**Data Appendix IV.**

**Data Extracts from Individual County Data Notebooks, containing their**

**Answers to Questions #5, #6, #7, #8, #12 and #14.**

**Data Appendix for Question #5.**

**Question #5. Creative Solutions. Does your county have an innovative program or another way to address needs for inpatient care or emergency MH services, other than what has been listed above?**

The numbers below indicate the number of counties that selected a specific response. For “Yes,” **Answers are shown below**.

|  |  |
| --- | --- |
| No | 16 |
| Yes | 31 |

Alameda

24/7/365 Crisis Line operated by a contractor.

Butte

"However, there are current efforts to address using MHSA Innovations funding."

Contra Costa

Miller Wellness Center (Assessment & Recovery Center)

Fresno

* Mobile Crisis Teams,
* Supervised Overnight Stay program
* Integrated Discharge Team.

Glenn

* Drop-In Wellness centers for Adults (Harmony House) and youth (TAY)
* Transitions Learning Center
* MHSA Innovation Program: Weekend Wellness
* System-Wide Mental Health Assessment Response Treatment Team (SMART) to reduce bullying and school threats.

Imperial

* TESS program: Transitional Engagement Supportive Services Program: goal is outreach and engagement activities to reach unserved and underserved SED and SMI persons older than 14; especially targets those discharged from LPS Conservatorship by courts or from a psychiatric hospital
* CIT training contract: to train police and other first responders, collaboration with staff from Crisis and Engagement Services, with follow-up meetings.

Kern

Crisis Case Management Outreach Team.

Kings

* PEI Outreach Team (1 therapist + 1 case manager+ 1 peer support specialist), to work with clients who have had recent crisis contact and facilitate smooth transition to treatment services;
* Keys to Success Program (K2S) for services to clients at nearby Board & Care facilities at risk of needing more intensive care, helps clients retain the lower LOC and transition into independent living;
* Family & Friends DBT program, designed to assist family and friends of clients struggling with issues of emotional dysregulation, with goal of aiding family and friends to help their loved ones more effectively.

Lake

* The crisis drop-in center originated in SB 82.
* We also have high triage appointments to prevent hospitalization and re-hospitalization.

Los Angeles

Use a combination of law enforcement and MH teams, SB 82 triage personnel teams, MH Urgent Care Centers, and other community-based teams and approaches to provide outpatient alternatives to hospitalization.

Madera

* SB 82 helped us get clinical staff who provide crisis work at OP BH clinics & at ED of local hospital(s). These services are supplied by case workers and peer support staff for persons in crisis but not needing hospitalization. Peer staff provide supportive phone calls and follow-up. Case managers provide access to food, clothing, shelter, other service links as necessary. Crisis clinical staff, through ASST training, provide clinical skills training, safety plans and therapeutic services until the client can be seen by a clinician for ongoing services.
* County entered into a partnership with 4 other central valley counties, to develop crisis residential beds in Merced thru SB 82. These services will provide much-needed crisis beds for this region.

Marin

The Care Team 1 provides outreach and engagement services to individuals who are homeless and have SMI. This team is supervised and staffed by Peer Specialists. The Care Team provides support and resources, and provides referrals to the Odyssey Full Service (see below, Q#6) when indicated.

Napa

We utilize hospital liaisons to outreach to individuals who are hospitalized to initiate discharge planning and assist individuals who are leaving inpatient care to transition to outpatient mental health services.

Nevada

Peer support at Emergency Dept. and Peer-run Respite Center.

Placer and Sierra

* County has developed a Co-Occurring FSP Team that focuses on outreach to persons who struggle w co-occurring disorders, who experience multiple psychiatric hospitalizations and who are not participating in post-hospitalization services. This team is comprised of clinical staff members that are trained in both MH and SUD services.
* Placer County also has clinical staff embedded in one of the local ERs 24/7. This ER sees approximately 75% of the individuals on involuntary MH holds.

Riverside

Opening Fall/Winter of 2015, there will be voluntary crisis stabilization units.

Sacramento

* Community Support Team (CST): consists of Peer/Family Support Specialists and County MH counselors who provide a mobile response to persons experiencing a crisis; also assists post-discharge from acute care services or after contacts with law enforcement and emergency rooms, to assure appropriate follow-up care including safety plans and education to individuals and family members to help prevent a relapse back into crisis.
* Regional Support Teams (RST) and Community Care Teams: result of the MHSA, CSS expansion and Community Planning Process, the 4 RSTs each implement a CCT, to enhance engagement and timely access to services at the RSTs using cult, and ling. competent services. These teams will deliver flexible, recovery-based individualized services, allowing for seamless transitions throughout the continuum of OP services and supports. Each team will include a team lead clinician/social worker/ psychiatrist and nurse, peer/family provider, and resources specialist. The new team(s) will have begun providing services by late summer of 2015.

San Bernardino

Ca Health Facilities Financing Authority (CHFFA) Grants to develop several resources:

* Psychiatric Triage Diversion;
* TAY BH Hostel (STAY), a crisis residential treatment program developed with MHSA Innovation funds,
* Community Crisis Response Teams (CCRT),
* Crisis Walk-In Center (CWIC),
* Managed Care partners including hospitals and various health plans,
* Arrowhead Regional Medical Center (ARMC) Collaboration.

San Diego

* IHOT= In-Home Outreach Team program with mobile teams that provide in-home outreach and engagement services to persons with SMI who are reluctant to engage in treatment.
* The Team includes peer and family support specialists, a licensed clinician and a case manager, who provide in-home assessment, crisis intervention, limited case management and support services to individuals and their families or caretakers, as necessary.

San Francisco

The Hummingbird Place is a peer-designed and managed Respite, a safe place that offers connection and breathing room to those in need of a healing refuge and new direction their path to wellness. It provides a less restrictive setting for those needing alternatives to hospitalization. Although it is near the Behavioral Health Center and the Psychiatric Emergency Services and inpatient units, this place has a non-institutional feel with homey bedding, backyard space, natural light, and art created by peers.

San Joaquin

* In progress: building a voluntary CSU for adults and children/youth
* Separate adult, juvenile, and forensics MCSTs
* Contractor offers Therapeutic Behavioral Services (TBS) to juveniles in home and community settings as alternatives to psychiatric hospitalization
* SAFE-T: provides in-home therapy and access to 24-hr crisis phone line and other services to juveniles
* Crisis Bed Program: for juveniles with MH crisis and who have run away or at risk
* InSPIRE Program: designed to enthusiastically engage the most difficult-to-engage high users of community MH services.

San Luis Obispo

Dedicated Crisis Response Team (in addition to MH Evaluation Team) to interface directly w local Emergency Deparments to help facilitate transfer and evaluation.

San Mateo

* Respite Center in development,
* San Mateo Ambulance Response Team (SMART) with specially-trained paramedic which does a BH assessment and can place a 5150 hold if needed and transport client to psychiatric emergency services or to other services
* PERT: Psychiatric Emergency Response team--their role is to respond to MH emergencies where the situation could be de-escalated and there is no immediate threat to safety of others.

Santa Clara

Pay for Success (PFS) is performance-based contracting within the social sector where government pays only if results are achieved. Social Impact Finance allows for financing that bridges timing gap between government payments and upfront capital needed to run PFS programs for six years. This program will include key players: County of Santa Clara, Funders, Telecare, and Evaluator. If successful outcomes are achieved, County of Santa Clara pays Telecare and Telecare repays funders. Project partners are The County of Santa Clara, Telecare Corporation, Standard Medicine and Third Sector Capital Partners. The program will serve severe mentally ill adults through Telecare who have been treated in the County’s emergency and inpatient psychiatric facilities using Assertive Community Treatment. The intent is to improve health and wellbeing of acutely mentally ill individuals and at the same time reduce utilization of inpatient and emergency psychiatric services. This would be the first Mental Health PFS project with success payments generated through cashable savings.

Santa Cruz

The law enforcement liaison program previously mentioned, the Maintaining Ongoing Stability through Treatment (MOST) program is a forensic assertive community treatment team (FACT) that is linked to a behavioral health court through an active partnership with probation and parole, law enforcement, the public defender, the district attorney, and mental health to ensure oversight is provided to individuals with a severe mental illness and/or co-occurring substance use disorder to ensure oversight and outreach are provided to improve outcomes.

Shasta

We currently have Full Service Partnership, the STAR program, also, county is creating an after-hours resource center. But it only serves 60 people.

Solano

The County is initiating a contract with a local service provider for respite beds for short term housing for individuals who have been released from the CSU who do not require hospitalization but need support. Also servicesas described in response to Q#6.

Sonoma

Two programs: Progress Foundation--Parker Hill and Community Support Network --Hope House, whose primary purpose is to increase system capacity for IMD alternatives for residential services. These programs allow for stabilization in the community that reduce the need for emergency MH services and inpatient care.

Stanislaus

* Respite Housing Peer Navigators as well as case managers that assist w post-crisis follow-up
* Warm Line staffed by individuals with lived experience
* Intensive support services for minors and their families

Sutter-Yuba

Currently underway: a 3-yr study of in-custody and out-of-custody (in-day reporting) program participants. Clinicians evaluate symptoms to determine need, provide a treatment plan, therapy, and discharge plan and aid-in-transitioning program to participants prior to custody release and to further provide case management to make connections to their primary care provider, medical professionals, financial assistance, and program connections.

Trinity

* Our county has a unique triage program within our MHP, and
* 6-bed board-and-care with a dedicated respite bed for short term use (up to 14 days).

Tulare

Tulare County has an Assertive Community Treatment (ACT) Team and Outreach and Engagement (O&E) Team funded through Mental Health Services Act (MHSA) Full-Service Partnership funds. ACT is a frequent and intensive team-based treatment approach for individuals who have the most serious and intractable symptoms of mental illness, and who consequently, have the greatest difficulty with basic daily activities. The O&E Team can quickly respond to meet the needs of consumers who are presenting with urgent conditions that could result in crisis if not immediately addressed.

Ventura

* Rapid Integrated Support and Engagement Team (RISE) provides ongoing engagement and support for those who are unable/unwilling to access treatment. Field-based outreach team.
* NAMI Helpline
* Individual WRAP Plans for Crisis
* Adult and Children’s Safety Plans for escalating symptoms and corresponding measures/resources to reduce severity.

Yolo

* Homeless Court is in development, similar to MH and Drug Courts.
* Bridge to Housing Program (B2H): short-term (90 days) to assist homeless county residents. Under this program, 71 long-term homeless residents [including 47 dogs and 22 cats] were moved from a river encampment to temporary housing.
* Implemented by a consortium of county agencies: Drug, Alcohol, and Mental health, County Administrators Office, District Attorney’s Office, Employment & Social Services, Environmental Health, Health Services, Probation, Public Defender's Office and Sheriff-- Animal Services, city of West Sacramento, several faith-based and private industry groups.
* Residents were provided assistance with job training, health insurance, disability benefits application, and one year's worth of free cell phone service.

**Data Appendix for Question #6.**

**Question #6. Prevention. Does your county have any programs implemented specifically as alternatives to locked facilities that haven’t been addressed above**?

This is an open question that could include MHSA-funded prevention programs designed to assist individuals in crisis, or to prevent first-break psychosis. Such programs could include local implementation of a program for more MH triage workers (funded by SB 82). This question could also be addressed by other strategies that engage public (county) and private partnerships.

The numbers below indicate the number of counties that selected a specific response. Detailed responses for ‘Yes’ answers are shown below.

|  |  |
| --- | --- |
| No | 5 |
| Yes | 42 |

Alameda

* Many Prevention and Early intervention Programs funded by PEI.
* We also are expanding Wellness Centers from 4 to 6 Centers; barrier-free services that consumers with a known or suspect mental illness can build recovery skills on a drop-in basis.

Amador

State-returned MHSA housing funds are being used now and over next 3 yrs to fund combination of Emergency Assistance and Move-In Assistance and a housing coordinator, as part of program to develop Permanent Supportive Housing.

Butte

There are 3 Triage Teams (SB 82) embedded in 3 hospital Emergency Departments in Chico, Oroville, and Paradise. The fourth Triage Team provides services in Torres Shelter and Jesus Center, which provide services to the homeless population. The team shares time between the two locations. The fifth Triage Team is embedded in the Crisis Phone Team supporting individuals that call in and other crisis services.

Contra Costa

First Hope Program is a treatment program to prevent first break psychosis; certified as an EBP by the Portland Identification and Early Referral Training Institute (PIER model).

Del Norte

* Several programs to assist persons in crisis and prevent hospitalization in addition to our standard outpatient services, including our FSP program designed to provide immediate assistance to clients at risk of homelessness and hospitalization.
* Our new perinatal program facilitates cooperation between MHP and other branches of DHHS, to provide optimal delivery of services to new mothers and families at risk of crisis.

El Dorado

* 6-bed Adult Residential Facility
* Transition Houses that are supported 24 hrs/day/7 days/week.

Fresno

* Rural Crisis Triage Teams
* PEI First Onset Team
* Crisis Field Clinicians

Glenn

* Weekend Wellness
* Harmony House Drop-In Center
* TAY Drop-In Center
* Transitions Learning Center

Humboldt

* Mobile Intervention Services Team (MIST)
* Street Outreach Services (SOS)
* Mobile Outreach

Imperial

* Have begun implementation of the PIER Model (Portland Identification and Early Referral model): an EBP early detection and intervention approach
* Staff also engage or outreach to other agencies which might identify and refer individuals experiencing first episode psychosis
* Some individuals have access to physical fitness services and equine therapy via existing contracts in place with the FSP program
* As an alternative to locked facilities, LPS conservatees who have achieved significant stability are able to reside in Board and Care facilities or independent placement,
* Case management support, collaborative support with family members and coordination of treatment-related services.

Lake

* SB 82: 1 MH triage worker/navigator; 2 mobile crisis workers, CIT training with law enforcement;
* MHSA: PEI services primarily to TAY with a first break or preventing a break;
* Prevention coordinates with other MH staff who work community suicide prevention, including the Suicide Prevention task force, trainings on QPR, MH First Aid, and ASIST.
* Two outreach crisis workers go into community rather than have clients go to ER;
* 4 Peer-Guided Wellness & Recovery Centers (Nat Am, Lat, Adult, TAY) that will assist community members of those groups with stigma reduction, wellness and recovery programs, and referrals to reduce possibility of crisis; can also be used post-crisis.

Lassen

Renaissance Center for Transitional Age Youth to prevent first-break psychosis.

Los Angeles

* Use a combination of law enforcement + MH teams, SB 82 Triage Personnel teams, hospital or Urgent Care Centers and other community-based teams and approaches to provide outpatient care.
* Our Innovation 2 project focuses on building community's capacity to address trauma and risk factors for trauma.

Madera

Please see responses to Question #5, previously given.

Marin

Several Full Service Partnership (FSP) Teams provide services to specific vulnerable populations, and consist of mental health clinicians, peer specialists; nurse practitioners/ psychiatrists; employment specialists, an independent living skills specialist, and a substance use specialist.

* The Odyssey Team serves people who are homeless or at risk of homelessness, hospitalization and institutionalization.
* The Support and Treatment After Release (STAR) Team serves those at risk for incarceration or re-incarceration.
* The MHP also runs two FSP teams that focus on the needs and strengths of Transitional Age Youth (TAY).

Also: 3 new teams are partly funded by SB 82 Investment in MH Wellness Act of 2013 Grant Program:

* The Outreach and Engagement Team provides long term outreach to individuals suffering from a mental illness but who do not necessarily want to seek out traditional services and supports; they also provide information, support and education for family members/caregivers of these individuals.
* The Transitions Team is a 3 to 6 month brief case management team that provides support, education and linkage to community services either as prior to or immediately after a MH crisis or post crisis support.
* The Mobile Crisis Response Team partners with law enforcement to provide field-based responses to acute MH crises.

Mendocino

AB 1420 program has been approved by the County Board of Supervisors, but the implementation date has been extended, and there is no set date to begin the program.

Monterey

* Developed a contract with the Felton Institute to implement the Prevention and Recovery in Early Psychosis program (PREP). This early intervention program treats persons with beginning symptoms of psychosis.
* We are in process of implementing mobile crisis services and expanding our access program.
* We also contract with Promotorres who work to engage underserved members of the community.
* One of our contract agencies, Interim Inc., runs a crisis residential program that serves clients after hospitalization or can be used to prevent hospitalization.

Napa

We have implemented a State funded Crisis Triage grant to outreach to individuals in the County to intervene in crisis situations as early as possible to reduce the need for more restrictive levels of services/placements.

We are utilizing SAMHSA Block Grant funds for First Episode Psychosis programming including a contract with a large organizational provider serving children using a Early Detection and Psychosis Treatment model and a series of trainings planned for internal and contracted providers to utilize an evidence based practice model for Cognitive Behavioral Therapy for Psychosis.

Nevada

* Wrap-around services and Assertive Community Treatment program thru contract providers (Turning Point, Victor, EMQ, and Sierra Forever Families).
* Also Odyssey House, a 10-bed adult residential Program that is staffed 24/7.

Orange

Orange County Center for Resiliency, Education, Wellness (OCCREW): provides assessment, individual and/or family therapy, psychiatric services, vocational and education assistance, Wellness Recovery Action Plans, and other wellness activities.

Placer Sierra

Placer County has started the planning process for a First Episode Psychosis program funded through Mental Health Block Grant. The planning has included review of currently operating programs in contiguous counties, such as the UC Davis EDAPT and SacEDAPT programs, training for the partner agencies and the larger community to recognize signs and symptoms associated with major mental illnesses and manifestation in younger populations, as well as specific training to a contract provider, Turning Point Community Programs, to provide early intervention once individuals are screening and identified as being at high risk. A new screening tool is being utilized by internal clinicians who conduct assessments for those under 18, which also more effectively identifies early major mental health symptoms.

Also funded under the MHBG are two other programs for children and youth. One is a Placement Review and Hospital Prevention Program, which is an intensive treatment program designed to prevent acute psychiatric hospitalizations, high level group home, or FFA placement failure. Children participating in this program have a mental health diagnosis and service plans that are reviewed and authorized by a multi-disciplinary team designated as the Family Resource Community Collaborate (FRCC). The FRCC meets to review plans for these children, reviews if lower level placements are possible, and if other services would be beneficial for these children and family. All FRCC meetings are facilitated by a Family Advocate and the family is an active participant in the process.

