Santa Cruz County Mental Health & Substance Abuse Services

Mental Health Services Act Prevention & Early Intervention Services

March 25, 2009

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County of Santa Cruz

HEALTH SERVICES AGENCY

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LETTER FROM THE MENTAL HEALTH & SUBSTANCE ABUSE DIRECTOR

January 29, 2009

Santa Cruz County Mental Health & Substance Abuse Services has completed a draft Prevention and Early Intervention Plan of the Mental Health Services Act (MHSA/Proposition 63). The report has been prepared according to instructions from the State Department of Mental Health (DMH) and the Oversight Accountability Commission (OAC).

The report is available for public review and comment from January 29, 2009 to March 1, 2009. There will be a public hearing on Thursday, March 19th, 2009 at 3:30 at 1400 Emeline, room 207, Santa Cruz, CA. You may provide comments in the following ways:

At the Public Hearing,
By fax: (831) 454-4663,
By telephone: (831) 454-4931 or (831) 454-4498,
By email to mhsa@co.santa-cruz.ca.us ,
Or by writing to:

Santa Cruz County Mental Health & Substance Abuse Services
Attention: Alicia Nájera, MHSA Coordinator
1400 Emeline Avenue
Santa Cruz, CA 95060

Sincerely,

Leslie Tremaine
Director

Executive Summary

The County of Santa Cruz held an extensive Prevention and Early Intervention (PEI) stakeholder planning process, establishing six different workgroups. The stakeholders included consumers, family members, educators, social service providers, health providers, law enforcement, family resource centers, and county and contract staff. Additionally, the County held focus groups to ensure the voices of parents, consumers, youth, transition age youth, seniors, and Veterans were heard. We also had key informant interviews with law enforcement and community health clinic representatives, for a total of 60 community and focus groups meetings. The County contracted with Applied Survey Research (ASR) to provide a snapshot of mental health prevention and intervention related data in order to guide the efforts of the PEI workgroups.

Per DMH requirements, the intent of PEI funding and services, as part of the overall MHSA process, is to engage persons prior to the development of serious mental illness or serious emotional disturbances, or in the case of early intervention, to alleviate the need for additional mental health treatment and/or to transition to extended mental health treatment. Prevention involves reducing risk factors or stressors, building protective factors and skills, and increasing support. Intervention is directed towards individuals/families for whom a short-duration (less than a year) and relatively low-intensity approach is appropriate to achieve intended outcomes.

The PEI workgroups had the primary responsibility of identifying the priority populations, risk factors, reviewing existing resources, and developing their recommendations within DMH criteria and requirements. Based on the workgroup recommendations the County's proposal is organized in three major project areas:

1. Early Intervention Services for Children
2. Early Intervention Services for Transition Age Youth & Adults
3. Early Intervention Services for Older Adults.

Project #1: Early Intervention Services for Children

This project area addresses three priority populations: children and youth from stressed families, onset of mental illness, and trauma exposed children and their families. Of particular concern are families needing parental/supervision skills affected by substance use/abuse, and/or are exposed to violence, abuse, and /or neglect. The desire is to decrease the negative impact of these factors by offering mental health services to youth and their families. This project also addresses disparities in access to services by including a focus on the needs of Latino children/families, as well as lesbian, gay, bisexual, transsexual, and questioning (LGBT) youth and their families. This project has an estimated cost of $901,000. Services will be leveraged whenever possible, such as Medi-Cal billing for services (if applicable) and contributions from First 5, and other community partners, as well as Mental Health Services Act Workforce Education & Training, as appropriate.

This component has four proposed strategies:

1. 0-5 Screening and Early Intervention (see page 22)

2. County-wide Parent Education and Support (see page 23)
3. Culture Specific Parent Education and Support (see page 25)
4. School-based Prevention and Early Intervention (see page 27)

Project #2: Early Onset Intervention Services for Transition Age Youth & Adults
This project seeks to provide education, training and treatment by expanding mental health awareness and services through traditional and non-traditional settings, Community Entry Points, (CRP), Professionals and Family members. This will be achieved by developing a network of care for use prior to being formally "diagnosed" at the earliest signs of possible serious mental illness. Through consultation, training and direct service delivery, a broad menu of services will be offered by Peer Counselors, Family Advocates, and Licensed counselors and psychiatrists to transition age youth and their families. This program will integrate evidence-based practices that are client-centered. This program addresses transition age youth and adults who are trauma exposed and are experiencing (or at risk of experiencing) the onset of serious mental illness. This project also addresses disparities in access to mental health services by including a focus on the needs of Latino youth as well as Lesbian, gay, bisexual, transsexual (LGBT) individuals and their families. This project has an estimated cost of $550,000. Services will be leveraged whenever possible, such as Medi-Cal billing for services (if applicable), "in kind" supervision, as well as Mental Health Services Act Workforce Education & Training, as appropriate.

This component has five proposed strategies:

1. Education and supports for the early identification of signs and early symptoms of Early Onset of Mental Disorders with Family Members, Professionals and Community Entry Points (see page 37)
2. Early Onset Intervention Services Utilizing service "Navigator," Psychiatry, Peer and Family Advocates, and Employment Services for Individuals and Family Members (see page 38)
3. Monthly Transition Age Youth Provider Roundtable service coordination meetings (see page 39)
4. Veterans advocacy and service coordination (see page 40)
5. Suicide Prevention services (see page 40)

Project #3: Early Intervention Services for Older Adults
This prevention strategy addresses the high rates of depression, isolation and suicides of Older Adults in Santa Cruz County. Strategies are aimed at identifying older adults at risk of trauma-induced mental illness, depression, anxiety, suicidal ideation, and late onset mental illness, as well as undiagnosed and misdiagnosed seniors. This group has been identified as an underserved population, often due to senior's isolation and challenges in accessing appropriate care. This project has an estimated cost of $300,000. Services will be leveraged whenever possible, such as Medi-Cal billing for services (if applicable), "in kind" supervision, as well as Mental Health Services Act Workforce Education & Training, as appropriate.

This component has three proposed strategies:

1. Field Based Mental Health Training and Assessment Services to provide mental health assessment and short-term services to older adults in their homes (see page 46)
2. Senior services and outreach including brief therapy and peer companions (see page 47)
3. Warm line providing quick telephone screening and referrals to senior resources for persons seeking service to older adults at risk of mental illness (see page 48)

Next Steps:
The draft PEI plan was presented to the Santa Cruz County Mental Health Services Act Steering Committee on January 26, 2009. They approved the posting of the draft plan for 30 days, and the public is invited to review and comment. There will be a public hearing on March 19, 2009. After the 30-day review, the County will summarize and analyze the comments, and make revisions, as necessary. The County will then send the plan to the State Department of Mental Health and the Oversight Accountability Commission for review and approval. The approval process generally takes about 60 days.

PEI Proposed Projects and Strategies

Project #	Strategy Name	Proposed Approach for Service Implementation *
#1-1	0-5 Screening and Early Intervention	County & Contract
#1-2	County-wide Parent Education and Support	County & Contract
#1-3	Culture Specific Parent Education and Support	County
#1-4	School-based Prevention and Early Intervention	Contract(s)
#2-1	Identification of signs and early symptoms of Early Onset of Mental Disorders with Family Members, Professionals and Community Entry Points	County
#2-2	Early Onset Intervention Services Utilizing Professional Navigator, Psychiatry, Peer and Family Advocates, and Employment Services for Individuals and Family Members	County & Contract
#2-3	Monthly Transition Age Youth Provider Roundtable Gatherings	(County & Contract)
#2-4	Veterans Advocate	Contract
#2-5	Suicide Prevention	Contract
#3-1	Field Based Mental Health Training and Assessment Services to Provide mental health assessment and short-term services to older adults in their homes	County
#3-2	Senior services and outreach including brief therapy and peer companion	Contract
#3-3	Warm line provides quick telephone screening and referrals to senior resources for persons seeking service to older adults	Contract

*** Please Note: Determination of service providers will need to be finalized based on best available information at the time of plan approval and implementation.**

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN FACE SHEET

Form No. 1

MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION COMPONENT
OF THE THREE-YEAR
PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2007-08 and 2008-09

County Name: Santa Cruz **Date: January 20, 2009**

COUNTY'S AUTHORIZED REPERSENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	**Project Lead**
Name: Leslie Tremaine Telephone Number: 831-454-4515 Fax Number: 831-454-4663 E-mail: leslie.tremaine@health.co.santa-cruz.ca.us	Name: Alicia Nájera Telephone Number: 831-454-4931 Fax Number: 831-454-4663 E-mail: alicia.najera@health.co.santa-cruz.ca.us
Mailing Address: 1400 Emeline Avenue, Santa Cruz, CA 95060	

AUTHORIZING SIGNATURE

I HEREBY CERTIFY that I am the official responsible for the administration of Community Mental Health Services in and for said County; that the county has complied with all pertinent regulations, laws and statutes. The county has not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and the administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2007-08, 2008-09 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief the administration budget and all related program budgets in all respects are true, correct and in accordance with the law. I have considered non-traditional mental health settings in designing the County PEI component and in selecting PEI implementation providers. I agree to conduct a local outcome evaluation for at least one PEI Project, as identified in the County PEI component (optional for "very small counties"), in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature _____ _____
County Mental Health Director Date

Executed at Santa Cruz, California

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

County: Santa Cruz **Date: January 20, 2009**

1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

a. The overall Community Program Planning Process
There were many people involved with the Planning Process. The County Staff that had primary responsibility were:

Leslie Tremaine: Leslie Tremaine is the Director of Santa Cruz County Mental Health & Substance Abuse Services. She has extensive experience in the Mental Health field with vast knowledge from her work as both direct practitioner and in (county and state level) administration. She is actively involved with the MHSA Steering Committee and has oversight of all MHSA activities.

Alicia Nájera: Alicia Nájera is the MHSA Coordinator and the Cultural Competence Coordinator for Santa Cruz County Mental Health & Substance Abuse Services. She has primary responsibility of the MHSA Community Planning Process. She kept the management team and the MHSA Steering Committee informed and involved, and worked closely with the consultant/facilitator.

Linda Betts: Linda Betts is the MHSA Administrative Assistant. Linda played a key role in the Community Planning process by handling key logistical matters, taking notes, interacting with all stakeholders, and keeping our website up to date for stakeholders to be kept abreast of our activities.

Jerry Solomon: Jerry Solomon is a psychologist and organizational consultant. He was hired to facilitate the work groups and worked closely with the MHSA Coordinator. Aside from direct services and extensive experience in managing community-based organizations, he previously worked with Santa Cruz County Mental Health & Substance Abuse Services as the consultant for the MHSA Workforce Education & Training component planning process.

b. Coordination and management of the Community Program Planning Process
Key staff involved with coordination and management of the Community Planning Process were: Leslie Tremaine, the Santa Cruz County Mental Health & Substance Abuse Services Director; Alicia Nájera, the MHSA Coordinator (and Cultural Competence Coordinator); and Linda Betts, the MHSA Administrative Assistant.

Additional staff instrumental in the Community Planning Process includes:

Dane Cervine: Dane Cervine is the Chief of Children's Mental Health Services. An active member of the workgroups, Dane ensured that key Children's staff were engaged in the process, and most importantly, worked actively to engage key community partners in the planning process.

Bill Manov: Bill Manov, Director of Alcohol & Drug Services for Santa Cruz County Mental Health & Substance Abuse Services. He actively participated in the planning process providing relevant information about the affects of substance use/abuse. He also engaged staff and community partners in the planning process.

Yana Jacobs: Yana Jacobs is one of the Adult Program Managers at Santa Cruz County Mental Health & Substance Abuse Services. Her years of experience in providing direct services and supervision/management of services to persons with severe mental illness were informative in this process.

Stan Einhorn: Stan Einhorn is one of the Children's Program Managers at Santa Cruz County Mental Health & Substance Abuse Services. He is an experienced psychologist and works closely with our community partners. He played a pivotal role encouraging their participation to become actively involved and engaged in the community planning process.

Steve Ruzicka: Steve Ruzicka is an Adult Supervisor at Santa Cruz County Mental Health & Substance Abuse Services. As a supervisor for both the Transition Age Team and the Older Adult Team, he was actively involved in the community planning process.

Kennedy Cosker: Kennedy Cosker works for the Health Services Agency as the Information Services Manager. He worked closely with the MHSA Coordinator and the MHSA Administrative Assistant to ensure the website was kept current with meeting dates, notes, and other relevant material.

c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process

The above-mentioned staff all played a key role in ensuring stakeholders had an opportunity to participate in the Community Program Planning Process.

The County of Santa Cruz would also like to acknowledge the valuable contributions from the MHSA Steering Committee. The Santa Cruz County MHSA Steering Committee was formed with the intention of having a cross section of member representatives, including mental health providers, employment, social services, law enforcement, consumers, and family members, as well as representatives from diverse geographical and ethnic/racial/cultural populations. The County staff that attend the MHSA Steering Committee meetings regularly are: Leslie Tremaine, Director; Alicia Nájera, MHSA & Cultural Competence Coordinator; Dane Cervine, Chief of Children's Mental Health; Yana Jacobs, Adult Mental Health Program Manager; and Linda Betts, MHSA Administrative Assistant. The MHSA Steering Committee members are:

Betsy Clark

Bob Gelwicks
Carol Williamson
Cecile Mills
Dan Cope
Ellen Timberlake
Ginny Gomez
Guy Grant
Jenny Sarmiento
John Wright
Laura Whitson
Linda Wilshusen
Nina Stratton
Stephan DuBose
Susan True

After the initial stakeholder meetings, we formed six workgroups by age breakdown (0-5, 6-12, 13-17, 18-25, 26-59, and 60+) to ensure development of PEI services across the lifespan. The workgroups continued informing other stakeholders of the PEI planning process, and additional persons participated as a result.

2. Explain how the county ensured that the stakeholder participation process accomplished the following objectives (please provide examples):

a. Included representatives of unserved and/or underserved populations and family members of unserved/underserved populations.
The County held "Town Hall" meetings in the fall of 2007 to inform the public about the Mental Health Services Act activities, and to solicit input, including the wish to be notified when the PEI activities commenced. Additionally, the Mental Health Services Act Steering Committee identified potential stakeholders that would include staff, contractors, consumers, family members, educators, law enforcement, social service providers, health providers, and family resource centers. The County provided outreach to persons identified, as well as previously involved stakeholders. Persons were called and emailed to inform them of the PEI process and were encouraged to spread the word to others that might be interested. A mailing list was created with the names of all interested parties.

The County of Santa Cruz held an extensive PEI stakeholder process, establishing six different workgroups meeting simultaneously. Each work group met from 6 to 7 times for a total of 38 workgroup meetings (this does not include the 3 initial meetings held by age group, or the meetings noted in "3b" below). Notes of each meeting were taken and posted electronically on our website. Additionally, the County held focus groups to ensure the voices of parents, consumers, youth, transition age youth, seniors, and Veterans were heard. We also had key informant interviews with law enforcement and community health clinic representatives, and two final meetings with the workgroups, for

a total of 60 community and focus group meetings. (See Appendix for meeting times and notes of these meetings).

b. Provided opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, race/ethnicity and language.

Meetings were held at various sites throughout the County, with the majority taking place in north Santa Cruz County (more heavily populated), mid County (Capitola), and Watsonville (south County). One meeting was held in the San Lorenzo Valley (Felton). The workgroups met during the day with special presentations on priority populations conducted in the evening. Focus groups were conducted with consumers of various ages: youth, transition age, adults and seniors, veterans, and family members. The focus groups were of diverse populations, one primarily LGBT, and two with Latinos (held in Spanish). The focus groups were held at various locations throughout the County, in the evening and during the day, depending on their preference.

c. Included outreach to clients with serious mental illness and/or serious emotional disturbance and their family members, to ensure the opportunity to participate.

Consumers and family members participated in the workgroups. Prior to commencing the PEI planning process the MHSA Coordinator and Facilitator met with each of the two Wellness Centers to brainstorm with them about including consumers in the process. Both stated that only a few consumers would participate in the workgroups on a consistent basis and encouraged us to have focus groups with the others. Meeting dates and times were posted at the Wellness Centers in Santa Cruz (Mental Health Client Action Network) and Watsonville (Mariposa), as well as posted on the web. Two focus groups were conducted with consumers (one at each Wellness site).

The NAMI president participated in the workgroup process and had regular communication with the MHSA Coordinator and Facilitator, as well as regularly sharing information about meetings and times with NAMI. Two focus groups were held with family members (NAMI parents, and a Latino/Spanish speaking parent group in Watsonville).

Additional focus groups were held with veterans, seniors, transition age youth, and a youth group.

3. Explain how the county ensured that the Community Program Planning Process included the following required stakeholders and training:

a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:

- **Individuals with serious mental illness and/or serious emotional disturbance and/or their families**
- **Providers of mental health and/or related services such as physical health care and/or social services**
- **Educators and/or representatives of education**
- **Representatives of law enforcement**
- **Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families**

The Mental Health Services Act Steering Committee and County staff reviewed the initial list of potential stakeholders and added additional names; those identified as stakeholders were invited to share information with others who might be interested. Each workgroup also spent time identifying additional stakeholders. Those stakeholders that participated in the planning process included persons from the following groups/agencies:

Sector	**Agencies**
Underserved Communities	Barrios Unidos, Community Action Board: Community Restoration Project, The Diversity Center, Queer Youth Task Force, Mariposas Art, Migrant Head Start, Communities Organized for Relational Power in Action (COPA)
Education	Cabrillo College, County Office of Education, Childcare Planning Council, ETR (Education, Training & Research), Head Start, Live Oak School District, Pajaro Valley Unified School District, North County SELPA
Individuals with Serious Mental Illness and/or their Families	Advocacy Inc, Mariposa Wellness Center, Listening Well, Mental Health Client Action Network, NAMI (president & members)
Providers of Mental Health Services	Community Support Services, County Mental Health & Substance Abuse Services, Family Service Agency, Front Street Inc., Parent Center, Santa Cruz Community Counseling Center, Survivors Healing Center, Youth Services, Psychologists (private practice)
Health	County Public Health, Health Improvement Partnership, Homeless Persons Garden Project, Homeless Persons Health Project
Social Services	Campus Kids Connection, Child Abuse Prevention Council, Child Welfare, Community Bridges, Community Connections, Court Appointed Special Advocates (CASA), Elder Day Care (EDC) Day Treatment, Families in Transition, Families Together, First 5 of Santa Cruz, Hospice

Social Services, cont.	of Santa Cruz, PAPAS: Supporting Father Involvement, Pajaro Valley Prevention Services Agency, Seniors Council, Suicide Prevention Services, Survivors Healing Center, Walnut Avenue Women's Center, Women's Crisis Support/Defensa De Mujeres, County Human Services Department.
Law Enforcement	County Probation Dept., County Sheriff, Watsonville City Police Dept.
Community Family Resource Centers	Community Family Resource Center, Del Mar Caregiver Resources, Live Oak Family Resource Center, Mountain Community Resource Center, La Manzana Community Resources
Employment	COE Youth Employment Program, Community Connection Career Services Employment Agency
Media	Radio Bilingue

b. Training for county staff and stakeholders participating in the Community Program Planning Process.

The County of Santa Cruz provided two, "Prevention and Early Intervention 101," training sessions on May 6th, 2008 from 5 p.m. to 7 p.m. in the North part of the County, and on May 9th from 9:30 a.m. to 11:30 a.m. in the Southern part of the County. The "PEI 101" material was also posted on our website. Additionally, the County contracted with Applied Survey Research (ASR) to provide a snapshot of mental health prevention and intervention related data in order to guide the efforts of the PEI workgroups. The ASR presentations were held on June 24th, 2008 in Santa Cruz, and June 27th, 2008 in Watsonville.

The County held three presentations on priority populations selected by the workgroups:

- Tuesday, August 19th from 6 p.m. to 8 p.m., we had a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon engaged the audience to gather input on desired outcomes for Trauma-Exposed individuals.
- Tuesday, August 26th from 6:30 p.m. to 8:30 p.m., we had a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and shared their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters included: Melody St. Charles, Kate Venturini, Ginny Gomez, Carol Williamson, and John Wright.
- Wednesday, September 3rd, from 7:00 p.m. to 8:30 p.m., Dr. Rivka Greenberg presented on "Stressed Families."

Additionally, the County included speakers as part of the workgroups to ensure that stakeholders were aware of programs and resources that already exist in Santa Cruz County, as well as to consider what prevention and early intervention services might enhance the services needed in our communities. The speakers included the following:

- Susan True, First 5
- Rita Flores, Family Services Agency (services targeted for seniors)
- Lorraine Cahn, County Children's Mental Health, Foster Youth being raised in the system
- Charise Olson, County Office of Education, Youth Employment program services
- Tove Beatty & Brandy Shaw, Family Resource Centers in Santa Cruz County
- Bill Manov, Chief – County Alcohol & Substance Abuse Services
- Stuart Rosenstein & Vanessa Wilson, The Diversity Center/Queer Youth Task Force
- John Beleutz, Del Mar Caregiver Resource Center, services that are targeted for caregivers
- Patrick Teverbaugh, County Mental Health Psychiatrist, on early intervention for first breaks
- Steve Ruzicka, County Older Adult Services
- Francie Newfield, Adult protective services, Veterans' Services, In-Home Support Services
- Kristie Clemens, Walnut Avenue Women's Center
- Joanne de los Reyes-Hilario, Women's Crisis/Defensa de Mujeres, domestic violence agency, 24 hour crisis line
- Bonita Mugnani, Survivors Healing Center, serving children and adult survivors of sexual abuse
- Chris López & Jordan Harding, Veterans Center, mental health services for veterans
- Kelly Wolfe, Court Appointed Special Advocates (on TAY services)
- Carly Galarneau, Suicide Prevention Services
- Javier Diaz and Ely Gonzalez, Community Restoration Project, working with high-risk youth (gang, drug issues) using strength-based approach; alternative to incarceration programs, and job training and job mentorship programs.
- Linda Perez, Pajaro Valley Prevention & Student Assistance (PVPSA), mental health programs in the Pajaro Valley Unified School District
- Joanne Allen, County Office of Education, and Leticia Gomez, PVPSA, on bullying

4. Provide a summary of the effectiveness of the process by addressing the following aspects:

a. The lessons learned from the CSS process and how they were applied in the PEI process.

After the extensive CSS community planning process, several stakeholders felt dissatisfied and thought that the input they provided was not taken into account.

Stakeholders came away feeling that the County made all the decisions about programming, and as a result, we learned that the process must be more transparent. During the PEI planning process we kept notes of each work group meeting (and summaries of focus groups), and posted them on our website, as well as disseminated them to the MHSA Steering Committee. This has allowed all stakeholders to see what has transpired in the meetings. The PEI workgroups had the primary responsibility of identifying the priority populations and risk factors, reviewing existing resources, and developing their recommendations. The County developed projects based on these recommendations and held two final meetings with workgroup participants to ensure that their ideas were indeed developed and reflected in our plan. The County also updated the MHSA Steering Committee (which is open to the public) at their monthly meetings.

In addition, we learned that we must manage community expectations. The Planning Estimates for our County are limited, so while we are soliciting input we must also help our stakeholders have realistic expectations as to what we can achieve with this funding.

b. Measures of success that outreach efforts produced an inclusive and effective community program planning process with participation by individuals who are part of the PEI priority populations, including Transition Age Youth.

As mentioned above, the County of Santa Cruz held an extensive PEI stakeholder workgroup process, with six different workgroups meeting simultaneously. Each work group met from 6 to 7 times. The workgroups were an inclusive community planning process representing public mental health (County and contract agencies), probation, family resource agencies, consumers, family members, health, education, veteran's advocates, Family Resource Centers, and other social service agencies. To ensure the voices of parents, consumers, youth, transition age youth, and seniors, were heard, the County also held focus groups with the following: English speaking parents, Spanish speaking parents, consumers (one in North County and one in South County), LGBT youth, transition age youth, seniors, and veterans. There was minimal participation from primary health and law enforcement due to their time constraints; therefore key informant interviews were conducted at their convenience. (See appendix.)

5. Provide the following information about the required county public hearing:

a. The date of the public hearing:

The public hearing was held at the Local Mental Health Board meeting on Thursday, March19, 2009 at 3:15 at 1400 Emeline Avenue, Santa Cruz, California.

b. A description of how the PEI Component of the Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any other interested parties who requested it.
The PEI draft plan was distributed to the Local Mental Health Board, the Mental Health Services Act Steering Committee, contractors, and to PEI Workgroups. It was also posted on our Internet site, and was made available in hard copy to anyone who requested it. We placed ads in our local newspapers to inform the community at large of its availability.

The plan was circulated for 30-day review and comment from January 29, 2009 to March 1, 2009.

c. A summary and analysis of any substantive recommendations for revisions.
The County received written comments from seven (7) individuals. Fourteen (14) individuals made comments at the Public Hearing (including two Mental Health Board Members).

Overall, the input was favorable, with many comments commending the staff and the consultant for creating a good planning process that was community-based, accessible, and involved. Furthermore, there was a general consensus that the Plan reflected the ideas of the workgroups.

There were numerous comments about veterans and services to veterans. There is a concern about the growing number of veterans, and the needs of both veterans and their families. Our plan includes a veterans advocate position that is intended to reach out to veterans and offer early intervention services to those in need. The position will be that of a “bridge builder” among various veteran organizations and other mental health and social service providers.

There were two comments about terminology, specifically regarding services to older adults. The workgroup discussed having services “where seniors reside”. The draft plan stated services would be provided in their “home”. This has been corrected to state, “where seniors reside”, as that was indeed our intention.

Other comments include providing services at primary care sites. This is already reflected in the plan (see Project #1, strategy #2; Project #2, strategy #1, and Project #3, strategy #1). Similar comments were made regarding Family Resource Centers. This is considered as one of the “Community Entry Points”, and the Plan has been amended to ensure they are listed as such. Additionally, Family Resource Centers may apply for one of the RFPs.

There was a comment from a participant stating a disappointment about Project #1 not being more “father friendly” and did not include more father involvement. The services reflected here are not geared towards mothers only. However, the County takes this point seriously and has come to an agreement with a Papás (a father involvement

program) to train staff on how to more effectively engage fathers in provision of services.

One individual wrote a four-page letter stating numerous concerns about Santa Cruz County Mental Health & Substance Abuse Services. The director and the MHSA Coordinator have offered to meet with him to discuss his concerns. He declined to do so.

d. The estimated number of participants:
There were twenty-six (26) members of the public, six (6) staff and nine (9) Local Mental Health Board members at the Public Hearing.

PEI PROJECT #1 SUMMARY

County: Santa Cruz
PEI Project Name: Early Intervention Services for Children
Date: January 16, 2009

Complete one Form No. 3 for each PEI project.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	X	X	X	❑
2. Psycho-Social Impact of Trauma	X	X	X	❑
3. At-Risk Children, Youth and Young Adult Populations	X	X		
4. Stigma and Discrimination	X	X	X	❑
5. Suicide Risk	X	X	X	❑

2. PEI Priority Population(s)	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	X	X	X	❑
2. Individuals Experiencing Onset of Serious Psychiatric Illness	X	X	X	❑
3. Children and Youth in Stressed Families	X	X		
4. Children and Youth at Risk for School Failure	❑	❑		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	❑	❑		
6. Underserved Cultural Populations	X	X	X	❑

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Stakeholder Input:
Santa Cruz considered input gathered from the CSS planning and Town Hall meetings (held in 2006 and 2007), but relied more heavily on the extensive PEI planning process. Aside from the educational forums and data presentations, there were workgroups that focused on prevention and early intervention needs of the various age groups across the lifespan. The three workgroups focusing on the needs of children (ages 0-5, 6-12, and 13-17) met a total of twenty times.

The workgroups included representatives from the following stakeholders: consumers, family members, Santa Cruz County Children's Mental Health, Cabrillo College Early Childhood Education, Families Together, Families in Transition, PAPAS (Supporting Father Involvement), County Office of Education, Childcare Planning Council, Health Improvement Partnership of Santa Cruz County, Community Bridges, Santa Cruz County Substance Abuse Services, Head Start, First 5, Women's Crisis Support, Walnut Avenue Women's Center, Survivor's Healing Center, Santa Cruz County Human Services Department, Pajaro Valley School District, Pajaro Valley Prevention & Student Assistant Agency, Education Training & Research, Family Services Agency, Youth Services, Suicide Prevention Services, NAMI, Community Action Board (Community Restoration Project), Veteran advocate's, COPA, Radio Bilingue, and Santa Cruz County Public Health.

The stakeholders wrestled with identifying the priority population given that each population was considered to be a priority. After considerable discussion and realization that there was an "overlap" among the State defined priority populations, the stakeholders decided to focus on Children and Youth in Stressed Families, Trauma-exposed Individuals, and the Onset of Serious Mental Illness. (Note: by choosing these priority populations the stakeholders realized that services to these groups would also invariably reach Children and Youth at Risk for School Failure, and Children and Youth at Risk of Juvenile Justice Involvement.)

The stakeholders went on to consider services provided in the County, service gaps, community entry points, and then finally moved on to recommending PEI services and strategies.

Data Analysis
The recommendations of the workgroups were based on the following considerations:

DATA FOR CHILDREN AGES 0-5:
Demographics: In 2007 there were 19,237 children between the ages of 0 to 5 living in Santa Cruz County; half were Latino. Twelve percent of children ages 0 to 5 were living below the federal poverty level.

Mental Health: A total of 147 children ages 0-5 were served by Santa Cruz County Mental Health between July 1, 2007 and March 31, 2008. Five percent of parents with of children ages 0-5 reported that they were experiencing symptoms of severe mental illness (according to the First 5 Santa Cruz County 2007-2008 Time 1 Family Survey).

Child Abuse: The rates of child abuse referrals for Santa Cruz County in 2006 was 56.6 per 1,000 children ages 0-5; substantiated cases was 16.3 per 1,000. The rates of substantiated cases in Santa Cruz County were higher with Latino's as compared to Caucasian children. The primary reason for admission into foster care for children 0-5 in Santa Cruz County between 2004 and 2006 was neglect. "What Works" data (from Santa Cruz Child Welfare Services) indicates that, "babies under the age of 5 with chronic health issues are more at risk for child abuse."

Other Considerations:
The PEI workgroup noted the following risk factors for children's (ages 0-5) mental health:

- Chronic disease/disabilities
- Substance abuse (of parents)
- Parents with mental illness
- Domestic violence.

Also informing this workgroup was the previous work for the following community plans: the Child Welfare System Improvement Plan, the Child Abuse Prevention Plan, and First 5. Some of the Community Blue Print Risk Factors include:

- Poor physical and/or mental health
- Lack of bonding/attachment between parent and child
- Lack of understanding child development
- Lack of appropriate parent practices
- Lack of screening for developmental delays and social/emotional health.

DATA FOR CHILDREN AGES 6-17:
Demographics: In 2007, there were 39,255 children ages 6 to 17 in Santa Cruz County; forty percent (40%) were Latino. In 2006, thirteen percent of children ages 6-17 were living below the federal poverty level in Santa Cruz County.

School: The annual dropout rate per 100 students in Santa Cruz County was 4.8 during the '05-'06 school year, up from .6 for '02-'03. There were 1,440 school age children enrolled in Santa Cruz County schools that were homeless and receiving services under the McKinney Act during the '06-'07 school year. About 20% (307) of these children were living in shelters.

Between 7% and 9% of respondents of the Santa Cruz County CHKS (grades 7, 9 and 11), reported being harassed at school during the last 12 months, "because they are gay or lesbian or someone thought they were," in the '06-'07 school year. Between 5% and 7% respondents reported that they had been harassed at school based on their physical or mental disability.

Mental Health: Between July 1, 2007 and March 31, 2008, Santa Cruz County Children's Mental Health served a total of 1,119 children and adolescents, between the ages of 6 and 16. More than half (52%) of these children were Latino and 42% Caucasian; the majority spoke English (81%), while 19% spoke Spanish.

Approximately 27-29 percent of 7th, 9th, and 11th graders, in Santa Cruz County, responding to the California Health Kids Survey (CHKS), reported in the'06-'07 school year, that they, "felt so sad and hopeless almost every day for two weeks or more that they stopped doing some usual activities."

Substance Abuse: Substance use among youth in Santa Cruz County is reportedly higher than in California overall. During the '06/'07 school year, the top two most commonly used substances reported by the CHKS respondents for the past 30 days were alcohol (15% among 7th graders, 33% among 9th graders, and 44% among 11th graders) and marijuana (7% of 7th graders, 20% of 9th graders, and 26% of 11th graders). Two percent of both 9th and 11th graders reported methamphetamine use within the last 30 days in 2006-07.

Child Abuse: The rate of child abuse referrals was 52.1 per 1,000 children ages 6 to 17 in 2006; the rate of substantiated cases among this population was 12.1 per 1,000.

- In 2005 to 2006 the primary reason for admission into foster care for children ages 6-17 in Santa Cruz County was neglect.
- The rate of child abuse referrals and substantiated cases in Santa Cruz County were higher among Latino as compared to Caucasian children.

Other Considerations:
The PEI workgroups (for ages 6-12 and 13-17) noted the following risk factors:

- Inadequate parenting skills
- Violence/abuse/neglect
- Family issues (including mental health, substance abuse, history of suicide, and/or child sexual abuse)

3. PEI Project Description: Early Intervention Services for Children

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

This project is composed of four strategies:

1. 0-5 Screening and Early Intervention
2. County-Wide Parent Education and Support

3. Culture Specific Parent Education and Support
4. School-based Prevention and Early Intervention.

<u>Project #1 - Strategy #1:</u> 0-5 Screening and Early Intervention
This strategy addresses the unique needs of early childhood, and speaks to the issues of: poor physical and/or mental health, lack of bonding/attachment between parent and child, lack of appropriate parenting practices, family violence, socio-economic stressors, social isolation, and trauma. We will implement screening, assessment, and early intervention for young children ages 0-5, with particular emphasis on serving ages 0-3.

This strategy will include:

- **A new assessment center for families with children aged 0-3**. This multi-disciplinary screening/assessment project will be implemented in conjunction with Dominican Hospital, First 5, and Child Welfare. The new assessment center will be housed at Dominican's Frederick Street site with coordination and support provided by Dominican staff. The program will include weekly site-based assessment (similar to the current Stanford clinic at Dominican), as well as field-based services. Initial referrals will come from Child Welfare's differential response, voluntary family maintenance, and regular foster care sectors. Linkages will be made, as appropriate, to related services, such as the Regional Center. The project is envisioned as eventually including a broader 0-5 population in need of screening, assessment, and treatment referred by the community (primary care, family resource centers, etc.) as resources allow. This plan would include a new treatment focus for children 0-3 within existing county and contract mental health programs. This begins in fiscal year 08/09, though ongoing capacity will depend on larger county budget.

    - **PEI funds utilized to add 1 FTE County mental health clinician** linked to the new assessment center for screening, assessment, and brief treatment/case management for the 0-3 target population described above. Foster children will be prioritized. Funds will be leveraged to allow for both Medi-Cal and non-Medi-Cal families, and services.
    - **Dominican Hospital** will provide in-kind facility, coordination, and case management capacity, as well as linkages to other appropriate services.
    - **First 5** will provide strategic planning and linkage assistance in program design and funding, particularly as the project broadens via grants and other funding sources to include broader target population and age range.
    - **County Mental Health** Children's program will supervise the new clinician and integrate this new PEI role into a new early childhood mental health continuum of county and contract target population services being concurrently developed through re-direction of existing EPSDT services. Children screened and assessed at the new Dominican assessment center needing brief or extended treatment would be referred for services with the appropriate provider: Children's Mental Health *Supportive*

Intervention Services (SIS), Parents Center, and Santa Cruz Community Counseling Center's *Child and Family Development Programs.*

The second part of this strategy is to:

- Increase mental health screening, assessment, and consultation at child care settings across the county, including Family Child Care Homes, Preschool and Child Care Centers, as well as Family, Friend and Neighbor/Informal Care Providers. Low income children are served in child care settings that range from federally subsidized centers, home visiting (such as Head Start), state subsidized centers (such as state preschool and general child care), and welfare to work efforts supporting working parents with vouchers in a range of home and center based care. Early childhood educators have long stated the need for these children, their educators, and families to have access to early behavioral and social emotional development consultation for children demonstrating early mental health concerns. Our plan is to:
    - Conduct Request for Proposal (RFP) to identify appropriate contractor(s); will include focus on leveraging related initiatives and funding streams.
    - Proposals should include services for both Medi-Cal and non-Medi-Cal clients and service activities.
    - Proposals should identify referral and linkage networks established or being developed for children/families who may need further treatment and related services.

Both strategies will utilize a spectrum of validated screening and assessment instruments, including the Ages and Stages Questionnaire (ASQ), ASQ Social Emotional (ASQ-SE), the Diagnostic Classification for 0-3 (DC: 0-3R), and additional instruments to be identified during program design/implementation.

Project #1 - Strategy #2: Countywide Parent Education and Support.
This strategy is designed to help address one of the key community needs identified during the PEI and CSS planning processes: providing increased outreach, engagement and support of stressed families throughout Santa Cruz County. The intent is to provide countywide child/family support through a, "population-based, public health model," of "tiered" activities and services. Because of this, Mental Health will collaborate with First 5 to develop an integrated Request for Proposal (RFP) in order to blend and leverage resources and implementation in a cohesive manner. The goal is to implement an evidence-based practice(s) that includes Universal, Selective, and Indicated levels as outlined in the MHSA Prevention & Early Intervention literature. Services will be provided for families with children ages 0 to 5 and ages 6 to 17. Our community is currently engaged in a First 5 sponsored learning collaborative reviewing new and existing practices, including: Triple-P (Positive Parenting Program), Incredible Years, Familias Fuertes (Strengthening Families), Positive Discipline, Cara Y Corazón, and Papas (Supporting Father Involvement). This community discussion will help shape the RFP and subsequent proposals.

We estimate that the planning and implementation of an integrated RFP, selection of an evidence-based practice, and initial training and rollout, will be accomplished in stages during the first 2 years**.** This strategy is envisioned as a truly transformative process, broadening and better integrating Santa Cruz County's various parent education and support processes. Hence, extensive community education and planning will be critical to successful implementation. Because of this, PEI funds will initially be used to establish, via contract, a Project Coordinator to provide staff support for the RFP process and community planning. This position will also assist with the coordination of required training in specific evidence-based practices chosen for implementation, including possible linkage with other counties and regions around start-up and recurrent training/certification needs.

Based on South Carolina's evaluation of a population-based, public health model of parent education and support (they utilized Triple-P), we estimate that a similar "saturation level" of trained providers supporting similar outcomes in Santa Cruz County would look like this (regardless of the specific model chosen):

- Train up to 80 key community/agency staff to provide a "brief consultation" model of mental health education, consultation, and assessment (Selective level). The idea is to engage families in the community *where they already seek out information and help.* This method will train people who are often asked for advice about parenting/problems, such as:
    - Family resource center staff
    - Health clinic staff, primary care physicians
    - Child care centers
    - School personnel, teachers
    - Shelters, substance abuse programs
    - Faith community
    - NAMI

- Train up to 40 key service providers in an early intervention (Indicated level) of assessment and brief treatment delivered in group, family, and individual formats. Since this level of service is targeted to brief treatment modalities that can include a diagnosis, we plan to integrate this service into a continuum of existing service providers so that EPSDT, Healthy Families, and Healthy KIDS funds can be leveraged to maximize access and capacity. We will also make training available to the private practice sector to similarly maximize community access for a consistent early intervention approach.
- Provide the general public in Santa Cruz County with education and training on mental health prevention and early intervention topics. The materials/methods selected will be consistent with the themes/approach of practices chosen for the Indicated and Selected levels of prevention and intervention, in order to provide a consistent, integrated message to community members about effective parenting approaches and places to seek further assistance. NOTE: These activities will be differentiated from the state-administered projects, which will "complement and

support county PEI Projects" per MHSA guidelines. Some of this will occur under the MHSA WET Training Academy.

We envision that the blended resources of PEI and First 5 funds would support a combination of start-up, training, coordination, and increased service capacity as the RFP and initial implementation process unfolds. The intent is to ensure fidelity for a consistent parent education and support approach across Santa Cruz County, while simultaneously maximizing and coordinating the variety of tools/practices that will obviously continue via various grant and funding source requirements. We also envision that PEI funded/linked programs and activities will demonstrate the ability to effectively reach out and engage Latino children/families, as well as LGBT youth and their family members.

