Mental Health Services Act: FY 2018-2019 Annual Update

PLAN

October 23, 2018

WELLNESS • RECOVERY • RESILIENCE

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County of Santa Cruz

HEALTH SERVICES AGENCY

1400 Emeline Avenue, Santa Cruz, CA 95060

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

LETTER FROM THE MENTAL HEALTH SERVICES ACT COORDINATOR

October 23, 2018

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

The report will be posted from November 19, 2018 to December 20, 2018 and a Public Hearing will be held on December 20, 2018 at 3pm at the Behavioral Health Services Building at 1400 Emeline Avenue, Santa Cruz, California. 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/HSAHome/HSADivisions/BehavioralHealth/MentalHealthServicesAct.aspx
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
Watsonville, CA 95076

Sincerely,

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

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION- Santa Cruz County

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

Behavioral Health Director	**Health Services Agency Director**
Name: Erik G. Riera	Name: Mimi Hall
Telephone Number: 831-454-4515	Telephone Number: 831-454-4449
E-mail: erik.riera@santacruzcounty.us	Email: mimi.hall@santacruzcounty.us
Local Mental Health Mailing Address: Santa Cruz County Behavioral Health 1400 Emeline Avenue Santa Cruz, CA 95060	

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

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

Erik Riera
Behavioral Health Director (Print)

Signature

12-27-18
Date

I hereby certify that for the fiscal year ended June 30, 2018, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892f); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated December 28, 2017 for the fiscal year ended June 30, 2017. I further certify that for the fiscal year ended June 30, 2018, that State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has compiled with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Cruz

County Mental Health Director	**MHSA Coordinator**
Name: Erik G. Riera	Name: Cassandra Eslami, LMFT
Telephone Number: 831-454-4515	Telephone Number: 831-763-8203
E-mail: erik.riera@santacruzcounty.us	E-mail: cassandra.eslami@santacruzcounty.us
Mailing Address: Santa Cruz County Behavioral Health 1400 Emeline Avenue Santa Cruz, CA 95060	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonplantation 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 January 29, 2019.

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.

Erik Riera, Santa Cruz County Behavioral Health Director

12.27.18
Date

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

Mimi Hall		12/27/18
Health Services Agency Director (Print)	Signature	Date

Description of Stakeholder Process

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

The Santa Cruz County MHSA Coordinator oversaw the community planning process for the MHSA Annual Update. The stakeholder/community engagement process was designed for inclusion with representation from behavioral health providers, social services, law enforcement, consumers, and family members, as well as representatives from diverse geographical and ethnic/racial/cultural populations. Oversight of MHSA stakeholder engagement activities were returned to the Local Mental Health Board receiving regular updates about MHSA activities. The County works closely with the Local Mental Health Board (which includes consumers, family members and other advocates), and meets regularly with the various mental health contract agency representatives.

When MHSA was initially implemented, Santa Cruz County had an extensive Community Services and Supports (CSS) Planning Process. Additionally, the County conducted planning processes for the CSS Housing component, the Workforce Education & Training Component, the Prevention & Early Intervention Component, Innovative Projects Component, and the Capital Facilities & Information Technology Components. The Community Planning Process consisted of workgroups, surveys, key informant interviews, and focus groups. A special effort was made to include consumers and family members. At that time focus groups were held in both North County and South County, in English and in Spanish. The County has held numerous Town Hall meetings to provide updates and hear from the community about the impact of the MHSA services.

In Fall 2018 three stakeholder meetings were held that focused on providing information about MHSA current programming, as well as gaining community and consumer feedback on current MHSA strengths and gaps within the community. There were 115 participants (collected on sign in sheets), which represented a range of stakeholders, including consumers, family members and providers. To ensure community inclusion the meetings times included evening hours and were offered at sites in North County, Mid County and South County. The group represented community service providers, such as Mental Health Client Action Network (MHCAN), Community Connection, Encompass Community Services, Pajaro Valley Prevention & Student Assistance, Volunteer Center, County Office of Education, NAMI, Front Street Inc., and the County. There was also a large presence of 31 consumers in the stakeholder meetings.

The first meeting was held in Mid-County on September 25th from 10:00am-12:00pm at the Santa Cruz County Sheriff's Office- Community Room, located at 5200 Soquel Avenue, Live Oak. The second meeting was held in South County on September 26th from 6:00pm-8:00pm at the Watsonville City Council Chamber, Watsonville. The third meeting was held in North County on October 11th from 6:00pm-8:00pm at the Santa Cruz Police Department- Community Room. All the meetings were announced via emails, announcements in the local newspapers and listed on the county MHSA website. Meeting announcements offered translation services if needed. Refreshments and light snacks were served at the meetings.

The goals of the MHSA stakeholder engagement were to provide information about county wide MHSA services, gain information from the community about their views/thoughts of the current services; while also learning more about current strengths, to leverage, and emerging needs in the community. The two-hour MHSA stakeholder engagement meetings were structured as follows: 1. brief PowerPoint regarding MHSA, current services and financial information 2. Workgroups that focused on questions supporting a strength and needs analysis of current MHSA programming 3. Larger group discussion with shares from each of the smaller work groups 4. Community Q&A 5. Next steps with agenda discussion for next MHSA stakeholder engagement meeting (January 2019).

Comments from the strengths and needs discussion were recorded by a notetaker and returned from each workgroup. The comments were very thoughtful and displayed a community dedicated to enhancing behavioral health services to better meet the needs of the consumer and their families. The main themes from each of the three meetings were on two topic areas: housing and peer-based services. Specific to peer-based services the strengths included MHCAN and Second Story, two local community run organizations utilizing peer-based services were frequently discussed as areas of strength with a request to be leveraged into additional services.

Feedback was also collected from notecards, to ensure attendees who were uncomfortable sharing in a large group format would be heard. The MHSA Coordinator responded to all questions left on notecards via email response. Samples of questions and comments included, "More representation from LGBTQ population, both student and adult"; "How can we engage the Sheriff's department with mental health crises situations"; "Make the flyers vibrant/noticeable so people pay attention"; "Create follow up teams (nurses, doctors, psychiatrists, MFT's, Social Workers…for regular follow up and weekly outreach where the consumers are…will not need infrastructure if teams go to the consumer" and "What efforts are being made to diversify leadership roles within county behavioral health services?".

b) General description of the stakeholders who participated in the planning process and that the stakeholders who participated met the criteria established in section 3200.270:
The County works closely with the Local Mental Health Board, contract agency representatives, family members, NAMI, consumers, Mental Health Client Action Network (MHCAN), Mariposa Wellness Center, agencies representing underserved communities (the Diversity Center, Queer Youth Task Force, Barrios Unidos, Migrant Head Start), community based agencies (such as Encompass, Front Street Inc., Pajaro Valley Prevention & Student Assistance, Family Services), educational institutions, social services, probation, juvenile detention, county jail, law enforcement, community resource centers, employment and health**.** The demographic breakdown below if of those that completed a demographic information sheet at the Fall 2018 stakeholder meetings:

AGE	
0-17	
18-25	7
26-35	6
36-42	9
43-59	27
60+	30
Blank	

Ethnicity	
Black/African American	1
Latino	9
White	53
American Indian	4
Asian	3
Arabian	
More than one	8
Other	4
Blank	2

Gender	
Male	23
Female	49
Transgender Female	
Transgender Male	
Genderqueer	3
Questioning/Unsure	
Other	5
Blank	

Primary Language	
English	75
Spanish	1
English & Spanish	2
Other	1
Blank	

Group Representing	
Client/Consumer	31
Family	14
Law Enforcement/Probation	
Social Services Agency	13
Veteran/Vet Advocate	1
Education	8
Healthcare	8
Mental Health provider	29
SUD provider	7
General Public	12
Other	8
Press	
Blank	

Note: Some people indicated they represented more than one group. Some people who attended the stakeholder engagement meetings chose not to provide attendance/demographic information.

c) The dates of the 30-day review process:
The draft plan of the MHSA update was available for review and comment from November 19, 2018-December 20, 2018.

d) Methods used by the county to circulate for the purpose of public comment the draft of the annual update to representatives of the stakeholder's interests, and any other interested party who requested a copy of the draft plan:
The MHSA draft plan was distributed to the Local Mental Health Board, contractors, and to interested stakeholders who attended the MHSA stakeholder engagement meetings and provided an email address. The draft plan was also posted on our county website MHSA webpage and made available in hard copy to anyone who requested it. We placed ads in the Santa Cruz Sentinel on December 9th and 12th notifying people of the Annual Update and how to obtain a copy.

e) Date of the Public hearing held by the local Mental Health Board:
The Public Hearing for the MHSA Annual Update was held on December 20, 2018 at 3:00 p.m. at 1400 Emeline Avenue, room 207, Santa Cruz, California.

f) Summary and analysis of substantive recommendations received during the 30-day public comment period and description of substantive changes made to the proposed plan:
Public Comment received via Santa Cruz County Behavioral Health Services MHSA website

- I support the MHSA revision which will fund the Second Story Respite House. I express concern about lack of commitment to beyond these two years. Second Story is effective and well loved. Other needs: hire a Family Advocate. Expand bed capacity at all levels. Increase step down residential - add beds at Telos. Create another CSU at Watsonville Hospital. Renovate the old veterinarian building next to Telecare to use for further crisis care. Youth crisis care needed. Obtain another board and care facility. Glad to hear of Increase beds at 7th Avenue. Hope for Help homeless mentally ill to get housed.

  Thank you for your comments. Your feedback is important to County Behavioral Health and continues to be an integral part of our planning process. We appreciate you taking the time to share your thoughts and opinions. We also encourage you to join the stakeholder meetings to ensure you can share your voice with other community members committed to high quality behavioral health services.

- As a counselor and mental health facilitator I want to thank the Santa Cruz community for supporting our citizens with mental health needs. We need more services, more beds, more practitioners, affordable housing and veteran services. There are more homeless youth with mental health issues out on the street than ever before. Our LGBTQ community in particular are at risk, NAMI, CMH and Family Services like Encompass, Walnut Street Center and monarch services are overloaded. Please find more money not less to meet the needs of our citizens. All of our wellbeing depends on it. Our citizens are worth it!

  Thank you for your comments. Your feedback is important to County Behavioral Health and continues to be an integral part of our planning process. We appreciate you taking the time to share your thoughts and opinions. We strive to continue our budget planning process in a way that meets the needs of all community members and value your opinion in this conversation.

- I am writing as a parent of an adult who is a client of the County Mental Health System. It has been an essential lifeline for our family in times of crisis and recovery. Second Story was there at just the right time, as was a case worker and staff at Telos. I am so happy to hear you are extending funding for Second Story. As a result, my son is living independently and working toward rejoining the workforce. Please do what you can to expand funding for mental health services in our county. It was clear that staff was stretched thin, and decisions were being made based on the lack of beds. This is an issue that can be solved with some careful planning.

  Thank you for your comments. Your feedback is important to County Behavioral Health and continues to be an integral part of our planning process. We are glad we were able to provide critical services when needed. We continue to work internally and externally with our partners to ensure bed availability and will continue to be strategic in our decision-making process to ensure crucial services.

- Please do not cut any funding for services, space, or personnel for NAMI. These individuals NEED and deserve lots of help!

