COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

CONDADO DEL SANTA CRUZ
Salud Mental y Tratamiento del Uso de Sustancias
POR NIÑOS Y ADULTOS

Mental Health Services Act*:*
FY 2022-2023 Annual Update

Contents

County of Santa Cruz
HEALTH SERVICES AGENCY
1400 Emeline Avenue, Santa Cruz, CA 95060
(831) 454-4170 FAX: (831) 454-4663

LETTER FROM THE MENTAL HEALTH SERVICES ACT COORDINATOR

April 20, 2022

We have completed a draft of the 2022-23 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 2020-2021. 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 was posted from March 22, 2022, to April 21, 2022, and a Public Hearing was held virtually on April 21st, 2022, at 3pm at the Behavioral Health Services Building at 1400 Emeline Avenue-Room 206/207, Santa Cruz, 95060. Call in information for that meeting was (916) 318-9542, Conference ID 416 793 331#.

Subsequently the Plan will be sent to the Santa Cruz County Board of Supervisors for adoption, and then to the Mental Health Services Oversight Accountability Commission and the State Department of Health Care Services.

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

- At the Public Hearing,
- By telephone: (831) 763-8203
- By internet: http://santacruzhealth.org/MHSA
- By email to: MentalHealth.ServicesAct@santacruzcounty.us
- By writing to:

  Santa Cruz County Behavioral Health
  Attention: Lauren Fein, MHSA Coordinator
  1400 Emeline Street, Building K
  Santa Cruz, CA 95062

Sincerely,

Lauren Fein

Lauren Fein, LMFT
Behavioral Health Program Manager
Mental Health Services Act Coordinator

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Cruz County

County Mental Health Director	**Project Lead**
Name: Erik G. Riera	Name: Lauren Fein
Telephone Number: 831-454-4515	Telephone Number: 831-454-4977
E-mail: erik.riera@santacruzcounty.us	E-mail: lauren.fein@santacruzcounty.us
Mailing Address: Santa Cruz County Behavioral Health Services 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 nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on August 23, 2022.

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. G Riera	DocuSigned by:	7/20/2022
Mental Health Director/Designee (PRINT)	Signature 5554D78ECC4749E...	Date

County: Santa Cruz

Date: 7/20/2022

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

Santa Cruz County

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

Local mental Health Director	**County Auditor-Controller**
Name: Erik G. Riera	Name: Christine Williams
Telephone Number: 831-454-4515	Telephone Number: 831-454-7341
E-mail: erik.riera@santacruzcounty.us	Email: Christine.williams@santacruzcounty.us
Local Mental Health Mailing Address: Santa Cruz County Behavioral Health Services 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.

DocuSigned by:
7/20/2022
5554D78FCC4749E...

Erik G. Riera
Local Mental Health Director (Print) — Signature — Date

I hereby certify that for the fiscal year ended June 30, 2021, 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 12/22/2021 for the fiscal year ended June 30, 2021. I further certify that for the fiscal year ended June 30, 2021, 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.

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.

DocuSigned by:
Christine Williams 7/21/2022
A0BD913F7FB5454...

Christine M. Williams Chief of Fiscal Services
County Auditor Controller (Print) — Signature — Date

COMMUNITY SURVEY PLANNING FOR MHSA 2022-2023 ANNUAL UPDATE

Considering the ongoing COVID-19 pandemic and to safely gain as much stakeholder feedback as possible Santa Cruz County conducted this year's annual planning update process virtually. The virtual process comprised of the county website, email and YouTube. All elements were created in either English with Spanish subtitles or in both languages when possible.

Each program currently funded by MHSA created a 3–5-minute video explaining their services, evaluation components for providing high quality programming, and how the programs use evidence-based practices to better meet the needs of the populations served. Each organization provided a brief overview of their annual program evaluation report or other information from performance measures/metrics/tools utilized to highlight your achievements.

These videos were then posted on YouTube on our County MHSA Channel. All videos have both English and Spanish subtitles available. A link to each video was also posted on our county MHSA website.

In order to increase accessibility, our website also featured a transcript, in both English and Spanish, of each video.

The county website, www.santacruzhealth.org/mhsa, was also updated to create a more user-friendly experience. On the annual update page, there was a clear step by step guide outlining the stakeholder engagement process as well as the following messages and action items:

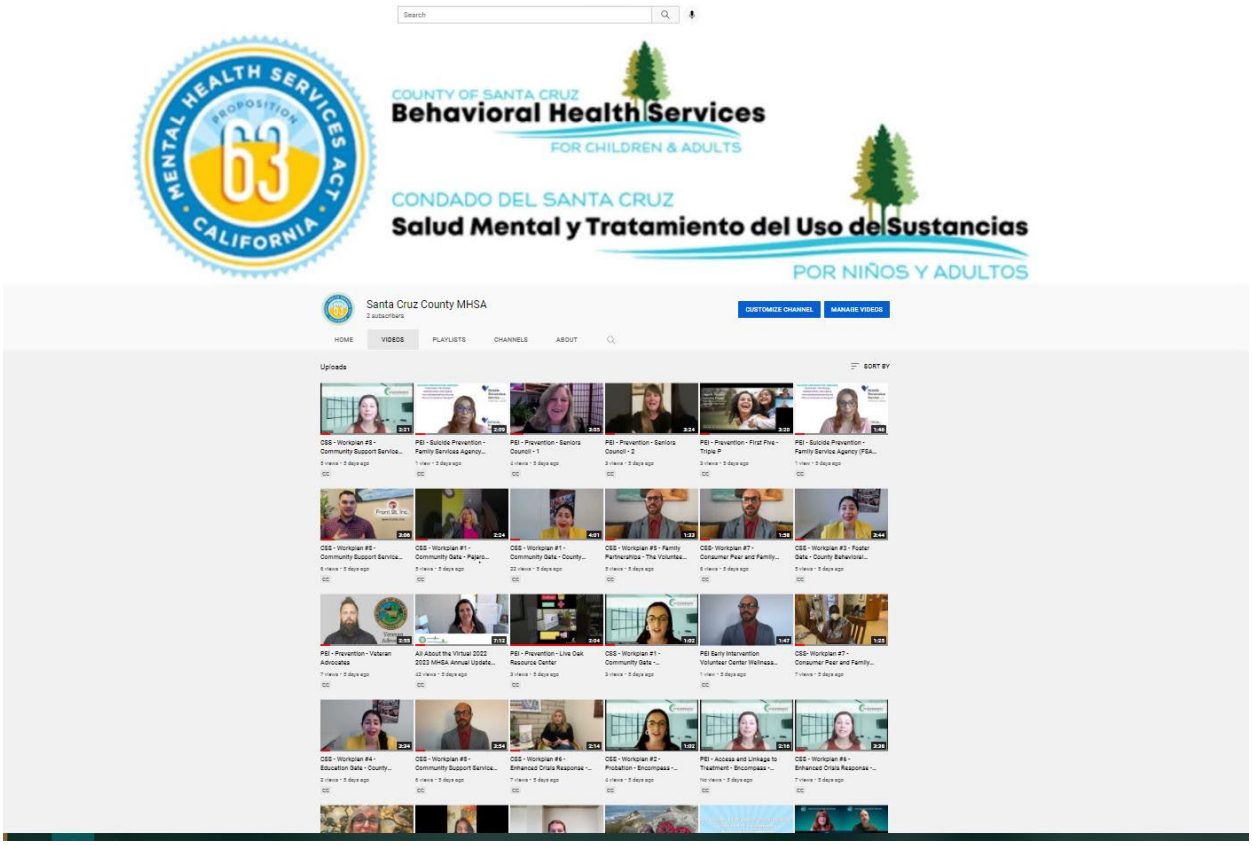
- A video and text describing the annual update process and how stakeholders could participate
- How community members could engage in the process
- Video links and transcripts for each program currently funded by MHSA

On March 1st, the MHSA YouTube channel and Stakeholder PEI/CSS videos went live. This was announced to our agency, community partners and their email lists through an email blast.

Additionally, there were two virtual public hearings at Mental Health Advisory board meetings in which the public could leave a public comment. These transpired on April 21st, 2021, and July 21st.

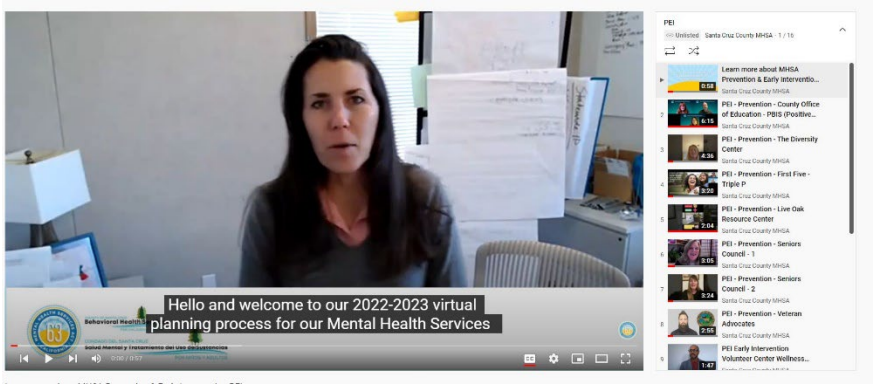
ATTACHMENTS:

Santa Cruz County MHSA YouTube Channel



Santa Cruz County MHSA Annual Update Webpage

Santa Cruz County MHSA Annual Planning "How To" Video



MHSA Annual Planning Email Blast

Hello community stakeholders!

It is time for the MHSA Annual Plan Update & **we can't do it without all of you!**

Gaining stakeholder feedback remains an invaluable part of the Community Planning Process for the Mental Health Services Act (MHSA) in Santa Cruz County. The Community Planning Process allows stakeholders the opportunity to provide feedback from their unique perspective about the programs and services being funded through MHSA. This year, due to ongoing COVID, we will be holding the Community Planning Process virtually.

HOW TO PARTICIPATE

WATCH

To learn more about MHSA and the Annual Update, watch this video with Cassandra Eslami, MHSA Coordinator.

LEARN

To learn more about the MHSA funded programs in our community, click on the images below.

COMMENT

Please submit feedback here to help us create our draft MHSA Annual Update for 2022-2023. Based on your feedback Santa Cruz County plans to release the draft MHSA plan for formal public comment on March 22nd.

At that time, the plan can be found on this webpage, in addition to a formal comment form. The 30-day formal public comment will be open from March 22nd to April 21st. Public comment will formally close at the April 21st Mental Health Advisory Meeting. Information on that meeting will be updated here.

For more information on MHSA, please visit santacruzhealth.org/mhsa
Thanks & have a great day!

¡Hola participantes interesados de la comunidad!

¡Es hora de la actualización del Plan Anual de MHSA y **no podemos hacerlo sin todos ustedes!**

Obteniendo comentarios de los participantes interesados sigue siendo una parte invaluable del Proceso de Planificación Comunitaria para la Ley de Servicios de Salud Mental (MHSA) en el Condado de Santa Cruz. El Proceso de Planificación Comunitaria brinda a las partes interesadas la oportunidad de brindar comentarios desde su perspectiva única sobre los programas y servicios que se financian a través de la MHSA. Este año, debido al COVID en curso, realizaremos el Proceso de Planificación Comunitaria virtualmente.

COMO PARTICIPAR

MIRE

Para obtener más información sobre MHSA y la Actualización anual, mire este video con Cassandra Eslami, coordinadora de la MHSA.

APRENDA

Para obtener más información sobre los programas financiados por la MHSA en nuestra comunidad, haga clic en las imágenes a continuación.

COMENTE

Envíe sus comentarios aquí para ayudarnos a crear nuestro borrador de la Actualización anual de la MHSA para 2022-2023. Según sus comentarios, el condado de Santa Cruz planea publicar el borrador del plan MHSA para comentarios públicos formales el 22 de marzo.

En ese momento, el plan se puede encontrar en esta página web, además de un formulario de comentarios formal. El comentario público formal de 30 días estará abierto del 22 de marzo al 21 de abril. Los comentarios públicos se cerrarán formalmente en la Reunión Asesora de Salud Mental del 21 de abril. La información sobre esa reunión se actualizará aquí.

Para obtener más información sobre la MHSA, visite santacruzhealth.org/mhsa

¡Gracias y que tenga un gran día!

PUBLIC COMMENTS & RESPONSES

After the public comment closed, we recognized that there was a clarification needed to our proposal to set aside unspent MHSA funds for Crisis Residential Programming so we opened the public comment period again from June 18, 2022, to July 21, 2022, to ensure that stakeholders could weigh in. This public comment period was closed at a virtual Public Hearing at 3pm on July 21st, 2022, at the Behavioral Health Services Building at 1400 Emeline Avenue-Room 206/207, Santa Cruz, 95060. Call in information for that meeting was (831) 454-2222, Conference ID 655 132 162#.

During the public comment period we received anonymous 34 comments on our county MHSA website. In addition to leaving a public comment, stakeholders were asked the following:

- Strengths of this plan
- Concerns about the plan
- Whether or not they support the Annual Update
- Support setting aside MHSA funding for the Capital and Operations of Crisis Residential Programs
- Programs or Initiatives they would like to advocate to be funded or expanded

STRENGTHS OF THE PLAN

Many stakeholders felt that despite virtual, the communication and video presentations for the stakeholder feedback process were “excellent” “easy to navigate” and “informative.”

CONCERNS OF THE PLAN

Some stakeholders had named that they “missed the in-person meetings” and hoped that next year the stakeholder process would also be “in person and online.” Many had questions about the financial summary section of the plan, which are listed and answered below. There was also overall confusion on the years reported on, which were 20-21, despite the title of the plan being “2022-2023 Annual Update.” In the future, this will be clarified and explained better.

Many stakeholders also cited that there are not enough programs for “homeless youth and adults” or those struggling with co-occurring mental health and substance use disorders. There was also an overwhelming desire for more housing in our county, which is a serious problem.

Twenty-five of the 34 comments, or 73% stated that they supported the annual update. 88% stated that they approved the setting aside of MHSA funding for Capital and Operations of Crisis Residential Programming. The other four comments stated that they “Need more information.”

COMMENT:

The financial summary indicated the following:
New funding for FY 22/23 totals $20,838,401 which is lower than the previous year's total of $22,797,684. Is that correct?
Expenditures from the previous year (estimated expenditures in last year's MHSA report) will be increased by a total of $4,286,985. CSS will increase by $3,408,537; PEI will be increased by $1,088,221, Innovation will be reduced by $209,773.

The plan assumes the use of some of the reserve balance totalling $1,515,690 (Beginning unspent funds of $15,108,395 vs. ending unspent of $13,592,705). It appears FY21/22 expenditures were lower than new funding due to uncertainty arising from COVID.
Comparing the FY21/22 projections by program from last year's MHSA report it appears the majority of the increase in the CSS is in FSP program 8- Community Support Services ($3.4M). What areas or initiatives is the increased expenditures targeted for?
Comparing the FY21/22 projections by program from last year's MHSA report it appears the majority of the increase in PEI expenditures is in PEI Program 3- Transition Age Youth and Adult Services ($954K). What areas or initiatives is the increased expenditures targeted for?

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

The funding for FY 22/23 totals are lower than the previous year. The increased CSS and PEI expenditures are targeted for ensuring contract providers are at minimum the same service level and funding level as prior year plus any estimated cost escalators as well as estimated cost escalators for county staffing. For PEI, the increased expenditures also include contracting with Volunteer Center to fund Wellness Connect, which is a program addressing Transition Aged Youth and first episode intervention.

COMMENT:
It is unclear when I looked at the Crisis Residential Program indicating additional MHSA funds being available and the request to reserve $2.5 and $5M for operations of the adult and children's facilities. Is the idea to reserve this out of the $13,592,705 unspent funds anticipated at the end of the next fiscal year? I completely support these two new facilities- just need to connect the dots.

RESPONSE:
We are requesting to reserve 2.5M & 5M out of the $13,592,705 unspent funds anticipated at the end of the next fiscal year for the Capital and Operations of Crisis Residential Programing.

COMMENT:
page 12-FYI- In the last year NAMI has added 3 full time employees bringing our total of bilingual support staff to 4. This might add to the statistics on Latinos being served.

The number of individuals to be served 2021-22 is the targeted number. It might be helpful to add the actuals reflected in the detailed schedules at the back next to the targeted number. Also, you might add the page numbers for the associated MHSA Quarterly & Annual Report for easy reference.

RESPONSE:
While this report is titled 22/23, the data reported is for 20/21 and the targets are for the following year, 21/22.

Thank you for your suggestion to add the page numbers, that will be added to this plan.

COMMENT:
More funding for Mhcan.

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

COMMENT:
Instead of police, we need more mental health services. Now.

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

COMMENT:
Data on Suicide Prevention with October 2017 (if correct) needs more current data.

Page 85- are dates 7/1/18-6/30/19 correct? This section does not include either the current MERTY crisis support team or the additional one which is planned to be added in the upcoming year?

Innovation Projects. The 'Healing the Streets' project is reflected in the funding summary on page 158 but there is no description of this innovative project?

RESPONSE:
Thank you for your comments. The following changes have been made and will reflect in the final Quarterly & Annual Report: added information on Healing the Streets – Innovation Project, correct dates on suicide prevention changed. The PEI program on Mobile Crisis will include language on MERTY.

COMMENT:
Information Technology & Capital Facilities. The financial schedules on pages 156-158 does not reflect the level of funding or reserves available for these two areas? Is there a current project to update the clinical and administrative systems?

RESPONSE:
Information technology and Capital Facilities components fund projects designed to enhance the infrastructure needed to support the behavioral health system, which includes improving or replacing existing technology systems and/or developing capital facilities to meet increased needs of the local mental health system. These funds are one-time funding, which was already expended.

COMMENT:
PEI Funding Schedule: What is the financial mapping of the PEI programs on pages 26-87 to the four categories reflected on page 157?

RESPONSE:
The financial mapping of PEI programs to the four categories listed on the budget is in process with plans to implement in the next three-year plan 2023-2026.

COMMENT:
The current plan to opt-in to the AOT legislation could be added to the innovation section or another appropriate section. This new program, which is being supported by the Treatment Advocacy Center, will provide 'prevention' of SMI individuals eligible for this approach from deteriorating further and provides a path towards treatment and recovery. This program is liable to be close to the approach of the Governor's 'Care Courts' and could put many common elements in place.

I did not see any mention of Wellness Connect which is using evidence - based practices to address first episode intervention. This could also be added to the innovation section.
Wellness Connect is a newer program so the financials would not be

Both AOT and the Wellness Connect team should be reflected in the financial projections (if not already included).

RESPONSE:
We have requested and received approval to defer any decision on implementing AOT until December 2022. Wellness Connect is a new program that is being funded by PEI. The financial projections will be reflected in next year's annual plan as this plan covers fiscal year 2020-2021.

COMMENT:
It is challenging to execute a plan. For each of the last 4 years there appears to have been a $3m carry over of unspent funds. What is being done to continually ensure funds are fully allocated or efficiently and effectively reallocated. Additionally, the prudent reserve has a minimum of 5%. Santa Cruz County consistently is closer to 15%, or about $2.7m. With important programs such as child residential services, sobering centers, mobil crisis response, and a crisis response center needed wouldn't these funds be better used for one of these services?

RESPONSE:
We appreciate the time you took to provide public comment. We take all comments seriously and discuss comments in our Behavioral Health Leadership Team meeting. Part of the three-year Program and expenditure plan stakeholder engagement process is to ensure that funds are fully allocated or efficiently and effectively reallocated. This process will begin in 2023 for the 2023-2026 three-year plan.

COMMENT:
There was a lot of estimating. In last year 's services, there was an estimate of how many clients they were going to serve and then it had the actual number of how many were served. In almost all categories

the Transitional Age Youth was overestimated on what they were going to serve. Is there anything changing in this year to make that number either raise how many get served or make that more actual?

RESPONSE:
We try to reset the targets every year on the estimate, so they are closer to the actuals of those served. However, the actuals have been difficult to set given COVID and the numbers that we've seen, but yes, I'm more than happy to work with Lisa Gutierrez-Wang, Children's Director as well as Karen Kern, Adult's Director to really reestablish those actuals. We also meet with the programs to do that, so thank you for that feedback.

COMMENT:
For some reason there was a change starting page 114 for prevention, it didn't have the intended numbers served, only actual numbers. Is there a reason why the reporting of the charts were sort of different at that point? There's the yellow highlight that has targeted going up to page 113, but then, after that, the color changes and there isn't targeted compared to actuals.

RESPONSE:
There are different requirements to report on given the program type so there's different reporting requirements for community support services than PEI and there's also different reporting requirements for FSP's so if that data wasn't included in the report, it is because it's not required by the state, so we don't require the programs to collect it.

COMMENT:
My feedback would be that it's really useful in trying to get feedback from somebody who isn't totally aware of how all the different programs work comparing 21 to 22, when I do have those numbers, it's really helpful. The numbers of the contracts for the full program types like aggregate, those were compared. But what each contract for each program, that was not separated and compared. And that would just be really useful information if I was to give feedback about it - to see how a program did, according to their intentions and then the next contract is whether it's increasing or decreasing or whatever.

RESPONSE:
The reason we do the comment form is so we can catalog all of this feedback and then it's written into the report so everyone can see it as well, if you can take the time to actually do the comment form. We're collecting all the comment forms this year for the first time through the website itself, and they are all logged for us, so we can pull them and then print them in the report and have a response as well. If anyone has any feedback on anything that they think would be more helpful, please complete a comment form at santacruzhealth.org/MHSA. If you have other feedback where you think it's not accessible, please let me know, and we're happy to continue taking comments via email, phone call or written mail.

During the public comment period we requested to reserve 2.5M & 5M out of the $13,592,705 unspent funds anticipated at the end of the next fiscal year for the Capital and Operations of Crisis Residential Programing.

COMMENT:

I spoke before about my son in jail with DUI and I just wanted to also put in that the that he has mental health issues too. It's just when all these when that happened and you wind up in the jail is, you know, it's kind of layered with mental health. So I just wanted to make sure that I'm in the right uh meeting so you could hear not just the DIY, but you could hear the mental health issues that I'm requesting a services in product county. There's just too many people who are suffering now with mental health issues. That and it's undermined group. So I just wanted to make that known. OK. Thank you very much. And thank you for your time and for being here.

Open to having more treatment centers. Yeah, available in the in town, in the city of Santa Cruz. I go to Janice and Janice is medical patients. But and I think new life is, but there's very few Treatment Centers for low income or no income.

RESPONSE:

Thank you for your feedback. I will Include that in the report. Also, just to let you know the way that the process works is every three years we go through a pretty extensive stakeholder process so that we can really ensure that the funding from MHA are going to the programs that are best suiting our community. And that next three-year plan and stakeholder engagement process will be in the beginning of 2023. So I'll definitely bring all the information back here as far as what that stakeholder process would be. But I definitely encourage, I'm so sorry I didn't get your name, but the woman who just spoke to be involved in that stakeholder process to bring these ideas then as well.

COMMENT

MHSA funding to program have to be that apply for that funding. Do they have to have a three year plan or can they be one year plan program?

RESPONSE

The three-year plan really sets what the programs are going to be and then the plans each year are really tracking the data for that. I I'm still new to this, so I can investigate it, but I'm under the impression that really kind of wants that plans in place then we have a road map for the next three years and then after those years we can reassess. I just I think it's kind of hard for programs to really figure out funding if they're switching every year. But again, I'm happy to.

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 270,861 according to 2020 Census estimates. In Santa Cruz, the breakdown of the population by race is 56.8% are White (Not of Latino origin), Latinos make up 34% of the county population, 1.5%, African American, 1.8% are American Indian and Alaskan Native persons, and 5.3% are Asian. 17.3% of the population is over 65 years old; persons 18 years and under comprised 19% of the population. The threshold language in Santa Cruz is Spanish. Slightly more than half of the population (50.5%) identify as female.

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

Cost Per Person Served Fiscal Year 2020-2021:

The approximate cost for children served in the CSS program is $1,766 and, in the PEI, programs is $144. The approximate cost for adults served in the CSS program is $2,125 and, in the PEI, program is $1,992, and INN is $4,899.

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 (PVPSA), and Santa Cruz County Behavioral Health provide the services in this work plan.