Finally, Strategy #2, for County-wide Parent Education and Support, incorporates information from the Surgeon General's report on Mental Health that 80% of "mental health care" in this country occurs in the context of primary health care provision. Hence, our strategy includes:

- 1 FTE County mental health clinician to coordinate with primary care physicians and community health clinics around mental health screening, consultation, and referral for families (all age groups, including adults), in the context of this county-wide parent education and support approach.
- This PEI funded position will link with local strategic planning efforts underway in our community, such as the *Health Improvement Partnership (HIP)* efforts to better integrate local health and mental health care. The HIP Council and the Safety Net Coalition have committed to two key foci that will help guide PEI activities in this area:
    - Improve screening and referral system for mental health services
    - Improve training/guidance for physicians and health care professionals in mental health issues

<u>Project #1 - Strategy #3:</u> Culture Specific Parent Education and Support

The objective of this strategy is to decrease the risk of violence, suicide, and other traumas that children and youth age 0 – 17 may be exposed to by providing education, skills-based training, early intervention and treatment referrals to parents, families, and children, that are in need of parental/supervision skills, are affected by substance abuse, and/or are exposed to violence, abuse, or neglect. These services will be culturally specific, trauma-informed, and oriented towards suicide prevention, with emphasis on education and support for youth and families that are Latino, LGBT or other marginalized communities.

We have chosen Cara Y Corazón and Jóven Noble (models currently used by the Alcohol and Drug program in Santa Cruz County) based on the positive experience to date, and relevance and effectiveness for the special needs of Latino families. Cara Y Corazón is a culturally based family strengthening and community mobilization approach that assists parents and other members of the extended family to raise and

educate their children from a positive bicultural base. Jóven Noble is a youth leadership development program.

Specific activities to implement this strategy include providing or arranging for provision of the following:

- Facilitator Trainings: Training of parent/family group facilitators, obtaining trainers through free or low-cost state and local resources, developing contracts with trainers, and coordinating and publicizing facilitator training events.

- Facilitator Supervision and Technical Assistance: Support group facilitators through co-facilitation, supervision, fidelity monitoring, and technical assistance/consultation.

- Outreach and Referrals: Publicize family/parent education, training and support groups through targeted public awareness campaigns; develop mechanisms for referring parents and families to the trainings from referral sources such as schools, community-based treatment, health and social service agencies, criminal justice, child welfare services, and other referral sources.

- Logistics: Work with facilitators and community partners to arrange and/or pay for facilities, materials, childcare, snacks, etc. All parent/family trainings and support groups should be conducted in locations that are accessible and welcoming to parents and families. Training sites may include schools, churches, family resource centers, or mental health and substance abuse treatment programs, for example.

- Continuity of Care: Ensure that parents, families, and youth who need ongoing support and/or more intensive treatment services are connected with these resources through developing ongoing parent support groups and developing referral relationships with youth and family treatment providers.

- Institutionalization: Leveraging EPSDT and Drug Medi-Cal, Adult Education Average Daily Attendance funds, and other public funds; grant writing; developing community supports and in-kind matches (e.g., facilities, assistance with marketing and outreach, in-kind staff time to be group facilitators, child care); developing and supporting a cadre of local trainers and group facilitators; and obtaining commitments from local partners to include the parent/family support curricula as a regular part of their programs.

Evaluation: Work with parent, family and child support service providers, County Mental Health Services Act staff, and contracted program evaluators to conduct evaluations of the implementation, fidelity and efficacy of local parent/family support service programs. Evaluation measures will include utilization data, client goal achievement measures, client satisfaction measures, and changes in key youth outcomes such as suicidality, trauma, and school participation.

- MHSA Workforce, Education, and Training funds may help offset costs of trainers, and some trainers can be obtained for free through State technical assistance contractors and local resources.
- Stipends for Family/Parent Group Facilitators, facility rental costs and other operational costs may be offset through Adult Education Average Daily Attendance funds and in-kind contributions of community-based agencies.

Project #1 - Strategy #4: School-based Prevention and Early Intervention.
Our PEI planning process identified the need for effective school-based, school-linked prevention and early intervention for mental health issues. As described earlier, this strategy is set in the context of prioritizing children and youth in stressed families, trauma-exposed individuals, and the onset of serious mental illness. By choosing these priority populations, our stakeholders realize that services to these groups will also invariably reach children and youth at risk for school failure, and/or at risk of juvenile justice involvement. A key guiding principle in service design has been that *when children are not at home, they are most often at school*. Hence, this strategy will expand and help integrate various school-based, school-linked prevention and early intervention efforts.

- Conduct Request for Proposal (RFP) to identify appropriate contractor(s); potential applicants include community-based agencies, school districts, and related collaborative planning partnerships.
- Applicants will be asked to incorporate and build on “lessons learned” from recent and current school-linked initiatives, such as the Pajaro Valley Unified School District’s *Safe Schools, Healthy Students* federal grant; the *North Santa Cruz County School Mental Health Partnership* grant; and the State Department of Mental Health’s *Early Mental Health Initiative (EMHI)* grants. Successful applicants will demonstrate how PEI funded activities will maximize and integrate with related prevention and early intervention programs and successful models (such as Drug and Alcohol prevention, Child Abuse prevention, Health promotion, for example).
- Similarly, successful applicants will demonstrate the ability to leverage and maximize relevant funding streams in order to increase and better integrate related efforts (e.g., Drug Medi-Cal, EPSDT, grants, and education funds)
- Successful applicants will also demonstrate the ability to effectively reach-out and engage Latino students/families, as well as LGBT students.
- Examples of important topics that emerged from our local PEI planning process include:
    - Understanding and supporting trauma-exposed individuals
    - Suicide prevention and education
    - LGBT mental health education and supports
    - Understanding age-appropriate behavior
    - Non-violent communication
    - Effects of psychiatric medication in children/youth
    - Anti-bullying and wellness approaches

4. Programs for Project #1

Program Title **Project #1 - Early Intervention Services for Children**	Proposed number of individuals or families through PEI expansion to be served Annually		Number of months in operation through June 2010
	Prevention	Early Intervention	
Strategy #1: 0-5 Screening & Early Intervention **County Clinician for mental health screening and assessment**	Individuals: 70 Families: 70	Individuals: 10 Families: 10	**12**
Strategy #1: 0-5 Screening & Early Intervention **Contract for Child Care Mental Health Consultation**	Individuals: 100 Families: 70	Individuals: 10 Families: 10	**12**
Strategy #2: County-Wide Parent Education & Support **Contract(s) for population-based public health service model**	Individuals: 250 Families: 250	Individuals: 100 Families: 100	**12**
Strategy #2: County-Wide Parent Education & Support **County Clinician for Primary Care consultation and training**	Individuals: 100 Families: 70	Individuals: 10 Families: 10	**12**
Strategy #3: Culture Specific Parent Education & Support **County Staff for Training Coordinator (plus facilitator stipends)**	Individuals: 100 Families: 75	Individuals: 100 Families: 75	**12**
Strategy #4: School-based Prevention & Early Intervention **Contract(s)**	Individuals: 200 Families: 25	Individuals: 50 Families: 50	**12**
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	1380	535	

5. Linkages to County Mental Health and Providers of Other Needed Services

Project #1 - Strategy #1: 0-5 Screening and Early Intervention
The new county position will become part of the Children's Mental Health *Supportive Intervention Services (SIS) team*, which provides screening, assessment, referral, and treatment services for foster children/youth. This position will focus on early childhood mental health issues, link to the new Dominican Hospital 0-3 assessment center, and coordinate with the SIS clinical supervisor regarding disposition and referral to the SIS team, as well as contract providers serving this population (Parents Center and the Santa Cruz Community Counseling Center's *Child and Family Development programs).*

The new contract (once vendor identified) for mental health consultation to child care settings will be monitored/coordinated by the Children's Mental Health contract and evaluation manager, to ensure linkage with our larger interagency System of Care, PEI, and MHSA goals.

Project #1 - Strategy #2: Countywide Parent Education and Support
A contract will be established with an appropriate vendor for a Project Coordinator to assist with planning/implementation of a joint Mental Health/First 5 RFP process. This position will assist with community forum review of the various parent education and support practices (already underway with in-kind funds from First 5), evidence-based practice literature review, training coordination, RFP coordination, contract support, and related duties. Both the Project Coordinator contract and eventual RFP-related contract(s) will be monitored/coordinated by the Children's Mental Health contract and evaluation manager, as well as First 5.

The new county position will become part of the Children's Mental Health *Community Gateway* team, which includes the Children's ACCESS team and linkages with our two Child Psychiatrists. The new position will be dedicated to coordination with the primary care and community health network, including specific linkages with the Health Improvement Partnership (HIP) and Safety Net Coalition for improved mental health screening, referral, and training protocols.

Project #1 - Strategy #3: Culture Specific Parent Education and Support
The new County position will serve as a Parent, Family, and Child Supports Coordinator, to be supervised by the Alcohol and Drug Program within the Mental Health and Substance Abuse Division. This will allow us to build on an existing network of dual diagnosis prevention expertise and community relationships, as well as ensure close coordination of PEI efforts with the County Alcohol and Drug Program. Training and group facilitator stipends, along with in-kind and cash contributions from community partners will help support an array of community facilitators that emerged from the County's, "Robert Wood Johnson Foundation *Reclaiming Futures,"* grant and the, "Together for Youth," alcohol and drug abuse prevention community collaborative. Linkages will be expanded through further development of partnerships with schools,

community-based service providers, and other key stakeholders to cooperatively support program outreach, facilities, childcare, and other key elements of the program.

Project #1 - Strategy #4: School-based Prevention and Early Intervention
The new contract(s) for school-based, school-linked prevention and early intervention services will be monitored/coordinated by the Children's Mental Health contract and evaluation manager, to ensure linkage with our larger interagency System of Care, PEI, and MHSA goals. It is expected that a variety of community agencies, schools/districts, and/or collaboratives may submit proposals. The RFP review team may suggest that some proposals be integrated or re-shaped in ways that end up supporting a more comprehensive school-based/linked prevention and early intervention approach across the county.

6. Collaboration and System Enhancements

Santa Cruz County has a long-standing (since 1989) interagency, Children's System of Care, a collaboration of key child/family serving agencies and partners that includes Mental Health/Substance Abuse, Child Welfare, Probation, Special Education, as well as a broader array of education and community partners. Per MHSA guidelines, our CSS plan was used to build on and expand services using the Children's System of Care model as our guide. Similarly, PEI will be used to specifically expand our System of Care beyond traditional *treatment* boundaries to support an array of new *prevention and early intervention* activities/services to our community. Hopefully, the new PEI services will help prevent stressed families, individuals exposed to trauma, and onset of mental health issues from escalating deeper into the public agency arenas mentioned above.

In addition to our longstanding System of Care partnerships, PEI will better link our core services to the larger community. This will occur via enhanced prevention and referral linkages with First 5, Dominican Hospital, non-traditional mental health service providers (such as physicians, nurses, teachers, family resource centers, and child care centers), various education collaboratives (such as Safe Schools/Healthy Students in Pajaro and the North Santa Cruz County School Mental Health Partnership), improved joint partnerships with our own Substance Abuse programs, improved strategic planning and service coordination with Child Welfare's federal/state *System Improvement Planning* process, as well as with our juvenile justice collaboration.

Finally, PEI activities will be closely linked with alcohol and drug prevention activities through the, "Together for Youth," community collaborative. "Together for Youth," is sponsored by the United Way and the County Alcohol and Drug Program, and has coordinated the substance abuse prevention efforts of schools and colleges, law enforcement, community-based health and social service providers, organizations serving youth, religious organizations, local business, and other key community partners since 1997. Alcohol and drug prevention addresses risk and protective factors in the individual, family and community that are substantially the same as the risk and

protective factors associated with mental health problems. “Together for Youth,” has built a network of relationships and a community understanding of a risk and protective factors-based approach to prevention that will be vital to County Mental Health as it seeks to roll out PEI prevention activities. Coordination will be achieved through participation of key PEI staff in the, “Together for Youth,” collaborative, and by locating one of the PEI staff positions (the Culturally Specific Parent, Family and Child Supports Coordinator) at the County Alcohol and Drug Program.

The new PEI activities will be reviewed and monitored through our local Children’s Network (SB-997 council) that includes a broad array of child/family-serving agencies/advocates, and are in alignment with the Santa Cruz *Community Assessment Project (CAP)* overarching goals for community health, safety and wellbeing (as tracked by the United Way).

7. Intended Outcomes

An MHSA Prevention and Early Intervention for Children/Youth *Logic Model* was developed during our PEI planning process that encapsulates many of our intended community outcomes which PEI efforts will support. Originally developed through our local *Community Blueprint for Children* report (an initiative of the Child Abuse Oversight Committee of the Santa Cruz County Children’s Network), it was adapted by our PEI 0-5-child subcommittee during the planning process, and then adapted again to serve as our overall logic model for this PEI Early Intervention Services for Children Project. As you’ll see in the logic model attachment, the individual/family Long-Term Outcomes our community hopes to see through PEI and our other prevention and early intervention community efforts are that:

- Children are emotionally healthy
- Children live in safe and nurturing families

The system level Long-Term Outcome is that:

- Our community will have a coordinated and comprehensive system of support to meet families and children’s needs.

We will know if these outcomes have been met by measuring Long-Term:

- Improvements in children’s health and development
- Lower foster care entry rates
- Reductions in child abuse reports
- Lower rates of juvenile crime, incarceration, and residential placement
- Lower incidence of alcohol and other substance abuse
- Success at school
- Increased accessibility, responsiveness and coordination of service delivery systems

8. Coordination with Other MHSA Components

The PEI Early Intervention Services for Children project will have essential links with other MHSA components. Elements of the Workforce, Education and Training (WET) component will help augment some of the PEI training activities. In addition, our goal through the four PEI strategies in this project is to craft as seamless a link as possible to Community Services & Supports (CSS) for children/youth and families needing more intensive treatment and ongoing supports. For instance, a family participating in one of the parent education workshops or brief consultations planned under PEI may have mental health needs that go beyond what the prevention workshop can provide. In these circumstances, the prevention providers would know (via the PEI training and education process) where to refer the family for further assessment and treatment. Depending on the vendors chosen for some PEI services, these organizations would either become a new key part of our larger System of Care, or, as an existing mental health provider be able to direct families served in their PEI component to more intensive services funded by CSS, EPSDT, Healthy Families, and other revenue sources.

9. Additional Comments (optional)

Although the above stated project and strategies are not geared solely to mothers and their children, it is often the case that fathers do not participate *and* are not actively engaged in services. We want to promote “father friendly” services, and will train providers on how to proactively engage fathers in services. Research has shown that father participation helps protect youth from maladjustment and psychological distress in later years.

PEI PROJECT #2 SUMMARY

County: Santa Cruz
PEI Project Name: Early Onset Intervention Services for Transition Age Youth & Adults

Date: January 16, 2009

Complete one Form No. 3 for each PEI project.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	❑	X	X	❑
2. Psycho-Social Impact of Trauma	❑	X	X	❑
3. At-Risk Children, Youth and Young Adult Populations	❑	X		
4. Stigma and Discrimination	❑	X	X	❑
5. Suicide Risk	❑	X	X	❑

2. PEI Priority Population(s)	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	❑	X	X	❑
2. Individuals Experiencing Onset of Serious Psychiatric Illness	❑	X	X	❑
3. Children and Youth in Stressed Families	❑	❑		
4. Children and Youth at Risk for School Failure	❑	❑		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	❑	❑		
6. Underserved Cultural Populations	❑	X	X	❑

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Stakeholder Input:
Santa Cruz considered input gathered from the CSS planning and Town Hall meetings held in 2006 and 2007, but relied more heavily on the extensive PEI planning process. Aside from the educational forums and data presentations there were workgroups that focused on prevention and early intervention needs of the various age groups across the lifespan. There was a workgroup that focused on the needs of transition age youth and one that focused on adults. The two work groups met a total of twelve times (six each).

The workgroups included the following stakeholders: consumers, family members, Santa Cruz County Children's Mental Health & Substance Abuse Services, Suicide Prevention, NAMI, County Office of Education, Women's Crisis Support, Cabrillo College Psychological Services, CASA of Santa Cruz, Veteran's advocate, Radio Bilingue, Mariposa Wellness Center, Santa Cruz County Probation, Survivors' Healing Center, Santa Cruz Community Counseling Center, Community Connection, Homeless Garden Project, Health Improvement Partnership, and Walnut Avenue Women's Center.

The two workgroups identified the priority population as Trauma-exposed Individuals and the Onset of Serious Mental Illness. While the workgroups were focused on two separate age groups, their recommendations blend well together for this project, especially given that the "adult" workgroup chose "first break" issues as their top priority. While some of the strategies will be specific to transition age youth, some will be available to a broader age-range of people.

The stakeholders then went on to consider services provided in the County, service gaps, community entry points, and finally moved to recommending PEI services and strategies.

Data Analysis:
The recommendations for this project were based in part on the following data:

Demographics:
There were an estimated 34,969 young adults between the ages of 18 and 25 and 131,826 adults between the ages of 26-59 in Santa Cruz County in 2007. A little over half of the young adults were Caucasian (57%) and almost a third (31%) were Latino, whereas about two-thirds of the adults ages 26-59 were Caucasian (65%) and about one third Latino (28%). About one in four (26%) youth between the ages of 18 and 24 and nine percent (9%) of adults (ages 26-59) were living below the federal poverty level in Santa Cruz County in 2006. About 7% of adults (7,802 individuals) ages 35 to 64 in Santa Cruz were veterans in 2006.

Mental Health:
Seventeen percent (17%) of respondents ages 18-24 reported that their general mental health was “fair” or “poor” according to the 2007 Santa Cruz County CEP Telephone Survey. Twenty-six percent (26%) of respondents of the 2005 California Health Interview Survey (ages 26-59) said that they needed help for emotional or mental health problems.

A total of 1,930 individuals ages 18 and over were evaluated for psychiatric conditions at Dominican Hospital in 2007. Sixteen percent (16%) of evaluations for hospitalization by Dominican Hospital’s emergency room and Behavioral Health Unit were performed with transitional age youth ages 18-25.

Forty-seven percent (47%) of Cabrillo College and 52% of UCSC students surveyed in the spring of 2007 reported having “felt so depressed that it was difficult to function” one or more times within the last school year. One in ten Cabrillo College (10%) and UCSC (11%) student respondents reported in a spring 2007 survey that they had seriously considered attempting suicide one or more times within the past school year.

The number of suicides for youth ages 18-29 in Santa Cruz County ranged from 4 in 2003 to 2 in 2006, reaching a high of 6 suicides in 2005. The number of suicides among adults ages 30 to 59 in Santa Cruz decreased from a high of 23 in 2003 to a low of 11 in 2006. The 2003-2005 three-year average suicide rate was 12.8 per 100,000 in Santa Cruz County, as compared to 8.9 per 100,000 in California.

Trauma Exposure:
A total of 85 children and youth ages 0-17 who were in foster care for three years or longer exited foster care either through emancipation or as a result of turning 18 while in care in Santa Cruz County between 2002 and 2006.

There were 1,007 calls to the police reporting domestic violence in 2003, and 890 calls in Santa Cruz County in 2006. (Note that historically there is an under count of domestic violence calls due to underreporting.)

Substance Abuse:
About one in five (19%) Santa Cruz County adults ages 18 and over reported binge drinking during the past month according to CHIS. The 2007 survey about binge drinking showed that 10% of survey respondents ages 16-20 reported that they had “seriously thought about suicide” and 5% reported having “seriously tried to commit suicide” as a result of drinking.

Homelessness:
Fifty-eight percent (58%) of the homeless individuals surveyed in the 2007 Santa Cruz County Homeless Census Survey reported suffering from depression, 28% reported having Post-Traumatic Stress Disorder, and 26% reported having a mental illness. Substance use was the second most frequently cited cause of homelessness among the survey respondents.

Other Considerations:
The PEI workgroups noted the following risk factors:

- Family issues (addiction, mental illness, violence, gangs, chronic illness, and/or suicide history)
- Violence, abuse (physical/sexual), discrimination and stigma
- Substance Use/Abuse
- Military exposure
- Untreated mental illness

3. PEI Project Description: Early Intervention Program for Transition Age Youth and Adults.

This project seeks to provide education, training, and treatment by expanding mental health awareness and services through traditional and non-traditional settings, community entry points, professionals, and family members. This will be achieved by developing a network of care that occurs prior to being "diagnosed" with a serious mental illness. Through consultation, training and direct service delivery, a broad menu of services will be offered by Peer Counselors, Family Advocates, and Licensed counselors and psychiatrists to transition age youth and their families. This program will integrate evidence-based practices that are client-centered. This program addresses transition age youth and adults who are trauma exposed and are experiencing (or at risk of experiencing) the onset of serious mental illness. This project also addresses disparities in access to mental health services by including a focus on the needs of Latino youth as well as lesbian, gay, bisexual, transsexual (LGBT) individuals, and their families.

This project is composed of five strategies:

1. Identification of signs and early symptoms of Early Onset of Mental Disorders with Family Members, Professionals and Community Entry Points.
2. Early Onset Intervention Services Utilizing Professional Navigator, Psychiatry, Peer and Family Advocates, and Employment Services for Individuals and Family Members
3. Monthly Transition Age Youth Provider Roundtable Gatherings
4. Veterans Advocate
5. Suicide Prevention

Strategy 1 and 2 are intertwined as they overlap between Training, Education, and Consultation along with providing short-term direct services when needs are identified. Strategies 1 and 2 will share a licensed mental health professional, a part time Psychiatrist, one Peer Advocate, one Family Advocate and one Employment Specialist. This will assure continuity of care by having the "trainers" also be the "system navigators" starting with identification of need to delivery of care through a multi disciplinary team approach. All efforts will be made to hire Bi-lingual/Bi-cultural staff.

Project #2 - Strategy #1: Identification of signs and symptom of Early Onset of mental disorders with Professionals and Community entry points

Project #2 - Strategy #1-Phase One:
Support Community Entry Points, Professionals, and Family members to Identify and Intervene with Persons At-Risk of Serious Mental Illness
This strategy is intended to promote early identification of, and intervention with, persons age 18 to 59 who are at-risk of serious mental illness or suicide by training and supporting targeted Community entry points and professionals who come in contact with young adults and adults so as to better recognize signs of depression, suicidal ideation and intent, and other mental illnesses**.** Specific activities include the following:

Outreach to Community Entry Points, Family members, and Professionals.
A licensed Mental Health Clinician with the working title of "Navigator" will provide professional mental health services that is a mobile service to various community entry points, family members and professionals throughout the County. Services will include:

- Outreach to Community entry points, Family members and Professionals to educate and raise awareness about early warning signs of suicide and serious mental illness, including features and symptoms of a psychotic first break among these community populations; encourage participation in training activities; and raise awareness of referral resources for persons needing family support, peer-to-peer consumer services, as well as referrals to county mental health. Targeted Community entry points and Professionals include alcohol and drug treatment programs; Cabrillo College/UCSC; adult education and Digital Bridges; local law enforcement agencies; probation and courts; Child Welfare Services, foster care and CASA; mental health providers who encounter persons who are at-risk but don't yet meet Adult Mental Health System of Care threshold criteria currently defined as serious mental illness, Schizophrenia, Bi-Polar and/or Depression Disorders with Psychotic features; primary medical care providers; social service agencies (e.g., Diversity Center, Walnut Ave. Women's Center, Survivors Healing Center, Women's Crisis Support/Defensa, shelters); NAMI; family resource centers; and Veterans services.

Once the Navigator(s) have engaged the broader Community Entry Points, Families, and Professionals, Phase Two will begin with the following:

Project #2 - Strategy #1 - Phase Two:
Training: Conduct training with Professionals, Family members and Community Entry Points regarding validated screening protocols to identify early signs of persons at-risk of serious mental illness, including suicide and/or first break psychosis, utilizing the key elements of the Portland Identification and Early Referral program (PIER), a research program with the mission of reducing the incidence of psychotic illnesses (such as schizophrenia and bi-polar disorder) in the Portland, Maine area.

- Training will include; how and where to refer for mental health services as well as alternative, non-traditional approaches; how to use Recovery oriented evidence-

based practices that are person centered to intervene with persons at-risk of severe mental illness, including intervention with moderate to severe depression and symptoms of psychotic first break; Portland Identification and Early Referral (PIER); how to manage clients symptoms in their home as well as various settings; how to adapt program services to make them more accommodating to, and effective with, the target population; and how to address the unique needs of Veterans, Youth ageing out of Foster Care, Latino, and LGBT persons.

- The Training component is integrated with the County's Workforce Education and Training, which will allow for a diverse group of trainers and approaches.
- Training and outreach will be on-going as needed, not a one time only service

Project #2 - Strategy #2: Early Onset Intervention Services Utilizing Professional Navigator, Psychiatry, Peer and Family Advocates, and Employment Services for Individuals and Family Members

Early Intervention Services will be designed based on an individuals need. The Navigator will receive the referrals from Professionals, Family members, and Community entry points. Services will be individualized to provide consultation, assessment, and short-term mental health services through weekly scheduled site visits, individual appointments on an as-needed basis, and/or telephone calls as needed. Consultation, assessment and services may include provision of information and/or training to Community entry points; how to adapt the Community entry points/Professional's setting to better serve clients at-risk of serious mental illness; implementation of best practice models; consultation with professionals and Community entry points regarding specific clients; and the provision of face-to-face assessment and/or treatment planning visits with at-risk clients and their family members. Settings in which dual diagnosis clients are seen will be specifically targeted for training, consultation, assessment, and short-term treatment.

Psychiatric Services and Medications will be made available by a referral from the "Navigator" to provide psychiatric consultation, medications assessment and monitoring, and psychiatric medications to clients at-risk of serious mental illness and suicide in professional and gatekeeper settings by appointment.

Linkage to other mental health resources will be provided with a, "warm hand off," in such a way that access is seamless and individuals do not get, "lost in the system."

Early intervention services to persons who are at risk of onset of mental illness (or have had a "first break") will be delivered utilizing the key elements of PIER and will include education and support to families.

This component will be a low cost/free service that is client centered driven by clients expressed goals. Services to transition age youth (TAY) and Adults will be culturally sensitive, trauma-informed and promote an independent and productive life for ALL at risk of onset of mental illness, especially targeting the LGBT and Latino youth. Services will include licensed mental health clinician providing assessment, crisis intervention and short-term case management services, peer counseling and employment services.

Early Intervention counseling strategies will be offered with special emphasis for individuals in foster care or ageing out of foster care, alcohol and drug programs as well as other community agencies, primary care clinics, and schools.

Family members will be provided individual counseling and supports that may include home visits from a Mental Health Professional, Psychiatrist, Family Advocate, or Peer Counselor.

Assessment of psychosocial and drug and alcohol treatment needs will be provided. All services will be client centered and plans will be driven by the individuals' stated goals.

The Peer Advocate will provide counseling and support and be available to assist individuals in learning about mental illness, identifying signs and symptoms, and networking with professionals and natural supporters. The goal of this program is to "normalize" signs and symptoms through anti-stigma education. The Peer Advocate will facilitate person-centered planning in order to help individuals discover a vision for a desirable future and to develop an action plan to achieve their goals. WRAP will be utilized by the Peer counselor both individually and in-group.

All services will include a Family/Peer advocate to enhance access and linkage throughout the County.

The Employment Services will offer assistance in finding jobs, paid stipends for first time job experience that is less than 20 hours per week, and a "work first" work crew option to fast track employment experience. Employment services will target TAY who are homeless or at risk of homeless and youth transitioning out of Foster Care.

The overall goal is that services are targeted to intervene and provide support during challenging times. Once issues are stabilized, within a few months to one year, individuals will be integrated back onto their personal life track/goals and on track. If more services are needed a, "warm hand off," will be provided to offer on-going services in the community to meet a longer-term on going need. Linkage to assistance with benefits will be provided for those individuals showing signs and symptoms of a disability.

Project #2 - Strategy #3: Monthly TAY Provider Roundtable

This program coordinates the delivery of peer and professional services to transition age youth and their families. Providers to include County Mental Health Children and Adult counselors/coordinators, outreach workers, Public Health's Homeless Persons Health Project, Homeless garden project, County Office of Education, CASA, Department of Rehabilitation, Law Enforcement, Food Stamp office, Benefit Reps, and others as appropriate.

A monthly community meeting will be set to enable care providers from the community to come together to discuss individuals that may be accessing multiple services. An

MOU among providers will be developed to create a Multi-Disciplinary team meeting that is a confidential and safe environment for resource sharing, non-duplication of service and effort, improved integration of services, and brainstorming new ideas to enhance better outcomes for individuals.

The challenge to coordinate services to this population will be greatly enhanced by a formalized monthly meeting that brings providers together to share critical information, identify needs, and agree on who will be the primary contact person and support. This meeting will provide a natural network/team approach for many providers who are currently working alone in the field, streets, etc., and thus create a "team" to work smarter and provide an integrated service.

Project #2 - Strategy #4: Veterans Advocate

In order to strengthen linkages and coordination between County Mental Health and local Veterans services the County will contract a Veterans Advocate. In addition this advocate will help ensure the inclusion of Vets and their families in other relevant PEI services (including, but not limited to, parenting education, school based prevention services, field based services for TAY, Adults and Older Adults).

This person will be responsible for knowing the various Veteran resources in the community, provide and/or support wellness activities, and assure the County is compliant with AB 3083 (linkages between County and Veterans agencies).

The County will also include education and training on Veterans issues in the Workforce Education Training Academy. This may include issues such as post-traumatic stress, effects on children and spouses, issues of isolation, and/or issues of adjusting post-war experience.

Project #2 - Strategy #5: Suicide Prevention Services

The County will contract with a community-based agency to provide suicide prevention services. The "Suicide Awareness for Everyone (SAFE)" will provide services across the life span, and include the following components:

- To raise community awareness
- Educational presentations
- Training for "gatekeepers" (community entry points)
- Information presentations
- Support for adults coping with difficulties, including loss of loved one

4. Programs for Project #2

Program Title Project #2: Early onset Intervention Services for Transition Age Youth and Adults	Proposed number of individuals or families through PEI expansion to be served Annually		Number of months in operation through June 2010
	Prevention	Early Intervention	
Strategy #1: Identification of signs & Symptoms of Mental disorders with Family members, professionals, and community entry point throughout the County.	Individuals: 120 Families: 40	Individuals: Families:	**12**
Strategy #2: Early Onset Intervention Services for Individuals and Family Members.	Individuals: Families:	Individuals: 96 Families: 45	**12**
Strategy #3: Roundtable	Individuals: 0 Families: 0	Individuals: 0 Families: 0	**12**
Strategy #4: Veterans Advocate	Individuals: 40 Families: 10	Individuals: 40 Families: 10	**12**
Strategy #5 Suicide Prevention Services	Individuals: 300 Families: 50	Individuals: Families:	**12**
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**560**	**191**	

5. Linkages to County Mental Health and Providers of Other Needed Services
This program will expand and broaden our mental health services. Currently, specialty mental health services are limited to those individuals who meet the target population of having a serious mental disability. By implementing this PEI program we will be creating a larger safety net that includes a broader group of participants from a wide spectrum of the community who are in need of mental health services yet not severe enough to warrant the traditional specialty services. The services will be a “no cost” service to the recipients.

Linkages to County Mental Health Services will be an integral part of the assessment process. One of the anticipated outcomes will be to expand our mental health services within the community rather than in the public mental health system. The program strives to enhance linkages to natural supports, strengthen knowledge and skills to care providers and individuals while at the same time recognizes that some people will need the specialty services offered through the County’s specialty mental health services or other needed services. If the program Navigators determines that an individual does need more targeted care they will provide referrals and a, “warm hand off,” to assure a seamless transition. If the individual meets the mental health target population they will be brought into the system of care and have access to the full array of services from intensive case management to hospital and locked care to supported housing and employment services based on individual needs.

6. Collaboration and System Enhancements

The Early Onset Professional and Community Entry Points supports, family supports and TAY/1st break case management, peer counseling, employment services and the monthly TAY Roundtable Team will create a natural County wide network of care that has a built-in system of collaboration that expands the reach of mental health services to drug and alcohol providers, educators, law enforcement and Human Resource agencies through outreach to individual homes, agencies, clinics, schools as well as the streets. Inherent in this program is a community-based collaboration. This mental health “safety net” expands the current definitions of services only for the “targeted mental health” services to include training, education, consultation, and outreach for our community service providers and families. The program educates the community about early signs and symptoms of mental illness as well as aims to reduce suicide, decrease numbers of individuals who become disabled due to a persistent mental illness, and ultimately will enrich the quality of life for individuals and create a mentally healthy community.

The current system will be enhanced by developing a larger network of care that includes those with mild or early warning signs with an added focus on prevention, education, consultation and training, thus broadening county mental health services to include prevention and early intervention rather than waiting for individuals to have a serious a persistent mental illness.

The Veteran's Advocate will help the County strengthen linkages and coordination between County Mental Health and local Veterans services. In addition this advocate will help ensure the inclusion of Vets and their families in other relevant PEI services.

7. Intended Outcomes

- Increased outreach and assessments to a larger population, not limited to those with a serious mental illness
- Engagement with identified LGBT individuals and groups, and Latino Youth
- Individuals with signs and symptoms of mental health issues will be stabilized and or linked to needed resources and services early on.
- Community entry points and families will be better trained and educated to know signs and symptoms and community services.
- On-going Community collaboration and networking to provide integrated supports for individual needs
- Prevention and early intervention for veterans through enhanced coordination of services

8. Coordination with Other MHSA Components

The supervisor of the FSP for TAY and Older Adults will provide supervision and support to this program's staff; this will greatly enhance a smooth transition from PEI to system of care when appropriate. The following is a list of MHSA supported components:

- Full Service Partnership Teams, including TAY, Older Adults and Homeless.
- Adult Service Teams for case management, access to mental health supported housing and supported employment services
- Access to the Wellness Centers, on-going psycho therapy and medication supports
- Residential Crisis House, a program that diverts individuals from inpatient psychiatric hospitalization
- Enhanced Support Services
- Family Advocacy, a program that responds to families in order to educate, and enhance access and linkage to services.

PEI PROJECT #3 SUMMARY

County: Santa Cruz
PEI Project Name: Early Intervention Services for Older Adults
Date: January 20, 2009

Complete one Form No. 3 for each PEI project.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	❑	❑	❑	X
2. Psycho-Social Impact of Trauma	❑	❑	❑	X
3. At-Risk Children, Youth and Young Adult Populations	❑	❑		
4. Stigma and Discrimination	❑	❑	❑	X
5. Suicide Risk	❑	❑	❑	X

2. PEI Priority Population(s)	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	❑	❑	❑	X
2. Individuals Experiencing Onset of Serious Psychiatric Illness	❑	❑	❑	X
3. Children and Youth in Stressed Families	❑	❑		
4. Children and Youth at Risk for School Failure	❑	❑		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	❑	❑		
6. Underserved Cultural Populations	❑	❑	❑	X

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s)

Stakeholder input:
Santa Cruz County considered input gathered from the CSS planning and Town Hall meetings held in 2006 and 2007, but relied more heavily on the extensive PEI planning process. Aside from the educational forums and data presentations, there were workgroups that focused on prevention and early intervention needs of the various age groups across the lifespan. The older adult workgroup met a total of six times. Additionally there was a focus group with seniors on October 6, 2008. (See appendix for notes of the workgroup meetings and the focus group.)

The workgroup included stakeholder representatives from consumers, family members, Santa Cruz County Mental Health, Santa Cruz County Human Services Department, Santa Cruz Community Counseling Center, Advocacy Inc., Family Services Agency, Veterans' advocates, Watsonville Senior Center, Hospice of Santa Cruz, Senior's Council, Diversity Center, Women's Crisis Support, Elder Day Care, Health Projects Center, and Del Mar Caregiver Resource Center.

The stakeholders earlier identified the Onset of Serious Mental Illness and Trauma Exposed Individuals as the priority populations. Presentations on services provided for this population were held during the older adult work group meetings. This workgroup went on to identify service gaps and community entry points, and then ended with recommending PEI services and strategies.

Data analysis
Demographics: There were an estimated 41,406 seniors ages 60 and over in Santa Cruz County in 2007. (This is an increase of 5,564 since 2003, when there were 35,842 seniors.) The majority of seniors were Caucasian (81%), while 12% were Latino in 2007.

Seven percent (7%) of seniors (ages 65 and over) were living below the federal poverty level in Santa Cruz County in 2006.

Veteran's accounted for nearly one-quarter (23%) of adults ages 65 and over (or 5,816 individuals) in Santa Cruz County in 2006.

Mental Health:
In 2006-07, a total of 288 clients, ages 60 and over, were served by the Santa Cruz County Mental Health. Females comprised nearly half (58%) this number with eighty two percent (82%) identified as Caucasian. One in five (21%) seniors ages 60 and over in Santa Cruz County reported that they needed help for emotional or mental health problems according to the 2005 California Health Interview Survey. Fifteen percent (15%) of seniors ages 65 and over, in Santa Cruz County, had a mental disability according to the 2006 American Community Survey.

The number of suicides among adults ages 60 and over living in Santa Cruz County ranged from a low of 4 in 2005 to a high of 16 in 2003. There were 10 suicides for this age group in 2006.

Elder Abuse:
The annual number of reported elder or dependent adult abuse increased from 331 reports in 2002 to 524 reports in 2006, an increase of 58% in Santa Cruz County.

Other Considerations:
The PEI workgroup noted the following risk factors:

- Loss of functioning
- Substance abuse
- PTSD & military involvement
- Bereavement and other loss

3. PEI Project Description:

This project addresses persons age 60 and older experiencing onset of serious mental illness, trauma-exposed individuals, victims of elder abuse, and disparities in access to services.

Project #3 - Strategy #1: Field Based Mental Health Training and Assessment Services to
Provide mental health assessment and short- term services to older adults where they reside
This prevention strategy addresses the high rates of depression, isolation and suicides of Older Adults in Santa Cruz County. Strategies are aimed at identifying older adults at risk of trauma-induced mental illness, depression, anxiety, suicidal ideation, and late onset mental illness, as well as undiagnosed and misdiagnosed seniors. This group has been identified as an underserved population, often due to senior's isolation and challenges in accessing appropriate care.

County mental health will hire a full time Occupational Therapist, (OT) with a specialty in Older Adult/psychiatry to provide outreach, assessment, and short-term case management to older adults in their homes and a variety of settings (where they reside). Referrals may be made by:

> Senior Network Services, Multi–Disciplinary team, Individuals and/or family members, County Mental Health, Adult Protective Services, Elder-day, Senior Centers, Skilled Nursing Facilities, Residential Care Facilities, Homeless Persons Resource Center, Primary Care offices and clinics, In Home Support Services, Private Case Management agencies, Meals on Wheels, Grey Bears, Linkages Program, Homeless Persons Health Clinic, Ombudsman office, Assisted Living settings, Law Enforcement, Hospital, Family members, and others.

This program helps identify at-risk seniors and will connect them to OT services that include a mental health assessment to determine if the individual needs County mental health services from the Older Adult Full Service Partnership Team, Older Adult Psychiatrist, or if they are in need of other community referrals and resources. Short-term case management will be available by the OT as well as linkage Brief Therapy and a Peer Support Companion program (see strategy #2). Services will target symptoms of depression, suicidal ideation, isolation, evaluation, and assistance with daily living skills, with an emphasis on supports and guidance to live in the least restrictive settings. Emphasis and value will be placed on helping seniors remain in their homes with linkage to community support services to enhance quality of life through nutrition, exercise, and proper linkage to physical health care and assistance, with meaningful daily activities when appropriate. Services will be client centered with a broad variety of resources to include traditional and non-traditional approaches.

The Supervisor of the Full Service Partnership, Older Adult team, will also provide supervision to the OT to ensure continuity of care and seamless transition if the client meets target population for on-going mental health services.

Through the Santa Cruz County MHSA Workforce Education and Training (WET), funds will be used for the development of a training curriculum that will include the following key elements identified during the development stages of the program: Understanding mental illness, how it manifests, confidentiality, identifying criteria for further assessment, communication skills and other core competency skills, related to mental health and older adults.

The program will hold trainings in conjunction with the County's Workforce Education and Training program at key senior organizations for staff, professionals, paraprofessionals, peer counselors, family members, and those who come in contact with older adults, to better recognize signs of depression and other mental illness, and assist seniors connect to services.

Project #3 - Strategy #2: Senior Services and Outreach including brief therapy and Peer companions

The County will contract with a community-based agency for early intervention counseling and therapy services. These services will follow a brief treatment model and may include mobile services where seniors reside when needed. Services will be provided to Medicare recipients.

Peer Companions will be older adults, 60 and over, likely hired through a Community Based Organization (CBO) with an existing seniors program. The Peer Companions will be trained as described in strategy #1. Peers will provide companionship and light respite work for frail elderly towards empowering these individuals to continue living independently in their homes. The CBO will take referrals by the OT (described in Strategy #1) in order to implement the client centered treatment goals. Peer Companion Support services will be mobile and short term, up to one year, to stabilize mental health

symptoms. Peer companions will be trained to know signs and symptoms of distress with knowledge of community resources. They will work closely with the OT for support, supervision, and referrals. Recruitment of Peer Companions will include monolingual Spanish speakers or bi-lingual capacity and trained to know the senior resources. They will provide services in private homes as well as Skilled Nursing Facilities, Senior Centers and Older Adult Residential Care Homes.

