Sonoma County Mental Health Services Act 2018-2019 Plan Update & Annual Update for 2016-2017

Appendices

Table of Contents

WELLNESS • RECOVERY • RESILIENCE

Appendix 1

MHSA Impact Statements for FY 2016-2017

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Action Network

program description

Across Ages and Cultures (AAC) is a bi-county (Mendocino and Sonoma Counties) substance use, violence prevention coalition committed to strengthening culturally, ethnically, and linguistically diverse youth, families, seniors and the community as a whole through education, direct support services and advocacy. AAC is a collaboration of over 30 entities representing non-profit, for-profit, government, schools, law enforcement, faith-based organizations and groups on the Redwood Coast region.

Targets for the program are at-risk and high-risk children, adults, and seniors primarily from Native American Pomo, Hispanic (English and Spanish speaking), Caucasian, and mixed heritage families.

contracted services

- Outreach
- Training
- Volunteer Recruitment
- Transportation

ACTION NETWORK

Program Name:
Across Ages and Cultures

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Reducing disparities in access to mental health services by decreasing stigma and increasing mental health awareness

Program Location:
Gualala, CA

For more information, go to:
http://www.actionnetwork.info

program demographics

Total numbers served: 1,068
(Aggregate of quarterly reports)

age

60+	73.1%
0 to 15	10.0%
Missing Data	8.2%
26 to 59	7.9%
16 to 25	0.7%

race/ethnicity

White	88.5%
Hispanic	8.1%
Multiple categories*	3.4%

**More than one race, Native American*

language

English	92.9%
Spanish	7.1%

gender

Female	70.8%
Male	29.2%

notable accomplishments

100% of families that participated in the Bright Beginnings program are satisfied with the program and each family has administered an ASQ-SE developmental assessment. The families are also aware of the services and programs that Action Network provides.

90% of families are aware of services at the Kashia Pomo Indian Reservation and 33% of families have administered the ASQ-SE. The teacher and principal of Kashia School have given feedback about seeing improvements in the children's writing skills, as every child can write their name and recognize letters now. Also their social skills have increased as they are using positive communication to resolve conflicts.

100% of families are aware of the Learning through Plan services. 95% have administered ASQ-SE assessments to their children. 100% of families are quite satisfied with the program.

Educational Outreach: Parents were satisfied and well informed of all services and programs. Parents were informed about mental health, substance abuse, suicide prevention, tutoring, health insurance, food stamps, etc.

Community Outreach: 90% of families that participated in Community Outreach became aware of our programs such as: Triple P parenting classes, access to Mental Health, Early Learning programs, Tutoring and Mentoring, English as a second language, counseling, and Anger Management.

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Alexander Valley Healthcare

feel good... we have you covered

program description

Alexander Valley Regional Medical Center (AVRMC) is a non-profit 501(c)3, Federally Qualified Health Center (FQHC) founded in 1996 by community volunteers to address the healthcare needs of the indigent, uninsured and underserved in the communities of Northern Sonoma County. Since 2002, AVRMC has been the sole medical service provider in an estimated 300 square mile region. AVRMC provides full scope primary care, dentistry, and behavioral health.

AVRMC implements and supports the Pediatric Screening Checklist (PSC) program to promote prevention, detection, and intervention of mental and/or emotional disorders in children 5-18 years old. The PSC is administered in the exam room by support staff in preparation for the physician. If the PSC is positive, the clinician pursues a brief interview of child's major areas of functioning (school, family, activities, friends, and mood). If the brief interview supports the PSC findings, the clinician decides whether a referral for behavioral health is indicated.

contracted services

- Implement the Pediatric Screening Checklist
- Brief interview by a clinician of child's major areas of functioning
- Referral to clinic behavioral health services

notable accomplishments

Children Aged	Total # of Children Screened *	Total # of Children Seen by Behavioral Health **
5-11 years	1,660	134
12-19 years	1,901	157
TOTAL	3,561	291

**=total seen in practice: physician, nurse, psychologist, LCSW or dental visit*
***=of those, number seen by psychologist or LCSW*

ALEXANDER VALLEY HEALTHCARE

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Children ages 5-18 years old

Program Location:
Cloverdale, CA

For more information, go to:
http://alexandervalleyhealthcare.org

program demographics

Total numbers served: 3,561

children screened

children seen by BH

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Alliance MEDICAL CENTER

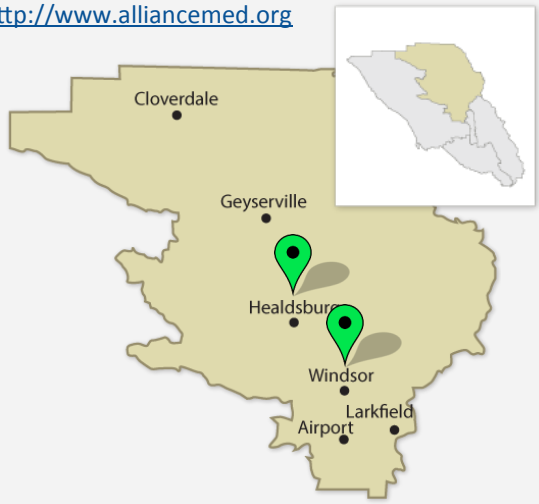
ALLIANCE MEDICAL CENTER

MHSA Component:
System of Care - Community Services and Supports (CSS)

Initiative/Population:
Community Intervention Program (CIP)

Program Location:
Healdsburg and Windsor, CA

For more information, go to:
http://www.alliancemed.org



program description

The purpose of Mental Health Services Act (MHSA) Community Services and Supports Community Intervention Program (CIP) is to directly address barriers to accessing mental health services and to provide culturally and linguistically competent services. Alliance houses mental health services and extends existing outreach activities to facilitate increased access to mental health services specifically among ethnic/linguistic minority populations who are uninsured, and who may be Medi-Cal beneficiaries who are able to receive appropriate care in the primary care setting.

Alliance expands the mental health service delivery in order to provide a coordinated system of care to its patients in a manner that increases the availability of integrated mental health, medical, and other social services, and enhances the quality of health care services available with an emphasis on services to underserved ethnic and cultural populations.

contracted services

- Face-to-face psychiatric consultation including medication support
- Psychiatric consultation to primary care providers and other providers in the clinics

notable accomplishments

Services provided were face-to-face psychiatric intakes and follow-up appointments; Individual level Interventions; Medication management; Screening and Assessments; and Crisis Intervention.

Patients were stabilized and kept from deteriorating into psychiatric disorders of severity requiring a higher level of care such as ER and 5150 hospitalizations.

program demographics

Total numbers served (Aggregate of quarterly reports): 39

age		race/ethnicity		language		gender	
26 to 59	82.1%	White	76.9%	English	87.2%	Female	59.0%
60+	15.4%	Other race/ethnicity	23.1%	Other language	12.8%	Male	41.0%
16 to 25	2.6%						

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

program description

The goal of Buckelew's **Family Service Coordination (FSC)** program is to empower family members of adults with mental illness by helping them gain competencies in system navigation, providing education about mental illness, helping them develop knowledge of, access to, and contact with community resources and supports. The FSC program maintains a flexible, collaborative, and recovery-oriented approach.

contracted services

- Systems Navigation
- Education and Support
- Community Outreach and Resource Development

BUCKELEW PROGRAMS SONOMA COUNTY

Program Name:
Family Service Coordination

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Families of adult Sonoma County residents with serious and persistent mental illness

Program Location:
Santa Rosa, CA

For more information, go to:
http://www.buckelew.org/programs/sonoma.html

program demographics

Total numbers served: 775
(Aggregate of quarterly reports)

age

Missing Data	46.1%
60+	26.6%
26 to 59	25.0%
16 to 25	2.3%

race/ethnicity

Missing Data	45.4%
White	43.4%
Multiple categories*	4.1%
More than one race	3.2%
Hispanic	1.9%
African American	1.5%
Declined to state	0.4%

**Asian, Pacific Islander, Other, Native American*

language

Missing Data	51.7%
English	47.0%
Other language	1.3%

gender

Female	40.5%
Missing Data	32.6%
Male	16.4%
Transgender	10.5%

WELLNESS • RECOVERY • RESILIENCE

notable accomplishments

During the fiscal year:

- Buckelew FSC received and made contact with **112** referrals provided by the Mobile Support Team
- **86** duplicated individuals attended the Sonoma County Behavioral Health Family Education & Support Group
- **80** duplicated individuals attended the West County Care and Share (Buckelew and NAMI)
- **147** duplicated individuals attended the Family Resource Clinic
- **36** duplicated individuals attended the Petaluma Education and Support Group
- **29** duplicated individuals attended the Spiritual Exploration and Support Group
- **104** duplicated individuals attended the Community Health Outreach Workers meeting (for service providers)
- Approximately **2,759** people were reached through community outreach and engagement efforts

Examples of community presentations/events given or attended and staff trainings given during the fiscal year:

- Sonoma State University Service & Internship Fair
- Interlink Self Help Center's Recovery Resource Fair
- Tabling Event - Guerneville School Back to School Night
- Wellness Music Festival - Arlene Francis Center
- PEERS Wellness Fair, SRJC Campus
- Latino Health Forum
- St. Joseph's Staff - Training on Mental Health Resources
- Petaluma Police Department Community Meeting
- Wellness and Advocacy Peer Support Specialist Class
- Family Justice Center Training
- African American Mental Health Conference
- Self Care Fair
- Petaluma Police Department Mental Health Awareness Panel

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

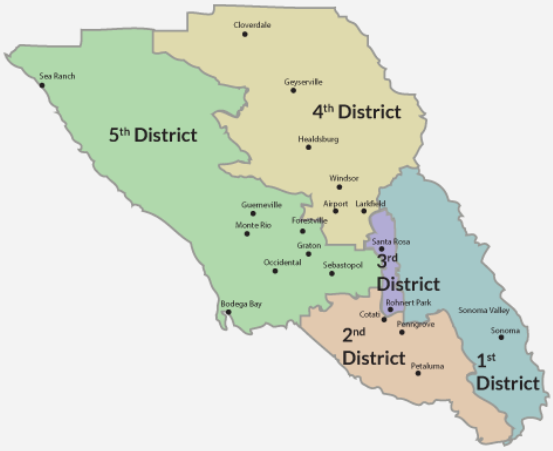
In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

NORTH BAY SUICIDE PREVENTION HOTLINE OF SONOMA COUNTY

Buckelew Programs Sonoma County

MHSA Component:
Prevention and Early Intervention (PEI)

Program Serves:
Sonoma County, CA



program description

The **North Bay Suicide Prevention (NBSP) Hotline of Sonoma County**, a program of Buckelew Programs, provides 24/7 suicide prevention and crisis telephone counseling. The Hotline's highly trained and supervised phone counselors provide crisis prevention and intervention to people in distress and/or their family and friends. Counselors help to enhance the callers' coping and problem-solving skills, giving people in crisis alternatives to violence to themselves or others and relief from the profound isolation of crisis, loss and/or chronic mental illness. Accredited by the American Association of Suicidology, the Hotline has been part of the National Suicide Prevention Lifeline (a toll free national number that connects callers to their closest certified crisis line) since its inception in 2005. The NBSP Hotline responds to calls from Sonoma County made to the National Lifeline.

Because no fees are charged for the phone service and help is accessible 24/7, the hotline is available for people of all ages and socio-economic levels. Factors that tend to inhibit individuals from seeking other sources of help, like cost and transportation, do not impede people from seeking support from the hotline. The hotline serves as a vital link to essential mental health support services and referrals throughout Sonoma County.

contracted services

- Hotline Calls
- Emergency Calls (from people who are actively suicidal)
- Monitoring of crisis Hotline calls
- Suicide Prevention Hotline Training Classes

program demographics

Total numbers served: 3,651
(Aggregate of quarterly reports)

age	
26 to 59	46.1%
60+	37.0%
16 to 25	9.0%
Missing Data	6.3%
0 to 15	1.6%

race/ethnicity	
White	47.9%
Missing Data	41.1%
Native American	3.8%
African American	3.7%
Hispanic	2.7%
Asian	0.7%
More than one race	0.1%
Other	0.1%

language	
English	99.9%
Other language	0.1%

gender	
Female	59.5%
Male	35.5%
Transgender	4.6%
Missing Data	0.3%

notable accomplishments

100% of the callers who were in a suicidal emergency received intensive and immediate support and intervention. For each of the **14** callers, emergency response teams were contacted and intervened.

60% of the **2,944** calls from people calling the hotline in crisis or experiencing depression, anxiety, anger, or other emotional states (for which there was a beginning and end rating) experienced a ***reduction*** in the intensity of their emotions. (Emotional state is rated at the beginning and end of the call on a scale of 0-5. 0 = poor, 5 = very good)

Suicide Prevention Hotline Training Classes completed this fiscal year:

- November - 7 students resulting in **7** new volunteers
- March - 11 students resulting in **8** new volunteers
- May - 5 students resulting in **5** new volunteers

100% of students who completed the Hotline Training Class Evaluation reported that their goals for the class were achieved. **100%** of students who completed the Class Evaluation also reported that their overall rating for the class was very good to excellent.

8 hotline volunteers were monitored with formal evaluation during this fiscal year. All call reports are reviewed daily for quality assurance purposes with feedback given to volunteers as needed. Staff provides supervision to volunteers on a regular basis. The evaluation process provided collaboration on goals for customer service/client relations, intervention skills, written skills, and team work.

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

program description

The **Crisis Assessment, Prevention, and Education (CAPE) Team** is a prevention and early intervention strategy specifically designed to intervene with transition age youth, ages 16 to 25, who are at risk of or are experiencing first onset of serious psychiatric illness and its multiple issues and risk factors: substance use, trauma, depression, anxiety, self-harm, and suicide risk. The CAPE Team aims to prevent the occurrence and severity of mental health problems for transition age youth.

The CAPE Team is staffed by Sonoma County Behavioral Health licensed and license-eligible mental health clinicians. Services are located in:

- Fifteen Sonoma County high schools - Analy, Cloverdale, El Molino, Elsie Allen, Healdsburg, Laguna, Maria Carrillo, Montgomery, Piner, Rancho Cotate, Ridgway, Santa Rosa High School, Sonoma Valley, Technology High School, Windsor

CAPE provides crisis response and training in mental health issues to the following sites:

- Santa Rosa Junior College (SRJC), Sonoma State University (SSU), Family Justice Center, Positive Images, VOICES

program services

- **Mobile Response** to schools by licensed mental health clinicians with youth who may be experiencing a mental health crisis.
- **Screening and Assessment** of at-risk youth in high schools and colleges.
- **Training and Education** for students, selected teachers, faculty, parents, counselors, and law enforcement personnel to increase awareness and ability to recognize the warning signs of suicide and psychiatric illness.
- **Peer-based and Family Services**, including increasing awareness, education and training, and counseling and support groups for at-risk youth and their families.
- **Integration and Partnership** with existing school and community resources, including school resource officers, district crisis intervention teams, student and other youth organizations, health centers, counseling programs, and family supports including National Alliance on Mental Illness (NAMI) and Sonoma County Behavioral Health Division (SC-BHD).

SONOMA COUNTY BEHAVIORAL HEALTH:

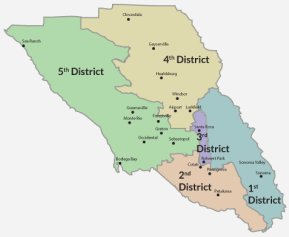
CRISIS ASSESSMENT, PREVENTION, AND EDUCATION (CAPE) TEAM

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Transition age youth at risk of experiencing first onset of mental illness

Program Location:
Sonoma County, CA

For more information, go to:
www.sonoma-county.org/health/services/cape.asp



program demographics

age

16 to 25	70.1%
0 to 15	27.1%
Unknown	1.8%
26 to 59	0.8%
60+	0.2%

race

White	43.2%
Unknown	24.8%
Other	15.2%
More than one race	10.0%
Asian/Pacific Islander	3.3%
Black/African-American	2.0%
Native American	1.0%
Declined to state	0.6%

ethnicity

Not Hispanic	48.6%
Hispanic/Latino	39.6%
Unknown	11.1%
Declined to state	0.6%

language

English	98.6%
Spanish	1.4%

sexual orientation

Heterosexual	44.3%
Unknown	38.9%
Bisexual	5.9%
Gay/Lesbian	4.5%
Other	3.9%
Declined to state	2.5%

gender

Female	61.1%
Male	34.8%
Transgender	2.7%
Other	1.0%
Unknown	0.4%

program statistics

512 - Total number of unduplicated clients served

565 - Total number of episodes

2,180 - Total number of encounters

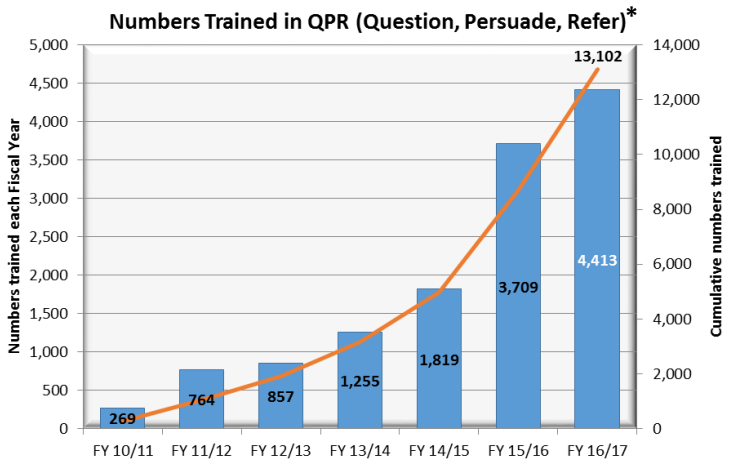
4,413 - Total number of people trained in QPR*

**QPR is an evidence-based training that teaches any person how to look for signs of suicide and how to talk to the person, and refer them on for care.*

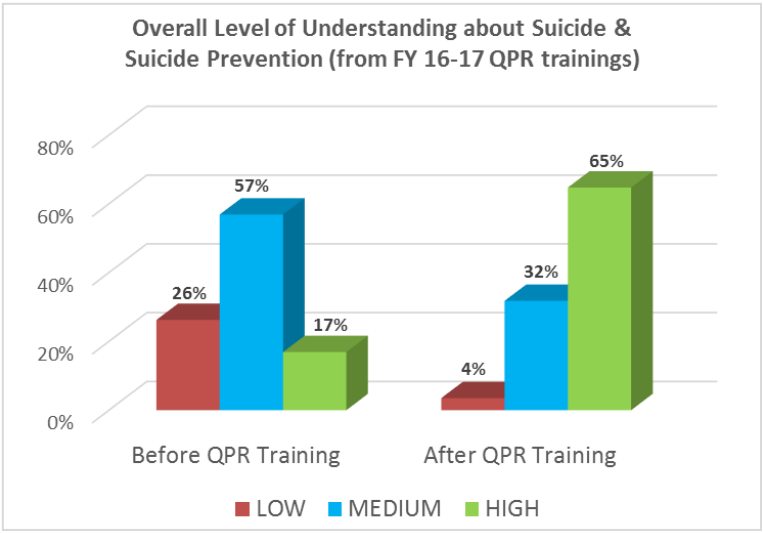
notable accomplishments

Training and education are a key part of the CAPE Team's mission. CAPE offers the following trainings:

- QPR (Question, Persuade, Refer) - A suicide prevention training geared towards the general public
- Classroom presentations on a variety of mental health topics and trainings for school/site staff on mental health topics as requested
- AMSR (Assessing and Managing Suicide Risk) - A suicide prevention training geared towards mental health professionals
- MHFA (Mental Health First Aid) - An overview of mental health topics & first response
- YMHFA (Youth Mental Health First Aid) - For adults assisting young people



**16 trained in FY 09/10 (not shown on graph). Includes some Community Intervention Program trainings.*



sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

program description

The purpose of the **Community Intervention Program (CIP)** is to provide outreach to disparate populations (those who have been historically underserved by mental health services) in an effort to engage people from these populations into mental health services. CIP focuses its activities on reaching, identifying, and engaging unserved individuals and communities in the mental health system, and reducing disparities identified by Sonoma County. The MHSA community planning process prioritized the following populations for outreach and engagement:

- People who are homeless
- People who abuse substances
- Veterans
- People experiencing a recent psychiatric hospitalization
- Ethnic and cultural populations – in particular, Latinos
- Individuals from the Lesbian, Gay, Bisexual, Transgendered, Queer, Questioning and Intersex (LGBTQQI) Community
- People who are geographically isolated

program services

CIP conducts outreach activities where these populations congregate and/or already receive other services. They do this by:

- *Direct Services*: Co-locating CIP staff in organizations that provide other services to these populations

SONOMA COUNTY BEHAVIORAL HEALTH:

COMMUNITY INTERVENTION PROGRAM (CIP)

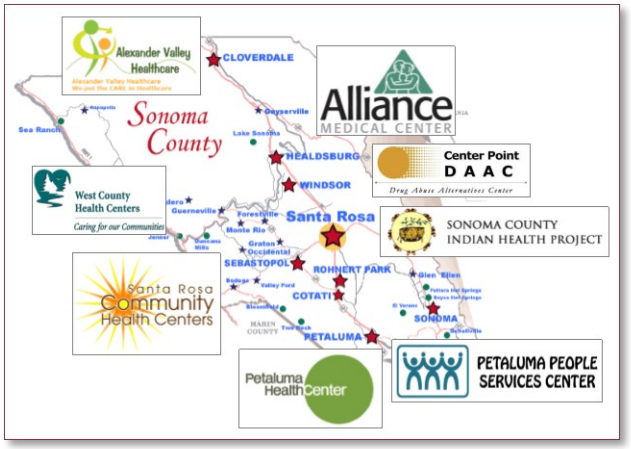
MHSA Component:
Community Services and Supports (CSS)

Initiative/Population:
Outreach & Engagement (to Increase Access)

Program Location:
Sonoma County, CA

For more information, go to:
http://www.sonoma-county.org/health/services/mentalhealthcrisis.asp

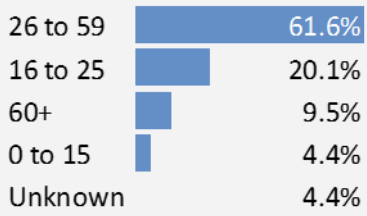
partnerships across the county



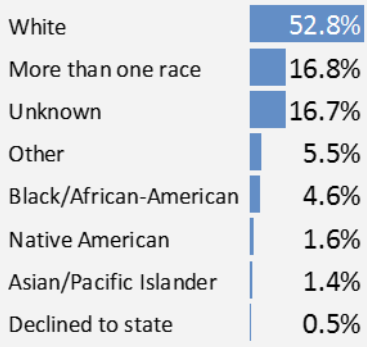
Community Intervention Program partners - increasing accessibility for Latinos, LGBTQQI, and geographically isolated communities

program demographics

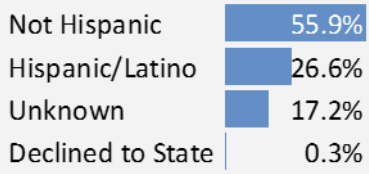
age



race

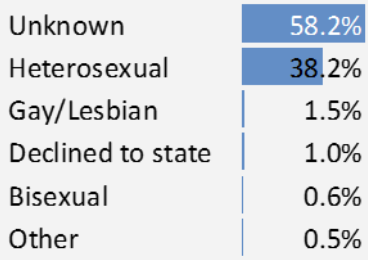


ethnicity

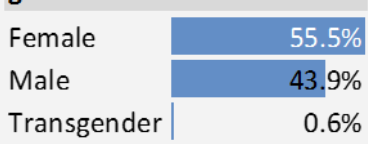


language

sexual orientation



gender



program services (continued)

- *Contracted Services*: Providing funding to organizations that serve these populations so they can hire their own staff

CIP conducts its outreach and engagement activities through the following staffing structure:

- Sonoma County Behavioral Health (SCBH)
  - SCBH CIP Team
  - Community Mental Health Centers (CMHCs) CIP Team
- Contractors
  - Alliance Medical Center
  - Drug Abuse Alternatives Center (DAAC)
  - Petaluma People Services Center (Mary Isaak Center)
  - Santa Rosa Community Health Centers
  - Sonoma County Indian Health Project
  - West County Health Centers
  - Human Services Department - Joblink

CIP conducts outreach and engagement activities to identify adults who live in geographically isolated areas outside of Sonoma County's service hub of Santa Rosa who may be in need of specialty mental health treatment. CIP leverages staff from SCBH Community Mental Health Centers (CMHCs) to engage in these activities. CMHC offices are located in Sonoma, Guerneville, Cloverdale, and Petaluma, and staff is familiar with the unique cultural issues in these areas.

program statistics *(for both SCBH & CMHCs CIP Teams)*

861 - Total number of unduplicated clients served

1,645 - Total number of encounters

4,181 - Approximate numbers reached at Health Fairs

outreach activities to priority communities

- Faith-based outreach
- Targeted outreach
- Work with law enforcement
- Fairs and gatherings
- Task forces and committees
- Training and consultation
- Urgent response

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

CBC COLLABORATIVE

program description

Community Baptist Church (CBC) is located in Santa Rosa and was the denomination's first African American church. Currently, CBC has an ethnically and culturally diverse congregation. CBC provides programming and services to children, youth, and their families including special services to seniors that are supported by volunteers and donations. MHSA-funded programs include:

Village Project is a weekly program for children ages 8-12 using a faith-based curriculum that focuses on character building.

The **Saturday Academy** is a weekly program that features topics of importance to youth of the church & the community. Adults from the community are asked to bring a youth relative or friend. The program focuses on building character through faith-based teachings, and other relevant issues (hygiene, fashion, health, education, respect for elders, etc.) using open discussion, role-playing, speakers, etc.

Rites of Passage is an eight-month Prevention & Early Intervention program for youth ages 14-18. This program uses adult mentors (civic & community leaders, elected officials, etc.) to provide youth with life skills to assist them in a successful transition into adulthood.

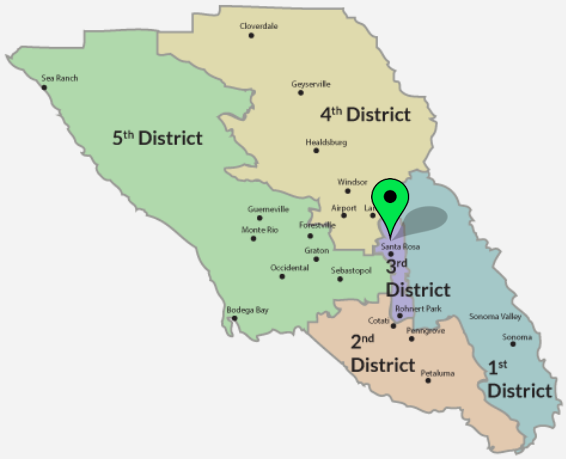
COMMUNITY BAPTIST CHURCH

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Reducing disparities in access to mental health services for African Americans

Program Location:
Santa Rosa, CA

For more information, go to:
http://cbcsr.org/



program demographics

Total numbers served: 3,319
(Duplicated)

age

0 to 15	36.4%
16 to 25	26.4%
26 to 59	26.0%
Unknown	6.9%
60+	4.4%

race/ethnicity

African American/Black	48.5%
White	17.1%
Hispanic/Latino	15.6%
Multiple categories*	7.0%
More than one race	6.3%
Native American	5.4%

**Unknown, Other, Asian/Pacific Islander*

language

English	87.5%
Unknown	6.8%
Spanish	5.6%
Other	0.1%

gender

Female	63.6%
Male	29.6%
Unknown	6.8%

WELLNESS • RECOVERY • RESILIENCE

program description (continued)

Safe Harbor Project is a multifaceted project utilizing various modalities to assist individuals and their families to gain knowledge and skills to enable them to better understand, manage and cope with issues that arise. Self help groups are facilitated by African American peers that represent an at-risk population to assist people to deal with "life-disputing" events, and provide education, support and referral using music therapy, gardening, etc.

contracted services

The following programs include promotion and education of mental health and suicide prevention resources:

- The Village Project emphasizes character building for children ages 8-12.
- Saturday Academy emphasizes character building for youth ages 12-18.
- Rites of Passage Program for youth 14 to 18.
- Safe Harbor Stress Reduction Program for adults.

Trainings:

- QPR (Question, Persuade, Refer) Training for Community Baptist Church Programs
- Mental Health First Aid (MHFA) Training

notable accomplishments

On May 23rd the Community Baptist Church Collaborative hosted the African American Mental Health Conference, "Out of the Darkness to Become the Light." Each Mind Matters and other mental health resources were given to 75 participants. Gigi Crowder, Dr. Josiah Rich, and Melba Smith discussed experiences of the African Americans struggling with mental health and substance use issues, and the effects of discrimination and racism.

Community Baptist Church Collaborative facilitated Question Persuade Refer (QPR) Certified Gatekeeper Workshops. The workshop goals are as follows:

- Enhance general awareness about suicide
- Teach the myths and facts about suicide
- Introduce the warning signs of suicidal thinking and behavior
- Teach three basic intervention skills that can help avert the tragedy of suicide.

Safe Harbor Project (SHP) offered "Music as Relief" at The Sam Jones Homeless Shelter which is part of Catholic Charities. SHP was invited to perform live music during the dinner hour providing stress reduction. Safe Harbor also performed at the 2017 CIBHS California Cultural Competence Summit in Santa Rosa.

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

council on aging
living better, together.

program description

Council on Aging (COA) will provide volunteer Senior Peer Support (SPS) to seniors 60 or older, who have an Axis-I diagnosis, residing in the broad geographic area served by the agency (Sonoma County cities of Santa Rosa, Sebastopol, Rohnert Park, Cotati, Windsor, Healdsburg, Cloverdale, Sonoma and their surrounding rural areas), and who require assistance as a means of maintaining their optimum level of functioning in the least restrictive setting possible.

contracted services

- Outreach strategies
- Recruitment and retention of Volunteers
- Training of volunteers
- Assessment of seniors referred for SPS services
- Care plans developed for seniors receiving SPS services
- Senior Peer Specialist

success story

"Dear Folks at COA, my thanks to the talented [SPS volunteer] for his work with me in the Peer Support Program. He has been a reliable, strong support to me as we worked together week by week to achieve the several goals I set out for myself. He has been a coach, a sounding board, a guide and a trustworthy professional style helper over the past few months. We got along very well and thanks to him I feel a lot better about my situation (which has a lot to do with the hardship of poverty.) My situation was able to shift due to new choices I have made with his input. Also, I'm learning to ask for what I need when I need it and I'm learning to go to the people who are willing and able to help me when I need the help! Thanks again to all of you on the team at the peer support program for the fine work you do!"

- Senior Peer Support client

COUNCIL ON AGING

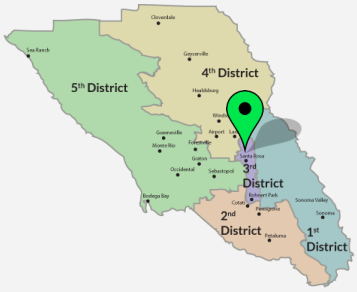
Program Name:
Senior Peer Support

MHSA Component:
System of Care - Community Services and Supports (CSS)

Initiative/Population:
Older Adult Intensive Services Full Service Partnership

Program Location:
Santa Rosa, CA

For more information, go to:
http://www.councilonaging.com/



program demographics

Total numbers served (Aggregate of quarterly reports): 123

age		race/ethnicity		language		gender	
60+	100.0%	White	92.7%	English	98.4%	Female	71.5%
		Other race/ethnicity	7.3%	Other language	1.6%	Male	28.5%

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

child parent institute

program description

The **Child Parent Institute (CPI)** participates in a community continuum of care, which includes screening, intervention, and support strategies, serves children and caregivers, and establishes a framework for success beyond a single program or strategy. CPI will provide Triple P (Positive Parenting Program) Levels 3, 4 and 5 in-home parent education and enhanced services that include mental health consultations. In addition, mental health consultations will be available to women living with or at-risk for Perinatal Mood Disorders.

The minimum number of clients to be served with this funding: 140 parents/caregivers. Children who have not received screening elsewhere (estimated 20 children) will receive the ASQ3 and ASQ-SE/ECBI.

contracted services

- Social/emotional & developmental screening of all children not previously screened, using ASQ 3 or ASQ-S/E
- Parents/caregivers will receive in-home Triple P Parenting services Levels 3, 4 and 5
- Mothers at risk of or experiencing perinatal mood disorders will receive individual counseling services in-home as well as appropriate resource and referral information (Target 40 women).
- Mental health services for high-risk families with additional mental health concerns of parent or child

EARLY CHILDHOOD MENTAL HEALTH (0-5) COLLABORATIVE:

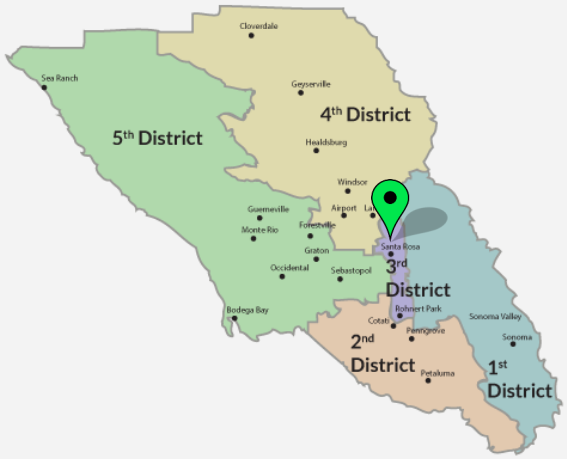
CHILD PARENT INSTITUTE

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Families of children 0-5 at risk of mental health problems

Program Location:
Santa Rosa, CA

For more information, go to:
http://www.calparents.org/



program demographics

Total numbers served: 549
(Aggregate of quarterly reports)

age	
0 to 15	39.0%
26 to 59	33.5%
Missing Data	19.7%
16 to 25	7.3%
60+	0.5%

race/ethnicity	
Hispanic	58.8%
White	32.2%
Missing Data	6.4%
African American	0.9%
Native American	0.9%
Asian	0.4%
Multi	0.4%

language	
English	52.1%
Spanish	47.0%
Missing Data	0.9%

gender	
Female	55.2%
Male	44.6%
Missing Data	0.2%

WELLNESS • RECOVERY • RESILIENCE

notable accomplishments

- **152** families received Triple P services
- **40** families received Level 3 Triple P services
- **112** families received Levels 4/5
- **4** families received Level 5
- **34** children received periodic developmental and social emotional screening
- **6** children were referred for further assessment
- **49** women were identified with Perinatal Mood Disorder (PMD) and were provided case management and treatment services
- **10** high risk families received brief consultations and were referred appropriately for mental health services

success story

One of the mothers served by the Perinatal Mood Disorder program this year was a Spanish-speaking mom with a 5 month old baby. She had an older child that she had left in Mexico with her mother when she came to the U.S. 10 years ago. She came hoping to make a better life for herself and to be able to send money home to her son. She has not seen him in 10 years and she has remarried and the baby was her second child. She was referred by a clinic due to continuing depression noted at well baby visits.

CPI's bilingual peer provider used the Mothers and Babies curriculum to increase the mom's focus on pleasant activities that she could do with her husband and her child. She started doing some floor activities with her baby. Mom also regularly used the mood scale to check in with herself to see how she was feeling and to help her husband understand her mood. CPI's provider helped her find more ways to stay connected with family and friends in Mexico and also to widen her circle of support in the U.S.

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

program description

The Sonoma County Department of Health Services Behavioral Health Division - Community Intervention Program (SCBH-CIP) funds **Drug Abuse Alternative Center (DAAC)** to increase access to mental health services to community members who are traditionally underserved or unserved by mental health services. DAAC's focus is to increase access to mental health services for people with substance use disorders.

CIP outstations a Sonoma County Behavioral Health staff psychiatrist at Santa Rosa Community Health Center's Turning Point Satellite Clinic, which is embedded in DAAC's Turning Point, a residential treatment program. Turning Point is a 112-bed site that serves both men and women specializing in substance use disorder treatment with a co-occurring mental health component. Treatment utilizes evidenced-based practices.

CIP-DAAC provides a mental health specialist to provide the following services:

- Screening of Turning Point residents for mental health concerns
- Care coordination with community psychiatrists

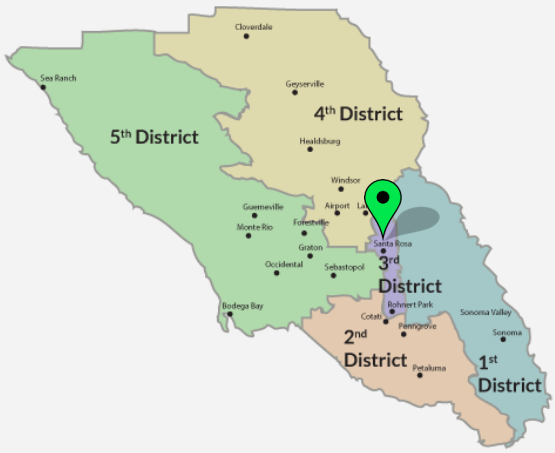
DRUG ABUSE ALTERNATIVES CENTER

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Community Intervention Program (CIP)

Program Location:
Santa Rosa, CA

For more information, go to:
http://www.daacinfo.org/



program demographics

Total numbers served: 208
(Aggregate of quarterly reports)

age

26 to 59	79.8%
16 to 25	17.8%
60+	2.4%

race/ethnicity

White	71.2%
African American	13.9%
Hispanic	9.1%
Multiple categories*	5.8%

**More than one race, Native American, Other*

language

English	86.1%
Spanish	13.9%

gender

Male	76.4%
Female	22.6%
Another gender identity	1.0%

WELLNESS • RECOVERY • RESILIENCE

program description (continued)

- Referral to psychiatric assessment to SCBH-CIP staff psychiatrist at Turning Point Satellite Clinic
- Treatment planning
- Referral and linkage to groups
- Individual Cognitive Behavioral Therapy
- Collateral coordination of care with other health providers

The overall goal of this program is to ensure at least 50% of clients with co-occurring Mental Health and Substance Use Disorder (SUD) successfully complete their treatment episode, or leave early with satisfactory progress.

Quality assurance measures include tracking referrals and outcomes, successful engagement and participation in group and/or individual sessions, and the measure of fidelity of the evidenced-based practices.

contracted services

- Screening for clients with co-occurring mental health concerns
- Referral to SCBH psychiatrist for evaluation
- Referral to co-occurring disorder groups
- Individual Cognitive Behavioral Therapy sessions
- Discharge

notable accomplishments

Through Quarter 2:

- **72** assessments were completed on DAAC clients
- **36** clients were referred to the SCBH psychiatrist or Santa Rosa Community Health for evaluation
- **67** clients were referred to the co-occurring disorders group
- Of the **80** clients who completed treatment, **81%** completed treatment successfully or left early with satisfactory progress
- The Mental Health Specialist provided **198** individual therapy sessions on-site to assessed clients

The Session Rating Scale (SRS) reviews Relationships, Goals and Topics, Approach or Method, and overall indicators as reported by clients (scale 1 to 10). The SRS scores through Quarter 2 were as follows:

- Relationships: “I feel heard, understood and respected." Average score = 8.6
- Goals and Topics: "We worked on and talked about what I wanted to work on and talk about." Average score = 8.5
- Approach or Method: “The therapist's approach is a good fit for me." Average score = 8.5
- Overall: "Overall, today's session was right for me." Average score = 8.5

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

early learning institute

program description

The **Early Learning Institute's (ELI)** Watch Me Grow (WMG) program serves families of children 0-5 across Sonoma County by:

a) providing comprehensive screenings to at-risk children who would otherwise not receive them
b) providing case management and referral assistance to families of children 0-5 for whom a screening identifies potential problems
c) providing mental-health support/positive parenting education services to parents of children with special needs and challenging behaviors, using Triple P (Positive Parenting Program) Levels 3 & 4 and/or the Parent Education and Support (PEAS) program.

contracted services

- Developmental and social-emotional screening, using evidence-based tools, the ASQ3 and ASQ/SE.
- Case management/facilitated referrals
- Navigation services
- Triple P and PEAS services for parent education and mental health support

notable accomplishments

- **418** children were given a periodic developmental and social emotional screening for the first time, using ASQ 3 and ASQ-S/E
- **434** children were rescreened
- **394** at risk families received case management and/or facilitated referrals
- **987** families received support/information to access services (navigation services)
- **44** individuals received either Triple P services, or Parenting Education and Support (PEAS), or both

EARLY CHILDHOOD MENTAL HEALTH (0-5) COLLABORATIVE:

EARLY LEARNING INSTITUTE

Program Name:
Watch Me Grow

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
High-risk children, birth to 5, and their families

Program Location:
Rohnert Park, CA

For more information, go to:
http://earlylearninginstitute.com/

program demographics

Total numbers served: 2,471
(Aggregate of quarterly reports)

age

26 to 59	48.9%
0 to 15	40.0%
Missing Data	8.0%
16 to 25	2.7%
60+	0.4%

race/ethnicity

Hispanic	54.3%
White	34.5%
Multi	4.4%
Missing Data	2.0%
African American	1.4%
Multiple categories*	1.3%
Asian	1.2%
Native American	0.9%

**Other, Declined to state, Pacific Islander*

language

English	58.5%
Spanish	41.3%
Other language	0.2%

gender

Female	51.1%
Male	48.9%

WELLNESS • RECOVERY • RESILIENCE

notable accomplishments (continued)

- **72%** of individuals receiving PEAS services reported a decrease in score on the Parental Stress Index

Watch Me Grow (WMG) continues to work in collaboration with a wide variety of community partners. They provide ASQ trainings and referral support to other screening partners, such as the Health Clinics and Community Action Partnership (CAP) Sonoma. They cross refer children with the Early Start program. WMG will continue to follow the children who do not qualify for Early Start, or who graduate early from Early Start services in order to monitor their development and refer back if the need arises.

WMG is working in partnership with Public Health Nursing to work out a system of non-duplicated referrals to Evidence-Based Home Visiting programs in Sonoma County. The WMG Navigator continues to be a hub for questions regarding services and referrals to various children's services birth through age 5 in Sonoma County. As more community partners are screening using the ASQ and occasionally the M-CHAT, it is vitally important that WMG continue to be screening the most vulnerable children so they can monitor the social-emotional health of the children.

ELI has been providing trainings to community programs including clinics and child care facilities in order to promote community screenings. They also participate in the Redwood Community Health Coalition (RCHC) Developmental Screening and Referral collaborative, which is working to streamline the referral system from the clinics to developmental services.

success stories

"I am very thankful the PEAS program exists. I knew I was not alone and my feelings were normal."

-ELI PEAS Parent

"I am thankful for your visit and for providing me with more resources where people can help me, what a beautiful program."

-ELI Watch Me Grow Parent

A concerned parent from out of state made a referral for her child with the WMG program. Her child had just been evaluated for services in their state for speech and occupational therapy, but their family was moving to Sonoma County in a couple months. She had no idea how to go about finding services for her child in this new environment. This mom was concerned that the move and all the changes would leave her child without services for a long period of time. His speech was quite delayed and they were only able to have a few sessions of private speech therapy before moving.

Fortunately, the WMG program was able to help her find the connections she needed to access services to their new school district. They were able to talk to teachers & get his information in before the moving trucks even arrived. She said, "He is doing great now & getting everything he needs. We are so grateful to your program, because without you, we couldn't have gotten started or known what to do".

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Goodwill Redwood Empire — Consumer Relations Program

program description

Working closely with Sonoma County Behavioral Health Division (SCBHD), the **Consumer Relations Program (CRP**) of Goodwill Industries of the Redwood Empire (GIRE) provides a peer perspective in transforming Sonoma County's mental health system to a recovery vision that is consumer-driven and holistic in its services and supports. CRP creates awareness of opportunities for involvement in system transformation activities.

Vision:

To vigorously promote peer perspectives and involvement in transforming the mental health delivery system through education, advocacy and employment.

GOODWILL INDUSTRIES OF THE REDWOOD EMPIRE (GIRE):

CONSUMER RELATIONS PROGRAM

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Consumer/Peer Support

Program Location:
Santa Rosa, CA

For more information, go to: http://www.gire.org/menus/programs.html

program demographics

Total numbers served: 283
(Aggregate of quarterly reports)

age

26 to 59	61.1%
60+	21.6%
Missing data	9.5%
16 to 25	4.6%
Declined to state	3.2%

race/ethnicity

White	69.3%
Missing data	8.8%
Multiple categories*	6.4%
Multi	6.0%
Hispanic	4.9%
African American	4.6%

**Declined to state, Asian, Native American*

language

English	86.2%
Missing data	9.5%
Multiple categories*	4.2%

**Spanish, Other, Declined to state*

gender

Female	62.9%
Male	30.0%
Multiple categories*	7.1%

**Missing data, Transgender*

WELLNESS • RECOVERY • RESILIENCE

contracted services

Consumer Education Coordinator recruits, trains, mentors and supports employees, and interns with lived mental health experience to work at mental health agencies and organizations. The program provides Peer Support training classes to those interested in employment in the mental health field.

Consumer Affairs Coordinator participates in County Quality Improvement activities, conducts extensive outreach to solicit ideas from consumers in the community, and facilitates the production of *Peer Voices Now!*, a newsletter by and for mental health peers and our community.

notable accomplishments

- **31** students were trained in mental health recovery and resiliency, communication, boundaries, codependency, co-occurring disorders, stigma, cultural responsiveness, mindfulness, crisis intervention and suicide prevention, emotional literacy, compassion fatigue and job satisfaction, Wellness Recovery Action Plan, PTSD, trauma-informed care, self-care, advocacy, community resources, employment in the mental health workforce, and more.
- **67** Consumer/Peer surveys were completed and significantly added peer voices to the MHSA Three-Year Integrated Plan Community Planning Process for 2017-2020.
- **20** Peer Support Specialists graduated from the Peer Support Specialist Training Program in FY 16-17. **4** graduates were hired in the local mental health workforce.
- The Consumer Education Coordinator facilitated a weekly support group for SCBH Peer Support Specialists that addressed both work and wellness issues that affected the participants' potential to succeed at work. **31** support group sessions were held in FY 16-17. Participants were engaged and involved in the group process. Group members were supportive of each other, and stated that they felt the group has been helpful.
- CRP delivered a presentation at the Regional Policy Forum on Peer Support Services.
- CRP delivered a presentation with Disability Rights California on A.B.L.E. accounts - the 2014 federal law benefitting Supplemental Security Income (SSI) recipients.
- CRP conducted community screenings of "Healing Voices", a mental health social action documentary, viewed by **112** people.

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Goodwill Redwood Empire — Interlink Self-Help Center (Peer Support, Hope, Empowerment)

program description

Interlink Self-Help Center, a program of Goodwill Industries of the Redwood Empire (GIRE) is managed and operated by consumers, for consumers, and all services are free. The focus is on maintaining an emotionally and physically safe environment that is stigma free and empowering. Six days a week members can take part in a wide variety of services including support groups, socialization activities, one-to-one peer support, goal planning, education and employment support, help identifying and accessing community resources and more.

Mission

The mission of Interlink Self-Help Center is to provide a safe environment in which those facing mental health challenges can improve their quality of life through self-help, mutual support and empowerment.

GOODWILL INDUSTRIES OF THE REDWOOD EMPIRE (GIRE):

INTERLINK SELF-HELP CENTER

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Consumer/Peer Support

Program Location:
Santa Rosa, CA

For more information, go to:
http://www.interlinkselfhelpcenter.org/

program demographics

Total numbers served: 446
(Aggregate of quarterly reports)

age

26 to 59	65.5%
60+	28.3%
16 to 25	5.6%
Declined to state	0.7%

race/ethnicity

White	76.5%
Multi	11.4%
Hispanic	4.7%
Other	4.7%
Multiple categories*	2.7%

**Native American, African American, Pacific Islander, Asian*

language

English	93.5%
Spanish	4.3%
Other	2.0%
Declined to state	0.2%

gender

Male	61.4%
Female	37.2%
Other identity	1.3%

WELLNESS • RECOVERY • RESILIENCE

contracted services

- Peer Counseling
- Linkage to Services
- Intern Program
- Peer Counseling Training
- Warm Line
- Social Activities

program statistics

New Members:	113
Average Daily Attendance:	42
MHSA Facilitated Groups held:	340
Peer Counseling Sessions:	11,463
Socialization Activities:	393
Individuals Completing Peer Counseling Training:	37
MHSA Counseling Sessions:	3,552
Number of interns trained:	5

notable accomplishments

There was a noticeable trend of better communication between members and staff this year. Members are clearly building more trust with staff and amongst themselves, resulting in more in-depth peer support sessions and more instances of members accessing each other for support. Members are also socializing together outside of the Center much more than in the past. Activities included going to the Wednesday Night Market, movies, the flea market, the mall, and coffee shops.

Interlink's Mental Health Month forum in May was "Nurturing Joy" with Dr. Michael Frederick Kozart, MD, which was well-attended, very interactive and inspirational. It was a refreshing way to frame and look at managing one's life through a more positive lens than is often suggested. Guided by the membership, Interlink dropped the poorly attended Thursday movie, in favor of increasing the Introduction to Peer Support class to twice a week and it continues to be well attended.

The Center responded to member requests for more information on nutrition by holding a variety of pick-up groups on the subject. For the March forum, Barbara Shreibman, RN, MSN, FNP-BC, presented on Nutrition and Mental Health and it was a big hit. Staff research and presentations on mindfulness and communications skills have been successful in refreshing staff commitment to their work; enabling them to go deeper in support of Interlink members and each other.

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Goodwill Redwood Empire

PPRC Petaluma Peer Recovery Center

program description

The **Petaluma Peer Recovery Center (PPRC)** is a consumer-run program dedicated to empowering the local mental health community through peer support and education. PPRC sponsors lectures, groups, workshops, and activities as defined as needed by the target population.

The target population is adult mental health consumers over the age of 18, specifically those who are diagnosed with severe and persistent mental illness. The PPRC works closely with Sonoma County Behavioral Health Division – Community Mental Health Centers in Petaluma to ensure mental health consumers with severe and persistent mental illness are able to benefit from the PPRC.

contracted services

- Recovery-Oriented Groups
- Lectures
- Workshops
- Activities
- Outreach

GOODWILL INDUSTRIES OF THE REDWOOD EMPIRE (GIRE):

PETALUMA PEER RECOVERY CENTER

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Consumer/Peer Support

Program Location:
Petaluma, CA

For more information, go to:
https://petalumaprp.wordpress.com/

program demographics

Total numbers served: 158
(Aggregate of quarterly reports)

age

26 to 59	74.1%
16 to 25	16.5%
60+	9.5%

race/ethnicity

White	55.1%
Hispanic	31.6%
Multiple categories*	10.1%
More than one race	3.2%

**Asian, African American, Native American*

language

English	83.5%
Spanish	12.7%
Other language	3.8%

gender

Female	51.3%
Male	48.7%

WELLNESS • RECOVERY • RESILIENCE

program statistics

Total Instances of Service:	1,698
Number of sign-ins:	466
Number of groups and activities:	188

notable accomplishments

During Fiscal Year 2016-17, the staff of PPRC embraced the opportunity for education about peer support and its services both in the Center, and in the community. PPRC engaged its participants, local service providers, and community members to learn more about the values and principles of peer support and to recognize and understand the mission of the Center. They began facilitating a twice weekly educational group, "Learning Peer Support," "Health, Wealth, and Happiness" and a "TED Talks Series." Other support groups initiated in 2016-17 included "Women's Group," "Advocacy: Peer, Self, and Beyond," and "Member's Meeting."

During FY 16-17, PPRC revamped its brochure and schedule, initiated hosting a monthly support group at the local homeless shelter and service center, and revived rarely used space within the Center by adding comfortable furniture. They increased the availability of art supplies, educational videos, and online programs. They welcomed a new staff member while maintaining a staffing plan of three. Community engagement continued with attendance at community panel discussions, County hearings, and service provider meetings around mental health and substance abuse in the South County area.

Newly energized partnerships include those with the Mary Isaak Center, Petaluma's homeless services center and shelter, and Petaluma People Services Center's counseling department. Both of these agencies have welcomed PPRC presentations, and the Mary Isaak Center began hosting a monthly support group facilitated by PPRC Staff.

Individualized peer counseling sessions continue to be valued, well utilized by members, and appreciated. Participants continue to respond positively, explaining the one-on-one support is often helpful in clarifying perspective and gaining further insight into a situation or theme.

PPRC's established ability to grow, as evidenced in FY 16-17 by its staff and membership's increased investment in communal collaboration and success, continue to make the Center a valued community asset that serves those wanting sincere connection, personal resiliency, and whole-person wellness.

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Goodwill Redwood Empire

GOODWILL INDUSTRIES OF THE REDWOOD EMPIRE (GIRE)

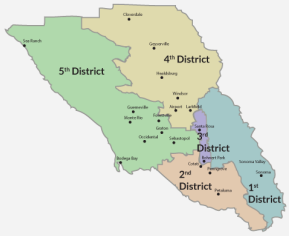
PEER WARMLINE CONNECTION OF SONOMA COUNTY

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Peers/Consumers

Program Location:
Sonoma County, CA

For more information, go to:
http://www.gire.org/menus/programs.html



program description

The **Peer Warmline Connection of Sonoma County** program provides compassionate & culturally appropriate services to consumers of mental health services. The Warmline is a peer-run program that is administratively controlled and operated by mental health consumers and emphasizes self-help as its operational approach.

The focus of the Warmline is to provide a telephone connection for people with mental health challenges who are isolated in their homes, feel the need to speak with another consumer about a variety of issues related to their mental health and/or are requesting information about a county resource in or out of the mental health system. The Warmline provides individuals with the opportunity to talk through their situations, vent their feelings, or make a connection that reduces their feelings of isolation.

contracted services

- Warmline calls
- Program Outreach
- Warmline Advisory Committee
- Peer Counseling Training Program

notable accomplishments

The Warmline continues to expand as a viable option for people seeking support, connection to resources or just someone to talk to. The past year has seen a dramatic reduction in the need for crisis response among callers. Need is being shifted from mental health mental providers (23.6%) and friends and family (18.2%). The Warmline seems to be alleviating some of the community impact on mental health services, therefore reducing costs.

Approximately 30-35% of callers who completed the Warmline survey said they would have called either the ER/CSU or a mental health provider if they hadn't called the Warmline. Another 33% said they would have called a family member or friend. This seems to indicate the Warmline is helping to alleviate some of the stress carried by family members and mental health providers as well as reducing mental health services costs.

The Warmline continues to help meet the needs of people who feel isolated, are seeking support in coping with a difficult situation, or just want to talk. Of the callers who completed the Warmline survey, 36% said they would not have called anyone else. Nearly 100% of callers reported feeling somewhat to much less isolated.

program demographics

Total numbers served (aggregate of quarterly reports): 1,986

age		race/ethnicity		language		gender	
26 to 59	49.9%	White	60.9%	English	76.6%	Male	42.6%
60+	25.2%	Missing Data	14.6%	Missing Data	14.1%	Female	35.6%
Missing Data	14.0%	Declined to State	8.8%	Declined to state	8.6%	Multiple categories*	13.5%
Declined to state	8.7%	Hispanic	5.4%	Multiple categories*	0.7%	Declined to state	8.3%
16 to 25	2.1%	Pacific Islander	3.9%	*Spanish, Other language		*Missing data, Transgender, Other identity	
0 to 15	0.1%	Other	3.2%				
		Multi	1.5%				
		Multiple categories*	0.9%				
		African American	0.8%				
		*Asian, Native American					

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Goodwill Redwood Empire
Wellness and Advocacy Center
Our center is a non-profit Mental Health consumer-operated self-help center

program description

The **Wellness and Advocacy Center** works with the Corrine Camp Consumer Advisory Committee, Sonoma County Behavioral Health, consumers, and family organizations to develop and support a wellness, recovery, and support center for consumers facing the challenges of serious mental illness. The center has been fully planned, developed and operated by consumers embracing a wellness mindset that fosters recovery for everyone. Self-help and client-run programs have been developed for job search classes, peer advocacy training, art classes with the Center's Art Director, peer-led self-help/support groups, supportive employment volunteer opportunities, cooking and life skills classes, a community garden and daytime socialization/recreational activities.

The Wellness Center serves the priority population identified in the Mental Health Services Act (MHSA) Plan, which includes transition age young adults, adults, older adults with serious mental illness, and consumer and family organizations. Persons of all sexual orientations, genders, ethnicities, and races are welcomed and served at the Wellness Center. The center serves approximately 35-50 consumers per day and has a strong recovery orientation focusing on programs and services that will empower individuals to take control of their lives, manage their most distressing difficulties, and enjoy meaningful lives as full members of the community.

The Center provides consumers with a rich, culturally diverse environment in which everyone, regardless of age, gender, sexual preference, or race, is able to access services and support. The center advances recovery and resiliency through its programs and supports.

GOODWILL INDUSTRIES OF THE REDWOOD EMPIRE (GIRE):

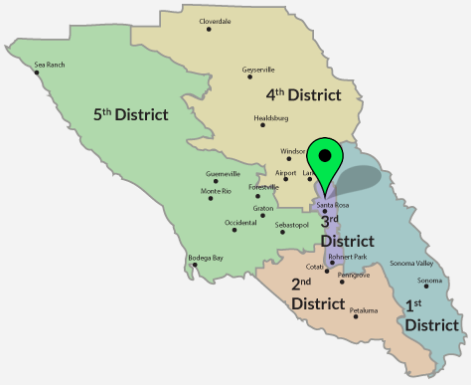
WELLNESS AND ADVOCACY CENTER

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Consumer/Peer Support

Program Location:
Santa Rosa, CA

For more information, go to:
http://wellnessandadvocacy.org/



program demographics

Total service contacts: 9,236

(Demographics below are for new members)

age	
26 to 59	65.4%
16 to 25	13.5%
Declined to state	11.5%
60+	9.6%

race/ethnicity	
White	51.0%
Multiple categories*	18.3%
Decline to state	16.3%
More than one race	14.4%

**Hispanic, African American, Asian, Other, Missing data*

language	
English	80.8%
Declined to state	14.4%
Missing data	2.9%
Other language	1.9%

gender	
Female	40.4%
Male	40.4%
Multiple categories*	19.2%

**Declined to state, Transgender*

WELLNESS • RECOVERY • RESILIENCE

program description (continued)

Through the center, consumers are able to access peer support to reduce isolation, participate in recreation and socialization activities, and learn about resources and community supports. Additionally, it is a place where consumers can take part in a variety of trainings, acquire life skills such as cooking, participate in a community garden, explore alternative treatment options, access employment assistance, volunteer opportunities and work experience.

contracted services

- Computer lab, Arts & Crafts Studio, Speakers Group, Wellness Workshops
- Job Search and Employment Readiness Activities
- Peer Counseling Sessions
- Peer Counseling Training
- Restaurant Intern Program
- Social Activities
- Outreach to outside agencies

notable accomplishments

During this fiscal year, **2,362** duplicated individuals participated in an array of groups including Community meetings, Empowering Ourselves Toward Success, Open Mic, Peer Support, Mining the Source writing group, Quarter Life group, Stretch/Walk group, Living with Depression, and Voices and Visions support group. **882** duplicated individuals were involved in individual peer support meetings.