Number of individuals to be served 2021-2022:

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: 287

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? Hiring and retaining bilingual (and bicultural) clinicians is a challenge. We are continually working with Santa Cruz County Personnel and community partners to address this issue.
Santa Cruz County, like most California counties, experienced challenges and hardships related to the ongoing COVID-19 pandemic. Challenges included recruit of staff, onsite staffing resources, client and family telehealth capabilities and issues in services related to infection prevention. While these the pandemic challenges have been recently alleviated with CDPH and CDC guidelines there are ongoing risk mitigation strategies in healthcare settings that can create lasting barriers.

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

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 105.

CSS PROGRAM #2: PROBATION GATE

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

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

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

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

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

Number of individuals to be served 2021-2022:

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

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

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 County Personnel and community partners to address this issue.

Santa Cruz County, like most California counties, experienced challenges and hardships related to the ongoing COVID-19 pandemic. Challenges included recruiting and retaining staff, Clinic-based and field staffing resources, client and family telehealth capabilities and issues in services related to infection prevention. While these the pandemic challenges have been recently alleviated with CDPH and CDC guidelines there are ongoing risk mitigation strategies in healthcare settings that can create lasting barriers.
Are there any new, changed or discontinued programs? No.

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 106.

CSS PROGRAM #3: CHILD WELFARE SERVICES GATE

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

- Consultation services for parents (with children in the Child Protective Services system) who have both mental health and substance abuse issues.
- Increased services, including expanded services for the 0 to 5 -child populations. These services include assessment, individual, group, collateral, case management, family therapy and crisis intervention.
- Services for general foster children/youth treatment with a community-based agency, as well as county clinical capacity.

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

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

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

Number of individuals to be served 2021-2022:

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

- Parents Center: 30
- Santa Cruz County Behavioral Health: 179

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

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

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 107.

CSS PROGRAM #4: EDUCATION GATE

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

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

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

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

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

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

Number of individuals to be served 2021-2022:

The unduplicated number of individuals to be served by program is:

Santa Cruz County Behavioral Health Services: 49

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

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

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 108.

CSS PROGRAM #5: SPECIAL FOCUS: FAMILY & YOUTH PARTNERSHIPS

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

The support, outreach, education, and services include:

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

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

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

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

Number of individuals to be served 2021-2022:

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

Volunteer Center/Family Partnerships: 50

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

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

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 109.

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 led 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 2021-2022:

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: 583

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

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

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 110.

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 2021-2022:
The unduplicated numbers of individuals to be served by program are:

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

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

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

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

Performance Outcomes (specify time period):
See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 112.

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 use disorder 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 adherence, 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.
- 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.

- 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.

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

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

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

Number of unduplicated individuals to be served 2021-2022:

Front Street- Wheelock (Residential & Outpatient)	16
Front Street- Willowbrook	40
Front Street- Opal Cliffs	14
Encompass- Supported Housing	60
Volunteer Center/Community Connection-Housing Support (employment)	55
Volunteer Center/Community Connection-Opportunity Connection	70
Volunteer Center/Community Connection Avenues	45
Volunteer Center/Community Connection Cabrillo College Connection	25
Santa Cruz County Behavioral Health Services North & South County Recovery	494
Santa Cruz County Behavioral Health Services Older Adult Team (OAS)	86
Santa Cruz County Behavioral Health Services MOST	136
Encompass Casa Pacific	40

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
Santa Cruz County, like most California counties, experienced challenges and hardships related to the ongoing COVID-19 pandemic. Challenges included recruit of staff, onsite staffing resources, client and

family telehealth capabilities and issues in services related to infection prevention. While these the pandemic challenges have been recently alleviated with CDPH and CDC guidelines there are ongoing risk mitigation strategies in healthcare settings that can create lasting barriers.

Are there any new, changed or discontinued programs?
Yes. In May 2021, the River Street Shelter closed and is no longer included in the MHSA plan. The River Street Shelter was run through a community-based organization, Encompass who experienced complicated issues with sustainability.

Performance Outcomes (specify time period):

See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 114.

COMMUNITY SERVICES AND SUPPORTS: HOUSING

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

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

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

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

1. The applicant(s) must be able to demonstrate that his/her conduct and skills in present or prior housing has been such that the admission to the property would not negatively affect the health, safety, or welfare of other residents, or the physical environment, or financial stability of the property.
2. Positive identification with a picture will be required for all adult applicants (photocopy may be kept on file). Eligible applicants without picture identification will be supported by County Mental Health or other service providers to obtain one. For purposes of the application, a receipt from the DMV showing an application for an ID will be sufficient. If deferred, the final picture identification will be required at the time of move-in.
3. A complete and accurate Application for Housing that lists a current and at least one previous rental reference, with phone numbers will be required (incomplete applications will be returned to the applicant). Applicants must provide at least 2 years residency history. Applications must include date of birth of all applicants to be considered complete. Requests for Consideration will be considered for MHSA applicants whose disability may result in insufficient or negative references.
4. A history of good housekeeping habits.
5. A history of cooperation with management regarding house rules and regulations; abiding by lease terms; and care of property.
6. Each applicant family must agree to pay the rent required by the program under which the applicant is qualified.
7. A history of cooperation in completing or providing the appropriate information to qualify an individual/family for determining eligibility in affordable housing and to cooperate with the Community Manager.
8. Any applicant that acts inappropriately towards property management staff or is obviously impaired by alcohol or drugs, uses obscene or otherwise offensive language, or makes derogatory remarks to staff, may be disqualified
9. Applicants must agree that their rental unit will be their only residence. When applicants are undergoing income limit tests, they are required to reveal all assets they own including real estate. They are allowed to own real estate, whether they are retaining it for investment purposes as with

any other asset, or have the property listed for sale. However, they may never use this real estate as a residence while they live in an affordable housing unit.

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

PROPOSED FUNDING PROJECTS

MHSA CRISIS RESIDENTIAL PROGRAMS

ADULT CRISIS RESIDENTIAL PROGRAM:

- Currently our inpatient program is operating at 97% capacity over the last 6-months. When the program is full, which is essentially 100% of the time, we send adults in crisis out of county for safe placement. This places a strain on them and their families and supports.
- We have minimal options in terms of alternative placement for hospitalization for adults. We have one local crisis residential program, Telos, which is limited to 10-beds, and is also full 100% of the time.
- Current plans include additional programming in the new proposed programming, including on-site health care, wellness and peer services, individual and group services, and in the future, a partial hospital or intensive outpatient program.
- The County is submitting an application for funding which is due no later than March 31 to support construction of the new proposed program.

CHILDREN'S CRISIS RESIDENTIAL PROGRAM:

- Santa Cruz County has no inpatient capacity for children, any child needing inpatient care has to be admitted out of County, sometimes as far as San Diego County.
- The new proposed program will offer an alternative for children to inpatient care, with intensive short-term services to support the child and allow them to safely return home and continue to benefit from ongoing services in the community.
- In addition, we are proposing to move the 4-chair Crisis Stabilization Program for children from its current location at 2250 Soquel, where it is co-located with the adult program, to a new site that would be dedicated for children only and have much more space and capacity to serve more children- up to 8.
- In addition, the new proposed Children's CSP will have treatment space, family meeting space, and on-site healthcare services.
- The County was recently awarded $7.6M from the California Health Facilities Finance Authority for construction of the new program, which is approximately 40% of what is needed to complete the project.
- The County is submitting an application for additional funding this spring.

Both programs will emphasize a warm and welcoming environment for all. They will support a strong emphasis on wellness and nutrition as well.

OUR ASK

- If we are successful in our grant submissions for construction, we need to demonstrate the ability to support the capital and operations costs for both proposed programs.
- We have additional MHSA funding that has been allocated to the County and we are proposing to set aside up to $2.5M for the Adult Crisis Program, and $5M for the Children's Crisis Residential Program to support operations for the first 2-years

PREVENTION & EARLY INTERVENTION - PEI

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

PREVENTION

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

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

EARLY INTERVENTION

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

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

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

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

- Senior Outreach-Family Service Agency of the Central Coast

STIGMA AND DISCRIMINATION REDUCTION

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

- NAMI

SUICIDE PREVENTION

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

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

ACCESS AND LINKAGE TO TREATMENT

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

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

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

PEI PROJECT- PREVENTION

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

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

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

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

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

1. *The Diversity Center*:
    a. The Diversity Center provides support services to LGBTQ students throughout the county. Services will include support to student Gay Straight Alliance (GSA) groups and offering LGBTQ counseling and advocacy, and LGBTQ-friendly pro-social activities.
    b. The Triangle Speakers program provides education and awareness about LGBTQ issues to the broader school and community population and provide identification and referral services for LGBTQ students showing early indicators of mental illness.
    c. The Queer Youth Task Force's Safe School Project supports school policies, practices and trainings that make schools safer for LGBTQ youth. They also provide trainings in LGBTQ cultural issues and counseling strategies.
2. *Positive Behavioral Intervention and Supports* (PBIS):
    a. Positive Behavior Intervention and Supports (PBIS) training is a model for establishing a positive school climate and helps schools focus existing resources in a school-wide prevention model as well as designing site-relevant interventions for children showing signs of distress. Successfully implemented, PBIS establishes clear expectations, emphasizes recognition for positive behavior and creates a school culture that is stable and consistent across campus areas and grade levels.
    b. School-Wide PBIS Trainings is composed of Tier 1, Tier 2 and Tier 3.
        i. Tier 1 develops a framework by focusing on developing school rules and teaching expectations, developing an acknowledgement system, responding to a problem behavior and discipline referral system, and developing an implementation plan.
        ii. Tier 2 is intervention level that serves between 15-25 students at once using a "check-in, check-out" system. This technique is an efficient use of resources rather than a one student at a time approach. Students can get support almost immediately upon referral. This level requires almost

no legwork from referring staff to begin implementation of the intervention with a student. The process being used is referred to as a "Check-in, Check-out" (CICO).

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

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

Number of individuals to be served each year:

The Diversity Center:

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

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? No **If so, what are the strategies to mitigate?**

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 #1: Children's Services

Agency: COE: **The Diversity Center**

Target population:

What is the unduplicated number of individuals served in preceding fiscal year? 2,778

What is the number of families served? 27

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. During the pandemic, many of our youth program participants were experiencing suicidal ideation, especially the ones who were sheltering in place with unsupportive families.

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 significant concerns about the mental health and/or safety of a program participant, the youth were referred to an in-house social worker to receive on-site individual therapy.

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)?

While youth were sheltering in place and school was virtual, many GSAs did not take place. TDC was able to connect with LGBTQ+ youth through the GSAs that were taking place. TDC also engaged with youth through our virtual programs (which increased to be offered daily during the early part of the pandemic). Activities included support groups, cooking and exercise classes, movie nights, homework help, etc. 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.

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

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

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). The Safe School Project works with administrators to problem-solve issues as they arise, and to recommend and implement anti-bullying curriculum.

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.

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

Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program.
The 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 our onsite therapist (new during the pandemic), as well as school and community therapists. We regularly 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 if they are struggling) with their gender identity to our in-house social worker, or 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 provide some on-site therapy, and we also work with youth (and their parents when appropriate) to make referrals to community therapists and other local support resources.

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

Program Name: Live Oak Community Resources

Agency: County Office of Education

Target population:

Demographics: See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 125.

What is the unduplicated number of individuals served in preceding fiscal year 166?

What is the number of families served? 276

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, mental health services like Cognitive Behavioral Therapy, housing assistance, and other benefits such as energy assistance, unemployment benefits rental and/or financial assistance and transportation. Depending on their presenting issues, they may be referred to follow-up with their designated Family Advocate for family case management services, parent education classes, and/or counseling services. As participants begin utilizing these services, more serious needs sometimes emerge. At this point, we may refer out for additional interventions with a partner such as County Mental Health Services. Whenever possible, we continue providing support concurrently with these other services. With the continued impact of COVID-19 and the county mandates for safety, services at LOCR Live Oak Community Resources stayed open throughout this past year. We have continued to provide advocacy support to our Live Oak families, coordinating financial/rental assistance for undocumented families, organizing on-site food distributions, providing emergency financial support for groceries, assisting with applications and renewals for ITIN's, assisting with the application process for state rental assistance, continuing our parent education classes and counseling on-line and via telephone and expanding our after-school tutoring program via Zoom.

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:

- Parental Resilience
- Social Connections
- Concrete Support in Times of Need
- Knowledge of Parenting and Child Development
- 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 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 twice a month food distribution, enrollment in government benefits such as Medi-Cal and CalFresh, assist in applying for unemployment benefits, vetting for counseling services, supporting with various financial assistance programs, seasonal assistance including back-to-school supplies and holiday gifts. Advocates also encourage participation in parental support programs and refer to other agencies as needed.
4. **Knowledge of Parenting and Child Development—** Increased at Parent Education Classes and reinforced by interaction with peers also enrolled in these programs.
5. **Social and Emotional Competence of Children—** Enhanced through counseling, the parent-led Cradle to Career strategies, and participation in tutoring program.

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

1. ADVOCACY- **provided case management to 34 unduplicated families.**
    a. Assessed family strengths and needs
    b. Supported family in setting and pursuing goals
    c. Facilitated enrollment in government benefits and/or additional financial assistance
    d. Referred to appropriate community resources
    e. Provided translation as needed
2. A LEADERSHIP ROLE IN THE LIVE OAK CRADLE TO CAREER (C2C) INITIATIVE – **engaged with 73 unduplicated parents and caregivers in Cradle to Career**
    a. Participated in monthly C2C steering committee meetings
    b. Supported monthly Parent Leadership Council meetings
    c. Worked with parent leaders to carry out strategies identified to improve selected data indicators in the areas of health, education, and character
    d. Worked with C2C promotoras to provide support around vaccination efforts
    e. C2C parents participated in LOCR parenting classes
3. COUNSELING SERVICES – **provided services to 33 unduplicated individuals.**
    a. Coordinated on-site counseling by MFT interns professionally supervised by Community Bridges – licensed Clinical Supervisor.
    b. Coordinate and submit referrals for families to on-site counseling services
    c. Counseling telehealth services are bicultural and are offered in both Spanish and English. In-person sessions started back up again in June 2021 for participants that preferred this option
4. COORDINATION OF PARENT EDUCATION CLASSES –**20 unduplicated parents and caregivers participated.**
    a. Scheduled and promoted classes and workshops

b. Enrolled families
c. Due to COVID-19, provided support for participants to participate in classes virtually via Zoom.

5. WEEKLY AFTER-SCHOOL TUTORING – **32 students enrolled during the school year.**
    a. Weekly one on one tutoring sessions via Zoom.
    b. Tutoring in language of preference

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 an increased risk of social isolation, untreated mental illness, and child abuse or neglect. Families with unaddressed chronic school attendance issues are at higher risk of school failure, and the removal of children from the home, and can even face 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
- Tracking of progress towards goals set by the family
- Cradle to Career Initiative indicators (complete C2C Data is still in progress for FY 20-21)
- Parent Education assessments administered before and after each training series
- Pre and post counseling assessments (DASS and SDQ)

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:

Cradle to Career Initiative indicators is 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 not yet complete. Together with other partners in the C2C steering committee, we are working to complete overview for the 20-21 FY.

An annual 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 § 46.2% reported an improvement in parenting skills.

- LOCR staff continued to work with me and has met my needs § 73.1% reported feeling overall satisfaction with their needs being met by LOCR staff.

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

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

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

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

Positive Parenting Program
At LOCR, we partner with Positive Discipline Community Resources (PDCR) and classes are offered to LOCR families. If a family cannot pay for the class, the parents either are offered a scholarship, to qualify for free classes. Triple P is a parenting program used in communities around the world, and officially adopted by First 5 Santa Cruz County, the Santa Cruz County

Health 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. With changes due to COVID-19, Parent Education services were offered via Zoom for individuals and in a virtual class or workshop format.

Cognitive Behavioral Therapy

CBT has proven effective in controlled studies to treat conditions including anxiety disorders, anger issues, and general stress (Hoffman et al. 2012). CBT is used in the early stages of traumatic response. CBT is a skills-based, present-focused, and goal-oriented treatment approach that targets thinking styles and behavioral patterns that cause and maintain a depression-like state. At LOCR, certified Marriage and Family Therapist interns work under the licensed supervision of Community Bridges' Clinical Supervisor to provide CBT and complimentary treatment methods to adults and children undergoing events such as bullying, family violence, or sexual assault, or experiencing conditions including depression and/ or anxiety. CBT is offered in both Spanish and English. Counseling participants often come referred by community partners such as the Juvenile Probation Department, local schools or school districts, and will sometimes receive a referral from a county nurse or caseworker. Participants take pre and post DASS (Depression Anxiety Stress Scales) or SDQ (Strengths and Difficulties Questionnaire) assessments to gauge program effectiveness.

After School Tutoring

Our after-school tutoring program is structured on a one-on-one model where a student is paired up with a tutor once a week. In addition to receiving individualized support around schoolwork, students and families are able to build rapport with their tutors over time. This year tutoring was offered via Zoom due to Covid-19 restrictions.

Explain how the practice's effectiveness has been demonstrated for the intended population.
All of the evidence-based practices listed above have been successful in diverse settings, including low-income minority populations that resemble the core population we serve.

Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.
For over 50 years, the Family Resource Collective has been building trusting relationships with the communities the centers individually serve. The Family Advocates build trust with each participant to ensure there is clear communication, when offering mental health services and parent support groups. This is an important step to ensure that families are educated about the requirements and benefits of the program and increase the number of participant's commitment to change. During the referral process the Advocates, explain the program to families and answer any questions or concerns they may have. Clear communication addresses stigma of mental health services, from participants who are fearful of receiving counseling services, due to immigration fears, and any financial burdens or language barriers.

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

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

Describe how the following strategies were used:

Access and Linkage *(Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):*
Individuals identified as needing mental health services are referred to our on-site bilingual MFT interns. Those needing services beyond our scope—such as psychiatric services or residential treatment—are referred out to the appropriate entities, like the County Mental Health Services. When we have a counseling waiting list, we also refer out to Santa Cruz Community Health Centers and Family Service Agency.

Timely Access to Mental Health Services for Underserved Populations *(Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):*
Counseling services at our site are billed to Medi-Cal, on a sliding scale fee, or provided free of charge. Counseling is offered both during and after school hours, and evenings depending on need. In response to COVID-19 and shelter in place mandates, we offered tele-health services to counseling participants. Currently, LOCR has a bilingual MFT intern that is available to serve Spanish-speaking participants (often counseling is provided for English-speaking children who have Spanish-speaking parents) under the supervision of our Clinical Supervisor. If more counseling is requested in Spanish and have a waitlist, we provide a warm handoff to a bilingual counselor either at Santa Cruz Community Health Centers or Family Service Agency. If an English-speaking client is on a waitlist, our Clinical Supervisor on-site will also see clients on a needed basis or refer to another partner agency.

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.

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

Target population: Students Elementary through High School

Demographics: See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 127.

What is the unduplicated number of individuals served in preceding fiscal year? 5 school districts representing 20 schools in Santa Cruz County. These in turn impacted more than 9,076 students.

Live Oak School District	*1,730 Students*
Cypress Charter High School	
Del Mar Elementary	
Green Acres Elementary	
Live Oak Elementary	
Shoreline Middle School	
Scotts Valley Unified School District	*2,635 Students*
Brook Knoll Elementary	
Scotts Valley High School	
Scotts Valley Middle School	
Vine Hill Elementary	
Santa Cruz City Schools	*1,987 Students*
Bayview Elementary	
Branciforte Middle School	
Delaveaga Elementary	
Gault Elementary	
Westlake Elementary	
Soquel Union Elementary School District	*1,745 Students*
Main Street Elementary	
New Brighten Middle School	
Santa Cruz Gardens Elementary	
Soquel Elementary	
San Lorenzo Valley Unified School District	*979 Students*
Boulder Creek Elementary	
San Lorenzo Valley Elementary	

What is the number of families served?
Using 1.96 as an average per family child number in California from census data, the approximate of families served was 4,631 (9,076/1.96)

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 determine the needs are severe enough or needs more assessment. At this level a school team would also be convening to discuss this highest level of supportive services, hence the decision to refer would be based on multiple inputs.

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:**

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

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

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

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

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

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

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

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

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

Describe how the following strategies were used:

Access and Linkage *(Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):*
PBIS regularly notes students who may need increased tiered services or outside referrals to collaborative agencies for additional support, especially around mental health concerns. This can happen from an individual evaluation or from a school team convened for Tier 2 and 3 supportive services.

Timely Access to Mental Health Services for Underserved Populations *(Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):*
Analysis of discipline data allows schools to address patterns of disproportionality to ensure appropriate behavior supports are provided equitably to students from diverse backgrounds. Additionally, PBIS acts as a large net, first addressing all students with creating positive norms in a school's functioning, then taking note of and supporting small groups of students needing targeted responses and finally individualizing services for the most at-risk population in the school. At each level PBIS aims to use culturally relevant language, varied supports and services and referrals for more severe mental health concerns.

Stigma and Discrimination reduction *(Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):*
PBIS promotes a positive school culture and climate as its prime directive and in that pursuit is included being supportive of differences, reducing stigma and bullying around multiple factors, including mental health diagnoses, and creating supports system-wide, in groups and individually to address issues which may arise that inhibit the desired school climate.

Supplemental Notes:

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

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

The Positive Parenting Program (Triple P)

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

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

Providers: First 5

Number of individuals to be served each year: 1300

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

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

Program Name: PEI Prevention- Triple P (Positive Parenting Program) **Agency**: First 5

Target population:

Demographics: See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 129.

What is the unduplicated number of individuals served in preceding fiscal year? In FY 2020-21, 150 parents/caregivers received Level 3 Individual, Level 4 Standard/Group, or Level 5 Triple P services. (Note: An additional 705 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? 134 families (intensive services)

Mental illness or illnesses for which there is early onset: Depression or anxiety (parents), Oppositional Defiant Disorder, Conduct Disorder (children)

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

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

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

Identification of type(s) of problem(s) and need(s) for which program will be directed, and activities to be included in program to bring about mental health and related functional outcomes (including

suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes).
Triple P practitioners conduct an initial intake interview with parents receiving intensive individual or group services. During the intake or initial session, the practitioner obtains background information about the family composition, children's behaviors, children's health and development (including medical/behavioral health/educational needs and services), and other family dynamics that may be causing or contributing to the current child or family challenges. At the end of the initial intake/session, parents complete the Triple P pre-assessment packet containing questionnaires about their parenting practices, child behaviors, parent-child relationship, parental well-being, family relationships, and parental teamwork.
Most parents sign up or are referred for specific services (brief or in-depth, individual or group), but the initial intake provides an opportunity to confirm that a) the parents are interested and committed to participating in Triple P services, and b) the practitioner is offering the appropriate level and type of Triple P service to the parent.

Outcomes:

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

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

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

Effective July 1, 2018, first 5 began utilizing a new set of research-based assessments, administered at pre- and post-intervention, to measure changes in parenting attitudes, skills and behaviors:

- **Child Adjustment and Parental Efficacy Scale (CAPES):** Measure of child behavioral and emotional adjustment in children aged 2 to 12 years old, and parental self-efficacy. Utilized July 2018 – current.
- **Parenting and Family Adjustment Scale (PAFAS):** Measures parenting practices and parent/family adjustment. Utilized July 2018 – current.
- **Lifestyle Behavior Checklist (Level 5 Lifestyle Triple P only):** Measures parents' perception of children's health- and weight-related behavior challenges (nutrition, physical activity) and parents' confidence in handling the behaviors. Utilized January 2010 – current.
- **Parental Attributions for Child Behavior (Level 5 Pathways Triple P only):** Measures the degree of parents' negative attributions (beliefs) about their children's behaviors. Utilized January 2010 – current.

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

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

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

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

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

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

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

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

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

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

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

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

The robust body of research has led Triple P to be designated as a highly effective evidence-based program (EBP) by multiple established clearinghouses, including California Clearinghouse on Evidence-Based Programs in Child Welfare; Substance Abuse & Mental Health Services Agency's National Registry of Evidence-Based Programs and Practices; Promising Practices Network; Technical Assistance Center on Social Emotional Intervention for Young Children; and the Coalition for Evidence-Based Policy.

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

First 5's rigorous evaluation of Triple P has demonstrated statistically significant improvements in child, parent and family well-being ever since its inception in Santa Cruz County. Outcome data from FY 2020-21 is currently being analyzed. However, a cumulative analysis of outcomes (using the new assessment tools adopted in July 2018) demonstrates positive outcomes such as:

Improvements in child behavior and emotional regulation.