Project #3 - Strategy #3: Warm Line provides quick telephone screening and referrals to senior resources for persons seeking services for older adults
Senior Network Services is the central coast resource hub for all senior services in Santa Cruz County provided through a contract with Area Agency on Aging. This service will reach older adults where they live **as so often** seniors call in for information and assistance. Senior Network Services will act as a referral agency to link older adult services to our prevention and early intervention services for seniors. Our plan seeks to enhance their services so that they are able to take the anticipated increase in volume of calls, make appropriate referrals, and can be better targeted to serve seniors with early onset of mental health conditions. This will be accomplished through education, consultation, and seamless linkage with mental health resources. Training of staff will be provided through the WET program as described in Strategy # 1. The OT (from strategy #1) will provide consultation to the Senior Network staff so that they are trained to recognize the early signs and symptoms of mental illness. This program will add a half time position to their existing services increasing the ability to respond quickly to community needs.

4. Programs for Project #3

Program Title Project #3: Early Intervention for Older Adults	Proposed number of individuals or families through PEI expansion to be served Annually		Number of months in operation through June 2010
	Prevention	Early Intervention	
Strategy #1: Field based mental health training and assessment services	Individuals: 10 Families: 24	Individuals: 48 Families: 24	**12**
Strategy #2: Senior Outreach through Peer Companions	Individuals: Families:	Individuals: 36 Families: 10	**12**
Strategy #3: Warm Line	Individuals: 200 Families: 50	Individuals: Families:	**12**
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**284**	**116**	

5. Linkages to County Mental Health and Providers of Other Needed Services

OT, Peer Companions and all newly trained staff in the community may refer seniors and their families to County Mental Health, Full Service Partnership teams, primary care providers, in-home support, and other providers as related to individual need, by making direct referrals to these agencies. A “warm hand-off” will be made with routine follow-up to ensure that individuals receive treatment or further assessment. Referrals will be made to non-traditional preventive programs such as senior centers, park and recreational programs, Meals on Wheels, Grey Bears, and Wellness Centers, to enhance access to services, supports, and meaningful daily activities.

By design, this program has designated the Supervisor of the Older Adult FSP to provide direct clinical supervision and support to the lead clinician, the OT. This will ensure continuity of care as well as on-going communication with this PEI program.

6. Collaboration and System Enhancements

This program will enable mental health to have a new and significant role in the larger network of care for seniors. Adding a mental health professional and the Peer Companion program will highlight mental health concerns and thereby enhance collaboration with all Senior Services throughout the County. System enhancements will improve access to mental health services by providing the capacity for person centered in-home assessments, brief treatment, peer support, and linkage to other service providers.

7. Intended Outcomes

- Lower number of senior suicides
- Reduced isolation through peer support
- Increased access to mental health services
- Increased quality of life through Peer Companion program, and linkages and collaboration with Grey Bears, Senior Centers, and in-home support services
- Increased collaboration with primary care providers

8. Coordination with Other MHSA Components

The County will have a major role on the Multi-Disciplinary Team that will promote coordination and collaboration with all County programs. The Occupational Therapist will be inter-connected with the FSP for Older Adults. The supervisor of this team will also supervise the OT for PEI. This will enable an integration of the PEI service component with the CSS plan when clients are found to meet the target population. The OT will attend weekly team meetings with the Older Adult FSP that will allow for in-person referrals as well as problem solving on a case-by-case basis. Referrals to the

FSP will be seamless and allow for an easy and personal transfer of services. In addition, the team will provide support and back-up when the OT is sick, on vacation, or in need of problem solving from a larger clinical perspective.
Other MHSA services to coordinate with will include:

- Older Adult Full Service Partnership Team, Older Adult therapist
- Adult Service Teams for case management, access to mental health supported housing, and supported employment and education services
- Access to the Wellness Centers, on-going psycho therapy, and medication supports
- Residential Crisis House, a program that diverts individuals from inpatient psychiatric hospitalization
- Enhanced Support Services Team
- Access to Older Adult Residential Care facilities

LOCAL EVALUATION OF A PEI PROJECT

County: Santa Cruz

PEI Project Name: Cara y Corazón

1.a. Identify the programs (from Form No. 3 PEI Project Summary) the county will evaluate and report on to the State.

Project #1 Strategy #3 (Culturally Specific Parent, Family and Child Supports) of the Early Intervention for Children project will be evaluated intensively and reported on to the State.

1.b. Explain how this PEI project and its programs were selected for local evaluation.

Strategy #3 was selected due to the fact that some of the programs being piloted locally, although they are very popular among parents and families and the agencies that refer them, have only preliminary data demonstrating their effectiveness. This data demonstrate that parents were very satisfied with the services and rated their families on a pre-post basis as improving in the areas of discipline, trust, communication, and respect. However, these evaluations were conducted with a relatively small number of participants, did not use validated measures, and did not look at changes in family or child functioning beyond parents' pre-post ratings.

Given the level of community support for these programs, we would like to evaluate them in greater depth to determine their effectiveness and improve them or seek other program models before we roll out implementation of culturally specific parent, family and child supports on a larger scale.

2. What are the expected person/family-level and program/system-level outcomes for each program?

Individual and family-level outcomes include:

- Improved family functioning in the areas of communication, trust, discipline, respect, and knowledge of effective parenting practices; and
- Improved child and youth behavior related to child development, school and juvenile justice involvement.

Systems-level outcomes include:

- Greater participation by community partners in mental health prevention efforts;
- Greater understanding among community partners of risk and protective factors and effective prevention strategies; and
- Improved integration of mental health and substance abuse prevention efforts.

3. Describe the numbers and demographics of individuals participating in this intervention. Indicate the proposed number of individuals under each priority population to be served by race, ethnicity, and age groups. Since some individuals may be counted in multiple categories, the numbers of persons on the chart may be a duplicated count. For "other", provide numbers of individuals served for whom a category in not provided (i.e., underserved cultural

populations; e.g., gay, lesbian, bisexual, transgender, questioning; hearing impaired, etc.). Please indicate at the bottom of the form an estimate of the total *unduplicated* count of individuals to be served. If the focus of the intervention is families, count each person in the family.

Population Demographics	PRIORITY POPULATIONS						
	Trauma	First onset	Child/youth Stressed Families	Child/Youth School Failure	Child/Youth Juvenile Justice	Suicide Prevention	Stigma/ Discrimination
ETHNICITY/ CULTURE							
African American			2				
Asian Pacific Islander	1		4			1	
Latino	8	3	126			5	8
Native American			2				
Other (Indicate if possible) White	2	1	34			1	2
AGE GROUPS							
Children & Youth (0-17)	11	4	168			7	10
Transition Age Youth (16-25)							
Adult (18-59)							
Older Adult (>60)							
TOTAL	11	4	168			7	10
Total PEI project estimated ***unduplicated*** count of individuals to be served _200_____							

4. How will achievement of the outcomes and objectives be measured? What outcome measurements will be used and when will they be measured?
The County will contract for program evaluation services to measure attainment of objectives and outcomes, and will consult with program evaluators to refine measurement tools and methodology. Criteria for selection of measurement instruments will include: reliability and validity of the instrument; consistency of domains measured by the instrument with the objectives of the program; ease of administration; and cultural

relevancy of the instrument. Process measures (e.g., number of groups conducted, number of parents/youth trained) will be collected on an ongoing basis and reported quarterly. Data on parent, family and child outcomes will be collected at baseline (program admission) and program departure, and post-departure if resources permit. Data on system level outcomes will be collected annually using surveys and key informant interviews with stakeholders and community members regarding their participation in mental health prevention efforts; changes in their understanding of risk and protective factors and effective prevention strategies; and perceptions of integration of mental health and substance abuse prevention efforts.

5. How will data be collected and analyzed?
Pre-post data on parent and youth education groups will be collected by group facilitators at the first and last group sessions, and at the last visit if a person's departure from the group is planned. Contracted program evaluators will conduct interviews and surveys with stakeholders and community partners, and will analyze all data.

6. How will cultural competency be incorporated into the programs and the evaluation?
Cultural competency will be a primary criterion for selecting a curriculum. Parents and youth education group participants will be asked to rate the cultural competency of the program as well. Data on participant race/ethnicity, language preference, and availability of program materials in Spanish will also be collected.

7. What procedures will be used to ensure fidelity in implementing the model and any adaptation(s)?
The models currently used by County Mental Health, known as Cara Y Corazón and Jóven Noble, have been implemented through a training of group facilitators and a County staff member serves as the fidelity monitor for local implementation. Fidelity is ensured through supervision of local trainers and observation of parent/family/child education groups. Depending on the model(s) chosen, fidelity measures may also include fidelity monitoring checklists, ratings of audio or videotapes of groups, and regular coaching/supervision of group facilitators.

8. How will the report on the evaluation be disseminated to interested local constituencies?

The evaluation report will be presented to the local MHSA Steering Committee, the Together for Youth prevention collaborative, the Local Mental Health Board, and be made available on the County Mental Health website.

Appendix

Prevention & Early Intervention Stakeholder Meetings

PEI "101"

- Tuesday, May 6th, 2008: 5:00 p.m. to 7:00 p.m., Simpkins Swim Center, 17th Avenue, Capitola
- Friday, May 9th, 2008: 9:30 a.m. to 11:30 a.m., 1432 Freedom Boulevard, Watsonville

First PEI meetings by age group

- 0-25: Monday, June 2nd, 2008: 10:00 a.m. to 12:00 p.m., Aptos Park, 100 Aptos Creek Road, Aptos
- 60+: Thursday, June 5th, 4:00 p.m. to 6:00 p.m., 1430 Freedom Blvd, Room 8, Watsonville
- 26-59: Friday, June 6th, 2008, 9:30 a.m. to 11:30 a.m., 1080 Emeline Ave, large Aud, Santa Cruz

ASR Presentation Meetings (PEI Data Feedback)

- Tuesday, June 24th, 6:00 p.m. – 8:00 p.m., Simpkins, 979 17th Avenue, Santa Cruz
- Friday, June 27th, 9:30 a.m. - 11:30 a.m., 1432 Freedom Blvd./9 Crestview, Watsonville

Prevention & Early Intervention planning meetings/presentations:

- **Tuesday, August 19th** from 6:30 p.m. to 8:30 p.m., 1080 Emeline Avenue, Santa Cruz. "Trauma-Informed Services," by Gabriella Grant and Dr. Jerry Solomon will engage the audience to gather input on desired outcomes for Trauma-Exposed individuals.
- **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m., 1080 Emeline Avenue, Santa Cruz. "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness shared their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson, John Wright, and Kate Venturini.
- **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m., at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville. Topic: "Best Practices in Working With Stressed Families." Rivka Greenberg, Ph.D.

Workgroup Meetings

0-5: Mondays from 9:30 a.m. to 11:30 a.m.

July 7: United Way, 1220 C 41st Avenue, Capitola
July 21: United Way, 1220 C 41st Avenue, Capitola
August 4: Career Center, 18 W. Beach Street, Watsonville
August 18: United Way, 1220 C 41st Avenue, Capitola
September 15: United Way, 1220 C 41st Avenue, Capitola
September 29: Career Center, 18 W. Beach Street, Watsonville

6-12: Mondays from 10 a.m. to 12:00 p.m.

June 30: County Office of Education, 809 Bay Avenue, Capitola
July 14: County Office of Education, 809 Bay Avenue, Capitola
July 28: "The Towers", 294 Green Valley Rd, Watsonville
August 11: Mountain Community Resource Center, 6134 Hwy 9, Felton
August 25: United Way, 1220 C 41st Avenue, Capitola

September 8: United Way, 1220 C 41st Avenue, Capitola
September 22: United Way, 1220 C 41st Avenue, Capitola

13-17: Wednesdays from 10:00 a.m. to 12 p.m.
July 2: County Office of Education, 809 Bay Avenue, Capitola
July 16: County Office of Education, 809 Bay Avenue, Capitola
July 30: Career Center, 18 W. Beach Street, Watsonville
August 13: HSA Small Auditorium, 1080 Emeline Avenue, Santa Cruz
August 27: United Way, 1220 C 41st Avenue, Capitola
September 10: Career Center, 18 W. Beach Street, Watsonville
September 24: United Way, 1220 C 41st Avenue, Capitola

18-25: Wednesdays from 10:00 a.m. to 12:00 p.m.
July 9: Santa Cruz Mental Health Services, 1400 Emeline, Santa Cruz
July 23: County Office of Education, 809 Bay Avenue, Capitola
August 6: Career Center, 18 W. Beach Street, Watsonville
August 20: MHCAN, 1051 Cayuga Street, Santa Cruz
September 3: MHCAN, 1051 Cayuga Street, Santa Cruz
September 17: Career Center, 18 W. Beach Street, Watsonville

26-59: Fridays from 9:30 a.m. to 11:30 a.m.
July 11: Vets Memorial Bldg, 846 Front St, Santa Cruz
July 25: 1432 Freedom Blvd./9 Crestview, Watsonville
August 8: Community Counseling Center, 195 Harvey West, Santa Cruz
August 22: United Way, 1220 C 41st Avenue, Capitola
September 5: Career Center, 18 W. Beach Street, Watsonville
September 19: Diversity Center, 1117 Soquel Avenue, Santa Cruz

60+: Tuesdays from 9:30 a.m. to 11:30 a.m.
July 1: Family Services, 104 Walnut Avenue, Santa Cruz
July 15: Family Services, 104 Walnut Avenue, Santa Cruz
July 29: Career Center, 18 W. Beach Street, Watsonville
August 12: Family Services, 104 Walnut Avenue, Santa Cruz
August 26: Family Services, 104 Walnut Avenue, Santa Cruz
September 9: Family Services, 104 Walnut Avenue, Santa Cruz

Key Informant Interviews
September 23, 2008 Manny Solano, Deputy Police Chief, Watsonville Police Department
October 7, 2008 Dorian Seamster, MD, Health Improvement Partnership of Santa Cruz.

Focus Groups:
Parents (English): Tuesday, 10/7/08 6:00 p.m. to 8:00 p.m.
Parents (Spanish): Tuesday, 10/2/08, 5:30 p.m. to 7:30 p.m.
Consumers (North County): Friday, 10/3/08, 11:00 a.m. to 1:00 p.m.
Consumers (South County): Thursday, 10/16/08, 10 a.m. to 2 p.m.
Seniors: Monday 10/6/08, 10:00 a.m. to 11:30 a.m.
Youth: Thursday, 10/16/08, 4:00 p.m. to 6:00 p.m., United Way
Transition Age Youth: Monday, 4:00 p.m. to 6:00 p.m., 10/20/08
Veterans/Veterans Advocates: Wednesday, 6:00 p.m. to 8:00 p.m., 12/10/09

Final Workgroup meetings:
Thursday, 1/8/09, 7:00 p.m. to 9:00 p.m., Simpkins Swim Center, 17th Avenue, Capitola
Friday, 1/9/09, 9:00 a.m. to 11:00 a.m., 1432 Freedom Boulevard, Watsonville

Work Group Meeting Notes

Mental Health Services Act: Prevention & Early Intervention

Workgroup: Ages 0 - 5

7/7/08 Meeting Notes

1. Introductions
2. Review of workgroup guidelines and rules
    a. We are to create and foster an integrated system
    b. The state has mandated that we use the Logic Model (will need to document that we are doing this and the State will evaluate us).
    c. Values and Guiding Principles
        i. Transformational programs and actions
        ii. Leveraging resources
        iii. Stigma and discrimination
        iv. Recognition of early signs
        v. Integrated and coordinated systems
        vi. Outcomes and effectiveness
        vii. Optimal point of investment
        viii. User friendly plans
        ix. Non-traditional settings.
3. The group will need to review its decision making model; we will try for consensus, and if unable to reach consensus use a majority vote to decide our recommendation. The group needs to decide who can vote on the final decisions made to the Steering Committee
4. Workgroup member's & agendas
    a. Jerry Solomon, Facilitator, Psychologist & MFT
    b. Erika Hearon (Community Bridges) Main goal is community-based prevention; agenda is to potentially get funding, and for collaborating with others so that there are more services. Looking at family based approach that addresses all members of the family in prevention.
    c. Dane Cervine (Santa Cruz County, Chief of Children's Mental Health Services, member of MHSA Steering Committee) as part of the CSS planning, there was data that showed that in the children's MH world there was intensive services for teenagers and few services for kids 0-5. To link the early findings in CSS and apply them to PEI to carry over some consistent themes where they merge. Unsure whether the County will seek funding (probably more minor role).
    d. Wilma Gold (Outgoing chair for Childcare Planning Council of SC County, Member of COPA), goal is to identify issues within the county and be strategic about how to bring people power to address these issues. Not interested in funding, but in bringing knowledge back.
    e. Deborah Helms (rep. Cabrillo College, overseeing the foster and kinship care education care program, the options for recovery program, and special ed training for adoptive parents programs) MFT. Interested in getting prevention and early intervention to very young children and more services that have to do with family relationships. Not interested in funding.
    f. Shawn Henson (Headstart, coordinating the mental health services in Family Services) new to county and surprised how few services there are for this age

group. Trying to do some internal things ourselves, starting out a program for violence prevention. Open to funding.

g. Cathy Simmons (County of Santa Cruz, Program Supervisor with Children's Mental Health) in my practical experience working with children there is high level of need to screen younger children to prevent deficits further on in their life. Would like to see more services addressed towards those that have in utero substance exposure.
h. Ellen Timberlake (County of Santa Cruz, Deputy Dir. of Human Services Dept.) member of the Steering Committee for MHSA, asked to represent public social services in the county. And a personal passion for the importance of prevention and early intervention. The more this can happen the less likely people in our community will need to require our services so we have a big investment to ensure that we get dollars like this and leverage them in the most effective way to provide more services. Do not think our department is interested in applying for funding, not directly. Our interest is to ensure that needs of our clients are addressed. We are interested in outcomes as a service provider, and that during this process recommendations for improvement don't get lost. (Will provide a consolidated view of the mental health early intervention prevention related recommendations.)
i. Susan True (Executive Director First 5) primary agenda is to try and have some kind of discipline around this process so that whatever we do it is good with the limited resources we will have. Not necessarily interested in funding but be part of the planning working together. On the MHSA Steering Committee
j. Deborah Vitullo (Santa Cruz Community Counseling Center, Clinical Supervisor) it is very difficult to diagnose kids 0-3 and working with parents where in many cases one of them has a mental illness. Would like to see funding address services to this group. Would like to get some of the funds.
k. Laura Segura (Women's Crisis Center)

5. Planning Process
    a. Next step, pick a priority population
        i. Children/Youth in stressed families
        ii. Children/Youth at risk of school failure
        iii. Children/Youth at risk of juvenile justice involvement
        iv. Trauma exposed
        v. Experience onset of serious mental illness
    b. State will do own initiative on Suicide Prevention and Stigma reduction of the mentally ill.
    c. Steering Committee will set funding percentage
    d. Program/s must be evidenced based with an evaluation component built in
    e. Need representation from stakeholders, as identified by the State
    f. Identify missing stakeholders
        i. Need Latino outreach
        ii. African-American community outreach
6. Priority populations, per the DMH, to focus on in this workgroup
    a. Trauma exposed
    b. Individuals experiencing the onset of a serious mental illness

   c. Children/Youth in stressed families
   d. Children/Youth at risk for school failure
   e. Children/Youth at risk of experiencing criminal juvenile justice involvement
   f. Overarching concerns is suicide prevention and reduction of stigma and discrimination for those identified as struggling with mental illness.
7. Workgroup decisions to be made:
   a. Narrow down priority population recognizing all have needs. In this group, are there one or two groups we want to focus on and is there more data that we need to start making recommendations about programs for prevention and early intervention in those areas.
   b. Making sure we have the appropriate stakeholders involved with this process. Who is not here around the table? Per the state DMH guidelines, we must be sure we have input from all required stakeholder groups. We must be mindful of these groups and make efforts to get information from them so that it is fed into our process. A person may represent more than one stakeholder group.
      i. Based on the data feedback we heard from Applied Survey Research, the major areas of underserved communities is the Latino and LGBT community.
      ii. Education
      iii. Consumers and/or their families
      iv. Providers
      v. Health organizations
      vi. Social Services
      vii. Law Enforcement; Input will be gathered by either a focus group or key informant interviews (asking one/two officers to attend one meeting to address our questions).
      viii. Stakeholders recommended but not required by DMH include representatives from Community Family Resource Centers, Employment, and Media
8. Review of MHSA PEI values and guiding principles. All in attendance stated that they were aligned with these values and principles.
   a. Transformational programs in action; looking for things that are brand new rather than incremental changes to existing programs that can transform a dilemma or problem.
      i. Leveraging resources
      ii. Stigma and discrimination reduction
      iii. Recognition of early signs
      iv. Integrated and coordinated systems
      v. Outcomes and effectiveness
      vi. Optimal point of investment
      ix. User friendly plan so that the consumer and family member are comfortable with what we are setting up in non-traditional settings.

Next meeting: July 21: United Way, 1220 C 41st Avenue, Capitola

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 0-5

July 21, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Dane Cervine, Erika Hearon, Deutron Kebebew, Cathy Simmons, Sherra Clinton (for Ellen Timberlake), Susan True, Deborah Vitullo, Desiree Sanchez, Ginny Gomez, Jaime Molina, Deborah Helms.

Notes (taken by Alicia) are a summary of the meeting (not verbatim).

1. Agenda was reviewed. Group already determined to make decisions using gradient consensus, so we will skip that item on the agenda. Also moved "determining priority populations" item up on the agenda.
2. Introductions.
3. **Thoughts about last meeting?** Like the idea of having strategies that cut across age groups (e.g. stressed families); this is a common theme among the PEI work groups. May be a smart way to go given limited resources.
4. **Stakeholders**. Who is missing? La Manzana has a new director: Celia Organista.
5. **Resource Material**. DMH gave outlines of various programs. Reaction/Comments? DMH is less rigid about their criteria about using best practice models, as long as we use logic model. Programs need to be culturally competent. We will need to evaluate the program(s). Group noticed that there is very little in the DMH resources. We will also look at other Counties and see what they are proposing. Group mentioned parent training, and prenatal programs. Triple P (Positive Parenting Program) was discussed briefly; there are some conversations in Santa Cruz about Triple P.
6. **Defining Priority Population**. Discussed the 5 proposed priority populations, and after brief review/discussion narrowed the priority population for this group to "Children and Youth in Stressed Families", and secondarily to "Trauma Exposed Individuals".
7. **Stressed Families**. Brain storm on what this looks like in the 0-5 age group: poverty; substance abuse; child welfare (CPA has seen referrals for this age group go way up in last five year, mostly neglect, including substance abuse of parents); scarcity of resources (time, money, both parents working, one or two jobs); parents with mental illness causing stress on family (especially if they can't get services); immigration status; immigration experience and/or knowing someone that has been deported, especially in their own family; domestic violence (and not enough resources to address this issue); single parents; multi-generation gang involvement; large families (with few resources); homelessness; isolated families; families with special needs kids; divorcing families; families with parent(s) involved in criminal justice system; Latino families involved with CPS (who don't connect with resources, sometimes there is a waiting list for Spanish speaking services); people that speak a different dialect and have different cultural norms (such as marrying at a very young age) – they don't always enroll in school or seek "traditional" (main stream) services. Today we are just brainstorming; we'll narrow this down next time.
8. **Where do these families show up?** Child welfare system (some served, some referred out); primary care physicians; head start and child care; substance abuse programs, and other families. Dominican Hospital has a home health care program for babies born

there; Sutter and Watsonville hospitals do not have such a program. A lot of families with children ages 0-5 do not have a lot of "institutional" relationships, but we are aware of a lot of families already.

9. **Existing Programs.** Group discussed various resources, such as WIC; SPIN (Special Parents Information Network – CC Pineiro); Positive Discipline; Cara y Corazón and Papás (both are parent education programs, with the latter focusing on fathers). Cara y Corazón takes a holistic approach, and addresses not only children's behaviors, but also provides parents support, and looks at substance abuse issues; program is in the process of being evaluated (by CDC and SAMSA. Papás stresses working with fathers, but also looks at co-parenting issues; families commit for 18 months and the group looks at the individual skills of the parent, the parent-child relationship, the couple/parents roles and communication skills, the family of origin issues, and community supports/stressors. There have been 30 years of research for this program. There are other programs at the Walnut Avenue Women's Center, the Cradle Project, and Defensa. Discussed the importance of the engagement process for these and other programs. Some parents need more help engaging, and may need to be escorted to meetings at first. Transportation is also and issue.
10. **Build on existing resources?** Group talked about the idea of building on what exists, and not creating a new system. Also discussed having mobile services (that go where families are), and other natural settings (such as faith communities). Thought about the idea of "training the trainer" programs, that could include training consumers. Cara y Corazón already does this and Papás is interested in this, too.
11. **Decisions.** Interventions adopted should be multi-tiered going from universal approaches to selective interventions.
12. **Evaluation of Meeting.** What worked? What didn't? People liked the fact that Jerry checked the temperature of the group during the brainstorm, and the fact that this was a very collaborative, nice group building on each other's ideas. Liked the broad discussions, and some decisions being made.

Next meeting: Monday, August 4, 2008 from 9:30 to 11:30. 18 West Beach Street, Room 6, Watsonville, CA

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 0-5

August 4, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Dane Cervine, Erika Hearon, Cathy Simmons, Shanna Clinton (for Ellen Timberlake), Susan True, Deborah Vitullo, Desiree Sanchez, Jaime Molina, Diane Oyler, Dorian Seamster, Laura Segura, and Shawn Henson.

1. Agenda was reviewed.
2. Introductions.
3. **Reviewed** the process so far, and gave information about the funding guidelines. (Between 840,000 to $1,050,000 for the 0 to 25 groups.) Noticed that all the groups looked at trauma, onset and stressed families. We are working on having 3 training events around these topics; these will be in the evenings. Announced that we will have an evening presentation on August 25th by Gabriella Grant from On Track regarding trauma-informed services. (**NOTE:** this presentation has been rescheduled for Tuesday, August 19th from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz).
4. **Stressed Families**. Recap of last meeting.
    a. **Indicators:** (group added d – g)
        i. Child Welfare
        ii. Isolation
        iii. Divorce
        iv. Children acting out/in
        v. Domestic violence
        vi. Substance abuse
        vii. Appear in system with "specific problem"
    b. **Risk Factors:** (group added j-n)
        i. Poverty & homelessness [10]
        ii. Substance abuse [10]
        iii. Scarcity of resources (time & money) [2]
        iv. Parents with mental illness [10]
        v. Immigration issues [0]
        vi. Domestic violence [10]
        vii. Gang involvement (multigenerational) [6]
        viii. Criminal justice involvement [1]
        ix. Language issues [0]
        x. Lack of support system [6]
        xi. Chronic disease/disability [12]
        xii. Isolation [2]
        xiii. Poor communication skills [2]
        xiv. "Kids having kids" [0]
    c. **First Responders:**
        i. Child welfare system
        ii. Primary care providers
        iii. Head Start
        iv. Child care providers

v. Substance abuse programs
vi. Dominican hospital perinatal program
vii. Family resource centers
viii. Law enforcement
ix. Shelters.

5. Group discussed the difference between indicators and risk factors and decided to list **measurable indicators:**
    a. Tox positive babies
    b. Child welfare (decrease in referrals, substantiated cases, 1st entry into foster care, recurrence, fewer out of home placements)
    c. Poverty measures
    d. Service wait lists (e.g., childcare, counseling)
    e. Pre-school expulsion
    f. Admission into substance abuse programs
    g. Witness to domestic violence
    h. Increased community involvement
    i. Improved communication skills
    j. Increased knowledge of child development
    k. Incarceration rates of parents
    l. System capacity
    m. Number of Spanish speaking mental health providers.
    n. Decrease in homeless youth
    o. Access to food bank.
6. **What about system changes?** Susan True said that First 5 did a "Service Integration Logic Model" that she will share with the group.
7. **Immigration issues:** noted that group realizes that issues may not be measured adequately.
8. **Risk Factors:** group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors. The risk factor that got the most dots was "chronic disease/disability" (12 dots), followed by "poverty & homelessness", "substance abuse", "parents with mental illness", and "domestic violence" (each with 10 dots). Group discussion of these results, including fact that even those that got no dots could still be of concern, and that families that have multiple risk factors really may need help (whether or not they were on this groups top list). We will look at other County plans to see if they have programs and/or outcomes that include these risk factors.
9. **Speakers:** Group discussion about who could possibly come to speak to this group about services for the zero to 5 populations. A long list was generated, and group acknowledged that we can't possibly invite them all and it may be problematic to invite some, but not others. Suggestion was made that everyone do a half page summary of programs that exist or are know about. Suggested speakers/topics were: Triple P; Papás; Cara y Corazón; Positive Discipline; Parent Education Collaborative; First 5; Beth Love of the Child Abuse Prevention Council; Public Heath nurses; Prenatal; SPIN; Voucher Project; Families Together; Nicole Young to provide overview of family support

services; Cabrillo College child development department; and pediatricians (Salud Para La Gente and Dr. Magarian).

10. **Resource Document:** Draft of resource document was handed out. This document is for mental health and substance abuse services in Santa Cruz County. Suggestion was made that we add a column that includes the fee schedule and/or eligibility requirements.
11. **Next Steps:** to review the resource document, look at existing programs (and do descriptions).
12. **Evaluation of Meeting:** What worked? What didn't? Not much feedback today. One person stated that he felt like this was a productive to talk about these issues; another said he liked the efforts to define terms we are using.

Next meeting: Monday, August 18, 2008 from 9:30 to 11:30. United Way (in the Begonia Shopping Center), 1220-C 41st Avenue, Capitola, CA

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 0-5

August 18, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Dane Cervine, Dani Beckerman, Deborah Helms, Deborah Vitullo, Desiree Sanchez, Diane Oyler, Ellen Timberlake, Erika Hearon, Linda Betts, Lindsay Steigner, Pam Bartholomew, and Susan True

1. Review of the agenda
    a. Evening presentations/meetings, dates and locations
    b. Review of top three priority populations (Trauma Exposed, Onset of Mental Illness, and Stressed Families)
2. Program speaker
    a. Susan True, Executive Director of "First 5," gave a brief overview of the history and goals of the programs.
    b. Workgroup would like to hear Jane Weed speak about the "Positive Discipline Curriculum," model (possibly for October meeting).
    c. Workgroup decided to forego future speakers due to time constraints.
3. Review of old business
    a. Identified three tiers (Universal, Selective, and Indicative) of services.
    b. Reviewed the workgroups priorities of "risk factors" for Trauma Exposed and Stressed Families populations.
    c. Reviewed who the Gatekeepers (first responders) are for children in stressed families
4. Outcomes
    a. Identified the outcomes of "Trauma Exposed," and "Youth and Children in Stressed Families," with regards to risk factors:
        i. Parents to have better understanding of child behavior development
        ii. Gatekeepers to be trained to detect early signs of mental illness in children
        iii. Access to early intervention (improves development)
        iv. Provide services once identified (easily accessible/culturally sensitive)
        v. To treat parents with mental illness (via rx, therapy groups)
        vi. Manage mental illness symptoms (life circumstances) to increase parenting effectiveness
        vii. To provide support for parents with mental illness (activity based)
        viii. To increase father involvement in families and in treatment
        ix. To educate parents effect upon a child's development
        x. Increase skills and support to deal with disease
        xi. Family: decrease in risk factors and increase in parenting effectiveness
    b. Workgroup needs to identify whether the outcomes are for the child, parent, or system.
    c. Ellen Timberlake asked, "Where are these goals showing up within the community?" (Offered to provide outcome info from HSD programs.) Would like to see a "cogent" system that would address universal education (via billboards, newspaper, public radio, word of mouth) that would incorporate a three-tiered system (universal, selective, indicative), with universal strategy and more treatment capacity.

5. Review of local resources
    a. Erika Hearon shared insights from the Family Resource Center (Live Oak)
        i. Services Family friendly, directed towards children
        ii. Because funding does not increase, collaborative methods work best.
        iii. Primary prevention strategy, "Positive Discipline Curriculum," meet with parent(s) and children, then just children. Widely embraced by community, accepted by families/cross cultures. Model is public domain and can easily be adaptive with minimal cost (Evidence-based practices more costly with regards to training and re-certifications.)
        iv. Implementation varies with site (Davenport versus Live Oak)
        v. Offer licensed counseling on a sliding scale, when identified, but finding this model less effective than peer counseling.
        vi. Resources (all) not there – "awareness" missing.
        vii. Surveys administered to parent at beginning and end of program
    b. MCR (?)
        i. Serves families in child welfare system (little services for children ages 0-3).
        ii. Pays for clinical supervisor and use interns to keep costs down (not enough (bilingual, bi-cultural) clinicians to provide assessment and services. No clinicians with training on evidenced-based practice.
        iii. Teachers trained in Positive Discipline Curriculum, used in school as classroom management tool.
6. The workgroup identified the need for additional data (suggestion to use ETR was offered).
    a. Susan True, Ellen Timberlake and Sherra Clinton to gather outcomes data from existing programs to help illustrate where our goals are showing up in the community.
7. Next steps for the workgroup are:
    a. Discuss "priority" outcomes (stay outcome focused)
    b. Come up with vision and outcomes statements
    c. Look at resource guide on evidenced based suggestions
    d. Discuss our group values on the community moving away from evidences based practices.
    e. What is our definition of strategy and outcomes

Next workgroup meeting will be 9/15/08 at United Way, and 9/29 at the Career Center in Watsonville (18 W. Beach St.)

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 0-5

September 15, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Linda Betts, Cathy Simmons, Cecile Mills, Dane Cervine, Dani Beckerman, Deborah Vitullo, Deutron Kebebew, Dorian Seamster, Ellen Timberlake, Guy Grant, Jaime Molina, Laura Segura, Lindsay Steigner, Rocio Mendoza, Shawn Henson, Susan True, and Susanna Arevalo

1. Agenda Review
2. Introductions
3. Outcomes:
    a. All workgroups are nearing the end of their planning. 0-5 workgroup focusing on early development issues. 6-17 workgroups (6-12 & 13-17 workgroups combined) have the same population issues and are focusing on "Stressed Families," and "Trauma-Informed counseling Services for youth." 18-25 workgroup focusing on "Transition Age Youth." 26-59 Workgroup working on a "First Break" program. And the 60+ workgroup have worked on, "in-home services and other programs."
    b. If we identify a group in the plan, we must provide services for them. Must consider, "do we have providers for that group?"
    c. Outcomes must be measured with an evaluative component (wording will include strategy).
    d. Susan True offered the following sources for "screening," American Academy of Pediatrics (to catch issues early), "Ages & Stages Questionnaire," (screening tool using strength based method, no meds) and "California Institute for Mental Health."
4. Ellen Timberlake and Sherra Clinton from Human Services Dept prepared a draft Logic Model for this meeting, that "lists risk and protective factors already brainstormed by the 0-5 workgroup around stressed families and trauma exposed youth. They took the list of strategies that have been either identified or discussed as examples. The attempt is to put these strategies in universal, selective, and indicated categories. This information and format will enable the workgroup to further discuss, prioritize, and adopt strategies. Next we tried to differentiate between short, intermediate, and long term desired outcomes across the individual, family, and system level. All the outcomes listed reside in one or more of the following community plans: the Child Welfare System Improvement Plan, Child Abuse Prevention Blueprint, and First 5. Included is an attempt to demonstrate examples of evaluation measures. This logic model was adapted from the extensive work done by the Community Blueprint for Prevention." Dane Cervine remarked that he was in favor of this logic model because of the MHSA language it incorporates and that outcomes seem cogent with specific strategies. The group proposed the following edits:
    a. Universal Strategies: 1st bullet, add "screening <u>all</u> for social…" 2nd bullet add "<u>to increase awareness and training</u>," add bullet #3, "Advocacy."
    b. Indicated Strategies: need to create one regarding the 0-3 age group, and the lack of actual treatment available.
    c. Short-Term & Intermediate Outcomes: reword the 2nd outcome to read, "Improved Child Bio, Psycho and Social Development

   d. System Factors, Universal Strategies: bullet #1, add "physical."
   e. System Factors, Selective Strategies: consider adding "gatekeepers."
   f. System Factors, Short & Long Term Outcomes: Reword to read, "To Improve New & Existing System Capacity and to Increase and Screen Collaboration."
5. Targeted gatekeepers (added parents and Community Based Organizations). Need appropriate educational needs for first 3 gatekeepers. The plan will need to show what each will be doing, their relationship to the community, and how they will continue communication with each other. The request for proposal should be crafted to encompass all gatekeepers that would force leveraging with community based organizations (targeting specific gatekeepers.
   a. Parents
   b. Primary Care Providers & Perinatal Program
   c. Family Resource Centers and Community Based Organizations
   d. Child Care and Headstart
   e. Child Welfare and Law Enforcement
6. Items that we need to try and come to some conclusions are:
   a. Pilot Program
   b. Assessment, Identification, and Treatment
   c. Program or proto type
   d. Program elements

Next meeting will be Monday, September 29, from 9:30-11:30, at Career Works on 18 W. Beach Street, Watsonville (room 2).

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 0-5

September 29, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Linda Betts, Cathy Simmons, Dane Cervine, Dani Beckerman, Deborah Vitullo, Deutron Kebebew, Ellen Timberlake, Guy Grant, Jaime Molina, Laura Segura, Shawn Henson, and Sherra Clinton

1. Agenda Review
2. Introductions
3. Outcomes:
    a. 0-5 workgroup focusing on early development issues. All other workgroups have completed their recommendations; 6-17 workgroups (6-12 & 13-17 workgroups combined) have the same population issues and focused on "Stressed Families," and "Trauma-Informed counseling Services" for youth. The 18-25 workgroup recommended "Transition Age Youth" counseling/case mgmt for youth with a focus on those aging out of the system. The 26-59 workgroup have recommended a "First Break" program. And the 60+ workgroup have recommended "in-home services and other programs."
    b. The workgroups focus is Stressed Families exposed to trauma
    c. Emphasis on 0-3
    d. Strategies: Screening, parent education, and services
    e. Include the following language, "father, gender, and family composition friendly."
4. After a review of the revised Logic Model (previously prepared by Ellen Timberlake and Sherra Clinton from Human Services Dept.), this workgroup recommended the following changes:
    a. Under "Factors that may increase risk of serious mental health issues in children," add another bullet, "Trauma."
    b. Under "Universal Strategies," add "and others" to "Screening by Pediatricians."
    c. Under "System factors that may increase risk for serious mental health issues in children," add another bullet, "Lack of collective knowledge and system awareness."
    d. Under "system factors that may increase protection against serious mental health issues in children," add two additional bullets, "Trauma-Informed Services," and, "Preventive Services."
    e. Under, "Indicated Strategies," add, "(with emphasis on children 0-3)."
5. **Next steps:** Focus groups and Key informant interviews during the month of October, with people who have not been able to attend the workgroup meetings. They will review recommendations (specific to the focus group) and respond back based on their personal experience. This information and the workgroups final recommendations will be submitted to county staff to prepare a "draft" plan for the MHSA Steering Committee to review. November we will reconvene with all workgroups to review the draft and submit additional changes/recommendations as needed. County staff will revise the draft and submit for a 30-day public review and set a time for public comment (to be held during a Mental Health Board meeting).