Thank you for your comments. We value the work of our community partners, including NAMI. The MHSA Annual Update had no plans for budgetary cuts for NAMI. We encourage you to join the stakeholder meetings to ensure you can share your voice with other community members committed to high quality behavioral health services.

- Cut no beds. Cut no programs. Add programs: more "Second Story" type peer support and peer run respite houses. More recovery programs with rented or purchased buildings like MHCAN for MH / emotional health support and services. These have NOW proven to enhance life experiences for many and have helped to keep people out of the hospital.

  Thank you for your comments. We highly value the work of all our community partners, including Encompass-Second Story. The MHSA Annual Update included PEI money to be used toward operating Second Story. County Behavioral Health is committed to finding solutions focused on securing housing for our clients.

- Please do not cut any of the mental health programs in our country. We also need all of the beds for the programs to thrive.

  Thank you for your comments. We continue to work closely with our community partners to enhance programming capacity. Your input is valuable in this process and we hope you will join upcoming community stakeholder meetings to share your thoughts and ideas.

- I am writing to support the need for Peer Services in the mental health community of Santa Cruz County. Please guarantee the futures of existing peer-run programs and consider expanding the number of peer-run services in the future, particularly Second Story Respite House. Thank you for your consideration.

  Thank you for your comments. We highly value the work of all our community partners, including Encompass-Second Story. The MHSA Annual Update included PEI money to be used toward operating Second Story. County Behavioral Health is working hard on programmatic design and function to support the role of peers in our service delivery model. We hope with continued support of legislation the reality of peer delivered services will soon be funded.

- I am very pleased to see that you are funding Second Story Respite House and Suicide Prevention Services. Both are needed services in our community. Thank you for taking care of those in our county needing mental health services.

  Thank you for your comments. Your feedback is important to County Behavioral Health and continues to be an integral part of our planning process. We appreciate you taking the time to share your thoughts and opinions. We also encourage you to join the stakeholder meetings to ensure you can share your voice with other community members committed to high quality behavioral health services.

- It is important to maintain the housing that exist for people who are trying to get help for their mental health issues. Housing such as 2nd story helps provide a safe place for people to get help and for the community as a whole.

  Thank you for your comments. We highly value the work of all our community partners, including Encompass-Second Story. The MHSA Annual Update included PEI money to be used toward operating Second Story. We recognize the worth of peer operated respite services and their value on the continuum of acute services in the community.

- Statements in the program challenges section of over 50% of programs reported staffing issues: Question is; what action is the county taking to work on this issue?

  Thank you for your question. County Behavioral Health is impacted by the statewide healthcare labor force shortage. We have focused efforts in many realms, including a traineeship program aimed at enticing license eligible employees into clinical roles upon graduation. Our Psychiatry department also works closely with established institutions, including Stanford, to provide placements for Nurse Practitioners and Psychiatrists in the hopes of securing employees upon completion. County Behavioral Health is committed to exploring options to assist in gaining qualified candidates to provide high quality services to our client population.

- Program performance is stated as client participation count; one program stated behavioral health wellness of that program and stated a percentage of participant that improved as a result of counseling. I understand that the County is working on a program level performance assessment that is planned for a launch in 2020. Question: How will the progress on this performance assessment be statused?

  Thank you for your question. County Behavioral Health is working closely with the Praed Foundation and a subcontractor to further utilize the CANS/ANSA tool as an outcome measurement tool for client and program ratings. We are currently working to expand the tool to provide a wide range of reports and assistance is deciphering/analyzing the data we currently collect. As we continue with this process, we are excited to share more information in upcoming community stakeholder meetings to help people better understand how we monitor programs and ensure we are utilizing resources to meets the needs of our clients.

- CBH is allocated a budget and is required to keep a reserve to cover the unexpected. What is the budget allocation process?

  *Thank you for your question. County Behavioral Health fiscal and program team annually reviews the complex needs of internal and external programs and works to ensure we can continue the allocations to ensure program capacity and need within the community. The budgetary process is complex**,** demanding and challenging. However, with continued careful planning, monitoring, and collaboration current allocations have been able to sustain the current community program level.*

- How will Second Story be sustained if there is no CBH budget for operations?

  Thank you for your question. County Behavioral Health has committed two years of funding to assist in supporting the operations of the peer respite house, Second Story. As many people are aware, Second Story received a large anonymous donation to assist in sustainability for the program. County Behavioral Health is working closely with Encompass-Second Story to assist in understanding and utilizing their resources/donation to provide long term sustainability to their program.

Public Hearing held on December 20, 20189 regarding MHSA Annual Update 2018-2019

- Community Member - Supports MHSA Plan
  13 individuals raised their hands in support of MHSA
- Community Member – attended MHCAN for 6 years; have been in crisis and MHCAN has helped me out. MHCAN does a lot for the little money that it gets. I support MHSA plan as it is.

- Community Member – transitioned from Building K with a lot of help from MHCAN. I support MHSA funds as is.
- Community Member Individual shared personal story. Going to MHCAN for several years. I support MHSA plan.
- Community Member – I support the MHSA plan, and would like to express my desire going forward, that the funding of peer services in Santa Cruz County continue, and that there be an effort made not to pull funding from one peer services program to fund another, and across the board, peer services be funded at a greater level

  5 individuals support this person's comment
- Community Member – request that the MHSA process in the future, give us more of an understanding of what's in it, so we all agree or understand what the priorities are, and what we might potentially be losing because we experienced that this year. I would like it to have a better feel for how it all works, more training on it. I support 2nd Story, MHCAN, other peer programs that make a difference. I support that serious mental illness is the focus, and not a lot of extraneous things that do not benefit the seriously mentally ill population
- Community Member: I support the MHSA funding, I support the additions for 2nd Story, and Noah Whitaker (Suicide Prevention Task Force Consultant) who is great
- Community Member– question about future funding: In MHSA under PEI, for this fiscal year, money is already allocated. Will there be additional funds and how is it going to work?

  Answer (Cassandra Eslami): We will talk about it in our Suicide Prevention Task Force and talk about it more as a larger team within Behavioral Health and with the Board of Supervisors to figure out what, based on the Task Force feedback and the Community Stakeholder feedback, people want to see move forward in the models of prevention, intervention and postvention and we will figure out what kind of financial plan we will need for sustainability of those models at that time. It is not included in this year's plan but will be included in next year's plan.
- Community Member Question: Is there any money allocated for the WET Program?

  Answer (Cassandra Eslami): WET money in the current MHSA Plan has been completed, as well as the capital funds, so we don't currently have any WET money at this time.

encompass
COMMUNITY SERVICES

CHANGING LIVES, BUILDING COMMUNITY SINCE 1973

12/18/18

To Whom it May Concern,

In response to the Mental Health Services Act 2018-19 Program and Expenditure Plan, Encompass is submitting this letter in support of continued funding for our Second Story Peer Respite contract. As a nonprofit organization with over forty programs in Santa Cruz County, Encompass Community Services has been providing services in behavioral health, family and social well-being, and housing since 1973. Our agency serves hundreds of individuals, families and children in the community each year by providing access to vital services, including: housing, counseling for individuals, families and youth, substance use recovery programs, and health and financial services.

We are proud to submit a letter of support for Second Story Peer Respite House, which is a nationally recognized peer-model program. This program provides staffing 24-hours a day, seven days per week, and is operated under the umbrella of Encompass Community Services. As a voluntary program for clients of Santa Cruz County's specialty mental health service system, Second Story's primary purpose is to provide an alternative to sub-acute psychiatric care and ultimately divert people from hospitalization. When people reach the point of crisis without this type of early intervention peer support, their only option is to access emergency services and this frequently leads to costly acute inpatient hospitalization. Breaking the cycle of hospitalization is vital to the health of our clients, as well as the prosperity of the greater Santa Cruz Community.

According to the National Alliance on Mental Illness (NAMI), the annual economic, the indirect cost of mental illness is estimated to be $79 billion. A large portion of that amount, approximately $63 billion, reflects the loss of productivity as a result of illnesses (https://namica.org/resources/mental-illness/mental-illness-facts-numbers). Through our unique peer respite model, Second Story provides an opportunity for people struggling with mental illness to thrive, and to receive support for life goals, including higher education, employment and volunteer opportunities in our surrounding community.

In light of the costs associated with psychiatric hospitalization, and the current homeless crisis throughout California, our hope is that the County will join with Encompass to continue funding support for our unique Second Story program.

With Regards,

M. Martinez

Monica Martinez, CEO

ADDRESS 380 Encinal Street Suite 200, Santa Cruz, CA 95060 | PHONE 831.469.1700 | FAX 831.426.1905 | EMAIL info@encompassCS.org | WEB www.encompassCS.org

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 276,603 according to 2015 estimates. In Santa Cruz, the breakdown of the population by race is 58.4% are White (Not of Latino origin), Latinos make up 33.5% of the county population, 1.4%, African-Americans, 1.8% are American Indian and Alaskan Native persons, and 4.8% are Asian. 11.9% of the population is over 65 years old; persons under 19 years comprised 25% of the population. The primary language in Santa Cruz County is English, with 31.6% of households speaking a language other than English. The threshold language in Santa Cruz is Spanish. Slightly more than half of the population (50.4%) is 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:

The approximate cost for children served in the CSS program is $1,848 and in the PEI programs is $443. The approximate cost for adults served in the CSS program is $2,396, in the PEI program is $290 and INN is $9,556.

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 2018-2019:

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 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.

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

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/17 to 6/30/18 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).
  - Services to Transition-age youth (TAY) in the Probation population (particularly as they age out of the juvenile probation system).
  - Services to Probation youth with high mental health needs, but low criminality.

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

Target Population: Youth and families involved with the Juvenile Probation system or at risk of involvement. This includes Transition-age youth aging out of the system with 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 2018-2019:
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.

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

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/17 to 6/30/18 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 2-10-year-old range, and particularly in the targeted 0-5-age range. To address these needs, we will continue to provide:

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

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

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

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

Number of individuals to be served 2018-2019:
The unduplicated numbers of individuals to be served by program are:
Parent Center: 30
Encompass Independent Living Program (ILP):13
Santa Cruz County Behavioral Health: 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.

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

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/17 to 6/30/18, 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 Education system at risk of school failure by

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

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

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

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

Number of individuals to be served 2018-2019:
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 7/1/17 to 6/30/18, 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, and
- Capacity for youth and family advocacy by contracting for these services with a community bases agency. Emphasis is on youth-partnership activities.
- Rehabilitative evaluation, individual, collateral, case management, and family counseling.

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

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

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

Number of individuals to be served 2018-2019:
The unduplicated numbers of individuals to be served by program are:
Volunteer Center/Family Partnerships: 12

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
Volunteer Center encountered staffing challenges which created barriers in meeting goals. As of October 2018, they are now fully staffed.

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

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/17 to 6/30/18, 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 2018-2019:

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?
Encompass ESS discontinued due to increasing costs associated with other Encompass CSS programming.

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/17 to 6/30/18, 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 2018-2019:

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 has requested a public hearing on their use permit, to lift restrictions, to take place in November 2018.

Are there any new, changed or discontinued programs?

No.