As measured by the CAPES (July 2018 – June 2020): Overall, 75% of parents reported improvements in their children's challenging behaviors, and 57% reported improvements in their children's emotional difficulties. Of the parents who began the program with more serious parenting issues, 86% reported improvements in children's challenging behaviors and 88% reported improvements in emotional difficulties.

Increased use of positive parenting styles.
As measured by the PAFAS (July 2018 – June 2020): On average, 60% of parents reported improvements in consistent parenting, and 65% reported decreased use of coercive parenting practices after completing the program.

Improvements in parental emotional well-being and family relationships.
As measured by the PAFAS (July 2018 – June 2020): On average, 60% of parents reported improved emotional well-being after participating in the program. In addition, 51% reported improvements in family relationships.

Increased parental confidence.
As measured by the CAPES (July 2018 – June 2020): Overall, 69% of parents reported improvements in their confidence as a parent. Of the parents who began the program with more serious parenting issues, 91% reported increased confidence by the end of the program. This local data suggests that Triple P is particularly effective for a broad population of parents, particularly those who are experiencing more serious parenting challenges at the onset of the program.

Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.
The local Triple P Coordinator (contractor for First 5) provides individualized implementation support to practitioners and their supervisors/managers and facilitates peer coaching during quarterly Triple P practitioner meetings.

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

Describe how the following strategies were used:

Access and Linkage *(Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):*
First 5 Santa Cruz County is implementing all five levels of Triple P interventions. Individual and group services are offered to families with children birth-16 years old, including children with special needs, in a wide variety of settings such as health clinics, schools, family resource centers, counseling centers, correctional facilities, and other government- or community-based agencies. This means that Triple P practitioners often work with families where the parents and/or children are currently receiving or need assistance accessing medical care and/or mental health services. In many instances, Triple P practitioners make referrals, advocate for, and coordinate services with social workers, therapists, Children's Mental Health clinicians, health clinics, and other behavioral health providers.

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

Timely Access to Mental Health Services for Underserved Populations *(Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):*
One of the main strengths of the Triple P program is its ability to reach families before more intensive mental health services are needed. At the same time, the higher "levels" of Triple P services are an effective method of supporting families whose children are already connected with mental health services. Increasing parents' confidence and capacity to provide safe, stable, nurturing caregiving is a critical component of promoting and restoring children's mental and emotional health.

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

Stigma and Discrimination reduction *(Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):*
Triple P is designed to provide parenting information and support to all parents seeking support, regardless of their socioeconomic status or risk level. First 5 Santa Cruz County disseminates bilingual messaging and materials through its countywide Level 1 social marketing campaign, which normalizes the need for parenting support and reduces the social stigma that often prevents parents from seeking help before costly treatment is required. Key social marketing and outreach activities include:

- Disseminating a monthly article with Triple P parenting tips through print and electronic media.
- Posting on social media and maintaining an advertising presence in key print and electronic media outlets.
- Coordinating outreach, classes, and other special events during the annual “Positive Parenting Awareness Month” in January, which has grown into a statewide movement.
- Distributing First 5’s locally-designed “parenting pocket guides” with bilingual Triple P parenting tips through schools, health care settings (clinics, pediatric offices, hospitals), childcare providers, county health and human service programs, correctional facilities, and other non-profits serving children and families.
- Utilizing “Triple P parenting strategy cards” to educate parents about positive parenting techniques during community outreach events and classes.

Program Name: Veterans Advocate **Agency:** Santa Cruz County Behavioral Health Services

Target population:

Demographics: See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 131.

What is the unduplicated number of individuals served in preceding fiscal year? 249

What is the number of families served? 103

Participants' risk of a potentially serious mental illness? 152

How is the risk of a potentially serious mental illness defined and determined?
Risk for serious mental illness is indicated by homelessness, incarceration, identification of traumatic events during military service, identification of traumatic events during childhood, previous mental health diagnosis, and substance use disorder.

Specify the type(s) of problem(s) and need(s) for which program will be directed. What activities are included in the program to bring about mental health and related functional outcomes (e.g., suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes)?
Veterans Advocate will work to identify veterans struggling with substance abuse, homelessness, incarceration, mental health challenges, and other health conditions. Veterans Advocate will assist veterans to access assistance through the Veterans Affairs programs, state programs, county programs and other local resources. Through identification of resources and support available the Veterans Advocate will contribute a reduction in suicide, incarceration, school failure, unemployment, homelessness and prolonged suffering

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 conducts interviews with 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 conditions. Veterans Advocate coordinates appropriate care and connection to available resources.

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

Reduction in homelessness-measured by referrals to housing programs and the result, reduction to incarceration measured by veterans that successfully complete veteran's treatment court, Reduction to financial instability measured by claims awarded by the Veterans Affairs, Reduction to availability of medical treatment measured by enrollment in the VA health care system, 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 and motivational interviewing skills to identify the specific challenges of each client and create pathways to success.

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

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

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

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

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

Describe how the following strategies were used:

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

Program Name: PEI #4 Peer Companion **Agency**: Seniors Council of Santa Cruz County

Target population:

Demographics: See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 133.

What is the unduplicated number of individuals served in preceding fiscal year? 15

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.

Due to the ongoing COVID 19 pandemic, we had to cease all **in-person** volunteer activity with clients on or around March 13, 2020. Senior Companions began making wellness phone calls and facetimes with clients to keep in touch and continue service. In July the Senior Companions began picking up pre-ordered groceries and prescription's that are delivered to their clients (following CDE guidelines so as not to interact physically with clients).

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

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

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

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

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

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

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

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

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

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.

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:
See Logic Model Attached

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

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

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

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

Timely Access to Mental Health Services for Underserved Populations *(Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):*
Susan Fisher manages the timing of assignment of her clients to our Senior Companions. Senior Companions flex their schedule to the needs/schedules of their assigned clients, including evenings and weekends. They provide transportation to various psychiatric and medical treatment providers and socialization activities. COVID-19 change: Senior Companions began picking up pre-ordered groceries and prescription's that are delivered to their clients (following CDE guidelines so as not to interact physically with clients).

Stigma and Discrimination reduction *(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 12 years and the other for 8 years).

PEI PROJECT- EARLY INTERVENTION

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

0-5 Early Intervention Stanford Neurodevelopmental Foster Care Clinic:

Purpose: This **Early Intervention** program provides multi-disciplinary team mental health/family assessments for foster children aged 0-5, through a multi-agency funded clinic at the Stanford Children's Health Specialty Services site and located in Santa Cruz County. The program includes with PEI supported mental health services, as well as in-kind and contracted services for Stanford University specialist time from a developmental psychologist and a pediatrician.

Target Population: Foster children aged 0-5.

Providers: Santa Cruz County Behavioral Health

Number of Individuals to be served each year: 90

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?
There were problems with getting the referral forms completed and processed smoothly between all agencies. There has been a high level of turnover of staffing from Social Services which has made the process of referrals challenging.

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

Program Name: PEI #1 0-5 Screening **Agency**: Santa Cruz County Behavioral Health Services

Target population: 0-5

Demographics: Children in foster care under the age of 5

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

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 are 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:
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.

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

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

Describe how the following strategies were used:

Access and Linkage *(Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs):*
Children's Mental Health has built and maintained a strong partnership with the Department of Family and Children's services. As a result, 95% of the children who come to the attention of child welfare receive an assessment (as outlined above) by Children's Mental Health. If for some reason these children do not qualify for our services, they may be referred to one of our contract agencies, like the Parent Center. In addition, we provide case management services to connect these children with other needed services for physical health, education and recreation.

Timely Access to Mental Health Services for Underserved Populations *(Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):*
Due to the partnership mentioned above, 95% of the at-risk youth in this county are receiving this service. Children's Mental Health provides bilingual and bicultural clinicians whenever possible to ensure cultural and language appropriateness when needed. Clinicians are also trained in engagement and treatment with families and young children to ensure effective services are provided. Children's Mental Health provided field-based services to ensure that all children and families can participate in case transportation is a barrier. Children's Mental Health mission is to work with families and communities to help youth stay in home, in school, and out of trouble. We strive to provide strength based; culturally appropriate, comprehensive community based mental health services using flexible "whatever it takes" approach to help families achieve their own positive outcome. Clinicians also flex their work time to ensure children and families can be seen at convenient times.

Stigma and Discrimination reduction *(Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):*
Children's Mental Health is committed to providing a safe and welcoming environment that children and families can depend on when seeking services. We pride ourselves on meeting children and caregivers where they are and working with them to help them get where they want to go. As mentioned earlier we provide field-based services when needed meeting our clients and families in the community, in their homes, or at their schools. We will happily help with transportation by picking people up providing mental health services "out of the office" if this increases the success of these services and improves the likelihood of active participation in services and reduces the stigma of receiving mental health services.

EMPLOYMENT SERVICES

Purpose: To offer support for person's experiencing early signs and symptoms of mental illness, by meeting individual goals to improve quality of life, and integrate in a meaningful way into the community.

Target Population: Transition age youth and adults with early signs and symptoms of mental illness.

Providers: Volunteer Center/Community Connection

Number of individuals to be served each year: 40

Were there any challenges or barriers in the program? If so, what are the strategies to mitigate? It is difficult to find employment opportunities in the community. A new job developer was hired to help address this issue.

Performance Outcomes: Demographic information of unduplicated clients served as required by the State: Please see data on page 134.

Program Name: Employment (Community Connection) **Agency**: Volunteer Center

Target population:

Demographics: See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 134.

What is the unduplicated number of individuals served in preceding fiscal year? 26

What is the number of families served? n/a

Mental illness or illnesses for which there is early onset: schizophrenia, bipolar dx, depression, PTSD, GAD

Description of how participant's early onset of a potentially serious mental illness will be determined: Through intake questionnaires, interviews with individuals, mental health care professionals, school counselors and family members.

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

college level. Services are provided in the community, at school, and in the workplace to reduce stigma and better serve the young adult population.

Outcomes:
List the mental health indicators used to measure reduction of prolonged suffering that result from untreated mental illness as measured by reduced symptom and/or improved recovery, including mental, emotional and relational functioning:
Improved access and retention in education, employment and volunteerism. Assessment through Recovery Evaluation at intake and at 3-month intervals to assess for reduction in isolation and prolonged suffering.

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 a Recovery Evaluation upon intake and at 3-month intervals to measure recovery outcomes. In addition, each consumer is encouraged to participate in Meaningful Activity including attending school, support group, training program, volunteer opportunities, or by becoming employed in part-time or full-time work. Data are collected on all activities performed by each consumer.

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:

Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome.
Utilization of Evidenced Based SAMHSA Supported Employment and Education models, as well as WRAP (Wellness Recovery Action Plan), will reduce risk of homelessness, incarcerations, hospitalization for risk to self, as well as prolonged suffering.

Explain how the practice's effectiveness has been demonstrated for the intended population.
Supported Employment and education models increase self-esteem and self- worth, which reduces risk of suicide, prolonged suffering potential hospitalizations. Employment and education reduce risks of incarceration and homelessness due to access to higher wages and financial security.

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

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:

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):*
All consumers are asked at intake to discuss their medical history and any health care practitioners currently involved in their care. Each consumer is encouraged to seek medical/mental health treatment and is given resources to access this care if no providers are listed. Staff members at Community Connection are in regular contact with SC Mental Health, TAY team and other community resources in order to ensure that all consumers are able to access services.

Timely Access to Mental Health Services for Underserved Populations *(Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program featur*es *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 consumers 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 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. We utilize trainings to help us as clinicians understand our own implicit bias and include open dialogue regarding prejudice and harmful societal norms in our intake process.

PEI: TAY Services

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

Target population: TAY

Demographics: See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 136.

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

What is the number of families served? 40

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

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

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

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

- 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

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

Describe the evidence that the approach is likely to bring about applicable outcomes: N/A
Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program. N/A
Describe how the following strategies were used:

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

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

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

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 7/1/20 to 6/30/21, which is attached.

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

Program Name: Senior Outreach **Agency**: Family Services Agency
Number of potential responders: 90

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.):
This year during the pandemic, we focused on working with staff of referring agencies to make sure clients eligible for our services were sent to us for phone or telehealth individual and group services. Agencies include Volunteer Center, VNA, Unite Us, Dignity Health, PAMF, Hospice and Senior Network services.

T**ypes of potential responders engaged in each setting** (e.g., nurses, principles, parents):
Social workers, physician offices, nurses, and staff at the various nonprofit agencies.

Demographic information See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is attached.

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:
Due to the pandemic, most information was distributed primarily through our website and consultations with medical offices, residential care facilities, senior centers and nonprofit agencies including the Grey Bears and Diversity Center. 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.

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 reference lists of local resources that include information on accessibility, housing, caregiver resources, home health, crisis intervention, case management and government services.

Timely Access to Mental Health Services for Underserved Populations *(Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available and cost of services):*
Peer counselors 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 need additional support are referred to other services including APS, County Access, Medi-Cal, Medicare licensed counseling, IHSS, MSSP, Stroke Center, CCCIL, Senior Network Services, Second Harvest and Liftline for transportation. 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):*
Mental health challenges are framed as an understandable consequence of the social and biological issues related to aging. 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. Individual and group counseling is done in a positive and supportive way by trained volunteers using active listening skills

PEI PROJECT- STIGMA AND DISCRIMINATION REDUCTION:

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

NAMI

Purpose: The local Santa Cruz County Chapter of the National Alliance for Mental Illness provides extensive classes, support groups and mental health awareness events. The focus of the MHSA funded services is to reduce stigma and discrimination through community-wide education presentations, a quarterly speaker series, and community and mental health awareness events. This is a Stigma and Discrimination Reduction program.

- **Target Population:** Families, consumers, schools, providers, and the public at large
- **Provider:** NAMI
- **Number of Individuals to be served each year:** 2,500
- **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** No.

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

Program Name: Stigma and Discrimination Reduction **Agency**: NAMI-SCC
Number of people reached: 4632 unduplicated count (For Q1 Q2, Q3, Q4) 2020/21
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, or by educating not only the clients, but also the family members, the providers, schools, and the community at large, the stigma against mental illnesses and the fear of seeking treatment is reduced for all.*

Education and Training Series – Training for Providers, Consumers and Families includes multi-week curriculum covering information about mental illness, how to work toward wellness and to communicate well with natural and professional supports. Post evaluations are given at the end of each class series.
Family Class Series**:** Increased confidence in working with mentally ill family members, less fear and stigma related to mental illness, more understanding of needs and triggers that are important for wellness of their loved one's health, and more understanding of resources available. We offer this class in Spanish.

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, County Office of Education, 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.

We have increased our partnerships in South County. We are now holding office hours at Salud para la Gente and meet regularly with staff and providers to provide education and report on the challenges those with mental illness who are patients of the clinic face. We have begun to partner with the faith-based communities.

We also partner with County office of Education and Pajaro Valley Prevention and Student Assistance (PVPSA) to help educate family members, stop stigma and help parents support their child's mental health.

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: (Answer questions in either A **or** B.)

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

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

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

Our 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/Helpline in English and Spanish-Is supervised by experienced volunteer and staff with linkage to MH as needed for acute calls. Many families and 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. The current English Helpline is not always answered immediately but usually within 24 hours. Many calls to both the English and Spanish Helplines are linked to support groups and classes. We have expanded our Spanish Helpline from 1 staff member to 2.5 FTE's and it operates during business hours five days a week. Additionally, NAMI has expanded our full range of classes and support groups for youth, peers and families to the Spanish speaking community.

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

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

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

Timely Access to Mental Health Services for Underserved Populations *(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 in the Latinx community 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 held in Spanish by bi-cultural staff help address needs and improve the outcomes of the consumer. We held the following in Spanish:

- 2 *Family to Family* 12-week Education Programs Classes
- 7 -*Ending the Silence* for Parents in English & Spanish to help parents support their child's mental health
- Monthly presentations held in Spanish on mental health topics.

Our Helpline we hired a bilingual/ bicultural program coordinator to grow our South County programming in English and Spanish. We are building our outreach to the Spanish speaking population of the County. We have increased our Warmline/Helpline in Spanish and hired 2FTE. We are hiring an

additional coordinator to manage our Bilingual programs and increase programming to serve the diverse needs of the community. We also send bilingual staff to food distribution sites and farmers markets to offer support and give information about our free weekly support group, helpline and classes held in Spanish.

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.

We regularly hold community mental health education meetings in Spanish for the community inviting providers, hospice, law enforcement, educators and community organizations to present information. We give presentation to Pajaro Valley Unified School District Counselors, Salud Para La Gente, Integrated Behavioral Health, Central Coast Center for Independent Living, Cabrillo College to introduce organizations to our program and help reduce stigma.

PEI PROJECT – SUICIDE PREVENTION

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

Suicide Prevention services:

Purpose: to provide educational presentations, grief support, and the suicide hotline. The Suicide Crisis Line is available 24 hours, 7 days per week for those who are suicidal or in crisis, as well as for community members who are grieving the loss of a loved one to suicide, are concerned about the safety of another person, or are looking for assistance with finding community resources. Outreach presentations and trainings (which help to reduce stigma, raise awareness, and promote help seeking) are provided regularly throughout the County to a range of different at-risk groups, stakeholders, and service providers for various populations (including domestic violence prevention, professional and peer mental health support organizations, etc.). One focus of community outreach activities continues to be reaching groups who are higher at risk than in the general population – for example, survivors of suicide loss are up to forty times more likely to die of suicide than others. Suicide Prevention provides prevention and early intervention services.

Target Population: Everyone in Santa Cruz County.

As of October 2021, Suicide Prevention Service staff has provided 62 presentations to 5,650 individuals at: Vet-Net, Pajaro Valley Children, Cabrillo College, Santa Cruz High School, Watsonville High School, Soquel High School, QPR training, Trauma Training, Calciano Symposium, Pacific Coast Charter, CIBHS/CSUMB, Alternative Family Solutions, Santa Cruz Mental Health Advisory Board, Walk a Mile, Denim Day, Sons In Retirement, CalFRESH, QYLA, DeWitt Anderson, Tierra Pacifica Charter School, Santa Cruz PRIDE, Scotts Valley Unified School District, Behavioral Health Department, Cabrillo College, California Institute for Behavioral Health, Solutions, Pajaro Valley PRIDE, Salud Para la Gente, Santa Cruz Connect, St. Patrick's Church, Twin Lakes Church-Mental Health Conference, and Watsonville High School.

Program staff has also provided 11 trainings to 290 individuals at Sobriety Works, Walnut Ave Family & Women's Center, Pacific Collegiate School, Linscott Charter School, Santa Cruz County Community Health Education, Santa Cruz CIT training, Walton Warriors, and Santa Cruz Human Services Agency.

Furthermore, in June 2017, staff conducted two Mental Health First Aid trainings in Santa Cruz County for 50 individuals at Santa Cruz Health Services Agency. Three additional will be held in November for Santa Cruz County's Health Services Agency and for the Pajaro Valley Unified School District. In addition, staff will be conducting an ASIST training in December for the Scotts Valley Unified School District staff. The training schedule for 2018 has not been finalized.

Suicide Prevention Service of the Central Coast trainings and presentations are advertised via the Livingworks website and via e-mail sent out by the Assistant Director for Community Outreach, that are then further distributed by community collaborators. Additional methods of information distribution and enrollment for trainings open to the public are currently being developed by program staff.

Currently, program services focused on postvention within Santa Cruz County include our WINGS support group (for anyone who's lost a loved one to suicide) and the 24-HR multilingual suicide crisis line. Suicide Prevention closely collaborates with the local chapters of Hospice, SERP, schools, and other local entities to provide further individualized services around grief and loss following a suicide. LOSS (Loving Outreach for Survivors of Suicide) is our bereavement support group held in Pacific Grove. Additional program services are developed and implemented based on need, sustainability and funding availability

- **Providers:** Family Services of the Central Coast
- **Number of individuals to be served each year:** 2,500
- **Were there any challenges or barriers in the program? If so, what are the strategies to mitigate?** No

Performance Outcomes: Narrative report for Family Service Agency-Suicide Prevention as required by the State:
Suicide Prevention: Organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This program does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness. Programs include, but not limited to, public and targeted information campaigns, suicide prevention hotlines, training, and education.

1. **Program Name**: PEI #3 Suicide Prevention **Agency**: Family Services Agency
2. **Number of people reached**:
    - Number of calls to the suicide crisis line:
        - (Santa Cruz location verified): 1,077
        - (Other Central Coast calls): 2,462
    - Number of follow-up calls:
        - (Santa Cruz location verified) 125
        - (Location unknown) 320
    - Number of 911 calls:
        - (Santa Cruz location verified) 33
        - (Location unknown) 52
    - Outreach Participants: 3,290

3. **Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.**
   We will conduct suicide prevention educational presentations and trainings, including offering ASIST, for County residents, at-risk populations, and anyone who works with at-risk populations. We will also participate at public events such as health fairs, public and private school activities, and County functions. We will respond to calls from individuals in crisis, at suicide risk, concerned about another person's safety, grieving a suicide loss, or seeking resources; hotline responders will be trained, monitored, and supervised in applying evidence-based risk assessment and safety planning tools to achieve safe outcomes for callers at risk.
4. **How will the Agency/County measure changes in attitude, knowledge and/or behavior related to reducing mental illness-related suicide?**
   Program staff will maintain records of all outreach activities. A written survey conducted of all youth and adult participants will demonstrate that 90% of participants have increased their knowledge of suicide warning signs and of ways to get help for themselves or someone else. Teachers and agency personnel will also be provided with evaluation forms to report on the effectiveness and applicability of the presentation and skill of the presenter. Program staff and responders will document the safety outcome of each call, including the caller's willingness and ability to remain safe, as well as caller satisfaction.
5. **How is the selected method likely to bring about the selected outcomes by indicating how evidence-based standard or promising practice standard has demonstrated the practice's effectiveness, or if using a community and/or practice-based standard indication how the Agency/County will ensure fidelity to determine the program's effectiveness?** 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**.

    - 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, Mental Health First Aid, and

SafeTALK (amongst other training modules), which are designated as "Programs with Evidence of Effectiveness." Information about the evidence base for these approaches may be found at: https://www.livingworks.net/ and https://www.mentalhealthfirstaid.org/. Program responders are trained to effectively utilize the Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Planning Tools with hotline callers, as well as document responses, risk status, and safety plans. Information on the evidence base for these tools can be found at: https://cssrs.columbia.edu/ and https://suicidesafetyplan.com/.

Explain how the practice's effectiveness has been demonstrated for the intended population.
The references listed above include a substantial amount of data and research summarizing the effectiveness of the evidence-based practices implemented here; in particular, the Applied Suicide Intervention Skills Training (ASIST) has been demonstrated to be an effective and adaptable tool for teaching anyone 16 and over to do an effective suicide intervention with someone at risk of suicide, while also addressing helper needs, community collaboration, and safety considerations. The Columbia Suicide Severity Rating Scale is universally recognized as the gold standard for suicide risk assessment and has been demonstrated in a wide body of research to be effective (and adaptable) for use in a crisis hotline setting, as well as across the lifespan and for various populations of differing cognitive abilities or risk levels. Stanley and Brown's Safety Planning tool is similarly regarded by the American Association of Suicidology, the Suicide Prevention Resource Center, and the National Suicide Prevention Lifeline as the signature tool for effectively helping suicidal individuals navigate and survive a suicidal crisis; these tools are used widely and routinely throughout our field and by member centers of the National Suicide Prevention Lifeline.

Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.
Staff and volunteers complete an extensive 40+ hour training before presenting/training or responding to suicidal callers 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. Compliance with the risk assessment practices of the C-SSRS and the Safety Planning tools are monitored annually by the National Suicide Prevention Lifeline (via Vibrant Health) and the American Association of Suicidology, through which we are accredited. Volunteers and staff implement continuous quality improvement activities, including documentation of C-SSRS responses and safety plans, as well as annual refresher training and 24/7 staff supervision and monitoring of responder activity to ensure that standards are being met and to address (through additional training, supervision, etc.) any issues.

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; staff and volunteers are also trained to directly transfer callers to other resources when needed or engage a team approach to ensuring that callers are connected with all appropriate resources. In situations involving

heightened risk, staff also coordinate follow-up calls with callers directly, as well as with partnering agencies, to ensure that the caller was able to receive 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):*
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, Facebook page, and Instagram account, 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. When engaging with members of the media, our staff are trained to use and spread the Responsible Reporting Guidelines for Suicide Prevention. This tool is put forth by the Suicide Prevention Resource Center as a practice guideline to increase factually accurate and effective messaging around suicide prevention and decrease sensationalizing approaches that may further increase risk). Furthermore, staff members and volunteers have been trained in and regularly employ the strategies for effective messaging around prevention, as put forth by the Each Mind Matters and Know the Signs campaigns. We utilize culturally appropriate, and age-appropriate content available through these public health and public awareness campaigns (throughout our social media and outreach activities) to increase awareness of and access to services (and to reduce stigma) throughout the year, with an enhanced focus during Mental Health Month in May and Suicide Prevention Month in September.