The second program is Integrated Services, designed to reduce group home placement for youth with a mental health illness receiving services through the Juvenile Division of the Probation Department. This includes provision of intensive Wraparound in-home services, Functional Family Therapy (an evidence-based, in home mental health model), Drug Court intensive service monitoring via specially training probation officers, and We Are Teens Always Helping (WATAH) which is a post-placement process for adolescents aged 12-16 to teach positive social development, effective decision making skills, provide community service, prosocial activities and ongoing family team meetings.

Riverside

* Using SB 82 funds to pay for community-based, mobile crisis response teams. The Regional Emergency Assessment at Community Hosp (REACH) team responds to local ERs and other locations for risk assessment of people in psychiatric crisis and facilitate diversion from locked facilities.
* The Community Response Evaluation and Support Team (CREST) does the same activities woth law enforcement agencies throughout the county.
* Further, this county has initiated a contract for FSP program called RISE (Riverside Integrated Services). This program is designed to divert consumers in IMDs into less restrictive placements with 24/7supoorts and services.

Sacramento

SacEDAPT (Early Diag. and Preventative Treatment) administered by UC-Davis Dept of Psychiatry, esp for ages 12-16; Respite Partnership Collaborative (RPC), a DBHS Innovation Project to be a community-driven collaborative--to provide a continuum of respite services and supports to reduce MH crisis (and has awarded 11 grants for this, see DN for details); Triage/Peer Navigators to provide services at key access points such as CSU, the main jail, Loaves & Fishes, and local ERs; Community Alternatives for Recovery and Engagement Plus (CARE+) which is an innovative program that joins intensive outpatient MH services with case-managed conservatorship, to help clients on the path to recovery and to independent living in the community.

San Benito

The Esperanza Center and FSP services to assist clients to stay in the community and maintain their health.

San Bernardino

County has 13 PEI program services designed to prevent MI or SED from becoming severe. All are categorized under various access points or initiatives:

* School-based Initiative, (e.g. Student Assistance Program, SAP),
* Community-based Initiative,
* System enhancement Initiative (includes Older Adult Community Services, OACS),
* Access Coordination and Enhancement (ACE) which seeks to improve the timeliness of access to Department of BH outpatient services for those recently discharged from an acute in-patient hospital, works w RBEST teams, and also involves SUD treatment services, and
* Long-Term Adult Residential treatment programs; also clients may transition to permanent supported housing such as the HOST program with FSP and case management provided on an outpatient basis and not in the residence.

San Diego

* "KickStart" is a county-wide PEI program that has 3 parts, all aimed at decreasing the likelihood and/or intensity of someone's first episode of psychosis.
* It provides 'gatekeeper' education to the general public about early identification of young persons at risk of psychosis.
* It provides confidential screening of young people age 10-25 who may be at risk for their first episode of psychosis.
* And it provides thorough assessment and treatment for young people age 10-25 who display signs of being at high risk for having their first episode of psychosis.

San Francisco

* Prevention and Recovery in Early Psychosis (PREP)
* Emergency Stabilization Housing (50% FSP)
* Comprehensive Crisis Services
* Peer Respite (Hummingbird Place)
* Programs & Triage Personnel (state MHSA funding and SB 82 --not local MHSA funding)--MHASAF Warmline 24/7 peer run phone line, Mobile Treatment Teams
* Crisis Stabilization Unit located at Edgewood that tries to stabilize children and youths to avoid sending them to inpatient hospitals

San Joaquin

* PEI-funded program that includes outreach, education, and short-term treatment for up to 2 years for individuals experiencing the onset of psychosis;
* This program includes assessment, group & individual CBT, family education and support, prescription medications, vocational and education support and case management.
* Program uses the PIER: Portland Identification and Early Referral model.

San Luis Obispo

* See answer to Question #5 above.
* Also, we are implementing a first-break psychosis program in conjunction with Cal Poly SLO and Cuesta College.

San Mateo

All covered previously, especially in answers to Questions #5 and #3.

Santa Barbara

* This county received an SB 82 Personnel (Triage) grant, which is funding 3 Triage Teams, one in each region of the county. The teams are staffed with clinicians, persons with lived experience, and medical personnel.
* Also received an SAMHSA grant to improve outreach and education about first episode psychosis (FEP) among teens and young adults.
* UCSB, SB City College, and Allan Hancock have been trained in the Transition to Independence Process (TIP) model specializing in FEP. All campuses now have established peer teams and outreach and education plans, dev. in collab w each campus. ADMHS TAY teams will begin circulating materials on campuses this month.

Santa Clara

Santa Clara County’s Prevention and Early Intervention (PEI) P3 Plan: PEI Interventions for individuals experiencing onset of serious psychiatric illness. The County’s PEI P3 Plan includes the REACH (Raising Early Awareness Creating Hope) community based organization (CBO) operated project. The project provides a continuum of services targeting youth and transition age youth (TAY), ages 11 to 25, who are experiencing ‘At Risk Mental States’ (ARMS) or prodromal symptoms. The service model is based on the PIER-Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, which is a replication study which occurred at six sites nationwide to build research evidence on the effectiveness of preventing the onset and severity of serious mental illness with psychosis. The program is currently operated by two community based organizations (CBOs), Momentum for Mental Health and Starlight.

Santa Cruz

<http://www.santacruzhealth.org/Portals/7/Pdfs/201504%20innovative%20project.pdf>

* The County began implementation of the PREP program, for first episode psychosis this past May utilizing grant funds from the SAMHSA block grant set aside from the State of California. The county will continue implementation of this program during the course of this year with additional funding made available through the state.
* The County also received approval for approximately $3M in funding to establish an new Innovations Program embedding both peer and family partners on two treatment teams, establishing an Office of Consumer and Family Affairs to oversee this program, which will look at how to effectively provide navigator functions for individuals and families, what supports and trainings are needed to have peers work together with families on a team which places equal value in their unique perspectives, and how to better outreach and engage individuals and families to support them through treatment.

Shasta

* Early Onset Program
* Youth Shasta Triumph and Recovery (STAR) Program
* Shasta County Suicide Prevention Workgroup
* Community Education Committee (Stand Against Stigma Campaign)

Siskiyou

The MHP has implemented a program in collaboration with the local hospital to provide on-site after hours crisis intervention and supportive services. This program is designed to address risk factors as defined under W&I Code 5150, to link individuals to supportive and other necessary services, to provide early intervention with the goal of keeping individuals in the community where they will continue to have access to family and other support networks, and to facilitate timely access to medically necessary MH and SU disorder services.

Solano

* The county contracts w a community provider for a relapse and aftercare program designed to prevent mental illness from becoming severe and disabling, and to improve timely access to services including outreach to underserved populations.
* The program includes light case management, multi-disciplinary coordination, medication management support, and peer recovery supports for consumers at risk of relapse and re-hospitalization and/or re-incarceration due to mental illness.

Sonoma

Many excellent programs, some with MHSA funding, some with state funding as in SB 82, etc. Also see answers to prior questions.

Stanislaus

* MHSA-funded FSP for homeless and those at risk of becoming homeless, for those with involvement (or risk of involvement) w criminal justice system, for those on LPS conservatorship to enable remaining in community, and for those w co-occurring MH & SUD conditions.
* Also, the LIFE Path, an early psychosis intervention programs in collab w CSU -Stanislaus.

Sutter-Yuba

Early intervention to remedy and avoid acute and long-term care.

Trinity

* MH--We provide medication education and social support for clients at their location, which has greatly increased stability for clients.
* We also are using block grant, SAMHSA-funded program for forensic services in the jail for adults and in juvenile hall for youth, both while incarcerated and while on probation.

Tulare

* Tulare County has an Assertive Community Treatment (ACT) Team. ACT is a frequent and intensive team-based treatment approach for individuals who have the most serious and intractable symptoms of mental illness, and who consequently, have the greatest difficulty with basic daily activities.

* Tulare County also has an Outreach and Engagement (O&E) Team that can quickly respond to meet the needs of consumers who are presenting with urgent conditions that could result in crisis if not immediately addressed.

* Additionally, Tulare County is piloting a First Episode Psychosis (FEP) as part of the Mental Health Block Grant-Set Aside funds for First Episode Psychosis. This pilot program will begin in fiscal year 2015/2016 and will target youth and transitional-age youth ages 13 to 25 years of age. The goal is to assess for psychosis using Yale Prime SIPS and provide interventions to address psychosis and triggers through Psychiatric services, EMDR evidence-based practice, and for those with substance abuse disorder the addition of the Hazeldon Co-Occurring Disorder practice which uses Cognitive Behavioral Therapy.

Ventura

* Rapid Integrated Support and Engagement Grant
* Ventura Early Intervention Prevention Services
* Crisis Intervention Training (Contract with Law Enforcement-CIT)

Yolo

* Crisis Intervention Program (CIP), SB 82 award for expanding CIP program, to have trained clinical staff available when law enforcement responds to a MH crisis, also a peer-counseling component.
* Also a CIT team
* First Episode Psychosis Program (FEP)
* Drop-in Wellness Center
* Housing Now Program (HNP): uses Critical Time Intervention (CTI) and other features.

# Data Appendix for Question #7 and #8, Combined

Question #7: Unmet needs. Please describe any specific unmet needs for children, transition-aged youth, adults or older adults in your county for either MH-related hospitalization or community-based crisis treatment services.

Question #8: If you could ask for any specific resource, program, or facility to meet serious, urgent MH needs in your community, what would be your top three priorities? Priorities listed may apply to one age group, several groups, or to all stages of the lifespan. These priorities included many of the needs identified under the responses for Question #7.

Responses for both questions are presented for Counties grouped by size of population.

## Small Population Counties: <200,000

**Alpine County:**

##### Combined Answer: for Q#7, Unmet Needs and Q#8, Priority Resource Needs

Key Findings (from MHSA Annual Update 2015 stakeholder meetings, surveys, input and open office hours)

Across the various stakeholder engagement efforts, community feedback pointed to several key needs and concerns. Despite these concerns, Alpine residents also provided positive feedback regarding ACBHS’s implementation of MHSA programs and services. Results of the needs assessment identified five key areas of service strength and need: 1) Education and Outreach, 2) Alternative Recreational and Art-Based Activities, 3) Targeted Services and Interventions, 4) Workforce Education and Training, and 5) County-Wide Coordination.

Education and Outreach:

Overall, Alpine residents reported increased awareness of MHSA programs and services as well as increased visibility of ACBHS presence in the community. In particular, stakeholders noted ACBHS’ increased program outreach within the Hung-A-Lel-Ti Community. For instance, one stakeholder stated, “[ACBHS] has done an amazing job at grassroots activity and working with the community to improve relationships.”

Nonetheless, the needs assessment revealed a need for more targeted education and outreach among the Bear Valley and Kirkwood communities. Due to these communities’ geographic location, isolation is a significant factor shaping mental health issues in these two regions. While in general, stakeholders reported ACBHS has done a good job of reducing stigma around mental health and creating access to mental health services among residents in Markleeville, it seems that stigma is still prevalent among Bear Valley residents. Additionally, while community members recognized ACBHS’ increased engagement with the Hung-A-Lel-Ti Community, further education and outreach with the community could be beneficial to continue building rapport and trust between Tribal members and Alpine residents. For instance, members of the Hung-A-Lel-Ti Community explained that despite advances in partnership between ACBHS and the Washoe Tribe, they were still reluctant to access mental health services in the Tribal Health Center as well as through ACBHS due to issues around privacy as well as current flux in the Leadership at the Tribal Health Center. While the Tribal Health Center is not run by ACBHS, this feedback indicates that some barriers remain among Hung-A-Lel-Ti Community members in accessing adequate mental health services.

Recreation-based Preventative Programming

Community members indicated positive awareness of the diversity of recreational activities for Markleeville residents, particularly afterschool and summer activities for youth. However, stakeholders also expressed the need for more afterschool and summer activities for transitional-age youth (TAY) in Bear Valley and Kirkwood to combat the onset of depression and anxiety that seem to be prevalent in these regions. In the Kirkwood survey, about 53% of respondents indicated that TAY were in need of mental health services.

Community members discussed factors contributing to depression and anxiety, including social isolation, a general lack of a sense of community, poverty and a lack of steady employment opportunities. Bear Valley and Kirkwood are ski resort communities with seasonal/highly transient adult population. About 80% of Kirkwood survey participants indicated that adults were in need of mental health services. Residents in both these regions expressed an interest in expanding ACBHS’s yoga and chair exercise classes to their communities, organizing an annual Wellness Fair similar to the one held in Markleeville, as well as creating socialization activities such as a cooking class or community potluck on Sunday evenings that include a “health and wellness” presentation and discussion.

Targeted Services and Interventions:

Community members responded well to the MHSA programs initiated in the past year, including Senior Socialization and Exercise and Combining Past and Present with the Hung-A-Lel-Ti Community. One resident noted, “There is a lot of [senior] socializing that goes on and for those of us who can be in isolation it really helps.” Another resident from the Hung-A-Lel-Ti Community mentioned looking forward to Create the Good and recreational activities with Tribal youth. And while the establishment of a Wellness Center at the Gym in the Hung-A-Lel-Ti Community was seen as a positive contribution, residents recommended keeping the Center open longer as well as offering more recreational activities such as basketball and volleyball. As one resident stated, “Opening the Wellness Center longer and coming up with more activities for the kids [would be helpful].” The Wellness Center is no longer located at the Gym due to expansion and flooding issues in 2014. While the Gym is not operated by ACBHS, this feedback indicates that there is a desire for even more recreation-based wellness activities in the community. Overall, community input and service data indicates an increase in attendance as well as consistent participation across MHSA programs and services.

While community members’ expressed overall satisfaction with MHSA programs, the needs assessment points to two key populations for more targeted services. These populations were TAY, particularly teens transitioning from high school to adulthood, and adults, particularly those with children ages 0–3. Additionally, stakeholders once again pointed to the need to expand services and clinical capacity within the Bear Valley and Kirkwood regions, particularly after business hours.

Workforce Education and Training:

Community members reported increased awareness of one-on-one counseling and availability of the school-based mental health clinician. The continuation of a designated Native Wellness Advocate has strengthened the cultural competence of the County’s MHSA programs and services. Overall, the needs assessment indicated Alpine residents’ increased awareness and comfort with accessing mental health services. The introduction of a school-based mental health clinician provided further opportunities for early detection and intervention.

Nonetheless, stakeholders reported that further skill building of ACBHS’ current workforce might be beneficial. Suggested trainings included motivational interviewing; co-occurring disorder treatment; and Screening, Brief Interventions, and Referral to Treatment (SBIRT). Additionally, several stakeholders suggested ACBHS provide trainings to partnering organizations through a train-the-trainer approach. As a potential PEI intervention, such a program could be particularly helpful in Bear Valley and Kirkwood given current resource constraints within the two regions.

County-Wide Coordination:

Stakeholders reported having clear points of contact and regular communication with ACBHS staff, particularly between local service providers, Hung-A-Lel-Ti Community members, and school administrative staff. Given the need for more outreach and services in Kirkwood and Bear Valley, stakeholders also identified a need for increased communication and service coordination with providers and agencies in these two regions.

One key finding from the needs assessment pointed to the need for ACBHS to strengthen coordination and linkages between the school, home, and community. While the introduction of Positive Behavioral Interventions and Supports Program (PBIS) in 2013 and the proposed implementation of Primary Intervention Program (PIP) in FY 2015/16 has strengthened school based interventions, community members expressed a strong need to expand these interventions to the home environment. A member of the Hung-A-Lel-Ti Community noted during the community work session that while it is important that schools implement PBIS and PIP, what happens to youth once they return home remains an issue.

**Amador County:**

Q#7, Unmet Needs:

None specified in response to this question in report. However, elsewhere in their report, there are extensive comments on programs for both limited-term and longer-term supported housing assistance and use of MHSA housing funds.

Q#8, Priority Resource Needs:

* Psychiatrist
* Sutter Amador Hospital Psychiatric Unit
* Crisis Residential Treatment

**Del Norte County:**

Q#7, Unmet Needs:

* There are several needs that would assist the Mental Health Branch in providing more successful services during crisis situations.
* In county temporary housing for clients in crisis would be help so that we could more closely monitor the clients and provide them with a safe environment, free from the triggers that led to the crisis situation.
* Additional therapists would also be helpful in crisis situations, and in assessments for potential hospitalizations.

Q#8, Priority Resource Needs:

* Crisis Stabilization Unit (CSU)
* Client Housing facility, crisis and non-crisis
* Increased client transportation

**El Dorado County:**

Q#7, Unmet Needs:

* Lack of Transitional Housing
* Long wait time and lack of space for beds in county
* No Crisis Residential Treatment or 23-hour services.

Q#8, Priority Resource Needs:

* MHRC type locked facility instead of sending clients out of County
* Adult Residential Facilities with a strong focus on Co-Occurring Disorders with a capacity for at least 25 – 30 clients.
* Early psychosis program for youth and TAY

**Glenn County:**

Q#7, Unmet Needs:

* For children and Transition Age Youth it is very difficult to find a psychiatric inpatient facility that can serve them.
* Psychiatric Services are scarce for all age groups including children, youth, adults, and older adults.
* We would like to expand our services at Harmony House by adding Telepsychiatry, clinical services, and more groups.
* We would also like to consider having a Crisis Stabilization Unit (CSU) or Respite Center to help stabilize people and help them avoid hospitalization.
* We would also consider developing a regional resource to help address the need for a CSU.
* Other unmet needs include expanding our weekend Wellness program for extended hours and
* Developing additional transitional housing options, similar to our Unity House, a Sober Living Environment (SLE).
* We would like develop additional transitional housing options, and create the opportunity to employ clients to work at the transition living house. We could use CalWORKs to pay people to manage the house, offer case management, and teach residents employment skills.

Q#8, Priority Resource Needs:

* A Crisis Stabilization Unit or Respite Center
* Transitional housing
* Additional psychiatric services in various locations in the county

**Humboldt County**:

Q#7, Unmet Needs:

* Crisis Residential
* Board and Care

Q#8, Priority Resource Needs:

* Mobile Crisis Intervention
* Crisis Residential
* Six additional beds in our Crisis Stabilization Unit

**Imperial County:**

Q#7, Unmet Needs:

* Currently Imperial County does not have a program that provides local transitional housing that provides housing and supportive services to emancipate foster or probation youth ages 18-25. Housing provides a fundamental level of stability for young people to achieve their goals of wellness, recovery, and eventual self-sufficiency. The lack of safe and affordable housing options is often a profound barrier for the transitional-aged youth population who needs access to these basic supports for recovery.
* Additionally, there has been an increase in the number of elderly adult population who are mentally ill and homeless. Available resources to provide intervention and support are extremely limited. Services needed would include food, clothing, shelter, medical care, benefits assistance and linkage to community services.