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/17 to 6/30/18, 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: Wheelock (Residential), Wheelock (Outpatient), Willowbrook, and Opal Cliffs.
- Encompass provides services at Casa Pacific
- Volunteer Center/Community Connection provides Housing Support (employment & education focus) and Opportunity Connection (pre-employment services, including peer support), Cabrillo college connection and Avenues (employment services for dual diagnosis clients).
- River Street Shelter
- Santa Cruz County Behavioral Health staff provides case management services.

Number of individuals to be served 2018-2019:
The unduplicated numbers of individuals to be served by program are:
Front Street- Wheelock (Residential & Outpatient): 16
Front Street- Willowbrook: 40
Front Street- Opal Cliffs: 14
Encompass- Supported Housing: 60
Volunteer Center/Community Connection-Housing Support (employment): 55
Volunteer Center/Community Connection-Opportunity Connection: 70
Volunteer Center/Community Connection Avenues: 45
Volunteer Center/Community Connection Cabrillo College Connection: 40
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
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?
MOST positions funded through the MIOCR grant (which ended in June 2018) are now funded through Santa Cruz County Behavioral Health funds.

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/17 to 6/30/18, 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.

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

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

Other Screening Criteria include:

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

PREVENTION & EARLY INTERVENTION - PEI

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

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

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

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

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

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

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

We have four major PEI programs in Santa Cruz County:

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

- Older Adult Services.

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

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

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

PEI Project #1 has four strategies:

1. **0-5 Early Intervention Stanford Neurodevelopmental Foster Care Clinic**:
   - **Purpose**: This **Early Intervention** program provides multi-disciplinary team mental health/family assessments for foster children aged 0-5, through a multi-agency funded clinic at the Stanford Children's Health Specialty Services site and located in Santa Cruz County. The program includes with PEI supported mental health services, as well as in-kind and contracted services for Stanford University specialist time from a developmental psychologist and a pediatrician.
   - **Target Population**: Foster children aged 0-5.
   - **Providers**: Santa Cruz County Behavioral Health
   - **Number of Individuals to be served each year**: 90
   - **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** 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:

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

Program Name: 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? 35 in 2017-18

What is the number of families served? 35 in 2017-18

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.

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

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

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

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

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

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

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

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

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

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.

2. The Positive Parenting Program (Triple P)

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

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

Providers: First 5

Number of individuals to be served each year: 1300

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

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

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

Program Name: PEI #1 Agency: First 5

Target population:

Demographics: (see Annual 2017-18 chart)

What is the unduplicated number of individuals served in preceding fiscal year? In FY 2017-18, 334 parents/caregivers received Level 3 Individual, Level 4 Standard/Group, or Level 5 Triple P services. (Note: An additional 1,564 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? _ Approximately 283 families were served in FY 2017-18.

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:

Parents are often referred to Triple P by licensed clinicians or medical professionals with knowledge of the parents' and/or children's mental health risks and needs

Although Triple P assessments are not diagnostic tools, the results of the Depression Anxiety Stress Scale (DASS) and Eyberg Child Behavior Inventory (ECBI) provide helpful information about parents' emotional well-being and the intensity and frequency of child behavior challenges. Assessment results that are in the "clinical range 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 style, child behaviors, parental well-being, and parental conflict.

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:

Decreased level of parental depression, anxiety and stress
Decreased intensity and frequency of child behavior problems

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 highest 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.

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

•**Eyberg Child Behavior Inventory (ECBI):** Measures the severity of child behavior issues from the parent's perspective

• **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. Used in place of the ECBI when Lifestyle Triple P is offered.

• **Parenting Scale (short form):** Measures the degree to which parenting practices are Lax/Permissive, Over-reactive or Hostile

• **Depression, Anxiety and Stress Scale (DASS – short form):** Measures parent's emotional well-being

• **Parenting Problem Checklist:** Measures the degree of conflict over parenting between parenting partners

• **Conflict Behavior Questionnaire (Teen Triple P only):** Measures the degree of conflict between parents and adolescents

• **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

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. 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 an 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:

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. A cumulative analysis of outcomes from the past 5 years demonstrates positive outcomes such as:

• **Improvements in child behavior.** Overall, the majority of parents (80%) reported improvements in their children's behaviors after completing the Triple P program. Of the parents who began the program with more serious parenting issues, 92% reported improvements in their children's behaviors.

• **Increased use of positive parenting styles.** Overall, the majority of parents (77%) reported improvements in parenting styles, indicating they became less lax (permissive), over-reactive, or hostile through the course of the Triple P program. Of the parents who began the program with more serious parenting issues, 82% reported improvements in their parenting styles by the end of the program.

• **Increased levels of parents' emotional well-being.** On average, parents reported significantly lower levels of stress, depression and anxiety (63%, 55% and 53% of parents, respectively) after completing in-depth Triple P services. Of the parents who began the program with more serious parenting issues, 90% reported improvements in their level of stress, 87% reported improvements in anxiety, and 86% reported improvements in their level of depression.

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

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

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

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.

NA

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, and other government- or community-based agencies. This means that Triple P practitioners often work with families where the parents and/or children are currently receiving or need assistance accessing medical care and/or mental health services. In many instances, Triple P practitioners make referrals, advocate for, and coordinate services with social workers, therapists, Children's Mental Health clinicians, health clinics, and other behavioral health providers.

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

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

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

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

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

• Distributing First 5's locally-designed "parenting pocket guides" with bilingual Triple P parenting tips through schools, health care settings (clinics, pediatric offices, hospitals), child care providers, county health and human service programs, and other non-profits serving children and families.
• Disseminating a monthly article with Triple P parenting tips through print and electronic media
• Maintaining a steady social media and advertising presence in key print and electronic media outlets
• Utilizing newly-developed "Triple P parenting strategy cards" to educate parents about positive parenting techniques during community outreach events and classes

In addition, First 5's Triple P Coordinator convenes quarterly meetings with Triple P practitioners. These meetings provide an opportunity for ongoing peer coaching, quality assurance and professional development. The Winter 2017 Triple P Practitioner Meeting featured a training by the Diversity Center on working with LGBTQ+ parents and/or children and included a panel of Triangle speakers. The Summer 2018 Triple P Practitioner Meeting will feature a training on understanding how to provide Triple P parenting support within the context of special needs, early childhood mental health, and trauma. This type of professional development helps ensure that Triple P practitioners are considering many dimensions of culture and diversity that impact children's mental health and parenting.

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

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

Target Population: School sites, education personnel, and students and families throughout the county.

Providers: The County Office of Education (COE) has subcontracted with the Diversity Center, the Live Oak Resource Center, and Positive Behavioral Interventions & Support.

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

2. Positive Behavioral Intervention and Supports (PBIS):

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

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

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

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

3. Live Oak Community Resources

Support and strengthen families by providing family case management, counseling services and coordination of parent education classes.

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

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

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

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

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

2017/2018 COE Final Narrative Report
From: The Diversity Center
Submitted: July 2018

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

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

- **Demographics**: See MHSA annual report for 17-18
- **What is the unduplicated number of individuals served in preceding fiscal year?** 4973
- **What is the number of families served?** 23
- **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 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.

We had 20 respondents to our 2018 Youth Program evaluation survey. Over half of the respondents (55%) were from Watsonville, and 68% were youth of color. Youth self-reported the following **as a result of their participation in our youth program**:

- 100% of youth felt better about themselves. (Evaluation goal #1)
- 100% of youth felt more comfortable expressing who they were. (eval goal #1)
- 100% felt more comfortable coming out to people. (eval goal #1)
- 100% made new friends. (eval goal #2/3)
- 100% had better relationships with some of their family members. (eval goal #2)
- 100% felt safer in their lives overall. (eval goal #5)
- 100% felt like they belonged to the LGBTQ+ community. (eval goal #3)

- 95% reported feeling proud of who they are. (eval goal #1)
- 95% felt more connected to other LGBTQ+ youth. (eval goal #2/3)
- 95% knew who or where to go to if they felt unsafe at school. (eval goal #5)
- 90% had better relationships with teachers and staff. (eval goal #2)
- 90% reported knowing a person or hotline they can call in tough times. (eval goal #4/5)
- 90% were very satisfied with the program (with ratings of 8-10 on a ten-point scale).
- 70% were dealing better with stress. (eval goal #4)

When asked to share an experience about the program, one youth said,

"I make a lot of friends when I come here, and they make me feel loved and appreciated. Everyone here treats me with respect and has helped me become a more confident person. Every Saturday is a fond memory."

Another youth said, "In my time being here I have somewhat discovered who I am. I know that I am loved and supported."

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

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 ensures fidelity to the program design and practice model.

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

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

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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**.

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

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

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

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

Program Name: PEI #4: Children's Services **Agency**: COE: Live Oak Community Resources

Target population:
Demographics: *See annual MHSA Report for 17-18*
What is the unduplicated number of individuals served in preceding fiscal year? *108*
What is the number of families served? *101*
Participants' risk of a potentially serious mental illness? *Varies*
How is the risk of a potentially serious mental illness defined and determined?

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

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

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

1) Parental Resilience

2) Social Connections

3) Concrete Support in Times of Need

4) Knowledge of Parenting and Child Development

5) Social and Emotional Competence of Children

This project addresses all five factors as follows:

1) Parental Resilience—*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 to other agencies.*

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

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

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

A. FAMILY CASE MANAGEMENT for 20 unduplicated families:

- *Assessed family strengths and needs*
- *Supported family in setting and pursuing goals*
- *Facilitated enrollment in government benefits*
- *Referred to appropriate community resources*
- *Met in LOCR office or conducted home visits as needed*
- *Provided translation as needed*
- *Conducted Multi-Disciplinary Team meetings to assess progress*

B. A LEADERSHIP ROLE IN THE LIVE OAK CRADLE TO CAREER (C2C) INITIATIVE, engaging 63 unduplicated parents and caregivers:

- *Participated in monthly C2C steering committee meetings*
- *Supported monthly Parent Leadership Council meetings*
- *Worked with parent leaders to carry out strategies identified to improve selected data indicators in the areas of health, education, and character*
- *Provided supports including refreshments and childcare for parent meetings*
- *Provided translation of written materials*

C. COUNSELING SERVICES for 14 unduplicated individuals:

- *Coordinated on-site counseling by professionally supervised MFT interns*
- *Referred families to on-site counseling services*

D. COORDINATION OF PARENT EDUCATION CLASSES for 82 unduplicated parents and caregivers

- *Scheduled and promoted classes*
- *Enrolled families*
- *Arranged childcare*

E. WEEKLY PARENT/CHILD PLAYGROUPS for 53 unduplicated caregivers and their children

- *One two-hour weekly group offered in English*
- *One two-hour weekly group offered in Spanish*
-

Specify any negative outcomes as a consequence of untreated mental illness (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes) that the Program is expected to affect, including reduction of prolonged suffering (mental, emotional and/or relational functioning).
Those who lack access to the Five Factors for Strengthening Families are at increased risk of isolation, untreated mental illness, and child abuse or neglect. Families with unaddressed chronic school attendance issues risk school failure, removal of children from the home, and even the criminal prosecution of parents.