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

Number of people reached: 60

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

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

How is the selected method likely to bring about the selected outcomes by indicating how evidence-based standard or promising practice standard has demonstrated the practice's effectiveness, or if using a community and/or practice-based standard indication how the Agency/County will ensure fidelity to determine the program's effectiveness? Answer questions in either A **or** B**.**

A. If an evidence-based practice or promising practice was used to determine the program's effectiveness:
   - **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome**.
   - **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:
With the assistance of the consultant, Santa Cruz County is able to gain expertise from prior plans implemented in Tulare/Kings County and Fresno County and implement current best practices that are effective, sustainable and accessible in a community setting.

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

The Suicide Prevention Task Force is utilizing the consultant during the 19-20 fiscal year to assist the facilitation of the county wide strategic plan sub-committee work within prevention, intervention and postvention models. The Suicide Prevention Task Force based on the guidance of the Consultant will remain in link with the Statewide Suicide Prevention Plan and local Schoolwide Suicide Prevention Plan efforts (AB2246) to ensure a collaborative planning process. During the Task Force work in FY18-19 the group reviewed ongoing monthly meetings task force members participated in detailed and thorough conversations on evidence-based practices in suicide prevention, including current trainings and models. In total we reviewed over thirty-five models to vote on the "best fit" for our county, given strengths and needs of our community

Santa Cruz County Suicide Prevention Task Force

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

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

Describe how the following strategies were used:

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

The Suicide Prevention Task Force is made up of a multidisciplinary collaborative of community stakeholders from throughout the county. The goal of the Task Force was to recognize and respond with an integrated service plan to the entire community, providing a network of suicide prevention services clearly defined for access at any time. By creating a Task Force inclusive of the community, we have a large network to share the plan and assist in educating on access and linkage for services.

In FY18-19 key informant interviews were conducted with 111 community members to gain information on current ideas, thoughts and feelings about suicide within Santa Cruz County. The interviews also sought information on knowledge of current programming to gain understanding of community knowledge on strengths and identified gaps.

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

The Suicide Prevention Task Force will create a plan inclusive of a robust model of interventions, which will assist in providing accessible and culturally competent services to those in need. Current service

models, which will be expanded or enhanced in the plan include county wide suicide prevention programs, crisis hotlines and Behavioral Health Access services. In addition, the plan will outline crisis service availability during non-business hours including MERT, Mental Health Liaisons, Crisis Stabilization Program and Psychiatric Health Facility.

Stigma and Discrimination reduction *(Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):*
An overarching goal of the Suicide Prevention Task Force is to decrease stigma associated with mental illness and suicide in the community. By educating and informing our community about behavioral health issues, treatment accessibility and options, recovery and healing we create a safer community for people experiencing these issues. Overarching community education on risk and protective factors as well as direct information on services will be a focus of stigma reduction.

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:

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

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

How will individuals be identified as needing assessment or treatment for serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention Program?

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

How will individuals, and, as applicable, their parents, caregivers, or other family members be linked to county mental health services, a primary care provider, or other mental health treatment?

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

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

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

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

Janus, Front Street, Homeless Persons Health Project and the Homeless Resource Center. Second Story staff promote and discuss with guests the importance of receiving services to co-create stronger ties to providers and families, if such discussions benefit person-centered services.

Demographic information
See the MHSA Quarterly & Annual Report for 7/1/20 to 6/30/21, which is on page 138.

Outcomes:

- **Number of individuals with SMI referred to treatment and kind of treatment.** 60 unduplicated
- **Number of individuals who followed through on the referral and engaged in treatment (attended at least once)**: 60 unduplicated last fiscal year
- **Average duration of untreated mental illness:** various
- **Average interval between referral and participation in treatment (at least once)**: Various_

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.
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):*
Second Story works in close collaboration with Santa Cruz County Behavioral Health Services to ensure guests seeking respite services are knowledgeable about the availability of services, including medical and other county offered services. The program also works with other community agency partners to ensure guests are referred and linked to the appropriate level of services and resources needed to promote healing and well-being. Second Story supports individuals with connecting to psychiatrists, primary care providers, surgery, and pre-planning appointments. When there is a challenge, the team connects with guests' coordinators and care teams. Further, the team provides referrals to individuals for substance use disorder treatment programs as part of discharge planning as requested by guests.

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

find support through others. All activities are directed by guests' expressed requests and needs. Forms in Spanish and English are provided, and translation services are engaged as needed for accessibility to services. Second Story staff builds strong relationship with families and providers in Watsonville with outreach to South County coordinators and families through NAMI.

Stigma and Discrimination reduction *(Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive):*
Second Story remains dedicated to serve as a respite and voluntary housing option for people by offering support and connection with a peer recovery model. Peers assist in learning with people how to be in relationship by building upon shared backgrounds and lived experiences. With the support of community partners, including NAMI, Front Street, and Housing Matters, Second Story has been able to reduce stigma surrounding mental illness. In addition, self-stigma has been reduced by promoting a safe place for guests to self-refer when recognizing a need for respite and connection when feeling vulnerable from mental health symptoms. Second Story supports an environment through which narratives about people and their experiences are shared. Peers discuss ways of seeing beyond the diagnosis and seeing beyond the need for alienating oneself from the community.

PEI PROJECT – ACCESS AND LINKAGE TO TREATMENT

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

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

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. The youth program is called MERTY (mobile emergency response team – youth). For this plant, MERT will be used to represent both programs). These teams provide crisis intervention services at different locations in the community, including office-based visits for walk-ins and appointments, evaluations with law enforcement in the community, local hospital emergency rooms, and individual homes. Mental Health Liaisons provide similar crisis assessment and intervention and disposition planning in collaboration with law enforcement for field-based crisis response model. MERT's and Mental Health Liaisons focus is to provide alternatives to psychiatric hospitalization by working with consumers to find the least restrictive treatment setting that ensures safety and an appropriate level of care. The goal is to stabilize the crisis situation, determine whether or not there is a need for psychiatric hospitalization, and develop an appropriate plan for that individual. The services are available to any resident of the County regardless of ability to pay, and type of insurance they may or may not have.

- **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 7/1/20 to 6/30/21, which is attached.
- **Performance Outcomes**: Narrative report for MERT/MHL as required by the State:

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

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

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

MERT provide additional outreach and walk-in availability for initial contact and needs assessment to link consumers to appropriate level of care. MERT/MHL has field-based services and the ability to respond in the community.

How will individuals be identified as needing assessment or treatment for serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention Program?
MERT/MHL clinicians will conduct a brief comprehensive assessment to determine level of care. If consumer meets mild to moderate criteria, they will be referred appropriately. If they merit specialty mental health criteria, they will be linked to Santa Cruz County Behavioral Health Services Psychiatrist for med-evaluation and ACCESS intake clinician to initiate higher level of care.

How will individuals, and, as applicable, their parents, caregivers, or other family members be linked to county mental health services, a primary care provider, or other mental health treatment?
MERT/MHL clinician will always review appropriate resources including all available treatment options to meet consumer's needs. Parents and other natural supports will be welcomed and included in this process with appropriate consent. MERT/MHL clinicians will encourage consumers to utilize family support and resources.

How will referrals be followed up to support engagement in treatment?
MERT clinicians will follow up a couple days after initial contact with consumers to ensure follow through. The MERT clinician sometimes meets with the consumer 2-3 times in make sure they are appropriately linked. MERT will also attempt make direct contact with all appropriate providers with the permission of the consumer. MERT wants to provide true "warm hand-off" approach with follow up.

Demographic information. See the MHSA PEI Annual Report for 7/1/20 to 6/30/21, 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

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
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.

INNOVATION PROJECTS

The intent of this component is to increase access to underserved groups; to increase the quality of services, including better outcomes; to promote interagency collaboration; and/or to increase access to services. The County's work plan name is Healing the Streets.

Healing the Streets (HTS) is a new program (October 2021) that provides services to people experiencing homelessness who have mental health needs and may also be using substances like drugs and alcohol in a way that negatively impacts their lives. HTS provides supportive case management services that includes access to physical and behavioral health care and housing assistance. This program combines street medicine with an expanded level of behavioral health services, case management and peer support using a Critical Time Intervention model, and connection to housing navigation and housing support funds (for those who are eligible). County partners and key stakeholders work together to serve community members experiencing homelessness in the cities of Watsonville and Santa Cruz. The HTS program is also funded by Substance Abuse and Mental Health Administration (SAMHSA).

A value of the HTS team is to take the lead from clients in setting goals and accessing services that they identify as a priority. The core HTS team (composed of County Behavioral Health staff and contracted Front Street. manager and peer staff members) work with key Health Services Agency staff across divisions to provide low barrier access to services and to increase client engagement.
HTS staff work collaboratively with a multitude of Watsonville and Santa Cruz agencies serving vulnerable populations that are experiencing homelessness and mental health challenges.

The HTS team works alongside these agencies to support clients in need in the following areas:

- Behavioral Health
- Substance Use Disorders
- Food
- Healthcare
- Street Medicine Support
- Benefits eligibility
- Housing navigation
- Reentry into all mentioned services

Providers: Front Street, Santa Cruz County Behavioral Health

Number of individuals to be served each year:

- 2021-2022: 200
- 2022-2023: 400

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.

CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES

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

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

ADDITIONAL ASSISTANCE NEEDS FROM EDUCATION & TRAINING PROGRAMS

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

The proposed training over the next three years is based on 3 different need areas: Core Competencies which will serve as the foundation to support the effective implementation and sustainability of Evidence Based Practices, the adoption of three national Evidence Based Practices: Integrated Illness Management and Recovery (I-IMR), Evidence Based Supported Employment (EBSE), and Integrated Dual Disorders Treatment (IDDT).

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

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

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

2. Evidence Based Practices
    a. Integrated Illness Management and Recovery (I-IMR): I-IMR is an Evidence Based Practice that has been proven effective to assist consumers in more effectively managing their psychiatric illness, promoting recovery, independent living and physical illness self-management. Thus, reducing the need for long-term intensive services in the community.
    c. Mental Health First Aid (MHFA) is an 8-hour course that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training helps participants identify, understand and respond to signs of addictions and mental illnesses. Mental Health First Aid is a research-based approach that provides skills-based training and teaches participants about mental health and substance-use issues. In 2019, we had five individuals from Behavioral Health complete the rigorous application process and get approved for the MHFA Facilitator training.
    d. Question, Persuade, Refer (QPR): County Behavioral Health is in process of piloting QPR for select County employees through our personnel department. If the survey data from pilot training shows positive results, we're considering training all County employees as a first phase of QPR training, with a second phase opening to the public. With employees trained in the QPR gatekeeper model they will learn three steps to saving the life of someone else; 1. Recognize the warning signs of suicide 2. Know how to offer hope 3. Know how to get help and save a life. The training is easily accessible online, affordable and can be completed in an hour.

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

A. 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 engagement by providing an opportunity for clients and families to provide feedback on the services they are receiving.

We have two primary information technology needs:

1. To increase consumer and family engagement. To create a simple way to gather feedback and enhance our consumer's experience, we purchased 'Happy or Not' kiosks. These kiosks ask a few questions (in both English and Spanish) to learn more about the consumer's experience. The data gathered from the kiosks are reviewed in our quarterly Quality Improvement meeting. Once analyzed, leadership presents solutions on how to improve upon areas of need and reinforce areas where we are doing well. We have placed 'Happy or Not' kiosks in both our North and South County clinic reception areas. Unfortunately, due to COVID, the terminals have been temporarily removed; however, will be re-established in the near future.

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.

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 CSS PROGRAM #1: COMMUNITY GATE					
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					**150**
Number of individuals/families **ACTUALLY SERVED**	156	161	153	184	**310**
Age Group					
• Children 0-15	110	114	107	135	**221**
• TAY 16-25	46	47	46	49	**89**
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	26	23	20	25	**45**
• Latino	116	122	119	125	**231**
• Other	14	16	14	34	**34**
Primary Language					
• English	112	111	107	137	**226**
• Spanish	44	50	46	47	**84**
• Other					
Culture					
• Veterans	N/A	N/A	N/A	N/A	**N/A**
• LGBTQ	11	13	9	11	**20**

AGENCY REPORTING: PVPSA CSS PROGRAM #1: COMMUNITY GATE					
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					**100**
Number of individuals/families **ACTUALLY SERVED**	222	210	208	185	**294**
Age Group					
• Children 0-15	181	169	159	143	**220**
• TAY 16-25	41	41	49	42	**74**
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	8	4	3	3	**8**
• Latino	205	194	189	164	**267**
• Other	9	12	16	18	**19**
Primary Language					
• English	193	181	178	156	**252**
• Spanish	29	29	30	29	**42**
• Other					
Culture					
• Veterans					
• LGBTQ					

AGENCY REPORTING: Santa Cruz County Behavioral Health Services CSS PROGRAM #1: COMMUNITY GATE					
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	165	167	189	206	**287**
Number of individuals/families **ACTUALLY SERVED**	165	167	189	206	**287**
Age Group					
• Children 0-15	84	91	86	99	**136**
• TAY 16-25	81	76	103	107	**151**
• Adults 26-59	0	0	0	0	**0**
• Older Adults 60+	0	0	0	0	**0**
Race/Ethnicity					
• White	65	65	68	69	**101**
• Latino	81	84	103	120	**156**
• Other	19	18	18	17	**30**
Primary Language					
• English	152	153	167	177	**254**
• Spanish	13	14	22	29	**33**
• Other	0	0	0	0	**0**

Culture					
• Veterans	0	0	0	0	**0**
• LGBTQ	19	16	16	17	**28**

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: Encompass CSS PROGRAM #2: PROBATION GATE					
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					**300**
Number of individuals/families **ACTUALLY SERVED**	122	126	119	143	**242**
Age Group					
• Children 0-15	86	89	83	105	**172**
• TAY 16-25	36	37	36	38	**70**
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	20	18	15	16	**35**
• Latino	92	95	93	97	**180**
• Other	10	13	11	30	**27**
Primary Language					
• English	86	87	83	107	**176**
• Spanish	36	39	36	36	**66**
• Other					
Culture					
• Veterans	N/A	N/A	N/A	N/A	**N/A**
• LGBTQ	9	10	7	9	**16**

AGENCY REPORTING: PVPSA CSS PROGRAM #2: PROBATION GATE					
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					**68**
Number of individuals/families **ACTUALLY SERVED**	27	24	31	33	**51**
• Children 0-15					
• TAY 16-25	21	20	24	25	**36**
• Adults 26-59	6	4	7	8	**15**

• Older Adults 60+					
Race/Ethnicity					
• White					
• Latino		1	1		**2**
• Other	27	23	25	29	**43**
Primary Language			5	4	**6**
• English					
• Spanish	22	19	27	27	**43**
• Other	5	5	4	6	**8**
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 CSS PROGRAM #3: CHILD WELFARE SERVICES GATE					
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					**30**
Number Actually Served	3	6	1	4	**14**
Age Group					
• Children 0-15	2	5	1	4	**12**
• TAY 16-25	1	1			**2**
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White		2		2	**4**
• Latino	3	2	1	2	**8**
• Other		2			**2**
Primary Language					
• English	3	6	1	4	**14**
• Spanish					
• Other					
Culture					
• Veterans					
• LGBTQ					

AGENCY REPORTING: Santa Cruz County Behavioral Health Services CSS PROGRAM #3: CHILD WELFARE SERVICES GATE					
System Development:	Q1	Q2	Q3	Q4	Annual

Number of individuals/families targeted:	126	117	117	104	**179**
Number of individuals/families **ACTUALLY SERVED**	126	117	117	226	**179**
Age Group					
• Children 0-15	89	81	77	72	**121**
• TAY 16-25	37	36	40	32	**58**
• Adults 26-59	0	0	0	0	**0**
• Older Adults 60+	0	0	0	0	**0**
Race/Ethnicity					
• White	38	36	40	33	**60**
• Latino	76	68	67	61	**102**
• Other	12	13	10	10	**17**
Primary Language					
• English	116	111	109	99	**163**
• Spanish	10	6	8	5	**16**
• Other	0	0	0	0	**0**
Culture					
• Veterans	0	0	0	0	**0**
• LGBTQ	4	6	5	5	**5**

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 CSS PROGRAM #4: EDUCATION GATE					
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:	27	25	20	27	**49**
Number of individuals/families **ACTUALLY SERVED**	27	25	20	27	**49**
Age Group					
• Children 0-15	10	9	5	10	**16**
• TAY 16-25	17	16	15	17	**33**
• Adults 26-59	0	0	0	0	**0**
• Older Adults 60+	0	0	0	0	**0**
Race/Ethnicity					
• White	8	9	6	6	**14**
• Latino	18	15	13	19	**32**
• Other	1	1	1	2	**3**

Primary Language					
• English	25	24	19	24	**45**
• Spanish	2	1	1	3	**4**
• Other	0	0	0	0	**0**
Culture					
• Veterans	0	0	0	0	**0**
• LGBTQ	3	3	4	4	**6**

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/Community Connection: Family Partner CSS PROGRAM #5: SPECIAL FOCUS: FAMILY PARTNERSHIPS					
Outreach & Engagement	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					**50**
Number of individuals/families **ACTUALLY SERVED**	52	50	49	46	**64**
Age Group					
• Children 0-15	43	40	36	34	**49**
• TAY 16-25	9	10	13	12	**15**
• Adults 26-59	0	0	0	0	**0**
• Older Adults 60+	0	0	0	0	**0**
Race/Ethnicity					
• White	19	20	16	14	**22**
• Latino	24	22	26	25	**33**
• Other	9	8	7	7	**9**
Primary Language					
• English	38	38	36	31	**46**
• Spanish	14	12	13	15	**18**
• Other	0	0	0	0	**0**
Culture					
• Veterans	0	0	0	0	**0**
• LGBTQ	7	7	8	8	**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: Telos CSS PROGRAM #6: ENHANCED CRISIS RESPONSE					
Outreach and Engagement	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					**20**
Number of individuals/families **ACTUALLY SERVED**	N/A	N/A	N/A	N/A	N/A
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**20**
Number Actually Served	3	5	3	3	**10**
Adults (26-59)					
Number of individuals/families targeted					**65**
Number Actually Served	27	30	28	26	**88**
Older Adults (60+)					
Number of individuals/families targeted					**15**
Number Actually Served:	4	4	4	7	**14**
Unduplicated Annual Target for all					**100**
Age Group					
• Children 0-15					
• TAY 16-25	3	5	3	3	**10**
• Adults 26-59	27	30	28	26	**88**
• Older Adults 60+	4	4	4	7	**14**
Race/Ethnicity					
• White	22	19	23	23	**71**
• Latino	8	12	11	10	**29**
• Other	4	8	1	3	**12**
Primary Language					
• English	34	35	30	27	**100**
• Spanish		1	4	8	**9**
• Other		3	1	1	**3**
Culture					
• Veterans	*Data not tracked*	*Data not tracked*	*Data not tracked*	*Data not tracked*	***Data not tracked***
• LGBTQ	4	1	2	1	**8**

Agency Reporting: Encompass: El Dorado Center CSS PROGRAM #6: ENHANCED CRISIS RESPONSE					
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**15**
Number Actually Served	4	2	2	3	11
Adults (26-59)					
Number of individuals/families targeted					**70**
Number Actually Served	31	31	36	33	131
Older Adults (60+)					
Number of individuals/families targeted					**15**
Number Actually Served:	7	2	3	6	18
Unduplicated Annual Target for all					**100**
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	4	2	2	3	**9**
• Adults 26-59	31	31	36	33	**91**
• Older Adults 60+	7	2	3	6	**13**
Race/Ethnicity					
• White	25	23	24	30	**73**
• Latino	8	8	12	8	**25**
• Other	9	4	5	4	**15**
Primary Language					
• English	40	33	39	40	**109**
• Spanish	2	2	2	2	**4**
• Other					
Culture					
• Veterans	*Data not tracked*	*Data not tracked*	*Data not tracked*	*Data not tracked*	***Data not tracked***
• LGBTQ	2	1	0	2	**4**

Agency Reporting: MHCAN: Peer Supports at the PHF CSS PROGRAM #6: ENHANCED CRISIS RESPONSE					
Outreach and Engagement	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:	**25**	**25**	**25**	**25**	**100**
Number of individuals/families **ACTUALLY SERVED**	32	29	34	23	**112**

Agency Reporting: Santa Cruz County Behavioral Health Services CSS PROGRAM #6: ENHANCED CRISIS RESPONSE					
System Development:	Q1	Q2	Q3	Q4	Annual

Number of individuals/families targeted:	169	158	135	201	**583**
Number of individuals/families **ACTUALLY SERVED**	169	158	135	201	**583**
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	29	20	19	35	**97**
• Adults 26-59	124	127	98	142	**425**
• Older Adults 60+	16	11	18	24	**91**
Race/Ethnicity					
• White	95	103	83	115	**344**
• Latino	47	37	35	48	**148**
• Other	27	18	17	38	**91**
Primary Language					
• English	151	138	117	184	**522**
• Spanish	9	13	8	6	**29**
• Other	9	7	10	11	**32**
Culture					
• Veterans	2	2	3	1	**4**
• LGBTQ	4	0	6	8	**18**

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 CSS PROGRAM #7: CONSUMER, FAMILY & PEER SERVICES					
System Development	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:	**20**	**20**	**20**	**20**	**80**
Number of individuals/families **ACTUALLY SERVED**	34	52	41	35	**162**
Full-Service Partnerships	Q1	Q2	Q3	Q4	**Annual**
Transition Age Youth (16-25)					
Number of individuals/families targeted					**200**
Number Actually Served	176	78	81	68	
Adults (26-59)					
Number of individuals/families targeted					**350**
Number Actually Served	328	298	172	130	
Older Adults (60+)					
Number of individuals/families targeted					**50**
Number Actually Served:	335	121	91	93	
Age Group					

• Children 0-15	(7)	(13)	(10)	(15)	
• TAY 16-25	176	78	81	83	**423**
• Adults 26-59	328	298	172	128	**966**
• Older Adults 60+	335	121	91	80	**526**
TOTAL UNDUPLICATED					**1915**
Race/Ethnicity					
• White	377	279	115	102	
• Latino	309	112	93	96	
• Other	153	106	80	93	
Primary Language					
• English	502	318	108	187	
• Spanish	114	97	47	32	
• Other	unk	unk	unk	unk	
Culture					
• Veterans	43	32	22	26	
• LGBTQ	146	101	79	74	

Agency Reporting: Volunteer Center/Community Connection: Mariposa CSS PROGRAM #7: CONSUMER, FAMILY & PEER SERVICES					
Outreach	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:					**40**
Number of individuals/families **ACTUALLY SERVED**	13	13	14	14	**14**
Full-Service Partnerships	Q1	Q2	Q3	Q4	**Annual**
Transition Age Youth (16-25)					
Number of individuals/families targeted					**8**
Number Actually Served	3	3	3	3	**3**
Adults (26-59)					
Number of individuals/families targeted					**25**
Number Actually Served	28	29	30	31	**28**
Older Adults (60+)					
Number of individuals/families targeted					**7**
Number Actually Served:	7	7	7	7	**7**
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	3	3	3	3	**3**
• Adults 26-59	28	29	30	31	**28**
• Older Adults 60+	7	7	7	7	**7**
Race/Ethnicity					
• White	17	18	18	18	**17**
• Latino	17	17	18	19	**17**
• Other	4	4	4	4	**4**
Primary Language					
• English	31	32	33	34	**31**

• Spanish	7	7	7	7	**7**
• Other	0	0	0	0	**0**
Culture					
• Veterans	0	0	0	0	0
• LGBTQ	4	4	4	4	4

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 CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:	115	107	99	104	**136**
Number of individuals/families **ACTUALLY SERVED**	115	107	99	104	**136**
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	9	9	6	6	**8**
• Adults 26-59	103	94	89	93	**122**
• Older Adults 60+	3	4	4	5	**6**
Race/Ethnicity					
• White	68	60	58	60	**78**
• Latino	37	39	33	35	**47**
• Other	10	8	8	9	**11**
Primary Language					
• English	110	102	96	99	**127**
• Spanish	5	5	3	35	**9**
• Other	0	0	0	9	**0**
Culture					
• Veterans	2	2	2	1	**2**
• LGBTQ	5	4	2	2	**5**

