and moving toward them.***

Police as first responders have two choices: Jail or ER. 20% of inmates in jail are suffering from a serious mental illness. ***Locally, Tamario Smith a 21 year old African American man with known mental illness, died in jail in 2020 from what was termed "acute water intoxication" due to over-consumption of water compounded by underlying mental health issues.***

AT least 20% of those killed by police have a mental illness. (Some research suggests as high as 50%.)

The presence of police often further alarms people in a mental health crisis. Jail is not the answer.

In 2018 CAHOOTS responded to 20% of 911 calls and saved the medical system @ 4million dollars. Money that could be spent on mental health services. These 24/7 teams of a medic and social service worker address and de-escalate non-violent mental health and social service related calls, resolving issues with immediate evaluation, care and connection to services, ***bypassing the criminal justice system. Mobile crisis intervention teams operate at about 1/3 the cost of police dispatch, saving millions of dollars to invest in services.***

California is likely to pass legislation adding a 988 phone/text number for mental health emergency calls. This is a perfect opportunity to plug in to Cahoots style mobile crisis support teams!*Callers who dial or text 988 would be connected with counselors and could be assisted by mobile crisis support teams staffed with mental health professionals.*

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of individuals in crisis. We support legislation being considered in California to establish a study committee to look carefully at how mental health crises are responded to within each of our local communities in strengthening our crisis response system.

Comment-
Thank you for the detailed draft MHSA document. As a Board Member of NAMI Santa Cruz I have the following input on the draft plan.

It appears that the plans for services in the coming year are the same as the programs currently being provided and it is not clear how any of the stakeholder input effected any shifts. In reading the text I could not identify any new initiatives.

The total expenditures for FY 2022/23 in total are very close to FY2021/22 which seemed to suggest a continuation of existing programs without new additions.

Key stakeholder input on expanded needs should be prioritized with explanations on what actions will be taken or if not, the reasons. As an example I would suggest the following be added to the MHSA programs and planned expenditures:

a. *Additional crisis residential beds in the County*
b. *Additional residential treatment beds in the County for co-occurring disorders*
c. *Addition of a Family Mentor/ Navigator on County Behavioral staff **
d. *Addition of two Peer Specialists on County Behavioral staff **

e. Addition of more Case Managers to be able to handle more clients and increase the treatment planning upon release from the various residential treatment facilities whether in or outside the County.

**note level of expenditures planned for Family Partnerships and Consumer, Peer and Family Services on page 183 is very low.*

Based on the FY2021/22 financial summary on page 181 it appears that there is $6,446,809 of MHSA funds available that have not been used for needed program expansion. These funds can be used to address needed expansions. The level of expected Funding Transfer in for FY2022/23 indicates a significant reduction close to $2 million ($15,339,273 vs. $17,379,936). Has the State indicated this lower level of funding?

The February 2021 Mental Health Services Act Expenditure Report reflected consistent increases in the estimated revenue for the past three fiscal years: FY19/20- $2,327M, FY20/21- $2,411M, FY21/22- $2,506M. With this historic trend an 11.7% reduction in planned transfers in to our County seems surprising.

Page 145 of the draft addresses Capital Facilities and reads: The purpose of Capital Facilities is to acquire, develop or renovate buildings for service delivery for mental health clients or their families.." The paragraph above states that "our stakeholder chose to spend the majority of funds in the information technology projects". Page 144 describes developing an RFP for systems upgrades from Practice Management to Share Care. How much capital funding is available, is it included in the funding transfer above in or an additional amount and should this capital be directed towards needed residential treatment beds.

Page 41 of the draft describes the value of the River Street Shelter and page 164 suggest a utlilzation rate until the fourth quarter of 30 individuals staying an average of 40 days. Stakeholder input from MHCAN highlighted the concern of "No safe place for consumers in the system once released from involuntary commitment". My understanding is the River Street Shelter has provided this option in the past.
I have heard informally that the River Street Shelter service is being discontinued yet the draft indicates no change in the status. With the shortage of residential options throughout the range of residential treatment options from acute, crisis, residential to supported living terminating this service would seem to be an major step back.

Thank you for the thoughtful work on the draft and your serious consideration of my thoughts above.

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of our community.
Our financials are based on statewide projections provided by Mike Geiss, which we received on February 4th, 2021. These projections allow us to formulate our financial landscape based on anticipated tax revenue. We, like most California counties, utilize these projections to make informed decisions. These projections are subject to change based on tax revenue.

More information on financials can be found at Fiscal Reporting Tool | Mental Health Services

Regarding River Street Shelter, this was a difficult decision to make and there were a number of factors that went into moving forward with this decision. Part of these factors come from funding reductions

that are beyond our control due to the Pandemic, other factors relate specifically to development that is happening on the property, state mandates for BH to utilize our funding for state mandated BH services first and foremost, the need to move another critical program for homeless adults who are recuperating from major surgery, and leases that expire in June.

The money directed to River Street Shelter is used for supportive services. The money will be redirected back into MHSA programming based on stakeholder feedback upon closure.

Comment-
Thanks for the work you do in providing services for community members with support for their mental health needs.

Many people in Santa Cruz County are now re-evaluating our systems for community safety, health and welfare and are clearly wanting to shift responsibility for mental health crisis response away from police. Instead of continuing to approach mental health as a criminal/legal issue, most of us are wanting funds, training and energy shifted to a method that is empathetic and based in a healthcare approach that actually serves people in crisis.

With that in mind, I'm writing to suggest that you include in your three-year plan (2020-23) the implementation of a county-wide Mobile Crisis Intervention Service (MCIS) in the style used by CAHOOTS in Eugene, Oregon for the past thirty-one years. (link below)

CAHOOTS operates MCIS 24 hours a day with mental health crisis workers and EMTs and respond to about 20% of 911/emergency calls in the Eugene/Springfield area. They are unarmed and highly skilled in communicating with people in the midst of mild to severe mental health crises. CAHOOTS crisis responders have never hurt a single client or been hurt.

MCIS programs like CAHOOTS are actually less expensive and more productive than police. And less violent; in 2016 Sean Arlt and Luke Smith were shot and killed by law enforcement officers in Santa Cruz County while each was experiencing a mental health crisis. Arlt was killed as a he wielded a garden rake.

Thank you for considering including a set of Mobile Crisis Intervention units for the county. Please let me know if this resonates with you as a strategy for helping those in need in our community.

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of individuals in crisis. We support legislation being considered in California to establish a study committee to look carefully at how mental health crises are responded to within each of our local communities in strengthening our crisis response system.

Comment-
I strongly urge you to put non-law enforcement mobile crisis response teams in Co. Mental Health Services Act. *There is ample evidence that such a move would make total sense.*

Response-

We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of individuals in crisis. We support legislation being considered in California to establish a study committee to look carefully at how mental health crises are responded to within each of our local communities in strengthening our crisis response system.

Comment-
Mental health intervention as an alternative to police intervention. I urge you.

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of individuals in crisis. We support legislation being considered in California to establish a study committee to look carefully at how mental health crises are responded to within each of our local communities in strengthening our crisis response system.

Comment-
Alternatives to police response. Plan omits alternate responses to police response - for example CAHOOTS.

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of individuals in crisis. We support legislation being considered in California to establish a study committee to look carefully at how mental health crises are responded to within each of our local communities in strengthening our crisis response system.

Comment-
Dear Friends, As a 45 year city resident I know Santa Cruz has a mental health problem, a drug problem and a very high suicide rate for our size. We have had far too many suicides, police murders of suicidal people, police murders of known patients with mental health problems. The presence of police while that child was on acid in Watsonville recently could have been de-escalated, but that youth was murdered by the police. He had a pocket knife.

We know the answers and why not get these systems in place ASAP? My son is 31 and lost his first girlfriend and his close first cousin to suicide in a 3 year period. He and I were both at the scene finding their bodies. He is 100% more likely to kill himself than young men his age. If police were called he would not be taken in easily. We have alternatives that can save millions of dollars, as CAHOOTS has done, in medical expenses. I know a local ER nurse at Dominican who says she spends enormous time on simple issues with mentally ill homeless clients, costing the system thousands of dollars.
There are answers-- please don't ignore the answer of an alternative mobile unit being deployed that has no siren and uses mental health experts to be on the scene 24/7. De-escalation is KEY. Mental illness doesn't stop at 5 pm.

Thank you for considering this vital service for Santa Cruz County 24/7.

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our

stakeholders to explore models that are focused on responding to the behavioral health needs of individuals in crisis. We support legislation being considered in California to establish a study committee to look carefully at how mental health crises are responded to within each of our local communities in strengthening our crisis response system.

Comment-
I am writing to support the inclusion of a CAHOOTS-style non-police mental health crisis response team in your three year plan. This method is shown to reduce costs, limit harmful police-public interactions (including killings), and lead to better outcomes for people suffering mental health emergencies. Our county would benefit greatly from this style of program.

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of individuals in crisis. We support legislation being considered in California to establish a study committee to look carefully at how mental health crises are responded to within each of our local communities in strengthening our crisis response system.

Comment-
Santa Cruz County needs a Mobile Crisis Intervention Services program, like the CAHOOTS program in Eugene, Oregon, to deal with mental health emergencies. Sending the police results in tragedies like the execution of Shawn Arlt, or the death on custody of Tamario Smith, because the police are not designed to deal with mental health. Please add establishing an MCIS program to the plan.

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of individuals in crisis. We support legislation being considered in California to establish a study committee to look carefully at how mental health crises are responded to within each of our local communities in strengthening our crisis response system.

Comment-
I will always be grateful for my internship and subsequent employment at County mental health .As an MFT, the opportunity to experience florid emotional distress in training was rare I am told.
And yes, "behavioral" health is more appropriate as it is descriptive.
The issues in Santa Cruz are heartbreaking and often driven by mental health issues and addiction. I moved from my home of 50 years to spare myself from having to protect myself from irrational and criminal conduct. Otherwise, the escalating trespassers and four terrifying fires on my property would have led to harm to someone. And of course ***I know mentally ill people are more often the victims of crime than perpetrators. So it is very complicated.***
If the street intervention response team can be funded, it would be helpful And I mean every day and evenings, paired with well trained law enforcement. ***Trained and compensated fully****.*

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of individuals in crisis. We support legislation being considered in California to establish a study committee

to look carefully at how mental health crises are responded to within each of our local communities in strengthening our crisis response system.

Comment-
We received a comment from a stakeholder in the community who was dissatisfied by services provided to a family member. We redacted the specifics of the comment as it included staff names and contained personal information.

Response-
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of our community.

Comment-
I am writing to request that Laura's Law (Assisted Outpatient Treatment) be added to Santa Cruz County's Three-Year Program and Expenditure Plan for Mental Health, and that the Santa Cruz County Board of Supervisors pass a resolution to implement Laura's Law.

I support Laura's Law because it will help to avoid tragedies such as the one that befell the Henderson family in Aptos in June 2013. James Henderson had a lengthy history of arrests and contact with the judicial system before he murdered his own parents, Edyth and Joseph Henderson. Perhaps if he'd had court-ordered mental health treatment his parents – who had attempted in vain to help him – would be alive today.

Studies of counties with similar laws have shown a significant reduction in violent and destructive behaviors as a result of court-ordered treatment. Counties that have enacted Laura's Law also report that simply having Laura's Law on the books has positive outcomes even for those patients who ultimately don't qualify under the law. Laura's Law would also address Santa Cruz's ongoing "revolving door" problem of mentally ill individuals in our community who are continually arrested and re-arrested.

On December 3, 2013, the Santa Cruz City Council Action unanimously approved an Action Item to engage the County to consider enacting Laura's Law. To date, there has been no public response by the County regarding this action. Why hasn't a resolution been passed yet?

Approximately 18 counties have passed their own Laura's Law resolution. I request that you do the same, to both keep our community safe and to provide treatment to our most vulnerable mentally ill.

Response-

We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of our community.

Comment-

Regarding Riverstreet Shelter - was that MHSA funding because it is referred to? Why is it in the report? Just explain what that means for money.

Response-

We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of our community.
The money directed to River Street Shelter is used for supportive services. The money will be redirected back into MHSA programming based on stakeholder feedback upon closure.

Comment-
During public comment, someone was asking for itemized account of where funding is going to.

Response-

We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. We will continue to work with our stakeholders to explore models that are focused on responding to the behavioral health needs of our community.
More information on financials can be found at Fiscal Reporting Tool | Mental Health Services

Mental Health Services Act (MHSA) Programs

In 2004, California passed Proposition 63, known as the Mental Health Services Act. Three components of MHSA focus on direct clinical services:

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

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

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

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

The population in Santa Cruz County is 273,213 according to 2019 Census estimates. In Santa Cruz, the breakdown of the population by race is 56.8% are White (Not of Latino origin), Latinos make up 34% of the county population, 1.5%, African American, 1.8% are American Indian and Alaskan Native persons, and 5.3% are Asian. 17.3% of the population is over 65 years old; persons 18 years and under comprised 19% of the population. The threshold language in Santa Cruz is Spanish. Slightly more than half of the population (50.5%) identify as female.

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

Cost Per Person Served Fiscal Year 2019-2020:

The approximate cost for children served in the CSS program is $2,214 and in the PEI programs is $28.99. The approximate cost for adults served in the CSS program is $2,727 and in the PEI program is $55.50 and INN is $5,615.

COMMUNITY SERVICES AND SUPPORTS (CSS)

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

CSS Program #1: Community Gate

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

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

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

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

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

Number of individuals to be served 2020-2021:

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

- Encompass: 150
- Pajaro Valley Prevention and Student Assistance (PVPSA): 100
- Santa Cruz County Behavioral Health: 175

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

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

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/19 to 6/30/20, which is attached.

CSS Program #2: Probation Gate

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

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

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

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

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

Number of individuals to be served 2020-2021:

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

- Pajaro Valley Prevention & Student Assistance: 68
- Encompass: 84

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

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

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/19 to 6/30/20, which is attached.

CSS Program #3: Child Welfare Services Gate

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

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

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

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

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

Number of individuals to be served 2020-2021:

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

- Parents Center: 30
- Encompass Independent Living Program (ILP): 13
- Santa Cruz County Behavioral Health: 200

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

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

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/19 to 6/30/20, which is attached.