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

Project outcomes are measured by:

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

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:

School attendance data is provided on an ongoing basis by Live Oak School District, comparing attendance before and after the family began receiving services

- *After several years of attempting different strategies to increase referrals from the school district for students with attendance issues, we have stepped away from this performance measure.*

Cradle to Career Initiative indicators are collected through annual student testing and surveys at the school site and reported back to the Cradle to Career Data Committee

- *Cradle to Career indicators measure long-term, school-wide trends. LOCR's influence on these trends is contributive, rather than attributive. The most recent indicators, along with successes from this year, are attached.*

An annual parent telephone survey is conducted each spring, which asks program participants how strongly they agree or disagree with the following statements:

- *As a result of participating in this class, I have improved parenting skills*
  - *100% of respondents in 2017-2018 agreed with this statement*
- *The Advocate continued to work with me until my issues were resolved*
  - *86% of respondents agreed with this statement*

A. **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.

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

The Protective Factors Framework
Studies show that building the Five Protective Factors promotes optimal child development and reduces child abuse and neglect (Center for the Study of Social Policy). Live Oak Community Resources Advocates are trained in Family Strengthening Case Management and use the Five Protective Factors framework at the beginning of their relationship with the family and throughout their time together, seeking out existing strengths to build on and identifying areas for growth. See attached overview of the Protective Factors framework for more information.

Motivational Interviewing
LOCR Advocates are also trained in Motivational Interviewing (MI), which has proven effective in supporting individuals through the process of behavior change (Case Western Reserve University Center for Evidence-Based Practices). Advocates use MI by framing conversations to help Case Management families discover their own interests in making a positive change in their lives and to express it in their own works. MI can also help families through personal changes, such as diet, exercise, reducing and eliminating the use of alcohol, tobacco, and other drugs, managing symptoms of mental illness and chronic physical conditions such as heart disease, diabetes, and obesity, among others.

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

Positive Parenting Program
Triple P is a parenting program used in communities around the world, and officially adopted by First 5 Santa Cruz County, the Santa Cruz County Health Services Agency, and the Santa Cruz County Human Services Department. The Community Bridges Family Resource Collective employs 10 certified Triple P educators who provide Parent Education in English and Spanish, working both in group and individual settings.

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

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

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:
NA

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

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 practical to medically necessary care and treatment, including but not limited to care provided by county mental health programs):

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

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

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

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

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

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

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

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

Target population:

Demographics: (See 2017-18 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
Caesar 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).

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.

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

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

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

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

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

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

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

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

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

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

Supplemental Notes:

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

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

Trauma Informed Systems:

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

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

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

  This is a Prevention Program.

  Target Population: Mental health providers, pre-school teachers, childcare workers, family advocates, and other staff in the prevention workforce.
  Providers: East Bay Agency for Children
  Number of individuals to be served each year: 675
  Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? No

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

Program Name: Trauma-Informed Systems **Agency**: East Bay Agency for Children
Target population:
Demographics: Please see MHSA Annual Report Attachment
What is the unduplicated number of individuals served in preceding fiscal year? 861
What is the number of families served? N/A

Participants' risk of a potentially serious mental illness? Exposure to early childhood trauma is a predictive factor for long term adverse health outcomes and involvement with child welfare, special education, and justice systems. Should I continue here…
How is the risk of a potentially serious mental illness defined and determined?

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)?

- Trauma is a pervasive, long-lasting public health issue that affects our workforce and system. Like people, organizations are susceptible to trauma in ways that contribute to fragmentation, numbing, reactivity, and depersonalization. When our organizations are impacted, it prevents us from responding effectively to each other and the people we serve. By equipping and supporting early childhood educators, prevention and mental health clinicians, and others to identify and assess early trauma risk factors and increase protective factors for children and caregivers, our public health workforce can better reduce the stigma related to trauma and the mental health risks. Specific focus will be on early screening and intervention to prevent system involvement in child welfare, special education, or criminal justice systems.

- The average annual turnover rate for child care staff is 30% in the United States. The assessment of studies into this high turnover agree that insufficient compensation was one key reason for high turnover. However, environmental and personal characteristics, such as lack of support from administrators and coworkers, and motivation, contribute to early childhood educators' decisions to leave the job. (Porter, 2012) The TIS (Trauma-Informed Systems) model addresses these stressors and utilizes trauma theory to transform a whole organizational approach to its workforce and communities served through a systemic process consisting of core components including: delivery of foundation curriculum across whole workforce (janitor to judge), building capacity among local workforce across disciplines and sectors to deliver foundational training, building learning communities within and across organizations to align TIS principles to policies and practices and engage in leadership activities to sustain system change.

- The TIS (Trauma-Informed Systems) model addresses these stressors and utilizes trauma theory to transform a whole organizational approach to its workforce and communities served through a systemic process consisting of core components including: delivery of foundation curriculum across whole workforce (janitor to judge), building capacity among local workforce across disciplines and sectors to deliver foundational training, building learning communities within and across organizations to align TIS principles to policies and practices and engage in leadership activities to sustain system change.

- Primary target audience for project is children ages 0-5 and their primary caregivers and educators and who are at risk for system involvement and identified as having been exposed to early trauma and adversity. Interventions will be focused on the workforce and building the capacity of workforce to identify, respond to, and heal early childhood trauma.

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):
Indicators will be measured using the CANS 0-5 and CANS 6-18 tool to track prevalence of trauma/ACES and progress outcomes related to adjustment to trauma and system involvement. Additionally, for the workforce education, East Bay Agency for Children will use metrics to measure learning and practice change related to trauma-informed care practices.

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:

We anticipate that by providing organizational supports and education to better equip early childhood educators and clinicians to identify and respond to signs and symptoms of exposure to early childhood trauma, we can interrupt the rising rates of early childhood entry into child welfare systems.

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:

Agency provides monthly unduplicated client count demographic reports, track trainer certification through competency rubric, and track learning and practice changes through regular surveys and pre/post TIS Attitude scales.

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

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

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

- Building the Santa Cruz workforce capacity to identify, respond to, and heal the effects of early exposure to trauma while equipping organizations with supports to sustain promising practices in the field through the implementation of the TIS model is expected to interrupt rising rates of children, ages 0-6, from entering the child welfare system and or entering restrictive or institutional educational settings. Early childhood is an optimal developmental period where immediate, quality interventions can disrupt long term adverse health outcomes associated with exposure to early trauma. Increasing our early childhood serving workforce capacity to understand and identify trauma risk factors and increase protective factors will decrease the percentage of system-impacted youth and families and prevent out of home placement.

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

The TIS Model is being tested regionally and most recently evaluated here: http://traumatransformed.org/wp-content/uploads/2015-2017-SFDPH-TIS-Evaluation-Report-11-28-17.pdf

TIS 101 trainers and ECE champions will be evaluated based on their competency in understanding and responding to early signs of trauma as well as ability to transfer understanding of trauma, resilience, and protective factors to caregivers in lives of at-risk children to disrupt cycles of institutionalization or system-involvement.

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

The agency is utilizing the following tools to collect and measure outcomes: pre/post TIS Attitude Scales, Evaluation of Learning, Commitment to Change scales and qualitative data collection.

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**:

4. **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):

By embedding trainers and change agents across multiple sectors, TIS Trainers are able to more immediately assess and link identified children to services offered and collaborate with other members of their cohort to more effectively access services in outside departments.

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):

By understanding trauma symptoms, cultural bias, and strategies for healing, our workforce is better able to discern and center priorities and needs for children and caregivers and link to more appropriate supports and culturally responsive 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):

Through the implementation of the TIS model, participants learn strategies to reduce stigma related to trauma and mental health risks and communicate with vulnerable populations in ways that increase likelihood of early intervention, increase perceptions of trustworthiness in the public systems, and through TIS tools and resources (environmental trauma screens, TIAA, etc), our service centers become more welcoming, inclusive, and culturally reflective of our communities most impacted by trauma.

PEI Project #2: Services for Diverse Communities

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

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:

Stigma and Discrimination Reduction: Activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.
Program Name: Stigma and Discrimination Reduction **Agency**: NAMI
Number of people reached: 3278 unduplicated count (For Q1 Q2, Q3, Q4) 2017/18

Identify who the program intends to influence:

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

Specify methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness, and/or seeking mental health services, and indicate timeframes for measurement of:

- **Changes in attitudes, knowledge and/or behavior related to seeking mental health services that are applicable to the specific program**.
  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.

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

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

NAMI Family-to-Family Education Program has been added to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP).
The research found that the family members who participated in Family-to- Family classes showed:

- 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.

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

(see above)

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.

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

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

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

Describe how the following strategies were used:

Access and Linkage (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):
Warmline - is supervised by experienced volunteer and staff with linkage to MH as needed for acute calls. Many families and the general public use the warm line for information on access to care, rehab, housing, case management, medications etc. Primary function is linkage to care and help in a crisis to offer support and some assistance. It is not always answered immediately but usually within 24 hours. Many are linked to support groups and classes.

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

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

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

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

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

Stigma and Discrimination reduction (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):
All of our programming includes stories of recovery by a trained speaker. The information in the classes, materials used in the Support Groups, and presentations allow for dignity and acceptance of individuals with disability to live successfully in the community. We reduce self-stigma by providing a safe place to share with other of similar lived experience. Community stigma reduction is provided through our educational presentations, brochures, events and newsletters. 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

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

Program Name: _MHCAN Shadow Speakers 2017-2018____ **Agency**: ____MHCAN
Target population:
Demographics: (fill out chart) General Population. Speakers: 41.1% & 33.6% POC, 26.1% LGBTQ
What is the unduplicated number of individuals served in preceding fiscal year? __3243_____
What is the number of families served? ___3243_____
Participants' risk of a potentially serious mental illness? _____4.2% and more_____
How is the risk of a potentially serious mental illness defined and determined?
Statistically 4.2% of adults, so almost one in 20, of which all are part of the interdependent network of humanity

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)?

Workplace education training, heightened awareness, stigma reduction

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):
suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes, prolonged suffering of various kinds

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

NA

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 do surveys and feedback forms at the speaker events which we tabulate and measure

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.

"The value of peer support services in both traditional health care settings and independent programs is well recognized. In 2007, the Centers for Medicare & Medicaid issued guidelines for development and implementation of peer support services; and in 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) released the *Consumer-Operated Service Evidence-Based Practices Toolkit*." From Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change.

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

Speakers Bureaus are great at stigma reduction and mental health education. Again from the above publication, "When integrated into service-provision teams, peers can help others to identify problems and suggest effective coping strategies (Armstrong et al., 1995; Corrigan and Phelan, 2004; Davidson et al., 1999; Gates et al., 1998; Mowbray, 1997). An example is found in Active Minds, a grassroots college student mental health advocacy group that reaches out to young people on college campuses across the United States with several programs including a speakers bureau.[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 have our standard model which we do not deviate from. The Shadow Speakers actually adapted their speaker's bureau from the Santa Cruz Diversity Center's Triangle Speakers. We met with Shawn Ordinario several times and he went over the way they did their bureau and we had multiple trainings with the initial participants who passed it on ever since. It is a standard model of a speaker's bureau with no innovative elements to lead it off track.