Q#8, Priority Resource Needs:

* Transitional homes for Transitional Age Youth population
* Increase of Inpatient psychiatric beds
* Mental Health Dual Diagnosis residential/transitional living

**Kings County:**

Q#7, Unmet Needs:

* In Kings County our penetration rates are dismal, however the County does have a significant population of individuals who are active duty military or in a state penitentiary and receive physical and mental health care from non-county providers, which impacts the penetration rate.
* We have a grave need for more bilingual staff to care for our high Latino/Spanish population.
* Kings County does not have any type of a crisis facility for adults or older adults. Hospital ER is used for 5150 crisis hold only.
* There is no crisis facility or hospitalization available for Children, Youth or TAY.

Q#8, Priority Resource Needs:

* A dedicated, children, youth and TAY out-patient treatment facility
* A children, youth and TAY residential facility
* A children, youth and TAY crisis facility

**Lake County:**

Q#7, Unmet Needs:

Lake County’s challenges include being a rural county, lots of poverty, substance abuse, and limited resources. Previously, a person in crisis has always had to go to one of two hospital emergency rooms for evaluation/crisis intervention. If the person was holdable under W&I 5150, we’d have to find placement at an out-of-county psychiatric hospital. Over the last year and a half, we have been building more of a crisis continuum – lower acute people will be able to use our crisis drop-in center and have peers help them. We are now doing more crisis outreach and working closer with law enforcement as well.

That all being said, we still have to ship people out of the community for all psych hospitalizations, we’re still developing the crisis drop-in center and we also struggle if there are multiple crises happening at the same time due to limited resources.

Q#8, Priority Resource Needs:

* Number one resource need: personnel. It’s difficult to recruit, hire, train and keep qualified staff, particularly in a rural area and for county wages. Currently we’re having a very difficult time trying to recruit for full-time nursing staff (RNs, LVN, and Licensed Psych Techs).
* Two: more training in-house to have MH knowing more about substance abuse and having AOD know more about crisis de-escalation.
* Three: more community education about preventing a crisis by educating people about pro-actively seeking help

**Lassen County:**

Q#7, Unmet Needs:

None specified.

Q#8, Priority Resource Needs:

* Regionalization
* Homeless Prevention for individuals with serious mental illness
* Work Force Development

**Madera County:**

Q#7, Unmet Needs:

* Increase in funding to support additional clinical/peer staff to lower caseloads.
* Increase local inpatient beds/facilities capacity.
* Increase in supervised housing facilities.
* Increase in local locked bed facilities (other than inpatient facilities).
* Increase in adult, older adult and child psychiatrists.
* Increase in job opportunities (outside the system) for clients to be able to support themselves with meaningful work.

Q#8, Priority Resource Needs:

* Increase in funding to support additional clinical/peer staff to lower caseloads.
* Increase local inpatient beds/facilities capacity.
* Increase in supervised housing facilities.

**Mendocino County:**

Q#7, Unmet Needs:

* Housing
* Emotional support from family and peer
* Employment
* Licensed mental health workers, LCSW
* Crisis residential program
* Bilingual/bicultural mental health workers and agencies
* Co-occurring disorder and substance use disorder treatment.

Q#8, Priority Resource Needs:

* Immediate implementation of Laura's Law
* Bilingual/Bicultural Mental health services
* Housing and employment
* Intensive outreach
* Dual diagnosis treatment track
* Peer support
* Mental health services in the jail
* Mobile crisis units in numerous areas of the county
* In county mental health crisis residential treatment facility
* Mental health and gang violence

**Modoc County:**

Q#7, Unmet Needs:

* We do not have access to a crisis stabilization unit, which necessitates transportation and admission to hospitals out of county - usually a 5-6 hour trip one way.
* Hospital beds are very difficult to find and admission waits are very long especially for those with medical needs or those who are young, old, or have behaviors that are difficult to manage.

Q#8, Priority Resource Needs:

* We desperately need access to crisis stabilization units, especially to ones located closer geographically.
* We need access to more beds in hospitals. We are holding individuals in crisis for very long times waiting to get access to a bed for treatment out of county.
* We need on-going funding to support a crisis stabilization team and/or a 24 hour crisis stabilization unit. Our economy of scale does not allow for sustainability of a unit based on numbers served without additional funding.

**Mono County:**

Q#7, Unmet Needs:

Due to our small size, and that all 5150 evaluations occur in our one hospital’s Emergency Department, we have had to provide the best “case management” crisis response that we can. Depending upon the ED physician on duty, we can sometime administer medications to patients who are willing. This is primarily for adults. With children and TAY’s we do our best to rally their natural supports and then we provide support to those systems.

While it would be in the best interests of our consumers who do need hospitalization to be able to travel to Nevada (3 hours from our ED), we have not been able to provide this service due to the battle regarding crossing a state line. When we can find a psychiatric hospital bed for a patient, it is located between 6-8 hours away. This is true for all of the above mentioned community members.

Q#8, Priority Resource Needs:

* Training for our ED physicians to administer psychiatric medications and create an in-house protocol.
* Having, within an hour’s distance, a 24 hour residential placement for further stabilization.
* Medication services for those with grave disability.

**Napa County:**

Q#7, Unmet Needs:

Shortage of adequate inpatient hospital beds when inpatient placement is necessary.

Q#8, Priority Resource Needs:

This question is much too focused on “serious, urgent MH Needs”, as there are many other needs that contribute to the problem of those with serious, urgent needs. Examples include:

* Needed community housing and other residential options
* Pro-active case worker interventions
* Job training and employment are also related to someone being able to maintain in the community
* There are situation where the Napa State Hospital and other hospital options are not available, but the critical needs are related to avoiding the situations that require such options

**Nevada County:**

Q#7, Unmet Needs:

* There are no inpatient psychiatric facilities or Institute for Mental Disease (IMD) in Nevada County
* No mobile crisis team
* No crisis stabilization unit for children
* No transitional housing for individuals being released from jail

Q#8, Priority Resource Needs:

* Mobile Crisis Team
* Inpatient Psychiatric Facility
* Crisis Stabilization Unit for Children

**Plumas County:**

Q#7, Unmet Needs:

Not answered in their report.

Q#8, Priority Resource Needs:

Not answered in their report.

**San Benito County:**

Q#7, Unmet Needs:

• Transportation in hospitalization

• Respite care as an alternative to hospitalization.

Q#8, Priority Resource Needs:

* Transportation in hospitalization
* Respite care – local respite facilities as an alternative to hospitalization.
* A mobile crisis team that would respond to crises in the community.

**Shasta County:**

Q#7, Unmet Needs:

* Local crisis residential for youth
* Emergency mental health services after-hours
* Crisis responders accompanying law enforcement
* More local residential facilities
* Services for co-occurring disorders
* Local diversion program/facility offering MH and SUD services as opposed to bringing to jail or emergency room.

Q#8, Priority Resource Needs:

* More services for youth
* Crisis residential for youth
* Crisis services

**Siskiyou County:**

Q#7, Unmet Needs: 

Q#8, Priority Resource Needs:



**Sutter/Yuba Counties:**

Q#7, Unmet Needs:

* There are a significant number of children needing services and a limited amount of options available to them. All children are transferred out of county for inpatient treatment due to the lack of services available locally.
* There is a significant need for transitional living and programs that provide a range of services in a Board and Care type of environment where the focus is on self-care and independence.
* Currently there are a limited Transition Aged Youth programs with only 5 programs for under 18 in the North State.

Q#8, Priority Resource Needs:

* Medical Psychiatric Inpatient Facilities
* Transitional Living Program with an IMD, interactive, intensive structure and guided support.
* Shelters for Men and Woman that welcome the mentally ill and have supportive programs to aid in their care.
* Dual Diagnosis Residential Programs

**Trinity County:**

Q#7, Unmet Needs:

We need a peer respite facility.

Q#8, Priority Resource Needs:

* Peer Respite
* Health care evaluation on weekends
* Psychiatrist for urgent care/crisis

## Medium-sized Counties: 200,000 – 749,999

**Butte County:**

Q#7, Unmet Needs:

One important unmet need is for crisis help for people experiencing emotional instability that does not result in suicidal or homicidal tendencies but are still fraught with anxiety, depression, mania and/or obsessive thoughts. In our county, only physical safety is addressed.

Q#8, Priority Resource Needs:

Since the homeless population often has the highest incidence of MH issues, I would like to see a stronger presence of MH workers and unless already provided, free group therapy where they can have a place to share their struggles because they are dealing with profound struggles. I would also like to see jail diversion programs for non-violent offenders; something that would help them to get on their feet when possible. Thirdly, I think it would be good for the county and the families of those with MI (mental illness) if there was a way for the person to stay within the county and not be transported out of county for the various services we cannot offer at this time.

* Crisis assistance for those dealing with a MH need not directly resulting in suicidal or homicidal intent. For example, immediate access to a trained and licensed provider that will use compassionate listening techniques and stays with a person for 2-4 hours and is then also accessible for immediate follow-up.
* Transitional assistance to ANYONE leaving a Crisis Team (PHF, CSU, Triage Team encounter) to create realistic, full-service support to allow an individual a shot at integrating back into their regular life after a critical event.
* Resources and programs to provide ways for people to avoid further crisis situations. A focus on the needs of people struggling with MH issues on a daily basis, leading towards recovery and away from continued crisis services. Need to refocus on people not the dollars gained by providing Crisis Services.

**Marin County:**

Q#7, Unmet Needs:

This MHP faces barriers to supporting individuals with serious mental illness in the community imposed by the realities of the local housing market. Occupancy rates are high, there is a limited stock of available units, and the cost of housing is significant. Section 8 vouchers are difficult to obtain, and those who have gotten them are often unable to find landlords who will accept them. There are multiple strategies that could be employed to assist individuals successfully stay in the community or return to the community. Of particular interest to the MHP is filling the unmet need of providing supportive transitional housing services.

Additional unmet needs include:

* locating placement settings that are equipped to care for individuals with both complex physical healthcare needs as well as psychiatric needs.
* developing additional supportive single room occupancy (SRO) placements.

Q#8, Priority Resource Needs:

* 12 bed Supportive Transitional Housing for Adults
* Single Room Occupancies (SRO) with supportive services
* Psychiatric Skilled Nursing Facility

**Merced County:**

Q#7, Unmet Needs:

* We have limited access to psychiatric facilities that serve our consumers who have private insurance and /or significant physical health issues within less than a 120 mile radius.
* We have only one contracted Board and Care provider in Merced County. It will not welcome those who have failed placement. As a result, we have to place consumers in Board and Care facilities out of county.
* The adult consumers living out of county are not able to access the Wellness Center in Los Banos or Merced.

Q#8, Priority Resource Needs:

* A psychiatric facility closer to Merced County that can accept both adults and youth with private insurance and can meet a consumer’s significant health issues.
* More psychiatrists for both youth and adults to provide treatment to the mentally ill population
* More Board and Care options in Merced County for placement

**Monterey County:**

Q#7, Unmet Needs:

* Monterey County currently must send all children needing hospitalization out of county. This burdens the families of children who must often travel hours to see the client in the hospital.
* For transition age youth and older adults, we have an overall bed shortage where we are now sending many clients to other out of county hospitals as our local inpatient unit is full.
* The lack of beds in the county has created difficulty especially for older adults with co-occurring dementia or significant physical health needs, such clients are very difficult to find services for.
* A 23 hour crisis stabilization facility for youth could be helpful to reduce hospitalizations.
* Additionally, there is some demand for a youth crisis residential facility as part of hospital diversion or as a step down program from the hospital.

Q#8, Priority Resource Needs:

* Hospital beds for Children/Teens in Monterey County
* Additional step-down crisis beds to prevent hospitalization and help people move out of the hospital to a lower level of care as soon as possible. This program would need to serve the uninsured and undocumented.
* Additional urgent and long term placements for complex clients such as clients with dementia, complex physical needs or complex criminal histories. This program would need to serve the uninsured and undocumented.

**Placer/Sierra Counties:**

Q#7, Unmet Needs:

Even though MHSA has provided a method to address many of the counties unmet needs, the County continues to identify some. The current unmet needs for Placer County are listed below:

* We have a significant unmet need for community-based crisis treatment for older adults who are isolated, depressed, and at-risk of suicide.
* We have a significant unmet need for integration of response to 5150 assessment between our Mobile Crisis Response Team and PD.
* We have a significant unmet need for comprehensive treatment of psychotic disorders in all age categories in our community. We lack a community-based education and outreach program for psychosis treatment - preventing rapid deterioration and revolving-door hospitalization. An example of the ideal program model is the SacEDAPT program at UC Davis which is a collaborative effort between UC Davis Department of Psychiatry and Sacramento County Mental Health.
* Transition aged youth ought to have a less dramatic environment to go to with a serious hospitalization than the PHF.
* As to what contributes to revolving door to hospitalizations, whether voluntary or not: There is not a comprehensive, intensive treatment program for young adults with early onset thinking disorders (as an example, the EDAPT program from UC Davis). Our county FSP teams have limited skills/training in working with TAY and addressing their unique needs.
* Workforce development: Very limited number of staff members who have adequate education/experience to deal with severely, persistently MI clients. It would be very beneficial to develop this workforce.

Q#8, Priority Resource Needs:

* We have a significant unmet need of qualified licensed mental health professionals addressing serious symptoms of Educationally Related Mental Health in our schools.
* We have a significant unmet need for 5150 training for less-than-qualified School

Psychologists providing mental health and crisis services in schools (NOTE: with the understanding 5150 Certification is restricted by legal code and different from 5150 training).

* We have a significant unmet need for Prevention and Early Intervention (PEI) for

 older adults who are at risk of isolation, depression, and ultimately crisis

 intervention (and rapidly becoming the highest risk population for suicide).

* Hiring of better credentialed providers (advanced degrees and clinical

experience) to treat varied needs of persons with most severe and persistent MI’s such as schizophrenia, and the resources to support this.

* Better transition/step down housing for persons being released from longer term

hospitalizations/jail/prison. This housing would not be the ‘least restrictive’ but would be a step down facility to help person transition to a more appropriate level of care, if indeed warranted. Should be linked to a permanent, clinically supported housing site for persons with highest long term needs (i.e. unlikely to progress within a reasonable time).

* Psychiatrists willing to be more aggressive in mandating treatment for those with

 histories of multiple hospitalizations.

**San Luis Obispo County:**

Q#7, Unmet Needs:

We are continuing to explore the feasibility of a Crisis Stabilization Unit.

Q#8, Priority Resource Needs:

* Crisis Stabilization Unit
* Jail based 1370 restoration
* Local free standing psychiatric hospital to treat youth and older adults

**San Joaquin County:**

Q#7, Unmet Needs:

* There are no 5150 placements, including Psychiatric Health Facilities or IMDs, which accept juveniles in San Joaquin County
* There is a shortage of PHF beds in San Joaquin County for adults (there is a means for developing further beds currently in process)
* There is a shortage of board & care beds in the county. Board and care facilities provide stable housing, which can help prevent mental health crises and hospitalization
* There are Medicare clients who are not accepted into St. Joseph’s Psychiatric Hospital because their beds are occupied by clients from out-of-county

Q#8, Priority Resource Needs:

* Additional intensive, assertive outreach programs such as San Joaquin’s InSPIRE (Innovative Support Program In Recovery Engagement) Program.
* Another 16-bed PHF and/or other longer-term facility for adults (in early process)
* Children’s psychiatric hospital, PHF or other long-term facility
* Children’s post-hospitalization transitional facility/crisis residential facility
* Restoration of competency for children/youth

**Santa Barbara County:**

Q#7, Unmet Needs:

* There is a shortage of inpatient psychiatric beds in the county for adults. Santa Barbara County has no psychiatric inpatient beds for children under the age of 18 located in the county
* While older adults may be hospitalized in the local Psychiatric Health Facility, there are no geriatric specialty services in the county
* Santa Barbara County lacks adequate housing options for clients with mental health needs, from room & board to supported housing and hospital step-down
* There is an increasing need and demand for TAY services countywide
* Outpatient clinic-based services (adult and child) are located in areas of the county that may not be easily accessible by clients. There is a need to better match service location sites with client geographic distribution in the county.
* Santa Barbara County has a large homeless population, but the level of available services is not sufficient
* Forensic services should to be expanded to address the restoration needs of the increasing population of residents deemed incompetent to stand trial (IST) and clients released from jail that have mental health issues.

Q#8, Priority Resource Needs:

* Housing for persons with mental illness
* Increased psychiatrist capacity
* Additional acute psychiatric beds in the county

**Santa Cruz County:**

Q#7, Unmet Needs:

The County recently completed phase I of a Strategic Planning Process for mental health services to identify needs and gaps in the community and make recommendations on strategies to address these needs and gaps areas. Specific recommendations to this question are:

* Crisis respite programs for children and adolescents
* Expanded substance use disorder treatment
* Expanded housing options for individuals who are homeless or at risk for homelessness in the community who also have a mental illness or co-occurring mental illness and substance use disorder.
* Expanded peer services and peer crisis respite services.

Q#8, Priority Resource Needs:

* Housing for persons with mental illness
* Increased psychiatrist capacity
* Additional acute psychiatric beds in the county

**Solano County:**

Q#7, Unmet Needs:

* The County’s resources for outpatient case management are inadequate to meet the need for community based treatment.
* Supportive housing capacity is inadequate to meet the needs of County consumers for housing with services that help avoid hospitalization.
* The County’s Crisis Stabilization Unit and Crisis Residential Facility are both located in Fairfield. Individuals needing crisis services in other communities in the County have to be transported to the CSU. Law enforcement is not always available or willing to transport individuals to the CSU
* PHF beds in the County are unavailable at times requiring transport to another County.

Q#8, Priority Resource Needs:

* Adequate and consistent availability of psychiatry staff.
* Additional case management resources to provide additional case management and wrap around services.
* Additional housing to meet needs of consumers. SRO and augmented licensed board and care facilities would fill gaps in current housing supply.

**Sonoma County:**

Q#7, Unmet Needs:

Sonoma County children and youth are in need of a Crisis Stabilization Unit that will meet their unique needs.

Q#8, Priority Resource Needs:

Sonoma County residents would benefit from a consumer - run respite program.