125 duplicated individuals actively engaged in job seeking activities-including on-line search & application. **49** duplicated individuals completed their resume with guidance from the Career & Computer Lab Specialist.

Members' art work was displayed at the Sonoma County Fair art show in July. Local consignment shop, Made Local Marketplace is providing consignment for Wellness and Advocacy artists, which offers great exposure to the larger community. The member art show Outside the Bubble was showcased at the Sonoma Artists' Guild through September. This offered the opportunity for five member artists to display and sell their work. A senior art show featuring works by older adult members also ran this quarter at the Finley Community Center. Several artists were featured at the Cultural Competence Summit in March and art sales were active. The Art Director provided outreach, including display and sale of member works, at Sonoma County's Behavioral Health Recovery Fair in May, as part of May is Mental Health Awareness Month.

The Garden Project gained significant momentum this fiscal year. One center member individually tended a vegetable and herb garden from spring through fall. In September, this same individual was hired as the new Garden Project Coordinator for the Wellness and Advocacy Center.


MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Jewish Family and Children's Services
OF SAN FRANCISCO, THE PENINSULA, MARIN AND SONOMA COUNTIES
parentsplace

program description

Jewish Family and Children's Services' (JFCS) Parents Place program provides a range of services that address the psycho-social and early intervention needs of Sonoma County children 0-5 who exhibit challenging behaviors that are difficult to understand or manage, and that can lead to difficulties at home, school or in the community. This program also provides early intervention educational services to parents and care givers to ameliorate the problems in the children.

contracted services

- Psychological assessments
- Level 2 Triple P seminars
- Level 3 Triple P Discussion Group
- Level 3 Triple P Primary Care
- Level 4 Triple P Individual
- Developmental and social/emotional screening of children who have not been screened by referring entity
- Evaluation

EARLY CHILDHOOD MENTAL HEALTH (0-5) COLLABORATIVE:

JEWISH FAMILY & CHILDREN'S SERVICES

Program Name:
Parents Place

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Children 0-5 years old

Program Location:
Santa Rosa, CA

For more information, go to:
http://parentsplaceonline.org/location/sonoma-county/

program demographics

Total numbers served: 501
(Aggregate of quarterly reports)

age

26 to 59	43.7%
0 to 15	39.1%
Missing data	15.8%
16 to 25	1.0%
60+	0.4%

race/ethnicity

White	44.7%
Missing data	25.1%
Hispanic	25.0%
Multiple categories*	3.0%
More than one race	2.2%

**African American, Asian, Native American, Pacific Islander*

language

English	58.9%
Spanish	21.6%
Missing data	19.4%
Other language	0.2%

gender

Missing data	64.1%
Female	21.0%
Male	15.0%

WELLNESS • RECOVERY • RESILIENCE

notable accomplishments

- 9 psychological assessments completed for children 0-5
- 15 Level 2 Triple P seminars offered (138 attendees)
- 111 families received Level 3, 4, or 5 Triple P services
- 89 individuals served in Level 3 Triple P Discussion Groups
- 9 individuals served in Level 3 Individual Sessions
- 13 individuals served in Level 4 or 5 Triple P services
- 3 children received developmental and social/emotional screening, using ASQ-3 and ASQ:SE-2

Impacts from Triple P client evaluations:

"Now I use positive reinforcement which I learned because of these Triple P meetings. It works like magic. I work half as hard and get twice the results."

"This program has absolutely opened my eyes to how supportive services can be."

"I feel so much more confident in my ability to help my child than before. The help, support, suggestions and willingness to listen to our circumstances have been invaluable."

"This program inspired me to trust my intuition. I learned new strategies to calm myself and help my children do the same during high stress times. I also learned to tune into my children's needs in a more productive way. I will now try to spend more time with each child (and make it special!). This is the best parenting service our family has had. Thank you!"

"Everything I have learned in this program works."

"I am so very grateful for the opportunity to have my son assessed. I learned so much and while it is hard to accept when your child is struggling it feels so much more manageable now that I understand why." (Psychological Assessments)

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Jewish Family and Children's Services
OF SAN FRANCISCO,THE PENINSULA, MARIN AND SONOMA COUNTIES

JEWISH FAMILY & CHILDREN'S SERVICES

Program Name:
Caring Connections

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Older adults

Program Location:
Santa Rosa, CA

For more information, go to:
http://www.jfcs.org

program description

Jewish Family and Children's Services (JFCS) Seniors At Home program in Sonoma County helps older adults and their families each year. One key component of these services involves matching clients with caring volunteers who want to give back in meaningful ways to make a positive difference in seniors' lives.

Caring Connections (CC) Program provides focused support to older clients recovering from depression or other challenging behavioral health issues. Concerned community members serve as volunteer visitors to these clients playing an integral role in their continued recovery with targeted support.

Clients referred by Sonoma County Behavioral Health can receive a minimum of 6 months of volunteer support. Volunteer Visitors visit weekly, working directly with an older adult to help him or her combat isolation, loneliness, and depression. Recruitment, screening, training and ongoing support of volunteers are provided by Seniors At Home.

contracted services

- Caring Connection Services
- Clinical Supervision of Caring Connection Volunteers
- Caring Connection volunteers, and staff attend training coordinated by West County Community Services (WCCS)

notable accomplishments

Clients, in conversation with their volunteers and program coordinator, stated unanimous satisfaction with the CC program, and expressed gratitude for their volunteers. Only one client had family present in their lives, and this family reported the program is "helpful - the only time my mom gets out to be around people, she really likes her volunteer and is touched by knowing that the volunteer is not paid to do this." Clients refer to their volunteers as "wonderful" and "very kind."

JFCS continued to implement the Futures and Friendship scales as a limited means to capture outcome data. In addition, some of the qualitative outcomes achieved by CC clients include:

- identifying means to increase income and securing a job,
- attending senior center activities
- identifying and applying for local rides program and adult day program
- sharing art activities with CC volunteer

These activities represent progress made toward client-centered goals for increasing social engagement with the support of the CC volunteer.

program demographics

Total numbers served (aggregate of quarterly reports): 23

age		race/ethnicity		language	
60+	100.0%	White	95.7%	English	100.0%
		Other race/ethnicity	4.3%		

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

LATINO Service Providers ¡Unidos Obtendremos Resultados!

program description

Latino Service Providers (LSP) was founded in 1989 by Latino leaders in education, government, and the social service sectors. LSP is currently comprised of over 1,000 members from neighborhood and community groups, mental health programs, public and private health service providers, education, law enforcement, immigration and naturalization agencies, social service agencies, community based organizations, city and county governments, criminal justice systems, and the business community.

The mission of LSP is to serve and strengthen Hispanic families and children by building healthy communities and reducing disparities in Sonoma County. LSP's vision is a community where Latinos are fully integrated by having equal opportunities, support, and access to services in the pursuit of a higher quality of life.

To reduce disparities, Latino Service Providers utilizes a networking model among community providers to exchange information about activities and resources that will promote economic stability, educational success, increase access to healthcare and mental health services and resources, housing, and legal services, reduce the stigma associated with Behavioral Health/ Mental Health issues, and address other areas of interest for families throughout Sonoma County.

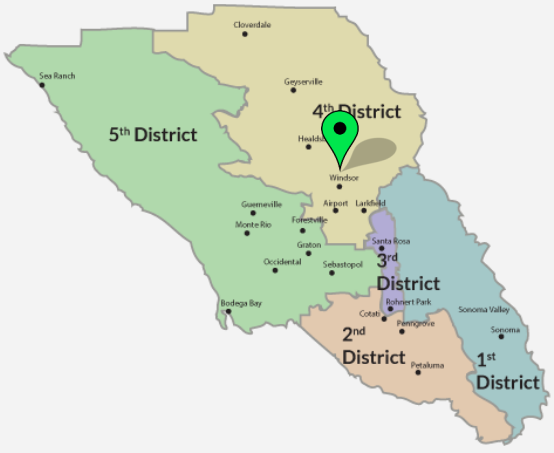
LATINO SERVICE PROVIDERS

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
California Reducing Disparities Initiative

Program Location:
Windsor, CA - Serves all of Sonoma County

For more information, go to:
http://www.latinoserviceproviders.org/



program demographics

Total numbers served: 85,625
(Duplicated)

age

Unknown	71.3%
26 to 59	19.6%
16 to 25	5.8%
60+	2.3%
0 to 15	0.6%
Declined to state	0.3%

race/ethnicity

Hispanic/Latino	59.0%
White	33.1%
Unknown	5.1%
Asian/Pacific Islander	1.3%
More than one race	0.6%
Native American	0.4%
African American/Black	0.3%
Other	0.2%
Declined to state	0.1%

language

Unknown	54.3%
English	32.6%
Spanish	12.9%
Other language	0.3%

gender

Female	75.1%
Male	21.3%
Unknown	3.6%
Transgender	0.1%
Declined to state	0.01%

contracted services

- Convene and facilitate monthly LSP meetings hosted by LSP members throughout the Sonoma County regions
- Maintain an Electronic Newsletter distribution system - A system of email distribution. Members submit announcements that are added to the e-newsletter, distributed one to three times per week via email
- Social media and communications: maintain website and other social media outlets for member communication. Continue media outreach using Spanish radio, TV, print
- Targeted engagement strategies to promote awareness and increase membership. Provide technical support when needed.
- Participate in community events, i.e. health fairs, to increase awareness and educate community on available social service resources.
- Develop website for recruitment of bilingual/bicultural staff for Sonoma County Behavioral Health Division (SC-BHD) Workforce
- Under the direction of the WET Specialist of Sonoma County develop a list of contacts at colleges, universities and community colleges in Bay Area
- Under the direction of the Sonoma County WET Specialist participate in activities to support bilingual/bicultural applicants to apply to Sonoma County Behavioral Health Division jobs
- Participate in North Bay Collaborative meetings
- Participate in local Workforce, Education and Training (WET) Advisory Board
- Coordinate with WET Specialist to organize and sponsor annual job fair to recruit bilingual/ bicultural clinicians

notable accomplishments

The Mi Futuro symposium was a success. The event exposed over 300 students and young participants between the ages of 16-30 to the field of behavior health and primary healthcare through hands-on interactive labs and intimate workshops on mental health, access to financial aid, mentoring and internships, and careers in behavioral health (mental health and substance abuse bilingual service providers).

The event helped raise community awareness of the need for a bilingual mental health workforce. Keynote speaker Sergio Aguilar-Gaxiola, UC Davis Center for Reducing Disparities was fabulous, as was Jason Carter, Gang Prevention Partnership, with the City of Santa Rosa. Twenty eight exhibitors were involved.

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

program description

Sonoma County Department of Health Services Behavioral Health Division has partnered with Santa Rosa Police Department and Sonoma County Sheriff's Office to implement the Sonoma County Behavioral Health (SC-BHD) Mobile Support Team. The **Mobile Support Team (MST)** is staffed by behavioral health professional who provide field-based support to law enforcement officers responding to a behavioral health crisis. The goals of MST are:

- Promote the safety and emotional stability of community members experiencing behavioral health crises;
- Minimize further deterioration of community members experiencing behavioral health crises;
- Help community members experiencing crises to obtain ongoing care and treatment;
- Prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate.

MST is staffed by licensed mental health clinicians, certified substance abuse specialists, post-graduate registered interns, mental health consumers and family members. MST staff receives specialized field safety training by law enforcement partners. MST operates during peak activity hours and days as informed by ongoing data review and coordination with law

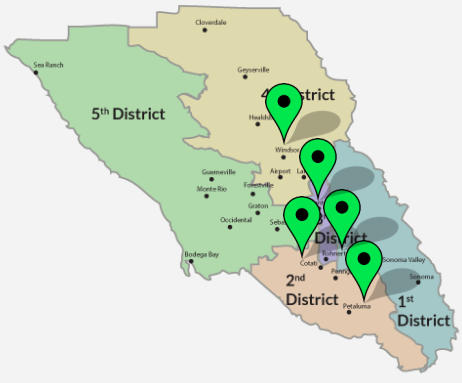
SONOMA COUNTY BEHAVIORAL HEALTH: MOBILE SUPPORT TEAM (MST)

MHSA Component:
Innovation (INN)

Initiative/Population:
Sonoma County residents who are experiencing a behavioral health crisis that requires law enforcement intervention

Operational Areas:
Santa Rosa, Windsor, Rohnert Park, Cotati, and Petaluma

For more information, go to:
www.sonoma-county.org/health/services/citmst.asp



program demographics

age	
26 to 59	50.3%
16 to 25	21.1%
60+	13.6%
0 to 15	11.1%
Unknown	3.9%

race	
White	45.7%
Unknown	41.9%
More than one race	4.3%
Other	3.4%
Black/African-American	3.2%
Asian/Pacific Islander	1.0%
Native American	0.3%
Declined to state	0.2%

ethnicity	
Not Hispanic	45.3%
Unknown	44.1%
Hispanic/Latino	10.4%
Declined to State	0.2%

language	
English	94.4%
Unknown Language	4.3%
Not Collected	0.5%
Spanish	0.5%
American Sign Language	0.2%
Japanese	0.2%

sexual orientation	
Unknown	81.8%
Heterosexual	15.2%
Gay/Lesbian	1.2%
Declined to state	0.9%
Bisexual	0.5%
Other	0.5%

gender	
Female	50.3%
Male	48.4%
Transgender	1.0%
Unknown	0.3%

program description (continued)

enforcement agencies. MST staff participates in law enforcement shift briefings to maintain open communication.

MST staff responds in the field to law enforcement requests to behavioral health crises. Once the scene is secured, MST provides mental health and substance use disorders interventions to individuals experiencing a behavioral health crisis, including an evidence-based assessment that assists in determining if the individual should be placed on an involuntary hold. MST staff provides crisis intervention, support and referrals to medical and social services as needed. Follow-up services are provided by mental health consumers and mental health consumers' family members to help link community members to ongoing care and treatment to mitigate future crisis.

program statistics

587 - Total number of unduplicated clients served

684 - Total number of episodes

1,595 - Total number of encounters

658 - Crisis calls received

177 - Crisis calls that resulted in a 5150* hold

**Section 5150 is a section of the California Welfare and Institutions Code (WIC) (in particular, the Lanterman–Petris–Short Act or "LPS") which authorizes a qualified officer or clinician to involuntarily confine a person suspected to have a mental disorder that makes him or her a danger to themselves, a danger to others, and/or gravely disabled. A qualified officer, which includes any California peace officer, as well as any specifically designated county clinician, can request the confinement after signing a written declaration.*

WELLNESS • RECOVERY • RESILIENCE

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

NAMI Sonoma County
National Alliance on Mental Illness

program description

National Alliance on Mental Illness (NAMI) Sonoma County provides services to families of mental health consumers. These services are provided within the Community Services & Supports (CSS) component of the Mental Health Services Act. NAMI provides family based advocacy, education and support services to families and caregivers of family members experiencing first onset of a serious psychiatric illness. NAMI services include Warmline calls, support groups and educational classes for families. The purpose of the NAMI Family Support Project is to provide support to family members of mental health consumers and to link them with ongoing NAMI family support groups and activities.

The Family Support Project provides a family support Warmline to accept referrals and to make follow up calls to family members who are referred by the Sonoma County Behavioral Health Division (SC-BHD) Mobile Support Team (MST). The Family Support Project provides immediate follow up support to family members of people experiencing a mental health crisis and who have been referred by the MST at SC-BHD.

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) SONOMA COUNTY

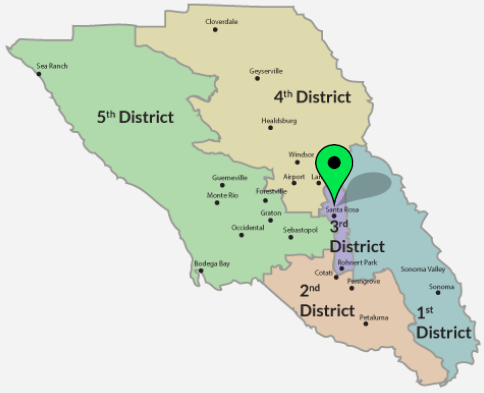
Program Name:
Family Based Advocacy, Education, and Support Services and Mobile Support Team

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Family members

Program Location:
Santa Rosa, CA

For more information, go to:
http://www.namisonomacounty.org/

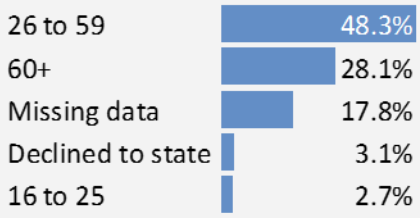


program demographics

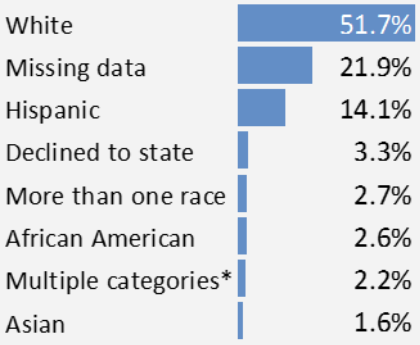
Total numbers served: 859

(Aggregate of quarterly reports)

age

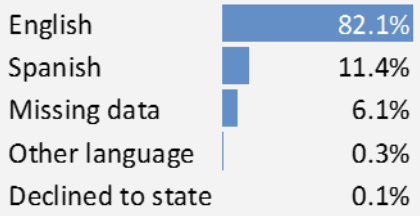


race/ethnicity

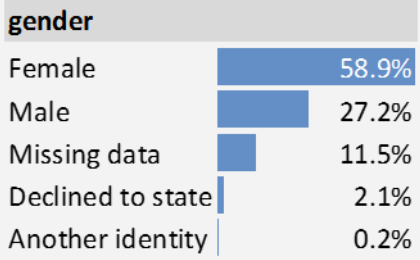


**Other, Pacific Islander, Native American*

language



gender



contracted services

- Warmline
- Advocacy and outreach focusing on underserved communities
- Referrals to NAMI Signature Programs through Warmline
- Families enrolled in Educational Groups (Family to Family, Homefront, Peer to Peer, Basics) through Warmline
- Families attending Support Groups (Family Support Group, Connection) through Warmline
- MST referrals
- MST families enrolled in Family to Family Group, Homefront, or Basics
- MST families referred to NAMI Signature Programs (Family Support Group, Family to Family, Basics, Homefront)
- Referrals to other resources

notable accomplishments

During the fiscal year, there were:

- 215 new individuals referred to the Family Support Project
- 386 new callers to the Warmline
- More than 80 events where NAMI conducted outreach or tabled
- More than 450 duplicated individuals that attended the Family Support Group
- More than 360 duplicated individuals that attended the NAMI Connection Group

NAMI hosted their first Self-Care Fair at the end of June. It was well attended considering it was the first of its kind. NAMI anticipates it becoming an annual event. The fair was a collaboration between Buckelew Programs, Goodwill Industries of the Redwood Empire and NAMI Sonoma County.

"I just love coming here. The group is so supportive!"

- Family Support Group attendee

“At times it feels like you are the only person I can talk to about my daughters depression.”

- Family Support Project mother

"NAMI Sonoma has given me the ability to understand my daughter and be an advocate for her. I feel I understand her mental illness and can support her."

- Family-to-Family class attendee

"I remember when I first called you, I was in a crisis. I am now in a much better state! Thank you so much!"

- Warmline caller, expressing their gratitude

"I have been alone in a bubble all this time, I didn't know there were other people who understood the challenges I face with my loved one!"

- Woman referred to Family Support Group

“Thank you so much for your help… You were the only one who gave us any information or referrals that worked out. Thank you for everything.”

- Individual served by the Family Support Project

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

NAMI Sonoma County
National Alliance on Mental Illness

program description

The **National Alliance on Mental Illness (NAMI) Sonoma County** provides services to families of mental health consumers. These services are provided within the Prevention and Early Intervention (PEI) component of the Mental Health Services Act. NAMI provides family based advocacy, education and support services to families & caregivers of family members experiencing first onset of a serious psychiatric illness. NAMI services include Warmline calls, support groups and educational classes for families. The purpose of the NAMI Family Support Project is to provide support to family members of mental health consumers and to link them with ongoing NAMI family support groups and activities.

The Family Support Project provides a family support Warmline to accept referrals and to make follow up calls to family members who are referred by the Sonoma County Behavioral Health Division (SC-BHD). The Family Support Project provides immediate follow up support to family members of people experiencing a mental health crisis who have been referred by the Crisis Assessment, Prevention and Education (CAPE) Team and the Full Service Partnership Transitional Age Youth (TAY) Team at SC-BHD.

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) SONOMA COUNTY

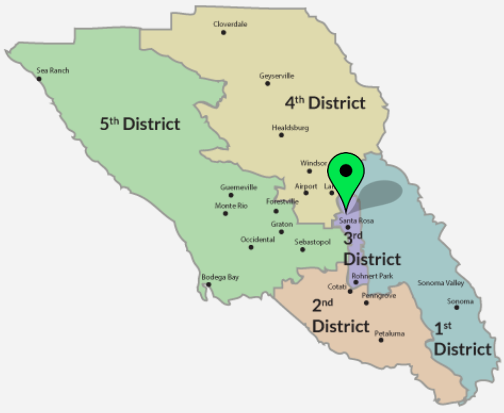
Program Name:
Family Based Advocacy, Education, & Support Services for CAPE and TAY Teams

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Family members

Program Location:
Santa Rosa, CA

For more information, go to:
http://www.namisonomacounty.org/



program demographics

Total numbers served: 89

(Aggregate of quarterly reports)

age

26 to 59	55.1%
Missing data	22.5%
60+	19.1%
16 to 25	3.4%

race/ethnicity

Hispanic	41.6%
Multiple categories*	30.3%
White	28.1%

**Missing data, More than one race, Asian*

language

English	56.2%
Spanish	40.4%
Missing data	3.4%

gender

Female	77.5%
Male	11.2%
Missing data	11.2%

WELLNESS • RECOVERY • RESILIENCE

contracted services

- CAPE Team referrals
- CAPE families enrolled in Family to Family Group or Basics
- CAPE families referred to NAMI Signature Programs
- TAY Team referrals
- TAY families enrolled in Family to Family Group or Basics
- TAY families referred to NAMI Signature Programs

notable accomplishments

The NAMI Peer and Family Support Manager receives referrals after the CAPE team has been in contact with an individual and family in crisis or from clinicians of the TAY program to provide additional support and resources to the families that are receiving TAY services. They receive referrals for parents, stepparents, guardians, foster parents, and grandparents. Upon referral, NAMI staff reaches out to the designated family members to offer them educational information related to mental health and to provide support through empathetic listening.

NAMI makes four attempts to initiate contact by phone (over a two month time span) and leave voicemail messages if possible. If after four tries the contact is not reciprocated, NAMI will then terminate contact. They leave the referred family with instruction for contacting NAMI when needed.

Once they have successfully connected with the individual referred to them, NAMI gauges the level of contact based on their specific needs and requests. Sometimes they conduct three to four sessions with the individual referred and sometimes they are in contact several times per week. On average, they are in contact with the referred families once per week for three to four months. All referred families are encouraged to reach out to NAMI as needed as well.

Upon contact, staff refers family members to NAMI Sonoma County's own Signature Programs: Family Support Groups (offered in English and Spanish), Family-to-Family educational classes (offered in English and Spanish), Connection Support Groups (for peers) and Peer-to-Peer educational classes. They also provide referrals to resources in the community beyond NAMI's programs as appropriate.

During the fiscal year, NAMI received approximately **75** family referrals from CAPE and approximately **14** from the TAY Team. Families share that they appreciate the support and feel like NAMI staff are often the only people they can talk to about what is going on with their loved one. Having the Family Support Specialist follow through with phone calls allows family members to brainstorm innovative ideas and strategies to practice self-care and be an advocate for their loved ones.

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

SONOMA COUNTY Human Services
council on aging — living better, together.
WEST COUNTY COMMUNITY SERVICES
Jewish Family and Children's Services — OF SAN FRANCISCO, THE PENINSULA, MARIN AND SONOMA COUNTIES
PETALUMA PEOPLE SERVICES CENTER

program description

The **Older Adult Collaborative (OAC)** is a five agency collaborative comprised of: the Sonoma County Human Services Department – Adult & Aging Division (A&A), Council on Aging (COA), Jewish Family and Children's Services (JFCS), Petaluma People Services Center (PPSC) and West County Community Services (WCCS).

The members of the collaborative are the primary senior services agencies in Sonoma County, serving older adults (60+) in their respective communities. The services provided include case management, nutrition programs, adult day services, peer support, counseling, and transportation programs, among others. COA, JFCS, PPSC, and WCCS are all nonprofit agencies, while A&A is a Division of Sonoma County Human Services Department.

Incorporated into the services mentioned above, the OAC implements Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors), an evidence-based prevention and early intervention model designed to reduce depression and suicide among older adults. The primary components of the Healthy IDEAS intervention include:

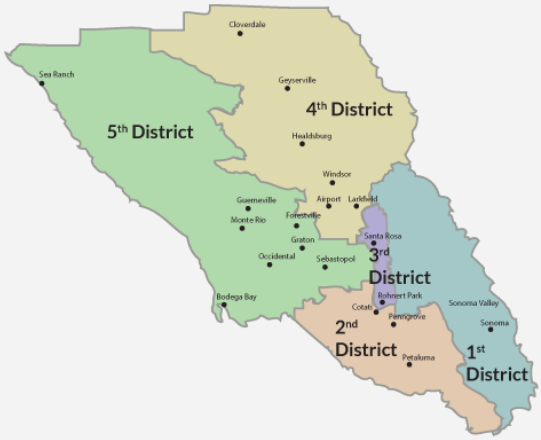
1) Administration of a depression screening by trained agency staff who are supervised by licensed professionals
2) Educating older adults about depression & its treatment
3) Referral of case managed clients to various community resources, including medical providers, in-home counseling, and/or psychotherapy for those older adults identified as at risk for depression
4) When appropriate, working with older adults to empower themselves through identification and completion of an activity goal, thereby learning how their own engagement in daily activities can reduce their depression symptoms.

SONOMA COUNTY HUMAN SERVICES: OLDER ADULT COLLABORATIVE

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Reducing depression in older adults

Program Location:
Sonoma County, CA



program demographics

Total numbers served: 3,738
(Aggregate of quarterly reports)

age	
60+	100.0%

race/ethnicity	
White	77.0%
Hispanic	12.4%
Asian	3.3%
African American	2.4%
Missing data	1.4%
Other	1.3%
Native American	1.2%
More than one race	0.6%
Pacific Islander	0.4%

language	
English	85.9%
Spanish	9.5%
Other language	4.2%
Missing data	0.3%

gender	
Female	68.0%
Male	32.0%
Another gender identity	0.03%

John Lyhne, playing with his band at his 70th birthday party

contracted services

- Healthy IDEAS intervention
  - Depression screening
  - Mental health education
  - Resource referrals
  - Establishing goals for activity engagement
- In-Home Counseling

notable accomplishments

- 3,738 older adults were offered depression screenings
- 3,206 older adults were screened for depression
- 544 older adults were referred for Mental Health Services
- 1,469 home visits were made to older adults
- 1,313 phone calls were made to older adults
- 440 community resource referrals were given to older adults

success story

Submitted by a Human Services Department Adult & Aging Social Worker:

On 2/1/17, John Lyhne was enrolled to Healthy IDEAS as a Linkages Case Management client. His initial PHQ9 was a score of 13, indicating "Moderate Depression." While John had no previous history of depression, he was having difficulty coping with his health condition, Inclusion Body Mitosis (IBM) and a recent diagnosis of Leukemia. IBM is causing weakness and wasting in John's muscles. He uses a walker, has frequent falls and will eventually be bed-bound totally dependent on others for care.

John's usual strategy for coping with life's challenges is music. He played bass in a band. He met with fellow band members two times per week to jam. But with the progression of his illness, John was fast losing his ability to compress the bass strings. This meant losing the one social and creative outlet that fed his soul and kept depression at bay.

The Healthy IDEAS model allowed John and I to work together to think outside the box and identify a goal that would make a difference in his mood. With some research John was able to identify a synthesizer that would allow him to gently tap keys with little muscle needed while still producing the bass sound and style. Learning a new instrument with depression and severe health conditions is a daunting task! Using the Healthy IDEAS Behavioral Activation techniques, we were able to break that large goal into smaller manageable goals.

1. Research instruments
2. Find funding/Purchase
3. Practice/Learn new instrument
4. Play with the band.

John had the coaching, support and encouragement of his Case Manager at each step of the way. This program has been essential in supporting clients with financial challenges to reach their goals.

On 5/10/17, John's Post PHQ9 score had dropped to 2, indicating no depression, a drastic improvement. At his 70th birthday party in September, John and his band played and put on a great show for his friends and family.

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

POSITIVE IMAGES

program description

Positive Images is an agency in Sonoma County serving the unique needs of Lesbian, Gay, Bisexual, Transgender, Queer, plus (LGBTQ+) youth ages 12 to 24. For the past 25 years, Positive Images has provided programs and services that help youth, service providers and the public develop positive, healthy, life affirming, and accepting behaviors and views of personal expression of gender identity and sexual preference. These services include:

- Engaging youth in programs, activities and services that increase resiliency and reduce risk
- Educating youth, schools, and service providers to reduce stigma and increase acceptance
- Training providers about LGBTQ+ issues

Services target LGBTQ+ youth of color ages 12-24 and their parents and caregivers. The purpose of this work is to reduce disparities in access to mental health services by decreasing stigma focusing on the LGBTQ+ population.

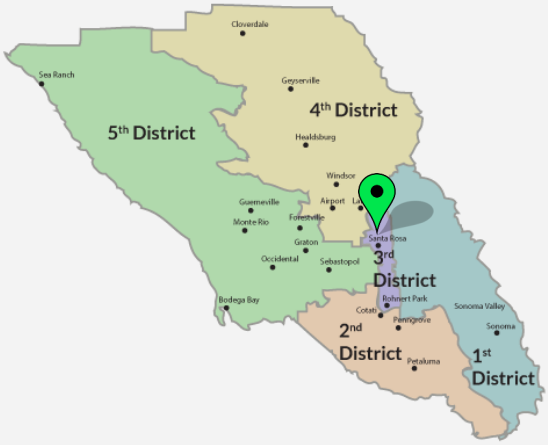
POSITIVE IMAGES

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Reducing Disparities in Access to the LGBTQ+ TAY community

Program Location:
Santa Rosa, CA

For more information, go to:
http://www.posimages.org/



program demographics

Total numbers served: 3,635
(Duplicated)

age

Unknown	62.2%
0 to 15	13.6%
16 to 25	13.3%
26 to 59	8.3%
60+	2.6%
Declined to state	0.1%

race/ethnicity

Unknown	64.8%
White	15.1%
Hispanic/Latino	9.4%
More than one race	4.3%
Multiple categories*	3.3%
Declined to state	1.9%
African American/Black	0.8%
Asian/Pacific Islander	0.5%

**Other, Native American*

language

Unknown	83.2%
English	16.8%
Other language	0.1%

gender

Unknown	69.5%
Female	14.3%
Male	10.1%
Transgender	6.1%
Declined to state	0.03%

contracted services

- Provide panel presentations to professionals and youth in the community that teach indicators of mental distress specific to the LGBTQ+ population
- Recruit LGBTQ+ youth and adults to participate in peer support and leadership training
- Provide public awareness activities to support outreach to youth and adults about Positive Images' LGBTQ+ resources and services
- Provide community information & referrals to Positive Images members on appropriate behavioral health resources
- Provide peer support meetings to Positive Images' members

notable accomplishments

Positive Images (PI) hit a marker of about 500+ people reached this year through their outreach efforts. PI staff attended about 8 events and had great feedback from the community about their existence in Sonoma County.

Through attendance at many of these events, Positive Images was able to reach out to the LGBTQ+ family communities and work with Trauma informed Care providers. They have built new and strong connections within Sonoma County. Collaborations with community members and other agencies/coalitions have offered new ways of visibility for the LGBTQ+ community in Sonoma County.

Positive Images weekly LGBTQ+ Support Groups have consistently seen an average of 30 members attending their meetings. Each month they have seen about 2 new additions to the membership. The Trans Youth Support groups have about 5-10 members every other week.

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

PETALUMA PEOPLE SERVICES CENTER

program description

Petaluma People Services Center (PPSC) will help to develop a community continuum of care, which includes screening, intervention, and support strategies, serves children and caregivers, and establishes a framework for success beyond a single program or strategy. PPSC, in partnership with Petaluma City School District (PCSD) will provide developmental and social-emotional screening for children in high-risk situations with no other access to screening, Triple P parent education, Triple P mental health services to families of children 0-5, and screening, referral, and treatment services for Perinatal Mood Disorder (PMD).

Triple-P Positive Parenting Program - Levels 2-5; Individual and group formats. Parent Education, early intervention, linkages and referrals to other resources and assistance.

Treatment and screening of PMD - Clinically relevant and appropriate strategies will be employed, which can include one-on-one therapy, referral to primary care physician for medication evaluation and assistance, or referral to appropriate community provider for group or individualized treatment.

Services are provided at McDowell School (office located in Library) Monday-Friday approximately 8am to 7pm. Services are also available in client homes, and at PPSC's agency site (1500 Petaluma Blvd South) by appointment.

EARLY CHILDHOOD MENTAL HEALTH (0-5) COLLABORATIVE:

PETALUMA PEOPLE SERVICES CENTER

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Children 0-5 years old

Program Location:
Petaluma, CA

For more information, go to:
http://petalumapeople.org/

contracted services

- Social/emotional and developmental screening, using ASQ 3 or ASQ-S/E when children were not screened by referring agency or medical home
- Level 2 Triple P—Positive Parenting Program seminars at community sites
- Triple P levels 3, 3 Discussion, 4, 4 Group, & 5
- Screening, referral, and treatment services for Perinatal Mood Disorder

program demographics

Total numbers served: 146

(Aggregate of quarterly reports)

age

0 to 15	54.1%
26 to 59	32.9%
16 to 25	13.0%

race/ethnicity

Hispanic	93.2%
White	6.2%
Missing data	0.7%

language

Spanish	95.2%
English	4.8%

gender

Female	67.8%
Male	32.2%

WELLNESS • RECOVERY • RESILIENCE

notable accomplishments

- 27 children received social/emotional and developmental screening, using ASQ-3 or ASQ:SE-2
- 47 individuals received Triple P services, including 7 individuals in Level 4 Group Sessions and 37 individuals in Level 4 or 5 Individual Sessions
- 1 woman received treatment services for Perinatal Mood Disorder (PMD)

success story

A single mother of twin 7 month old girls participated in Triple P Level 4/5. One twin was biting and the ASQSE, ASQSE3 results indicated a referral to Early Start for further evaluation. Mom was contacted and participating in that program within 2 weeks. The other twin was crying more than usual every day and mom did not know what to do.

Using Tip Sheets and a monitoring form, mom and child were both participating in placing happy faces on the chart with problem resolved in 3 weeks. Once the one twin stopped crying, the other twin started so mom repeated the steps to resolve the problem. Now mom and the twins have utilized the happy faces and chart as part of their routine which has helped mom to be closer and more loving to the twins.

Another area of concern for mom was how and when to reduce the use of diapers. Parent Educator utilized Tip Sheets to educate mother on when and how to transition twins when time is right. Mother has stayed in touch with Parent Educator and states how thankful she is for the program because she understands how problems can affect her relationship with her children. Mom says she will stay informed of Triple P programs for future use.

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

PETALUMA PEOPLE SERVICES CENTER

program description

Petaluma People Services Center's (PPSC) Mary Isaak Center (MIC) will house mental health services and extend existing outreach activities to facilitate increased access to mental health services specifically among homeless populations who are uninsured, and who may be Medi-Cal beneficiaries who are able to receive appropriate care in the homeless shelter setting.

PPSC will provide 23-26 hours of direct community based mental health services to individuals, couples, and families who are residents at the Mary Isaak Center in Petaluma and to individuals residing in transition housing units in Petaluma. Services are prioritized as follows:

- Single people in the emergency shelter on the 1st floor after initial goals have been met and after completing 3 months of stable residency
- Families residing on the 2nd floor (transitional housing, families may stay up to 2 years)
- Single people residing in COTS community-based transitional housing.

contracted services

- Psychotherapy and or psycho-educational groups weekly
- Outpatient mental health services to individuals and couples utilizing best practices, including Brief and Strategic Therapy, Cognitive Behavioral Therapy (8-10 individual sessions)
- Sign clients up for Medi-Cal & other eligibility benefits

PETALUMA PEOPLE SERVICES CENTER

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Community Intervention Program (CIP) - Individuals who are homeless and receiving services at the Committee on the Shelterless (COTS) shelter, Mary Isaak Center

Program Location:
Petaluma, CA

For more information, go to:
http://petalumapeople.org/

notable accomplishments

Group sessions were well attended and client feedback on adaptation skills, art therapy, ACEs (Adverse Childhood Experiences) and one-on-one group work was also very effective and well received.

program demographics

Total numbers served: 636
(Aggregate of quarterly reports)

age

26 to 59	76.7%
60+	15.1%
16 to 25	4.4%
0 to 15	3.8%

race/ethnicity

White	83.3%
African American	7.5%
Hispanic	6.8%
Multiple categories*	2.4%

**Asian, More than one race, Declined to state, Native American, Pacific Islander*

language

English	97.6%
Spanish	2.2%
Other language	0.2%

gender

Male	54.2%
Female	45.4%
Another identity	0.3%

WELLNESS • RECOVERY • RESILIENCE

notable accomplishments (continued)

Good Morning Group: Focused on mindfulness based practices, particularly around relaxation, self-control, and affect regulation. Promotes self-care and responsibility for one's feelings, behaviors and actions. The group averages between 25-30 participants. Clients have shown consistent improvement around socialization and interpersonal communication leading to overall reduction in stress and anxiety in shelter.

Stress Relief for Families: Topics are meant to introduce the idea that play and relaxation is important for parents. Some activities are meant to give parents ideas about ways to interact with their child/children. Activities have included guided meditation, grounding techniques, relaxation through mandala coloring, and various other art-related activities. The average attendance to this group is between 8-10.

Seeking Safety Group: Consists of an empirically validated program focusing on cognitive behavioral therapies and interventions that serve to assist residents in attaining safety from the effects of trauma and substance abuse. The group averages between 25-30 participants. Residents showed more focus and integration as evidenced by increased engagement in group & completion of homework.

Safe Healing and Learning Family Group: Focused on communication, parent/child dynamics, relaxation and play therapy integrated with the needs of the children. Families were very engaged in group discussion and psycho-education around child development. Clients actively asked questions and utilized peer support to further knowledge of positive parent child practices.

Drama Therapy Group: Focused on creative Drama Therapy expression to target and alleviate trauma-related symptoms through storytelling, one-on-one dialogues, mask work, mask making, personal journey journals, monologues. Clients have shown increase in expression of personal feelings and ability to recognize when feelings have become overwhelming, particularly due to traumatic association. Clients use previously learned relaxation techniques to manage their symptoms, including progressive relaxation and controlled breathing.

Men's Group: Focused on issues specific to men, including changing male roles in society, interpersonal communication, changes in family dynamics, depression & anxiety, & nurturing. Group averages 8-10 people per session. Men have shown an increase in social skills as related to gender issues as evidenced by self-report and observation. The group has shown a reduction in stress related to interpersonal communication, particularly in the dorms & during the evenings. Group members have shown an increase in resiliency & a reduction in depressive symptoms as evidenced by more engagement in group and desire to be more involved in their daily affairs.

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

PS+

Cloverdale Unified School District

Petaluma City Schools

Cotati-Rohnert Park Unified School District

Healdsburg Unified School District

West Sonoma County Union High School District

Center Point DAAC
Drug Abuse Alternatives Center

NAMI Sonoma County
National Alliance on Mental Illness

Community SOS Counseling

West County Community Services

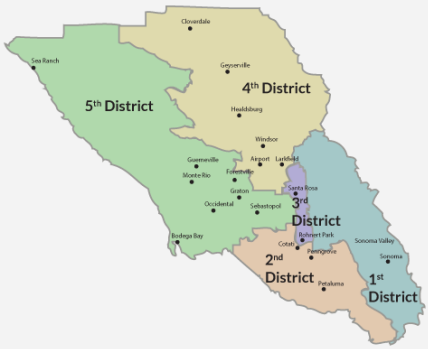
Windsor Unified School District
Over 150 Years of Excellence

PROJECT SUCCESS+

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Student Assistance Program - School-aged youth ages 13 to 18 years

Program Location:
Sonoma County, CA



program description

The **Sonoma County Project SUCCESS+ (Schools Using Coordinated Community Efforts to Strengthen Students) Collaborative** was formed to ensure the development and coordination of a countywide prevention and early intervention system of care for adolescents at 16 mainstream and alternative high schools in Sonoma County.

In FY 16-17, membership in the Collaborative consisted of six districts (Petaluma, Cotati-Rohnert Park, Windsor, Cloverdale, Healdsburg, and West Sonoma County) and included partner community-based organizations for service delivery (West County Community Services, Drug Abuse Alternatives Center, SOS Counseling and National Alliance for Mental Illness). The contract was managed by the Health Policy, Planning and Evaluation (HPPE) division of the Sonoma County Health Services Department.

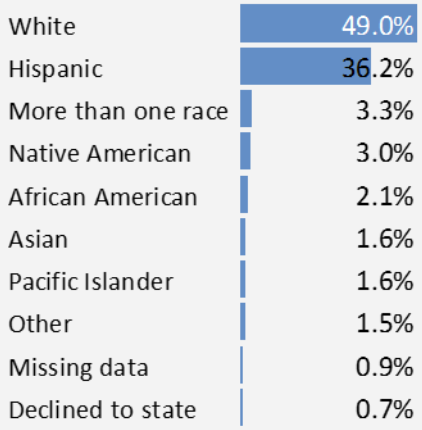
Project SUCCESS is an evidence-based student assistance program (NREPP) which is also listed as Tier 1 for the Sonoma County Upstream Investments Initiative Portfolio. Enhancements were added to the model, with developer-input, as Project SUCCESS+ (or PS+) to address a broader spectrum of behavioral health issues increasing emphasis on mental health issues through the delivery of culturally appropriate prevention education, early identification, screening strategies, individual and group level interventions, and referrals for needed services.

program demographics

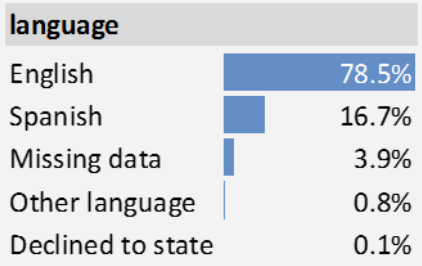
Total numbers served: 1,496
(Aggregate of quarterly reports)

age

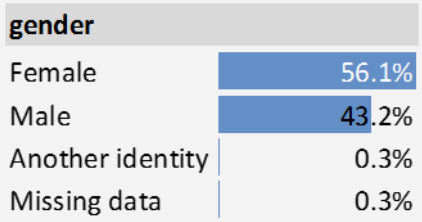
race/ethnicity



language



gender



contracted services

- Prevention Education Series (PES)
- Screening
- Individual and Group Level Interventions
- Family engagement and parent programs
- Referral and Resources
- School Staff Development
- School-wide Awareness and Outreach
- Community Coalitions
- Yearly evaluation report

notable accomplishments

Prevention Education Series (PES): Overall survey data aggregated across all schools for FY 16-17 shows that **2,134** of the 2,710 students **(78.7%)** participating in PES and taking the survey have increased their knowledge on either Alcohol and Other Drugs (AOD) or Mental Health issues. PES topics included:

- Mental Health Promotion
- Resiliency Stress/Coping Skills
- AOD Risks and Prevention
- "The Other Side of Cannabis" and Marijuana Prevention

Schoolwide Prevention Activities:

- **54** activities
- **8,755** participants

Parent Engagement Activities:

- **22** activities
- **1,675** participants
- **90.3%** of parents/guardians completing surveys showed increased knowledge of the mental health/AOD prevention topic presented (or about the PS+ program)
- **88.7%** surveyed showed increased confidence in being able to apply what they learned or in discussing the topic with their children

School Staff Presentations:

- **24** activities
- **641** participants
- **87.1%** of staff completing surveys showed increased knowledge of the mental health/AOD prevention topic presented (or about the PS+ program)
- **75.1%** surveyed showed increased confidence in being able to apply what they learned

There were **996** participants in individual level interventions and **784** students received individual screenings. There were **389** students that participated in at least three group level interventions. The focus of groups included: Anger Management, Health and Wellness, Coping Skills, Stress and Anxiety Reduction, Social Skills and Study Skills.

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

program description

The purpose of Mental Health Services Act (MHSA) Community Services and Supports Community Intervention Program is to directly address barriers to accessibility and provide culturally/linguistically competent services by partnering with **Sonoma County Indian Health Project (SCIHP),** who has demonstrated significant experience serving diverse ethnic and cultural communities. SCIHP will house mental health services and extend existing outreach activities to facilitate increased access to mental health services specifically among ethnic/linguistic minority populations who are uninsured, and who may be Medi-Cal beneficiaries who are able to receive appropriate care in the primary care setting.

SCIHP will expand the mental health services delivery in order to provide a coordinated system of care to its patients in a manner that increases the availability of integrated mental health, medical, and other social services, and will enhance the quality of health care services available with an emphasis on services to underserved ethnic and cultural populations.

Sonoma County Behavioral Health (SCBH) contracts for a structured approach to meeting the mental health needs of SCIHP clients. There are four types of service and specific criteria for each service type will guide access and utilization of mental health services. The four service levels are:

- Service Type 1. Psychiatric consultation, training and education to primary care providers
- Service Type 2. Face-to-face psychiatric consultation (time limited)
- Service Type 3. On-going psychiatric treatment/management
- Service Type 4. Non-physician mental health services

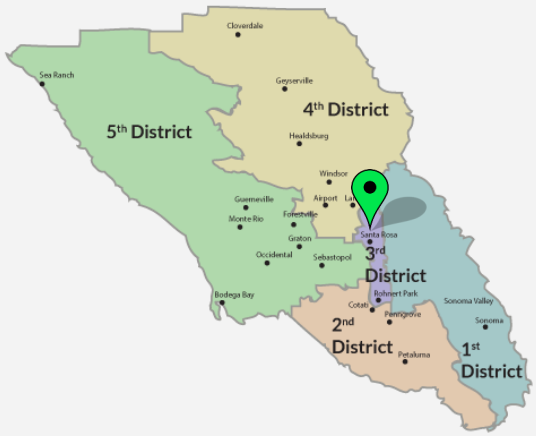
SONOMA COUNTY INDIAN HEALTH PROJECT

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Community Intervention Program (CIP) - Native Americans

Program Location:
Santa Rosa, CA

For more information, go to:
http://scihp.org/services/behavioral-health-services/



program demographics

Total numbers served: 392

(Aggregate of quarterly reports)

age

26 to 59	56.4%
60+	39.3%
16 to 25	2.8%
0 to 15	1.5%

race/ethnicity

Native American	87.0%
More than one race	6.6%
White	4.8%
Other race/ethnicity	1.5%

language

English	100.0%

gender

Female	55.9%
Male	44.1%

WELLNESS • RECOVERY • RESILIENCE

contracted services

- Psychiatric services including medication support
- Psychiatric consultation to primary care providers and other providers in the clinics
- Provide support to psychiatrists to ensure on-going psychiatric treatment and management. Provide assistance to ensure smooth bi-directional referral between clinic and Sonoma County Behavioral Health Division
- Provide case management to assist people with mental health issues receiving psychiatry services in establishing eligibility for and gaining access to federal, state, and local programs that provide or financially support the provision of medical, social, housing, education, employment, or other related services. This includes providing follow-up to ensure service options are accessed.

notable accomplishments

Psychiatric Case Management:

A total of **157** duplicated clients were provided case management support during this fiscal year. A total of **16** also received psychotherapy services. A total of **12** referrals and follow-ups were made to Roseland Pediatrics psychiatry services for children and adolescents. A total of **48** referrals were made to Brookwood Health Center adult psychiatry services for clients not meeting Medi-Cal eligibility.

Psychiatry:

A total of **392** duplicated clients were provided psychiatric evaluation and medication management during this fiscal year. Services occurred over the course of **1,057** visits.

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.



SONOMA COUNTY
INDIAN HEALTH PROJECT

program description

Sonoma County Indian Health Project (SCIHP) provides services to Native American tribes of Northern California, Pomo, Miwok, Wappo and other tribe members from other nations who reside in Sonoma County. Services provided include medical and dental clinic, behavioral health, pharmacy, diabetes program, WIC, Nutrition/Senior Lunch, and Community Health Outreach. The clinic is also a social network gathering place for Native people to meet and support each other.

contracted services

- Facilitate presentations and workshops conducted by Native American Health experts addressing obstacles to Native Americans seeking mental health services through education and outreach to the Native community to foster normalcy for accessing mental health services at SCIHP
- Recruit Native "Aunties and Uncles" and 5 Native American mentors to provide support services to transition age youth and families who will be trained to increase their awareness of signs and symptoms of mental illness and to be proficient in accessing resources available in the community
- Provide routine screening for depression for transition age youth ages 15-24 in the medical clinic

SONOMA COUNTY INDIAN HEALTH PROJECT

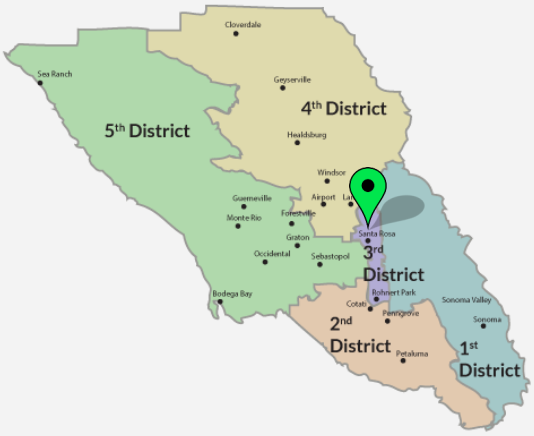
Program Name:
Aunties and Uncles

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Transition Age Youth

Program Location:
Santa Rosa, CA

For more information, go to:
http://scihp.org/services/behavioral-health-services/



program demographics

Total numbers served: 1,379
(Duplicated)

age

16 to 25	89.1%
0 to 15	10.9%

race/ethnicity

Native American	87.9%
Hispanic/Latino	5.1%
African American/Black	3.9%
White	2.9%
Unknown	0.1%

language

English	98.9%
Unknown	1.1%

gender

Female	65.3%
Male	34.7%

notable accomplishments

In partnership with MHSA funding, SCIHP Behavioral Health staff was able to take its next step in outreach to underserved tribes. For four weeks during the summer of 2017, the Aunties and Uncles staff organized and facilitated a weekly summer youth program at the Kashia reservation's Community Center. The program was an unprecedented collaboration, bringing together SCIHP staff, Coleen McCloud with the Community Center, as well as Kashia families. Fourteen unduplicated youth attended throughout the four weeks of the program, reaching middle-school ages. The activities included rock painting, beading, traditional regalia, and clay molding. The activities were well-received by the youth overall, and they particularly loved the rock painting, eagerly finding new rocks on which to paint.

Cecilia Dawson, SCIHP's Outreach Worker, led a presentation on the use of dentalium in traditional regalia, explaining that dentalium shells were at one time used as money by local Natives. This represented an opportunity to facilitate positive social connection and build a bridge between SCIHP Mental Health staff and a respected community worker within the Kashia community, creating a foundation of trust with the goal of reducing stigma around receiving mental health services.

SCIHP's 2nd Annual Memorial Gathering was held with great attendance and positive outcome in July at Ya Ka Ama. 225 were present in total, including the entirety of the Behavioral Health staff, who were available for one-on-one sessions throughout the gathering. 90% of attendance was Native Americans. The majority of those in attendance from the community had lost someone to suicide, experienced a recent death in their community, or were there to support a loved one who had lost someone to suicide.

This event was powerful community-based evidence showing that when the Sonoma County Native community is offered a Mental Health wellness opportunity in a way that works for them, they will participate. As Cecilia Dawson said, "Every dance and song sung is medicine, prayer is healing in our traditional way." This event represents a yearly opportunity to heal together, build resiliency, create new relationships, increase the visibility and acceptance of SCIHP's mental health services, and reduce the stigma around losing a loved one to suicide.

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Santa Rosa Community Health Centers

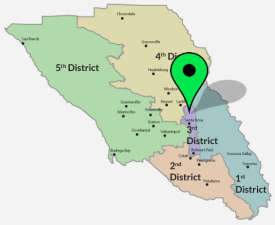
SANTA ROSA COMMUNITY HEALTH CENTERS

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Community Intervention Program (CIP)

Program Location:
Santa Rosa, CA

For more information, go to:
http://srhealthcenters.org/



program description

This Mental Health Services Act (MHSA) Community Services and Supports Community Intervention program is an outreach strategy to directly address barriers to access and provide culturally and linguistically competent services, integrated mental health and medical services, and a coordinated system of care by partnering with **Santa Rosa Community Health Centers (SRCHC)**. SRCHC has demonstrated significant experience serving diverse ethnic and cultural communities. SRCHC will provide:

- Psychiatry and associated nursing case management services
- Integrated health services with the SRCHC's mental health and medical services
- A strengthened bi-directional referral process and collaboration between the SRCHC and the County's public mental health system to facilitate increased access specifically among ethnic/linguistic minority populations and to promote integrated health care.

contracted services

- Psychiatric consultation, training and education to primary care providers
- Face-to-face psychiatric consultation (time limited)
- On-going psychiatric treatment/management
- Nurse case management

notable accomplishments

A team of psychiatrists have presented training materials on the safe management of high-risk medications to primary care staff and trainees at Santa Rosa Community Health and are in conversation with the Nurse Practitioner and Family Medicine Residency programs to develop a new comprehensive Mental Health curriculum.

Nurse case management for patients on therapeutic medications to support their mental health outcomes continues to be critical for monitoring adherence to treatment regimes. It has been very effective to have the case management team also use a non-licensed coordinator. This has been particularly important with linking transitioning services.

program demographics

Total numbers served (aggregate of quarterly reports): 497

age		race/ethnicity		language		gender	
26 to 59	54.3%	White	64.6%	English	82.5%	Female	50.9%
0 to 15	24.5%	Hispanic	24.3%	Spanish	14.9%	Male	48.9%
16 to 25	12.1%	Missing data	4.2%	Missing data	2.0%	Another identity	0.2%
60+	9.1%	African American	3.8%	Other language	0.6%		
		Multiple categories*	2.6%				
		More than one race	0.4%				

**Native American, Asian, Pacific Islander*

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

Santa Rosa Community Health Centers

program description

The **Santa Rosa Community Health Centers (SRCHC)** MHSA PEI contract goals are as follows:

- Ensure earlier access to mental health services, to lower the incidence of mental illness and suicide, to enhance wellness and resilience, and to reduce stigma and discrimination in Sonoma County for children from early childhood through the School years.
- Engage children, youth and their parents prior to the development of serious mental illness or serious emotional disturbances and to alleviate the need for additional mental health; or to transition the individual to extended mental health treatment.
- Build capacity for mental health prevention and early intervention services at sites where people go for other daily activities (e.g., health providers, education facilities, and community organizations).

contracted services

- Triple P (Positive Parenting Program) interventions for Latino teens, parents and children at one school-based Health Center and/or the Lombardi Health Center and/or school site
- Community Outreach to promote early intervention and reduce stigma
- Student Assistance Programs
- Early Screening for identification of behavioral health issues early enough to reduce escalation

SANTA ROSA COMMUNITY HEALTH CENTERS

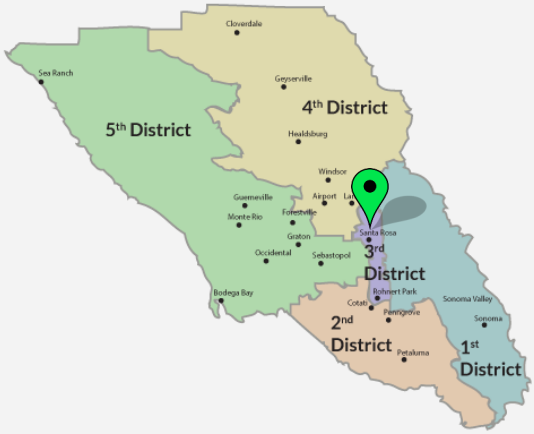
Program Name:
Early Childhood Education

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
School-Linked Student Assistance Programs for ages 5-18

Program Location:
Santa Rosa, CA

For more information, go to:
http://srhealthcenters.org/



program demographics

Total numbers served: 712
(Aggregate of quarterly reports)

age

26 to 59	54.2%
0 to 15	24.6%
16 to 25	16.7%
60+	4.5%

race/ethnicity

Hispanic	58.4%
White	22.9%
Missing data	13.8%
Multiple categories*	2.7%
African American	2.2%

**Native American, Asian, Pacific Islander, More than one race*

language

English	55.1%
Spanish	44.8%
Other language	0.1%

gender

Female	66.6%
Male	33.4%

WELLNESS • RECOVERY • RESILIENCE

contracted services (continued)

- Brief Therapy
- Patient Support Groups
- Parent Child Interaction Therapy (PCIT) early intervention services to parents of children in preschool or elementary school

notable accomplishments

Triple P was expanded to Vista Family Health Center during this fiscal year, in addition to two Spanish language series at Roseland Pediatrics. SRCHC also continued to utilize some of the Triple P principles and materials in a drop-in program at their Lombardi location that is part of integrated medical visits.

The Mental Health Educator noticed a sense of empowerment in the parents who participate. The parents report feeling more confident about using different parenting strategies and appreciate the opportunity to learn and discuss the specific challenges that can be associated with parenting in a different cultural environment, one that can bring new parenting expectations and/or may be different than what they may have grown up with themselves.

PCIT enrollment is starting to grow. It continues to be a high-value program for helping improve the quality of interactions between parents and young children. It is even being considered for use as a model in the clinic for coaching medical team members to improve their communication and quality of relationships with each other.

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

SANTA ROSA JUNIOR COLLEGE
People Empowering Each other to Realize Success
PEERS COALITION

program description

The PEI Program, based in the **Santa Rosa Junior College (SRJC)** Student Health Services department, uses a comprehensive approach to assist the college community in identifying and responding to students experiencing significant mental health problems, and to promote mental health and reduce stigma across the college. Student outreach efforts are focused on reaching transition age youth through orientations and first year experience courses. Online mental health screenings, educational content, and trainings are made available to all students.

