COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

Santa Cruz County Behavioral Health is located on the unceded territories of the Amah Mutsun Tribal Band

County of Santa Cruz
Mental Health Services Act (MHSA)
FY 2023-2026 Three-Year Plan
& FY 2023-2024 Annual Update

Draft Issued: March 20, 2023

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FY 2023-2026 Three-Year Plan
&
FY 2023-2024 Annual Update

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

RDA CONSULTING

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

Message from the Mental Health Services Act Coordinator

The Santa Cruz Behavioral Health Services has completed a Draft of the FY 2023-26 Three-Year Program and Expenditure Plan of the Mental Health Services Act (MHSA/Proposition 63), as required under Welfare and Institutions Code Section 5847. This Plan covers fiscal years 2023-2026. This Plan is not intended as a binding contract with any entity or provider of services. Services will be monitored on a continual base, and the County may make changes, as necessary. These changes would be presented In the required Annual Update plans during the three-year period.

A draft plan Is posted for public comment from March 20, 2023, to April 20, 2023. A Public Hearing will be held during the Mental Health Advisory Board meeting on April 20, 2023, at 3pm at the Behavioral Health Services Building at 1400 Emeline Avenue-Room 206/207, Santa Cruz, 95060. The Public Hearing will be held in-person and virtually.

Following Public Hearing, the Plan will be submitted for review and approval to the Santa Cruz County Board of Supervisors for adoption, and then to the Mental Health Services Oversight Accountability Commission and the State Department of Health Care Services.

Community members may review the plan and provide comments in the following ways:

- At the Public Hearing on April 20, 2023
- 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: MHSA Coordinator
  1400 Emeline Street, Building K
  Santa Cruz, CA 95062

Sincerely,

Mental Health Services Act Coordinator

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MHSA County Fiscal Accountability Certification

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County/City: _____

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

Local Mental Health Director	**County Auditor-Controller/City Financial Officer**
Name:	Name:
Telephone Number: E-mail:	Telephone Number: E-mail:
Local Mental Health Mailing Address:	

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

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

_____ _____ _____
Local Mental Health Director (PRINT) Signature Date

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

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is an Annual Revenue and Expenditure report attached, is true and correct to the best of my knowledge.

_____ _____ _____
County Auditor Controller / City Financial Officer (PRINT) Signature Date

Santa Cruz County Overview

The County of Santa Cruz

Santa Cruz County is located at the northern tip of Monterey Bay, approximately 65 miles south of San Francisco, 35 miles north of Monterey, and 35 miles southwest of Silicon Valley. Santa Cruz County has a population of 267, 792.[1]

Its natural beauty is present in the pristine beaches, lush redwood forests, and rich farmland. It has an ideal Mediterranean climate with low humidity and sunshine 300 days a year. There are four incorporated cities in the County.[2] The largest is the City of Santa Cruz, with a population of 61,950. Watsonville has a population of 52,067 (notably, 84.3% of community members identify as Hispanic), Scotts Valley has 12,232 residents, and Capitola has 9,846 residents. Spanish is the only threshold language in Santa Cruz County.

There is a diversity of community members within the County; 56% identify as White/Caucasian, 34% Hispanic, 5% Asian, 4% Multiracial, 2% Native American, and 2% Black. Additionally, 18% of community members are foreign-born, 18% of residents are 65 years of age or older, and 18% of residents are under the age of 18. As of 2021, the County had a per capita personal income of $47,619, median income of $96,093, and a median value for single-family housing of $826,500.

The County of Santa Cruz Behavioral Health Services

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

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[1] United States Census Bureau, 2021 population estimates. https://www.census.gov/quickfacts/santacruzcountycalifornia

[2] County of Santa Cruz, About Santa Cruz County. https://www.co.santa-cruz.ca.us/AboutUs.aspx

SCBHS develops the Mental Health Services Act (MHSA) three-year plan and annual updates and provides program implementation and oversight. MHSA services are designed to address the most significant behavioral health needs of the county and to ensure services and access for all residents, with an emphasis and priority focus on serving individuals at highest risk for experiencing behavioral health service gaps and access barriers. This includes individuals who are experiencing homelessness, individuals that do not speak English as their primary language, community members of color, and low-income community members living in Santa Cruz County.

The Santa Cruz Mental Health Plan (MHP) serves racial and ethnic groups at rates relatively comparable to overall population demographics. However, when comparing MHP consumers against the Medi-Cal population, the MHP falls short in its service provision to residents who identify as Latino. The MHP serves residents who identify as Black and/or Asian at a rate comparable to their representation among Medi-Cal beneficiaries. Overall, however, individuals who identify as white are overrepresented as consumers of the MHP.

SCBHS, like many behavioral health and county government services, has experienced impacts in service delivery due to the COVID-19 pandemic. SCBHS has continued to see increased community need for behavioral health services, especially for serving Spanish speaking residents and individuals experiencing homelessness. There Is a need to serve these specific populations in more culturally informed ways with consideration to language and physical accessibility to services. There has also been increased need for preventive and early intervention services in the community across all population groups. Additionally, staff vacancies and long recruitment periods present ongoing challenges to SCBHS in addressing the increasing demand for supportive services and programs.

Project Overview

MHSA Background

The Mental Health Services Act (Proposition 63) was approved by California voters in 2004 to expand and transform the public mental health system. The MHSA requires that every three years, the entities that receive funding under MHSA must submit a plan that details the programs that will be administered using those funds. In addition to program details, entities are required to include budget projections as well as program updates with outcome measurement reports from the previous service year.

Three components of the MHSA focus on direct services:

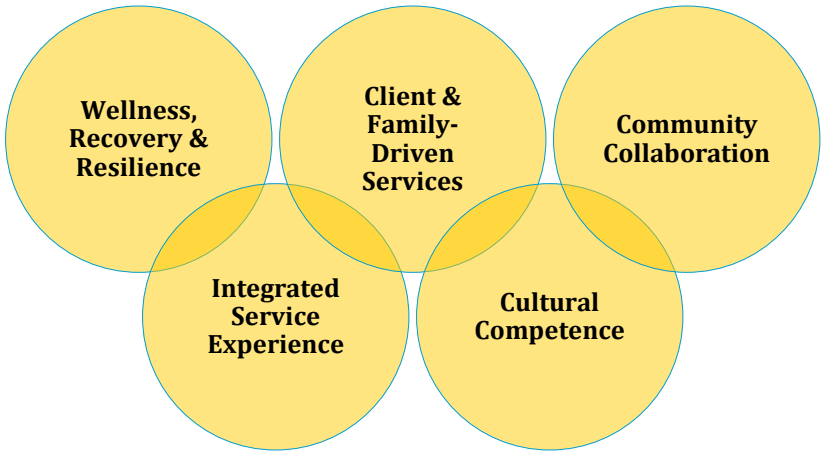
- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI); and
- Innovative Programs (INN).

The remaining two components focus on infrastructure and human resources:

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

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

Figure 1. MHSA Core Values



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

Three-Year Plan Contents

The MHSA Three-Year Program and Expenditure Plan for FY 2023-2026 outlines Santa Cruz County's proposed programs and strategies to address mental health service gaps and better meet identified community needs. The purpose of the Three-Year Plan is to provide a roadmap to program and service development and provision for the County and to ensure the community is engaged in both plan development and annual implementation. SCBHS will also be required to complete annual updates to this plan during the noted period. These annual updates will provide an opportunity for ongoing community engagement and timely identification of behavioral health needs within the County. This Three-Year Plan includes program status updates and accomplishments in FY 2021-2022 as well as program plans beginning in FY 2023-2024. These plans are based upon a community needs assessment and stakeholder input provided during a Community Program Planning Process (CPPP).

SCBHS contracted with Resource Development Associates (RDA) to facilitate CPPP activities and summarize information for this plan.

The Three-Year Plan includes the following sections:

- **Overview of the community program planning process** that took place in Santa Cruz County between February and March 2023.

- **Sharing of behavioral health needs identified through the CPPP** that identifies both strengths, challenges, gaps, and opportunities to improve the public behavioral health service system in Santa Cruz County.

- **Description of Santa Cruz County's MHSA programs** by component, which includes an explanation of each program, its target population, the behavioral health needs it addresses, and the goals and objectives of the program. This section of the plan also provides information on the expected number of unduplicated clients served and the program budget amount.

Community Program Planning Process (CPPP)

Overview

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

As a part of the Three-Year planning process, SCBHS convened a series of community meetings, surveys, and focus groups to inform program planning efforts and budget allocation. For the FY 23-26 Three-Year Plan, the majority of engagement events and meetings took place in a virtual format via Zoom. Additional information about the SCBHS CPP process is provided in the following sections—including CPPP methodology, CPPP activities, the Three-Year Plan review process, and stakeholder participation.

Due to staffing impacts and constraints as referenced in the introduction, the ongoing circulation of COVID-19 and other illnesses this winter, and significant inclement weather, the majority of engagement activities and events were provided in a virtual format. Supporting a virtual engagement period also allowed for further distribution of MHSA overview and training materials through posting to YouTube and social media sites. Outreach and promotion materials as well as engagement opportunities were supported in both English and Spanish.

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

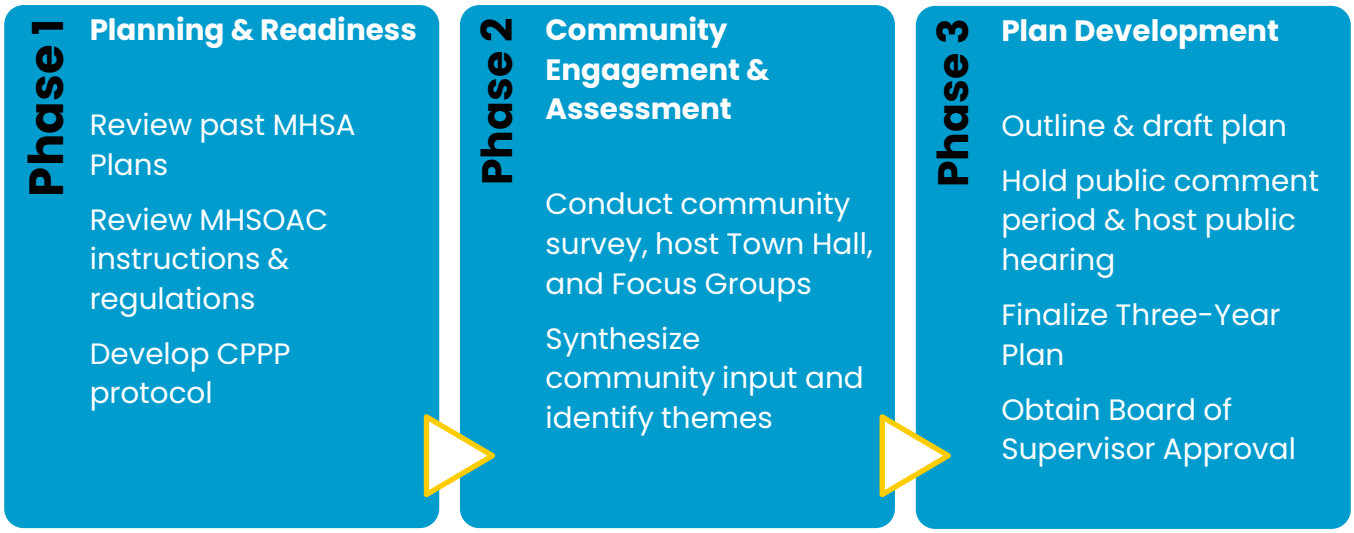
Methodology

In February 2023, SCBHS initiated the planning process for the MHSA Three-Year Plan for FY 2023 -2026. The MHSA Planning Team consisted of leadership

and service providers from SCBHS and RDA Consulting.

The planning team developed a community focused framework to engage with providers, consumers, and their families as well as the broader Santa Cruz community. The CPPP moved through three unique phases (Figure 2) to support development of the FY 2023-2026 Three-Year Plan.

Figure 2. Community Program Planning Process (CPPP)



CPPP Engagement Activities

SCBHS conducted community meetings and information-gathering activities to engage consumers, partners, and community members of the planning process to ensure that the plan reflects community experiences and suggestions.

Table 1. CPPP Activities, Dates & Participant Numbers

Activity	Date(s)	Participants
Community Survey	February 10 – 27, 2023	95
Town Hall & Listening Session	February 16, 2023	25
Focus Groups (5)	February, 2023	98
30-day Public Comment	March 20 through April 20, 2023	TBD
Public Hearing	April 20, 2023	TBD

Community Survey

RDA designed and administered a countywide survey to include input from a wide range of consumers, community members, and partners, particularly those unable to attend the community town hall or a focus group. The survey was open from February 10th through February 27th, 2023 and was available in both English and Spanish. This anonymous survey included both Likert-scale and open-text questions regarding respondents' experiences with MHSA services in Santa Cruz County, particularly how well SCBHS' MHSA-funded programs, services, and activities have been adapted to meet the community's mental health needs. The survey also included questions regarding respondent demographic characteristics and relationship to MHSA services to track and characterize community engagement. The survey was available online and promoted through posting to SCBHS' website, posted on the SCBHS Facebook page, and shared with MHSA partner listservs. Additionally, community partners including NAMI helped to further distribute the survey within the community.

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

Town Hall & Listening Session

SCBHS and RDA convened a virtual town hall and community listening session to gather input from providers and community members about their experiences with the behavioral health system and their recommendations for improvement. The town hall, hosted via Zoom, provided a platform to incorporate an MHSA training and educational overview for consumers, partners, providers and community in attendance. It also provided overviews of MHSA program areas and provided time for community discussion and for SCBHS & RDA to hear directly from those in attendance the strengths, opportunities for improvement and gaps in the current behavioral health system and programs for Santa Cruz County.

Meeting attendance was tracked by the number of Zoom participants. Participants were encouraged to complete a demographic survey that was provided at the beginning and end of the meeting period. In addition, the

recording was posted to the County's MHSA YouTube channel for continued promotion and access throughout the CPPP process.

Focus Groups

Focus groups were hosted to engage and hear directly from consumers, providers, and community partners. Five focus groups were conducted and were each approximately 1-hour in length. Four focus groups were conducted virtually, and one was conducted in-person (see Table 1 for additional details). Focus groups were promoted through the SCBHS website, Facebook page, and a flier was shared with community partners.

The five focus groups included:

- Behavioral health providers [virtual]
- Consumers & community members [2 virtual, 1 in-person at Mental Health Client Action Network (MHCAN)]
- Spanish speaking consumers & community members [virtual]

The topic areas captured through the focus groups included understanding the community need for behavioral health services, areas of strength of the current system and programs, sharing of experiences and areas for improvement within the current system and programs, as well as understanding what gaps in services and support there continue to be.

Individuals who participated in the consumer & community-based focus groups were provided a $35.00 gift card as a thank you for their time and contribution to planning efforts. Focus Group Protocols are included in Appendix A.

Local Review Process

Public Posting, Public Hearing, Public Comments

Following the Community Program Planning Process, a draft of the Three-Year Plan is to be posted publicly for 30 days for public comment, in accordance with MHSA regulations. During the 30-day public posting period and public hearing event, community members can provide public comment. After the

public comment period, the three-year plan will be updated to include public comments received and presented by the SCBHS team at a public hearing convened by the Local Mental Health Advisory Board (MHAB), scheduled for April 20, 2023, at 3:00 PM. Any comments from the public and the MHAB made during the 30-day public comment period or at the Public Hearing will be included in the Three-Year Plan as an appendix before the Final MHSA Three-Year plan is submitted and presented to the Board of Supervisors for approval.

CPPP Events Participation & Demographics

A total of 218 stakeholders participated in the needs assessment and CPPP activities during February 2023, including the community survey, community town hall and listening session, and community focus groups. Participation numbers likely represent duplicated individuals as individuals may have participated in more than one CPPP activity. The following sections report stakeholder affiliation and demographic characteristics of CPPP participants.

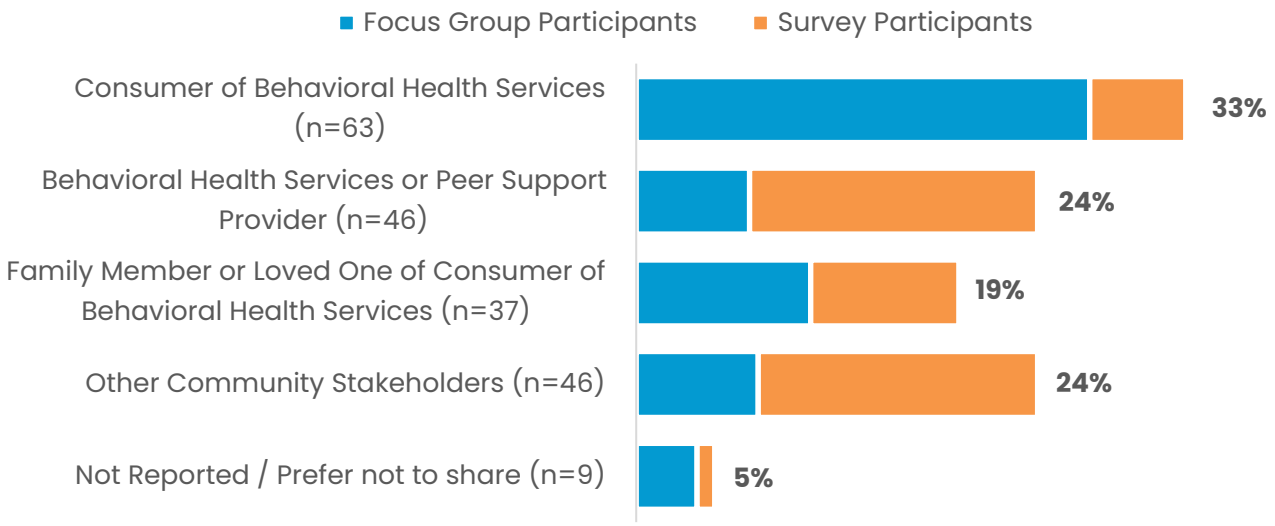
Stakeholder Affiliation of CPPP Participants

As part of the community survey and when registering or attending focus groups, participants were asked to report their relationship to SCBHS. Stakeholder affiliation was not collected for participants attending the town hall, resulting in the likely underreporting of some stakeholder groups. Stakeholder affiliation is reported below in Figure 3 for the 193-focus group and survey participants.

RDA and SCBHS engaged a wide range of stakeholder groups. Over half of stakeholders were former and current consumers of behavioral health services (33%) or family members and loved ones of consumers of behavioral health services (19%). One in five stakeholders (24%) were behavioral health service providers, including SCBHS Adult System of Care providers, Youth System of Care Providers, and Peer Support Providers. One-quarter of stakeholders (24%) were other community stakeholders, representing non-behavioral health service providers, county or community-based agencies, other community groups—including social services providers, medical and health service providers, education providers, veterans' service providers,

board and care providers, consumer advocates, and other interested community members. Stakeholder affiliation was not reported by 5% of focus group and survey participants. Detailed information about stakeholder affiliation for community survey and focus group participants is available in the Appendix B.

Figure 3. Stakeholder Affiliation of Community Focus Group and Survey Participants (N=193)[3]



Demographic Characteristics of CPPP Participants

During each activity, participants were asked to fill out an optional, anonymous demographic form. Demographic forms were partially or fully completed by 100% of survey participants (N=95), 100% of MHCAN focus group participants (N=37), and 38% of individuals (N=33) participating in the community town hall and virtual focus groups (i.e., provider focus group, Spanish community focus group, and general community focus groups).

Demographic data limitations. The low demographic form completion rate among town hall and virtual focus group participants likely owed to the virtual platform, wherein participants were given the link to the demographic form at the start and end of the discussion and asked to complete the optional

[3] Stakeholder affiliation sums to greater than 100% as some participants identified with multiple stakeholder groups.

demographic form at their convenience. In contrast, the MHCAN focus group was held in-person and participants were asked to complete a demographic form as they signed in. The community survey included the demographic form at the end of the survey. The MHCAN focus group also used a condensed version of the demographic form asking only age, gender identity, and race/ethnicity. Given the differences in demographic form completion and demographic information collected across CPPP activities, demographics are reported separately for community survey participants, town hall and virtual focus group participants, and MHCAN focus group participants. More detailed information demographic information is available in Appendix B.

Demographic characteristics.

Demographic characteristics collected across all CPPP activities (i.e., age, gender identity, and race/ethnicity) CPPP participants are reported in Table 2. Most participants were adults (ages 26-59) Nearly two-thirds of survey participants were female, and one-third were male. In comparison, nearly two-thirds of MHCAN participants were male and one-third were female. Most participants identified their race as White.