CSS Program #4: Education Gate

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

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

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

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

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

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

Number of individuals to be served 2020-2021:

The unduplicated number of individuals to be served by program is

Santa Cruz County Behavioral Health Services: 38

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

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

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/19 to 6/30/20, which is attached.

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

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

The support, outreach, education, and services include:

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

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

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

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

Number of individuals to be served 2020-2021:

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

Volunteer Center/Family Partnerships: 50

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

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

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/19 to 6/30/20, which is attached.

CSS Program #6: Enhanced Crisis Response

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

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

To accomplish the above, we provide the following services:

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

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

Providers:

- Encompass (Telos and EDC)
- Mental Health Client Action Network (Peer Supports)
- Santa Cruz Behavioral Health (Specialty Staffing)

Number of individuals to be served 2020-2021:

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

- Encompass-Telos: 100
- Encompass- El Dorado Center: 100

- MHCAN (Peer Supports at the Psychiatric Health Facility): 100 (outreach)
- Santa Cruz County Behavioral Health: 1000

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

No.

Are there any new, changed or discontinued programs?

No.

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/19 to 6/30/20, which is attached.

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

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

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

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

Providers:

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

Number of individuals to be served 2020-2021:
The unduplicated numbers of individuals to be served by program are:

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

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
Yes. MHCAN's use permit has been modified by the City of Santa Cruz limiting daily attendance to a maximum of 50 clients to be served per day and restricting hours of operation. MHCAN requested a process though the City of Santa Cruz to allow a review of the use permit to increase capacity.

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

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/19 to 6/30/20, which is attached.

CSS Program #8: Community Support Services

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

To accomplish the above, we have several specialty teams:

- The Recovery Team and South County Adult Team provide intensive wrap around services to persons with chronic mental health conditions and severe functional impairments to provide support services to assist individuals to remain in the least restrictive residential setting and prevent acute hospitalizations. These teams focus on an array of recovery-oriented supports that include case management, psychiatry, psychotherapy, occupational therapy, linkage to housing, employment, and education. Additional clinicians will manage the county-wide residential authorization to Substance Abuse services.
- The Maintaining Ongoing Stability through Treatment "MOST" team serves individuals that have a psychiatric disability and are involved in the criminal justice system. It is a Forensic Assertive Community Treatment (FACT) program that combines evidence-based program of wrap around mental health services inclusive of case management, psychiatry, psychotherapy, employment skill development, with additional supports specific to the criminal justice system. This program seeks to reduce jail bed days, the occurrence of new offenses and probation violations. In addition to demonstrating improved stability in the community, the program seeks to reduce psychiatric inpatient bed days, reduce days of homelessness, increase treatment compliance and increase days in pro-social activities such as employment.
- The Older Adults Team (60 and above with a complex medical condition) focuses on older adults with a major mental illness and complex medical conditions who need an FSP to maintain in the community. With the addition of the INN funding, to provide whole person care inclusive of psychiatric condition, medical condition and SUD condition, additional supports will be available to the older adult population.

The teams are supported with these ancillary services:

- Front Street: Housing support to provide services and supports to adults living independently to help them maintain their housing and mental health stability. Community Connection staff offer an employment specialist and peer counselor, and Encompass provide case managers.
- Adult care facility beds provide 24/7 care, bi-lingual, bi-cultural services. The Board and Care facilities include Wheelock and Willowbrook.
- Opal Cliffs provides an adult residential setting to provide intensive supervision and support to individuals returning from Locked Care settings to prepare to re-integrate into housing and community services.
- River Street Shelter. This is an emergency shelter for homeless adult men and women. The shelter is a clean and sober environment where residents can begin or continue the process of rebuilding their lives, maintaining sobriety, and reconnecting with the community as they move towards ending homelessness. River Street Shelter staff provides expertise and specialized services for individuals with psychiatric disabilities and substance abuse challenges. Staff works individually with residents to assist them in connecting with community resources for obtaining benefits, physical health services, employment, and housing. Specialized counseling is available for those residents with mental health and substance abuse issues, to support them in maintaining psychiatric stability and achieving individualized goals.
- Casa Pacific. This is a 15-bed residential treatment program for those individuals with co-occurring mental health and substance use disorders. Residents are provided with specialized co-

occurring treatment in a clean and sober environment that also prepares them for maintaining sobriety in the community following discharge.

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

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

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

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

Number of unduplicated individuals to be served 2018-2019:

Front Street- Wheelock (Residential & Outpatient)	16
Front Street- Willowbrook	40
Front Street- Opal Cliffs	14
Encompass- Supported Housing	60
Volunteer Center/Community Connection-Housing Support (employment)	55
Volunteer Center/Community Connection-Opportunity Connection	70
Volunteer Center/Community Connection Avenues	45
Volunteer Center/Community Connection Cabrillo College Connection	25
Santa Cruz County Behavioral Health Services North & South County Recovery	450
Santa Cruz County Behavioral Health Services Older Adult Team (OAS)	60
Santa Cruz County Behavioral Health Services MOST	100
Encompass River Street Shelter	100 (FSP) 125 (outreach)
Encompass Casa Pacific	40

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? No.
Are there any new, changed or discontinued programs?
Yes. Starting in 2021-2022 River Street Shelter behavioral health supportive services will no longer be included in the MHSA plan. The River Street Shelter will no longer be operational. **Performance Outcomes (specify time period)**:

See the MHSA Quarterly & Annual Report for 7/1/19 to 6/30/20, which is attached.

COMMUNITY SERVICES AND SUPPORTS: HOUSING

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

The County has developed housing at Bay Avenue Apartments, Capitola. The Bay Avenue project provides five MHSA units for seniors 60 years and older, at risk of homelessness. "Aptos Blue" opened in February 2014, and it provides five MHSA for adults with mental illness who are homeless, or at risk of homelessness. County staff also developed Lotus Apartments for five transition age youth and adults located mid county. Santa Cruz County Behavioral Health Services FSP team provides the initial referral to clients who enter the MHSA housing team.

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

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

1. The applicant(s) must be able to demonstrate that his/her conduct and skills in present or prior housing has been such that the admission to the property would not negatively affect the health, safety, or welfare of other residents, or the physical environment, or financial stability of the property.
2. Positive identification with a picture will be required for all adult applicants (photocopy may be kept on file). Eligible applicants without picture identification will be supported by County Mental Health or other service providers to obtain one. For purposes of the application, a receipt from the DMV showing an application for an ID will be sufficient. If deferred, the final picture identification will be required at the time of move-in.
3. A complete and accurate Application for Housing that lists a current and at least one previous rental reference, with phone numbers will be required (incomplete applications will be returned to the applicant). Applicants must provide at least 2 years residency history. Applications must include date of birth of all applicants to be considered complete. Requests for Consideration will be considered for MHSA applicants whose disability may result in insufficient or negative references.
4. A history of good housekeeping habits.
5. A history of cooperation with management regarding house rules and regulations; abiding by lease terms; and care of property.
6. Each applicant family must agree to pay the rent required by the program under which the applicant is qualified.
7. A history of cooperation in completing or providing the appropriate information to qualify an individual/family for determining eligibility in affordable housing and to cooperate with the Community Manager.
8. Any applicant that acts inappropriately towards property management staff or is obviously impaired by alcohol or drugs, uses obscene or otherwise offensive language, or makes derogatory remarks to staff, may be disqualified
9. Applicants must agree that their rental unit will be their only residence. When applicants are undergoing income limit tests, they are required to reveal all assets they own including real estate. They are allowed to own real estate, whether they are retaining it for investment purposes as with any other asset, or have the property listed for sale. However, they may never use this real estate as a residence while they live in an affordable housing unit.

Other Screening Criteria include:

1. Income / Assets, 2. Credit and Rental History, 3. Criminal Background, 4. Student Status

PREVENTION & EARLY INTERVENTION - PEI

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

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

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

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

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

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

- Senior Outreach-Family Service Agency of the Central Coast

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

- NAMI
- MHCAN-Shadow Speakers

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

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

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

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

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

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

School Mental Health Partnership Collaborative (The County Office of Education):
Purpose: Under the auspices of the Santa Cruz County Schools/Mental Health Partnership collaborative, to provide targeted **Prevention** services to local schools and in the community through a range of evidence-based and promising practices.

Target Population: School sites, education personnel, and students and families throughout the county.
Providers: The County Office of Education (COE) has subcontracted with the Diversity Center, the Live Oak Resource Center, and Positive Behavioral Interventions & Support.

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

2. *Positive Behavioral Intervention and Supports* (PBIS):
    a. Positive Behavior Intervention and Supports (PBIS) training is a model for establishing a positive school climate and helps schools focus existing resources in a school-wide prevention model as well as designing site-relevant interventions for children showing signs of distress. Successfully implemented, PBIS establishes clear expectations, emphasizes recognition for positive behavior and creates a school culture that is stable and consistent across campus areas and grade levels.
    b. School-Wide PBIS Trainings is composed of Tier 1, Tier 2 and Tier 3.

i. Tier 1 develops a framework by focusing on developing school rules and teaching expectations, developing an acknowledgement system, responding to a problem behavior and discipline referral system, and developing an implementation plan.
ii. Tier 2 is intervention level that serves between 15-25 students at once using a "check-in, check-out" system. This technique is an efficient use of resources rather than a one student at a time approach. Students can get support almost immediately upon referral. This level requires almost no legwork from referring staff to begin implementation of the intervention with a student. The process being used is referred to as a "Check-in, Check-out" (CICO).
iii. Tier 3 consists of seven training modules focused on conducting behavioral assessment and developing function-based support for students with mild to moderate challenging behaviors.

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

Number of individuals to be served each year:

The Diversity Center:

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

<u>PBIS</u>

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

<u>Live Oak Resource Center</u>

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

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

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

2019/2020 COE Narrative Report
From: The Diversity Center
Submitted: July 2020

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

- **Demographics**: (See 2019-2020 Demographics Report)
- **What is the unduplicated number of individuals served in preceding fiscal year?** 4,498
- **What is the number of families served?** 29
- **Participants' risk of a potentially serious mental illness?**

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

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

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

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

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

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

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

If the Agency/County intends the Program to reduce any other negative outcome as a consequence of untreated mental illness, list the indicators that the County will use to measure the intended reductions:
See evaluation methodology below which details the outcomes we evaluate that contribute to promoting mental health.

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

We conduct an annual evaluation of our youth program. We use a survey as our evaluation instrument. We are evaluating if program participants report the following outcomes:

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

Data is then analyzed by the Executive Director and Development Director (who has 15 years of evaluation expertise) in collaboration with program coordinators. While our evaluations have been overwhelmingly positive, if we find we are not meeting program outcomes, the program implementation will be revisited and additional training will be identified for staff.

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

This funding supports prevention on multiple levels. The Diversity Center's youth program is on the ground in schools supporting and building Gender and Sexuality Alliances (GSAs). Having a safe place for youth to connect and know they will be accepted can literally be a lifeline for youth (and a reason to go to school). Our Triangle Speakers Program brings trained community speakers into schools to promote "lived equality" and to destigmatize being LGBTQ+ and to help school climates become more welcoming. The Safe School Project works with administrators to problem-solve issues as they arise, and to recommend and implement anti-bullying curriculum. Additionally, our youth program evaluation shows the impact our program has on local youth.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Performance Outcomes: Narrative report for PBIS as required by the State:
Program Name: PBIS **Agency**: Santa Cruz County Office of Education
Target population:
Demographics: (See 2018-2019 Demographics Report)

What is the unduplicated number of individuals served in preceding fiscal year?

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

Live Oak School District	*1,949 Students*
Cypress Charter High School	
Del Mar Elementary	
Green Acres Elementary	
Live Oak Elementary	
Shoreline Middle School	
Scotts Valley Unified School District	*2,502 Students*
Brook Knoll Elementary	
Scotts Valley High School	
Scotts Valley Middle School	
Vine Hill Elementary	
Santa Cruz City Schools	*2,590 Students*
Bayview Elementary	
Branciforte Middle School	
Delaveaga Elementary	
Gault Elementary	
Westlake Elementary	
Soquel Union Elementary School District	*1,934 Students*
Main Street Elementary	
New Brighten Middle School	
Santa Cruz Gardens Elementary	
Soquel Elementary	
San Lorenzo Valley Unified School District	*2,502 Students*
Boulder Creek Elementary	
San Lorenzo Valley Elementary	
Pajaro Valley Unified School District	*17,394 Students*
Alianza Charter School	
Amesti Elementary	
Ann Soldo Elementary	
Aptos High School	
Aptos Junior High School	
Bradley Elementary	
Calabasas Elementary	
Ceasar Chavez Middle School	
Diamond Technology Institute	
E.A. Hall Middle School	
Freedom Elementary	
Hyde Elementary	
Lake View Elementary	
Landmark Elementary	
MacQuiddy Elementary	

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

What is the number of families served?

Using 1.96 as an average per family child number in California from census data, the approximate of families served was 14,072 (27,583/1.96)

Participants' risk of a potentially serious mental illness?

Varies per the usual general school aged population statistics*

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

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

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

PBIS is aimed at keeping students in school and engaged with the educational community at the specific school site and learning and growing that can occur when this happens. It is the hope that many students who may have higher risk factors for institutional involvement (CPS, Probation), suicidal ideation and/or mental health disorders will receive enough support and protective factors to reduce the percent of school going youth who experience these outcomes. Taken from: Horner, Sugai & Lewis, 2015 - "Is School-Wide Support Positive Behavior Support an Evidence Based Practice?"**:

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

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

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

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

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

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

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

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

Nothing more than mentioned in 4, part A above.

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

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

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

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

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

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

The article mentioned above, Horner, Sugai & Lewis, 2015 - "Is School-Wide Support Positive Behavior Support an Evidence Based Practice?" has an extensive listing of the most relevant research to date that shows the effectiveness of PBIS to reduce problem behaviors, increase a positive school culture and climate and by correlation help reduce negative outcomes such as those listed in the question: suicide, incarceration, school failure, prolonged suffering, etc.

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

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

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

Districts assess themselves for fidelity with the assistance of the official trainer (from CSUMB & Santa Clara County Office of Education), using the Tiered Fidelity Inventory Tool. It has not been universally utilized, but will be highly encouraged this fiscal/school year.