The **People Empowering Each Other to Realize Success (PEERS) Coalition** mobilizes the student voice to increase the ability to effectively raise awareness of mental health and increase utilization of services. PEERS interns work with Student Health Services' staff in addressing priority needs of SRJC students through outreach activities and widespread community collaboration. Interns serve in a variety of roles including representation on the County Mental Health Board, planning workshops and events, and educating students about mental wellness and bystander interventions.

The PEI Program staff have established community partnerships to better serve students and host an annual mental health networking event. PEI program staff works closely with the SRJC Crisis Intervention Resource Team (CIRT) to provide trainings for faculty and staff on recognition and response to students of concern. The CIRT team collaborates with Sonoma County Behavioral Health Crisis Assessment, Prevention and Education (CAPE) Team to implement mobile crisis support and threat assessment services for students that are a danger to self and/or others. Additionally, the PEI Program collaborates with CAPE on trainings, including assisting with QPR (Question, Persuade, Refer) trainings in local high schools.

SANTA ROSA JUNIOR COLLEGE

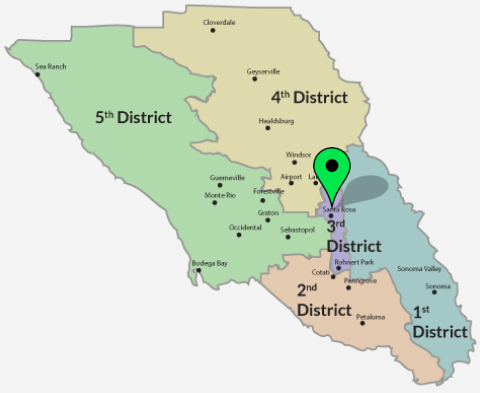
Program Name:
People Empowering Each Other to Realize Success (PEERS)

MHSA Component:
Prevention and Early Intervention (PEI)

Initiative/Population:
Transition age youth

Program Location:
Santa Rosa, CA

For more information, go to:
http://www.santarosa.edu/



program demographics

Total numbers served: 3,356
(Duplicated)

age

Unknown	64.9%
16 to 25	22.2%
26 to 59	10.8%
60+	1.9%
0 to 15	0.1%
Declined to state	0.03%

race/ethnicity

Unknown	64.1%
White	15.4%
Hispanic	11.2%
More than one race	3.6%
Asian/Pacific Islander	3.0%
African American	1.2%
Native American	0.7%
Other	0.5%
Declined to state	0.2%

language

Unknown	74.9%
English	20.5%
Spanish	3.5%
Multiple categories*	1.2%

**Chinese, Tagalog, Vietnamese, Other language*

gender

Unknown	64.4%
Female	23.9%
Male	10.9%
Another identity	0.4%
Multiple categories*	0.4%

**Transgender, Declined to state*

contracted services

- Provide QPR training to SRJC staff and students
- Psycho educational interventions in classrooms
- SRJC CIRT Team will train faculty and staff in early recognition and appropriate response to students at risk for mental health issues.
- Promote on-line mental health screenings to SRJC students.
- Develop and present PEERS Coalition Workshops
- Implement National College Health Assessment Survey
- Add customized content monthly to Student Health 101 online magazine
- Host a Mental Health Collaborative Event
- Facilitate outreach activities at the College

notable accomplishments

- **436** students and staff received **QPR Suicide Prevention training**
- **432** students received anonymous **online mental health screenings**
- **469** students attended a **PEERS workshop**. Topics included gender roles, substance abuse, and social connection.
- **3,117** unique visitors read articles in **Student Health 101 online magazine**. **70%** of students engaged said they intended to get involved, take advantage of campus resources, ask for help, or help a friend.
- PEERS hosted an **Each Mind Matters event** on each campus during the month of May, engaging **50** students on the Petaluma campus, and **152** in Santa Rosa.
- PEERS hosted suicide prevention advocate **Kevin Berthia** as a guest speaker for their October PEERS workshop. **275** students, staff and community members gathered to hear his inspiring story. Community agencies and on campus support groups tabled at the event to share resources with attendees.
- PEERS designed and hosted the **4th annual Wellness Fair**. **360** students attended the fair which included hands on activities within the 7 Realms of Wellness. Community partners and a variety of campus clubs came together to provide students with tips and resources on how to support self-care and wellness.
- PEERS hosted a **Mental Health Networking Breakfast** in February, which was attended by **28** mental health service providers.
- **346** students attended **"Student Health & Success"**, a presentation that reviews the signs and symptoms of stress, anxiety, and depression, and covers resources and support available to the students.
- PEERS provided **outreach about SRJC mental health services** at a variety of events on campus. Additionally, they created a video **"Asking for Help"** which profiles 3 different SRJC students and how asking for help led to more success in school. This video so far has had **1,952** views.
- Longitudinal data shows SRJC students are **receiving more information about mental health** and that help-seeking behavior has resulted in **more students accessing Student Psychological Services**. Since 2010, when SRJC first received PEI funding, there has been a steady increase in students reporting on the National College Health Assessment (NCHA) Survey that they received information on mental health topics at SRJC. There has also been a steady increase in the number of unduplicated students seen by SRJC therapists on campus. The PEERS believe that their work in educating students about mental health and stigma reduction efforts has contributed to this increase.

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

WEST COUNTY COMMUNITY SERVICES (WCCS)

CRISIS SUPPORT SERVICES

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Individuals and families living in poverty; Parents at risk of being involved with the child welfare system; Individuals with severe and persistent mental illness; Individuals who are or are on the verge of becoming homeless

Program Location:
Guerneville, CA

For more information, go to:
https://www.westcountyservices.org/

program description

The **West County Community Services (WCCS) Crisis Support Services** program is designed to stabilize individuals and families in their existing homes, shorten the amount of time that individuals and families stay in shelters, and assist individuals & families with securing affordable housing.

contracted services

Provide information, resource information & referral assistance & advocacy to clients five hours per week to assist them with access to basic human needs. Assistance includes services provided directly by WCCS and by referral to other service providers. Supportive services include individual case management to help with employment, housing, health care, and other benefits.

notable accomplishments

WCCS Crisis Support provided housing deposit assistance and assisted clients in applying for HEIP. WCCS provided food and clothing to families as well as bus passes to access physical and behavioral health services. The program provided referrals to the Empowerment Center, Health Center, Clean Day, community food resources and Russian River Counselors.

WCCS Crisis Program provided Season of Sharing rental assistance help, also providing food boxes and clothing help. The program also provided bus passes and gave referrals to West County Health Centers, DAAC, Orenda Center and West County Senior Center.

program demographics

Total numbers served (Aggregate of quarterly reports): 295

age		race/ethnicity		language		gender	
26 to 59	51.9%	White	79.0%	English	86.8%	Female	63.1%
0 to 15	31.5%	Hispanic	13.6%	Spanish	13.2%	Male	36.3%
60+	12.9%	Multiple categories*	5.8%			Another identity	0.7%
16 to 25	3.1%	More than one race	1.7%				
Declined to state	0.7%	*African American, Asian					

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

WEST COUNTY COMMUNITY SERVICES (WCCS)

RUSSIAN RIVER EMPOWERMENT CENTER

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Mental health consumers

Program Location:
Guerneville, CA

For more information, go to:
https://www.westcountyservices.org/

program description

Based on a philosophy of consumer empowerment, the **Russian River Empowerment Center (RREC)** is a consumer-operated program that provides a centralized location where people with psychiatric disabilities receive individual and group peer counseling and support.

The focus of the program is to provide supports, activities, and services to increase the quality of life of mental health consumers who are severely and persistently mentally ill.

West County Community Services (WCCS) will provide transportation assistance to the Empowerment Center. This transportation service will broaden the membership by offering transportation for individuals living in Forestville and Sebastopol, as well as Guerneville.

contracted services

- Membership
- Art, cooking, gardening, computer lab, support groups, etc.

notable accomplishments

90% of Russian River Empowerment members have reported they are satisfied with the program. Members report that they feel supported and valued as a team member and many report that coming to the programs increased their quality of life by feeling a sense of validated community support. They report enjoying group discussions and group level activities as well as the resources and referrals they receive.

As membership numbers have been steadily rising, people often report their gratitude of the program and staff support they all receive. There is an increase in group participation and relationships are also steadily improving. Many of the members, however, report they do not receive family support outside of the program, so they are especially appreciative of the strong relationships they have established within the program.

program demographics

Total numbers served: 314

(Aggregate of quarterly reports)

age	
26 to 59	92.4%
60+	7.0%
16 to 25	0.6%

race/ethnicity	
White	97.5%
Other	2.5%

language	
English	100.0%

gender	
Male	66.2%
Female	33.8%

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

WEST COUNTY COMMUNITY SERVICES

program description

West County Community Services (WCCS) has managed its **Senior Peer Counseling** Program since 2002. Seniors struggling with issues of aging and mental health are matched with trained volunteer Senior Peer Counselors. The program strives to reach at-risk seniors before they experience crisis, helping them to remain self-sufficient, independent, and out of the institutional care system. WCCS works with clients to instill hope and promote wellness through providing in home peer support as well as groups accessibly located in different areas of the County.

A key component of this program is WCCS's free 35 hour Senior Peer Counseling Training Program for volunteers who are seniors themselves. Senior Peer Counselors (SPCs) are trained in issues related to aging, and each peer counselor brings a special area of skill that reflects his/her own life experience. They are trained in active listening, communication techniques, problem solving, assertiveness, and grief issues, and they learn how to screen for depression, anxiety and a multitude of other mental health issues. A recovery orientation is integrated throughout. They are also

WEST COUNTY COMMUNITY SERVICES (WCCS)

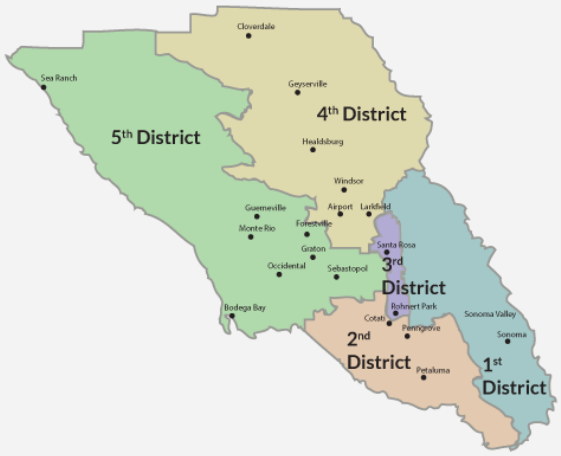
SENIOR PEER COUNSELING

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Older Adult Intensive Services Full Service Partnership

Program Location:
Sonoma County, CA

For more information, go to:
https://www.westcountyservices.org/



program demographics

Total numbers served: 365
(Aggregate of quarterly reports)

age	
60+	98.9%
26 to 59	1.1%

race/ethnicity	
White	95.1%
Multiple categories*	3.3%
More than one race	1.1%
Other	0.5%

**Hispanic, Missing Data*

language	
English	100.0%

gender	
Female	71.5%
Male	28.5%

WELLNESS • RECOVERY • RESILIENCE

program description (continued)

trained in reporting elder abuse according to current law, and in making appropriate referrals to other community resources. Once trained, SPCs provide counseling, outreach, information, education and support to seniors in their homes or at the agency.

contracted services

- Assessments by Senior Programs Clinical supervisor as needed
- Senior Peer Counseling or Group Services
- Clinical Supervision of Senior Peer Counselors
- Behavioral Health, recovery-oriented training for agency senior peer volunteers

notable accomplishments

WCCS SPC clients are matched with an SPC volunteer who provides **12** weeks of one-on-one peer counseling (1 hour sessions in the client's home). WCCS also provides **5** support groups for seniors: Mature Women's Support Groups are held in Windsor, Sebastopol and at a site in central Santa Rosa. Transitions Men's Support Groups are held in Santa Rosa and Sebastopol. All of these groups are ongoing and most clients tend to remain for months or even years.

During this fiscal year, **148** unique clients received one-on-one Senior Peer Counseling (SPC) and/or attended Senior Support Groups.

Trainings held for volunteer Senior Peer Counselors included:

- "The Anatomy of Trust" (Brene Brown)
- "Home Visit Safety"
- "Alzheimer's and other Dementias"
- "Adapting to the Spectrum of Loss in Later Life"
- "Spirituality & Aging"
- "The Nuances of Grief Counseling"
- "Trauma Informed Therapy"

Client Satisfaction Surveys for the year show clients receiving one-on-one services are appreciative and find services useful:

- **91%** Strongly Agree and 9% Agree that "My experience with WCCS's Senior Peer Counseling was positive"

Geriatric Depression Scale results also reflect the success of this program:

- **80%** of clients had a decrease in their GDS score. 11.5% had no change in their GDS score. Only 8.5% of clients had an increase in their GDS score.

"It is my belief that I was assigned a very special person to come by every week and hold my unsteady hand from some recent sadness and listen to my thoughts in a very interested, non-judgmental and caring way. I learned that your outlook on life matters. I experienced a wonderful teacher. Thank you!"

- SPC client receiving one-on-one services

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH SERVICES ACT:

transforming mental health care in Sonoma County

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support the local mental health services system throughout California.

program description

Russian River Health Center (RRHC), a clinic of **West County Health Centers**, is designated as a Federally Qualified Health Center in western Sonoma County. RRHC provides primary care, mental health, and dental care to people in the lower Russian River area.

The Mental Health Services Act provides funding for a Licensed Clinical Social Worker (LCSW) for RRHC. The purpose of the LCSW at RRHC is to increase access to mental health services to populations identified at high need. These populations include: people who are in geographically isolated communities, people who identify as members of the LGBTQQI community, and people who are homeless.

contracted services

- Warm Hand Off from primary care provider
- Rapid psychosocial assessment
- Mobilization of psychosocial supports
- Stabilization counseling (case management)
- Follow-up services through the crisis
- Linkage with needed services including referral to RRHC or other therapy services or for assessment for specialty mental services

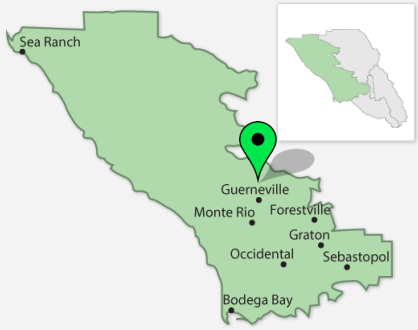
WEST COUNTY HEALTH CENTERS

MHSA Component:
System of Care - Community Services & Supports (CSS)

Initiative/Population:
Community Intervention Program (CIP)

Program Location:
Guerneville, CA

For more information, go to:
http://www.wchealth.org/



notable accomplishments

- **130** individuals received crisis resolution services, including **17** that received crisis intervention
- **967** visits were provided to **344** persons for case management/short term counseling. Services focused on homeless or potentially homeless persons with a history of mental illness and included such areas as managing and improving health/chronic conditions, intervention to address symptoms of trauma, interpersonal or family stressors, housing crises, and mood disorders.

program demographics

Total numbers served (aggregate of quarterly reports): 344

age		race/ethnicity		language		gender	
26 to 59	68.0%	White	83.7%	English	97.4%	Female	62.8%
60+	25.6%	Hispanic	7.6%	Other language	2.3%	Male	36.6%
16 to 25	6.4%	Multiple categories*	4.4%	Declined to state	0.3%	Another identity	0.6%
		Declined to state	2.0%				
		Missing data	1.5%				
		Other	0.6%				
		More than one race	0.3%				

**Native American, Asian*

Appendix 2

MHSA Newsletters for FY 2016-2017

MHSA Communications - Newsletters

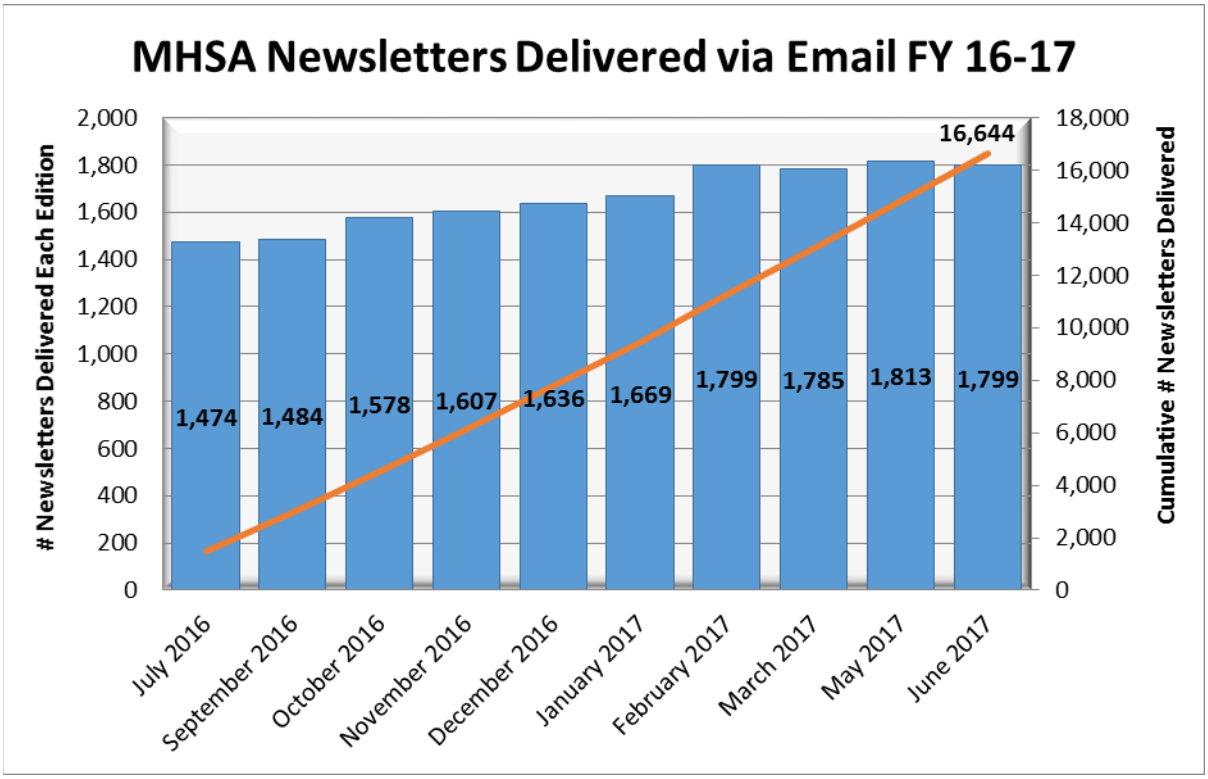
Fiscal Year 16-17

HARD COPY/PDF

A hard copy version of the newsletter is produced every 1-3 months and is shared with a variety of community groups and stakeholders, including the Mental Health Board, the Board of Supervisors, Behavioral Health program managers, and contractors. An archive of the newsletter PDFs is available on the MHSA website.

EMAIL

An email version of the newsletter is produced and sent out every 1-3 months. People can subscribe to the email newsletter via the MHSA website.



Attached:

MHSA Newsletters for Fiscal Year 16-17

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act Newsletter

24th Edition, July 29, 2016

SPOTLIGHT ON POSITIVE IMAGES

In the wake of the mass shooting in Orlando that targeted an LGBT night-club where 49 people were killed and 53 people injured, the Behavioral Health Division would like to acknowledge the important work of one of the Department of Health Care Services' contractors, Positive Images, as a critical resource here in Sonoma County.

Positive Images is a Mental Health Services Act (MHSA) funded agency in Sonoma County serving the unique needs of Lesbian, Gay, Bi-sexual, Transgender, Queer, Plus (LGBTQ+) youth ages 12 to 24. For the past 25 years, Positive Images has provided programs and services that help youth, service providers and the public develop positive, healthy, life-affirming, and accepting behaviors and views of personal expression of gender identity and sexual preference. These services include:

- Engage youth in programs, activities and services that increase resiliency and reduce risk
- Educate youth, schools, and service providers to reduce stigma and increase acceptance
- Train providers about LGBTQ+ issues

JIM FOSTER MFT, EXECUTIVE DIRECTOR AND CO-FOUNDER, IS RETIRING!

Jim Foster has dedicated his entire career life to working with youth and their families, first as a teacher and then as a counselor and therapist. Under Jim's guidance as Executive Director from 1990-2016, Positive Images became a peer-led organization with members of the group assuming strong roles in leadership. This leadership has been responsible for many of the ideas and forward movements of the organization, including the initial establishment of a Positive Images office and eventually a Queer Youth Center, the first and only center of its kind in Sonoma County.

JAVIER ROSALES, NEW PROGRAM DIRECTOR AT POSITIVE IMAGES!

Since graduating from Sonoma State University, Javier has grown to understand that creating true community and acceptance for LGBTQ+ youth takes determination and effort. As a gay man, he knows the crucial need to foster safe spaces where people feel supported. Javier will be leading Positive Images into a new office space in 2016 and working with stakeholders in the community to identify current needs for LGBTQ+ individuals in Sonoma County.

For more information about Positive Images programs and services go to: www.posimages.org

For more information about MHSA programs and services contact Amy Faulstich at: Amy.Faulstich@sonoma-county.org

RESILIENCE IN THE WAKE OF TRAGEDY

Proyecto #SomosOrlando

Proyecto Somos Orlando (We are Orlando Project) is a grassroots movement that began hours after the Pulse Nightclub shooting to provide immediate services for the Latino community that was deeply impacted by the tragedy. Learn more about stressors that affect Latinos and how two celebs are raising awareness.

www.huffingtonpost.com/entry/mental-health-latinos-after-orlando_us_577f612be4b05b4c02fc455c

LATINO SERVICE PROVIDERS LAUNCHES NEW WORKFORCE DEVELOPMENT PROGRAM!

Latino Service Providers (LSP) is proud to announce their new Workforce Development (WFD) Program! With Mental Health Services Act (MHSA) funding, LSP is contracting with Sonoma County Department of Health Services Behavioral Health Division (SC-BHD) to assist in the recruitment of bilingual/bicultural job candidates exploring career opportunities with the Division.

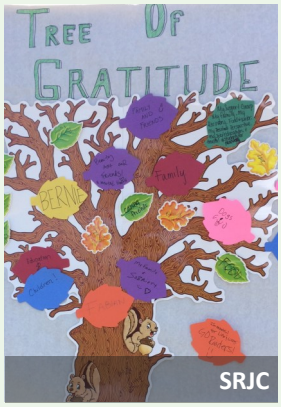
In the WFD Program, LSP focuses on increasing the number of bilingual/bicultural Spanish Behavioral Health service providers, increasing access to Behavioral Health services and resources, and reducing stigma. LSP will:

- Maintain a web-based clearinghouse for recruitment and support of a bilingual/bicultural Spanish Behavioral Health workforce
- Provide technical assistance to potential candidates for Behavioral Health positions at SC-BHD
- Seek and support those interested in pursuing a career in Behavioral Health in entry, mid and high level management
- Participate in an annual behavioral/primary health career pathways symposium designed to recruit and expose students to careers in behavioral health, primary healthcare and the allied health fields

For more information, visit the WFD Program website or the LSP website:
www.bhworkforcesonoma.com
www.latinoserviceproviders.org

HIGHLIGHTS FROM MAY IS MENTAL HEALTH MATTERS MONTH 2016!

SANTA ROSA JUNIOR COLLEGE (SRJC)

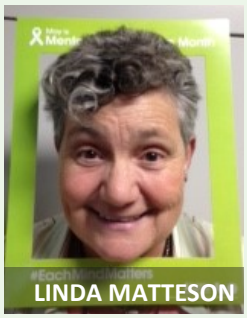


SRJC


WINDSOR HIGH SCHOOL

SANTA ROSA JUNIOR COLLEGE (SRJC)

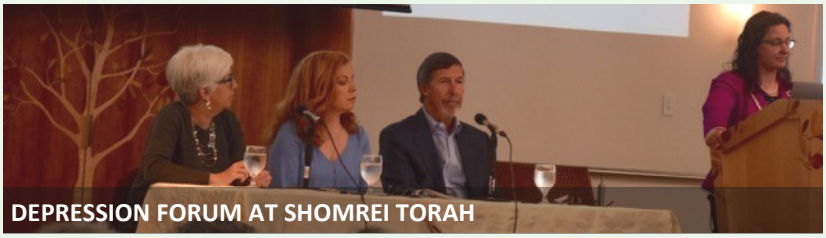

SONOMA COUNTY BOARD OF SUPERVISORS


LINDA MATTESON

ANALY HIGH SCHOOL


KEVIN BRIGGS

PAPER TIGERS SCREENING


DEPRESSION FORUM AT SHOMREI TORAH

42ND ANNUAL NATIONAL SUICIDE PREVENTION WEEK
SEPTEMBER 5 - 11, 2016

National Suicide Prevention Awareness Week is Sept. 5-11, 2016, and **World Suicide Prevention Day** is Sept. 10. **Each Mind Matters** has developed a toolkit for Suicide Prevention Week with useful materials that can assist you in planning activities and events in your county and community.

This year, Each Mind Matters is encouraging a special focus on older adults and has provided a range of tools including a data briefing, hand-outs, a presentation and a drop-in article to support outreach to this population.

The toolkit is available at: www.eachmindmatters.org/get-involved/spread-the-word/suicide-prevention-week-2016

Below are just a few of the many resources included in the toolkit:

KNOW THE SIGNS

The **Know the Signs (KTS)** campaign is an effective way to promote suicide prevention in your community. KTS provides numerous suicide prevention resources, including:

- **Graphics, posters, and flyers** available for free download
- A **drop in article** that can be customized or used as-is for placement in newsletters, blogs, and local media
- Suicide prevention **infographics**
- Pre-written **Facebook and Twitter posts** and graphics
- Some helpful **guidelines** when posting about suicide prevention on social media
- And much more!

Visit KTS: www.suicideispreventable.org

Other ideas for suicide prevention activities:

- Participate in the **Suicide Prevention Week Email Campaign** and encourage staff, providers and community partners to know the signs, find the words and reach out within their own networks.
- Focus on older adults through **specially tailored presentations, resources, and trainings**
- Invite young people to play a role in suicide prevention. The **Directing Change Program & Film Contest** encourages young people to create 60-second films about suicide prevention or mental health. Encourage participation, host a local screening, or ask your local movie theater to screen films. For more information and to download films, visit:

  www.directingchange.org

For more information about MHSA programs and services, or to submit updates, events, success stories, or other content for this newsletter, please contact Amy Faulstich at amy.faulstich@sonoma-county.org. To sign up for this newsletter, go to: www.sonoma-county.org/mhsa.

Newsletter designed by Bruce Robbins.

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act Newsletter

25th Edition, September 2, 2016

Suicide Prevention Issue

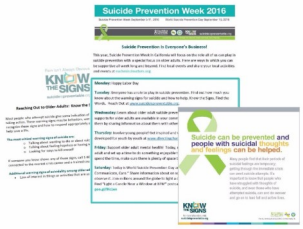
42ND ANNUAL NATIONAL SUICIDE PREVENTION WEEK

SEPTEMBER 5 - 11, 2016

The September issue of the MHSA Newsletter is dedicated to the people of Sonoma County, California, and across the globe that will come together during this year's **National Suicide Prevention Week (Sept. 5-11, 2016)** to spread awareness about the warning signs of suicide and to offer support to those who have lost someone to suicide.

This issue will highlight the many suicide prevention resources and tools that are available, as well as upcoming events and trainings. We will also be recognizing some of the excellent suicide prevention efforts taking place here in Sonoma County.

SUICIDE PREVENTION WEEK TOOLKITS AND RESOURCES



Each Mind Matters has created a **Suicide Prevention Week Toolkit** to make it easy for you to get involved and raise awareness in your community. This year they offer a special focus on older adults with a range of tools to support outreach to this population. www.eachmindmatters.org/get-involved/spread-the-word/suicide-prevention-week-2016/

The **Suicide Prevention Resource Center (SPRC)** has put together a list of **ideas for action** to help you get involved with suicide prevention and mental health promotion this month and throughout the year: www.sprc.org/resources-programs/suicide-prevention-month-ideas-action-september-2016

The **American Association of Suicidology (AAS)** has created a comprehensive **Media and Information Kit** that includes fact sheets, templates, and ideas for planning events: www.suicidology.org/about-aas/national-suicide-prevention-week

UPCOMING ASSESSING & MANAGING SUICIDE RISK (AMSR) TRAINING

SPRC
SUICIDE PREVENTION RESOURCE CENTER

9/7/16, 8:30am-5:00pm
North Coast Builders Exchange
1030 Apollo Way, Santa Rosa

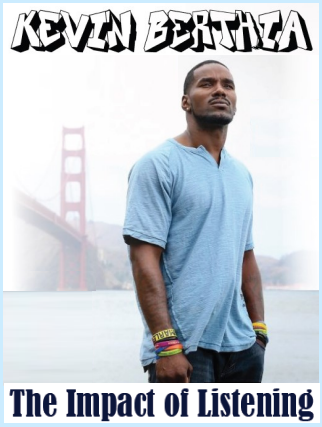
The Sonoma County Behavioral Health Division (SC-BHD) is offering an **"Assessing & Managing Suicide Risk (AMSR)"** workshop on September 7, 2016.

The 6 1/2 hour, one-day workshop was developed by the **Suicide Prevention Resource Center (SPRC)** for behavioral health professionals and focuses on assessing suicide risk, planning treatment, and managing the ongoing care of the at-risk client.

Facilitated by Melissa Ladrech, LMFT, Katie Bivin, LMFT and Patti Mills, MFTi. 6.5 **continuing education credits** available from NBCC, APA, and CA Board of Behavioral Sciences. Space is limited. To register, use the following link:

www.eventbrite.com/e/assessing-and-managing-suicide-risk-september-7th-tickets-26542811263

KEVIN BERTHIA TO SPEAK AT SRJC DURING MENTAL ILLNESS AWARENESS WEEK IN OCTOBER



Oct. 13, 2016, 5-7pm
Santa Rosa Junior College
Student Activities Center
Bertolini Building
1501 Mendocino Ave,
Santa Rosa

The Sonoma County Department of Health Services Behavioral Health Division and Santa Rosa Junior College invite you to attend a speaking engagement with special guest, suicide survivor, **Kevin Berthia** and his powerful story *"The Impact of Listening."*

Enjoy networking opportunities, learn about local resources and what you can do to help prevent suicide and reduce stigma around mental health challenges.

SONOMA COUNTY HIGH SCHOOL STUDENT AMONG REGIONAL WINNERS IN DIRECTING CHANGE CONTEST

The **Directing Change Program & Film Contest** is part of *Each Mind Matters: California's Mental Health Movement*. The program offers young people the exciting opportunity to participate in the movement by creating 60-second films about suicide prevention and mental health that are used to support awareness, education and advocacy efforts on these topics.

The winners for the 2016 Contest have been announced and Sonoma County's own **Alex Diaz Pena** from **El Molino High School** has won Second Place in the Suicide Prevention category in Region 5 (which contains 32 counties) for his film *"A Conversation Can Save a Life"*.

View Alex's film: https://youtu.be/nD5oHL63jW8

For more information: www.directingchange.org

SONOMA COUNTY'S CRISIS ASSESSMENT, PREVENTION & EDUCATION (CAPE) TEAM TRAINS THOUSANDS IN SUICIDE PREVENTION

SC-BHD's Crisis Assessment, Prevention & Education (CAPE) Team

QPR stands for **Question, Persuade, and Refer** — the 3 simple steps anyone can learn to help save a life from suicide. Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to *question, persuade, and refer* someone to help.

The Sonoma County Behavioral Health Division (SC-BHD) is committed to sharing this important suicide prevention technique with high school students, faculty, and the community-at-large.

Since 2010, SC-BHD has trained over **8,700** individuals in QPR, primarily through its **Crisis Assessment, Prevention and Education (CAPE) Team** and **Community Intervention Program (CIP)**. In Fiscal Year 2015-16 alone, over **3,700** individuals (mostly high school students) were trained. Trainings are conducted in English and Spanish.

QPR trainees consistently report a significant increase in their knowledge of areas such as facts concerning suicide prevention, warning signs of suicide, how to ask someone about suicide, and information about local resources for help with suicide, among others.

UPCOMING WEBINAR - "AFTER RURAL SUICIDE: A GUIDE FOR COORDINATED COMMUNITY POSTVENTION RESPONSE"

Thursday, September 22, 2016
2:00 - 3:00pm

Rural areas of California often experience higher rates of suicide deaths than urban areas. Suicide hits rural communities hard, affecting a large proportion of people where "everybody knows everybody" and resources may be sparse.

"Postvention" is the process of providing support to help loss survivors and the community at large heal after a suicide occurs. A postvention response plan can help reduce the likelihood of contagion and help organizations and individuals to respond both promptly and appropriately. Although postvention guides exist for schools, until now no guide has been designed to address the needs of rural areas.

This new guide, funded by the Central Region Workforce and Education Training (WET) Coordinators and created by the **California Mental Health Service Authority (CalMHSA)**, provides a framework to creating a coordinated plan to mobilize support.

Sandra Black and Anara Guard, authors of the guide, will describe its contents and how best to put it to use. They will also describe the Core Team structure recommended in the guide. There will be time for discussion. Please register today!

https://calmhsa.webex.com/calmhsa/onstage/g.php?MTID=ecb211464b825bcfe05e87f329e80e841

4TH ANNUAL SANTA ROSA OUT OF THE DARKNESS COMMUNITY WALK

When you walk in the **Out of the Darkness Walks**, you join the effort with hundreds of thousands of people to raise awareness and funds that allow the **American Foundation for Suicide Prevention (AFSP)** to invest in new research, create educational programs, advocate for public policy, and support survivors of suicide loss. Each year, nearly 200,000 people walk in 350 cities across the country.

This year's **Santa Rosa Community Walk** will take place on **October 15, 2016** at **Howarth Park**! Registration/check-in begins at 9am and the walk begins at 10am. For more information, to register, or to donate, go to: http://afsp.donordrive.com/event/santarosa

The **Adverse Childhood Experiences & Resiliency Fellowship** Master Trainer Program will train 25 local representatives as trainers who can then train others as Presenters. They are looking for representatives from a variety of sectors spanning the regions of Sonoma County – please help spread the word or consider applying yourself.

The deadline for the application is September 12, 2016, and notifications of acceptance will be sent out by September 27, 2016. The two-day training with Dr. Anda and Laura Porter is scheduled for October 18-19. Community of Practice Session dates will be announced soon.

Questions about the application or application process can be directed to: hwhitewolfe@schsd.org or 707.565.5266

For more information about MHSA programs and services, or to submit updates, events, success stories, or other content for this newsletter, please contact Amy Faulstich at amy.faulstich@sonoma-county.org. To sign up for this newsletter, go to: www.sonoma-county.org/mhsa

Newsletter designed by Bruce Robbins.

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act Newsletter

26th Edition, October 3, 2016

Mental Health Awareness Week
October 2-8

In 1990, the United States Congress established the first full week of October as **Mental Health Awareness Week** in recognition of the **National Alliance on Mental Illness' (NAMI)** efforts to raise mental illness awareness. Since then, mental health advocates across the country have joined with others in their communities to sponsor activities, large and small, for public education about mental illness. Mental Health Awareness Week is October 2-8, an annual event where advocates across the nation will come together to spread awareness about the importance of mental health and to speak out against the stigma around mental illness.

GRATEFUL SUICIDE SURVIVOR, KEVIN BERTHIA, TO SPEAK AT SRJC

The Impact of Listening
with Kevin Berthia

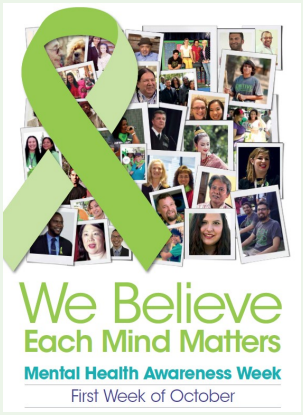
Thursday, October 13th, 2016
5:00pm to 7:00pm
Student Activities Center
Bertolini Building
Santa Rosa Junior College
1501 Mendocino Ave, Santa Rosa

In recognition of Mental Health Awareness Week, **Santa Rosa Junior College** and the **Sonoma County Department of Health Services Behavioral Health Division** are hosting a public speaking engagement with grateful suicide survivor, **Kevin Berthia**, to hear his powerful story, *The Impact of Listening*. As a former community college student and athlete, Kevin is especially attuned to young people attempting to deal with all the complexities of life, the demands of school, and the pressures that sometimes accompany athletic performance.

SANTA ROSA JUNIOR COLLEGE

People Empowering Each other to Realize Success
PEERS COALITION

2016 MENTAL HEALTH AWARENESS WEEK TOOLKIT



Each Mind Matters, California's Mental Health Movement, has developed a toolkit with valuable resources that can be customized to raise awareness in your community and help reduce the stigma surrounding mental health challenges. The toolkit includes:

- **Social media guide** filled with ways to help you promote mental health awareness on your social channels
- **Daily email messages** that you can personalize and share with your network to communicate the importance of mental health.
- **Mental Health Support Guide**, a brochure providing tips to help reduce stigma and find support for a mental health challenge.
- **The "We Believe Each Mind Matters" 11" x 17" poster** (pictured above)
- And more!

Download the toolkit at the following link:

www.eachmindmatters.org/get-involved/spread-the-word/2016-mental-health-awareness-week/

4TH ANNUAL SANTA ROSA OUT OF THE DARKNESS COMMUNITY WALK

When you walk in the **Out of the Darkness Walks**, you join the effort with hundreds of thousands of people to raise awareness and funds that allow the **American Foundation for Suicide Prevention (AFSP)** to invest in new research, create educational programs, advocate for public policy, and support survivors of suicide loss. Each year, nearly 200,000 people walk in 350 cities across the country.

This year's **Santa Rosa Community Walk** will take place on **October 15, 2016** at **Howarth Park**. Registration/check-in begins at 9am and the walk begins at 10am. For more information, to register, or to donate, go to: http://afsp.donordrive.com/event/santarosa

MENTAL HEALTH AWARENESS WEEK - Share the facts about mental health:

- Mental health challenges are very common. In fact, **50%** of us will experience a mental health challenge in our lifetime.
- Mental well-being is a **fundamental** component of the World Health Organization's definition of health.
- **Half** of all mental disorders start by **age 14** and three-quarters by age 24.
- Unfortunately, research shows that many people do not reach out for support. For young people, an average of **6 to 8 years** passes from the time they first experience symptoms to the time when they get help.
- People recover from mental illness all the time. With support and treatment, between **70% and 90%** of individuals report reduced symptoms and improved quality of life.

Good mental health enables people to realize their potential, cope with the normal stresses of life, work productively, & contribute to their communities.

Mi Futuro Esta En Carreras de Salud: My Future is in Healthcare Careers

Santa Rosa Junior College and **Latino Service Providers**, in cooperation with community sponsors, invite you to a **Health Career Symposium**.

Who: 16-30 year olds
What: Participate in health-related interactive stations
When: Friday, January 27, 2017, 8:30am to 4:30pm
Where: Santa Rosa Junior College, 1501 Mendocino Avenue

- Will expose participants to career opportunities in mental health & primary health
- Will raise awareness of mental health stigmas in the Latino Community
- Will reveal the impact of mental health in primary healthcare & the community

www.myfutureisinhealthcare.eventbrite.com

LATINO SERVICE PROVIDERS RECEIVES STATE MENTAL HEALTH GRANT!

On July 11, 2016 the **California Department of Public Health (CDPH)** announced an intent to award $13 million in grants to California Reducing Disparities Pilot Projects to help reduce mental health disparities in communities that have traditionally been underserved.

The funding will be distributed to 11 pilot projects statewide that provide mental health services to five target populations, including African American, Asian and Pacific Islander, Latino, Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ), and Native American communities. The grant monies are part of CDPH's **California Reducing Disparities Project (CRDP)**. This will be the third release of CRDP grant funds.

The primary goal of the CRDP grants is to invest in new and existing community programs that have shown promise in reducing mental health disparities in these underserved communities. The CRDP is funded by the **Mental Health Services Act (MHSA)** (Proposition 63) that was passed in November 2004. This act imposes a one percent income tax on personal income that exceeds $1 million.

The 11 awardees receiving grants totaling $1,180,000 in funding for more than five and a half years include local organization, **Latino Service Providers (LSP)**, an MHSA funded contractor. LSP was provided technical assistance and support from the **Behavioral Health Division** and contractor **Kawahara and Associates** to submit an application to the **Office of Health Equity (OHE)** for the CRDP funding specific to their communities. Latino Service Providers received a grant to recruit and train mental health Promotores to launch a community-wide bilingual and Spanish speaking educational campaign to reduce stigma on mental health, increase awareness of resources, and encourage workforce development in behavioral health careers.

The **Directing Change Program & Film Contest** is part of **Each Mind Matters: California's Mental Health Movement**. The program offers young people the exciting opportunity to participate in the movement by creating 60-second films about suicide prevention and mental health that are used to support awareness, education and advocacy efforts on these topics. Learning objectives surrounding mental health and suicide prevention are integrated into the submission categories of the film contest, giving young people the opportunity to critically explore these topics. For more information, visit: www.directingchange.org

THE IMPACT OF DIRECTING CHANGE

From 2012 through 2016...

4,000	Students around California that have participated in Directing Change.
308	High schools that have participated in Directing Change.
1,651	Short films created by youth for youth.
49,000	and counting...The number of times films have been viewed online.

For more information about MHSA programs and services, or to submit updates, events, success stories, or other content for this newsletter, please contact Amy Faulstich at amy.faulstich@sonoma-county.org. To sign up for this newsletter, go to: www.sonoma-county.org/mhsa.

Newsletter designed by Bruce Robbins.

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act Newsletter

27th Edition, November 15, 2016

This issue of the Mental Health Services Act (MHSA) Newsletter will focus on Sonoma County Behavioral Health's many MHSA-funded mental health services for **Older Adults**. Additionally, in honor of Veterans Day, we will highlight the multitude of mental health resources that are available to our **Veterans**.

OLDER ADULT SERVICES AT SONOMA COUNTY BEHAVIORAL HEALTH

SCBH's Older Adult Services team

The **Older Adult Services (OAS)** at Sonoma County Behavioral Health (SCBH), in combination with the Mental Health Services Act (MHSA), reaches seniors in Sonoma County, far and wide. Older Adult Services consists of a multidisciplinary team of Psychiatrists, a Psychiatric Registered Nurse, Clinicians (PSCs) and a Client Support Specialist. OAS also has Liaisons to **Adult Protective Services (APS)** and **In Home Supportive Services (IHSS)**, who provide outreach to seniors who are often vulnerable and benefit from this support.

Because of this rich diversity of providers, OAS is able to deliver client driven care and meet more of the community based needs of older clients, such as home visits for assessments and follow up care.

Full Service Partnership and Prevention and Early Intervention

With MHSA dollars, Older Adult Services has been able to expand services to promote paths to prevention and recovery at Behavioral Health and the community. Older Adults Services **Full Service Partnership (FSP)** provides comprehensive, intensive services for Older Adults who are experiencing mental illness and are interested in participating in a program designed to address their emotional, physical and living situation needs. This FSP program is able to provide intensive and innovative services, beyond the reach of traditional outpatient services. MHSA provides the means for this FSP to fund three Peer Support programs that offer guidance to discover meaningfulness and develop community connections, for FSP recipients, as well as older adults in the community.

In collaboration with Human Services, the Older Adult Services Liaison to IHSS meets with older adults who show symptoms of depression, serious mental illness and/or suicidal thinking, and provides an in-home assessment and linkage to services--MHSA services for older adults including peer support, in-home counseling, and **Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)**. The programs at SCBH Older Adult Services believe all individuals can live healthier, more connected and fulfilling lives.

SONOMA COUNTY BEHAVIORAL HEALTH DIVISION LAUNCHES SYSTEM-WIDE TRAINING FOR CLINICAL STAFF!

Pictured: Susan Castillo, Christina Amarant, Mike Kennedy, Debbie Nicolellis (Senior Training Associate at Boston University, Center for Psychiatric Rehabilitation), Sid McColley, Randye Royston, Melissa Ladrech

The Sonoma County Behavioral Health Division is dedicated to providing recovery-oriented services to all of the clients we serve. The Division is pleased to announce that we will be building the capacity of our system to deliver Boston University's **Psychiatric Rehabilitation Approach (PRA)**.

PRA is a collaborative and evidence-based approach centered in recovery-oriented practices. PRA focuses on supporting and empowering individuals with severe mental illness to live, learn, work, and socialize in the environments and roles of their choice by developing the emotional, social and intellectual skills needed to function well in the community. The valued roles of their choice may include, but are not limited to: worker, volunteer, resident, homeowner, spouse, friend, trainee or student. The approach fosters success and satisfaction in these roles that are an essential part of the process of recovery.

The **mandatory** four-hour **Psychiatric Rehabilitation Approach Overview** training for all clinical staff (AODS counselors/specialists, MFTs, LCSWs, ASWs, Interns, RNs, Psychiatrists, Peer Support Specialists, Senior Client Support Specialists and Care Managers) was held on **October 10, 2016**.

VETERANS MENTAL HEALTH RESOURCES

On Veterans Day (November 11), we honor the brave men and women who have served our country and protected our freedom. The wounds of war are not always visible. This edition highlights resources, services, and support for veterans and their families who are facing a mental health challenge.

Military OneSource
Service members, family members, surviving family members, service providers and leaders rely on Military OneSource for policy, procedures, timely articles, cutting-edge social media tools and support. All in one place, empowering our military community. www.militaryonesource.mil

VA National Center for PTSD
Conducts research and provides education on the prevention, understanding and treatment of trauma and PTSD. Short whiteboard videos help explain PTSD. www.ptsd.va.gov

U.S. Department of Veterans Affairs Mental Health
This section of the Department's comprehensive website contains information on self-help, finding help, and detailed info on anxiety, bipolar, depression, military sexual trauma, PTSD, schizophrenia, substance use and suicide prevention. www.mentalhealth.va.gov

The Soldiers Project
Connects current and former service members from the Iraq and Afghanistan wars, along with their families and loved ones, to free, confidential therapy from licensed mental health professionals. This project began in southern California and has a branch in Sacramento. 1-877-576-5343
www.thesoldiersproject.org

NAMI Veterans and Military Resource Center
A basic description of mental health concerns, how to ask for treatment and how to transition to civilian life. Links to resources for Veterans and active duty military, families, friends and advocates.
www.nami.org/Find-Support/Veterans-and-Active-Duty

California Association of County Veterans Service Officers
California Association of County Veterans Service Officers advocate and connect veterans regardless of the type of service or discharge. They also serve veterans' dependents and survivors. Their page also links to other state veterans organizations, such as VFW, American Legion and CalVet. 1-844-737-8838
www.cacvso.org

D-Stress Line
Provides peer support for all Marines, whether regular, reserve, Veteran or retiree, attached sailors, and their families via anonymous 24 hour counseling with clinician backup. 1-877-476-7734 or via live chat. www.dstressline.com

Veterans Crisis Line (also known as the Military Crisis Line)
A 24/7 national crisis line accessible via telephone, text or online chat, offering free confidential support to Veterans, service members and their loved ones. Callers do not have to be registered with the VA or enrolled in VA health care. Support for deaf and hard of hearing individuals is available. Responders are specially trained in helping Veterans. Dial 1-800-273-8255 and press 1. www.veteranscrisisline.net

Supporting Student Veterans
Many community colleges have veterans clubs that are connected with the Student Veterans of America (SVA). Founded in 2008, SVA is a coalition of student veterans groups on college campuses across the United States. These groups coordinate campus activities, provide pre-professional networking, and provide general support for student veterans in higher education.
www.studentveterans.org

Half of Us
Video bios of veteran college students, information to help the vet, family, friends and fellow students understand and support.
www.halfofus.com/situation/veteran-issues

(continued in right-hand column)

KEVIN BERTHIA SPEAKS AT SANTA ROSA JUNIOR COLLEGE

Pictured (clockwise from top-left): suicide prevention advocate Kevin Berthia, event flier, SRJC PEERS Coalition staff with Sonoma County Supervisor Shirlee Zane, who presented the PEERS with a gold resolution for Mental Health Awareness Week.

On October 13, 2016, the **Santa Rosa Junior College (SRJC) PEERS Coalition (People Empowering Each Other to Realize Success)** hosted **Kevin Berthia**, a suicide prevention advocate and speaker. The event was funded with Mental Health Services Act (MHSA) dollars. Over 200 people attended to hear Kevin's powerful story of hope. Thank you to everyone who helped make this event a success!

(Veterans Resources, continued from left-hand column)

PTSD Coach App (for iPhone/Android/Desktop Computer)
The PTSD Coach app can help you learn about and manage symptoms that often occur after trauma.
www.ptsd.va.gov/public/materials/apps/PTSDCoach.asp

inTransition
inTransition assigns a personal coach to support veterans moving between health care systems or providers.
intransition.dcoe.mil

Guide to VA Mental Health Services for Veterans and Families
Guidebook listing mental health resources available to veterans and their families.
www.mentalhealth.va.gov/docs/Guide_to_VA_Mental_Health_Srvcs_FINAL12-20-10.pdf

For more information about MHSA programs and services, or to submit updates, events, success stories, or other content for this newsletter, please contact Amy Faulstich at amy.faulstich@sonoma-county.org. To sign up for this newsletter, go to: www.sonoma-county.org/mhsa.

Newsletter Content: Amy Faulstich; Design: Bruce Robbins

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act Newsletter

28th Edition, December 23, 2016

EachMind MATTERS
California's Mental Health Movement
www.eachmindmatters.org

SanaMente
Movimiento de Salud Mental de California
www.sanamente.org

SCBH'S ELLA JACKSON PRESENTS AT NATIONAL TCOM CONFERENCE!

SCBH's Ella Jackson & John Lyons, founder of the Praed Foundation

The **Transformational Collaborative Outcomes Management (TCOM) Conference** is a national conference offered once a year by the **John Praed Foundation**. The conference brings together individual providers, supervisors, policy analysts, quality assessment and improvement managers and researchers from across the country for a 3 day conference. John Lyons, founder of the Praed Foundation, responsible for developing the CANS and ANSA, as well as other assessment tools, has designed the conference as a forum for participants to gain increased skills and knowledge in the implementation and effective utilization of these assessment tools.

This year's conference was held in Princeton, New Jersey, and offered presentations from Chapin Hill Policy Fellows, Policy Administrators overseeing the Child Welfare system for the state of New Jersey, a collective of supervisors from Italy working on cultural and linguistic adaptations of the CANS for use in Italian schools and many other specialty presenters.

Ella Jackson, Clinical Specialist for Sonoma County Behavioral Health's (SCBH) Transitional Recovery Team & Older Adult Intensive Team, was selected to present. Her presentation, "Addressing Staff Resistance through Humor, Reflective Process and an Individualized Approach", had some of the largest numbers of attendees of any of the breakout sessions. John Lyons was in attendance. Ella was invited to present at the next conference in 2017. The Praed Foundation is making a copy of her presentation available on their website.

www.praedfoundation.org

BEHAVIORAL HEALTH DIVISION STAFF PROVIDES CRISIS INTERVENTION TRAINING (CIT) FOR LOCAL LAW ENFORCEMENT!

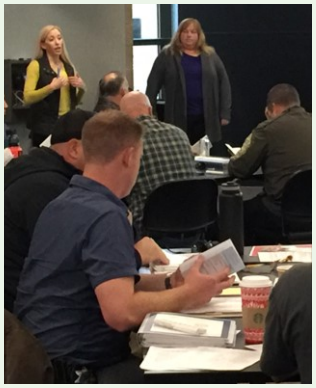
SCBH's Sid McColley addresses the CIT Academy

On December 5-8, 2016, the Sonoma County Behavioral Health Division (SCBH) conducted its 16th Crisis Intervention Training (CIT) Academy for Law Enforcement. The 4-day, 32 hour training academy is designed to increase officers' skills to intervene with mental health consumers, individuals with substance use issues, and individuals in crisis.

The CIT Academy is conducted twice each year. The goals of CIT include:

- Ensure the safety of officers and civilians
- Increase officer understanding of mental illness
- Improve relationships with the community, particularly with mental health professionals, people with mental illness, and family members.

To date, the SCBH Academy has trained over 500 law enforcement personnel, including officers from Sonoma County Sheriff's Department and police departments from Santa Rosa, Petaluma, Cotati, Sonoma Valley, Sebastopol, Cloverdale, Windsor, Healdsburg, and Santa Rosa Junior College.



On left: Cpt. Mark Essick addresses the CIT Academy
On right: SCBH's Katie Bivin & Karin Sellite conduct Question, Persuade, Refer (QPR) suicide prevention training at CIT Academy

Friday, January 27, 2017, 8:30am - 2:10pm
Santa Rosa Junior College, 1501 Mendocino Avenue, Santa Rosa, CA

Latino Service Providers & Santa Rosa Junior College, in cooperation with community sponsors, invite you to a Spring Health Career Symposium for Youth, **"Mi Futuro esta en Carreras de Salud: My Future is in Healthcare Careers."**

The day will expose you to career opportunities in mental & primary health, raise awareness of mental health stigmas in the Latino community, the impact of mental health in primary healthcare and the community beyond. Interactive stations will get your hands dirty in the fields of your future. Dynamic speakers to plant new ideas. Workshops and tabling will offer educational/financial resources. Come explore your future in healthcare!

WHO SHOULD ATTEND?

- 16 - 30 Year Olds
- Interested in a career in Mental Health
- Interested in a career in Primary Healthcare
- Counselors and School Administrators

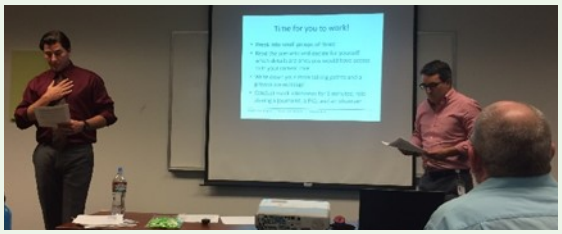
To Register: https://mifuturo2017.eventbrite.com

LATINO Service Providers — ¡Juntos Obtendremos Resultados!

SANTA ROSA JUNIOR COLLEGE

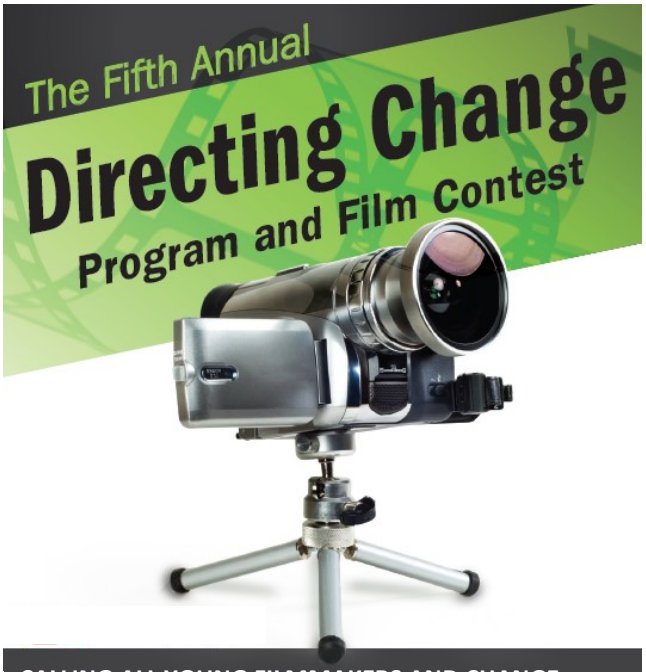
PROPOSITION 63 MENTAL HEALTH SERVICES ACT CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

SUICIDE & MENTAL ILLNESS IN THE NEWS: TRAININGS WITH STAN COLLINS FROM "EACH MIND MATTERS" FEATURED IN LOCAL NEWS MEDIA



Stan Collins from Each Mind Matters & Scott Alonso from DHS

Stan Collins from the **Each Mind Matters** campaign conducted a training on November 9, 2016 for local Sonoma County press on learning state-of-the-art recommendations for reporting appropriately on suicide. The training was held to continue an important dialogue and discuss recommendations for communicating about suicide and mental illness with a review of the AP stylebook entry on "Mental Health" and the "Framework for Successful Messaging" on suicide prevention. Print and broadcast journalists, editors, managers and producers, Public Information Officers and Communication Specialists representing law enforcement, emergency medical services, hospitals, mental health/suicide prevention organizations and professionals, community partners, faith communities, and others in related fields were invited. The event was sponsored by the Sonoma County Department of Health Services (DHS) and Marin Health & Human Services funded with MHSA dollars. To read the article in the Sonoma Index-Tribune, go to:
www.sonomanews.com/home/6411565-181/county-health-officials-stress-suicide?artslide=0



CALLING ALL YOUNG FILMMAKERS AND CHANGE AGENTS!

MAKE A DIFFERENCE AND WIN CASH PRIZES BY CREATING 60-SECOND FILMS THAT WILL BE USED TO RAISE AWARENESS AND HELP YOUNG PEOPLE ACROSS CALIFORNIA.

SUBMISSION CATEGORIES:
SUICIDE PREVENTION • MENTAL HEALTH MATTERS • THROUGH THE LENS OF CULTURE

SUBMISSIONS ARE DUE MARCH 1, 2017

The **Directing Change Program & Film Contest** is part of **Each Mind Matters: California's Mental Health Movement**. The program offers young people the exciting opportunity to participate in the movement by creating 60-second films about suicide prevention and mental health that are used to support awareness, education and advocacy efforts on these topics. Learning objectives surrounding mental health and suicide prevention are integrated into the submission categories of the film contest, giving young people the opportunity to critically explore these topics.

In the 2016 Contest, Sonoma County's own **Alex Diaz Pena** from **El Molino High School** won Second Place in the Suicide Prevention category in Region 5 (which contains 32 counties) for his film *"A Conversation Can Save a Life"*.

View Alex's film:
https://youtu.be/nD5oHL63jW8

For more information, visit:
www.directingchange.org

For more information about MHSA programs and services, or to submit updates, events, success stories, or other content for this newsletter, please contact Amy Faulstich at amy.faulstich@sonoma-county.org. To sign up for this newsletter, go to: www.sonoma-county.org/mhsa.