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 were trained by the Triangle Speakers from the Diversity Center and adhere to their model

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

We have an active Quality Assurance dept if there are complaints and require 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):

By meeting speakers and educators at various in community locations, churches, schools, inservices in other

Nonprofits. (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs): In the speakers' bureau, people talk about accessing resources experientially and in that way, it is much more accessible to people who may be having issues but are shy about self-disclosure or seeking help

Timely Access to Mental Health Services for Underserved Populations (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services): As we not only speak outwardly in the greater community but inwardly in our own, in the PHF, in the locked places, in the step downs, in the housing- we are able to share methods of accessing resources one on one in questions during the question and answer part of the speaking as well as sharing our own paths with resources in the main speaking portion.

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

There are 3 angles to this-

One, within our own community, people become freer to talk about themselves, our own lives, which is genuinely therapeutic as you learn to see your life in different frames of reference, in other people's lives, next to other people's lives, in community with others living our lives... Two, Within people who are like us in the larger community, they get to see the way others receive people like us and react to that in a good way, not a negative way, which is often a novel experience as we tend to be universally regarded as a negative. Three, for others, those who are not of us, they get to learn that they have nothing to fear from us. Fourthly- as an example, today, those of us who have found the speaker's bureau therapeutic have also gained real skills. We had a prospective city council member tour MHCAN today and she said, "People like you, you ought to be able to be in Santa Cruz, in your places like MHCAN. You deserve to live. Not everyone thinks so, but I do." We were literally floored. As she was facing a whole room of seasoned speakers, who now know how to express themselves, she was able to receive much feedback on why her statements were offensive and she did in every particular. So, the speakers bureau helps us to defend ourselves against prejudice by giving us the greater competence and capability in speaking publicly.

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

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

How will individuals be identified as needing assessment or treatment for serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention Program?
The program will accept up to six (6) adults age 18 and older, with an average length of stay of seven days. The focus of treatment is on providing Recovery-based support by peer staff through a mutual understanding of mental health challenges based on the staff's "lived experiences" using the evidence-based practice called "Intentional Peer Support or IPS". Through the interview process and assessment peer staff will utilize community-based partners for referrals to ensure client connectedness.

How will individuals, and, as applicable, their parents, caregivers, or other family members be linked to county mental health services, a primary care provider, or other mental health treatment?
Santa Cruz County Behavioral Health Services will augment services when called upon by the person who has admitted self to the program. Santa Cruz County Behavioral Health Services will continue to make available psychiatric medication supports, case management and therapy services. Clients may "self-refer" to the program, with the support of the case manager.

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

Outcomes: New program (FY19-20)

- **Number of individuals with SMI referred to treatment and kind of treatment?** 90 unduplicated
- **Number of individuals who followed through on the referral and engaged in treatment (attended at least once)**: 90 unduplicated per year
- **Average duration of untreated mental illness:** various
- **Average interval between referral and participation in treatment (at least once)**: various
-

1. **Indicate if the Agency/County intends to measure outcomes in addition to those required (listed in #7 above), and if so, what outcome(s) and how will it be measured? Include timeframes for measurement**.

   _____ No __X___ Yes

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

   A. Less than 5% will exit to higher level of care annually
   B. Program will track service referrals per consumer and submitted to county quarterly
   C. Program will facilitate linkage to county Behavioral Health Case Manager upon admission of consumer 100% of the time

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

   Access and Linkage (Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):
   Second Story works in close collaboration with Santa Cruz County Behavioral Health Services to ensure clients seeking respite services are knowledgeable about availability of services, including medical and other county offered services. Second Story also works with other community agency partners to ensure people are referred and linked to the appropriate level of services and resources needed to promote healing and wellbeing.

   Timely Access to Mental Health Services for Underserved Populations (Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):
   Second Story promotes a welcoming environment that is accessible to clients 24/7 as a diversion to a sub-acute or inpatient program. This respite housing option allows clients, who might otherwise end up in an inpatient setting, a safe alternative for connection and relationship building that can assist in their recovery and wellness.

   Stigma and Discrimination reduction (Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):
   Second Story remains dedicated to serve as a respite and voluntary housing option for people by offering support and connection with a peer recovery model. These peers assist in helping people by providing relationship building based in shared backgrounds and lived experience. With the support of community partners, including NAMI, Second Story has been able to reduce stigma surrounding mental illness. In addition, self-stigma has been reduced by promoting a safe place for people to self-refer when recognizing a need for respite and connection when feeling vulnerable from mental health symptoms.

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

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

PEI Project #4 has three proposed strategies:

A. Employment Services:

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

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

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

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

2. **Target population**:
   - **Demographics**: (fill out chart)
   - **What is the unduplicated number of individuals served in preceding fiscal year?** _____40_____
   - **What is the number of families served?** ____n/a_____
   - **Mental illness or illnesses for which there is early onset:** ___schizophrenia, bipolar dx, depression, PTSD,
   - **Description of how participant's early onset of a potentially serious mental illness will be determined:**
   Through intake questionnaires, ANSA measures and interviews with individuals, mental health care professionals and family members.

3. **Identification of type(s) of problem(s) and need(s) for which program will be directed, and activities to be included in program to bring about mental health and related functional outcomes** (including suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes).
   Primary types of needs/problems: School failure, lack of education and skills, unemployment, underemployment. Activities will include academic and employment counseling and skill building. Clients will have an opportunity to volunteer and meet employers in order to better prepare to enter the workforce. Clients are given opportunities to attend classes specific for mental health consumers at the college level. Services are provided in the community, at school, and in the workplace to reduce stigma and better serve the 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. ANSA assessment at intake and at 6-month intervals.
   - **List the indicators used to measure the intended reductions**:
   School attendance, employment, volunteerism and ANSA assessment.
   - **Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects cultural competence**:
   Each consumer is given an ANSA assessment upon intake and at 6 month intervals to measure recovery outcomes. In addition, each consumer is encouraged to participate in Meaningful Activity including attending school, training program, volunteer opportunities, or by becoming employed in part-time or 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.**

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:**
  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 to determine particular aspects of mental health recovery and community involvement.

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

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

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

All services are welcoming and designed to reduce stigma and discrimination. We meet persons where they are, literally. We meet them in the community, in their homes, or at their schools. We employ persons with lived experience to further reduce the impact of receiving mental health services. We pick people up and encourage all interaction be "out of the office" to increase the likelihood of retention in services and to reduce the "self-stigma" of receiving mental health services.

Clinical Services:

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

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

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

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

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

Target population:

Demographics: See MHSA 17-18 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

Veterans' Advocacy and Service Coordination:

Purpose: The Veteran Advocate services veterans and their families throughout the County. The Veteran Advocate is responsible for brokering federal, state, and local programs to the veterans in the community. The focus is on providing needed services regardless of the veteran's discharge or benefit status. Individual case management, brokering of services and interface with the community-based organizations to assist with benefits, housing, health care, mental health and substance abuse treatment for veterans are developed and referred. The position also provides a vital community-organizing role linking various veteran service providers in efforts of service collaboration and education to the veteran community regarding available services. The Veteran Advocate provides both prevention and early intervention services.

Target Population: Veterans and their families

Providers: Santa Cruz County Behavioral Health

Number of individuals to be served each year: 250

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

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

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

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? 147

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

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

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

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

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.

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 skills to identify the specific challenges of each client.

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. One on one confidential interview allows each client the opportunity to be honest about their needs. Through compassion and active listening the Veterans Advocate is able to present mental health services in way that positive and will help to reduce the suffering each client is facing.

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

Number of people reached:
Number of calls to the suicide crisis line:
(Santa Cruz location verified) 1,242
(Location unknown) 1,547
Number of follow-up calls:
(Santa Cruz location verified) 22
(Location unknown) 35
Number of 911 calls:
(Santa Cruz location verified) 24
(Location unknown) 20
Outreach Participants: 5,383

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

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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.

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?

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:
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".

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.

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.

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.

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 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. 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?

Once the plan is completed metrics will be tied to the implemented prevention, intervention and postvention modalities 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 18-19 fiscal year to design the county wide plan involving prevention, intervention and postvention models. Once the models and best practice interventions have been identified for implementation and community stakeholder processes have been held, we will ensure a robust system for data driven training and evaluations to establish a baseline for continued system improvement. 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.

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. Task Force members include:

Cassandra Eslami	CBH
Pam Rogers-Wyman	CBH
Marty Riggs	CBH
Carol Williamson	NAMI
Betty Nadeau	Community
Noah Whitaker	Consultant
Michael Paynter	COE
Cynthia Nollenberger	CBH
Sarah Leonard	MHCAN
Erica Padilla-Chavez	PVPSA
Shar Ames	PVUSD

David Corboy	Dignity Health
Shelly Barker	HIP
Chad Hickerson	Telecare
Travis DeYoung	Veterans Advocate
Bek Phillips	MHAB
Carly Memoli	FSA Suicide Prevention
Amy Marlo	SC Hospice
Todd Liberty	Sheriff-SCC
Joel Miller	Faith based
Dwayne Tait	SCUSD
Jennifer Herrera	HSD-Public Health
Stephany Fiore	Coroner
Stan Einhorn	CBH
Nader Oweis	UCSC Chief of Police

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.

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 7/1/17 to 6/30/18, 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.

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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 7/1/17 to 6/30/18, 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.

PEI Project #4: Services for Older Adults

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

PEI Project #4 has two proposed strategies:

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

Performance Outcomes: See the MHSA PEI Annual Report for 7/1/17 to 6/30/18, which is attached.

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

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

Program Name: Senior Outreach Agency: Family Services Agency

Number of potential responders: __480__annual_____

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 and Diversity Center.

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

Specify the methods to be used to reach out and engage potential responders and the methods to be used for potential responders and public mental health services providers to learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness:
By reaching out to different disciplines engaged with at risk seniors through visits and 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 a health fair, residential care facilities, senior centers and nonprofit agencies including the Grey Bears.

Describe how the following strategies were used:

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

All participants in our outreach are informed of local County mental health resources, including the 24/7 multilingual suicide crisis line and resources for seniors through the local directory. Program staff and volunteers have lists of local resources that include information on accessibility, housing, caregiver resources, home health and help, 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, Medicare licensed counseling, IHSS, MSSP, Stroke Center, CCCIL, Senior Network Services 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.

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:

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

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

Target population:

Demographics: (fill out chart)

What is the unduplicated number of individuals served in preceding fiscal year? ____12_____

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).

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

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

- social ties/social support
- mood and behavior improvement
- personnel expression
- companionship
-

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

N/A

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

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

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

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

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

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:

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

See Logic Model Attached

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

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

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

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 8 years and the other for 5 years).