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

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

Answered A

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

Answered A

Describe how the following strategies were used:

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

PBIS regularly notes students who may need increased tiered services or outside referrals to collaborative agencies for additional support, especially around mental health concerns. This can happen from an individual evaluation or from a school team convened for Tier 2 and 3 supportive services.

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

Analysis of discipline data allows schools to address patterns of disproportionality to ensure appropriate behavior supports are provided equitably to students from diverse backgrounds. Additionally, PBIS acts as a large net, first addressing all students with creating positive norms in a school's functioning, then taking note of and supporting small groups of students needing targeted responses and finally individualizing services for the most at-risk population in the school. At each level PBIS aims to use culturally relevant language, varied supports and services and referrals for more severe mental health concerns.

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

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

Supplemental Notes:

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

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

Trauma Informed Systems

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

Trauma informed Systems (TIS) is an organizational change model to support organization in creating contexts that nurture and sustain trauma-informed practices. The model has multiple components, including:

- Trauma 101 foundational training to create a shared language and understanding of trauma
- Train the trainer program to harness trauma expertise within the workforce
- TIS Champions embedded in the workforce to spearhead TIS change efforts
- Leadership engagement and promotion of system change at the program and policy level

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

This is a Prevention Program.

Target Population: Mental health providers, pre-school teachers, childcare workers, family advocates, and other staff in the prevention workforce.
Providers: East Bay Agency for Children
Number of individuals to be served each year: 675
Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? No
Are there any new, changed or discontinued programs? TIS will be funding by grant funding starting fiscal year 2021-2022 and will no longer be funded by MHSA
Performance Outcomes: Unduplicated number of served as required by the State

TRAUMA TRANSFORMED

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

Target population:

- **Demographics**: (fill out chart) Please see attached
- **What is the unduplicated number of individuals served in preceding fiscal year?** ___433____
- **What is the number of families served?** ___0_____
- **Participants' risk of a potentially serious mental illness?** ___0___
- **How is the risk of a potentially serious mental illness defined and determined?**

n/a

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

Early Childhood Care and Education Cohort:

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

Activities included:

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

Santa Cruz County Trauma-informed Systems (TIS) Collaboration:

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

- 15 TIS 101 trainings for 406 participants
- Maintained Santa Cruz embedded and certified TIS Trainers with 5 trainer learning communities to coach and improve ability of trainers to disseminate knowledge and practice change. We certified 11 trainers this year.
- Build capacity for organizational leaders and champions to apply learning and TIS principles to practices and policies by facilitating 9 learning sessions with champions across 8 agencies, 5 leadership learning communities with leaders across 8 agencies, and one joint champions leadership meeting

- 4 targeted presentations to H.S.A and other agencies to enhance and advance implementation and knowledge dissemination
- Participated in planning and facilitating monthly Behavioral Health Leadership TIS meetings

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

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

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

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

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

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

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

ECE Educator Group:
What about this training was most useful in supporting your work responsibilities?
- The techniques and self-care
- The handouts and tools provided to take back to the center to use with the children
- The games learned, breathing exercises, ways to speak with parents, strategies on a day to day basis
- Thank you for help in understanding development and expressing emotions

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

ECE Leadership Group:
Please let us know one thing you learned over the course of our work together:
- So much. I don't know if I could have made it personally and professionally without this training.
- I learned the relationship building tool, to connect, more empathy and respect more

- I learned that I'm not the only one who has stress at work and that I feel I have too much work. I learned that trauma/stress is part of our lives and I learned things that I can do to feel less stress
- Take time to appreciate the staff (new and senior) for the work they do on a daily basis

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

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

TIS LEADERSHIP AND CHAMPION GROUPS

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

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

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

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

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

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

TIS TRAININGS

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

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.

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

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

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

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

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

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

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

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

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

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

Describe how the following strategies were used:

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

This is not a direct service model. However, our TIS consultant did advocate and support the coordination of care and access to services in the following ways**:**

1 – Worked with Children's Behavioral Health Management and Access to ensure that referrals coming in from Early Childhood Education as well as families of young children who are experiencing behavioral health challenges, would be thoroughly assessed and referred appropriately.

2. Met with Early Childhood Educators and Leadership providing education on how and where to refer families for behavioral health services and providing contact numbers and information on intake procedures.

3. Providing education to Early Childhood Educators on ways to support families in accessing behavioral health services.

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

While the activities from this year do not include direct services, training county staff to use trauma-informed approaches increases likelihood that they will understand the impact of trauma

and stress and how that can contribute to mental health challenges, and therefore be better equipped to recognize the true depth of impact that children and families carry, and then more willing to provide services.

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

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

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

The Positive Parenting Program (Triple P)

Purpose: Triple P is a **Prevention** Program and provides a five-tiered public health model of progressive mental health information, prevention, training, screening, and early intervention. It is an evidence-based practice increasingly deployed throughout California, addressing both prevention and early intervention needs.

Target Population: All Santa Cruz County families in need of public information about parenting skills and resources, as well as families needing various levels of enhanced training supports, and brief treatment.

Providers: First 5

Number of individuals to be served each year: 1300

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

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

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

Target population:

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

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

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

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

Most parents sign up or are referred for specific services (brief or in-depth, individual or group), but the initial intake provides an opportunity to confirm that a) the parents are interested and

committed to participating in Triple P services, and b) the practitioner is offering the appropriate level and type of Triple P service to the parent.

Outcomes:

- **List the mental health indicators used to measure reduction of prolonged suffering that result from untreated mental illness as measured by reduced symptom and/or improved recovery, including mental, emotional and relational functioning**:
  - Improved child behaviors.
  - Improved parenting practices.
  - Decreased level of parental stress.
  - Increased confidence in parenting abilities.

- **Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects cultural competence**: Although all levels of Triple P services are provided and evaluated in Santa Cruz County, the evaluation methodology described in this report pertains to the most intensive levels of service (Levels 4 & 5), since these are frequently the parents who report moderate to severe child behavior problems and/or distress related to parenting.

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

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

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

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

All Triple P client forms and assessment measures are available in both English and Spanish. The majority of Triple P program materials are also available in English and Spanish. If program materials are not yet available in Spanish through Triple P International (parent company), then First 5 develops Spanish-language teaching aids in accordance with Triple P's policies. Bilingual practitioners are trained to offer neutral assistance to clients who have difficulty reading or understanding the assessment questions (i.e. avoid conveying bias or leading parents to select a particular answer). If parents have low literacy levels, then practitioners assist parents by reading the assessment questions and responses options, and marking off parents' verbal responses on the assessments.

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

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

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

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

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

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

The robust body of research has led Triple P to be designated as a highly-effective evidence-based program (EBP) by multiple established clearinghouses, including: California Clearinghouse

on Evidence-Based Programs in Child Welfare; Substance Abuse & Mental Health Services Agency's National Registry of Evidence-Based Programs and Practices; Promising Practices Network; Technical Assistance Center on Social Emotional Intervention for Young Children; and the Coalition for Evidence-Based Policy.

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

First 5's rigorous evaluation of Triple P has demonstrated statistically significant improvements in child, parent and family well-being ever since its inception in Santa Cruz County. Outcome data from FY 2018-19 is currently being analyzed. However, a cumulative analysis of outcomes from January 2010 – June 2018 demonstrates positive outcomes such as:

- **Improvements in child behavior.** Overall, the majority of parents (79%) reported improvements in their children's behaviors after completing the Triple P program. Of the parents who began the program with more serious parenting issues, 91% reported improvements in their children's behaviors.
- **Increased use of positive parenting styles.** Overall, 67% of parents reported they were less over-reactive, 66% reported they were less permissive, and 50% reported they had a less hostile parenting style after completing intensive Triple P services. Of the parents who began the program with more serious parenting issues, 83% reported they were less over-reactive, 81% were less permissive, and 89% were had less hostile parenting styles by the end of the program.
- **Increased levels of parents' emotional well-being.** On average, parents reported significantly lower levels of stress, depression and anxiety (64%, 55% and 53% of parents, respectively) after completing in-depth Triple P services. Of the parents who began the program with more serious parenting issues, 90% reported improvements in their level of stress, 84% reported improvements in anxiety, and 84% reported improvements in their level of depression.

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

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

The local Triple P Coordinator (contractor for First 5) observes selected practitioners as they conduct classes and completes a Fidelity Checklist to document adherence to both the Triple P content and teaching process. The Coordinator and practitioner meet soon afterward for a feedback and coaching session to reinforce and enhance skills. The Coordinator also provides implementation support and facilitates peer coaching during the quarterly Triple P practitioner meetings and agency-specific meetings.

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

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

NA

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

Describe how the following strategies were used:

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

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

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

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

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

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

  Triple P is designed to provide parenting information and support to all parents seeking support, regardless of their socioeconomic status or risk level. First 5 Santa Cruz County disseminates bilingual messaging and materials through its countywide Level 1 social marketing campaign, which normalizes the need for parenting support and reduces the social stigma that often prevents parents from seeking help before costly treatment is required. Key social marketing and outreach activities include:
  - Distributing First 5's locally-designed "parenting pocket guides" with bilingual Triple P parenting tips through schools, health care settings (clinics, pediatric offices, hospitals), child care providers, county health and human service programs, correctional facilities, and other non-profits serving children and families.

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

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

Target population:

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

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

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

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

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

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

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

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

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

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

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

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

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

If an evidence-based practice or promising practice was used to determine the program's effectiveness:
Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.

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

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

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

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

Through interviews the Veterans Advocate will use direct questions and active listening to identify challenges that each client is facing. By identifying these challenges and making the appropriate referrals, this program will assist clients by identifying support systems available. The Veterans Advocate will reduce incarceration by assisting veterans who are part of the Veterans treatment court to coordinate care with the Veterans Justice Outreach Program. The Veterans Advocate will work closely with the Housing and Urban Development Veterans Affairs Supportive Housing Program to assist veterans to find long term housing options. The Veterans Advocate will also work with Supportive Services for Veteran Families, Transitional and Emergency Housing programs to reduce homelessness among Veterans. The Veterans advocate will also enroll veterans in the VA health care system, make referrals to mental health programs, make referrals to employment assistance programs, and assist with education programs and professional development. The Veteran Advocate will produce evidence of the success this program by tracking referrals made and conduct follow up phone calls/ visits to track outcomes. The Veteran Advocate will work directly with the Veteran Services Office, which has long been a source of support for Veterans in Santa Cruz County. The efforts of the Veteran Advocate will increase the effectiveness of the Veteran Services Office and increase the accessibility of benefits available to the Veterans of Santa Cruz County.

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

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

Describe how the following strategies were used:

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

The Veterans Advocate has the opportunity to reach out to veterans in the community and identify their needs through face to face interviews. The Veterans Advocate is able to assess the needs of each client and make appropriate referrals based on those needs.

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

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

Peer Companion

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

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

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

Target population:

- **Demographics**: (fill out chart)
- **What is the unduplicated number of individuals served in preceding fiscal year?** ___14_____
- **What is the number of families served?** ____0_____
- **Participants' risk of a potentially serious mental illness?** _____
- **How is the risk of a potentially serious mental illness defined and determined?**

Susan Fisher will assess risk and assign older adult MHSA clients to the Senior Companions and monitor their activities. Adjustments to planned activities will occur throughout the contract period based on the assessment of MHSA staff in collaboration with the Senior Companion Program Coordinator.

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

MHSA clients who are referred will be older adults at risk of elder abuse, trauma induced mental illness, depression, anxiety, suicidal ideation, and late onset mental illness. Senior Companions will provide peer support services to MHSA older adult clients selected for participation by Susan to help reduce psychiatric hospitalization and promote long term stability and an increased quality of life. To accomplish our goals Senior Companions use a variety of strategies including: encouraging social interaction; promoting physical activities & exercise; promoting activities that enhance emotional and mental health; assisting with arts & craft activities; assisting in reality orientation, encouraging socially appropriate behavior and providing transportation to socialization events and treatment appointments.

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

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

A minimum of 70% of MHSA clients participating will show improvement on at least one of the following quality of life indicators:

- social ties/social support

- mood and behavior improvement
- personnel expression
- companionship

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

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

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

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

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

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

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

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

6. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program**.
   See Assignment Plan and Senior Companion Eval Tool attached. These are the tools used to measure the outcomes targeted in the logic model for both clients served and Senior Companions who serve those clients.

Describe how the following strategies were used:

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

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

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

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

  Susan Fisher provides training and collateral information to Senior Companion assigned to her clients. In addition, Senior Companions attend monthly training through the Seniors Council. Current Senior Companions have been volunteering under Susan's supervision for many years (one volunteer for 10 years and the other for 6 years).

PEI Project- Early Intervention

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

1. **0-5 Early Intervention Stanford Neurodevelopmental Foster Care Clinic**:
   - **Purpose**: This **Early Intervention** program provides multi-disciplinary team mental health/family assessments for foster children aged 0-5, through a multi-agency funded clinic at the Stanford Children's Health Specialty Services site and located in Santa Cruz County. The program includes with PEI supported mental health services, as well as in-kind and contracted services for Stanford University specialist time from a developmental psychologist and a pediatrician.
   - **Target Population**: Foster children aged 0-5.
   - **Providers**: Santa Cruz County Behavioral Health
   - **Number of Individuals to be served each year**: 90
   - **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** There were problems with getting the referral forms completed and processed smoothly between all agencies. There has been a high level of turnover of staffing from Social Services which has made the process of referrals challenging.

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

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

Target population:

Demographics: Children in foster care under the age of 5

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

Mental illness or illnesses for which there is early onset: adjustment disorder, PTSD, anxiety disorders, mood disorders, attachment disorders

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

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

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

Most of these children have been removed from the care of their biological parents and/or caregivers due to serious abuse and neglect. Many of these children have survived traumatic events (such as witnessing domestic violence, parental drug addiction and criminality) and all of them have been living in poverty. Many of these children have not received developmentally appropriate parenting and have developmental delays related to expressing feelings and needs which can result in

aggression, defiance and acting out behaviors. In addition, many of these children experience challenges in sleeping, eating, toileting and social realms. Due to parental instability and challenges and then removal from family, many of these children experience attachment-challenges as well. Many of these children also have unmet needs with regards to health and education.