Newsletter Content: Amy Faulstich; Design: Bruce Robbins

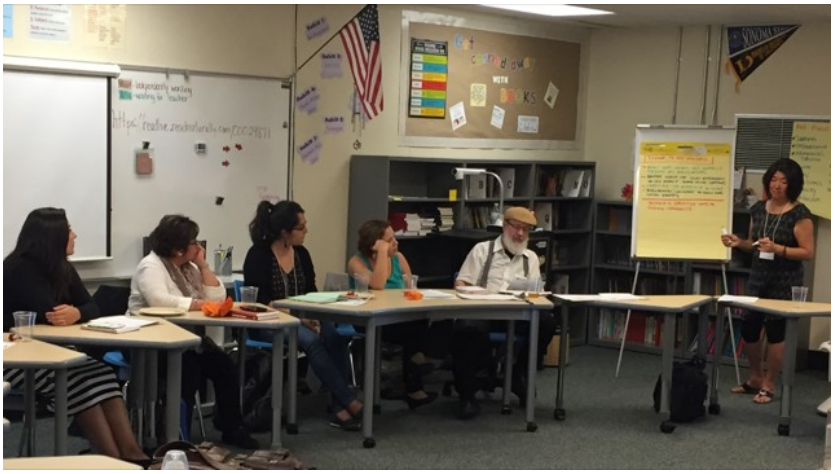
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act Newsletter

29th Edition, January 13, 2017

SUSAN CASTILLO & WANDA TAPIA DISCUSS IMPORTANCE OF STATE MENTAL HEALTH GRANT AWARDED TO LATINO SERVICE PROVIDERS



Members of the Testimonios project's Concilio Advisory Group

On July 11, 2016, the **California Department of Public Health (CDPH)** announced an intent to Award $13 million in grants to California Reducing Disparities Pilot Projects to help reduce mental health disparities in communities that have traditionally been underserved. Local organization **Latino Service Providers (LSP)**, a Mental Health Services Act (MHSA) funded contractor, was among the 11 awardees receiving grants totaling $1.18 million in funding over the course of five and a half years.

Latino Service Providers work within the Latino community with a unique program called **Testimonios**. The goal of this project is to recruit and train mental health **Promotores** to launch a community-wide bilingual and Spanish speaking educational campaign to reduce stigma surrounding mental health, increase awareness of resources, and encourage workforce development in behavioral health careers.

SUSAN CASTILLO
Community Mental Health Section Manager for Sonoma County Behavioral Health

What are you most excited about achieving through this program/ initiative?

I am excited for the opportunity to infuse culturally responsive mental health services through this program. I am also very pleased that Latino Service Providers is receiving statewide recognition for their model of community engagement. I am also excited that our MHSA Coordinator, Amy Faulstich, will be participating in this project as a partner, furthering the Behavioral Health Division's outreach to the Latino community and increasing access to mental health resources within the Latino community.

What is the value of community partnership to achieving success?

The value of this community partnership is to highlight a successful

(continued on page 2)

THE CONSUMER RELATIONS PROGRAM OF GOODWILL-REDWOOD EMPIRE INVITES YOU TO A THEATRICAL PREMIERE SCREENING OF…

HEALINGVOICES

Wednesday, March 8, 2017
Glaser Center, 547 Mendocino Avenue, Santa Rosa

Light refreshments will be served at 5:30pm
Screening starts at 6:00pm

Join us for Sonoma County's theatrical premiere of **HEALING VOICES**, a groundbreaking social action documentary which explores the experience labeled as "psychosis" and has brought together communities around the world to engage in healing and hopeful community dialogue.

This FREE event includes Q&A with key members of the Sonoma County mental health and public health communities.

For more information, please visit:
www.healingvoicesmovie.com

SAVE THE DATE: MARCH 15 & 16, 2017

CIBHS | LEADERS IN POLICY, TRAINING, EVALUATION, AND RESEARCH

The California Institute for Behavioral Health Solutions (CIBHS) presents the **"2017 Cultural Competence Summit XX: Supporting Community Defined Practices"** to take place at the Hyatt Vineyard Creek Hotel in Santa Rosa! The Summit will highlight Community Defined Practices used by disparate communities to reduce stigma and to increase access to mental health services for populations that have historically been unserved or underserved.

For more information, visit: www.cibhs.org

(continued from page 1)

model of how local government can support smaller local organizations to compete for funding at a statewide level, ultimately benefiting the entire county. This funding will support the implementation of community defined practices for mental health, changing the way we think about service provision and access to care. The other value achieved through this project is the opportunity for Latino youth to explore careers in behavioral health. The Behavioral Health Division is always working to find ways to diversify our workforce and recruit bilingual and bicultural Spanish-speaking providers within our system of care.

WANDA TAPIA

Executive Director for Latino Service Providers

What are you most excited about achieving through this program/ initiative?

There are many exciting outcomes that will result from this program. First, a basic one-on-one communication method using traditional Latino cultural practices. Second, with media messaging, we are reaching virtually every demographic, from the young to the old. By investing in Youth Promotores, we are empowering them to be their own healers and advocates. These young people may go on to be our mental health service providers! This initiative will lead to an evidence based practice that may be adopted throughout California and further.

What is the value of community partnership to achieving success?

It takes a community to reduce stigma and reduce disparities in the field of mental health. A comprehensive community wide campaign of acceptance and knowledge about mental health issues, access and authentic support will result in better understanding and the ability to respond to mental health issues for ourselves and our loved ones. It is imperative that we remain united through today's climate and with the support of our community based organizations, media, educational institutions, artists, and individuals we can achieve success.

For more information on Latino Service Providers and the California Reducing Disparities Project (CRDP):

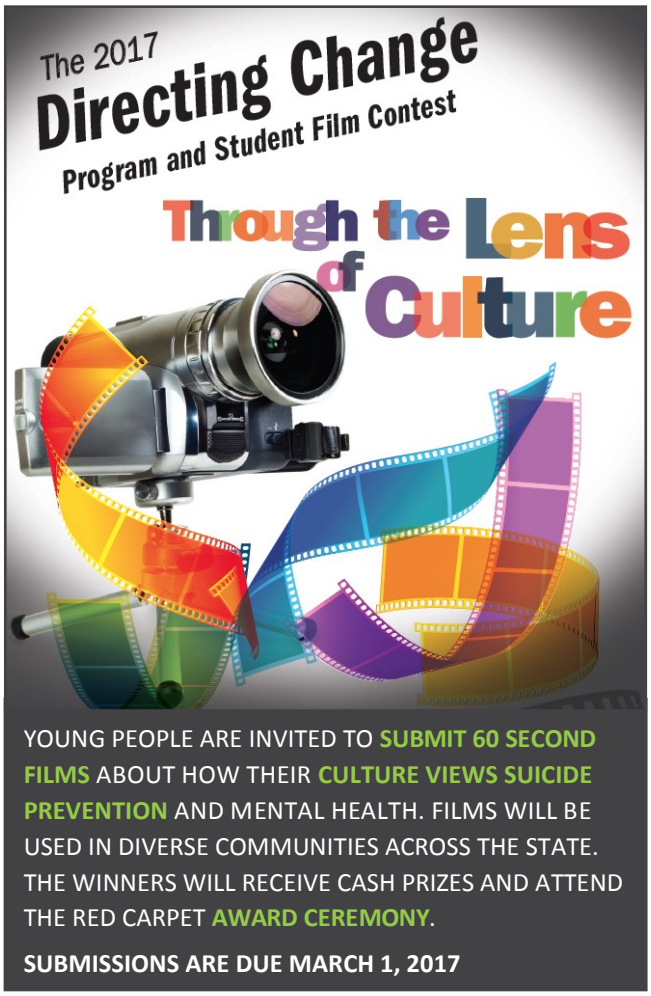
www.latinoserviceproviders.org

www.cdph.ca.gov/programs/Pages/OHECaliforniaReducingDisparitiesProjectPhaseII.aspx

SCIHP AWARDED STATE MENTAL HEALTH GRANT!

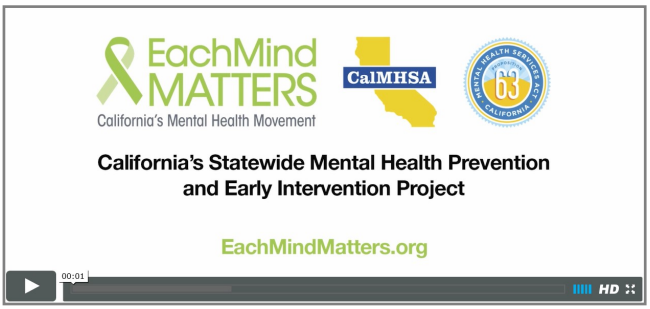
SONOMA COUNTY INDIAN HEALTH PROJECT

On January 12, 2017, the **California Department of Public Health (CDPH), Office of Health Equity** announced the intent to award for the Native American Implementation Pilot Project as part of Phase II of the California Reducing Disparities Project (CRDP). CDPH will award $1.14 million to **Sonoma County Indian Health Project (SCIHP)** over six years to implement Phase II of CRDP. The primary goal of the project is to validate community-defined evidence practices through rigorous evaluation. Congratulations!



Visit www.DirectingChange.org for contest rules and educational resources.

CA STATEWIDE PREVENTION & EARLY INTERVENTION PROJECT VIDEO



Watch the video at: http://tinyurl.com/CalMHSA-PEI

UPCOMING WEBINARS:

"Changing conversations about mental health & suicide in schools & communities: Free programs & resources"
1/26/17, 2:30pm-3:30pm, Each Mind Matters
https://attendee.gotowebinar.com/register/1669408675583618563

"Suicide prevention in schools"
1/24/17, 10am-11:30am, CA Department of Education
http://tinyurl.com/CDE-SuicidePrevention

For more information about MHSA programs and services, or to submit updates, events, success stories, or other content for this newsletter, please contact Amy Faulstich at amy.faulstich@sonoma-county.org. To sign up for this newsletter, go to: www.sonoma-county.org/mhsa.

Newsletter Content: Amy Faulstich; Design: Bruce Robbins

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

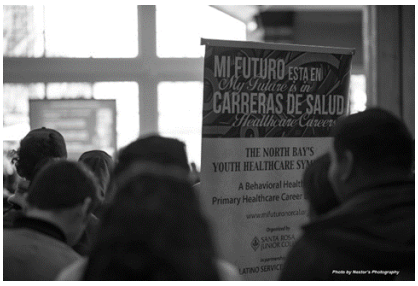
Mental Health Services Act Newsletter

30th Edition, February 21, 2017

SPOTLIGHT ON WORKFORCE, EDUCATION & TRAINING (WET)

This issue of the Mental Health Services Act (MHSA) Newsletter highlights several MHSA funded local and regional **Workforce, Education & Training (WET)** programs and services in Sonoma County. These activities support the County's efforts to recruit bilingual and bicultural (especially Spanish-speaking) behavioral health providers. This issue also highlights the work of WET staff that are facilitating training to support peers - individuals with lived mental health experience - that are working in the Sonoma County Behavioral Health Division workforce.

MI FUTURO ESTA EN CARRERAS DE SALUD: THE NORTH BAY'S SECOND ANNUAL YOUTH HEALTHCARE SYMPOSIUM



On January 27, 2017, **350 students** assembled with local healthcare professionals in the Bertolini Student Center at Santa Rosa Junior College (SRJC) for the North Bay's second annual youth healthcare symposium: **Mi Futuro Esta en Carreras de Salud (My Future is in Healthcare Careers)**. Mi Futuro is an event that informs, motivates, and compels youth to consider careers in the mental health and primary healthcare fields.

Musetta Perezarce, Dr. Sergio Aguilar-Gaxiola, & Wanda Tapia

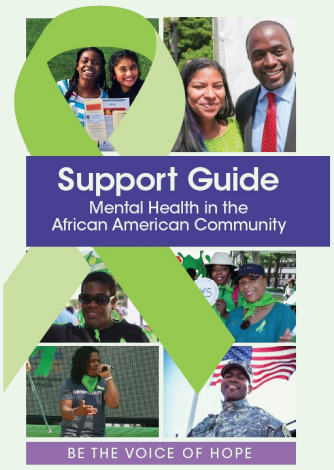
After Kaiser Permanente Nursing Supervisor and SRJC teacher **Musetta Perezarce** and Latino Service Providers Executive Director **Wanda Tapia** welcomed the standing room only audience to the 2017 conference, the event's keynote speaker, **Sergio Aguilar-Gaxiola** MD, PhD, Professor of Clinical Internal Medicine, School of Medicine, University Of California, Davis, asked symposium attendees to examine what he calls the "Treatment Gap", or healthcare gaps and disparities in Latinos.

Dr. Aguilar-Gaxiola explained how unmet healthcare needs can play a significant role in mental illness, and only a minority of Latinos with even severe disorders are receiving treatment. Using data and statistics to show that Latino health workers are underrepresented in the California workforce, Dr. Aguilar-Gaxiola challenged the youth to consider their future in healthcare and how they could contribute to the alleviation of unmet needs, to the increase and allocation of treatment resources, and to the expansion of the healthcare workforce among Latinos.

The symposium is funded in part by the **Mental Health Services Act (MHSA)**.

(continued on Page 2)

IN RECOGNITION OF BLACK HISTORY MONTH, "EACH MIND MATTERS" CREATES MENTAL HEALTH SUPPORT GUIDE FOR AFRICAN AMERICAN COMMUNITIES



February is a time to honor **Black History Month** – a time to celebrate the contributions African American leaders have made to our society for hundreds of years.

It is also a prime opportunity to reflect and ensure that the next wave of dreamers, trailblazers, and game-changers have the supportive environments they need to reach their full potential. African Americans have historically been underserved or unserved by the mental health system.

The **Each Mind Matters** team recently convened a strategic council of African American leaders and stakeholders to develop a mental health support guide and a church fan for the African American Community. To download these free resources and learn about the strategic council, please visit:

www.eachmindmatters.org/get-involved/spread-the-word/mhsc-africanamerican/

CALLING ALL YOUNG FILMMAKERS and change agents! Make a difference and win cash prizes by creating 60 second films that will be used to **RAISE AWARENESS** and **HELP YOUNG PEOPLE** across California. Submission categories are ***Suicide Prevention***, ***Mental Health Matters***, & ***Through the Lens of Culture***.

Submissions are due **MARCH 1, 2017**

Visit www.DirectingChange.org for contest rules and educational resources.

(continued from page 1)

The following organizations contributed to the Mi Futuro event: Sutter Santa Rosa Regional Hospital, Kaiser Permanente Santa Rosa, St. Joseph Health System, Sonoma County Department of Health Services Behavioral Health Division, California Office of Statewide Health Planning & Development (OSHPD), Petaluma Health Care District, Sonoma County Office of Education, Career Technical Education Foundation Sonoma County, Santa Rosa Junior College, and Latino Service Providers.

For more information go to the Mi Futuro website at: www.mifuturonorcal.org

BEHAVIORAL HEALTH DIVISION STAFF FEATURED IN BAY AREA WORKFORCE CO-LEARNING COLLABORATIVE (WCC) NEWSLETTER

United Advocates for Children and Families (UACF) is a non profit organization with a mission to improve the quality of life for all children and youth with mental, emotional, and behavioral challenges and to eliminate institutional discrimination and social stigma. In January 2015, UACF was awarded a contract with California's Office of Statewide Health Planning and Development (OSHPD) to serve Bay Area Public Mental Health Services (PMHS) employers, including enhancing their ability to employ and support consumers and family members in the workforce. This project is known as the **Bay Area Workforce Co-learning Collaborative (WCC)**.

Melissa Ladrech

The latest WCC quarterly newsletter features two Sonoma County Behavioral Health Division (SC-BHD) staff members, **Melissa Ladrech** and **Wendy Wheelwright**. The newsletter highlights a two-day "Training for Trainers" (T4T) that UACF and WCC partners completed in February 2016. The title of the training was "Strategies for Employers to Support Consumers and Family Members in the Workforce". The training curriculum was facilitated by three WCC partners, including Melissa Ladrech, SC-BHD's interim Quality Improvement Manager and former WET Coordinator.

Welcome to the new WET Coordinator

Wendy Wheelwright

The WCC newsletter also featured Wendy Wheelwright, SC-BHD's new WET Coordinator, and her work training peer providers and staff. Wendy has been a clinician within Community Mental Health for the past 20 years. Prior to assuming her role at SC-BHD, she worked with Progress Foundation overseeing the start-up, day-to-day operation, and expansion of the SC-BHD Crisis Residential Unit from a single 6-bed program to multiple 10-12 bed programs.

Wendy also has extensive experience as a forensic therapist, working with mandated treatment programs, Probation, CPS, and Victim Assistance. Wendy has a strong passion for teaching and currently holds a faculty position with the University of San Francisco, teaching in the Masters in Counseling program on weekends and evenings. Wendy is also an opera singer in her spare time.

Congratulations to Melissa and Wendy for being featured in the WCC newsletter! For more information about UACF and the WCC, go to:

www.uacf4hope.org/bay-area-workforce-co-learning-collaborative

EACH MIND MATTERS WEBINAR SERIES

Each Mind Matters, California's Mental Health Movement, is offering a new webinar series that is part of statewide efforts to prevent suicide, reduce stigma and discrimination related to mental illness, and to promote the mental health and wellness of students. These initiatives are funded by counties through the Mental Health Services Act (Prop 63) and administered by the California Mental Health Services Authority (CalMHSA), an organization of county governments working to improve mental health outcomes for individuals, families and communities.

"Changing conversations about mental health & suicide in schools & communities: Free programs & resources"
(Held on 1/26/17). View the webinar recording here:
https://attendee.gotowebinar.com/recording/3448414091657277954

"Learning Exchange: Tips and Tools for May is Mental Health Awareness Month"
March 7, 2017, 1-2 pm
https://attendee.gotowebinar.com/register/1842279391725737729

"SanaMente: Resources for Latino Communities"
April 4, 2017, 1-2 pm
https://attendee.gotowebinar.com/register/294849816537989633

"Mental Health Resources for Diverse Communities"
May 2, 2017, 1-2 pm
https://attendee.gotowebinar.com/register/8210419842362519297

"Skills Building Webinar: Suicide Prevention"
June 6, 2017, 1-2 pm
https://attendee.gotowebinar.com/register/3870779388925992193

COMMUNITY INPUT SURVEY FOR MHSA 3-YEAR INTEGRATED PLAN - WE WANT TO HEAR FROM YOU!

In Sonoma County, the **Mental Health Services Act (MHSA)** aims to create a local mental health system that focuses on wellness and recovery, is consumer, client and family member driven, promotes a vision in which recovery is possible, and delivers culturally responsive and linguistically appropriate services.

The **Behavioral Health Division** is undertaking an integrated planning process to strengthen and enhance existing MHSA services. We need your input on current services offered and underserved populations living with mental health challenges. We also need your feedback on new ideas for expanded services that could be provided in the future, as well as your ideas of new and/or expanded services you would like to see supported by the MHSA funds in Sonoma County.

The **Community Input Survey** should take no longer than 3-5 minutes to complete. All sections of the survey are anonymous. Thank you for taking the time to share your opinions and ideas for the **3-Year Integrated Plan**, and we look forward to hearing from you. The survey closes on **March 10, 2017**. To complete the survey, visit:

www.surveymonkey.com/r/MHSANewsletter

For more information about MHSA programs and services, or to submit updates, events, success stories, or other content for this newsletter, please contact Amy Faulstich at amy.faulstich@sonoma-county.org. To sign up for this newsletter, go to: www.sonoma-county.org/mhsa.

Newsletter Content: Amy Faulstich; Design: Bruce Robbins

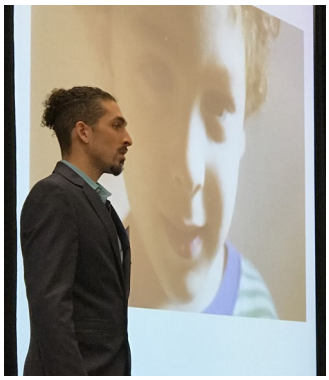
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act Newsletter

31st Edition, March 31, 2017

BEHAVIORAL HEALTH DIVISION'S COMMUNITY PARTNERS FEATURED AT STATEWIDE CULTURAL COMPETENCE SUMMIT



Left: Congressman Patrick Kennedy and Kevin Berthia. Right: Javier Rivera

The Sonoma County Behavioral Health Division (SC-BHD) would like to acknowledge the work of our community partners that participated in the recent **Cultural Competence Summit XX** on March 15 and 16 in Santa Rosa. This statewide behavioral health conference was organized by the California Institute for Behavioral Health Solutions and highlighted community-defined practices used by cultural communities to reduce stigma and to increase access to mental health services and treatment throughout California counties. The following community partner organizations will be recognized by the Sonoma County Board of Supervisors for their work at the Summit: Positive Images, Latino Service Providers, Sonoma County Indian Health Project, Community Baptist Church, and Kawahara and Associates.

Keynote Speakers

The first day of the Summit featured keynote addresses given by former Congressman Patrick Kennedy of Rhode Island and suicide survivor Kevin Berthia. (The attendance of both speakers was secured by SC-BHD.) Community partner Positive Images' Javier Rivera delivered a keynote address on the final day of the Summit.

Congressman Kennedy & SC-BHD Director Mike Kennedy

Upon his retirement from Congress, **Patrick Kennedy** founded the Kennedy Forum, which unites the community of mental health, and co-founded One Mind for Research, a global leader in open science collaboration in brain research. Congressman Kennedy's remarks at the Summit focused on "mental health parity", which seeks to ensure that mental health is treated on-par with physical health.

Kevin Berthia shared his journey of hope and recovery as a suicide survivor. In 2005, Berthia plotted to take his own life by jumping off the Golden Gate Bridge but it was a first responder's listening ear that eventually brought Kevin to the safe side of the railing. **Javier Rivera**, the Program Director of Positive Images, and LGBTQ+ partner with SC-BHD, spoke about the work of his organization to provide culturally relevant services to youth.

(continued on next page)

THE MANY FACES OF YOUTH MENTAL HEALTH: FOSTERING SOLUTIONS, RESILIENCY AND HOPE

The **Teen Health Advocacy Coalition (THAC)** of Sonoma County, in conjunction with the Sonoma County Behavioral Health Division, presents "The Many Faces of Youth Mental Health: Fostering Solutions, Resiliency and Hope."

May 4, 2017, 8am-4:30pm
Finley Center, 2060 West College Avenue, Santa Rosa
Cost: $55, includes meals & optional CEU credits

This conference will bring together a dynamic group of speakers that include survivors and professionals to address the issues surrounding youth mental health and to provide tangible resources to youth serving providers, educators, community members, parents and youth themselves.

The keynote speaker will be **Kevin Hines**, an award-winning global speaker, bestselling author, and suicide prevention and mental health advocate who has reached millions with his story of an unlikely survival of a Golden Gate Bridge jump.

To register, visit:
www.picatic.com/manyfacesofmentalhealth

May is Mental Health Matters Month

Every May the nation comes together to raise awareness about mental health. **Each Mind Matters (EMM)** encourages everyone to start conversations, listen openly to one another and support a loved one with mental health challenges. EMM has created its **May is Mental Health Matters Month 2017 Toolkit** to assist you in carrying the mental health movement forward in your community. The toolkit includes:

- Sidewalk Talk - Volunteer Opportunity & 7 Listening Tips
- "Say This, Not That" tip sheet to start meaningful conversations
- Lime Green Spirit and Ribbon Wall Activities
- Pre-written social media posts to use on your channels
- Drafted email blasts to distribute to your network every Monday during May
- "May is Mental Health Matters Month" 11x17 poster
- Link to videos to inspire your May activities

www.eachmindmatters.org/get-involved/spread-the-word/toolkit-may-mental-health-matters-month-2017/

(continued from Page 1)

Community Partner Participation

Two community partners who contract with SC-BHD – Latino Service Providers (LSP) and Sonoma County Indian Health Project (SCIHP) – delivered presentations at the Summit. SC-BHD staff, as well as consultant Kawahara and Associates, provided assistance to these partners in applying for their conference presentations.

Left: Musetta Pezearce and Wanda Tapia. Right: Dave Smith and Cecilia Dawson

LSP and SCIHP are both funded by the state's Mental Health Services Act (MHSA), which is administered locally by SC-BHD. Each of these contractors recently received over a million dollars from the state for their work reducing disparities for those seeking mental health services and bolstering the local mental health workforce, with a focus on the Latino and California Native American community here in Sonoma County.

Latino Service Providers received funding last year from the California Department of Public Health (CDPH) totaling $1.18 million over five years. This funding will aid LSP in recruiting and training mental health Promotores. These Promotores are launching a community-wide bilingual and Spanish-speaking educational campaign to reduce stigma surrounding mental health, increase awareness of resources, and encourage workforce development in behavioral health careers. LSP is also assisting the County in recruiting and hiring bilingual and bicultural Spanish-speaking staff.

Sonoma County Indian Health Project received $1.14 million from CDPH as part of Phase II of the California Reducing Disparities Project. SCIHP's Aunties and Uncles Program, a Community-Defined Evidence Practice, will provide community-level suicide prevention and mental health stigma and discrimination reduction with its implementation of the Sonoma County funded model.

Left: Manchester Pt. Arena Band of Pomo Indians. Right: James Coffee, Jr. and his band.

The Community Baptist Church Collaborative's MHSA-funded Safe Harbor program participated in the Summit by sharing their music. Sonoma County Indian Health Project also worked with local Native American dancers to provide a blessing of the food with the Manchester Pt. Arena Band of Pomo Indians.

SAVE THE DATE!

WELLNESS • RECOVERY • RESILIENCE

The Behavioral Health Division presents a Public Hearing to review the Mental Health Services Act (MHSA) Three-Year Integrated Plan for 2017-2020 and Annual Update for 2015-2016

Tuesday, May 16, 2017
5:00 to 7:00 PM
Finley Center, Person Senior Wing
2060 West College Avenue
Santa Rosa 95401

Please join us for an informative evening discussing the services provided by MHSA-funded programs throughout the community, and by Sonoma County Behavioral Health. You'll hear from individuals who are transforming their lives with the help of these programs. There will also be an opportunity for public comment.
Contact: 707-565-4850

Aging with Dignity: Preparing for Graceful Transitions

May 18, 2017 - Finley Community Center, Person Senior Wing
2060 West College Avenue, Santa Rosa

Presented by Santa Rosa Family Residency Program, the 5th Annual **Asian & Pacific Islander Health Forum** is Northern California's premier health education conference focusing on the Asian and Pacific Islander Communities. Seating is Limited - Registration is now open. To download registration, exhibitor, and sponsorship forms, visit: http://asianhealthforum.wix.com/apihf

EACH MIND MATTERS WEBINAR SERIES

Each Mind Matters, California's Mental Health Movement, is offering a new webinar series that is part of statewide efforts to prevent suicide, reduce stigma and discrimination related to mental illness, and to promote the mental health and wellness of students.

"SanaMente: Resources for Latino Communities"
April 4, 2017, 1-2 pm
https://attendee.gotowebinar.com/register/294849816537989633

"Mental Health Resources for Diverse Communities"
May 2, 2017, 1-2 pm
https://attendee.gotowebinar.com/register/8210419842362519297

"Skills Building Webinar: Suicide Prevention"
June 6, 2017, 1-2 pm
https://attendee.gotowebinar.com/register/3870779388925992193

For more information about MHSA programs and services, or to submit updates, events, success stories, or other content for this newsletter, please contact Amy Faulstich at amy.faulstich@sonoma-county.org. To sign up for this newsletter, go to: www.sonoma-county.org/mhsa.

Newsletter Content: Amy Faulstich; Design: Bruce Robbins

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act Newsletter

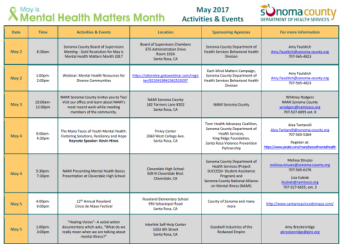
32nd Edition, May 1, 2017

May is Mental Health Matters Month

Every May, Sonoma County comes together to raise awareness about mental health. In Sonoma County, approximately seven percent of the population lives with a serious mental illness. Each year, 20 percent of Sonoma County residents will experience a mental health issue that impacts their ability to function effectively in some area of their life.

Through increased outreach efforts and other opportunities during **Mental Health Matters Month**, the Behavioral Health Division, in collaboration with community partners, emphasizes the importance and effectiveness of increasing awareness of mental health services and decreasing stigma by hosting a variety of activities and events. This year's Activity & Event Calendar can downloaded at the following link:

www.sonomacounty.ca.gov/Health/News/May-is-Mental-Health-Matters-Month-2017/


May is Mental Health Matters Month — May 2017 Activities & Events

The **Each Mind Matters** campaign encourages everyone to start conversations, listen openly to one another and support a loved one with mental health challenges. For Mental Health Matters Month tools and resources go to:

www.eachmindmatters.org/get-involved/spread-the-word/toolkit-may-mental-health-matters-month-2017/

BOARD OF SUPERVISORS TO PROCLAIM MAY 2017 AS "MENTAL HEALTH MATTERS MONTH" IN SONOMA COUNTY

Board will also recognize local "Reducing Disparities" organizations for their work at the recent Cultural Competence Summit

At the Sonoma County Board of Supervisors meeting on May 2, 2017, the Department of Health Services will be requesting that the Board adopt a gold resolution proclaiming May 2017 as Mental Health Matters Month in Sonoma County. Since 1949, activities associated with National Mental Health Matters Month have increased the public's awareness of mental health issues. Through increased outreach efforts and other opportunities during this month, Department staff, contract providers, Sonoma County Mental Health Board members, and National Alliance on Mental Illness (NAMI) staff will emphasize the

(continued on next page)

THE RESULTS ARE IN! SEE THE DIRECTING CHANGE REGIONAL WINNERS

In the past 4 years, over 4,000 young adults have participated in the **Directing Change Program and Film Contest** by creating 60-second films on suicide prevention and mental health. The regional winners for the 2017 Contest have been announced, including the following Sonoma County films:

"Reach Out" (Analy High School)
Regional 3rd Place, High School Suicide Prevention
Filmmakers: Brad Demarest, Payton Cords & Ben Tiche
Advisor Name: Ann Humphrey
https://youtu.be/a7B5vao68Wk

"Reading the Signs" (El Molino High School)
Statewide 2nd place, Through the Lens of Culture - Suicide Prevention
Filmmakers: Jesse Osman
Advisor Name: Seth Friesen
https://youtu.be/W2e93ulplnY

Congratulations to these Sonoma County filmmakers!
For more information: www.directingchange.org

SanaMente INTRODUCES NEW WEBSITE, RESOURCES FOR LATINOS

SanaMente has developed new materials and resources to support Latino mental health. In the past year, 1 in 5 Latinos experienced a mental health challenge. However, Latinos are one of the groups least likely to seek help for mental illness due to reasons which include language fluency, cultural barriers and access to health coverage. The new vibrant Spanish language SanaMente website features a mental health support guide, fotonovelas and activity guides, fact sheets, and more! Visit the site here: www.sanamente.org/

(continued from Page 1)

importance and effectiveness of increasing awareness of mental health services and decreasing stigma; promoting peer employment, empowerment, and self-help; integrated mental health and substance use service delivery; and similar principles of recovery in community mental health.

The following organizations will also be recognized by the Board for their work at the recent **Cultural Competence Summit XX 2017**: Latino Service Providers, Sonoma County Indian Health Project, Positive Images, Community Baptist Collaborative, and Kawahara and Associates.

The Summit, organized by the California Institute for Behavioral Health Solutions (CIBHS) and hosted and planned this year by Sonoma County, highlighted Community Defined Practices used by cultural communities to reduce stigma and to increase access to mental health services and treatment throughout California counties.

Latino Service Providers (LSP) delivered two presentations at the conference, including a workshop on "Growing a Bilingual Workforce". **Sonoma County Indian Health Project (SCIHP)** conducted a workshop on their Aunties and Uncles Project entitled, "Healing California Native Communities Through Meaningful and Collaborative Partnership". SCIHP also worked with local Native American dancers of the Manchester Pt. Arena Band of Pomo Indians to provide a blessing of the food at the Summit.

Javier Rosales, interim executive director of **Positive Images**, delivered a keynote address on "Practicing Cultural Humility and Understanding LGBTQ+ Challenges". **Community Baptist Collaborative's** Reverend Lee Turner gave a blessing and then shared music from the Collaborative's Safe Harbor Project. **Kawahara and Associates** provided key technical assistance to the "Reducing Disparities" organizations that applied to present at the conference. Kawahara also supported LSP and SCIHP in their successful grant award from the California Department of Public Health's Office of Health Equity of $1.18 and $1.14 million, respectively.

The Behavioral Health Division would like to offer a special thanks to the **MHSA Integrated Plan Advisory Committee**, which played an active role in guiding the local MHSA integrated planning process. Between November 2016 and April 2017, stakeholder representatives met frequently to provide oversight and direction in the community engagement process. Committee members also played a key role in the distribution of the **MHSA Community Input Survey** that collected feedback on current services offered, underserved populations living with mental health challenges, and new ideas for expanded services that could be provided in the future. For more information on the Committee and its work, see the DRAFT MHSA Three-Year Integrated Plan at: www.sonoma-county.org/mhsa

The Behavioral Health Division presents a Public Hearing to review the Mental Health Services Act (MHSA) Three-Year Integrated Plan for 2017-2020 and Annual Update for 2015-2016

Tuesday, May 16, 2017
5:00 to 7:00 PM
Finley Center, Person Senior Wing, 2060 West College Avenue, Santa Rosa

Please join us for an informative evening discussing the services provided by MHSA-funded programs throughout the community, and by Sonoma County Behavioral Health. You'll hear from individuals who are transforming their lives with the help of these programs. There will also be an opportunity for public comment. The MHSA Three-Year Plan and Annual Update is available at: www.sonoma-county.org/mhsa

Please submit comments or questions to: Amy.Faulstich@sonoma-county.org

Contact: 707-565-4850

Aging with Dignity: Preparing for Graceful Transitions

May 18, 2017 - Finley Community Center, Person Senior Wing 2060 West College Avenue, Santa Rosa

Presented by Santa Rosa Family Residency Program, the 5th Annual **Asian & Pacific Islander Health Forum** is Northern California's premier health education conference focusing on the Asian and Pacific Islander Communities. Seating is Limited - Registration is now open. To download registration, exhibitor, and sponsorship forms, visit: http://asianhealthforum.wix.com/apihf

EACH MIND MATTERS WEBINAR SERIES

Each Mind Matters, California's Mental Health Movement, is offering a new webinar series that is part of statewide efforts to prevent suicide, reduce stigma and discrimination related to mental illness, and to promote the mental health and wellness of students.

"Mental Health Resources for Diverse Communities"
May 2, 2017, 1-2 pm
https://attendee.gotowebinar.com/register/8210419842362519297

"Skills Building Webinar: Suicide Prevention"
June 6, 2017, 1-2 pm
https://attendee.gotowebinar.com/register/3870779388925992193

For more information about MHSA programs and services, or to submit updates, events, success stories, or other content for this newsletter, please contact Amy Faulstich at amy.faulstich@sonoma-county.org. To sign up for this newsletter, go to: www.sonoma-county.org/mhsa.

Newsletter Content: Amy Faulstich; Design: Bruce Robbins

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

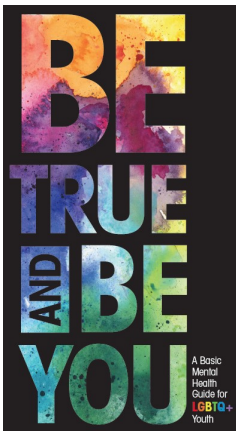
WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act Newsletter

33rd Edition, June 20, 2017

RECOGNITION OF PRIDE MONTH - NEW RESOURCES FOR THE LGBTQ+ COMMUNITY

Just in time for Pride Month, the **Each Mind Matters LGBTQ+ Strategic Council** announced the release of new materials for the LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, and other identities) community. Pride Month is held in June to commemorate the Stonewall riots, which occurred in June 1969, and to recognize the impact LGBTQ+ people have had in the United States. Pride Month promotes self-affirmation and equal rights for the LGBTQ+ community, and celebrates diversity in sexual orientation and gender identity.



Each Mind Matters collaborated with a strategic council of LGBTQ+ community leaders and stakeholders to create mental health materials for key segments of the LGBTQ+ population, including youth/young adults and older adults. To view the new resources online and learn more about the strategic council, visit:

www.eachmindmatters.org/new-resources-lgbtq-community/

The Behavioral Health Division partners with Positive Images to provide support to LGBTQ+ youth in Sonoma County. For more information, go to:

http://posimages.org/

September 15-16, 2017 at Sonoma State University

The **LGBTQ+ Summit** establishes a culturally diverse coalition that defines the collective impact that attendees want to have in their communities. The Summit's goals and projects seek to raise LGBTQ+ awareness, inspire community development and empower direct action. Attendees will gain awareness, information, and concrete ways to participate in activities that empower and motivate the community regardless of sexual orientation, gender identity, and/or personal stance.

By collaboratively creating and designing a specific project, each attendee will be empowered to implement short and long term goals in their work or family environments, and/or the many interwoven systems that impact LGBTQ+ peoples. For more information, visit: www.lgbtqsummit.com/

BOARD OF SUPERVISORS PROCLAIMS MAY AS MENTAL HEALTH MATTERS MONTH IN SONOMA COUNTY!

HIGHLIGHTS FROM May is Mental Health Matters Month 2017

In recognition of **Mental Health Matters Month** this past May, many great events were held throughout Sonoma County. The Behavioral Health Division would like to thank everyone that participated to increase education around mental health. In this issue are just some of the photos we received from our community partners from their mental health month activities.

*The **Sonoma County Mental Health Board** listens to public comment during the public hearing for the Mental Health Services Act Three-Year Integrated Plan and Annual Update.*

*Individuals from MHSA-funded organizations **Positive Images** and **Santa Rosa Junior College's PEERS Coalition** were among the many people who gave public comment at the hearing.*

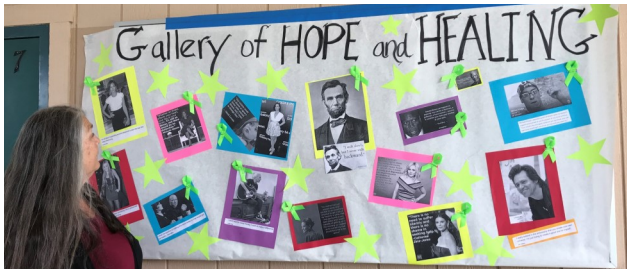
HIGHLIGHTS FROM May is Mental Health Matters Month 2017

*Left: Stan Collins from Each Mind Matters addresses attendees of the **Teen Health Advocacy Coalition of Sonoma County's "Many Faces of Youth Mental Health" conference**. Right: Sonoma County Behavioral Health's Amy Faulstich, speakers Kevin Briggs & Kevin Berthia, and Santa Rosa Junior College's Jeane Erlenborn.*

*The **Petaluma Police Department (PPD)** displays lime green ribbons in support of Mental Health Matters Month. During May, PPD collaborated with Buckelew Programs & other organizations to bring mental health resources to the community.*

*Left: Honor Jackson addresses attendees of Community Baptist Church Collaborative's first annual **African American Mental Health Conference**. Right: Melba Smith, Assistant Program Manager of Goodwill's Wellness and Advocacy Center.*

*Six individuals graduate from Sonoma County's **Forensic Assertive Community Treatment (FACT)** program. FACT provides community-based treatment as an alternative to incarceration to people referred through the Mental Health Court.*



*Project SUCCESS Plus created a "Gallery of Hope and Healing" at **Laguna High School** in Sebastopol to help celebrate Mental Health Matters Month.*

*Traditional dancers perform at the **5th Annual Asian & Pacific Islander (API) Health Forum**, Northern California's premier health education conference focusing on the API communities.*

Sonoma County Behavioral Health presents its 2nd annual

YOUTH MENTAL HEALTH TRAINING ACADEMY

July 10-14, 2017 8am-5pm
Sonoma County Office of Education
5340 Skylane Blvd, Santa Rosa

The ideal participants are individuals who are new to or have limited experience with working with youth with mental health challenges. Participants will visit key service sites. The purpose of this **FREE** Training Academy will be to increase and/or improve Sonoma County youth providers' understanding of and capacity to work with mental health issues in the adolescent population.

8.0 Continuing Education Units (CEUs) provided (per day) for LCSWs, LMFTs, and RNs

For more information, contact:
Melissa.Totz@sonoma-county.org

Self Care Fair

June 24, 2017 11am-3pm
Community Baptist Church
1620 Sonoma Ave, Santa Rosa

Learn how you can take care of yourself with the resources and tools available in our community. Free food, goodies, and more!

Through community collaboration with:

Buckelew Programs, Goodwill Industries of the Redwood Empire, National Alliance on Mental Illness (NAMI) Sonoma County, California Mental Health Services Authority (CalMHSA)

For more information about MHSA programs and services, or to submit updates, events, success stories, or other content for this newsletter, please contact Amy Faulstich at amy.faulstich@sonoma-county.org. To sign up for this newsletter, go to: www.sonoma-county.org/mhsa.

Newsletter Content: Amy Faulstich; Design: Bruce Robbins

Appendix 3

First 5 Sonoma County MHSA PEI 0-5 Program Evaluation Report for FY 16-17

WELLNESS • RECOVERY • RESILIENCE

First 5 Sonoma County
Program Evaluation Report
7/1/2016 - 6/30/2017

Mental Health Services Act:
Prevention and Early Intervention (0-5)

March 2018

Prepared For
First 5 Sonoma County

Prepared By
Learning for Action

Learning for Action enhances the impact and sustainability of social sector organizations through highly customized research, strategy development, and evaluation services.

About First 5 Sonoma County

The mission of First 5 Sonoma County is to maximize the healthy development of all Sonoma County children from the prenatal stage through age five through support, education, and advocacy. To achieve this mission, the First 5 Sonoma County Commission funds an array of programs, services, and initiatives designed to achieve its Strategic Plan goals in the areas of health and healthy development, early childhood education, parent support and education, and school readiness. The Evaluation Committee of the Commission provides guidance to evaluation efforts for First 5 Sonoma County.

First 5 Sonoma County
490 Mendocino Avenue, Suite 203
Santa Rosa, CA 95401
(707) 565-6686
www.first5sonomacounty.org

About Learning for Action

Established in 2000, and with offices in San Francisco and Seattle, Learning for Action (LFA) provides highly customized research, strategy, and evaluation services that enhance the impact and sustainability of social sector organizations across the U.S. and beyond. LFA's technical expertise and community-based experience ensure that the insights and information we deliver to nonprofits, foundations, and public agencies can be put directly into action. In the consulting process, we build organizational capacity, not dependence. We engage deeply with organizations as partners, facilitating processes to draw on strengths, while also providing expert guidance. Our high quality services are accessible to the full spectrum of social sector organizations, from grassroots community-based efforts to large-scale national and international foundations and initiatives.

Learning for Action
170 Capp Street Suite C
San Francisco, CA 94110
(415) 392-2850
www.learningforaction.com

About this Evaluation Report

In Sonoma County, the Department of Health's Behavioral Health Division has allocated a portion of its Mental Health Services Act funding for Prevention and Early Intervention to provide services to children from birth to five and their families (MHSA-PEI 0-5). Because this effort aligns so closely with First 5 Sonoma County's priority outcomes in early childhood mental health, First 5 has partnered with Behavioral Health to support these MHSA-PEI 0-5 efforts. MHSA provides direct funding to four MHSA-PEI 0-5 grantees, while First 5 provides coordination, evaluation, and training services, as well as supporting services that supplement the MHSA effort. This annual program-level evaluation report is one outcome of this partnership. LFA, First 5 staff, Behavioral Health staff, and MHSA grantees collaborate to develop a plan for evaluation, collect quantitative data to measure program effectiveness, and to analyze results to understand the key accomplishments, challenges, and lessons learned.

This report is intended to be a resource to guide program implementation and improvement, as well as to inform the First 5 Sonoma County Commission and the Behavioral Health Division of the impact of their investments and to identify lessons learned to inform future funding decisions.

Table of Contents

I. Executive Summary

Program Details	
Program Name	Mental Health Services Act: Prevention and Early Intervention 0-5 (MHSA-PEI 0-5 program)
Contractor	Child Parent Institute (CPI), Early Learning Institute (ELI), Jewish Family and Children's Services (JFCS), Petaluma People Services Center (PPSC)
Term of Grant	July 1, 2016 – June 30, 2017
2011-20 Strategic Plan Goal Area	▪ Goal 1: Health and Healthy Development of Children ▪ Goal 2: Supported and Nurturing Families ▪ Goal 4: Integrate Systems and Effect Policy Change to Better Serve Children and Families
Priority Outcome	▪ Priority Outcome 1B: Increase early detection of, and intervention for, developmental concerns ▪ Priority Outcome 2A: Increase support for parents to strengthen their parenting capacity ▪ Priority Outcome 4C: Reduce child abuse and neglect and promote early childhood mental health
Strategic Plan Core Program Outcomes (First 5 Sonoma County Pathways to Results)	**Community Outcomes:** ▪ Decrease in substantiated reports for child abuse and neglect ▪ Decrease in recurrence of substantiated reports for child abuse and neglect ▪ Decrease in out-of-home placements ▪ Decrease in number of children visiting the emergency room for suspected maltreatment **Program-Level Outcomes:** ▪ Decrease in children exhibiting difficult behaviors ▪ Decrease in negative parent-child interactions ▪ Decrease in Perinatal Mood Disorder (PMD) among identified/treated women ▪ Children whose screenings show developmental/social-emotional delays are referred for further assessment
First 5 Funding Amount	First 5 Sonoma County provides training and evaluation services for the MHSA-PEI 0-5 grantees. Grant funding for direct services comes from Sonoma County's Mental Health Services Act.
Level of Evidence at Start of Grant[1]	▪ Triple P – Positive Parenting Program®: Evidence-Based Practice (Achieved Tier 1 placement in Portfolio of Model Upstream Programs) ▪ Screenings with Ages and Stages Questionnaire® (ASQ-3 and ASQ:SE-2): Evidence-Based Practice ▪ PMD: Interpersonal Psychotherapy for Perinatal Mood/Anxiety Disorders (Achieved Tier 1 placement in Portfolio of Model Upstream Programs) ▪ Parent Education and Support (PEAS) Program: Emerging Practice

Key Accomplishments

MHSA-PEI 0-5 achieved key goals at program level. Achievements include:

- **Over 1,000 at-risk children 0-5 and their families received services:** Agencies met the majority of their targets and supported parents to become confident nurturers who promote their children's healthy social-emotional development.
- **Decrease in children exhibiting difficult behaviors:** Children in families receiving Triple P Levels 4 and 5 showed substantial improvement, exhibiting a decrease in difficult behaviors as measured by the ECBI.
- **More than 480 children were screened and referred for further assessment:** MHSA-PEI 0-5 grantees used the ASQ-3 and ASQ:SE-2 to screen children for developmental or social-emotional delays and referred those deemed at risk for further assessment. Navigation assistance supported providers and caregivers to identify referrals and guide families to resources.

Opportunities and Emerging Challenges

- **Leverage the knowledge of ACEs and trauma-informed care to support community recovery efforts:** With experience training community partners, grantees can continue to support trauma-informed practices to ensure families and children are supported. As families recover from the wildfires, grantees continue to provide referrals and connections to community partners to improve family functioning and resiliency.
- **Seek innovative funding:** As community needs continue to shift, funding is needed to sustain the delivery of effective services. In partnership with First 5, MHSA grantees can leverage the collaborative to identify and pursue additional sources of funding to continue meeting the needs of children and families in Sonoma County.
- **Continue to support addressing families' unmet basic needs before connecting with treatment services:** Grantees are well-connected to community support services to improve family stability, and can help to connect families with the supports they need to meet urgent needs and relieve key stressors in their lives.

II. Program Description

In Sonoma County, the Mental Health Services Act (MHSA) funds four grantees through its Prevention and Early Intervention 0-5 program (MHSA-PEI 0-5). MHSA-PEI 0-5 grantees are funded to perform a variety of services, all of which aim to reduce risk factors, build protective factors and skills, and increase support for families and children from before birth to age five. The four MHSA grantees including Child Parent Institute (CPI), Early Learning Institute (ELI), Jewish Family and Children's Services (JFCS), and Petaluma People Services Center (PPSC) work together to build a continuum of care that includes screening, interventions, and support strategies for children and their families.[2] These services and supports occur at a critical time early in a child's life when the foundation for sound mental health is built. MHSA grantees' work is rooted in the science of adverse childhood experiences (ACEs)[3], and aims to reduce children's exposure to ACEs as well as to prevent the transmission of ACEs across generations. Because of the natural alignment of goals between MHSA and First 5, the two organizations have partnered to support the four MHSA-PEI 0-5 grantees. Sonoma County's Department of Health, Behavioral Health Division Mental Health Services Act provides direct funding to grantees for services, while First 5 provides coordination, evaluation, and training support.[4]

One of the ways in which First 5 helps to facilitate coordination and collaboration among the MHSA grantees is by convening bi-monthly MHSA collaborative meetings. In collaborative meetings, MHSA-PEI 0-5 grantees meet to discuss coordination of their work, referral capacity, challenges, and best practices. The collaborative also works to identify ways to integrate the work of early childhood mental health providers and build an effective system of early childhood social-emotional health. The MHSA collaborative provides a setting where these four agencies can convene and reflect on their efforts to provide services for children and families in Sonoma County.

As an evaluation partner, First 5 assists grantees in developing their specific Scope of Work, identifying program and process outputs, and targets associated with outcome measures for delivered services. First 5 provides ongoing feedback and support as grantees report on service provision throughout the year via quarterly progress reports. First 5 Sonoma County also funds intervention services for children whose screenings reveal developmental or social-emotional delays.

The four MHSA-PEI 0-5 grantees –Child Parent Institute (CPI), Early Learning Institute (ELI), Jewish Family and Children's Services (JFCS), and Petaluma People Services Center (PPSC) – provide the following services as part of a comprehensive prevention and early intervention (PEI) program:

- Parent education and intervention services using Triple P—Positive Parenting Program, levels 2, 3, 4, and 5 (described in more detail below);
- Developmental and social emotional screenings of children 0-5, using the Ages and Stages Questionnaire (ASQ-3) and the ASQ Social-Emotional (ASQ:SE-2);
- Further assessment or referral for services to children with identified concerns;
- Re-screening children at age-appropriate intervals;
- One-Call Navigator to link callers with the appropriate services for families with children birth to 5;
- Psychological assessments as needed;
- Case management for children in at-risk families for whom a developmental or social-emotional screening identifies potential delays;
- Education and support for parents of children with special needs;
- Identifying women with Perinatal Mood Disorder (PMD);
- Referrals, case management, and treatment for women identified with PMD; and
- Mental health services for families with mental health concerns of either parent or child (beyond PMD).

Of the services listed above, the two that account for the majority of services provided by MHSA-PEI 0-5 grantees are Triple P parent education services and developmental and social emotional screenings for children 0-5. Grantees focus on providing screening services to young children for a variety of developmental and social-emotional delays using the ASQ-3 and ASQ:SE-2. MHSA-PEI 0-5 grantees target a variety of groups for each of the mental health services they provide.

Triple P – Positive Parenting Program

Triple P – Positive Parenting Program® is a multi-level evidence-based[5] program proven to significantly reduce child abuse and out-of-home placement by increasing the knowledge, skills, and confidence of parents. Parents receive the services, and their children benefit because the family relationship improves. At its core, Triple P focuses on strengthening the relationship between the parent and the child and incorporates trauma informed principles such as a safe environment, stability and mutual respect and attunement. The program aims to prevent problems for children in various settings (e.g. family, school, or community) before they arise. Triple P supports the mental health and well-being of both caregivers and children. Each of the five levels offers tips, tools, and strategies to support parents. These levels progress in intensity of intervention as follows:[6]

- Level 1 is a social marketing and promotional campaign to reduce the stigma of seeking parenting help and to increase parental awareness of Triple P resources in the community. This campaign is called "Stay Positive." First 5 Sonoma County was the pilot site for the Stay Positive program in the U.S. The program currently includes marketing materials in English and Spanish to explain and promote Triple P services.
- Level 2 consists of a series of three seminars, introducing groups of parents/caregivers to positive parenting concepts and strategies.
- Level 3 consists of brief, flexible parent consultation, targeting parents who have children with mild to moderate behavioral difficulties or a one-time brief discussion group on a single topic, such as discipline.
- Level 4 is a more intensive intervention for parents who have children with moderate to severe behavioral/emotional difficulties, and is delivered in a group or in an individual setting. Level 4 individual interventions are frequently delivered in the home.
- Level 5 is delivered in conjunction with Level 4 and is an enhanced family intervention when parenting is complicated by relationship conflict, depression, or high stress.

Together, the four MHSA-PEI 0-5 grantees (CPI, ELI, JFCS, and PPSC) provide Triple P Levels 2 through 5 in Sonoma County. First 5 Sonoma County coordinates Triple P training and parenting support materials for Levels 2 through 5 to the MHSA-PEI 0-5 grantees and more than 30 agencies in the community. These agencies form a strong provider network, delivering consistent evidence-based messages about positive parenting throughout the community, supporting parents to become confident, competent nurturers who promote their children's healthy social-emotional development.

The MHSA-PEI 0-5 grantees report process and outcome measures to Cricket Mitchell Consulting (CMC) to assess fidelity to the Triple P model. The CMC report on the data shared by MHSA-PEI 0-5 grantees is included as Appendix A. This evaluation report aims to complement the CMC report with additional data on grantee activities, community-level outcomes, and other targets achieved by the four grantees.

Program Theory

Need for the Program

The MHSA-PEI 0-5 program addresses the needs of the following populations in Sonoma County:

- **Children at risk for abuse, neglect, or mental health issues.** In 2016, 243 Sonoma County children ages 0-5 had substantiated reports of child abuse or neglect at a rate of 8.0 substantiated cases per 1,000 children.[7] While this rate has declined since 2010, it is probable that many more children are abused or neglected than these statistics show, since they do not include unsubstantiated cases or the vast number of cases that are unreported. In one study, mothers responding to anonymous telephone surveys reported incidences of physical child abuse at rates 40 times greater than official child abuse reports.[8] A growing body of research seeks to quantify the prevalence of ACEs. In a nationally representative non-clinical sample using data from the 2011/2012 National Survey of Children's Health, approximately 33% of children aged birth to 17 in California experienced one or two ACEs, and 9% experienced 3 or more.[9] Because wide ranging mental health consequences can be attributed to adverse childhood experiences, supporting families to develop positive relationships with children and address any early problems contributes to future positive mental health and well-being for caregivers and their children.
- **Women with Perinatal Mood Disorder.** Up to 20% of women experience diagnosable pregnancy-related mood disorders.[10] Sonoma County had 5,158 births in 2016,[11] meaning that nearly 1,000 Sonoma County women could have experienced pregnancy-related mood disorders in that year alone. Infants with untreated depressed mothers are at an increased risk for child abuse and neglect.[12] A longitudinal study of families investigated by child protective services found that depressed mothers are more likely to cause their children harm than mothers who are not depressed.[13] Untreated maternal depression also impacts child development. Living with a mother who is mentally ill or severely depressed is an ACE that can impact a child's future wellbeing. Treating women with depression can be considered an intervention to help reduce a child's potential exposure to ACEs and promote better outcomes for the mother and child.
- **Children with a developmental delay.** Nationwide, developmental disabilities were reported in approximately 15% of children in the US in 2006-2008.[14] Sonoma County has 30,482 persons under age six,[15] which suggests that more than 4,500 children under six in Sonoma County could have developmental disabilities. Research indicates that the majority of young children who are eligible for early intervention programs due to developmental delays do not receive services: nationwide, only 9% of nine-month-olds with developmental delays and only 12% of 24-month-olds with developmental delays receive early intervention services.[16]
- **Young children who are not screened for a social-emotional or developmental delay.** Only 53% of parents in California and 51% of parents nationwide report that a doctor or other health care provider asked them to complete a questionnaire about their specific concerns or observations about their child's development, communication, or social behaviors.[17]

How the Intervention Links to Outcomes

The following research findings show that the services provided by MHSA-PEI 0-5 grantees support positive outcomes for mothers and their children:

- **Triple P – Positive Parenting Program has been shown to reduce child maltreatment.** The Triple P program has more than 35 years of program development and evaluation. A recent meta-analysis of Triple P identified moderate effects in children's social, emotional, and behavioral outcomes, parenting practices, and parenting satisfaction and efficacy.[18] In Australia, a population-based trial evaluating Triple P communities and comparison communities found that Triple P communities experienced a significant reduction in parental depression, coercive parenting, psychosocial problems,

and emotional difficulties.[19] Additionally, a random sample, population-based trial by the Centers for Disease Control (CDC) in 18 South Carolina counties found that counties with the Triple P program experienced a significant reduction in child maltreatment, out-of-home placements, and children with injuries requiring hospitalization or emergency room treatment.[20] If Sonoma County were to achieve a similar saturation of trained providers as existed in the South Carolina CDC study (and with all other factors being equal), First 5 would expect that population-wide implementation of Triple P would achieve an annual decrease of 217 cases of child maltreatment, 77 cases of out-of-home placement, and 19 cases of children's injuries resulting in hospitalization or emergency room treatment amount the 0-5 population in Sonoma County. Although there are significant contextual differences between Sonoma County, Australia, and South Carolina, Triple P is an evidence-based model; programs in diverse regions implementing the Triple P model with fidelity should be able to expect results similar to those highlighted by these studies.