6. This group has finished their recommendations. **Thank you!**

Mental Health Services Act: Prevention & Early Intervention

Workgroup: Ages 6-12

June 30, 2008 Meeting Notes

1. Introductions
    a. Jerry Solomon – Contracted through the County as facilitator for the PEI planning process
    b. Charise Olson (representing COE, JoAnn Allen/oversees student support services)
    c. Rita Flores – Asst. Dir. for Family Services
    d. Cecile Mills – Educator/worked with students (6-12 yr olds) since 1971 (goal: what is working and not working)
    e. Lisa Russell – Sr. Research Scientist with ETR Assoc./Background in Mental Health research
    f. Leticia Gómez – Mgr of PVPSA (Pajaro Valley Prevention & Student Assistance)
    g. Rosio Rodriguez – representing Latino community
    h. Mariana España – Women's Crisis Support, manage children/youth program
    i. Stan Einhorn – Program Mgr with Children's Mental Health services/oversee contracts for providers in the community
    j. Eileen Brown – Director of Student Services for Santa Cruz City Schools
    k. Tove Beatty – Executive Director of Mountain Resources serving the San Lorenzo Valley
    l. Kate Venturini – Mother of consumer/child
2. Review of workgroup ground rules and the state Department of Mental Health (DMH) guidelines for Prevention & Early Intervention
    a. No hidden agenda's
    b. This process will be transparent
    c. We should be proposing programs that "leverage" funds (i.e. give office space for a program, provide admin support, or take on an intern and do supervision)
3. Agenda's brought to this process
    a. Jerry – known throughout community and will add integrity to this process; Outcomes would like to see youth and senior's identified early and their needs addressed sooner, and services in non-traditional settings
    b. Rita Flores – Family Services is a contractor with the county Mental Health department (gatekeeper for kids 0-21), because agency is a non-profit, concerned about loosing funding
    c. Charise Olson – County office of Education, represent youth/ear and voice for education on early signs of mental illness (student support services to assist youth outside of the school). No dollar agenda
    d. Eileen Brown – not here for dollars, envision a coordinated plan involving all agencies, education & training for counselors/teachers on noting signs of early mental illness to prevent school failure
    e. Kate Venturini – system does not work well for people trying to find service, need a better system to find all available services, clearer pathways for consumers coming into the system.
    f. Tove Beatty – Mountain Resources community is integrated with the San Lorenzo Valley School District, providing 30 hours a week of free counseling for 1.5 years. Would like to see services locally accessible to families. Interested in

community-based organizations. Not interested in funding but is concerned about "matching funds" transparency. Envision consolidating all resources.

g. Stan Einhorn – from the county perspective; implementation of best practices of how to get services to kids with drug & alcohol problem, and juvenile justice problems that work. We need a better means of getting mental health and resource information out to the public (i.e., media, websites).
h. Leticia Gómez – share what we know through the community, what's worked and what hasn't. Cultural Competency is needed to improve existing programs; take a holistic approach to families, following them thru the services they use.
i. Lisa Russell – As a researcher, hoping to understand community needs and preferences and see what sort of grant writing I could do to try and bring in more money to this community to see that those things that are at risk of falling out of the fundable list don't.
j. Cecile Mills – Want to see evaluations on what we are working on, how effective has it been, are we going to do it again, whom do we go to get questions answered adequately, need a good reference library. Utilize the web to have a site that is a resource, a single portal, for people to use as a one-stop shop, including a feedback option. Utilize existing programs in community to do their own surveys and share this information with each other.
k. Mariana España – Improve the crisis line (currently, volunteers go through 60+ hours of training, but are unable to counsel), used as a gateway for referrals. Concerned about the children that currently are not using services but do need support.

4. Priority populations, per the DMH, to focus on in this workgroup
    a. Trauma exposed
    b. Individuals experiencing the onset of a serious mental illness
    c. Children/Youth in stressed families
    d. Children/Youth at risk for school failure
    e. Children/Youth at risk of experiencing criminal juvenile justice involvement
    f. Overarching concerns is suicide prevention and reduction of stigma and discrimination for those identified as struggling with mental illness.
5. Workgroup decisions to make
    a. Narrow down priority population recognizing all have needs. In this group, are there one or two groups we want to focus on and is there more data that we need to start making recommendations about programs for prevention and early intervention in those areas.
    b. Making sure we have the appropriate stakeholders involved with this process. Who is not here (Per the state DMH guidelines, we must be sure we have representation from all groups.)? Must be mindful of these groups and make an effort to get information from them so that it is fed into our process. (Current stakeholders may represent more than one group.)
        i. Based on the data feedback we heard from Applied Survey Research, the major areas of underserved communities is the Latino and LGBT community.
        ii. Education
        iii. Consumers and/or their families

iv. Providers
v. Health organizations
vi. Social Services
vii. Law Enforcement (due to understaffing and having this group participate in meetings, we will do a focus group or invite one/two officers to sit in one meeting and concentrate questions to them)
viii. Recommended (having value) but not required would be, Community Family Resource Centers, Employment, and Media

6. Ideas and thoughts
    a. Can see this age group benefiting a lot, which would accomplish the purposes of this money in terms on long-term impact.
    b. Would like to see some way of tapping into 6-12 years olds, those involved who are successful, and those who are struggling.
    c. Educate law enforcement, emergency room staff, and 911 operators on how to deal with children having an episode.
    d. The county could put something similar to a virtual space on line for kids to access and use to share stories with anonymity.
    e. Have a mental health court to deal with only those identified with a mental illness, and train court personnel on mental health illness. Some reactions to this are that people with mental illness do not trust these courts because they are based on fear (Marin County model).
    f. Hook up volunteers or mental health providers with law enforcement and ride with them for purposes of identifying when someone may be having a mental break or physical problem.
    g. Update the county data base for resources
7. State values and guiding principles and the expectation that we are aligned with these values;
    a. Transformational programs in action; looking for things that are brand new rather than incremental changes to existing programs that can transform a dilemma or problem.
        i. Leveraging resources
        ii. Stigma and discrimination reduction
        iii. Recognition of early signs
        iv. Integrated and coordinated systems
        v. Outcomes and effectiveness
        vi. Optimal point of investment (biggest bang for the buck)
        vii. User friendly plan so that the consumer and family member are comfortable with what we are setting up in non-traditional settings.

Next workgroup meetings:
7/14/08, County Office of Education, 10-12
7/28/08, Watsonville Towers (confirmation pending)

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 6 to 12

July 14, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Stan Einhorn, Cecile Mills, Leticia Gómez, Rocio Rodríguez, Tove Beatty, Mariana España, Eileen Brown, JoAnn Allen, Rita Flores, Lisa Russell, Kate Venturini, and Alicia Nájera.

Meeting was tape-recorded; these notes (taken by Alicia) are a summary of the meeting (not verbatim).

1. Agenda was reviewed. No changes were made.
2. Introductions.
3. Old Business:
4. **Decision Making**: Ideally the group would reach consensus. Possible problem is that we have a small work group that meets consistently, and non-participating individuals may attend only when it is time to vote. Solution?
5. Cecile presented a letter to Jerry and read it to the group expressing her concerns about the PEI planning, including her belief that the planning is not inclusive, there are insufficient numbers of family members and consumers, the meeting times are inconvenient, most people get paid to be at meetings (but not consumers or family members), meeting times are not posted and meetings are in "lecture mode".
6. Tove pointed out that identifying as a consumer is confidential, and that it is presumptuous to think that everyone at the meeting "is on the clock".
7. JoAnn, Stan and Eileen all presented ideas about representing and/or including input from 6 to 12 year olds and/or their families.
8. Jerry told group about meetings he and Alicia had with MHCAN (Mental Health Client Action Network) and Mariposa. Both agencies said that the best way to get consumer involvement is to have focus groups (which can be held at their sites). DMH also encourages alternate approaches to gaining input from stakeholders including surveys, key informant interviews, and focus groups.
9. Cecile mentioned that the meetings were not posted at MHCAN or Mariposa, and said that the County Website says the "survey is closed". Alicia was not sure what this was about. Jerry said he would appreciate hearing concerns ahead of time so that these concerns can be addressed rather than waiting until the meeting and focusing upon complaints rather than the task in front of the group. Jerry will follow up with Mariposa and MHCAN about posting the meeting times for the PEI workgroups.
10. Returned to question of decision making… Various persons chimed in about consulting with 6 to 12 year olds/families/representatives about our process, doing web surveys to get input, or accessing families to get input. It was suggested that meetings be videotaped. Jerry noted that how we get input is driven by what this group decides.
11. **Obtaining Stakeholder input**. Should we narrow down the focus, and then get input? Some people will not get addressed due to limited funds.
12. Discussed doing a resource map, then we will know where the gaps are.

13. How do people get into the system? Where do they go for services? Cecile said we might have some success with 6 to12 year olds; can do a questionnaire with teachers. Can meet with family members (not necessarily do a survey).
14. JoAnn mentioned that she has some resources (tied to a grant) that group may use that will also fulfill her requirements.
15. Group discussed how to narrow this down… Stan pointed out that PEI will not fund services that already exist, plus programs need to be evidence-based, and preventative (we want to keep kids from getting into the system).
16. Discussed education as part of intervention. Teachers, parents, primary care physicians all need better education about early intervention and referrals for serious mental illness seen in children. Teachers get some education, but also feel a lot of pressure. If child doesn't qualify for special education programs there are often no other places to refer within the school system.
17. Program ideas: promote mental health and well being (for teachers and students), family support (e.g., list of what to do, not every child needs a psychiatrist). Also talked about natural access points (e.g. clergy), and how to get information out about programs that do exist.
18. Group focus narrowed down to Trauma, Onset of Mental Illness, and Stressed Families. (Can address School Failure and Juvenile Justice Involvement via these others.)
19. Next Steps: Look at resources compiled by DMH and explore models. Which has the most component that we need? Look at these (and possibly other models). Also need to review ASR data. Do we need additional data?

Next meeting: Monday, July 28, 2008 from 10 to 12 in Watsonville (294 Green Valley Road, 3rd Floor, room 320).

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 6 to 12

July 28, 2008 meeting notes

Attendees: Ginny Gómez, Leticia Gómez, Eileen Brown, Linda Pérez, Mariana España, Kathleen Kilpatrick, Lisa Russell, Rocio Mendoza, Alicia Nájera, Jerry Solomon.

1. Agenda Review. Will move up reviewing local resources on the agenda.
2. Introductions.
3. **Review Local Resources**: Presentation of the Pajaro Valley Unified School District Integrated Mental Health Services by Linda Perez, of Pajaro Valley Prevention & Student Assistance (PVPSA). PVPSA provides services to the Pajaro Valley Unified School District. Pyramid of services includes:
    a. Mental Health Foundation and Maintenance: School Resources and Supports for Healthy Development (such as classroom teachers, guidance counselors and academic support programs, parent involvement, school safety personnel, after school programs, sports, arts, and extra curricular activities).
    b. Universal Prevention: Education, skill building, and wellness programs (such as youth development, school health curriculum, bullying and other prevention programs, parent education and involvement programs, school nurses.
    c. Selective Prevention: Screening, monitoring, and brief intervention (such as Seven Challenges insight/prevention groups, Primary Intervention Program (EMHI), Families and Schools Together (FAST), Primary Care Provider referrals, conflict resolution teams).
    d. Indicated Prevention: Early Intervention and treatment (such as, secondary student assistance program, seven challenges insight/prevention groups, drug medi-cal minor consent services, Kida Korner elementary student assistance program, student study teams, school psychologist).
    e. Mental Health Treatment: individual and family counseling (such as Safe Schools/Health Students dedicated County clinician, probation team and Wrap-around services, AB3632 SDC-ED Mental Health services, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Supportive Intervention Services (SIS), Supportive Adolescent Services (SAS), and Safe Schools/Healthy Students Counseling).
    f. Crisis care: Mental Healthy Emergency Response Team, Suicide Hotline, Criminal Justice Interventions.
4. Despite all these services what **challenges** still exist? Teachers feel pressure from "no child left behind"; still need to demonstrate how programs support academic success; confidentially/privacy issues and information sharing; lack of common language between mental health and education providers; turf issues (need integrated approach and maximize resources); fragmented funding stream (need consistent funding); staff changes/turnover.
5. **What is working?** Do have resources, do social marketing, using evidence-based models. Children that get services through Kids Korner seem to feel comfortable with counseling (a way of addressing issue of stigma and discrimination). Issue of how expensive evidence based models was discussed. For example, one program required they purchase the training (about $7,000 per person), pay for the trainer to observe the

staff, pay for the evaluation, lots of administrative time, and staff only get certified for 2 to 3 years (then need to be re-certified). If there is staff turnover then need to get new staff trained).

6. **Decision Making:** The ideal is to reach a consensus, but should we need to vote on an item who would be allowed to vote? Group discussed various options and decided that persons that have attended at least 50% of the meetings, and 3 of the last 5 meetings can vote. Also, the group agreed that a person could send a proxy for their vote, and only one vote per agency. (Note: Leticia Gomez and Linda Perez, both of PVSA, will alternate attendance of this meeting.)
7. **Priority Populations:** Last time group narrowed it down to children and youth in stressed families, trauma exposed individuals, and onset of serious mental illness.
8. **What does Onset of Serious Mental Illness look like** for this age group? Behavior (either acting out or very withdrawn), school avoidance, pattern of missing school, somatic symptoms, parents in distress about their child, hyperactivity/attention issues, violence, bullying (both the victim and the perpetrator), Primary Care Provider or emergency services, day care centers, home schooled children, kids that show up at domestic violence shelters, anxiety (fears, phobias), depression, compulsive behaviors.
9. **Next Time:** think about what children and youth in stressed families, and trauma exposed individuals look like.
10. **Feedback** about meeting: Liked the informational presentation; perhaps we could do another presentation on trauma exposed (Mariana can talk to Gabriella Grant about this, and see if she could do this on August 25th, perhaps in the evening); liked the discussion, and narrowing down. **Note:** there was a discussion about the possibility of having an evening meeting.

Next Meeting: Friday, August 11, 2008. From 10 to 12 at United Way (in the Begonia Shopping Center), 1220-C 41st Avenue, Capitola, Ca.

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 6 to 12

August 11, 2008 meeting notes

Attendees: Mariana España (Defensa de Mujeres/Women's Crisis, in charge of children/youth programs), Pam Barthalomew (Peer to Peer for Nami, family member and consumer), Tove Beatty (Executive Director of Mountain Community Resource Center, family member), Cecile Mills (Teacher, consumer), Stan Einhhorn (Program Manager at Children's Mental Health, family member), Lisa Russell (ETR, researcher, family member), Alicia Nájera (MHSA coordinator), Jerry Solomon (facilitator, family member).

*Note: There was a mix up on the agenda as to the location and start time of the meeting, so the group had a slight delay. (The location was incorrectly listed as the United Way, instead of the Mountain Community Resource Center, and the time was listed as starting at 9:30, instead of 10.)

1. Introductions.
2. **Funding Guidelines:** The MHSA Steering Committee decided on funding guidelines for the PEI work groups as follows: 0-25 $840,000 to $1,050,000; 26-59 $210,000 to $350,000; 60+ $140,000-$280,000. These amounts are guidelines only and not set in stone.
3. **Priority Populations for all groups** have been identified, as follows:
    a. 0-5: Children & Youth in Stressed Families, and Trauma-Exposed Individuals;
    b. 6-12: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    c. 13-17: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    d. 18-25: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    e. 26-59: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    f. 60+: Onset of Serious Mental Illness, and Trauma-Exposed Individuals.
4. Evening **presentations/meetings** announced.
    a. **Tuesday, August 19th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon will engage the audience to gather input on desired outcomes for Trauma-Exposed individuals.
    b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
    c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined. **NOTE:** Alicia shared that there has

been some difficulty in lining up a presenter; one resource stated that the Governor has told them not to work (due to budget). Tove mentioned that ASR may be able to do presentation; she saw them do one a couple of weeks ago on family profiles.

5. **Data:** Cecile presented a letter with a request that we start gathering data about the services in Santa Cruz County (including number of people served, number of people eligible for services, types of treatments, etc). Stan mentioned that there is a 17 year report that is available at the County website that gives this time of information for this age group. With PEI we will be able to set up our system ahead of time to gather the data we want to collect. Discussion focused on what are we doing, is it working, and what do we need to do to make them better (instead of "re-inventing the wheel").
6. What are the **risk factors** for children and youth in stressed families? Group brain stormed the following: domestic violence; exposure to violence, including emotional/physical/sexual abuse; parental involvement with the criminal justice system; parent with a mental illness; lack of access to basic needs (food, clothing, shelter); socially marginalized (not engaged with parents, extra curricular activities, fun); not having adequate adult supervision; latch key children; lack of transportation; residential and/or school instability; foster/kinship care; parental literacy; poor parenting skills; reactive (not proactive) in seeking services; poor self care (including nutrition).
7. What are **indicators** for children and youth in stressed families? (Indicators differ from risk factors in that they are measurable.) Group came up with the following: school attendance; school failure; school expulsion; prodromol (behavioral acting out/in); lack of social; substance abuse (huffing, smoking, etc); "virtual" lives; anti-social behavior; cruelty; late developmental milestones; body weight; increased risk taking.
8. Who are the **gate keepers** for children/youth in stressed families: parents; family members; primary care providers; emergency services; day care centers; home school providers; teachers and other school personnel; coaches; social services (family resource centers, ymca, etc); faith-based communities.
9. **Speakers?** Group talked about having speakers come to this meeting for the purpose of who is doing the work for this age group already, and what are the needs? Ideas for speakers includes: Cecile Mills (what is not available); family resource centers panel (to include family advocates, and discuss what services are being provided and what are the needs); Nicole Young; Jaime Molina (Cara y Corazón); Defensa (domestic violence and sexual assault response); Family Services; Families Together; Parents Center; juvenile justice. Tove Beatty agreed to pull together a panel of the family resource providers, as well as contact the juvenile justice contact she has.
10. **Resource Document:** Handed out the draft resource manual and asked people to look it over and inform us about any corrections/changes.
11. **Next Time:** think about what <u>trauma exposed individuals</u> look like.
12. **Feedback** about meeting: Pam said she would like to do more outreach to families. Jerry reminded group that we will do focus groups to get additional feedback.

Next Meeting: Friday, August 25, 2008. From 10 to 12 at United Way (in the Begonia Shopping Center), 1220-C 41st Avenue, Capitola, Ca.

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 6 to 12

August 25, 2008 meeting notes

Attendees: Tove Beatty, Stan Einhhorn, Cecile Mills, Brandy Shaw, Leticia Gomez, Charise Olsen (for Joanne Allen), Guy Grant, Rocio Mendoza, David Bianci (for Rita Flores), Ginny Gomez, Laura Segura, Alicia Nájera, and Jerry Solomon.

1. Agenda Review.
2. Introductions.
3. **Speakers: Tove Beatty and Brandy Shaw**. Spoke about the Family Resource Centers in Santa Cruz County: La Manzana, Mountain Community Resource Center, Live Oak, Familia Center, and the Davenport Resource Center. Resource centers often try to be a one-stop shopping center for resources for families; services have diminished over time due to cut backs in funding. Some do offer limited case management; Mountain Community resource center offers free mental health counseling. Resource centers do not have the resources to deal with long-term issues of drugs, poverty and housing. The resource centers in our county do collaborate (such as the Parent Education Collaborate that offers parenting education using "Positive Discipline"), but it is a challenge because the needs of each community are unique. Mountain Community and Davenport offer disaster response. Brandy Shaw spoke about "Families Together" which works with families referred by children's protective services. It was noted that there are hardly any resources for children ages 6 to 12.
4. **Evening presentations/meetings** announced.
    a. **Tuesday, August 19th** we had a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon engaged the audience to gather input on desired outcomes for Trauma-Exposed individuals.
    b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
    c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is Dr. Rivtka Greenberg.
5. **Stressed Families Risk factors**. Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, but had to put the rest on other factors.
    a. Violence/abuse/neglect [12]
    b. Substance use/abuse [14]
    c. Parental mental illness/incarceration [0]

   d. Economics [8]
   e. Foster care [0]
   f. Latch key kids [0]
   g. Nutrition [8]
   h. Socially marginalized [7]
   i. Parental skills/supervision [14]
6. **Onset of Mental Illness Risk Factors**: Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors.
   a. Change of behavior [6]
   b. School attendance [7]
   c. Somatic symptoms [11]
   d. Parents expressing concern [6]
   e. Victims of violence [2]
   f. Bullying [8]
   g. Prodromol emotional/behavioral symptoms [10]
   h. Children of parents receiving support/intervention [1]
   i. Trauma [11]
   j. Nutrition [4]
7. What are the **risk factors** for trauma exposed youth? Group brain stormed the following: poor parenting skills, economics, drugs/alcohol, attention issues, ptsd, lack of support for child, continued exposure to trauma, targeted at school, medication effects (leading to increased suicidality), normalization/desensitization to violence, decreased ability to assess trauma (providers/teachers), increase support for training "incentives", decreased understanding of mental illness issues, "vocabulary" of trauma.
8. **Outcomes:** Brainstorm about possible outcomes (system wide, by program or by consumer):
   a. To improve parent-child relationships
   b. To increase school success to targeted students
   c. To train gate keepers in early detection and appropriate intervention
   d. To decrease bullying of targeted students
   e. Children to have a satisfactory experience with gate keepers
   f. To promote kids abilities and increase their access to strategies for emotional/physical support
   g. To reduce exposure to trauma
   h. Increase access to mental health services to consumers
   i. To offer mental health advocates at each school
9. **Next Steps:** Review Department of Mental Health Resource manual to stimulate thinking; think about what programs we are interested in.

Next Meeting: Friday, September 8, 2008. From 10 to 12 at United Way (in the Begonia Shopping Center), 1220-C 41st Avenue, Capitola, Ca.

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 6 to 12

September 8, 2008 meeting notes

Attendees: Stan Einhhorn, Cecile Mills, Leticia Gomez, Joanne Allen, Guy Grant, Rocio Mendoza, Rita Flores, Ginny Gomez, Mariana España, Lisa Russell, Alicia Nájera, and Jerry Solomon.

1. Introductions.
2. Recap of previous meetings.
3. **Trauma Exposed Individuals Risk Factors**: Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors.
    a. Continued exposure to trauma (8)
    b. Normalized/de-sensitized to violence (8)
    c. Inadequate parenting skills (11)
    d. Drug/alcohol exposed (7)
    e. PTSD (10)
    f. Targeted at school (7)
    g. Effects of RX (9)
4. **Speakers:** Joanne Allen and Leticia Gómez on "bullying". Joanne works for the County Office of Education and Leticia works at Pajaro Valley Prevention & Student Assistance Program. Joanne trains schools about what bullying looks like, how to assess it, and what to do about it. She states that it is necessary to have schools create a culture and climate where bullying behavior is not tolerated. Three things that can be done: identify areas (where it is happening); provide support for the "target" (skills development and counseling); and separation from the bully (awareness, support, counseling). The big think is for schools to recognize the problem. Leticia talked about the model program that PVPSA is using for PVUSD. It is a very costly (evidence-based) model that they got funding for (but only for 8 more months). After schools get trained the number of reports goes up.
5. **Outcomes Ages 6-12 (also shared the outcomes for workgroup 13-17).** Both work groups address stressed families and traumatized youth. Discussed the ideas this group has come up with and added/edited them:
    a. Targeted at-risk youth will be offered trauma-informed services.
        i. <u>Strategy: Identify and provide rapid access to school-based counseling and support services for those being bullied and bullying.</u>
        <u>Evaluation</u>:
        Utilization data
        Consumer goal achievement measures
        Consumer satisfaction measures
        ii. <u>Strategy: Create and support a mental health advocate program within each school to assist in early detection and prevention of serious mental illness by offering emotional/physical support to targeted youth.</u>
        <u>Evaluation</u>:
        Rates of suspension/expulsion

Attendance data
Reduced exposure to trauma
Utilization data
Consumer goal achievement measures
Consumer satisfaction measures

iii. Strategy: To provide on site advocacy (in a designated space) at all schools
iv. Strategy: To provide positive role models/mentors

b. To improve the quality of life for targeted stressed families in order to decrease the risk of violence, suicide, and other family traumas youth might be exposed to.
   i. Strategy: Offer professional/peer-to-peer mental health individual and/or group services on-site at all FRCs.
      Evaluation:
      Utilization data
      Consumer goal achievement measures
      Consumer satisfaction measures
   ii. Strategy: Improve the parenting skills of both mothers and fathers.
      Evaluation: Standardized pre- and post- measures regarding knowledge of parenting strategies and non-violent communication patterns.
   iii. Strategy: To offer outreach services to families who are hard-to-reach/resistant to services. (Discussed possibility of offering services at different venues, such as probation, ATO, organized sports, faith organizations, parenting groups at schools, and in the home.)

c. To educate/train targeted gatekeepers to identify youth exposed to trauma and/or at risk of a serious mental illness and how to effectively assist them.
   i. Strategy: Train all medical settings serving targeted groups to identify early signs and symptoms of mental illness and/or trauma exposure. Offer service providers helpful ways to respond to youth/families.
      Evaluation: Referral data from service agencies.

6. **Next Steps:** Need to finalize our list of proposed programs.

Next Meeting: Friday, September 22, 2008. From 10 to 12 at United Way (in the Begonia Shopping Center), 1220-C 41st Avenue, Capitola, Ca.

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 6 to 12

September 22, 2008 meeting notes

Attendees: Alicia Nájera, Cecile Mills, Ginny Gomez, Guy Grant, Linda Betts, Linda Perez, Lisa Russell, Mariana España, Rita Flores, Stan Einhorn, and Tove Beatty.

1. Introductions.
2. Recap of previous meetings.
3. Priorities:
    a. Youth in Stressed Families
        i. Inadequate Parental Skills/Supervision
        ii. Substance Use/Abuse
        iii. Exposure to violence/abuse/neglect
    b. Trauma-Informed
        i. Inadequate Parental Skills/Supervision
        ii. PTSD
        iii. Effects of medication on youth
4. Gatekeepers:
    a. Parents/Family
    b. Peers/Youth
    c. PCP's (primary care physicians)
    d. Teachers/School personnel
    e. Activities – i.e. Coaches, Boys/Girls Club, Little League
5. **Outcomes Ages 6-12** (because many of the recommendations mirrored the 13-17 workgroup, collapsed both into one document). Reiterated that this group determined that their target population is LGBT and Latino youth. Discussed the outcomes draft and came up with the following changes:
    a. When noting "LGBT and Latino youth" in parentheses, use i.e. at the beginning and eliminate etc. at the end.
    b. Change "non-traditional settings," to "non-clinical" or "non-clinical based" settings.
    c. Include "school based services" in non-clinical settings.
    d. Outcome 1, strategy 1, and bullet 2: Delete "classes," and insert, "training for parents." Insert, "i.e. in the parenthesis and add, "effects of medication on children. Move, "FRC's," to end of sentence with parentheses around it and use "i.e." Add another bullet for "support/resource access."
    e. Outcome 2, delete "LGBT and Latino." Delete, "and," after peer and add / before, "professional." Delete "targeted," and add, "LGBT, Latino and other marginalized." Strategy 2, add, "and other," after, "school-based." Delete the last sentence. Add, "Strategy 4 – PCP's must be educated on trauma-informed services."
    f. Outcome 3, add, "resources," after mental health services. Add, "Evaluation – tract usage, utilization, and consumer satisfaction."

g. Outcome 4, Strategy 1, delete, “the Training Academy,” and add back in after, “venues,” within parentheses and i.e. before it. Add, “Strategy 3 – Maximize leveraging with state funds.” Add, “Evaluation – Standards for assessing media.”
h. Outcome 5, Strategy 2, delete, “through the,” and add, “at venues (i.e. Training Academy).” Strategy 3, add, “at risk of suicide,” after, “symptoms of mental illness.” Delete, “helpful.”

6. **Next Steps:** Focus Groups in October. County Staff will prepare a draft based on the recommendations from all workgroups and focus groups and make cost estimates. November we will hold two “all workgroup” meetings to review and make changes as needed. Recommend workgroup members attend the Public Review of the plan at the Mental Health Board meeting when notified.

This workgroup has completed their recommendations.

Mental Health Services Act: Prevention & Early Intervention

Workgroup: Ages 13 - 17

July 2, 2008 Meeting Notes

1. Introductions
2. Review of workgroup guidelines and rules
    a. We are to create and foster an integrated system
    b. The state has mandated that we use the Logic Model (will need to document that we are doing this and the State will evaluate us).
    c. Values and Guiding Principles
        i. Transformational programs and actions
        ii. Leveraging resources
        iii. Stigma and discrimination
        iv. Recognition of early signs
        v. Integrated and coordinated systems
        vi. Outcomes and effectiveness
        vii. Optimal point of investment
        viii. User friendly plans
        ix. Non-traditional settings.
    d. The group will need to review its decision making model; we will try for consensus, and if unable to reach consensus use a majority vote to decide our recommendation. The group needs to decide who can vote on the final decisions made before that time arises.
3. Workgroup member's & agendas
    a. Jerry Solomon, Facilitator, Psychologist & MFT
    b. Benita Mugnani (Ex. Dir. Survivor Healing Center) is the voice for those who experienced child sexual abuse. Her agency would like to apply for funding.
    c. Rita Martinico (Director of Youth Programs at Walnut Avenue Resource Center) She is attending these workgroup meetings to be educated about the process, learn about other services in the community (working with youth 11-17) and have a voice at the table. They are considering applying for funding
    d. Allen Harrison (Youth Leadership Coordinator for Family). Here to learn about this process, wants to make sure the voice of the youth are heard and make changes in the services they receive.
    e. Michael Paynter (Coordinator at the County Office of Education) wants to be sure the best methods for offering services will get applied to this age group.
    f. Carly Galarneau (Suicide Prevention Service) here to be a part of the process and learn about other organizations, form partnerships with other organizations and interested in funding if opportunity presents itself.
    g. Jesus Ramirez (Coordinator and Youth Radio Producer for Radio Bilingue) here to be part of process and interested in funding.
    h. Holly Heath (Mental Health Client Supervisor at Children's Mental Health) here to support the creation of more services for her clients.
    i. Jenny Sarmiento (Chief Ex. Officer of Pajaro Valley Prevention Student Assistance) providing services to children who live in the Santa Cruz, Watsonville, and north Monterey area. Wants to be part of the process and to explore the possibilities of applying for funds. Wants to make sure we maximize

these resources. As part of a cooperative effort between Healthy Starts, school districts, psychologists and other mental health workers in Watsonville, they are looking at gaps in services for uninsured children. She hopes that through these funding sources we can provide services to children so they can avoid the more costly decision to seek services in emergency rooms.

j. Bill Manov (Chief of Alcohol and Drug Services for the County of Santa Cruz), there are commonalties of risk and protective factors that predict mental health problems and alcohol and drug abuse. His agency has developed a lot of community partnerships and prevention strategies with research to back them up. A lot of local infrastructure already exists to provide prevention services and hopes we "do not reinvent the wheel." He is interested in dual diagnosis issues that will capitalize on this infrastructure and wants to explore how we can do this together with PEI. Not necessarily interested in funds for his program, but is interested in strengthening the youth development structure, our contract agencies and community partners.
k. Jorge Savala (Leader for COPA) COPA was recently formed when 24 different churches, congregations, schools, and nonprofits in Santa Cruz and Monterey County met to develop plans for affordable housing, health care and community safety. He is here to focus upon community safety and to develop additional after school and recreational programs for the youth to keep them out of the justice system (and I hope to stop gangs).
l. Ron Indra (High School Teacher in Social Studies) receives a small grant from the Community Foundation of Santa Cruz to construct an assessment tool for school districts and schools to use to determine safety issues for GLBTQ.
m. Janet Seminerio (Women's Crisis Support) They have intervention programs for domestic violence and sexual assault and have been offering established models of prevention services for 10 years. We are interested ink exploring the creation of a program that addressing all areas of family violence. Our experience could contribute to the whole idea. We have programs in place that could be appropriate to be expanded or adapted to address that need, and would like funding for that.
n. Martine Watkins, representing JoAnn Allen (County Office of Education). Just received a grant to consolidate agencies to have a better collaborative work relationship with each other. Want to know how we can fit into the group and figure out where we can assist and help.
o. Shane Hill (Clinical Psychologist, specializing in Transgendered People) here as a voice for the Transgendered community. He currently offers trainings at Scotts Valley Elementary School on Trans youth and Children's Mental Health. He hopes to have these trainings offered at all the schools resulting increased cultural competency when working with transgender children.
p. Bill McCabe (Asst. Dir. of Youth Services) interested in the process, not necessarily in funding. Have many programs for youth and LGBT youth.

4. Planning Process
    a. Next step, pick a priority population from:
        i. Children/Youth in stressed families
        ii. Children/Youth at risk of school failure
        iii. Children/Youth at risk of juvenile justice involvement

        iv. Trauma exposed
        v. Experience onset of serious mental illness
    b. State will do own initiative on Suicide Prevention and Stigma reduction of the mentally ill.
    c. Steering Committee will set funding percentage
    d. Program/s must be evidenced based with an evaluation component built in
    e. Need representation from stakeholders, as identified by the State
    f. Identify missing stakeholders
        i. Need Latino outreach
        ii. African-American community outreach
5. Priority populations, per the DMH, to focus on in this workgroup
    a. Trauma exposed
    b. Individuals experiencing the onset of a serious mental illness
    b. Children/Youth in stressed families
    c. Children/Youth at risk for school failure
    d. Children/Youth at risk of experiencing criminal juvenile justice involvement
    e. Overarching concerns is suicide prevention and reduction of stigma and discrimination for those identified as struggling with mental illness.
6. Workgroup decisions to be made:
    a. Narrow down priority population recognizing all have needs. After we've determined which populations we are focusing upon we can collect data that we need to start making recommendations about programs for prevention and early intervention in those areas.
    b. Making sure we have the appropriate stakeholders involved with this process. Who is not here around the table? Per the state DMH guidelines, we must be sure we have input from all required stakeholder groups. We must be mindful of these groups and make efforts to get information from them so that it is fed into our process. A person may represent more than one stakeholder group.
        i. Based on the data feedback we heard from Applied Survey Research, the major areas of underserved communities is the Latino and LGBT community.
        ii. Education
        iii. Consumers and/or their families
        iv. Providers
        v. Health organizations
        vi. Social Services
        vii. Law Enforcement; Input will be gathered by either a focus group or key informant interviews (asking one/two officers to attend one meeting to address our questions).
        viii. Stakeholders recommended but not required by DMH include representatives from Community Family Resource Centers, Employment, and Media
7. Review of MHSA PEI values and guiding principles. All in attendance stated that they were aligned with these values and principles.

a. Transformational programs in action; looking for things that are brand new rather than incremental changes to existing programs that can transform a dilemma or problem.
    i. Leveraging resources
    ii. Stigma and discrimination reduction
    iii. Recognition of early signs
    iv. Integrated and coordinated systems
    v. Outcomes and effectiveness
    vi. Optimal point of investment
    vii. User friendly plan so that the consumer and family member are comfortable with what we are setting up in non-traditional settings.

Next meeting: Wednesday, July 16, 2008 from 9:30 to 11:30. County Office of Education, 809 Bay Avenue, Capitola

Mental Health Services Act: Prevention & Early Intervention
Work Group: Ages 13 - 17
July 16, 2008 meeting notes

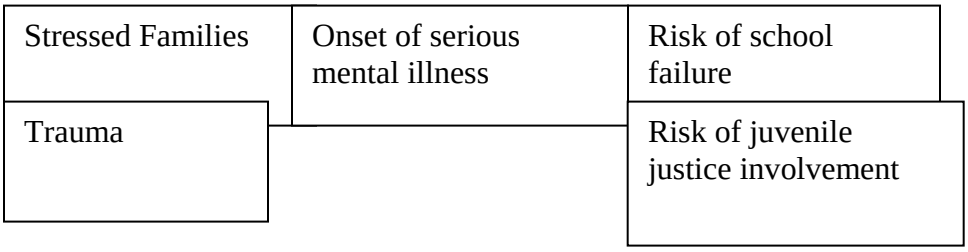
Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Jenny Sarmiento, Holly Heath, Bill McCabe, Nora Rhaimian, Martine Watkins, Alexis May (for Carly Galagneau), Emily Marsh, Mary Cross, Denise Gannon, Ginny Gómez, Jesús Ramírez, Janet Seminerio, David True, Jaime Molina, and Yolanda Pérez-Logan.

Meeting was tape-recorded; these notes (taken by Alicia) are a summary of the meeting (not verbatim).

1. Agenda was reviewed. No changes were made.
2. Introductions.
3. **Decision Making**: Ideally the group would reach consensus. Possible problem is that we have a small work group that meets consistently, and non-participating individuals may attend only when it is time to vote. Discussed various options, including the role of the MHSA Steering Committee. **Group decision**: when it comes time to vote persons that have participated in at least 50% of the meetings will be allowed a vote. Participants can send a designated alternate if they cannot attend a particular meeting; can contact Jerry (425-8785) or Linda Betts (454-4498) to let them know if you can't attend a meeting.
4. **Resource Material**. DMH gave outlines of various programs. Reaction/Comments? Can find out more information about programs by searching the web. Note that some are specific to particular communities, so we would need to document that we've considered this. Look at material as "models". Discussed using logic model to figure out what we will use. The group needs to decide upon its target population(s) and priority needs before deciding on model. Jerry agreed, and said that models may stimulate our thinking; also, he will share models that other Counties are using for PEI programs.
5. **Suicide Information**. Local statistics were disseminated. (Note: these are not for publication.) Brief discussion. Noted that interventions need to be early, and need to teach children how to cope with stress and suicidal thoughts.
6. **Defining Priority Population**. Discussed the 5 proposed priority populations (Children and youth in stressed families; children/youth at risk of juvenile justice involvement; and after brief review/discussion narrowed the priority population for this group to Onset of Serious Mental Illness and to Trauma Exposed. Long discussion regarding these 5 groupings, including the fact that they are inter-related (e.g. if you look at children at risk of school failure you may also be dealing with a child from a stressed family, and/or has suffered some kind of trauma, and/or is at risk of juvenile justice involvement, etc). Discussion included: school failure, expulsion & drop out problem (wanting to get more information about this problem comparing North and South County, and comparing cultural groups); disproportionate number of minorities being expelled; cultural factors that may impact these issues; how to serve gang involved, lgbt, Latino kids, foster and group home kids. Also discussed onset of serious mental illness and use of drugs/alcohol. Many think we need to involve family in services (though some kids may be already "differentiating" from their families). Various questions considered: what

type of service is needed? How much is needed? Where is the entry point? (Is the entry point the stressed family, or the child at risk?) Discussed using screening tools and agreed that this will not be helpful unless there are services we can refer to. Also talked about educational programs geared toward parents, teachers and school staff, to help them understand what mental illness looks like. Considered educating peers as well.

7. Group did not come to a decision about which group is the **priority population,** but considered the groups as related to each other as indicated below (either being a subset or connected to each other). Group will think about this and come back to this issue next time.



8. **Feedback about meeting**: Consider bring teens to meeting to give input (will consider this, but may hold off until we have more concrete ideas); appreciate keeping people "on track; would like a break in the middle to have a chance to network (this is not what the group agreed to, but will bring this back up next time as "old business"); appreciate people sharing their ideas as well as being open to others (this hasn't happened in some of the other groups); like the format and the facilitation is good.

Next meeting: Wednesday, July 30, 2008 from 9:30 to 11:30. 18 West Beach Street, Room 6, Watsonville, CA

Mental Health Services Act: Prevention & Early Intervention
Work Group: Ages 13 - 17
July 30, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Jenny Sarmiento, Holly Heath, Bill McCabe, Nora Rahimian, Martine Watkins, Carly Galagneau, Denise Gannon, David True, Jaime Molina, Silvia Diaz, Ron Indra, Cecile Mills, Kathleen Kilpatric, Kaleo Kaluhima, Stuart Rosenstein, Shane Hill, Brenda Armstrong, Bonita Magnoni, Rita Martinico, and Yolanda Pérez-Logan.

1. Agenda was reviewed and accepted. Jerry provided a recap of the workgroup's process. The MHSA Steering Committee has decided that a range of $840,000 to $1,050,000 be used as a guideline for funding in the 0 to 25 age workgroups.
2. **Introductions:** Jenny Sarmiento stated that she and Silvia Diaz might alternate in attending these meetings.
3. **Review of Priority Populations.** Discussion about the overlap of the priority groups for this age group: Children and youth in stressed families, trauma exposed individuals and the onset of serious mental illness. Any one of these groups could be an "umbrella" for the others. Some members of group spoke of 13 to 17 year olds as being autonomous and accessing services on their own; others agreed, but felt that they do better when their families are involved. Group agreed that we should encourage family involvement. **Children/youth at risk of school failure.** School failure is seen as a likely outcome of being within our three priority populations. The educational system rarely identifies or addresses the underlying causes of common indicators of school failure: drop in grades, attendance, suspension or expulsion. There are a disproportionate number of minority students that are suspended and expelled in the county. There are systems in place to deal with these issues, but they are not adequate.
4. **Onset of serious mental illness**. The group agreed to explore the precursors to serious mental illness and early indicators of the problem that families and primary providers might notice. Many cases in Santa Cruz precipitated by drug use. Gaps in services exist (especially if person in not on Medi-Cal); this is problematic since early intervention may be more successful. State exception to PEI: services may be a bit longer for Onset than for other priority populations.
    a. **Who are the first to see persons with Onset of Serious Mental Illness?** Police, teachers, parents, relatives, school nurse, counselors, crisis line workers, friends, hospital staff, primary care providers, juvenile hall staff, foster care system employees, truancy workers, neighbors, housing authority staff, extra curricular activity employees, church-faith communities, employers.
    b. **What behaviors do persons with the onset of serious mental illness present?** Alcohol/drug/tobacco use, suicidal thoughts, risky sexual behavior, withdrawal, depression, violence/aggression, anxiety, self-harming, prostitution, isolation, truancy, socially inappropriate behavior, highly dependent, changed behavior, detention & warnings from school, DUI, public inebriation, frequent use of health services, runaway, pregnancy, being in violent relationship, stds, exploitation, bullying, signs of physical abuse, exclusion/left out/ostracized, body language,

loss of work, unusual thinking, journaling/art, obsessive, parents identify issues, self identified, over-achiever, changes in body weight, changes in sleep, parental divorce, homelessness.