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

Outcomes:

List the mental health indicators used to measure reduction of prolonged suffering that result from untreated mental illness as measured by reduced symptom and/or improved recovery, including mental, emotional and relational functioning:
Mental health indicators used include the CANS assessment at intake and at 6-month intervals, caregiver, educational provider and clinician observation and reports of reduction in acting out and improved ability to regulate and express emotions, reduction in developmental delays and challenges in daily living and reduction in mental health symptoms.

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

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

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

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

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

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

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

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

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

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

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

Describe how the following strategies were used:

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

Children's Mental Health has built and maintained a strong partnership with the Department of Family and Children's services. As a result, 95% of the children who come to the attention of child welfare receive an assessment (as outlined above) by Children's Mental Health. If for some reason these children do not qualify for our services, they may be referred to one of our contract agencies, like the Parent Center. In addition, we provide case management services to connect these children with other needed services for physical health, education and recreation.

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

Due to the partnership mentioned above, 95% of the at-risk youth in this county are receiving this service. Children's Mental Health provides bilingual and bicultural clinicians whenever possible to ensure cultural and language appropriateness when needed. Clinicians are also trained in engagement and treatment with families and young children to ensure effective services are provided. Children's Mental Health provided field-based services to ensure that all children and families can participate in case transportation is a barrier. Children's Mental Health

mission is to work with families and communities to help youth stay in home, in school, and out of trouble. We strive to provide strength based, culturally appropriate, comprehensive community based mental health services using flexible "whatever it takes" approach to help families achieve their own positive outcome. Clinicians also flex their work time to ensure children and families can be seen at convenient times.

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

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

Employment Services

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

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

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

2. **Target population**:
   - **Demographics**: (fill out chart)
   - **What is the unduplicated number of individuals served in preceding fiscal year?** _____49_____
   - **What is the number of families served?** ____n/a_____
   - **Mental illness or illnesses for which there is early onset:** ___schizophrenia, bipolar dx, depression, PTSD, GAD
   - **Description of how participant's early onset of a potentially serious mental illness will be determined:**

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

3. **Identification of type(s) of problem(s) and need(s) for which program will be directed, and activities to be included in program to bring about mental health and related functional outcomes** (including suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes).
   Primary types of needs/problems: School failure, lack of education and skills, unemployment, underemployment, prolonged suffering, isolation, lack of support system, lack of knowledge of services. Activities will include academic and employment counseling, skill building and symptom management. Opportunities to participate in groups with peers and information to find meaningful activities. Clients will have an opportunity to volunteer and meet employers in order to better prepare to enter the workforce. Clients are given opportunities to attend classes specific for mental health consumers at the college level. Services are provided in the community, at school, and in the workplace to reduce stigma and better serve the young adult population.

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

Improved access and retention in education, employment and volunteerism. ANSA assessment at intake and at 6-month intervals to assess for reduction in isolation and prolonged suffering.

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

- **Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects cultural competence**:
  Each consumer is given an ANSA assessment and Recovery Evaluation upon intake and at 6 month intervals to measure recovery outcomes. In addition, each consumer is encouraged to participate in Meaningful Activity including attending school, support group, training program, volunteer opportunities, or by becoming employed in part-time or full-time work. Data are collected on all activities performed by each consumer.

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

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

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

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

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

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

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

Ongoing trainings and supervision will ensure fidelity.

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

1. **Describe the evidence that the approach is likely to bring about applicable outcomes**:
   Because Community Connection is a para-professional organization, we provide practice-based tools to meet program effectiveness. We base these tools on Evidence Based Practices including supported employment, supported education, and Motivational Interviewing.

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

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

6. **Describe how the following strategies were used**:
   - **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):
     All consumers are asked at intake to discuss their medical history and any health care practitioners currently involved in their care. Each consumer is encouraged to seek medical/mental health treatment and is given resources to access this care if no providers are listed. Staff members at Community Connection are in regular contact with SC Mental Health, TAY team and other community resources in order to ensure that all consumers are able to access services.

   - **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):
     Community Connection is composed of a diverse employee pool including employees with lived experience, gender fluidity and those who are bilingual/bicultural. Our team is available to meet consumers anywhere in the community and to provide transportation to needed appointments and health/mental health care issues. Our services are payer blind and free to consumers.

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

PEI: TAY Services

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

Target population:

Demographics: See MHSA 18-19 report attached

What is the unduplicated number of individuals served in preceding fiscal year? 51 TAY

What is the number of families served? ____40_____

Mental illness or illnesses for which there is early onset: ___Psychosis NOS, schizophrenia, bipolar disorder, PTSD, Anxiety Disorder, OCD, Eating Disorders, Major Depression, Mood Disorder NOS, Substance-induced psychotic disorder_____

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

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

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

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

Outcomes:

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

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

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

ANSA reports- collected every 6 months

FSP Reports- collected continually

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

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

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

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

ANSA reports- determine areas of clinical concern for individuals

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

Explain how the practice's effectiveness has been demonstrated for the intended population.
ANSA reports- data used to develop treatment plan goals

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

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

FSP data reports
ANSA data reports

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

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

N/A

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

Describe how the following strategies were used:

Access and Linkage (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):
Referrals to ACCESS if deemed client meets system-of-care criteria for County MH services, referrals to vocational, educational and housing programs. Psycho-education for clients and their families

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

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

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

Psycho-education for clients and their families

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

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

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

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

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

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

2. **Number of potential responders:** __1511__annual_____

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

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

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

6. **Specify the methods to be used to reach out and engage potential responders and the methods to be used for potential responders and public mental health services providers to learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness**:
   By reaching out to different disciplines engaged with at risk seniors through visits and phone outreach, we are creating awareness of mental health issues that help responders to identify and allow for a response to signs and symptoms. In addition to program materials to staff, materials were distributed to clients through medical offices, a health fair, residential care facilities, art exhibit, senior centers and nonprofit agencies including the Grey Bears and Diversity Center.

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

All participants in our outreach are informed of local County mental health resources, including the 24/7 multilingual suicide crisis line and resources for seniors through the local directory. Program staff and volunteers have lists of local resources that include information on accessibility, housing, caregiver resources, home health, crisis intervention, case management and government services.

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

  Program presentations and informational trainings teach participants how to recognize problems associated with aging including depression, drug and alcohol issues, loss, grief and suicidal ideation. In addition to the service provided by senior peer counselors, resources available to seniors who are in need of additional support are identified that might include APS, County Access, Medi-Cal, Medicare licensed counseling, IHSS, MSSP, Stroke Center, CCCIL, Senior Network Services, Second Harvest and Liftline for transportation. Outreach services are available to all County residents, agencies, and organizations; however, special effort is used to prioritize underserved populations, such as LGBTQI, veterans and their families and any seniors with histories of substance use, sexual or physical abuse, domestic violence, and isolation.

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

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

PEI Project-Stigma and Discrimination Reduction:

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

NAMI

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

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

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

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

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

4. **Specify methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness, and/or seeking mental health services, and indicate timeframes for measurement of**:
   - **Changes in attitudes, knowledge and/or behavior related to seeking mental health services that are applicable to the specific program**, or
     By educating not only the clients, but also the family members, the providers, schools, and the community at large, the stigma against mental illnesses and the fear of seeking treatment is reduced for all.
     Education and Training Series – Training for Providers, Consumers and Families includes multi-week curriculum covering information about mental illness, how to work toward wellness and to communicate well with natural and professional supports. Post evaluations are given at the end of each class series.
     Family Class Series: Increased confidence in working with mentally ill family members, less fear and stigma related to mental illness, more understanding of needs and triggers that are important for wellness of their loved one's health, and more understanding of resources available.
     Peer to Peer Education Series: increased wellness for the consumer, new tools to help with wellness/recovery, and an ability to understand some of the triggers environmental

and physiological that contribute to stress and periods of emotional crisis. Wellness plans are part of the program and support of each other in a peer-based community is an important part of not feeling alone.
Provider Education Series: reducing stigma and increased knowledge of mental illness and linkage to care. Encourages therapists to consider serving persons with serious mental health needs.

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

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

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

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

NAMI Family-to-Family Education Program has been added to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP).
The research found that the family members who participated in Family-to-Family classes showed:

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

Two research studies have been conducted on NAMI Basics

- A 2008 study conducted by Missouri State University psychologist Dr. Paul Deal found that parents/caregivers who took the NAMI Basics course reported knowing more about the symptoms, assessment and treatment of mental illness

than they did before taking the course. The study also found that these parents felt better about themselves as caregivers after taking the course.

- A 2009-2010 study conducted by Dr. Kimberly Hoagwood of Columbia University and Dr. Barbara Burns of Duke Medical Center found that parents who took the NAMI Basics course reported taking better care of themselves, feeling more capable of advocating for their children and being able to communicate more effectively with their children after taking the course. The results of this study were published on May 6, 2011 in the Journal of Child and Family Studies.

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

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

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

(See above)

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

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

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

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

Evidence that our approach is providing applicable outcomes include positive post evaluation reports from participants. In addition, NAMI has thriving support groups, presentations, and classes due to a stellar reputation.

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

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

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

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

  Warmline - is supervised by experienced volunteer and staff with linkage to MH as needed for acute calls. Many families and the general public use the warm line for information on access to care, rehab, housing, case management, medications etc.

Primary function is linkage to care and help in a crisis to offer support and some assistance. It is not always answered immediately but usually within 24 hours. Many are linked to support groups and classes.

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

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

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

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

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

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

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

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

Shadow Speakers

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

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

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

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

4. **Specify methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness, and/or seeking mental health services, and indicate timeframes for measurement of**:
   - **Changes in attitudes, knowledge and/or behavior related to seeking mental health services that are applicable to the specific program**, or
     People often have a disconnect between the mass mainstream media portrayal of people with mental health diagnoses and the real life people with mental health diagnoses. The Shadow Speakers enable
     People to meet people in person who have severe mental health diagnoses and to acknowledge their charm, wit, candor, poignant life stories and humanity.
   - **Changes in attitude, knowledge, and/or behavior related to seeking mental health services that are applicable to the specific program**.
     We also get new members from people who hear about MHCAN from hearing speakers or from people they knew who heard speakers. We get a lot of feedback that the speakers bureau is very helpful in changing people's attitudes toward themselves and others with severe mental health diagnoses.
5. Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:
   B. If an evidence-based practice or promising practice was used to determine the program's effectiveness:
      1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome**.
   The CalMHSA Promising Practices Program identifies speakers bureaus themselves as a promising best practice.

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

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

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

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

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

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

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

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

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

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

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

- **Access and Linkage** (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs): *As the Shadows Speakers reach across the entire county with various places to speak, we are able to connect with people's families, allies and themselves to help them get resources and referrals. We get a lot of email and a lot of phone calls from family members after Shadow Speakers- and a lot of people reach out to us from the inpatient settings as well.*
- **Timely Access to Mental Health Services for Underserved Populations** (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services): *The Shadow Speakers enables us to reach people in communities where we may not already have anchored members. We are able to appear before different communities and make bridges for service and referral. We are able to communicate quickly to large, varied groups of people in different communities. For example, we now have a group of MHCANers in the local Baptist church community who outreach to people there in need of services.*
- **Stigma and Discrimination reduction** (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):

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

PEI Project- Suicide Prevention

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

Suicide Prevention services:

Purpose: to provide educational presentations, grief support, and the suicide hotline. The Suicide Crisis Line is available 24 hours, 7 days per week for those who are suicidal or in crisis, as well as for community members who are grieving the loss of a loved one to suicide, are concerned about the safety of another person, or are looking for assistance with finding community resources. Outreach presentations and trainings (which help to reduce stigma, raise awareness, and promote help seeking) are provided regularly throughout the County to a range of different at-risk groups, stakeholders, and service providers for various populations (including domestic violence prevention, professional and peer mental health support organizations, etc.). One focus of community outreach activities continues to be reaching groups who are higher at risk than in the general population – for example, survivors of suicide loss are up to forty times more likely to die of suicide than others. Suicide Prevention provides prevention and early intervention services.

Target Population: Everyone in Santa Cruz County.

As of October 2017, Suicide Prevention Service staff has provided 62 presentations to 5,650 individuals at: Vet-Net, Pajaro Valley Children, Cabrillo College, Santa Cruz High School, Watsonville High School, Soquel High School, QPR training, Trauma Training, Calciano Symposium, Pacific Coast Charter, CIBHS/CSUMB, Alternative Family Solutions, Santa Cruz Mental Health Advisory Board, Walk a Mile, Denim Day, Sons In Retirement, CalFRESH, QYLA, DeWitt Anderson, Tierra Pacifica Charter School, Santa Cruz PRIDE, Scotts Valley Unified School District, Behavioral Health Department, Cabrillo College, California Institute for Behavioral Health, Solutions, Pajaro Valley PRIDE, Salud Para la Gente, Santa Cruz Connect, St. Patrick's Church, Twin Lakes Church-Mental Health Conference, and Watsonville High School.

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

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

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

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

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

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

1. **Program Name**: PEI #3 Suicide Prevention Service, a program of Family Service Agency

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

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

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

5. **How is the selected method likely to bring about the selected outcomes by indicating how evidence-based standard or promising practice standard has demonstrated the practice's**

effectiveness, or if using a community and/or practice-based standard indication how the Agency/County will ensure fidelity to determine the program's effectiveness?

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

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

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

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

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

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

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

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

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

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

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

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

any community members with histories of substance use, sexual or physical abuse, domestic violence, and isolation, among others.

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

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

Number of people reached: 60

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

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

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

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

How is the selected method likely to bring about the selected outcomes by indicating how evidence-based standard or promising practice standard has demonstrated the practice's effectiveness, or if using a community and/or practice-based standard indication how the Agency/County will ensure fidelity to determine the program's effectiveness? Answer questions in either A **or** B**.**

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

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

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

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

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

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

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

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

Santa Cruz County Suicide Prevention Task Force

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

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

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

Describe how the following strategies were used:

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

  The Suicide Prevention Task Force is made up of a multidisciplinary collaborative of community stakeholders from throughout the county. The goal of the Task Force was to recognize and respond with an integrated service plan to the entire community, providing a network of suicide prevention services clearly defined for access at any time. By creating a Task Force inclusive of the community, we have a large network to share the plan and assist in educating on access and linkage for services.