Agency Reporting: Santa Cruz County Behavioral Health Services: OAS CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
System Development:	Q1	Q2	Q3	Q4	Annual

Number of individuals/families targeted:	58	67	54	55	**86**
Number of individuals/families **ACTUALLY SERVED**	58	67	54	55	**86**
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	0	0	0	0	**0**
• Adults 26-59	0	0	0	0	**0**
• Older Adults 60+	58	69	54	55	**86**
Race/Ethnicity					
• White	50	58	46	45	**73**
• Latino	2	3	1	3	**4**
• Other	6	8	7	7	**9**
Primary Language					
• English	56	67	51	51	**82**
• Spanish	0	0	0	1	**1**
• Other	2	2	3	3	**9**
Culture					
• Veterans	0	0	0	0	**0**
• LGBTQ	3	3	0	2	**4**

Agency Reporting: Santa Cruz County Behavioral Health Services: RECOVERY TEAM CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
System Development:	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted:	322	324	321	349	**494**
Number of individuals/families **ACTUALLY SERVED**	322	324	321	349	**494**
Age Group					
• Children 0-15	2	0	1	1	**4**
• TAY 16-25	3	6	2	3	**12**
• Adults 26-59	242	241	236	262	**365**
• Older Adults 60+	75	77	82	83	**113**
Race/Ethnicity					
• White	224	231	224	239	**340**
• Latino	65	60	66	70	**100**
• Other	33	33	31	40	**54**
Primary Language					
• English	298	304	297	322	**460**
• Spanish	17	14	17	18	**23**
• Other	7	6	7	9	**11**

Culture					
• Veterans	2	2	2	3	**3**
• LGBTQ	7	7	7	8	**8**

Agency Reporting: Front Street: Supported Housing CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**5**
Number Actually Served	0	0	1	1	**1**
Adults (26-59)					
Number of individuals/families targeted					**20**
Number Actually Served	14	15	15	15	**16**
Older Adults (60+)					
Number of individuals/families targeted					**5**
Number Actually Served:	10	9	9	9	**10**
Age Group					
• Children 0-15					
• TAY 16-25	0	0	1	1	**1**
• Adults 26-59	14	15	15	15	**16**
• Older Adults 60+	10	9	9	9	**10**
Race/Ethnicity					
• White	16	17	18	18	**17**
• Latino	4	4	4	4	**6**
• Other	4	3	3	3	**4**
Primary Language					
• English	24	24	25	25	**27**
• Spanish	0	0	0	0	**0**
• Other	0	0	0	0	**0**
Culture					
• Veterans	0	0	0	0	**0**
• LGBTQ	0	0	0	0	**0**

Agency Reporting: Front Street: Wheelock CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
Agency Reporting	**Front Street: Wheelock**				
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**2**
Number Actually Served	0	0	0	0	0
Adults (26-59)					
Number of individuals/families targeted					**12**
Number Actually Served	11	12	10	10	**12**

Older Adults (60+)					
Number of individuals/families targeted					**2**
Number Actually Served:	6	6	6	6	**8**
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59	11	12	10	10	**12**
• Older Adults 60+	6	6	6	6	**8**
Race/Ethnicity					
• White	13	14	11	11	**14**
• Latino	3	3	4	4	**5**
• Other	1	1	1	1	**1**
Primary Language					
• English	16	17	16	16	**19**
• Spanish	1	1	1	1	**1**
• Other					
Culture					
• Veterans					
• LGBTQ					

Agency Reporting: Front Street: Willowbrook CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**0**
Number Actually Served	0	0	0	0	**0**
Adults (26-59)					
Number of individuals/families targeted					**20**
Number Actually Served	21	22	21	24	**27**
Older Adults (60+)					
Number of individuals/families targeted					**20**
Number Actually Served:	20	20	20	20	20
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	0	0	0	0	**0**
• Adults 26-59	21	22	21	24	**27**
• Older Adults 60+	20	20	20	20	**20**
Race/Ethnicity					
• White	33	34	33	35	**36**
• Latino	4	4	4	5	**5**
• Other	4	4	3	4	**6**
Primary Language					
• English	41	42	41	44	**47**
• Spanish	0	0	0	0	**0**
• Other	0	0	0	0	**0**

Culture					
• Veterans	0	0	0	0	**0**
• LGBTQ	1	1	1	1	**1**

Agency Reporting: Front Street: Housing Property Management CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					10
Number Actually Served	0	0	0	0	**0**
Adults (26-59)					
Number of individuals/families targeted					30
Number Actually Served	53	54	55	55	61
Older Adults (60+)					
Number of individuals/families targeted					10
Number Actually Served:	4	3	2	2	4
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	0	0	0	0	**0**
• Adults 26-59	53	54	55	55	61
• Older Adults 60+	4	3	2	2	4
Race/Ethnicity					
• White	0	0	0	0	**0**
• Latino	0	0	0	0	**0**
• Other	57	57	57	57	65
Primary Language					
• English	56	56	56	56	64
• Spanish	1	1	1	1	1
• Other	0	0	0	0	**0**
Culture					
• Veterans	0	0	0	0	**0**
• LGBTQ	0	0	0	0	**0**

Agency Reporting: Front Street: Opal Cliff Residential CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**2**
Number Actually Served	2	2	1	1	**2**
Adults (26-59)					
Number of individuals/families targeted					**12**
Number Actually Served	11	10	11	11	**11**
Older Adults (60+)					
Number of individuals/families targeted					**2**
Number Actually Served:	3	2	2	2	3

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

Agency Reporting: Encompass: Housing Support CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**0**
Number Actually Served	0	0	0	0	**0**
Adults (26-59)					
Number of individuals/families targeted					**60**
Number Actually Served	23	19	21	19	**23**
Older Adults (60+)					
Number of individuals/families targeted					**0**
Number Actually Served:	15	19	19	19	**19**
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	0	0	0	0	**0**
• Adults 26-59	23	19	21	19	**23**
• Older Adults 60+	15	19	19	19	**19**
Race/Ethnicity					
• White	32	31	32	31	**34**
• Latino	2	2	3	3	**3**
• Other	4	5	5	4	**5**
Primary Language					
• English	38	38	40	38	**42**
• Spanish	0	0	0	0	**0**
• Other	0	0	0	0	**0**
Culture					

• Veterans	*Data not tracked*	*Data not tracked*	*Data not tracked*	*Data not tracked*	***Data not tracked***
• LGBTQ	2	2	4	4	**4**

Agency Reporting: Volunteer Center/Community Connection: Housing Support (Employment) CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**15**
Number Actually Served	1	1	1	1	**1**
Adults (26-59)					
Number of individuals/families targeted					**20**
Number Actually Served	11	11	11	13	**13**
Older Adults (60+)					
Number of individuals/families targeted					**15**
Number Actually Served:	4	3	3	4	**4**
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	1	1	1	1	**1**
• Adults 26-59	11	11	11	13	**13**
• Older Adults 60+	4	3	3	4	**4**
Race/Ethnicity					
• White	12	12	12	13	**13**
• Latino	1	1	1	1	**1**
• Other	3	2	2	4	**4**
Primary Language					
• English	15	14	14	17	**17**
• Spanish	0	0	0	0	**0**
• Other	1	1	1	1	**1**
Culture					
• Veterans	1	0	0	1	**1**
• LGBTQ	4	4	4	5	**5**

Agency Reporting: Volunteer Center/Community Connection: College Connection CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
Outreach	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted					**40**
Number Actually Served	22	22	11	11	22

Agency Reporting: Volunteer Center/Community Connection: Opportunity Connection CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**10**
Number Actually Served	0	0	0	2	**2**
Adults (26-59)					
Number of individuals/families targeted					**50**
Number Actually Served	24	25	25	25	**26**
Older Adults (60+)					
Number of individuals/families targeted					**10**
Number Actually Served	11	10	9	9	**11**
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	0	0	0	2	**2**
• Adults 26-59	24	25	25	25	**26**
• Older Adults 60+	11	10	9	9	**11**
Race/Ethnicity					
• White	24	23	22	24	**26**
• Latino	2	3	3	3	**3**
• Other	9	9	9	12	**13**
Primary Language					
• English	34	34	33	36	**38**
• Spanish	0	0	0	0	**0**
• Other	1	1	1	0	**1**
Culture					
• Veterans	0	0	0	0	**0**
• LGBTQ	7	6	6	7	**7**

Agency Reporting: Volunteer Center/Community Connection: Avenues Employment Services CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**25**
Number Actually Served	4	4	3	3	**6**
Adults (26-59)					
Number of individuals/families targeted					**10**
Number Actually Served	22	26	13	10	**34**
Older Adults (60+)					
Number of individuals/families targeted					**0**
Number Actually Served	1	2	4	5	**5**
Age Group					
• Children 0-15	0	0	0	0	**0**

• TAY 16-25	4	4	3	3	**6**
• Adults 26-59	22	26	13	10	**34**
• Older Adults 60+	1	2	4	5	**5**
Race/Ethnicity					
• White	15	18	11	12	**28**
• Latino	6	7	4	3	**9**
• Other	6	7	5	3	**8**
Primary Language					
• English	23	27	17	18	**40**
• Spanish	4	5	3	0	**5**
• Other	0	0	0	0	**0**
Culture					
• Veterans	0	0	0	1	**1**
• LGBTQ	3	3	0	0	**3**

Agency Reporting: Encompass: Casa Pacific

CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**6**
Number Actually Served	2	1	1	1	**3**
Adults (26-59)					
Number of individuals/families targeted					**28**
Number Actually Served	13	13	13	11	**32**
Older Adults (60+)					
Number of individuals/families targeted					**6**
Number Actually Served	1	1	3	4	**5**
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	2	1	1	1	**3**
• Adults 26-59	13	13	13	11	**32**
• Older Adults 60+	1	1	3	4	**5**
Race/Ethnicity					
• White	8	8	8	11	**23**
• Latino	7	4	6	3	**13**
• Other	1	3	3	2	**4**
Primary Language					
• English	14	13	16	15	**37**
• Spanish	2	2	1	1	**3**
• Other	0	0	0	0	**0**
Culture					

• Veterans	*Data not tracked*	*Data not tracked*	*Data not tracked*	*Data not tracked*	***Data not tracked***
• LGBTQ	0	0	1	3	**3**

Agency Reporting: Encompass: River Street Shelter CSS PROGRAM #8: COMMUNITY SUPPORT SERVICES					
Outreach	Q1	Q2	Q3	Q4	Annual
Number of individuals/families targeted					**125**
Number Actually Served	5	10	10	3	**21**
Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Transition Age Youth (16-25)					
Number of individuals/families targeted					**5**
Number Actually Served	1	2	2	0	**3**
Adults (26-59)					
Number of individuals/families targeted					**85**
Number Actually Served	23	22	32	11	**50**
Older Adults (60+)					
Number of individuals/families targeted					**10**
Number Actually Served	1	2	2	1	**2**
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	1	2	2	0	**3**
• Adults 26-59	23	22	32	11	**50**
• Older Adults 60+	1	2	2	1	**2**
Race/Ethnicity					
• White	17	17	22	8	**33**
• Latino	1	2	4	2	**6**
• Other	7	7	10	2	**16**
Primary Language					**3**
• English • Spanish • Other	*Data not tracked*	*Data not tracked*	*Data not tracked*	*Data not tracked*	*Data not tracked*
Culture					
• Veterans	4	2	2	1	**5**
• LGBTQ	1	1	2	0	**3**

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.

PREVENTION

Agency Reporting: The Diversity Center (COE)
PREVENTION

	Q1	Q2	Q3	Q4	**Annual**
Unduplicated Client Count	344	1783	278	373	**2778**
Age:					
0-15	303	973	185	280	**1741**
16-25	41	810	93	93	**1037**
26-59					
60 +					
Language:					
English	276	1429	205	285	**2195**
Spanish	56	349	69	88	**562**
Other	12	5	4		**21**
1986Race:					
American Indian or Alaskan Native	4	14	6	1	**25**
Black	12	42	14	8	**76**
White	186	1407	149	244	**1986**
Other	102	227	109	120	**558**
More than one	30	93			
Declined to answer	10				
Ethnicity					
Latino	102		109	120	**331**
African	2	3	2	2	**9**
Asian Indian/South Asian	7	19	6	5	**37**
Filipino	3	5	3	4	**15**
Other	190	704	149	196	**1239**
More than one	30	14	9	34	**87**
Declined to State	10			12	**22**
Veteran					
Yes					
No	344	1783	278	373	**2778**
Declined to State					

Sexual Orientation					
Gay or Lesbian	94	367	52	42	**926**
Homosexual or straight	90	742	92	92	**1016**
Questioning or Unsure	55	86	56	71	**268**
Queer	61	364	78	118	**621**
Another Sexual Orientation	19	224		19	**262**
Declined to State	25			31	**56**
Gender Assigned at birth					
Male		789			**789**
Female		994			**994**
Declined to answer	0	0	0	0	**0**
Current Gender Identity					
Male	94	506	68	99	**767**
Female	197	609	98	126	**1030**
Transgender Male	34	263	42	41	**380**
Transgender Female	19	94	29	26	**168**
Gender Queer		269	27	55	**351**
Questioning or Unsure		42	11	23	**76**
Declined to State			3	3	**6**
Write in Option	0	0	0	0	**0**
Disability:					
Yes:	0	0	0	0	**0**
Communication Domain	0	0	0	0	**0**
Difficulty Seeing	26	68	28	28	
Difficulty Hearing		36			
Difficulty Having Speech Understood	0	0	0	0	**0**
Mental Domain		241			
(Mental illness, learning disability, developmental disability, dementia)	59	25	88	78	
Physical/mobility	34	35	10	10	**89**
Chronic health condition	40		17	21	
Other (specify)		1378			**1378**
No	0	0	0	0	**0**
Declined to State	0	0	0	0	**0**

Agency Reporting: Live Oak Family Resource Center (COE)

PREVENTION

	Q1	Q2	Q3	Q4	**Annual**
Unduplicated Client Count	23	52	86	115	**276**

Age:					
0-15	1	27	25	35	**88**
16-25	2	3	4	4	**13**
26-59	18	20	54	73	**165**
60 +	2	2	3	3	**10**
Language:					
English	7	32	34	32	**105**
Spanish	13	18	15	73	**119**
Other	1	2	37	10	**50**
Race:					
American Indian or Alaskan Native	0	0	1	0	**1**
Black	0	0	0	0	**0**
White	5	10	11	9	**35**
Other	0	0	3	0	**3**
More than one	18	42	69	106	**235**
Declinde to State	0	0	2	0	**2**
Ethnicity					
Latino	20	45	73	108	**246**
African	0	0	0	0	**0**
Asian Indian/South Asian	0	0	1	0	**1**
Filipino	0	0	0	0	**0**
Other	3	7	12	7	**29**
More than one	0	0	0	0	**0**
Declined to State	0	0	0	0	**0**
Veteran					
Yes	0	0	0	0	**0**
No	23	52	86	115	**276**
Declined to State	0	0	0	0	**0**
Sexual Orientation					
Gay or Lesbian	0	0	0	0	**0**
Heterosexual or straight	0	0	0	0	**0**
Questioning or Unsure	0	0	0	0	**0**
Queer	1	0	0	1	**2**
Another sexual orientation	0	0	0	0	**0**
Declined to State	22	52	86	114	**274**
Gender Assigned at birth					
Male	5	20	18	32	**75**
Female	18	32	68	83	**201**
Declined to amswer	0	0	0	0	**0**
Current Gender Identity					
Male	5	20	18	32	**75**
Female	18	32	68	83	**201**
Transgender Male	0	0	0	0	**0**
Transgender Female	0	0	0	0	**0**
Gemder queer	0	0	0	0	**0**

Questioning or Unsure	0	0	0	0	**0**
Declined to answer	0	0	0	0	**0**
Write in Option	0	0	0	0	**0**
Disability:					
Yes:	1	1	0	2	**4**
Communication Domain	0	0	0	0	**0**
Difficulty Seeing	0	0	0	0	**0**
Difficulty Hearing	0	0	0	0	**0**
Difficulty Having Speech Understood	0	0	0	0	**0**
Mental Domain	0	0	0	0	**0**
(mental illness, learning disability, developmental disibility, dementia)	0	0	0	0	**0**
Physical/mobility	0	0	0	0	**0**
Chronic health condition	0	0	0	0	**0**
Other (specity)	0	0	0	0	**0**
No	22	51	86		**159**
Declined to State	0	0	0	0	**0**
Other Relevant Data					

Agency Reporting: PBIS (COE)

Districts: LOED, SCCS, SLVUSD, SUED, SVUSD

PREVENTION

	Q1	Q2	Q3	Q4	**Annual**
Unduplicated Client Count	9,076	9,076	9,076	9,076	**9,076**
Age:					
0-15	8,099	8,099	8,099	8,099	**8,099**
16-25	977	977	977	977	**977**
26-59					
60 +					
Language:					
English	7910	7910	7910	7910	**7910**
Spanish	1166	1166	1166	1166	**1166**
Other					
Race:					
American Indian	40	40	40	40	**40**
Black	94	94	94	94	**94**
White	4829	4829	4829	4829	**4829**

Other	1,269	1,269	1,269	1,269	**1,269**
More than one	565	565	565	565	**565**
Declined to State	2279	2279	2279	2279	**2279**
Ethnicity					
Latino	3051	3051	3051	3051	**3051**
African	94	94	94	94	**94**
Asian Indian/South Asian	319	319	319	319	**319**
Filipino	67	67	67	67	**67**
Other	3985	3985	3985	3985	**3985**
More than one	539	539	539	539	**539**
Declined to State	1021	1021	1021	1021	**1021**
Veteran					
Yes					
No					
Declined to State	9076	9076	9076	9076	**9076**
Sexual Orientation					
Gay or Lesbian					
Homosexual or straight					
Questioning or Unsure					
Queer					
Another Sexual Orientation					
Declined to State	9076	9076	9076	9076	**9076**
Gender Assigned at birth					
Male					
Female					
Declined to amswer	9076	9076	9076	9076	**9076**
Current Gender Identity					
Male					
Female					
Transgendergender					
Gemderqueer					
Questioning or Unsure					
Another gender idenity					
Declined to answer	9076	9076	9076	9076	**9076**
Disability					
Yes:					
Communication Domain					
Difficulty Seeing					
Difficulty Hearing					
Difficulty Having Speech Understood					
Mental Domain					

(mental illness, learning disability, developmental disibility, dementia)					
Physical/mobility					
Chronic health condition					
Other (specity)	600	600	600	600	**600**
No					
Declined to State	4365	4365	4365	4365	4365

Agency Reporting: FIRST 5: TRIPLE P
PREVENTION

	Q1	Q2	Q3	Q4	Annual
Unduplicated Client Count	32	41	50	93	**150**
Age:					
0-15	0	0	0	0	**0**
16-25	4	5	4	7	**11**
26-59	26	35	45	84	**111**
60 +	2	1	1	2	**4**
Declined to State					**24**
Language:					
English	23	26	40	67	**105**
Spanish	9	15	10	26	**45**
Other	0	0	0	0	**0**
Race:					
American Indian or Alaskan Native	0	0	0	0	**0**
Black	2				**2**
White	28	37	43	64	**113**
Asian			1		**1**
Native Hawaiian /Other Pacific Islander	1	4	3	4	**8**
Other	1		3	25	**26**
More than one	0	0	0	0	**0**
Declined to State	21	28	20	33	**67**
Ethnicity					
Latino	32	41	50	93	**150**
African	0	0	0	0	**0**
Asian Indian/South Asian	0	0	0	0	**0**
Filipino	0	0	0	0	**0**
Other				1	**1**
More than one	0	0	0	0	**0**
Declined to State	11	13	30	59	**82**
Veteran					
Yes				1	**1**

No	32	41	48	68	**125**
Declined to State			2	24	**24**
Unknown**	0	0	0	0	**0**
Sexual Orientation					
Gay or Lesbian			1	1	**1**
Heterosexual or Straight	26	29	39	59	**102**
Questioning or Unsure	0	0	0	0	**0**
Queer	0	0	0	0	**0**
Another Sexual Orientation		3	2	3	**5**
Declined to State	6	9	8	30	**42**
Unknown**	0	0	0	0	**0**
Gender Assigned at birth					
Male	7	10	10	20	**30**
Female	23	30	38	50	**94**
Declined to State	2	1	2	23	**26**
Unknown**	0	0	0	0	**0**
	0	0	0	0	**0**
Current Gender Identity					
Male	8	10	11	21	**32**
Female	24	31	39	50	**96**
Transgender Male	0	0	0	0	**0**
Transgender Female	0	0	0	0	**0**
Gender Queer	0	0	0	0	**0**
Questioning or Unsure	0	0	0	0	**0**
Declined to State				22	**22**
Write in Option	0	0	0	0	**0**
Disability					
Yes***(total unique clients with disability)*	4	5	5	11	**14**
• Communication Domain	0	0	0	0	**0**
Difficulty Seeing	1		1	1	**2**
Difficulty Hearing	0	0	0	0	**0**
Difficulty Having Speech Understood					
• Mental Domain					
(mental illness, learning disability, developmental disability, dementia)	1	4	5	11	**11**
• Physical/mobility	1	1			**1**
• Chronic health condition	2	1			**2**
• Other (Specify)	1 (unspecified)	1 (post polio syndrome)			**1 (post polio syndrome)**

No	28	36	44	58	**112**
Declined to State			1	24	**24**
Unknown**					
Other Relevant Data					
Children of parents receiving intensive services *(unduplicated)*	56	68	83	158	**254**
Parents in brief services (L2 Individual, Seminars, Workshops, Inmate Program) *(unique within each brief services; may duplicate Intensive Service clients in this report)*	L2 Indiv: 45 Seminars: 13 Workshops: 64 Inmate: 17 **Total: 135** *(unique across all brief services)*	L2 Indiv: 23 Seminars: 35 Workshops: 53 Inmate: 12 **Total: 116** *(unique across all brief services)*	L2 Indiv: 74 Seminars: 48 Workshops: 126 Inmate: 21 **Total: 268** *(unique across all brief services)*	L2 Indiv: 152 Seminars: 18 Workshops: 63 Inmate: 22 **Total: 255** *(unique across all brief services)*	**L2 Indiv: 283 Seminars: 113 Workshops: 288 Inmate: 42 Total: 705** ***(unique across all brief services)***

Agency Reporting: Veterans Advocate
PREVENTION

	Q1	Q2	Q3	Q4	**Annual**
Unduplicated Client Count	67	62	61	59	**249**
Age:					
0-15	0	0	0	0	**0**
16-25	0	1	1	1	**3**
26-59	27	26	26	15	**94**
60 +	40	35	34	43	**152**
Declined to answer	0	0	0	0	**0**
Language:					
English	67	62	61	59	**249**
Spanish	4	3	3	2	**12**
Other	0	0	1	0	**1**
Race:					
American Indian or Alaskan Native	0	0	0	0	
Black	3	5	5	3	**16**
White	49	47	42	49	**187**
Asian	1	0	1	0	**2**
Native Hawaiian or Other Pacific Islander	0	0	0	0	**0**
Declined to answer	8	4	8	4	**24**

Other	6	6	5	3	**20**
Ethnicity					
Hipanic or Latino	4	5	4	3	**16**
Not hispanic or Latino	55	52	48	49	**204**
Declined to answer	7	4	8	4	**23**
Other	1	1	1	3	**6**
Veteran					
Yes	64	57	60	57	**238**
No	3	5	1	2	**11**
Declined to State	0	0	0	0	**0**
Sexual Orientation					
Gay or Lesbian	1	1	1	0	**3**
Heterosexual or Straight	52	45	41	38	**176**
Bisexual	0	0	0	0	**0**
Queer	0	0	0	1	**1**
Another Sexual Orientation	0	0	0	0	**0**
Declined to answer	14	16	19	20	**69**
Gender Assigned at birth					
Male	55	52	55	56	**218**
Female	9	6	2	2	**19**
Declined to amswer	2	4	4	1	**11**
Current Gender Identity					
Male	55	52	55	56	**218**
Female	9	6	2	2	**19**
Transgendergender	0	0	0	0	**0**
Gemderqueer	0	0	0	0	**0**
Questioning or Unsure	0	0	0	0	**0**
Another gender idenity	0	0	0	0	**0**
Declined to answer	2	4	4	1	**11**