5. **Children/youth in Stressed Families**
    a. **Who are the first to see Children/youth in Stressed Families?** Same as listed in #4a above. Added: family resource centers, children's protective services, homeless services, community based agencies that are family-oriented, unemployment agencies, family court, web-based social service providers, eligibility workers, immigration rights workers.
    b. **How do Children/youth in Stressed Families present? What do we see?** Similar to #4b above. Added: multiple families living together, atypical cultural response, poverty, underemployment, abandonment and neglect, language barriers, lack of housing, sexual/physical/emotional abuse, employment problems, lack of care giving adults, incarcerated youth or adult, divorce, blended families, sexualized family behavior, legal involvement, lgbt emergence, inability to get help, parents with serious mental illness, lack of parental authority/skills (especially regarding issues of stigma towards persons with serious mental illness, or homophobia), cultural clash, communication issues, chronic or catastrophic illness, out of home placement, denial of issues/problems, victims of crime.
6. The group noticed that some items identified are risk factors others are indicators of the problem. We need to consider what is easily measurable. The workgroup will continue to invite youth, ages 13 to 17, to the meetings and to conduct a focus group with them before we issue recommendations.
7. **Feedback on meeting**: Feeling antsy about not deciding the priority population before going on to brainstorm; need to go through a logic model process to decide priority population; some people have specific agenda and it would be good for people to re-state this; liked the brainstorming; interesting how diverse each work group is; wish meetings were at different times; appreciate having meetings in Watsonville; we came up with a great list; appreciate inclusive leadership; include SLV.
8. **Next Time**: Program presentation. Have people restate their "agenda". Jerry will separate the lists generated today into risk factors and those that are indicators of the problem. We will narrow the priority populations to be addressed and begin discussing outcomes for this group.

Next meeting: Wednesday, August 13, 2008 from 9:30 to 11:30. 1080 Emeline Avenue, Santa Cruz, Ca. (Meeting will be in the small auditorium in the basement of the Health Services Clinic.)

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 13-17

August 13, 2008 meeting notes

Facilitator: Dr. Jerry Solomon

Attendees: Adam Harrison, Aimée Mangan, Belinda Rubalcava, Carly Galarneau, Carol Williamson, Cecile Mills, Ginny Goméz, Holly Heath, Janet Seminerio, Javier Diaz, Jenny Sarmiento, Kaleo Kaluhiwa, Linda Betts, Martine Watkins, Mary Cross, Michael Paynter, Nora Rahimian, Pam Bartholomew, Ron Indra, and Vanessa Wilson

1. Agenda Review
2. All attendees shared introductions and personal agendas.
3. Old business
   a. Review of State DMH guidelines, funding allocation and the three age groups for Prevention & Early Intervention.
   b. Jerry reported on MHSA Steering Committee's guidance regarding workgroup funding:
      i. 0-25 age group, $840,000 - $1,050,000
      ii. 26-59 age group, $210,000 - $350,000
      iii. 60+ age group, $140,000 - $280,000
   c. **Priority groups** determined by each workgroup:

	Stressed Families	Trauma Exposed	Onset of Serious Mental Illness
0-5	X	X	
6-12	X	X	X
13-17	X	X	X
18-25		X	X
26-59		X	X
60+		X	X

   d. Three **evening meetings** for all workgroups have been added to the schedule:

August 19, 2008 (6:30-8:30 p.m.) 1080 Emeline Avenue (Large Auditorium)	"Trauma-Informed Services," presented by Gabriella Grant (the purpose is to expose everyone to evidence based practices). Q&A to follow. At the end, Dr. Jerry Solomon will lead the group to look at outcomes.
August 26, 2008 (6:30-8:30 p.m.) 1080 Emeline Avenue (Large Auditorium)	"Onset of Mental Illness," presented by Dr. Charles Johnson, with a panel of consumers and family members to share what worked/what didn't.
September 3, 2008 (7-8:30p.m.) 85	"Stressed Families," presenter TBA.

Nielson St., Watsonville (Pajaro Valley Health Trust)	Jerry will lead the group to look at outcomes.

4. The group brainstormed a Program Speaker List for the workgroup:
    a. Barrios Unidos
    b. Triangle Speakers
    c. Defensa de Meujeras
    d. Walnut Avenue Resource Center programs for boys and girls.
    e. PVSDSA
    f. Y.E.S. program
    g. Youth Services – Nuestro Futuro
    h. Green Body & Mind
    i. Stigma & Discrimination
    j. Suicide Prevention
    k. NAMI
    l. CRP – Youth in Probation
    m. United Advocates for Children/Families
    n. Protection & Advocacy
    o. Green Body Mind
5. Priority Populations
    a. Onset of serious mental illness
        i (26) Exposure to violence
        ii (24) Substance use/abuse
        iii (12) Genetics
        iv (11) Isolation
        v (10) Nutrition
        vi (7) Homelessness
        vii (5) Bullying
        viii (4) Sexual behavior
    b. Youth in Stressed Families
        i. (26) Sexual/emotional/physical abuse
        ii. (22) Economics: poverty, employment, housing
        iii. (22) Criminal Justice involved families
        iv. (20) Victims of crime/discrimination/stigma
        v. (10) Divorce/loss
        vi. (8) Parents with a mental illness
        vii. (6) Emerging as a LGBT person
        viii. (5) Neglect and abandonment
    c. Trauma exposed youth
        i. Gatekeepers
            1) Extracurricular programs
            2) Community leaders
            3) Peers/friends
        ii. Risk Factors
            1) Parental distress
            2) Witnessing/involved with violence (domestic, abuse, gang, etc.)

3) Substance abusing parents
4) Family with mental illness
5) Incarcerated parents
6) Divorce/loss
7) Poverty
8) Immigration issues
9) Youth incarceration
10) LGBT emergence
11) Homelessness
12) Nutrition
13) Gang involvement
14) Lack of education/awareness of trauma involved practices by service providers
15) Stigma/discrimination
16) Oppression
17) Family history of suicide
18) Inept/wrong diagnosis of mental illness
19) Medication
20) Inadequate parenting skills
21) Difficult peer interactions
22) Difficulty with attention

iii. Indicators

1) Similar to Onset and Stressed families indicators
2) Inappropriate affect
3) Kids "under the radar"
4) Physical issues (sexual milestones, physical complaints)
5) Self harm
6) Self medicating

6. A draft of local mental health resources was shared with the workgroup and members were encouraged to send their comments and additions to either Alicia or Linda. Copies of the DMH document describing priority populations were distributed, as were definitions of common mental health terms and acronyms.
7. **Next steps** for the workgroup are to identify the top three risk factors for Trauma Exposed Youth; and begin to think about outcomes they'd like to see addressed by programs recommended by this group.

Next meeting will be on 8/27/08 from 9:30 a.m. – 11:30 a.m. at the United Way, located in the Begonia Shopping Center at 1220-C 41st Avenue, Capitola.

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 13 - 17

August 27, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Martine Watkins, Stuart Rosenstein, Bonita Magnoni, Rita Martinico, Guy Grant, Emily Marsh, Belinda Rubalcava, Patricia Shroeder, Janet Seminerio, Pam Bartholomew, Ginny Gomez, Vanessa Wilson, Javier Diaz, and Yolanda Pérez-Logan.

1. Agenda review.
2. Introductions.
3. **Speakers**: Stuart Rosenstein and Vanessa Wilson on the subject of LGBT services and issues in Santa Cruz County. Stuart is from the Queer Youth Task Force (and they sponsor the Queer Youth Leadership Awards every year). Services include the Gay Straight Alliances (GSA) which function like a club at several of the high schools (with strong programs at Watsonville High and Santa Cruz high); LGBT Task Force (which function on an ad hoc basis at PVUSD and Santa Cruz City Schools; Strange (at Youth Services); the Scene (at the Diversity Center); and Triangle Speakers (panel of people that speak about their lgbt/queer experience. Law AB537 states that schools have to be safe, but some schools are not very welcoming (e.g. Triangle Speakers are not welcome at 2 schools). There is a small number of youth that are being reached, based in large part because programs are not fully funded. Issues for this age group include dealing with schools (from students to administrators) that are not queer friendly; coming out (even with "liberal" parents; suicide; homophobia & harassment; drug/alcohol issues; bullying; and homelessness (30% of homeless youth are queer). Issue of bullying and homophobia also affects straight kids who are called names; it is especially problematic when youth complain to adults and nothing is done about it. Suggestions for prevention include having support groups (not just social groups) that have licensed therapist facilitating them (e.g. a "coming out" support group), and trainings on queer issues required for teachers and staff at youth programs.
4. **Trauma Risk Factors**. Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors.
    a. Economics – poverty, homeless [11]
    b. Stigma, discrimination, oppression [2]
    c. Nutrition [5]
    d. Medication [3]
    e. Difficulty with peer interactions [2]
    f. Difficulty with attention [0]
    g. Family issues (mental health, substance abuse, history of suicide, child sexual abuse) [20]
    h. Parent issues – distress, inadequate parenting skills [5]
    i. Immigration issues [4]
    j. Incarceration of youth or parent [4]
    k. LGBT emergence [17]

   l. Gang involvement [4]

5. **Recap from PEI "101": Universal Prevention:** risk free for everyone; low cost, desirable and accepted. **Selective Prevention:** targeted to high-risk groups; moderate costs; minimal effects. **Indicated Prevention:** targeted at high-risk individuals (showing signs, but not in the system), currently showing signs of a mental illness. **Early Intervention:** addresses early manifestation; low intensity/short duration; supports well being; avoid the need for more extensive/intensive mental health services; may include individual screening for potential mental health needs.
6. **Brainstorm on possible outcomes.**
   a. To increase high school graduate rates
   b. To improve parent-child interactions
   c. To train gate-keepers to recognize early signs
   d. To decrease suicide risk in targeted group
   e. To decrease family factors which put children at risk (immigrant families, kids at risk of suicide)
   f. To improve parent-child relationships (in families with issues mentioned above, in LGBT)
   g. To provide universal information/education regarding suicide prevention, substance abuse, domestic violence, child sexual abuse, lgbt.
   h. To provide user-friendly information regarding mental health services for consumers, providers, and families.
   i. To provide services to violence exposed targeted groups (child sexual abuse, children with incarcerated parents
   j. To provide education and training regarding trauma exposed, lgbt emergence, suicide, and immigration issues.
7. **Next Steps**: We will finish up desired out comes next time. Before next meeting review State Department of Mental Health Resource Guide. Link to PEI Resource Materials link: http://www.dmh.ca.gov/DMHDocs/docs/notices07/07_19_Enclosure6.pdf

Next meeting: Wednesday, September 10, 2008 from 9:30 to 11:30. Career Center, 18 West Beach Street, Room 2, Watsonville, Ca.

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 13 - 17

September 10, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Linda Betts, Bonita Mugnani, Carly Galarneau, Cecile Mills, David True, Ginny Gómez, Guy Grant, Holly Heath, Jaime Molina, Janet Seminerio, Javier Diaz, Martine Watkins, Rocio Rodriguez, Silvia Diaz, and Yolanda Perez-Logan.

1. Agenda review.
2. Introductions.
3. **Program Speaker:**
   a. Carly Galarneau for "Suicide Prevention of the Central Coast." Serving Monterey, San Benito and Santa Cruz Counties for 40 years, we are a program of the Family Service Agency of the Central Coast. Services are across the lifespan, free, and confidential. Trained volunteers answer the crisis line 24/7 (with 60-80 volunteers working throughout the year). They are supported by 4 social workers. Two trainings are offered per year (40 hours) and everyone is asked for a one-year commitment at that time. We use the "language line" service that is an over the phone interpreter service, with 150 different languages available. There are approximately 200-450 calls received per month with most people calling because it is confidential and private. Follow-up is limited due to confidentiality. Calls can extend anywhere from 15 minutes to 3 hours with 90% of callers "de-escalated." We are integrated with some schools but it could be better. My wish is for more universal and gatekeeper training/resources in Santa Cruz County. That everyone would know about the crisis hot line (it be printed everywhere), and the community resources they can point you to.
4. **Priority Age Groups** given to Youth in Stressed Families and Onset of Serious Mental Illness. Will be collapsing the "youth at risk of failure in schools" and "youth at risk of legal system" with the 6-12 age group due to outcomes being almost identical. The "plan" will be written by county staff, based upon what we want to see as components/vision in the age appropriate services. The focus will be to look at existing organizations that offer services, let them know what we want and need, for the purpose leveraging.
5. **Focus Groups** will be conducted once we have concrete information to share and get their reactions. These meetings will be offered (by invitation) to those who will/would be using services and have not been able to attend workgroup meetings. They will be private and confidential. Contact with the groups we need to hear from will be made with organizations that have access to this population. Workgroups will reconvene to assess the information gathered from the focus groups.
6. **Training Academy –** Brief explanation of the Workforce, Education & Training plan (that includes the training academy) that was approved by the state and how it will provide trainings to the public health community. It is anticipated that many trainings will dovetail into some of the strategies discussed. (Community based organizations and consumers will be included as trainers where applicable.)

7. **Outcomes –** Discussion led to redefining some of the outcomes/strategies and adding strategies. Revised 13-17 Outcomes will be emailed to workgroup prior to next meeting. Crafted shared statements to include the 6-12 & 13-17 age groups.
    a. Outcome #1; delete mental health. Strategy #2; add the word; create a position that will be a system navigator…
    b. Outcome #2; define (youth in) stressed families. Strategy #1; Add peer-to-peer in the delivery of services. Bullet o: On-site services should be noted as "non-traditional," and in parentheses (i.e. Family Resource Center's).
    c. Outcome #3; Because the state has mandated we expand services to the underserved, and this group recognized LGBT and Latino youth as their priority groups, this language will not change. Add strategy; Record trainings, i.e. Television/web cast/DVD.
    d. Outcome #4; add "at risk of suicide." Strategy #1: Strategy #2: add, and other venues.
    e. Outcome #5, move to "System-wide" category. Include "to dramatically increase suicide prevention for the 13-17 age group, and targeted gatekeepers on suicidality."
8. **Evaluations –** Must be built into each program. At present, there are no programs that have hard data available. Can call out specifically where improvements are made (do have utilization data showing where the demand for services are). By evaluating programs annually, we will know whether to continue to re-fund them.
9. **Next steps** will be to refine the outcomes, look at targeted "priorities," and determine what kind of evaluation to build and what to measure.

Next meeting: Wednesday, September 24, 2008 from 9:30 to 11:30. United Way (Begonia Shopping Center) 1220-C 41st Avenue, Capitola.

Mental Health Services Act: Prevention & Early Intervention
Work Group: Ages 13 - 17
September 24, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Linda Betts, Bill McCabe, Bonita Mugnani, Brenda Armstrong, Carly Galarneau, David True, Ginny Gómez, Guy Grant, Holly Heath, Jaime Molina, Janet Seminerio, Javier Diaz, Kaleo Kaluhiwa, Michael Paynter, Patricia Schroeder, and Yolanda Perez-Logan.

1. Agenda review
2. Introduction
3. **Program Speaker:**
    a. Javier Diaz and Ely Gonzalez for Community Restoration Program – working within the local community, providing programs dealing with youth (and some adults) having, i.e. drug, gang, school, issues, using strength based approach. The first program is weekend work projects as an alternative to incarceration and to provide job skills. The second program is job training mentorship's (shadow/support) partnered with local businesses thru word of mouth and Watsonville newspapers. The third program, in collaboration with the County office of Education, is the Work Investment Act that is a 6-week orientation; covering work readiness ($150 stipend), job shadowing (4 times @ $25 each stipend), and work experience (200 hrs maximum). The fourth program is the Cal Group Program geared towards youth and young adults with gang issues (can participate if lower offense). This is an alternative to incarceration working for i.e. Habitat for Humanity, cleaning parks. The fifth program is, "REAL," Reforming Education Advocating for Leadership. Organized and run by youth, to discuss youth issues, work on community based projects/presentations and raise money for field trips. The primary issue of concern with this group is unhealthy relationships due to, i.e. Domestic Violence, Sexual Abuse, Teen Pregnancy, and Dating Violence. The goal is to provide a safe place for youth to meet (referred to as "youth circle"). Currently a, "Girl Space," group has been organized, facilitated by a woman. The need for a male youth circle has been recommended. There is no waiting list, serving all walk-ins and referrals from probation. The number one reason youth do utilize the services is to gain employment skills towards getting a job.
4. **Meeting Outcomes**
    a. Outcomes have been separated into three categories: Trauma-informed Services to Youth, Support to Stressed Families, and System-wide. (Practices have to be evidence based.) After review and discussion, the workgroup made the following changes:
        i. Outcome 1, delete "other marginalized youth." Delete "inadequate" and replace with "needing." The phrase, "youth/families needing parental skills, substance use/abuse issues, and/or exposure to violence, abuse and/or neglect," shall be used in place of "and other marginalized youth,"

throughout the recommendations. Strategy 3, delete “Create” and replace with “Identify” and add “school” after “support a.”

ii. Outcome 2, add strategy 2, “Service providers will be required to have been trained to provide “trauma-informed” services.

iii. Outcome 4, delete

iv. Outcome 5, add, “peers/youth and social services” to list of gatekeepers.

b. This workgroup agreed that Outcome 5 then outcome 2 is their priorities.

5. **Next steps** will be to submit these recommendations to County staff. During the month of October, Focus Groups and Key Informant Interviews will be conducted to reach those who have not been able to participate in the planning process. Their responses/feelings will be included with the recommendations. County Staff will prepare the draft plan to submit to the Steering Committee (S.C.) on 10/27/08. In November, two “all-workgroup” meetings will convene to review the draft plan. County staff will do any changes needed to the draft plan. Once the final draft has been prepared using state language, a 30-Day Public Review will be posted in the newspaper and the public will be invited to comment on the draft plan at the Mental Health Board meeting (dates will be announced).
6. This workgroup has completed their recommendations. Thank you!

Mental Health Services Act: Prevention & Early Intervention

Workgroup: Ages 18 - 25

July 9, 2008 Meeting Notes

1. Introductions
2. Review of workgroup guidelines and rules
    a. We are to create and foster an integrated system
    b. The state has mandated that we use the Logic Model.
    c. Values and Guiding Principles
        i. Transformational programs and actions
        ii. Leveraging resources
        iii. Stigma and discrimination
        iv. Recognition of early signs
        v. Integrated and coordinated systems
        vi. Outcomes and effectiveness
        vii. Optimal point of investment
        viii. User friendly plans
        ix. Non-traditional settings
    d. The group will need to review its decision making model; we will try for consensus, and if unable to reach consensus use a majority vote to decide our recommendation. The group needs to decide who can vote on the final decisions made to the Steering Committee.
3. Workgroup member's & agendas
    a. Jerry Solomon, Facilitator, Psychologist & MFT
    b. Carly Galarneau (Suicide Prevention Services alternating with Diane Brice). She is interested in funding for suicide prevention. She wishes to work on collaborations with other organizations.
    c. Lorraine Cahn (County of Santa Cruz, Program supervisor for Children's Mental health). She would like to see what we could do to get jobs in the community for this age group. Does not think her agency will be applying for funds.
    d. Paula Comunelli (CEO, Listening Well, a person with a diagnosis and a community leader around mental health issues). She is working with various client leaders around the state to develop a summit meeting to create a system that works for everyone. The new system would create shared leadership with consumers. By polling consumers involved with the Mental Health Client Action Network and Mariposa Center, she created a consumer priority list. The major priorities that consumer's felt needed to be addressed included: mental health advocacy, self-care, and meaningful work. She would like funding to support training facilitators to offer Listening Well events throughout the county in both English and Spanish.
    e. Richard Fairhurst (Parent of child with brain disorder). His motivation is to offer children with brain disorder more program options, have fewer holes in the system. He would like to offer education about these issues to all school levels.
    f. Adriana Guevara (County of Santa Cruz, Mental Health Client Specialist working with Transitional Age Youth). She is trained as a social worker with bulk of experience in forensic mental health. Transitional youth age range should be broadly defined. My goal is to reach persons before their first break and let

people know where they can go to get services. Often young people with mental illness self-medicate with drugs and as a result you see the large majority of persons in jail or prison. She would like to develop a program that educates the community about resources and reduces stigma. Does not know if our agency will be applying for funds.

g. Chris Hogeland (County of Santa Cruz, program supervisor at the Homeless Persons Health Project). Many youth are not severely or chronically mentally ill at this point. But they are at great risk and could benefit from early intervention to prevent homelessness. Not here for funding, but would like to get other homeless providers here at the table to represent a link between homelessness and mental illness. Interested in creating employment programs.
h. Fred Koelher (CASA, Court Appointed Special Advocates). He sees transitional age from ages 15-25. We need to support the child after they "age out" of the system. Would be inclined to apply for funds, for training and supervision of the volunteers.
i. Susan Paradise (Nurse for Santa Cruz Community Connection). She is involved with two programs for transition age youth, Independent Living Program serving ages 15-21 and Transition Counseling serving ages 18-24. Believes that employment needs are very high; the self-esteem of youth goes up when they are employed. When the youth turns 18, the services they can access are dramatically reduced, during the time when, statistically, they will have their first break.
j. Carol Williamson (President of Santa Cruz Chapter of NAMI, parent of bi-polar child, and member of the MHSA Steering Committee). Families need so much help navigating the mental health system. Often problems emerge in high school; the parents know something is wrong but are afraid to tell the school, fearing they might encounter discrimination against their child and the stigma attached with labeling. There is a national provider education program that NAMI created that she would like to see implemented locally. NAMI's local family-to-family training program has a wait list because we do not have enough teachers. NAMI would like to apply for funds to offer provider education.
k. Denise Wyldbore (representative of COPA, Communities Operating for Empowerment and Action, has family member with Bi-Polar disease). She wants to coordinate with other people to put together youth programs within the Live Oak area including education for families and youth about where to access services. May be interested in funding.
l. Diana Carpenter (Manager of the Sexual Assault Dept. for the Women's Crisis Support). Nearly 85% of our clients are between the ages of 17-26 and are survivors of sexual assault. Would like to see more training for providers of transitional age youth about sexual assault and how to treat it. Particularly, a way to continue services after the 12 meetings we can offer. Also here as an advocate for LGBT youth. Not sure if agency will be applying for funds.
m. Charise Olson (County Office of Education, former coordinator of a youth employment program). If funding needs appropriate she would like to apply.

4. Planning Process
    a. Next step, pick a priority population
        i. Children/Youth in stressed families

        ii. Children/Youth at risk of school failure
        iii. Children/Youth at risk of juvenile justice involvement
        iv. Trauma exposed
        v. Experience onset of serious mental illness
    b. State will offer its own initiative on Suicide Prevention and Stigma reduction of the mentally ill.
    c. The Steering Committee will establish funding ranges for each age group.
    d. Program/s must be evidenced based with a built in evaluation component.
    e. Need representation from stakeholders, as identified by the State
    f. Identify missing stakeholders
        i. Need Latino outreach
        ii. African-American community outreach
5. Priority populations, per the DMH, to focus on in this workgroup
    a. Trauma exposed
    b. Individuals experiencing the onset of a serious mental illness
    c. Children/Youth in stressed families
    d. Children/Youth at risk for school failure
    e. Children/Youth at risk of experiencing criminal juvenile justice involvement
    f. Overarching concerns is suicide prevention and reduction of stigma and discrimination for those identified as struggling with mental illness.
6. Workgroup decisions to be made:
    a. Narrow down priority population recognizing all have needs. In this group, are there one or two groups we want to focus on and is there more data that we need to start making recommendations about programs for prevention and early intervention in those areas.
    b. Making sure we have the appropriate stakeholders involved with this process. Who is not here around the table? Per the state DMH guidelines, we must be sure we have input from all required stakeholder groups. We must be mindful of these groups and make efforts to get information from them so that it is fed into our process. A person may represent more than one stakeholder group.
    c. Based on the data feedback we heard from Applied Survey Research, the major areas of underserved communities is the Latino and LGBT community.
    d. Required stakeholders include:
        i. Education
        ii. Consumers and/or their families
        iii. Providers
        iv. Health organizations
        v. Social Services
        vi. Law Enforcement; Input will be gathered by either a focus group or key informant interviews (asking one/two officers to attend one meeting to address our questions).
    e. Stakeholders recommended but not required by DMH include representatives from Community Family Resource Centers, Employment, and Media
7. Review of MHSA PEI values and guiding principles. All in attendance stated that they were aligned with these values and principles.

a. Transformational programs in action; looking for things that are brand new rather than incremental changes to existing programs that can transform a dilemma or problem.
    i. Leveraging resources
    ii. Stigma and discrimination reduction
    iii. Recognition of early signs
    iv. Integrated and coordinated systems
    v. Outcomes and effectiveness
    vi. Optimal point of investment
    vii. User friendly plan so that the consumer and family member are comfortable with what we are setting up in non-traditional settings.

Next Meeting: July 23: County Office of Education, 809 Bay Avenue, Capitola

Mental Health Services Act: Prevention & Early Intervention
Work Group: Ages 18 - 25
July 23, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Carly Galarneau, Ginny Gómez, Tara Fisher, Diana Carpenter, Susan Paradise, Charise Olson, Fred Koelher, Richard Fairhurst, Carol Sedar, Carol Williamson, Elisa Ramírez, Mariea Boisa, Diane Brice, Steve Ruzicka, Denise Wyldbore, Cecile Mills.

1. Agenda was reviewed. No changes were made.
2. Introductions.
3. **Decision Making**: Ideally the group would reach consensus. Possible problem is that we have a small work group that meets consistently, and non-participating individuals may attend only when it is time to vote. Discussed various options. **Group decision**: when it comes time to vote persons that have participated in at least 33% of the meetings will be allowed a vote. Participants can send a designated alternate if they cannot attend a particular meeting
4. **Stakeholders**. Fact that meeting times are not posted at MHCAN and Mariposa Wellness Centers was brought up; Alicia informed the group that she spoke to directors of both sites and they agreed to post the meeting times. Meeting times will be sent to all PEI workgroups, even though some meeting locations have not been secured. As it is updated it will be sent out again to the workgroups; date on the bottom of page will indicate when it was last updated. Work group members can disseminate the information about meeting times and locations to other interested stakeholders. **Who is missing?** Request that someone from UCSC or Cabrillo attend. Diane Avelar (from Cabrillo) is a member of this work group, but absent today; Sara Peck (from Cabrillo) isn't back at work until mid August. Will contact UCSC. There are no transition age consumers, or consumers that began services when they were this age. Steve Ruzicka will check with staff to see if one (or more) of their clients may want to participate. Drug & alcohol rep is not present; Alicia will check will Bill Manov. Some brainstorming about stakeholders; everyone to think about this and talk to others. Discussed how not everyone can come to meetings; we can consider inviting guest speakers to one or more meetings. Can consider doing a focus group and/or survey as well.
5. **Resource Material**. DMH gave outlines of various programs. Can find out more information about programs by searching the web. Note that some are specific to particular communities, so we would need to document that we've considered this. Look at material as "models". Discussed using logic model to figure out what we will use. Reaction/Comments? Some people found the information confusing (e.g. TAY box was checked, but program described a different population); some felt like people are wanting to sell their programs; some programs feel like "deluxe" models, but we don't have a "deluxe budget". Some felt like this was a good tool to spur some thinking. Need to consider what services we do have in our community and what are the gaps.
6. **Defining Priority Population**. Discussed the 5 proposed priority populations (Children and youth in stressed families; children/youth at risk of juvenile justice involvement; and after brief review/discussion narrowed the priority population for this group to Onset of

Serious Mental Illness and to Trauma Exposed. There was much discussion about these five, including the overlap among them. It was difficult decision, but group honed in on "onset of serious mental illness" and "trauma exposed individuals". Did not have time to brainstorm about these two. Next time we meet we will explore further what "trauma exposed individuals" means.

7. **Feedback about meeting:** There was an appreciation for the different points of view and different voices in the group. One person labeled it as "one of the most positive meetings" she has attended. Another felt that while it was productive, it would be helpful to have handouts on the parameters of the program, information on trauma, and a directory of resources (which we will have next time). May consider having potential clients at meeting as well.

Next meeting: Wednesday, August 6, 2008 from 10 to 12 at CASA: 294 Green Valley Road, Suite 326, Watsonville, Ca. This is in the old Watsonville hospital; enter where it says "The Towers".

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 18 - 25

August 6, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Carly Galarneau, Tara Fisher, Diana Carpenter, Susan Paradise, Charise Olson, Fred Koelher, Richard Fairhurst, Carol Sedar, Carol Williamson, Mariea Boisa, Steve Ruzicka, Denise Wyldbore, Kathy Martínez, Bill Manov, Ivan Diamond, Chris Hogeland, Lorraine Cahn, and Dianne Avelar.

1. Brief update/overview on the process so far.
2. Introductions.
3. **Funding Guidelines**: The MHSA Steering Committee decided on funding guidelines for the PEI work groups as follows: 0-25 $840,000 to $1,050,000; 26-59 $210,000 to $350,000; 60+ $140,000-$280,000. These amounts are guidelines only; not set in stone.
4. **Priority Populations for all groups** have been identified, as follows:
    a. 0-5: Children & Youth in Stressed Families, and Trauma-Exposed Individuals;
    b. 6-12: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    c. 13-17: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    d. 18-25: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    e. 26-59: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    f. 60+: Onset of Serious Mental Illness, and Trauma-Exposed Individuals.
5. **Evening presentations/meetings announced.**
    a. **Tuesday, August 19th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon will engage the audience to gather input on desired outcomes for Trauma-Exposed individuals.
    b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
    c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined.
6. **Risk Factors: Onset of Serious Mental Illness.** Group brainstormed the following as risk factors for "onset":
    a. Substance Use
    b. Domestic violence
    c. Sexual abuse/abuse
    d. Isolation
    e. Homelessness

   f. Genetics/family history
   g. Failed relationships
   h. Life transitions
   i. Lack of support
   j. Loss/death
   k. Failure (dreams, school, work)
   l. Different/discrimination/stigma
   m. Sexual orientation
   n. Socio economic status

7. **Who are the first responders to persons with "onset"?** Group brainstormed the following:
   a. Parents/family
   b. Peers
   c. Schools
   d. Criminal justice, police
   e. Counseling centers
   f. Primary care providers
   g. Family and children services, mandatory reporters
   h. Emergency room
   i. Employers
   j. Bus drivers
   k. Neighbors
   l. Crisis lines, hotlines
   m. Dorm resident assistants (college)
   n. Alcohol & drug treatment providers
   o. Dominican Behavioral Health Unit
   p. Communities of faith
   q. Activity programs (sports, etc)
   r. "The mall"
8. **Risk Factors for Trauma-Exposed individuals.** Group recognized that many of the risk factors noted above would be included here. Brainstorm by group came up with the following:
   a. Substance Use
   b. Domestic violence
   c. Sexual abuse/abuse
   d. Isolation
   e. Homelessness
   f. Failed relationships
   g. Life transitions
   h. Lack of support
   i. Loss/death
   j. Failure (dreams, school, work)
   k. Different/discrimination/stigma
   l. Sexual orientation
   m. Socio economic status
   n. Addicted family member

   o. Leaving the foster care/youth care/initiation of contact with birth family
   p. War torn (multigenerational)
   q. Immigration issues
   r. Family gang involvement
   s. Parent with mental illness or chronic/catastrophic physical illness
   t. Person with mental illness or chronic/catastrophic physical illness
   u. Exposure to earlier trauma
   v. Cost of living in Santa Cruz
   w. Teen pregnancy
   x. Witnessing violence
   y. Victim of crime
   z. Peer pressure
   aa. Catastrophic events

9. **First Responders for Trauma-Exposed?** Will get to this item next time.
10. **Program Speakers?** Group had discussion about whom, if anyone, we would like to have come talk to the group. Idea is that since we don't want to create a whole new program it would be useful to have better idea of what services already exist for this age group. Ideas include: Barrios Unidos, UCSC and Cabrillo (regarding mental health services), NAMI, and a system overview, which could include County Mental Health (children and adult), COE (Charise), foster care (Susan P.). Group liked the idea of a system overview.
11. **To at our Next Meeting:** complete the first responders (for Trauma), do an exercise to hone in on the risk factors, have a program speaker. Jerry also encouraged everyone to attend the evening meetings (mentioned above).
12. **Feedback about meeting.** Comments (not exactly verbatim) included the following:
    a. "I like doing stuff, having an activity"
    b. "I like the windows, the natural light"
    c. "Thank you for the prodromal information you sent me; can you send research on 1st break research?" (Was referred to resource document and google site.)
    d. "I Appreciate the way you facilitate; you are always respectful"
    e. "This was confusing, especially the onset and trauma risk factors; it feels like we are moving slowly"
    f. "I appreciate the way you facilitate, always in control. It helps me relax."
    g. "I like that you convey information about what happens in other groups."
    h. "I appreciate everyone's voice".
    i. "I got confused. We said we were going to do just a brainstorm, but then began discussing things."
    j. "I don't want to lose sight of the first break issues."
    k. "The discussion between one and another (priority groups) didn't seem necessary."

Next meeting: Wednesday, August 20, 2008 from 10 a.m. to 12 p.m. at MHCAN, 1051 Cayuga Street, Santa Cruz, CA.

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 18 - 25

August 20, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Carly Galarneau, Tara Fisher, Charise Olson, Fred Koelher, Carol Sedar, Carol Williamson, Mariea Boisa, Chris Hogeland, Lorraine Cahn, Amy Daniels, Paula Communelli, Cecile Mills, Ginny Gomez, and Stephen Dubuous.

1. Introductions.
2. **Evening presentations/meetings** announced.
    a. **Tuesday, August 19th** from 7:00 p.m. to 9:00 p.m. we had a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento). Jerry Solomon engaged the audience to gather input on desired outcomes for Trauma-Exposed individuals. There will be a follow training by Gabriella tentatively scheduled for Friday, October 24th from 10 a.m. to 3 p.m. Let Alicia or Linda Betts know if you did not attend sign up for this presentation and want to attend.
    b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
    c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined.
3. **Risk Factors for Trauma-Exposed individuals.** Group did a “dot” exercise to prioritize risk factors brain stormed at last meeting. Number in brackets indicates the number of votes:
    a. Family members- addiction, mental illness, violence, gangs, chronic illness, suicide history [24]
    b. Foster care – transitions, re-contacting birth family [15]
    c. Exposure to early trauma [10]
    d. Victim of violence/discrimination, stigma [23]
    e. Catastrophic events [0]
    f. Immigration issues [1]
    g. Teen pregnancy [0]
    h. Peer pressure [3]
    i. War exposed [0]
    j. Economics [3]

4. **Risk Factors: Onset of Serious Mental Illness** Group did a "dot" exercise to prioritize risk factors brain stormed at last meeting. Number in brackets indicates the number of votes:
    a. Substance Use/Abuse [21]
    b. Domestic violence [4]
    c. Abuse sexual/physical/emotional [14]
    d. Failed relationships – love/family [3]
    e. Isolation [4]
    f. Lack of support [7]
    g. Homelessness [7]
    h. Loss/death [0]
    i. Discrimination/stigma [1]
    j. Emerging lgbt [1]
    k. Economics [2]
    l. Failure (dreams, school, work) [4]
    m. Genetics/family history [10]
5. **Speakers:** Loraine Cahn and Cherise Olson spoke about the services they offer to transition age youth. **Lorraine** works in Children's Mental Health. Foster youth that are in "permanency planning" and are essentially being "raised by the system" are referred to the Supportive Adolescence Team comprised of mental health clinicians, social workers, independent living program (ILP) and transition housing program THP) staff. This team is staff by two county programs and Santa Cruz Community Counseling Center. ILP helps youth get jobs, obtain drivers license, get into school, etc. THP supplies vouchers to help youth obtain housing. **Charise** works for YEP (Youth Employment Program) to help foster youth obtain jobs, and works on whatever might be the obstacle to employment. Program serves youth age 14 to 21 and offers 200-hour internships, job shadowing, skill development, and guidance counseling focusing on work. Youth are referred by foster care (probation). **Mariea** shared that she works at Community Connection and that agency has family advocates, college connection, and career services for persons over age 18. They get funding from Department of Rehabilitation and provide guidance and work readiness services, help with job applications, have funds for interview clothes and serve persons with serious mental illness. **Lorraine** also shared that Jennifer Greco (also at Children's Mental Health) works with all 17 to 21 year olds in the system (they don't have to be in probation or social services). She helps link youth that need to move to "adult" transition team.
6. **Discussion about the services described above.** The challenge is that the capacity of the system is limited. Amy Daniels shared that she is a family advocate, and any one can call her for assistance (whether the person is in the "system" or not). Also discussed the need for better integration of services.
7. **Outcomes.** Outcomes can be system wide, by program or individual. Group brainstormed the following possible outcomes:
    a. To educate and train gate keepers regarding signs and symptoms
    b. To offer lgbt referral support and counseling
    c. To offer transitioning services to foster youth
    d. To provide education to potential consumers regarding early identification of symptoms

   e. To provide paid stipends and work crews (to persons at risk of mental illness)
   f. To offer transition age youth service that promote their life goals towards productive independence
   g. To create a system that integrates all transition age youth services with transferal and follow up
   h. To have a current resource guide available that is user friendly (phone and website)
   i. Peer outreach workers
   j. To support families of transition age youth
   k. To create a speakers bureau.

8. **Next Steps**: Group to review the transition age youth programs in the DMH Resource Guide; group to think about "given our priorities, what outcomes would we like to see?"

Next meeting: Wednesday, September 3, 2008 from 10 a.m. to 12 p.m. at MHCAN, 1051 Cayuga Street, Santa Cruz, CA.

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 18 - 25

September 3, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Carly Galarneau, Tara Fisher, Charise Olson, Fred Koelher, Carol Sedar, Carol Williamson, Mariea Boisa, Lorraine Cahn, Amy Daniels, Ginny Gomez, Susan Paradise, Bill Manov, Susan Paradise, Adriana Guevara, Diana Carpenter, Denise Wyldbore, Jesus Ramírez, Guy Grant, and Stephen Dubuous.

1. Agenda review.
2. Recap of previous meetings: onset of serious mental illness risk factors, trauma risk factors, review of prevention (universal, selective and indicated) and early intervention.
3. Introductions.
4. **Evening presentation/meeting announced. Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Dr. Rivka Greenberg.
5. **Outcomes.** Jerry handed out list of outcomes and strategies (see below). Discussion about what is already happening in the community, and what we can build on. It was pointed out that we want to do early intervention, and not just training to recognize signs and symptoms. Question came up about "first break"; the adult group will be focusing on first break, and therefore this group will not with the understanding that any first break program not be constrained by age of onset. Group decided that we need more direct services for 18 to 25 year olds. Elements of this would include:
    a. Increased capacity of counseling services to transition age youth (and their families)
    b. Low cost or free
    c. County wide
    d. Visibility (provide outreach to youth and gatekeepers)
    e. Peer to peer services, and professional, in non-traditional settings
    f. Case management "light"
    g. Advocacy/mentoring
    h. Access point of entry
    i. Psychiatric services
6. **Speaker:** Dr. Patrick Teverbaugh, County psychiatrist. Patrick used to be the doctor for the transition age team. He advises that if people get interested in life early on they are better functioning adults. He says that based on studies there is not much evidence that there is a way to delay or prevent onset of mental illness. He has seen that while medications can help that a big part of the treatment is the psychosocial realm (keeping an interest in school, keeping your mind active, engaging in social activities). Patrick thinks that outreach at schools, programs for drug/alcohol/tobacco use, and engagement (in exercise or socially) should not be seen as "extra". Work and job programs can also be helpful.
7. **Next Steps**: Think about model(s). What services do we want, what can we build on? We have just one or two meetings left.

Next meeting: Wednesday, September 17, 2008 from 10 a.m. to 12 p.m. at Career Services, 18 West Beach, room 2, Watsonville, CA.

Hand out on outcomes:

Workgroup 18-25

To offer services that are culturally sensitive, trauma-informed and promote an independent and productive life for targeted TAY.

- Strategy: Train gatekeepers to (1) identify early signs and symptoms of mental illness and/or trauma exposure and (2) become familiar with services available to TAY.
- Strategy: Educate gatekeepers about unique cultural issues facing LGBT and Latino consumers.
- Strategy: Create a peer-to-peer mentoring program.
- Strategy: Require that programs reach out to LGBT youth.
- Strategy: Require services to TAY in foster care.
- Strategy: Provide paid stipends and work crew options to TAY at high risk of developing a mental illness.

To offer supportive services to family members of targeted TAY.

- Strategy: Involve the family early in treatment planning and offer them support services.
- Strategy: Offer peer-to-peer support groups.
- Strategy: Educate family about mental illness and the services available to the consumer.

To create an integrated/coordinated system to deliver TAY services.