**Stanislaus County:**

Q#7, Unmet Needs:

* Safe and affordable housing for both adults and transition age youth, shelters for families
* More supportive employment opportunities
* Transportation
* No acute psychiatric inpatient geriatric units
* No local acute hospitalization options for minors, more outreach and engagement, and
* More integration between behavioral health (Mental Health and SUD) and physical healthcare

Q#8, Priority Resource Needs:

* Full Service Partnership program for children and youth
* Crisis Stabilization Unit
* More affordable and safe housing options

**Tulare County:**

Q#7, Unmet Needs:

One of the most pressing unmet needs within Tulare County is the limited housing options. Per the NAMI website (https://www2.nami.org/), lack of safe and affordable housing is one of the most significant barriers to recovery for people living with mental illness; a safe place to live is essential to recovery. Without options to meet this basic need, too many cycle in and out of homelessness, jails, shelters and emergency departments—or remain institutionalized.

Q#8, Priority Resource Needs:

* Mental Health Services for the incarcerated
* Increased psychiatric inpatient facilities for children and youth in the central valley
* Better funding distribution for SB 82

**Yolo County:**

Q#7, Unmet Needs:

Yolo County’s LMHB has determined the following unmet needs in the community:

* 23-hour crisis stabilization unit
* Supportive Housing options for SMI adults and transition aged youth

Q#8, Priority Resource Needs:

Yolo County’s LMHB has determined the following as top three priorities:

* 23-hour crisis stabilization unit or detox center
* Supportive Housing options for SMI adults and transition aged youth
* Transportation services

## Large Population Counties: > 750,000

# Alameda County

Q#7, Unmet Needs:

Unmet needs for adults: More on-demand services both maintenance and crisis. More community based services for case management. More supportive housing. More integrative health care (behavior health and primary care provided at one location.)

 Hospitalization

o Under the age of 12 can be problematic at times to find a bed but overall it is not

o Adolescents are covered by Willow Rock and it meets our need

Community Based Crisis Treatment Services

o CSOC is underserved in this area.

o Alameda County Behavioral Health Care Services (BHCS) is conducting a planning process where department staff and stakeholders – including consumers, family members, BHCS staff, contract providers, and emergency and medical personnel – come together to discover ways in which the existing mental health crisis system could be strengthened. The purpose of this planning process was to design a crisis system that:

- Provides crisis services across the lifespan, in the communities where people live, at the time in which they are most needed, in a way that ensures personal and public safety.

- Ensures that people have access to the appropriate level of care, reserving locked and emergency settings for those who need it most, while providing alternatives to hospitalization that promote recovery.

- Maximizes the opportunity to engage people in services following a crisis, ensures smooth transitions for people to move between levels of care, and reduces the likelihood of future crisis events.

Older adults in this County tend to over utilize the hospital emergency rooms to address both behavioral health and health care needs. Much of the over utilization appears to be connected to the limited outpatient support services.

Older Adult Placement Options remain a challenge, especially shortage of skilled nursing facilities that will accept individuals with behavioral health needs.

In general, service gaps for seniors include: peer support services, intensive case management support services, affordable transportation services, affordable housing, integrated support services (Primary Care & Behavioral Health), and older adult substance use disorder programs.

BHCS is conducting a planning process to address Alameda County BHCS crisis needs. Survey respondents identified that there are not enough crisis-specific services for older adults in Alameda County. The survey highlighted the following gaps:

 Mobile Response

 Peer Respite

 Crisis Stabilization

 Affordable Transportation

 Crisis Residential 12

 Affordable Housing

 Case Management Services

 Ongoing Outpatient Services

Q#8, Priority Resource Needs:

* Crisis Stabilization Units in key geographic locations
* Crisis residential facilities
* Licensed Board and Care homes

# Contra Costa County

Q#8 and #7, combined answers by MHB members:

These two questions were answered by members of the Mental Health Commission representing varying viewpoints.

Member #1:

1) I know from anecdotal accounts about the bed shortage at Psychiatric Emergency and that people of all ages are turned away or have to wait days before a bed becomes available for treatment.

2) I understand that there are board and care and/or treatment facility issues in our county. It is particularly difficult for families of dependent children or even adult dependent children, when the care facility is out of the local area, and sometimes out of state.

3) I’m not sure how to frame this issue but I know it’s a problem: Family members struggle to find the resources that exist to help them with a child experiencing their first psychic experience.  It can be months before a parent figures out the system, accepts the seriousness of the problem, and finally gets to the place that can help them.  I love our New Hope program and feel that this process may ultimately address most of this “gap” in service. But, I believe that New Hope focuses on pre schizophrenic behavior and because many of the young people that I get involved with are initially diagnosed or suspected to be bipolar, or depression with PTSD, or something that does not fit into the New Hope range, these young people are left out. The problem may be complicated by many other factors: Parent is in denial and is looking for a quick fix, people have private insurance that cover their young adults and/or children and work with their pediatrician/md and therapist, and there is so much stigma and scariness associated with severe mental illness that families are afraid/reluctant to ask.

What we need:

Expand New Hope to include treatment and support for all families with an age appropriate dependent child that presents mental health symptoms. I love the question process that takes place with the parent/guardian and child that works as a triage to determine if they qualify.  The same triage process could work for all levels of MI, specific directed early treatment providing a supported/educational process to guide the family through recovery, regardless of the diagnosis.

Member #2:

1) Unmet needs.  Please describe any specific unmet needs for children, transition-aged youth, adults or older adults in your county for either MH-related hospitalization or community-based crisis treatment services.

A. The obvious unmet needs for children and transition-aged youth adults are inpatient residential beds.

B. We need a program of outreach toward older adults to identify those are who are in need of behavioral health services, especially older adults who are in residential care facilities.

2)  If you could ask for any specific resource, program, or facility to meet serious, urgent MH needs in your community, what would be your top three priorities?

A. Do away with the eligibility process before seeing those in need. Everyone's behavioral health needs should be seen first.

B. All health needs, which includes behavioral health needs, should be met without questions, first.

C. Have program that follows after Emergency and Psych Emergency Care.

### Member #3:

West County Needs for Mental Health Patients:

A) Unmet needs.  Please describe any specific unmet needs for children, transition-aged youth, adults or older adults in your county for either MH-related hospitalization or community-based crisis treatment services.

Children: 14 and under

1. In the whole county there are no Psychiatric hospital beds for children who are in a psychotic and suicidal crisis. When these children are placed on medications at PES, they need to be hospitalized (a minimum of two weeks) to be monitored how affective the medications are and if there are any side effects. It is dangerous and a medical neglect to release a child to their parents care who are introduced to new a psychiatric medications given to them at PES.
2. Many severe psychiatric children who have histories of violence are refused acceptance of hospitalization in hospitals out of county. As a result, many have their hospitalization in Psych Emergency Services (PES) department in Martinez. Some of these children are placed far away from family. Some of the teenagers are sent to Juvenile Hall for their hospitalization.
3. In Contra Costa County, we need a partial hospitalization program for teenagers (13-18 years of age). There are counties that have such programs because we don’t have such a program; the programs in other counties have to take our patients, which are overcrowding these programs. Our patients in our county are placed on waiting list in these other counties.

Children, TAY and Adults who are newly diagnosed.

1. The closure of Doctors Hospital in San Pablo gives West County Behavior Health Patients no place to go when in a mental health crisis. Walk in Emergency Room. The Hospital is located in Central County, which isn’t accessible easily by public transportation. The next available hospital is located in Alameda County, Berkeley, which has limited bed space for West County Patients. If patents go to Berkeley, many end up going to John George in Fremont, which is 45 minutes away minimally could be hours in traffic from West County. Many patients go there with no visits from family or friends due to the distance. After discharge, they are forced to take public transportation if family or friends can’t come and pick them up.
2. The closure of the hospital doesn’t help patients who have anxiety attacks who need immediate medical attention to relieve its symptoms. The ambulance drive distance is very costly on the health care system and the patient.
3. Adults/Children need to be diagnosed properly and this can’t be done by a 4-hour visit at PES and a once a month visit with a psychiatrist. For both Children and Adults in our county patients can’t see a psychiatrist or therapist once a week so as a result these patients aren’t diagnosed properly. There is a need for more psychiatrist and psychologist who can treat

psychiatric patients so they can be seen once a week, especially for patients who are recovering from a major psychiatric crisis.

4. As with the children, we don’t have enough Partial Hospitalization programs for Adults who recovering from a crisis and a hospitalization and still need to be cared for. It is such day programs that help stabilize the patient and adjust medications dosages as needed. This also helps the patient deal with a new psychiatric diagnosis and gradually help them return to normal daily living.

5. In West County, it is hard to find a psychiatrist in this area. Most of the psychiatrists work in Central County and Berkeley. Patients are forced to take several different means of public transportation to see a therapist/psychiatrist for an appointment. When in a crisis, it’s hard for patients to seek help for themselves that results in more visits to PES in Martinez or arrest and placed in criminal custody.

6. The majority of the population in both Juvenile Hall and Contra Costa Jail come from West County this includes the Behavior Health Patients. Many of the prisoners who are mentally ill refuse to accept treatment for their mental illness while incarcerated. The criminal Justice system here in California has become the place to send our mentally ill patients for treatment. Law enforcement officers have the belief that while these patients are sent to jail or prison they will get the proper mental health services they need which isn’t the case. The mentally ill that are incarcerated will be lucky if they see a therapist or psychiatrist once a month. Prison and Jails are for criminals and not the mentally ill patient. Many are placed there for repeated minor offenses that are exaggerated as felonies because law enforcement officers want them off the streets because they are a bother to society.

7. Most of our homeless population in West County suffers from mental health diagnosis. Many of them are sent to Jail and then released. The jail system is a revolving door to them. After discharge from jail they are the same mentally with no tools like DPT, CBT treatment, housing and other means to stabilize their mental health needs and homeless situation. Many of our mentally ill homeless patients are victims of violence due to living on the streets. A lot of the women are raped and beaten and taken advantage of due to living on the streets.

B.)  If you could ask for any specific resource, program, or facility to meet serious, urgent MH needs in your community, what would be your top three priorities?

1. A Hospital in our county that takes in Children in Mental Health crisis so our children don’t have to be sent out of county. A hospital policy that takes in all patients with no refusal of services to certain patients.
2. Partial Hospitalization Program for Teenagers. For teenagers who newly diagnosed with a mental illness, teens exiting hospitalization can have further treatment and care to stabilize them and to gradually bring them back to their normal daily living of school and home life. A program that takes in all patients with no policy of refusal of services to some patients
3. Partial Hospitalization Program for Adults as mentioned above. A program that takes in all patients with no policy of refusal of services to some patients.

#### Summary by Chair-- Mental Health Commission

The above responses give you a sense of what the Mental Health Commission as citizen advocates sees as the top unmet needs.

There are services for crisis through Psych Emergency (PES), and the Inpatient Ward at Contra Costa Regional Medical Center (CCRMC), but space is very limited and patients are discharged way too quickly. There are services in the community for those with a serious mental illness such as full service partnerships, but for many with a serious mental illness that need a stabilized inpatient stay beyond 14 days or highly structured partial hospitalization (patient goes home to sleep)-- there are not programs in county.

Housing for the seriously mentally ill is the number one service identified by consumers and family members as most needed. Board & Care facilities now used do not meet the needs of those who are homeless either in quantity or more importantly treatment needs.

Our jails both in Martinez and West County have no mental health programs besides medication and assessment. Inmates in M module in the Martinez Facility for the seriously mental ill are locked in solitary confinement for 23 hours a day. West County has AA & NA programs but no treatment programs for the seriously mentally ill though there may be designated hours for Mental Health Staff to see inmates in a small office with little or no confidential needs.

We have no children inpatient Psychiatric beds in our county, and there have been woefully long stays even months that children have resided in PES.

There needs to be a working relationship established between Behavioral Health Administration and the Regional Center to care for both adults and children who are dually diagnosed—so that the best programs and funding can be utilized for care.

# Fresno

Q#7, Unmet Needs:

* Lack of Youth and Adult Crisis Residential Treatment programs
* Lack of in -County IMD, SNF facilities
* Lack of group home RCL level 14 facilities within the County
* Lack of field crisis mobile teams
* Shortage of in County Psychiatric adult Hospital beds
* Lack of youth psychiatric hospital beds
* No State hospital beds in the County

Q#8, Priority Resource Needs:

* Crisis Residential Treatment beds – Adults
* IMD/SNF’s - Adults
* Crisis Residential Treatment beds – Children
* RCL Level 14 Group Homes for SED Children in Fresno

# Kern

Q#7, Unmet Needs:

* For children, Kern County Mental Health is working to increase dedicated evidence based programs and is also working with CiBHS to increase evidence based clinical services for children and their families.
* For older adults, the Department is contracting with a hospital to open a geriatric psychiatric unit to meet the unmet needs of elder psychiatric hospitalization.
* For adults and transition-age youth, the Department is developing a new housing plan to address housing needs, and has added a housing coordinator to be dedicated to that endeavor.
* Across all age groups, the Department does not have services dedicated for people under the influence, and is in the exploration stage of reviewing sobering crisis stations in other counties to develop an implementation plan for Kern County.

Q#8, Priority Resource Needs:

* Crisis/emergency service expansion in the remote regions of the county
* A voluntary recovery center for intoxicated persons experiencing a mental health crisis
* We are presently developing AOT and MH Court programs

**Los Angeles County:**

Q#7, Unmet Needs:

**Child:**

* Increased funding for Unaccompanied Minors, who are more likely to be indigent
* Increased focus on CSEC
* Appropriate placement and mental health services for the LGBTQ population, specifically for clients whose identification is transgender.
* The one area that seems to be an ongoing issue for this population is the lack of post-hospital discharge placement (w/ safe containment) for children & youth who constantly AWOL, are suicidal and/or homicidal, and/or have developmental disabilities that prevent them from keeping themselves safe.
* There are very few resources for youth with co-occurring disorders (substance use or have cognitive deficits and mental health) who are Medi-cal beneficiaries.

**Transition Age Youth:**

* IMDs for TAY (TAY MH issues, social and familial needs are very different than the majority of adult clients that are housed in IMDS),
* Urgent care centers for TAY
* Directly operated clinics/ wellness clinics that are TAY specific or address TAY issues
* MH providers serving Probation TAY (many providers criminalize these youth rather than assessing and treating trauma specific behaviors),
* TAY board and care homes,
* Increased transitional housing for TAY
* Co-occurring substance abuse services (inpatient as well as intensive outpatient services) remain a significant unmet need.

**Adults:**

The expansion of needed services -- as advanced through the Affordable Care Act (ACA) and increased community pressure to address large numbers of homeless and justice-involved adults and their families -- has resulted in ever growing numbers of new clients seeking services across the adult programs offered in the Department.  Creating system capacity and assuring consumers can safely transition from mental health related hospitalizations or jail settings to the community  or be seen in lower levels of care – for example within urgent care centers or crisis residential services -- are key areas of work underway for the Adult System of Care.  Increased referrals from law enforcement and new community engagement efforts like SB-82 have resulted in a growing recognition of the need to increase staffing at our adult, community based programs.  New populations seeking treatment require staff trained in the best, evidence-based practices to assure quality services which are outcome-drive and cost-efficient.  Preparing staff to handle challenging new populations of consumers successfully is essential as we collaborate across County Departments to assure a seamless system of care; one that can address substance use, physical health and emotional well-being on both an individual and community level.

Older Adults:

The population of older adults is expected to at least double within the next few decades with the aging of the “baby boomers” and healthcare advances in terms of treating chronic health conditions.   Given this, program capacity issues for both in-patient and out-patient mental health care, will need to be increased and  strengthened in order to meet current and projected community need.  An expansion of the full range and continuum of mental health services is needed for older adults.  This would include increased services and supports in Older Adult Wellness Centers, Older Adult Field Capable Clinical Services, Older Adult Full Service Partnership, IMD step down, IMD and in-patient/gero-psychiatric facilities.  Furthermore, workforce development and training around mental health, aging, substance use, cognitive decline and medical co-morbidities needs to continue in order to properly equip clinicians to provide high quality care to older adults. Collaboration and partnerships with primary and specialty health care should continue to be fostered to access older adults who might be reluctant to access traditional mental health services due to the stigma attached to accessing mental health services.   In addition, affordable housing options should continue to be expanded to provide clean, safe and supportive environments for older adults to reside.

Q#8, Priority Resource Needs:

* Funding additional Mental Health Urgent Care Centers
* Juvenile Justice Diversion (for both males and females, and particularly for Latino and African American children and youth who are disproportionally represented within that system)
* Substance use and abuse prevention, outpatient and inpatient treatment
* Trauma focused treatment (to counter exposure to and impact of community violence; domestic violence; sexual abuse, etc.), including treatment for the LGBTQ population and youth who have or are in the process of transitioning

**Orange County**:

Q#7, Unmet Needs:

With nearly 3.1 million people living in a 789-squre-mile area, Orange County is California’s third most populous county and ranks second only to San Francisco in population density. In 2011 alone, 65,749 persons visited Orange County’s Emergency Department’s (EDs) because of mental/behavioral health concerns. This represents a 49% increase over similar visits just five years earlier. Therefore, additional crisis stabilization and crisis residential resources are needed to address the psychiatric emergencies throughout the County.

Q#8, Priority Resource Needs:

If the Orange County Mental Health Board (OCMHB) could ask for any specific resource, program or facility to meet urgent MH needs in our community, it would be:

* Psychiatric beds for children under 12 years of age
* Increased wraparound services for our homeless population with mental/behavioral health concerns
* Transportation services for our clients who are not mobile

**Riverside County:**

Q#7, Unmet Needs:

Concerning Mental Health related hospitalization issues:

* Inpatient beds are limited in our county and thus local access to inpatient services is difficult.  This results in:
	+ Frequent placement of our consumers in facilities that are at a significant distance from their residence.
	+ Discharge is problematic because transportation to their homes can be difficult for them or their family members to arrange.
	+ Additionally, when family relationships are a precipitating factor to hospitalization this is very difficult to address when consumers are placed so far away from their homes.
* Another barrier to hospital discharge is the limited post-hospitalization housing options. There is limited board and care placement capacity and limited other housing options.
* There is great need for children’s psychiatric beds. Riverside County has no beds for children under age 12 so they always have to go out-of-County. Children usually have to wait, sometimes for days, in psychologically unhealthy environments for out-of-County beds to open up.
* Regarding crisis services, there is a need for an integrated, comprehensive telephone crisis service, especially for after-hours availability. Crises could be prevented by training responders comprehensively on community resources. Consumers frequently report that finding out about services is cumbersome, complicated and requires trial-by-error approaches.