  In FY18-19 key informant interviews were conducting with 111 community members to gain information on current ideas, thoughts and feelings about suicide within Santa Cruz County. The interviews also sought information on knowledge of current programming to gain understanding of community knowledge on strengths and identified gaps.

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

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

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

Stigma and Discrimination reduction (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):
An overarching goal of the Suicide Prevention Task Force is to decrease stigma associated with mental illness and suicide in the community. By educating and informing our community about behavioral health issues, treatment accessibility and options, recovery and healing we create a safer community for people experiencing these issues. Overarching community education on risk and protective factors as well as direct information on services will be a focus of stigma reduction.

PEI Project- 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.

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

1. 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 the few 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 specialty mental health service system. One of the primary purposes of this program is to provide a client-centered alternative to sub-acute psychiatric care for people who historically have had to access acute inpatient hospital and/or sub-acute programs (e.g., Telos or the Crisis Stabilization Program/Psychiatric Health Facility at Telecare) as their only alternatives for support on their journey to recovery. 2nd Story also assists guests with connecting to physical health appointments, with smoking cessation, and transforming the way they see themselves in the world and interact with others.

2. 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 will accept up to 5 adults age 18 and older, with an average length of stay of 14 days. Treatment consists of Recovery-based support by trained peer staff through a mutual understanding of mental health challenges based on the staff's "lived experiences" using an evidence-based practice called "Intentional Peer Support" (IPS). Individuals seeking service are self-referred, screened by Second Story staff through an interview and assessment process. Peer staff will utilize community-based partners (e.g., County Behavioral Health) for additional guest support team services to ensure connectedness. Second Story will maintain connection with county coordinators of care or other contract providers to identify individuals needing assessment or treatment.

3. 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 staff work closely with Santa Cruz County Behavioral Health Services to augment guest self-referrals and linkage to resources as indicated. Santa Cruz County Behavioral Health Services will continue 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. In crisis situations, 2nd Story will engage the MERT Team and/or other liaisons for support.

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

Second Story supports guest requests for connection to resources, and will coordinate with other mental health system providers and family members. Substantial collaboration exists with Mental Health Access Team, Santa Cruz County Behavioral Health Services coordinators, NAMI, program managers, and psychiatrists. Second Story will maintain regular contact with other mental health contractors and resources including, Homeless Persons Health Project and the Homeless Resource Center.

Demographic information-

See report submitted 7/31/20, with Second Story FY 2019-20 quarterly demographic data.

5. Outcomes:
    - 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_

6. Indicate if the Agency/County intends to measure outcomes in addition to those required (listed in #7 above), and if so, what outcome(s) and how will it be measured? Include timeframes for measurement.

    __X__ No_____ Yes

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

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

Second 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. Second 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 team. 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 (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):

Second Story promotes a welcoming environment that is accessible to 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, participation in community events, so that people may find support through others on-site. All activities are directed by guests' expressed requests and needs.
Form in Spanish and English are provided and translation services are engaged as needed for accessibility to services.

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

Second Story remains dedicated to serve as a respite and voluntary housing option for people by offering support and connection with a peer recovery model. 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, Second 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. Second Story supports an environment through which narratives about people and their experiences are shared. Peers discuss ways of seeing beyond the diagnosis, seeing beyond the need for alienating ourselves from our community.

Mobile Crisis

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

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

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

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

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

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

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

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

How will individuals, and, as applicable, their parents, caregivers, or other family members be linked to county mental health services, a primary care provider, or other mental health treatment?

MERT/MHL clinician will always review appropriate resources including all available treatment options to meet consumer's needs. Parents and other natural supports will be welcomed and included in this process with appropriate consent. MERT/MHL clinicians will encourage consumers to utilize family support and resources.

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

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

Outcomes:

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

Indicate if the Agency/County intends to measure outcomes in addition to those required (listed in #7 above), and if so, what outcome(s) and how will it be measured? Include timeframes for measurement.

____x__ No _____ Yes

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

Describe how the following strategies were used:

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

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

MERT clinicians available during regular Monday through Friday business hours. MHL are available 7 days a week from 8am-7pm. There is a 24-hour 800 number available for providing after-hours information, consultation, and linkage to emergency services.

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

MERT /MHL values and provides in team training/discussions regarding establishing good rapport through welcoming practices. Clinicians also are provided time to attend the 15-hour NAMI Provider Education Training.

MHL are actively involved with development and training for the local county CIT trainings for law enforcement officials, focused on stigma reduction.

Santa Cruz County Behavioral Health also provides various training including consumer panels to increase empathy, awareness, sensitivity, and general welcoming skills.

INNOVATIVE PROJECTS- "INN"

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

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

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

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

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

Providers: Front Street

Number of individuals to be served each year: 60

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
Challenges in securing and retaining Peers for employment opportunities. Challenges with telehealth implementation and consumer adherence to the intervention, which are being mitigated through a continuous process improvement project to improve enrollment and utilization of the devices. In addition, challenges with finding appropriate facilities for supportive housing model. Once the housing opportunities were found the contract process has taken months to finalize and secure housing.

Performance Outcomes: Demographic information of unduplicated clients:

Annual Target: 60

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

B. New Innovative Project Budget By FISCAL YEAR (FY)*							
EXPENDITURES	Beg: April 2017					Ends: March 2022	
NON RECURRING COSTS (equipment, technology)	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Contractor: Telehealth Devices @ $1,000/each x 60 devices	60,000	-	-	-	-	-	60,000
Contractor: Telehealth Integration Fees @ $30,000	30,000	-	-	-	-	-	30,000
Iphone (for Medical Assistant @ approx. $200/each)	200						200
Total Non-recurring costs	90,200	-	-	-	-	-	90,200
Personnel	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Medical Assistant (Salaries & Benefits)	21,509	90,924	96,099	96,099	98,489	75,719	478,839
Medical Assistant (Operational Costs)	1,549	4,192	4,217	4,217	4,229	3,030	21,434
Total Personnel	23,058	95,116	100,316	100,316	102,718	78,749	500,273
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Contractor: Integrated Health Housing Support Team	162,718	671,346	684,773	698,468	712,436	545,013	3,474,754
Contractor: Master Lease & Rent Subsidies	95,000	380,000	391,400	410,970	431,519	339,821	2,048,710
Total Contract Operating Costs	257,718	1,051,346	1,076,173	1,109,438	1,143,955	884,834	5,523,464
OTHER EXPENDITURES (please explain in budget narrative)	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Contractor: Telehealth Connection/Software Fees (60 devices)	12,420	49,680	50,400	51,120	51,840	39,420	254,880
Contractor: Program Evaluation	50,000	25,000	25,000	50,000	50,000	25,000	225,000
Total Other Expenditures	62,420	74,680	75,400	101,120	101,840	64,420	479,880
BUDGET TOTALS	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Non-recurring costs	90,200	-	-	-	-	-	90,200
Personnel	23,058	95,116	100,316	100,316	102,718	78,749	500,273
Contract Operation Costs	257,718	1,051,346	1,076,173	1,109,438	1,143,955	884,834	5,523,464
Other Expenditures	62,420	74,680	75,400	101,120	101,840	64,420	479,880
Total Gross Budget	**433,396**	**1,221,142**	**1,251,889**	**1,310,874**	**1,348,513**	**1,028,003**	**6,593,817**
Administrative Cost @ 15% Net of INN Funds	45,408	103,162	106,666	114,702	119,375	91,288	580,602
Grand Total	**478,804**	**1,324,304**	**1,358,555**	**1,425,576**	**1,467,888**	**1,119,291**	**7,174,419**
C. Expenditures By Funding Source and FISCAL YEAR (FY)							
Estimated total mental health expenditures for the entire duration of this INN Pro	**FY1617**	**FY1718**	**FY1819**	**FY1920**	**FY2021**	**FY2122**	**Total**
Innovative MHSA Funds	348,128	790,911	817,774	879,381	915,210	699,875	4,451,280
Federal Financial Participation	73,188	303,440	310,828	316,242	322,725	246,951	1,573,374
Behavioral Health Subaccount	19,988	79,953	79,953	79,953	79,953	59,965	399,765
Other funding* - MHSA CSS	37,500	150,000	150,000	150,000	150,000	112,500	750,000
Total Proposed Administration	478,804	1,324,304	1,358,555	1,425,576	1,467,888	1,119,291	7,174,419
*If "Other funding" is included, please explain.							

WORKFORCE EDUCATION & TRAINING

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

A. **CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES**

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

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

B. **ADDITIONAL ASSISTANCE NEEDS FROM EDUCATION & TRAINING PROGRAMS**

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

The proposed training over the next three years is based on 3 different need areas: Core Competencies which will serve as the foundation to support the effective implementation and sustainability of Evidence Based Practices, the adoption of three national Evidence Based Practices: Integrated Illness Management and Recovery (I-IMR), Evidence Based Supported Employment (EBSE), and Integrated Dual Disorders Treatment (IDDT).

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

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

1. Core Competencies Training
    a. Motivational Interviewing (MI), an approach developed by William Miller, has been well established as an effective way to promote behavior change in individuals. The pre-requisite to participating in the face-to-face MI training, is currently available.

Individuals first need to complete a free, four-hour, self-paced online course entitled the Tour of Motivational Interviewing: An Interprofessional Road Map for Behavior Change http://healtheknowledge.org/course/index.php?categoryid=53#TourOfMI.

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

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

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

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

    d. Mental Health First Aid (MHFA) is an 8-hour course that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training helps

participants identify, understand and respond to signs of addictions and mental illnesses. Mental Health First Aid is a research-based approach that provides skills-based training and teaches participants about mental health and substance-use issues. In 2019, we had five individuals from Behavioral Health complete the rigorous application process and get approved for the MHFA Facilitator training.

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

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

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

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

D. IDENTIFICATION OF SHORTAGES IN PERSONNEL

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

1. Psychiatrists (adult and child)
2. Bilingual mental health providers (psychiatrist, therapists, case managers)

3. Forensic mental health providers
4. Psychiatric Nurse practitioners
5. Clinical psychologists
6. Highly skilled practitioners treating co-occurring (mental health & substance abuse) disorders
7. Data Processing Programmer Analyst
8. Licensed Clinicians (LCSW, MFT, PhD)

INFORMATION TECHNOLOGY

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

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

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

We have two primary information technology needs:

1. To increase consumer and family empowerment. Access to knowledge is a human right. Every client will be tech literate and have Internet access to increase communication between each other and all the supports that promote recovery, wellness, resiliency, and social inclusion. Our goal is to have computer access for consumers in housing and kiosks at existing clinic sites, and to provide technical support and training (for consumers and staff). We will begin with the addition of six terminals at sites in both Santa Cruz and Watsonville, and available to both children, adult and family members. Security issues will be addressed by posting signs in English and Spanish stating:
   "This is a public computer. For your security we advise that you take these steps: 1. Do not save your logon information. 2. Do not leave the computer unattended with sensitive information on the screen. 3. Delete your temporary files and your history. 4. Do not enter sensitive information on public computers."

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

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

One of the challenges we found in implementing the first and second phases is that we lack the administrative capacity to both negotiate and implement at the same time. Our administrative have diligently set priorities and we are reaching our benchmarks. As you know with health reform and changes to Medi-Cal, the challenge is staying current with changes and doing new implementation at the same time.

CAPITAL FACILITIES

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

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

ATTACHMENTS-

MHSA Quarterly and Annual Reports

COMMUNITY SERVICES AND SUPPORTS (CSS)

Intent: To provide services and supports for children and youth who have been diagnosed with or may have serious emotional disorders, and adults and older adults who have been diagnosed with or may have serious and persistent mental illness.

CSS Program #1: Community Gate:

- **Purpose**: To address the mental health needs of children/youth in the Community at risk of hospitalization, placement, and related factors. These services include assessment, individual, group, and family therapy with the goal of improved mental health functioning and maintaining youth in the community.

Agency Reporting	**Encompass**				
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					150
Number of individuals/families **ACTUALLY SERVED**	155	165	177	153	294
Age Group					
• Children 0-15	117	124	133	113	214
• TAY 16-25	38	41	44	40	80
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	338	34	29	24	55
• Latino	98	108	117	103	193
• Other	19	23	31	26	46
Primary Language					
• English	101	109	114	101	187
• Spanish	44	48	51	46	91
• Other	10	8	12	6	16
Culture					
• Veterans					
• LGBTQ	14	19	17	11	26

Agency Reporting	**PVPSA**				
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					100
Number of individuals/families **ACTUALLY SERVED**	72	106	204	257	356
Age Group					
• Children 0-15	65	91	176	213	297
• TAY 16-25	7	15	28	44	59

• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White		3	10	13	15
• Latino	65	96	187	233	321
• Other	7	7	7	11	20
Primary Language					
• English	60	86	176	229	310
• Spanish	9	19	28	28	43
• Other	3	1			3
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					175
Number of individuals/families **ACTUALLY SERVED**	168	216	256	290	290
Age Group					
• Children 0-15	96	96	80	89	146
• TAY 16-25	72	76	104	104	144
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	63	62	62	74	102
• Latino	92	97	101	97	156
• Other	2	3	4	4	6
Primary Language					
• English	143	152	164	176	256
• Spanish	25	20	20	17	34
• Other					
Culture					
• Veterans					
• LGBTQ	16	16	16	19	24

CSS Program #2: Probation Gate

- **Purpose**: To address the mental health needs (including assessment, individual, group, and family therapy) of youth involved with, or at risk of involvement, with the Juvenile Probation system. The System of Care goal (shared with Probation) is keeping youth safely at home rather than in prolonged stays of residential placement or incarcerated in juvenile hall.