- **Triple P – Positive Parenting Program may prevent or reduce harm from adverse childhood experiences.** Adverse childhood experiences (ACEs) are traumatic experiences that can damage a child's developing brain and body and lead to toxic stress and lifelong problems with health, wellness, and learning.[21] ACEs include abuse and neglect as well as experiences such as divorce or living with a parent who is depressed or alcoholic. The ACE study found a connection between childhood trauma and adult chronic disease and mental health issues such as depression. [20] Research over the past two decades confirms that the more ACEs a child experiences, the greater the risk for adult chronic disease, mental illness, substance abuse, obesity, violence or being a victim of violence, and suicide.[22] Furthermore, epigenetic research has shown that toxic stress can alter the way in which genes are expressed, and whether or not they are expressed at all.[23,24] Without intervention, parents may pass ACEs onto their children in a cycle that produces negative outcomes across multiple generations. When early experiences are nurturing, stable, and predictable, healthy brain development is supported. As a result, responsive caregiving early in life is associated with better physical and mental health, fewer behavioral problems, higher educational achievement, better employment, and less involvement with social systems in adulthood.[25] Triple P helps build protective factors and reduce risk for future physical and mental health problems among children, adolescents, and adults.
- **Evidence-based screening tools are critical to identifying women with Perinatal Mood Disorder (PMD)**. In one study, routine clinical evaluation (using no screening tool) resulted in a 6% detection rate for postnatal depression, while screenings that used the Edinburgh Postnatal Depression Scale (EDPS) resulted in a 35% detection rate.[26]
- **Treatment for perinatal mood disorders supports mothers' and children's health.** Several studies have shown that psychological and psychosocial interventions are effective in reducing depression symptoms among new mothers.[27] Untreated early maternal depression is associated with "adverse cognitive and emotional infant development."[28] Children of depressed mothers exhibit poor mental and motor development, low interpersonal functioning, and behavioral problems.[29] Living with a mother who is depressed, particularly in the first three years of life when the brain is developing rapidly can alter a child's brain and stress response.[30] Effects for the child are long-lasting; untreated maternal depressive symptoms are associated with poor self-control and executive functioning in preschool as well as acting out and behavior problems in elementary school.[31, 32] There is increasing evidence that maternal depression is linked to a child's risk of developing depression or other emotional disorders later in life.[33] Research shows that remission of maternal depression is associated with decreases in children's problem behaviors and psychiatric symptoms.[34] Effectively, detecting and treating PMD is an intervention that can improve maternal and child well-being and mental health outcomes.
- **Screening with valid and reliable instruments is critical to identifying children with developmental and social-emotional delays.** When pediatricians rely upon clinical judgment alone, they fail to detect developmental delays in children over 70% of the time.[35] Valid, reliable screening instruments are able to identify developmental delays 70-80% of the time.[36]
- **Early intervention is more efficient and effective than remediation later in life.** Because the brain's elasticity decreases with age, early intervention produces more favorable outcomes for

children with developmental delays than do interventions later in life.[37] The "emotional and physical health, social skills, and cognitive linguistic capacities" developed during early years lay an important foundation for later school, work, and community success.[36]

- **Education for parents of children with developmental and social-emotional disabilities may improve child development outcomes.** Education for parents as a key component in early intervention may have the following results: parents increase their knowledge and provide better childcare; relationships between parents and children are enhanced; and children acquire specific skills, such as language development.[38]

Long-Term Cost Savings

MHSA-PEI 0-5 is well-positioned to generate long-term cost savings to Sonoma County public and private sectors based on the following research findings:

- **Triple P is highly cost-effective and likely to spur significant long-term savings.** Child maltreatment is associated with extremely high direct and indirect costs, including hospitalization, mental health care, child welfare services, law enforcement, special education, adult criminal justice system involvement, and lost labor productivity.[39] Recent Cost-Benefit Analyses conducted by Research Development Associates for Sonoma County found that the next two years of Triple P implementation offer up to $840,666 in cost savings.[40] A reduction in the number of out-of-home placements, reduced social worker time spent on substantiated cases of abuse and neglect, and a reduction in emergency room-related costs contributed to the total cost savings for Sonoma County. (See Appendix E) A study of nine counties in South Carolina found that building the infrastructure needed to implement Triple P would cost less than $12 per child.[41] Additional research shows that Triple P will pay for itself if it averts less than 1.5% of conduct disorder cases.[42]
- **Treating depression generates cost savings by reducing lost productivity due to depression impairment.** There is a strong relationship between severity of depression and work performance, suggesting improvement in depression symptoms may be linked to improvement in work functions.[43] People suffering from depression are less productive at work, and have even higher annual sick days and rates of short-term disability than do people suffering from other chronic diseases.[44] One study found that primary care depression management saves $9,592 to $14,306 (in 2000 dollars) per quality-adjusted life-year. These savings derive from increased productivity and fewer depression-impaired days per month.[45] Additionally, treating maternal depression supports positive outcomes for child development and stable home environments, which also generate cost savings, as described below.
- **Early childhood interventions generate public savings.** Early childhood interventions are "more effective and less costly" than addressing problems at a later age through downstream interventions, such as clinical treatment, special education, and incarceration.[46] Children who participate in interventions before kindergarten are more likely to graduate from high school, live independently, and avoid teen pregnancy and violent crime.[47] These improved outcomes generate a cost savings of between $30,000 and $100,000 per child, meaning that $13 in cost savings is generated for every dollar spent on early intervention.[46] Up to 67% of behavioral and physical problems that cause adults to seek social services could be attributable to ACEs.[48] Reducing the number of ACEs children are exposed to and their effects has the potential to decrease a variety of health, education, and disability problems resulting in significant cost savings for government, public, and private sectors.[49]

Evaluation Methods

This evaluation report includes data from the following sources:

- **Quarterly progress reporting:** Progress reports submitted by CPI, ELI, JFCS, and PPSC to First 5 Sonoma County and Behavioral Health during the span of the grant period.

- **Annual demographic data:** Data on populations served, submitted by CPI, ELI, JFCS, and PPSC to First 5 Sonoma County for the Annual Report to First 5 California.
- **Communications with First 5 Sonoma County staff and grantees:** Emails and calls with First 5 Sonoma County staff members and MHSA grantees. First 5 and LFA also co-facilitated a group conversation with grantees, where CPI, ELI, and PPSC shared reflections about successful program implementation and factors influencing current community needs.
- **Triple P data and reports:** Cricket Mitchell Consulting (CMC) uses a database of Triple P outcome data to create reports summarizing these data (as produced by CMC).

CMC data for Triple P outcomes includes the use of two measures: 1) the ECBI (Eyberg Child Behavior Inventory), which measures child-related outcomes, and 2) the *Protective Factors Survey* (PFS), which measures parental perception of change (See Appendix D). To analyze Triple P outcomes, CMC calculated the percent of clients showing Positive Reliable Change.[50] Prior to fiscal Year 2014-15, program staff collected parent outcome data from Triple P parents using the Parenting Scale. The PFS has been used for the third consecutive year in fiscal year 2016-17. First 5 is working closely with other agencies across the county to promote widespread adoption of the PFS. MHSA grantee use of the PFS provides an important opportunity for cross-agency communication.

To analyze the MHSA-PEI 0-5 data, LFA used the following approaches:

- Descriptive statistics to show rates and frequency distributions; and
- Content analysis of qualitative data to supplement and provide context for quantitative data.

The MHSA-PEI 0-5 Pathway to Results provides a complete overview of the program strategies, measureable outcomes, and accompanying targets. The Pathway can be found in Appendix B following this report.

III. Reaching the Target Population

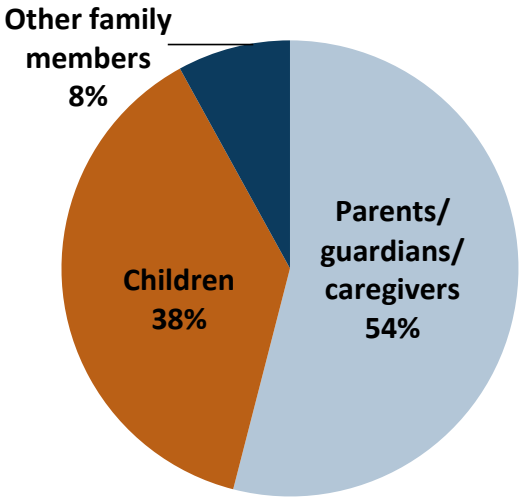
The MHSA-PEI plan summarizes the target populations for its services as follows:

> *The target populations for PEI funding support are at-risk children ages 0-5 in Sonoma County and their parents/caregivers. These at-risk populations include children in stressed families—especially those with parents and caregivers with depression, including perinatal mood disorders, and other forms of mental illness, and those impacted by alcohol and other drug problems; children at risk of school failure; trauma-exposed children, including those exposed to domestic violence; children with special needs; and children with challenging behaviors.*
>
> *In addition, consistent with PEI planning participants across workgroups, early childhood workgroup members identified Latino children and their families as priority populations given demographic trends in the county as well as disproportionate health outcomes and a lack of culturally-appropriate services for Latino populations.*[51]

Number Served

Exhibit 1 summarizes the populations served by all four of the MHSA-PEI 0-5 grantees during FY 2016-17. A recorded total of 2,755 clients (parents/caregivers, children 0-5, and other family members) were served by MHSA-PEI 0-5 providers. These numbers may reflect some duplication, as it is possible that some grantees served the same clients. For specific information on numbers served under each service, please see the Additional Progress Achieved table in the following section. The population served by each of the four MHSA-PEI 0-5 grantees individually is summarized in Appendix C.

Exhibit 1. Numbers Served in FY 2016-17
(n=2,755)



Race, Ethnicity, and Language of Participants

As summarized in Exhibits 2 and 3, the majority of the parents/caregivers and children served under MHSA-PEI 0-5 in FY2016-17 are Hispanic/Latino. This has consistently been the case for the last two years that data has been collected for the program.

Exhibit 2. Ethnicity of Parents/ Caregivers Served in FY 2016-17 (n=1,486)

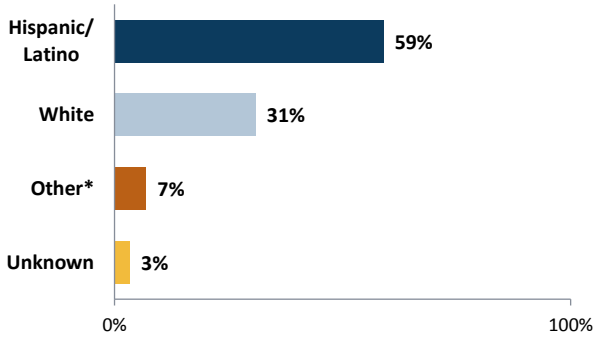
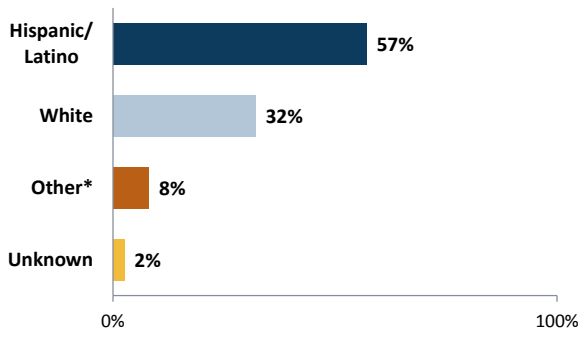


Exhibit 3. Ethnicity of Children 0-5 Served in FY 2016-17 (n=1,037)



*Includes, in descending order of population size: multi-racial, Alaska Native/ American Indian, Asian, Black/African-American, other, & Pacific Islander. For specific numbers for each population, please see Appendix C.

Nearly half of MHSA-PEI 0-5 parents/caregivers and children speak Spanish as their primary language (Exhibits 4 and 5). Grantees continue to offer services in Spanish for Triple P which has bolstered Hispanic/Latino participation. Recruiting bicultural and bilingual staff is a priority for the MHSA-PEI 0-5 grantees.

Exhibit 4. Primary Language of Parents/ Caregivers Served in FY 2016-17 (n=1,486)

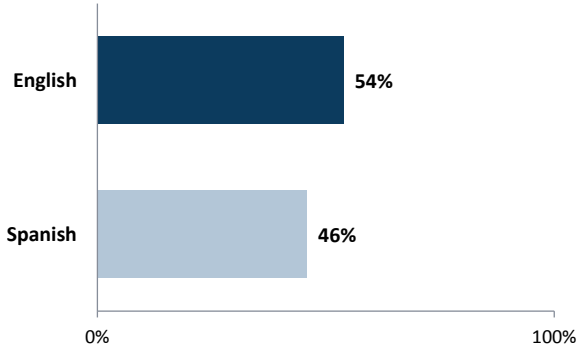
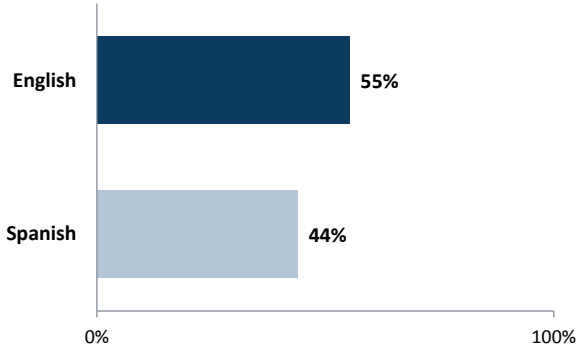


Exhibit 5. Primary Language of Children 0-5 Served in FY 2016-17 (n=1,037)



Special Needs Population

Of the 1,037 children served by MHSA-PEI 0-5 programs from July 1, 2016, to June 30, 2017, a total of 794 (77%) were reported to have special needs.[52] The vast majority of these children were served through ELI's Watch Me Grow program.

IV. Progress Achieved

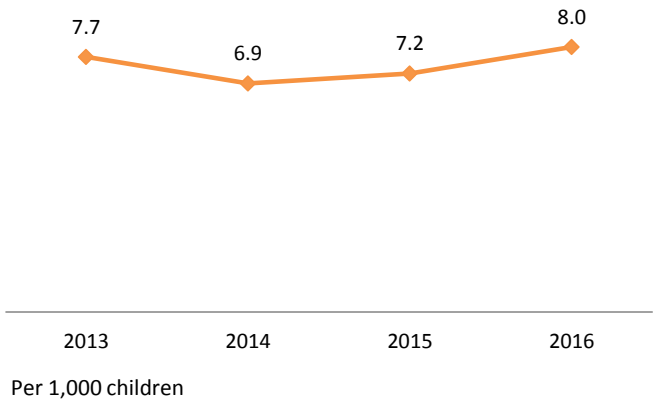
This report is intended to summarize progress achieved from July 1, 2016 to June 30, 2017 and related program implementation and improvement considerations. As of the time of this report in early 2018, the context in which families, children, and providers operate in Sonoma County has shifted dramatically. The traumatic October 2017 wildfires in the North Bay, and in Sonoma County in particular, drastically impact the needs of families and children, and the context in which MHSA-PEI 0-5 grantees and other providers deliver services. Although this report summarizes results achieved prior to the fires, the recommendations are considered within the current context of shifting community needs. This is an important consideration as the collaborative and collective community work to rebuild after the fires.

Community-Level Outcomes

In order to understand the context within which MHSA-PEI 0-5 grantees are working, three outcomes are tracked at the county level. These are: 1) substantiated reports of child abuse and neglect, 2) recurrence of substantiated reports of abuse and neglect, and 3) out-of-home placements. These results cannot be wholly attributed to the work of grantees; there are numerous and complex factors in the community landscape that can impact rates of child abuse and neglect, such as employment or shifting economic contexts. However, monitoring community-level trends is important for understanding the need for interventions and services, and serves as one way to assess community-level changes.

- **Substantiated reports of child abuse and neglect.** The total number of substantiated reports of child abuse and neglect in Sonoma County has fluctuated slightly since 2013. In 2013, the rate was 7.7 per 1,000 children and further decreased to 6.9 in 2014. Most recently, from January-December 2016, the rate of substantiated reports of child abuse and neglect increased to 8.0 per 1,000 children.[53] However, this rate has consistently remained below California's statewide rate which, during the same time period, was 13.2 per 1,000 children.

Exhibit 6. Rate of Substantiated Reports of Child Abuse and Neglect for Children under Six Years of Age



- **Recurrence of substantiated reports of child abuse and neglect.** The recurrence of substantiated reports of child abuse and neglect for children under age six was 6.8% (17 of 250) in 2012 and decreased in 2015 to 3.8% (8 of 210).[54] From July-December 2016, reoccurrence increased to 6.8% (5 of 74). It is important to note that the relatively small number of substantiated reports makes it difficult to determine whether fluctuations in recurrence rates indicate larger trends or simply reflect a change in a very small number of cases. While these rates have fluctuated over the past few years, the total number of substantiations is declining, as noted above.
- **Out-of-home placements.** The rate of out-of-home placements per 1,000 children has fluctuated somewhat in recent years. The rate increased from 3.7 per 1,000 children in 2010 to 4.0 in 2011. However, the latest data show the rate declined to 3.3 in 2015 and then up in 2016 to 3.6 per 1,000 children in Sonoma County.[55] For comparison, California's rate of out-of-home placements for children under six years of age was 6.8 per 1,000 children in 2016.

Overall, trends for these rates show slight increases in substantiated reports of child abuse and neglect, reoccurrence, and out-of-home placements. Over the four-year period, we see similar fluctuations in rates for each of the three outcomes – there is a pattern with a slight dip in 2014 and 2015 and then back up by 2016. Sonoma County's rates remain below the state average. Grantees and First 5 continue to monitor rates of child abuse and neglect in order to understand the evolving community landscape. Considering in particular, what might we learn from the trend we are seeing across these rates? What factors might be contributing to these changes and how can that help inform the need for interventions and services?

Grantee-Level Outcomes

While implementing the MHSA-PEI 0-5 program during the 2016-17 fiscal year, the four grantees contributed to progress on three core outcomes as targeted in the First 5 Sonoma County Strategic Plan and the MHSA-PEI 0-5 Pathway to Results:[1]

- Decrease in children exhibiting difficult behaviors
- Decrease in negative parent-child interactions
- Increase in children deemed at risk for developmental or social-emotional delays who are referred for follow-up assessments

Progress Achieved toward Core Outcomes[2]
07/01/2016 06/30/2017

Core Program Outcome	Intervention Linked to Outcome	Specific Target		Actual Results 2014-15	Actual Results 2015-16	Actual Results 2016-17	Progress Toward Target
Decrease in children exhibiting difficult behaviors[56]	Triple P Services, Levels 4/5	**40%** of children will show positive reliable change on the ECBI **Intensity** subscale[57]		*36% (10 of 28)*	*56% (31 of 55)*	**71%** (22 of 31)	⊕ **178%**
		40% of children will show positive reliable change on the ECBI **Problem** subscale[58]		*50% (14 of 28)*	*53% (29 of 55)*	**79%** (26 of 33)	⊕ **198%**
Decrease in negative parent-child interactions	Triple P Services, Levels 4/5	Parents show improvement from the pre-test to post-test on the PFS **Family Functioning/Resiliency** subscale		*34% (12 of 35)*	*22% (13 of 58)*	**3%** (1 of 31)	**NA**[3]
		Parents show improvement from the pre-test to post-test on the PFS **Social Connections** subscale		*26% (9 of 35)*	*21% (12 of 58)*	**17%** (5 of 30)	**NA**
		Parents show improvement from the pre-test to post-test on the PFS **Concrete Support** subscale		*14% (5 of 35)*	*14% (8 of 58)*	**8%** (2 of 25)	**NA**
		Parents show improvement from the pre-test to post-test on the PFS **Nurturing and Attachment** subscale		*14% (5 of 35)*	*15% (8 of 54)*	**8%** (2 of 24)	**NA**
		Parents show improvement from the Pre PFS to the Post PFS on **Knowledge of Parenting and Child Development** Items	There are many times that I don't know what to do as a parent.[58]	*26% (9 of 35)*	*36% (21 of 58)*	**17%** (5 of 30)	**NA**
			I know how to help my child learn.	*57% (20 of 35)*	*50% (29 of 58)*	**53%** (16 of 30)	**NA**
			My child misbehaves just to upset me.[60]	*34% (12 of 35)*	*38% (22 of 58)*	**60%** (18 of 30)	**NA**
			I praise my child when he/she behaves well.	*39% (13 of 33)*	*43% (23 of 54)*	**47%** (14 of 30)	**NA**
			When I discipline my child, I lose control.[60]	*41% (14 of 34)*	*33% (18 of 54)*	**63%** (19 of 30)	**NA**

[1] MHSA-PEI 0-5 Pathway to Results in Appendix B provides a complete overview of the program's measureable outcomes and accompanying targets.
[2] Progress toward FY16-17 targets is measured using the following definition: ⊖ *Not Achieved* (more than 5 numeric or percentage points below target); ☑ *On Track/Achieved* (0-5 numeric or percentage points below target); ⊕ *Exceeded* (1-5+ numeric or percentage points above target).
[3] This is the third year the PFS measure was used; specific targets for outcomes related to PFS have not been set.

Progress Achieved toward Core Outcomes[2] 07/01/2016 06/30/2017						
Core Program Outcome	**Intervention Linked to Outcome**	**Specific Target**	**Actual Results**			**Progress Toward Target**
			2014-15	*2015-16*	**2016-17**	
Increase in children deemed at risk for develop-mental or social-emotional delays who are referred for follow-up assessments	Periodic develop-mental & social emotional screening	**300** children will be screened	*364 children screened*	*359 children screened*	**482** children screened	⊕ **161%**
	At-risk children referred for further assessment	At least **110** children will be referred for assessment	*200 children referred*	*204 children referred*	**292** children referred	⊕ **265%**

When I first called to request services, I was desperate and frustrated. My son was acting out of control and I didn't know what to do. It was a relief to know there was assistance available and working with you has turned things around so much for us.

-CPI Triple P Parent

Overall, 2016-17 results are evidence of significant progress towards achieving the three core outcomes for MHSA prevention and early intervention programs. Children in families receiving Triple P Levels 4 and 5 showed substantial improvement, exhibiting a decrease in difficult behaviors as measured by the ECBI. Parents and caregivers demonstrated an increase in knowledge of parenting and child development as measured by the *Protective Factors Survey*. Most notably, grantees collectively screened 482 children at risk for development or social emotional delays and referred 292 children. Screenings are a critical step to ensure children receive targeted services or referrals to support their development and social-emotional health.

Child behavioral outcomes are showing substantial improvement as measured by the ECBI.[59] Seventy-one percent of children exhibited positive reliable change from pre-treatment to post-treatment in the frequency of problem behaviors as measured by the Intensity subscale and parent/caregiver observations of a child's behavior. Positive Reliable Change is the difference from pre-treatment to post-treatment that can be considered reliable and is not likely to be due to measurement error.[60] Seventy-nine percent of children exhibited positive reliable change on the Problem subscale, which measures the extent to which child behaviors are perceived as concerning by the parent or caregiver. After targeted support through Triple P services, children are exhibiting fewer problem behaviors, and the frequency of behaviors decreased as well. Since 2014-15, grantees delivering Levels 4 and 5 collectively exceeded one or both of these targets; most recently grantees far exceeded targets at nearly twice the expected rate.

Three years of *Protective Factors Survey* data indicate that the measures of "Knowledge of Parenting and Child Development" may best capture the change we would expect to see among parents receiving Triple P services. Grantees now have three years of PFS data for parents participating in Triple P Levels 4 and 5. When protective factors are present, the overall well-being of children and families is improved. While a small percentage of parents showed improvement this year on each of the subscales (Family Functioning/Resiliency, Social Connections, Concrete Support, and Nurturing/Attachment), we see the most consistent improvement on items measuring parent's Knowledge of Parenting and Child Development. These items closely relate to the type of change one would expect

to see as a result of Triple P services – how parents are interacting with their child and interpreting their child's behavior.

> **I am very thankful the PEAS program exists. I knew I was not alone and my feelings were normal.**
>
> ***-ELI PEAS Parent***

Grantees far exceeded goals for screening and rescreening children at risk of developmental or social-emotional delays. Screenings and referrals contribute to children's growth and healthy development by supporting providers to connect families with necessary services and interventions. Grantees provide critical services in this area to strengthen the early childhood mental health system by connecting the most vulnerable children and families to appropriate services. Grantees collectively screened 482 children at risk for developmental and social-emotional delays. Additionally, agencies far surpassed the goal for providing referrals for additional screening when necessary: 292 children received referrals for further assessments, far exceeding the target of 110. Agencies report that other organizations in the county—including medical providers, schools, and health centers—are increasingly completing screenings, likely the result of trainings from grantees.

Additional Accomplishments

In addition to the key accomplishments described above specifically related to Strategic Plan outcomes, the four grantees also accomplished the following through the MHSA-PEI 0-5 program:

Additional Progress Achieved 07/01/2016 06/30/2017				
Agency	**Program Outcome**	**Specific Target**	**Actual Results**	**Progress Toward Target**
CPI	Provide Triple P services	**100** families will receive the following appropriate Triple P services:	**152** families received services	⊕ **152%**
		- Level 3: **30** families will receive services	**40** families served	⊕ **133%**
		- Levels 4/5: **70** families will receive Level 4 (**10** of the 70 Level 4 families will also receive Level 5)	112 families served with Levels 4/5 (**4** families received Level 5)	⊕ **160%**
	Periodic developmental and social emotional screening, using ASQ-3 and ASQ-SE 2	Children not already screened will be screened and referred for further assessment as needed	**34** children screened and referred as needed	☑ **NA**
		10 children will be referred for further assessment and/or services	**6** children referred for further assessment	☑ **60%**
	Identify women with PMD and provide case management & treatment	**40** women will be identified and treated	**49** women received services	⊕ **123%**
	Provide mental health consultations/services for high risk families	**20** families will receive brief consultations, referred appropriately for mental health services	**10** families received consultations/services	⊖ **50%**
ELI	Periodic developmental and social emotional screening, using ASQ-3 and ASQ:SE-2	**300** children will be screened	**418** children screened for the first time	⊕ **139%**
		350 children will be rescreened	**434** children rescreened	⊕ **124%**
		100 children will be referred for further assessment and/or services	**286** children referred for further assessment and/or services	⊕ **286%**
	Case management for children in at-risk families for whom a screening identifies potential problems	**240** families will receive case management and/or facilitated referrals	**394** families served	⊕ **164%**
	Navigation services	**100** families will receive support/information to access services	**987** families served	⊕ **987%**
	Provide PEAS parent support or Triple P or both	**40** individuals will receive either PEAS or Triple P, or both	**44** individuals received services	⊕ **110%**
	Provide PEAS parent support or Triple P or both	**50%** of individuals receiving PEAS services will report a decrease in score on the Parental Stress Index	**72%** (27 of 38)	⊕ **144%**

JFCS	Provide Triple P services	Level 2: **23** total Seminars will be offered	**15** seminars offered	⊖ **54%**
		Level 2: **180** attendees to seminars	**138** attendees	⊖ **77%**
		75 families will receive the following appropriate Triple P services:	**111** families served	⊕ **148%**
		- Level 3 Individual Sessions: **40** individuals will receive services	**9** individuals served	⊖ **23%**
		- Level 3 Discussion Groups: **15** individuals will participate	**89** individuals served	⊕ **593%**
		- Levels 4 or 5: **10** individuals will receive Levels 4 or 5	**13** individuals served	⊕ **130%**
	Provide psychological assessments for children 0-5	**5** assessments will be completed	**9** assessments completed	⊕ **180%**
	Developmental and social emotional screening, using ASQ-3 and ASQ:SE-2	Children not already screened before referral to JFCS will receive ASQ-3 & ASQ:SE-2 screening	**3** children screened with ASQ-3 / ASQ:SE-2	☑ **NA**
PPSC	Provide Triple P services	Level 2: **6** Level 2 Seminar Series will be offered	**1** Level 2 Seminar Series offered	⊖ **16%**
		Level 2: **27** attendees to seminars	**5** attendees	⊖ **19%**
		70 individuals will receive the appropriate level of Triple P services	**47** individuals received services, which includes: - **3** individuals in Level 3 Individual - **7** individuals in Level 4 Group Sessions - **37** individuals in Level 4 or 5 Individual Sessions	⊖ **67%**
	Periodic developmental and social emotional screening, using ASQ-3 or ASQ:SE-2	Children not already screened before referral to PPSC will receive ASQ-3 & ASQ:SE-2 screening	**27** children screened	☑ **NA**
	Provide screening, referral, and treatment services for Perinatal Mood Disorder	**9** women will receive screenings	**0** woman screened	⊖ **0%**
		4 women will receive treatment	**1** woman received treatment	⊖ **25%**
	Provide screening, referral, and treatment services for Perinatal Mood Disorder	**3** women will be referred to Primary Care provider or other care provider	**0** women received referrals	⊖ **0%**
		65% of women will move below the clinical cut-off score (10) on the post EPDS	**0%** (0 of 1)	⊖ **NA**

Results on these additional program outcomes show that three providers (CPI, ELI, and JFCS) met or far exceeded nearly all of their targets. PPSC nearly met targets for delivering Triple P services but did not meet targets for delivery of PMD services to women. PPSC attributes this to other community providers meeting this need, resulting in fewer referrals to their organization for PMD services.

Efforts to Sustain the Early Childhood Mental Health System

Evaluation results indicate that grantees are on well on track or exceeding many of the program outcomes that will help to ensure the healthy development of children and families, and support and strengthen family resiliency. Grantees share that several factors have contributed to their ability to successfully implement MHSA services, all of which will be important for sustaining a coordinated and effective early childhood mental health system:

- **Increased support for perinatal mood disorder (PMD) services has built the system's capacity to provide critical services shown to improve mental health outcomes.** As noted earlier, treatment for perinatal mood disorders supports mothers' and children's health. Perinatal mood disorder services focus on mother-infant attachment in the early months and support the development of parental resilience. Research shows that detecting and treating PMD is an intervention that can improve maternal and child well-being and mental health outcomes. Increasing agencies' capacity to provide services that address PMD is, thus, an important prevention-based strategy that will strengthen the system's ability to serve mothers and children. In 2017, CPI received additional funding from First 5 to deliver Mothers and Babies, a program that promotes healthy mood management and supports new and pregnant mothers in coping with stress. Mothers and Babies is designed to be delivered by providers from a variety of educational and professional levels, including clinic and community-based workers. Employing a curriculum that can be offered by a wider range of providers than the curriculum previously in place supports CPI to serve more women. The additional funding has allowed CPI to continue this program and deliver PMD services to more women.

- **Investment in the Developmental Screenings and Early Intervention Systems Pilot increased provider capacity to deliver screenings and referrals.** With the targeted and strategic assistance of First 5 and support from MHSA-PEI 0-5 grantees, provider capacity to complete screenings is increasing in Sonoma County. First 5 funded the Developmental Screening and Early Intervention Systems Pilot program to train and support providers at Federally Qualified Health Centers (FQHCs) in completing ASQ-3 screenings. MHSA grantees continue to lead efforts that build and strengthen system level capacity to deliver screenings. As a result of this initiative, providers and staff members have increased awareness and understanding about the need to consistently track and use evidence based screening tools. ELI coordinated in-person ASQ-3 trainings at local health centers to increase staff knowledge and comfort with using the tool to screen and score results. Prior to this pilot initiative, standardized evidence-based screening tools were used at some but not all of the FQHCs. The pilot initiative allowed Redwood Community Health Coalition to develop referral resources that standardize and simplify the referral process, leading to an increase in referrals, screenings, and calls to the ELI navigator.

- **Early Learning Institute's Navigation Services provide critical system coordination support for providers and families.** The One Call Navigator services provided by ELI served nearly 1,000 families. Through the Navigation warmline, and accompanying online ELI General Referral Form, ELI helps refer and direct families to services in the community. As a provider offering an array of developmental assessment, screening, and

I am thankful for your visit and for providing me with more resources where people can help me, what a beautiful program.

-ELI Watch Me Grow Parent

support services, ELI is well positioned to serve in this capacity. ELI navigates a range of calls or questions from both caregivers and providers: For caregivers who are unsure if a child presents a developmental delay, Watch Me Grow will complete a screening. Caregivers can call the warmline and explain their concerns or questions about a child. The navigator will solicit additional information as needed to advise the caregiver about next steps over the phone. The navigator assists providers by coaching and supporting them to engage parents in discussion around early developmental and social emotional screenings and connecting children to services. Thanks to an additional grant from First 5, this is the second year that full-time Navigation support was feasible. Demand continues to be very high: the agency has seen an increase in both providers and caregivers contacting the navigator to determine how to best support a child's development.

- **MHSA grantees integrate and support the education of adverse childhood experiences (ACEs) and trauma-informed care in Sonoma County.** A variety of county-wide ACEs and Trauma-Informed Care initiatives support the ongoing work of First 5 and grantee agencies to expand and strengthen community awareness of ACEs. In recent years, Sonoma County has emerged as a nationally visible leader in ACEs and trauma-informed care. For example, the Sonoma County ACEs Connection is a coalition of community members and agencies including public health, substance abuse treatment, education, early childhood, community-based organizations, medical clinics, and mental health agencies including the MHSA grantees. The coalition aims to bring together the community to prevent, heal, and treat ACEs while promoting resiliency. The MARC (Mobilizing Action for Resilient Communities) initiative grant was awarded to Sonoma County to provide trainings for providers on ACEs and trauma informed care. The MARC project sought to support communities to foster solutions to prevent ACEs and become models of innovative efforts to promote resilience. With the help of the Sonoma County ACEs Connection, grantees integrate knowledge of trauma-informed care into their work and have a strong commitment to raise awareness of ACEs and resiliency in the community.

- **The MHSA collaborative strengthens the effectiveness and sustainability of Sonoma County's early childhood mental health system.** MHSA-PEI 0-5 grantees are key partners in the Early Childhood Mental Health system of care. The collective efforts of grantees to deliver effective services, train providers, and identify community needs support the coordinated system of early childhood mental health in Sonoma County. Agencies regularly engage in outreach, training, and partnership efforts. Examples of these efforts include: participation in the Santa Rosa Community Health Center resource fair to promote screenings within the community; activities with the Perinatal Mental Health Partnership; meetings with the Teen Parent Collaborative; and representation on the Breastfeeding Coalition. The collaborative also serves as an educator, building awareness among community partners in recognizing early childhood mental health as a priority. Grantees participated in organizing and planning the Summit on Early Childhood Mental Health in September 2017, titled "Building Relationships to Support Families in Times of Stress." More than 200 community members and experts across a number of sectors attended, including public health, education, child welfare, health, behavioral and mental health, early childhood education centers, and community-based organizations. In the months prior to the event, grantees organized resources, promoted the event, designed workshops, and arranged speakers. The event aimed to ensure participants:

  1. Expanded their understanding of early childhood mental health as the capacity to form close relationships, manage and express emotions, and explore the environment and learn;
  2. Recognized the importance of early relationships in promoting optimal brain development paving the way for social emotional, cognitive skills and communication throughout the lifetime; and
  3. Built additional skills to support young children and their families in healing from trauma and building resilience.

V. Learning for Action: Building on Successes and Lessons Learned

Grantees achieved several program-level outcomes that ensure the healthy development of children and contribute to supportive relationships and strengthening family resiliency. Agencies exceeded most of their service targets and have many accomplishments to be proud of from the past year. Their work to provide Triple P services and to identify and treat mothers with PMD is likely to lead to lower rates of child abuse in Sonoma County, and strengthen the health and well-being of families. Additionally, grantees' efforts to screen children resulted in identifying over 480 children in need of services and further assessment. Now that these children's needs have been identified, they can receive targeted support and early intervention services to promote their optimal development. MHSA-PEI 0-5 grantees' efforts support the effective design and delivery of prevention, intervention, and treatment services that build a strong foundation for young children.

Over the course of the year, MHSA grantees, First 5, and the evaluation team identified several factors that have contributed to grantees' successful program implementation. The following considerations point to opportunities that MHSA-PEI 0-5 grantees can explore, in partnership with First 5 staff, to sustain effective practices, streamline services, address emerging challenges, and maximize the impact of grantees' critical efforts to address the mental health needs of Sonoma County's children and families.

- **Leverage knowledge of adverse childhood experiences (ACEs) and trauma-informed care to support community recovery efforts.** The substantial county-wide efforts to educate various sectors, providers, and community organizations about trauma-informed care will likely support the community in the months and years to come. As families and children continue to recover from the traumatic events of the wildfires, grantees can support trauma-informed practices and ensure that those who need referrals know how to access services. There is an opportunity to leverage the work of the ACEs Connection and put into practice what it means to be a trauma-informed community.
- **Seek innovative funding sources through the MHSA collaborative and partnerships.** Strong evaluation results demonstrate grantees are exceeding and far exceeding targets and the demand for services indicate a need for evidence-based mental health services in the county. Some of these needs are still unknown, as Sonoma County agencies continue to assess emerging mental health service needs in the months after the wildfires. However, grantees are anticipating a major shift in MHSA-PEI 0-5 funding that will likely not support the extent of the need. Although MHSA-PEI 0-5 funding for FY 2016-17 remained relatively stable, at the time of this report, grantees have been notified of a potential decline in funding for 2018. The collaborative provides a supportive venue in which to brainstorm and discuss alternative methods of funding. Grantees continue to leverage the collaborative as a place to strategize and identify innovative sources of funding in an effort to sustain services and supports delivered.
- **Continue to remain aware of shifting landscape and immigration-related pressures that may impact service provision.** Grantees observe families of immigrant status may be reluctant to access services; families fear receiving services will make them identifiable to government agencies. Families may also delay receiving services in fear of immigration-related concerns. Agencies are supporting families as much as possible through these issues in an effort to prioritize the safety and well-being of families while addressing the need for services. There may be a decline in the provision of services for immigrant families as a result of these fears. Grantees and community partners should continue to monitor this need and strategize on ways they may help to mitigate barriers to families in need of services. For example, grantee organizations may consider providing training to staff to ensure all staff members understand how to engage with families on this topic, and how to refer families to the supports and protections to which they are entitled.

- **Continue to support addressing families' unmet basic needs before connecting with treatment services.** While the focus to date has been on developing parenting skills, there is a need now more than ever to step back and check in with parents about basic needs (e.g. food, housing, legal services). As families recover from the wildfires, they are in need of support that goes beyond the scope of MHSA services, but that must be addressed before mental health treatment is possible. Although PFS is not designed to be a clinical tool, the survey may be useful in equipping agencies and First 5 with findings that have implications for connecting families to additional resources and community partners. Survey results can be used to assist agencies in identifying family needs and areas where support would improve family functioning and resiliency. MHSA grantees are well-connected to community support services to improve family stability, and can help to connect families with the supports they need to meet urgent needs and relieve key stressors in their lives.
- **Expand efforts to attract bilingual specialists and build the service provider workforce.** Several agencies report difficulty retaining bilingual and bicultural specialists and Masters level clinicians. This presents a challenge for grantees and impacts their ability to effectively serve the large Spanish-speaking population of families and children in Sonoma County. Agencies are actively trying to recruit and retain more bilingual providers; however there is a high need to strengthen a pipeline or pathway into mental health service careers.

Evaluation Next Steps

LFA recommends that grantees revisit evaluation targets in context of shifting needs and new data. As the provider landscape and community needs continue to shift, grantees can work with First 5 and evaluators to adjust evaluation targets. Grantees should work with First 5 and evaluators to adjust evaluation targets based on what we've learned from the data to date and our expectations of the work going forward in light of major changes in funding and service provision.

Grantees, in collaboration with other Sonoma County partners, can also continue to identify how to best use the Protective Factors Survey as a measure of program effectiveness. For example, setting reasonable yet aspirational targets on the Knowledge of Parenting and Child Development items (as three years of data have shown the most consistent improvement on these items) will enhance the tool's utility for assessing and serving the needs of children and families. Additionally, First 5 can be a valuable partner in identifying areas where tools can strengthen providers' capacity to build protective factors among families and caregivers, and which items of the PFS to prioritize.

* * *

As a result of the collective work of MHSA grantees in Sonoma County, children and families are supported in an early childhood mental health system of care that strengthens family resiliency and provides guidance and services to address the developmental and early intervention needs of young children. Grantees contribute to positive child and family outcomes that are likely to make a lasting difference. The evaluation findings summarized in this report affirm the value of the services the MHSA-PEI 0-5 grantees provide and reflect their ongoing commitment to address these critical needs of children and families in the future.

VI. Endnotes

[1] Please see the First 5 Sonoma County Evaluation Plan for a complete description of the evidence-based continuum, and definitions of each level of evidence.

[2] Sonoma County Department of Health Services, Mental Health Division Mental Health Services Act, Prevention and Early Intervention Plan. Retrieved: http://www.sonoma-county.org/health/about/pdf/mhsa/pei_plan.pdf

[3] SAMHSA (2016). Retrieved from https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences

[4] For a complete description of the First 5 Sonoma County evaluation approach, please see http://first5sonomacounty.org/Results/Reports/

[5] Please see the First 5 Sonoma County Evaluation Plan for a complete description of the evidence-based continuum, and definitions of each level of evidence.

[6] Triple P America. http://www.triplep.net/glo-en/the-triple-p-system-at-work/the-system-explained/

[7] Webster, D. et al. (2017). CCWIP reports. University of California at Berkeley California Child Welfare Indicators Project website. Retrieved from http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx

[8] Theodore, A., et al. (2005). *Epidemiologic features of the physical and sexual maltreatment of children in the Carolinas*. Pediatrics 115; 331. Retrieved from http://pediatrics.aappublications.org/content/115/3/e331.full.pdf

[9] Sacks et al. (2014) Child Trends Research Brief: Adverse Childhood Experiences: National and State-Level Prevalence. Retrieved from: https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

[10] Stone, S. & Menken, A. (2008). *Perinatal and Postpartum Mood Disorders: Perspectives and Treatment Guide for the Healthcare Practitioner.* Springer Publishing Company.

[11] SoCoDATA. Sonoma County Births by year. Retrieved from https://data.sonomacounty.ca.gov/Fun/Sonoma-County-Births-By-Year/exx5-5heu

[12] Earls, M. (2010). Clinical Report- Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice. Pediatrics, DOI: 10.1542/peds.2010-2348. Retrieved from: http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348.full.pdf+html

[13] Conron, K. et al. (2009). *A longitudinal study of maternal depression and child maltreatment in a national sample of families investigated by child protective services*. Archives of Pediatrics and Adolescent Medicine 163(10). Retrieved from: http://archpedi.jamanetwork.com/article.aspx?articleid=382254

[14] Boyle, et al. (2011). Trends in the prevalence of developmental disabilities in US children, 1997-2008. Pediatrics; originally published online May 23, 2011; DOI: 10.1542/peds.2010-2089.

[15] California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060 (Jun. 2015); U.S. Census Bureau, Current Population Estimates, Vintage 2013 (Jun. 2015). Retrieved from: www.kidsdata.org.

[16] Feinberg, et al. (2011). *The Impact of Race on Participation in Part C Early Intervention Services.* Journal of Developmental & Behavioral Pediatrics 32:284-291.

[17] National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from: www.childhealthdata.org.

[18] Sanders, et al. (2014). *Towards a public health approach to parenting: A systemic review and meta-analysis of the Triple P-Positive Parenting Program*. Clinical Psychology Review, 32: 337–357.

[19] Sanders, et al. (2008). *Every Family: A Population Approach to Reducing Behavioral and Emotional Problems in Children Making the Transition to School.* Journal of Primary Prevention.

[20] Prinz, et al. (2009). *Population-based prevention of child maltreatment: the U.S. Triple P System population trial.* Prevention Science. Published with open access at www.springerlink.com

[21] Feletti et al. (1998). *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*. American Journal of Preventive Medicine. 14(4): 245-258.

[22] Anda et al. (2006) *The Enduring Effects of Abuse and Related Adverse Experiences in Childhood.* European Archives of Psychiatry and Clinical Neuroscience. 256: 174-186.

[23] Szyf, M. (2009). The early life environment and the epigenome. Biochimica Biophysica Acta (BBA). 1790(9): 878-885.

[24] National Scientific Council on the Developing Child (2010). *Early Experiences Can Alter Gene Expression and Affect Long-Term Development: Working Paper No. 10.* http://www.developingchild.net

[25] Shonkoff, J.P. (2010) Building a New Biodevelopmental Framework to Guide the Future of Early Childhood Policy. Child Development, January/February 2010. 81(1): 357–367. http://steinhardt.nyu.edu/scmsAdmin/media/users/eez206/srb_conference/Building_a_New_Biodevelopmental_Framework_-_J__Shonkoff.pdf.

[26] Evins, G., Theofrastous, J., & Galvin, S. (2000). *Postpartum depression: a comparison of screening and routine clinical evaluation.* American Journal of Obstetrics and Gynecology 182(5): 1080-1082.

[27] Hodnett, D. (2007). *Psychosocial and psychological interventions for treating postpartum depression (Review)*. The Cochrane Collaboration. Published in The Cochrane Library 2007, Issue 4.

[28] Murray, L. and Cooper, P. (1997). *Effects of Postnatal Depression on Infant Development*. Archives of Disease in Childhood 77(2): 99-101.

[29] Dawson, G., Ashman, S. B., Panagiotides, et al. (2003). *Preschool Outcomes of Children of Depressed Mothers: Role of maternal behavior, contextual risk, and children's brain activity*. Child Development. 74(4):1158-1175. Abstract available at: http://www.blackwell-synergy.com/doi/abs/10.1111/1467-8624.00599

[30] Ronsaville, D.S. et al. (2006) *Maternal and environmental factors influence the hypothalamic-pituitaryadrenal axis response to corticotropin- releasing hormone infusion in offspring of mothers with or without mood disorders.* Development & Psychopathology. 18: 173-194.

[31] Moore, K.A. et al. (2006) Depression Among Moms: Prevalence, Predictors, and Acting Out Among Third Grade Children. Child Trends Research Brief. March 2006. Retrieved from: https://www.childtrends.org/wp-content/uploads/2013/03/Child_Trends-2006_03_31_RB_MomDepression.pdf

[32] Canadian Paediatric Society. (2004) Maternal Depression and Child Development. 9(8): 575-583. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2724169/

[33] Gump, B. B. et al (2009). *Trajectories of maternal depressive symptoms over her child's life span: Relation to adrenocortical, cardiovascular, and emotional functioning in children.* Development and Psychopathology. 21: 207-225.

[34] Wickramaratne, et al. (2011). *Children of depressed mothers 1 year after remission of maternal depression: Findings from the STAR*D-Child study.* American Journal of Psychiatry 168(6):593-602.

[35] Glascoe, F. (2000). *Early detection of developmental and behavioral problems*. Pediatrics in Review 21(8): 272-280.

[36] Squires, J., Nickel, R., & Eisert, D. (1996). *Early detection of developmental problems: strategies for monitoring young children in the practice setting.* Journal of Developmental and Behavioral Pediatrics 17(6): 420-427.

[37] Center on the Developing Child at Harvard University. (2012). In Brief: The Science of Early Childhood Development. Retrieved from: www.developingchild.harvard.edu

[38] Mayoney, et al. (1999). Parent Education in Early Intervention: A Call for Renewed Focus. Topics in Early Childhood Special Education 19: 131-139.

[39] Fromm, S. (2007). Total estimated cost of child abuse and neglect in the United States. Prevent Child Abuse America.

[40] Cost-Benefit Analyses for Sonoma County- Triple P. Developed by Research Development Associates.

[41] Foster, et al. (2008). The cost of public health infrastructure for delivering parenting and family support. Children and Youth Services Review 30:493-501. As cited in Sanders, M. (2008). Triple P-Positive Parenting Program as a public health approach to strengthening parenting. Journal of Family Psychology 22(3): 506-517.

[42] Mihalopoulos, et al. (2007). Does the Triple P- Positive Parenting Program provide value for money? Australian and New Zealand Journal of Psychiatry 41(3):239-246. As cited in Sanders, M. (2008). Triple P-Positive Parenting Program as a public health approach to strengthening parenting. Journal of Family Psychology 22(3): 506-517.

[43] Beck, et al. (2011). *Severity of depression and magnitude of productivity loss.* Annals of Family Medicine 9(4): 305-311.

[44] National Alliance on Mental Illness. *The Impact and Cost of Mental Illness: The Case of Depression.* Retrieved from www.nami.org

[45] Rost, et al. (2005). *Cost-Effectiveness of Enhancing Primary Care Depression Management on an Ongoing Basis.* Annals of Family Medicine 3(1): 7-14.

[46] National Scientific Council on the Developing Child. (2007). *The Science of Early Childhood Development.* Retrieved from http://www.developingchild.net

[47] Glascoe, F. (2000). *Early detection of developmental and behavioral problems*. Pediatrics in Review 21(8): 272-280.

[48] Chapman D. P. et al. (2007) *Adverse childhood events as risk factors for negative mental health outcomes.* Psychiatric Annals. 37(5):359–364.

[49] Anda R. F., Brown D. W. (2010) Adverse childhood experience and population health in Washington: The face of a chronic public health disaster. Retrieved from: http://www.legis.state.wv.us/senate1/majority/poverty/ACEsinWashington2009BRFSSFinalReport%20-%20Crittenton.pdf.

[50] Positive Reliable Change is the difference from pre-treatment to post-treatment that can be considered reliable and is not likely to be due to measurement error. Positive Reliable Change is a more accurate measure of change than looking at the percent of families moving from above to below clinical cut-off points. For additional information on reliable change, please see Appendix A.

[51] http://www.mhsoac.ca.gov/Counties/PEI/docs/PEIplans/Sonoma_PEI.pdf [Accessed 1/15/15]

[52] First 5 California defines special needs as, Children with identified disability, health, or mental health conditions requiring early intervention, special education services, or other specialized services and supports; or Children without identified conditions, but requiring specialized services, supports, or monitoring. The reported number of children with special needs may be an under estimate because all of the children in the Watch Me Grow program are considered to have special needs.

[53] UC Berkeley's CSSR database. Retrieved from http://cssr.berkeley.edu/ucb_childwelfare/RecurAlleg.aspx.

[54] 6 Month Reoccurrence Disposition per calendar year. UC Berkeley's CSSR database. Retrieved from http://cssr.berkeley.edu/ucb_childwelfare/RecurAlleg.aspx.

[55] Webster, D. et al. (2016). CCWIP reports. University of California at Berkeley California Child Welfare Indicators Project website. Retrieved from http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx.

[56] The results for this target reflect outcome data for MHSA-funded Triple P agencies in Sonoma County for clients who entered services prior to their sixth birthday.

[57] LFA, CIBHS, and First 5 worked together to determine a realistic, accurate target for ECBI results. These targets are realistic and reflect outcomes typically seen in research studies that also use a Reliable Change Index to measure progress on the ECBI. (Sanders, M. et al. *The Triple P-Positive Parenting Program: A Comparison of Enhanced, Standard, and Self-directed Behavioral Family Intervention for Parents of Children with Early Onset Conduct Problems*. Journal of Consulting and Clinical Psychology, Vol 68(4), Aug 2000, 624-640) For discussion of the Eyberg Child Behavior Inventory (ECBI) and the Parenting Scale, see Appendix D.

[58] Items were reverse scored to reflect strength based responses.

[59] ECBI results are from clients who completed Triple P Levels 4/5 and have pre/post ECBI data. See Appendix A.

[60] Positive Reliable Change is a more accurate measure of change than looking at the percent of families moving from above to below clinical cut-off points. For additional information on reliable change, see Appendix D.

VII. Appendices

A. CMC: Triple P Positive Parenting Program Results

B. Pathway to Results

C. Numbers Served By Grantee

D. Description of Triple P Outcome Measures

E. Cost-Benefit Analyses

A. CMC: Triple P Positive Parenting Program Results

Triple P Positive Parenting Program – First 5 Sonoma

L4/5 Outcome Data for MHSA-Funded Families *(ECBI data revised 3/9/18)*

Clients Age 0-5

These tables report outcome data for MHSA-funded Triple P families in Sonoma County for clients who entered services prior to their sixth birthday.

FY 2016-2017: The ECBI outcomes are based on 43 clients who completed L4/5 within four provider organizations:

- **Child Parent Institute** (28 completed; 23-25 have pre/post ECBI outcome data)
- **Jewish Family and Children's Services** (4 completed; 0 have pre/post ECBI outcome data)
- **Petaluma People Services Center** (11 completed; 8 have pre/post ECBI outcome data)

Table 1. FY 2016-2017 Triple P Level 4/5 Outcome Data± for MHSA-Funded Clients who Completed Triple P Level 4/5 (n=43)

	Percent Improvement± from the Average Pre-Score to the Average Post- Score	Effect Size Estimate± (Cohen's *d*)	Percent of Clients Showing Reliable Change± from Pre- to Post-		
			Positive Change	No Change	Negative Change
Eyberg Child Behavior Inventory (ECBI)					
Intensity Raw Score	30.4%* (n=31) [pre=136.0]	1.13	71.0% (n=22)	22.6% (n=7)	6.5% (n=2)
Problem Raw Score	68.7%* (n=33) [pre=16.5]	1.28	78.8% (n=26)	15.2% (n=5)	6.1% (n=2)

±Please see Appendix B. of the Aggregate Report for a description of the First 5 Sonoma Triple P outcome measures and the outcome indicators (percent improvement in average scores; effect size estimate; and, percent of clients showing reliable change).

*A statistically significant improvement, $p \leq .01$.

Table 2. FY 2016-2017 Triple P Level 4/5 Clinical Cutpoint Data± for MHSA-Funded Clients who Completed Triple P Level 4/5 and Have Outcome Data

	Clients with Pre-Scores In the Clinical Range (At or Above the Clinical Cutpoint)	Clients with Pre-Scores In the Clinical Range who Have Post-Scores In the Non-Clinical Range (Below the Clinical Cutpoint)
Eyberg Child Behavior Inventory (ECBI)		
Intensity Raw Score (n=31)	48.4% (n=15)	73.3% (n=11)
Problem Raw Score (n=33)	60.6% (n=20)	95.0% (n=19)

±Please see Appendix B. for a description of the Eyberg Child Behavior Inventory.

<u>FY 2016-2017:</u> The PFS outcomes are based on 43 clients who completed L4/5 within four provider organizations:

- **Child Parent Institute** (28 completed; 23-24 have pre/post PFS outcome data)
- **Jewish Family and Children's Services** (4 completed; 0 have pre/post PFS outcome data)
- **Petaluma People Services Center** (11 completed; 1-7 have pre/post PFS outcome data)

Table 3. FY 2016-2017 Triple P Level 4/5 Outcome Data[±] for MHSA-Funded Clients who Completed Triple P Level 4/5 (n=43)

	Percent Improvement[±] from the Average Pre- Score to the Average Post- Score	Effect Size Estimate[±] (Cohen's *d*)	Percent of Families Showing Reliable Change[±] from Pre- to Post-		
			Positive Change	No Change	Negative Change
Protective Factors Survey (PFS)					
Family Functioning/ Resiliency Scale Score	2.2% (n=31) [pre=5.4]	.12	3.2% (n=1)	80.6% (n=25)	16.1% (n=5)
Social Emotional Support Scale Score	5.4% (n=30) [pre=5.4]	.24	16.7% (n=5)	76.7% (n=23)	6.7% (n=2)
Concrete Support Scale Score	16.4% (n=25) [pre=4.7]	.46	8.0% (n=2)	88.0% (n=22)	4.0% (n=1)
Nurturing and Attachment Scale Score	7.9%* (n=24) [pre=6.0]	.68	8.3% (n=2)	87.5% (n=21)	4.2% (n=1)

[±]Please see Appendix B. for a description of the First 5 Sonoma Triple P outcome measures and the outcome indicators (percent improvement in average scores; effect size estimate; and, percent of families showing reliable change).

*A statistically significant improvement, $p \leq .01$.

Table 4. FY2016-2017 Triple P Level 4/5 Protective Factors Survey Pre/Post Change on Knowledge of Parenting and Child Development Items – Families That Completed Triple P Level 4/5 (n=43)				
	Pre Mean and Standard Deviation	**Post Mean and Standard Deviation**	**Percent Mean Change**	**Percent of Clients That Improved**
Protective Factors Survey (PFS) Knowledge of Parenting and Child Development Items				
12. There are many times that I don't know what to do as a parent. (n=30)	2.70 (±1.4)	2.43 (±1.7)	-9.9%	16.7%
13. I know how to help my child learn. (n=30)	5.37 (±1.4)	6.17 (±0.7)	14.9%*	53.3%
14. My child misbehaves just to upset me. (n=30)	4.70 (±1.7)	5.37 (±1.9)	14.2%	60.0%
15. I praise my child when he/she behaves well. (n=30)	5.57 (±1.8)	6.57 (±0.7)	18.0%*	46.7%
16. When I discipline my child, I lose control. (n=30)	5.17 (±1.6)	6.07 (±1.0)	17.4%*	63.3%

Note1: Percent of clients improved indicates the proportion that have a post rating that is more positive, or favorable, than their pre rating.
Note2: Items 12, 14 and 16 have been reverse-scored and reflect strength-based responses.
Note3: ± indicates the standard deviation
*A statistically significant improvement, $p \leq .01$.