Agency Reporting: Seniors Council: Senior Peer Companion
PREVENTION

	Q1	Q2	Q3	Q4	**Annual**
Total Served (Unduplicated)	13	13	14	15	**55**
Age Group					
• Children 0-15	0	0	0	0	**0**
• TAY 16-25	0	0	0	0	**0**
• Adults 26-59	0	0	0	0	**0**
• Older Adults 60+	13	13	14	15	**55**
Race/Ethnicity					
• White	11	11	12	13	**47**
• Latino	1	1	1	1	**4**
• Other	1	1	1	1	**4**
Primary Language					
• English	12	12	13	14	**51**
• Spanish	1	1	1	1	**4**
• Other	0	0	0	0	**0**
Culture					
• Veterans	2	2	2	2	**8**
• LGBTQ	0	0	0	0	**0**

EARLY INTERVENTION

Agency Reporting: Santa Cruz County Behavioral Health Services/ 0-5 Early Intervention Stanford Neurodevelopmental Foster Care Clinic EARLY INTERVENTION					
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	1	1	1	1	4
Number of individuals/families **ACTUALLY SERVED**	1	1	1	1	**4**
Age Group					
· Children 0-15	1	0	0	1	**2**
· TAY 16-25	0	1	1	0	**2**
· Adults 26-59	0	0	0	0	**0**
· Older Adults 60+	0	0	0	0	**0**
Race/Ethnicity					
· White	0	0	0	1	**1**
· Latino	1	1	1	0	**3**
· Other	0	0	0	0	**0**
Primary Language					
· English	1	1	1	1	**4**
· Spanish	0	0	0	0	**0**
· Other	0	0	0	0	**0**
Culture					
· Veterans	0	0	0	0	**0**
· LGBTQ	0	0	0	0	**0**

Agency Reporting: Employment (Community Connection) EARLY INTERVENTION					
	Q1	Q2	Q3	Q4	**Annual**
Unduplicated Client Count	18	14	16	12	**26**
Age:					
0-15	0	0	0	0	**0**
16-25	16	12	12	8	**22**
26-59	2	2	4	4	**4**
60 +	0	0	0	0	**0**

Declined to answer	0	0	0	0	**0**
Language:					
English	15	10	14	11	**21**
Spanish	3	4	2	1	**5**
Other	0	0	0	0	**0**
Race:					
American Indian or Alaskan Native	0	0	0		**0**
Black	0	0	0	0	**0**
White	7	6	9	7	**11**
Asian	1	0	0	1	**1**
Native Hawaiian or Other Pacific Islander	0	0	0	0	**0**
Declined to answer	0	0	0	0	**0**
Other	0	0	0	0	**0**
Ethnicity					
Hipanic or Latino	6	7	5	4	**9**
Not hispanic or Latino	0	0	0	0	**0**
Declined to answer	0	0	0	0	**0**
Other	4	1	2	1	**5**
Veteran					
Yes	0	0	0	0	**0**
No	18	14	16	12	**18**
Declined to State	0	0	0	0	**0**
Sexual Orientation					
Gay or Lesbian	0	0	0	0	**0**
Heterosexual or Straight	10	10	12	8	**17**
Bisexual	0	0	0	0	**0**
Queer	0	0	0	0	**0**
Another Sexual Orientation	3	1	0	1	**3**
Declined to answer	5	3	2	2	**5**
Gender Assigned at birth					
Male	12	10	10	16	**16**
Female	6	4	9	9	**9**
Declined to amswer	0	0	0	1	**1**
Current Gender Identity					
Male	9	7	10	14	**9**
Female	5	4	4	8	**8**
Transgendergender	0	0	0	0	**0**
Gemderqueer	0	0	0	0	**0**
Questioning or Unsure	1	0	0	0	**0**
Another gender idenity	0	0	0	0	**0**
Declined to answer	3	3	2	4	**4**

Agency Reporting: Santa Cruz County Behavioral Health Services: Services ACCESS

EARLY INTERVENTION

July 1, 2018, to June 30, 2019	Q1	Q2	Q3	Q4	Annual
Total Served (Unduplicated)	61	54	66	59	101
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	47	41	39	40	68
• Adults 26-59	14	12	26	19	32
• Older Adults 60+	0	1	1	0	1
Race/Ethnicity					
• White	25	22	31	21	41
• Latino	32	28	31	30	51
• Other	4	4	4	8	9
Primary Language					
• English	59	50	62	53	93
• Spanish	2	4	4	5	7
• Other	0	0	0	1	1
Culture					
• Veterans	0	0	0	0	0
• LGBTQ	4	4	7	7	8

OUTREACH AND INCREASING EARLY SIGNS OF MENTAL ILLNESS

Agency Reporting: Senior Outreach (FSA)					
	Q1	Q2	Q3	Q4	**Annual**
Unduplicated Client Count	8	11	11	10	18
Age:					
0-15	0	0	0	0	**0**
16-25	0	0	0	0	**0**
26-59				2	2
60 +	8	11	11	8	16
Language:					
English	7	9	9	9	16
Spanish	1	2	2	1	2
Other	0	0	0	0	**0**
Race:					
American Indian or Alaskan Native	0	0	0	0	**0**
Black	1	2	2	2	2
White	6	8	8	6	12
Other		1	1	1	2
More Than One	0	0	0	0	**0**
Declined to answer	1			1	2
Ethnicity					
Latino	1	2	2	2	3
African	1	2	2	2	2
Asian Indian/South Asian	1	1	1	1	2
Filipino	0	0	0	0	**0**
Other	2	1		2	4
More than One	0	0	0	0	**0**
Declined to State	3	5	6	3	7
Veteran					
Yes			1		1
No	8	11	10	10	17
Declined to State	0	0	0	0	**0**
Sexual Orientation					
Gay or Lesbian	0	0	0	0	**0**
Heterosexual or Straight	0	0	0	0	**0**
Bisexual	0	0	0	0	**0**
Queer	0	0	0	0	**0**
Another Sexual Orientation	0	0	0	0	**0**
Declined to answer	10	13	17	12	24

Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	2	2	2	1	3
Female	6	9	9	9	15
Declined to amswer	0	0	0	0	**0**
Current Gender Identity					
Male	0	0	0	0	**0**
Female	1	1		1	2
Transgender Male	0	0	0	0	**0**
Transgender Female	0	0	0	0	**0**
Gemder Queer	0	0	0	0	**0**
Questioning or Unsure	0	0	0	0	**0**
Declined to State	7	10	11	9	16
Write In Option	0	0	0	0	**0**
Disability					
Yes:	0	0	0	0	**0**
• Communication Domain	0	0	0	0	**0**
Difficulty Seeing	0	0	0	0	**0**
Difficulty Hearing	0	0	0	0	**0**
Difficulty Having Speech Understood	0	0	0	0	**0**
• Mental Domain	0	0	0	0	**0**
(mental illness, learning disability, developmental disability, dementia)	0	0	0	0	**0**
• Physical/mobility	0	0	0	0	**0**
• Chronic health condition	0	0	0	0	**0**
• Other (Specify)	0	0	0	0	**0**
No	0	0	0	0	**0**
Declined to State	8	11	11	9	17

STIGMA AND DISCRIMINATION REDUCTION

See “Attachment – NAMI Survey” below

ACCESS AND LINKAGE TO TREATMENT

Agency Reporting: Encompass: Second Story ACCESS TO LINKAGE AND TREATMENT					
	Q1	Q2	Q3	Q4	**Annual**

Unduplicated Client Count	20	21	21	21	**52**
Age:					
0-15	0	0	0	0	**0**
16-25	1	3	3	2	**7**
26-59	19	16	14	17	**38**
60 +		2	4	2	**7**
Declined to answer	0	0	0	0	**0**
Language:					
English	20	20	21	21	**51**
Spanish	0	0	0	0	**0**
Other		1			**1**
Race:					
American Indian or Alaskan Native			1		**1**
Black	2			1	**3**
White	11	12	10	11	**29**
Asian	1	2	4	3	**4**
Native Hawaiian or Other Pacific Islander	0	0	0	0	**0**
Declined to answer	0	0	0	0	**0**
Other	6	7	6	6	**15**
Ethnicity					
Hipanic or Latino	3	4	1	3	**6**
Not hispanic or Latino	17	17	20	18	**46**
Declined to answer	0	0	0	0	**0**
Other	0	0	0	0	**0**
Veteran					
Yes No Declined to State	*Data not tracked*	*Data not tracked*	*Data not tracked*	*Data not tracked*	***Data not tracked***
Sexual Orientation					
Gay or Lesbian			1	1	**1**
Heterosexual or Straight	14	9	13	11	**25**
Bisexual	0	0	0	0	**0**
Queer	1				**1**
Another Sexual Orientation	2	3	1	1	**3**
Declined to answer	2	9	6	8	**22**
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	7	9	7	6	**20**
Female	13	12	14	15	**32**
Declined to amswer	0	0	0	0	**0**
Current Gender Identity					
Male	6	9	7	6	**19**
Female	12	12	14	15	**31**
Transgender gender	0	0	0	0	**0**
Gemderqueer	1				**1**

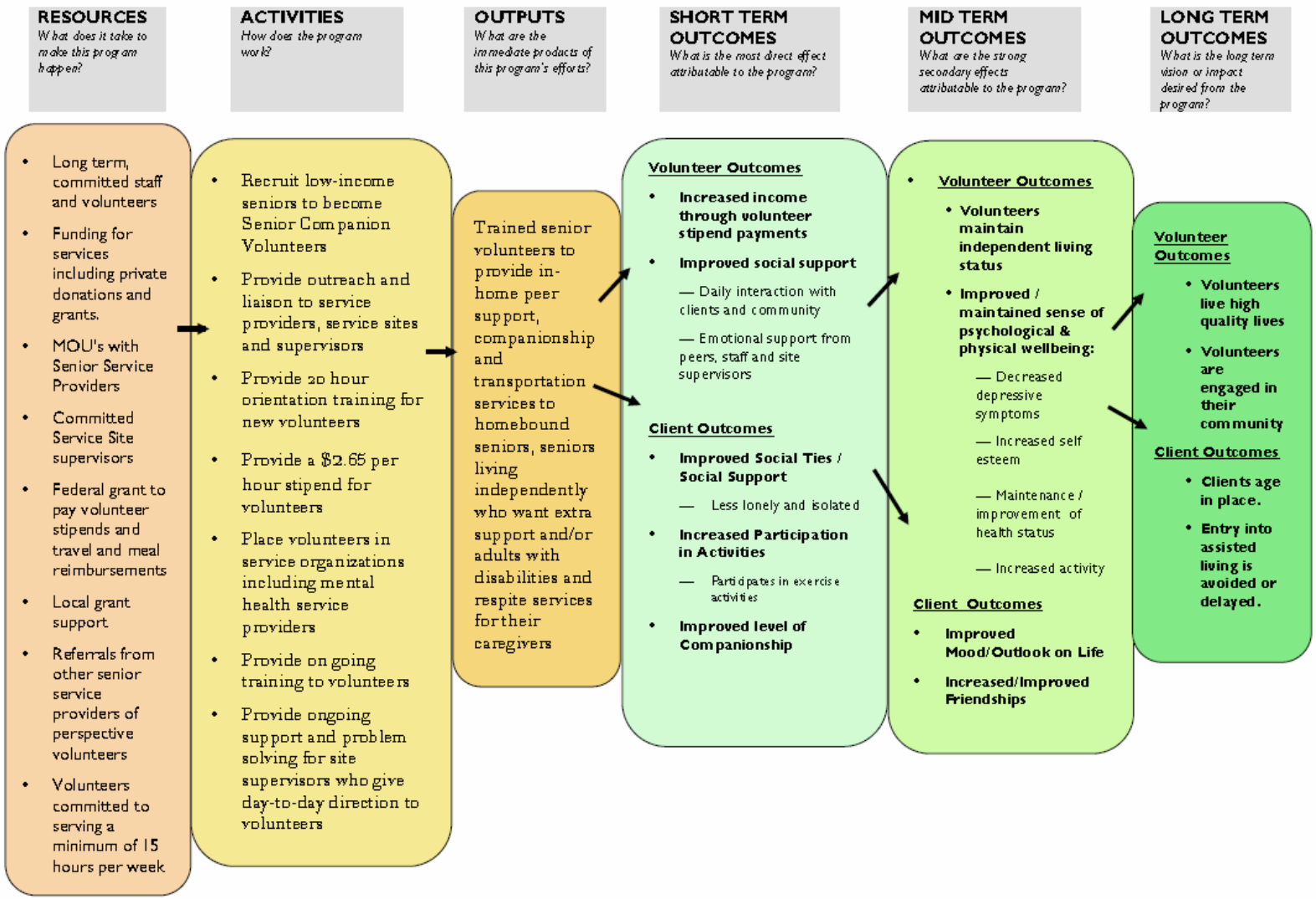
Questioning or Unsure	0	0	0	0	**0**
Another gender idenity	0	0	0	0	**0**
Declined to answer	1				**1**

Agency Reporting: Santa Cruz County Behavioral Health Services: MERT/MHL

ACCESS TO LINKAGE AND TREATMENT

	Q1	Q2	Q3	Q4	**Annual**
Total Served (Unduplicated)	72	71	56	81	**260**
Age Group					
• Children 0-15	20	18	10	18	**56**
• TAY 16-25	20	13	15	19	**64**
• Adults 26-59	25	34	22	35	**111**
• Older Adults 60+	7	6	9	9	**29**
Race/Ethnicity					
• White	38	43	35	45	**150**
• Latino	23	16	13	23	**70**
• Other	11	12	8	13	**40**
Primary Language					
• English	61	67	52	73	**234**
• Spanish	5	1	1	3	**10**
• Other	6	3	3	5	**16**
Culture					
• Veterans	1	1	1	1	**2**
• LGBTQ	0	5	3	7	**12**

Seniors Council – SENIOR COMPANION PROGRAM Logic Model



Companionship/Respite Senior Companion Assignment Plan FY 20-21

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

Senior Companion (print) _____

Senior Companion Signature _____

Coordinator Signature _____

Volunteer Site _____

Client Name (or number) _____

Client Date of Birth _____ Client Age _____

Check Service Being Provided (choose only one)

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

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

Supervisor (print) _____

Supervisor Signature _____ Date: _____

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

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

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

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

Companionship/Respite Senior Companion Assignment Plan FY 20-21

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

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

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

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

THIS SECTION TO BE COMPLETED IN THE SPRING.

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

K-12 Foster Grandparent Assignment Plan FY 20-21

It is a federal requirement that Foster Grandparents have an Assignment Plan (AP) for each child with whom they are assigned to work. The children must have a documented economic disadvantage and/or exceptional or special need, verified by an appropriate professional. The Foster Grandparent is assigned to your organization to provide one-on-one assistance based on need of selected children. The completed AP becomes the volunteer's "job description." The signature of the supervisor/teacher below signifies acceptance and approval of this AP.

Foster Grandparent (print) _____

Foster Grandparent Signature _____

Coordinator Signature _____

CONFIDENTIALITY: The Foster Grandparent Program recognizes and respects the confidentiality of all the children involved in the program. Please be assured that all the information that you provide will only be used in aggregate and no specific child will be identified.

Student's Name (or number) _____

School/Volunteer Site _____

Grade Level:
☐ TK ☐ K-3 ☐ 4-6 ☐ 7-9 ☐ 10-12 ☐ Other

Check Need:
☐ **Economically Disadvantaged**
☐ **Exceptional or Special Needs**
☐ **Both**

*I certify that I am qualified to attest to the needs described above or have consulted with or reviewed documentation prepared by an appropriate professional who verified the needs.

Supervisor/Teacher (print) _____

Supervisor/Teacher Signature _____ Date: _____

Section 1 Select the needs that best describe the reasons this child has been assigned to a Foster Grandparent for one-on-one mentoring and tutoring.

YOU MAY CHECK MORE THAN ONE BOX.

☐ Learning Disabilities	☐ Health Impairment
☐ Literacy Needs	☐ Hearing Impaired
☐ Language/Communication	☐ Visually Impaired
☐ Developmental Disabilities	☐ Speech Impaired
☐ Emotional/Social	☐ Substance Abuse
☐ Abused/Neglected	☐ Motor Skills
☐ Homeless	☐ Math/Logic
☐ Physically Challenged	☐ Academic Performance

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

	N/A	Weekly	2-3 times per week	Daily
Assist with cognitive activities				
Comfort/Communicate				
Model proper social skills				
Play games/puzzles				
Read or tell stories				
Assist with mobility				
Positive encouragement/redirection				
Share meals/help feed				
Help with schoolwork				
Assist with handwriting				

NAMI Santa Cruz County Connection Support Group Evaluation SurveyMonkey

K-12 Foster Grandparent Assignment Plan FY 20-21

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

Check the boxes to indicate which skills you expect the student to improve.

At least one ACADEMIC PERFOMANCE SKILL must be checked.

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

THIS SECTION TO BE COMPLETED IN THE SPRING.

	No Improvement	Some Improvement	Moderate Improvement	Significant Improvement	N/A
SOCIAL & EMOTIONAL DEVELOPMENT SKILLS					
☐ Developing & managing social relationships	☐	☐	☐	☐	☐
☐ Student's ability to exhibit self control	☐	☐	☐	☐	☐
☐ Students level of cooperation	☐	☐	☐	☐	☐
ACADEMIC PERFORMANCE SKILLS					
☐ Completion of assignments	☐	☐	☐	☐	☐
☐ Participation in the classroom	☐	☐	☐	☐	☐
☐ Interest in school	☐	☐	☐	☐	☐
LANGUAGE ARTS & LITERACY SKILLS					
☐ English language skills	☐	☐	☐	☐	☐
☐ Grade specific reading skills	☐	☐	☐	☐	☐
☐ Letter recognition, spelling, and writing ability	☐	☐	☐	☐	☐
LOGIC & MATH ABILITIES					
☐ Student's learning of general math skills	☐	☐	☐	☐	☐
☐ Student's understanding of grade specific math skills	☐	☐	☐	☐	☐
☐ Addition, subtraction, multiplication, or division skills	☐	☐	☐	☐	☐
SMALL & LARGE MOTOR SKILLS					
☐ Student's hand/eye coordination	☐	☐	☐	☐	☐
☐ Student's use of classroom supplies	☐	☐	☐	☐	☐
☐ Basic Writing and penmanship	☐	☐	☐	☐	☐

NAMI Santa Cruz County Connection Support Group Evaluation SurveyMonkey

Head Start & Pre-School — Foster Grandparent Assignment Plan — FY 20-21

It is a federal requirement that Foster Grandparents have an Assignment Plan (AP) for each child with whom they are assigned to work. The children must have a documented economic disadvantage and/or exceptional or special need, verified by an appropriate professional. The Foster Grandparent is assigned to your organization to provide one-on-one assistance based on need of selected children. The completed AP becomes the volunteer's "job description." The signature of the supervisor/teacher below signifies acceptance and approval of this AP.

Foster Grandparent (print) _____

Foster Grandparent Signature _____

Coordinator Signature _____

CONFIDENTIALITY: The Foster Grandparent Program recognizes and respects the confidentiality of all the children involved in the program. Please be assured that all the information that you provide will only be used in aggregate and no specific child will be identified.

Student's Name (or number) _____

School/Volunteer Site _____

Grade Level:

☐ Pre-School ☐ Head Start ☐ Other

Check Need:

☐ **Economically Disadvantaged**

☐ **Both**

☐ **Exceptional or Special Needs**

*I certify that I am qualified to attest to the needs described above or have consulted with or reviewed documentation prepared by an appropriate professional who verified the needs.

Supervisor/Teacher (print) _____

Supervisor/Teacher Signature _____ Date: _____

Section 1 Select the needs that best describe the reasons this child has been assigned to a Foster Grandparent for one-on-one mentoring and tutoring.

YOU MAY CHECK MORE THAN ONE BOX.

☐ Learning Disabilities	☐ Health Impairment
☐ Literacy Needs	☐ Hearing Impaired
☐ Language/Communication	☐ Visually Impaired
☐ Developmental Disabilities	☐ Speech Impaired
☐ Emotional/Social	☐ Substance Abuse
☐ Abused/Neglected	☐ Motor Skills
☐ Homeless	☐ Math/Logic
☐ Physically Challenged	☐ Academic Performance

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

	N/A	Weekly	2-3 times per week	Daily
Assist with cognitive activities				
Comfort/Communicate				
Model proper social skills				
Play games/puzzles				
Read or tell stories				
Assist with mobility				
Positive encouragement/redirection				
Share meals/help feed				
Help with schoolwork				
Assist with handwriting				

Head Start & Pre-School Foster Grandparent Assignment Plan FY 20-21

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

Check the boxes to indicate which skills you expect the student to improve.

At least one SOCIAL & EMOTIONAL DEVELOPMENT SKILL must be checked.

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

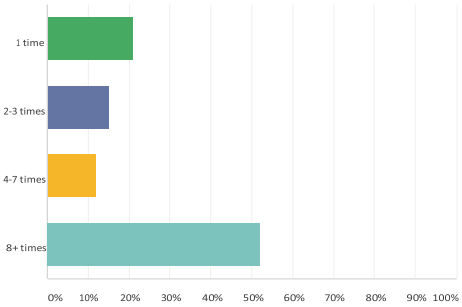
THIS SECTION TO BE COMPLETED IN THE SPRING.

	No Improvement	Some Improvement	Moderate Improvement	Significant Improvement	N/A
SOCIAL & EMOTIONAL DEVELOPMENT SKILLS					
☐ Developing & managing social relationships	☐	☐	☐	☐	☐
☐ Student's ability to exhibit self control	☐	☐	☐	☐	☐
☐ Students level of cooperation	☐	☐	☐	☐	☐
ACADEMIC PERFORMANCE SKILLS					
☐ Completion of assignments	☐	☐	☐	☐	☐
☐ Participation in the classroom	☐	☐	☐	☐	☐
☐ Interest in school	☐	☐	☐	☐	☐
LANGUAGE ARTS & LITERACY SKILLS					
☐ English language skills	☐	☐	☐	☐	☐
☐ Grade specific reading skills	☐	☐	☐	☐	☐
☐ Letter recognition, spelling, and writing ability	☐	☐	☐	☐	☐
LOGIC & MATH ABILITIES					
☐ Student's learning of general math skills	☐	☐	☐	☐	☐
☐ Student's understanding of grade specific math skills	☐	☐	☐	☐	☐
☐ Addition, subtraction, multiplication, or division skills	☐	☐	☐	☐	☐
SMALL & LARGE MOTOR SKILLS					
☐ Student's hand/eye coordination	☐	☐	☐	☐	☐
☐ Student's use of classroom supplies	☐	☐	☐	☐	☐
☐ Basic Writing and penmanship	☐	☐	☐	☐	☐

NAMI Santa Cruz County Connection Support Group Evaluation SurveyMonkey

Q1 How many times have you attended our Connection Support Group?