INNOVATIVE PROJECTS- "INN"

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

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

Target Population: Program participants will be consumers who (1) have co-occurring psychiatric and 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 Peers for employment opportunities. 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 July – Sept 2017	Quarter 2 Oct – Dec 2017	Quarter 3 Jan – March 2018	Quarter 4 April – June 2018	Annual
Unduplicated Client Count	42	47	48	70	76
Age:					
0-15	0	0	0	0	0
16-25	1	0	0	0	0
26-59	20	27	26	39	39
60 +	13	20	22	30	30
Language:					
English	32	42	36	41	41
Spanish	1	3	3	2	2
Other	1	1	1	1	1

Race:					
American Indian	1	3	3	3	3
Black	3	3	3	3	3
White	24	34	30	33	33
Other	5	5	5	5	5
More than one	1	1	1	1	1
Declined to State	0	0	6		
Ethnicity					
Latino	3	5	5	4	4
African	2	2	1	2	2
Asian Indian/South Asian	1	2	2	2	2
Filipino	1	1	1	1	1
Other	5	23	18	6	6
More than One	12	10	10	10	10
Declined to State	8	4	11		
Veteran					
Yes	2	1	1	1	1
No	-	39	33	37	37
Declined to State	-	7	14		
Sexual Orientation					
Gay or Lesbian	2	1	1	1	1
Heterosexual or Straight	28	38	33	36	36
Questioning or Unsure	2	0	2	2	2
Queer	0	0	0	0	0
Another Sexual Orientation	0	0	0	0	0
Declined to State	2	4	4		
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	22	24	21	22	22
Female	12	14	11	14	14
Declined to State		9			
Current Gender Identity					
Male	20	29	26	28	28
Female	12	17	14	17	17
Transgender Male	-	0	0	0	0
Transgender Female	-	0	0	0	0
Gender Queer	-	0	0	0	0
Questioning or Unsure	1	0	0	0	0
Declined to State	1	1	1		
Write in Option		0	0		
Disability					
Yes:					
• Communication Domain					
Difficulty Seeing	9	9	9	9	9
Difficulty Hearing	4	2	2	2	2
Difficulty Having Speech Understood	4	4	4	4	4
• Mental Domain	34	47	48	45	45

(mental illness, learning disability, developmental disability, dementia)					
• Physical/mobility	6	5	4	5	5
• Chronic health condition	30	37	35	42	42
• Other (Specify)	-	0	0		
No	-	0	0		
Declined to State	-	0	0		
Other Relevant Data					

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 & 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.

We offer trainings with the overarching goal of increasing culturally appropriate skills in order to improve public mental health services. Trainings reflect the core values of consumer and family driven services, community collaboration, recovery/resiliency strength-based services, integrated services, and cultural competency.

B. **ADDITIONAL ASSISTANCE NEEDS FROM EDUCATION & TRAINING PROGRAMS**

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

The proposed training over the next three years is based on 3 different need areas: Core Competencies which will serve as the foundation to support the effective implementation and sustainability of Evidence Based Practices, the adoption of 3 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

b. Cognitive Behavioral Therapy

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.

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

4. 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 will be 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. Future LEAN projects will be focused on improving other organizational operations and programs. The County is seeking funding to support a LEAN facilitator, and future training and certification of staff in the LEAN model.

C. 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:					138
Number of individuals/families **ACTUALLY SERVED**	68	84	82	63	138
Age Group					
• Children 0-15	49	61	61	48	102
• TAY 16-25	19	23	21	15	36
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	9	11	13	11	20
• Latino	55	69	65	50	114
• Other	4	4	4	2	4
Primary Language					
• English	46	55	52	40	90
• Spanish	22	28	30	23	47
• Other	0	1	0	0	1
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**PVPSA**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					70
Number of individuals/families **ACTUALLY SERVED**	77	88	91	69	123
Age Group					
• Children 0-15	68	7	82	59	104
• TAY 16-25	9	13	9	10	19
• Adults 26-59					
• Older Adults 60+					

Race/Ethnicity					
• White	0	1	1	0	2
• Latino	77	75	79	57	107
• Other	0	12	11	12	14
Primary Language					
• English	38	4+	53	47	72
• Spanish	38	33	32	15	44
• Other	1	6	6	7	7
Culture					
• Veterans					
• LGBTQ					

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**	130	107	124	140	225
Age Group					
• Children 0-15	73	67	63	79	
• TAY 16-25	56	40	61	61	
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	38	36	42	50	
• Latino	5	65	70	74	
• Other	16	7	12	17	
Primary Language					
• English	105	92	105	121	
• Spanish	18	15	19	16	
• Other		2	2	3	
Culture					
• Veterans					
• LGBTQ					

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**	25	21	44	45	55
• Children 0-15	25	21	42	42	52
• TAY 16-25	0	0	2	3	3
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White					
• Latino	22	18	39	38	47
• Other	3	3	5	7	8
Primary Language					
• English	17	14	30	32	39
• Spanish	7	5	11	10	13
• Other	1	2	3	3	3
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Encompass**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**84**
Number of individuals/families **ACTUALLY SERVED**	39	47	47	37	75
Age Group					
• Children 0-15	27	33	34	27	55
• TAY 16-25	12	14	13	10	20
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	5	6	8	6	11
• Latino	32	39	38	30	62
• Other	2	2	1	1	2
Primary Language					
• English	26	30	30	23	49
• Spanish	13	16	17	14	25
• Other	0	1	0	0	1

Culture					
• Veterans					
• LGBTQ					

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**	29	34	42	43	46
Age Group					
• Children 0-15	26	30	33	33	35
• TAY 16-25	3	4	9	10	11
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	15	18	12	13	13
• Latino	8	10	27	27	27
• Other	6	6	3	3	6
Primary Language					
• English	21	22	22	23	23
• Spanish	8	12	20	20	23
• Other	0	0	0	0	0
Culture					
• Veterans					
• LGBTQ					

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

Culture					
• Veterans					
• LGBTQ	2	2	3	2	3

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**195**
Number of individuals/families **ACTUALLY SERVED**	117	120	136	154	227
• Children 0-15	88	93	84	93	
• TAY 16-25	29	27	52	61	
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	33	31	37	43	
• Latino	65	73	80	91	
• Other	19	15	17	30	
Primary Language					
• English	94	95	107	129	
• Spanish	15	20	18	17	
• Other		5	5	1	
Culture					
• Veterans					
• LGBTQ					

CSS Program #4: Education Gate

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

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**38**
Number of individuals/families **ACTUALLY SERVED**	29	24	32	36	63
Age Group					
• Children 0-15	15	11	21	22	
• TAY 16-25	14	13	11	14	
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	6	4	8	9	
• Latino	19	17	22	23	
• Other	4	3	2	4	
Primary Language					
• English	20	16	27	32	
• Spanish	5	5	5	4	
• Other	4	3	3	3	
Culture					
• Veterans					
• LGBTQ					

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:					6
Number of individuals/families **ACTUALLY SERVED**	41	29	34	27	12
Age Group					
• Children 0-15	13	16	19	15	5
• TAY 16-25	28	13	15	12	7
• Adults 26-59					
• Unknown					
Race/Ethnicity					
• White	6	7	7	5	3
• Latino	24	16	23	18	9
• Other	11	6	4	4	
Primary Language					
• English	41	18	19	15	4
• Spanish	0	1	15	12	8
• Other					
Culture					
• Veterans					
• LGBTQ	0	8	7	6	10

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					6
Number Actually Served	8	6	8	10	24
Adults (26-59)					
Number of individuals/families targeted					45
Number Actually Served	30	33	30	31	78
Older Adults (60+)					
Number of individuals/families targeted					9
Number Actually Served:	7	6	7	11	17
Unduplicated Annual Target for all					60
Race/Ethnicity					
• White	32	34	38	35	83
• Latino	11	8	5	13	26
• Other	2	3	2	4	10
Primary Language					
• English	43	43	43	48	113
• Spanish	2	1	2	4	5
• Other	0	1	0	0	1
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Encompass: Enhanced Support Services**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					0
Number Actually Served	1	1	2	2	3
Adults (26-59)					
Number of individuals/families targeted					20
Number Actually Served	16	17	19	16	23
Older Adults (60+)					
Number of individuals/families targeted					0

Number Actually Served:	2	2	2	2	2
Unduplicated Annual Target for all					
Race/Ethnicity					
• White	14	15	17	15	21
• Latino	4	4	4	3	5
• Other	1	1	2	2	2
Primary Language					
• English	19	20	23	20	28
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Encompass: Telos**				
Outreach and Engagement	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					20
Number of individuals/families **ACTUALLY SERVED**					
System Development	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					70
Number of individuals/families **ACTUALLY SERVED**					152
Unduplicated Annual Target for all					100
Age Group					
• TAY 16-25	6	9	11	10	26
• Adults 26-59	30	32	35	27	106
• Older Adults 60+	5	8	10	9	21
Race/Ethnicity					
• White	32	36	39	33	107
• Latino	7	8	16	10	34
• Other	2	5	1	3	12
Primary Language					
• English	39	46	51	43	142
• Spanish	2	2	4	3	9
• Other	0	1	1	0	2
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Santa Cruz County Behavioral Health Services-Access**				
Number of individuals/families **ACTUALLY SERVED**	278	273	323	327	1053
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	45	40	61	64	
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	198	199	222	217	
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	34	31	36	45	
Unduplicated Annual Target for All					
Number Actually Served:					
Age Group					
• Children 0-15					
• TAY 16-25	45	40	61	64	
• Adults 26-59	198	199	222	217	
• Older Adults 60+	34	31	36	44	
Race/Ethnicity					
• White	194	193	199	228	
• Latino	54	52	85	71	
• Other	30	28	40	28	
Primary Language					
• English	257	256	295	304	
• Spanish	14	7	17	17	
• Other	0	10	8	6	
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**MHCAN @ PHF**				
System Development	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					100
Number of individuals/families **ACTUALLY SERVED**	46	64	55	52	217
Outreach	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	4	4	5	8	21
Adults (26-59)					
Number of individuals/families targeted					

Number Actually Served	34	48	37	38	158
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	8	12	13	6	39
Race/Ethnicity					
• White	23	35	26	24	134
• Latino	7	11	10	16	34
• Other	0	7	0	0	7
Primary Language					
• English	42	57	49	44	78
• Spanish	4	7	6	7	13
• Other	0	0	0	1	1
Culture					
• Veterans	3	5	7	5	7
• LGBTQ	13	28	32	29	61

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:					80
Number of individuals/families **ACTUALLY SERVED**	44	74	62	48	123
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					200
Number Actually Served	95	104	99	103	271
Adults (26-59)					
Number of individuals/families targeted					300
Number Actually Served	154	271	201	216	482
Older Adults (60+)					
Number of individuals/families targeted					95
Number Actually Served:	142	138	144	10	213
Age Group					
• TAY 16-25	95	104	99	103	21
• Adults 26-59	154	271	201	216	482
• Older Adults 60+	142	138	144	110	213
• unknown					
Race/Ethnicity					
• White					189
• Latino					102
• Other					139
Primary Language					
• English					225
• Spanish					84
• Other					106
Culture					
• Veterans					29
• LGBTQ					97

Agency Reporting	**Volunteer Center/Community Connection: Mariposa**				
System development	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**50**
Number of individuals/families **ACTUALLY SERVED**	51	38	42	41	69
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					25
Number Actually Served	2	2	3	4	4
Adults (26-59)					
Number of individuals/families targeted					50
Number Actually Served	28	34	39	41	44
Older Adults (60+)					
Number of individuals/families targeted					25
Number Actually Served:	9	9	10	11	11
Age Group					
• TAY 16-25	2	2	3	4	4
• Adults 26-59	28	34	38	40	44
• Older Adults 60+	9	9	10	11	11
• Unknown		57	59	37	106
Race/Ethnicity					
• White	22	23	25	27	35
• Latino	11	15	20	21	16
• Other	18	7	6	8	12
Primary Language					
• English	51	33	38	45	48
• Spanish	0	11	12	10	10
• Other	0	1	1	1	1
Culture					
• Veterans	0	1	1	1	1
• LGBTQ	0	1	2	1	2