Specific to Older Adults:

* Housing is always an issue. There is a need for decent assisted living options that are affordable especially for people who are low income (not at poverty level / SSI) but also for people who bring in $1,200-$3,200 a month.
* Medication Assistance: There are a lot of older adults who bring in $2000 a month. This means that they have large co pays for medications and pay for a supplemental medical policy because they do not qualify for Medi-Cal.
* As mentioned above, transportation is an issue within Riverside County’s broad geography.
* There is a need for geriatric specialists.
* There is a need for additional community supports to prevent crises:
	+ There is a need for outreach program for shut-ins, recently widowed, etc that supports pleasurable activities.
	+ More mental health services at locations like senior centers and supported housing.
* There also are challenges with access to primary health care, dental care, vision, and nutrition.

Regarding Transition Age Youth (TAY):

* Current environments are unwelcoming to TAY and their families or other support persons. The demand for services coupled with limited resource results in overcrowded conditions.
* TAY are in need of specialized care that is developmentally informed rather than being treated as adults.
* TAY are often housed with adults suffering from significant mental health symptoms during the evaluation process.
* Parents and support persons are often left out, are confused about care, and have difficulty navigating care following hospitalization.
* There is a lack of resources for TAY who, while no longer in an acute crisis, require additional support before transitioning home or back to the community.Families or youth may not be prepared to return home or to the community following discharge from the hospital. Parents abandon youth due to lack of resources and appropriate levels of service if they pick them up.

Additional specifics regarding children:

In Riverside County specifically, roughly 2,760 children per year are evaluated at county Emergency Treatment Services (ETS) facility. These hospitalization numbers may be somewhat larger in Riverside County because RCDMH does not have access to information from the private hospitals in the region. The number of hospitalizations has not decreased at all in the past several years.

ETS does not have a separate facility for children. Children stay in a small room as they are monitored. Families express that the environment does not fully meet the needs of the children awaiting evaluation by psychiatrists or a bed in a longer term psychiatric facility. Given that the CA Hospital Association reported in 2012 that 2/3 of all people who go to emergency psychiatric rooms do not need to be hospitalized, there is much room for improvement here.

Currently, RCDMH employs a Youth Hospital Intervention Program (YHIP) to help divert children from hospital stays. This team which consists of a hired Parent Partner and a Clinical Therapist reaches out to children and their families who have been hospitalized and links them to mental health services in the communities. The YHIP team employs the philosophy of department in their efforts to help the families.

The philosophy of the department includes a long history of recovery oriented, family driven, strength based, needs driven, culturally relevant, outcome oriented, and community based mental health treatment. YHIP intersects with the full range of children’s treatment modalities in the department which includes everything from clinical assessments, outpatient services including Trauma Focused Cognitive Behavioral Therapy, to Wraparound Programs, Therapeutic Foster Care, Multi-Dimensional Family Therapy, and Parent Child Interaction Therapy.

Regional Administrators of the Department agreed that more fully developing our Youth Hospital Intervention Program (YHIP) to serve severely emotionally disturbed/severely mentally ill (SED/SMI) will best assist in the most important changes needed. The current YHIP team intersects with our adult crisis diversion teams (CREST, REACH), local emergency rooms, and child psychiatric hospitals to provide hospital diversion and post hospitalization linkage to children. In order to more effectively divert these children from an ETS stay, the program needs to be reorganized, decentralized with training made available to staff in evidence based treatment modalities. And, the number of overall staff available to attend to diversion needs must be increased.

 County partners agree that hospital diversion is of prime importance. Of all our county partners, child welfare, in particular has expressed a desire to more fully develop hospital diversion programs for children. They have a keen interest in decreasing the number of children detained into their system which might be due to children being abandoned at psychiatric hospitals by frustrated parents. Similarly, the Department of Probation seeks to have children appropriately treated for mental health disorders in order to help stabilize their probationers in the community.

 In addition to a hospital diversion program as described above, Riverside needs a separate, family friendly emergency treatment service. Children and families report a secondary trauma from sitting in waiting rooms as adults with persistent untreated symptoms of mental illness display frightening behaviors in emergency waiting rooms. This is a problem across the county. So, the need is for all three regions in order to decrease travel time to ETS.

Concerning Community Based Crisis services, the CREST and REACH teams are having a positive effect in engaging consumers in more appropriate levels of care and decreasing hospitalizations.  However, these teams are not fully operational in all regions and thus some areas are still experiencing an overuse of crisis and/or inpatient services. Additionally, even when CREST and REACH are fully staffed there will be consumers in more rural areas in the county that will not be included in their service areas.

Q#8, Priority Resource Needs:

* More IMD Beds
* Alternatives to State Hospital
* More designated psychiatric hospital beds located in Riverside County

**Sacramento County**:

Q#7, Unmet Needs:

* Crisis Services. The community planning processes undertaken by DBHS have highlighted crisis services as an unmet need. The unmet need for crisis services increases hospitalization rates and emergency room usage. These services are generally the most expensive available in Sacramento County and often inappropriate for persons experiencing a mental health crisis. DBHS planning efforts specifically show crisis respite as well as crisis residential facilities for youth under 18 years of age as a particularly acute need in our community.
* Exploited Children. DBHS community planning efforts also highlight the identification and treatment of commercially sexually exploited children as another unmet need in our community. DBHS participates in ongoing collaborative initiatives with child protective services, the courts, and the probation department to address this unmet need.

Q#8, Priority Resource Needs:

The Sacramento County Mental Health Board, in an August 5, 2015, public meeting, decided that its top three priorities are the following:

* Reopening the Crisis Stabilization Unit to direct access, as operated by Sacramento County prior to 2009. The Mental Health Board previously stated this priority in a March 13, 2015, letter to the Sacramento County Board of Supervisors.
* Additional crisis residential beds. The Mental Health Board previously stated this priority in a March 13, 2015, letter to the Sacramento County Board of Supervisors.
* Establishment of a mental health “urgent care” center. In stating this priority, the Mental Health Board echoes the sentiment of a March 24, 2015, letter by the Mental Health Improvement Coalition. This letter reports that the opening of a behavioral health urgent care center is an “area of agreement” in the ongoing effort to rebalance the Sacramento County behavioral health continuum.

**San Bernardino County:**

Q#7, Unmet Needs:

The County of San Bernardino Department of Behavioral Health has identified a variety of unmet needs and pursued several specific strategies to meet these needs. The STAY, a crisis residential treatment facility for transition-aged youth, was created to meet a treatment gap for this age group. Due in part to the success of this program, DBH has been awarded two grants under SB82, the Investment in Mental Wellness Act of 2013, to address unmet crisis needs. With these grants, DBH is developing two new crisis residential treatment facilities for adults. Some of the goals of these projects include reducing the impact of psychiatric conditions on hospital emergency departments as well as reducing unnecessarily lengthy psychiatric hospital stays. The crisis residential facilities will help provide a new level of care between inpatient hospitalization and outpatient care that did not previously exist, therefore providing an additional option for more appropriate care. Another grant application is being developed, proposing a crisis stabilization unit for both adults and adolescents, further helping to close the gap of crisis services.

DBH and the Sheriff’s Department have been collaborating since 2008, providing Crisis Intervention Training (CIT) to Sheriff’s Deputies to support their skill sets in effectively navigating psychiatric crises. DBH’s Community Crisis Response Team (CCRT) is often called upon by law enforcement to assist in such situations, as well. Further, under a different component of SB82, DBH was awarded an additional grant to develop a new mobile triage service, called TEST, which is described in prior sections of this report. Some of the personnel are co-located with law enforcement to provide immediate support for psychiatric crises, but also provide longer-term follow-up and care coordination to help community members effectively and appropriately engage in behavioral health care.

Another recognized unmet need is individuals who have not yet been activated into the best level/type of behavioral health services for them. DBH has recently begun a new program, RBEST, to test new ways of activating consumers and their families into treatment. This mobile team has already engaged 300 individuals, helping link them into appropriate levels of care, understanding the true nature of barriers to treatment, and reducing need for emergency services. One significant lesson from the project in the first year is the high rate of need for concurrent Substance Use Disorder services in this population. San Bernardino County operates and manages a continuum of SUD services; however, the SUD benefit has been significantly underfunded for decades, both by Medi-Cal and other funding sources. DBH is engaging in the Drug Medi-Cal Waiver which will allow the department to focus expanding the level of care for Substance Use Disorders. DBH is also engaged in the development of co-occurring disorders specific programming.

While DBH provides a wide array of needed and effective services, we recognize there are still significant unmet needs in our communities. One of the significant challenges for our County is related to its size and geographical diversity. Much of the County is a managed care geographically excluded area, which means insurance companies and managed care plans have different requirements for building networks of providers in some zip codes, versus others. The result is that County programs have built provider panels in these geographic areas for SMHS, which are also recognized as health professional shortage areas, creating an available network of behavioral health providers, with general health care provider networks being much more impacted, or in some cases not present at all.

Over the next several years, DBH will be working extensively with the managed care plans in our region, IEHP, IEHP-Kaiser and Molina on implementation of multiple strategies impacting health care coordination and access to care.

Members of the Behavioral Health Commission and DBH staff are involved with the County’s Community Vital Signs project, which is exploring ways of coordinating countywide strategy and approaches to improving overall health and wellness in the County. This project has taken a strengths-based approach, exploring what various sectors in our County have done well, but also acknowledging where there are areas of improvement. A consistent topic of focus is in the need to coordinate efforts and strategies, as a community, across sectors. Programs like those mentioned above, including CIT, CCRT, and TEST, are examples of such partnership in action. Continued work that improves close collaboration and partnership between County departments as well as other organizations across the County will further help close gaps in unmet needs.

Q#8, Priority Resource Needs:

While San Bernardino County has identified many top priorities, the following three are submitted for the purposes of this report.

* Support the elimination of the IMD and managed care geographic exclusions.
* Comprehensive, recovery-oriented approach to justice involved individuals suffering with behavioral health issues.
* Increased capacity for enhanced services such as:
	+ Crisis stabilization and crisis residential beds/facilities.
	+ Integrated Health strategies to address physical health, mental health, Substance Use Disorder, and complex care coordination without limits to number of day visits.
	+ Family education and support programs.

**San Diego County**:

Q#7, Unmet Needs:

* Need increased availability of Crisis Stabilization services
* Crisis Residential services specific to the TAY population
* Increase additional capacity at existing programs.
* Need resources to address opioid dependence in seniors and dual diagnosis treatment

Q#8, Priority Resource Needs:

* Additional supervised living options on a continuum of various levels of care
* Increase in intensive level of care programs such as Assertive Community Treatment
* Increase in availability of Crisis Stabilization services for Children & Youth

# San Francisco

Q#7, Unmet Needs:

* More opportunities and more effective outreach to teens and transition aged youth in ways that meet them where they are and provide safety and trust for them to share. We have many great programs where teens are referred or sent to but very few ways for them to reach out for help without adult intervention, so they primarily rely on their friends.
* Availability of culturally competent outreach within communities about mental health and substance abuse services by community residents
* Peers for seniors with mental health issues and outreach to seniors, especially shut-ins
* Mental Health information kiosks in libraries staffed by peers

Q#8, Priority Resource Needs:

* 24 hour mobile crisis and maintain continuum of care with community placement and stability
* 24 hour drop in respite center and peer staffed members in community clinic
* Increase in jail diversion services for people with mental illness

**San Mateo County:**

Q#7, Unmet Needs:

* Crisis residential for children and youth

Q#8, Priority Resource Needs:

* Crisis residential for children and youth
* Expand Psychiatric Emergency Response Team (PERT) both geographically and the hours of operation
* Supported Housing

**Santa Clara County:**

Q#7, Unmet Needs:

Santa Clara County operates a robust well-funded service delivery system. However, living in a county with a high cost of living impacts the ability of many residents to find cheap affordable housing. While the County has invested significant resources to improve housing condition for low income individuals, finding available housing is difficult due to the expensive real estate market. Many of our most vulnerable populations struggle with finding housing and maintaining permanent housing. In addition, transitional housing, crisis residential, respite care facilities, skilled nursing facilities and other residential/housing programs designed to support the needs of individuals with behavior health issues are in short supply. This creates delays in getting individuals released from hospitals, jails, and short term acute care facilities.

Q#8, Priority Resource Needs:

* Mobile crises services for adults
* Increased residential services for all populations
* Inpatient hospitalization services for youth and children.

**Ventura County:**

Q#7, Unmet Needs:

* Crisis Stabilization for Youth
* Crisis Residential for Youth
* Geriatric Psychiatric Unit
* MHRC for Adults (to be completed in 2017)

Q#8, Priority Resource Needs:

* More supported housing for SPMI adults
* Geriatric psychiatric facility
* Crisis Residential Facility for youth
* Year-round homeless shelter w/Wrap-Around Services
* Dual-Diagnosis (MH/SUD) Treatment Center/s
* Increased number of clinicians
* Expand Crisis Team to allow more prompt and “hands-on” response
* Add more Bilingual Crisis Services
* Provide an Assisted Outpatient Treatment Team (AOT)
* BH Clinician to go with Police on Mental Health Calls

**Data Appendix for Question #12.**

Question #12. Have any SUD treatment strategies been shown to be especially successful in your county?

**Yes: 47 None (or No response): 3**

**If yes, please describe.**

**Alameda:** Yes

* client-centered care through use of ASAM Criteria to match clients with appropriate treatment modalities and through use of treatment plan-based treatment
* psychiatric consultation to substance use treatment providers regarding their clients with co-occurring mental illnesses
* motivational interviewing.

**Alpine:** Yes.

Family night – an evening each week that families are invited to attend and share a meal. Often several members of the family are in recovery or currently in outpatient treatment with AC BHS. All individuals in county SUD services or community members who have been in county run or other SUD treatment in the past are invited, along with their families. There is a psycho-educational component which sparks discussion among attendees. Homework assignments augment the program. Most readings and homework come from the Red Road to Recovery curriculum.

**Amador:** Yes.

Matrix Program – Simultaneous attendance of 12 Step program.

**Butte:** Yes. Drug Court due to required compliance.

**Contra Costa:** Yes.

* Co-location of BH treatment
* SBIRT Implementation in Primary Health Care Clinics
* Buprenorphine Clinics for Pain Management patients and safely treating opioid users,
* Ongoing Case Management for the Top 5% of high utilizers among AB109 SUD population.

**Del Norte:** Yes.

* Several of our groups, held at the MHB’s Service Center, have been quite successful at assisting our clients with SUDs.
* The peer led dual diagnosis, relapse prevention, and men’s support groups have all been successful.
* Our recent addition of in-person psychiatry has given the Mental Health Branch added flexibility in providing more timely services to clients in need of immediate services.

**El Dorado:** Yes.

* Collaborative case management between Mental Health, Alcohol and Drugs Program, Probation and Courts through the County’s problem solving courts.
* Collaboration between Mental Health’s Intensive Case Management Team (ICM) and Alcohol and Drugs Program when clients need SUD treatment.

**Fresno:** Yes.

* This county requires contractors to use evidence-based programs/practices.
* Many providers use a client/child focused, strength-based wellness and recovery model.
* SUD treatment is particularly successful when paired with mental health services and a comprehensive, case-management approach.

**Glenn:** Yes.

* Drug Courts
* Perinatal Program

Humboldt: Yes.

* Healthy Moms: Integrated care
* Holistic trauma informed treatment

**Imperial:** Yes. Evidenced-based practices such as:

* Functional Family Therapy
* Motivational Interviewing
* Cognitive Behavioral Therapy

Kern: Yes.

* Matrix Model
* Seeking Safety
* Motivational Interviewing

**Kings:** Yes.

Drug Court prior to Proposition 47.

**Lake:** Yes.

Trauma Informed SUD Treatment

**Lassen**: Yes. Integration with MH and Primary Care

**Los Angeles:** Yes.

LA County has a coordinated entry system into the SUD network where clients are assessed and referred to a SUD treatment provider that best matches his/her needs (includes level of care, co-occurring disorders needs, linguistic and cultural needs, etc.).

**Madera:** No, none.

Marin: Yes.

Clients with justice involvement have experienced improved positive outcomes when receiving individualized treatment partnered with care management services.

Mendocino: Yes. Therapeutic courts programs.

**Merced:** Yes.

* Merced County has the same level of care system throughout the programs so that all clients are assessed and placed in the appropriate level of care regardless of their referral source.
* The Implementation of Evidenced Based Practices better serves our clients.
* The Adult Drug Courts have been implemented and are very successful.

**Modoc:** Yes. Drug Court before changes in sentencing due to Prop. 47.

Mono: Yes.

We have a higher success rate with those who are seeking services for sobriety. However, we are not nearly as successful at working with those who have identified health and/or legal issues who would engage better with our services if we did not require abstinence.

Monterey: Yes.

This county has a long history of strong collaboration with the court system and probation.

* Currently programs like Drug Court and the continuation of proposition 36 services have been successful diversion programs that have engaged clients in treatment.
* Additionally, Monterey County has a strong collaboration with probation offering rapid assessments and referrals to substance use treatment for clients coming out of Prison who are part of the AB109 population.

**Napa:** Yes.

* Collaboration between shelter and AOD tx, collaboration between mental health and physical healthcare, Drug Court is supportive and an important component
* Increasing focus on client centered approach (offering client services based on where they are in their path to recovery rather than forcing one size fits all treatment approach
* Ongoing case management throughout treatment
* Availability of Mental Health assessments and medication evaluations
* Ongoing access to treatment regardless of past failures

Nevada: Yes. Specialty Treatment Courts:

* Mental Health Court
* Prop 36 Drug Court
* Dependency Drug Court
* Youth Empowerment Services Court
* Assisted Outpatient Treatment Court
* Homeless Court.

**Orange:** Yes.

* Cognitive Behavioral Therapy (CBT)
* Drug Courts/DUI Courts
* Screening, Brief Intervention, and Referral to Treatment (SBIRT)
* Motivational Interviewing (MI)
* Implementation of a centralized gatekeeping system for residential treatment services.

Placer: Yes.

* Integrated treatment approaches such as between substance use and mental health, primary care, criminal justice system, child welfare services, etc.
* Working together with natural partners toward health.
* Case management and motivational enhancement are other successful strategies.