B. Pathway to Results

First 5 Sonoma County

Mental Health Services Act—Prevention and Early Intervention 0-5 (MHSA-PEI 0-5): Pathway to Results

Organizations: Child Parent Institute (CPI), Early Learning Institute (ELI), Jewish Family and Children Services (JFCS), Petaluma People Services Center (PPSC)

Grant Period: July 1, 2016 – June 30, 2017

Strategies/ Activities	Measureable Short Term Program Outputs	Measureable Long Term Program Outcomes	Specific Targets	Measurement Tool	Timeline
I. Screening and Services for Women Experiencing Perinatal Mood Disorder (PMD)					
A. Screening *(CPI , PPSC)*	▪ Identify women with PMD ➲ CPI – min. 40 women screened ➲ PPSC – 9 women screened ▪ Demographic data on populations served (for descriptive purposes and for State Annual Reporting)		▪ Providers meet the targets specified in their SOWs	▪ Providers' data tracking on numbers served (Number of screenings), self-reported in First 5 Sonoma County quarterly progress report ▪ Edinburgh Postnatal Depression Scale (EPDS) ▪ PHQ-9 ▪ Whooley Depression Screen	
B. Intervention – PMD case management, psychotherapy , referral to medical provider *(CPI, PPSC)*	▪ Provide case management and treatment to women identified with PMD: ➲ CPI – 40 women ➲ PPSC – 4 women receive treatment (approx. 24 sessions) 3 women will be referred to Primary Care provider or other care provider ▪ Demographic data on populations served (for descriptive purposes and for State Annual Reporting)	▪ Decrease in PMD among identified/ treated women ▪ Decrease in substantiated reports for child abuse and neglect (measured at community level)**	▪ Providers meet the targets specified in their SOWs ▪ For those women who have completed a pre- and post-intervention EPDS, and who were at or above the clinical cut-off point on the pre-intervention EPDS, 65 percent will move below the clinical cut-off point (score of 10) on the post-intervention EPDS	▪ Edinburgh Postnatal Depression Scale (EPDS)	

Strategies/ Activities	Measureable Short Term Program Outputs	Measureable Long Term Program Outcomes	Specific Targets	Measurement Tool	Timeline
II. Education and Early intervention for Parents/Caregivers and Providers					
C. Positive Parenting Program (Triple P) *(CPI, PPSC, ELI, JFCS)*	▪ Provide positive parent education services using the level of Triple P appropriate to parents' needs: ➲ CPI – 100 families ➲ Level 3: 30 families ➲ Level 4: 70 families (in conjunction with Level 5) ➲ PPSC - ➲ Level 2: 2 Level 2 Seminar Series (three 90-minute sessions per series), with 20 total participants ➲ Levels 3, 4, and 5: 70 families ➲ ELI – 40 families ➲ Using Level 3, 4, or 5 as appropriate ➲ Some amount of families may receive PEAS instead (please see area D of this document for more information) ➲ JFCS - ➲ Level 2: 180 attendees to total of 23 seminars ➲ Level 3 Discussion Groups: 15 attendees to a total of 3 sessions ➲ Level 3 Individual: 40 individuals ➲ Levels 4 and 5: 15 individuals ▪ Demographic data on populations served (for descriptive purposes and for State Annual Reporting) ▪ For full list of outputs to be measured, please see Triple P Pathway to Results.	For Level 4 and 5: ▪ Decrease in children exhibiting difficult behaviors** ▪ Decrease in negative parent-child interactions ** Note: ▪ First 5 Sonoma will also be monitoring the recurrence of substantiated reports of child abuse and neglect and the number of children visiting the emergency room for suspected maltreatment in Sonoma County.	▪ Providers meet the targets specified in their SOWs <u>Note:</u> The following targets will be measured by First 5 in collaboration with CMC. Providers of Triple P need to gather this information but only need to provide it to CMC. **Intensity Score:** The numerical score on the ECBI Intensity subscale, which measures the intensity of a child's behavioral problems, as rated by the parent. **Problem Score:** The numerical score on the ECBI Problem subscale, which measures the extent to which the parent view the child's behaviors as problematic, as rated by the parent. ▪ 40 percent of children will show reliable, positive change on the Intensity score, as calculated by CMC ▪ 40 percent of children will show reliable change on the Problem score, as calculated by CMC. ▪ Protective Factor Survey	For Level 4 and 5: ▪ Protective Factors Survey pre/post testing ▪ ECBI pre/post testing For all Levels: ▪ Other data to be self-reported in regular progress reports submitted to CIBHS	<u>Data Collection:</u> Semi-annual data sent to CIBHS(sent in at the beginning of January and July) <u>Reporting back:</u> 60 days after data is submitted

Strategies/ Activities	Measureable Short Term Program Outputs	Measureable Long Term Program Outcomes	Specific Targets	Measurement Tool	Timeline
D. Other education and early intervention programs	▪ Parent Education and Support Program (PEAS) ➲ ELI – 40 families ➲ Families receive either PEAS or Triple P (or both) ➲ 6 visit model, which includes Triple P Level 3. ▪ Mental Health Services for High Risk Families ➲ CPI – 20 (estimate) limited consultations will be available to families with other mental health concerns of either parent or child. These families will be referred to an appropriate community agency or program. ▪ Demographic data on populations served (for descriptive purposes and for State Annual Reporting)		▪ Providers meet the targets specified in their SOWs ▪ For ELI, 50% of parents will report a decrease in score on the Parental Stress Index, which is a proxy measure for an increased understanding of typical child development, including early childhood social, emotional and behavioral issues.	▪ Providers' data tracking on number of families receiving assistance, self-reported in First 5 Sonoma County quarterly progress report ▪ For ELI, the Parental Stress Index (PSI). ▪ For CPI, data on where families are referred for additional services	
III. Social/Emotional Screening of Children					
E. Periodic developmental and social emotional screening *(ELI, PPSC, CPI)*	▪ Provide comprehensive developmental and social emotional screenings to children 0-5. Information provided to parents to allow reporting to medical home. ➲ ELI – 300 children screened/350 rescreened, 100 of whom are referred for further assessment and/or services ➲ PPSC – screen children who are referred to PPSC and have not already been screened ➲ CPI – screen children who are referred to CPI and have not already been screened ➲ JFCS – screen children who are referred to JFCS and have not already been screened ▪ Demographic data on populations served (for State Annual Reporting)	▪ Children deemed at risk are referred for follow-up assessments**	▪ Providers meet the targets specified in their SOWs	▪ Providers' data tracking on numbers served (Number of screenings), self-reported in First 5 Sonoma County quarterly progress report ▪ ASQ3 or ASQ SE (developmental screening) done for all children not yet screened by ASQ	

Strategies/ Activities	Measureable Short Term Program Outputs	Measureable Long Term Program Outcomes	Specific Targets	Measurement Tool	Timeline
IV. Assessment and Facilitated Referral to Services for High-Risk Children and their Families					
F. Navigation/ Case Management *(ELI)*	▪ Provide community-wide case management for children in at-risk families in targeted populations for whom a screening identifies potential problems ➲ ELI – 240 families receiving case management and/or facilitated referrals ➲ ELI Navigator – 100 additional callers linked to appropriate services ▪ Demographic data on populations served (for descriptive purposes and for State Annual Reporting)		▪ Providers meet the targets specified in their SOWs	▪ Providers' data tracking on number of families receiving case management, self-reported in First 5 Sonoma County quarterly progress report	
G. Psychological Assessments of Children 0-5 *(JFCS)*	▪ Provide psychological assessments for children 0-5 ➲ JFCS – 5 children ▪ Demographic data on populations served (for descriptive purposes and for State Annual Reporting)		▪ Providers meet the targets specified in their SOWs	▪ Providers' data tracking on number of assessments provided, self-reported in First 5 Sonoma County quarterly progress report ▪ Results of assessments and where clients were referred	

***Outcome links to the First 5 Sonoma County Pathways to Results framework*

Demographic data on populations served to be captured for Descriptive Purposes and for the State Annual Report:

- # of children served less than 3 years old
- # of children served, ages 3-6th birthday
- # of parents/ guardians/primary caregivers served
- # of other family members served
- # of providers served
- Race/ethnicity of providers, children, and parents/primary caregivers served
  - ➲ Please use the following categories: Alaska Native/American Indian, Asian, Black/African-American, Hispanic/Latino, Pacific Islander, White, Multiracial, Other (Specify: ____), Unknown
- Primary language of providers, children, and parents/primary served
  - ➲ Please use the following categories: English, Spanish, Cantonese, Mandarin, Vietnamese, Korean, Other (Specify: ____), Unknown
- # of children less than 3 years with special needs
- # of children 3-6 years with special needs

C. Numbers Served, by Grantee

This section contains the numbers served by each grantee, as well as demographic information on the population served by each grantee.

Numbers Served by Grantee FY 2016 17						
		Child Parent Institute	**Early Learning Institute**	**Jewish Family & Children's Services**	**Petaluma People Services Center**	**Total**
Total Served	Parents/Guardians/ Primary Caregivers	244	1,183	19	40	1,486
	Children	190	794	11	42	1,037
	Other Family Members Served	167	25		40	232
	Total Population Served	601	2,002	30	122	2,755
Parent/ Caregiver's Ethnicity	Hispanic/Latino	158	684	4	37	883
	White	69	377	13	3	462
	Multi-racial	1	44	2		47
	Asian	1	14			15
	Black/ African-American	3	12			15
	Alaska Native/ American Indian	1	7			8
	Pacific Islander		1			1
	Other		15			15
	Unknown	10	29			39
Parent/ Caregiver's Primary Language	Spanish	129	522		37	688
	English	112	659	19	3	793
	Other		2			2
	Unknown	3				3
Child's Ethnicity	Hispanic/Latino	120	435		37	592
	White	54	266	9	5	334
	Multi-racial	3	42	2		47
	Black/ African-American	2	13			15
	Other		4			4
	Alaska Native/ American Indian	1	8			9
	Asian	1	9			10
	Pacific Islander					0
	Unknown	9	16			25
Child's Primary Language	English	97	462	11	4	574
	Spanish	91	331		38	460
	Other					0
Special Needs Children			794			794

D. Description of Triple P Outcome Measures

This section contains brief descriptions of the instruments used to measure progress for parents and children who receive Triple P. These descriptions were provided by CMC.

Eyberg Child Behavior Inventory (ECBI)

The Eyberg Child Behavior Inventory (ECBI) is an outcome measure completed by the child's parent/caregiver before and after participation in Triple P Level 4/5. This 36-item measure has two components: one that assesses the frequency, or intensity, of current child behavior problems displayed by children between the ages of 2-16; and one that assesses the extent to which these behaviors are currently perceived as problematic to the child's parent/caregiver.

Possible ECBI Intensity Raw Scores range from 36-252, with a clinical cut-off point of 131; and possible ECBI Problem Raw Scores range from 0-36, with a clinical cut-off point of 15.

Protective Factors Survey

The *Protective Factors Survey* (PFS) is a collective impact measure implemented by all Sonoma County Human Services Department's Children, Youth and Families grantees; and, is implemented before and after participation in Triple P Level 4/5 for all clients, regardless of age. This 20-item questionnaire is designed for use with caregivers receiving child maltreatment prevention services with the purpose of providing agencies with feedback for continuous improvement and evaluation. It assesses five domains of protective factors: family functioning and resilience; social emotional support; concrete support; nurturing and attachment; and, knowledge of parenting and child development. Items in the first four domains sum to create subscales that can be used to identify pre/post change.

Possible scores on the PFS Family Functioning/Resilience, Social Emotional Support, Concrete Support and Nurturing & Attachment Scales range from 1-7; and, there are no clinical cut-points. As a strength-based measure, higher scores indicate a greater presence of that domain of protective factors.

Outcome Indicator: Percent of Clients Showing Reliable Change

The percent of clients showing reliable change reflects those with an amount of change on an outcome measure from pre-Triple P to post-Triple P that meets or exceeds the value of the Reliable Change Index (RCI). RCI, as calculated using the Jacobson-Truax (1991) method, is the amount of change that can be considered reliable based on the difference from pre- to post-, taking the variability of the pre-treatment group and measurement error into consideration. It reflects an amount of change that is not likely to be due to measurement error ($p<.05$) [see Wise, E.A. (2004). Methods for Analyzing Psychotherapy Outcomes: A Review of Clinical Significance, Reliable Change, and Recommendations for Future Directions. Journal of Personality Assessment, 82(1), 50-59].

The percent of clients with positive change, no change, and negative change are reported in Tables; and, Graphs present reliable change in these three categories for each measure.

Outcome Indicator: Percent Improvement in Average Pre- and Post- Scores

The percent improvement in the average scores from pre-Triple P to post-Triple P is reported for each outcome measure, when available. A paired t test analysis is conducted with each set of scores; and, when the difference observed is not likely to be due to chance ($p<01$), this is indicated with a footnote.

In addition to reporting the percent of change in average scores in Tables, Graphs present the average pre-score and the average post-score, with solid lines indicating the clinical cut-points when applicable.

Outcome Indicator: Effect Size Estimate, Cohen's d

Cohen's d is a standardized effect size measure that estimates the magnitude, or strength, of a relationship. In this dashboard report it estimates the strength of the relationship between the average pre score and the average post score, expressed in terms of standard deviations. An effect size of .5 indicates that the average pre score is .5 standard deviations greater than the average post score. While there is no absolute agreement about what magnitude of an effect size is necessary to establish practical or clinical significance, conventional interpretations of Cohen's d are that effect sizes of .2 to .3 represent a "small" effect; effect sizes around .5 reflect a "medium" effect; and, effect sizes of .8 or greater represent a "large" effect. However, an alternate schema has been proposed for the social sciences, where the recommended minimum effect size representing a "practically" significant effect is .41, with 1.15 representing a moderate effect and 2.70 a strong effect [see Ferguson, C.J. (2009). An Effect Size Primer: A Guide for Clinicians and Researchers. Professional Psychology: Research and Practice, 40 (5), 532-538].

E. Cost-Benefit Analyses

Developed by Research Development Associates (RDA)

In addition to the long term cost-savings described on page 7, estimates of further cost savings are listed below.

Net Costs & (Net Savings) over 2 Year & 4 Year Periods

	Conservative Estimate	Optimistic Estimate
Two Years of/after Implementation		
Costs of Triple P Direct Service	$ 1,512,596	$ 588,305
Costs of Triple P Implementation*	$ 444,822	$ 444,822
Total Costs	**$ 1,957,417**	**$ 1,033,126**
Savings from Out-Of-Home Placements	$ 154,303	$ 154,303
Savings from Social Worker Time	$ 1,048,452	$ 1,437,782
Savings from ER visits	$ 281,708	$ 281,708
Total Savings	**$ 1,484,462**	**$ 1,873,793**
Net Costs (Net Savings) - 2 years	**$ 472,955**	**$ (840,666)**

Four Years of/after Implementation		
Costs of Triple P Direct Service	$ 3,025,191	$ 1,176,609
Costs of Triple P Implementation*	$ 889,643	$ 889,643
Total Costs	**$ 3,914,834**	**$ 2,066,253**
Savings from Out-Of-Home Placements	$ 820,417	$ 820,417
Savings from Social Worker Time	$ 5,698,701	$ 7,814,846
Savings from ER visits	$ 1,412,372	$ 1,412,372
Total Savings	**$ 7,931,491**	**$ 10,047,635**
Net Costs (Net Savings) - 4 years	**$ (4,016,656)**	**$ (7,981,383)**

* MHSA Collaborative Implementation Costs for Level 4, only

Appendix 4

Sonoma County Behavioral Health WET Training Calendar for FY 16-17

WELLNESS • RECOVERY • RESILIENCE

Workforce Education & Training (WET)

Training Calendar for FY 2016-2017

Date	Training Topic and Facilitator(s)	Type of Training
July 6, 2016	5150 Training Michael Kozart, M.D., Tamara Winer, PRA ***Open to Licensed Clinicians Only***	Specialty Patients' Rights & 5150 Certification
July 6, 2016	Outreach Teams Susan Castillo, Section Manager, Melissa Ladrech, LMFT ***Open to all Staff***	Staff Development System Navigation
July 11, 2016	Master Clinical Supervision Series Audrey Boggs, PhD, Quality Assurance Manager ***Required Training for Health Managers and Clinical Specialists***	Leadership Development Intern Program
July 25, 2016	Youth Mental Health Academy – Day 1 SCBH: Susan Castillo, Melissa Ladrech, Phyllis King; VOICES; NAMI ***Open to Community Providers***	Specialty: Best Practices – Youth and Family
July 26, 2016	Youth Mental Health Academy – Day 2 SCBH: Wendy Tappon, Cynthia Morfin ***Open to Community Providers***	Specialty: Best Practices – Youth and Family
July 27, 2016	Youth Mental Health Academy – Day 3 SCBH: Susan Castillo, Amy Faulstich, Katie Bivin; SCOE: Debra Sanders; SELPA: John Fischer ***Open to Community Providers***	Specialty: Best Practices – Youth and Family
July 28, 2016	Youth Mental Health Academy – Day 4 SCBH: Dr. Michael Kozart, Megan Burns, Tamara Winer, Karin Sellite, Katie Bivin, Melonie Lopes ***Open to Community Providers***	Specialty: Best Practices – Youth and Family
July 29, 2016	Youth Mental Health Academy – Day 5 SCBH: Cruz Cavallo, Melissa Ladrech	Specialty: Best Practices – Youth and Family

Date	Training Topic and Facilitator(s)	Type of Training
	Open to Community Providers	
August 3, 2016	Safety with Clients: Intuition, De-Escalation, & Home Visits Angela Avery, Safety Coordinator, Waid Allred, SCSS, Stephanie Meyler, LCSW ***Required Training for All Staff***	Staff Development Field Safety
August 15, 2016	DBT: Skills Group Facilitator Training – Session 1A Melissa Ladrech, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
August 18, 2016	DBT: Skills Group Facilitator Training – Session 1B Melissa Ladrech, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
August 22, 2016	DBT: Skills Group Facilitator Training – Session 2A Melissa Ladrech, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
August 25, 2016	DBT: Skills Group Facilitator Training – Session 2B Melissa Ladrech, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
August 29, 2016	DBT: Skills Group Facilitator Training – Session 3A Melissa Ladrech, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
September 1, 2016	DBT: Skills Group Facilitator Training – Session 3B Melissa Ladrech, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
September 7, 2016	Assessing and Managing Suicide Risk Katie Bivin, LMFT, Melissa Ladrech, LMFT ***Open to Community Providers***	Specialty Suicide Prevention
September 12, 2016	Master Clinical Supervision Series Audrey Boggs, Psy.D., Quality Assurance Manager	Leadership Development Intern Program

Date	Training Topic and Facilitator(s)	Type of Training
	Required Training for Health Managers and Clinical Specialists	
September 28, 2016	Documentation Training Audrey Boggs, Psy.D., Quality Assurance Manager ***Required Training for All Staff***	Staff Development Documentation
October 5, 2016	5150 Training Michael Kozart, M.D., Tamara Winer, PRA ***Open to Licensed Clinicians Only***	Specialty Patients' Rights & 5150 Certification
October 10, 2016	Overview of Psychiatric Rehabilitation Approach Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
October 11, 2016	Psychiatric Rehabilitation Approach: Managers and Supervisors Deborah Nicolellis, MS, CRC, CPRP ***Open to Health Managers and Clinical Specialists***	Specialty: Evidence-Based – Supervision
October 12, 2016	Psychiatric Rehabilitation Approach: Managers and Supervisors Deborah Nicolellis, MS, CRC, CPRP ***Open to Health Managers and Clinical Specialists***	Specialty: Evidence-Based – Supervision
October 13, 2016	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 1 Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
October 14, 2016	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 2 Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
October 17, 2016	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 1 Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice

Date	Training Topic and Facilitator(s)	Type of Training
October 18, 2016	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 2 Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
October 27, 2016	Outreach Efforts Susan Castillo, Section Manager, Cruz Cavallo, LMFT, ***Open to All Staff and Community***	Community Mental Health Lecture System Navigation
November 7, 2016	DBT: Skills Group Facilitator Training – Session 4A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
November 10, 2016	DBT: Skills Group Facilitator Training – Session 4B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
November 11, 2016	Psychiatric Rehabilitation Approach: Webinar –Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
November 12, 2016	Psychiatric Rehabilitation Approach: Webinar – Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
November 14, 2016	Master Clinical Supervision Series Audrey Boggs, Psy.D., Quality Assurance Manager ***Required Training for Health Managers and Clinical Specialists***	Leadership Development Intern Program
November 14, 2016	Psychiatric Rehabilitation Approach: Readiness Development and Choosing Overview Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
November 15, 2016	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 1 Cohort A Deborah Nicolellis, MS, CRC, CPRP	Specialty: Evidence-Based Practice

Date	Training Topic and Facilitator(s)	Type of Training
	Open to selected Staff and Contractors	
November 16, 2016	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 2 Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
November 17, 2016	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 1 Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
November 18, 2016	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 2 Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
November 28, 2016	DBT: Skills Group Facilitator Training – Session 5A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
November 30, 2016	DSM-5 Kristin Dempsey, CIBHS ***Required for all Clinical Staff and Contractors***	Specialty: Diagnostics
December 1, 2016	DBT: Skills Group Facilitator Training – Session 5B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
December 5, 2016	DBT: Skills Group Facilitator Training – Session 6A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
December 7, 2016	Gender and Sexuality Javier Riviera, Positive Images ***Required for All Staff***	Staff Development Cultural Competency
December 8, 2016	5150 Training Michael Kozart, M.D., Tamara Winer, PRA	Specialty

Date	Training Topic and Facilitator(s)	Type of Training
	Open to Licensed Clinicians Only	Patients' Rights & 5150 Certification
December 8, 2016	DBT: Skills Group Facilitator Training – Session 6B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
December 12, 2016	DBT: Skills Group Facilitator Training – Session 7A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
December 13, 2016	Psychiatric Rehabilitation Approach: Webinar –Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
December 14, 2016	Psychiatric Rehabilitation Approach: Webinar – Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
December 15, 2016	DBT: Skills Group Facilitator Training – Session 7B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
December 19, 2016	DBT: Skills Group Facilitator Training – Session 8A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
December 22, 2016	DBT: Skills Group Facilitator Training – Session 8B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
January 9, 2017	DBT: Skills Group Facilitator Training – Session 9A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
January 9, 2017	Master Clinical Supervision Series: Session VII Audrey Boggs, PhD, Quality Assurance Manager	Leadership Development Intern Program

Date	Training Topic and Facilitator(s)	Type of Training
	Required Training for Health Managers and Clinical Specialists	
January 10, 2017	Team Training YFS: Documentation Wendy Wheelwright, LMFT ***Open to YFS Teams***	Staff Development Documentation
January 11, 2017	Minor Consent Linda Garrett, JD, Risk Management Services ***Required Training for All Staff working with Youth***	Staff Development Legal Compliance
January 12, 2017	DBT: Skills Group Facilitator Training – Session 9B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
January 23, 2017	DBT: Skills Group Facilitator Training – Session 10A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
January 26, 2017	Cultural Responsiveness Committee: Mental Health Recovery Peer Panel ***Open to all Staff***	Staff Development Recovery Model
January 26, 2017	DBT: Skills Group Facilitator Training – Session 10B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
January 26, 2017	CMHL: Let's Take A Walk On The Wild Side – The Human Animal Bond Dr. Gillian Squirrel ***Open to All Staff and Community***	Community Mental Health Lecture Homeless Outreach
January 30, 2017	DBT: Skills Group Facilitator Training – Session 11A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
February 1, 2017	Law & Ethics Linda Garrett, JD, Risk Management Services	Staff Development Legal Compliance

Date	Training Topic and Facilitator(s)	Type of Training
	Required Training for All Staff	
February 2, 2017	Team Training CSU: DSM5 Wendy Wheelwright, LMFT ***Open to CSU Staff***	Staff Development Diagnostics
February 2, 2017	Team Training FACT: DSM5 Wendy Wheelwright, LMFT ***Open to FACT Staff***	Staff Development Diagnostics
February 2, 2017	DBT: Skills Group Facilitator Training – Session 11B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
February 6, 2017	Psychiatric Rehabilitation Approach: Implementation Planning – Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
February 6, 2017	Psychiatric Rehabilitation Approach: Implementation Planning – Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
February 6, 2017	Team Training CSU: DSM5 Wendy Wheelwright, LMFT ***Open to CSU Staff***	Staff Development Diagnostics
February 7, 2017	Psychiatric Rehabilitation Approach: Functional Assessment – Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
February 8, 2017	Psychiatric Rehabilitation Approach: Functional Assessment – Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice

Date	Training Topic and Facilitator(s)	Type of Training
February 9, 2017	Psychiatric Rehabilitation Approach: Functional Assessment – Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
February 10, 2017	Psychiatric Rehabilitation Approach: Functional Assessment – Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
February 15, 2017	Team Training MADF: DSM5 Wendy Wheelwright, LMFT ***Open to MADF Staff***	Staff Development Diagnostics
February 23, 2017	Team Training Access: DSM5 Wendy Wheelwright, LMFT ***Open to Access Staff***	Staff Development Diagnostics
February 23, 2017	CMHL: Human Sexuality in the Context of Mental Health Recovery Wendy Wheelwright, LMFT ***Open to All Staff and Community***	Community Mental Health Lecture Integrated Health
February 24, 2017	Assessing and Managing Suicide Risk Cruz Lopez, LMFT, Melissa Ladrech, LMFT ***Open to all Clinical Staff and Community Partners***	Specialty Suicide Prevention
February 27, 2017	DBT: Skills Group Facilitator Training – Session 12A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
February 28, 2017	Psychiatric Rehabilitation Approach: Webinar –Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
March 1, 2017	Peer Perspectives: Releasing Hope Susan Standen ***Required for All Staff***	Staff Development

Date	Training Topic and Facilitator(s)	Type of Training
		Peer Perspective; Cultural Responsiveness
March 2, 2017	Team Training FACT: Documentation Wendy Wheelwright, LMFT ***Open to FACT Staff***	Staff Development Documentation
March 2, 2017	Psychiatric Rehabilitation Approach: Webinar –Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
March 2, 2017	DBT: Skills Group Facilitator Training – Session 12B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff***	Specialty Evidenced Based Practice
March 2, 2017	Team Training Access: Documentation Wendy Wheelwright, LMFT ***Open to Access Staff***	Staff Development Documentation
March 13, 2017	Psychiatric Rehabilitation Approach: Implementation Planning – Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
March 13, 2017	Psychiatric Rehabilitation Approach: Implementation Planning – Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
March 14, 2017	Psychiatric Rehabilitation Approach: Direct Skills Teaching – Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
March 14, 2017	Team Training YFS: DSM5 Wendy Wheelwright, LMFT ***Open to YFS Staff***	Staff Development Diagnostics

Date	Training Topic and Facilitator(s)	Type of Training
March 15, 2017	Psychiatric Rehabilitation Approach: Direct Skills Teaching – Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
March 16, 2017	Psychiatric Rehabilitation Approach: Direct Skills Teaching – Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
March 17, 2017	Psychiatric Rehabilitation Approach: Direct Skills Teaching – Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
March 20, 2017	DBT: Skills Group Facilitator Training – Didactic Session 1A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
March 22, 2017	Contractor Training Seneca: DSM5 Wendy Wheelwright, LMFT ***Open to Seneca Staff***	Contractor Staff Development Diagnostics
March 22, 2017	Team Training MST: DSM5 & Documentation Wendy Wheelwright, LMFT ***Open to MST Staff***	Staff Development Diagnostics & Documentation
March 23, 2017	Cultural Responsiveness Committee: HIV Meghan Murphy, MSW ***Open to all Staff***	Staff Development HIV Best Practices
March 23, 2017	DBT: Skills Group Facilitator Training – Didactic Session 1B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
March 23, 2017	Team Training MSM: DSM5 Wendy Wheelwright, LMFT ***Open to Medical Staff***	Staff Development Diagnostics

Date	Training Topic and Facilitator(s)	Type of Training
March 23, 2017	CMHL: The Impact of HIV on Sex and Sexuality Meghan Murphy, MSW ***Open to All Staff and Community***	Community Mental Health Lecture HIV & Integrated Health
March 27, 2017	DBT: Skills Group Facilitator Training – Consultation Session 1A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
March 30, 2017	DBT: Skills Group Facilitator Training – Consultation Session 1B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
March 30, 2017	Team Training Access: Documentation Wendy Wheelwright, LMFT ***Open to Access Staff***	Staff Development Documentation
April 3, 2017	DBT: Skills Group Facilitator Training – Didactic Session 2A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
April 4, 2017	Team Training YFS: Documentation Wendy Wheelwright, LMFT ***Open to YFS Staff***	Staff Development Documentation
April 5, 2017	Staff Development: Working with Latino Communities Latino Service Providers ***Required for All Staff***	Staff Development Cultural Responsiveness
April 5, 2017	5150 Training Michael Kozart, M.D., Tamara Winer, PRA ***Open to Licensed Clinicians Only***	Specialty Patients' Rights & 5150 Certification
April 6, 2017	DBT: Skills Group Facilitator Training – Didactic Session 2B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice

Date	Training Topic and Facilitator(s)	Type of Training
April 7, 2017	Team Training IHT: Documentation Wendy Wheelwright, LMFT ***Open to IHT Staff***	Staff Development Documentation
April 10, 2017	DBT: Skills Group Facilitator Training – Consultation Session 2A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
April 11, 2017	Team Training CAPE: DSM5 & Documentation Wendy Wheelwright, LMFT ***Open to CAPE Staff***	Staff Development Diagnostics & Documentation
April 13, 2017	Team Training OAT: Documentation Wendy Wheelwright, LMFT ***Open to OAT Staff***	Staff Development Documentation
April 13, 2017	DBT: Skills Group Facilitator Training – Consultation Session 2B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
April 17, 2017	DBT: Skills Group Facilitator Training – Didactic Session 3A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
April 18, 2017	Psychiatric Rehabilitation Approach: Webinar –Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
April 19, 2017	Psychiatric Rehabilitation Approach: Webinar –Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
April 20, 2017	DBT: Skills Group Facilitator Training – Didactic Session 3B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice

Date	Training Topic and Facilitator(s)	Type of Training
April 24, 2017	DBT: Skills Group Facilitator Training – Consultation Session 3A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
April 27, 2017	DBT: Skills Group Facilitator Training – Consultation Session 3B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
April 27, 2017	CMHL: Human Sexuality – Understanding Sexual Pleasure Dr. Daniela Dominguez, Ph.D. ***Open to All Staff and Community***	Community Mental Health Lecture Integrated Health
May 1, 2017	DBT: Skills Group Facilitator Training – Didactic Session 4A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
May 3, 2017	Staff Development: Compassion Fatigue Sean Kelson, Meghan Murphy, Jane Paul, & Wendy Wheelwright ***Open to All Staff***	Staff Development Self-Care
May 4, 2017	DBT: Skills Group Facilitator Training – Didactic Session 4B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
May 8, 2017	DBT: Skills Group Facilitator Training – Consultation Session 4A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
May 8, 2017	Master Clinical Supervision Series Audrey Boggs, PhD, Quality Assurance Manager ***Required Training for Health Managers and Clinical Specialists***	Leadership Development Intern Program
May 9, 2017	BH Roundtable: Contractor Training	Contractor Staff Development

Date	Training Topic and Facilitator(s)	Type of Training
	Christina Amarant, LMFT ***Open to Foster Family Agencies***	CCR
May 9, 2017	BH Roundtable: Contractor Training Christina Amarant, LMFT ***Open to Short Term Residential Treatment Programs***	Contractor Staff Development CCR
May 11, 2017	DBT: Skills Group Facilitator Training – Consultation Session 4B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
May 15, 2017	Psychiatric Rehabilitation Approach: Implementation Planning – Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
May 15, 2017	Psychiatric Rehabilitation Approach: Implementation Planning – Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
May 16, 2017	Psychiatric Rehabilitation Approach: Resource Development and Assessment – Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
May 17, 2017	Psychiatric Rehabilitation Approach: Resource Development and Assessment – Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
May 18, 2017	Psychiatric Rehabilitation Approach: Training for Trainers Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
May 19, 2017	Psychiatric Rehabilitation Approach: Training for Trainers Deborah Nicolellis, MS, CRC, CPRP	Specialty: Evidence-Based Practice

Date	Training Topic and Facilitator(s)	Type of Training
	Open to selected Staff and Contractors	
May 19, 2017	Assessing and Managing Suicide Risk Melissa Ladrech, LMFT & Patricia Mills, LMFT ***Open to all Clinical Staff and Contractors***	Specialty Suicide Prevention
May 22, 2017	DBT: Skills Group Facilitator Training – Didactic Session 5A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
May 22, 2017	DBT: Skills Group Facilitator Training – Didactic Session 5B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
May 25, 2017	CMHL: Human Sexuality – Transgender Medicine Dr. Suegee Tamar-Mattis, MD, Dr. Shawn Giamattei, Ph.D. ***Open to All Staff and Community***	Community Mental Health Lecture Integrated Health
May 30, 2017	Mental Health First Aid Cruz Lopez, LMFT, Melissa Ladrech, LMFT ***Open to all Community Providers, Educators, Family Members, Law Enforcement, and Interested Public***	Specialty Best Practices
May 31, 2017	Mental Health First Aid Cruz Lopez, LMFT, Melissa Ladrech, LMFT ***Open to all Community Providers, Educators, Family Members, Law Enforcement, and Interested Public***	Specialty Best Practices
June 5, 2017	DBT: Skills Group Facilitator Training – Consultation Session 5A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
June 7, 2017	Staff Development: ACEs and Resiliency Grace Harris, LMFT ***Open to All Staff***	Staff Development Trauma-Informed Care
June 8, 2017	DBT: Skills Group Facilitator Training – Consultation Session 5B	Specialty

Date	Training Topic and Facilitator(s)	Type of Training
	Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Evidenced Based Practice
June 12, 2017	DBT: Skills Group Facilitator Training – Didactic Session 6A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
June 13, 2017	Psychiatric Rehabilitation Approach: Webinar –Cohort A Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
June 14, 2017	Psychiatric Rehabilitation Approach: Webinar –Cohort B Deborah Nicolellis, MS, CRC, CPRP ***Open to selected Staff and Contractors***	Specialty: Evidence-Based Practice
June 15, 2017	DBT: Skills Group Facilitator Training – Didactic Session 6B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
June 19, 2017	DBT: Skills Group Facilitator Training – Consultation Session 6A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
June 19, 2017	DBT: Skills Group Facilitator Training – Consultation Session 6A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
June 22, 2017	DBT: Skills Group Facilitator Training – Consultation Session 6B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
June 22 2017	CMHL: Substance Use Treatment – AA Sonoma County Public Information and Cooperation with the Professional Communities Committee ***Open to All Staff and Community***	Community Mental Health Lecture Substance Use Disorder Treatment

Date	Training Topic and Facilitator(s)	Type of Training
June 26, 2017	DBT: Skills Group Facilitator Training – Didactic Session 7A Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice
June 29, 2017	DBT: Skills Group Facilitator Training – Didactic Session 7B Wendy Wheelwright, LMFT, Laura Porter, LMFT ***Open to selected Staff and Contractors***	Specialty Evidenced Based Practice

Appendix 5

Sonoma County Behavioral Health Question Persuade Refer (QPR) Outcomes

WELLNESS • RECOVERY • RESILIENCE

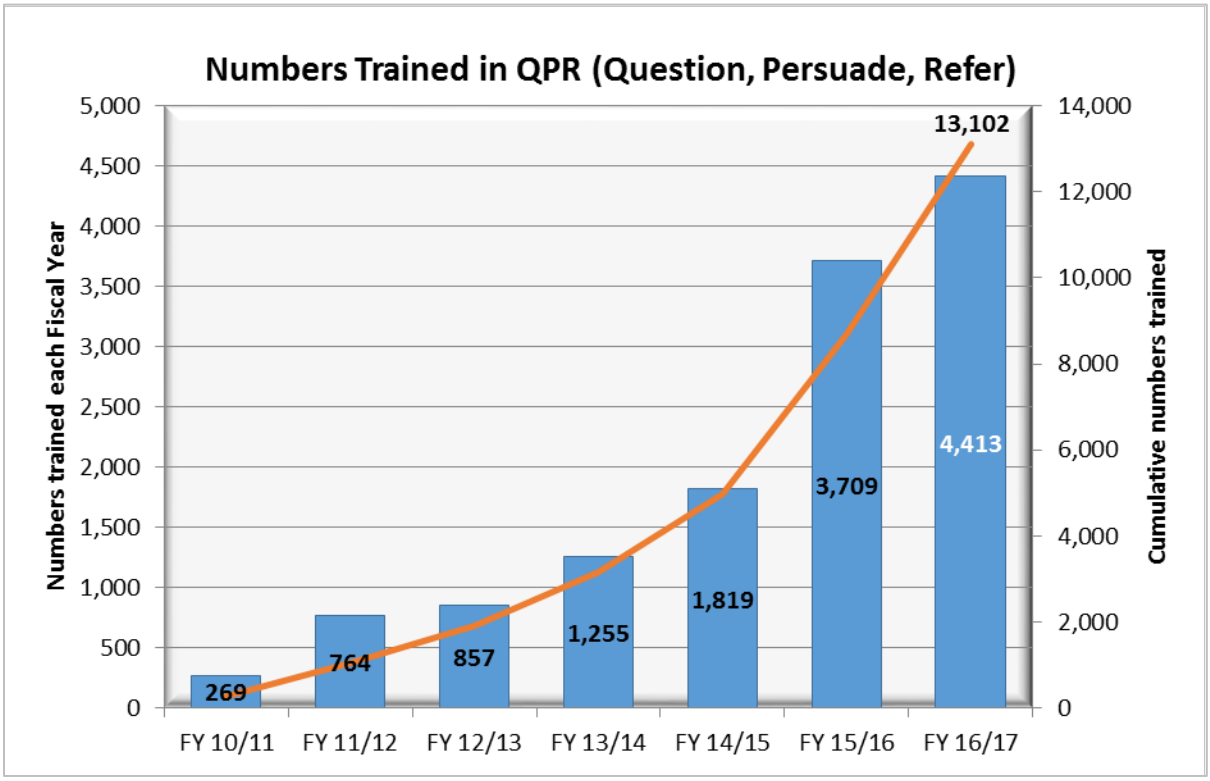
Question, Persuade, Refer (QPR)

Gatekeeper Suicide Prevention Training

QPR stands for **Question, Persuade, and Refer** — the 3 simple steps anyone can learn to help save a life from suicide. Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.

The Sonoma County Behavioral Health Division (SCBH) is committed to sharing this important suicide prevention technique with high school students, faculty, and the community-at-large. Since 2010 (through Fiscal Year 2016-17), SC-BHD has trained over **13,000** individuals in QPR, primarily through its **Crisis Assessment, Prevention and Education (CAPE) Team** and **Community Intervention Program (CIP)**. In Fiscal Year 2016-17 alone, over **4,400** individuals (mostly high school students) were trained. Trainings are conducted in English and Spanish.

QPR trainees consistently report a significant increase in their knowledge of areas such as facts concerning suicide prevention, warning signs of suicide, how to ask someone about suicide, and information about local resources for help with suicide, among others.



**16 people trained in FY 09/10 (not shown on graph)*

Attached:

QPR Pre and Post Surveys

QPR Outcomes Report FY 16-17

Date: _____

Location of Training: _____

QPR Pre-training Survey
SECTION I: Please provide the following information **BEFORE** the Gatekeeper Training. The anonymous information you provide will be used to assess the effectiveness of the QPR training.

1. Age: _____

2. Gender:
   - ☐ Female
   - ☐ Male
   - ☐ Transgender
   - ☐ Intersex
   - ☐ Other: _____
   - ☐ Decline to state

3. Primary Language:
   - ☐ English
   - ☐ Spanish
   - ☐ Chinese
   - ☐ Tagalog
   - ☐ Vietnamese
   - ☐ Other: _____
   - ☐ Decline to state

4. Race/Ethnicity: [choose one]
   - ☐ African American
   - ☐ Asian/Pacific Islander
   - ☐ Caucasian
   - ☐ Hispanic/Latino
   - ☐ Native American
   - ☐ Multi-Racial
   - ☐ Other: _____
   - ☐ Decline to state

5. Sexual Orientation:
   - ☐ Straight
   - ☐ Gay
   - ☐ Lesbian
   - ☐ Bisexual
   - ☐ Other: _____
   - ☐ Decline to state

6. Highest grade completed:
   - ☐ Junior High/Middle School
   - ☐ High School
   - ☐ Trade/vocational school
   - ☐ 2 years of college
   - ☐ 4 years of college
   - ☐ 5+ years of college
   - ☐ Decline to state

7. Other Cultural Populations:
   [if applicable, choose all that apply]
   - ☐ LGBTQ – Two Spirit
   - ☐ Veteran of the U.S. Armed Forces
   - ☐ Homeless
   - ☐ Individual in the foster care/ child welfare system

8. How would you rate your knowledge of suicide in the following areas?

   a) Facts concerning suicide prevention:
   ☐ Low ☐ Medium ☐ High

   b) Warning signs of suicide:
   ☐ Low ☐ Medium ☐ High

   c) How to ask someone about suicide:
   ☐ Low ☐ Medium ☐ High

   d) Persuading someone to get help:
   ☐ Low ☐ Medium ☐ High

   e) How to get help for someone:
   ☐ Low ☐ Medium ☐ High

   f) Information about local resources for help with suicide:
   ☐ Low ☐ Medium ☐ High

   g) Do you feel that asking someone about suicide is appropriate?
   ☐ Always ☐ Sometimes ☐ Never

   h) Do you feel likely to ask someone if they are thinking of suicide?
   ☐ Always ☐ Sometimes ☐ Never

   i) Please rate your level of understanding about suicide and suicide prevention:
   ☐ Low ☐ Medium ☐ High

ⓘ STOP HERE. Please complete the <u>BACK</u> of this form when your instructor tells you to do so.

QPR Post-training Survey

SECTION II: Please complete this section **AFTER** the QPR training.

1. Now that you have received the QPR Gatekeeper training, please indicate how you would rate your knowledge of suicide in the following areas?

   a) Facts concerning suicide prevention:
   ☐ Low ☐ Medium ☐ High

   b) Warning signs of suicide:
   ☐ Low ☐ Medium ☐ High

   c) How to ask someone about suicide:
   ☐ Low ☐ Medium ☐ High

   d) Persuading someone to get help:
   ☐ Low ☐ Medium ☐ High

   e) How to get help for someone:
   ☐ Low ☐ Medium ☐ High

   f) Information about local resources for help with suicide:
   ☐ Low ☐ Medium ☐ High

   g) Do you feel that asking someone about suicide is appropriate?
   ☐ Always ☐ Sometimes ☐ Never

   h) Do you feel likely to ask someone if they are thinking of suicide?
   ☐ Always ☐ Sometimes ☐ Never

   i) Please rate your level of understanding about suicide and suicide prevention:
   ☐ Low ☐ Medium ☐ High

2. Please provide your OVERALL rating of the quality of this training:
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

3. Would you recommend QPR training to others? ☐ YES ☐ NO ☐ Undecided

4. Comments:

THANK YOU!

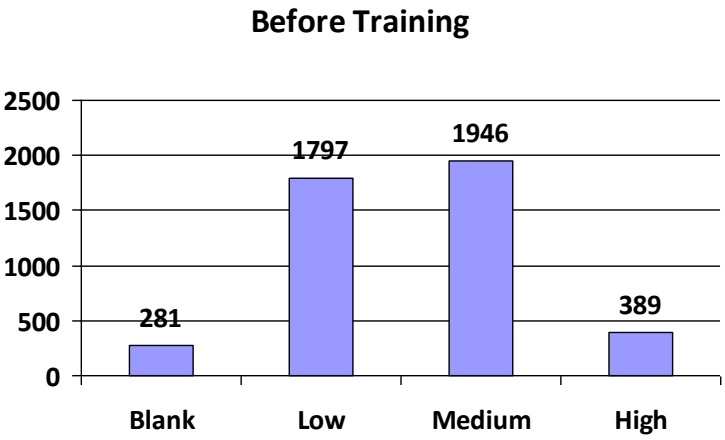
QPR Training Outcomes Report - Date Range

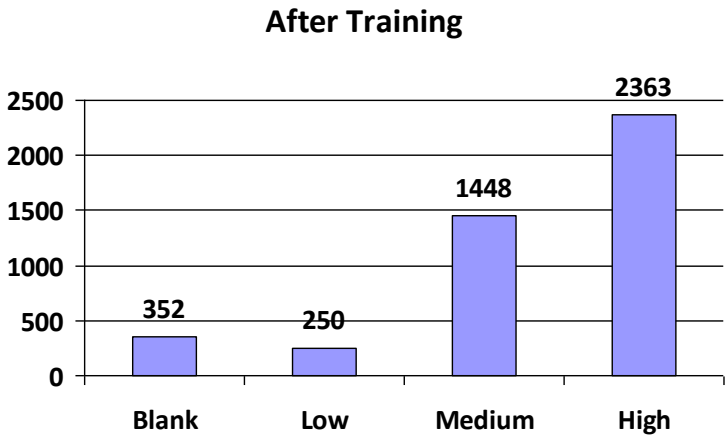
Report Range: 7/1/2016 to 6/30/2017

Report Filters: Training Location: All; Training Type: All; Trainee Type: All; Trainer: All

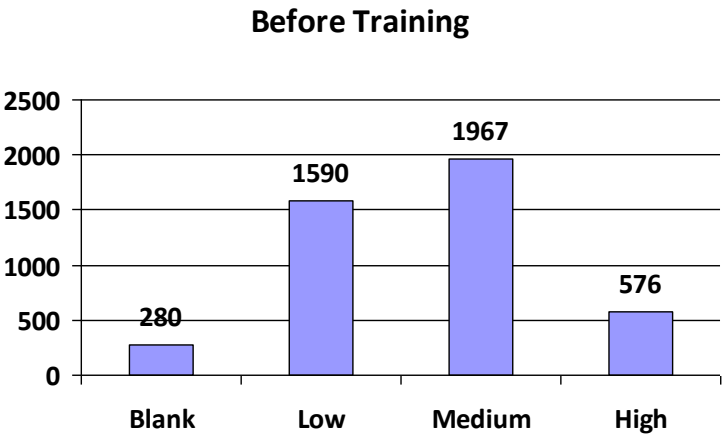
How would you rate your knowledge of suicide in the following areas?

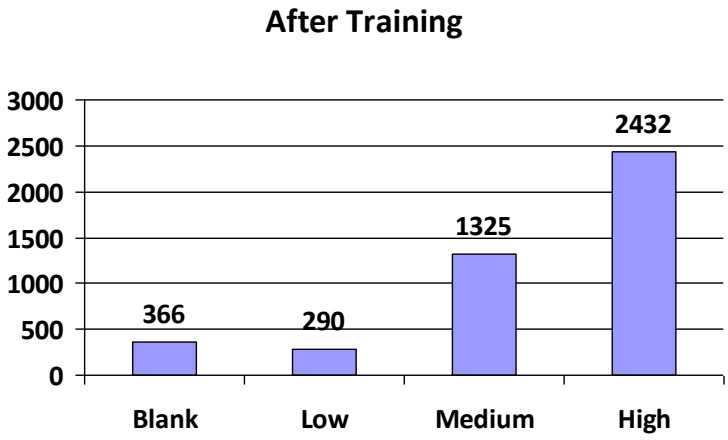
Facts concerning suicide prevention:



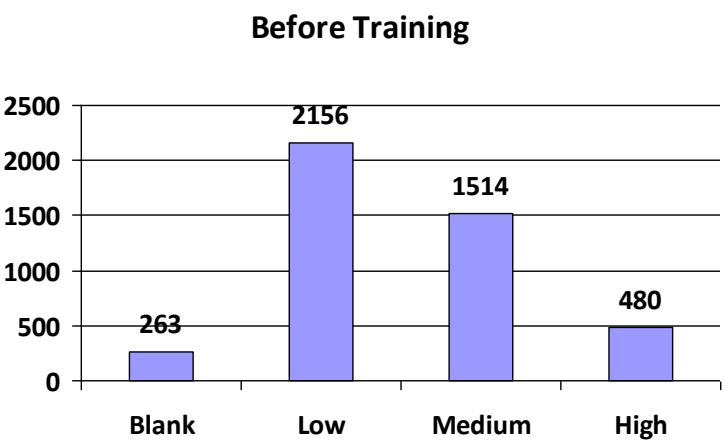


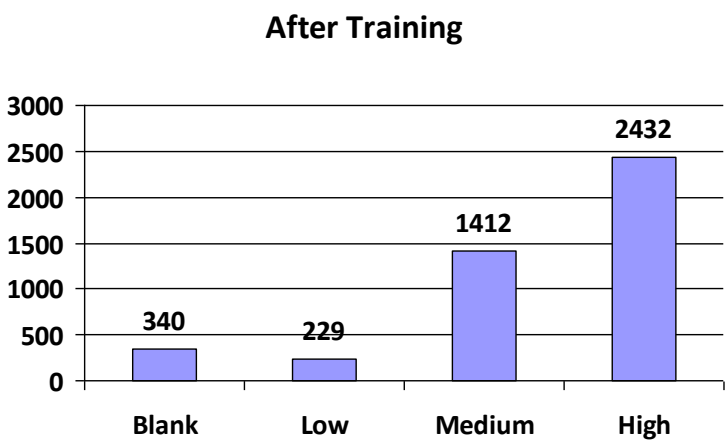
Warning signs of suicide:



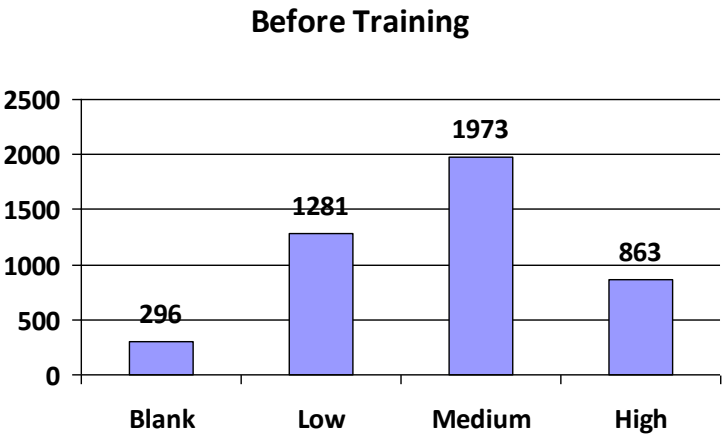


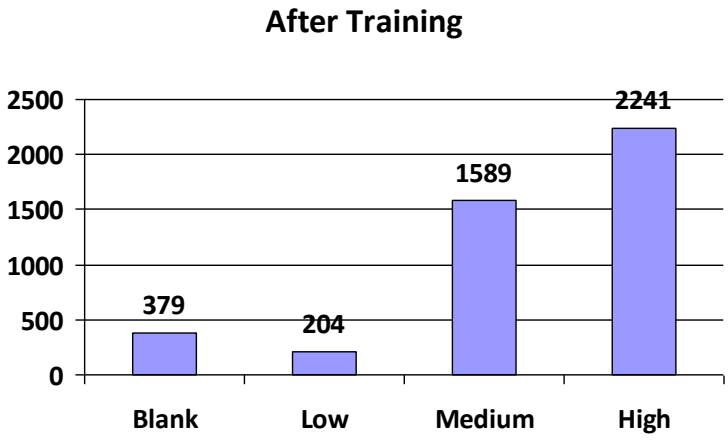
How to ask someone about suicide:



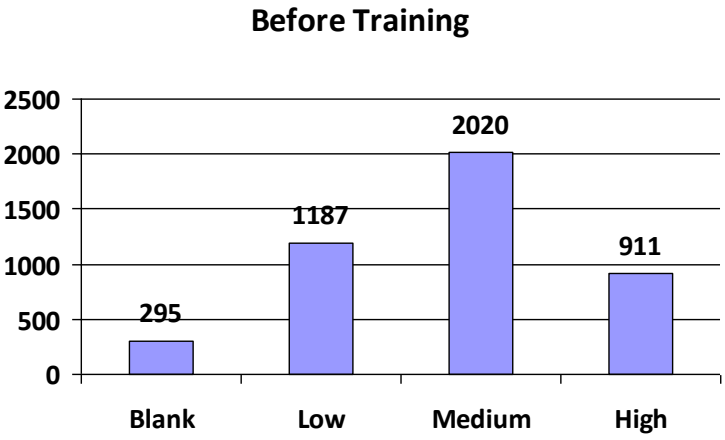


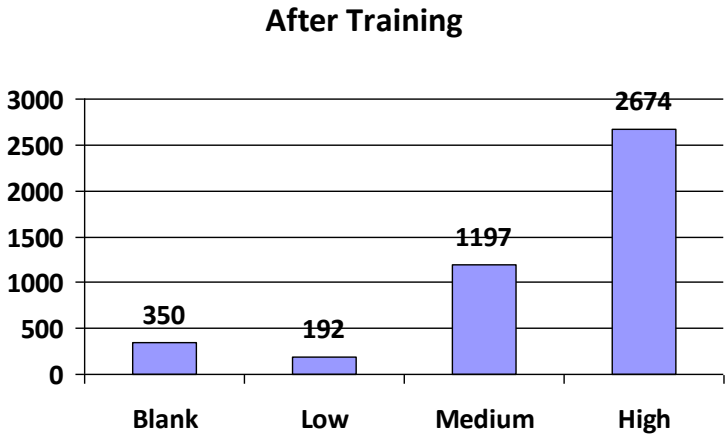
Persuading someone to get help:



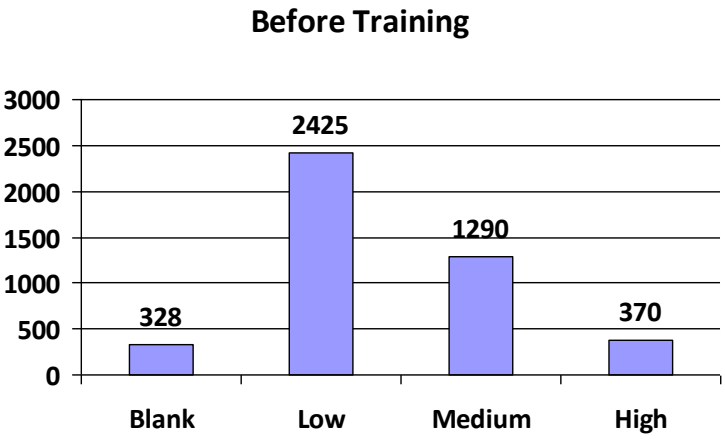


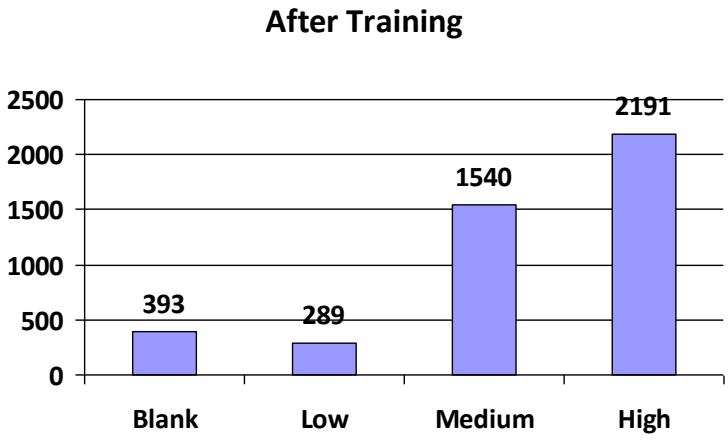
How to get help for someone:



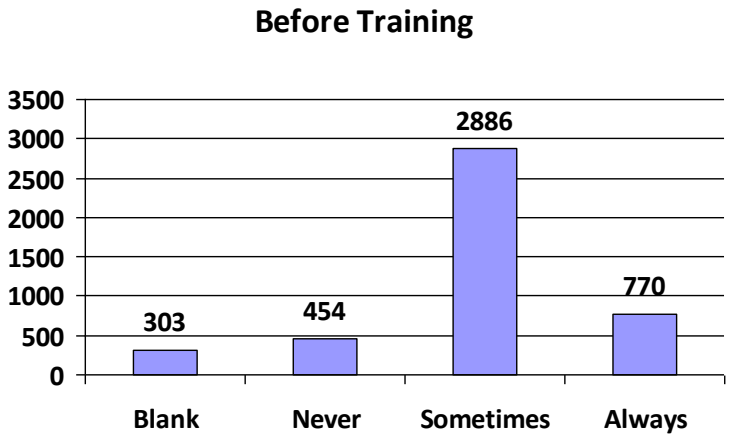


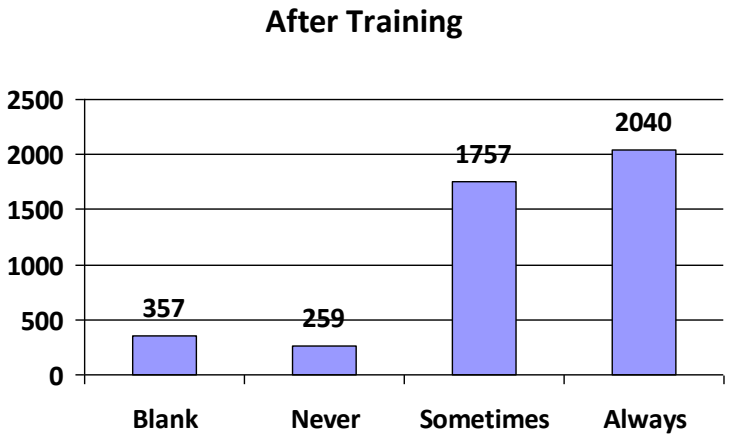
Information about local resources for help with suicide:



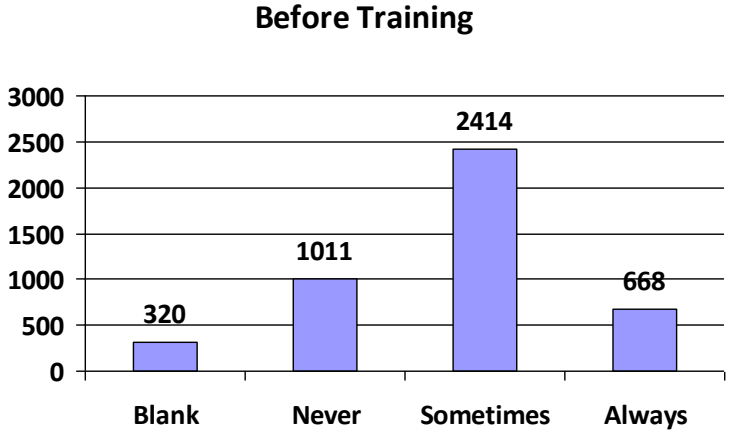


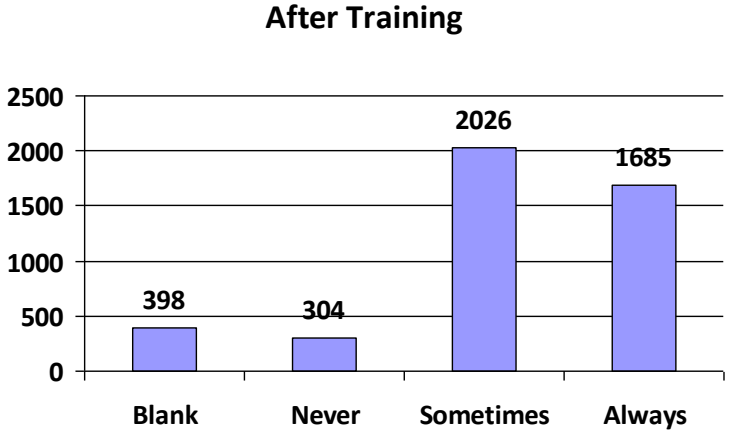
Do you feel that asking someone about suicide is appropriate?



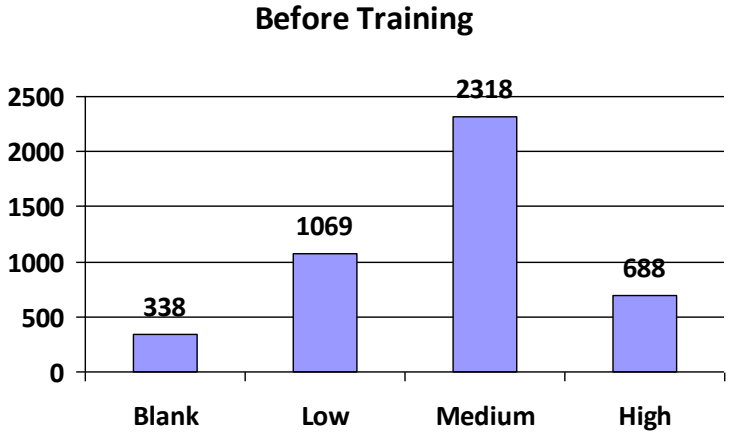


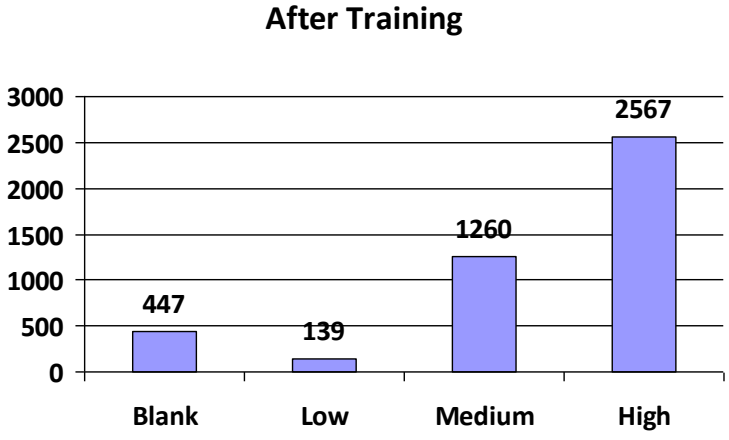
Do you feel likely to ask someone if they are thinking of suicide?