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**	64	65	77	94	123
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	5	9	6	6	6
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	54	53	69	80	80
Older Adults (60+)					
Number of individuals/families targeted					7
Number Actually Served	3	3	2	7	
Unduplicated Annual Target for All					
Number Actually Served:					
Age Group					
• Children 0-15					1
• TAY 16-25	5	9	6	6	6
• Adults 26-59	54	53	69	80	80
• Older Adults 60+	3	3	2	7	7
Race/Ethnicity					
• White	42	46	52	66	66
• Latino	15	14	22	23	23
• Other	5	4	2	6	6
Primary Language					
• English	58	58	74	88	88
• Spanish	2	5	3	3	3
• Other	2	2	0	3	3
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Santa Cruz County Behavioral Health Services-RECOVERY**				
Number of individuals/families **ACTUALLY SERVED**	260	277	260	314	
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	4	5	5	9	
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	203	222	196	233	
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	50	50	59	71	
Unduplicated Annual Target for All	260	277	260	314	
Number Actually Served:					
Age Group					
• Children 0-15					1
• TAY 16-25	4	5	5	9	9
• Adults 26-59	203	22	196	233	233
• Older Adults 60+	50	50	59	71	71
Race/Ethnicity					
• White	178	179	186	233	233
• Latino	59	73	59	60	60
• Other	20	27	15	21	21
Primary Language					
• English	219	238	226	283	283
• Spanish	29	31	29	26	26
• Other	9	8	4	5	5
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Santa Cruz County Behavioral Health Services-OAS**				
Number of individuals/families **ACTUALLY SERVED**	30	37	32	38	61
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served	0	1	1	0	0
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	0	1	0	1	1
Older Adults (60+)					

Number of individuals/families targeted					37
Number Actually Served	30	35	31	37	
Unduplicated Annual Target for All					
Number Actually Served:					
Age Group					
• Children 0-15					0
• TAY 16-25	0	1	1	0	0
• Adults 26-59	0	1	0	1	1
• Older Adults 60+	30	35	31	37	37
Race/Ethnicity					
• White	26	29	25	30	30
• Latino	0	1	1	2	2
• Other	4	7	6	6	6
Primary Language					
• English	29	36	31	36	36
• Spanish	0	0	0	1	1
• Other	3	1	1	1	1
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Front Street: Housing Support**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					15
Number Actually Served	6	6	4	4	6
Adults (26-59)					
Number of individuals/families targeted					60
Number Actually Served	64	66	67	64	73
Older Adults (60+)					
Number of individuals/families targeted					15
Number Actually Served:	23	24	25	22	26
Race/Ethnicity					
• White	78	81	81	74	85
• Latino	9	9	8	9	12
• Other	6	6	7	7	8
Primary Language					
• English	93	96	96	90	105
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ	1	1	2	2	4

Agency Reporting	**Front Street: Wheelock (outpatient & residential)**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served					
Adults (26-59)					16
Number of individuals/families targeted	13	12	12	13	14
Number Actually Served	12	12	12	12	13
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:	4	4	4	4	4
Race/Ethnicity					
• White	10	9	9	9	10
• Latino	4	4	4	4	4
• Other	3	3	3	4	4
Primary Language					
• English	16	15	15	16	17
• Spanish	1	1	1	1	1
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	**Front Street: Willowbrook**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served					
Adults (26-59)					
Number of individuals/families targeted					20
Number Actually Served	21	23	25	22	25
Older Adults (60+)					
Number of individuals/families targeted					20
Number Actually Served:	20	20	21	20	22
Race/Ethnicity					
• White	29	31	34	30	35
• Latino	5	5	5	5	5

• Other	7	7	7	7	7
Primary Language					
• English	40	42	42	42	42
• Spanish	1	1	1	0	1
• Other	0	0	0	0	0
Culture					
• Veterans	2	2	1	0	2
• LGBTQ	1	1	1	1	1

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	0	0	0	0	
Number Actually Served	0		1	1	1
Adults (26-59)					
Number of individuals/families targeted	39	39	39	39	
Number Actually Served	42	45	42	45	58
Older Adults (60+)					
Number of individuals/families targeted	1	1	1	1	
Number Actually Served:	2	2		0	2
Race/Ethnicity					
• White					
• Latino					
• Unknown					
Primary Language					
• English	44	47	43	46	61
• Spanish					
• Other					
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					
Number Actually Served	0	0	0	1	1
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	12	12	12	12	15

Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served:	3	3	3	3	3
Race/Ethnicity					
• White	12	12	12	13	15
• Latino	3	3	2	2	3
• Other	0	0	1	1	1
Primary Language					
• English	14	14	15	16	18
• Spanish	1	1	0	0	1
• 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					0
Number Actually Served	1	1	1	1	1
Adults (26-59)					
Number of individuals/families targeted					60
Number Actually Served	19	20	21	24	27
Older Adults (60+)					
Number of individuals/families targeted					0
Number Actually Served:	10	11	12	12	14
Race/Ethnicity					
• White	25	26	28	30	34
• Latino	2	2	2	3	3
• Other/Unknown	3	4	4	4	5
Primary Language					
• English	30	32	34	35	40
• Spanish	0	0	0	1	1
• Other	0	0	0	1	1
Culture					
• Veterans					
• LGBTQ					

Agency Reporting	Community Connection: Housing Support (employment)				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					10
Number Actually Served	0	1	1	1	1
Adults (26-59)					
Number of individuals/families targeted					35
Number Actually Served	16	16	16	19	21
Older Adults (60+)					
Number of individuals/families targeted					5
Number Actually Served:	1	1	1	12	3
Race/Ethnicity					
• White	14	14	14	16	19
• Latino	1	3	3	4	4
• Other	1	1	1	2	2
Primary Language					
• English	17	18	17	20	23
• Spanish	0	0	1	2	2
• Other					
Culture					
• Veterans	0	0	1	2	1
• LGBTQ	1	1	1	1	1

Agency Reporting	Community Connection: College Connection				
Outreach	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted					25
Number Actually Served	30	32	32	31	44

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	2	3	3
Adults (26-59)					
Number of individuals/families targeted					45

Number Actually Served	33	36	37	31	42
Older Adults (60+)					
Number of individuals/families targeted					5
Number Actually Served	4	5	8	9	9
Race/Ethnicity					
• White	31	32	34	33	40
• Latino	4	6	6	3	6
• Other	3	4	7	7	8
Primary Language					
• English	38	37	42	40	51
• Spanish	0	4	4	2	2
• Other	0	1	1	1	1
Culture					
• Veterans	0	0	1	1	1
• LGBTQ	4	6	6	6	7

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	7	8	3	2	11
Adults (26-59)					
Number of individuals/families targeted					
Number Actually Served	26	32	18	24	51
Older Adults (60+)					
Number of individuals/families targeted					
Number Actually Served	1	1	1	0	1
Race/Ethnicity					
• White	15	20	9	17	35
• Latino	12	15	8	4	16
• Other	7	6	4	5	12
Primary Language					
• English	34	41	18	26	55
• Spanish	0	0	3	0	7
• Other	0	0	0	0	1
Culture					
• Veterans	0	1	2	2	3
• LGBTQ	1	2	0	2	4

Agency Reporting	**Encompass: River Street Shelter**				
Outreach and Engagement	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**20**
Number of individuals/families **ACTUALLY SERVED**	46	49	50	41	112
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					5
Number Actually Served	3	2	2	2	4
Adults (26-59)					
Number of individuals/families targeted					40
Number Actually Served	31	38	36	40	105
Older Adults (60+)					
Number of individuals/families targeted					5
Number Actually Served:	7	8	8	12	27
Unduplicated Target for all					150
• Children 0-15					
• TAY 16-25	3	2	2	2	4
• Adults 26-59	31	38	36	40	105
• Older Adults 60+	7	8	8	12	27
Race/Ethnicity					
• White	26	31	34	34	87
• Latino	6	7	4	4	19
• Other	9	10	8	16	30
Primary Language					
• English	39	46	44	52	134
• Spanish	0	0	0	0	0
• Other	2	2	2	2	2
Culture					
• Veterans	0	2	5	3	9
• LGBTQ					
•					

Agency Reporting	**Encompass: Casa Pacific**				
Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					5
Number Actually Served	6	3	1	1	6

Adults (26-59)					
Number of individuals/families targeted					20
Number Actually Served	18	21	20	24	47
Older Adults (60+)					
Number of individuals/families targeted					5
Number Actually Served	2	0	0	0	2
Race/Ethnicity					
• White	13	14	16	21	35
• Latino	10	8	5	4	15
• Other	3	2	0	0	5
Primary Language					
• English	22	22	19	22	48
• Spanish	4	1	1	2	5
• Other	0	1	1	1	2
Culture					
• Veterans					
• LGBTQ					

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.

PEI Project #1: Early Intervention Services for Children

This project area addresses three priority populations: children and youth from stressed families, onset of mental illness, and trauma exposed children and their families. Of particular concern are families needing parental/supervision skills affected by substance use/abuse, and/or are exposed to violence, abuse, and /or neglect. The desire is to decrease the negative impact of these factors by offering mental health services to youth and their families. This project also addresses disparities in access to services by including a focus on the needs of Latino children/families, as well as lesbian, gay, bisexual, transsexual, and questioning (LGBT) youth and their families

Agency Reporting		Santa Cruz County Behavioral Health Services			
Work Plan/Program/Service		0-5 Screening			
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)			1		
Age Group					
• Children 0-15					35
• TAY 16-25					
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White					7
• Latino					12
• Other					16
Primary Language					
• English					20
• Spanish					8
• Other					7
Culture					
• Veterans					
• LGBTQ					

Agency Reporting		First 5			
Work Plan/Program/Service		Triple P			
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	91	84	116	149	334
Age Group					
• Children 0-15					
• TAY 16-25	12	8	6	12	27
• Adults 26-59	77	76	108	135	303
• Older Adults 60+	2	0	2	2	4
Race/Ethnicity					
• White	45	38	32	32	89
• Latino	37	49	73	102	209
• Other	10	7	11	15	36
Primary Language					
• English	246	243	312	404	829
• Spanish	145	283	318	517	961
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting		Live Oak Family Resource Center (via COE)			
Work Plan/Program/Service		School Based PEI			
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	33	38	47	55	173
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59					
• Older Adults 60+					
• unknown					
Race/Ethnicity					
• White					
• Latino					
• Other					
Primary Language					
• English					
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting		Diversity Center (via COE)			
Work Plan/Program/Service		School Based PEI			
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)					1945
Age Group					
• Children 0-15					367
• TAY 16-25					1454
• Adults 26-59					71
• Older Adults 60+					10
• Unknown					43
Race/Ethnicity					
• White					749
• Latino					606
• Other					30
Primary Language					
• English					165
• Spanish					270
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting		Positive Behavioral Intervention Program/COE			
Work Plan/Program/Service		School Based PEI			
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)					
Age Group					
• Children 0-15					25262
• TAY 16-25					2875
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White					7992
• Latino					18487
• Other					
• unknown					
Primary Language					
• English					18141
• Spanish					9597
• Other					399