Agency Reporting	**PVPSA**				
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					68
Number of individuals/families **ACTUALLY SERVED**	42	44	51	43	72
• Children 0-15	33	36	45	36	61
• TAY 16-25	9	8	6	7	11
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	1			1	2
• Latino	38	42	50	42	67
• Other	3	2	1		3
Primary Language					
• English	37	39	43	37	63
• Spanish	4	5	8	6	8
• Other	1				1
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Encompass**				
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					150
Number of individuals/families **ACTUALLY SERVED**	155	165	177	153	294
Age Group					
• Children 0-15	117	124	133	113	214
• TAY 16-25	38	41	44	40	80
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	338	34	29	24	55
• Latino	98	108	117	103	193
• Other	19	23	31	26	46
Primary Language					
• English	101	109	114	101	187
• Spanish	44	48	51	46	91
• Other	10	8	12	6	16
Culture					
• Veterans					
• LGBTQ	14	19	17	11	26

CSS Program #3: Child Welfare Services Gate

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

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

Agency Reporting	**Encompass ILP**				
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					
Number of individuals/families **ACTUALLY SERVED**	44	39	42	37	58
Age Group					
• Children 0-15				1	1
• TAY 16-25	44	39	41	36	57
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	11	10	12	8	14
• Latino	25	23	24	23	35
• Other	8	6	5	6	9
Primary Language					
• English	38	34	37	30	49
• Spanish	6	5	4	7	9
• Other					
Culture					
• Veterans					
• LGBTQ	13	14	14	8	17

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					200
Number of individuals/families **ACTUALLY SERVED**	143	180	206	226	226
• Children 0-15	94	105	100	93	148
• TAY 16-25	49	45	50	48	77
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	47	48	42	45	71
• Latino	81	88	89	80	129
• Other	4	3	4	2	4
Primary Language					
• English	124	133	139	129	198
• Spanish	18	17	11	12	26
• Other					
Culture					
• Veterans					
• LGBTQ	6	6	8	7	9

CSS Program #4: Education Gate

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

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					
Number of individuals/families **ACTUALLY SERVED**	39	47	51	58	58
Age Group					
• Children 0-15	10	13	6	9	18
• TAY 16-25	29	23	24	21	40
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	11	12	11	11	17
• Latino	26	24	18	19	38
• Other					
Primary Language					
• English	30	31	25	27	49
• Spanish	9	5	5	3	9
• Other					
Culture					
• Veterans					
• LGBTQ	2	2	4	4	5

CSS Program #5: Special Focus: Family Partnerships

- **Purpose**: Family and Youth Partnership activities provided by parents and youth, who are or have been served by our Children's Interagency System of Care, to support, outreach, education, and services to parent and youth services in our System of Care.

Agency Reporting	**Volunteer Center-Family Partnerships**				
Outreach & Engagement	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					50
Number of individuals/families **ACTUALLY SERVED**	37	44	53	50	60
Age Group					
• Children 0-15	37	28	40	41	53
• TAY 16-25	6	6	13	9	12
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	12	15	17	17	19
• Latino	22	22	27	26	35
• Other	9	7	9	7	11
Primary Language					
• English	30	30	35	36	47
• Spanish	13	14	18	14	18
• Other					
Culture					
• Veterans					
• LGBTQ	8	9	13	10	13

CSS Program #6: Enhanced Crisis Response

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

Agency Reporting	**Encompass: El Dorado Center**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					15
Number Actually Served	5	11	7	4	18
Adults (26-59)					
Number of individuals/families targeted					70
Number Actually Served	33	40	42	20	85
Older Adults (60+)					
Number of individuals/families targeted					15
Number Actually Served:	11	3	5	5	20
Unduplicated Annual Target for all					100
Race/Ethnicity					
• White	32	37	32	19	81
• Latino	13	11	16	8	29
• Other	4	6	5	2	13
Primary Language					
• English	46	51	49	27	114
• Spanish	3	2	4	2	8
• Other		1			1
Culture					
• Veterans					
• LGBTQ	4	2	2	1	7

Agency Reporting	**Encompass: Telos**				
Outreach and Engagement	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					20
Number of individuals/families **ACTUALLY SERVED**					
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					20
Number Actually Served	7	4	3	4	16
Adults (26-59)					
• Number of individuals/families targeted					65

• Number Actually Served	43	46	29	18	105
• **Older Adults (60+)**					
• Number of individuals/families targeted					15
• Number Actually Served	7	7	6	4	19
Race/Ethnicity					
• White	38	43	28	14	95
• Latino	12	10	8	7	27
• Other	7	4	2	5	18
Primary Language					
• English	54	51	35	22	130
• Spanish	2	5	3	4	9
• Other	1	1			1
Culture					
• Veterans					
• LGBTQ	4	4		1	8
Agency Reporting	**Santa Cruz County Behavioral Health Services-Access**				
Number of individuals/families **ACTUALLY SERVED**	324	607	798	896	896
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	54	57	35	30	153
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	230	241	157	85	639
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	40	36	33	11	104
Race/Ethnicity					
• White	201	222	135	65	551
• Latino	82	75	50	37	218
• Other		5	7	5	18
Primary Language					
• English	305	308	208	109	821
• Spanish	15	18	6	8	44
• Other	1	3	3	0	6
Culture					
• Veterans	3	3	1	1	7
• LGBTQ	9	9	7	3	23

Agency Reporting	**MHCAN @ PHF**				
Outreach	Q1	Q2	Q3	Q4	Annual

Number of individuals/families targeted:	25	25	25	25	100
Number of individuals/families **ACTUALLY SERVED**	68	108	48	62	

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

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

Agency Reporting	**MHCAN**				
System Development	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:	20	20	20	20	80
Number of individuals/families **ACTUALLY SERVED**	26	34	78	34	172
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					200
Number Actually Served	211	247	101	108	
Adults (26-59)					
Number of individuals/families targeted					350
Number Actually Served	313	344	208	445	1783
Older Adults (60+)					
Number of individuals/families targeted					50
Number Actually Served:	637	709	401	790	
TOTAL UNDUPLICATED					2537
Race/Ethnicity					
• White	326	378	209	387	
• Latino	147	159	123	235	
• Other	164	173	69	43	
Primary Language					
• English	434	486	295	559	
• Spanish	145	156	89	114	
• Other	17	67	17	36	
Culture					
• Veterans	39	48	29	45	37
• LGBTQ	124	142	98	122	188

Agency Reporting	**Volunteer Center/Community Connection: Mariposa**				
Outreach	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					**50**
Number of individuals/families **ACTUALLY SERVED**	43	54	4	14	71
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					8
Number Actually Served	3	2	5	5	5
Adults (26-59)					

Number of individuals/families targeted					25
Number Actually Served	36	23	31	31	41
Older Adults (60+)					
Number of individuals/families targeted					7
Number Actually Served:	10	6	11	11	13
Race/Ethnicity					
• White	27	14	23	23	32
• Latino	17	13	18	18	20
• Other	5	1	6	6	7
Primary Language					
• English	41	26	39	39	49
• Spanish	8	5	8	8	10
• Other					
Culture					
• Veterans	4	1	2	2	4
• LGBTQ	2	1	5	5	5

CSS Program #8: Community Support Services

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

Agency Reporting	**Santa Cruz County Behavioral Health Services MOST**				
Number of individuals/families **ACTUALLY SERVED**	115	139	152	158	158
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	17	19	11	9	15
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	92	102	100	88	131
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	6	8	7	4	12
Unduplicated Annual Target for All					100
Race/Ethnicity					
• White	79	82	71	60	101
• Latino	27	37	36	32	44
• Other	1	2	1	1	2
Primary Language					
• English	112	122	112	96	149
• Spanish	3	7	6	5	9
• Other					
Culture					
• Veterans	1	1	1	2	2
• LGBTQ	5	5	4	4	5

Agency Reporting	**Santa Cruz County Behavioral Health Services OAS**				
Number of individuals/families **ACTUALLY SERVED**	54	58	79	88	88
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served					
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	2	1			1
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	52	41	59	65	87
Unduplicated Annual Target for All					60
Race/Ethnicity					

• White	47	35	59	58	78
• Latino	3	2	3	2	5
• Other					
Primary Language					
• English	53	40	54	63	86
• Spanish					
• Other	1	2	2	2	2
Culture					
• Veterans					
• LGBTQ	2	1	1	1	2

Agency Reporting	**Santa Cruz County Behavioral Health Services-RECOVERY**				
Number of individuals/families **ACTUALLY SERVED**	3309	369	419	473	473
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	7	5	2	11	21
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	227	223	225	224	332
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	73	67	83	80	117
Unduplicated Annual Target for All					450
Number Actually Served:					
Race/Ethnicity					
• White	217	210	207	215	322
• Latino	70	56	67	67	104
• Other	9	8	8	8	11
Primary Language					
• English	282	271	279	284	430
• Spanish	21	15	22	25	32
• Other	5	6	5	5	6
Culture					
• Veterans	1	1	2	2	3
• LGBTQ	7	7	4	4	9

Agency Reporting	**Front Street: Housing Support**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					5
Number Actually Served	1	1	1	1	1
Adults (26-59)					
Number of individuals/families targeted					20
Number Actually Served	15	16	16	17	17
Older Adults (60+)					

Number of individuals/families targeted					5
Number Actually Served:	8	8	8	9	9
Race/Ethnicity					
• White	19	19	19	20	20
• Latino	3	3	34	4	4
• Other	2	3	3	3	3
Primary Language					
• English	24	25	25	27	27
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Front Street: Wheelock**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					2
Number Actually Served					
Adults (26-59)					
Number of individuals/families targeted					12
Number Actually Served	11	12	9	9	
Older Adults (60+)					
Number of individuals/families targeted					2
Number Actually Served:	5	6	6	6	
Race/Ethnicity					
• White	11	11	11	11	
• Latino	3	3	3	3	
• Other	2	1	1	1	
Primary Language					
• English	15	15	14	14	
• Spanish	1	1	1	1	
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Front Street: Willowbrook**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served					
Adults (26-59)					
Number of individuals/families targeted					20
Number Actually Served	25	25	24	26	32
Older Adults (60+)					
Number of individuals/families targeted					20
Number Actually Served:	19	17	17	17	19

Race/Ethnicity					
• White	34	35	34	36	39
• Latino	2	2	3	4	4
• Other	8	5	3	3	8
Primary Language					
• English	44	42	41	43	51
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ	2	2	1	1	2

Agency Reporting	**Front Street: Housing Property Management**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served					
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	50	50	52	58	65
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:					
Race/Ethnicity					
• White					
• Latino					
• Other	50	50	52	58	65
Primary Language					
• English	48	48	50	56	63
• Spanish	2	2	2	2	2
• Unknown					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Front Street: Opal Cliffs**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					1
Number Actually Served	2	2	2	2	2
Adults (26-59)					
Number of individuals/families targeted					12
Number Actually Served	10	10	10	10	12
Older Adults (60+)					
Number of individuals/families targeted					1
Number Actually Served:	3	3	3	3	3
Race/Ethnicity					
• White	14	13	13	13	15

• Latino					
• Other	2	2	2	2	2
Primary Language					
• English	16	16	15	15	17
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Encompass: Supported Housing**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served					
Adults (26-59)					
Number of individuals/families targeted					60
Number Actually Served	15	21	22	22	27
Older Adults (60+)					
Number of individuals/families targeted					0
Number Actually Served:	12	12	15	16	18
Race/Ethnicity					
• White	2	29	31	32	39
• Latino	1	1	2	2	2
• Other/Unknown	4	3	4	4	4
Primary Language					
• English	27	33	37	38	45
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ	5	5	5	5	5

Agency Reporting	**Community Connection: Housing Support (employment)**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					15
Number Actually Served					
Adults (26-59)					
Number of individuals/families targeted					20
Number Actually Served	17	18	18	18	18
Older Adults (60+)					
Number of individuals/families targeted					15
Number Actually Served:	2	2	2	2	2
Race/Ethnicity					
• White	15	16	16	16	16
• Latino	2	2	2	2	2

• Other	2	2	2	2	2
Primary Language					
• English	18	19	19	19	19
• Spanish					
• Other	1	1	1	1	1
Culture					
• Veterans					
• LGBTQ	3	3	3	3	3

Agency Reporting	**Community Connection: College Connection**				
Outreach	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted					25
Number Actually Served	23	23	29	30	30

Agency Reporting	**Community Connection: Opportunity Connection**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					10
Number Actually Served	1	1	1	1	1
Adults (26-59)					
Number of individuals/families targeted					50
Number Actually Served	29	33	32	29	35
Older Adults (60+)					
Number of individuals/families targeted					10
Number Actually Served	10	12	11	11	12
Race/Ethnicity					
• White	27	32	30	27	36
• Latino	3	3	3	3	3
• Other	10	11	14	14	9
Primary Language					
• English	39	46	43	40	47
• Spanish					
• Other	1	1	1	1	1
Culture					
• Veterans	1	1	1	1	1
• LGBTQ	4	5	5	3	5

Agency Reporting	**Community Connection: Avenues Employment Services**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					

Number of individuals/families targeted					25
Number Actually Served	9	6	9	4	13
Adults (26-59)					
Number of individuals/families targeted					10
Number Actually Served	16	22	24	20	38
Older Adults (60+)					
Number of individuals/families targeted					0
Number Actually Served	1	2	3	1	4
Race/Ethnicity					
• White	12	17	20	12	28
• Latino	5	7	7	6	12
• Other	9	6	9	7	15
Primary Language					
• English	23	25	33	23	49
• Spanish	3	4	3	2	5
• Other		1			1
Culture					
• Veterans	1				1
• LGBTQ	2	1	3	2	5

Agency Reporting	**Encompass: River Street Shelter**				
Outreach and Engagement	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					125
Number of individuals/families **ACTUALLY SERVED**	32	28	32	4	71
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					5
Number Actually Served	6	4	2		7
Adults (26-59)					
Number of individuals/families targeted					80
Number Actually Served	40	34	29	13	80
Older Adults (60+)					
Number of individuals/families targeted					10
Number Actually Served:	10	9	4	1	12
Race/Ethnicity					
• White	34	30	21	8	58
• Latino	9	6	4	2	15
• Other	13	12	10	4	26
Primary Language					
• English					