Table 2. Selected Demographic Characteristics of CPPP Participants, by CPPP Activities[4]

Demographic Characteristic		Community Survey N (%)	MHCAN Focus Group N (%)	Town Hall & Community Focus Groups N (%)
Age Group	Transition Age Youth (16-25)	9 (9%)	1 (3%)	9 (10%)
	Adults (26-59)	66 (69%)	28 (76%)	20 (23%)
	Older Adults (60+)	19 (20%)	8 (22%)	4 (5%)
	Unknown / Not reported	--	--	53 (62%)
Gender Identity	Female	58 (61%)	11 (30%)	14 (16%)
	Male	30 (32%)	23 (62%)	18 (21%)
	Another Gender Identity	2 (2%)	3 (8%)	--

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

	Unknown / Not Reported	5 (5%)	--	54 (63%)
Race / Ethnicity	White / Caucasian	68 (72%)	23 (62%)	19 (22%)
	Hispanic / Latinx	29 (31%)	5 (14%)	11 (13%)
	Black / African American	8 (8%)	7 (19%)	16 (19%)
	Another Race / Ethnicity	10 (4%)	2 (5%)	1 (1%)
	Unknown / Not Reported	11 (12%)	--	54 (63%)
TOTAL PARTICIPANTS		**95**	**37**	**68**

Community Program Planning Process (CPPP) Findings

This section presents strengths, needs, and services of Santa Cruz County's MHSA programming that were identified through the community program planning process. This section is divided into themes related to the following areas of focus:

- **Community Survey** (Likert-scale questions & themes summary); this section is further divided into themes related to the following areas of focus:
    - SCBHS Services Provided
    - Access to SCBHS Services
    - Experience with SCBHS Services

- **Qualitative Data Findings** (Town Hall, Focus Groups & open-ended Survey responses); this section is further divided into themes related to the following areas of focus:
    - Behavioral Health System & Service Strengths
    - Behavioral Health System & Service Challenges
    - Behavioral Health System & Service Gaps
    - CPP Process Identified Recommendations

Community Survey

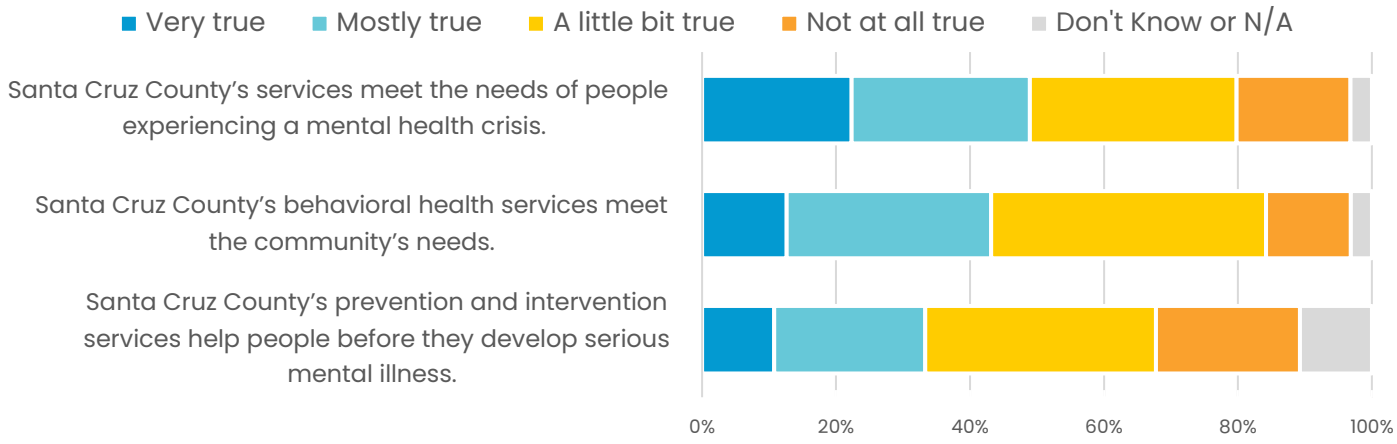
As mentioned, 95 individuals participated in the community survey. The community survey included 12 Likert-scale questions, where participants were asked to rate how true various statements were regarding participants' experiences with MHSA services in Santa Cruz County. Likert-scale responses included Very true, Mostly true, A little bit true, Not at all true, or Do not know /

not applicable. The survey also included 5 open-ended questions, which were analyzed as qualitative data for key themes along with information gathered through the town hall and focus groups.

SCBHS Services Provided

Survey participants responses about how well SCBHS services meet the community's needs are summarized in **Figure 4**. Less than half of participants (43%, n=41) felt SCBHS services are meeting the community's needs overall. In particular, most participants (56%, n=52) felt that it was a little bit or not at all true that SCBHS prevention and early intervention services help individuals before they develop serious mental illness. Additionally, about half of participants (48%, n=45) felt it was a little bit or not at all true that SCBHS services meet the needs of people experiencing a crisis.

Figure 4. Community Survey Responses about SCBHS Services Provided (N=95)

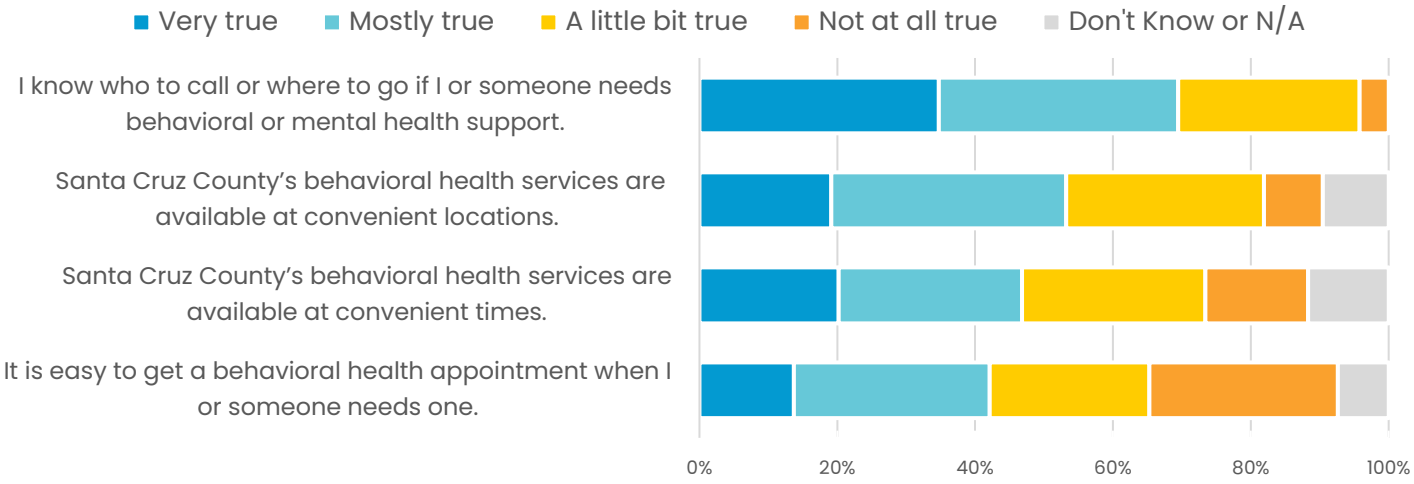


Access to SCBHS Services

Survey participants responses about how ease of accessing SCBHS services are summarized in **Figure 5**. The majority of participants (69%, n=66) reported they knew where to go or who to call to access services if they or someone needs mental health support. Participants' perceptions of accessing services were more varied. About half of participants felt services were generally available at convenient locations (53%, n=50) and at convenient times (47%,

n=44). Additionally, 51% of participants (n=48) felt it was a little bit or not at all true that it is easy to get a behavioral health appointment when needed.

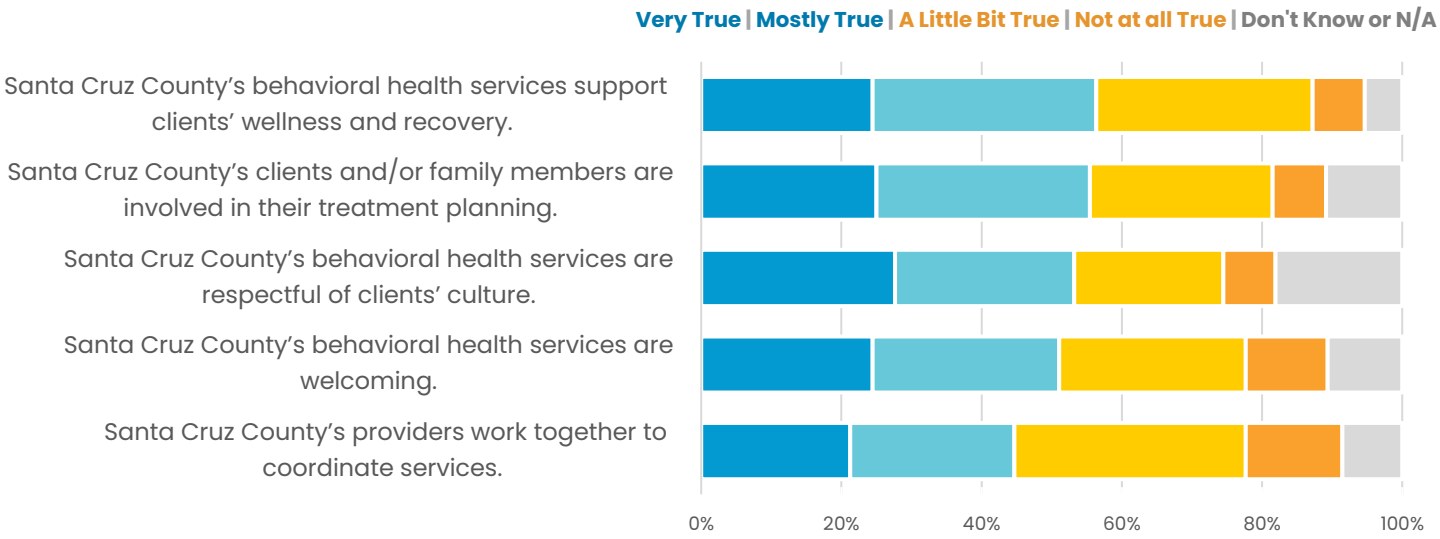
Figure 5. Community Survey Responses about Access to SCBHS Services (N=95)



Experience with SCBHS Services

Survey participants responses about their overall experience with SCBHS services are summarized in **Figure 6**. Overall, about half of participants felt that SCBHS services support clients' wellness and recovery (56%, n=53), clients and/or their families are included in treatment planning (55%, n=51), services are respectful of clients' culture (53%, n=50), and services are welcoming (51%, n=48). However, behavioral health providers and consumers or consumers' family members and loved ones had different perceptions of SCBHS service experiences. In general, approximately 40-50% of consumers and family members or loved ones reported services support clients' wellness and recovery, are welcoming, respect clients' culture, and include clients in treatment planning, compared to 60-70% of providers. Perceptions about service coordination were also mixed, with 45% of stakeholders (n=42) reporting it is very or mostly true that providers work together to coordinate services, while 47% (n=44) felt this was a little bit or not at all true.

Figure 6. Community Survey Responses about the Experience with SCBHS Services (N=95)



Qualitative Data Findings

As previously mentioned, a total of 218 stakeholders participated in CPPP activities during February 2023, including the community survey, community town hall and listening session, and community focus groups. The following section provides reporting on themes shared by providers, partners, consumers, and community members during all CPPP activities and are organized by strengths, challenges, identified service gaps and recommendations for improvement and meeting of community needs.

Behavioral Health System & Service Strengths

Community members viewed the quality, approach, and abundance of staff and providers as a key strength of the County's system of care. Providers and staff were frequently described as helpful, caring, kind, compassionate, and welcoming to behavioral health consumers, with specific praise given to their "quality of care and attention", providing a "family kind of feel", and "centering the person." Community members also lauded the system of care staff for their knowledge and experience, with "well-trained clinicians" supporting "high quality" behavioral health services that meet the needs of consumers. Some community members and providers found the system to have enough existing and available staff and providers, such as "an abundance of psychiatrists at the specialty mental health level." With respect to strengths of staff approach to consumer care, several community members shared personal knowledge or experiences about the cultural responsivity within the behavioral health system of care.

> "One of the things that has helped me keep participating is the therapist I was assigned to, that he was from the same racial background, and he was really helpful and never criticized me. It kept me there and made me want to finish the program."
> -Community Focus Group Attendee

Many community members and several providers described County behavioral health services as easily accessible, with a "robust network" of options that provide timely care and are well-known within the community. Members shared that a range of service options provided consumers with choices about where to obtain the care needed and at varying levels of care. Crisis lines, substance abuse treatment, and services for homeless populations were among those cited as having "plenty of options available" within the County. Several community members and providers described providers as accommodating, affordable, and timely, citing elements

> "It's wonderful that there is an accessible County Behavioral Health presence in both North and South Counties, and that there is a Monday through Friday service to get assessed and connected to services."
> -Community Survey Respondent

such as walk-in hours, flexible and quick scheduling, and low or no cost services as facilitating increased access to needed care. Likewise, several consumers praised the County system for providing "good outreach" and generating awareness of available services, including distribution of resource pamphlets "that are convenient for social service providers and people on the streets."

Service providers and community members also cited communication and collaboration as a strength within the system of care, particularly among behavioral health providers, the County, cities, and other local systems (e.g., law enforcement), as well as with consumers and families. Providers described positive collaborations between County behavioral health and specialty mental health, as well as with nonprofits such as NAMI. Providers also demonstrated ways in which communication between providers and the community has addressed local service gaps, citing the development of the Mobile Emergency Response Team for Youth (MERTY) as a primary example.

"Santa Cruz city and County is a good size for relational collaboration. [They] have relationships with each other as providers [and] work together with the County on projects and clients. The County size facilitates good relationships with the County and providers."
-Provider Focus Group Attendee

"I went with a friend of mine to HPHP to get services, and the care coordination between his PCP and his psychiatrist was great. I really appreciated that they know each other, they talked. The care and comfort they were trying to give him to help the client could express himself and figure out a way to get his needs met."
-Community Focus Group Attendee

Community members also witnessed communication and care coordination across providers and between providers and consumers, noting that providers have "good relationships with patients" and that "clients and family members are involved in their treatment planning." Cross-system coordination between County behavioral health and law enforcement in addressing crisis response was cited as another example of strong collaboration within the system of care, with one individual noting, "that partnership is important to me as a community member."

Throughout the community engagement period, community members, consumers, and providers frequently highlighted several specific programs by name as key strengths within the County system of care. Most frequently, individuals praised MHCAN for providing basic needs and supportive services within the community (e.g., food, hygiene, transportation, support groups), with some describing it as a "core" County resource that also offers "community and family" for those in need. Consumers and providers also praised MERT and MERTY for their emergency response coordination for adults and youth, Healing the Streets and the Homeless Persons Health Project (HPHP) for their focused support of unhoused populations, and NAMI for its education support, community, and resources to consumers and families. Several individuals also expressed appreciation for the County's crisis services, prevention and intervention services, and mental health hotline/helplines.

"MCHAN is a soft place to fall. The support groups gave me the confidence to continue and not give up."
-Community Focus Group Attendee

"MERT and MERTY have provided significant help to families that helps avoid police response"
-Town Hall Attendee

"NAMI does wonderful work to educate families about mental illness and helping their children"
-Town Hall Attendee

Behavioral Health System & Service Challenges

Many **community members expressed challenges accessing services**, some due to lack of awareness of what services are available, as well as how to obtain them. Many providers, especially those who are private providers contracted with the county, expressed that they were not aware of the full network of services that are available, and that there is some lack of clarity about what is available and what the requirements are for certain services, as well as who the correct person to contact is. Some respondents connected the long wait lists for services to an **increased need for mental and behavioral health care in the county**, especially in recent years.

"[There is a] lack of communication regarding available services. I did not know there were services available and spent months trying to find a provider for my child."
- Community Survey Respondent

"I work with conserved clients…I do not have a good understanding of all services provided in the county. Partnering with all facilities of all levels with the information of services provided could be very beneficial. Educating more people/places may increase use of services."
- Community Survey Respondent

"At some point it was difficult for me to access services because of my daily activities… Going work every day without seeing my mental health provider"
- Community Focus Group Attendee

"There are a lot of people who need services, but then most of them don't have medical insurance, and can't afford it, especially for people with the heaviest mental issues. If they are aware/able to accommodate these people, that would be great." - Community Focus Group Attendee

Even once they were aware of what services are available, community members shared challenges accessing those programs or providers. Many consumers and family members, as well as other providers, came across **long wait lists to get into services through the county**. Once past the wait lists, many consumers encountered other barriers such as **transportation to offices, difficulties accessing virtual services, or lack of insurance or financial means to pay for services**. Some

community members noted that some of those with the least amount of financial resources are often those who need services the most.
Some community members identified **specific populations in the county who experience unique needs and barriers, such as people experiencing homelessness or housing insecurity, low-income individuals and families, and people with serious mental illness**. For those who are unhoused, there is a recognized need to focus on meeting basic needs, such as housing in the long term, and access to bathroom, for example, in the short term, before they can address their mental health needs. For low-income individuals and families, basic needs such as rent, food, and utilities may take precedence over care for their mental health. For people with serious mental illness, a lack of enough beds in higher-level care facilities can lead to a "revolving door of insecurity for SMI, Including jail and street life." Additionally, community members identified "stigma or unpleasant past experiences with mental health" as a major challenge for many people to access mental health services.

"Lack of awareness, social stigma, cost, and limited access are some of the most prominent factors standing in the way of people pursuing mental health treatment. High cost and insufficient insurance coverage, underfunding."
- Community Focus Group Attendee

It is crucial to have appropriate levels of care available when and where they are needed. Many community members identified a **need for more comprehensive crisis services in Santa Cruz County**. These include the mobile crisis response services, as well as the Acute Psychiatric Health Facility.

"[The county's] crisis response is too narrow in scope, does not operate 24/7 like CAHOOTS, does not come to people's homes where they are most likely to have a crisis, still includes police which puts people at serious risk of harm or death, and even when a mental health liaison is requested explicitly, they too often come late, *after* police arrive, or not at all."
- Community Survey Respondent

"[A contracted-provider] remains a concern for those of us who know someone who has experienced it firsthand. The level of expertise and professionalism exhibited there is below the standards we should accept as a community. Better oversight is needed."
- Community Survey Respondent

Many respondents called for the mobile crisis response service to be available 24 hours a day instead of its current hours and requested that it not be tied to law enforcement, as that can be a barrier to accessing care. The acute psychiatric health facility is currently run by a contracted provider, and many community members and providers expressed concern with the way that it is currently being managed as well as its lack of capacity. Some people expressed a preference for a nonprofit provider for these acute care services.

Community members and providers alike shared concerns about **staffing shortages throughout the county system of care**, including psychiatrists, therapists, counselors, and specialty mental health case managers. Some respondents also noted a high turnover rate for staff and providers. This shortage of providers leads to longer wait times, and high turnover rates pose a further challenge to clients' continuity of care. Providers also noted that longer wait times can lead to further decline in clients' mental health, therefore leading to the need for a higher level of care. While this poses a challenge for consumers, it is also a challenge for providers, as they have to take on larger caseloads and are not able to provide the quality of care that they would prefer. Though many community members had wonderful experiences with providers, some shared difficult experiences with staff, such as the administrative personnel who take calls and make appointments. Additionally, some clients called for additional and continued training of providers, especially in areas such as cultural competency and trauma-informed care.

"The staff shortages and turnover, it affects client's continuity of care; we work so hard to build that relationship and turnover makes it hard for clients to receive the same level of care."
- Provider Focus Group Attendee

"In particular, there is a shortage of psychiatrists and therapists in the county. The nearest psychiatrist is over an hour away, and many people who need therapy have to wait months for an appointment."
- Community Survey Respondent

Another challenge raised by both community members and providers was a lack of coordination and communication among providers, between providers and clients, and between providers and other local systems. Clients noted that there are many occasions when it felt like their providers

were not communicating with each other, or "like some information is hidden from" them. Clients also expressed challenges with providers' follow through on referrals to other providers or services. Providers expressed a lack of coordination with other county systems, such as law enforcement or the jail. One provider noted that there is lack of coordination between services, post-incarceration, post-psychiatric health facility or community support program, or while at shelters. A lack of warm handoff to therapists, outpatient providers, and ensuring a sufficient amount of medications until a pharmacy is open

"When I have been trying to work with behavioral health team members that are less communicative it has been incredibly challenging to obtain the services and support needed for our clients.... Attempting to navigate county services without support or referrals often is incredibly difficult and time consuming."
- Community Survey Respondent

"There are various groups that are working on behavioral health in Santa Cruz County, but many don't know about each other--committees trying to reinvent the wheel every time a new one starts, and we need some kind of common communication platform--so we all see each other's meeting information--times, dates, minutes, projects, representatives, etc. to make some headway on the basic needs of the community--which are not being met."
- Community Survey Respondent

can pose challenges to clients' continuity of care.

Some survey respondents noted a clear **need for more funding of the behavioral and mental health system in Santa Cruz County**. Many gave examples of how this lack of funding affects the service provision in the county, by contributing to shortages of staff, facilities, and programs.

"The behavioral health system needs more funding so that professionals can be hired to work in this field. I believe that this will help people get the help they need sooner and prevent them from becoming too sick or having an episode of illness that is so severe that it requires hospitalization or an extended stay at a treatment facility."
- Community Survey respondent

"This MHSA engagement process is also shorter than previously, with no in-person events, no presentations on present providers, not enough notification and options for participation, and not enough information to give meaningful feedback about how MHSA funds are being spent and how MHSA funds should be spent."
- Community Focus Group Attendee

Some community members and providers mentioned a **need for communication between the county and the larger community**, as this can be a source of rich feedback for the behavioral health system. Some also noted that the current **community engagement process was shorter than the last time it was performed** and therefore lost some opportunities for meaningful conversations with the community.

Behavioral Health System & Service Gaps

Santa Cruz County is very diverse, and there are some **populations that are not being served well** by the SCBHS. Community members and providers noted the following communities which they perceived may be falling through the cracks of the system:

- Unhoused populations
- People with physical disabilities
- People with dual-diagnosis or co-occurring substance use disorder and mental health disorder
- Low-income individuals and families
- Individuals with private insurance
- Children, youth, and transition-aged youth (TAY)
- People with specific diagnoses, such as personality disorders, post-traumatic stress disorder, schizophrenia, and bipolar disorders
- Older adults
- Specific linguistic groups, especially the Mixteco/Mixtec-speaking population
- African immigrant population
- Incarcerated or formerly incarcerated people with mental health needs

- LGBTQIA community

These noted communities have unique needs, challenges, and barriers to accessing appropriate mental health care.

"Our programs are 95% white; we run a division of Spanish programs but missing BIPOC community in English; missing community support groups for youth; rise in suicide of teen girls; LGBTQ+ community– working on that but at capacity; we need more culturally appropriate/ sensitive providers – the whole system, not just providers"
- Provider Focus Group Attendee

Participants in the community engagement activities also noted some services which are lacking in the behavioral health infrastructure in the County. These ranged from "inadequate provisions for group therapy" to a lack of long-term supportive housing. Peer support and recovery services were regularly called out as one of the biggest strengths of the behavioral health system of services, but they have limited availability. **One gap in services that was mentioned repeatedly via many different sources is a lack of non-crisis services**. There is a general sense that unless a person is in a severe mental health crisis, they are not going to be able to access services through the county system of care. This leads to some clients' mental health

"If we look at systems change, we have to look at recovery, to not have so many people go into crisis. We need to not just look at what happens to people on the worst day of their lives; we need to strengthen services before they get in crisis; we have limited resources so we need to reduce the number of people going into crisis"
- Provider Focus Group Attendee

"The triage system that exists for mental health services actively pushes people through the cracks in the system. Just because you are not suicidal, delusional, violent, or schizophrenic, should not mean you are less worthy of care."
- Community Survey Respondent

"People who need mental health treatment are often not given access to services unless they are in a crisis situation. They might have to wait a long time until they reach a point where their mental health becomes so bad that they require other types of care."
- Community Survey Respondent

conditions getting worse while they wait to get services. While crisis services are important, it is also critical to give attention to prevention and recovery services in order to assist people to not have their mental health needs escalate to the point of a crisis.