Culture					
• Veterans					
• LGBTQ					

Agency Reporting		Santa Cruz County Behavioral Health Services			
Work Plan/Program/Service		Trauma Informed Systems			
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	19	183	297	305	804
Age Group					
• Children 0-15					
• TAY 16-25	3	1	5	16	25
• Adults 26-59	18	53	189	188	448
• Older Adults 60+	0	8	19	18	45
• Declined to state	2	121	126	94	343
Race/Ethnicity					
• White		45	91	103	239
• Latino		15	94	109	218
• Other/declined to state					492
Primary Language					
• English		48	89	133	270
• Spanish		3	11	12	26
• Other/missing info	25	115	146	71	355
Culture					
• Veterans					
• LGBTQ					

PEI Project #2: Services for Diverse Communities

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

Agency Reporting		NAMI			
Work Plan/Program/Service					
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	1676	1970	1920	1410	3278
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White					
• Latino					
• Other					
Primary Language					
• English					
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting		MHCAN-Shadow Speakers			
Work Plan/Program/Service					
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	46	64	55	52	217
Age Group					
• Children 0-15					
• TAY 16-25	4	4	5	8	21
• Adults 26-59	34	48	37	38	158
• Older Adults 60+	8	12	13	6	39
Race/Ethnicity					
• White	23	35	26	24	134
• Latino	7	11	10	16	34
• Other	0	7	0	0	7
Primary Language					
• English	42	57	49	44	78
• Spanish	4	7	6	7	13
• Other	0	0	0	1	1
Culture					
• Veterans					
• LGBTQ					

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

This project seeks to provide education, training, and treatment by expanding mental health awareness and services through traditional and non-traditional settings, Community Entry Points (CEP), Professionals, and Family members. This will be achieved by developing a network of care for use prior to being formally "diagnosed" at the earliest signs of possible serious mental illness. This program addresses transition age youth and adults who are trauma exposed and are experiencing (or at risk of experiencing) the onset of serious mental illness. This project also addresses disparities in access to mental health services by including a focus on the needs of Latino youth as well as Lesbian, gay, bisexual, transsexual (LGBT) individuals, and their families.

Agency Reporting		Volunteer Center (Community Connection)			
Work Plan/Program/Service					
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)					
Age Group					
• Children 0-15					
• TAY 16-25	22	15	19	22	36
• Adults 26-59	2	2	3	2	4
• Older Adults 60+					
Race/Ethnicity					
• White	13	8	11	12	20
• Latino	6	5	6	6	10
• Other	11	3	5	6	6
Primary Language					
• English	2	15	21	23	37
• Spanish	0	1	1	1	2
• Other	0	1	0	0	1
Culture					
• Veterans					
• LGBTQ	1	2	5	3	8

Agency Reporting		Santa Cruz County Behavioral Health Services			
Work Plan/Program/Service		Veterans Advocate			
July 1, 2015 to June 30, 2016	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)					
Age Group					
• Children 0-15					
• TAY 16-25	2	1	1	0	4
• Adults 26-59	19	23	29	24	95
• Older Adults 60+	36	43	31	41	151
Race/Ethnicity					
• White	47	57	49	60	213
• Latino	8	10	2	2	22
• Other	2	2	2	2	10

Primary Language					
• English	57	67	61	65	250
• Spanish	0	0	0	0	0
• Other	55	64	58	62	239
Culture					
• Veterans					
• LGBTQ	2	1	0	1	4

Agency Reporting		Santa Cruz County Behavioral Health Services			
Work Plan/Program/Service		Services for Transition Age Youth and Adult			
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	58	53	53	65	93
Age Group					
• Children 0-15					
• TAY 16-25	51	49	44	53	
• Adults 26-59	7	4	9	11	
• Older Adults 60+				1	
Race/Ethnicity					
• White	26	23	23	27	
• Latino	27	27	27	33	
• Other					
Primary Language					
• English	55	50	50	60	
• Spanish	3	3	3	5	
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting		Santa Cruz County Behavioral Health Services			
Work Plan/Program/Service		MERT			
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)	50	68	78	78	
Age Group					
• Children 0-15	23	32	27	20	
• TAY 16-25	10	16	30	12	
• Adults 26-59	11	17	18	32	
• Older Adults 60+	6	2	3	14	
Race/Ethnicity					
• White	33	3	44	55	
• Latino	6	21	19	11	
• Other	12	25	27	14	

Primary Language					
• English	48	61	69	68	
• Spanish	2	3	3	6	
• Other	0	4	6	4	
Culture					
• Veterans					
• LGBTQ					

PEI Project #4: Services for Older Adults

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

Agency Reporting		Family Service Agency			
Work Plan/Program/Service		Senior Outreach Program			
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)					29
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59					1
• Older Adults 60+					27
Race/Ethnicity					
• White					14
• Latino					4
• Other					
Primary Language					
• English					23
• Spanish					2
• Other					
Culture					
• Veterans					0
• LGBTQ					

Agency Reporting		Santa Cruz County Behavioral Health Services			
Work Plan/Program/Service		Peer Council & Companion			
July 1, 2017 to June 30, 2018	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Annual Count**
Total Served (Unduplicated)					12
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59					

• Older Adults 60+					12
Race/Ethnicity					
• White					10
• Latino					0
• Other					2
Primary Language					
• English					10
• Spanish					1
• Other					1
Culture					
• Veterans					1
• LGBTQ					

BUDGET

FY 2018-19 Mental Health Services Act Annual Update Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Cruz 11/15/18

	Fiscal Year 2018/19			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated Other Funding
FSP Programs				
1. Community Gate	0			
2. Probation Gate	0			
3. Child Welfare Gate	0			
4. Education Gate	0			
5. Family Partnerships	0			
6. Enhanced Crisis Response	955,130	591,249	363,881	0
7. Consumer, Peer, and Family Services	496,266	359,787	98,989	37,490
8. Community Support Services	6,293,199	4,192,355	2,100,844	0
9.	0			
10.	0			
11.	0			
12.	0			
13.	0			
14.	0			
15.	0			

16.		0			
17.		0			
18.		0			
19.		0			
Non-FSP Programs					
1.	Community Gate	1,784,661	1,015,500	608,270	160,891
2.	Probation Gate	144,684	144,684	0	0
3.	Child Welfare Gate	1,200,848	359,342	553,332	288,174
4.	Education Gate	288,171	147,812	109,171	31,188
5.	Family Partnerships	10,452	10,452	0	0
6.	Enhanced Crisis Response	1,551,458	997,635	553,823	0
7.	Consumer, Peer, and Family Services	25,300	25,300	0	0
8.	Community Support Services	2,681,357	1,920,826	651,531	109,000
9.		0			
10.		0			
11.		0			
12.		0			
13.		0			
14.		0			
15.		0			
16.		0			
17.		0			
18.		0			
19.		0			
CSS Administration		1,488,401	1,024,800	463,601	

CSS MHSA Housing Program Assigned Funds	0			
Total CSS Program Estimated Expenditures	16,919,927	10,789,742	5,503,443	626,742
FSP Programs as Percent of Total	71.8%			

FY 2018-19 Mental Health Services Act Annual Update Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Cruz Date: 11/15/18

	Fiscal Year 2018/19			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs				
1. Prevention & Early Intervention Services for Children	960,993	606,281	279,446	75,267
2. Culture Specific Parent Education & Support	301,664	268,523	33,141	0
3. Services for TAY & Adults	3,277,635	2,800,392	477,243	0
4. Services for Older Adults	194,012	119,512	74,500	0
5.	0			
6.	0			
7.	0			
8.	0			
9.	0			
10.	0			
PEI Administration	853,268	636,194	217,074	
PEI Assigned Funds	0			
Total PEI Program Estimated Expenditures	5,587,572	4,430,902	1,081,404	75,267

FY 2018-19 Mental Health Services Act Annual Update Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Cruz 11/15/18

	Fiscal Year 2018/19			
	A	B	C	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Integrated Health & Supported Housing	1,305,270	764,489	310,828	229,953
2.	0			
3.	0			
4.	0			
5.	0			
6.	0			
7.	0			
8.	0			
9.	0			
10.	0			
11.	0			
12.	0			
13.	0			
14.	0			

15.	0			
16.	0			
17.	0			
18.	0			
19.	0			
20.	0			
INN Administration	38,224	38,224		
Total INN Program Estimated Expenditures	1,343,494	802,713	310,828	229,953

FY 2018-19 Mental Health Services Act Annual Update Expenditure Plan
Funding Summary

County: Santa Cruz Date: 11/15/18

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,558,282	4,082,397	344,572	0	0	
2. Estimated New FY2018/19 Funding	10,271,932	2,567,983	675,785			
3. Transfer in FY2018/19[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY2018/19	0	0				0
5. Estimated Available Funding for FY2018/19	11,830,213	6,650,380	1,020,357	0	0	
B. Estimated FY2018/19 Expenditures	10,789,742	4,430,902	802,713	**0**	**0**	
C. Estimated Unspent Fund Balance	1,040,471	2,219,478	217,644	0	0	

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	3,578,419
2. Contributions to the Local Prudent Reserve in FY 2018/19	0
3. Distributions from the Local Prudent Reserve in FY 2018/19	0

4. Estimated Local Prudent Reserve Balance on June 30, 2019	3,578,419

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

FY 2018-19 Mental Health Services Act Annual Update Expenditure Plan
2017-18 to 2019-20 Funding Summary

County: Santa Cruz Date: 11/15/18

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	631,370	3,920,422	744,053	16,233	0	
2. Estimated New FY2017/18 Funding	11,060,865	2,765,216	727,688			
3. Transfer in FY2017/18[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY2017/18	0	0				0
5. Estimated Available Funding for FY2017/18	11,692,235	6,685,638	1,471,741	16,233	0	
B. Estimated FY2017/18 MHSA Expenditures	10,133,953	2,603,241	1,127,169	16,233	0	
C. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,558,282	4,082,397	344,572	0	0	
2. Estimated New FY2018/19 Funding	10,271,932	2,567,983	675,785			
3. Transfer in FY2018/19[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY2018/19	0	0				0
5. Estimated Available Funding for FY2018/19	11,830,213	6,650,380	1,020,357	0	0	
D. Estimated FY2018/19 Expenditures	10,789,742	4,430,902	802,713	**0**	**0**	

E. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,040,471	2,219,478	217,644	0	0	
2. Estimated New FY2019/20 Funding	10,770,296	2,692,574	708,572			
3. Transfer in FY2019/20[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY2019/20	0	0				0
5. Estimated Available Funding for FY2019/20	11,810,767	4,912,052	926,216	0	0	
F. Estimated FY2019/20 Expenditures	11,296,860	4,728,149	840,441	**0**	**0**	
G. Estimated FY2019/20 Unspent Fund Balance	513,907	183,903	85,775	**0**	**0**	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	3,578,419
2. Contributions to the Local Prudent Reserve in FY 2018/19	0
3. Distributions from the Local Prudent Reserve in FY 2018/19	0
4. Estimated Local Prudent Reserve Balance on June 30, 2019	3,578,419

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.