**Plumas**: Yes.

* Consistent drug testing.
* Knowledgeable addiction counselors.
* Solution-focused, client-centered therapy.
* Incentives for maintaining sobriety.
* Intensive Outpatient Treatment/IOT Check-ins.
* Engaging consumers at their stage of change (instead of where the courts say they should be).

Riverside: Yes.

* Individualized IOT (Intensive Outpatient Treatment) developed around specific population needs (MH Court, Drug Court, Veterans Court, MOMS Program)
* Intensive case management
* Motivational Enhancement and Interviewing Techniques/Strategies.

**Sacramento:** Yes.

* Motivational Interviewing
* Cognitive Behavioral Therapy
* Trauma Informed Treatment
* Seeking Safety
* Substance Misuse/Criminal Thinking programs

San Benito: Yes.

* Drug Court
* Sober Living Environment (SLE)

San Bernardino: Yes.

The Screening Assessment and Referral Center (SARC) model provides a comprehensive assessment of an individual’s bio-psycho-social background as it relates to their SUD. The assessment captures a myriad of information necessary to provide a primary diagnosis to establish criteria and medical necessity to support the need of SUD treatment. The SARC then uses the assessment information to determine proper level of treatment based on American Society of Addiction Medicine (ASAM) criteria where the individual is referred to the properly identified level of treatment which will best address that person’s needs. Additionally, interim case management services are provided for the individual until they are fully engaged in SUD treatment. All practices utilized in the SARC are evidence-based practices and supported by SAMHSA and DHCS.

Co-Occurring SUD services are provided to individuals and utilize evidenced-based practices that address the challenges directly impacting clients who live with SUD and non-severe mental illness. This is achieved through the use of practices including motivational enhancement therapy, cognitive behavioral therapy and twelve-step facilitation curriculum which is recognized as an evidence-based practice for individuals who are engaged in co-occurring disorder programs.

**San Diego:** Yes.

* Satellite programs at school sites
* Motivational Interviewing
* Cognitive Behavioral Therapy and Dialectical Behavior Therapy interventions.

**San Francisco:** Yes.

* Equitable availability of opioid agonist treatment modalities for opioid use disorder within the safety net, including treatment within primary care clinics, hospital, jail and mental health clinics.
* Central treatment access point (TAP) at 1380 Howard, San Francisco.
* Community access to syringes, wound care and rescue naloxone has prevented many infections and overdose deaths.

San Joaquin: Yes.

* Seeking Safety for Trauma
* Motivational Interviewing
* Vocational programming, such as working with CalWORKS
* Drug Court
* Co-occurring disorder training to all county Behavioral Health staff and contractors
* SBIRT
* Perinatal program
* Outpatient Counseling
* Residential Treatment Programs

**San Luis Obispo:** Yes. (No program list or description was provided).

San Mateo: Yes.

We have had great success with a new medication assisted treatment program using a prescription called Vivitrol to aid in treating alcohol dependence and prevent relapse.

**Santa Barbara:** Yes.

* Contingency management (incentives)
* Motivational Interviewing
* Psychiatric services where available

Santa Clara: Yes.

* Cognitive Behavioral Therapy
* Motivational Interviewing
* CRM

Santa Cruz: Yes.

* Case management,
* Medication assisted treatment program
* Jail diversion programs (Example: Serial Inebriate Program)
* PACT Program

Shasta: Yes.

* Visions of the Cross’s continuum of care
* Addicted Offender Program (AOP)
* The Day Reporting Center
* Sober family housing
* Right Road’s weekly visiting physician, monitoring Suboxone.

**Sierra**: Not described separately in the Placer-Sierra counties Data Notebook.

**Siskiyou:** Yes.

Intensive outpatient treatment with weekly contracts.

**Solano:** No response given in the report.

**Sonoma**: Yes.

This county has a well-developed network of substance use disorders treatment service providers that provide a variety of services throughout Sonoma County. These providers have strong working relationships which allow them to successfully collaborate whenever possible rather than compete.

**Stanislaus**: Yes.

* Sober Living Environments paired with Intensive Outpatient Treatment
* Residential and outpatient co-occurring treatment programs Moral Reconation Therapy
* Perinatal Intensive Outpatient Treatment
* Narcotic Treatment Programs.

**Sutter-Yuba**: Yes.

* Evidence based practices
* MRT matrix and Seeking Safety
* Cognitive behavioral therapies

**Trinity:** Yes

These evidence-based practices:

* Moral Reconation Therapy (MRT) with criminal justice population
* The Matrix model.

**Tulare**: Yes.

With a non-punitive approach, tailoring treatment programs to the consumer. Adopting a harm reduction approach with the goal of achieving sobriety as opposed the requiring immediate abstinence.

**Ventura**: Yes.

* Science-Informed Practices: Evidence Based
* NIATx-A model of Process Improvement specifically designed for Behavioral Health Care settings to improve access and retention in treatment.
* SAMHSA’s TIP 43-Medication Assisted Treatment (MAT) for Opioid Addiction in Opioid Treatment programs
* SEEKING SAFETY – a treatment manual for PTSD and Substance Abuse
* S.T.E.P. – Systematic Training for Effective Parenting
* THE BRAIN – Understanding Neurobiology through the Study of Addiction
* Trauma Recovery and Empowerment Model
* Relapse Prevention
* Living in Balance (Both English and Spanish)
* DBT Skills Workbook (Dialectical Behavioral Therapy)
* M.R.T – Moral Reconation Therapy
* Mind Over Mood
* Indicators: ASAM Placement Criteria and the ASI – Addiction Severity INDEX
* Gender Specific Programs: A New Start for Moms (funded by MHSA) Perinatal, Mental Health and Substance Abuse Treatment for Mothers carrying, taking care of, or attempting to obtain custody of their children. This program is for Co-Occurring (MH/SUD) challenges.

**Yolo:** Yes.

This county has been successful using the following SUD treatment interventions with our SMI/ SED consumer population:

* Seeking Safety
* Cognitive Behavioral Interventions (specifically for substance abuse)
* Moral Reconation Therapy (MRT)
* Thinking for a Change
* Change Companies (interactive journaling)

**Data Appendix for Question #14.**

# Q#14: Prevention Strategies-- from Data Notebook

**Does your county implement coordinated programs to address prevention of both SUD and mental illness in children, transition-aged youth and young adults?**

Yes\_\_\_\_ No\_\_\_\_\_\_

If yes, please provide a brief description of program, target audience, activities.

Part 1: Counties which Answered “No.”

**Alameda County: No. *(…But…)***

While there is definite benefit to have coordinated programs, currently BHCS does not jointly fund any MH/SUD prevention programs. The main reason for this is that the definition for “prevention” is different depending on which funding stream (MH/SUD) you look at. On the SUD side , prevention is defined more narrowly as only “primary” prevention meaning services can only be provided to those not in need of treatment. Whereas on the MH side, prevention is defined more broadly, e.g. preventing a mental illness from becoming severe or disabling as well as increasing access to underserved populations.

BHCS recognizes that SUD and MH issues may come hand in hand so we have taken the approach in SUD prevention of looking at the risk factors for substance use experimentation, which include many mental health issues such as depression, anxiety and bullying. Because of this approach, BHCS SUD prevention providers are able to weave in MH issues into their programming. Similarly on the MH side, education around SUD issues are also addressed since we know substance use can be a coping mechanism/self-medication tool. So even though BHCS does not fund blended prevention programs (at the moment) the communities we serve do receive both MH and SUD prevention

Kern County

Los Angeles County

Mendocino County

Mono County

Shasta County: No: X. “But we need to start doing this.”

Solano County

Part 2: Counties which Answered “Yes.”

**Alpine County**



**Amador County**

One Circle Foundation – Promotes resilience and healthy development in children, adolescents, adults and community. It is based on evidence based practices of motivational interviewing and strengths based approaches.

Project SUCCESS – Designed to reduce and prevent substance abuse among students 12 – 18 years. Prevention education series addressing tobacco, alcohol and other drugs, mental health and families/relationships.

**Butte County**

The County prevention programs blend youth development principles with youth-led environmental prevention strategies and school climate initiatives to reduce youth substance use and bullying/harassment. The Committed Program Model was initiated in response to the growing awareness of young people’s involvement in alcohol and drug use as well as awareness that it is critical to create environments for youth by youth that are alcohol and drug free. In addition to the national and statewide data, DBH-Prevention Unit’s local data collection findings provide evidence that young people are growing up in an environment saturated with messages about alcohol, are readily able to access alcohol, are experiencing loneliness, isolation and disengagement in schools and communities.

The Committed Program Model blends youth development principles with innovative youth-led environmental prevention strategies and school climate initiatives. The Committed Program Model is designed to build leadership skills, broaden young peoples’ (junior high and high school aged) social network, and implement youth-led projects to improve school climate and reduce youth access to alcohol. The Committed Program has been successfully replicated in over 22 schools/settings throughout California including traditional, alternative and group home settings.

‘Committed’ was initiated in response to the growing awareness of young people’s use of alcohol, tobacco and other drugs (ATOD), and to address youth’s reported feelings of loneliness, isolation, or disengagement at school. Committed Program Model Goals: The Committed Program Model includes 35 sessions that prepare youth for five major events or projects; with each session involving a youth led meeting agenda. The model is designed so that the Chapter experiences success and a sense of accomplishment, while remaining youth friendly and relevant to youth culture. The sessions and key events are structured to foster high expectations among youth and their adult partners (relationship enhancement) to address school climate; foster mental and emotional health and well-being; and, foster academic commitment and achievement.

**Contra Costa County:**

The First Hope Program, a MHSA funded Prevention & Early Intervention program of Contra Costa County Behavioral Health Services, provides early identification, assessment and intensive treatment services to young people, ages 12-25, and their families, who show signs and symptoms indicating they are at Clinical High Risk (CHR) for psychosis. As mentioned earlier in this Data Notebook, First Hope uses an evidence-based practice, the Portland Early Identification and Referral (PIER) Model, which has been effective in preventing conversion to psychosis and the subsequent disability associated with psychotic disorders. First Hope has a multi-disciplinary team that is composed of psychologists, mental health clinicians, psychiatrists, occupational therapists, and employment/education specialists.

The George and Cynthia Miller Wellness Center (Miller Wellness Center) is meant to serve several purposes in Contra Costa Behavioral Health Services’ system of care, including diverting children and adults from Psychiatric Emergency Services (PES). Through a close relationship with PES, the goal is also to allow children and adults who are evaluated at PES to quickly step-down to the Miller Wellness Center if they do not need hospital level of care. The Miller Wellness Center will offers urgent same-day appointments for individuals who are not open to the Contra Costa Mental Health System, or who have disconnected from care after previously being seen. Services will include brief family therapy, medication refills, substance abuse counseling, or general non-acute assistance. In addition, the Center is expected to have appointment slots for patients post psychiatric inpatient discharge. This will provide the opportunity to ensure a successful transition, make sure meds are obtained and appointments are scheduled in the home clinic. These appointment slots will be offered to patients being discharged from inpatient hospitals who have serious mental illness. Short term substance abuse counseling and referral for ongoing treatment for substance abuse will also be provided.

Drug and alcohol usage and the impact on the symptoms reported are given special attention during the assessments. Differential diagnosis and dual diagnosis are identified and addressed. Referrals are made to more intensive drug and alcohol programs if indicated. During the treatment phase psychoeducation with both clients and family members address the interplay of drug usage and symptoms that indicate clients are at Clinical High Risk (CHR) and increased risk for psychosis with continued usage. During the individual and family treatment, recovery approaches include risk reduction and abstinence models. Clients are also encouraged to attend AA, NA or other group resources.

The James Morehouse Project at El Cerrito High School, a MHSA funded Prevention & Early Intervention program of Contra Costa County Behavioral Health Services, is a student health center that partners with community based organizations, government agencies and local universities, provides a range of youth development groups designed to increase access to mental health services for at-risk high school students. These on-campus groups address coping with anger, violence and bereavement, factors leading to substance abuse, teen parenting and caretaking, peer conflict and immigration acculturation.

Also an MHSA funded program, La Clinica de la Raza reaches out to at-risk Latinos in Central and East County to provide behavioral health assessments and culturally appropriate early intervention services to address symptoms of mental illness brought about by trauma, domestic violence and substance abuse. Clinical staff also provide psycho- educational groups that address the stress factors that lead to serious mental illness.

Two MHSA PEI funded behaviorists (one with AOD specialty) have been hired at regional county health clinics to offer not only improved behavioral health services in each County clinic but also to help patients navigate appropriate external resources.

El Dorado County:

* Friday Night Live / Club Live
* Teen Court
* Drug Free Coalitions

**Fresno County:**

This effort is in development:

Fresno County’s new SUD Strategic Prevention Plan for Jan. 1, 2016 - June 30, 2020 includes requirement for SUD prevention providers to participate in MH First Aid training to develop skills in identifying MH issues in SUD prevention participants and increase knowledge regarding how to handle and where to refer those individuals to for appropriate services. Prevention services will be targeting the 10-25 year old age range.

Glenn County:

Glenn County provides a broad range of services in the schools. The MHSA Innovation program has funded the SMART program. This program identifies high risk youth who may pose a threat to the school or community. It also provides training services and support on bullying and provides information on how to make referrals to Behavioral Health Services. Our Transition Age Youth Peer Mentors provide information on suicide and substance use through tabling events at the schools. One of our substance abuse prevention counselors also teaches groups and provides training at the schools.

**Humboldt County**

Friday Night Live & Club Live: Middle and High School Students

* Bullying prevention and substance abuse prevention

Project Alert: Middle and High School Students

* Handling emotions
* Finding alternatives to drinking and drugs
* Promoting efficacy and self-esteem

North Coast Youth Summit: 7th - 12th grade students

* Bullying prevention and sources of strength
* Mental and emotional wellness, and suicide prevention
* Positive coping
* Creating a climate of change from Crisis to Opportunity

#### Imperial County

The Outreach and Engagement Program provides outreach services to unserved and underserved SED and SMI individuals in the neighborhoods where they reside, including those who are homeless, in order to reduce the stigma associated with receiving mental health treatment and increase access to mental health services. The program also provides education to the community regarding mental illness and symptoms, early identification of mental illness, and resources to improve access to care through outreach at local schools; homeless shelters; substance abuse treatment facilities and self-help groups; low-income housing; faith-based organizations; and community-based organizations. The program assists individuals in obtaining mental health treatment services from ICBHS by providing information pertaining to programs, services, and the intake assessment process; conducting home visits; scheduling intake assessment appointments; and providing transportation to intake assessment appointments when necessary.

Target Audience: unserved and underserved SED and SMI individuals

Activities: the Outreach and Engagement Program staff participate in local health fairs and presentations at local community agencies and schools to provide education and awareness  of mental illness and symptoms, early identification of mental illness, and resources/access to care to community partners and unserved/underserved SED and SMI individuals. Outreach workers also provide one-on-one education to unserved and underserved SED and SMI individuals to engage them into the mental health system, including assistance with scheduling a first intake appointment and transportation to the appointment, as needed.

1. **PIER Model**

*Description:*

Imperial County Behavioral Health Services (ICBHS) has begun the implementation of the Portland Identification and Early Referral (PIER) Model, an early detection and intervention approach. This evidence-based model focuses on the prodromal phase of a developing psychotic illness and advocates psychosocial interventions and drug treatments that are tailored to the individual. PIER’s emphasis is on family psycho-education and supported education and employment for the individual.

The objective of the PIER model is to transition an individual identified with early serious mental illness into an evidence-based treatment model as quickly as possible to improve outcomes in treatment and allow for transition back into the community. Specific goals of PIER include: interrupting the very early progression of psychotic disorders, improving outcomes and preventing the onset of the psychotic phase of Serious Mental Illness like Bipolar Disorder, Major Depression, and Schizophrenia.

*Target Audience:*

Individuals between the age of 12 to 25 identified with early signs of serious mental illness (prodromal stage of psychosis or first psychotic break).

*Activities:*

Staff focuses on outreach efforts to establish formal relationships with agencies that might identify and refer individuals experiencing the prodromal phase of psychosis or the first episode psychosis. These agencies include but are not limited to primary care, local high schools, the local Junior College, external university campuses, alternative education, emergency room departments, and law enforcement.  Clients are assessed to determine their needs which may include low dose medication, therapy, and mental health rehabilitation technician services. In an effort to treat the whole person, ICBHS will also be contracting with community agencies (Imperial Valley Regional Occupational Program and Department of Rehabilitation) to ensure the individuals receiving treatment are also provided with supported education and employment services. Individuals also have access to physical fitness services and equine therapy via existing contracts in place with the Full Service Partnership program.

To enhance collaboration with the community the PIER Model includes a Steering Committee that meets quarterly with the purpose of developing relationships with community stakeholders.

The purpose of these meetings is increase supportive community contacts. During these meeting members evaluate ICBHS efforts and activities designed to educate key audiences  and discuss the importance of early detection and intervention of psychosis for the purposes of developing a network of early identifiers while developing and maintaining relationships with community members.

**Too Good for Drugs**

*Description:* Too Good for Drugs emphasizes six research-based components which, used in combination, lead to healthy development and academic success:

* Bonding
* Norms
* Skills
* Caring and Support
* Meaningful Participation
* High Expectations

These six components emerged from three different bodies or research. Some researchers studied people at high risk. Other researchers studied children who became competent adults in spite of high risk. Still other researchers studied differences between effective and ineffective schools, and differences between effective and ineffective classrooms. In spite of their differing areas of focus, their findings are remarkably similar. Protective Factors – the first three components (bonding, norms and skills) come from the research of David Hawkins, Richard Catalano and others. These are protective factors, which reduce or buffer risk. This program provides countless opportunities to help children practice their communication and decision-making skills, to model healthy behavior and also to apply them to specific problem areas. Skills will reduce a child’s risk of involvement in one of these problem behaviors also protect against involvement in others. The most promising prevention approaches teach generic skills and also apply them to specific problem areas. Families and communities are also critical learning environments; when families are involved, children are twice as likely to use and retain the skills taught.