Recommendations

Community members and providers offered a number of recommended opportunities for improving the County's behavioral health system of care, including recommendations for development of new programs and expansion of existing programs and services. **Many community members recommended that the County devote more efforts toward outreach, education, spreading awareness, and community engagement to improve understanding and acquisition of services**. Specific examples included more community outreach, incorporating mental health training and workshops in high schools and the community, using social and public media sources to increase awareness, and establishing ongoing forums to solicit community feedback.

> "The number one thing we can do as a community is provide education about what mental health services are available and dispel myths about how those services work."
> -Community Survey Respondent

Another key recommendation offered by community members and providers involved the hiring, retention, training, and professional development of provider staff. Individuals recommended that the County work to hire and recruit additional staff while also examining factors that may influence staff hiring and retention (e.g., working conditions, salary, job posting awareness). Other ideas included establishing pipelines for the County to "hire supervising clinicians that nonprofits may have lost" and/or support licensure acquisition for recent social science graduates. Community

> "We're losing staff, including behavioral health staff. We need to look at working conditions and cost of living and address that, [as it] impacts quality of services."
> -Provider Focus Group Attendee

members also recommended additional training for behavioral health provider staff in a variety of areas, including communication and patient engagement, mental health and co-occurring conditions, and training from people with lived experiences.

Behavioral health providers and members of the community also shared ideas for service areas in need of new or expanded programs and providers, including acute care, emergency and crisis services, as well as non-crisis, prevention, and step-down services. For the latter, individuals expressed a need for accessible services to support those at lower levels of care, or who may not be experiencing acute or immediate crisis (or meet specialty mental health criteria), but still need behavioral health support. Similarly, new prevention programs were recommended to support individuals before existing symptoms worsen or they reach periods of crisis. Additionally, many providers and community members advocated for new step-down and/or intensive outpatient (IOP) programs to facilitate the transition between higher and lower levels of care and/or living arrangements. Outpatient programs were also described as a need within the community, particularly for individuals with specific needs (e.g., disabilities).

> "[I] recommend more preventative and early intervention services that reduce barriers for folks earlier in their mental health journey who may not meet specialty mental health criteria."
> -Town Hall Attendee

In terms of emergency, crisis, and acute care services, individuals expressed a need for existing emergency response programs (e.g., MERT, MERTY) to expand their operating hours, and/or the development of new mobile crisis response units that operate on a 24-hour basis – including units that do not include law enforcement. In addition, individuals recommended expanding the number of inpatient and acute care beds within the County to meet the existing need, as well as additional mental health crisis helpline support services.

Other key program types and modalities recommended for new development or expansion included co-occurring and dual-diagnosis

services, peer support programs, and additional housing supports. Community members and providers alike saw a need for increased services focused on treating dual-diagnosis and co-occurring conditions, such as Substance Use Disorder (SUD), physical disabilities, eating disorders, and perinatal mood disorders (e.g., postpartum depression). In praising programs like MHCAN and Second Story, providers and the community recommended expansion of peer-support and peer-run programs (e.g., peer respite

"I am looking forward to seeing more peer support services - I believe Second Story is immensely successful in terms of client satisfaction rate, as are the NAMI support groups and classes."
-Community Survey Respondent

"We need more affordable housing. It often feels like a waste of time and money to continue to fund case management programs to get people housed when there is nowhere to house them."
-Community Survey Respondent

programs), including incorporating peers into existing programs and systems that may not have utilized them before (e.g., emergency rooms). Additionally, many individuals identified housing as a significant need, recommending more affordable and temporary housing options, respite housing for youth and families, long-term supportive housing, and interim or step-down housing options.

Other recommendations and vision from community members and behavioral health providers included targeting and reducing accessibility barriers to care (e.g., living situation, lack of insurance), ensuring that all services are provided in a culturally responsive and trauma-informed manner, increasing communication and care coordination among providers, and developing new and upgraded behavioral health facilities.

Annual Update, Three-Year Plan and PEI Reports

Community Services and Supports

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

SCBHS has not proposed any changes or modifications to programming for FY 2023 - 2024. SCBHS will continue to engage with consumers, families, providers, partners, and broader community to Identify community needs and evolve programming to meet those needs in future years and to be reported in the next MHSA Annual Update during the FY2023-2026 period.

Program demographic reports and annual service updates FY2021-2022 are Included in Appendix C.

CSS #1 Community Gate

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

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

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

Probation, Child Welfare, and Special Education, including ensuring alternatives to residential care.

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

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

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

- Encompass: 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 recruitment of staff, onsite staffing resources, client and family telehealth capabilities and issues in services related to infection prevention. While these the pandemic challenges have been recently alleviated with CDPH and CDC guidelines there are ongoing risk mitigation strategies in healthcare settings that can create lasting barriers.

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

CSS #2 Probation Gate

Purpose

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

To achieve our goal, we have increased dual diagnosis (mental health/substance abuse) services for youth that are:

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

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

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

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

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

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

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

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

CSS #3 Child Welfare Services Gate

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

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

By ensuring comprehensive screening, assessment, and treatment for children in the foster care system, we are supporting family reunification

efforts and permanency planning for court dependents, helping the youth perform better in school, minimizing need for hospitalization, and supporting children in the lowest level of care safely possible.

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

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

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

- Parents Center: 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 recruitment of staff, onsite staffing resources, client and family telehealth capabilities and issues in services related to infection prevention. While these the pandemic challenges have been recently alleviated with CDPH and CDC guidelines there are ongoing risk mitigation strategies in healthcare settings that can create lasting barriers.

Are there any new, changed or discontinued programs? No

CSS #4 Education Gate

Purpose: This program is designed to create school-linked screening/assessment and treatment of children/youth suspected of having

serious emotional disturbances. In addition, specific dual diagnosis (mental health/substance abuse) service capacity has been created and targeted to students referred from Santa Cruz County's local schools, particularly those not referred through Special Education.

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

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

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

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

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

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

- Santa Cruz County Behavioral Health Services: 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 recruitment of staff, onsite staffing resources, client and family telehealth capabilities and issues in services related to infection prevention. While these the pandemic challenges have been recently alleviated with CDPH and CDC guidelines there are ongoing risk mitigation strategies in healthcare settings that can create lasting barriers.

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

CSS #5 Special Focus: Family Partnership

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

The support, outreach, education, and services include:

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

Having family partners integrated into our Wraparound teams has provided invaluable peer resources for these families. It has helped parents navigate

the juvenile justice, court, and health service systems and provided a peer-family advocacy voice.

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

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

Number of individuals to be served:
The unduplicated numbers of individuals to be served by program are:
Volunteer Center/Family Partnerships: 70

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.

CSS #6 Enhanced Crisis Response

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

step down from psychiatric hospitalization or locked skilled nursing facility to a lower level of care in the community.

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

To accomplish the above, we provide the following services:

- Telos. This is a licensed crisis residential program that provides voluntary alternatives to acute psychiatric hospitalization, and its primary function is hospital diversion via an intensive service model. Individuals are referred directly from the community, from the Crisis Stabilization Program at the Santa Cruz County Behavioral Health Center, Santa Cruz County Jail and as "step-down" from the Psychiatric Health Facility. The "step down" intention is to reduce the length of time an individual spends in locked care and provide a safe environment to continue to recover prior to returning to the community.

- El Dorado Center (EDC). This is a residential treatment program with capacity to provide sub-acute treatment services to individuals returning to the community from a locked care setting. The treatment is guided by recovery oriented and strength-based principles. Staff collaborates with residents in identifying their strengths, skills, and areas they want to improve upon as they continue the healing process in preparation for transitioning back to community living.

- Peer Supports at the Psychiatric Health Facility. The focus of this program is to provide peer support to individuals receiving treatment at the County inpatient PHF, operated by Telecare Corporation. Peer led activities include daily groups, aftercare planning and individual support.

- Specialty Staffing. This is a centralized unit providing clients and providers with information and referrals to Santa Cruz County's Behavioral Health system through Access Services. Access provides walk-in crisis services, crisis intervention, intake assessments, referral and linkage to County and community-based services. One clinician will serve as the primary County-led gate to Substance Use services (SUDs).

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

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

Number of individuals to be served:
The unduplicated numbers of individuals to be served by program are:
- Encompass-Telos: 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? Challenges continue to be recruitment of staff, onsite staffing resources, client and family telehealth capabilities and issues in services related to infection prevention. The CRZ fires impacted service provision as staff were impacted by the fire and subsequent slides and water. While the pandemic challenges have been 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

CSS #7 Consumer, Peer, & Family Support Services

Purpose

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

- **The Wellness Center.** Located in Santa Cruz at the Mental Health Client Action Network (MHCAN) self-help center. It is a client-owned and operated program that offers a menu of services and programming for persons with psychiatric disabilities. The programming is provided by individuals with lived experience and trained in the Intentional Peer Support model. The TAY Academy operates out of MHCAN, as well, and is focused on transitional age youth. The TAY Academy offers prosocial and life skill development.
- **Mariposa Wellness Center**. This Mariposa Wellness Center is in Watsonville. Mariposa offers a variety of activities and support services for adults and their families experiencing mental health challenges, including bi-cultural outreach activities to underserved populations in south county. Activities include peer-led social integration, I-IMR and recovery support groups, work readiness and employment services, healthy lifestyle classes, connection to meaningful activities, peer groups for monolingual Spanish speaking adults and individual/group rehab counseling.

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

Providers:

- For North County Wellness: Mental Health Consumer Action Network

- For Mariposa Wellness Center: Community Connection of the Volunteer Center

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

- MHCAN: 600 (FSP) 80 (outreach)
- Mariposa Wellness Center: 80 (FSP) 40 (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.

CSS #8 Community Support Services

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

To accomplish the above, we have several specialty teams:

- The North Recovery Team and South County Recovery Team provide wrap around services to persons with chronic mental health conditions and severe functional impairments to provide support services to assist individuals to remain in the least restrictive residential setting and reduce acute hospitalizations. 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 based on the Forensic Assertive Community Treatment (FACT) model that combines evidence-based program of wrap around mental health services inclusive of case management, psychiatry, psychotherapy, employment readiness, with additional supports specific to the criminal justice system. This program seeks to reduce jail bed days, recidivism, and probation violations. In addition to demonstrating improved stability in the community, the program seeks to reduce psychiatric inpatient bed days, reduce days of homelessness, increase treatment adherence, and increase days in pro-social activities such as employment and education. A dedicated clinician to staff behavioral court and support the Mental Diversion program.
- The Older Adult Services Team (60 years old plus a complex medical condition) focuses on older adults with a major mental illness who need a coordinator care team to maintain living least restrictive level of care by providing mental health services inclusive of case management, psychiatry, psychotherapy.

The teams are supported with these ancillary services:

- Front Street and Encompass provides support to adults living independently, helping them maintain their housing and mental health stability. Community Connection staff offer an employment specialist and peer counselor. Adult care facilities provide 24/7 care, bi-lingual, bi-cultural services. The Board and Care facilities include Front Street, Wheelock, Opal Cliffs and Willowbrook. Services provided in an adult

residential setting include supervision, medication management, pro-social activities.

- Casa Pacific is a 12 bed residential treatment program for those individuals with co-occurring mental health and substance use disorders. Residents are provided with specialized co-occurring treatment in a clean and sober environment that also prepares them for maintaining sobriety in the community following discharge.

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

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

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

- Front Street provides services at Wheelock (Residential), Wheelock (Outpatient), Willowbrook, Front Street Board Care 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:

Table 3. Unduplicated individuals to be served

Program	# Clients
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?
Challenges continue to be recruitment of staff, onsite staffing resources, client and family telehealth capabilities and issues in services related to infection prevention. The pandemic continued to impact capacity, service provision due to the need to comply with infection mitigation and containment mandates. The CRZ fires impacted service provision as staff were impacted by the fire and subsequent slides and water. While the pandemic challenges have been 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.

CSS #8 Housing

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

Target Population: The target population is defined as very low-income adults, 18 years of age and older, with serious mental illness, and who do not have stable permanent housing, have a recent history of homelessness, or are at risk for homelessness.

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

Program requirements include lack of stable housing or at risk of becoming homeless. The Housing Support team worked intensively to educate the client and to mitigate any problems that could have resulted in eviction notices from property management.

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

1. The applicant(s) must be able to demonstrate that their conduct and skills in present or prior housing did not and will not negatively affect the health, safety, or welfare of other residents, or the physical environment, or financial stability of the property.
2. Picture id is required for all adult applicants. Eligible applicants without picture id are supported by County Mental Health or other service providers to obtain one. A receipt from the DMV showing an application for an ID will be sufficient with picture id will be required at the time of move-in.

3. A complete and accurate Application is required, incomplete applications will be returned. Applicants must provide at least 2 years residency history and birthdates of each applicant. MHSA applicants whose disability results in insufficient or negative references are provided a Request for Consideration.
4. A history of good housekeeping habits.
5. A history of cooperation with management regarding house rules and regulations; abiding by lease terms; and care of property.
6. Each applicant family must agree to pay the rent required.
7. Demonstrated cooperation in completing and providing the necessary information to determine eligibility for affordable housing.
8. Applicants must agree that their rental unit will be their only residence. When applicants are undergoing income limit tests, they are required to reveal all assets they own including real estate. They are allowed to own real estate, whether they are retaining it for investment purposes as with any other asset, or have the property listed for sale. However, they may not use this real estate as a residence while they live in an affordable housing unit.
9. An applicant may be disqualified if obviously impaired by alcohol or drugs, uses obscene or otherwise offensive language, or makes derogatory remarks.

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

Prevention & Early Intervention

Prevention & Early Intervention (PEI) programs and initiatives focus on engaging community individuals before the development of a serious mental illness or serious emotional disturbances, or in the case of early intervention, to alleviate the need for additional mental health treatment and/or transition to extended mental health treatment.

SCBHS has not proposed any changes or modifications to programming for FY 2023 - 2024. SCBHS will continue to engage with consumers, families, providers, partners, and broader community to Identify community needs and evolve programming to meet those needs in future years and to be reported in the next MHSA Annual Update during the FY2023-2026 period.

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

Complete program demographic reports and annual service updates for FY2021-2022 are Included in Appendix D.

PEI #1 Prevention

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

Program Name: Triple P Positive Parenting Program

Agency: First 5

Target population:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** In FY 2021-22, 193 parents/caregivers received Level 3 Individual, Level 4 Standard/Group, or Level 5 Triple P services. (Note: An additional 727 parents/caregivers participated in brief Level 2 Individual consultations, Level 2 Seminars or Level 3 Workshops, but this figure is likely to include some duplicate clients.)
- **What is the number of families served?** 178 families (intensive services)

- **Mental illness or illnesses for which there is early onset:** Depression or anxiety (parents), Oppositional Defiant Disorder, Conduct Disorder (children)
- **Description of how participant's early onset of a potentially serious mental illness will be determined:**
    1. Parents are often referred to Triple P by social workers, licensed clinicians, or medical professionals with knowledge of the parents' and/or children's mental health risks and needs.
    2. Although Triple P assessments are not diagnostic tools, the results of the Child Adjustment and Parent Efficacy Scales (CAPES) and the Parenting and Family Adjustment Scales (PAFAS) provide helpful information about parents' emotional well-being and children's social, emotional, and behavior challenges. Assessment results that indicate areas of concern are discussed with parents, and parents are connected to concurrent child and/or adult mental health services as needed.

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

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

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

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

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

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

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

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

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

- **Parental Attributions for Child Behavior (Level 5 Pathways Triple P only):** Measures the degree of parents' negative attributions (beliefs) about their children's behaviors. Utilized January 2010 – current.
- **Acrimony Scale (Level 5 Family Transitions Triple P only):** Measures the degree of co-parenting conflict between divorced or separated partners. Utilized January 2010 – current.

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

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

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

All Triple P client forms and assessment measures are available in both English and Spanish. Most Triple P program materials are also available in English and Spanish. If program materials are not yet available in Spanish through Triple P International (parent company), then First 5 develops Spanish-language teaching aids in accordance with Triple P's policies.

Bilingual practitioners are trained to offer neutral assistance to clients who have difficulty reading or understanding the assessment questions (i.e. avoid conveying bias or leading parents to select a particular answer). If parents have low literacy levels, then practitioners assist parents by reading the assessment questions and responses options and marking off parents' verbal responses on the assessments.

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

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

A. **If an evidence-based practice or promising practice was used to determine the program's effectiveness:**
    a. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome**.
    Triple P is backed by over 30 years of rigorous international research. A particularly compelling study was conducted in South

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

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

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

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

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

First 5's rigorous evaluation of Triple P has demonstrated statistically significant improvements in child, parent, and family well-being ever since its inception in Santa Cruz County. Outcome data from FY 2021-22 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 2021): Overall, 77% of parents reported improvements in their children's challenging behaviors, and 59% reported improvements in their children's emotional difficulties. Of the parents who began the program with more serious parenting issues, 88% reported improvements in children's challenging behaviors and 91% reported improvements in emotional difficulties.
- **Increased use of positive parenting styles.**
  - As measured by the PAFAS (July 2018 – June 2021): On average, 64% of parents reported improvements in consistent parenting, and 72% 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 2021): On average, 63% of parents reported improved emotional well-being after participating in the program. In addition, 55% reported improvements in family relationships.

- **Increased parental confidence.**
    - As measured by the CAPES (July 2018 – June 2021): Overall, 76% of parents reported improvements in their confidence as a parent. Of the parents who began the program with more serious parenting issues, 93% reported increased confidence by the end of the program.

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

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

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

All individual and group services have been offered by phone and/or video during the COVID-19 pandemic. Some Triple P practitioners are beginning to resume in-person services, but virtual services are likely to remain an integral part of the local Triple P system. While COVID-19 created significant

disruptions to Triple P services, the shift to providing virtual sessions and Zoom classes has made it more feasible for some parents to participate because the usual childcare and transportation barriers have been removed.

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

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

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

- Disseminating a monthly article with Triple P parenting tips through print and electronic media.
- Posting on social media and maintaining an advertising presence in key print and electronic media outlets.

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

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

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** 3,881
- **What is the number of families served?** 23
- **Mental illness or illnesses for which there is early onset:**
  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.
- **Description of how participant's early onset of a potentially serious mental illness will be 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 or social work intern to receive on-site individual therapy, or a referral/warm handoff was made to appropriate behavioral health services.

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

While youth were sheltering in place and school was virtual, many Gender and Sexuality Alliance (GSA) school clubs did not take place. TDC was able to connect with LGBTQ+ youth through the 18 county-wide 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 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.

Outcomes:

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

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

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

1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome**.
   This funding supports prevention on multiple levels. The Diversity Center's youth program is on the ground in schools supporting and 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.

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

2. **Explain how the practice's effectiveness has been demonstrated for the intended population**.
   We evaluate effectiveness from our annual youth program evaluation and Triangle Speakers has a post-panel survey. We have

not had the capacity to do additional evaluation to study the long-term impact we have on the schools we work with.

1. **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program**.
   The Executive Director has regular supervision meetings with program coordinators to ensure fidelity to the program design and to troubleshoot any issues that arise.

Describe how the following strategies were used:

- **Access and Linkage**
  The Diversity Center regularly made referrals to our onsite therapist (when we had one for the first part of this grant cycle), as well as our MSW intern and school and community therapists. We regularly see youth who are struggling as they come to terms with the sexual and gender identity as well as their families if they are struggling and need support.
- **Timely Access to Mental Health Services for Underserved Populations**
  The Diversity Center provided some no-cost on-site therapy in the first part of the grant cycle. We have just received some new funding that will allow us to hire a full-time clinician. 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**
  Many youth in The Diversity Center's programs are struggling with mental health issues and suicidal ideation. We strive to create a warm and welcoming space for all. Our trans teen support groups are safe places for teens to share their struggles. Support groups are a way for teens to support and learn from each other and it helps break the social isolation that many feel.

Program Name: Live Oak Resource Center, PEI #1
Agency: COE, Live Oak Resource Center
Target population:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** 276
- **What is the number of families served?** 219
- **Mental illness or illnesses for which there is early onset:** Varies
- **Description of how participant's early onset of a potentially serious mental illness will be determined:**
  Each participant 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 fluctuation in positive cases, we continued to have in-person services at Live Oak Community Resources 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, tax preparation, providing education and support regarding vaccines, assisting with the application process for state rental assistance, continuing our parent education classes and counseling on-line and in-person, and re-starting parent and child play groups once again at the center.

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

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

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

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

3) **Concrete Support in Times of Need**— Provided through case management, Family Advocates connect families with twice a month food distribution, enrollment in government benefits such as Medi-Cal and CalFresh, assist in applying for unemployment benefits, vetting for counseling services, supporting with various financial assistance programs, seasonal assistance including back-to-school supplies and holiday gifts. Advocates also encourage participation in parental support programs, and refer to other agencies as needed.

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

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

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

A. Family Case Management- **provided case management to 20 unduplicated families.**
    - Assessed family strengths and needs
    - Supported family in setting and pursuing goals

- Facilitated enrollment in government benefits and/or additional financial assistance
- Referred to appropriate community resources
- Provided translation as needed

B. A LEADERSHIP ROLE IN THE LIVE OAK CRADLE TO CAREER (C2C) INITIATIVE – **engaged with 21 unduplicated parents and caregivers in Cradle to Career**
    - Participated in monthly C2C steering committee meetings
    - Supported monthly Parent Leadership Council meetings
    - Worked with parent leaders to carry out strategies identified to improve selected data indicators in the areas of health, education, and character
    - Worked with C2C promotoras to provide support around vaccination efforts

    C2C parents participated in LOCR parenting classes

C. COUNSELING SERVICES – **provided services to 65 unduplicated individuals.**
    - Coordinated on-site counseling by professionally supervised counseling interns
    - Coordinate and submit referrals for families to on-site counseling services
    - Counseling services are bicultural and are offered in both Spanish and English, with the option of in-person or telehealth
    - Counseling is billed to Medi-Cal or offered at no charge

D. COORDINATION OF PARENT EDUCATION CLASSES –**56 unduplicated parents and caregivers participated.**
    - Scheduled and promoted classes and workshops
    - Enrolled families
    - Arranged childcare for in-person classes as well as provided support for those participate in classes virtually via Zoom.