- Strategy: Create a “TAY Service Council” to coordinate services
- Strategy: Create a system navigator position.
- Strategy: Create a user-friendly (consumer/provider) mental health resource website that is regularly updated.
- Strategy: Establish a 24-hour information and referral line.
- Strategy: Require all programs to build in client transferal mechanisms and well as follow-up protocols.
- Strategy: Create a Speakers Bureau

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 18 - 25

September 17, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Linda Betts, Bill Manov, Carly Galarneau, Carol Williamson, Diana Carpenter, Dianne Avelar, Fred Koelher, Guy Grant, Joanne Yablonksy, John Wright, Patrick Meyer, Lorraine Cahn, Steve Ruzicka, Tara Fisher, and Yana Jacobs

1. Agenda review.
2. Introductions.
3. Recap of previous meetings: Priority population, Transition Age Youth - Trauma involved, and Onset of Serious Mental Illness.
4. **Speaker:** Kelly Wolf, CASA (Court Appointed Special Advocates), designer and program manager for the "Independent Living Advocacy Program." CASA serves 0-18 age youth, with 9 staff, and 150 Volunteers. Served 196 children in '06-'07, providing a voice for those taken under the protection of the juvenile court because of severe abuse and neglect by their family. The Independent Living Advocacy Program was designed to provide professional, volunteer advocacy for the older youth, transitioning out of the system. The goal is to support youth on their path to becoming healthy, successful, contributing young adults in the community. Incorporates three components: Independent Living Advocate (ILA) Role, staffed through volunteers, with 2-4 cases each working collaboratively with community partners to meet the youth's goals. Independent Living Consultants (ILC) is comprised of trained and professionally supported CASA advocates and community members, becoming the "expert" on resources and information one specific area (i.e. housing, education, employment…). ILA's and CASA's can contact particular ILC's when a youth's needs are identified. The third component is the "Peer Mentor," comprised of emancipated foster youth ("nothing about us without us"). With this program in place, mental health needs can be more readily addressed because the time a therapist has with these youth will not be spent advocating.
5. **Outcomes:** Jerry compiled the outcomes and strategies into a one-page document for review by the workgroup members with emphasis on the three major outcomes: Educations (gatekeepers), System wide, and addressing direct counseling for psycho/social needs of TAY. This document was reviewed and edited as requested by the group. See proposed project and strategies below.
6. **Gatekeepers:** Prioritized the list:
    a. Parents and families
    b. School staff, students, and programs
    c. Social service providers
    d. Health care professionals
7. Phone numbers as requested for the following:
    a. Women's Crisis Support: 831-425-4030 and 831-722-4532
    b. Parents Center: 831-426-7322 and 831-728-6445
    c. Suicide Prevention: 1-877-663-5433

8. This workgroup has completed their tasks. One more meeting will be held (tba) when the draft plan is ready for review.

Prevention and Early Intervention for Transition Age Youth

Proposed Project: Coordination of the delivery of peer and professional support/counseling evidence-based services to transition age youth and their families in traditional and non-traditional settings. This program addresses transition age youth (persons ages 16-25) experiencing onset of serious mental illness, trauma-exposed individuals, and disparities in access to services.

Strategy #1: To offer low cost/free client-centered mental health services to transition age youth that are culturally sensitive, trauma-informed, and promote an independent and productive life for TAY at risk of onset of mental illness, especially targeting the LGBT and Latino youth.

- (Early intervention) Counseling services to TAY with special emphasis in foster care and alcohol/drug programs
- Assessment of psychosocial and drug/alcohol treatment needs with treatment planning/consumer goal statements
- Outreach programs to LGBT and Latino youth
- Peer-to-peer programs
- Advocacy
- Paid stipends and work crew options

Outcomes: Increased access to mental health services to at risk transition age youth.

Evaluation:

Strategy #2: To offer mental health/support services to family members (or other support system) of targeted TAY.

- Involve the family/support system early in treatment planning and offer them support services
- Offer peer-to-peer support groups
- Educate family about mental illness and the services available to the consumer and family

Outcomes: Increased mental health education and support to family members/support system of targeted TAY

Evaluation:

Strategy #3: To provide training, technical assistance and consultation to gatekeepers serving targeted youth to help them identify youth at risk of suicidal behavior or serious mental illness, and how to effectively assist them in a culturally sensitive manner.

Targeted gatekeepers are: parents/family/support system; school staff, students, and school programs; social service agencies; and health care providers.

- Training, technical assistance and consultation will include early intervention, how to clinically manage at risk transition age youth in diverse program settings, and how to adapt programs to better serve at risk transition age youth.
- Create a speakers bureau
- Educate gatekeepers about unique cultural issues facing LGBT and Latino consumers

Outcome: Targeted gatekeepers will demonstrate increased knowledge about the signs and symptoms of suicidal behavior and mental illness.

Evaluation:

Referral date from service agencies
Activity data on training and technical assistance and consultation contacts

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 26-59

July 11, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Bill Manov, Donna Jacobs, Nina Stratton, Norma Paige, Kristie Clemens, Jim Brown, Karen Dawson, Bonnie Jay, Alexis may, Emily Marsh, Sandra Sandoval, Joanne.

Meeting was tape-recorded; these notes (taken by Alicia) are a summary of the meeting (not verbatim).

1. Reviewed agenda.
2. **Introductions:** People introduced themselves and their interest in participating in PEI (including whether they think their agency will want to seek funding).
    a. Jerry: facilitator, psychologist for 35 years, involved with various community-based agencies; would like to see a more rapid response to persons with mental illness.
    b. Nina: a "highly employable" consumer; would like to see posttraumatic stress disorder (ptsd) be recognized, especially among Vets and homeless populations.
    c. Norma is a parent of two sons with mental illness, wants parents to be acknowledged for the work they do.
    d. Joanne works at Women's Crisis/Defensa de Mujeres; they have the only confidential shelter in Santa Cruz; helps women transition into work with drug/alcohol issues and/or mental illness; also interested in PTSD; does anticipate seeking funds; is also on the Women's Commission.
    e. Kristie: Walnut Ave Women's Center; works with domestic violence issues, and also is a family resource center; PTSD.
    f. Jim: Diversity Center; wants to provide the voice and represent the LGBT community; not necessarily going to seek funding.
    g. Donna: Not This Time Vets, non-profit agency; Veteran's Services Advocate, and mother of a Marine; feels Veterans are not taken care of, and that they are truly the underserved; would like the County to provide mental health and physical health care; also working with law enforcement agencies to provide training regarding "alternative sentence law", and establishing a Veteran's ombudsmen; care of Veteran's needs to change, and hopes MHSA funding to help.
    h. Karen: Community Counseling Housing Support program; have about 135 clients, most are ages 26-59; have 1.5 clinical staff; half are doing well, other half do well at times, then go in hospital; need additional support.
    i. Bonnie: Community Support Services in El Dorado Center; working in the mental health field for 18 years; shocked to see El Dorado Center was to be cut by the budget crisis; wants to create a "sensory room" to help stabilize persons; does not want to see these programs cut.
    j. Alexis: Suicide Prevention Services; provides community education and training as well as a 24 hour crisis line, and support for persons dealing with loss; wants to focus on integrated services to support people after the crisis; may apply for funds.

k. Emily: Suicide Prevention, new administrative coordinator.
l. Sandra: volunteer at the Diversity Center; information and referral call line staffed solely by volunteers, needs staff training; concerned about coordination of services.
m. Bill: County Alcohol/Drug services; provides funding for community based agencies providing alcohol/drug services in Santa Cruz; interested in both youth and adult services; adult mental health system only deals with persons with serious mental health issues; haven't had the resources to provide adequate mental health services for person's with alcohol/drug issues and less chronic mental health issues.
n. Alicia: MHSA Coordinator, Program Manager, 25 years experience in a variety settings and different populations; wants to ensure we have a good process and get stakeholder input, and adhere to State DMH guidelines.
o. **Comments?** There is a great need, and many ideas, however the "pot" of money is pretty small, so our challenge is to focus on what would be most helpful in our County.
p. **Appeals?** There is no formal appeals process for the plan, but the workgroups will work on their portion of the plan and will forward their recommendations to the MHSA Steering Committee who is responsible for final approval. Plan will undergo 30-day review and anyone in the community can comment on the plan; after review we send the plan to the DMH for their approval and funding. We do not have to go to the Board of Supervisors prior to submitting our plan to DMH.
q. **Target population?** Each priority population called out by the State is as important as the other. One member commented that Vets are especially in need of services, and the their whole family is affected. Jerry commented that most of the work groups have identified stressed families is a group that needs services. **WRAP** (Wellness Recovery Action Plan) is a possible tool useful to stressed families, and that is has been tailored to serve the lgbt and veterans community.

3. **Ground Rules** reviewed.
4. **Decision-making**. Ideally the group would reach consensus. Possible problem is that we have a small work group that meets consistently, and non-participating individuals may attend only when it is time to vote. The group decided that when it comes time to vote persons that have participated in at least 50% of the meetings will be allowed a vote. Participants can send a designated alternate if they cannot attend a particular meeting; can contact Jerry (425-8785) or Linda Betts (454-4498) to let them know if you can't attend a meeting.
5. **Leveraging.** State would like us to leverage our PEI programs, and this can include in-kind services, administrative costs, or site.
6. **Stigma and Discrimination (regarding serious mental illness) and Suicide Prevention** are two overarching concerns. DMH will offer statewide programs; may do this by offering additional funds for Counties to do these programs. Goal for PEI is to recognize early signs of mental illness. Also DMH wants counties to have integrated services to ensure connection to referral sources. PEI is an outcome driven program; we will need to evaluate the programs we develop. The challenge is proving something didn't happen. Will also need to consider offering services in non-traditional settings.

7. **Priority Population?** We need to consider which is our priority population (trauma exposed individuals, children/youth in stressed families, children/youth at risk of school failure, children/youth at risk of juvenile justice involvement, and/or onset of serious mental illness
8. **Resource Map.** It would be helpful to know what services are available for this age group. Where are the gaps in services?
9. **Stakeholders.** Who is missing? We can offer focus groups, or key informant interviews if stakeholders can't attend ongoing meetings. Underserved communities (e.g. Latinos), Education (perhaps consider Sara Peck from Cabrillo), health providers (get input from Homeless Persons Health Project, Salud Para La Gente, Planned Parenthood); law enforcement (Officer Seelig, Christine Swannick, Tony Jack). Consider also involving family resource centers, employment and media. Call Jerry with any names of possible stakeholders and he'll invite them to our meetings.
10. **Next Steps.** Review the ASR report, and review the resource guide provided by DMH.
11. **Review of Meeting.** Jerry felt he talked too much, and hopes future meetings will be more interactive. People appreciated the integrity of the process, and Jerry's easy manner of communicating. Concern expressed about PEI 101 being repeated again (Jerry said that this is the last overview), and there is "skimpy" information for the 25-59 year old group. There was appreciation for the focus of the meeting, and a hope that people that come to the meeting are open to others' concerns.

Next meeting: Friday, July 25, 2008, Ag Extension (behind old court house in the corner of the parking lot), 1432 Freedom Blvd, Watsonville

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 26 to 59

July 25, 2008 meeting notes

Attendees: Bill Manov, Emily Marsh, Kristie Clemens, Darrie Gawhorn, Nancy Kael, Will O'Sullivan, Karen Dawson, Jim Brown, Norma Paige, Art Anton, Joanne de los Reyes, Bonita Mugnani, Alicia Nájera, Jerry Solomon.

1. Agenda Review.
2. Introductions.
3. **Decision Making**: Consensus is the ideal, but we may need to vote on a decision. Who is allowed to vote? Various ideas were proposed. Group decided that persons need to have attended 50% of the time and attended 3 of the last 5 meetings. People may designate a proxy to vote, if they cannot attend. Will not restrict one agency to one vote, especially if they are representing different programs (e.g., Santa Cruz Community Counseling Center).
4. **DMH Resource Guide**. Programs should be evidence based. State has loosened their stance on this, but we will still need to evaluate programs. Need to use logic model; can use Resources as a model. As other Counties submit their Plans we will review and see if there is anything of interest to us, and share with the workgroups.
5. **Priority Populations**. Discussed the five groups, and decided to narrow our focus to Trauma Exposed Individuals and to Onset of Serious Mental Illness. What do these two mean for this work group?
6. **Trauma Exposed Individuals**. Veterans; incest/sex abuse survivors; domestic violence (repercussions of the trauma can lead to alcohol or drug use, mental illness, post traumatic stress disorder); homelessness; onset of mental illness can lead to trauma; trauma and substance abuse are co-indicated, as are depression and suicide. Also touched on these issues: don't want to duplicate services, want to deal with the underserved, and want to look at holistic, integrated approach. Refer to page 14 of the State Department of Mental Health Resource list to see how they describe "trauma exposed".
7. **Who are the trauma-exposed individuals**? Veterans, persons coming out, persons that have alcohol/drug dependence, survivors of dysfunctional families, incarcerated, or were incarcerated, untreated mental illness, homeless. Also, victims of: job loss, domestic violence, sexual assault, child sexual abuse, racism, hate crimes, discrimination, violence, harassment, natural disasters.
8. **Where do trauma exposed individuals show up**? Emergency room, diversity center, detox center, substance abuse centers, homeless services center, jail, the streets, survivors healing center.
9. **Who are the trauma-exposed individuals we don't see**? People who do not report, isolated, fearful, hiding (don't feel it is safe), don't identify as having a problem (domestic violence, alcohol or drug abuse), feel stigmatized, undocumented, had a bad experience in the past when tried to get services, in the closet, "protected" by their role (priest, teacher, coaches).
10. **Who are at risk of suicide**? LGBT, substance abusers, injured workers (even though workers comp is supposed to serve them – it often fails), isolated and move to despair.

11. **Reaction to meeting**: Facilitation was great; feel overwhelmed; put notes on board; great to see we're getting into it now. We should do a brainstorm for "onset to serious mental illness", like we did for trauma exposed.

Next Meeting: Friday, August 8, 2008. From 9:30 to 11:30 at Community Counseling Center, 195 Harvey West, Santa Cruz, Ca. (In the back.)

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 26 to 59

August 8, 2008 meeting notes

Attendees: Emily Marsh (Suicide Prevention), Kristie Clemens (Walnut Avenue Women's Center), Darrie Ganzhorn (Homeless Person's Garden Project), Will O'Sullivan (Santa Cruz Community Counseling Center), Karen Dawson (SCCCC- mental health housing), Sandra Sandoval (for Jim Brown) (Diversity Center), Norma Paige (NAMI, family member), Joanne de los Reyes (Defensa de Mujeres/Women's Crisis), Bonita Magnani (Survivors Healing Center), Pam Barthalemew (MHCAN, consumer), Dorian Seamster (Safety Clinics), Bonnie Jay (El Dorado Center), Carol Williamson (NAMI), Betsy Clark (SCCCC), John Wright (Counseling Center, and Mariposa), Cecile Mills (educator and consumer), Rocio Mendoza (consumer), Alicia Nájera (MHSA Coordinator), and Jerry Solomon (consultant/facilitator).

1. Introductions. People also stated the agency/group they represent; several hoped to receive funding from the PEI programs.
2. **Funding Guidelines**: The MHSA Steering Committee decided on funding guidelines for the PEI work groups as follows: 0-25 $840,000 to $1,050,000; 26-59 $210,000 to $350,000; 60+ $140,000-$280,000. These amounts are guidelines only; not set in stone.
3. **Priority Populations for all groups** have been identified, as follows:
    a. 0-5: Children & Youth in Stressed Families, and Trauma-Exposed Individuals;
    b. 6-12: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    c. 13-17: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    d. 18-25: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    e. 26-59: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    f. 60+: Onset of Serious Mental Illness, and Trauma-Exposed Individuals.
4. Evening presentations/meetings announced.
    a. **Tuesday, August 19th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon will engage the audience to gather input on desired outcomes for Trauma-Exposed individuals.
    b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
    c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined.
5. **Trauma-Exposed Individuals.** Recap of last meeting.
6. **Risk Factors**: (group added k-l)

a. Veterans [5]
b. Survivors of sexual abuse [14]
c. Domestic violence [10]
d. Homeless [10]
e. LGBT (coming out) [5]
f. Substance dependence [8]
g. Incarcerated [5]
h. Untreated mentally ill [16]
i. Victims of discrimination [4]
j. Violence/hate crimes [3]
k. Diagnosed as mentally ill [12]
l. Immigrants [4]

7. **First Responders**: (group added i-s)
    a. Emergency Room
    b. Diversity center
    c. Detox center
    d. Substance abuse programs
    e. Homeless services
    f. Jail
    g. The streets
    h. Survivor's Healing Center
    i. Parents/family
    j. School teachers/counselors
    k. Mental health programs
    l. Dominican Behavioral Health Unit
    m. Police
    n. EMT (1st response)
    o. Family resource centers
    p. Crisis line
    q. Primary care providers
    r. General public
    s. Faith based communities
8. **Trauma: Risk Factors Exercise.** Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors. The risk factors that got the most votes (noted in brackets above) were: survivors of sexual abuse, domestic violence, homeless, untreated mentally ill, and diagnosed as mentally ill. Group discussion of the results. Noted that some risk factors may be subsets of other risk factors.
9. **Onset of Serious Mental Illness.** Group did brain storm of risk factors: genetics, nutrition, lack of support, stress, lack of education, low socio-economic status, substance use/abuse, "just folks", family trauma, exposure to physical/sexual/emotional abuse, loss (death, divorce, foreclosure of home), isolation, victim of crime, racism, discrimination, military, predisposition. Discussion during the brainstorm included the need to look at risk factors at earlier age groups and intervene earlier. Group talked about possibility of

having a program for "first breaks", which could include alternatives to hospitalization, and support for person/family while going through this experience.

10. **Resources.** Draft resource list was handed out. Group asked to review, add or edit information to keep this up to date.
11. **Program speakers?** Group made list of possible speakers to come to this work group to do a 10-15 minute presentation. List included: Delphine Brody, Dr. Pat Teverbaugh, Ms. Mariposa –acupuncture. At September 9th meeting Women's Crisis Support/Defensa de Mujeres, Walnut Avenue Women's Center, and Survivor's Healing Center will do presentation about their services.
12. **Next Steps.** Need to review resource guide; attend the evening meetings; will finish up risk factors.
13. **Reaction to meeting**: Liked getting up and moving around; it is hard to sit for two hours!

Next Meeting: Friday, August 22, 2008. From 9:30 to 11:30 at United Way (in the Begonia Shopping Center.) 1220-C 41st Avenue, Capitola.

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 26 to 59

August 22, 2008 meeting notes

Attendees: Emily Marsh, Darrie Ganzhorn, Jim Brown, Norma Paige, Joanne de los Reyes-Hilario, Betsy Clark, Cecile Mills, Rocio Mendoza, Guy Grant, Bill Manov, Carly Galarneau, Alicia Nájera, and Jerry Solomon.

1. Agenda Review.
2. Introductions.
3. Evening **presentations/meetings** announced.
    a. **Tuesday, August 19th** we had a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon will engaged the audience to gather input on desired outcomes for Trauma-Exposed individuals.
    b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
    c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined.
4. **Speaker: Bill Manov.** Spoke about drug and alcohol services in Santa Cruz County and handed our resource referral directory. The County does provide some assessment, referral and case management, but actually provides very little direct services; the County contracts with community based agencies for direct services. Funding resources include Medi-Cal, Prop 36, and some "discretionary" funds. Funds have decreased over the years; used to pay for 6-8 months of residential treatment, and not the maximum is 2-3 months with a step down to sober living environment plus case management. Have a trained clerical person that can answer referral line (454-4050) from Monday thru Friday from 8 a.m. to 5 p.m. One big issue that Bill sees is that persons that have substance use problems are often dually diagnosed, but do not qualify for County Mental Health because their mental health issue is not a "serious mental illness". Vision is to have a strong mental health dual diagnosis treatment program, with training and consultation to drug & alcohol staff, psychiatric support (to assess and treat), and to provide support for medications.
5. **Onset of Mental Illness**. Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors.
    a. **Risk Factors**:
        i. Genetic predisposition [1]
        ii. Lack of support/isolation [6]

iii. Substance abuse/use [14]
iv. Exposure to crime [3]
v. Military exposure [9]
vi. Discrimination/racism/stigma [2]
vii. Loss/divorce [0]
viii. Abuse – physical/sexual/emotional [9]
ix. Nutrition [3]
x. Stress [0]
xi. Economics [3]
xii. Family history of suicide and/or mental illness [10]

6. **Wrap up:** Work groups will warp up by the end of September. We need to come up with outcomes and proposed programs. We will have MHSA Steering Committee look at proposals, and will be doing focus groups also. Need to have work groups look at resource guide to think about proposed programs.
7. **Outcomes:** First Break. Group brain stormed possible outcomes, including:
    a. To provide early identification of serious mental illness
    b. To improve global assessment of functioning by early treatment
    c. To enhance resilience and protective factors
    d. To promote social support, recovery, and academic achievement and/or employment
    e. To decrease hospitalizations, involvement with criminal justice, drop outs
    f. To decrease loss of housing
    g. To promote diversion for greater use of mental health resources/intensity by providing early assessment and intervention
    h. 80% of persons who request services receive assistance
8. **Next Steps:** Think about outcomes. Explore programs to achieve outcomes, and think about measurable outcomes for evaluation.

Next Meeting: Friday, September 5, 2008. From 9:30 to 11:30 at Career Center, 18 West Beach Street, Watsonville, CA.

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 26 to 59

September 5, 2008 meeting notes

Attendees: Emily Marsh, Norma Paige, Joanne de los Reyes-Hilario, Cecile Mills, Guy Grant, Carly Galarneau, Kristie Clemens, Bonita Magnani, Carol Williamson, Carol Sedar, Pam Bartholomew, John Wright, Alicia Nájera, and Jerry Solomon.

1. Agenda Review.
2. Introductions.
3. **Speakers: Kristie Clemens** (Walnut Avenue Women's Center)**, Joanne de los Reyes-Hilario** (Women's Crisis/Defensa de Mujeres) and **Bonita Magnani** (Survivors' Healing Center). Each person presented their agency and the work that they do. **Walnut Avenue Women's Center**: supportive services to women and children; early childhood education; teenage parent program; toddle center; community education (helping youth make health choices and have healthy relationships); domestic violence programs (including 24 hour hotline, groups for parents, groups for kids, and individual counseling); and have 3 "safe homes". **Women's Crisis/Defensa de Mujeres**: crisis intervention; 24 hour crisis line; services to domestic violence and sexual assault victims; help with restraining orders; go to court, police or district attorney's office with clients; have drop-in counseling groups; have shelter for women in immediate danger; offer 8 week family workshop (for parents and group for kids); work with youth that have witnessed domestic violence, including teen support group. **Survivors' Healing Center**: small agency (only 3 staff) that serves youth and adult child sexual abuse victims; offer extensive therapy groups; serve men, women, LGBT, Latinos. **All three agencies:** work together and often refer to each other.
4. **Outcomes: Onset of Serious Mental Illness (& First Break).** Discussion about the proposed projects the group has come up with. Group wants to make sure we state that these are to be client-centered services. Projects fall into two main categories: onset of serious mental illness (which includes ptsd), and first break.
    a. To promote early detection of serious mental illness (in a stigma neutral fashion).
        i. Strategy:
            1) Train gatekeepers in early signs and symptoms of mental illness, suicidality, trauma-exposed youth, and how to make effective, helpful referrals.
        ii. Evaluation:
            1) Utilization data
            2) Consumer goal achievement measures
            3) Consumer satisfaction measures
            4) Global Assessment of Functioning
    b. To provide comprehensive client-centered services to those of all ages experiencing or at risk of experiencing a psychotic break.
        i. Strategy
            1) To offer evidence-based treatment (EPPIC?) to treat the primary signs and symptoms of psychotic disorders and provide on-going recovery services for (up to two years).

2) To engage family members early in the treatment process and enlist them as allies in assisting the consumer.

ii. Evaluation:

1) Decrease the use of the Behavioral Health Unit
2) Decrease the use of emergency room services
3) Decrease in the loss of work/school/family time
4) Completion of a WRAP plan
5) Improved Global Assessment of Functioning (GAF)

c. To provide a program that enhances resilience and protective factors for those identified as "at risk" for developing serious mental illness.

i. Strategy:

1) Offer professional and peer-to-peer psycho-educational and recovery services

ii. Evaluation:

1) Utilization data
2) Consumer goal achievement measures
3) Consumer satisfaction measures
4) Global Assessment of Functioning

5. **Client Outcomes:** Group reviewed the above and brainstormed more outcomes: avoid hospitalization; return to life activities (work, school, maintain housing); self sufficient/functioning; mental health education (to understand diagnosis); to expose person to persons that are successful in their recovery; WRAP; safety; to having a neighborhood advocate; to create safe place, supportive environment to address isolation; to have an easy, rapid access for social/economic needs; decrease distress; increase functioning.

LAST MEETING: Friday, September 19, 2008. From 9:30 to 11:30 at the Diversity Center, 1117 Soquel Avenue, Santa Cruz, Ca.

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 26 to 59

September 19, 2008 meeting notes

Attendees: Emily Marsh, Norma Paige, Joanne de los Reyes-Hilario, Guy Grant, Carly Galarneau, Kristie Clemens, Bonita Magnani, Carol Sedar, John Wright, Bill Manov, Jim Brown, Betsy Clark, Karen Dawson, Will O'Sullivan, Darrie Ganzhorn, Yana Jacobs, Alicia Nájera, and Jerry Solomon.

1. Agenda Review.
2. Introductions.
3. **Speakers: Chris López (with Jordan Harding)** from the Veteran's Center on 41st Avenue, Capitola. Chris is the outreach worker for the Veteran's Center, and is a medically retired Veteran himself after being wounded in Bagdad. Chris described the mental health services available at the Capitola site. Staff includes LCSWs, MFTs, and psychologists. These are outpatient services, and they specialize in PTSD. Services are free for combat veterans (or sexually traumatized veterans), and their families. Combat veterans are persons serving in a war zone for 30 days. The Veterans Center has a free shuttle to the Palo Alto Veterans clinic, and they are going to get a motor home to do outreach. Chris spends a significant amount of time at Camp Roberts engaging persons as they are discharged. Chris encourages all Veterans to get registered to get service connected, even if they don't see any problems when they first come home. Chris can be reached at 588-9865 if further information is needed.
4. **Carol Sedar** read some quotes about serious mental illness and spoke about the importance of remembering the focus of this work group.
5. **Reviewed the Outcomes** for this group. After discussion group decided Outcome #1, is the priority of the group, while stressing the importance of #2. (The group actually wants both of these to be funded). Targeted gatekeepers are: Social Services (including Diversity Center, detox centers, substance abuse services, veterans services, family resource centers, mental health and domestic violence programs, homeless programs); educators (teachers and counselors); and emergency services (including police, jail, and primary care providers). The group came up with the following:
    a. Outcome 1: To provide comprehensive client-centered services to those of all ages experiencing or at risk of experiencing a psychotic break.
        i. Strategy
            1) To offer evidence-based treatment (EPPIC?) to treat the primary signs and symptoms of psychotic disorders and provide on-going recovery services for up to two years. This program shall:
                - Engage family members early in the treatment process and enlist them as allies in assisting the consumer.
                - Offer a peer-to-peer program for exposure to persons that are successful in their recovery and can serve as mental health advocates for consumers.
                - Offer a program that enhances resilience and protective factors for those identified as "at risk" for developing serious mental illness.

ii. Evaluation
    1) Decrease the use of the Behavioral Health Unit
    2) Decrease the use of emergency room services
    3) Decrease in the loss of work/school/family time
    4) Completion of a WRAP plan
    5) Improved Global Assessment of Functioning (GAF)
    6) Utilization data
    7) Consumer goal achievement measures
    8) Consumer satisfaction measures
    9) Global Assessment of Functioning

b. Outcome 2: To promote early detection of serious mental illness or risk for suicidal behavior in a stigma-sensitive fashion.
    i. Strategy
        1) Provide training, consultation, and technical assistance to targeted gatekeepers in early signs and symptoms of mental illness and the warning signs for suicidal behavior. Train targeted gatekeepers on strategies to effectively assist individuals at risk of serious mental illness or suicidal behavior, including how to make appropriate and helpful referrals.
    ii. Evaluation
        1) Utilization data
        2) Gatekeeper referrals to service agencies

Mental Health Services Act: Prevention & Early Intervention

Workgroup: Ages 60+

July 1, 2008 Meeting Notes

1. Introductions
2. **Review** of workgroup guidelines and rules
    a. We are to create and foster an integrated system
    b. The state has mandated that we use the Logic Model (will need to document that we are doing this and the State will evaluate us).
    c. Values and Guiding Principles
        i. Transformational programs and actions
        ii. Leveraging resources
        iii. Stigma and discrimination
        iv. Recognition of early signs
        v. Integrated and coordinated systems
        vi. Outcomes and effectiveness
        vii. Optimal point of investment
        viii. User friendly plans
        ix. Non-traditional settings.
    d. Will need to come back to the decision making model; will try for consensus, then go to majority, however there are times when there is a very hot issue with people who have never attended the meetings, will all of a sudden attend and everybody votes in a certain direction. So the issue of honoring the process is that we need to decide how we will proceed if we run into this situation.
3. **Workgroup member's & agendas**
    a. Jerry Solomon, Facilitator, Psychologist & MFT
    b. Francie Newfield (Human Services Dept., Mgr of Adult Protection Services, support MSSP: Multi-Purpose Senior Services Program) The MSSP is reverting back to the state and requires an RFP/Contract award to continue. Committed to continuing services. Aware of the need to have mental health services around issues of depression and isolation, and the need to have a differential diagnostic process for people who are showing sudden signs of psychosis (which sometimes are related to dementia and sometimes not). To include support for the caregivers. Come up with a better screening program for places we want to refer people to.
    c. Rita Flores (Asst. Agency Dir., Family Services Center), involved with the Senior Outreach Program, believe peer counseling is the way for seniors; if you take a young therapist of 25 to deal with a senior there is no connection. Excellent model for this age group. Work together with other groups and bring peer counseling to them.
    d. Cecile Mills (Education, Instructional Development, Publishing, Training and sits on the MHSA Steering Committee). Interested in evaluation (the county needs to have information to determine what works with people, if they have evidence for it) and concerned people slip thru the cracks in this system. Need for good measurement and evaluation and outcomes of what's happening to people in the system.
    e. Linda Robinson (Advocacy Inc., Coordinator for Long Term Care Ombudsman program). Work with seniors; want to see more services to people living in long-

f. Steve Ruzicka (Supervisor for Older Adult Team at the County Mental Health). Here to get a sense of the needs of the greater community, what is needed, with the hopes of expanding the team (currently 2 staff). Getting a new Psychiatrist specializing in gerontology in August.
g. Ann Pomper (Director for Hospice of Santa Cruz County & worked with Santa Cruz Community Counseling Center for many years). Not interested in the funds, interested in knowing what's going on and us connecting. Last year served over 800 people who were dying; 80% are seniors. Need to engage well with rest of community, making connections, and need to know what's going on. Believe Hospice is at risk at the federal level and wants the community know so they can be championed. Building advocacy and letting you know what Hospice has in terms of end of life services and education so that everyone has access to these services.
h. Laura Orick (Shelter Manager for Women's Crisis Support). They serve women in this age group but it is a small proportion of clientele. Here to learn more about services in the community. Learn about the process. Not interested in any funding.
i. Betsy Clark (Mgr of Adult Programs for the Santa Cruz Community Counseling Center & sit on the MHSA Steering Committee.). Not interested in trying to create a program or bolster up a program. Interested in learning more about the services that are available in the community. Even for people who are treated for serious mental illness, things change, as they get older. In addition to physical problems there is more isolation and there are fewer choices for people.
j. Clay Kempf (Executive Director of the Seniors Council). His agency creates an area plan for seniors under the auspices of the Older American Act. Mental Health, especially loneliness, depression, & isolation has risen in surveys we have done in the past, as a higher priority need then seen previously. I am here to make sure existing community programs get support and are integrated into existing services. Not looking for funding.
k. Jane Schwicherath Has a Master's Degree with a specialty in aging and earned a Gerontology Certificate. Is current regarding research on LGBT (Lesbian, Gay, Bisexual & Transgender) aging issues. Here not to create a program or try and get funding but to champion for the LGBT senior. The depression and isolation for LGBT seniors is much more than for others. They grew up in a time when it was illegal, immoral and could be locked away for being gay. There is tremendous fear in this group to even be out. Most LGBT seniors go back into the closet when they need services. Expanding to do education and LGBT cultural competency within skilled nursing facilities and assisted living facilities, to improve the education and understanding.
l. Chris DiMaio (Retired Psychiatrist and Combat Vietnam Vet). Not here for the money. Representing the Diversity Center, specifically the "Rainbow Vet" organization that was formed to address the needs of gay veterans, many who do

not feel completely welcome in either the gay or Veterans community and frequently feel isolated, with no social outlets. There are many veterans in Santa Cruz who have never talked with other gay veterans, particularly with Latina and Latino Vets. One thing we see as important is to have someone to coordinate services for veterans, and coordination for services for the families. Outreach services are needed.

4. **Planning Process**
    a. Next step, pick a priority population
        i. Children/Youth in stressed families
        ii. Children/Youth at risk of school failure
        iii. Children/Youth at risk of juvenile justice involvement
        iv. Trauma exposed
        v. Experience onset of serious mental illness
    b. State will do own initiative on Suicide Prevention and Stigma reduction of the mentally ill.
    c. Steering Committee will set funding percentage
    d. Program/s must be evidenced based with an evaluation component built in
    e. Need representation from stakeholders, as identified by the State
    f. Identify missing stakeholders
        i. Need Latino outreach
        ii. African-American community outreach
5. **Priority populations**, per the DMH, to focus on in this workgroup
    a. Trauma exposed
    b. Individuals experiencing the onset of a serious mental illness
    c. Children/Youth in stressed families
    d. Children/Youth at risk for school failure
    e. Children/Youth at risk of experiencing criminal juvenile justice involvement
    f. Overarching concerns is suicide prevention and reduction of stigma and discrimination for those identified as struggling with mental illness.
6. **Workgroup decisions** to be made:
    a. Narrow down priority population recognizing all have needs. In this group, are there one or two groups we want to focus on and is there more data that we need to start making recommendations about programs for prevention and early intervention in those areas.
    b. Making sure we have the appropriate stakeholders involved with this process. Who is not here around the table? Per the state DMH guidelines, we must be sure we have input from all required stakeholder groups. We must be mindful of these groups and make efforts to get information from them so that it is fed into our process. A person may represent more than one stakeholder group.
        i. Based on the data feedback we heard from Applied Survey Research, the major areas of underserved communities is the Latino and LGBT community.
        ii. Education
        iii. Consumers and/or their families
        iv. Providers
        v. Health organizations

vi. Social Services
vii. Law Enforcement; Input will be gathered by either a focus group or key informant interviews (asking one/two officers to attend one meeting to address our questions).
viii. Stakeholders recommended but not required by DMH include representatives from Community Family Resource Centers, Employment, and Media

7. **Review of MHSA PEI values and guiding principles**. All in attendance stated that they were aligned with these values and principles.
    a. Transformational programs in action; looking for things that are brand new rather than incremental changes to existing programs that can transform a dilemma or problem.
        i. Leveraging resources
        ii. Stigma and discrimination reduction
        iii. Recognition of early signs
        iv. Integrated and coordinated systems
        v. Outcomes and effectiveness
        vi. Optimal point of investment
        vii. User friendly plan so that the consumer and family member are comfortable with what we are setting up in non-traditional settings.

Next meeting: Tuesday, July 15, 2008 from 9:30 to 11:30. Family Services, 104 Walnut Avenue, Santa Cruz

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 60+

July 15, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Chris Dimaio, Rita Flores, Clay Kempf, Francie Newfield, Laura Orick, Isleen Glatt, Linda Robinson, Kelly Sims, Angie Ledesma, and Karen Dawson.

Meeting was tape-recorded; these notes (taken by Alicia) are a summary of the meeting (not verbatim).

1. Agenda was reviewed. No changes were made.
2. Introductions.
3. **Decision Making**: Ideally the group would reach consensus. Possible problem is that we have a small work group that meets consistently, and non-participating individuals may appear when it is time to vote. Discussed the need for input from others, and need for focus groups, as well as the fact that that some persons may send designees to meetings, if they cannot attend. **Group decision**: when it comes time to vote persons that have participated in at least 50% of the meetings, and attended 3 of the last 5 meetings can vote. Attendance counts if person sent a "designee" in their place.
4. **Stakeholders**. Who is missing? John Gillette? Not sure if Linda called him. There is (or will be) a new geriatric doctor at the county; we will invite him/her. If stakeholder cannot come to meeting consistently, we may invite them to come at least one time. Clay mentioned that he is keeping the Senior Centers and meal sites informed of the PEI process. People felt like this group was representative, and will poll people if additional information is needed. Will hold off on focus groups until we are clear what we want from them.
5. **Resource Material**. DMH gave outlines of various programs. Reaction/Comments? Most persons found that the information was "thin" relative to this population, and that we will either need to "shoe horn" in to one of the programs, or look for other models. DMH has loosened the criteria, but we do still need to evaluate the programs proposed. Jerry is reviewing programs that other Counties are proposing and will share those that he thinks might be useful.
6. **Defining Priority Population**. Discussed the 5 proposed priority populations, and after brief review/discussion narrowed the priority population for this group to Onset of Serious Mental Illness and to Trauma Exposed.
7. **Trauma Exposed**. Brain storm on what this looks like in the 60+ age group: war exposed individuals, ptsd, long history of domestic violence, cultural clash, bereavement and loss (death of friends, spouse, loss of license, loss of functioning), declining health, higher risk of suicide, isolation, "sandwich generation", care giver issues, transitions into long term care/nursing homes/selling home/moving away, no longer "seen"/involved, loss of looks and abilities, loss of bodily functions, being single, loneliness, over medication, and homelessness. Today we are just brainstorming; we'll narrow this down next time.
8. **Onset of Serious Mental Illness**. Escalating health issues (post surgery, loss of hearing, loss of vision), multiple losses, isolation, previous exposure to trauma, exacerbation of

behaviors and/or mental illness, lack of mobility (can lead to depression), addiction to pain medication or sleep medication, drugs/alcohol, dependence turning into addiction, tolerance changes, sleep disturbance, homeless, poor nutrition, moving to long term care, loss of control (not allowed to make decisions), depression and anxiety, retirement (or no longer productive/active), death and dying issues. Older generation is more "shame based" about talking about mental health issues and secrecy. We may come up with program that deals directly with older adults, or one that deals with issues (such as care giver issues) that can be open to persons that are under 60.

9. **How do we intervene now**? There appears to be good interaction among agencies, if the person is in the system. Many agencies conduct assessments and see what else is needed. **Who are the first responders?** Fire department, police, children, PCPs, taxi drivers, neighbors, emergency responders, home care workers, housing management, beauticians, bankers, DMV, pharmacy, PG & E, maintenance and repair, mail carriers, animal control, in-home support, etc. **Why didn't they report?** Many people don't know what to do. Some people don't know when to report, or don't want to interfere. Others are fearful (of litigation, of the person). Some are in denial. Some people get discouraged because a previous report was not taken seriously. **How does the community know about resources?** Do we have friendly "portals"? Idea of "system navigators was brought up (as it also has in other groups). In Santa Cruz we have an adequate system, but it doesn't work for everybody. Resources are shrinking. There are waiting lists. What do we do about this? Discussed ideas such as buddy system, different models of getting services (neighborhood programs instead of senior centers), "creating community", friendly visitor program, more one on one programs (less groups), cross-generational programs (seniors paired with latch key kids), involve education (e.g. Cabrillo?), etc. Group noted that the senior population is changing. Also want to acknowledge Latino and LGBT groups.
10. **Evaluation of meeting**. Jerry appreciates the energy of this group. Several people agreed. People appreciate Jerry's facilitation, and keeping the group moving. There was both a sense of optimism, and that there are things to be done.

Next meeting: Tuesday, July 29, 2008 from 9:30 to 11:30. 18 West Beach Street, Room 6, Watsonville, CA

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 60+

July 29, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Linda Betts, John Beleutz, Kathleen Johnson, Clay Kempf, Chris DeMaio, Rocio Mendoza, Cecile Mills, Jane Schwicherath, Steve Ruzicka, Kelly Sims, and Ann Pomper

These notes (taken by Linda) are a summary of the meeting (not verbatim).