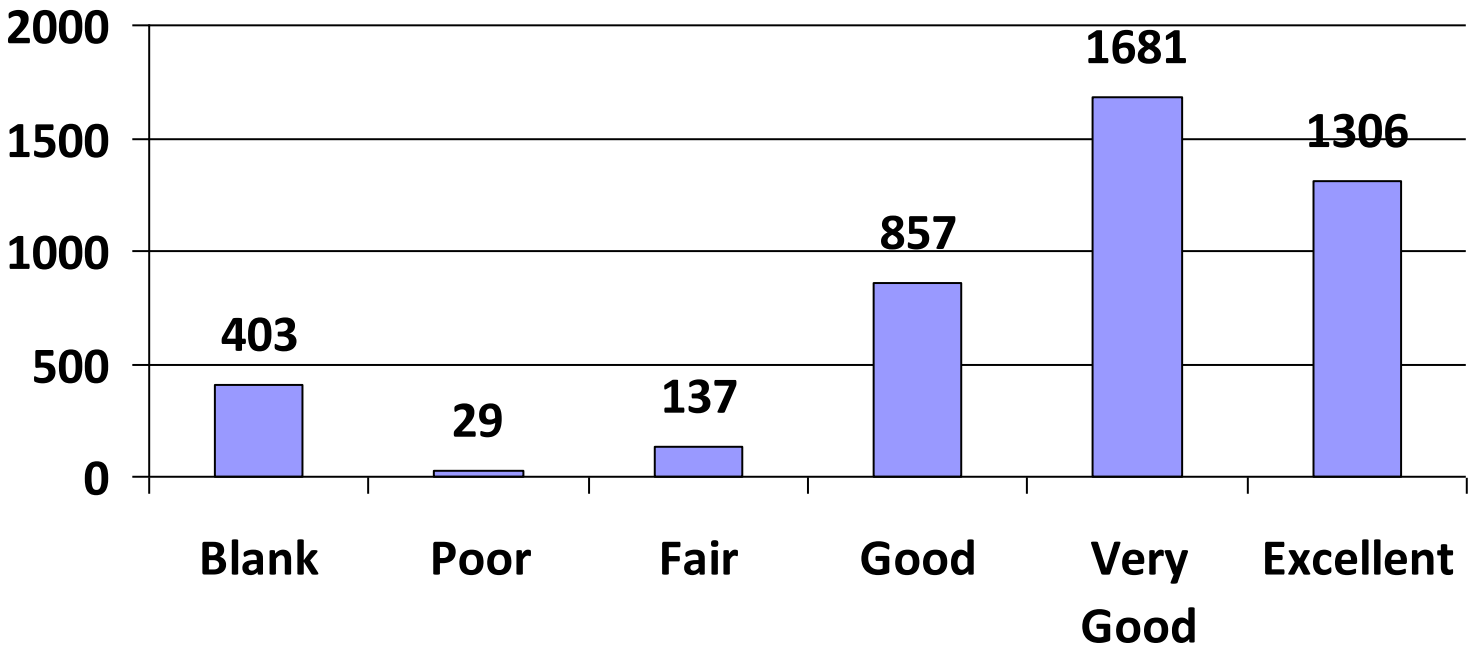


Please rate your level of understanding about suicide and suicide prevention:

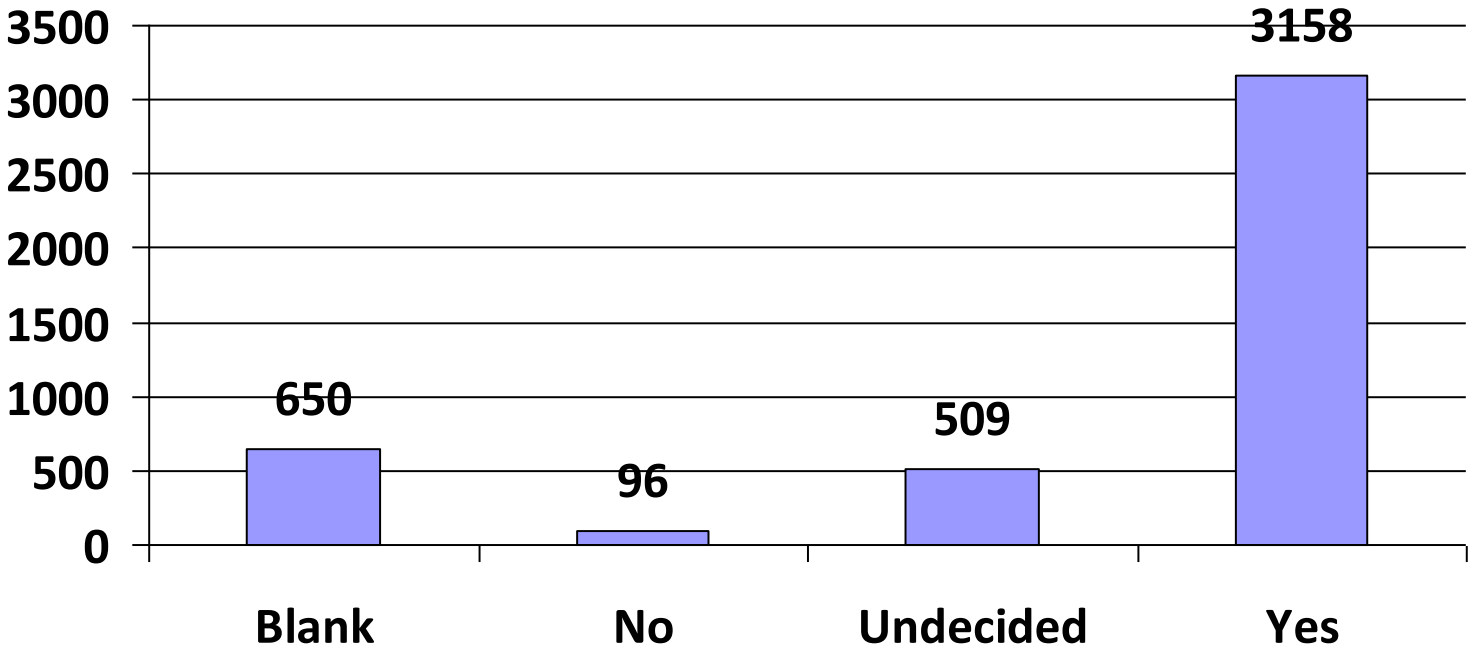




Please provide your OVERALL rating of the quality of this training:



Would you recommend QPR training to others?



Appendix 6

Integrated Health Team (IHT) Final Innovation Report

May 2018

MHSA Innovation Assessment:
Integrated Health Team

Executive Summary

Background:

On average, people with persistent mental illness die 20 years younger than their peers.[1] In Sonoma County, it is known that a significant portion of consumers living with serious and persistent mental illness (SPMI) decline care in health clinic settings. Sonoma County Department of Health Services Behavioral Health Division (BHD) launched the Integrated Health Team (IHT) program in 2012 to improve the physical health of people living with SPMI. To accomplish this goal, this innovation project trained and launched an integrated, multi-disciplinary team of peer health educators, physicians, nurses, psychiatrists, behavioral health specialists, and care managers. The project was established to address unmanaged physical health conditions that lead to early morbidity for consumers living with SPMI, by offering assessment, stabilization, case management, and triage services through a team of peer health educators, physicians, nurses, psychiatrists, behavioral health specialists, and care managers.

Purpose of this Report:

As an innovative and unproven project, the IHT was established with the following learning goal: How can we improve the physical health of people living with SPMI participating in integrated settings?

Although IHT has not been funded by the state Mental Health Services Act (MHSA) for several years, it was initially seeded with MHSA funding. This assessment addresses the MHSA "Final Innovative Project Report" requirement as described in Article 2, Section 3580.020, and is structured in accordance with the Section 3580.020 regulations.

Methods:

This mixed-methods, multi-stakeholder rapid assessment draws on the following four data sources:

[1] Improving life expectancy in people with serious mental illness: should we place more emphasis on primary prevention? *The British Journal of Psychiatry*, accessed from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5623876/

harder + co | community research

1. **Key informant interviews and focus groups:** Harder+Company interviewed nine key informants that offered both administrative and clinical perspectives of BHD and the IHT program as well as the Bridges to Health program.

2. **Administrative Data:** With the support of the BHD, Harder+Company reviewed aggregate and de-identified client demographic information for the IHT program.

3. **Consumer Perception Surveys:** With the support of the BHD, Harder+Company reviewed aggregate and de-identified results of the Consumer Perception Survey conducted with IHT clients.

4. **Grant reports:** Harder+Company reviewed narrative grant reports that support both the IHT and Bridges to Health programs.

Outcomes:

Through this IHT assessment, several outcomes came to life, related to (1) programmatic growth, (2) health education efforts and improved health status, and (3) patient satisfaction.

1. **The IHT program expanded, and its integration with physical health team members increased.** Beginning with IHT's inception, the number of clients served rose steadily. In its first full year, IHT served 227 clients with SPMI, and in the most recent full (fiscal) year for which data are available, the number of clients served had risen by more than 92%, to 435.

2. **Health education and coaching bring services to the community, and may contribute to improved health outcomes.** During this study perios, clients also experienced a statistically significant decrease in Low-Density Lipoprotein cholesterol levels.

3. **Patients are satisfied with the services they receive through IHT,** according to Consumer Perception Surveys administered to IHT clients. For instance, 97% of respondents agreed that they "like the services that I received here." Furthermore, 88% of IHT clients responded that they "would recommend this agency to a friend or family member."

What Was Learned:

Several key lessons emerged and are described briefly here:

1. **The strengthened partnership between behavioral health and primary care providers offers lessons for other integration efforts.** With IHT and their health clinic partners, genuine appreciation for diverse perspectives and an increase in communication appears to have inspired true team-based care on behalf of clients living with SPMI.

2. **However, the challenges to streamline electronic communication limited the scope of collaboration.** Currently, the two main collaborating agencies under the IHT model—BHD and the Bridges to Health primary care clinic—use separate database systems which do not "talk to" each other.

3. **The increase in cardiovascular health is a particularly bright spot of this innovation.** It seems likely that the health education efforts related to heart disease management may have contributed to this outcome. By

further unpacking this question, promising lessons might be uncovered for both clinicians and policymakers.

4. **The sustainability of this innovation may require creativity.** In light of future uncertainties, stakeholders shared that new funding sources that may be important in the near future.

Background

People with persistent mental illness die 20 years younger than their peers, on average.[2] In light of this tragedy and in search of solutions, Sonoma County Department of Health Services Behavioral Health Division (BHD) conducted a series of in-depth discussions with funded-partners, case managers, consumers and family members, and learned that a significant proportion of consumers with serious and persistent mental health illness (SPMI) were actively declining care in health clinic settings. When asked why clients with SPMI experience barriers accessing health care in Federally Qualified Health Care (FQHC) settings, BHD case managers shared that clients sometimes feel they are not welcome in a health clinic setting, have been unable to sufficiently build trust with FQHC providers, and experience difficulties navigating the primary care system. The primary care system, in turn, has minimal capacity to support clients with SPMI. As a result, in 2012 BHD launched the Three-Pronged Integrated Community Health Model, hereinafter referred to as the "Integrated Health Team" (IHT) program.

The IHT was established as a client-centered, holistic approach that incorporates community health education strategies as a core component of primary care and behavioral health service provision. To accomplish this goal, this innovation project trained and launched an integrated, multi-disciplinary team of peer health educators, physicians, nurses, psychiatrists, behavioral health specialists, and care managers. The project was established to address unmanaged physical health conditions that lead to early morbidity for consumers living with serious and persistent mental illness (SPMI), by offering assessment, stabilization, case management, and triage services through a team of peer health educators, physicians, nurses, psychiatrists, behavioral health specialists, and care managers.

As an innovative and unproven project, the IHT was established with the following learning goal and hypothesis:

Learning Goal: How can we improve the physical health of people living with SPMI participating in integrated settings?

Hypothesis: Peer involvement in the delivery of health education messages and the creation of individualized care plans, in an integrated primary care and mental health setting, will result in improved physical health outcomes for SPMI.

In an effort to test and document whether the current Innovation has had a positive impact, BHD sought to examine the following:

- What types of support and training are needed by consumer peer health educators?
- What are the elements that can lead to a successful interdisciplinary team that includes peers and retrained mental health workers?
- Does the inclusion of health education curriculum delivered through the retraining of mental health staff and the training of consumer health educators result in improved physical health outcomes for consumers?
- In what ways does the integrated health planning process, in tandem with the interdisciplinary case management meetings, help to address primary care and behavioral health problems?

[2] Improving life expectancy in people with serious mental illness: should we place more emphasis on primary prevention? *The British Journal of Psychiatry*, accessed from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5623876/

Final Innovative Project Report

Although IHT has not been funded by the state Mental Health Services Act (MHSA) for several years, it was initially seeded with MHSA funding. This assessment addresses the MHSA "Final Innovative Project Report" requirement as described in Article 2, Section 3580.020, and is structured in accordance with the Section 3580.020 regulations, detailed below.

Section 3580.020(a)(1) - Name of the Innovative Project

Three-Pronged Integrated Community Health Model (more commonly referred to as the Integrated Health Team, or IHT).

Section 3580.020(a)(2) - Brief summary of the priority issue addressed by the Innovative Project.

On average, people with persistent mental illness die 20 years younger than their peers.[3] In Sonoma County, it is known that a significant portion of consumers living with SPMI decline care in health clinic settings. BHD launched the IHT program in 2012 to improve the physical health of people living with SPMI.

Section 3580.020(a)(3) – Description of any changes that the County made to the Innovative Project during the course of its implementation.

As an innovative project, by nature, changes and course corrections are expected, and in this regard the experience of IHT was no exception. The following two changes occurred: (1) The innovative project MHSA funds were used to leverage additional resource, and (2) funding challenges limited the role of peer navigators.

> **(1) The innovative project MHSA funds were used to leverage additional resources.** As the IHT program grew, community members identified a need for more support and an enhanced infrastructure. With the IHT project having laid the foundation of a fully integrated health clinic in a specialty mental health system, key stakeholders were able to successfully apply to SAMHSA for the Bridges to Health grant. This new funding helped grow the program's reach. According to one interviewee, "We would have never gotten SAMHSA funding without [the IHT program], and that is a big deal." Increasing the capacity of the on-site health clinic enabled the IHT team to better integrate its care and services with the on-site physical health team members, and furthermore, allowed limited MHSA funds to be leveraged for other county priorities.
>
> **(2) Funding challenges have limited the role of peer navigators with lived mental health experience.** As part of the large-scale innovation they promote, IHT and Bridges to Health aimed to embed people with lived mental health experience on every multidisciplinary care team. Unfortunately, however, funding constraints have prevented the programs from systematically including peer navigators with lived experience on each team. "We in the county," one interviewee shared, "have not been able to find a consistent way to fund peer provider positions, especially because the state of California has not come up with a way that certified peer providers can claim for Medi-Cal, which is very frustrating." Nonetheless, these efforts led to an increase in the capacity of peer providers in Sonoma County, which contracted with Goodwill

[3] Improving life expectancy in people with serious mental illness: should we place more emphasis on primary prevention? *The British Journal of Psychiatry*, accessed from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5623876/

Enterprises to train and certify at least 14 peer providers.

Section 3580.020(a)(4) – Provide program information collected during the reporting period, disaggregated by key demographics.

Exhibits one through five, below, provide IHT client demographic information extracted from BHD's AVATAR information system.[4]

Exhibit 1. IHT clients by age category (n = 573)

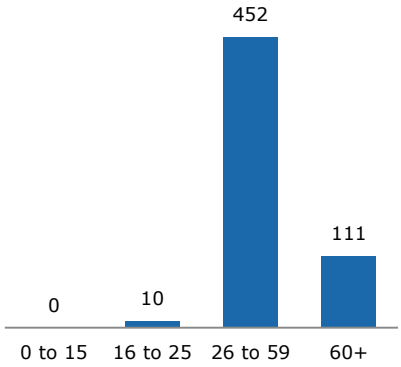


Exhibit 2. IHT clients by gender (n = 573)

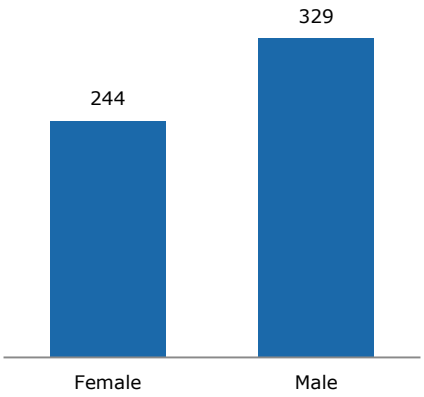


Exhibit 3. IHT clients by ethnicity (n = 573)

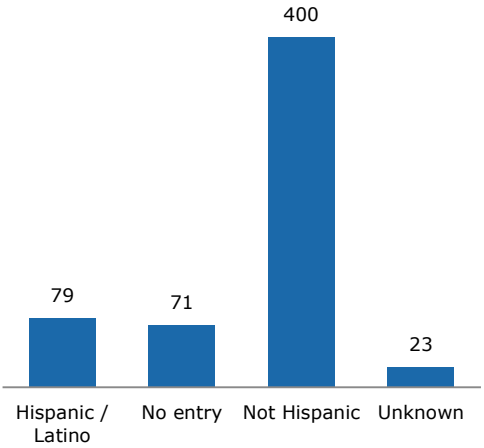
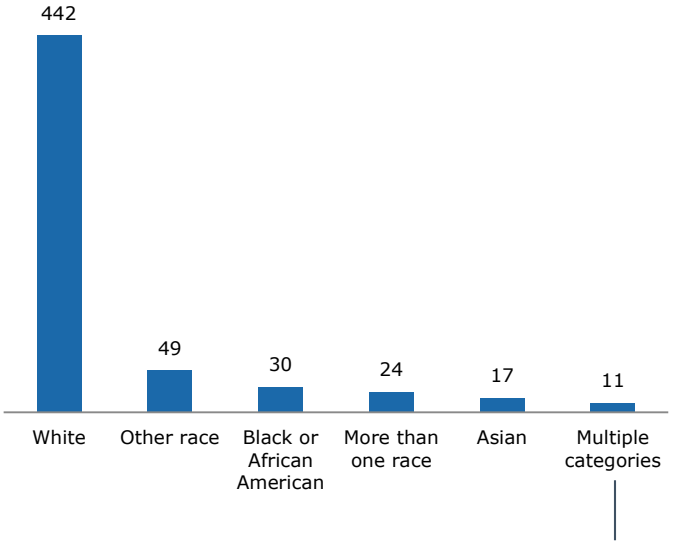


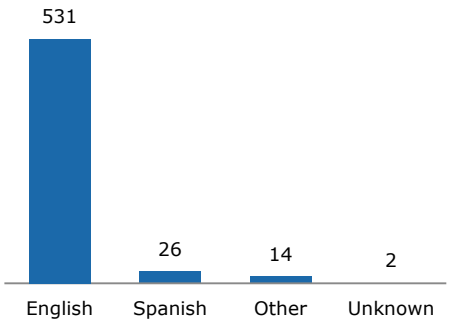
Exhibit 4. IHT clients by race (n = 573)



Note: "Multiple categories" is a collapsed category of the following racial groups: American Indian or Alaskan Native, Native Hawaiian or other Pacific Islander, and Unknown.

[4] Data provided in Exhibits one through five cover time period 1/1/14 to 6/30/17. While current Innovation Regulations—which took effect on October 1, 2015—require additional demographic analyses for sexual orientation, disability status, and veterans status, the IHT program has not been funded b MHSA since prior to the approval of these regulations. As a result, IHT client data are only available by the demographic categories specified by the previous Innovation Regulations.

Exhibit 5. IHT clients by primary language (n = 573)



Section 3580.020(a)(5) - Final evaluation results, including but not limited to:

3580.020(a)(5)(A) Description of the evaluation methodology:

As its primary focus, this assessment reviews the IHT program. However, due to its thorough integration with the Santa Rosa Community Health Centers' (SRCHC) Bridges to Health clinic, the assessment incorporates key findings related to the Bridges to Health clinic as well. This mixed-methods, multi-stakeholder rapid assessment draws on the following data sources:

- **Key informant interviews and focus groups:** Harder+Company interviewed nine key informants that offered both administrative and clinical perspectives of BHD and the IHT program[5] as well as the Bridges to Health program.[6]
- **Administrative Data:** With the support of the BHD, Harder+Company reviewed aggregate and de-identified client demographic information for the IHT program.
- **Consumer Perception Surveys:** With the support of the BHD, Harder+Company reviewed aggregate and de-identified results of the Consumer Perception Survey conducted with IHT clients.
- **Grant reports:** Harder+Company reviewed narrative grant reports that support both the IHT and Bridges to Health programs.

3580.020(a)(5)(B) Outcomes of the Innovative Project:

The IHT program expanded, and its integration with physical health team members increased.

Beginning with IHT's inception, the number of clients served rose steadily. In its first full year, IHT served 227 clients with SPMI, and in the most recent full (fiscal)

[5] BHD informants include: Amy Faulstich, Mental Health Services Act Coordinator; Bruce Robbins, Program Planning and Evaluation Analyst; Helene Barney, Health Program Manager; Kathleen Spence, Health Program Manager; Randye Royston, Section Manager; and Sid McColley, Acute & Forensics Section Manager

[6] SRCHC informants include: Barbara Scherrer, Program Director; Mary Papsco, Nurse Practitioner; and Monica Gonzalez, Care Coordinator.

year for which data are available, the number of clients served had risen by more than 92%, to 435.

Exhibit 6. Number of clients served in IHT[7]

Unique IHT clients	Number
Calendar Year 2013	227
Fiscal Year 2014-15	392
Fiscal Year 2015-16	411
Fiscal Year 2016-17	435
Jan 2014-June 2017	573

In the year leading to IHT's formal launch in 2012, efforts focused on co-locating the primary care clinic by building out a physical space, hiring a nurse practitioner, and connecting consumers who were not already connected to care. The clinic initially was open only for limited hours and with limited focus areas; it focused particularly on health issues related to metabolic syndromes that disproportionately affect people who take anti-psychotic medications. Full integration developed only over time. Integration of services required education of staff roles and awareness of staffs' skills and specialties. Internal communication was facilitated by having the IHT's Nurse Practitioner attend staff meetings, communicate directly with the Psychiatrists, write notes that are added to the specialty mental health chart, and provide Behavioral Health staff education about physical health issues common to clients.

As the IHT program grew, the number of hours of care coordination that the Bridges to Health clinic provided to support the physical health and well-being of clients living with SPMI increased greatly, as illustrated in Exhibit 7 below.

Exhibit 7. Number of hours of care coordination provided at Bridges to Health clinic. [8],[9]

Hours of care coordination provided at Bridges to Health clinic	Hours (#)
Jan – Mar 2016	768
Apr – May 2016	624
Jun – Sep 2016	1,734
Oct – Nov 2016	1,368

Although the scale of the clinic services grew over time, multiple interviewees shared that one of the biggest barriers to growth is the challenge that many clients face in being able to get to their appointments. Many clients with SPMI lack access to transportation (see sidebar for more details).

Transportation is a significant barrier to care.

Interviewees shared that transportation issues lead to frequent no-shows at the Bridges to Health clinic. As a result, staff now offer more support groups and classes at community-based sites, such as at Board and Care homes.

However, for on-site clinical needs, many patients rely on the county for transportation, but clinic staff expressed concern about the sufficiency and sustainability of county-provided transportation. As one interviewee summarized, "Many of our patients depend on the county to come and see us [at the clinic]. So, even though we have a full schedule, our numbers go down because of transportation issues, and that jeopardizes our work."

[7] These IHT data were provided by Sonoma County BHD staff, from the AVATAR data system.
[8] Note: Not all Bridges to Health clients are IHT clients, but key informants surmise that the clientele highly overlaps, since the clinic is co-located with the IHT program and since Bridges to Health clinic services are only available to patients who are identified as having severe mental illness and who are eligible for Sonoma County Behavioral Health.
[9] These data are from Bridges to Health grant reports, provided by Sonoma County Behavioral Health.

Health education and coaching bring services to the community, and may contribute to improved health outcomes.

In addition to providing acute care, IHT also collaborates to provide health education and coaching. Together with Bridges to Health team members, IHT helps ensure their clients receive rapid HIV testing; Flu, Pneumovac, and Hepatitis B vaccines; and health education classes. Through collaboration with the Bridges to Health clinic, they connect their clients to health education groups and individualized health coaching that focuses on nutrition, exercise, and disease as well as medication management for clients, family members, and caregivers. These services are offered at the clinic, in patients' homes, at Board and Care facilities, and the local Wellness Center.

In 2017, clients experienced a statistically significant decrease in Low-Density Lipoprotein[10] cholesterol levels when compared to the prior year. In the span of only three months, the percent of patients in the "at risk" category for LDL levels decreased from 27.8% to 8.7%. This decrease occurred in the context of the aforementioned health education and coaching, and also after multidisciplinary care team members were provided with a training in heart disease management.[11]

Patients are satisfied with the services they receive through IHT.

Patients generally like and are satisfied with the services they receive, according to Consumer Perception Surveys administered to IHT clients. For instance, 97% of respondents agreed that they "like the services that I received here." Furthermore, 88% of IHT clients responded that they "would recommend this agency to a friend or family member."

Exhibit 8. IHT Consumer Perception Survey results, client satisfaction, Spring 2015 (n=34)

Survey question	IHT clients who agreed with the statement
I like the services that I received here.	97.1%
I would recommend this agency to a friend or family member.	88.2%

3580.020(a)(5)(C) – Any variation in outcomes based on demographics of participants, if applicable:

No disparities in outcomes were identified through this assessment.

3580.020(a)(5)(D) – Assessment of which activities or elements of the Innovative Project contributed to successful outcomes:

Case-level coordination is the foundation of the IHT and Bridges to Health collaboration, according to all interviewees who participated in a focus group for this assessment (n=3). They agreed that, "The medical case management is really the key, and that includes medication case management and coordination of services…The health education piece is fabulous too, but case management and coordination is more huge. It's the most important."

[10] Low-density lipoprotein, or LDL, is also known as "bad cholesterol".
[11] These data are from Bridges to Health grant reports, provided by Sonoma County Behavioral Health.

According to IHT staff, case coordination significantly streamlines care for patients. "With the Bridges to Health team, we can do things in an almost immediate way," reported one interviewee. They added, "We had a client with asthma who lost her nebulizer and we just called over to the clinic and I was able to pick one up on the spot…Normally, you'd have to call an [off-site] primary care clinic and wait for someone to call back."

When asked what element best leads to a successful interdisciplinary team, one interview responded, "We like each other. That's the secret sauce." When partners "like each other," one imagines that the quality of communication may improve. With regards to communication, another interviewee shared that,

> *Communication is the most important element [of a successful multidisciplinary care team]. Verbal communication happens easily between my team members and Bridges to Health because we're all on site and across the hall from each other. Informal communication and consulting happens all the time. Also, formal verbal communication and information is shared at team meetings every morning, where we go over our list of patients to be seen that day and do case conferencing at that time. We also have formal case conferences with complicated patients.*

Cross-agency collaboration also serves to build staff capacity. According to one member of the IHT Multidisciplinary Care Team,

> *Another element of education that happens between our teams is that not everyone on the IHT team is medically trained, they are social workers or psychiatrists or psychologists, so when I go to the meetings, I'm looking at the case list from a medical point of view and adding in thinks like, 'Well, their diabetes is under better control,' or 'They can't take ibuprofen because of lithium.' So, there's an education factor [for the team]."*

Interviewees also shared that peer navigators are important for clients who may not otherwise engage with licensed professionals. In describing the unique value of peers as part of the care teams for clients with SPMI, one interviewee shared that, "It was amazing the way she connected with our patients. It was just amazing the way she will talk to them and convince them to come and see [name]. They felt so comfortable with her, and after she left, a lot of patients were still looking for her."

"Case management is important for the general population, but it's especially important for this population [people with SPMI]"

–Clinic staff

"Having peers is hugely important for some clients that you just can't engage any other way…It makes all the difference."

–County IHT staff

3580.020(a)(5)(E) – Explanation of how the evaluation was culturally competent:

The evaluation assessed cultural sensitivity among staff. Cultural competence is a deep area of focus for BHD, and as part of that focus, IHT clients were asked to provide feedback regarding IHT staff sensitivity to their cultural backgrounds. While more than 97% of surveyed clients shared that they like the services they receive through IHT, relatively fewer—82%—agreed that "staff were sensitive to my cultural background (race, religion, language, etc.). Exhibit 9, below, highlights survey results related to client perceptions of IHT staff.

Exhibit 9. IHT Consumer Perception Survey results, perceptions of staff, Spring 2015 (n=34)

Survey question	IHT clients who agreed with the statement
I like the services that I received here.	97.1%
Staff were sensitive to my cultural background (race, religion, language, etc.)	82.4%

The findings provided above underscore the importance of cultural competence in the IHT program, as well as opportunities for continuous quality improvement. In that vein, and as part of their efforts to promote equity and reduce disparities, IHT and Bridges to Health offer all education and materials in Spanish and solicit feedback from consumers to determine whether the materials meet their linguistic and cultural needs. Because the county's Latino population continues to grow, [12] IHT has identified the Latino community as a focal sub-population. They strive to recruit bilingual, bicultural Spanish-speaking staff, and have hired two care coordinators that speak fluent Spanish. The programs have also implemented multiple Cultural Competency and Responsiveness Trainings.

Furthermore, this evaluation sought to learn in particular about the role of peers and clients in the design and delivery of culturally-competent health education. The health education component of IHT was co-designed and operated by peers with lived experience of mental health issues, who met regularly with clients to reinforce health education messages, and who tailored health education approaches according to the input and expressed needs of the consumers.

3580.020(a)(5)(F) – Explanation of how stakeholders contributed to the evaluation:

From the very beginning, stakeholders were engaged in the development of IHT. The Innovation (INN) component planning began with convening the INN Community Advisory Committee[13] to conduct an extensive review of stakeholder feedback and input collected and documented throughout the sequenced implementation of prior MHSA components. The INN Community Planning Process involved review of broad-based community input provided by diverse stakeholders from across Sonoma County including consumers and family members, representatives from underserved racial/ethnic populations, particularly the Latino and African American communities. The INN Advisory Committee also reviewed feedback from consumer advisory groups and provider groups representing underserved communities that have been established as a result of MHSA planning to provide continuous feedback and input into MHSA-funded projects and processes. In the end, the INN Community Advisory Committee reached unanimous agreement on a set of projects to put forward in the INN plan that would contribute to learning and to informing Sonoma County mental health practice.

---

[12] Hispanic Demographic Trends, Demographics Report 2017, *Sonoma County Economic Development Board,* accessed from: sonomaedb.org/WorkArea/DownloadAsset.aspx?id=2147539271

[13] The INN Advisory Committee provided representation from a cross section of stakeholders represented in all prior MHSA planning processes: mental health consumers in recovery, family members of consumers, mental health providers, representatives from underserved populations including African American and Latino groups, faith-based leadership, and law enforcement.

In-depth planning discussions revealed that a significant proportion of SPMI consumers were actively declining behavioral health treatment in primary care settings. Based on the feedback, consumers, family members, and other interested community members helped develop the IHT model to mitigate and improve the physical health conditions of people living with SPMI.

As a part of the evaluation, client consumer perception surveys were completed by IHT clients. Consumer perception surveys added an important component to the evaluation. Furthermore, nine additional key informants were engaged through interviews, each of who had a unique perspective to offer regarding the successes and challenges of the IHT.

Additionally, Sonoma County BHD is in the process of engaging the Quality Improvement Committee for further input.

Section 3580.020(a)(6) – Will the County continue the Innovative Project, and if so what is the source of ongoing funding?

As an MHSA project, IHT closed when MHSA funding was redirected from IHT to other programs. However, the IHT project continues through services that leverage Medi-Cal funds as well as through the SAMHSA Bridges to Health grant program. In the Summer of 2018, a community planning process will lead to decisions regarding the future of the project, particularly in light of the upcoming end of the SAMHSA grant period, in October 2018.

Section 3580.020(a)(7) Did the Innovative Project achieve its intended outcomes? What was learned?

Through this project, BHD learned that full integration of a FHQC into a county specialty mental health system is possible but requires time and effort to address physical logistics, to facilitate bidirectional communication between systems, and to build a collaborative team atmosphere. Yet, by all accounts, the IHT project was successful in enhancing the integration of care for clients living with SPMI. Finally, with regards to health outcomes, there is ample evidence that improved integration even contributed to increased cardiovascular health status for this community.

Several specific lessons were learned that relate to this and other efforts to improve the integration of care for clients living with SPMI:

1. **The strengthened partnership between behavioral health and primary care providers offers lessons for other integration efforts.** With IHT and the Bridges to Health clinic, genuine appreciation for diverse perspectives and an increase in communication appears to have inspired true team-based care on behalf of clients living with SPMI.

2. **However, the challenges to streamline electronic communication limited the scope of collaboration.** Currently, the two main collaborating agencies under the IHT model—BHD and the Bridges to Health primary care clinic—use separate database systems which do not "talk to" each other. In the words of one interviewee, "This is a great challenge…without using Electronic Health Records to communicate, there is an increased chance of error. There are many complicated and overlapping diagnoses and medications." An ideal integrated health clinic would utilize the same EHR and scheduling platform(s), or have two platforms that could communicate. Sonoma County BHD is in the process of implementing Electronic Health Records through AVATAR, which would then facilitate information flow between BHD and the Bridges to Health EHR system (eClinicalWorks).

3. **The increase in cardiovascular health is a particularly bright spot of this innovation.** What interventions, specifically, contributed most to the noteworthy decrease in Low-Density Lipoprotein risk levels? It seems likely that the health education efforts related to heart disease management may have contributed to this outcome. By further unpacking this question, promising lessons might be uncovered for both clinicians and policymakers.

4. **The sustainability of this innovation may require creativity.** In light of future uncertainties, stakeholders discussed new funding sources that may be important as the end of the SAMHSA grant period approaches. For instance, stakeholders discussed the possibility of further leveraging Medi-Cal and Medicare funds through managed care contract rate negotiations as well as transitioning more services to the FQHC model in order to claim additional Medi-Cal funds.

Section 3580.020(a)(8) – Description of how the County disseminated the results of the Innovative Project to stakeholders

This evaluation report will be disseminated as a part of the draft annual update that will be circulated to stakeholders for a thirty-day review and comment period. At the close of that period, the Sonoma County mental health board will conduct a public hearing on the draft annual update and will record and analyze any substantive recommendations or revisions. Next, the BHD Director will approve the plan, and the mental health board will then review the adopted plan or update and make recommendations to BHD for revisions. Then, Sonoma County will submit the adopted plan to the Board of Supervisors for approval. The approved plan will be sent to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after Board of Supervisor adoption.

Section 3580.020(b) – Include a copy of any presentations, reports, articles, manuals, CDs, DVDs, videos, or any other materials developed to communicate successful new or changed mental health practices, lessons learned and evaluation results of the Innovative Project.

Mental Health Services Act reports and presentations can be found at this webpage: http://www.sonoma-county.org/health/about/behavioralhealth_mhsa.asp#reports

Appendix 7

Reducing Disparities Final Innovation Report

WELLNESS • RECOVERY • RESILIENCE

Reducing Disparities Community Fund Initiative Innovation Evaluation Report

Name of the Innovative Project: Reducing Disparities Community Fund

Background

In accordance with WIC Section 3910 Innovative project general requirements, Sonoma County proposed an Innovative Project to introduce a mental health practice or approach that is new to the overall mental health system that would make a change to an existing practice in the field of mental health and apply a promising community-driven practice that has been successful in non-mental health contexts or settings.

Based upon the goal of developing funding strategies that are truly responsive to community needs, Sonoma County created a model for a diverse cross-section of community members to shape service strategies, design procurement processes, and decide how public resources would be allocated. The *Reducing Disparities Community Fund Initiative* (hereafter, called the *Initiative*) was created to test that idea. The *Initiative* envisioned a community-driven grant making model, built on philanthropic flexible funding strategies designed to incubate new ideas, coupled with characteristics that defined the Sonoma County Prevention and Early Intervention (hereafter, PEI) planning process, most notably a decision-making body that was at least 50 percent people of color who were experienced and content knowledgeable.

The central purpose of Sonoma County's *Initiative* was to increase access to underserved groups living with or at risk for serious mental illness. The proposal was to develop a hybrid model that combined features of the Community Foundation of Sonoma County's donor-directed funds and venture capital funds to seed grassroots community-based organizations by using flexible funding strategies that incubate new ideas and projects. The proposed methodology was to build on the work and lessons learned throughout the sequenced rollout of the MHSA components, particularly Sonoma County's PEI process. The primary learning goal was to demonstrate that community-driven funding initiatives, implemented within an existing institutional framework - in this case, the County's Mental Health Division - are an effective and sustainable way of increasing access to underserved groups throughout Sonoma County.

A seven-stage methodology was proposed to implement the Reducing Disparities Community Fund Initiative Innovation Project in Sonoma County.

1. Establish the *Reducing Disparities Community Funding Initiative* Board
2. Develop the *Initiative* model
3. Develop a communication strategy for engaging the broader community
4. Provide technical assistance to community applicants
5. Review proposals and make funding decisions
6. Launch Innovation Projects
7. Provide training and technical assistance to grantees

Roadblocks from the Start

Stage 1. Establish Reducing Disparities Community Fund Initiative Board

The organizing structure for designing and operating the *Reducing Disparities Community Fund Initiative* (*Initiative*) was to establish a volunteer Board. The Innovation Advisory Committee, comprised of staff and community members who participated in the PEI selection process, set out to identify, recruit and select *Initiative* Board members who would guide the development and implement the action steps of the *Initiative*. In addition, the Advisory Committee established criteria for *Initiative* Board membership and solicited input from leaders recruited from underserved racial/ethnic communities, and mental health consumers and their families.

In Sonoma County's proposal, the primary learning objectives were to demonstrate that community-driven funding initiatives implemented within an existing institutional framework - in this case the Mental Health Division - are an effective and sustainable way of increasing access to underserved groups throughout Sonoma County. The intention was to recruit and empower community members who have not been involved in making funding decisions for local mental health projects to direct the use of public funds by increasing their influence over funding decisions for mental health prevention and early intervention services. Establishing the *Initiative* Board was challenging based upon the tight knit communities of color who were traditionally marginalized within Sonoma County. Identifying impartial *Initiative* Board members was difficult due to all organizations were either interested in applying for funding for their organizations or who were not at all interested in mental health services within their community. Neutrality was difficult to achieve and this was a key impediment for this social experiment.

Stage 2. Develop Reducing Disparities Community Fund Initiative Model

As part of the refining of the *Initiative*, MHD and the *Initiative* Board needed to identify a fiscal intermediary to support flexibility in the timely distribution of funds. The *Initiative* Board would then develop the grant program model and implementation plan to meet all State guidelines for Innovation Projects.

Sonoma County reached out to the local philanthropic community hoping to identify a foundation that would agree to serve as fiscal intermediary for the *Initiative*. An agreement did not materialize, even after several attempts to identify a fiscal agent. Behavioral Health staff noted that the local philanthropic community was hesitant to take on this role due to a lack of clarity about the *Initiative's* goals and the anticipated challenges of working in partnership with a government entity. In addition, local foundations had little experience and minimum capacity to integrate a diverse community-based board that would require a great deal of training, capacity-building and attention to driving the *Initiative*.

Early Modifications

Based on this early assessment, Sonoma County was compelled to make changes to the *Initiative* that affected the scope of the project, implementation actions, timelines and evaluation plans**.** As with many new ideas, the *Initiative* needed to modify its strategies while keeping the intended goals and objectives of the original Innovation Plan. That meant developing mechanisms to ensure public funds would be used in accordance with state guidelines, and establishing the *Initiative* Board with the capacity to effectively decide how funds should be distributed to organizations that could serve communities of color effectively and increase access to mental health services. For the *Initiative* to achieve its vision, funding decisions, and public dollars, needed to "live" outside of the public sector, in this case, outside Sonoma County Behavioral Health Division, but stand up to principles of financial responsibility and proper stewardship of funds. A recommendation was made to identify a fiscal intermediary to support the timely and effective distribution of public dollars. A second recommendation was to identify an experienced, impartial community leader and facilitator who could build the capacity of community members serving on the *Initiative* Board, and provide prospective community applicants, many of which had little experience responding to public funding opportunities, with technical assistance. A local consulting firm with decades of experience working with nonprofits in marginalized communities, Kawahara & Associates, was engaged to provide such technical assistance in capacity building and organizational development. In the interim, Sonoma County Behavioral Health decided to hold funding and place the *Initiative* on pause so as not to compromise the original learning objectives.

Available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes.

Kawahara & Associates, a local consulting firm specializing in program and organizational development, was engaged to provide individualized technical assistance to grassroots organizations and nascent programs that serve the African American, Asian American, Latino/Hispanic, Native American and LGBTQ communities. Upon early assessment, organizations were identified as having a wide range of organizational capacity and need. Some groups had been operating with a core of volunteers with minimal funding or formal administrative structure. Other organizations had organizational structure, but limited programmatic capacity due to lack of leadership, constant staff turn-over, lack of clarity, accountability or direction. Providing technical assistance to this group as a whole was

challenging, but a model was developed that could move the group as a cohort and yet, provide the individualized support to each organization based upon their unique status and challenges. The training and TA plan included the following:

1) Conducting an organizational assessment of internal strengths and weaknesses;
2) Developing goals and SMART objectives both for the organization and for specific program services;
3) Developing a theory of change and corresponding logic model for program services;
4) Developing and implementing simple program evaluations that documented quantitative outputs and qualitative outcomes;
5) Completing required reporting for the County;
6) Accessing mental health resources for staff, consumers, and general public;
7) Completing grant applications; and
8) Enhancing and expanding programming based upon organizational learning and stakeholder input.

These trainings resulted in the following organizational improvements:

1) Successful grant application to the Office of State Health Planning, Evaluation and Development to develop interest and opportunity for young adults to pursue a career in mental health and primary health care fields.
2) Successful application and award of 501c3 status to an organization.
3) Redesign of community engagement and input into program design that decentralized services to provide better access for outlying geographic communities.
4) Two successful grant applications to the Office of Health Equity for the expansion of community mental health education (promotores) to the Latino community through partnerships with the local Community College, high schools and media and expansion of the Aunties and Uncles Program in the Native American community, decentralizing the model to increase community engagement and access.
5) Program evaluations demonstrating effectiveness in reducing mental health stigma, awareness of mental health struggles and community resources for support.
6) Increase in capacity to obtain community donations.
7) Strengthening community networks for an increase in sharing and leveraging resources.

Below is a summary of events and activities that indicate the original *Initiative* model and transition to a model focused on building the capacity of providers focused on reducing disparities in underserved populations.

YEAR	ACTIVITY	PROGRAM OUTCOME	FISCAL OUTCOME
2010	Identification and recruitment of *Initiative* Board members Initial meetings with local philanthropy to establish fund distribution channel	Potential board members faced with conflicts of interest, e.g. self-interest in applying for *Initiative* funds Identified challenges with grassroots model and distribution of government funding	*Initiative* funds unable to be distributed to community
2011	Additional outreach to community members and partners for *Initiative* Board Additional conversations with other foundations, legal counsel	Progress inhibited by lack of community resources and legal challenges Re-examining alternative models	*Initiative* funds unable to be distributed to community
2012	Modified community *Initiative* Board established to review proposals, make PEI awards 2011 MHSA Collaboration Survey with PEI and CSS funded providers	Four organizations receive Reducing Disparities PEI funding Secured Consultant to conduct organizational assessment of PEI reducing disparities providers	
2013	LSP member survey and evaluation design Group training and individual technical assistance for PEI/RD providers on collecting data, analysis and reporting	Increased accountability and capacity of PEI/RD providers in reporting to funders and stakeholders LSP successfully awarded 501c3 status.	LSP awarded $11,000 OSHPD grant for Mi Futuras, workforce development for mental health careers in the Latino/a community
2014	Group training and individual technical assistance for PEI/RD providers on developing SMART objectives, theory of change and evaluation	Design and implementation of Program Evaluation for Positive Images and CBC.	CalMHSA grants to SCIHP
2015	Three grant applications submitted to OHE for CRDP grant.	Board development, staff transition, and sustainability planning for Positive Images	LSP and SCIHP each awarded OHE funding of $1.4 million over 5 years (actualized in 2016)

Evaluation of Innovative Project

(A) Description of the evaluation methodology

Harder + Company was retained as the evaluation team for Sonoma MHSA to identify the impact of collaboration and systems transformation on community awareness of mental health issues and resources and resulting service utilization, especially for underserved populations. The evaluation framework includes monitoring client and service delivery data, assessing the accessibility of services, and examining levels of collaboration among MHSA funded providers that is designed to provide valuable information about the performance of the system and its impact on the well- being of clients, consumers and family members. Evaluation methodologies included program surveys, evaluations of learning circles, reviewing documented increased capacity to meet contract deliverables and secure additional funding to expand mental health outreach, education and engagement of underserved communities.

In addition to understanding client-level impacts, *systems change* was identified as a critical, macro-level component of the evaluation. Two key components to systems change specific to this innovative project were posed by the following questions:

- To what extent are MHSA-funded PEI programs collaborating that influence increases in reducing mental health disparities in underserved populations?

- In what other ways are PEI programs contributing to systems transformation in reducing mental health disparities in underserved populations?

(B) Outcomes of the Innovative Project including those related to the selected primary purpose, with a focus on whatever was new or changed compared to established mental health practices;

Kawahara & Associates conducted organizational assessments for the Reducing Disparities PEI funded grantees which revealed a spectrum of strengths and limitations. These organizational assessments led to group trainings and individualized technical assistance sessions that increased the capacity of grassroots organizations in the following areas:

- Manage grant funding and increase accountability to completing scope of work;
- Develop and strengthen evaluation and reporting systems;
- Collect quantifiable and qualitative data for reporting and program development analysis
- Utilize data and other information to further improve or develop programming that would reduce disparities in their communities;
- Secure additional funding from state sources or local foundations.

These collective trainings increased the PEI/RD grantees' organizational ability resulting in stronger mental health programming and community impact. In addition, all providers

increased their capacity to seek additional funding from government, local foundations or community sources. Specific outcomes included:

- Increased community education and reduction of mental health stigma in the African American and Native American communities through special events featuring guest speakers, music festivals and memorial/ceremonial gatherings.
- Increased funding to expand mental health prevention and education in the Latino and Native American communities each receiving a $1.4 million five-year grant from the State Office of Health Equity to engage and train young adults as promotores/leaders to provide community education on mental health conditions and resources.
- Additional local support for the LGBTQQI youth community with a fundraising event generating over $15,000.
- Increase in bi-lingual Spanish speaking staff and Latino/Latina representation in the mental health workforce through the Latino Health Forum (professional training and awareness) and the Mi Futuro es en Cuidado de Salud (My Future is in Healthcare) funded by the Office of State Health Planning, Evaluation and Development to stimulate young Latinos/Latinas to pursue careers in the mental health field.

(C) Assessment of which activities or elements of the Innovative Project contributed to successful outcomes;

Both group training and individualized technical assistance sessions were beneficial and effective. The group trainings on grant writing, development of SMART objectives, theory of change and logic modeling allowed administrative efficiencies and group dynamics that promoted questions, discussions and improved learning. Over time, the cohort developed more trust and comradery amongst each other, promoting the sharing of resources and ideas resulting in collaborations and greater efficiencies.

(D) Explanation of how the evaluation was culturally competent and how stakeholders contributed to the evaluation;

The evaluation focused on reducing disparities for underserved communities and increase the mental health systems' ability to provide culturally appropriate services for those communities. Engagement and participation of those providers and communities in the evaluation at the service level were key to developing findings and recommendations that held integrity and true meaning for the service providers. Increasing the providers' knowledge and ability to craft evaluation design, implement tools and analyze data was key in assuring the evaluation was grounded in community and culturally appropriate.

(6) Whether and how the County will continue the Innovative Project, the source of ongoing funding, if applicable, the reason for the decision, and how the County involved stakeholders in the decision.

No, Sonoma County ended the Innovative Project in FY 2014-15. However, Behavioral Health staff continue to engage with the original *Initiative* Board members to support the PEI/RD grantees: Latino Service Providers, Community Baptist Collaborative, Sonoma County Indian Health Project, and Positive Images – and, through other PEI strands, continue to build their capacity and deepen their own understanding of mental health services. Behavioral Health staff noted the importance of spending time working with these members so they could deepen their understanding regarding the nature of the mental health network, service assets and gaps, and to hone their thinking on how community-based organizations, rooted in underserved communities, could help transform the mental health system by increasing access to the County's diverse cultural populations.

In 2013, the Office of Health Equity (OHE), based on multiple glowing referrals from county peers, contacted Sonoma County Behavioral Health to understand how the County was able to meaningfully engage diverse cultural groups throughout all phases of PEI planning, including shaping funding strategies. Behavioral Health staff, in tandem with the original *Initiative* Board members, decided to reignite the *Initiative*. The group morphed and leveraged their expertise to offer in-depth consultation to OHE as it sought to strengthen its grant making strategies at the state level. Through the California Reducing Disparities Project, the original *Initiative* Board members provided OHE with advice regarding promising strategies to engage grassroots organizations and technical assistance to encourage deep and meaningful participation. While the original vision was not realized, *Initiative* members were able to maintain the original spirit that drove this work – empowering disenfranchised communities to become involved in funding decisions that impact diverse populations.

Utilizing PEI funding, Sonoma County continues to increase the organizational capacity and strengthen contractors in collaborative activities in reducing disparities for marginalized communities.

(7) Whether the Innovative Project achieved its intended outcomes and a summary of what was learned.

The Innovation Project as originally proposed did not achieve its intended outcomes as the implementation of the structure had too many practical challenges that were not anticipated, nor was there a method to mitigate the obstacles. The revised approach of increasing capacity among providers who were best positioned to reduce disparities was adopted and had success when technical assistance was embraced by the PEI/RD providers.

Evaluation findings are summarized below:

- More agency staff members are now conversant in Spanish – Eighty-three percent of the agencies reported line staff who speak both English and

Spanish, followed by 75 percent that have Executive Directors who can do the same.

- There was a 13 percent increase in agencies with African American Program Managers and an 89 percent increase in Native American Program Managers.
- There was a 12 percent increase in number of Native American volunteers at funded agencies and 8 percent increase in African American volunteers.
- Share of agencies that reported serving African Americans increased from 58 percent to 67 percent.
- More agencies are promoting activities to increase cultural responsiveness: 13 percent increase in staff training in cultural competencies, increase in distribution of educational materials, increase in implementing policies to recruit staff diversity.
- Increase in collaboration amongst MHSA funded programs: Eighty-seven percent of agencies increase coordination of services with other MHSA-funded programs, a 9 percent increase in two years. Fifty-six percent of agencies increased collaboration in joint funding opportunities (17% increase in two years) and seventy-five percent of agencies increased co-sponsorship of events with other MHSA-funded programs (17% increase).

(8) Description of how the County disseminated the results of the Innovative Project to stakeholders, and if applicable to other counties (e.g. as the County determined that the information would be of benefit to other counties).

Updates, findings and outcomes of the *Initiative* are consistently written into the monthly MHSA Newsletter distributed to stakeholders. (See below) In addition, each PEI/RD program has an annual Impact Report that is distributed widely in the community through email, community meetings, and through public forums culminating in a final review and approval by the local Board of Supervisors.

(**b) The County shall include a copy of any presentations, reports, articles, manuals, CDs, DVDs, videos, or any other materials developed to communicate successful new or changed mental health practices, lessons learned and evaluation results of the Innovative Project.**

See next page for a sample newsletter report.

PREVENTION & EARLY INTERVENTION (PEI) REDUCING DISPARITIES PROJECT

PROJECT BACKGROUND

In 2009, in accordance with California's Welfare and Institutions Code (WIC) Section 3910 (Mental Health Services Act [MHSA] Innovation Project general requirements), Sonoma County proposed an Innovation Project to introduce a mental health practice or approach that is new to the overall mental health system that would make a change to an existing practice in the field of mental health and apply a promising community-driven practice that has been successful in non-mental health contexts or settings.

In an effort to promote funding strategies that are truly responsive to community needs, Sonoma County sought to create a space for a diverse cross-section of community members to shape service strategies, design procurement processes, and decide how public resources would be allocated. The Reducing Disparities Community Fund Initiative**,** now known as the **Prevention Early Intervention (PEI) Reducing Disparities Project**, was created to test that idea.

PEI REDUCING DISPARITIES TECHNICAL ASSISTANCE PROJECTS

As part of Sonoma County's ongoing commitment to serve disparate communities, the Behavioral Health Division (SC-BHD) contracted with **Kawahara & Associates**, a local consulting firm specializing in program and organizational development, to provide individualized technical assistance to grassroots organizations and promising programs that served the African American, Asian American, Latino/Hispanic, Native American and LGBTQ+ communities. Kawahara & Associates provided technical assistance to the following organizations:

- Community Baptist Church (CBC)
- Santa Rosa Community Health Centers
- Latino Service Providers (LSP)
- Sonoma County Indian Health Project (SCIHP)
- Positive Images

Kawahara & Associates

Training and support was provided on the following:

1) Developing goals and SMART objectives
2) Developing a theory of change and corresponding logic model
3) Developing and implementing simple program evaluations that documented quantitative outputs and qualitative outcomes
4) Completing required reporting for funders
5) Accessing mental health resources for staff, consumers, and general public
6) Completing grant applications
7) Enhancing and expanding programming based upon organizational learning and stakeholder input

These trainings resulted in the following organizational improvements:

1) Successful grant application to the Office of Health Equity to develop interest and opportunity for young adults to pursue a career in mental health and primary health care fields
2) Successful application and award of 501c3 status to an organization

3) Redesign of community engagement and input into program design that decentralized services to provide better access for outlying geographic communities
4) Successful grant application to the Office of Health Equity for expansion of community education (Promotores) to the Latino community through partnerships with the local community college, high schools and media
5) Program evaluations demonstrating effectiveness in reducing mental health stigma, awareness of mental health struggles, and community resources for support

THE CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP) & CAPACITY BUILDING WITH THE PEI REDUCING DISPARITIES COHORT

Of the four PEI Reducing Disparities MHSA contractors (Latino Service Providers, Community Baptist Church, Sonoma County Indian Health Project, & Positive Images), three agencies submitted applications to the California Office of Health Equity (OHE) for the **California Reducing Disparities Project (CRDP)** funding specific to their communities. Of those three, Latino Service Providers was in the final round for funding consideration on a proposal that would recruit and train mental health Promotores to launch a community-wide bilingual and Spanish-speaking educational campaign to reduce stigma surrounding mental health, increase awareness of resources, and encourage workforce development in behavioral health careers. This infusion of OHE funding will leverage statewide MHSA funding to enhance and expand PEI services for the Latino community in Sonoma County.

Upcoming support for PEI Reducing Disparities contractors in FY 16-17 will include the transition of reporting quantitative data through the new SC-BHD performance management system, Sonoma Web Infrastructure for Treatment Services (SWITS). This web-based system will provide a more streamlined process for contractors to report their activities and encourage greater accountability. Future training and support for PEI Reducing Disparities contracts will also include defining, collecting and analyzing qualitative data for individual and community outcomes. Additionally, ongoing organizational

development in the areas of leadership development, fund development, and evaluation will be made available to the PEI Reducing Disparities contractors.

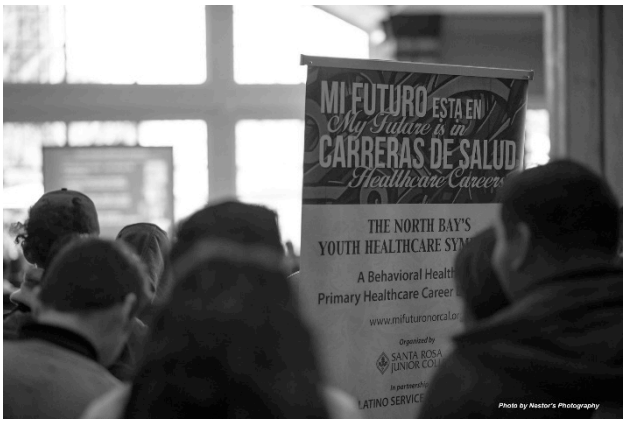
REDUCING DISPARITIES WORK TODAY

On July 11, 2016, the **California Department of Public Health (CDPH)** announced an intent to award $13 million in grants to California Reducing Disparities Pilot Projects to help reduce mental health disparities in communities that have traditionally been underserved. Local organization **Latino Service Providers (LSP)**, a Mental Health Services Act (MHSA) funded contractor, was among the 11 awardees receiving grants totaling **$1.18 million** in funding over the course of five and a half years.

On January 12, 2017, the California Department of Public Health (CDPH) Office of Health Equity announced the intent to award for the Native American Implementation Pilot Project as part of Phase II of the California Reducing Disparities Project (CRDP). CDPH will award **$1.14 million** to **Sonoma County Indian Health Project (SCIHP)** over six years to implement Phase II of CRDP. The primary goal of the project is to validate community-defined evidence practices through rigorous evaluation.

The Division has expanded the MHSA contract with Latino Service Providers (LSP) to include workforce development strategies. LSP strategies include helping the Division with recruitment of behavioral health providers who are specifically Spanish-speaking and bicultural to match the demographics of Sonoma County. For more information, go to:

http://www.bhworkforcesonoma.com/professional-resources



With MHSA funding, LSP is also supporting pipeline projects with high school and college students, inspiring future generations to consider careers in behavioral health. LSP sponsors the annual youth career symposium, My Future is in Healthcare Careers or **Mi Futuro Esta en Carreras De Salud**.

In January 2017, Behavioral Health Division staff and Kawahara & Associates provided technical assistance to PEI Reducing Disparities contractors to submit applications for the **California Institute for Behavioral Health Solutions (CIBHS) Cultural Competence Summit** on March 15 & 16. The Summit will highlight community-defined practices used by disparate communities to reduce stigma and to increase access to mental health services for populations that have historically been unserved or underserved.

SCIHP will be presenting their Aunties and Uncles program at the Summit. LSP, the SC-BHD and the Santa Rosa Junior College will be presenting on growing a bilingual bicultural behavioral health workforce. LSP will also present on their work with electronic and social media and the Latino community to increase mental health awareness. CBC will be offering music and a welcoming prayer and SCIHP will be offering a Native American blessing and traditional dancers at the Cultural Competence Summit.

###end###

Appendix 8

Peer Housing Needs Assessment and Survey

WELLNESS • RECOVERY • RESILIENCE

Sonoma County Housing Needs Assessment

April 2018

harder + co community research

sonomacounty DEPARTMENT OF HEALTH SERVICES

Contents

Executive Summary

The following report presents findings from the 2017 Housing Needs Assessment Survey. The report draws on information provided by over 500 Sonoma County Behavioral Health Division (BHD) clients, representing 14 BHD programs.

Findings

Listed below are key findings that emerged from the survey. These findings provide information on the living situation of BHD clients, including barriers to securing and maintaining housing. Additionally, the findings also point to the potential differences between individuals experiencing episodic homelessness and those who have been homeless for more than one year.

Demographics

- The majority (84 percent) of survey respondents are currently not homeless, but among the 15 percent who reported being homeless, nearly half (48 percent) have been homeless for more than one year.

- Demographic findings indicate a slightly older population of individuals who have been homeless for more than one year, with 52 percent indicating they are 49 years of age or older. Additionally, a larger percent of individuals who have been homeless for more than one year are female (60 percent compared to 27 percent) and white (96 percent compared to 81 percent).

Housing

- Almost half (44 percent) of all respondents report living in an apartment or home that they rent or own.

- Among homeless respondents, the majority (40 percent) report living in a homeless shelter.