E. WEEKLY PARENT/CHILD PLAYGROUPS – **57 unduplicated caregivers and their children**
    - One two-hour weekly group offered in English
    - One two-hour weekly group offered in Spanish

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

Outcomes:

- **List the mental health indicators used to measure reduction of prolonged suffering that result from untreated mental illness as measured by reduced symptom and/or improved recovery, including mental, emotional, and relational functioning**:
  Project outcomes are measured by:
  i. An annual parent survey which asks program participants how strongly they agree or disagree with the following statements:
     1. As a result of participating in this class, I have improved parenting skills
     2. The Advocate continued to work with me until my issues were resolved
  ii. Tracking of progress towards goals set by the family
  iii. Cradle to Career Initiative indicators (complete C2C Data is still in progress for FY 20-21)
  iv. Parent Education assessments administered before and after each training series
  v. Pre and post counseling assessments (DASS and SDQ)

- **Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects cultural competence**:
  i. Cradle to Career Initiative indicators are collected through annual student testing and surveys at the school site and reported back to the Cradle to Career Data Committee.
     1. 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 21-22 FY.

ii. An annual survey is conducted each spring, which asks program participants how strongly they agree or disagree with the following statements:
    1. As a result of participating in this class, I have improved parenting skills
        a. 58.6% reported an improvement in parenting skills.

iii. LOCR staff continued to work with me and has met my needs
    1. 86.2% reported feeling overall satisfaction with their needs being met by LOCR staff.

How is the Early Intervention Program likely to reduce suicide, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and/or removal of children from their homes?
If an evidence-based practice or promising practice was used to determine the program's effectiveness:

3. **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:

   a. 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.

   b. 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.

c. 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.

d. 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, whom 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, as well as in person for both individual classes and workshops.

e. 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.

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.

4. **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

Describe how the following strategies were used:

- **Access and Linkage**
  Individuals identified as needing mental health services are referred to our on-site bilingual counselors. Those needing services beyond our scope—such as psychiatric services or residential treatment—are referred out to the appropriate entities, like the County Mental Health Services. When we have a counseling waiting list, we also refer out to Santa Cruz Community Health Centers and Family Service Agency.
- **Timely Access to Mental Health Services for Underserved Populations**
  Counseling services at our site are billed to Medi-Cal, on a sliding scale fee, or provided free of charge. Counseling is offered both during and after school hours, and evenings depending on need. In response to COVID-19 we offered tele-health services to counseling participants, and this year began seeing counseling participants in person, as preferred. Currently, LOCR has a bilingual counselor and an MFT intern that are both available to serve Spanish-speaking participants (often counseling is provided for English-speaking children who have Spanish-speaking parents) under the supervision of our Clinical Supervisor. If more counseling is requested in Spanish and have a waitlist, we provide a warm handoff to a bilingual counselor either at Santa Cruz Community Health Centers or Family Service Agency. 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**
  All services are provided in a warm, welcoming, neighborhood-based environment, which is comfortable and familiar to our participants. When we refer someone to parent education classes or counseling, we do so in a neutral, non-judgmental way, mentioning it as just one in our range of services. Parent education is offered to connect with other parents who may be facing the same challenges. Confidentiality is respected across all our programs.

Program Name: PBIS
Agency: Santa Cruz County Office of Education
Target population:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?**
  Five school districts representing 20 schools in Santa Cruz County. These in turn impacted more than 10,070 students.

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

- **What is the number of families served?**
  Using 1.96 as an average per family child number in California from census data, the approximate of families served was 5,138 (10,070/1.96)
- **Mental illness or illnesses for which there is early onset:**

Varies per the usual general school aged population statistics. 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). 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. 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. 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.[5]

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

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

[5] (youth.gov website July, 2017: http://youth.gov/youth-topics/youth-mental-health/prevalance-mental-health-disorders-among-youth)

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.

"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."[6]

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)

[6] 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

	Team-based comprehensive assessment Linking of academic and behavior supports Individualized intervention based on assessment information focusing on (a) prevention of problem contexts, (b) instruction on functionally equivalent skills, and instruction on desired performance skills, (c) strategies for placing problem behavior on extinction, (d) strategies for enhancing contingence reward of desired behavior, and (e) use of negative or safety consequences if needed. Collection and use of data for decision-making

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

Outcomes:
List the mental health indicators used to measure reduction of prolonged suffering that result from untreated mental illness as measured by reduced symptom and/or improved recovery, including mental, emotional, and relational functioning:
There is research that shows the most at risk youth in schools tend to have increased rates of office referrals, discipline, suspensions, expulsions and school failure and this in turn correlates with increased involvement with the criminal justice system, less protective factors and poorer social-emotional functioning (Baglivio, Epps, Swartz, Huq, Sheer & Hardt, 2014; Bridgeland, Dilulio, Morrison, Civic & Peter, 2006; Boyd, 2009; Gonzales, 2012). PBIS uses rates of suspension/expulsion along with office discipline referrals (ODRs) to monitor and evaluate the effectiveness of the program and ultimately by correlation a reduction in the number of students with too few protective factors and therefore at risk of institutional involvement and decreased emotional and/or relational functioning.

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.

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

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

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

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

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

PBIS was developed specifically for schools and school aged youth to increase a supportive and healthy school culture and climate, reduce office referrals and school failure and increase relational and social-

emotional functioning. The Journal of Positive Behavior Interventions, along with the Horner, Sugai & Lewis, 2015 article outline numerous elements of the program, target populations and effectiveness.

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

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

Describe how the following strategies were used:

Access and Linkage

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

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

PBIS promotes a positive school culture and climate as it's prime directive and in that pursuit is included being supportive of differences, reducing stigma and bullying around multiple factors, including mental health

diagnoses, and creating supports system-wide, in groups and individually to address issues which may arise that inhibit the desired school climate.

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

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** 237
- **What is the number of families served?** 97
- **Mental illness or illnesses for which there is early onset:** 168
- **Description of how participant's early onset of a potentially serious mental illness will be determined:**
  Risk for serious mental illness is indicated by homelessness, identification of traumatic events during military service, identification of traumatic events during childhood, pervious mental health diagnosis, and substance use disorder.

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

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

Veterans Advocates conduct interviews with each client and screens them for placement in appropriate programs including county mental health, VA counseling programs, and VA residential programs. Veterans Advocates work to identify warning signs of PTSD, depression, and other mental health conditions. Veterans Advocates coordinate appropriate care and connection to available resources.

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

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

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

Data will be gathered in real time and tracked via excel spreadsheet and online tool: VetPro. Outcomes will be measured each quarter and analyzed to determine successfulness of efforts. Veterans Advocates will maintain professionalism with all clients and utilize active listening and motivational interviewing skills to identify the specific challenges of each client and create pathways to success.

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

- **Describe the evidence that the approach is likely to bring about applicable outcomes**:
  Through interviews the Veterans Advocate will use direct questions and active listening to identify challenges that each client is facing. By

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

- **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program**.
  The Veterans Advocate will track progress and outcomes through follow ups to ensure the client has been able to access the resources available and their needs are being met. The Veteran Advocate will report to the director of County mental health to review outcomes and develop strategies to improve the program. The Veterans Advocate will work closely with the Veterans Services Office to coordinate efforts and ensure effectiveness.

Describe how the following strategies were used:

- **Access and Linkage**

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

- **Timely Access to Mental Health Services for Underserved Populations**
  The Veterans Advocate will do extensive outreach to the veteran community. The veteran population has a high risk of mental health challenges based on the nature of military service. The Veterans Advocate is able to assist low income and homeless veterans by providing access to benefits earned during service. Through identification and early intervention, the Veterans Advocate is able to assist veterans with all of their needs. The Veteran Advocate has the ability visit veterans who are otherwise not able to find transportation to an office.

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

Program Name: Peer Companion
Agency: Seniors Council of Santa Cruz County

Target population:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** 14
- **Description of how participant's early onset of a potentially serious mental illness will be determined:**
  The Senior Program Coordinator will assess risk and assign older adult MHSA clients to the Senior Companions and monitor their activities. Adjustments to planned activities will occur throughout the contract

period based on the assessment of MHSA staff in collaboration with the Senior Companion Program Coordinator.

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

Due to the ongoing COVID 19 pandemic, all **in-person** volunteer activity with clients continued to be on-hold **until April of 2022**. Senior Companions continued making wellness phone calls and facetimes with clients to keep in touch and continue service. Senior Companions also served their clients by picking up pre-ordered groceries and prescriptions.

In April 2022, Senior Companions were cleared by the Seniors Council to begin once again serving their clients in person. This has made a welcomed and impactful difference for the well-being of clients.

Outcomes:

- **List the mental health indicators used to measure reduction of prolonged suffering that result from untreated mental illness as measured by reduced symptom and/or improved recovery, including mental, emotional, and relational functioning**:
  A minimum of 70% of MHSA clients participating will show improvement on at least one of the following quality of life indicators:
  - social ties/social support

- mood and behavior improvement
- personnel expression
- companionship

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

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

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

- **Explain how the Agency/County will measure fidelity to the practice according to the practice model and program design in implementing the program**. See Assignment Plan and Senior Companion Eval Tool included in Appendices.

These are the tools used to measure the outcomes targeted in the logic model for both clients served and Senior Companions who serve those clients.

Describe how the following strategies were used:

- **Access and Linkage**
  This service is provided by Susan Fisher, OTR/L with Santa Cruz County Mental Health Services.

- **Timely Access to Mental Health Services for Underserved Populations**
  Susan Fisher manages the timing of assignment of her clients to our Senior Companions. Senior Companions flex their schedule to the needs/schedules of their assigned clients, including evenings and weekends. They provide transportation to various psychiatric and medical treatment providers and socialization activities. COVID-19 change: Senior Companions began picking up pre-ordered groceries and prescription's that are delivered to their clients (following CDE guidelines so as not to interact physically with clients).

- **Stigma and Discrimination reduction**
  Susan Fisher provides training and collateral information to Senior Companion assigned to her clients. In addition, Senior Companions attend monthly training through the Seniors Council. Current Senior Companions have been volunteering under Susan's supervision for many years (one volunteer for 13 years and the other for 9 years).

PEI #2 Early Intervention

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

hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia, and negative symptoms).

Program Name: Employment (Community Connection)
Agency: Volunteer Center of Santa Cruz

Target population:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** 50
- **What is the number of families served?** 12
- **Mental illness or illnesses for which there is early onset:** Schizophrenia Spectrum Disorders, PTSD, Bipolar, Major Depression
- **Description of how participant's early onset of a potentially serious mental illness will be determined:** Intake questionnaires, psychosocial assessments, ANSAs, interviews with individuals/mental health care professionals/school counselors/family members/other support people.

Identification of type(s) of problem(s) and need(s) for which program will be directed, and activities to be included in program to bring about mental health and related functional outcomes.
Primary types of needs/problems: School failure, lack of education and skills, unemployment, underemployment, prolonged suffering, isolation, lack of support system, lack of knowledge of services, incarceration, unstably housed, first episode of psychosis.
Activities: supported employment and education counseling (including the opportunity to volunteer and meet employers in order to better prepare to enter the workforce and opportunities to attend classes specific for mental health consumers at the college level), skill building and symptom management, opportunities to participate in groups with peers and information to find meaningful activities. Services are provided in the community, at school, and in the workplace to reduce stigma and better serve the young adult population.
Outcomes:

- **List the mental health indicators used to measure reduction of prolonged suffering that result from untreated mental illness as**

measured by reduced symptom and/or improved recovery, including mental, emotional, and relational functioning:
Improved access and retention of support services, education, employment, and volunteerism opportunities, as well as reduced hospitalizations due to a mental health crisis, and reduction of relapse of psychosis and SUD

- **Explain the evaluation methodology, including how and when outcomes are measured, how data is collected and analyzed, and how the evaluation reflects cultural competence**:
  Completion of yearly ANSAs and Recovery Evaluations every 3 months. Data is collected via Google Forms. Evaluations include culturally inclusive questions including racial/ethnic/gender/LGBTQIA+ identity.

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

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**.
   Motivational Interviewing, NAVIGATE Model SEE (Supported Employment and Education)/IRT (Individual Resiliency Training)/Family Education, and Case Management have all been shown to reduce the experience of severe mental health challenges, being unhoused, substance misuse, incarcerations, harm to self/others, and reliance on government funding for wellbeing.

2. **Explain how the practice's effectiveness has been demonstrated for the intended population**.
   The above mentioned practices have been shown to increase independence, autonomy, resilience, and grit while reducing recurrence of mental health challenges, psychosis, and dependence on substances.

3. **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**
   We will ensure fidelity through ongoing supervision and trainings of staff as well as oversight and consultation from the NAVIGATE creators.

Describe how the following strategies were used:

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

Program Name: Transition Age Youth (TAY) and Adult Services

Agency: Santa Cruz County Behavioral Health Services
Target population:

- **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.
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:
CANS and 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:
CANS and ANSA, reports are collected every 6 months & FSP Reports are 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?

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

    - CANS and ANSA reports- determine areas of clinical concern for individuals.
    - 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**.
    - CANS and ANSA reports- data used to develop treatment plan goals.
    - Review of CANS and ANSA scores in weekly supervision sessions with clinical staff used to determine focus of treatment interventions, level-of-care services, and goal setting.
- **Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.**
    - FSP data reports
    - CANS and ANSA data reports

Describe how the following strategies were used:

- **Access and Linkage**
  Referrals to ACCESS are made, if deemed client meets system-of-care criteria for County mental health services, referrals to vocational, educational, and housing programs. Psychoeducation is provided for clients and their families.

- **Timely Access to Mental Health Services for Underserved Populations**
  Referrals are made to ACCESS for Assessments if deemed to meet system-of-care criteria for County mental health services.

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

PEI #3 Outreach

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

Program Name: Senior Outreach
Agency: Family Services Agency

Number of Potential Responders served in previous fiscal year (FY2021-2022): 70

Settings in which potential responders were engaged :
Agencies include Volunteer Center, Unite Us, Dignity Health, PAMF, Hospice and Senior Network Services. We also get referrals from private physician offices. This year during the pandemic, we focused on working with staff of referring agencies to make sure clients eligible for our services were sent to us for phone or telehealth individual and group services.

Types of potential responders engaged in each setting:
Social workers, physician offices, nurses, and staff at the various nonprofit agencies.

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:
Most information was distributed primarily through our website and phone consultations with medical offices, residential care facilities, senior centers and nonprofit agencies including the Grey Bears, Meals on Wheels and the

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**
  All participants in our outreach continue to be informed of local County mental health resources, including the 24/7 multilingual suicide crisis line (now 988) 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**
  Peer counselors are trained to 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, 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 Lift line 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**
  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. The pandemic has further impacted seniors with greater isolation from family and friends and increased risk of sickness and death. Mental health challenges are framed as an understandable consequence of the social and biological issues related to aging. Individual and group counseling is done in a positive and supportive way by trained volunteers using active listening skills

PEI #4 Stigma and Discrimination Reduction

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

Program Name: Stigma and Discrimination Reduction
Agency: NAMI-SCC

Number of people reached in previous fiscal year (FY2021-2022): 16,988 unduplicated count
Target #: 2,500

Identify who the program intends to influence:

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

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

- **Changes in attitudes, knowledge and/or behavior related to seeking mental health services that are applicable to the specific program**
  We ask participants to fill out evaluations upon participation in any of our programs to ensure we meet the stated goals. Each of our programs has a slightly different goal related to the following: reducing stigma, access to mental health care, and/or an increased understanding of mental health conditions. All of these are central themes in NAMI programming, and are interwoven throughout our

classes, groups, and presentations. Our methods of delivery include psychoeducation, structured conversations, NAMI tools and structures, and promoting a culture of sharing lived experience. We analyze our surveys monthly, and will be submitting the outcomes to County Behavioral Health on a quarterly basis starting next year.

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

- **If an evidence-based practice or promising practice was used to determine the program's effectiveness:**
  1. **Provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome**.
     NAMI Family-to-Family Education Program has been added to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP).

     The research found that the family members who participated in Family-to- Family classes showed:
     - Significantly greater overall empowerment as well as empowerment within their family, the service system and their community
     - greater knowledge of mental illness
     - a higher rating of coping skills
     - lower ratings of anxiety related to being able to control conditions
     - higher reported levels of problem-solving skills related to family functioning.

     Two research studies have been conducted on NAMI Basics
     - A 2008 study conducted by Missouri State University psychologist Dr. Paul Deal found that parents/caregivers who took the NAMI Basics course reported knowing more about the symptoms, assessment and treatment of mental illness than they did before taking the course. The study also found that these parents felt better about themselves as caregivers after taking the course.

- A 2009-2010 study conducted by Dr. Kimberly Hoagwood of Columbia University and Dr. Barbara Burns of Duke Medical Center found that parents who took the NAMI Basics course reported taking better care of themselves, feeling more capable of advocating for their children and being able to communicate more effectively with their children after taking the course. The results of this study were published on May 6, 2011 in the Journal of Child and Family Studies.

  An evaluation of participants of the **NAMI Peer-to-Peer** by the University of Maryland found that taking the course improved self-image, increased self-motivation and willingness to help others with mental health challenges. In addition, participants:
  - Felt less alone.
  - Learned new relapse prevention skills.
  - Reported more acceptance towards their illness.
  - Embraced advocacy and used the class to help others.
  - Experienced improved relationships with loved ones.

Explain how the Agency/County will ensure fidelity to the practice according to the practice model and program design in implementing the program.
Our staff and volunteers are trained in accordance with NAMI National Guidelines and by certified NAMI trainers. We maintain fidelity by listening to quarterly national teleconferencing calls and also by meeting quarterly to discuss successes and challenges in delivering the programs.

Describe the evidence that the approach is likely to bring about applicable outcomes:
Evidence that our approach is providing applicable outcomes include positive post evaluation reports from participants. In addition, NAMI has thriving support groups, presentations, and classes due to a stellar reputation.

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

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

Describe how the following strategies were used:

- **Access and Linkage**
  Warmline/Helpline in English and Spanish- is supervised by experienced volunteer and staff with linkage to MH as needed for acute calls. Many families and the general public use the warm line for information on access to care, rehab, housing, case management, medications etc. Primary function is linkage to care and help in a crisis to offer support and some assistance. It is not always answered immediately but usually within 24 hours. Many are linked to support groups and classes.

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

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

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

- **Timely Access to Mental Health Services for Underserved Populations**
  Traditionally family members of individuals living with mental illness have been underserved; even in provider organizations who have served families in the past, budget cuts, and staffing shortages have decreased that ability to work with families, even on an emergency basis. Our classes, support groups and individual advocacy helps to address their needs and improve the outcomes of the consumer. All of

our programs are free, offered on a regular basis, do not involve an extensive intake process, and many of our programs are drop-in friendly.

We also added two new peer programs in Spanish - our Peer-to-Peer/Persona a Persona class, and our Connection/Conexion support group. In a county where a high percentage of the population speaks Spanish, language accessibility is a high priority. We are excited to be able to now offer all of our peer and family programs in Spanish!

- **Stigma and Discrimination reduction**
  All of our programming includes stories of recovery by a trained speaker. The information in the classes, materials used in the Support Groups, and presentations allow for dignity and acceptance of individuals with disability to live successfully in the community. We reduce self-stigma by providing a safe place to share with other of similar lived experience. Community stigma reduction is provided through our educational presentations, brochures, events and newsletters. Our trained speakers tell how different treatments helped them recover. School presentations (Ending the Silence) normalize mental health challenges and encourage students to talk to someone they trust.

  A recent research study by NAMI National of 932 students compared students who had seen the ETS presentation to a control group who did not see the presentation, and concluded that NAMI Ending the Silence is effective in changing high school students' knowledge and attitudes toward mental health conditions and toward help-seeking. The effect is a robust one, occurring across different presenters, across different study schools, and across the diverse populations within those schools.

PEI #5 Suicide Prevention

Organized activities that the County undertakes to prevent suicide because of mental illness. This program does not focus on or have intended outcomes for

specific individuals at risk of or with serious mental illness. Programs include, but not limited to, public and targeted information campaigns, suicide prevention hotlines, training, and education. (Note: According to the new regulation, this service is optional, but Santa Cruz County does offer this service.)

Program Name: Suicide Prevention
Agency: Family Services Agency

Target population:

- **What is the unduplicated number of individuals served in preceding fiscal year (FY2021-2022)?** *(target is 3,500)*
  Suicide Prevention and Crisis Lifeline
  Calls to Lifeline 3,456
  (Santa Cruz County location verified): 977

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

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

  Suicide Prevention and Resources Education and Outreach: 4,285

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

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

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

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

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

Suicide Prevention and Resources Education and Outreach

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

Suicide Loss Survivor Support Groups

Research shows that there is a higher risk of suicide for individuals who have lost a loved one to suicide. SPS works closely with experienced and qualified community members and Family Service Agency volunteers to host a new

group facilitator training for current clients, volunteers and staff who may be interested in becoming a facilitator for our support groups.

How will the Agency/County measure changes in attitude, knowledge and/or behavior related to reducing mental illness-related suicide?

There is very limited research available to support the efficacy of suicide prevention interventions, but some helpful data is available for a population-based program where an intervention with very low risks, low cost and data not available, a prevention program may need to rely on best practices, expert consensus and lessons from related prevention fields and the National Suicide Lifeline is considered as a reliable source.