1. Agenda was reviewed. No changes were made.
2. Introductions.
3. **Review** of the priority populations for this age group. The discussion then moved on to the pros and cons, and priority, of the different areas that people show up within these populations. They are:
    a. Trauma Exposed Individuals (Symptom)
        i. Isolation, Loneliness (6)
        ii. Caregiver Issues (9)
        iii. Environmental Issues (0)
        iv. Over Medication (2)
        v. Homelessness (2)
        vi. PTSD, to include War exposed (5)
        vii. Military Stressed Families (4)
        viii. Domestic Violence/Abuse (4)
        ix. Bereavement/Loss (7)
        x. Declining Health (0)
        xi. Sandwich Generation, Stressed Families/Kids (4)
        xii. Culture Clash (1)
    b. Onset of Serious Mental Illness (Cause)
        i. Alcohol/Illegal Drugs (9)
        ii. Environmental Transitions (1)
        iii. Sleep Disturbance (0)
        iv. Poor Nutrition (7)
        v. Death & Dying (0)
        vi. Health Related (6)
        vii. Multiple Loss (7)
        viii. Isolation (4)
        ix. Prior Exposure to Trauma (3)
        x. Loss of Functioning (10)
        xi. Medication – Over/Under/Cost (7)
        xii. Suicidality (5)
4. The group discussed situations they had encountered amongst the, “high frequency,” populations identified. The main themes that regularly appeared were caregiver’s issues (being seen as needing services/who will take care of the caregiver?), LGBT Seniors (under-counted and underserved, going back into the closet in order to receive services), and seniors experiencing loss of control of their lives. Overarching themes of, “not being

seen," as one ages and the stigma this age group holds regarding being identified with a mental illness. It was also agreed that the Hispanic community is not well represented. Attempts will be made to have presentations from the LGBT Latino community, the Health Project Center that reaches out to caregivers, the Ombudsman organization, a Nursing Home, and the Seniors Council, at future meetings.

5. Next meeting: Narrow items down, collapse as appropriate. Consider outcomes for each of the high frequency populations.
6. Review of our local resources (a working resource list), to be added to by workgroups.
7. Evaluation of meeting. The group agreed that the level of openness and honesty generated by the facilitator promotes a sound forum in which to participate in these workgroups.

Next meeting: Tuesday, August 12, 2008, at Family Services Conference Room, 104 Walnut Avenue, Santa Cruz

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 60+

August 12, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Rita Flores, Clay Kempf, Francie Newfield, Laura Orick, Kelly Sims, Angie Ledesma, Jane Schwicherath, Sheri Anselma, Rocio Mendoza, Cecile Mills.

1. Agenda was reviewed. Cecile wanted to add a letter requesting data; she'll submit PDF to Alicia to be distributed to group.
2. Introductions.
3. **Funding Guidelines**: The MHSA Steering Committee decided on funding guidelines for the PEI work groups as follows: 0-25 $840,000 to $1,050,000; 26-59 $210,000 to $350,000; 60+ $140,000-$280,000. These amounts are guidelines only; not set in stone.
4. **Priority Populations for all groups** have been identified, as follows:
    a. 0-5: Children & Youth in Stressed Families, and Trauma-Exposed Individuals;
    b. 6-12: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    c. 13-17: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    d. 18-25: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    a. 26-59: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    b. 60+: Onset of Serious Mental Illness, and Trauma-Exposed Individuals.
5. **Evening presentations/meetings announced.**
    a. **Tuesday, August 19th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon will engage the audience to gather input on desired outcomes for Trauma-Exposed individuals.
    b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
    c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined.
6. **Program Speaker: Rita Flores, Family Services Agency**. Rita spoke about the services at Family Services Agency that are targeted for seniors. The **Senior Outreach Program** is the oldest of its kind in the State of California. There are 35 volunteers who go through 40 hours of training (on how to do active listening, on domestic violence, trauma, etc) and have meetings twice monthly that are either group supervision or additional training by various speakers. Volunteers learn about the specific traumas this age group face (grief, isolation, loss of physical abilities, serious issues with their adult

children, etc). The Senior Outreach Program works because the volunteers are the same age. They serve about 100 people. Don't keep extensive records on clients, but do send out a customer satisfaction survey every year and the feedback/comments are very moving. FSA also has the **Renaissance Program**, which provides mental health counseling to seniors with Medi-Care. Services have to be provided by licensed clinical social workers or licensed psychologists. FSA does not charge a co-pay; FSA gets no reimbursement if there is a "no show". Forty percent of Renaissance clients have had a prior mental health hospitalization. Volunteers who visit persons in nursing homes staff the **"I U Venture" program**. Sometimes they bring others with them, or bring art or other activities to engage the seniors.

7. **Risk factors for "onset" and "trauma."** (At previous meeting, discussed the risk factors for these.) Group rated these as follows:
    a. Onset risk factors
        i. Loss of functioning [10]
        ii. Substance abuse [9]
        iii. Medication over/under/cost [7]
        iv. Poor nutrition [7]
        v. Health issues [6]
        vi. Suicidality [5]
        vii. Isolation [4]
        viii. Prior exposure to trauma [3]
    b. Trauma risk factors
        i. PTSD & military involvement [9]
        ii. Caregivers [9]
        iii. Bereavement/loss [9]
        iv. Isolation/loneliness [6]
        v. Multiple loss [7]
        vi. Domestic violence [4]
8. **Gatekeepers:** Last time group brainstormed the following (and added a few more today): emergency services, primary care providers, taxi drivers, home care workers (IHSS), housing management, beauticians, PG & E, mail carriers, animal control, pharmacies, department of motor vehicles, faith communities, funeral homes, family, neighbors, library, medical equipment vendors.
9. **Priority populations:** Group discussed need to serve persons that are 60+ and are underserved (or maybe resisting services), in residential care, and are monolingual non-English speaking.
10. **Outcomes:** Brain storm on possible outcomes: peer/mentoring/buddy/friendly visitor program (to address loneliness & isolation); nutritional education (discussion about whether this is relevant – meal sites have strict standards, is this a mental health issue? Change in physical can lead to mental issues, poor nutrition may indicate other issues); to train gat keepers in early detection of nutrition problems; to offer appropriate nutrition; increase community wide awareness of nutrition; to offer education and support to caregivers of the elderly; to train gatekeepers regarding LGBT, Latinos, cultural competence; to increase counseling services; to promote the value of services in our community; to decrease the incidence of suicide; to provide transportation (accessibility, isolation); to increase quality of life of caregivers; provide respite for caregivers; provide

education for caregivers; to provide in home services to care givers; to develop meaningful activities for home-bound seniors (calling latch key kids or other home bound seniors); to train homebound seniors (or those in nursing home) to be counselors/buddies; t feel valued and engaged; working with people; breaking fear and creating community safety; decrease in self-stigma; increase social opportunities (library, matinee movie club); early identification of bereaved (skilled nursing facilities/hospice/funeral directors); identification of those who lose their driver's license; physical decline (diabetes, incontinent); identification and outreach to marginalized groups (LGBT & Latinos).

11. **Next Steps**. "Dot" exercise on outcomes; attend evening meetings; review draft resource map (and make additions/edits).
12. **Evaluation of meeting**. One person said she is not "outcome focused" and felt this discussion helped; another said she feels "overwhelmed" because we have identified so much need for so few resources; the final comment was "I didn't feel everyone could be heard; the meeting felt antagonistic at times".

Next meeting: Tuesday, August 26, 2008 from 9:30 to 11:30. Family Services Agency, 104 Walnut Avenue, Santa Cruz, Watsonville, CA

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 60+

August 26, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Angie Ledesma, Cecile Mill, Chris DiMaio, Clay Kempf, Francie Newfield, Ginny Goméz, Guy Grant, John Beleutz, Laura Orick, Linda Robinson, Pam Bartholomew, Sheri Anselmi, and Steve Ruzicka.

1. Agenda was reviewed.
2. Introductions.
3. **Funding Guidelines**: The MHSA Steering Committee decided on funding guidelines for the PEI work groups as follows: 0-25 $840,000 to $1,050,000; 26-59 $210,000 to $350,000; 60+ $140,000-$280,000. These amounts are guidelines only; not set in stone.
4. **Program Speaker: John Beleutz, Del Mar Caregiver Resource Center -** The Del Mar Caregiver Resource Center has been providing services for 18 years, covering Monterey, San Benito, and Santa Cruz Counties. Services are available in Spanish. John spoke about the services that are targeted for caregivers. Traditionally, caregivers do not take care of themselves, the presumption being that the caregiver is competent. Approx. 33,000 caregivers in Santa Cruz County. Women are more affected than men. Outreach through advertising and fairs generally do not reach the target population; clients usually referred through physicians and cancer centers. Services provided are: respite (includes financial assistance and relief for caregivers), family consultation, financial & legal consultation, counseling (short term, 6 sessions), support groups, workshops & training, and online & telephone resources. Currently, there is a wait list for respite care.
5. **Reviewed risk factors for "onset" and "trauma."**
    a. Onset risk factors
        i. Loss of functioning [10]
        ii. Substance abuse [9]
        iii. Medication over/under/cost [7]
        iv. Poor nutrition [7]
        v. Health issues [6]
        vi. Suicidality [5]
        vii. Isolation [4]
        viii. Prior exposure to trauma [3]
    b. Trauma risk factors
        i. PTSD & military involvement [9]
        ii. Caregivers [9]
        iii. Bereavement/loss [9]
        iv. Isolation/loneliness [6]
        v. Multiple loss [7]

    Domestic violence [4]
6. **Gatekeepers:** Emergency services, primary care providers, taxi drivers, home care workers (IHSS), housing management, beauticians, PG & E, mail carriers, animal control, pharmacies, department of motor vehicles, faith communities, funeral homes, family, neighbors, library, and medical equipment vendors.
7. **Priority populations:** Persons that are 60+ and are underserved (or maybe resisting services), in residential care, and are monolingual non-English speaking.

8. **Outcomes:** Onset & Trauma (U=Universal, S=Selective, ST=Strategy). The group refined and clarified some of the outcomes that were identified at the last meeting and added a few more.
    a. To educate gatekeepers to detect and treat bereavement/loss (ST)
    b. To offer support to those losing drivers license (ST)
    c. To identify early and provide counseling to those experiencing physical decline (ST)
    d. To educate system providers about LBGT and Latino concerns (ST)
    e. To ensure that services are accessible: transportation/in-home (U)
    f. To improve the quality of life for caregivers: respite in-home services, telephone/camcorder (S)
    g. To increase involvement: latch key program calling other home-bound, buddies (S)
    h. To increase mental health services to home-bound and in SNF
    i. To promote community wide sense of safety (U)
    j. To create social spaces in "non-traditional" setting, i.e. library
    k. To train gatekeepers in early detection of mental illness
    l. To offer education/support to caregivers of the elderly
    m. To train gatekeepers regarding LGBT issues/cultural competency
    n. To increase counseling services
    o. To promote the values of seniors in our community
    p. To increase awareness of the incidence of suicide
    q. To improve quality of life for 60+ consumers receiving mental health services
    r. To improve 60+ consumers about budgeting for healthy nutritious meals
    s. To offer those in SNF nutritional options for their diet
    t. Improved capacity for exercise
    u. Improve skills of consumer gatekeepers in early detection, etc.
    v. Early identification for those at risk for substance abuse/Rx problems
    w. To improve gatekeepers skills in responding to the needs of those identified with mental illness to make appropriate referrals
    x. To improve awareness of older adult mental health issues/services (U)
    y. To reduce depression/anxiety among targeted groups
    z. To increase and broaden (alternative) services that support mental health
    aa. To offer healing life styles to those over 60
9. **Strategies:** The workgroup started the process of strategizing for outcomes; 24-hour call line, gatekeeper training component to train and educate on how to respond (need a program to refer them to or create the program), increase existing in-home and long-term care facilities peer to peer counseling (social support, target LGBT/Latinos), train gatekeepers: PCP's, medical equipment providers, SVC providers, Community of faith, Housing mgmt, using a hi-intensity format the 1st year and low intensity the 2nd. Include the use of video/community TV, handouts, and information/referral services.

Next meeting: Tuesday, Sept. 9, 2008 from 9:30 to 11:30. Family Services Agency, 104 Walnut Avenue, Santa Cruz, Watsonville, CA

Mental Health Services Act: Prevention & Early Intervention

Work Group: Ages 60+

September 9, 2008 meeting notes

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Linda Betts, David Bianchi, Clay Kempf, Francie Newfield, Laura Orick, Jan Hilkert (for Kelly Sims), Chris DiMaio, Guy Grant, Steve Ruzicka, Sheri Anselmi, John Belutz, Ginny Gomez, Angie Ledesma, Jane Schwicherath, and Linda Robinson.

1. Introductions.
2. **Speakers: Steve Ruzicka and Francie Newfield.** Steve talked about the **Older Adult Services (OAS) Team** at County Mental Health. This team serves people 60 years and older that have a serious and persistent mental illness (usually a psychotic disorder) as well as a complex medical condition. There are two care coordinators for the whole county, service 15 to 20 clients each, 1 therapist, and a recently hired full time psychiatrist. Primary focus is on servicing clients that have Medi-Cal coverage, but do see some with no insurance. Care coordinators help clients with housing, discharge plans, social groups, outings, and transportation for medical appointments. Francie talked about three programs: Veterans' services, Adult Protective Services (APS), and In Home Support Services (IHSS). **Veterans' Services** on Front Street and in Watsonville; not connected to 41st Avenue Veterans services. They do not provide mental health services, but do assist in preparing claims and file appeals. They provide van shuttle to the VA hospital in Palo Alto every day, as well as a bus service on Fridays. Also provide survivor benefits, burial benefits. Medical team also comes down to Santa Cruz once a week. **Adult Protective Service:** there is no mandate at the federal level (and no funding), but there is a state mandate to provide this service (and limited state and county funding). Investigate abuse of older adults (65 years or older) and/or dependent adults (adults with physical or cognitive disability). Most common complaint is financial abuse; often occurs with individuals that have dementia. Referral number is 866-580-4357. They record referrals, screen calls and have immediate and 10-day response times, depending on the allegations. If there is a physical risk they call law enforcement. Some people refuse help from APS, but if multiple referrals come in about a person then APS may go to the Public Guardian to try to get the person conserved (and protected). Referrals on person in licensed facilities go to the ombudsman/advocacy office. **In Home Support Services:** serves people of all ages (children, too). Provide domestic services based on assessment. Referrals can be made at 454-4101. Providers are fingerprinted and have background checks. There is a financial criterion; persons need to be eligible for SSI (medi-cal). **Questions** about the services raised the issue that services are limited; if client does not meet criteria for OAS there are not many other resources, and even then the OAS services are limited. Do refer to Family Services Renaissance Program (but their funding is limited and they are required to use only LCSWs and licensed psychologists). Do refer to primary care providers for issues such as depression, but do not have a psychiatrist in Santa Cruz.
3. Outcomes
    a. To increase access to in-residence professional/peer-to-peer trauma-informed mental health/support services to those over 60.
        i. Strategy

1) Offer in-home professional assessment/diagnosis/treatment planning
2) Offer in-home/in residence peer, as well as professional counseling.
3) Access to psychiatric evaluation
4) Access to case management
5) Offer a buddy program; latchkey kid match, etc.

ii. Evaluation
1) Utilization data
2) Consumer goal achievement measures
3) Consumer satisfaction measures
4) Global Assessment of Functioning

b. To provide trauma-informed mental health services to caregivers of those with chronic/catastrophic illness.
i. Strategy
1) Offer caregiver-targeted counseling
2) Provide respite care.
3) Peer-to-peer support/education groups, as well as professional support
4) Telephone/cam/internet support (and training)

ii. Evaluation
1) Utilization data
2) Consumer goal achievement measures
3) Consumer satisfaction measures
4) Global Assessment of Functioning

c. To promote factors that support resilience and are protective for mental wellness for those 60+.
i. Strategy
1) Create social gathering spaces in non-traditional settings, i.e. libraries.
2) Promote physical activity and awareness regarding healthy nutrition.
3) Provide referral information to at-risk individuals.

ii. Evaluation

d. To educate/train targeted gatekeepers to identify those 60+ who are at risk of developing a serious mental illness, suicide and/or are trauma-exposed in order to teach them effective helpful responses.
i. Strategy
1) Offer trainings to service providers for detection of early signs and symptoms of mental illness, suicide prevention and trauma involvement with emphasis upon Latino and LGBT consumers.
2) Have central access point where gatekeepers/consumers can call to find out about services (perhaps adding this on to an existing service)

ii. Evaluation
1) Referral data from service agencies.

4. **Priorities:** This group had a vote and decided to recommend "a" as their first priority, and "b" as their second priority. Group discussed how there might be overall training gatekeepers across the lifecycle, and that if so, recommendation "b" could fall under that. If that is the case we want to be sure that we have trainings that speak specifically about older adult issues.
5. **Gatekeepers:** As part of recommendation "b" the group talked about gatekeepers. Gatekeepers include: emergency services, primary care providers, taxi drivers, para-transit, home care workers (IHSS), housing management, beauticians, PG & E, mail carriers, animal control, pharmacies, department of motor vehicles, faith communities, funeral homes, family, neighbors, library, medical equipment vendors, library, meals on wheels drivers, caregivers, long term care facilities, and financial institutions. Group talked about **top tier of gatekeepers** as being: health and social service providers, transit providers, faith based communities, and beauticians.
6. **Group finished its task!!!** Jerry and Alicia thanked everyone for their attendance and participation.
7. **Next Steps**: Jerry and Alicia will be conducting focus groups and key informant interview to get further input (as well as reactions to the recommendations of the workgroups). We will convene the workgroups to view a draft of the recommendations. The MHSA Steering Committee will review the draft of the PEI Plan, and once they approve the draft plan will be posted for 30 days for review and comment by the public. There will also be a Public Hearing (date to be determined), and all workgroup participants are encouraged to come and give their opinion.

No more meetings scheduled: the group accomplished their task! **Thank you** everyone for your time, ideas, and participation in the 60+ workgroup!

Key Informant Interviews

MHSA PEI
Key Informant interview
September 23, 2008

Interviewed: Manny Solano, Deputy Police Chief, Watsonville Police Dept.
Interviewer: Jerry Solomon, PhD

The interview: The interviewer met at Mr. Solano's office on September 23, 2008 for a one-hour interview. The interview was recorded and is summarized below.

Introduction

Mr. Solano was given a brief explanation of the MHSA PEI process. His importance as a stakeholder to the process was discussed. He was eager to discuss his twenty years of experience with the relationship between law enforcement and mental illness and drug abuse. He noted how frustrating it is for he and his officers because they get involved only after a person is accused of breaking a law. He supports the funding of mental health programs that offer people treatment before they offend.

Relationship with the Behavioral Health Unit

Mr. Solano stated that when responding to a call the police must assess the situation rapidly to determine if there has been a crime committed, in which case an arrest is made; or if someone is exhibiting signs of mental illness, in which case they are brought to the Behavioral Health Unit for assessment. He reports that there have been good interactions with the BHU during the past few years. The two organizations have worked to coordinate their services and to accommodate to each other's needs.

Need for officer training

Mr. Solano welcomed the idea of additional training of police officers about mental illness and effective strategies to de-escalate difficult situations that sometimes arise. Currently the Police Department doesn't offer trainings to assist officers to make helpful social service recommendations. He remarked that Alan Lamb, LCSW, at Watsonville Mental Health, helped train his officers in the past and he was very pleased with the results. He believes his volunteers and officers would like to know about available resources they could offer people they encounter that are in distress.

Mr. Solano volunteered that he has thirty recently hired officers needing training and orientation in how to assist the mentally ill. He was very open to a collaborative training model with the mental health community for his officers.

Outcomes for over 60

Mr. Solano supported the recommended outcomes for this age group. His officers often respond to complaints regarding the elderly who regularly go off their medications. They work closely with Adult Protective Services who assist in making appropriate referrals. "We work as a team."

Gatekeepers he believed to be important include: utility and public works, Retirement Village management staff, para- and metro transit; rescue missions, Salvation Army; food pantries, Meals On Wheels, The Resitar and Plaza Hotel.

First Break Program

Mr. Solano supported the establishment of a first break program in Santa Cruz County.

It can often be a dangerous situation if police are called into a first break situation. The officer is responsible to assess whether a person needs to be held involuntarily at the BHU for his or her own or for the public's safety. Often there are weapons present.

Mr. Solano spoke with compassion about the situation, "We know the people pretty well because we're a small town, so we try to do the best we can for the individual and their family." The BHU responds well when his officers arrive and the two agencies have well-established protocols. He has not received any complaints from his officers regarding the current system.

Transition Aged Youth

The group between 18 and 25 years of age is less of an issue for Watsonville compared with the City of Santa Cruz police according to Mr. Solano. Watsonville has fewer homeless in this age group. The homeless in Watsonville tend to be over forty years old. Prostitution is not a common issue in this age group. Occasionally, "some kids find an abandoned home and crash there, but this is not a major problem for the police."

6-17

Mr. Solano has dealt with the consequences of drug abuse for most of his career. He has been especially interested in youth drug prevention. He stated that increasing methamphetamine use among youth living in Watsonville is an increasing police concern.

He believes that residential treatment is the most effective intervention for youth and that current services are inadequate to address the needs of Watsonville's youth. "We need more low cost and affordable counseling of all sorts." The best drug treatment results Mr. Solano has seen have been with those attending faith-based programs. The police are often frustrated when outpatient services are offered to people who are on the streets still engaging in problem behaviors.

Mr. Solano agrees that supporting stressed families and youth will assist anti-gang efforts. He felt that it was especially important to involve the churches in Watsonville. He suggested that counseling and follow up services be made available at churches in the area.

One of the Police Department's pressing concerns is how to project drug use and other social forces influencing youth today into the future so that programs can be created to deal with upcoming law enforcement concerns.

Mr. Solano stated that his officers would probably benefit from LGBT focused trainings, but believes that most of the new officers are more sensitive to these issue than in years passed. He was pleased that the first gay pride parade in Watsonville this past summer went well, with no problems reported by the police or the community.

Closing Quotes

"I think the available mental health services are good, but I need to know more about what is currently being offered in our county."

"Currently there are no officer complaints regarding the mental health system."

"We need assistance in creating projections of how social factors will be influencing law enforcement concerns in the upcoming years."

"Some police forces have added mental health staff to respond to issues more rapidly. We'd welcome having someone like that working with us."

MHSA PEI
Key Informant interview
October 7, 2008

Interviewer: Jerry Solomon, PhD

Interviewed: Dorian Seamster, MD Health Improvement Partnership of Santa Cruz.

The interview: Ms. Seamster met at the interviewer's office on October 7, 2008 for a one-hour interview. The interview is summarized below.

Introduction

Ms. Seamster was given a brief overview of the MHSA PEI recommendations. Her importance as a stakeholder to the process was discussed. She was eager to share her experience the public health clinics and patients with mental illness and drug abuse. She stated that at one time there was a mental health provider available in the clinics and that it was a very helpful to the patients.

Ms. Seamster was asked to react to the recommendations from a Primary Care Provider (PCP) perspective. "The recommendations sound great and it would be wonderful to be able to fund them all. I'm concerned that there be adequate funding for any one strategy, to really make an impact."

Priority Need

Ms. Seamster commented on the long recognized need for mental health and social work support for clinic patients. "One of the top three priorities identified at the Safety Net Clinicians retreat was access to mental health services, particularly for the 0-5 age group."

Ms. Seamster remarked that currently PCP's often perform basic psychological assessments as well as some counseling with many of their patients. It would be very helpful to have a means of connecting PCP's with other agencies for counseling referrals. She believed that clinic staff would benefit from meeting regularly with County Mental Health staff in order to create systems for referral and feedback. She believes it would be helpful to focus on children because many are eligible for County mental health services.

When asked about on-site counseling at the clinics, Ms. Seamster acknowledged the lack of space for these services. Planned Parenthood organizes their clinic-based services by scheduling their staff when room space is available at the clinic.

Educating PCPs

"Educating PCP's to assess signs of mental illness and make appropriate referrals is a major priority." Many PCP find it difficult to keep current with medications that might be used when treating patients with depression. Therefore, specialty training in the psychopharmacological management of depression and anxiety would be very helpful.

Offering trainings to PCP's is currently being explored by the Health Improvement Partnership (HIP). It would be very helpful if the PEI education program recommended by the workgroup worked in tandem with HIP's efforts to train all Pediatricians in the county.

Comments to the Steering Committee

Ms. Seamster wanted to be sure that those making the decisions regarding the recommendations understand the importance of the primary care clinics in detecting the early signs of mental illness in the community at large.

Her primary concerns are the mental health needs of children and women who present with physical symptoms that often mask or co-occur with mental illness.

Ms. Seamster was adamant about the Steering Committee making sure that the scarce financial resources that are currently available to us be used wisely and that there be community involvement throughout the process.

Focus Groups Notes

MHSA PEI
Youth Focus Group
October 16, 2008

Facilitated by: Alicia Nájera, LCSW, MHSA Coordinator and Linda Betts, MHSA Administrative Assistant.

On October 16, 2008 we met with 7 youth, 4 girls and 3 boys that identify as "LGBT," at the United Way offices in Capitola, CA. Participants were offered pizza and beverages, and at the end of the session were given $10 voucher cards for their participation.

We provided an overview of MHSA, and specifically described the PEI stakeholder process and the workgroup recommendations, and asked them to provide feedback about their experiences, and their recommendations for PEI.

Each participant shared their views/opinions based on personal experience on what kind of issues they have encountered and what could help LGBT youth.

Issues/Concerns: The primary focus of issues encountered centered on their identity of being "LGBT." Specifically, they spoke of negative reactions from parents to "coming out," and to being called names or bullied at school. They also touched on other issues, such as being in foster care ("too many rules"), and medication ("that isn't always the answer; why go there first?").

Sources of Support:

- Everyone in the group felt that the Gay Straight Alliances (GSA) offer support and a safe place away from home; they wish that every high school and middle school had a GSA.
- Peer support is particularly important in coping with the "coming out" process, and peers help "keep one sane".
- Ideally, they would go to their parents when bullied, but not all parents are supportive or understand.
- One participant shared an experience in an exercise called, "What's in a name?" Provided statistics on suicide and how names can have a negative connotation attached to it and what some of the negative affects they have on people. She found this particularly helpful.

Recommendations:

- **Education** about the LGBT youth for parents ("can they be understanding, proud and compassionate?"), and educators. Education through various media venues – things people say and the "real" effect it has on kids/LGBT.
- **Counseling services**. They called out counselors needed with training on LGBT issues, peer counselors, counseling for parents of youth who "come out," and counselors to focus on "self esteem" issues for all students.
- **Support**, such as having someplace safe to go to after "coming out" to parent/s, particularly if it did not go well. Having supportive adults in youth's life.

- **Outreach & Activities**: Collaboration with other schools; beach bonfires (or other casual settings) where people can gather and share thoughts/ideas. They also talked about having activities that are *family* friendly, visiting senior's (buddy system) because "they have a lot of knowledge to share," and dances (that are LGBT friendly).

MHSA PEI
Transition Age Youth Focus Group
October 20, 2008

Facilitated by: Alicia Nájera, LCSW, MHSA Coordinator and Linda Betts, MHSA Administrative Assistant.

On October 20, 2008 we met with 7 transition age youth (TAY), 3 young women and 4 young men, at the Career Works offices in Watsonville, CA. Participants were offered pizza and beverages, and at the end of the session were given $10 voucher cards for their participation.

We provided an overview of MHSA, specifically described the PEI stakeholder process and the workgroup recommendations, and asked them to provide feedback about their experiences, and their recommendations for PEI.

The participants were a mix of persons receiving services from social services and mental health (entering into foster care as a young child), and persons entering into the mental health system of care as either an adolescent or young adult. Each participant shared their views/opinions based on personal experience on what kind of issues they have encountered. Some provided ideas about what could help youth transitioning from foster care, while others spoke of (mental health and substance use) recovery. All spoke about their experiences with mental health services and their goal towards independence.

A big focus of concern in this focus group was that of lack of communication and not being listened to. All of the participants have had numerous service providers in their lives for many years, and despite the fact that they were involved in different parts of "the system", the concerns they raised resonated with one another.

The issues and concerns fell into the following categories:

Lack of Communication/Explanation:

Several people mentioned that the adult service providers did not introduce themselves, much less explain to them what was happening.

- "No one talked to me or explained what was going on (age 8) as I am being removed from my home to a foster home. Suddenly there are many new adults in my life and a different home. I could have benefited from having a coordinator assigned to me and/or counseling prior to being taken away from home."
- "I was transported to a hospital without anyone providing information as to what was happening and/or going to happen."

Not being listened to:

Many of the participants felt the service providers (in mental health and social services) made judgments and felt they knew what the participant felt or needed.

- Tried to communicate to case workers about being abused in foster care, not taken seriously
- Can tell when being judged – can make mental illness symptoms worse if coordinator comes with preconceived ideas as to what illness I "must" have.

- "Sometimes I know I need to be hospitalized, but my (doctor/coordinator) doesn't think so."
- "My worker told me she thought I was depressed, but didn't bother asking me if I thought I was."

Hospitalization issues:

Participants in this focus group spoke of the unpleasant experiences they had being hospitalized.

- More traumatizing when police/ambulance/fire respond to a suicide attempt.
- Released from hospital with too many medications. It took a long time for my doctor to figure out which one(s) to use. (Believes medications are overused in hospitals as a means/objective to keep everyone calm so that staff is safe.)
- As a child, during hospitalization, felt totally betrayed and treated like an animal
- "I had to stay in the hospital longer waiting for housing to be available."

Access Issues:

Participants shared their stories about problems in accessing services.

- Tried to get mental health services, but was denied services.
- Difficulty in accessing services from one County to another (Medi-Cal was still coded as being of another County).
- "As a child, no tried to help, they just assumed I was energetic with a vivid imagination."

Other service issues:

- "It is traumatizing when my counselor/coordinator is changed." Change is hard; want to stay with the same one because a rapport has already been built.
- Takes a long time to be approved for SSI
- Lack of housing and/or risk of loosing it

Things that worked well for these participants:

- HPHP asked if I needed help
- My best counselor was educated and had personal experience as a foster child – knows how I felt, lived the experience
- Appreciate when a doctor works "with" me
- My stay at DBHU was ok
- Great doctor and coordinator thru Emeline Clinic

The participants' recommendations fall into the following categories:

Client Centered Services:

- Listen to me!
- Listen to children.
- If counselor had listened to me, I'd have gotten help sooner.

Advocacy:

- An advocate to work with people trying to get in a hospital and see a doctor.
- It would help to have an advocate there to explain how the system works and to organize steps to be taken with move (from one County to another).

Additional Services:

- More counseling/peer to peer (would keep me out of the hospital, supports me to reach/accomplish goals, keeps me sober).
- Provide peer counselor or advocate to accompany client when visiting coordinator (questions on meds can be very confusing and misunderstandings occur).

- Offer short-term services to those who start with ACCESS. "I was brushed off because I did not have SSI/Medi-Cal, and feel I was falsely assessed based on appearance and dress (did not look homeless and was keeping myself together). Not until I attempted suicide and was subsequently hospitalized was I assessed and assigned a coordinator/team. This experience may have been avoided with short-term services until I could have been assessed in depth."

Increased skills in service providers:

- Would appreciate honesty from counselors – "if they don't know, find out."
- Remember that everyone is different (even if diagnosis same).
- All providers to have a better understanding of what clients are going through.
- Foster children should be told what their rights are. (One person spoke of being forced to attend religious services by her foster parents.)
- No judging – be careful of personal appearance and how we move, it's not a mirror of my mental health (have been treated incorrectly based on this).

Alternative Services:

- Emphasis on medicating needs to change > use other alternatives (i.e. art therapy). Medications can make symptoms worse.
- Too many medications cause side effects and other symptoms.
- For children – other options besides hospitalization (treat at home?).

MHSA PEI
Consumer Focus Group
Mariposa Wellness Center, Watsonville
October 16, 2008

On October 16, 2008 Alicia Nájera, LCSW, MHSA Coordinator, and Linda Betts, MHSA Administrative Assistant met with consumers in Watsonville, California. Mariposa staff was contacted and they agreed to host and assist in identifying clients who would be willing to participate in a focus group. Participants were offered pizza and beverages, and at the end of the session were given $10 voucher cards for their participation. There were 8 participants in the group of mostly men.

We provided an overview of MHSA, specifically describing the PEI stakeholder process, and asked them to provide feedback about their experiences with the mental health system and their recommendations for PEI.

Each participant shared their views/opinions based on personal experience on what worked best when they became part of the system, what didn't, and what would they tell the MHSA Steering Committee to be mindful of as they make their decisions on programs/strategies.

The common themes that emerged from the group about what did **not** work for them are:

- **Problems with medication**
  - Electric shock and drugs
  - Cost of drugs
  - Allergic reaction to drugs
  - No explanation of what symptoms or side effects of drugs can be expected
  - Medication stopped when released from jail, got sick and ended up in jail, again
- **Problems with hospitalization(s)**
  - Feeling "institutionalized"
  - Threats of hospitalization, particularly when against the patient's will (lack of rights)
  - Housing all mentally ill patients together, (severe cases with the less severe)
  - Symptoms got worse when hospitalized/institutionalized
  - Did not feel safe at DBHU (observed fighting)
- **Lack of Explanation**
  - No one explained what was happening to "me"
  - Few, if any, bilingual staff (at hospital)

The themes that emerged about things that did/do work, or are helpful are:

- **Peer and Social Support**
  - MHCAN – meetings
  - Mariposa – meetings, group gatherings, food, it is a safe place in the community that keeps one from isolation
  - Being around people (not crowds)
  - Parental/family support during the transition period between incarceration and connecting to services
  - Peer counselors

  - Having friends who have gone or are going through the same thing, understanding/empathy
  - Respite
- **Recovery**
  - Staying involved with school/work
  - Once stabilized, working at a job, provides independence (and off SSI)
  - The system supporting recovery
- **Medications**
  - Having the right medication
- **Professional Support**
  - Provided (truthful) information by the doctor regarding a new medication (the need to personally understand the illness and why the specific med can work if the directions are followed)
  - Doctor spending time with client, providing information (education) during each step in the process, developing a good rapport with each other
  - Specific staff were named as being "very nice and a good influence"

Aside from the items mentioned above that are helpful, the participants recommend the following:

- Someone (advocate) to help clients with getting a job
- Mental health screening at an early age (pre-school?)
- Match mental health coordinators with expertise of a specific illness to the individual that has been diagnosed with it.

MHSA PEI
Consumers/Clients** Focus Group
Mental Health Client Action Network
October 3, 2008

Interviewer: Jerry Solomon, Ph.D.

Goal: To obtain feedback from clients about their

- Experiences with the mental health system
- Reactions to the PEl workgroups recommendations
- Comments to the MHSA Steering Committee

Participants: MHCAN staff was contacted and they agreed to host and to assist in identifying clients who would be willing to participate in a focus group.
Participants were offered pizza and beverages at the start of the group and were given $10 food vouchers at the end of the group. Ten clients actively participated; equal numbers of men and women. Ages ranged between 25 and 60. All currently use MHCAN's services.

Format: The interviewer introduced himself to the group and explained the purpose of the two-hour meeting. He briefly described the PEl workgroup recommendations and then asked each participant to react to the following questions:

- What helped you the most in your recovery from mental illness?
- What aspect(s) of the mental health system was least helpful to you?
- Of the recommendations being made, which might have been most helpful to you and your situation?
- Is there anything that you want to make sure that the MHSA Steering Committee hears from you?

One participant suggested that it might helpful to structure the feedback allowing each person five minutes to answer the questions. The group agreed to this.

Discussion: All participants agreed that it was important to create programs that addressed the needs of the mentally ill as early as possible in the process. All participants supported the recommended PEl programs. Most chose not to prioritize anyone program because they all seemed equally important. Many believed they might have personally benefited if some of the proposed programs had been available to them.

They all agreed how important it is to receive services that are sensitive to their needs. There were varying reports of the effectiveness of providers that many had met along the way. While many benefited from the diagnostic process, most talked

about the importance of being listened to and feeling respected. "I want to explain to others, in my own words, what I am feeling," They all worried about limited financial resources and the recent loss of funding for many local mental health programs.

Many discussed their experiences with the absence of integration of services resulting in multiple treatment plans that were often contradictory. Many lamented the forced changing of helpful providers.

The clients universally gave their support to MHCAN and the safety they all experience there. Many clients felt strongly that it was important to continue programs such as Pioneer House that serve dual diagnosed people.

Conclusions: All agreed resoundingly that it was critically important to their recovery that providers listen and attempt to understand their experiences, rather than just diagnosing them.

For some the most important factor was having rapid access to psychiatric medications and therapy, especially while in jail.

Almost all agreed that change doesn't occur until the person makes a commitment to their own recovery. "Until that happens, nothing can change." But when that does happen those attending the focus wanted to be certain that you knew that. .. "Mental health programs work,"

** When asked, most people who have used the mental health system prefer to be called "clients" rather than "consumers." Most found the label "consumer" unacceptable.

MHSA PEI
Parents and Family Members Focus Group
October 7, 2008

Interviewer: Jerry Solomon, PhD
Goal: To obtain feedback from family members of the mentally ill about their

- Experiences with the mental health system
- Reactions to the PEI workgroups recommendations
- Comments to the MHSA Steering Committee

Participants: The Santa Cruz chapter of NAMI was contacted and agreed to locate participants for the focus group. Six people participated. All were parents of children with serious mental illness. Most began noticing problems with their child's behavior in their teenage years.
Format: The interviewer introduced himself and explained the purpose of the two hour focus group. He gave a brief overview of the MHSA process and presented the PEI recommendations prepared by the various workgroups. The remainder of the group focused upon participants' reactions to the following questions:

- Did the PEI recommendations address what hasn't worked and strengthened what has worked in the mental health system?
- Might any of the recommended programs have helped you and your child as s/he entered the system?
- Does any recommendation seem more important to you to be funded than another?
- What do you want the Steering Committee to know that might help them with their decision?

Discussion: The participants began their discussion by exploring what hasn't worked for them and/or their child since they've encountered the mental health system.

- Many parents acknowledged multiple missed opportunities throughout the years. A few lamented about not having better knowledge of child behavior and development. "As a parent, I had nothing to compare my child's symptoms to…I assumed they were normal." Others talked about working with mental health providers who did not have experience treating serious mental illness. "Many providers don't want to think a young child is seriously mentally ill."
  Many agreed with one parent's statement, "No pediatrician will diagnose a young child with depression or mental illness."
  One mother talked about not knowing where to get help for her child. It took her nearly two years to locate assistance.
- Ambivalence regarding labeling a child for funding reasons
- Too many treatment plans involving drugs
- A few parents shared experiences of being treated badly, or indifferently by mental health staff. Others talked about how frightened they were when their child was placed in isolation.

What did work

- Once a parent located services they were next faced with the challenge of paying for services. Many found effective services for their children within a few hour car ride from Santa Cruz if they had private insurance or had the means to pay out of pocket for services.

- One parent related that she had a positive experience with County Mental Health when her son entered the system.
- All agreed that meeting other parents and receiving peer education and support was invaluable in assisting them cope with their child's mental illness.

What would you recommend to the Steering Committee?

Most of those in attendance urged the Steering Committee to consider the following:

1. Provide better access to information regarding the services available locally. All liked the idea of an interactive website for local mental health needs and/or a funded systems navigator position.
2. Create a mental health system similar to the Regional Center, vendoring services and collaborating with other systems (i.e., teleconferencing). This could be especially helpful when offering services to the 0-5 age group where trained providers are less available.
3. There is a need for trained/skilled professionals to work with infants and children. Until that is available a policy should be established that children are automatically referred to Langley Porter for assessment. Ideally, the mental health system would provide time for psychiatrists to be available to consult with primary care providers.
4. All pediatricians should be trained in assessing the signs and symptoms of serious mental illness in infants and youth and be familiar with local services.
5. Treat the families as allies in treatment planning. Offer family members respite.
6. Participants strongly supported the recommendations regarding the educating of parents about mental illness and "the system" by other parents and professionals. They felt a community-wide media campaign promoting mental wellness was an excellent idea.

Other comments:

1. Consider occupational therapy as another means of treatment
2. Services offered to youth on-site at the schools is crucial.
3. Research other service models that manage scarce resources. Fore example, might we want to collaborate with the Veterans Administration in working with people with severe trauma?
4. It's important to take into account the comments made during the CSS planning process.

MHSA PEI
Focus Group with Spanish Speaking Parents
October 21, 2008

Facilitator: Alicia Nájera, LCSW (MHSA Coordinator)

On October 21, 2008, I met with a group of eight (8) parents and family members at the Mariposa Wellness Center in Watsonville, California. All of them were Spanish-speaking women. The group was conducted in Spanish. The participants were offered mixed fruit and beverages, and at the end of the session were given $10 voucher cards for their participation.

I provided an overview of MHSA, specifically described the PEI stakeholder process and the workgroup recommendations, and asked them to provide feedback about their experiences, and their recommendations for PEI.