*Target Audience:*

Individuals grade levels K-12

*Activities:*

14-week presentations at school sites for grades 9th to 12th and 12-week presentations at school sites for grades Kindergarten to 8th grade; presentations focus on Too Good for Drugs curriculum, specifically for each grade level. These activities consist of the following:

* Role-playing activities,
* pre and post-tests,
* educational games focusing on goal setting,
* decision-making,
* identifying and managing emotions,
* effective communication,
* bonding and relationships,
* addiction and drug trends.
1. Prevention Task Force

*Description:*

Prevention Task Force goals are to reduce marijuana use in Imperial County; decrease access to alcohol among under age persons; promote community awareness to decrease the use of alcohol and other drugs. People involved in this task force are as follows:

* The Office of Assembly - Assembly Member
* Brawley Police - Community Service Officer
* Calexico Police - Police Officer
* Center for Family Solutions - Director of Counseling
* Court Appointed Special Advocates of Imperial County - Executive Director
* Imperial Valley Regional Occupational Program - Manager and Youth Development Specialist(s)
* Imperial Valley College - Administration
* Imperial Valley College - Mental Health Counselor
* Imperial County Office of Education - Alternative Education
* Imperial County Probation Department - Juvenile Probation Officer
* Imperial County Public Health Department - Program Supervisor and Health Educator
* Imperial County Child Protection Services - Supervisor
* Imperial County Work Training Center - Job Development Specialist
* Imperial County Behavioral Health Services - Manager, Supervisor, Mental Health Worker and Community Service Worker
* Sober Roads, Inc. - Substance Abuse Counselor
* Student Well-Being and Family Resources - Director
* Sure Helpline Crisis Center - Drug and Alcohol Educator
* US Department of Homeland Security - Border Enforcement Agent
* US Department of Justice - Drug Enforcement Agent

*Target Audience:*

Law Enforcement, Education, Tribal Community, Faith-Based

*Activities:* To collaborate in accomplishing goals and objectives stated in Strategic Prevention Frame-Work.

1. **Transitional Engagement Supportive Services:**

The Transitional Engagement Supportive Services (TESS) Program provides outreach and engagement activities to unserved and underserved SED and SMI individuals over the age of 14. The TESS Program targets individuals who are discharged from Lanterman-Petris Short Act (LPS) Conservatorship by the courts, acute care psychiatric hospitals, or Imperial County Behavioral Health Services-Crisis and Referral Desk; or who are referred by the community and in need of supportive services while transitioning to mental health outpatient treatment.

The TESS Program services assist the individual with reintegrating back into the community and provide a supportive environment including gaining entry into the mental health system. The TESS Program also assists non-active individuals who are referred to the McAlister Institute for 14-day drug and alcohol detox (adults) or 21-day drug and alcohol detox (adolescents).

Services available to clients at the TESS Program include: initial intake assessment; mental health services – nurse and rehabilitation technician; medication support; targeted case management; and crisis intervention. The TESS Program provides linkage to variety of community resources, including, but not limited to, emergency shelter, clothing, and food baskets; permanent housing; SSI/SSA benefits or appeal; DSS/Cash Aid; Section 8 Housing; substance abuse treatment and/or rehabilitation; general physician and/or dentist; MHSA programs; and driver’s license/ID.

Individuals 14 years and older who are currently non-active into the mental health system.

*Activities:*

The role of the mental health rehabilitation technician (MHRT) for the TESS Program is to provide outreach and engagement services to unserved and underserved populations. The TESS MHRT contacts local community shelters on a weekly basis to establish contact with potential consumers living in such facilities. The TESS MHRT educates local community shelter staff and potential consumers regarding the services offered by ICBHS. The TESS Program staff has also established a referral process with local medical hospital El Centro Regional Medical Center (ECRMC). Program staff works in collaboration with ECRMC – emergency room staff, law enforcement, school districts and other community agencies within Imperial County to identify individuals who are exhibiting psychiatric symptoms in order to educate them on the referral process and services of care offered by ICBHS.

**Kings County**

Kings County uses MHSA Prevention and Early Intervention (PEI) to deploy our Prevention Coordinators into Jr. and High schools to provide a school based life skills evidenced based program called CAST, Coping and Support Training. It targets 14 to 19 year olds but because we have used it in Jr high schools as well we do have groups with 12 and 13 year olds in it. The program seeks to prevent suicide among teens, improve moods, decrease drug use and improve on school performance. CAST focuses on building strategies for coping with academic pressures, handling stressful relationships, managing anger, and also emphasizes seeking out support from responsible adults and setting personal life goals.

Our elementary school based program that targets 4th, 5th and 6th graders uses Substance Abuse Prevention and Treatment (SAPT) block grant funding to put Prevention Coordinator in the schools to teach SHOES. A best practice program that teaches the same skills as CAST with a heavy emphasizes on bullying but through a more interactive approach geared at holding the younger student’s interest.

Kings County used MHSA Innovation funds to begin a program called Circle of the Horse which uses Equine Facilitated Psychotherapy (EFP) therapy. The innovation is the Implementation Learning Council (ILC) that is comprised of some tribal members and Behavioral Health Staff and a contracted provider to service to our Native American youth. The program is working with the equine provider, Central Union, as well as the Tachi Yokut Tribe to use EFP as a means﻿ to address behaviors of students, who are underperforming, and/or have been involved in disciplinary actions at the school.

Truancy Intervention Prevention Program (T.I.P.P.) is a collaboration between SARB, Office of Education, The District Attorney’s office and Behavioral Health and is designed to keep children in school, avoid incarceration, substance use and or mental illness. LIFE STEPS (Strategic Training and Education Program), a course that is a part of the program, focuses on providing psycho-education to families with truant or chronically absent students on the following topics: importance of being involved in children’s education; the understanding of both parental and child roles; setting limits and boundaries; substance abuse, mental health, gangs/criminal activity and other issues that impact truancy/chronic absenteeism and children’s educational success. Additionally, the course provides information on how to access resources and services that may be needed by the family. The course includes guest speakers from Child Welfare, Office of Education, and Law Enforcement.

Lake County

When it comes to prevention, LCBH fully recognizes that there are different funding streams for both Mental Health and Substance Use Disorders. Our primary prevention money for Mental Health comes from MHSA funds while our prevention for SUD is primarily from SAPT Block Grant. Each have their own requirements and state reporting. That being said, LCBH has recognized the importance of overall prevention and many of the prevention efforts, whether MH or SUD, are directed to the same populations. Therefore, over this past year, LCBH has built a fully integrated Prevention Unit. It is made up of the following:

Team Leader – supported by MHSA but also responsible for supervising all of the prevention unit.

Prevention Coordinator – funded half-and-half by MHSA and SAPT BG. Coordinates prevention efforts for both MH and SUD, doing outreach and organizing prevention events.

3 Wellness Centers – Native American, Latino, and Adult. A fourth, the TAY drop in center, is contracted to the County and coordinates closely with our Prevention Unit so that all 4 Wellness Centers work in tandem. The centers all have a lead person and 3 part-time peer workers each, along with volunteers. The centers all are doing prevention activities that are centered around SAMHSA’s 8 Dimensions of Wellness and measuring for outcomes for the activities they present.

2 part-time workers who go into the schools in the community and do prevention programs around SUD. One of the workers also focusses on the Friday Night Live prevention program for youth.

**Lassen County**

Renaissance Program for transitional age youth and young adults.

Madera County

Currently in the process of coalition building to establish a Lead & Seed program – coalition will include youth as members and will focus on environmental strategies to prevent youth alcohol use.

A Pathways program for sex offender youth ages 13-18.

Marin County

Our school based prevention services are co-occurring capable and provide screening and early intervention for both mental health and substance use disorders. In addition several of our adolescent prevention providers also offer mental health and substance use treatment services which minimizes challenges with referral and accessing services.

In addition we offer our monolingual Spanish speaking community a promotores program where trained community members provide both substance use and mental health screening, brief intervention and referral to treatment.

Merced County

Currently the AOD Prevention Unit is operating the following programs:

Recovery Assistance For Teens (RAFT)

 IOM Category- Indicated Youth

                Services- Screening and Referral, Educational Groups

 Description- RAFT offers an educational based approach to work with youth that have had academic, legal, or social consequences for drug involvement but do not meet the criteria for treatment. Youth are placed into weekly educational groups which cover information based around how to change behavior over an 8 week period.

**Friday Night Live Mentoring (SAPT)/ Middle School Mentoring (MHSA PEI)**

                IOM Category- Selective Youth

                Services- Screening, Alternative Activities, Educational Groups

                Description- FNLM is an afterschool mentoring program that uses older youth to mentor younger youth who are struggling in a variety of areas. This program uses the evidence based curriculum, "Project ALERT!" for its educational purposes.

**Club Live**

                IOM Category- Universal

                Services- Alternative Activities, Environmental Prevention

                Description- Club Live offers afterschool enrichment activities that provide opportunities for leadership, team building, and community service projects. As a part of the Friday Night Live programs, Club Live is based in the evidence based practice of youth development and follows the Friday Night Live Standards of Practice.

**Strategic Prevention Framework State Incentive Grant to Reduce Underage Drinking (SPF SIG)**

                IOM Category- Universal

                Services- Community Mobilization, Environmental Prevention

                Description- SPF SIG is a grant funded operation which brings community based service providers, law enforcement and local government  agencies to address the core issues in the community that lead to underage drinking. This includes, increased enforcement, community  social norms, visibility, and training.

**Prevention Community Wide**

                IOM Category- Universal

                Services- Community Based Process, Information Dissemination, Education, Screening and Referral, Alternative Activities

                Description- This program provides an array of services depending on the needs of the community/agency/ family that is requesting assistance and or support. The Prevention Unit offers workshops, speaking engagements, trainings, program development, consultation, and many other services that may assist an agency or community address their concerns with AOD use.

**Areas in need of support**-

The AOD prevention unit relies almost completely on a 20% Prevention Set Aside from the Substance Abuse Prevention and Treatment Bock Grant, making it extremely difficult to expand services to the community. Areas the Unit would like to address in the future include family based services, funded program evaluation, and the addition of a fulltime AOD Prevention Unit Staff housed on the west side of the county.

Modoc County

We have an active Prevention Collaborative that meets monthly (schools, PH, SS, Mental Health, SUD staff, nonprofit groups, etc.) to plan and co-ordinate community wide prevention efforts. BH staff members regularly provide services in the schools collaboratively with other stakeholders.

Monterey County

The Monterey County Behavioral Health Bureau coordinates Alcohol and Drug Program Prevention and MHSA Prevention and Early Intervention Services including outreach and education efforts and coordinating presentations as some of the strategies to reduce the impact of mental and substance use disorders in Monterey County. Target audiences include: middle school youth; high school youth; community members and parents. Presentation topics include suicide prevention, alcohol and drug abuse, depression, marijuana use, etc.

The PEI Coordinator also attends alcohol and drug program coalition meetings and works with the Sun Street Center, and Sunrise House who provide AOD Prevention services along with other agencies to coordinate Family Fun Festival during Mental Health Awareness Month and participate in community resource fairs and trainings throughout the year.

In addition, the Health Department is in the process of centralizing all prevention services within the Public Health Bureau in order to increase coordination efforts among all prevention services (AOD, PEI, Youth Violence, Tobacco Cessation, etc.). Prevention staff will work together to integrate prevention services within the Health Department in an effort to address various prevention issues within the county.

Napa County

* Friday Night Live programs – school based prevention / peer support program – Jr. and Sr. High level.-
* MHSA PEI Supported programming.

Nevada County

Athlete Committed Program

Data shows that athletes are one of the highest at-risk groups for alcohol and substance abuse. Nevada Union and Bear River High School athletes report that 35% of the athletes in their school use alcohol or other drugs and 14% report parents and guardians are willing to host parties that include alcohol or other drugs.

Athlete Committed is an evidence-based prevention and intervention health program that offers insight, education and strategies around issues such as alcohol, drug abuse, hazing, obesity and sportsmanship.

Program components include: comprehensive training for all coaches and athletic directors & principals on creating a program of excellence; an Athletic Code that promotes a character based athletic program with consequences for code infractions.

Student Intervention Program (SIP) – Community Recovery Resources (CoRR)

This 4 week diversion program goals are to provide an effective, targeted diversion program to reduce recurrence of youth substance abuse and increase school attendance. The program consists of group therapy, individual sessions and session also attended by the teen’s parent or guardian.

Orange County

Orange County Behavior Health Services’ (BHS) prevention programs emphasize overall behavioral health, and staff are trained to be co-occurring capable in their service delivery regardless of the funding source of their programs. The majority of the prevention funding is directed toward children, youth and young adults. Prevention programs that include screening as an activity, screen for both mental health conditions and substance abuse, and prevention programs generally use curriculum/ interventions that enhance both mental health wellness and healthy coping/AOD refusal skills with some content covering both areas for many programs. In addition, staff is capable of referring and linking to both mental health and alcohol and drug services. Prevention programs partner with agencies, such as Probation, Social Services Agency (Family Resource Centers), Orange County Department of Education, School Districts, and many community-based organizations in providing these services at their agency sites; so behavioral health prevention programs are providing these services across multiple service systems.

For example, BHS in Orange County has school-based prevention programs partnering with the school districts, targeting students in elementary, middle and high-schools, and their teachers and parents. Educational classes are provided to students in the school with age-appropriate curriculum usually covering some mental health and substance abuse content for many of these classroom series. These classes seek to reduce risk-factors contributing to mental illness, substance abuse, bullying, violence, and school failure while building resiliency and protective factors in students. Education and support in the form of workshops and/or classes are also provided to parents covering behavioral health concerns including developmental milestones and developmental challenges that occur through adolescence. Teachers are also provided education on the behavioral health services available.

Within BHS’ Prevention and Intervention Division, both SAPT and MHSA/PEI funded services are provided in the community, and there are a lot of efforts to coordinate these services. For example, a mental health school-based program (funded by MHSA/PEI), Transitions, being provided in one school district may become aware of a need for more substance abuse education/training in the school district. As a result, another program (funded by SAPT), the AOD Prevention Team, will schedule the training desired in the same school district. Both of these programs with different funding sources have the same supervisor allowing for easy coordination of between mental health and SUD prevention services.

Placer – Sierra Counties

Placer has a small prevention program targeted at Seniors ages 55 and up (to decrease isolation and reduce risk factors related to substance use in Seniors).

Placer has a variety of Prevention strategies targeting youth including, but not limited to:

* 1. Underage drinking:

Social host ordinance work, Parent Pledge, Teen Plan, family communication, Town Hall meetings, community and school forums, newsletter, website, Facebook, Twitter FNL, parent presentations, focus groups, AlcoholEdu, shoulder taps, compliance checks, underage signage for retailers, LEAD trainings, Committed program, media outreach via print, online, radio, email blasts, key event targeting *(ie homecoming, graduation, summer)* building community capacity to address and support coalitions.

* 1. Prescription drugs:

Community Rx Take Backs 2x a year, working collaboratively on permanent disposal options, Secure, Monitor, Dispose campaign, school. Parent/community information dissemination and norm change, community partnerships and capacity building of coalitions, prevention website, newsletter, Facebook, Twitter, creation and dissemination of media ie., print, online, radio and eblasts to keep Rx issue in forefront

* 1. Marijuana:

Assessment of marijuana issues completed (teen clinic survey, focus groups both parents and teens, community survey, student survey) and logic model and plan developed for new Strategic Plan (2014-2019). Strategies identified to be used include developing media messages re: to harms, consequences, negative effects of MJ use, working with schools and other partners to increase parent/teen access to accurate information, dissemination of Teen Plan to encourage good choices, building youth skills in understanding media messaging, continuing to educate parents on the important role they place in their teens decisions, media messages disseminated through newsletter, website, facebook, online, eblasts. Educate community in re: to MJ use trends from local data, and provide parents with resources.

Plumas County

1. Friday Night Live and Club Live-Peer driven prevention based on a youth development framework. Motivated by youth-adult partnerships that enhance and improve local communities. Community service, social action activities, participation in advocacy for safe and healthy environments and promotion of healthy policies are organized by youth to appeal to youth. This program is currently in place at Quincy Jr/Sr High School, Portola Jr/Sr High School and Greenville Jr/Sr High School and serves around 40 young people in Plumas County.
2. Brief Intervention for Substance Using Adolescents-Individual prevention services for youth who have been suspended for alcohol and other drug related offenses or who have been referred by a school employee or themselves. During brief intervention session, the youth will gain skills and resources to assist in coping with life’s pressures during critical stages, which have the potential to otherwise lead to negative choices. Available at Chester Jr/Sr High School, Quincy Jr/Sr High School, Portola Jr/Sr High School and Greenville Jr/Sr High School. Eight Plumas County youth have completed this program.
3. Alcohol and Other Drug Education-Discuss alcohol and other drug use/abuse and possible negative consequences associated with use. Meet minimum of once a month at Jim Beckwourth High School and Plumas County Community School. About 15 students attend both schools combined.

Riverside County

Seeking Safety is a program that is funded through MHSA Prevention and Early Intervention. This program is a present focused, coping skills program designed to simultaneously help individuals with a history of trauma and substance use. It is a manualized, flexible program that is adaptable to various populations and settings. It is conducted in group and individual format. Seeking Safety focuses on coping skills and psycho-education and has five key principles:

(1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions);

(2) integrated treatment (working on trauma symptoms and substance use at the same time);

(3) a focus on restoring ideals that have been lost due to trauma and substance use:

(4) four content areas: cognitive, behavioral; interpersonal, and case management: and

(5) attention to provider processes (helping providers work on counter-transference, self- care, and other issues).

The treatment’s 25 topics are evenly divided among cognitive, behavioral, and interpersonal domains, with each addressing a safe coping skill relevant to both disorders. The program is provided to TAY and adults by contract providers.

Riverside County Wellness Connection is a relatively new group that meets on a monthly basis in an attempt to keep informed as to what the other agencies are doing and to look for opportunities for coordinated engagements in the future. Members of the group include: Mental Health PEI Coordinator, Substance Use Prevention Coordinator, Riverside County Office of Education Tobacco Use Prevention Coordinator, Riverside County Public Health Tobacco Use Health Educator and the DPSS Family Resource Center Supervisor.

One of the accomplishments of this group so far has been participating cooperatively in the strategic planning process for each agency.  It is hoped that this effort will result in possibilities in the near future for more formalized cooperative programs.

**Sacramento County:**

Alcohol and drug services are divided into treatment programs and prevention programs. While there are no specific ADS prevention programs in DBHS to address prevention of both SUD and mental illness we do have coordinated programs crossing multiple service systems that address SUD and mental illness in children, transition-aged youth and young adults which lead to reduced numbers of persons using drugs and/or abusing alcohol. Some of these programs are listed below.