Suicide Prevention and Crisis Lifeline

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

Suicide Prevention and Resources Education and Outreach

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

Suicide Loss Survivor Support Groups

Risk of suicide and suicide risk factors has been shown to increase among people who have lost a friend/peer, family member, co-worker, or other close contact to suicide (source: Pitman A, Osborn D, King M, Erlangen A). Care and attention to the bereaved is therefore of high importance. These programs have not typically been evaluated for their impact on suicide, attempts, or ideation, but they may reduce survivors' guilt, feelings of depression, and complicated grief.[7]

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

Suicide Prevention and Crisis Lifeline

Many paths in life can bring someone to the brink of suicide, and a shorter phone number might seem to be a naïvely simple solution. But researchers have repeatedly found that simple works: Callers routinely credit the existing hotline, which is on track to take 2.5 million calls this year, with keeping them safe. And while the role of crisis Lifelines traditionally were limited to de-escalation and service linkage, Lifelines are increasingly moving towards providing outreach and follow-up to suicidal individuals. Hotlines have the opportunity to not just defuse current crises but also provide brief interventions to mitigate future risk including safety planning, a promising approach to reduce crisis callers' future suicide risk.

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

Suicide Prevention and Resources Education and Outreach

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

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

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

Suicide Prevention and Crisis Lifeline

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

Outreach and Education Activities

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

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

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

and monitoring of responder activity to ensure that standards are being met and to address (through additional training, supervision, etc.) any issues.

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

Describe how the following strategies were used:

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

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

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

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

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

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

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

  Program presentations and trainings teach participants how to recognize suicide warning signs, the various ways to support anyone

experiencing a suicidal crisis (including encouraging the individual to seek further medical/mental health support), and the local available resources available to County residents in need of additional resources and support. Outreach services are available to all County residents, agencies, and organizations; however, special emphasis is given to ensure the provision of services to (and the adherence of these services to cultural and linguistically appropriate standards) to traditionally underserved populations, such as transition-age youth and young adults, transgender individuals, veterans and their families, foster care youth, LGBTQQIA+ community members, Latinx community members, and any community members with histories of substance use, sexual or physical abuse, domestic violence, and isolation, among others.

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

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

PEI #6 Access and Linkage to Treatment

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

Program Name: Second Story

Agency: Encompass

Target Population:

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

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

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

2nd Story assists persons served entering the program with linkage to primary care and mental health treatment appointments, recovery services

for substance use disorders, and referrals to various County programs for services, including crisis response. 2nd Story also provides access and linkage to community resources, including housing, educational, and employment resources.

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

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

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

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

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

2nd Story supports guest requests for connection to resources, and coordinates with other mental health system providers and family members. 2nd Story connects providers, guests, and families to NAMI Santa Cruz trainings

which include Peer to Peer, Family to Family and Provider Training all of which happen throughout the year.

Substantial collaboration exists with Mental Health Access Team, Santa Cruz County Behavioral Health Services coordinators, NAMI, program managers, and psychiatrists. Second Story maintains regular contact with other mental health contractors and resources including, the Psychiatric Health Facility, Janus, Front Street, Homeless Persons Health Project, and the Homeless Resource Center. 2nd Story staff promote and discuss with guests the importance of receiving ser ices to co-create stronger ties to providers and families if such discussions benefit person-centered services.

Describe how the following strategies were used:

Access and Linkage

2nd Story works in close collaboration with Santa Cruz County Behavioral Health Services to ensure guests seeking respite services are knowledgeable about the availability of services, including medical and other county offered services. The program also works with other community agency partners to ensure guests are referred and linked to the appropriate level of services and resources needed to promote healing and well-being. 2nd Story supports individuals with connecting to psychiatrists, primary care providers, surgery, and pre-planning appointments. When there is a challenge, the team connects with guests' coordinators and care teams. Further, the team provides referrals to individuals for substance use disorder treatment programs as part of discharge planning as requested by guests.

Timely Access to Mental Health Services for Underserved Populations

2nd Story promotes a welcoming environment that is accessible to guests 24/7 as a diversion to, or step-down from, sub-acute or inpatient programs. This respite housing option allows guests, who might otherwise end up in an inpatient setting, a safe alternative for connection and relationship building that can assist in their recovery and wellness. We assist underserved populations by offering activities that include family involvement and participation in community events so that people may find support through others. All activities are directed by guests' expressed requests and needs. Forms in Spanish and English are provided, and translation services are

engaged as needed for accessibility to services. 2nd Story staff builds strong relationship with families and providers in Watsonville with outreach to South County coordinators and families through NAMI.

Stigma and Discrimination reduction
2nd Story remains dedicated to serve as a respite and voluntary housing option for people by offering support and connection with a peer recovery model. Peers assist in learning with people how to be in relationship by building upon shared backgrounds and lived experiences. With the support of community partners, including NAMI, Front Street, and Housing Matters, 2nd Story has been able to reduce stigma surrounding mental illness. In addition, self-stigma has been reduced by promoting a safe place for guests to self-refer when recognizing a need for respite and connection when feeling vulnerable from mental health symptoms. 2nd Story supports an environment through which narratives about people and their experiences are shared. Peers discuss ways of seeing beyond the diagnosis and seeing beyond the need for alienating oneself from the community.

Program Name: Mobile Emergency Response Team & Mental Health Liaison Team
Agency: Santa Cruz Behavioral Health Services
Target population: All Individuals, all ages

- **What is the unduplicated number of individuals to be serviced annually:** 150

This **Access & Linkage - Mobile Crisis** program referred to as the Mobile Emergency Response Team (MERT) & Mental Health Liaison (MHL) Team. MERT and MHL purpose is to provide crisis intervention and stabilization services for children, adolescents, and adults of Santa Cruz County who are experiencing an urgent or emergent mental health related crisis. The youth program is called MERTY (mobile emergency response team – youth). For this plan, MERT will be used to refer to both programs. These teams provide crisis intervention services at different locations in the community, including office-based visits for walk-ins and appointments, evaluations with law enforcement in the community, local hospital emergency rooms, and individual homes. Mental

Health Liaisons provide similar crisis assessment and intervention and disposition planning in collaboration with law enforcement for field-based crisis response model. MERT's and Mental Health Liaisons focus is to provide alternatives to psychiatric hospitalization by working with consumers to find the least restrictive treatment setting that ensures safety and an appropriate level of care. The goal is to stabilize the crisis situation, determine whether or not there is a need for psychiatric hospitalization, and develop an appropriate plan for that individual. The services are available to any resident of the County regardless of ability to pay, and type of insurance they may or may not have.

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

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

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

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

MERT/MHL clinicians will conduct a brief comprehensive assessment to determine level of care. If consumer meets mild to moderate criteria, they will be referred appropriately. If they merit specialty mental health criteria, they will be linked to Santa Cruz County Behavioral Health Services Psychiatrist for med-evaluation and ACCESS intake clinician to initiate higher level of care.

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

MERT/MHL clinician will always review appropriate resources including all available treatment options to meet consumer's needs. Parents and other natural supports will be welcomed and included in this process with appropriate consent. MERT/MHL clinicians will encourage consumers to utilize family support and resources.

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

MERT clinicians will follow up a couple days after initial contact with consumers to ensure follow through. The MERT clinician sometimes meets with the consumer 2-3 times in make sure they are appropriately linked. MERT will also attempt make direct contact with all appropriate providers with the

Describe how the following strategies were used:

Access and Linkage

Consumers were seen in crisis (including first break) and there was direct follow up, including a med- eval and intake assessment into SMI care as needed. MERT clinicians contacted consumers within 24 hours of initial contact to address any linkage concerns. MERT/MHL clinicians directly assist with linkage and access.

Timely Access to Mental Health Services for Underserved Populations

MERT/MHL services are payer source blind. We will assess anyone in crisis regardless of their benefits or insurance coverage. If they need help with benefits, we link them to an eligibility worker. We will make the referral call with the consumer, when possible, to help them address any roadblocks. We have the ability through the ATT language line to communicate in any language. We hold a high value in providing a welcoming approach to all served. Working in conjunction with community agencies, we are able to reach out in ways that previously were more difficult to do. Family and other natural supports are seen as valuable assets for consumers, and we encourage the active utilization of all helpful assets. Currently, we have MERT

clinicians available during regular Monday through Friday business hours. MHL are available 7 days a week from 8am-7pm. There is a 24-hour 800 number available after-hours information, consultation, and linkage to emergency services.

Stigma and Discrimination reduction

MERT /MHL values and provides in team training/discussions regarding establishing good rapport through welcoming practices. Clinicians also are provided time to attend the 15-hour NAMI Provider Education Training. MHL are actively involved with development and training for the local county CIT trainings for law enforcement officials, focused on stigma reduction. Santa Cruz County Behavioral Health also provides various training including consumer panels to increase empathy, awareness, sensitivity, and general welcoming skills.

Capital Facilities and Technology Needs

Funds and guidelines for Capital Facilities and Technology Needs were packaged together by the State Department of Mental Health. (Note: Infrastructure programs do not allow the County to hire staff to provide services.)

The Information Technology funds are to be used to:

- Modernize and transform clinical and administrative information systems to improve quality of care, improve operational efficiency, and improve cost effectiveness.
- Increase consumer and family engagement by providing an opportunity for clients and families to provide feedback on the services they are receiving.

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

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

Workforce Education & Training

This infrastructure component was designed to strengthen the public mental health workforce both by training and educating current staff (including concepts of recovery and resiliency), and to address occupation shortages in the public mental health profession by a variety of means.

Culturally & Linguistically Appropriate Services

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

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

Additional Assistance Needs from Education & Training Programs

An ongoing challenge is how to sustain the training and education program, given that the State has not distributed additional Workforce Education and Training (WET) funding and SCBHS has expended designated funds in previous program years. There are no MHSA designated WET funds for FY2023-2026, however, the County of Santa Cruz recognizes that we still need work in our efforts to transform our service delivery system to one which is more client and family centered, recovery oriented, fosters an environment of enhanced communication and collaboration while promoting self-directed

care, utilizes Evidenced Based Practices which have been demonstrated most effective at supporting recovery and independence in the community, and measures outcomes on a client, program and system level.

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

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

Core Competencies Training

Motivational Interviewing (MI), an approach developed by William Miller, has been well established as an effective way to promote behavior change in individuals. The prerequisite to participating in the face-to-face MI training, is currently available.

Individuals first need to complete a free, four-hour, self-paced online course entitled the Tour of Motivational Interviewing: An Interprofessional Road Map for Behavior Change
http://healtheknowledge.org/course/index.php?categoryid=53#TourOfMI

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

Evidence Based Practices

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.

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.

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 amid a system wide engagement effort with our CANSA Project. The CANSA project combines the workforce and efforts of both the Child and Adolescent Needs and Strengths Assessment (CANS), and the Adult Needs and Strengths Assessment (ANSA). The CANS and ANSA are tools

designed to serve as opportunities for communication and collaboration by engaging consumers in treatment discussions, which focus on identifying strengths and actionable needs. The result is a comprehensive assessment and treatment plan that reflects clients voice and choice. The CANS and ANSA also serve as a foundation for collaboration within the treatment system by facilitating shared knowledge without consumer having to retell their story to each provider. The CANS and ANSA also provide important feedback and data to program managers and administrators to better understand system needs, service delivery, outcomes, and trends.

Identification of Shortages of Personnel

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

- Psychiatrists (adult and child)
- Bilingual mental health providers (psychiatrist, therapists, case managers)
- Forensic mental health providers
- Psychiatric Nurse practitioners
- Clinical psychologists
- Highly skilled practitioners treating co-occurring (mental health & substance abuse) disorders
- Data Processing Programmer Analyst
- Licensed Clinicians (LCSW, MFT, PhD)

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.

There were no MHSA innovation funds expended during FY2021-2022 for the Healing the Streets project, as had been previously proposed through the last Annual Update. The SCBHS will continue with focused services for people experiencing mental health concerns and homelessness and has supported the Healing the Streets project through other funding sources. MHSA

innovation funding during the FY2023-2026 time is shifting to support of the Crisis Now Model.

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

The Crisis Now model is a 5-County Innovation project with focused efforts toward three pillars of crisis service:

- Receiving
- Call Center
- Mobile Crisis Teams.

SCBHS and other involved counties, are working with Recovery Innovations International as a consulting team to guide this 5-County project.

The project plan is in the development stage and additional information will be shared out with community and partners as well as updates about the project included in the next Annual Update as required by MHSA.

Fiscal Year 2023-2024 Expenditure Plan & Funding Summary

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

County: Santa Cruz Date: 3/15/23

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

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

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

total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

Community Services and Supports (CSS) Component

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

County: Santa Cruz Date: 3/15/2023

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

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

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

Prevention and Early Intervention (PEI) Component

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

County: Santa Cruz Date: 3/15/23

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

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

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

Innovation (INN) Component

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

County: Santa Cruz Date: 3/15/23

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

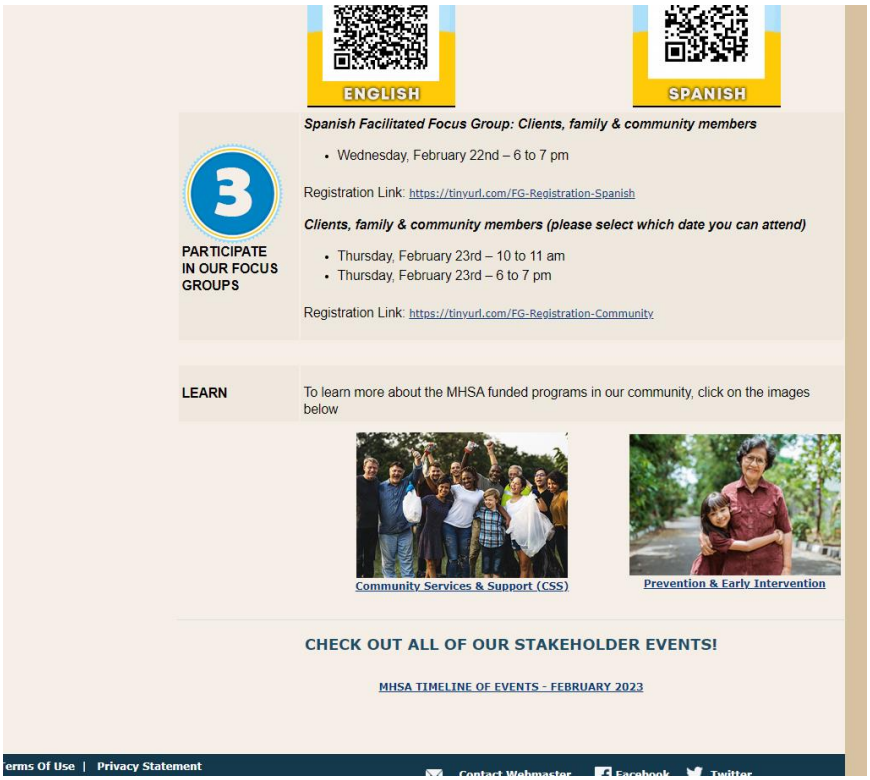
	Fiscal Year 2024/25			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Crisis Now	1,643,478	1,643,478		
2.				
3.	-			
INN Administration	246,522	246,522		
Total INN Program Estimated Expenditures	1,890,000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

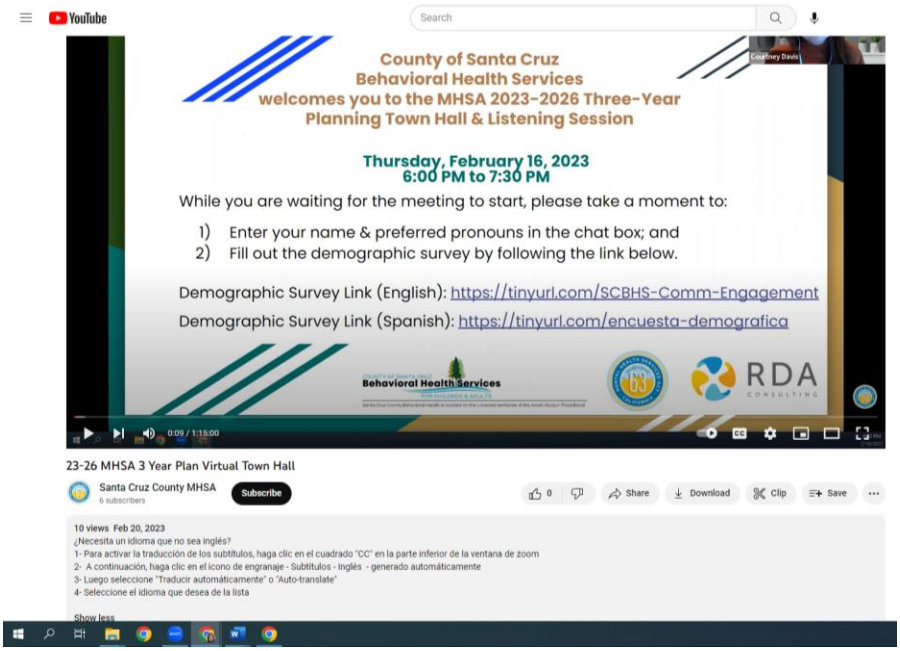
	Fiscal Year 2025/26			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Crisis Now	1,807,826	1,807,826		
2.	-			
3.	-			
INN Administration	271,174	271,174		
Total INN Program Estimated Expenditures	2,079,000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

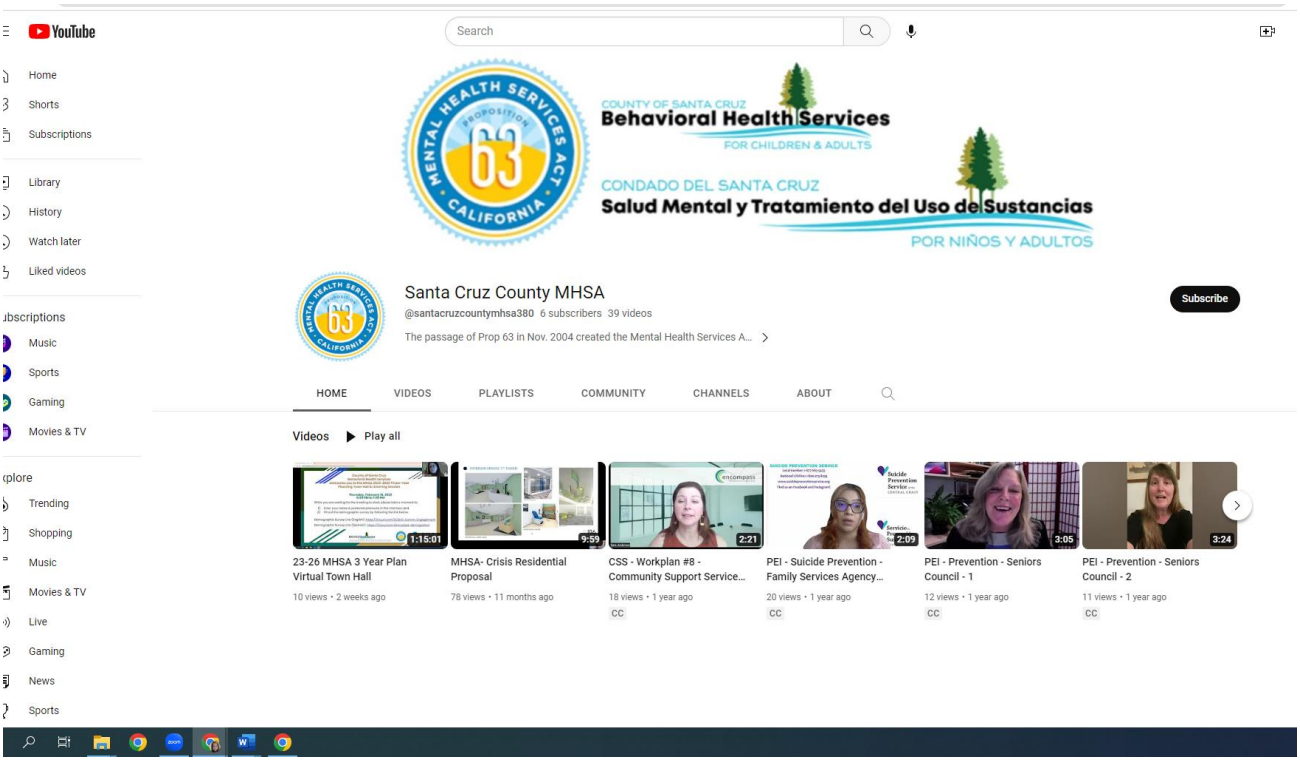
Appendix

Appendix A. CPPP Outreach & Promotion Materials

CPPP Website & YouTube Promotion


ENGLISH
SPANISH
3
PARTICIPATE IN OUR FOCUS GROUPS
Spanish Facilitated Focus Group: Clients, family & community members
Wednesday, February 22nd – 6 to 7 pm
Registration Link: https://tinyurl.com/FG-Registration-Spanish
Clients, family & community members (please select which date you can attend)
Thursday, February 23rd – 10 to 11 am
Thursday, February 23rd – 6 to 7 pm
Registration Link: https://tinyurl.com/FG-Registration-Community
LEARN
To learn more about the MHSA funded programs in our community, click on the images below
Community Services & Support (CSS)
Prevention & Early Intervention
CHECK OUT ALL OF OUR STAKEHOLDER EVENTS!
MHSA TIMELINE OF EVENTS - FEBRUARY 2023
erms Of Use | Privacy Statement
Contact Webmaster
Facebook
Twitter


YouTube
Search
County of Santa Cruz
Behavioral Health Services
welcomes you to the MHSA 2023-2026 Three-Year
Planning Town Hall & Listening Session
Thursday, February 16, 2023
6:00 PM to 7:30 PM
While you are waiting for the meeting to start, please take a moment to:
1) Enter your name & preferred pronouns in the chat box; and
2) Fill out the demographic survey by following the link below.
Demographic Survey Link (English): https://tinyurl.com/SCBHS-Comm-Engagement
Demographic Survey Link (Spanish): https://tinyurl.com/encuesta-demografica
Behavioral Health Services
RDA
CONSULTING
0:09 / 1:15:00
23-26 MHSA 3 Year Plan Virtual Town Hall
Santa Cruz County MHSA
6 subscribers
Subscribe
Share
Download
Clip
Save
10 views Feb 20, 2023
¿Necesita un idioma que no sea inglés?
1- Para activar la traducción de los subtítulos, haga clic en el cuadrado "CC" en la parte inferior de la ventana de zoom
2- A continuación, haga clic en el icono de engranaje - Subtítulos - Inglés - generado automáticamente
3- Luego seleccione "Traducir automáticamente" o "Auto-translate"
4- Seleccione el idioma que desea de la lista
Show less



Survey, Town Hall & Focus Group Promotional Materials

Survey Social Media Posts (English & Spanish)

Town Hall & Listening Session Flyers and Social Media Posts

Calling all Santa Cruz County community members & partners!