• Spanish					
• Other					
Culture					
• Veterans	2	2	1		4
• LGBTQ	1	2	1	1	5

Agency Reporting	**Encompass: Casa Pacific**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					6
Number Actually Served	6	7	3	1	11
Adults (26-59)					
Number of individuals/families targeted					28
Number Actually Served	16	15	17	13	29
Older Adults (60+)					
Number of individuals/families targeted					6
Number Actually Served	3	2	1	1	4
Race/Ethnicity					
• White	17	15	13	7	36
• Latino	8	9	6	6	15
• Other			2	2	3
Primary Language					
• English	22	20	18	12	49
• Spanish	3	4	3	3	5
• Other					
Culture					
• Veterans					
• LGBTQ	2	2	2	1	4

PREVENTION & EARLY INTERVENTION (PEI)

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

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

Agency Reporting: Triple P

PREVENTION

Work Plan #1: Triple P (First 5) Prevention Program Annual Target #: 1,300

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual**
Unduplicated Client Count	96	86	100	49	196
Age:					
0-15					
16-25	7	6	8	6	13
26-59	83	77	91	41	176
60 +	6	3	1	2	7
Declined to State					
Language:					
English	60	62	65	43	118
Spanish	36	24	35	6	78
Other					
Race:					
American Indian or Alaskan Native	4	3	3	2	5
Black	1	1		1	2
White	82	70	85	41	163
Asian	1	3	1	1	3
Native Hawaiian /Other Pacific Islander		1			1
Other	1				1
More than one	6	4	2	3	8
Declined to State	1	4	9	1	13
Ethnicity					
Latino	66	53	60	22	127
African					
Asian Indian/South Asian					
Filipino					
Other	29	30	32	27	57
More than One					

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Declined to State	1	3	8		12
Veteran					
Yes	3	2	4	3	4
No	91	80	90	46	181
Declined to State	1	3	6		10
Unknown**	1	1			1
Sexual Orientation					
Gay or Lesbian	3				3
Heterosexual or Straight	68	72	79	44	140
Questioning or Unsure					
Queer					
Another Sexual Orientation	1		1		2
Declined to State	23	13	20	5	50
Unknown**	1	1			1
Gender Assigned at birth					
Male	27	24	34	17	54
Female	68	58	61	30	131
Declined to State		3	5	2	10
Unknown**	1	1			1
Current Gender Identity					
Male	27	24	33	17	54
Female	69	59	61	31	133
Transgender Male					
Transgender Female			1	1	1
Gender Queer					
Questioning or Unsure					
Declined to State		3	5		8
Write in Option					
Disability					
Yes***(total unique clients with disability)*	14	13	12	12	25
• Communication Domain					
Difficulty Seeing	3	2	1	2	5
Difficulty Hearing		1	1	2	2
Difficulty Having Speech Understood					
• Mental Domain					
(mental illness, learning disability, developmental disability, dementia)	7	6	8	6	12
• Physical/mobility	3	3	2	1	5
• Chronic health condition	2	3	1	3	5
• Other (Specify)		1	1	1	1
No	81	69	81	37	160
Declined to State		3	7		10
Unknown**	1	1			1
Other Relevant Data					

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Parents in brief services (L2 Individual, Seminars, Workshops) *(unique within all brief services, but may duplicate Intensive Service clients in this report)*	217	278	272	243	939

Agency Reporting: Live Oak Family Resource Center (COE)

Prevention

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	69	92	62	67	166
Age:					
0-15	2	4	4	4	8
16-25	4	4	4	4	10
26-59	43	60	49	55	120
60 +	20	24	5	5	28
Language:					
English	29	35	22	8	53
Spanish	40	52	40	59	113
Other	0	5	0	0	0
Race:					
American Indian or Alaskan Native	0	0	0	0	1
Black	0	1	0	0	1
White	34	45	20	8	55
More than one	32	27	29	43	78
Other	3	19	13	16	31
Ethnicity					
Hipanic or Latino	41	53	44	63	122
African	0	1	0	0	0
Other	25	34	16	3	42
Veteran					
Yes	0	0	0	0	0
No	28	41	26	37	77
Declined to State	41	51	36	30	89
Sexual Orientation					
Gay or Lesbian	0	0	1	1	1
Heterosexual or Straight	29	39	23	36	75
Declined to answer	40	53	38	30	90
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	10	17	13	15	37
Female	59	75	49	52	129
Declined to amswer	0	0	0	0	0

Current Gender Identity					
Male	10	17	13	15	37
Female	59	75	49	52	129
Transgendergender	0	0	0	0	0
Gemderqueer	0	0	0	0	0
Questioning or Unsure	0	0	0	0	0
Another gender idenity	0	0	0	0	0
Declined to answer	0	0	0	0	0

Agency Reporting: The Diversity Center (COE)

Prevention

	Q1: July, Aug, Sept	Q2: Oct, Nov, Dec	Q3:Jan, Feb, March	Q4: April, May, June	Annual
Unduplicated Client Count	1282	886	258	2072	4498
Age:					
0-15	484	593	67	334	1478
16-25	787	278	188	1653	2906
26-59	11	14	3	45	73
60 +	-	1	-	27	28
Declined to answer	-	-	-	13	13
Language:					
English	972	651	181	1213	3017
Spanish	303	235	77	798	1413
Other	7	-	-	61	68
Race:					
American Indian or Alaskan Native	6	21	4	69	100
Black	19	32	6	59	116
White	1204	641	220	1422	3487
Asian	20	19	10	50	99
Native Hawaiian or Other Pacific Islander	24	-	-	-	24
Declined to answer	9	39	18	299	365
Other	-	134	-	173	307
Ethnicity					
Hispanic or Latino	686	475	85	992	2238
Not hispanic or Latino	560	315	161	394	1430
Declined to answer	10	44	12	458	524
Other	26	52	-	228	306
Veteran					

Yes	N/A	N/A	N/A	N/A	
No	N/A	N/A	N/A	N/A	
Declined to State	N/A	N/A	N/A	N/A	
Sexual Orientation					
Gay or Lesbian	80	79	29	194	382
Heterosexual or Straight	814	611	167	1654	3246
Bisexual	103	32	33	128	296
Queer	149	49	-	69	267
Another Sexual Orientation	93	73	12	27	205
Declined to answer	43	42	17	-	102
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male					
Female					
Declined to answer	1282				
Current Gender Identity					
Male	464	317	80	870	1731
Female	623	498	149	1051	2321
Transgender	67	40	12	18	137
Genderqueer	66	10	5	21	102
Questioning or Unsure	31	2	3	22	58
Another gender identity	19	13	3	58	93
Declined to answer	12	6	6	32	56

Agency Reporting: PBIS (COE) **Prevention**

Work Plan #1: PVUSD, SCCS, LOSD, SUESD, SVUSD, SLVUSD, COE- PBIS Annual Target #: Prevention Program

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	54,752	54,752	54,752	54,752	54,752
Age:					
0-15					
16-25					
26-59					
60 +					
Language:					
English					
Spanish					
Other	54,752	54,752	54,752	54,752	54,752
Race:					
American Indian					
Black					
White					
Other					
More than one					
Declined to State	54,752	54,752	54,752	54,752	54,752
Ethnicity					
Latino	35,348	35,348	35,348	35,348	35,348
African	350	350	350	350	350
Asian Indian/South Asian					
Filipino	1,356	1,356	1,356	1,356	1,356
Other	16,026	16,026	16,026	16,026	16,026
More than One	974	974	974	974	974
Declined to State	698	698	698	698	698
Veteran					
Yes					
No	54,752	54,752	54,752	54,752	54,752
Declined to State					
Sexual Orientation					
Gay or Lesbian					
Homosexual or Straight					
Questioning or Unsure					
Queer					
Another Sexual Orientation					
Declined to State	54,752	54,752	54,752	54,752	54,752

Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male					
Female					
Declined to State	54,752	54,752	54,752	54,752	54,752
Current Gender Identity					
Male					
Female					
Transgender Male					
Transgender Female					
Gemder Queer					
Questioning or Unsure					
Declined to State	54,752	54,752	54,752	54,752	54,752
Write in Option					
Disability					
Yes:					
• Communication Domain					
Difficulty Seeing					
Difficulty Hearing					
Difficulty Having Speech Understood					
• Mental Domain					
(mental illness, learning disability, developmental disability, dementia)					
• Physical/mobility					
• Chronic health condition					
• Other (Specify)					
No					
Declined to State	54,752	54,752	54,752	54,752	54,752
Other Relevant Datat					

Agency Reporting: Trauma Informed Systems

Prevention

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD / Annual
Dates	Jul. 1-Sept. 30, 2019	Oct. 1-Dec. 31, 2019	Jan. 1-Mar. 30, 2020	Apr. 1- June 30, 2020	**329**
Behavioral Health Orientatio	0	11	0	0	11
COVID-19 Training	0	0	0	64	64
Crianza con Amor	0	5	15	0	20
Healing Circle	0	0	6	0	6
Healing Organizations Work	0	16	8	1	25
Leadership LC	0	0	2	1	3
TIS 101 Training	32	66	86	0	184
TIS 3.0 Clinic	16	0	0	0	16
Age:					
0-15	0	0	0	0	0
16-25	3	4	7	0	14
26-59	20	42	48	0	110
60 +	0	3	0	0	3
Declined to State	25	49	62	66	202
Language:					
English	20	35	27	0	82
English and Spanish	12	20	37	0	69
Spanish	0	1	19	0	20
Missing Info	16	42	34	66	158
Other	0	0	0	0	0
Race:					
American Indian	0	1	0	0	1
Black	1	0	0	0	1
White	11	24	21	0	56
Other	7	12	10	1	30
More than one	3	3	5	0	11
Declined to State	26	58	81	65	230
Ethnicity					
Latinx	13	26	47	1	87
African	0	0	0	0	0
Asian Indian/South Asian	0	1	1	1	3
Filipino	0	0	1	0	1
Other	4	12	6	0	22
More than One	1	4	1	0	6
Declined to State	30	55	61	64	210

Veteran					
Yes	-	-	-	-	-
No	-	-	-	-	-
Declined to State	48	98	117	66	329
Sexual Orientation					
Gay or Lesbian	-	-	-	-	-
Homosexual or Straight	-	-	-	-	-
Questioning or Unsure	-	-	-	-	-
Queer	-	-	-	-	-
Another Sexual Orientation	-	-	-	-	-
Declined to State	48	98	117	66	329
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	-	-	-	-	-
Female	-	-	-	-	-
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**YTD / Annual**
Dates	Jul. 1-Sept. 30, 2019	Oct. 1-Dec. 31, 2019	Jan. 1-Mar. 30, 2020	Apr. 1- June 30, 2020	**329**
Declined to State	48	98	117	66	329
Current Gender Identity					
Male	9	13	11	1	34
Female	16	43	54	1	114
Transgender Male	0	1	0	0	1
Transgender Female	0	0	0	0	0
Gender Queer	0	0	0	0	0
Questioning or Unsure	0	0	0	0	0
Declined to State	23	41	52	64	180
Write in Option	0	0	0	0	0
Disability					
Yes:	--	---	---	---	---
· Communication Domain	--	---	---	---	---
Difficulty Seeing	--	---	---	---	---
Difficulty Hearing	--	---	---	---	---
Difficulty Having Speech Un	--	---	---	---	---
· Mental Domain	--	---	---	---	---
(mental illness, learning disa	--	---	---	---	---
· Physical/mobility	--	---	---	---	---
· Chronic health condition	--	---	---	---	---

· Other (Specify)	--	---	---	---	---
No	--	---	---	---	---
Declined to State	48	98	117	66	329
Other Relevant Data					
			The COVID-19 pandemic hit at the end of this quarter, limiting capacity for TIS 101 trainings and requiring all meetings to migrate online.	Pandemic and shelter-in-place orders were ongoing at this time.	

Agency Reporting: Employment (Community Connection)

Early Intervention Program

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	35	22	23	26	48
Age:					
0-15	0	0	0	0	0
16-25	31	18	21	21	42
26-59	4	4	5	5	6
60 +	0	0	0	0	0
Declined to answer	0	0	0	0	0
Language:					
English	33	21	23	23	43
Spanish	1	1	3	3	4
Other	1	0	1	0	1
Race:					
American Indian or Alaskan Native	0	0	0	0	0
Black	1	0	0	0	1
White	18	9	9	10	20
Asian	2	1	1	1	3
Native Hawaiian or Other Pacific Islander	0	0	0	0	0
Declined to answer	1	0	0	0	1
Other	4	3	4	5	8
Ethnicity					
Hipanic or Latino	9	9	12	10	15
Not hispanic or Latino	0	0	0	0	0
Declined to answer	0	0	0	0	0
Other	0	0	0	0	0
Veteran					
Yes	2	2	3	0	3
No	0	0	0	0	0
Declined to State	0	0	0	0	0

Sexual Orientation					
Gay or Lesbian	0	0	0	0	0
Heterosexual or Straight	14	8	13	13	22
Bisexual	0	0	0	0	0
Queer	1	0	0	0	1
Another Sexual Orientation	7	2	3	6	7
Declined to answer	13	10	10	7	15
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	15	10	15	15	22
Female	11	8	8	8	15
Declined to amswer	9	4	3	3	11
Current Gender Identity					
Male	13	8	12	12	19
Female	10	6	7	7	14
Transgendergender	0	0	0	0	0
Gemderqueer	2	0	0	0	2
Questioning or Unsure	1	1	1	1	1
Another gender idenity	0	0	0	0	0
Declined to answer	9	7	6	6	12

Work Plan #3: Veterans Advocate

Prevention

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	62	64	61	41	228
Age:					
0-15	0	0	0	0	0
16-25	0	0	2	1	3
26-59	20	20	22	16	78
60 +	42	44	37	24	147
Declined to answer	0	0	0	0	0
Language:					
English	62	64	61	41	228
Spanish	4	2	6	1	13
Other	0	0	0	0	0
Race:					
American Indian or Alaskan Native	0	0	0	1	1
Black	2	5	3	2	12
White	51	48	43	30	172
Asian	0	0	3	1	4
Native Hawaiian or Other Pacific Islander	0	0	0	0	0
Declined to answer	3	7	4	4	18
Other	6	4	8	3	21
Ethnicity					
Hipanic or Latino	5	4	8	3	20