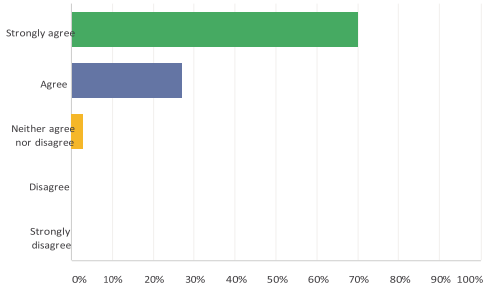
Answered: 100 Skipped: 2



ANSWER CHOICES	RESPONSES	
1 time	21.00%	21
2-3 times	15.00%	15
4-7 times	12.00%	12
8+ times	52.00%	52
TOTAL		100

Q2 This support group is helpful for me

Answered: 100 Skipped: 2

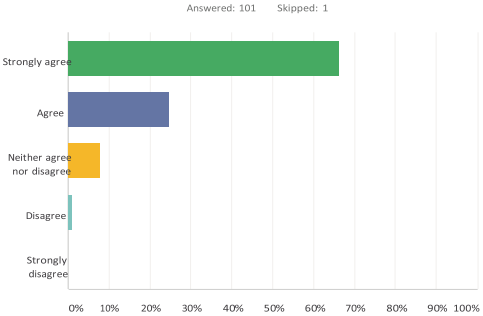


ANSWER CHOICES	RESPONSES	
Strongly agree	70.00%	70
Agree	27.00%	27
Neither agree nor disagree	3.00%	3
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		100

NAMI Santa Cruz County Connection Support Group Evaluation SurveyMonkey

Q3 This support group is an important part of my self-care

Answered: 101 Skipped: 1

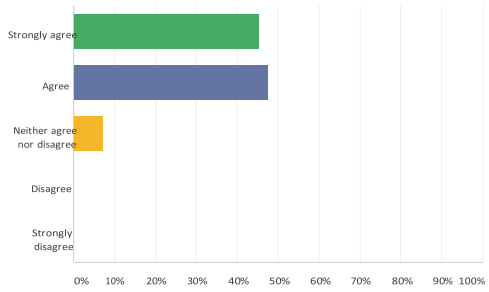


ANSWER CHOICES	RESPONSES	
Strongly agree	66.34%	67
Agree	24.75%	25
Neither agree nor disagree	7.92%	8
Disagree	0.99%	1
Strongly disagree	0.00%	0
TOTAL		101

NAMI Santa Cruz County Connection Support Group Evaluation SurveyMonkey

Q4 This support group gives me practical information to help me deal with my problems or challenges

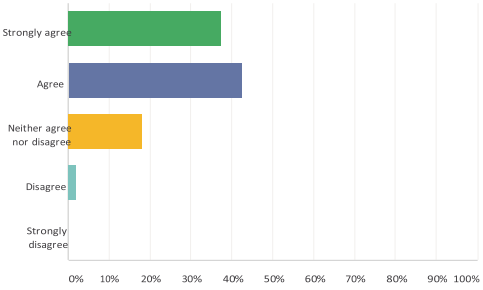
Answered: 99 Skipped: 3



ANSWER CHOICES	RESPONSES	
Strongly agree	45.45%	45
Agree	47.47%	47
Neither agree nor disagree	7.07%	7
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		99

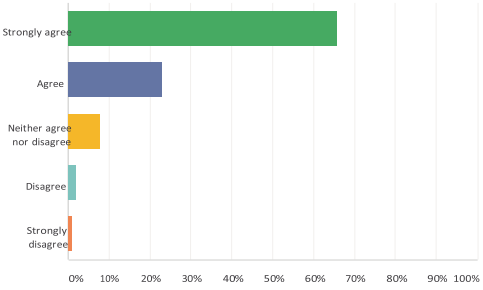
Q5 This support group gives me a better understanding of the resources available in my community

Answered: 99 Skipped: 3



Q7 The facilitators of this support group communicated effectively

Answered: 100 Skipped: 2

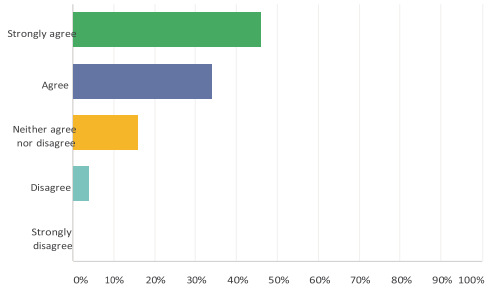


ANSWER CHOICES	RESPONSES	
Strongly agree	66.00%	66
Agree	23.00%	23
Neither agree nor disagree	8.00%	8
Disagree	2.00%	2
Strongly disagree	1.00%	1

ANSWER CHOICES	RESPONSES	
Strongly agree	37.37%	37
Agree	42.42%	42
Neither agree nor disagree	18.18%	18
Disagree	2.02%	2
Strongly disagree	0.00%	0
TOTAL		99

Q6 This support group has improved my ability to access and advocate for mental health services

Answered: 100 Skipped: 2

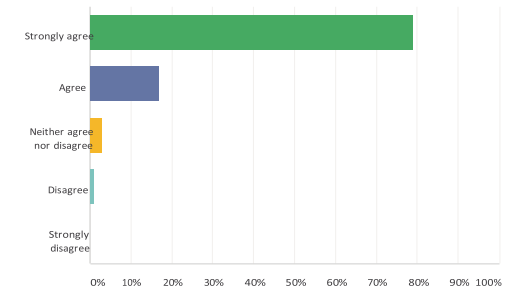


ANSWER CHOICES	RESPONSES	
Strongly agree	46.00%	46
Agree	34.00%	34
Neither agree nor disagree	16.00%	16
Disagree	4.00%	4
Strongly disagree	0.00%	0
TOTAL		100

TOTAL		100

Q8 I would recommend this program to others

Answered: 100 Skipped: 2



ANSWER CHOICES	RESPONSES	
Strongly agree	79.00%	79
Agree	17.00%	17
Neither agree nor disagree	3.00%	3

Disagree	1.00%	1
Strongly disagree	0.00%	0
TOTAL		100

Q9 How have NAMI Connection Support Groups affected your life?

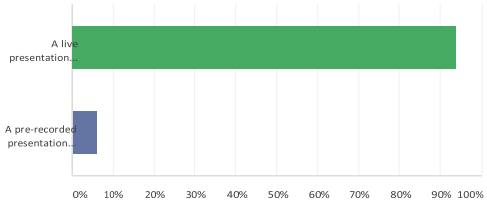
Answered: 79 Skipped: 23

Q10 If applicable, please share your thoughts with us regarding our new Friday evening support group. Has the switch from afternoon been helpful for you?

Answered: 20 Skipped: 82

Q1 I participated in Ending the Silence through

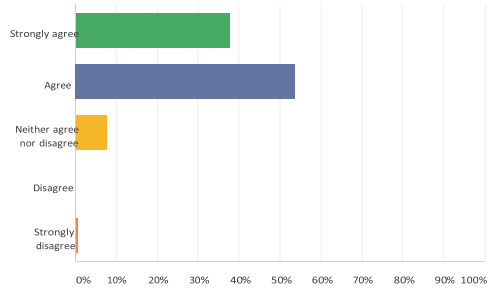
Answered: 652 Skipped: 4



ANSWER CHOICES	RESPONSES	
A live presentation via Zoom or other videoconferencing platform	93.87%	612
A pre-recorded presentation via the NAMI-SCC website	6.13%	40
TOTAL		652

Q2 As a result of this presentation, I know how to helpmyself or a friend if I notice any of the warning signs.

Answered: 641 Skipped: 15



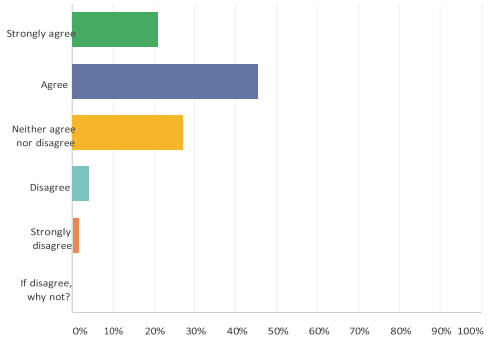
ANSWER CHOICES	RESPONSES	
Strongly agree	37.75%	242
Agree	53.67%	344
Neither agree nor disagree	7.64%	49
Disagree	0.31%	2
Strongly disagree	0.62%	4
TOTAL		641

SurveyMonkey

Ending the Silence Evaluation 2021

Q3 I feel more comfortable talking about mental health to a friend or trusted adult because of this presentation.

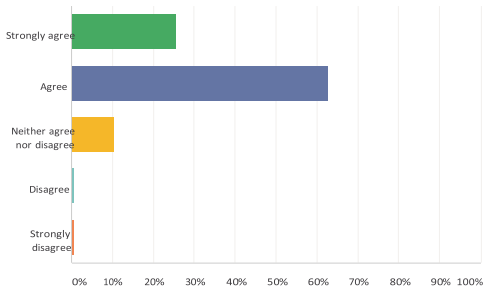
Answered: 641 Skipped: 15



ANSWER CHOICES	RESPONSES	
Strongly agree	21.06%	135
Agree	45.71%	293
Neither agree nor disagree	27.30%	175
Disagree	4.21%	27
Strongly disagree	1.72%	11
If disagree, why not?	0.00%	0
TOTAL		641

Q4 I learned about helpful tools and resources to support myself or a loved one with mental health concerns

Answered: 643 Skipped: 13

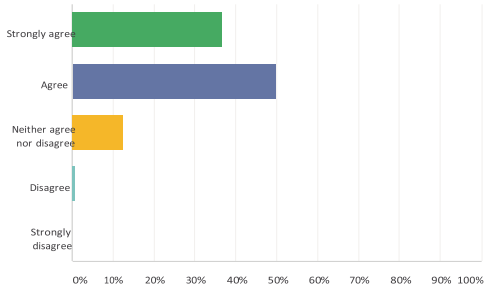


ANSWER CHOICES	RESPONSES	
Strongly agree	25.51%	164
Agree	62.83%	404
Neither agree nor disagree	10.42%	67
Disagree	0.62%	4
Strongly disagree	0.62%	4
TOTAL		643

SurveyMonkey

Q5 I would recommend this program to others

Answered: 642 Skipped: 14



ANSWER CHOICES	RESPONSES	
Strongly agree	36.76%	236
Agree	49.69%	319
Neither agree nor disagree	12.46%	80
Disagree	0.93%	6
Strongly disagree	0.16%	1
TOTAL		642

Q6 What will you do differently as a result of seeing this presentation?

Answered: 593 Skipped: 63

SurveyMonkey

Ending the Silence Evaluation 2021

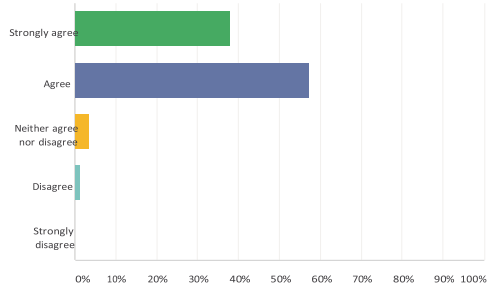
Q7 Any other comments?

Answered: 459 Skipped: 197

ETS Staff Evaluation

Q1 As a result of this presentation, I have a better understanding of my role in managing student mental health concerns

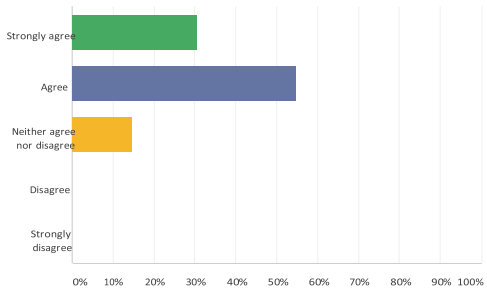
Answered: 82 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	37.80%	31
Agree	57.32%	47
Neither agree nor disagree	3.66%	3
Disagree	1.22%	1
Strongly disagree	0.00%	0
TOTAL		82

Q2 As a result of this presentation, I am better prepared to manage mental health challenges in my classroom

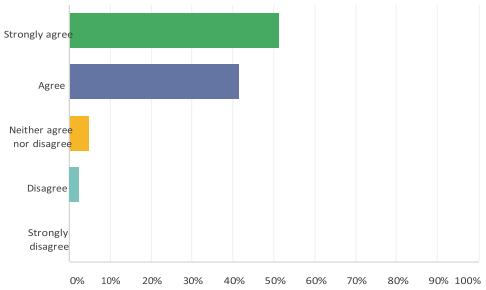
Answered: 82 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	30.49%	25
Agree	54.88%	45
Neither agree nor disagree	14.63%	12
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		82

Q3 I would recommend this program to others

Answered: 82 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	51.22%	42
Agree	41.46%	34
Neither agree nor disagree	4.88%	4
Disagree	2.44%	2
Strongly disagree	0.00%	0
TOTAL		82

Q4 What else would you have liked to know from this presentation?

Answered: 41 Skipped: 41

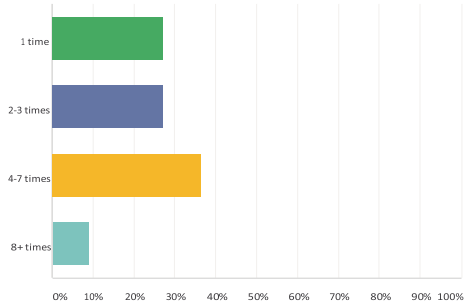
ETS Staff Evaluation

Q5 How has this presentation affected your understanding about mental health in the classroom?

Answered: 42 Skipped: 40

Q1 How many times have you attended our Family Support Groups?

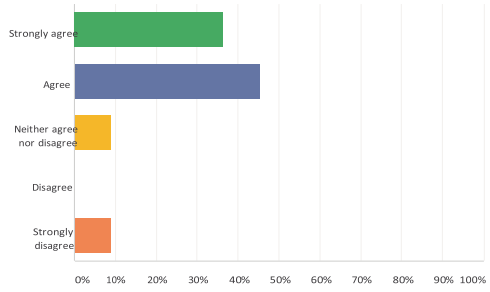
Answered: 11 Skipped: 0



ANSWER CHOICES	RESPONSES	
1 time	27.27%	3
2-3 times	27.27%	3
4-7 times	36.36%	4
8+ times	9.09%	1
TOTAL		11

Q2 This support group has produced positive changes in my life

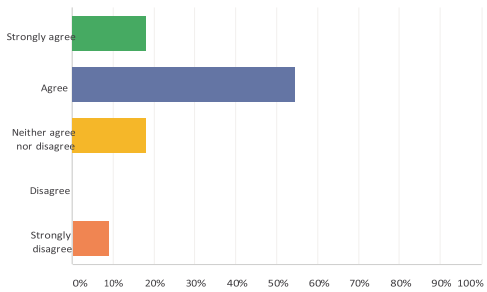
Answered: 11 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	36.36%	4
Agree	45.45%	5
Neither agree nor disagree	9.09%	1
Disagree	0.00%	0
Strongly disagree	9.09%	1
TOTAL		11

Q3 This support group is an important part of my self care

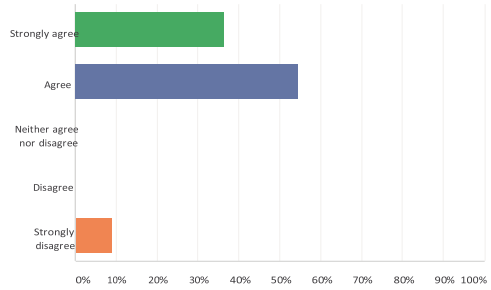
Answered: 11 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	18.18%	2
Agree	54.55%	6
Neither agree nor disagree	18.18%	2
Disagree	0.00%	0
Strongly disagree	9.09%	1
TOTAL		11

Q4 This support group gives me practical information to help support my family member

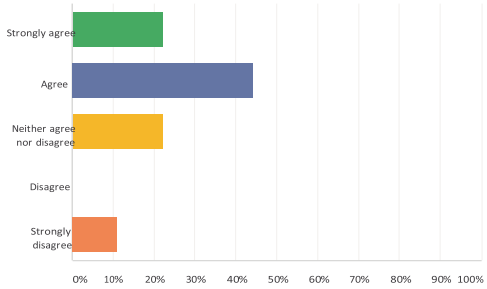
Answered: 11 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	36.36%	4
Agree	54.55%	6
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	9.09%	1
TOTAL		11

Q5 This support group has improved my ability to access and advocate for mental health services for my loved one

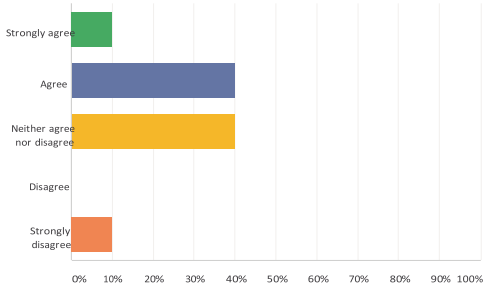
Answered: 9 Skipped: 2



ANSWER CHOICES	RESPONSES	
Strongly agree	22.22%	2
Agree	44.44%	4
Neither agree nor disagree	22.22%	2
Disagree	0.00%	0
Strongly disagree	11.11%	1
TOTAL		9

Q6 This support group has helped me improve my relationship with my loved one

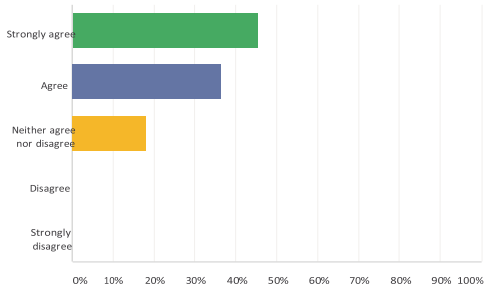
Answered: 10 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly agree	10.00%	1
Agree	40.00%	4
Neither agree nor disagree	40.00%	4
Disagree	0.00%	0
Strongly disagree	10.00%	1
TOTAL		10

Q7 The facilitators of this support group communicated effectively

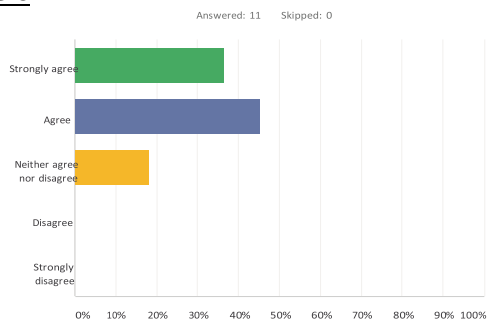
Answered: 11 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	45.45%	5
Agree	36.36%	4
Neither agree nor disagree	18.18%	2
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		11

Q8 I would recommend this program to others

Answered: 11 Skipped: 0



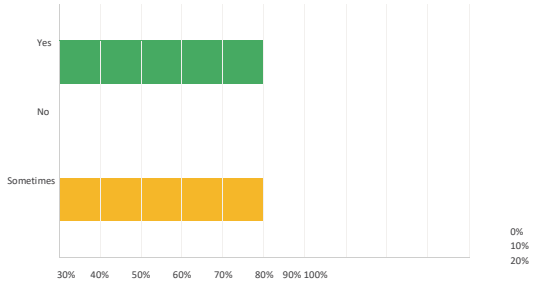
Q9 How have NAMI Family Support Groups affected your life?

Answered: 7 Skipped: 4

ANSWER CHOICES	RESPONSES	
Strongly agree	36.36%	4
Agree	45.45%	5
Neither agree nor disagree	18.18%	2
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		11

Q10 Are you able to join our groups on Thursday nights?

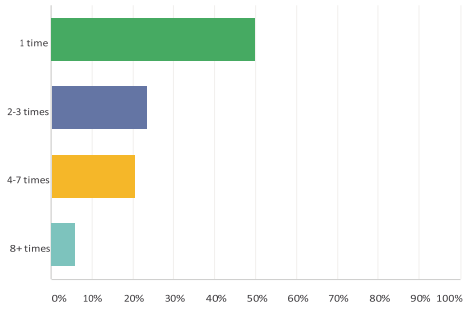
Answered: 4 Skipped: 7



ANSWER CHOICES	RESPONSES	
Yes	50.00%	2
No	0.00%	0
Sometimes	50.00%	2
TOTAL		4

Q1 How many times have you attended our Family Support Groups?

Answered: 34 Skipped: 0



ANSWER CHOICES	RESPONSES	
1 time	50.00%	17
2-3 times	23.53%	8
4-7 times	20.59%	7
8+ times	5.88%	2
TOTAL		34

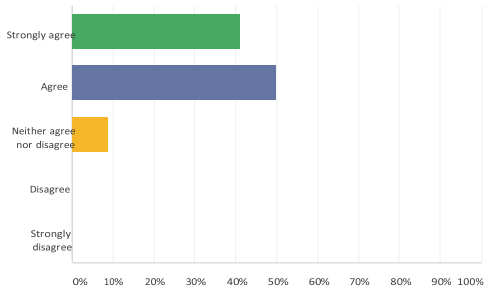
Q2 How did you hear about our support group? Please be as specific as possible.

Answered: 30 Skipped: 4

NAMI Santa Cruz County Parents/Caregiversbof Youth Support Group Evaluation SurveyMonkey

Q3 This support group has produced positive changes in my life

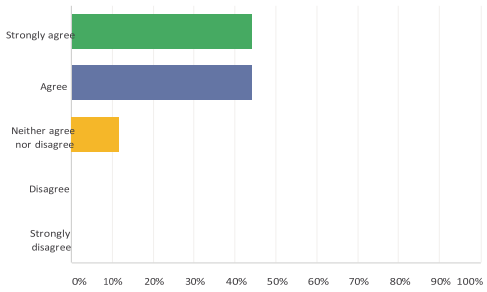
Answered: 34 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	41.18%	14
Agree	50.00%	17
Neither agree nor disagree	8.82%	3
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		34

Q4 This support group is an important part of my self care

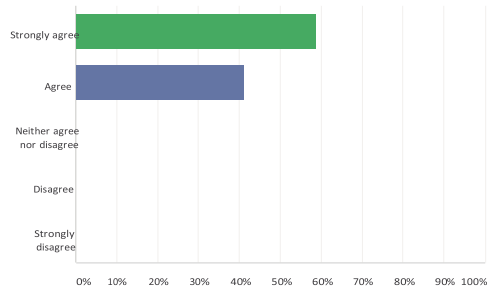
Answered: 34 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	44.12%	15
Agree	44.12%	15
Neither agree nor disagree	11.76%	4
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		34

Q5 This support group gives me practical information to help support my child/loved one

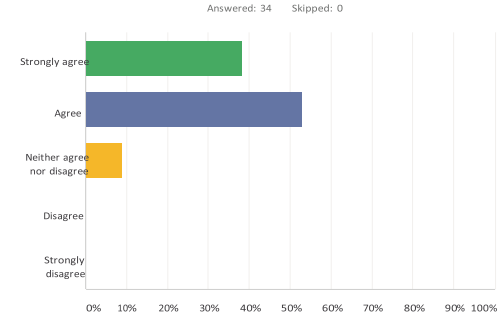
Answered: 34 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	58.82%	20
Agree	41.18%	14
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		34

Q6 This support group has improved my ability to access and advocate for mental health services for my loved one

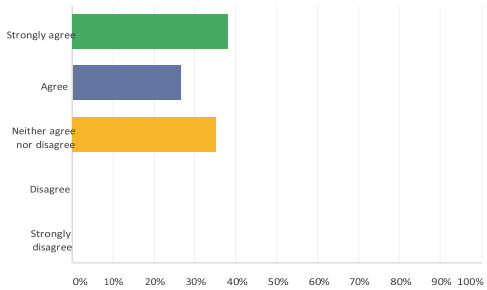
Answered: 34 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	38.24%	13
Agree	52.94%	18
Neither agree nor disagree	8.82%	3
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		34

Q7 This support group has helped me improve my relationship with my loved one

Answered: 34 Skipped: 0

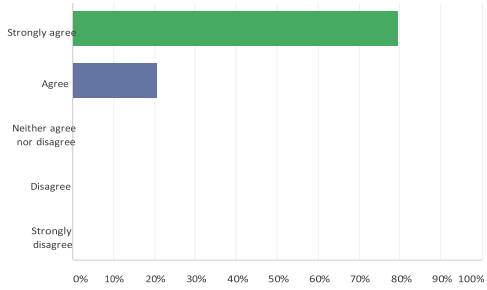


ANSWER CHOICES	RESPONSES	
Strongly agree	38.24%	13
Agree	26.47%	9
Neither agree nor disagree	35.29%	12
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		34

7 / 10

Q8 The facilitators of this support group communicated effectively

Answered: 34 Skipped: 0

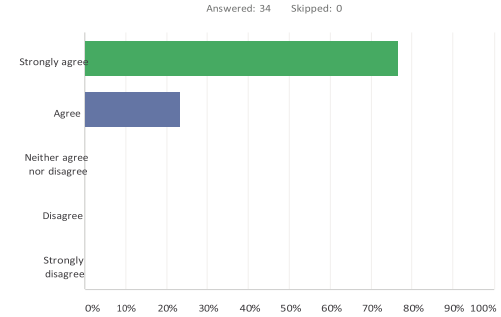


ANSWER CHOICES	RESPONSES	
Strongly agree	79.41%	27
Agree	20.59%	7
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		34

8 / 10

Q9 I would recommend this program to others

Answered: 34 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	76.47%	26
Agree	23.53%	8
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		34

9 / 10

Q10 How has this group affected your life?