Town Hall & Community Listening Session

[Virtual meeting to be held using Zoom video conferencing]

Learn about the Mental Health Services Act (Prop. 63) as well as MHSA behavioral health programs and services that are part of the three-year plan. Community members and partners will be able to share input and experiences to inform and support planning too!

You can join through your computer, cell phone app, or dial-in by phone. The town hall will be held using the Zoom video conferencing platform. Meeting information is below:

Date: Thursday, February 16, 2023
Time: 6:00 pm to 7:30 pm
Weblink: https://us06web.zoom.us/j/81469835976
Dial-In: Phone Number: 669 900 6833
Meeting ID: 814 6983 5976

*A recording of the Town Hall will be posted to the County of Santa Cruz YouTube Channel for those who wish to view but are unable to attend.

Other ways to share:
Community members & partners are also invited to share feedback through the County of Santa Cruz Behavioral Health Services online planning survey. You can share experiences, provide feedback, and help identify service gaps.

Survey link: https://tinyurl.com/SCBHS-Community-Survey

Survey QR Code:

The online planning survey must be completed by February 27, 2023.

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

Reunión comunitaria y diálogo

Conozca la Ley de Servicios de Salud Mental (MHSA o Proposición 63), así como los programas y servicios de salud del comportamiento de la MHSA que forman parte del plan de tres años.

Fecha: jueves, 16 de febrero de 2023

Hora: 6:00 pm to 7:30 pm

La reunión se llevará a cabo utilizando la plataforma de videoconferencia Zoom

Encuesta de Comentarios para la Comunidad y Los Socios

Esta encuesta recopilará los pensamientos, las opiniones y los comentarios de la comunidad sobre el sistema de salud del comportamiento actual, así como sobre otras necesidades no satisfechas en el Condado de Santa Cruz.

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

Town Hall & Community Listening Session

Learn about the Mental Health Services Act (Prop. 63) as well as MHSA behavioral health programs and services that are part of the three-year plan. Community members and partners will be able to share input and experiences to inform and support planning too!

Date: Thursday, February 16, 2023

Time: 6:00 pm to 7:30 pm

Where: Virtual using Zoom

Community & Partner Feedback Survey

This survey will collect community thoughts, opinions, and feedback on the current behavioral health system as well as other unmet needs within Santa Cruz County.

Focus Groups Promotion

El Departamento de Servicios de Salud del Comportamiento del Condado de Santa Cruz lo invita a participar...

Grupos de Enfoque Virtuales para la Comunidad

Los grupos de enfoque están abiertos a clientes de SCBHS (anteriores o presentes), familiares de clientes y miembros de la comunidad interesados. Estamos interesados en conocer sus experiencias al acceder y participar en los servicios, ayudar a amigos y familiares a acceder a los servicios y/o experiencias con la atención y las necesidades de salud del comportamiento en el condado de Santa Cruz en general. Los comentarios que comparta sobre sus experiencias ayudarán a informar el trabajo sobre el Plan de tres años de la Ley de Servicios de Salud Mental para 2023-2026 para la implementación de programas y servicios.

Grupo de enfoque facilitado en español para clientes, familiares y miembros de la comunidad. El grupo de enfoque se llevará a cabo el:

Miércoles 22 de febrero – 6 a 7 pm

Por favor confirme su asistencia al grupo de enfoque. Los grupos de enfoque virtuales se facilitarán utilizando la plataforma Zoom. La información de acceso al grupo de enfoque se proporcionará después del registro.

Confirma su asistencia aquí: https://tinyurl.com/FG-Registration-Spanish

Los grupos de enfoque serán discusiones en grupos pequeños (hasta 10 personas) para aprender de las experiencias personales y observadas. **Las personas que participen tendrán la opción de recibir una tarjeta de regalo de $35.00 como agradecimiento por su tiempo y compartir.**

La información compartida durante los grupos de enfoque se mantendrá confidencial. Solo se compartirán temas e ideas clave compartidos durante los grupos de enfoque como parte de la planificación de tres años y no se compartirán comentarios que identifiquen a un individuo.

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

Santa Cruz County Behavioral Health is located on the unceded territories of the Amah Mutsun Tribal Band

The **County of Santa Cruz Behavioral Health Services** invites you to participate...

Virtual Community Focus Groups

Focus groups are open to SCBHS clients (past or present), family members of clients and interested community members. We are interested in learning about your experiences accessing and participating in services, helping friends and family to access services, and/or experiences with behavioral health care and needs in Santa Cruz County overall. The feedback you share about your experiences will help inform work on the Mental Health Services Act Three-Year Plan for 2023-2026 for program and service delivery.

There are two opportunities to participate!

Thursday, February 23, 2023, from 10:00 to 11:00 am
Or
Thursday, February 23, 2023, from 6:00 to 7:00 pm

Please RSVP to attend. Virtual focus groups will be hosted using the Zoom platform. Log-in information will be provided after registration.

RSVP here: https://tinyurl.com/FG-Registration-Community

Focus groups will be small group (up to 10 individuals) discussions to learn from personal and observed experiences. **Individuals who participate will have the option to receive a $35.00 gift card for their time and sharing.**

Information shared during focus groups will be kept confidential. Only key themes and ideas shared during the focus groups will be shared as part of the three-year planning and no comments will be shared that identify an individual.

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

Santa Cruz County Behavioral Health is located on the unceded territories of the Amah Mutsun Tribal Band

Grupos de Enfoque Virtuales para la Comunidad

Grupo de enfoque facilitado en español para clientes, familiares y miembros de la comunidad.
El grupo de enfoque se llevará a cabo el:

Miércoles 22 de febrero – 6 a 7 pm

Por favor confirme su asistencia al grupo de enfoque.
https://tinyurl.com/FG-Registration-Spanish

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS
Santa Cruz County Behavioral Health is located on the unceded territories of the Amah Mutsun Tribal Band

Virtual Community Focus Groups

There are two opportunities to participate!

Thursday, February 23, 2023, from 10:00 to 11:00 am
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https://tinyurl.com/FG-Registration-Community_

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS
Santa Cruz County Behavioral Health is located on the unceded territories of the Amah Mutsun Tribal Band

Community Survey Questionnaire

Santa Cruz County Behavioral Health Services
Community & Partner Feedback Survey

Santa Cruz County Behavioral Health Services (SCBHS) has partnered with RDA Consulting (RDA) to help prepare the 2023-2026 Three-Year Plan and 2023-2024 Annual Update under the Mental Health Services Act (MHSA).

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

This survey is voluntary and confidential, and only RDA will see your responses. This survey will take 5-10 minutes to complete. When the results of this survey are reported, your answers will not be tied to you.

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

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

1. **Which of the following best describes your connection to Santa Cruz County Behavioral Health Services:**
   ☐ Behavioral Health Provider
   ☐ Medical or Health Care Provider
   ☐ Education Provider
   ☐ Social services Provider
   ☐ Peer Support Provider
   ☐ Client/consumer of behavioral health services
   ☐ Family or loved one of client/consumer of behavioral health services
   ☐ Interested Community Member
   ☐ Law Enforcement/Probation
   ☐ Legal/justice system agency
   ☐ Veterans' services provider
   ☐ Other (please share:_____)

☐ Prefer not to share

2. **How true are the following statements about the overall behavioral health system in Santa Cruz County?**

Behavioral Health System	Not at all true	A little bit true	Mostly true	Very True	Do not know or N/A
Services Provided					
Santa Cruz County's behavioral health services meet the community's needs.	☐	☐	☐	☐	☐
Santa Cruz County's prevention and intervention services help people before they develop serious mental illness.	☐	☐	☐	☐	☐
Santa Cruz County's services meet the needs of people experiencing a mental health crisis.	☐	☐	☐	☐	☐
Access to Services					
I know who to call or where to go if I or someone needs behavioral or mental health support.	☐	☐	☐	☐	☐
It is easy to get a behavioral health appointment when I or someone needs one.	☐	☐	☐	☐	☐
Santa Cruz County's behavioral health services are available at convenient times.	☐	☐	☐	☐	☐
Santa Cruz County's behavioral health services are available at convenient locations.	☐	☐	☐	☐	☐
Experience with Services					
Santa Cruz County's behavioral health services are welcoming.	☐	☐	☐	☐	☐
Santa Cruz County's behavioral health services are respectful of clients' culture.	☐	☐	☐	☐	☐
Santa Cruz County's clients and/or family members are involved in their treatment planning.	☐	☐	☐	☐	☐
Santa Cruz County's providers work together to coordinate services.	☐	☐	☐	☐	☐
Santa Cruz County's behavioral health services support clients' wellness and recovery.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above (optional):					

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

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

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

6. **Please share any other comments or feedback related to behavioral health system or services in Santa Cruz County here.**

7. **Please share any other comments or feedback on this survey.**

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

Gift cards will be sent by email after the survey closes on February 27, 2023.

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

☐ Yes, I would like to receive a $10 gift card if I am among the first 100 respondents to complete this survey.
☐ No, I do not want to receive a $10 gift card.

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

Name: _____
Email Address: _____

DEMOGRAPHICS FORM

1. What is your age range?
   - ☐ Under 16
   - ☐ 16-25
   - ☐ 26-59
   - ☐ 60 and older
   - ☐ Prefer not to share
2. What is your race? (Check all that apply)
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White
   - ☐ Other (please share):
   - ☐ Prefer not to share
3. What is your ethnicity? (Check all that apply)
   - ☐ Caribbean
   - ☐ Central American
   - ☐ Mexican/Mexican-American/Chicano
   - ☐ Puerto Rican
   - ☐ South American
   - ☐ Other Hispanic or Latino
   - ☐ African
   - ☐ Asian Indian/South Asian
   - ☐ Cambodian
   - ☐ Chinese
   - ☐ Eastern European
   - ☐ European
   - ☐ Filipino
   - ☐ Japanese
   - ☐ Korean
   - ☐ Middle Eastern
   - ☐ Vietnamese
   - ☐ Other Non-Hispanic or Non-Latino
   - ☐ Other (please share):
   - ☐ Prefer not to share
4. What is your primary language?
   - ☐ English
   - ☐ Spanish
   - ☐ Other (please share):
     _____
   - ☐ Prefer not to share
5. What was your sex assigned at birth?
   - ☐ Female
   - ☐ Male
   - ☐ Intersex
   - ☐ Other (please share):
   - ☐ Prefer not to share
6. What is your current gender identity?
   - ☐ Woman/Female
   - ☐ Man/Male
   - ☐ Non-Binary
   - ☐ Agender
   - ☐ Another gender (please share):
   - ☐ Prefer not to share
7. How do you describe your sexual orientation?
   - ☐ Gay or Lesbian
   - ☐ Heterosexual or Straight
   - ☐ Bisexual
   - ☐ Pansexual
   - ☐ Asexual
   - ☐ Queer
   - ☐ Questioning
   - ☐ Don't know
   - ☐ Another sexual orientation (please share):
   - ☐ Prefer not to share
8. Are you a veteran of the United States military?
   - ☐ Yes
   - ☐ No
   - ☐ Prefer not to share
9. Do you experience any disabilities? (Check all that apply).
   - ☐ Difficulty seeing
   - ☐ Difficulty hearing, or having speech understood
   - ☐ Mental disability (i.e., learning disability, developmental disability, dementia)
   - ☐ Impaired physical mobility
   - ☐ Chronic health condition
   - ☐ No disability
   - ☐ Other disability (please share):
   - ☐ Prefer not to share
10. What is your zip code? _____

SCBHS MHSA Three Year Plan FY 23-26

Community Member Focus Group Protocol

Focus Group Details

Date		
Group		
Interviewer		
Note Taker		

Introduction

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

During this focus group, we want to learn about your experiences accessing and participating in services, helping friends and family to access services, and/or your experiences with behavioral health care and needs in Santa Cruz County overall. We will not ask you to share your personal history, such as any diagnoses. You do not have to answer any questions or share any information you feel uncomfortable discussing. This discussion is meant to be focus on your experience engaging with Santa Cruz mental health programs and services. The feedback you share about your experiences will help inform work on the Mental Health Services Act Three-Year Plan for 2023-2026 for program and service delivery.

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

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

Introductions

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

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

System Strengths

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

System Challenges

- What have been some of the biggest challenges with behavioral health care in Santa Cruz County? Where has the system not worked for the community overall? For the community members with unique needs (e.g Spanish-speaking community in particular)?
  Prompts: *service accessibility (location, hours of operation, etc), language/ cultural sensitivity, timely appointments, staffing, program capacity, program availability/ continuum of care, service coordination/ communication within SCBHS, service coordination/ communication across partner agencies, etc.*
- What, if anything, has been tried to address these challenges? What worked? What hasn't worked?

- What kinds of things do you recommend to address these challenges?
    - What would be needed to bring about these changes?

System Gaps

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

Check-Out:

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

Thank you for your participation! We genuinely appreciate the time you took to speak with us today!

If you have any other comments or feedback you would like to share, feel free to email us or take the MHSA survey. We also encourage you to share the MHSA survey with your networks. The survey will be closed on February 27th.

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

SCBHS MHSA Three Year Plan FY 23-26

Provider Focus Group Protocol

Focus Group Details

Date	
Group	
Interviewer	
Note Taker	

Introduction

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

During this focus group, we want to hear about your experiences as a provider in Santa Cruz county, including what is working well, what has been challenging, service gaps and needs, and strategies for improvement. The feedback you share will help inform work on the Mental Health Services Act Three-Year Plan for 2023-2026 for program and service delivery.

This focus group will take approximately 1 hour. Please note that everything shared here today will be anonymous - no names or identifying information will be paired with what you share.

We really want to hear from all of you, so please give everyone the opportunity to share. And we want to be sure everyone feels comfortable sharing honestly, so please keep what is said here confidential to the group.

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

Introductions

To start could you please share:

- Your name
- The program(s) you work with and who those programs serve
- How long you've been working with those programs or SCBHS

System Strengths

- From your experience, what has been working well with the SCBHS system of care? What are some of the key strengths?
  Prompts: service accessibility (location, hours of operation, etc), language/ cultural sensitivity, timely appointments, staffing, program capacity, program availability/ continuum of care, service coordination/ communication within SCBHS, service coordination/ communication across partner agencies, etc.
- What improvements to the system have you seen over the last few years?
- What has helped facilitate these improvements or system strengths?

System Challenges

- What have been some of the key challenges with the SCBHS system of care? Where has the system not worked for consumers? For you as service providers?
  Prompts: service accessibility (location, hours of operation, etc), language/ cultural sensitivity, timely appointments, staffing, program capacity, program availability/ continuum of care, service coordination/ communication within SCBHS, service coordination/ communication across partner agencies, etc.
- What has been tried to address these challenges? What worked? What hasn't worked?
- What recommendations do you have to help address these challenges?
  - What would be needed to bring about these changes?

System Gaps

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

- What is needed to better serve these populations?

Check-Out:

- In one or two sentences, what is your hope or vision for the SCBHS system of care over the next three years?

Thank you for your participation! We genuinely appreciate the time you took to speak with us today!

If you have any other comments or feedback you would like to share, feel free to email us or take the MHSA survey. We also encourage you to share the MHSA survey with your networks, including your teams and consumers. The survey will be closed on February 27th.

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

Appendix B. Complete CPPP Stakeholder Affiliation & Demographic Data

Table 4. Complete Stakeholder Affiliation of Community Focus Group and Survey Participants

Stakeholder Affiliation	Focus Groups N (%)	Survey N (%)	Total N (%)
Consumer of Behavioral Health Services	**52 (53%)**	**11 (12%)**	**63 (33%)**
Family Member or Loved one of Consumer of Behavioral Health Services	**20 (20%)**	**17 (18%)**	**37 (19%)**
Behavioral Health Services Provider	**12 (12%)**	**28 (29%)**	**40 (21%)**
Peer Support Provider	**1 (1%)**	**5 (5%)**	**6 (3%)**
Other Community Stakeholder	**14 (14%)**	**32 (34%)**	**46 (24%)**
Social Services Provider	--	11 (12%)	11 (6%)
Medical or Health Care Provider	--	8 (8%)	8 (4%)
Public Health Provider	1 (1%)	--	1 (1%)
Education Provider	--	3 (3%)	3 (2%)
Veterans' Service Provider	--	1 (1%)	1 (1%)
Board & Care Provider	--	1 (1%)	1 (1%)
Law Enforcement / Probation Officer	--	1 (1%)	1 (1%)
Consumer Advocate	--	2 (2%)	2 (1%)
Interested Community Member	8 (8%)	5 (5%)	13 (7%)
Other Community Partner	5 (5%)	--	5 (3%)
Unknown / Not Reported	**7 (7%)**	**2 (2%)**	**9 (5%)**
TOTAL	**98 (100%)**	**95 (100%)**	**193 (100%)**

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

Table 5. Complete Demographic Characteristics of CPPP Participants, by CPPP Activities

Demographic Characteristic		Community Survey N (%)	MHCAN Focus Group N (%)	Town Hall & Community Focus Groups N (%)
Age Group	Transition Age Youth (16-25)	9 (9%)	1 (3%)	9 (10%)
	Adults (26-59)	66 (69%)	28 (76%)	20 (23%)
	Older Adults (60+)	19 (20%)	8 (22%)	4 (5%)
	Unknown / Not reported	--	--	53 (62%)
Gender Identity	Female	58 (61%)	11 (30%)	14 (16%)
	Male	30 (32%)	23 (62%)	18 (21%)
	Another Gender Identity	2 (2%)	3 (8%)	--
	Unknown / Not Reported	5 (5%)	--	54 (63%)
Race / Ethnicity	White / Caucasian	68 (72%)	23 (62%)	19 (22%)
	Hispanic / Latinx	29 (31%)	5 (14%)	11 (13%)
	Black / African American	8 (8%)	7 (19%)	16 (19%)
	Another Race / Ethnicity	10 (4%)	2 (5%)	1 (1%)
	Unknown / Not Reported	11 (12%)	--	54 (63%)
Primary Language	English	87 (92%)	--	28 (33%)
	Spanish	3 (3%)	--	5 (6%)

	Another Language	1 (1%)	--	--
	Unknown / Not Reported	4 (4%)	--	53 (62%)
Sexual Orientation	Heterosexual or Straight	56 (59%)	--	25 (29%)
	LGBTQ+	30 (32%)	--	3 (3%)
	Don't Know / Unknown / Not Reported	9 (9%)	--	58 (68%)
U.S. Veteran Status	U.S. Veteran	6 (6%)	--	3 (3%)
	Not a U.S. Veteran	84 (88%)	--	28 (33%)
	Unknown / Not Reported	5 (5%)	--	55 (64%)
Disability Status	Any Disability	28 (29%)	--	9 (10%)
	No Disability	59 (62%)	--	19 (22%)
	Unknown / Not Reported	8 (8%)	--	58 (67%)
TOTAL PARTICIPANTS		**95**	**37**	**68**

Data Notes:

1) Primary language, sexual orientation, veteran status, and disability status were not included in the MHCAN demographic form.

2) Race and ethnicity data sums to greater than 100% as some participants identified with multiple races and ethnicities. Another race/ethnicity includes Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, or Other race.

3) Percentages for other demographic characteristics may not sum exactly to 100% due to rounding.

4) The most reported disabilities were a chronic health condition or a mental disability (i.e., learning disability, developmental disability, dementia). Other reported disabilities included difficulty seeing, difficulty hearing or having speech understood, impaired physical mobility, or another disability.

Appendix C. Community Services and Supports (CSS), FY2021-2022 Annual Reports

CSS #1 Community Gate

Community Gate addresses the mental health needs of children and youth in the community who are at risk of hospitalization, placement, and related factors. These services include assessment, individual group, and family therapy with the goal of improved mental health functioning and maintaining you in the community.

Encompass Youth Services – Community Gate (CSS #1)

Community Supports & Services: 2021-2022

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**150**
Number of individuals/families **ACTUALLY SERVED**	175*	167	181	184	314
Age Group					
• Children 0-15	127	119	131	132	231
• TAY 16-25	48*	48	50	52	83
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	30*	35*	31*	29	55
• Latino	133*	123*	138*	140	238
• Other	12*	9*	12*	15	21
Primary Language					
• English	129*	122*	123*	133	255
• Spanish	46*	45*	58*	50*	88
• Other				1	1
Culture					
• Veterans	N/A	N/A	N/A	N/A	N/A
• LGBTQ	13*	9	16	12	25

These numbers represent the total unduplicated client count for each period.

**Corrected numbers dur to revision of available data*

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

Community Supports & Services: 2021-2022

Agency Reporting	**Pajaro Valley Prevention and Student Assistance**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**100**
Number of individuals/families **ACTUALLY SERVED**	166	146	108	109	218
Age Group					
• Children 0-15	131	119	87	89	169
• TAY 16-25	35	27	21	20	49
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	4	3	3	2	4
• Latino	152	136	98	101	202
• Other	10	7	7	6	12
Primary Language					
• English	139	120	90	88	180
• Spanish	27	26	18	21	38
• Other					
Culture					
• Veterans					
• LGBTQ			1	1	1

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

Community Supports & Services: 2021-2022

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	200	190	201	214	323

Number of individuals/families **ACTUALLY SERVED**	200	240	274	323	323
Age Group					
· Children 0-15	106	107	87	105	155
· TAY 16-25	93	83	114	109	167
· Adults 26-59	1	0	0	0	1
· Older Adults 60+	0	0	0	0	0
Race/Ethnicity					
· White	67	61	65	68	109
· Latino	119	115	123	126	189
· Other	14	14	13	20	25
Primary Language					
· English	172	160	171	176	275
· Spanish	28	30	30	37	47
· Other	0	0	0	1	1
Culture					
· Veterans	0	0	0	0	0
· LGBTQ	18	17	20	24	33

CSS #2 Probation Gate

Probation Gate addresses the mental health needs (including assessment, individual, group, and family therapy) of youth involved with, or at risk of involvement, with the Juvenile Probation system. The system of care goal (as shared with Probation) is to keep youth safely at home rather than in prolonged stays of residential placement or incarcerated in a juvenile hall.