- While most respondents indicated they were satisfied with their current housing, only a little over half (57 percent) reported that they are able to or are interested in staying in their current housing situation.

- Financial services and/or assistance are needed to assist clients with finding and/or maintaining housing. Nearly half (44 percent) of respondents indicated lack of income as a barrier to securing or maintaining housing, followed by insufficient savings (29 percent). Relatedly, when asked to indicate the types of assistance needed to find or maintain housing, 28 percent reported needing an ongoing rental subsidy and 14 percent reported needing temporary financial assistance.

- When asked to describe their preferred housing situation, the majority of respondents (79 percent) indicated an apartment or house, followed by mobile homes (14 percent) and supportive housing (13 percent).

Considerations

Given the findings, we have listed a number of considerations for BHD and Sonoma County to explore as it works to address the housing needs of their client population. These are further discussed in the final section of the report.

- **Further exploration of the chronically homeless population.** To more precisely understand the chronically homeless population and if/how the services and supports needed differ from the non-chronically homeless population we suggest additional information-gathering activities, such as interviews, focus groups, and secondary research (e.g., research on the chronically homeless population county- and state-wide).

- **Explore the types of resources and supports that can be provided to BHD clients.** Given that that both barriers to securing and maintaining housing and assistance needed to secure and maintain housing were primarily information and finance-based, BHD should explore how best to provide information to clients about their housing options.

- **Consider the types of supports and services needed for individuals with a history of incarceration and/or inpatient psychiatric services.** Given that survey respondents indicated difficulty with either securing housing upon their release or finding housing that was considered safe and secure, additional services and supports may be needed to help individuals secure housing upon their release from inpatient psychiatric facilities or incarceration.

- **Review focus group findings gathered by the Peer Leader Group for additional perspectives and insights into the housing needs of BHD clients**.

Introduction

In September 2017, the Sonoma County Behavioral Health Division (BHD) worked with Harder+Company Community Research (Harder+Company) to conduct a housing needs assessment survey. The survey aims to provide BHD with the information it needs to better understand the housing needs of its clients. The survey findings will also be used to help inform the County's application for No Place Like Home funding. The No Place Like Home program provides financing for County's to acquire, design, build, and/or restore permanent supportive housing for individuals living with a serious mental illness who are homeless, chronically homeless, or at-risk of chronic homelessness. The survey aimed to explore the following questions:

- What are the housing needs of BHD clients? How many BHD clients are homeless, have unstable housing, and/or are unsatisfied with their housing?
- What types of barriers do BHD clients experience when attempting to secure housing?
- What types of housing would BHD clients like to have access to?

To ensure the survey was useful to BHD and reflective of the clients BHD serves, Harder+Company worked closely with a group of peer leaders to draft the survey. Survey input was also provided by BHD program managers and BHD staff. The survey was conducted between September 14, 2017 and December 29, 2017 and administered across 14 BHD programs with a total of 558 surveys collected. Paper surveys were administered to BHD clients and were either completed by clients independently or with a case manager, program staff member, or peer leader. All surveys were administered in English.

It is important to note that during the data collection period (October 2017), several massive wildfires broke out throughout Sonoma County. The fires were incredibly destructive, burning over 140,000 acres and destroying over 7,000 structures. Not only were Sonoma County BHD staff overseeing emergency shelters, but many were also directly impacted by the fires and/or assisting clients impacted by the fires. As such, survey data collection was on hiatus for most of October and November. While the original target was to reach 80 percent of BHD clients, given the events and capacity of BHD staff, survey administration was extended through the end of December with approximately 40 percent of BHD clients surveyed. It is also important to note that the survey itself was not updated to include specific questions about the fire. While open-ended responses allowed clients to include any information about if/how the fires impacted their housing, none of the surveys we received after the fire included responses from clients indicating they had been displaced due to the fires.

Methods

Data entry was completed by Sonoma BHD staff using Optical Mark Recognition (OMR) software. OMR software scanned the completed surveys and exported the responses into an Excel file. All surveys were reviewed for quality assurance to ensure the software selected the correct survey response. All free/open response options were manually entered by a BHD staff person and reviewed by a member

from the Harder+Company project team. Survey analysis was conducted using SPSS.

The following report summarizes findings from the survey and includes recommendations for BHD to consider as it works to improve the housing options available to its clients. The appendices provide additional information, including a copy of the survey administered to clients and detailed data tables summarizing information gathered from each of the survey questions.

Limitations

The following data limitations should be considered when interpreting findings presented in this report:

- **Selection bias:** Participants who completed the survey could differ in important ways from other BHD clients who either did not receive the survey or chose not to respond to the survey.

- **Survey was only administered in English:** Given that the survey was only administered in English, participants whose primary language is one other than English may not have felt comfortable completing the survey. For future projects, we recommend assessing the language needs of BHD clients in order to determine if administering the survey in multiple languages would be appropriate.

- **Number of participants:** Due to the pause in survey administration as a result of the fires and staff capacity, the original target of reaching 80 percent of BHD clients was not attainable.

- **Limitations of survey data:** Given that a primary goal of the housing needs assessment was to hear from as many BHD clients as possible, a survey was selected as the best method for gathering data from a large number of respondents. While the survey allowed us to obtain feedback from a number of clients, the type of data we obtained is less expansive than the type of data that could have been obtained from individual interviews or focus groups. Recognizing the need and desire to gather in-depth information from BHD clients, a group of peer leaders conducted a total of six focus groups at supportive housing facilities and peer-run service centers. The findings from these focus groups are included in a separate report and should be considered when reflecting upon the housing needs of Sonoma County BHD clients.

- **Survey does not include specific questions about the fire:** Wanting to ensure the survey remained consistent for data analysis purposes, the survey was not modified after the fires. While this prevents us from exploring specific questions related to the fire, as noted above, none of the free response options included information regarding the fire. Additionally, by keeping the survey consistent we are able to analyze results for all surveys in aggregate.

While there are limitations to the findings, they nonetheless provide useful and actionable information about the housing needs of Sonoma County BHD clients.

Survey Results

Participant Characteristics

Participant characteristics, including demographic information, of survey respondents are summarized below.

Exhibit 1 includes the number of BHD clients per program that completed the survey. The Integrated Health Team (IHT) and the Community Mental Health Centers (includes Petaluma, Sonoma Valley, Guerneville, and Cloverdale) had the highest number of clients complete the survey, representing 31 percent and 23 percent of total survey participants, respectively.

Exhibit 1. Survey Participants by Program (n=558)

Program	%	n
Integrated Health Team (IHT)	31%	170
Community Mental Health Centers*	23%	129
Access Team	10%	58
Integrated Recovery Team (IRT)	9%	52
Older Adult Team (OAT)	8%	42
Forensic Assertive Community Treatment Team (FACT)	6%	33
Telecare	5%	29
Transition Age Youth (TAY) Team (includes VOICES)	3%	18
Older Adult Intensive Team (OAIT)	3%	14
Foster Youth Team	2%	13

*Includes Community Mental Health Centers located in Petaluma, Sonoma Valley, Guerneville, and Cloverdale.

With regards to participant demographics, the majority of participants were 49 years or older (51 percent), primarily male (52 percent), and identified as White/Caucasian (75 percent) (see Exhibits 2 and 3). When compared to the race/ethnicity of Sonoma County (Exhibit 3), the demographic characteristics of survey participants are primarily similar to the general population of Sonoma County.

Exhibit 2. Age and Gender Identify of Survey Participants

Demographic Characteristic	%	n
Age (n=558)		
Under 18	1%	6
18-24	8%	43
25-32	12%	69
33-40	16%	90
41-48	12%	67
49 and over	51%	283
Gender (n=557)		
Male	52%	287
Female	47%	260
Genderqueer/Gender non-binary/Trans male/Trans female*	1%	7
Declined to answer	1%	3

*To ensure confidentiality we have combined categories with low responses.

Exhibit 3. Race/Ethnicity of Survey Participants and Sonoma County Residents

Race/Ethnicity	Survey Respondents (n 557)		Sonoma County (n 497,776)	
	%	n	%	n
White/Caucasian	75%	419	64%	320,566
Latino/Hispanic	16%	89	26%	129,634
Native American/AK Native	5%	27	1%	2,326
African American/Black	5%	26	1%	6,669
Native Hawaiian/Pacific Islander	3%	16	0.3%	1,395
Asian	2%	12	4%	19,173
Other race/ethnicities	1%	8*	0.4%	1,954
Declined to answer	1%	7	N/A	N/A

*Other responses include: Italian/Indian, Arabic, Portuguese, Eritrean, Italian, Greek, and English, Hungarian, Jewish, and Syrian.

The survey also asked participants to indicate their primary source of income. The results presented in Exhibit 4 indicate that the majority (79 percent) of participants reported social security, which includes Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), as their primary source of income. Only ten percent of participants reported not having a source of income. Given that survey participants are BHD clients who have access to case managers that are able to connect them to services, it seems appropriate that only a small percent of participants reported no source of income. However, having a primary source of income does not preclude one from experiencing barriers to accessing housing, as is illustrated in later sections of the report.

Exhibit 4. Primary Source of Income (n=557)

Primary source of income	%	n
Social Security (e.g., SSI, SSDI)	79%	440
No income	10%	53
Earnings/job	9%	51
General Assistant/General Relief	3%	17
Family/friends	3%	16
Other*	2%	13
Declined to answer	0.2%	1

*Other responses include: CalWORKS, Unemployment, Food stamps, Cash Assistance Program for Immigrants (CAPI), child support, special needs trust, and tribal income.

Current Housing Status

Homeless Status

While Exhibit 5 below indicates that a majority (84 percent) of survey participants are currently not homeless, among those that are homeless, almost half (48 percent) have been homeless for more than a year (Exhibit 6). The U.S. Department of Housing and Urban Development (HUD) defines chronically homeless as a "homeless individual with a disability1 who lives in a place not meant for human habitation, a safe haven, or in an emergency shelter" and has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for "at least 12 months or on at least four separate occasions in the last three years, as long as the combined occasions equal at least 12 months."2 Additionally, a family with an adult head of household, or if there is not adult, a minor head of household, who meets all of the criteria above is also considered chronically homeless2. Given that we do not have information regarding the disability status of survey respondents, we are unable to accurately classify respondents as chronically homeless or non-chronically homeless. For the purposes of this report, we have grouped respondents as "homeless" or "homeless for more than one year".

Understanding the population of chronically homeless individuals in Sonoma County is an area for further consideration as the needs and barriers of this population may vary from those experiencing more episodic periods of homelessness. Additionally, research indicates that this population is most in-need of services, with a mortality rate four to nine times higher than the general population3.

Exhibit 5. Homeless Status

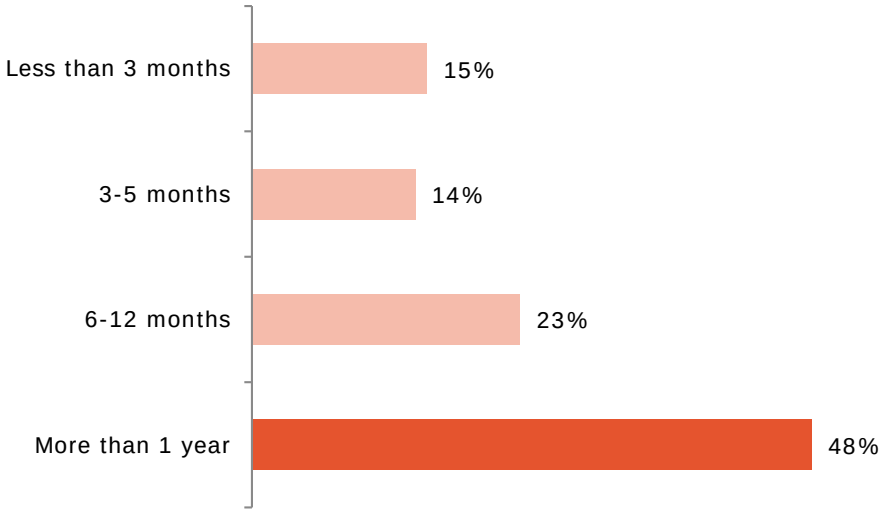
Homeless Status (n 527)	%	n
No	84%	443
Yes	15%	80
Declined to answer	1%	4

[1] Disability is defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)) and includes a "physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury". https://www.hudexchange.info/resources/documents/HomelessAssistanceActAmendedbyHEARTH.pdf

[2] https://www.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf

[3] https://www.usich.gov/resources/uploads/asset_library/BkgrdPap_ChronicHomelessness.pdf

Exhibit 6. Length of Time Homeless (n=52)



When we further explore the demographics of survey respondents (see Exhibits 7-9 below) that indicated they have been homeless for more than a year, we see that these individuals are predominately White/Caucasian (96 percent), female (60 percent) and older (52 percent are 49 years of age or older).

Exhibit 7. Demographic comparison among homeless and those who have been homeless for more than one year: Race/Ethnicity

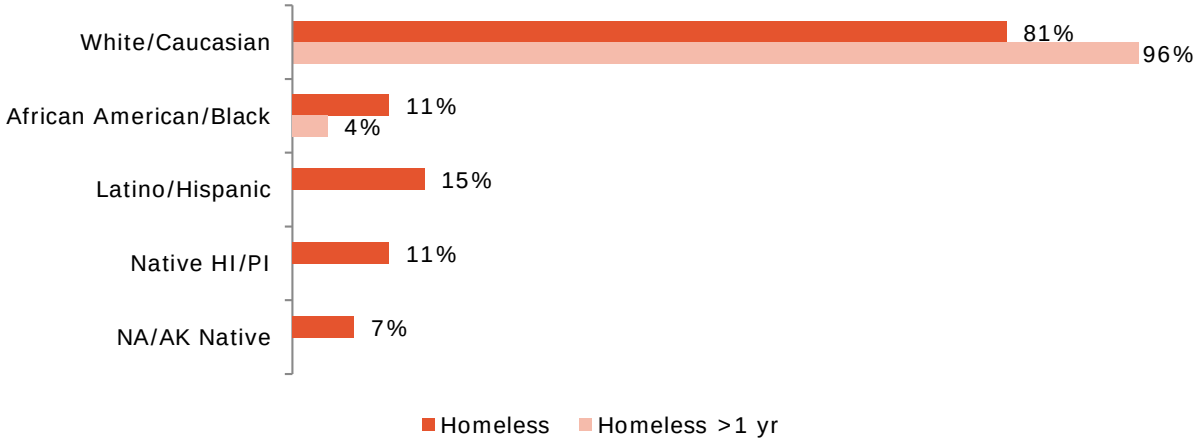


Exhibit 8. Demographic comparison among homeless and those who have been homeless for more than one year: Gender Identity

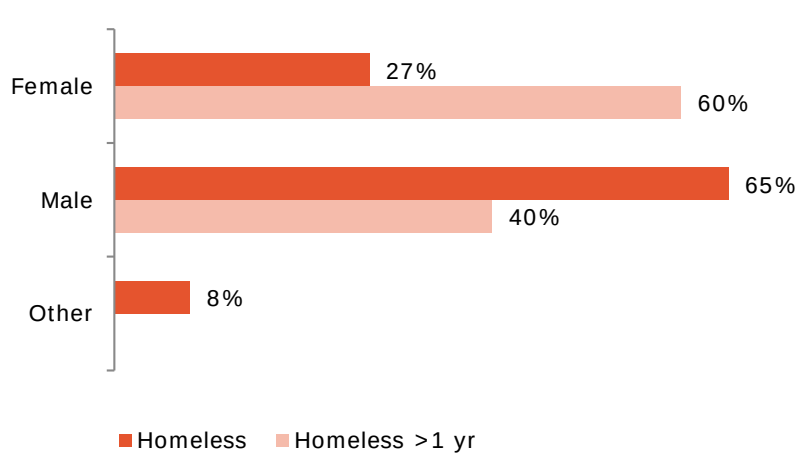
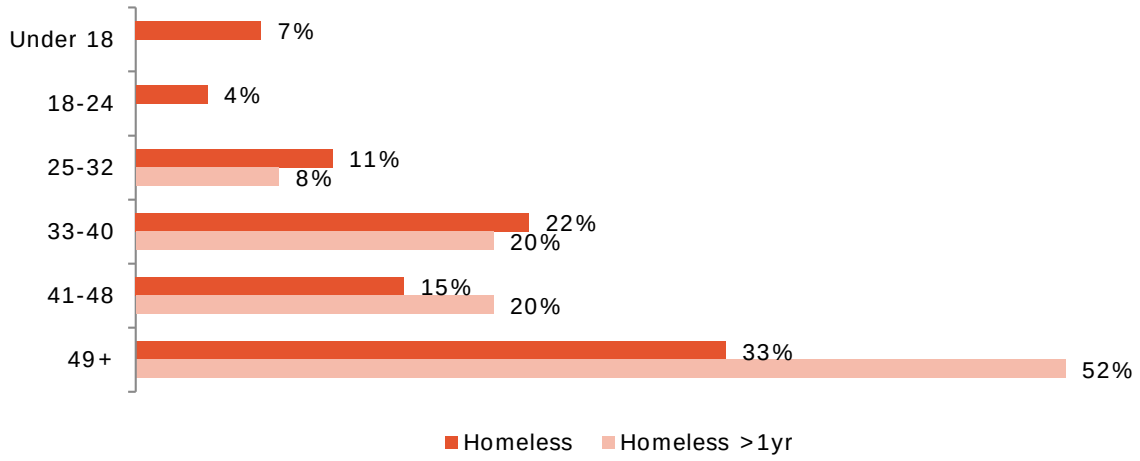


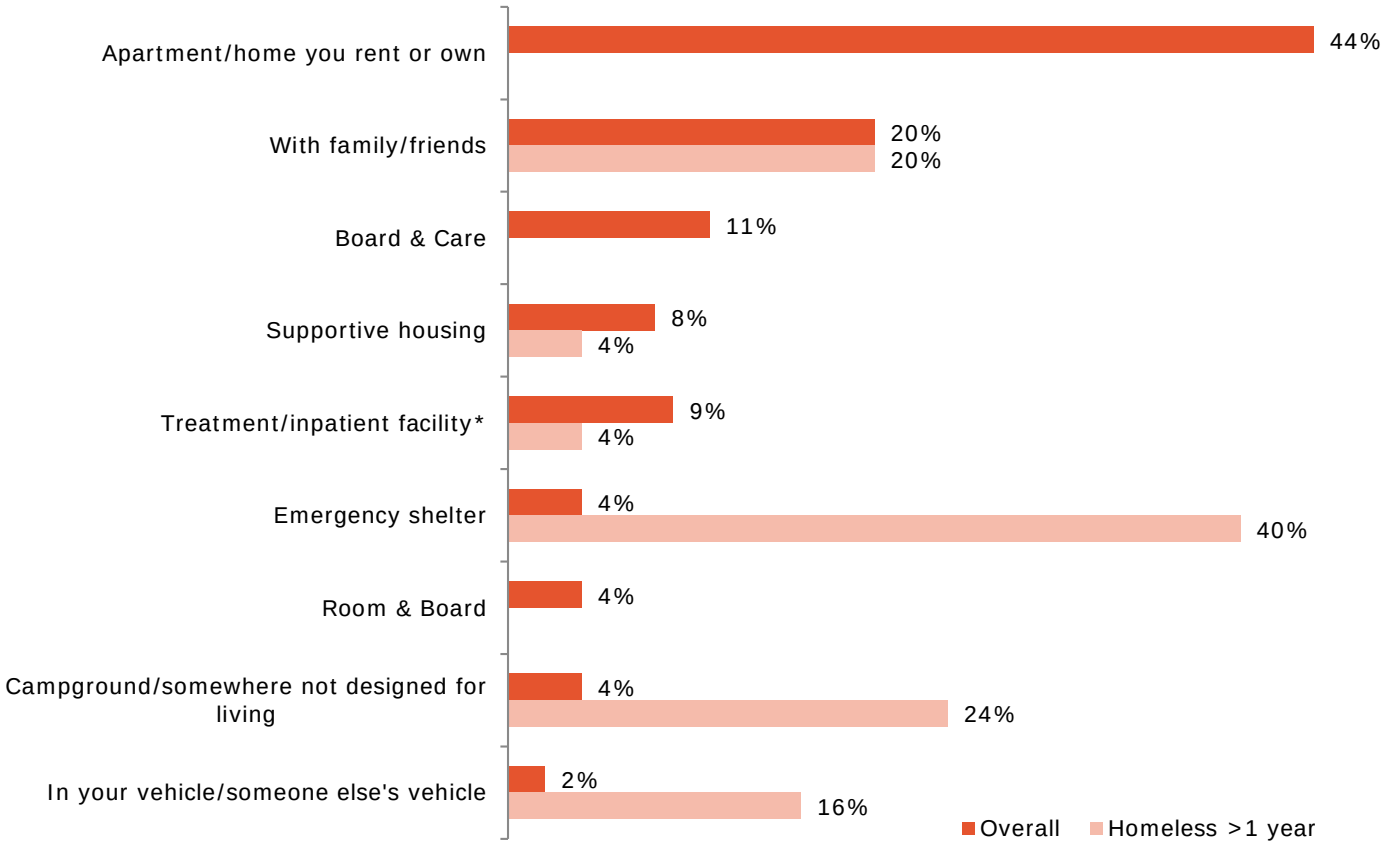
Exhibit 9. Demographic comparison among homeless and those who have been homeless for more than one year: Age



Housing Type

As shown in Exhibit 10, most respondents live in an apartment or home that they rent or own (44 percent) or with family and friends (20 percent). Only 11 percent report living in a Board & Care facility and less than 10 percent report living in supportive housing (8 percent), treatment or inpatient facilities (9 percent), emergency shelters (4 percent), or board and care (4 percent). Among those individuals that have been homeless for more than a year, the majority (40 percent) report living in an emergency shelter, followed by a campground or somewhere not designed for living (20 percent), such as on the street or at a bus or train station, with family or friends (20 percent), or in their vehicle or someone else's vehicle (16 percent).

Exhibit 10. Current Living Situation (n=540)



*This category includes residential treatment facilities, substance abuse/addiction treatment facilities, and inpatient facilities

With regards to where in Sonoma County survey respondents are currently living (see Exhibit 11), over half report living in Santa Rosa (60 percent). Eleven percent of respondents reported living in Petaluma and six percent reside in Rohnert Park. The Other-Sonoma County category captures cities or towns that each only had a small number of survey respondents, these include locations such as Forestville, Penngrove, Monte Rio, Geyserville, and Glen Ellen, when combined 12 percent of respondents reported living in one of these cities or towns. When comparing city of residence among homeless and non-homeless respondents, the results were similar, with the majority of homeless and non-homeless clients living in Sonoma County, Petaluma, and other cities and towns within Sonoma County (e.g., Forestville, Penngrove, Monte Rio, etc.).

Exhibit 11. Current City (n=486)

City	%	n
Santa Rosa	60%	289
Other – Sonoma County*	12%	56
Petaluma	11%	53
Rohnert Park	6%	30
Guerneville	5%	26
Cloverdale	2%	11
City of Sonoma	2%	11
Other – Non-Sonoma County**	2%	10

*Other- Sonoma County cities that were reported include, Forestville, Penngrove, Cazadero, Graton, Monte Rio, Occidental, Geyserville, and Glen Ellen.
**Other – Non-Sonoma Counties that were reported include, Marin County, Mendocino County, and Solano County.

Length of Time in Current Housing Situation

As demonstrated in Exhibit 13, the majority of respondents (64 percent) have been at their current living situation for one year or longer. Additionally, well over half (66 percent) of respondents indicated that they have not stayed in a shelter, outdoor space, or place not designed for living in the last three years (Exhibit 14). Given that 84 percent of survey respondents are not currently homeless, these findings suggest that the majority of survey respondents have some type of housing and have been living there for at least a year.

Exhibit 13. Length of Time at Current Living Situation (n=551)

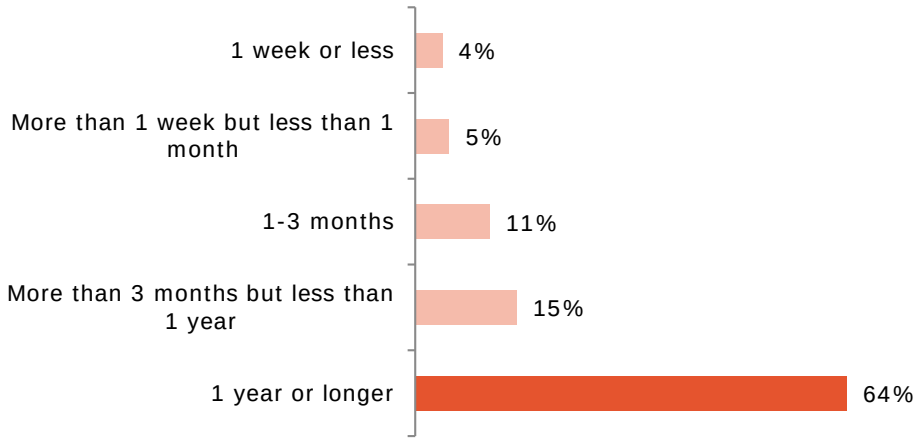


Exhibit 14. Number of Occasions Staying in Shelters, Outdoor Spaces, or Places not Designed for Living in the Last Three Years (n=542)

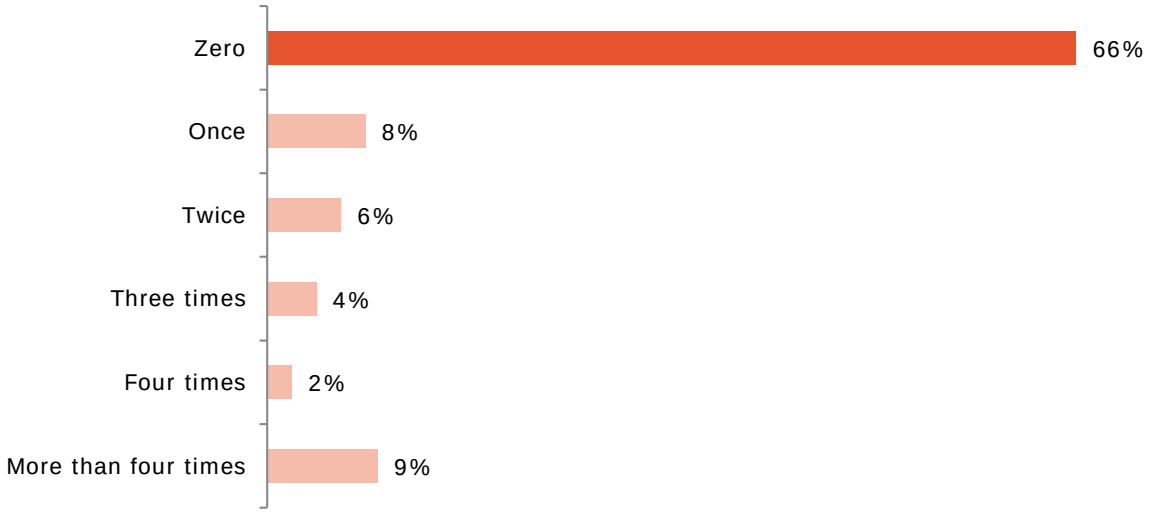
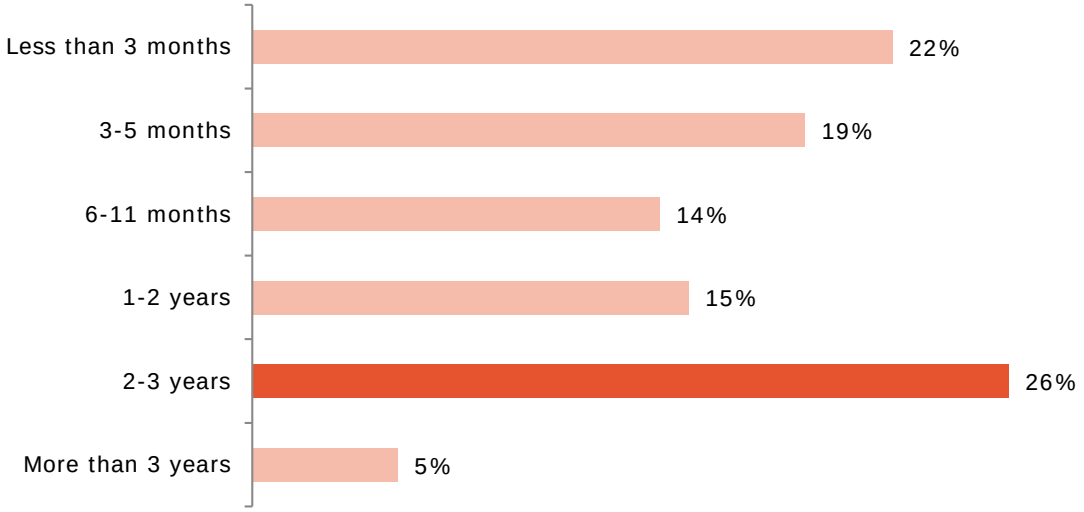


Exhibit 15. Number of months spent in shelters, outdoor spaces, or places not designed for living in the last three years (n=110)



Of the respondents that indicated staying in a shelter, outdoor space, or place not designed for living at least once in the last three years, just over a quarter (26 percent) have spent the last two to three years living in such places and five percent have spent more than three years living in shelters, outdoor spaces, or places not designed for living (Exhibit 15). These findings are consistent with the data presented in Exhibit 10 which indicates that the top two living situations for survey respondents that have been homeless for more than a year include emergency shelters and campgrounds or places not designed for living. Additionally, given that over a third of these individuals have been living in unstable and/or outdoor environments for two years or more, the type and level of housing services needed may differ than those who have been experiencing episodic periods of homelessness and considerations should be made for assisting individuals as they transition into more stable and traditional living situations.

Housing Subsidies and On-Site Services

The majority of respondents live in unsubsidized housing (62 percent) and housing without on-site services (61 percent). Among the 34 percent of respondents that live in housing with on-site services, the three most common services available include meals (23 percent), medication management (22 percent), and assistance with scheduling appointments (19 percent). Other services include transportation (17 percent), case management (17 percent), and peer support groups (15 percent).

Housing Satisfaction

In general, most clients reported being either satisfied or very satisfied with their current housing situation. As shown in Exhibit 16, well over half were either satisfied or very satisfied with the size and cost of their current living situation, 69 percent and 66 percent, respectively. Additionally, almost three-quarters of respondents were either satisfied or very satisfied with the physical condition of their current living situation (73 percent), the location of their current living situation (70 percent), and the safety of their current living situation (74 percent).

When asked if they are able and/or interested to stay in their current living situation, a little over half (57 percent) of respondents indicated they are able and/or interested in staying, while over a third (35 percent) are either not interested or are unable to stay in their current living situation. Among those respondents that are currently homeless, the majority (86 percent) are either not interested or are unable to stay in their current living situation. When housing satisfaction is further explored by comparing those respondents who are able or interested to stay in their current living situation to those who are not, there is greater dissatisfaction among respondents who are unable or uninterested in staying in their current living situation (see Exhibits 17 and 18). For example, among the respondents who are unable or uninterested in staying in their current housing situation, 34 percent are either dissatisfied or very dissatisfied with the size of their living situation, compared to only three percent who are able or interested in staying in their current living situation. Similarly, among those who are unable or uninterested in staying in their current living situation, 23 percent are either dissatisfied or very dissatisfied with the safety of their current living situation, compared to four percent of those who are able or interested in staying in their current living situation.

Furthermore, level of satisfaction with current housing also differed by housing type. Survey respondents living in supportive housing, a room and board or board and care facility, or in an apartment or home they rent or own were more likely to be satisfied or very satisfied with various characteristics of their housing, such as size, condition, safety, and cost. Respondents living in cars, campgrounds, or places not designed for living were the least likely to be satisfied across dimensions of housing characteristics. Additionally, respondents living in emergency shelters were also more likely to be dissatisfied with the size and location of their current housing situation. Findings are shown in detail in Exhibit 19.

Exhibit 16. Satisfaction with Current Housing

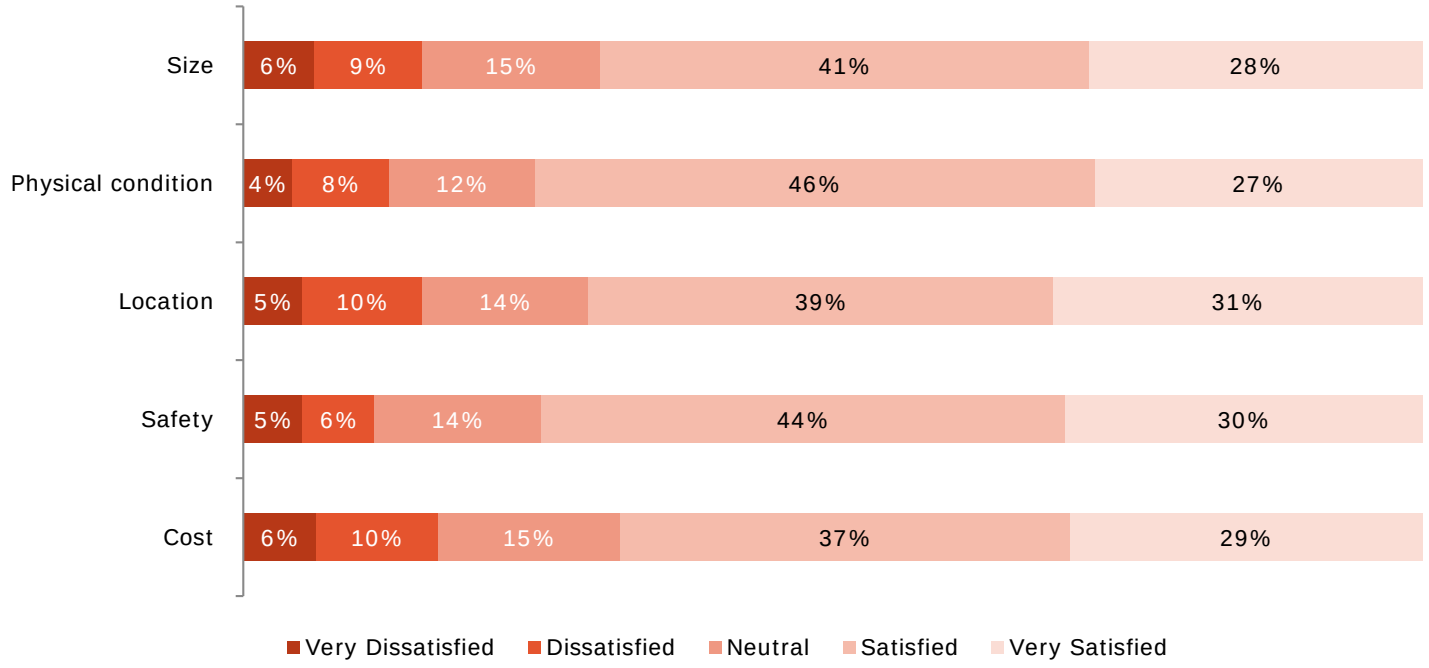


Exhibit 17. Satisfaction with Size of Current Housing, by Ability or Interest to Stay in Current Housing

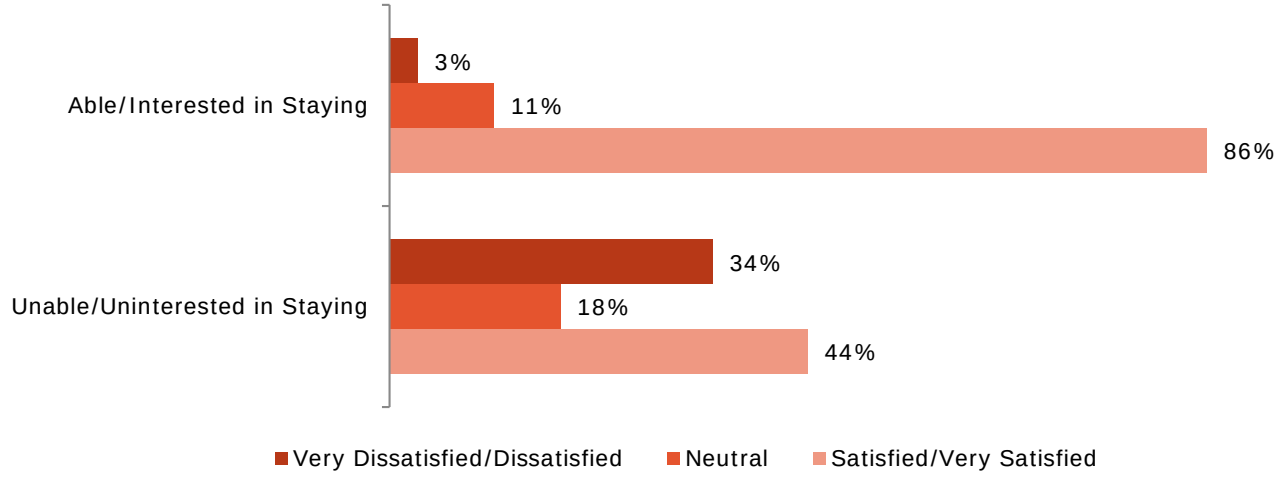


Exhibit 18. Satisfaction with Safety of Current Housing, by Ability or Interest to Stay in Current Housing

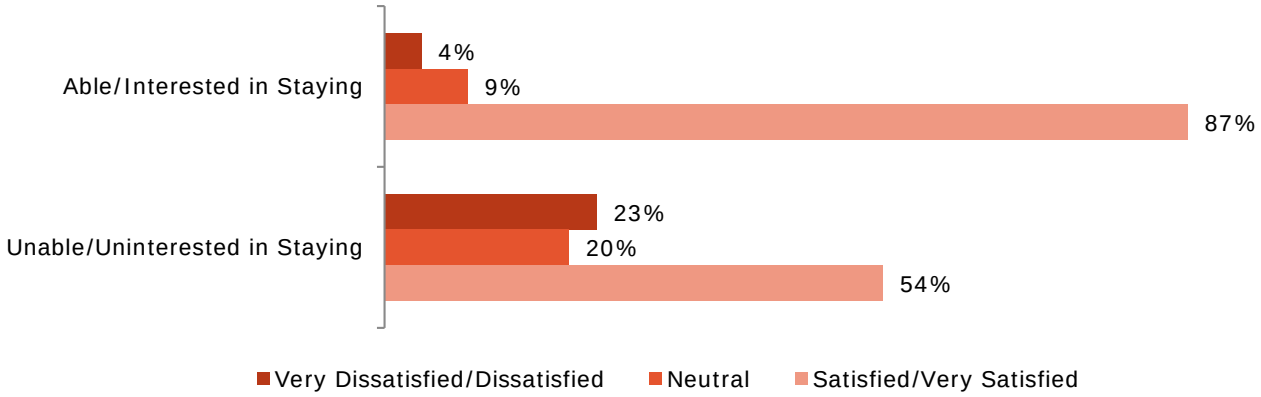
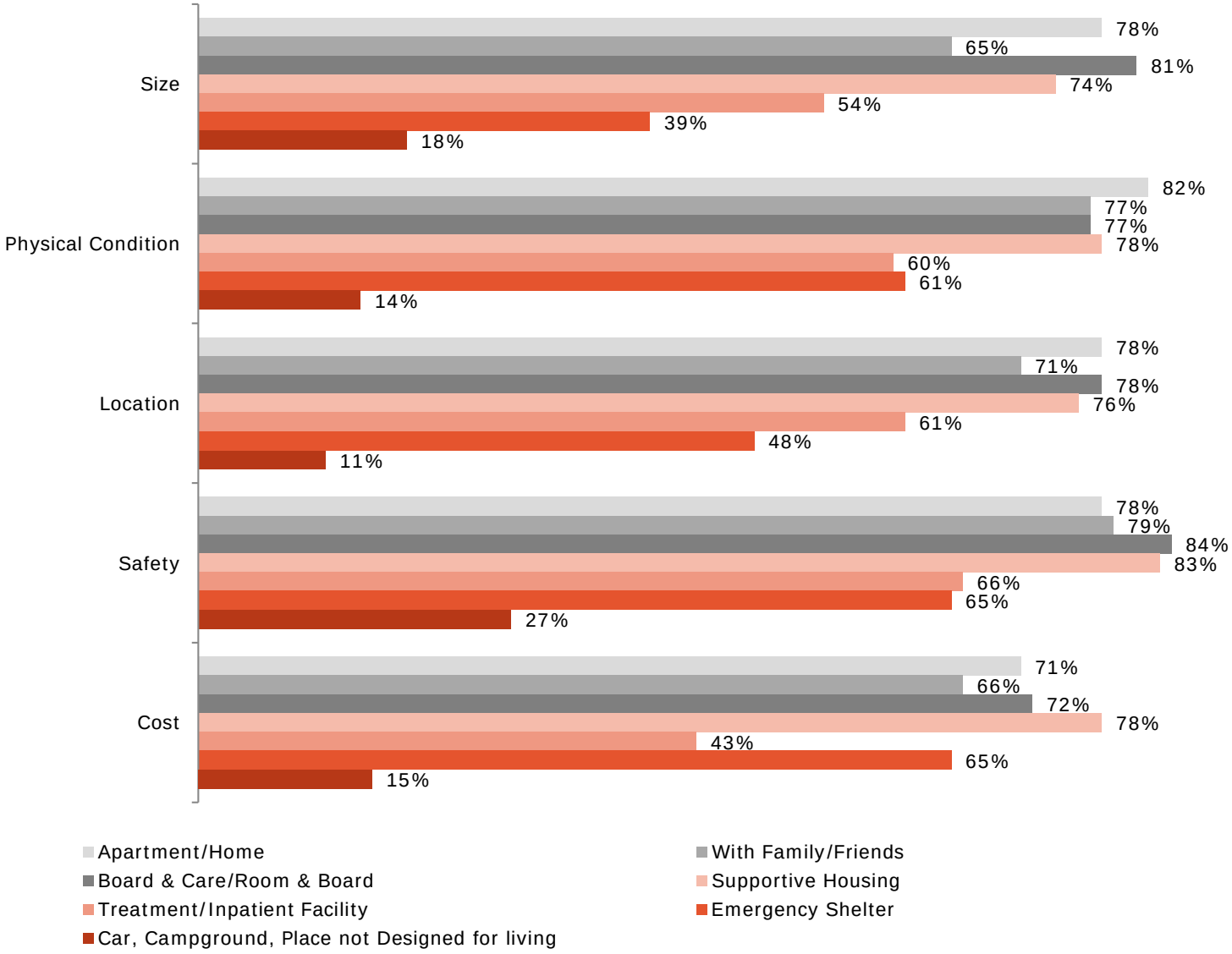


Exhibit 19. Satisfaction with Current Housing, by Housing Type



Future Plans

Locating and Securing Housing

As discussed above, 35 percent of respondents are either unable or uninterested in staying in their current housing for the foreseeable future. These respondents listed a variety of reasons why they need to or wish to move. The most frequently cited reasons include:

- Not in permanent housing (17 percent)
- Health or safety concerns (9 percent)
- Personal conflict with others (6 percent)

Additionally, when asked if they need assistance with finding or staying in their current housing, a little less than half (44 percent) of respondents indicated they do need assistance with either finding housing or staying in their current housing. Among the respondents that indicated they need assistance, two of the top three types of services/assistance needed are financial-based and the other is information-based. These include:

- Ongoing rental subsidy (28 percent)
- Rental housing information (19 percent)
- Temporary financial assistance (14 percent)

Preferred Housing

When asked to indicate the type of housing they would like to have, respondents overwhelmingly selected an apartment or house (79 percent). Other preferences included, mobile homes (14 percent), supportive housing (13 percent), and a shared living space (13 percent). Exhibit 20 includes complete responses to the survey item.

Exhibit 20. Preferred Living Situation (n=547)

Residence of choice	%	n
Apartment/house	79%	438
Mobile home	14%	80
Supportive housing	13%	72
Shared living space	13%	70
Other*	7%	39
Don't know	3%	17
Sanctioned campground	3%	14
Declined to answer	1%	8

*Other responses include: Stay in current housing, Live closer to family/friends, Board and Care, Live in different city/county/state, Female-only housing, Hotel/motel, Le-Ellen, Mig House, In the country, Safer housing, Senior housing, Sloan.

Furthermore, when asked to indicate the various barriers that get in the way of securing their ideal or preferred type of living situation, respondents selected a variety of reasons, with lack of affordable housing (53 percent), lack of income (44 percent), and insufficient savings as the three most commonly cited barriers (Exhibit 21). Financial barriers, such as lack of income and insufficient savings are aligned with the findings above regarding the financial assistance needed to find or maintain housing. Lack of affordable housing is also further emphasized by the number of responses survey respondents provided to open-ended questions, with many commenting on the need for affordable housing. As noted by one participant, "If there was more affordable housing, residents would have the finances to provide essential necessities like furniture to put in the home". Another respondent explained how affordable housing would help them as they pursue higher education, "I would love to see affordable housing. I'm about to start junior college and I need stable long-term housing."

Exhibit 21. Barriers to Securing Preferred Living Situation (n=481)

Barriers to securing ideal living situation	%	n
Lack of affordable housing	53%	293
Lack of income	44%	248
Insufficient savings (e.g., not enough money to cover a deposit)	29%	164
Serious health problem and/or health condition	19%	107
No rental history/poor rental history (e.g., failure to pay)	18%	102
Poor credit history	16%	91
Other*	12%	67**
Sporadic employment history	11%	61
Criminal background	9%	51
Recent history of substance abuse or actively using drugs or alcohol	9%	51
Housing rules/regulations	7%	40
No high school diploma/GED	1%	8

*Other responses include: No barriers, Conservatorship, Lacks/needs family support, Needs housing voucher, Board and Care, Keep away order/not allowed, Age, Current housing is temporary, Discrimination against those with HUD vouchers, Help with logistics of moving, Housing opportunity lost during incarceration, Lack of facilities in Sonoma County, Lack of Section 8 availability, Lives in rural area, Low income, Need more services, On probation, On waiting list, safety issue, and Wants improvement to current residence.
**66 respondents answered this question but 1 response fell into multiple "other" categories. This response was recoded as two separate responses, so the total number of "other" responses listed above is equal to 67.

Lastly, the survey also explored other potential barriers to securing housing by asking respondents about their history with incarceration and inpatient psychiatric services. Among survey respondents, 10 percent reported being incarcerated in the last 12 months, while about a third (31 percent) reported receiving inpatient psychiatric services in the last 12 months. Among those who had experienced incarceration within the past year, 31 percent reported experiencing problems securing housing upon their release. Additionally, among respondents who had received inpatient psychiatric services within the past year, the majority (70 percent) reported being released to housing they considered safe and stable, while almost a quarter (24 percent) were not. These findings indicate a potential need for tailored housing supports and services for clients with a history of incarceration and/or receiving inpatient psychiatric services in order to ensure they are able to secure safe and stable housing upon release.

Key Findings and Considerations

Summary of Key Findings

Findings from the housing needs assessment survey provide insight into the current living situation of BHD clients, services needed to find and maintain housing, barriers to securing housing, as well as information regarding preferred living situation. Additionally, the findings also explore potential differences between individuals experiencing episodic homelessness and those who have been homeless for more than one year. Below we have summarized key findings from the report.

Demographics

- While the majority (84 percent) of survey respondents are currently not homeless, among the 15 percent who reported being homeless, nearly half (48 percent) have been homeless for more than one year.

- Demographic findings indicate a slightly older population of individuals who have been homeless for more than one year, with 52 percent indicating they are 49 years of age or older, compared to 33 percent of those who have been homeless for less than one year. Additionally, a larger percent of individuals who have been homeless for more than one year are female (60 percent compared to 27 percent) and white (96 percent compared to 81 percent).

Housing

- Almost half (44 percent) of all respondents report living in an apartment or home that they rent or own.

- Among homeless respondents, the majority (40 percent) report living in a homeless shelter, followed by 24 percent living in a campground or somewhere not designed for living.

- While most respondents indicated they were satisfied with their current housing, slightly over half (57 percent) reported that they are able to or are interested in staying in their current housing situation. When asked to explain their reasons for needing and/or wanting to move, the two most commonly cited responses included not living in permanent housing and health and safety concerns.

- When reviewing data regarding barriers to securing or maintaining housing as well as services needed to secure or maintain housing, findings are consistent with one another and point to a need for financial assistance. Nearly half (44 percent) of respondents indicated lack of income as a barrier to securing or maintaining housing, followed by insufficient savings (29 percent). Relatedly, when asked to indicate the types of assistance needed to find or maintain housing, 28 percent reported needing an ongoing rental subsidy and 14 percent reported needing temporary financial assistance.

- The majority of respondents indicated an apartment or house would be their preferred housing environment, followed by a mobile home (14 percent) or supportive housing (13 percent).

Together, survey findings provide valuable insight into the experience of those who are currently homeless, including those who have been so for more than a year, as well as the unstable living situation for those who do have housing. Additionally, survey findings also include information about housing preferences that will be useful for Sonoma County to consider as it prepares an application for No Place Like Home Funding.

Considerations

Given the findings, we have listed a number of considerations for BHD and Sonoma County to explore as it works to address the housing needs of their client population.

- **Further exploration of the chronically homeless population.** In order to accurately understand the chronically homeless population in Sonoma County, future surveys should explicitly ask about disability status. While we have organized findings by respondents that have been homeless for more than one year and those who have not, without disability information we are unable to accurately categorize respondents as chronically homeless or non-chronically homeless. To more precisely understand the chronically homeless population and if/how the services and supports needed differ from the non-chronically homeless population we suggest additional information-gathering activities, such as interviews, focus groups, and secondary research (e.g., research on the chronically homeless population county- and state-wide). It is also important to explore the factors contributing to chronic homelessness and if/how they differ from factors contributing to episodic homelessness.

- **Explore the types of resources and supports that can be provided to BHD clients.** Given that that both barriers to securing and maintaining housing and assistance needed to secure and maintain housing were primarily information and finance-based, BHD should explore how best to provide information to clients about their housing options. Additionally, helping connect clients to financial resources and services may also help. This may also point to the need for broader discussions about financial programs designed to facilitate access to affordable housing.

- **Consider the types of supports and services needed for individuals with a history of incarceration and/or inpatient psychiatric services.** Given that survey respondents indicated difficulty with either securing housing upon their release or finding housing that was considered safe and secure, additional services and supports may be needed to help individuals secure housing upon their release from inpatient psychiatric facilities or incarceration. Additional information gathered from this client population would help illuminate the types of services needed.

- **Review focus group findings for additional perspectives and insights into the housing needs of BHD clients.** In order to gain further insight into the living situations of BHD clients and the barriers they have experienced when attempting to find and maintain housing, we recommend reviewing the survey data in conjunction with the focus group findings prepared by the peer leader group. The focus group findings may offer additional details about the unique challenges and needs of BHD

clients with regards to housing.

Lastly, it is important to keep in mind that the housing needs of Sonoma County have also been greatly impacted by the recent fires. Given that housing is even more of a concern for Sonoma County residents, not just those receiving BHD services, it is important to consider how the changing housing landscape in Sonoma County is further impacting BHD clients.

harder+co | community research

harderco.com

Harder+Company Community Research works with public- and social-sector organizations across the United States to learn about their impact and sharpen their strategies to advance social change. Since 1986, our data-driven, culturally-responsive approach has helped hundreds of organizations contribute to positive social impact for vulnerable communities. Learn more at www.harderco.com. Follow us on Twitter: @harderco.

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

This section to be completed by SCBH Program Manager

Program RU: _____

Client ID: _____

HOUSING SURVEY

The following survey is part of a County-wide Housing Needs Assessment being conducted by the Sonoma County Behavioral Health Division. The information gathered from these surveys will help the County develop a picture of the current housing status of their clients, as well as current and anticipated housing needs.

IMPORTANT! *This document will be scanned for data entry. Please fill in the circle next to your selection like this:* ●

1. What is your age? _____

2. What is your gender? (Check one)

◯ Male ◯ Female ◯ Genderqueer/Gender Non-Binary

◯ Trans Female ◯ Trans Male ◯ Declined to answer

◯ Other (please specify): _____

3. What is your race/ethnicity? (Select all that apply)

◯ African American/Black ◯ Asian ◯ White/Caucasian

◯ Native American/Alaskan Native ◯ Latino/Hispanic ◯ Native Hawaiian/Pacific Islander

◯ Declined to answer ◯ Other (please specify): _____

4. Currently, what is your primary source of income? (Select all that apply)

◯ Earnings/job ◯ Social Security (e.g., SSI, SSDI) ◯ No income

◯ Family/friends ◯ General Assistance/General Relief ◯ Declined to answer

◯ CalWORKS ◯ Unemployment

◯ Other (please specify): _____

5. Do you have any children under the age of 18?

◯ Yes ◯ No *(skip to Q #6)* ◯ Declined to answer *(skip to Q #6)*

5a. If yes, how many children under the age of 18 do you have? _____

5b. If yes, how many of your minor (under 18) children do you live with? _____

6. Are you currently homeless?

◯ Yes ◯ No *(skip to Q #7)* ◯ Declined to answer *(skip to Q #7)*

6a. If yes, approximately how many months have you been homeless? _____

7. Where are you currently living? (Select all that apply)

◯ Apartment/home that you own ◯ Room & Board ◯ Emergency shelter (including hotel/motel voucher)

◯ Apartment/home that you rent ◯ Board & Care ◯ Substance abuse/addiction treatment facility

◯ With family/friends ◯ Supportive housing ◯ In your vehicle/someone else's vehicle (e.g., car, van, RV)

◯ Residential treatment facility ◯ Inpatient facility ◯ Campground

◯ Somewhere not designed for living (e.g., on the street, bus or train station, etc.)

◯ Other (please specify): _____

8. What is the zip code of where you are currently living? _____ ◯ Don't know ◯ Declined to answer

9. How long have you been at your current living situation?

◯ One week or less ◯ More than one week but less than one month

◯ One to three months ◯ More than three months but less than one year

◯ One year or longer ◯ Declined to answer

10. Do you have subsidized housing? (Housing where you pay lower rent because the federal, state, or county government is paying for part of or all of your rent [e.g., Section 8])

◯ Yes ◯ No ◯ Don't know ◯ Currently homeless ◯ Declined to answer

11. Have you ever lost a Section 8 housing voucher because you were unable to find a housing situation that would accept it?

◯ Yes ◯ No ◯ I've never had a Section 8 voucher ◯ Don't know ◯ Declined to answer

12. Does your current housing provide on-site services?

◯ Yes ◯ No *(skip to Q #13)* ◯ Don't know *(skip to Q #13)* ◯ Declined to answer *(skip to Q #13)*

12a. If yes, what on-site services are available? (Select all that apply)

◯ Case management ◯ Scheduling appointments ◯ Peer support groups

◯ Medication management ◯ Meals ◯ Transportation

◯ Other (please specify): _____

13. For the following questions, please indicate how satisfied you are with your current living situation.

How satisfied are you with:	Very satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied	Not Applicable
a. The size of your current living situation	◯	◯	◯	◯	◯	◯
b. The physical condition of your current living situation	◯	◯	◯	◯	◯	◯
c. The location of your current living situation	◯	◯	◯	◯	◯	◯
d. The safety of your current living situation	◯	◯	◯	◯	◯	◯
e. The cost of your current living situation	◯	◯	◯	◯	◯	◯

14. Are you able to, and interested in, staying in your current living situation for the foreseeable future?

◯ Yes *(skip to Q #15)* ◯ No ◯ Don't know *(skip to Q #15)* ◯ Declined to answer *(skip to Q #15)*

14a. If no, why do you need or want to leave? (Select all that apply)

◯ Health or safety concerns
◯ Non-payment of rent or past-due rent
◯ Personal conflict with others
◯ Received an eviction notice
◯ Non-payment of utilities/utilities shut off
◯ Being discharged or services are being ended/terminated
◯ Family member or friend is being evicted
◯ Housekeeping concerns (unable to keep housing clean)
◯ Housing does not meet or respect cultural needs
◯ Unable to pay future rent/rent increase
◯ Threat of abuse by partner, family member, etc.
◯ I am not in permanent housing
◯ Housing is or will be condemned
◯ Conflict with housing management
◯ Declined to answer
◯ Other (please specify): _____

15. Do you need assistance finding or staying in your current housing?

◯ Yes ◯ No *(skip to Q #16)* ◯ Don't know *(skip to Q #16)* ◯ Declined to answer *(skip to Q #16)*

15a. If yes, what type of assistance do you need? (Select all that apply)

◯ Ongoing rental subsidy (e.g., Section 8 voucher)
◯ Help finding housing that accepts Section 8 vouchers
◯ Rental housing information
◯ Landlord mediation/landlord conflict resolution
◯ Housing repairs
◯ Neighbor/roommate conflict resolution
◯ Legal assistance
◯ Budgeting assistance
◯ Temporary financial assistance (e.g., first and last month's rent, etc.)
◯ Other (please specify): _____

16. On how many separate occasions have you stayed in shelters, outdoor spaces, or places not designed for living in the last three years?

◯ 0 *(skip to Q #17)* ◯ 1 ◯ 2 ◯ 3 ◯ 4
◯ More than 4 occasions ◯ Don't know *(skip to Q #17)* ◯ Declined to answer *(skip to Q #17)*

16a. In total, about how many months did you stay in shelters, outdoor spaces, or places not designed for living in the last three years?

_____ *(0-36 months)* ◯ Don't know ◯ Declined to answer

17. In the last 12 months, have you been incarcerated?

◯ Yes ◯ No *(skip to Q #18)* ◯ Declined to answer *(skip to Q #18)*

17a. If yes, did you experience any problems securing housing upon your release?

◯ Yes ◯ No ◯ Don't know ◯ Declined to answer

18. In the last 12 months, have you received inpatient psychiatric care?

◯ Yes ◯ No *(skip to Q #19)* ◯ Declined to answer *(skip to Q #19)*

18a. If yes, were you released to housing that you considered safe and stable?

◯ Yes ◯ No ◯ Don't know ◯ Declined to answer

19. If you had your choice, where would you like to live? (Select all that apply)

◯ Apartment/house ◯ Shared living space ◯ Supportive housing

◯ Mobile home ◯ Sanctioned campground ◯ Don't know ◯ Declined to answer

◯ Other (please specify): _____

20. What gets in the way of securing this type of living situation? (Select all that apply)

◯ Lack of affordable housing ◯ No rental history/poor rental history (e.g., failure to pay) ◯ Criminal background

◯ Housing rules/regulations ◯ Poor credit history ◯ Recent history of substance abuse or actively using drugs or alcohol

◯ Lack of income ◯ Sporadic employment history ◯ Serious health problem and/or health condition

◯ No high school diploma/GED ◯ Insufficient savings (e.g., not enough money to cover a deposit)

◯ Other (please specify): _____

21. Is it important for you to live with people that reflect, share, or accept your gender, sexual orientation, culture, veteran status, etc.?

◯ Yes ◯ No ◯ Don't know ◯ Declined to answer

22. Do you have any additional comments about housing that you would like to share?

_____

_____

Those are all of our questions. Thank you for completing the survey!