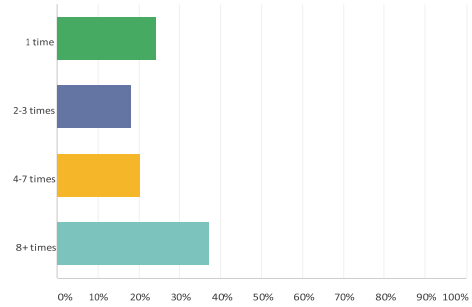
Answered: 27 Skipped: 7

10 / 10

Q1 How many times have you attended our Family Support Groups?

NAMI Santa Cruz County Parents/Caregiversbof Youth Support Group Evaluation SurveyMonkey

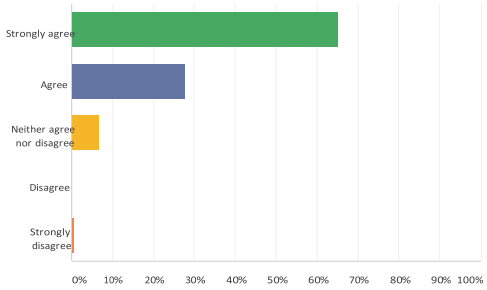
Answered: 148 Skipped: 3



ANSWER CHOICES	RESPONSES	
1 time	24.32%	36
2-3 times	18.24%	27
4-7 times	20.27%	30
8+ times	37.16%	55
TOTAL		148

Q2 This support group has produced positive changes in my life

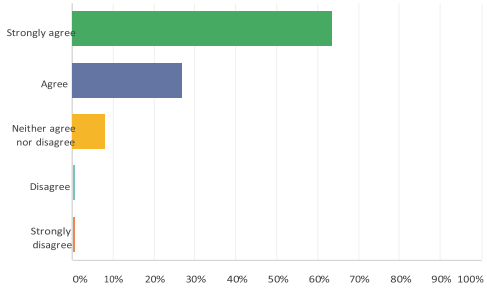
Answered: 149 Skipped: 2



ANSWER CHOICES	RESPONSES	
Strongly agree	65.10%	97
Agree	27.52%	41
Neither agree nor disagree	6.71%	10
Disagree	0.00%	0
Strongly disagree	0.67%	1
TOTAL		149

Q3 This support group is an important part of my self care

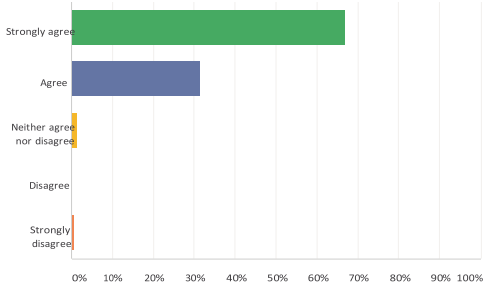
Answered: 148 Skipped: 3



ANSWER CHOICES	RESPONSES	
Strongly agree	63.51%	94
Agree	27.03%	40
Neither agree nor disagree	8.11%	12
Disagree	0.68%	1
Strongly disagree	0.68%	1
TOTAL		148

Q4 This support group gives me practical information to help support my family member

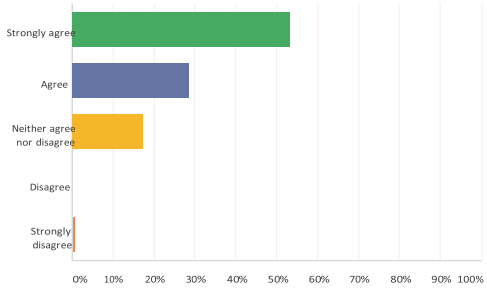
Answered: 150 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly agree	66.67%	100
Agree	31.33%	47
Neither agree nor disagree	1.33%	2
Disagree	0.00%	0
Strongly disagree	0.67%	1
TOTAL		150

Q5 This support group has improved my ability to access and advocate for mental health services for my loved one

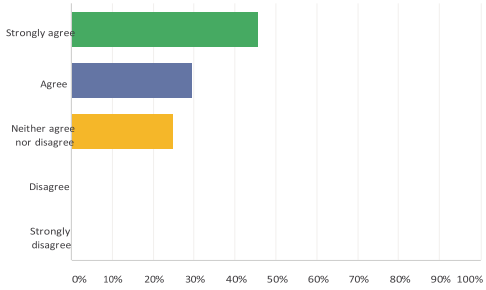
Answered: 150 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly agree	53.33%	80
Agree	28.67%	43
Neither agree nor disagree	17.33%	26
Disagree	0.00%	0
Strongly disagree	0.67%	1
TOTAL		150

Q6 This support group has helped me improve my relationship with my loved one

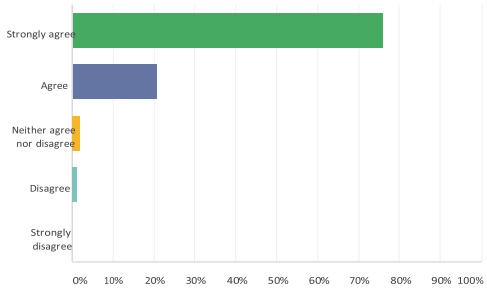
Answered: 149 Skipped: 2



ANSWER CHOICES	RESPONSES	
Strongly agree	45.64%	68
Agree	29.53%	44
Neither agree nor disagree	24.83%	37
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		149

Q7 The facilitators of this support group communicated effectively

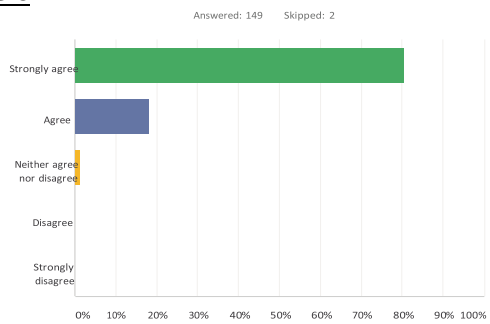
Answered: 150 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly agree	76.00%	114
Agree	20.67%	31
Neither agree nor disagree	2.00%	3
Disagree	1.33%	2
Strongly disagree	0.00%	0
TOTAL		150

Q8 I would recommend this program to others

Answered: 149 Skipped: 2



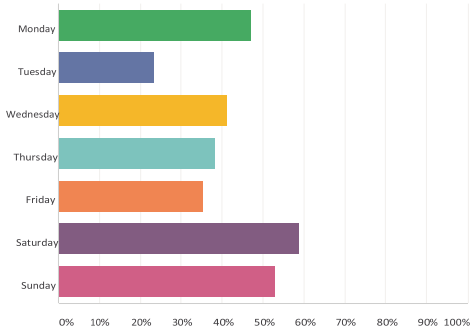
Q9 How have NAMI Family Support Groups affected your life?

Answered: 100 Skipped: 51

ANSWER CHOICES	RESPONSES	
Strongly agree	80.54%	120
Agree	18.12%	27
Neither agree nor disagree	1.34%	2
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		149

Q10 We are considering offering an in-person group in an outdoor space during the daytime. Which days of the week work best for you?

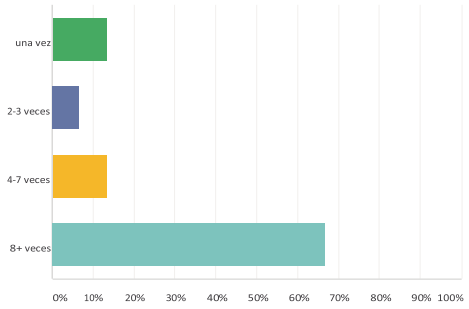
Answered: 34 Skipped: 117



ANSWER CHOICES	RESPONSES	
Monday	47.06%	16
Tuesday	23.53%	8
Wednesday	41.18%	14
Thursday	38.24%	13
Friday	35.29%	12
Saturday	58.82%	20
Sunday	52.94%	18
Total Respondents: 34		

Q1 ¿Cuántas veces ha asistido a nuestros Grupo de Apoyo para Familias?

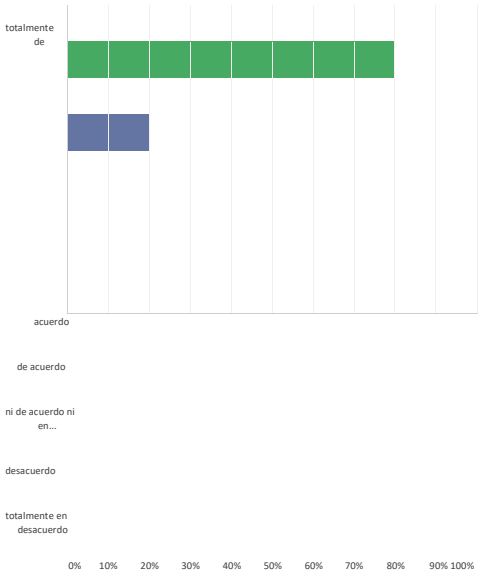
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
una vez	13.33%	2
2-3 veces	6.67%	1
4-7 veces	13.33%	2
8+ veces	66.67%	10
TOTAL		15

Q3 Este grupo de apoyo es una parte importante de mi autocuidado

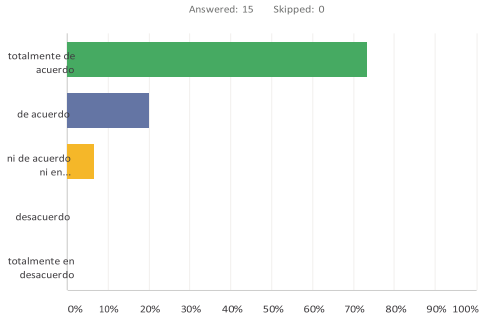
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
totalmente de acuerdo	80.00%	12
de acuerdo	20.00%	3
ni de acuerdo ni en desacuerdo	0.00%	0
desacuerdo	0.00%	0
totalmente en desacuerdo	0.00%	0
TOTAL		15

Q2 Este grupo de apoyo ha producido cambios positivos en mi vida

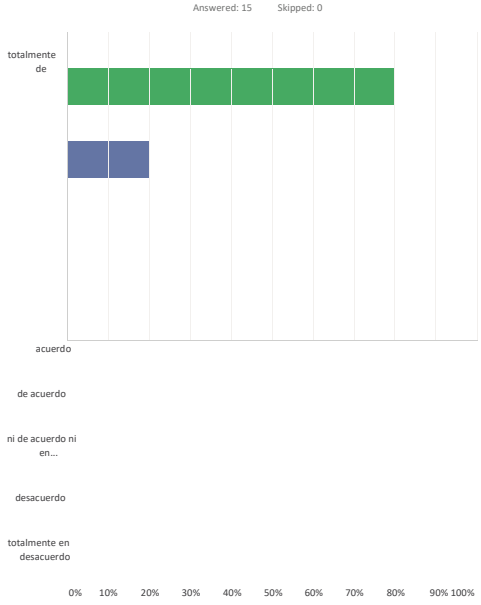
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
totalmente de acuerdo	73.33%	11
de acuerdo	20.00%	3
ni de acuerdo ni en desacuerdo	6.67%	1
desacuerdo	0.00%	0
totalmente en desacuerdo	0.00%	0
TOTAL		15

Q4 Este grupo de apoyo me da información práctica para ayudar a apoyar a mi familiar

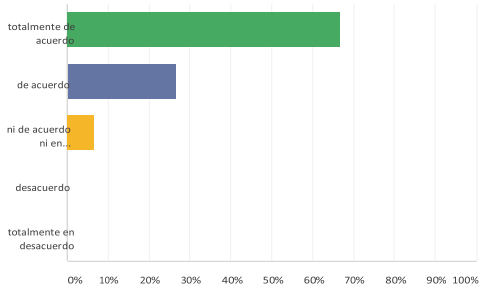
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
totalmente de acuerdo	80.00%	12
de acuerdo	20.00%	3
ni de acuerdo ni en desacuerdo	0.00%	0
desacuerdo	0.00%	0
totalmente en desacuerdo	0.00%	0
TOTAL		15

Q5 Este grupo de apoyo ha mejorado mi capacidad de obtener acceso y abogar por los servicios de salud mental para mi ser querido

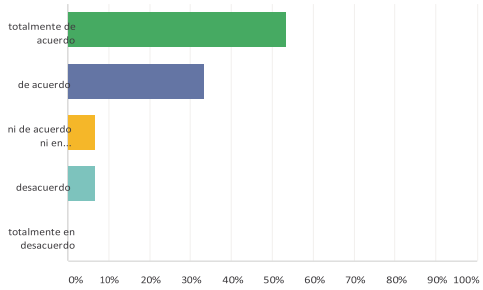
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
totalmente de acuerdo	66.67%	10
de acuerdo	26.67%	4
ni de acuerdo ni en desacuerdo	6.67%	1
Desacuerdo	0.00%	0
totalmente en desacuerdo	0.00%	0
TOTAL		15

Q6 Este grupo de apoyo me ha ayudado a mejorar mi relación con mi ser querido

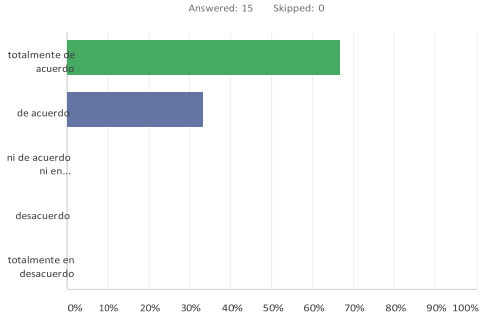
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
totalmente de acuerdo	53.33%	8
de acuerdo	33.33%	5
ni de acuerdo ni en desacuerdo	6.67%	1
desacuerdo	6.67%	1
totalmente en desacuerdo	0.00%	0
TOTAL		15

Q7 Los facilitadores de este grupo de apoyo se comunicaron efectivamente

Answered: 15 Skipped: 0



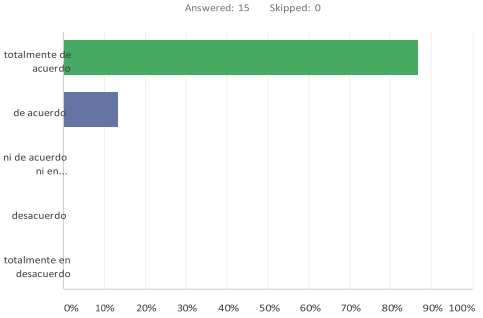
ANSWER CHOICES	RESPONSES	
totalmente de acuerdo	66.67%	10
de acuerdo	33.33%	5
ni de acuerdo ni en desacuerdo	0.00%	0
Desacuerdo	0.00%	0
totalmente en desacuerdo	0.00%	0
TOTAL		15

Q9 ¿algún otro comentario?

Answered: 12 Skipped: 3

Q8 Recomendaría este programa a otros

Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
totalmente de acuerdo	86.67%	13
de acuerdo	13.33%	2
ni de acuerdo ni en desacuerdo	0.00%	0
desacuerdo	0.00%	0
totalmente en desacuerdo	0.00%	0
TOTAL		15

Spanish Familia Survey Data
Fall 2021 Class

As a result of this class :	Totally Agree	Agree	don't agree or disagree	Disagree	strongly disagree
I am able to recognize the signs and symptoms of mental health conditions.	71%	29%	0%	0%	0%
I have a better understanding of which types of services a mentally ill person may need	57%	43%	0%	0%	0%
I have a better undrstanding of what it means to live in recovery as it relates to	86%	14%	0%	0%	0%
I am better prepared to manage a crisis that may result from mental health condition	71%	29%	0%	0%	0%
I am better equiped to handle the stress and negative impact caused by stigma	57%	43%	0%	0%	0%
I am better capable to access services and support my family or I may need	57%	43%	0%	0%	0%
Would recommend this class to others	86%	14%	0%	0%	0%

May share my story on Website, publication, etc. Yes 57% Yes, but change my name No 14%

Spring 2021 Class As a result of this class :	Totally Agree	Agree	don't agree or disagree	Disagree	strongly disagree
I am able to recognize the signs and symptoms of mental health conditions.	67%	33%	0%	0%	0%
I have a better understanding of which types of services a mentally ill person may need	67%	33%	0%	0%	0%
I have a better undrstanding of what it means to live in recovery as it relates to MH conditions	83%	17%	0%	0%	0%
I am better prepared to manage a crisis that may result from mental health condition	67%	17%	16%	0%	0%
I am better equiped to handle the stress and negative impact caused by stigma	67%	17%	16%	0%	0%
I am better capable to access services and support my family or I may need	50%	34%	0%	16%	0%
Would recommend this class to others	100%	0%	0%	0%	0%

May share my story on Website, publication, etc. Yes 50% Yes, but change my name 50%

Santa Cruz County Mental Health & Substance Abuse Services

Innovation Project: Integrated Health and Housing Support 2021-2022

Annual Target: 60

	Quarter 1 Jul. to Sept. 2021		Quarter 2 Oct. to Dec. 2021		Quarter 3 Jan. to Mar. 2022		Quarter 4 Apr. to Jun. 2022		Annual Unduplicated	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Unduplicated Client Count	113		111		109				128	
Gender Assigned at Birth										
Male	55	49%	59	53%	61	56%	-	-	64	50%
Female	58	51%	52	47%	48	44%	-	-	64	50%
Declined to State	0	0%	0	0%	0	0%	-	-	0	0%
Sexual Orientation										
Heterosexual or Straight	47	42%	49	44%	51	47%	-	-	55	43%
Gay or Lesbian	2	2%	1	1%	1	1%	-	-	2	2%
Bisexual	5	4%	5	5%	5	5%	-	-	6	5%
Queer	0	0%	0	0%	0	0%	-	-	0	0%
Questioning or Unsuare of Sexual Orientation	0	0%	0	0%	0	0%	-	-	0	0%
Another Sexual Orientation	0	0%	0	0%	0	0%	-	-	0	0%
Declined to State	59	52%	56	50%	52	48%	-	-	65	51%
Age										
0 Years to 5 Years	0	0%	0	0%	0	0%	-	-	0	0%
16 Years to 25 Years	1	1%	1	1%	0	0%	-	-	1	1%
26 Years to 59 Years	60	53%	58	52%	58	53%	-	-	64	50%
60 Years and Older	52	46%	52	47%	51	47%	-	-	63	49%
Declined to State	0	0%	0	0%	0	0%	-	-	0	0%
Ethnicity										
Hispanic or Latino	15	13%	15	14%	15	14%	-	-	17	13%
Not Hispanic or Latino	77	68%	77	69%	75	69%	-	-	86	67%
Declined to State	21	19%	19	17%	19	17%	-	-	25	20%
Race										
White	84	74%	82	74%	82	75%	-	-	95	74%
Hispanic or Latino	15	13%	15	14%	15	14%	-	-	17	13%
Black or African American	2	2%	3	3%	3	3%	-	-	3	2%
American Indian and Alaskan Native	0	0%	0	0%	0	0%	-	-	0	0%
Asian	9	8%	8	7%	8	7%	-	-	9	7%
Native Hawaiian and Other Pacific Islander	0	0%	0	0%	0	0%	-	-	0	0%
Other	3	3%	2	2%	1	1%	-	-	3	2%
Two or more Races	0	0%	0	0%	0	0%	-	-	0	0%
Declined to State	0	0%	1	1%	0	0%	-	-	1	1%
Language										
English	107	95%	106	95%	104	95%	-	-	122	95%
Spanish	3	3%	2	2%	2	2%	-	-	3	2%
Other	3	3%	3	3%	3	3%	-	-	3	2%
Veteran Status										
Yes	0	0%	0	0%	0	0%	-	-	0	0%
No	16	14%	18	16%	18	17%	-	-	20	16%
Declined to State	97	86%	4	4%	4	4%	-	-	108	84%

BUDGET

FY 2022-23 Mental Health Services Act Three-Year Plan
Community Services and Supports (CSS) Funding

County: Santa Cruz Date: 5/16/22

	Fiscal Year 2022/23			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated Other Funding
FSP Programs				
1. Community Gate	-	-	-	-
2. Probation Gate	-	-	-	-
3. Child Welfare Gate	-	-	-	-
4. Education Gate	-	-	-	-
5. Family Partnerships	-	-	-	-
6. Enhanced Crisis Response	1,816,065	882,238	751,652	182,175
7. Consumer, Peer, and Family Services	503,356	372,399	130,957	-
8. Community Support Services	13,140,697	9,482,933	3,521,019	136,745
Non-FSP Programs				
1. Community Gate	3,616,240	1,388,318	1,589,421	638,501
2. Probation Gate	374,619	192,843	181,776	-
3. Child Welfare Gate	1,922,905	448,907	934,052	539,946
4. Education Gate	346,454	131,284	166,756	48,414
5. Family Partnerships	199,683	11,024	99,525	89,134
6. Enhanced Crisis Response	2,825,912	1,637,959	1,106,396	81,557
7. Consumer, Peer, and Family Services	60,145	56,254	0	3,891
8. Community Support Services	2,464,998	1,813,047	454,901	197,050
CSS Administration	1,185,425	855,956	329,469	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-
Community Program Planning	14,400	14,400	-	-
Total CSS Program Estimated Expenditures	28,470,899	17,287,562	9,265,924	1,917,413
FSP Programs as Percent of Total	89.4%			

FY 2022/23 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Santa Cruz County Date: 05/16/22

	Fiscal Year 2022/23			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs				
1. Children's Services	1,147,605	707,454	354,121	86,030
2. Services for Diverse Communities	288,648	255,380	33,268	-
3. Transition Age Youth and Adult Services	4,028,706	3,531,767	496,939	-
4. Older Adult Services	47,863	47,863	-	-
5.				
6.				
PEI Administration	486,311	398,664	87,647	-
PEI Assigned Funds	-	-	-	-
Total PEI Program Estimated Expenditures	5,999,133	4,941,128	971,975	86,030

FY 2022/23 Mental Health Services Act Annual Update
Innovation (INN) Funding

County: Santa Cruz County Date: 2/28/22

	Fiscal Year 2022/23			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Program				
1. Healing the Streets	1,530,640	338,092	21,784	1,170,764
2.	-	-	-	-
3.	-	-	-	-
INN Administration	33,809	33,809	-	-
Total INN Program Estimated Expenditures	1,564,449	371,901	21,784	1,170,764

Mental Health Services Act 3-Year Expenditure Plan
2020-21 to 2022-23 Funding Summary

County Santa Cruz Updated: 5/16/22

	MHSA Funding				
	A	B	C	D	E
	Community Services and Supports	Prevention and Early Intervention	Innovation	Capital Facilities & Technological Needs	Prudent Reserve
A. Estimated FY 2020/21 Funding					
1. Estimated Unspent Funds from Prior Fiscal Years	2,066,623	2,327,542	278,954		
2. Estimated New FY2020/21 Funding	15,715,081	3,928,770	1,033,887		
3. Transfer in FY2020/21	-				
4. Access Local Prudent Reserve in FY2020/21	-	-			
5. Estimated Available Funding for FY2020/21	17,781,704	6,256,312	1,312,841		
B. Estimated FY2020/21 MHSA Expenditures	11,331,964	2,950,273	690,791		
C. Estimated FY2021/22 Funding					
1. Estimated Unspent Funds from Prior Fiscal Years	6,449,740	3,306,039	622,049		
2. Estimated New FY2021/22 Funding	17,326,232	4,331,558	1,139,884		
3. Transfer in FY2021/22	-	-	-		
4. Access Local Prudent Reserve in FY2021/22	-	-	-		
5. Estimated Available Funding for FY2021/22	23,775,972	7,637,597	1,761,933		
D. Estimated FY2021/22 Expenditures	13,784,038	3,777,529	581,674		
E. Estimated FY2022/23 Funding					
1. Estimated Unspent Funds from Prior Fiscal Years	9,991,934	3,860,068	1,180,259	-	
2. Estimated New FY2022/23 Funding	15,837,185	3,959,296	1,041,920	-	
3. Transfer in FY2022/23	(2,083,252)	-	-	2,083,252	
4. Access Local Prudent Reserve in FY2022/23	-	-	-	-	
5. Estimated Available Funding for FY2022/23	23,745,567	7,819,365	2,222,179	2,083,252	
F. Estimated FY2022/23 Expenditures	17,287,562	4,941,128	371,901	2,083,252	
G. Estimated FY2022/23 Unspent Fund Balance	6,458,305	2,878,237	1,850,278	-	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2022	2,997,367
2. Contributions to the Local Prudent Reserve in FY 2022/23	0
3. Distributions from the Local Prudent Reserve in FY 2022/23	0
4. Estimated Local Prudent Reserve Balance on June 30, 2023	2,997,367