Encompass– Probation Gate (CSS #2)

Community Supports & Services: 2021-2022

Agency Reporting	**Encompass**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**84**
Number of individuals/families **ACTUALLY SERVED**	136	131	142	144	245
Age Group					

• Children 0-15	99	93	103	103	180
• TAY 16-25	37	38	39	41	65
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	23*	28*	24*	23	43
• Latino	104*	96*	108*	109	186
• Other	9*	7*	10*	12	16
Primary Language					
• English	100*	96*	96*	104	175
• Spanish	36*	35*	46*	39	69
• Other				1	1
Culture					
• Veterans	N/A	N/A	N/A	N/A	N/A
• LGBTQ	9	7	13	9	20

Showing an unduplicated client count based on the percentage of MHSA funding. In this report, the number of clients is based on the FY 2020-2021 percentage; the number will be updated once the FY2021-22 percentage is provided. In FY20-21 Youth Services – Probation Gate was 78% funded by MHSA.
**Corrected numbers due to revision of available data*

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

Community Supports & Services: 2021-2022

Agency Reporting	**Pajaro Valley Prevention and Student Assistance**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**68**
Number of individuals/families **ACTUALLY SERVED**	25	15	15	7	45
Age Group					
• Children 0-15	16	10	14	6	31
• TAY 16-25	9	5	1	1	14
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White					

• Latino	21	12	15	7	41
• Other	4	3			4
Primary Language					
• English	20	13	10	5	37
• Spanish	5	2	5	2	8
• Other					
Culture					
• Veterans					
• LGBTQ					

CSS #3 Child Welfare Services Gate

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

Parent Center– Child Welfare Gate (CSS #3)

Community Supports & Services: 2021-2022

Agency Reporting	**Parent Center**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**30**
Number of individuals/families **ACTUALLY SERVED**	5	3	3	10	21
Age Group					
• Children 0-15	5	3	3	9	
• TAY 16-25				1	
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	4	2		6	
• Latino	1	1	2	3	
• Other			1	1	
Primary Language					
• English	5	3	3	9	
• Spanish				1	
• Other					
Culture					

• Veterans					
• LGBTQ					

Encompass– Child Welfare Gate (CSS #3)

Community Supports & Services: 2021-2022

Agency Reporting	**Encompass**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**13**
Number of individuals/families **ACTUALLY SERVED**	15	17	13	10	18
Age Group					
• Children 0-15	1	1	0	0	1
• TAY 16-25	14	16	13	10	17
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	1	1	1	1	1
• Latino	12	13	10	8	15
• Other	2	3	2	1	2
Primary Language					
• English	13	14	10	8	15
• Spanish	2	3	3	2	3
• Other					
Culture					
• Veterans	*Data not tracked*				
• LGBTQ	2	4	4	4	4

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

Community Supports & Services: 2021-2022

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

Number of individuals/families targeted:	93	78	75	80	141
Number of individuals/families **ACTUALLY SERVED**	93	110	126	141	141
Age Group					
· Children 0-15	66	58	47	49	88
· TAY 16-25	26	20	28	31	52
· Adults 26-59	1	0	0	0	1
· Older Adults 60+	0	0	0	0	0
Race/Ethnicity					
· White	32	30	25	28	49
· Latino	52	40	39	42	77
· Other	9	8	11	10	15
Primary Language					
· English	85	70	67	72	127
· Spanish	7	8	8	8	13
· Other	1	0	0	0	1
Culture					
· Veterans	0	0	0	0	0
· LGBTQ	5	4	5	5	7

CSS #4 Education Gate

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

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

Community Supports & Services: 2021-2022

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	21	21	15	16	33
Number of individuals/families **ACTUALLY SERVED**	21	25	29	33	33
Age Group					

· Children 0-15	8	8	1	2	9
· TAY 16-25	13	13	14	14	24
· Adults 26-59	0	0	0	0	0
· Older Adults 60+	0	0	0	0	0
Race/Ethnicity					
· White	3	3	4	5	5
· Latino	17	17	11	11	27
· Other	1	1	0	0	1
Primary Language					
· English	19	19	14	14	29
· Spanish	2	2	1	2	4
· Other	0	0	0	0	0
Culture					
· Veterans	0	0	0	0	0
· LGBTQ	3	4	2	2	4

CSS #5 Special Focus: Family Partnership

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

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

Community Supports & Services: 2021-2022

Agency Reporting	**Volunteer Center / Community Connect**				
System Development:	Q1	Q2	Q3	Q4	**Annual**

Number of individuals/families targeted:					**50**
Number of individuals/families **ACTUALLY SERVED**	25	23	29	33	49
Age Group					
• Children 0-15	19	17	22	25	37
• TAY 16-25	6	6	7	8	12
• Adults 26-59					
• Older Adults 60+					
Race/Ethnicity					
• White	10	5	6	7	13
• Latino	11	11	16	18	25
• Other	4	7	7	8	11
Primary Language					
• English	18	14	18	22	33
• Spanish	7	9	11	11	16
• Other					
Culture					
• Veterans	-	-	-	-	-
• LGBTQ	4	3	3	1	4

CSS #6 Enhanced Crisis Response

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

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

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

Community Supports & Services: 2021-2022

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					

Number of individuals/families targeted					**15**
Number Actually Served	8	4	5	8	**18**
Adults (26-59)					
Number of individuals/families targeted					**70**
Number Actually Served	37	31	27	36	**93**
Older Adults (60+)					
Number of individuals/families targeted					**15**
Number Actually Served:	4	4	2	5	12
Age Group					
• Children 0-15					
• TAY 16-25	8	4	5	8	18
• Adults 26-59	37	31	27	36	93
• Older Adults 60+	4	4	2	5	12
Race/Ethnicity					
• White	29	26	26	30	79
• Latino	11	6	6	12	25
• Other	9	7	2	7	19
Primary Language					
• English	48	37	33	48	120
• Spanish	1	2	1	1	3
• Other					
Culture					
• Veterans	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected
• LGBTQ	1	3	6	4	7

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

Community Supports & Services: 2021-2022

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					**20**
Number Actually Served	2	3	7	9	**19**
Adults (26-59)					
Number of individuals/families targeted					**65**
Number Actually Served	32	29	33	24	**92**
Older Adults (60+)					
Number of individuals/families targeted					**15**
Number Actually Served:	4	3	4	5	15
Age Group					
• Children 0-15					
• TAY 16-25	2	3	7	9	19
• Adults 26-59	32	29	33	24	92
• Older Adults 60+	4	3	4	5	15

Race/Ethnicity					
• White	29	25	25	21	81
• Latino	5	6	9	8	23
• Other	4	4	10	9	22
Primary Language					
• English	36	34	38	35	116
• Spanish	2	1	3	2	6
• Other	0	0	3	1	4
Culture					
• Veterans	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected
• LGBTQ	1	3	1	0	3

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

Community Supports & Services: 2021-2022

Agency Reporting	**MHCAN**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**100**
Number of individuals/families **ACTUALLY SERVED**	27	33	28	31	119

Demographic breakdown not required for Outreach & Engagement

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

Community Supports & Services: 2021-2022

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	202	146	153	193	627
Number of individuals/families **ACTUALLY SERVED**	202	328	467	627	627
Age Group					
· Children 0-15	0	0	0	0	0
· TAY 16-25	45	31	26	40	128
· Adults 26-59	134	103	117	130	438

· Older Adults 60+	23	12	10	23	61
Race/Ethnicity					
· White	110	83	85	102	339
· Latino	65	41	55	68	208
· Other	27	22	13	23	80
Primary Language					
· English	183	134	143	174	572
· Spanish	13	8	9	13	38
· Other	6	4	1	6	17
Culture					
· Veterans	0	1	0	1	2
· LGBTQ	6	7	2	3	14

CSS #7 Consumer, Peer, & Family Support Services

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

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

Community Supports & Services: 2021-2022

Agency Reporting	**MHCAN, Outreach Reporting**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**80**
Number of individuals/families **ACTUALLY SERVED**	32	65	47	52	189

Demographic breakdown not required for Outreach & Engagement

Community Supports & Services: 2021-2022

Full Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					**200**
Number Actually Served	123	120	178	67	**502**
Adults (26-59)					

Number of individuals/families targeted					**350**
Number Actually Served	178	221	329	223	**1052**
Older Adults (60+)					
Number of individuals/families targeted					**50**
Number Actually Served:	96	61	76	83	201
Age Group					
• Children 0-15	(17)	(12)	(5)	(23)	(33)
• TAY 16-25	123	120	178	67	502
• Adults 26-59	111	221	329	223	1051
• Older Adults 60+	96	61	76	83	201
Race/Ethnicity					
• White	167	172	243	147	703
• Latino	124	121	118	162	707
• Other	39	109	222	64	345
Primary Language					
• English	279	152	299	128	809
• Spanish	39	43	54	41	211
• Other	12	207	230	204	735
Culture					
• Veterans	31	37	25	42	54
• LGBTQ	63	121	143	172	253

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

Community Supports & Services: 2021-2022

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					**8**
Number Actually Served					**1**
Adults (26-59)	1	0	0	0	
Number of individuals/families targeted					**25**
Number Actually Served	19	14	10	9	**19**
Older Adults (60+)					
Number of individuals/families targeted					**7**
Number Actually Served:	7	6	5	5	7
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	1	0	0	0	1
• Adults 26-59	19	14	10	9	19
• Older Adults 60+	7	6	5	5	7
Race/Ethnicity					
• White	12	11	8	8	12
• Latino	12	7	5	4	12
• Other	3	2	2	2	3

Primary Language					
• English	21	16	13	12	21
• Spanish	6	4	2	2	6
• Other	0	0	0	0	0
Culture					
• Veterans	0	1	1	1	1
• LGBTQ	3	2	1	1	3

Annual Outreach Target: 50 - No outreach numbers reported.

CSS #8 Community Support Services

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

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

Community Supports & Services: 2021-2022

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					**6**
Number Actually Served	1	1	1	3	**4**
Adults (26-59)					
Number of individuals/families targeted					**28**
Number Actually Served	10	15	16	12	**31**
Older Adults (60+)					
Number of individuals/families targeted					**6**
Number Actually Served:	1	1	0	2	2
Age Group					
• Children 0-15					
• TAY 16-25	1	1	1	3	4
• Adults 26-59	10	15	16	12	31
• Older Adults 60+	1	1	0	2	2
Race/Ethnicity					
• White	8	15	12	11	25
• Latino	2	2	5	3	8
• Other	2	0	0	3	4
Primary Language					
• English	11	16	16	17	35

• Spanish	1	1	1	0	2
• Other					
Culture					
• Veterans	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected
• LGBTQ	2	3	3	3	5

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

Community Supports & Services: 2021-2022

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					
Number Actually Served					
Adults (26-59)					
Number of individuals/families targeted					**60**
Number Actually Served	17	16	14	11	**19**
Older Adults (60+)					
Number of individuals/families targeted					**0**
Number Actually Served:	14	12	14	11	16
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59	17	16	14	11	19
• Older Adults 60+	14	12	14	11	16
Race/Ethnicity					
• White	25	24	23	19	29
• Latino	2	2	2	1	2
• Other	4	2	3	2	4
Primary Language					
• English	31	28	28	22	35
• Spanish					
• Other					
Culture					
• Veterans	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected
• LGBTQ	3	4	3	3	4

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

Community Supports & Services: 2021-2022

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition 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	10	10	12	12	**17**
Older Adults (60+)					
Number of individuals/families targeted					**2**
Number Actually Served:	6	5	5	5	5
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59	10	10	12	12	17
• Older Adults 60+	6	5	5	5	5
Race/Ethnicity					
• White	9	8	10	10	13
• Latino	6	6	6	6	8
• Other	1	1	1	1	1
Primary Language					
• English	13	12	14	14	18
• Spanish	3	3	3	3	4
• Other					
Culture					
• Veterans	0	0	0	0	0
• LGBTQ	0	0	0	0	0

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

Community Supports & Services: 2021-2022

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition 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	12	13	13	13	**13**
Older Adults (60+)					
Number of individuals/families targeted					**2**
Number Actually Served:	3	2	2	2	3
Age Group					
• Children 0-15					
• TAY 16-25					
• Adults 26-59	12	13	13	13	13
• Older Adults 60+	3	2	2	2	3
Race/Ethnicity					
• White	13	13	13	13	14
• Latino					
• Other	2	2	2	2	2
Primary Language					
• English	15	15	15	15	16

• Spanish					
• Other					
Culture					
• Veterans	0	0	0	0	0
• LGBTQ	0	0	0	0	0

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

Community Supports & Services: 2021-2022

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition 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	22	23	26	26	**29**
Older Adults (60+)					
Number of individuals/families targeted					**20**
Number Actually Served:	20	20	21	18	23
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	0	0	0	0	0
• Adults 26-59	22	23	26	26	29
• Older Adults 60+	20	20	21	21	23
Race/Ethnicity					
• White	34	35	41	41	41
• Latino	6	5	5	5	7
• Other	2	3	1	1	4
Primary Language					
• English	42	43	47	47	52
• 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

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

Community Supports & Services: 2021-2022

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	369	339	344	358	505

Number of individuals/families **ACTUALLY SERVED**	369	412	458	505	505
Age Group					
· Children 0-15	2	0	1	2	5
· TAY 16-25	11	3	3	5	13
· Adults 26-59	267	252	258	275	376
· Older Adults 60+	89	84	82	76	111
Race/Ethnicity					
· White	245	223	234	235	337
· Latino	83	76	80	84	111
· Other	41	40	30	39	57
Primary Language					
· English	342	313	320	329	469
· Spanish	19	17	17	20	25
· Other	8	9	7	9	11
Culture					
· Veterans	2	2	1	0	2
· LGBTQ	8	8	11	12	13

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

Community Supports & Services: 2021-2022

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	56	57	68	66	101
Number of individuals/families **ACTUALLY SERVED**	56	57	88	101	101
Age Group					
· Children 0-15	0	0	0	0	0
· TAY 16-25	0	0	0	0	0
· Adults 26-59	0	2	0	1	3
· Older Adults 60+	56	55	68	65	98
Race/Ethnicity					
· White	45	47	59	53	84
· Latino	6	4	3	5	7

· Other	5	6	6	8	10
Primary Language					
· English	53	55	66	63	96
· Spanish	1	0	0	0	1
· Other	2	2	2	3	4
Culture					
· Veterans	1	1	1	1	1
· LGBTQ	2	3	3	3	3

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

Community Supports & Services: 2021-2022

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	99	110	106	96	144
Number of individuals/families **ACTUALLY SERVED**	99	118	139	144	144
Age Group					
· Children 0-15	0	0	0	0	0
· TAY 16-25	7	9	7	8	9
· Adults 26-59	87	92	93	83	124
· Older Adults 60+	5	9	6	5	11
Race/Ethnicity					
· White	57	59	62	58	85
· Latino	33	38	31	28	42
· Other	9	13	13	10	17
Primary Language					
· English	95	104	101	91	138
· Spanish	4	5	4	4	5
· Other	0	1	1	1	1
Culture					
· Veterans	1	1	0	0	1
· LGBTQ	2	3	3	3	3

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

Community Supports & Services: 2021-2022

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					**25**
Number Actually Served	0	2	1	2	**3**
Adults (26-59)					
Number of individuals/families targeted					**10**
Number Actually Served	5	8	15	15	**26**
Older Adults (60+)					
Number of individuals/families targeted					**5**
Number Actually Served:	3	2	2	3	5
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	0	2	1	2	3
• Adults 26-59	5	8	15	15	26
• Older Adults 60+	3	2	2	3	5
Race/Ethnicity					
• White	5	10	13	14	24
• Latino	1	0	1	3	4
• Other	2	2	4	3	6
Primary Language					
• English	8	12	18	20	34
• Spanish	0	0	0	0	0
• Other	0	0	0	0	0
Culture					
• Veterans	0	1	1	1	2
• LGBTQ	1	2	6	7	8

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

Community Supports & Services: 2021-2022

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition 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	8	13	12	11	**15**
Older Adults (60+)					
Number of individuals/families targeted					**15**

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

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

Community Supports & Services: 2021-2022

Full-Service Partnerships	Q1	Q2	Q3	Q4	Annual
Q1Transition Age Youth (16-25)					
Number of individuals/families targeted					**10**
Number Actually Served	2	2	1	1	**2**
Adults (26-59)					
Number of individuals/families targeted					**50**
Number Actually Served	18	19	17	18	**23**
Older Adults (60+)					
Number of individuals/families targeted					**10**
Number Actually Served:	4	5	7	6	7
Age Group					
• Children 0-15	0	0	0	0	0
• TAY 16-25	2	2	1	1	2
• Adults 26-59	18	19	17	18	23
• Older Adults 60+	4	5	7	6	7
Race/Ethnicity					
• White	16	18	17	16	20
• Latino	3	3	3	3	5
• Other	5	5	5	6	7
Primary Language					
• English	24	26	25	25	32
• Spanish	0	0	0	0	0
• Other	0	0	0	0	0
Culture					
• Veterans	0	1	0	1	1

• LGBTQ	5	5	4	3	5

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

Community Supports & Services: 2021-2022

Agency Reporting	**Volunteer Center/ Community Connection**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:					**40**
Number of individuals/families **ACTUALLY SERVED**	12	14	12	14	19

Demographic breakdown not required for Outreach & Engagement

Appendix D. Prevention & Early Intervention (PEI), FY2021-2022 Annual Reports

PEI #1 Prevention

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

Prevention & Early Intervention Report: 2021-2022 Annual Target #: 1,300

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Unduplicated Client Count	43	41	75	94	193
Age:					
0-15					
16-25	1	1	6	6	10
26-59	42	40	69	82	177
60 +				1	1
Declined to State				5	5
Language:					
English	25	23	52	53	113
Spanish	18	18	23	36	74
Other					1
Declined to State				5	5
Race:					
American Indian		1	3	3	4
Black		1	1	1	1
White	39	30	62	74	163
Other		5	3	4	6
More than one	3	1	4	5	9
Declined to State	1	3	2	7	10
Ethnicity					
Latino	31	35	54	72	136
African					
Asian Indian/South Asian					
Filipino					
Other (e.g., Asian)			1		1
More than One					
Declined to State	12	6	20	22	56
Veteran					
Yes	1	1	1	1	3
No	41	38	72	87	180
Declined to State		1	2	6	9
Unknown**	1	1			1
Sexual Orientation					
Gay or Lesbian					
Heterosexual or Straight	34	31	54	73	148
Questioning or Unsure					
Queer					
Another Sexual Orientation (e.g., bisexual)	2	1	4	1	6
Declined to State	6	8	17	20	38
Unknown**	1	1			1
Gender Assigned at birth					
Male	11	15	22	17	43
Female	30	23	43	67	130

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Declined to State	1	2	10	10	19
Unknown**	1	1			1
Current Gender Identity					
Male	10	17	24	19	45
Female	32	24	49	69	141
Transgender Male			1	1	1
Transgender Female	1				1
Gender Queer					
Questioning or Unsure					
Declined to State			1	5	5
Write in Option					
Disability					
Yes***(total unique clients with disability)*	2	3	6	8	14
• Communication Domain					
Difficulty Seeing				2	2
Difficulty Hearing	1	1	3	2	3
Difficulty Having Speech Understood			1		1
• Mental Domain					
(mental illness, learning disability, developmental disability, dementia)	1	1	1	3	6
• Physical/mobility			2		2
• Chronic health condition			1		1
• Other (Specify)		1 ("nerves")	1 ("nerves")	1 (ADHD)	2 ("nerves," ADHD)
No	40	35	67	80	168
Declined to State		2	2	6	10
Unknown**	1	1			1
Other Relevant Data					
Children of parents receiving intensive services *(unduplicated)*	73	70	120	175	329
Parents in brief services (L2 Individual, Seminars, Workshops, Inmate Program) *(unique within each brief service, and overall; may duplicate Intensive Service clients in this report)*	L2 Indiv: 190 Seminars: 6 Workshops: 41 Inmate: 18 **Total: 253** *(unique across all brief services)*	L2 Indiv: 102 Seminars: 16 Workshops: 30 Inmate: 13 **Total: 158** *(unique across all brief services)*	L2 Indiv: 90 Seminars: 10 Workshops: 85 Inmate: 15 **Total: 194** *(unique across all brief services)*	L2 Indiv: 113 Seminars: 8 Workshops: 14 Inmate: 27 **Total: 161** *(unique across all brief services)*	L2 Indiv: 488 Seminars: 39 Workshops: 160 Inmate: 55 **Total: 727** *(unique across all brief services)*
Children of parents in brief services (L2 Individual, Seminars, Workshops, Inmate Program) *(estimated; includes duplicates)*	L2 Indiv: 329 Seminars: 9 Workshops: 82 Inmate: 11 **Total: 431**	L2 Indiv: 183 Seminars: 28 Workshops: 67 Inmate: 23 **Total: 301**	L2 Indiv: 184 Seminars: 18 Workshops: 183 Inmate: 12 **Total: 397**	L2 Indiv: 209 Seminars: 21 Workshops: 34 Inmate: 17 **Total: 281**	L2 Indiv: 893 Seminars: 77 Workshops: 343 Inmate: 42 **Total: 1,355**

* Clients who did not consent to have their data included in the program evaluation ("non-consenters") were reported by participating partner agencies to First 5 at the end of the fiscal year, which increased the client numbers—specifically the "Declined to State" numbers—in the Q4 and Annual columns.
** "Unknown" - These clients were using older program forms that did not yet include all options for this demographic question.
*** Some clients had multiple disabilities, so the total number of specific disabilities may be greater than the unduplicated number of clients.