Not hispanic or Latino	52	49	44	31	176
Declined to answer	3	7	4	4	18
Other	1	4	5	3	13
Veteran					
Yes	59	61	55	40	215
No	3	3	6	1	13
Declined to State	0	0	0	0	0
Sexual Orientation					
Gay or Lesbian	1	0	0	1	2
Heterosexual or Straight	49	47	43	27	166
Bisexual	0	0	0	0	0
Queer	0	0	0	0	0
Another Sexual Orientation	0	0	0	0	0
Declined to answer	12	17	18	13	60
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	59	56	49	37	201
Female	3	8	8	2	21
Declined to amswer	0	0	4	2	6
Current Gender Identity					
Male	55	51	49	37	192
Female	3	8	8	2	21
Transgendergender	0	0	0	0	0
Gemderqueer	0	0	0	0	0
Questioning or Unsure	0	0	0	0	0
Another gender idenity	0	0	0	0	0
Declined to answer	4	5	4	2	15

Agency Reporting Santa Cruz County Behavioral Health Services					
EARLY INTERVENTION		Services for Transition Age Youth and Adult			
July 1, 2018 to June 30, 2019	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	70	67	68	65	129
Age Group					
• Children 0-15					
• TAY 16-25	50	58	45	45	86
• Adults 26-59	20	9	22	19	41
• Older Adults 60+			1	1	2
Race/Ethnicity					
• White	24	27	30	24	55
• Latino	41	35	33	35	66
• Other	0	1	2	2	3
Primary Language					
• English	65	63	66	61	120
• Spanish	4	3	2	3	8
• Other	0	1	0	1	1
Culture					

• Veterans	0	0	0	0	0
• LGBTQ	5	5	6	4	9
•					

Agency Reporting		Santa Cruz County Behavioral Health Services			
ACCESS AND LINKAGE TO TREATMENT		MERT			
July 1, 2018 to June 30, 2019	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	83	176	287	334	334
Age Group					
• Children 0-15	1	27	30	12	80
• TAY 16-25	24	27	42	15	101
• Adults 26-59	35	14	34	25	116
• Older Adults 60+	7	8	20	6	37
Race/Ethnicity					
• White	39	57	77	28	179
• Latino	35	35	32	16	109
• Other	2	3	2	2	9
Primary Language					
• English	77	92	112	43	295
• Spanish	6	9	10	4	25
• Other	0	2	4	8	14
Culture					
• Veterans	0	1	1	0	2
• LGBTQ	6	5	9	2	17

Agency Reporting: Senior Outreach (FSA)

Outreach and Increasing Early Signs of Mental Illness Program

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	10	13	17	12	24
Age:					
0-15					
16-25					
26-59	1	0	0	0	1
60 +	9	13	17	12	23
Declined to answer					
Language:					
English	8	12	13	9	19
Spanish	2	1	4	3	5
Other					
Race:					
American Indian or Alaskan Native					
Black					
White	9	11	13	10	19
Asian					

Native Hawaiian or Other Pacific Islander					
Declined to answer	4	2	3	4	7
Other	2	4	5	2	5
Ethnicity					
Hipanic or Latino	3	2	5	4	6
Not hispanic or Latino					
Declined to answer	5	7	5	5	11
Other	2	4	5	2	5
Veteran					
Yes	2	2	1	2	2
No	8	11	16	10	22
Declined to State					
Sexual Orientation					
Gay or Lesbian					
Heterosexual or Straight					
Bisexual					
Queer					
Another Sexual Orientation					
Declined to answer	10	13	17	12	24
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	2	3	4	2	5
Female	8	10	13	10	19
Declined to amswer					
Current Gender Identity					
Male					
Female					
Transgender					
Genderqueer					
Questioning or Unsure					
Another gender idenity					
Declined to answer	9	12	15	12	21

Agency Reporting Senior Council					
PREVENTION					
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)					20
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59					
• Older Adults 60+					20
Race/Ethnicity					
• White					18
• Latino					1
• Other					1
Primary Language					
• English					18
• Spanish					1
• Other					1
Culture					
• Veterans					2
• LGBTQ					

BUDGET

Mental Health Services Act Three-Year Plan

2020-21 to 2020-23 Funding Summary

County: Santa Cruz Date: 4/19/21

	MHSA Funding				
	A	B	C		F
	Community Services and Supports	**Prevention and Early Intervention**	**Innovation**	**Housing Program**	**Prudent Reserve**
A. Estimated FY 2020/21 Funding					
1. Estimated Unspent Funds from Prior Fiscal Years	1,773,297	2,168,465	246,227	6,693	
2. Estimated New FY2020/21 Funding	13,208,751	3,302,188	868,997		
3. Transfer in FY2020/21a/	-				
4. Access Local Prudent Reserve in FY2020/21	-	-			
5. Estimated Available Funding for FY2020/21	14,982,048	5,470,653	1,115,224	6,693	
B. Estimated FY2020/21 MHSA Expenditures	**11,266,753**	**3,169,504**	**800,688**	-	
C. Estimated FY2021/22 Funding					

	1. Estimated Unspent Funds from Prior Fiscal Years	3,715,295	2,301,148	314,536	6,693	
	2. Estimated New FY2021/22 Funding	13,890,802	3,472,700	913,869		
	3. Transfer in FY2021/22a/ Access Local Prudent					
	4. Reserve in FY2021/22					
	5. Estimated Available Funding for FY2021/22	17,606,097	5,773,849	1,228,405	6,693	
D. Estimated FY2021/22 Expenditures		**13,028,500**	**3,701,395**	1,228,405	6,693	**-**
E. Estimated FY2022/23 Funding						
	1. Estimated Unspent Funds from Prior Fiscal Years	4,577,598	2,072,454	-	-	
	2. Estimated New FY2022/23 Funding	11,657,847	2,914,462	766,964		
	3. Transfer in FY2022/23a/ Access Local Prudent					
	4. Reserve in FY2022/23					
	5. Estimated Available Funding for FY2022/23	16,235,445	4,986,916	766,964	-	
F. Estimated FY2022/23 Expenditures		**13,679,925**	**3,886,465**	766,964	-	
G. Estimated FY2022/23 Unspent Fund Balance		2,555,520	1,100,451	-	-	

**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, 2020			2,997,367
2. Contributions to the Local Prudent Reserve in FY 2020/21			-
3. Distributions from the Local Prudent Reserve in FY 2020/21			-
4. Estimated Local Prudent Reserve Balance on June 30, 2021			2,997,367

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

Mental Health Services Act Three-Year Plan

Community Services and Supports (CSS) Component Worksheet

County: Santa Cruz Date: 4/19/21

	Fiscal Year 2020/21			
	A	**B**	**C**	**D**
	Estimated Total Mental Health Expenditures	**Estimated CSS Funding**	**Estimated Medi-Cal FFP**	**Estimated Other Funding**
FSP Programs				
1. Community Gate	0			

2.	Probation Gate	0			
3.	Child Welfare Gate	0			
4.	Education Gate	0			
5.	Family Partnerships	0			
6.	Enhanced Crisis Response	1,216,918	509,383	541,905	165,630
7.	Consumer, Peer, and Family Services	435,933	326,865	109,068	0
8.	Community Support Services	7,755,872	4,797,092	2,607,659	351,121
9.		0			
10.		0			
11.		0			
Non-FSP Programs					
1.	Community Gate	2,882,626	1,076,843	1,202,581	603,202
2.	Probation Gate	270,418	135,209	135,209	0
3.	Child Welfare Gate	1,365,032	406,163	662,643	296,226
4.	Education Gate	345,762	159,986	144,814	40,962
5.	Family Partnerships	19,019	10,452	8,567	0
6.	Enhanced Crisis Response	2,402,346	1,342,159	978,630	81,557
7.	Consumer, Peer, and Family Services	20,207	20,207	0	0
8.	Community Support Services	2,324,539	1,676,542	387,182	260,815
9.		0			
10.		0			
11.		0			
CSS Administration		1,118,120	791,451	326,669	0
CSS MHSA Housing Program Assigned Funds		0			
Community Program Planning		14,400	14,400	0	0

Total CSS Program Estimated Expenditures	20,171,192	11,266,752	7,104,927	1,799,513
FSP Programs as Percent of Total	83.5%			

	Fiscal Year 2021/22			
	A	**B**	**C**	**D**
	Estimated Total Mental Health Expenditures	**Estimated CSS Funding**	**Estimated Medi-Cal FFP**	**Estimated Other Funding**
FSP Programs				
1. Community Gate	0	0	0	0
2. Probation Gate	0	0	0	0
3. Child Welfare Gate	0	0	0	0
4. Education Gate	0	0	0	0
5. Family Partnerships	0	0	0	0
6. Enhanced Crisis Response	1,536,341	666,310	687,856	182,175
7. Consumer, Peer, and Family Services	407,034	304,845	102,189	0
8. Community Support Services	8,942,557	6,011,744	2,648,469	282,344
9.	0			
10.	0			
11.	0			
Non-FSP Programs				
1. Community Gate	2,817,064	1,103,077	1,165,206	548,781
2. Probation Gate	279,637	151,188	128,449	0
3. Child Welfare Gate	1,339,216	425,709	632,964	280,543
4. Education Gate	332,933	146,700	144,365	41,868
5. Family Partnerships	11,686	11,686	0	0
6. Enhanced Crisis Response	2,932,320	1,801,751	1,049,012	81,557
7. Consumer, Peer, and Family Services	76,561	76,561	0	0
8. Community Support Services	1,980,730	1,615,532	209,355	155,843

9.	0			
10.	0			
11.	0			
CSS Administration	999,930	698,997	300,933	-
CSS MHSA Housing Program Assigned Funds	0			
Community Program Planning	14,400	14,400	0	
Total CSS Program Estimated Expenditures	21,670,409	13,028,500	7,068,798	1,573,111
FSP Programs as Percent of Total	83.6%			

	Fiscal Year 2022/23			
	A	**B**	**C**	**D**
	Estimated Total Mental Health Expenditures	**Estimated CSS Funding**	**Estimated Medi-Cal FFP**	**Estimated Other Funding**
FSP Programs				
1. Community Gate	0	0	0	0
2. Probation Gate	0	0	0	0
3. Child Welfare Gate	0	0	0	0
4. Education Gate	0	0	0	0
5. Family Partnerships	0	0	0	0
6. Enhanced Crisis Response	1,613,158	699,626	722,249	191,284
7. Consumer, Peer, and Family Services	427,386	320,087	107,298	0
8. Community Support Services	9,389,685	6,312,331	2,780,892	296,461
9.	0			
10.	0			
11.	0			
Non-FSP Programs				
1. Community Gate	2,957,918	1,158,231	1,223,466	576,220

2.	Probation Gate	293,619	158,747	134,871	0
3.	Child Welfare Gate	1,406,176	446,994	664,612	294,570
4.	Education Gate	349,580	154,035	151,583	43,961
5.	Family Partnerships	12,270	12,270	0	0
6.	Enhanced Crisis Response	3,078,936	1,891,839	1,101,463	85,635
7.	Consumer, Peer, and Family Services	80,389	80,389	0	0
8.	Community Support Services	2,079,767	1,696,309	219,823	163,635
9.		0			
10.		0			
11.		0			
CSS Administration		1,049,927	733,947	315,980	-
CSS MHSA Housing Program Assigned Funds		0			
Community Program Planning		15,120	15,120	-	-
Total CSS Program Estimated Expenditures		22,753,929	13,679,925	7,422,238	1,651,766
FSP Programs as Percent of Total		83.6%			

Mental Health Services Act Three-Year Plan

Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Cruz Date: 24/19/21

	Fiscal Year 2020/21			
	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	902,731	540,275	287,148	75,308
2. Services for Diverse Communities	234,022	180,013	54,009	0
3. Transition Age Youth and Adult Services	2,404,295	2,090,033	314,262	0
4. Older Adult Services	37,116	37,116	0	0
PEI Administration	431,620	322,067	109,553	0
PEI Assigned Funds				
Total PEI Program Estimated Expenditures	4,009,784	3,169,504	764,972	75,308

	Fiscal Year 2021/22			
	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	873,930	528,441	271,519	73,970
2. Services for Diverse Communities	248,711	189,194	59,517	
3. Transition Age Youth and Adult Services	2,901,452	2,626,456	274,996	
4. Older Adult Services	36,785	36,785		
PEI Administration	429,543	320,519	109,024	0
PEI Assigned Funds				
Total PEI Program Estimated Expenditures	4,490,421	3,701,395	715,056	73,970

	Fiscal Year 2022/23			
	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	917,627	554,863	285,095	77,669
2. Services for Diverse Communities	261,147	198,654	62,493	77,669
3. Transition Age Youth and Adult Services	3,046,525	2,757,779	288,746	
4. Older Adult Services	38,624	38,624		
PEI Administration	451,020	336,545	114,475	0
PEI Assigned Funds				
Total PEI Program Estimated Expenditures	4,714,942	3,886,465	750,809	77,669

Mental Health Services Act Three-Year Plan

Innovations (INN) Component Worksheet

County: Santa Cruz Date: 4/19/21

	Fiscal Year 2020/21

	A	B	C	D
	Estimated Total Mental Health Expenditures	**Estimated INN Funding**	**Estimated Medi-Cal FFP**	**Estimated Other Funding**
INN Programs				
1. Integrated Health & Supported Housing	1,400,569	696,250	365,599	338,720
2.	-			
3.	-			
INN Administration	104,438	104,438	0	0
Total INN Program Estimated Expenditures	1,505,007	800,688	365,599	338,720

	Fiscal Year 2021/22			
	A	B	C	D
	Estimated Total Mental Health Expenditures	**Estimated INN Funding**	**Estimated Medi-Cal FFP**	**Estimated Other Funding**
INN Programs				
1. Integrated Health & Supported Housing	1,178,008	686,091	319,452	172,465
2. New INN Project - to be determined based on Stakeholder feedback.	382,088	382,088		
3.	-			
INN Administration	160,227	160,227		
Total INN Program Estimated Expenditures	1,720,322	1,228,405	319,452	172,465

	Fiscal Year 2022/23			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. New INN Project - to be determined based on Stakeholder feedback.	666,925	666,925		
2.	-			
3.	-			
INN Administration	100,039	100,039		
Total INN Program Estimated Expenditures	766,964	766,964	0	0