The participants began by sharing their stories about their loved ones needing mental health services. They are some of the participants of the Mariposa family group that meets weekly, and told me they find the mutual support and education to be extremely helpful. Here are some of their stories:

- Nephew is dually diagnosed. School told family he was taking drugs; family had not noticed. He began hearing voices and is now getting services. He is under family's care, but he does not want family involved. Staff tell them, "it is confidential," yet they get charged for services (T-house). Family was not told anything about what was going on with nephew; they sought out information (in groups).
- "Nervous" child told mom to take him to the doctor. He was diagnosed with obsessive-compulsive disorder.
- Son was "normal," graduated from high school with good grades. He began isolating, drinking lots of water, and digging holes in the back yard. He stopped sleeping and he began talking to himself. He was jailed for a bike ticket and was referred to County Mental health, but he refused to go. He was eventually hospitalized. The hospital did a good job of explaining to the family what was happening.
- Son was aggressive as a child. He had problems in school and parents noticed he started using drugs. When he was in his early thirties he began hearing voices, not sleeping, and not eating. He was hospitalized and stabilized. He stopped using medications because he felt fine but relapsed. He is stabilized again and has stopped drinking alcohol.
- Son began isolating and getting depressed when he was a teenager. Mom looked for help, and he finally accepted services. He is on medication, but does not do much. He tends to sleep most of the day and often does not eat.

The participants recommended the following:

- Counseling services to parents about how to deal with a child with mental illness
- Group counseling with a mental health professional facilitating the group
- Mental Health education (for families)
- Counseling at schools
- Activities at no/low cost (there are lots of activities, but families can't afford them)
- Home visits when their child is sick

- For coordinators to have more time to serve their children
- Employment services

MHSA PEI
Focus Group with Seniors
October 6, 2008

Facilitator: Alicia Nájera, LCSW (MHSA Coordinator)

On October 6, 2008, I met with a group of nine (9) seniors at the Senior Center in Watsonville, California. All of them were Spanish-speaking women. The group was conducted in Spanish.

The women were eager to share their life experiences and their thoughts about prevention. They stated *"nosotras sabemos, pero ellos piensan que saben todo";* they "know a lot", even though they often feel dismissed by youth "who think they know everything".

The women shared their thoughts about problems and risks that youth face nowadays. They spoke of youth driving recklessly driving, and taking the car while the parents were away at work. Several echoed in agreement. There was recently a car crash that involved a young driver, and this was fresh on their minds. There was much discussion about youth being "mal educados" and disrespectful. (Note: "mal educados" translates literally to "poorly educated", but is correctly translated to meaning "ill mannered".) In their opinion youth do not obey, do not respect their elders, do not greet you, and talk back. They also noted that there are problems with alcohol/drugs ("vicios") and gangs. "Youth get together to do bad things".

They talked about the problems that families face such as having little support among extended family members, and single women trying to raise their children. "Cuando estan chicos los niños hacen caso a la familia, pero cuando estan grandes le hacen mas caso al ambiente social y a sus amigos." ("When children are little they listen to what their families have more say, but when the children are older they are more influenced by the social ambiance and their friends".)

After discussion the problems, the women came up with the following suggested solutions:

- Offering financial support
- Counseling services at schools
- Having a class for teacher to teach youth manners
- Parent education
- Activities (music, sports, etc) so that youth can be involved in productive (rather than destructive) things
- Seniors can teach a manners class

An over riding theme from this group was the lack of "educación" (manners) and respect among the youth. One woman echoed the sentiment of the group by stating "escuela no tuvimos, pero educación sí". ("We may not have had much schooling, but we were well mannered".)

The group then focused on the needs of seniors. They noted the following concerns among seniors (in general, not just themselves): the lack of company, the need to be heard, the need for attention and affection, acknowledgement from doctors and store personnel, help with hygiene, help with personal care.

The group was eager to suggest solutions and services they would like to see:

- More funding to IHSS
- Counseling
- Activities and distractions
- A senior outreach program in Spanish (and not require the outreach volunteers to be bilingual).
- Transportation to go to North County, for drivers to give the senior time to eat their lunch before coming to take them back, and wished there were more convenient bus stops.
- Group therapy (in Spanish)

The women stated they enjoyed the focus group and were happy they were asked to share their opinions.

MHSA PEI
Veteran's Focus Group
December 10, 2008

Facilitated by: Alicia Nájera, LCSW, MHSA Coordinator with notes taken by Linda Betts, MHSA Administrative Assistant.

On December 10, 2008 we met with five Veterans advocate; four were Veterans, two were family members, and two worked with Veterans. (Some had multiple roles.) Participants were offered light snacks (fruit platter) and beverages (water and juice).

We provided an overview of MHSA and the components, focusing on the PEI guidelines. We shared the workgroup recommendations, and asked for feedback and recommendations.

Issues/Concerns:

- It should be mandated that everyone put veterans first when planning strategies and services. Many felt that the Veterans needs are neglected/over looked.
- Most vets will not "present" just anywhere, but will run into trouble with law enforcement first, resulting in a criminal record. Need to train all first responders (Law Enforcement, EMT's) to recognize and learn how to deal with combat veterans.
- Discussed the fact there is a need to train on posttraumatic stress disorder, and other veterans issues that affect the entire family, their employment and their neighborhood. The question came up as how will we get medical professionals and law enforcement to attend trainings?
- To reach veterans through services may not be suitable. For the most part, many are not willing to discuss their problem in a clinical or group setting. A social event, where groups can gather over food (for instance), would be more conducive to creating an atmosphere of camaraderie and openness.

Recommendations:

- **Training and education** about veterans issues for first responders, expanded to include families and clergy, regarding signs and symptoms of PTSD and mental illness
- **Leverage funds.** Coordinate with the VA or Dept of Defense for money. Also bridge services between community service providers and veteran services. We discussed how recommended services in PEI would not exclude veterans.
- **Intake Forms** should include "are you a veteran?"
- **Alternative sentencing Law**. This law allows judge discretion to recommend PTSD treatment in place of jail for those "identified" as a combat vet. Collaborate with system to offer alternatives through mental health services, public and county.
- **Outreach.** Where veteran's make the most impact is the place to reach out to them (a broader issue and the impact on the family). The most effective way of reaching out to veterans is through socialization. The Wellness centers provide this and could be developed with Vets in mind.
- **Use of VA Memorial Building**. The County owns the building on Front Street. Some brainstorming on how to use (and support) the building: establish an office there for downtown outreach workers; collaborate with entities that rent space a provision that

enables (fixed number) veterans to participate free of charge (for instance, rock concerts would give away 10 tickets to vets).

- **Services to Veterans and their families**. Treatment for combat veterans should include immediate family members.

Final Thoughts:

- **Veterans should be a focus in PEI.** While it is understood that Veterans and their families will not be excluded from any PEI program, it was strongly felt by everyone in the group that there should be a particular program that specifically focuses on Veterans.
- **Wellness Center.** Some members of the group like the ideas of the Wellness Center, such as exists in the mental health arena. There are some wellness activities, but could build on this. Part of the attraction is to draw out veterans that are isolated and not getting (needed) services. "The social aspect is at the heart of prevention and early intervention, and it's a good way to get people to relax and talk."
- **Trainings.** Many in our community need to have a better understanding of issues that veterans and their families face. The facilitator mentioned that the Workforce Education Training Academy should be able to include some training on veterans' issues.
- **Alternative Sentence Law.** Would like to see all law enforcement trained. Facilitator mentioned that that might not be feasible under PEI, but that if the Training Academy has trainings they could be invited. Also discussed how mental health jail staff would be good targets for training on veterans' issues, and the Alternative Sentence Law in particular.
- **"System of Care" for Veterans.** Everyone in our community that provides services for veterans should collaborate and coordinate. We are already working on how to improve this.
- **Advocate for Veterans.** There needs to be an advocate position between County services and the VA

Final Workgroup Meeting

"Cross walk" document comparing Workgroup recommendations
and County's proposed projects

Recommendations	Proposed Projects
Early Childhood (0-5): **Strategy #A:** To provide screening by pediatricians (and others) for bio-psycho-social and emotional health and development of children ranging ages 0 to 5. **Strategy #B:** Provide parent education for families with children ages 0 to 5. **Strategy #C:** To provide therapeutic intervention for children ages 0 to 5, with a focus on 0 to 3 year olds. **Strategy #D:** To provide education to gatekeepers on physical, social, emotional, health, and development of children (ages 0 to 5), with targeted training to designated providers on screening assessment and treatment of young children. **Children (6-17):** **Strategy #E:** To provide on site services at non-clinical settings (i.e., school based, Family Resource Centers) to screen for and provide peer and professional support/counseling ▪ Providers will be trained to provide "trauma informed" services **Strategy #F:** Provide skill-based training to parents at non-clinical venues (i.e., Family Resource Centers, school-based programs). ▪ Parent/child non-violent communication classes; understanding age-appropriate behavior; effects of psychiatric medication in children. ▪ Support and resource access	**Project #1: Early Intervention Services for Children** Priority populations: children and youth from stressed families, onset of mental illness, and trauma exposed children and their families. Focus: families needing parental/supervision skills, are affected by substance use/abuse, and/or are exposed to violence, abuse and /or neglect. Goal: to decrease the negative impact of these factors. This program also addresses disparities in access to services by prioritizing the Latino and LGBT population. **Strategy #1: Early Childhood Screening and Early Intervention** (A, C, D, E, F and G) Addresses the unique needs of early childhood. ➢ New assessment center for children aged 0-3. Includes weekly site-based assessments, as well as field-based services. This is a multi-disciplinary project, in coordination with Dominican Hospital, First Five, and Child Welfare. Referrals will come from Child Welfare. Plan to expand services to children in county and contract mental health programs, and extend age range to 0-5. ➢ Increase mental health screening, assessment, and consultation at child care settings (including Family child Care Homes, Pre-school, child care centers, as well as "informal" care providers). **Strategy #2: County-Wide Parent Education & Support** (B, D, E, F) Goal is to implement evidenced-based practice to provide increased outreach, engagement, and support of stressed families throughout Santa Cruz County. The County is engaged in a community learning collaborative reviewing new and existing practices. Plan is to work with key early childhood stakeholders to finalize selection of an evidence based practice, utilize request for proposal for selection of contractor(s), do initial provider trainings, and implement initial phases over 2 year start up period.

Recommendations	Proposed Projects
(Continued from previous page) **Strategy #G:** To educate/train targeted gatekeepers (i.e. parents/family, peers/youth, Primary Care Providers, Teachers/School personnel, Social Service Providers, Activities – i.e. coaches, Boys and Girls Club, Little League) to identify youth exposed to trauma (i.e. violence, child sexual abuse, homophobia, racism) and/or at risk of suicide and/or a serious mental illness and how to effectively assist them. ▪ Offer training/educational events at non-clinic based venues (i.e., FRCs, schools). ▪ Offer training and educational events through venues (i.e. Training Academy) and other venues. Train all health care providers serving targeted groups to identify early signs and symptoms of mental illness, suicide risk, and/or trauma exposure. Offer service providers ways to respond to youth and their families. **Strategy #H:** Provide rapid access to school-based and other counseling support services for those being bullied and bullying. **Strategy #I:** Identify and support a school mental health advocate from existing staff within each school to assist in early detection and prevention of suicide and serious mental illness by offering emotional/physical support to targeted youth.	**Project #1: Early Intervention Services for Children** (continued from previous page) **Strategy #3: Culture Specific Parent Education & Support** (B, F) County to provide culturally specific, trauma-informed, and oriented towards suicide prevention, with priority given to youth and families that are Latino, LGBT or other marginalized communities. We have chosen Cara y Corazón and Jóven Noble (models that have been used by the Alcohol and Drug) based on the positive experience to date and relevance and effectiveness for the special needs of Latino families. Cara y Corazón is a culturally based family strengthening and community mobilization approach that assists parents and other members of the extended family to raise and educate their children from a positive bicultural base. Jóven Noble is a youth leadership development program. **Strategy #4: School-based Prevention & Early Intervention** (E, H and I) Focus will be on youth in stressed families, trauma-exposed individuals, and onset of serious mental illness (as well as youth at risk of school failure and risk of juvenile justice involvement). County will conduct a request for proposal to identify appropriate contractor(s) that will build on lessons learned from recent school-linked activities, integrate with related prevention & early intervention, and demonstrate ability to effectively reach out and engage Latino students/families, and LGBT.

Recommendations	Proposed Projects
Transition Age Youth: **Strategy #J:** To offer low cost/free client-centered mental health services to transition age youth that are culturally sensitive, trauma-informed, and promote an independent and productive life for TAY at risk of onset of mental illness, especially targeting the LGBT and Latino youth. ▪ (Early intervention) Counseling services to TAY with special emphasis in foster care and alcohol/drug programs ▪ Assessment of psychosocial and drug/alcohol treatment needs with treatment planning/consumer goal statements ▪ Outreach programs to LGBT and Latino youth ▪ Peer-to-peer programs ▪ Advocacy ▪ Paid stipends and work crew options **Strategy #K:** To offer mental health/support services to family members (or other support system) of targeted TAY. ▪ Involve the family/support system early in treatment planning and offer them support services ▪ Offer peer-to-peer support groups ▪ Educate family about mental illness and the services available to the consumer and family **Strategy #L:** To provide training, technical assistance, and consultation to gatekeepers serving targeted youth to help them identify youth at risk of suicidal behavior or serious mental illness, and how to effectively assist them in a culturally sensitive manner.	**Project #2: Early Onset Intervention Services for Transition Age Youth & Adults** Priority populations: transition age youth and adults who are trauma exposed and are experiencing (or at risk of experiencing) the onset of serious mental illness. Focus: Persons seen as being most at risk: substance abuse/use; military exposure; family history of suicide and/or mental illness; and abuse (physical, sexual and/or emotional). Goals: To provide prevention and early intervention to persons affected, and their families. To coordinate the delivery of peer and professional support/counseling evidence-based client-centered services in traditional and non-traditional settings. This project also addresses disparities in access to services. **Strategy #1: Identification of Signs & Early Symptoms of Mental Disorders with Family Members, Professionals, and Community Entry Points throughout the County (L, N)** Promote early identification of, and intervention with, persons age 18 to 59 who are at-risk of serious mental illness or suicide by training and supporting targeted community entry points and professionals. Phase 1: Outreach Community Entry Points (e.g. Primary Care, Alcohol & Drug Programs, etc.), Professionals, and Family members to identify and intervene with persons at-risk of serious mental illness. Phase 2: Conduct training with professionals, family members, and community entry points on how to identify early signs of persons at-risk of serious mental illness, including suicide and/or first break psychosis. Also inform audiences on how and where to refer for mental health services; how to use recovery oriented client-centered services; and how to manage symptoms in various settings.

Recommendations	Proposed Projects
(continued from previous page) **First Break:** **Strategy #M:** To offer evidence-based treatment (EPPIC?) to treat the primary signs and symptoms of psychotic disorders and provide on-going recovery services for up to two years. This program shall: ▪ Engage family members early in the treatment process and enlist them as allies in assisting the consumer. ▪ Offer a peer-to-peer program for exposure to persons that are successful in their recovery and can serve as mental health advocates for consumers. ▪ Offer a program that enhances resilience and protective factors for those identified as "at risk" for developing serious mental illness. **Strategy #N:** Train targeted gatekeepers in early signs and symptoms of mental illness and the warning signs for suicidal behavior. Train targeted gatekeepers on strategies to effectively assist individuals at risk of serious mental illness or suicidal behavior, including how to make appropriate and helpful referrals.	**Project #2: Early Onset Intervention Services for Transition Age Youth & Adults** (continued from previous page) **Strategy #2: Early Onset Intervention Services for Individuals and Family Members** (J, K, M) Provide early intervention services to transition age youth & adults who are at risk of onset of mental illness or risk of suicide. In conjunction with the training and consultation services described in strategy #1 the County will provide client-centered clinical services (receiving referrals from professionals, family members, and community entry points), consultation, assessments, and short-term mental health services; referral to psychiatrist and/or longer-term services, as needed; and counseling and support to family members. Peer advocates will provide counseling, support, and network with professional and natural supporters. Employment Services will offer assistance in finding jobs or paid stipends for work crew options. Staff will serve as "system navigators" in order to assure continuity of care. County will also contract with Suicide Prevention (which will serve persons across the lifespan) see *page 181*. **Strategy #3: Monthly TAY Roundtable** (J, K) County will coordinate the delivery of peer and professional services to transition age youth and their families. Providers to include children and adult mental health homeless persons health project, counselors/coordinators, outreach workers, homeless garden project, County Office of Education, CASA, employment services, and others as appropriate. The Monthly community meeting will enable care providers to be aware of resources and enhance the coordination of services; this is an activity requested by TAY providers. There will be no cost associated with this strategy, other than staff time. **Strategy #4: Veterans Services** (*See page181*).

Recommendations	Proposed Projects
Older Adults: **Proposed Project**: This program addresses persons age 60 and older experiencing onset of serious mental illness, trauma-exposed individuals, and disparities in access to services. **Strategy #O: To provide direct mental health services to older adults in Santa Cruz County** Offer in-home professional assessment/diagnosis/treatment planning Offer in-home/in residence peer, as well as professional counseling Access to psychiatric evaluation Access to case management **Strategy #P: To provide education to gatekeepers about the early signs and symptoms of mental illness in the older adult population.** Offer trainings to service providers for detection of early signs and symptoms of mental illness, suicide prevention and trauma involvement with emphasis upon Latino and LGBT consumers. Have central access point where gatekeepers/consumers can call to find out about services (perhaps adding this on to an existing service)	**Project #3: Early Intervention for Older Adults** Priority populations: Persons age 60 and older experiencing onset of serious mental illness, trauma-exposed individuals, and disparities in access to services. Focus: Address onset of mental illness risk factors that include loss of functioning, substance abuse, medication issues, poor nutrition, multiple losses, health issues, suicidality isolation, and prior exposure to trauma. Trauma exposed individuals include persons suffering from PTSD and military involvement, bereavement & loss, isolation/loneliness, and domestic violence. Goal: To provide prevention and early intervention to persons affected, and their caretakers. This project addresses issue of stigma, isolation, and lack of transportation by putting an emphasis on providing services in the home. **Strategy #1: Field Based Mental Health Training and Assessment Services** (O, P) County to hire an Occupational Therapist (OT) to provide outreach, assessments, and short-term case management to older adults where they reside. Referrals may come from a variety of senior service programs, family members, and others. The OT will link with psychiatric services, case management services, therapy services, and/or linkage to peer support services, as appropriate. We will also train staff (at key senior organizations), professionals, family members, and others that come in contact with older adults to better recognize signs of depression and other mental illness, and help seniors connect to services. County to contract with community-based agency for early intervention counseling services (provided) where older adults reside.

Recommendations	Proposed Projects
(see previous page)	**Project #3: Early Intervention for Older Adults** (continued from previous page) **Strategy #2: Senior Outreach through Peer Companions** (O) County will contract with a community-based agency that can build on existing seniors programs to provide in-home peer counseling services. The peers will be trained (as described above) to recognize signs and symptoms of distress, and will provide companionship and light respite work for elderly. Services will be mobile and short-term (up to one year). Peers will work closely with the OT for support, supervision, and referrals. Recruitment of peer companions will include Spanish-speaking capacity. **Strategy #3: Warm line** (P) Provides quick telephone screening and referrals for persons seeking services for older adults. Senior Network Services, the central coast resource hub for all senior services in Santa Cruz County, will add a half-time position to existing services to increase capacity to respond quickly to community needs. Services will be enhanced so that Senior Network Services is able to take an anticipated increase in volume of calls, make appropriate referrals, and can be better targeted to serve Seniors with early onset of mental health condition. The OT will provide consultation to Senior Network staff.

Common Themes Across Work Groups
Workgroups were structured to focus on issues of specific age groups. While there are specific strategies in prevention and early intervention, depending on the age group targeted, it was interesting to see the following themes:

- Need for training, education, and consultation services about signs and symptoms of mental illness.
- Need for information about community resources.
- Need for information about signs and symptoms of suicide risk.
- Need for services affecting Veterans and their families.
- Need to evaluate the effectiveness of the services provided.

Prevention Services Across the Life Span (to be incorporated in the Projects listed above)
1. Education, Training and Consultation
Target audiences: Primary Care Providers, Community Entry Points, family members, and peer supports.
Goals of this strategy:

1. To increase awareness of the signs and symptoms of mental illness across the life span (early childhood, youth, transition age youth, adults, and older adults).
2. To increase awareness of the signs and symptoms of mental illness across diverse populations (Veterans, Latinos, LGBT, and the families of these groups).
3. To increase the knowledge of community resources available.

County PEI staff along with existing Workforce Education Training Academy will provide these educational services.

2. Suicide Prevention
County to contract for, "Suicide Awareness for Everyone (SAFE):"

- To raise community awareness
- Educational presentations for youth
- Training for "gatekeepers" (community entry points)
- Information presentations
- Support for adults coping with difficulties, including loss of loved one
- 24 hour crisis line

3. Veterans and Their Families
In order to strengthen linkages and coordination between County Mental Health and local Veterans services the County will contract a Veterans Advocate. In addition this advocate will help ensure the inclusion of Vets and their families in other relevant PEI services (including, but not limited to, parenting education, school based prevention services, field based services for TAY, Adults and Older Adults).

This person will be responsible for knowing the various Veteran resources in the community, provide and/or support wellness activities, and assure the County is compliant with AB 3083 (linkages between County and Veterans agencies).

The County will also include education and training on Veterans issues in the Workforce Education Training Academy. This may include issues such as post-traumatic stress, effects on children and spouses, issues of isolation, and/or issues of adjusting post-war experience.

4. Evaluation
The County proposes to focus a special evaluation of Cara y Corazón. Additionally, all programs provided at the County or by contract agencies will be expected to take part in overall evaluation activities using a Participatory Action Research (PAR) model. This approach is intended to provide real

time feedback to improve program performance and to guide decisions about the accountability and "value added" by these new services, as future funding plans are considered.

Note: The MHSA Steering Committee prefers not to use the term "gatekeeper" as that implies keeping people out. You will see the term "community entry point" instead.

MHSA Prevention and Early Intervention for Children/Youth Logic Model

Individual & Family Levels

* Modified from Community Blueprint for Children Logic Model

Systems That Factors That May Increase Risk for Serious Mental Health Issues in Children

- Poor physical and/or mental health
- Lack of a collective responsibility for children's well being.
- Fractured health and social support systems
- Lack of screening for development and delays
- Family violence
- Substance use
- Lack of collective knowledge & system awareness
- Socio-economic stressors
- Social isolation
- Trauma

Systems That May Increase Protection Against Serious Mental Health Issues in Children

- Good physical and mental health
- Collective responsibility for children's health, safety and well being
- Coordinated and responsive health and social service systems
- Trauma-Informed Services
- Preventive Services

If These STRATEGIES Happen… (Examples)

Universal

1. Screening for bio-psycho-social health and development of very young children
   a. By designated service providers
2. Community education
   - Education to gatekeepers on physical, social, emotional health and development
   - Community education

Selective

3. Assessment for bio-psycho-social health of very young children
4. Parent education
   - Targeted training to designated providers on screening assessment and treatment

Indicated

3. Therapeutic intervention
   o (Targeted specifically to meet gaps in services for the 0 to 3 population)
   - Brief mental health treatment services for targeted children & youth and their families

Then We Can Expect to See These Results… (Short-Term Outcomes)

And Then We Want to See These Results… (Intermediate Outcomes)

A) Improved Parent-Child Relationships

- Parents know about effective parenting practices.
- Parents understand the nature and importance of parent-child bonding and attachments.
- Parents understand their children's needs.
- Parents use effective parenting practices.
- Parents and children have positive, nurturing relationships.
- Parents are responsive to their children's needs.

B) Improved Child Social, Physical, and Emotional Health and Development

- Parents/caregivers understand child health and development, including the importance of the early years.
- Parents understand the importance of
- Parents/caregivers provide care that fosters optimal development in children.
- Children develop optimally
- health care, including developmental assessments

C) Improved Family Support and Functioning

- Families understand the importance of using informal and formal support systems.
- Families understand available resources to promote health, safety, stability and self-sufficiency.
- Families understand behaviors that support healthy family dynamics.
- Families access the resources
- Children and families are healthy, safe and self-sufficient.
- Families have healthy interactions.

D) Improved Child Safety

- Parents and allies know how to ensure children's safety in their homes and community.
- Parents and allies ensure children's safety in their homes and community.

And Then We Hope to See These Results (Long-Term Outcomes)

- The community has a coordinated and comprehensive system of support to meet families and children's needs.
- Children are emotionally healthy.
- Children live in safe and nurturing families.

Evaluation - We Will Know if These Outcomes Have Been Met by Measuring…

Short Term

- Positive changes in knowledge, attitudes and beliefs about issues such as parenting practices, child development and bonding/attachment.
- Positive changes in knowledge of where and how to access supports.

Intermediate

- Utilization of informal and formal support systems
- Children making progress toward meeting development milestones
- Early identification of children with special needs
- Parenting attitudes and practices
- Health-related behaviors
- Parent-child interactions
- Health care utilization
- Existence of and accessibility of resources

Long Term

- Improvements in children's health and development.
- Lower foster care entry rates.
- Reduction in child abuse reports (suspected and substantiated).
- Lower juvenile crime, incarceration & placements
- Success in school
- Reduced alcohol & substance abuse
- Increased accessibility, responsiveness and coordination of service

MHSA Prevention and Early Intervention for Children/Youth Logic Model

System Level

* Modified from Community Blueprint for Children Logic Model

If These STRATEGIES Happen… (Examples)	Then We Can Expect to See These Results… (Short-Term Outcomes)	And Then We Want to See These Results… (Intermediate Outcomes)	And Then We Hope to See These Results (Long-Term Outcomes)
	E. Improved System Capacity and Collaboration		
	▪ Gate keepers have increased knowledge of how to educate parents on how to support the social emotional health of young children ▪ Health Care providers know how to screen children for socio-emotional issues and where to refer children for assessment. ▪ Providers of services gain knowledge on how to access new funding. ▪ Increased Peer-to-peer education/support for parents.	▪ Gate keepers educate parents on how to support the social emotional health of young children ▪ Children are screened and referred for assessment (when needed). ▪ Providers of services have the capacity to leverage needed funds.	

Budgets & Budget Narratives

PEI REVENUE AND EXPENDITURE BUDGET WORKSHEET

Form No. 4

County Name: **Santa Cruz** Date: 3/16/09
PEI Project 1 Name: Children and Adolescents (0-17)
Provider Name (if known):
Intended Provider Category: Various
Proposed Total Number of Individuals to be served: FY 09-10 __1915 FY 10-11 _1915_
Total Number of Individuals currently being served: FY 09-10 _____0 FY 10-11 ____0_
Total Number of Individuals to be served through PEI Expansion: FY 09-10 __1915 FY 10-11 _1915_
Months of Operation: FY 09-10 ___12_ FY 10-11 ___12_

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	**FY 09-10**	**FY 10-11**	**Total**
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
Sr. Mental Health Client Specialist (2FTE)	$160,428	$160,428	$320,856
Parent/Family Support Coordinator (1 FTE)	$ 82,389	$ 82,389	$164,778
b. Benefits and Taxes @ 44.22%	$107,374	$107,374	$214,782
c. Total Personnel Expenditures	$350,191	$350,191	$700,382
2. Operating Expenditures			
a. Facility Cost	$18,000	$18,000	$36,000
b. Other Operating Expenses	$30,577	$30,577	$61,154
c. Total Operating Expenses	$48,577	$48,577	$97,154
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Contractor TBD: MH Consultation	$100,000	$100,000	$200,000
Contractor TBD: Provide outreach, engagement & support for stressed families	$200,000	$200,000	$400,000
Contractor: Group Facilitator Stipends	$25,000	$25,000	$50,000
Contractor TBD: School-Based Prevention & Early Intervention	$200,000	$200,000	$400,000
Contracted Trainers TBD	$20,000	$20,000	$40,000
a. Total Subcontracts	$545,000	$545,000	$1,090,000
4. Total Proposed PEI Project Budget	$943,768	$943,768	$1,887,536
B. Revenues (list/itemize by fund source)			545,000
FFP	$64,543	$64,543	$129,086
MAA	$23,250	$23,250	$46,500
Other	$10,000	$10,000	$20,000
Other MHSA	$15,000	$15,000	$30,000
1. Total Revenue	$112,793	$112,793	$225,586
5. Total Funding Requested for PEI Project	$830,975	$830,975	$1,661,950
6. Total In-Kind Contributions	$0	$0	$0

PEI PROJECT 1 BUDGET NARRATIVE
Children and Adolescents (0-17)

Personnel Expenditures	Cost
• 1 FTE Senior Mental Health Client Specialist: County Clinician for mental health screening and assessment	$80,214
• 1 FTE Senior Mental Health Client Specialist: County Clinician for Primary Care consultation and training	$80,214
• 1 FTE Sr. Staff Development Trainer: County staff training coordinator for Parent and Family support	$82,389
• Benefits and Insurance have been budgeted at 44.22% (determined by the annual average benefit cost for county staff)	$107,374
Total Personnel Expenditures	**$350,191**
Operating Expenditures	
• Facilities costs include office space costs for the above staff and room rental space for trainings	$18,000
• Other operating expenses include:	$30,577
o Employee mileage	
o Cell/desk phone	
o Office furniture and supplies	
o Computer and network charges	
o Training Materials	
o Childcare snacks	
Total Operating Expenditures	**$48,577**
Sub-Contracts/Professional Services	
• Contractor TBD: MH consultation (screening and assessment) at childcare settings	$100,000
• Contractor TBD: Provide outreach, engagement and support of stressed families.	$200,000
• Contractor TBD: Group facilitator stipends	$25,000
• Contractor TBD: School-based prevention and early intervention	$200,000
• Contracted Trainers TBD:	$20,000
Total Sub-Contracts/Professional Services	**$545,000**
Total Project Budget	**$943,768**
Revenue	**$112,793**

Revenues will include FFP, MAA and Adult Education Average Daily Attendance.

Total Funding Request	**$830,975**
Total In-kind Contributions	**$0**

PEI REVENUE AND EXPENDITURE BUDGET WORKSHEET

Form No. 4

Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: Santa Cruz Date: 3/16/09
PEI Project Name: Transition Age Youth & Adults
Provider Name (if known):
Intended Provider Category: Various
Proposed Total Number of Individuals to be served: FY 09-10 751 FY 10-11 751
Total Number of Individuals currently being served: FY 09-10 0 FY 10-11 0
Total Number of Individuals to be served through PEI Expansion: FY 09-10 751 FY 10-11 751
Months of Operation: FY 09-10 12 FY 10-11 12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	**FY 09-10**	**FY 10-11**	**Total**
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
Sr. Mental Health Client Specialist (2FTE)	$160,428	$160,428	$320,856
Psychiatrist (0.10 FTE)	$16,925	$16,925	$33,850
			$0
b. Benefits and Taxes @ 44.22%	$78,425	$78,425	$156,850
c. Total Personnel Expenditures	$255,778	$255,778	$511,556
2. Operating Expenditures			
a. Facility Cost	$18,000	$18,000	$36,000
b. Other Operating Expenses	$41,150	$41,150	$82,300
c. Total Operating Expenses	$59,150	$59,150	$118,300
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Volunteer Center	$137,332	$137,332	$274,664
Santa Cruz Community Counseling Center	$12,000	$12,000	$24,000
Transportation (Bus Passes/Taxi)	$1,500	$1,500	$3,000
Contractor TBD: Veteran's Advocacy & Services	$40,000	$40,000	$80,000
Contractor TBD: Trainers	$10,000	$10,000	$20,000
Contractor TBD: Suicide Prevention Services	$56,000	$56,000	$112,000
a. Total Subcontracts	$256,832	$256,832	$513,664
4. Total Proposed PEI Project Budget	$571,760	$571,760	$1,143,520
B. Revenues (list/itemize by fund source)			256,832
FFP	$8,449	$8,449	$16,897
MAA	$7,000	$7,000	$14,000
1. Total Revenue	$15,449	$15,449	$30,897
5. Total Funding Requested for PEI Project	$556,312	$556,312	$1,112,623
6. Total In-Kind Contributions	$42,271	$42,271	$84,541

PEI PROJECT 2 BUDGET NARRATIVE
Transition Age Youth and Adults (18-59)

Personnel Expenditures	**Cost**
• 1 FTE Senior Mental Health Client Specialist: County Clinician referred to as Navigator will provide professional mental health services that is a mobile service to various community entry points, family members and professionals throughout the county.	$80,214
• 1 FTE Senior Mental Health Client Specialist: County Clinician to provide assessment, crisis intervention and short-term case management services and linkage to peer counseling and employment services to TAY and adults.	$80,214
• 0.10 FTE Psychiatrist: To provide psychiatric consultation, medications assessment and monitoring, and psychiatric medications to clients at risk serious mental health illness and suicide.	$16,925
• Benefits and Insurance have been budgeted at 44.22% (determined by the annual average benefit cost for county staff)	$78,425
Total Personnel Expenditures	**$255,778**
Operating Expenditures	
• Facilities costs include office space costs for the above staff.	$18,000
• Other operating expenses include:	$41,150
o Employee mileage	
o Cell/desk phone	
o Office furniture and supplies	
o Computer and network charges	
o Training Materials	
o Psychiatric medications	
o Fleet car usage	
Total Operating Expenditures	**$59,150**
Sub-Contracts/Professional Services	
• Volunteer Center: Will provide –	$137,332
o 1 FTE employment specialist will offer assistance in finding jobs;	
o 1 FTE Peer Advocate will provide counseling, support and education on mental health illnesses signs and symptoms, and will network with professionals and natural supporters.	
o Work stipends for first time job experience	
o Transportation services	
• Santa Cruz Community Counseling Center: Flexible Case Funds for emergency food, shelter and clothing	$12,000
• Contractor TBD: provide client transportation services	$1,500

• Contractor TBD: Contract a Veteran's Advocate to provide advocacy & service coordination	$40,000
• Contracted Trainers TBD:	$10,000
• Family Service Agency – Suicide Prevention Services: Contract will provide suicide prevention services	$56,000
Total Sub-Contracts/Professional Services	**$256,832**
Total Project Budget	**$571,760**
Revenue	**$15,449**

Revenues will include FFP and some WET funds that support part of the costs of trainers and training materials for professionals and gate openers.

Total Funding Request	**$556,312**
Total In-kind Contributions	**$42,271**

- An existing supervisor will provide in-kind supervision; an estimate of 10% of their time will be to supervise the county staff. CSS Family Advocate will respond to families in order to educate, and enhance access and provide linkage to services.

PEI REVENUE AND EXPENDITURE BUDGET WORKSHEET

Form No. 4

Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: Santa Cruz Date: 3/16/09
PEI Project Name: Older Adult Services
Provider Name (if known):
Intended Provider Category: Various
Proposed Total Number of Individuals to be served: FY 09-10 400 FY 10-11 400
Total Number of Individuals currently being served: FY 09-10 0 FY 10-11 0
Total Number of Individuals to be served through PEI Expansion: FY 09-10 400 FY 10-11 400
Months of Operation: FY 09-10 12 FY 10-11 12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	**FY 09-10**	**FY 10-11**	**Total**
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
Occupational Therapist (1FTE)	$85,358	$85,358	$170,716
			$0
			$0
b. Benefits and Taxes @ 44.22%	$37,745	$37,745	$75,491
c. Total Personnel Expenditures	$123,103	$123,103	$246,207
2. Operating Expenditures			
a. Facility Cost	$6,000	$6,000	$12,000
b. Other Operating Expenses	$8,871	$8,871	$17,742
c. Total Operating Expenses	$14,871	$14,871	$29,742
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Senior Network Resource Center	$22,620	$22,620	$45,240
Family Service Agency of Central Coast	$40,000	$40,000	$80,000
Santa Cruz Community Counseling Center	$5,000	$5,000	$10,000
Contractor TBD: Peer Counselor	$24,960	$24,960	$49,920
a. Total Subcontracts	$92,580	$92,580	$185,160
4. Total Proposed PEI Project Budget	$230,554	$230,554	$461,109
B. Revenues (list/itemize by fund source)			92,580
FFP	$55,243	$55,243	$110,485
			$0
			$0
1. Total Revenue	$55,243	$55,243	$110,485
5. Total Funding Requested for PEI Project	$175,312	$175,312	$350,624
6. Total In-Kind Contributions	$12,271	$12,271	$24,542

PEI PROJECT 3 BUDGET NARRATIVE
Older Adult Services (>59)

Personnel Expenditures	Cost
• 1 FTE Occupational Therapist: County staff to provide outreach, assessment and short-term case management to older adults in their homes and a variety of settings.	$85,358
• Benefits and Insurance have been budgeted at 44.22% (determined by the annual average benefit cost for county staff)	$37,745
Total Personnel Expenditures	**$123,103**
Operating Expenditures	
• Facilities costs include office space costs for the above staff and room rental space for trainings	$6,000
• Other operating expenses include: o Employee mileage o Cell/desk phone o Office furniture and supplies o Computer and network charges	$8,871
Total Operating Expenditures	**$14,871**
Sub-Contracts/Professional Services	
• Senior Network Resource Center to add 0.5 FTE to Warm Line Sr. Network Resource to provide telephone screening, referrals and resources for persons seeking services for older adults.	$22,620
• Family Service Agency of Central Coast to provide mobile short-term therapy.	$40,000
• Santa Cruz Community Counseling Center: Flexible Case Funds for emergency food, shelter and clothing.	$5,000
• Contractor TBD: To provide a peer counselor/companions that will provide companionship and light respite work.	$24,960
Total Sub-Contracts/Professional Services	**$92,580**
Total Project Budget	**$230,554**
Revenue - FFP	**$55,243**
Total Funding Request	**$175,312**
Total In-kind Contributions	**$12,271**
An existing supervisor will provide in-kind supervision; an estimate of 10% of their time will be to supervise the county staff.	

PEI Administration Budget Worksheet

Form No. 5

County: **Date:**

	Client and Family Member FTEs	Total FTEs	Budgeted Expenditure FY 2009-10	Budgeted Expenditure FY 2010-11	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator					$0
b. PEI Support Staff (Sr. Dept. Administrative Analyst		1.0	$94,326	$94,326	$188,652
c. Other Personnel (list)					$0
					$0
					$0
					$0
d. Employee Benefits			$41,711	$41,711	$83,422
e. Total Personnel Expenditures			$136,037	$136,037	$272,074
2. Operating Expenditures					
a. Facility Costs			$6,000	$6,000	$12,000
b. Other Operating Expenditures			$37,632	$37,632	$75,264
c. Total Operating Expenditures			$43,632	$43,632	$87,264
3. County Allocated Administration					
a. Total County Administration Cost			$119,000	$119,000	$238,000
4. Total PEI Funding Request for County Administration Budget			$298,669	$298,669	$597,338
B. Revenue					
1. Total Revenue			$68,781	$68,781	$137,561
C. Total Funding Requirements			$229,888	$229,888	$459,777
D. Total In-Kind Contributions			$73,966	$73,966	$147,932

PEI ADMINISTRATION BUDGET NARRATIVE

Personnel Expenditures	**Cost**
• 1 FTE Senior Departmental Administrative Analyst: To provide PEI administrative and fiscal support.	$94,326
• Benefits and Insurance have been budgeted at 44.22% (determined by the annual average benefit cost for county staff)	$41,711
Total Personnel Expenditures	**$136,037**
Operating Expenditures	
• Facilities costs include office space costs for the Sr. Dept'l Admin Analyst.	$6,000
• Other operating expenses include: o Employee mileage o Cell/desk phone o Office furniture and supplies o Computer and network charges o Contract for program evaluation	$37,632
Total Operating Expenditures	**$43,632**
County Allocated Administration	
• Total County Administrative Cost	$119,000
Total PEI Funding Request for County Administrative Budget	**$298,669**
FFP Revenue	**$68,781**
Total Funding Request	**$229,288**
Total In-kind Contributions	**$73,966**

MHSA Coordinator and admin support staff will provide additional support to PEI Analyst and PEI programs.

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY

FORM No. 6

Instruction: Please provide a listing of all PEI projects submitted for which PEI funding is being requested. This form provides a PEI project number and name that will be used consistently on all related PEI project documents. It identifies the funding being requested for each PEI project form from Form No. 4 for each PEI project by the age group to be served, and the total PEI funding request. Also insert the Administration funding being requested from Form No. 5 (line C).

County:	Santa Cruz
Date:	3/16/2009

		Fiscal Year			**Funds Requested by Age Group**			
#	List each PEI Project	FY 09/10	FY 10/11	Total	Children, Youth, and their families*	Transition Age Youth*	Adults	Older Adults
1	Children & Adolescents (0-17)	$830,975	$830,975	$1,1661,950	$1,1661,950			
2	Transition Age Youth & Adults	$556,312	$556,312	$1,112,624		$834,468	$278,156	
3	Older Adults	$175,312	$175,312	$350,624				$350,624
				$0				
	Administration	$229,888	$229,888	$459,776				
	Total PEI Funds Requested:	$1,792,487	$1,792,487	$3,584,974	$1,1661,950	$834,468	$278,156	$350,624

*A minimum of 51 percent of the overall PEI component budget must be dedicated to individuals who are between the ages of 0 and 25