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

Prevention & Early Intervention Report: 2021-2022

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Unduplicated Client Count	58	34	60	67	219
Age:					
0-15	3	7	6	19	35
16-25	7	3	3	3	16
26-59	45	22	46	41	154
60 +	3	2	3	6	14
Declined to State	-	-	-	-	-
Language:					
English	16	8	12	18	54
Spanish	39	24	45	43	151
Other	3	2	3	6	14
Declined to State	-	-	-	-	-
Race:					
American Indian	0	0	1	0	1
Black	0	0	0	0	0
White	14	4	9	14	41
Other	0	2	3	7	12
More than one	43	27	46	46	162
Declined to State	1	1	1	0	3
Ethnicity					
Latino	40	28	50	53	171
African	0	0	0	0	0
Asian Indian/South Asian	0	0	0	3	3
Filipino	1	0	0	0	1
Other	0	2	2	2	6
More than One	16	3	8	9	36
Declined to State	1	1	0	0	2
Veteran					
Yes	1	0	0	0	1
No	25	19	22	23	89
Declined to State	32	15	38	44	129
Unknown**	-	-	-	-	-
Sexual Orientation					
Gay or Lesbian	0	0	0	0	0
Heterosexual or Straight	26	9	25	21	81
Questioning or Unsure	-	-	-	-	-
Queer	-	-	-	-	-
Another Sexual Orientation (e.g., bisexual)	-	-	-	-	-
Declined to State	32	25	35	46	138

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Unknown**	-	-	-	-	-
Gender Assigned at birth					
Male	12	11	15	23	61
Female	46	23	45	44	158
Declined to State	0	0	0	0	0
Unknown**	-	-	-	-	-
Current Gender Identity					
Male	12	11	15	23	61
Female	46	23	45	44	158
Transgender Male	-	-	-	-	-
Transgender Female	-	-	-	-	-
Gender Queer	-	-	-	-	-
Questioning or Unsure	-	-	-	-	-
Declined to State	-	-	-	-	-
Write in Option					
Disability					
Yes***(total unique clients with disability)*	2	1	2	3	8
• Communication Domain					
Difficulty Seeing					
Difficulty Hearing					
Difficulty Having Speech Understood					
• Mental Domain	1		1	1	3
(mental illness, learning disability, developmental disability, dementia)					
• Physical/mobility				1	1
• Chronic health condition	1	1	1	1	4
• Other (Specify)					
No	31	19	32	27	109
Declined to State	25	14	24	37	100

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

Prevention & Early Intervention Report: 2021-2022

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Unduplicated Client Count	-	-	-	-	-
Age:					
0-15	555	484	418	327	1784
16-25	672	462	580	383	2097
26-59	-	-	-	-	-
60 +	-	-	-	-	-
Declined to State	-	-	-	-	-
Language:					
English	689	693	740	454	2576
Spanish	544	247	258	256	1305
Other	-	-	-	-	-
Declined to State	-	-	-	-	-
Race:					
American Indian	1	1	-	-	2

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Black	2	2	2	2	8
White	1195	914	966	676	3751
Other	25	25	25	25	100
More than one	5	5	5	5	20
Declined to State	-	-	-	-	-
Ethnicity					
Latino	548	251	262	260	1321
African	-	-	-	-	-
Asian Indian/South Asian	2	2	3	3	10
Filipino	1	1	0	0	2
Other (e.g., Asian)	636	636	636	640	2548
More than One	-	-	-	-	-
Declined to State	-	-	-	-	-
Veteran					
Yes	-	-	-	-	-
No	970	970	970	971	3881
Declined to State	-	-	-	-	-
Unknown**	-	-	-	-	-
Sexual Orientation					
Gay or Lesbian	248	278	657	424	1807
Heterosexual or Straight	722	203	60	47	1032
Questioning or Unsure	35	45	29	31	140
Queer	122	120	152	108	502
Another Sexual Orientation (e.g., bisexual)	100	100	100	100	400
Declined to State	-	-	-	-	-
Unknown**	-	-	-	-	-
Gender Assigned at birth					
Male	384	223	282	178	1067
Female	545	425	418	232	1620
Declined to State	299	299	298	298	1194
Unknown**	-	-	-	-	-
Current Gender Identity					
Male	384	247	307	205	1143
Female	484	469	441	287	1681
Transgender Male	50	47	49	45	191
Transgender Female	44	26	28	27	125
Gender Queer	85	75	75	71	306
Questioning or Unsure	179	71	87	78	415
Declined to State	5	5	5	5	20
Write in Option	-	-	-	-	-
Disability					
Yes***(total unique clients with disability)*					
• Communication Domain					
Difficulty Seeing	87	87	87	87	350
Difficulty Hearing	10	10	10	10	40
Difficulty Having Speech Understood					
• Mental Domain					

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
(mental illness, learning disability, developmental disability, dementia)	142	141	141	141	565
• Physical/mobility	3	4	4	4	15
• Chronic health condition	6	6	6	7	25
• Other (Specify)					
No	722	722	721	721	2886
Declined to State					

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

Prevention & Early Intervention Report: 2021-2022

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Unduplicated Client Count	10,070	10,070	10,070	10,070	10,070
Age:					
0-15	9087	9087	9087	9087	9087
16-25	983	983	983	983	983
26-59	-	-	-	-	-
60 +	-	-	-	-	-
Declined to State	-	-	-	-	-
Language:					
English	7910	7910	7910	7910	7910
Spanish	1164	1164	1164	1164	1164
Other					
Declined to State					
Race:					
American Indian	39	39	39	39	39
Black	97	97	97	97	97
White	4834	4834	4834	4834	4834
Other	1238	1238	1238	1238	1238
More than one	534	534	534	534	534
Declined to State	-	-	-	-	-
Ethnicity					
Latino	3051	3051	3051	3051	3051
African	96	96	96	96	96
Asian Indian/South Asian	320	320	320	320	320
Filipino	66	66	66	66	66
Other (e.g., Asian)	4080	4080	4080	4080	4080
More than One	538	538	538	538	538
Declined to State	-	-	-	-	-
Veteran					
Yes					
No					
Declined to State	10,070	10,070	10,070	10,070	10,070
Unknown**					
Sexual Orientation					
Gay or Lesbian					
Heterosexual or Straight					
Questioning or Unsure					
Queer					

	Quarter 1	Quarter 2	Quarter 3	Quarter 4*	Annual*
Another Sexual Orientation (e.g., bisexual)					
Declined to State	10,070	10,070	10,070	10,070	10,070
Unknown**					
Gender Assigned at birth					
Male					
Female					
Declined to State	10,070	10,070	10,070	10,070	10,070
Unknown**					
Current Gender Identity					
Male					
Female					
Transgender Male					
Transgender Female					
Gender Queer					
Questioning or Unsure					
Declined to State	10,070	10,070	10,070	10,070	10,070
Write in Option					
Disability					
Yes***(total unique clients with disability)*					
• Communication Domain					
Difficulty Seeing					
Difficulty Hearing					
Difficulty Having Speech Understood					
• Mental Domain					
(mental illness, learning disability, developmental disability, dementia)					
• Physical/mobility					
• Chronic health condition					
• Other (Specify)	598	598	598	598	598
No					
Declined to State					
Unknown**	4376	4376	4376	4376	4376

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

Prevention & Early Intervention Report: 2021-2022

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	61	56	61	59	237
Age:					
0-15	0	0	0	0	0
16-25	0	0	1	0	1
26-59	26	21	14	15	76
60 +	35	35	46	44	160
Declined to answer	0	0	0	0	0
Language:					
English	62	56	61	59	237

Spanish	8	4	8	4	24
Other	1	0	1	0	2
Race:					
American Indian or Alaskan Native	0	1	0	0	1
Black	4	4	3	4	15
White	42	39	48	48	177
Asian	0	1	0	1	2
Native Hawaiian or Other Pacific Islander	0	1	0	0	0
Declined to answer	12	7	5	4	28
Other	3	3	5	2	13
Ethnicity					
Hipanic or Latino	9	8	9	9	35
Not hispanic or Latino	40	38	42	46	166
Declined to answer	12	7	5	4	28
Other	0	3	5	0	8
Veteran					
Yes	60	53	61	56	230
No	1	3	0	3	7
Declined to State	0	0	0	0	0
Sexual Orientation					
Gay or Lesbian	1	1	1	0	3
Heterosexual or Straight	40	33	43	42	158
Bisexual	0	0	0	0	0
Queer	0	0	1	0	0
Another Sexual Orientation	0	1	0	0	1
Declined to answer	20	21	16	17	74
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	54	39	55	50	198
Female	3	7	3	5	18
Declined to amswer	4	10	3	4	21
Current Gender Identity					
Male	54	39	55	50	198
Female	3	7	3	5	18
Transgendergender	0	0	0	0	0
Gemderqueer	0	0	0	0	0
Questioning or Unsure	0	0	0	0	0
Another gender idenity	0	0	0	0	0
Declined to answer	4	10	3	4	21

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

Prevention & Early Intervention Report: 2021-2022

Unduplicated Client Count	**#**	**Race**	**#**	**Sexual Orientation**	**#**	**Primary Language***	**#**
		American Indian	1	Gay or Lesbian	0	English	10
Quarter 1	14	Asian	1	Heterosexual or Straight	11	Spanish	1
Quarter 2	14	Black	0	Questioning/Unsure	0	Other	1
Quarter 3	14	White	10	Queer	0		

Quarter 4	12	Other	0	Another sexual orientation	0	**Disability**	**#**
Annual		More than one	0	Declined to state	1	Yes:	
		Declined to state	0			Communication domain:	
Age	**#**			**Gender assigned at birth**	**#**	Difficulty seeing	3
0-15		**Ethnicity**	**#**	Male	7	Difficulty hearing	3
16-25		Latino	1	Female	5	Difficulty having speech understood	0
26-59		African	0	Declined to state	0	Mental domain	12
Age60+	12	Asian Indian/South Asian	0	**Current Gender Identity**	**#**	(mental illness, learning disability,	
		Cambodian	0	Male	7	Developmental disability, dementia)	
Veteran	**#**	Chinese	0	Female	5	Physical/mobiity domain	1
Yes	2	Eastern European	0	Transgender Male	0	Chronic health condition	10
No	10	Filipino	0	Transgender Female	0	Other (specify):	0
Declined to state		Japanese	1	Genderqueer	0		
		Korean	0	Questioning or unsure	0	No	0
		Middle Eastern	0	Declined to state	0	Declined to state	0
		Vietnamese	0	Write in option:		**Other relevant data**	
		Other	10			N/A	
		More than one	0				
		Declined to State	0				

Peer Companion Evaluation Documents

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

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

Senior Companion (print) _____

Senior Companion Signature _____

Coordinator Signature _____

Volunteer Site _____

Client Name (or number) _____

Client Date of Birth _____ Client Age _____

Check Service Being Provided (choose only one)

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

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

Supervisor (print) _____

Supervisor Signature _____ Date: _____

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

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

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

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

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

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

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

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

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

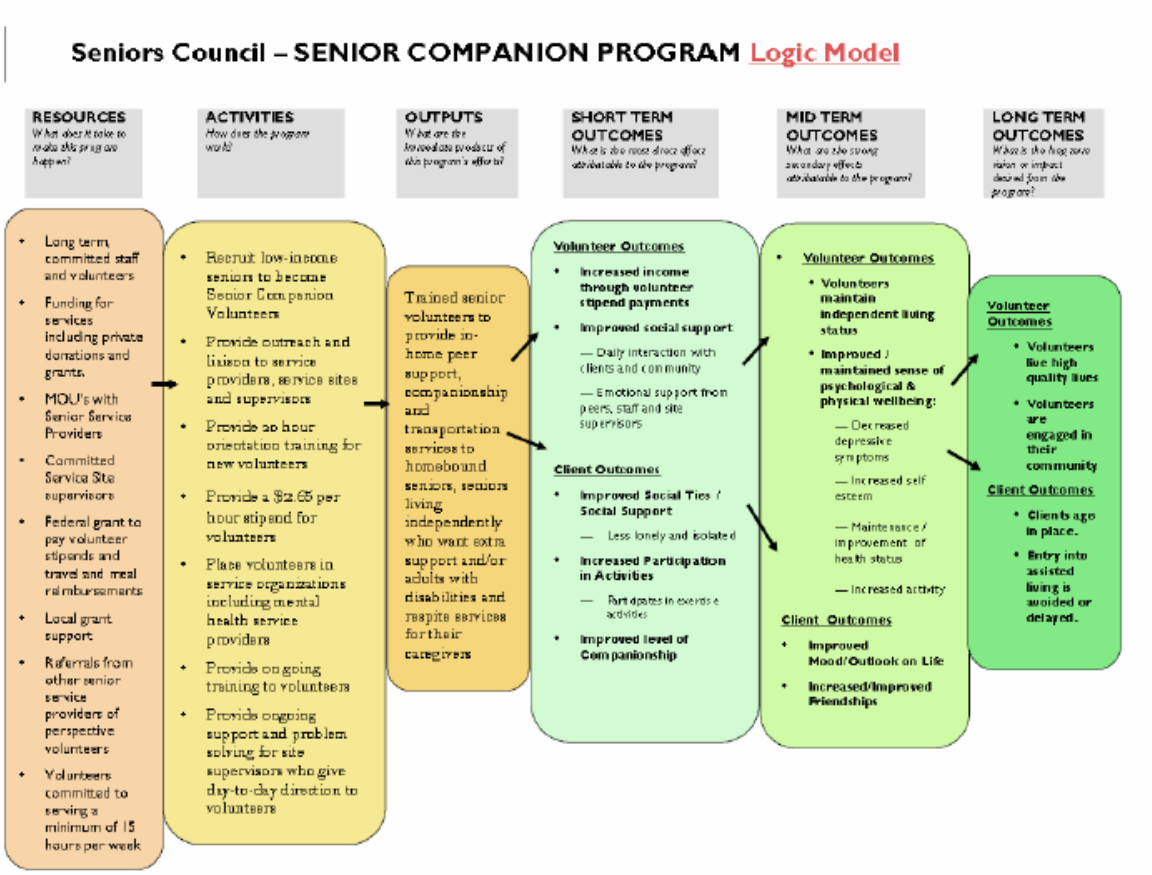
COMPANIONSHIP

- ☐ Develops one-on-one friendships
- ☐ Improved contact with family
- ☐ Improved contact with peers

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
Less lonely and isolated	☐	☐	☐	☐	☐
Relationships with other people	☐	☐	☐	☐	☐
Relationship with people who will help in time of need	☐	☐	☐	☐	☐
Participates in arts and crafts	☐	☐	☐	☐	☐
Plays games with others	☐	☐	☐	☐	☐
Participates in exercise activities	☐	☐	☐	☐	☐
Improve Self-esteem	☐	☐	☐	☐	☐
Engages in conversation about life and memories	☐	☐	☐	☐	☐
Writes letters	☐	☐	☐	☐	☐
Improved socially appropriate behaviors	☐	☐	☐	☐	☐
Improved morale and outlook in life	☐	☐	☐	☐	☐
Improve reality orientation	☐	☐	☐	☐	☐
Develops one-on-one friendships	☐	☐	☐	☐	☐
Improved contact with family	☐	☐	☐	☐	☐
Improved contact with peers	☐	☐	☐	☐	☐



PEI #2 Early Intervention

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

Prevention & Early Intervention Report: 2021-2022

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	8	17	29	29	37
Age:					
0-15	0	0	0	0	0
16-25	5	11	22	23	29
26-59	3	6	7	6	8
60 +	0	0	0	0	0
Declined to answer	0	0	0	0	0
Language:					
English	7	12	23	25	31
Spanish	1	3	4	4	4
Other	0	2	2	0	2
Race:					
American Indian or Alaskan Native	0	0	0	0	0
Black	0	0	1	1	1
White	4	5	12	12	17

Asian	0	1	2	0	2
Native Hawaiian or Other Pacific Islander	0	0	0	0	0
Declined to answer	0	0	0	0	0
Other	0	0	0	0	0
Ethnicity					
Hipanic or Latino	3	9	12	13	14
Not hispanic or Latino	0	0	0	0	0
Declined to answer	0	0	0	0	0
Other	1	2	2	3	3
Veteran					
Yes	0	0	0	0	0
No	8	17	29	29	37
Declined to State	0	0	0	0	0
Sexual Orientation					
Gay or Lesbian	0	0	1	1	1
Heterosexual or Straight	12	12	18	17	22
Bisexual	0	0	0	0	0
Queer	0	0	0	0	0
Another Sexual Orientation	2	2	5	5	6
Declined to answer	3	3	5	6	8
Gender Assigned at birth	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Male	4	12	17	18	20
Female	4	5	12	11	17
Declined to amswer	0	0	0	0	0
Current Gender Identity					
Male	3	12	17	18	20
Female	4	3	10	10	15
Transgendergender	0	1	1	1	1
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	0	1	1	0	1

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

Prevention & Early Intervention Report: 2021-2022

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	0	1	0	2	3
Number of individuals/families **ACTUALLY SERVED**	0	1	1	3	3
Age Group					
· Children 0-15	0	1	0	2	3
· TAY 16-25	0	0	0	0	0

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

PEI #3 Outreach

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

Prevention & Early Intervention Report: 2021-2022

Unduplicated Client Count	**#**	**Race**	**#**	**Sexual Orientation**	**#**	**Primary Language***	**#**
		American Indian	0	Gay or Lesbian	0	English	19
Quarter 1		Asian	1	Heterosexual or Straight	0	Spanish	1
Quarter 2		Black	1	Questioning/Unsure	0	Other	1
Quarter 3		White	15	Queer	0		
Quarter 4	21	Other	0	Another sexual orientation	0	**Disability**	**#**
Annual		More than one	0	Declined to state	20	Yes:	
		Declined to state	3			Communication domain:	
Age	**#**			**Gender assigned at birth**	**#**	Difficulty seeing	0
0-15	0	**Ethnicity**	**#**	Male	3	Difficulty hearing	0
16-25	0	Latino	2	Female	17	Difficulty having speech understood	0
26-59	1	African	1	Declined to state	0	Mental domain	
Age60+	19	Asian Indian/South Asian	1	**Current Gender Identity**	**#**	(mental illness, learning disability,	0
		Cambodian	0	Male	0	Developmental disability, dementia)	0

Veteran	#	Chinese	0	Female	2	Physical/mobiity domain	0
Yes	1	Eastern European	0	Transgender Male	0	Chronic health condition	0
No	20	Filipino	0	Transgender Female	0	Other (specify):	
Declined to state		Japanese	0	Genderqueer	0		
		Korean	0	Questioning or unsure	0	No	0
		Middle Eastern	0	Declined to state	18	Declined to state	7
		Vietnamese	0	Write in option:		**Other relevant data**	
		Other	2			Clients seen at home	3
		More than one	0				
		Declined to State	14				

PEI #4 Stigma and Discrimination Reduction

No demographic reporting required for Outreach & Engagement activities.

PEI #5 Suicide Prevention

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

Prevention & Early Intervention Report: 2021-2022

Agency Reporting	**Suicide Prevention, Family Service Agency**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	53	16	1	3	58
Number of individuals/families **ACTUALLY SERVED**	53	56	56	58	58
Age Group					
· Children 0-15	0	0	0	0	0
· TAY 16-25	34	12	1	2	37
· Adults 26-59	17	4	0	0	18
· Older Adults 60+	2	0	0	1	3
Race/Ethnicity					
· White	22	4	1	3	24
· Latino	25	10	0	0	26
· Other	6	2	0	0	8

Primary Language					
· English	48	14	1	2	22
· Spanish	4	2	0	0	4
· Other	1	0	0	1	2
Culture					
· Veterans	0	0	0	0	0
· LGBTQ	4	1	0	0	5

PEI #6 Access and Linkage to Treatment

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

Prevention & Early Intervention Report: 2021-2022

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Unduplicated Client Count	23	25	21	32	66
Age:					
0-15	-	-	-	-	-
16-25	2	1	2	4	5
26-59	18	23	17	23	54
60 +	3	1	2	5	7
Declined to answer	-	-	-	-	-
Language:					
English	23	25	21	32	66
Spanish	-	-	-	-	-
Other	-	-	-	-	-
Race:					
American Indian or Alaskan Native	1	-	-	-	-
Black	0	2	1	3	4
White	12	12	11	18	34
Asian	2	5	3	3	6
Native Hawaiian or Other Pacific Islander	-	-	-	-	-
Declined to answer	-	-	-	-	-
Other	8	6	6	8	21
Ethnicity					
Hipanic or Latino	8	6	6	6	19
Not hispanic or Latino	15	19	15	26	47
Declined to answer	-	-	-	-	-
Other	-	-	-	-	-
Veteran					
Yes	*Data not tracked*				
No					
Declined to State					
Sexual Orientation					
Gay or Lesbian	0	0	0	1	1
Heterosexual or Straight	22	23	21	30	62
Bisexual	1	0	0	0	0
Queer	-	-	-	-	-
Another Sexual Orientation	-	-	-	-	-
Declined to answer	0	2	0	1	2

Gender Assigned at birth					
Male	10	11	11	17	33
Female	13	14	10	15	33
Declined to amswer	-	-	-	-	-
Current Gender Identity					
Male	10	10	11	16	32
Female	13	15	10	16	34
Transgender	-	-	-	-	-
Genderqueer	-	-	-	-	-
Questioning or Unsure	-	-	-	-	-
Another gender idenity	-	-	-	-	-
Declined to answer	-	-	-	-	-

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

Prevention & Early Intervention Report: 2021-2022

Agency Reporting	**Santa Cruz County Behavioral Health Services**				
System Development:	Q1	Q2	Q3	Q4	**Annual**
Number of individuals/families targeted:	131	88	76	93	361
Number of individuals/families **ACTUALLY SERVED**	131	213	277	361	361
Age Group					
· Children 0-15	33	19	6	11	65
· TAY 16-25	31	24	14	15	79
· Adults 26-59	52	36	42	53	171
· Older Adults 60+	15	9	14	14	46
Race/Ethnicity					
· White	55	49	41	52	177
· Latino	54	24	17	19	112
· Other	22	15	18	22	72
Primary Language					
· English	113	79	67	79	311
· Spanish	7	3	2	4	16
· Other	11	6	7	10	34
Culture					
· Veterans	0	0	0	0	0
· LGBTQ	5	5	2	4	12

Appendix E. Public Hearing Notice & Document of MHAB Review

[Added to Final Draft]

Appendix F. Public Comments

[Added to Final Draft]

Appendix G. Board of Supervisors Approval of Plan

[Added to Final Draft]

Appendix H. Prudent Reserve Assessment/Reassessment

[Completed for to Final Draft]

State of California
Health and Human Services Agency Department of Health Care Services

MENTAL HEALTH SERVICES ACT

PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City:_____

Fiscal Year:_____

Local Mental Health Director

Name:_____

Telephone:_____

Email:_____

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

_____ _____

Local Mental Health Director (PRINT NAME) Signature Date

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

DHCS 1819 (02/19