Juvenile Justice Diversion and Treatment Program (JJDTP): JJDTP is jointly administered by DBHS, Sacramento County Probation Department, and River Oak Center for Children and is contracted for services to The River Oak Center for Children. JJDTP provides screenings, assessments and intensive mental health services and FSP supports to eligible youth (and their families) involved in the Juvenile Justice System. Youth must meet serious emotional disturbance criteria and be between the ages of 13 through 17 at enrollment. Pre-adjudicated youth are screened and given an assessment. With court approval, these youth will have the opportunity to avoid incarceration and voluntarily participate in this program as long as clinically necessary up to their 26th birthday. Adjudicated youth are referred, assessed, and have the opportunity to voluntarily receive intensive, evidence-based services that are delivered in coordination with a specialized Probation Officer. Family and youth advocates compliment clinical services.

Adult and Juvenile Drug Courts: Referrals to mental health programs

Crossover Youth Practice Model (CYPM): The CYPM Model is a particular approach intended to improve the handling and outcomes of youth who penetrate the child welfare and juvenile justice systems by building and enhancing communication and collaboration across multiple systems. The CYPM Model is in the implementation stages in Sacramento County and representatives from child welfare, probation, courts, mental health and education make up the implementation and data teams.

### San Mateo County:

**Leadership and Resiliency Program:**

This program utilizes a multi-tiered approach that involves the identification of high risk youth. It organizes activities to promote clinical resiliency through after school alternative activities, including outdoor/adventure activities and community service projects. The alternative activities focus on social skills building and improvement, learning about managing risk, and conflict resolution.

**Friday Night Live:**

This program is designed to engage youth more actively in program decision-making, planning, and implementation in order to deliver programs that foster autonomy, safety, community partnerships, youth/adult partnerships, and demonstrate cultural and civic competence, all of which research identifies as key developmental outcomes. Young people involved in FNL will experience the following:

• A physically and emotionally safe environment

**Responsible Alcohol Merchant Awards (RAMA):**

RAMA rewards merchants for their commitment to reduce teen access to alcohol. Merchants receive awards for their prevention efforts (i.e. carding all individuals under the age of 25). These awards are recognized by the City Council.

• Opportunities for involvement and connection to community and school

• Opportunities for leadership and advocacy

• Opportunities to engage in skill-building activities; and

• Caring and meaningful relationships with adults and youth.

San Bernardino County:

The department provides programming in MHSA funded programs such as Prevention and Early Intervention (PEI) and Community Services and Supports (CCS) via the Transitional Age Youth (TAY) centers, which include education, and access to 12 step recovery support and groups. However, DBH has implemented separate efforts to allow for more focus on Substance Use Disorder (SUD) prevention, which has very different social dynamics than mental health. There is far more stigma around addiction especially due to the large focus in the law enforcement arena on addiction and its relation to criminal behavior. This is a specialized field. DBH uses prevention-targeted interventions derived from public health strategies by Community Based Organizations (CBO’s) to assist in further community specific prevention efforts, which have been very successful.

In the recent past, mental health and SUD were combined but funding specificity, especially with regards to prevention set aside funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Substance Abuse Prevention and Treatment Block Grant (SAPT) Block Grant, as well as the special nuances of both specialties resulted in the ability of DBH to focus 100% of our prevention efforts on each specialty separately, so that neither mental health, nor SUD was short changed.

San Diego County

1) Alcohol and Drug Services programs have mental health counselors embedded to support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment, to reduce stigma associated with mental health concerns and to provide additional support or referrals according to need.

2) Binge and Underage Drinking Initiative (BUDI), established approximately 1996, provides coordination and facilitation as stated in the County prevention Plan and leverages resources. Developed an Alcohol Policy Panel, a voluntary leader group which provides quarterly community breakfasts to inform community of efforts to reduce underage /binge drinking. Provides support and assistance to regional prevention contractors on BUDI work in each region. Leads media and data collection workgroup to develop media advocacy and community strategies. Provides coordination and assistance in region wide community organizing efforts, and supports RBSS policies. Participates in the Law Enforcement Task Force to reduce Binge and Underage Drinking. Developed a law enforcement handout regarding underage drinking on hired motor coaches. There are additional activities surrounding the ongoing issue of focused media advocacy to inform community including specific policy issues regarding alcohol density and the prevalence of community problems.

3) Prescription Drug Abuse Task Force (PDATF), established 2008, provides coordination and facilitation of services as stated in the County Prevention Plan and leverages resources. Hosts quarterly UPDATF meetings to inform community of local efforts to reduce prescription drug use/misuse. Membership includes local, state and federal organizations, community organizations, community members and others. Sponsors a medical doctor workgroup to develop a prescription drug policy for hospitals in region. Developed a local ordinance to install drop boxes and supports community take back days. There are a variety of activities surrounding the ongoing issue of focused media advocacy to inform community that includes patient information regarding pain medicine for persons discharged for the emergency departments and a patient pain medicine agreement.

4) Marijuana Initiative (MI), established 2005, developed the Key Leadership Team. Provides coordination and facilitation services as stated in the County Prevention Plan and leverages resources. Developed community awareness information. Completed a community assessment and literature review and provided a community forum. Also, there are activities surrounding the ongoing issue of focused media advocacy to inform community of harms to youth who use marijuana. Spice/synthetic marijuana is also addressed under the Marijuana Initiative.

5) Methamphetamine Strike Force (MSF), established 1996, provides coordination and facilitation services as stated in the County Prevention Plan and leverages resources. Provides quarterly MSF breakfast meetings to inform community of local efforts to reduce meth and bath salt use throughout the region. Membership includes local, state and federal organizations, community organizations, community members and others. Leveraged support of www.no2meth.org and 877-no2-meth (877-662-6384) hotline to report meth crimes and obtain treatment referrals. Supports Tip the Scale projects in county. Ongoing collaboration with county domestic violence (DV) partners regarding meth, families and DV. Also, there are activities surrounding the ongoing issue of focused media advocacy on meth issues in region. Bath salts are addressed under the Methamphetamine Strike Force as well.

San Francisco County

Strengthening Families Program, aim to reduce initiation of alcohol in 9th graders, and binge drinking in 11th graders.

Our primary prevention programs aimed at youth alcohol use patterns are part of the population health alcohol prevention strategy that includes healthier neighborhood stores, etc.

**San Joaquin County**

The following programs target both substance use and mental health prevention:

* Friday Night Live: a youth development program that focuses on alcohol and drug prevention and development of pro-social protective factors through engaging youth as active leaders and resources in their community. Targets high school and middle-school aged youth.
* Nurturing Parenting Programs: *Alcohol and Kids Don’t Mix*, a 5-session parenting class about the importance of not drinking while pregnant or raising children. Also, *Community Based Education in Nurturing Parenting*, a 10-session class focusing on brain development, discipline, building empathy and self-worth and ways to deal with anger, stress and alternatives to spanking. Also, *Strengthening Multi-Ethnic Families and Communities*: a violence prevention and parent training. (Also: PEI-Funded Skill-Building for Parents/Guardians: curriculum includes Triple P, Nurturing Parenting Programs and Parent Cafes)
* TAY mentoring: Starting 2015/16, two BHS contractors will implement evidence-based Transition to Independence, an intensive mentoring project for high-risk youth, ages 16-25 with emotional and behavioral difficulties.
* Trauma Screenings and short-term interventions for trauma in schools for children ages 6-12.

The following are predominantly targeting substance use prevention:

* Students in Prevention: a Peer-to-peer drug education and prevention program that hires and trains high-school students to make classroom presentations to 4-12 grade students. A TAY component includes college-age youth as peer educators.
* Red Ribbon Celebration in October: drug-free activities for youth and families in schools, including wristbands, poster contests, rallies, assemblies, guest speakers, health fairs and family nights.
* Youth Prevention Education: *Project Towards No Drug Abuse* is a 12-session, classroom-based program for high school students. *Project ALERT* is designed for 7th and 8th grade students and delivered in 14 sessions. *Too Good for Drugs* is a 10-week school-based prevention program for k-8th grade students.
* Speaker’s Bureau/Health Fairs: BHS prevention staff set up booths at local health fairs and speak at public engagements on request.
* Extensive involvement in Friday Night Live, school based and community based prevention activities and staffing, etc.

San Mateo County

AOD’s Strategic Prevention Framework (SPF) seeks to reduce access and availability to alcohol and other drugs, enhance community connections and supports, and build the capacity of an effective prevention system within San Mateo County. AOD implements community based prevention partnerships in five community areas in San Mateo County, specifically, East Palo Alto, Redwood City, Pescadero/Half Moon Bay, San Mateo, and Pacifica/Daly City.

Community based partnerships are comprised of local government, parents, educators, law enforcement, businesses, faith based leaders, health providers and other community activists who are mobilizing at the local level to make their communities safer, healthier and to reduce the problems associated with alcohol and other drugs. A community based partnership is an evidenced based strategy that promotes coordination and collaboration and makes efficient use of limited resources. By connecting multiple sectors of the community in a comprehensive approach, community based partnerships are able to plan, coordinate and achieve measurable outcomes.

Each community based partnership is responsible for conducting its own assessment of the specific community area to identify unique issues and needs related to substance use prevention. Based on the assessment, goals and objectives are developed as well as a corresponding implementation plan.

Community based partnerships are expected to develop a plan which uses environmental strategies based on a community systems perspective that views a community as a set of persons engaged in shared social, cultural, political, and economic processes. Environmental strategies are based on the belief that substance abuse is a product of multiple environmental conditions and circumstances. According to this view, individuals do not engage in substance abuse solely on the basis of personal characteristics, but rather as a result of a complex set of factors in their environment. These include: the rules and regulations of the social institutions to which individuals belong, the norms of the communities in which they live, the mass media messages to which they are exposed, and the accessibility and availability of alcohol and other drugs. Therefore, effective prevention requires “intervention” in various facets of community life that are designed to change individuals and the environment in which they live.

Environmental strategies incorporate prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems, and policies. Environmentally based approaches reach entire populations and reduce collective risk, making them cost effective prevention strategies. If a community based partnership has identified a community need for individualized or small-group targeted directed activities, practices, strategies or interventions, these should be leveraged in coordination with local partners and/or funded The primary purpose of county and SAPT funding is to strengthen the capacity of partnerships to reduce and prevent youth and adult substance abuse in the community by generating positive, lasting changes to local policies, organizational practices, the consistent enforcement of laws and policies, and sustaining community efforts over time.

We also work closely with the County Office of Education in training school personnel in early identification and intervention.

**Santa Barbara County**

* Environmental prevention programs for youth and young adults
* Screening, Brief Intervention, Referral to Treatment (SBIRT) for all clients, particularly youth and young adults
* Santa Barbara County ADMHS integrated mental health and substance abuse services for transition-aged youth
* Intervention and treatment services in local high school settings.

Santa Clara County

Behavioral Health Prevention funds, supports, and monitors Prevention programs that are delivered in conjunction with other partners.

First, Prevention collaborates with Mental Health by providing a full-time Prevention Analyst in School-Linked Services, a school-based program that strives to support children, youth and families by addressing mental health and substance use issues.

Second, Prevention partners with school districts, Mental Health, the Juvenile Court system, and faith-based organizations to deliver the Strengthening Families Program (SFP), a national evidence-based curriculum for youth and caregivers. Mental Health and Prevention partner in providing the SFP by sharing training resources as we each deliver this ten-session program in schools across the county. The SFP has demonstrated outcomes in both substance use and mental health prevention. Curriculum topics addressing both mental health and substance use include stress management, peer pressure, coping skills, empathy, and anger management. The Prevention Strengthening Families Programs is offered in fifteen schools, as well as faith-based organizations.

We also partner with the Juvenile Court System, offering Strengthening Families on-site to transition-aged youth and families involved in a community court.

Prevention also partners with school districts by providing the evidence-based Too Good for Drugs (TGFD) program which is delivered on 45 middle and high school campuses. Students learn about depression, the relationship between alcohol, drugs and suicide, as well as learn about their feelings and how to share them.

A fourth collaborative effort is the Prevention 90-minute Parent Workshops, offered in conjunction with community-based and faith-based organizations as well as schools. The curriculum not only focuses on the effects of drugs and alcohol, but also educates parents on how to improve family climate, which affects mental health in all family members.

Fifth, we partner with The Hub, a County Social Services drop-in center for foster transition-age youth and young adults. Weekly psychoeducation classes are available to foster youth and young adults on developing healthy relationships, communication skills and other topics that affect both mental health and substance use.

Santa Clara County has utilized MHSA dollars to fund the Prevention and Early Intervention Primary Care Behavioral Health (PCBH) efforts. This program provided training for Primary Care Providers, Mental Health providers, and Psychiatrists, working together to primarily treat mental health issues, in alignment with the MHSA act. These dollars also provide individualized training to the PCBH MH Providers in brief, episodic treatment intervention called Problem Solving Therapy, based in CBT, and developed in the United Kingdom expressly for PCBH.

We also provide class trainings offered by the University of Massachusetts for interdisciplinary provider and clinic management staff in PC and PCBH to attend a semester to better understand their roles and additional ways to collaborate for the patients identified by the PCPs. This funding was used to support three community based and independently operated primary care clinics committed to integrating behavioral health into their clinic practice, as well as five County operated PC clinics where BH staff are collocated.

Unlike many PCBH models, our patients served have access to psychiatry treatment services, both on a consultative basis to the PCP, as well as on an ongoing basis, as for those individuals discussed below.

The services offered in these sites provide triage services, 5150 assessment and de-escalation of crisis services, as well as one-shot prevention visits with an LCSW, brief episodic care for those individuals with Mild to Moderate BH needs identified either through the PCPs on-site, or through the BH Call Center.

This program also offers a maintenance recovery service for individuals with Serious Mental Illness who have improved their functionality with intervention and support from the specialty MH System, and are able to maintain their well-being with the more limited support available in PCBH. For this last group of individuals, the PCBH clinics are able to support some limited and minor slips in functioning with the limited and scarce resource of Rehab Counselors who are also embedded at a majority of the County clinics (not available at all in the CBO clinics) through the braided funding structure and programming that was designed by our County.

Santa Cruz County

Our agency is a combined mental health and substance use disorders agency and we are working to build coordinated capacity throughout the agency including capacity for substance abuse expertise on the mental health treatment teams, and are in the process of developing a new MAT program within our new Integrated Behavioral Health Team in the county FQHC Clinic that will include outpatient substance abuse counseling.

Our MOST Team (previously referenced) includes treatment for individuals with co-occurring mental health and substance use disorders. The budget planning for next year will include a new intensive outpatient/partial hospital program with a residential component for individuals with co-occurring mental health and substance use disorders who also struggle with issues of homelessness.

The Division has also been recommended for funding through HUD for a new permanent housing program that will serve chronically homeless adults who either have a severe mental illness and substance use disorder or mild to moderate mental illness and or severe substance use disorder.

There are numerous other examples including identification of older adults in the jail who have mental illness and substance use disorders that are identified and targeted for intensive outreach and case management services.

The County also has the Homeless Health Care Project for Homeless Persons which provides mental health and substance use disorder services for homeless individuals as well as primary care services. The County funds an outreach program for homeless adults who have frequent contact with law enforcement called the PACT program which is a collaboration with multiple agencies, and the majority of clients they work with have substance use and mental health issues.

#### Siskiyou County

The MHP provides education through a coordinated effort between MHSA and the AOD programs. Prevention education is disseminated through the Athlete’s Committed student emotional wellness program which targets middles and high school age children and youth.

#### Sonoma County

Sonoma County Behavioral Health Division uses Substance Abuse Prevention and Treatment Block Grant and Mental Health Services Act dollars to fund *Project SUCCESS Plus* (*PS+*). *Project SUCCESS* is a school-based substance use prevention and early intervention program and is considered a model program by SAMHSA. *PS+* mental health staff works closely with other *Project SUCCESS* staff to identify youth who may be having mental health issues, and then refer that youth to a *PS+* for further screening, assessment, and care. *PS+* is a collaborative effort project of *Sonoma County Office of Education* and 17 high schools throughout Sonoma County. These high schools partner with community partner agencies to provide this service.

Project Success Plus (PS+) Performance Outcomes for 2013/14

* 92.6% of students receiving the Classroom Prevention Education Series for 50 minutes over eight weeks report an increased knowledge of access and availability of alcohol and other drug and behavioral health services
* 66.7% of students participating in Short-term Prevention/Education Groups report an increase in school connectedness
* 90.0% of parents who participated in Parent Engagement Presentations report an increased knowledge of alcohol and other drug and behavioral health issues, and 86% report an increased confidence in addressing these issues with their children
* 60% of NAMI participants report an increased knowledge of support services, and 75% report feeling more confident in their ability to access support.

Stanislaus County

South Modesto Youth Leadership: Both SUD (SAPT-funded) and MH (MHSA-funded) programs fund opportunities for 30-40 youth (and their families at times) to attend training, camping, conferences and community driven efforts with the focus of SUD prevention/awareness, stigma reduction as well as access and linkage to mental health services when necessary.

**Cross County Youth Leadership:** SUD Prevention & MHSA Prevention & Early Intervention (PEI) support various youth leadership groups that typically meet quarterly and have representatives from Josie's place, Juvenile Justice, 4 PEI contracted youth leadership groups, and South Modesto Youth leadership. Both SUD and PEI would seek ways to support these groups around prevention work for these at risk populations.

**Behavioral Health Promotoras:** SUD and PEI have begun to partner on training support and coordinated efforts for our 9 full-time behavioral health promotoras to attend SUD related training and conferences to increase their capacity on SUD, given alcohol and drug abuse is extremely common and present within the Latino community (both youth and adults). This topic is becoming a common conversation within the promotora work as stigma reduction efforts seem to be working and requests for: training, resources and information related to SUD prevention and mental health prevention is emerging from almost all promotora communities.

**Training:** Coordinated efforts around training for school based contractors such as SUD's student assistant specialist through the Center for Human Services and PEI's contracted school based partners are being asked to attend co-sponsored trainings from both programs to ensure all contractors are talking with one another and making appropriate referrals when necessary to each other.

**Prevention Network meeting:**  As of Feb. 2014, both SUD and PEI have merged our prevention network meetings. The purpose of prevention network meeting is to get all SUD Prevention partners such as law enforcement, CBO's and the county SUD team and our mental health prevention contractors to have a coordinated time to come together and learn about the county wide prevention efforts from one another with hopes to maximize on resources, partnerships and communication. The group meets 6 times a year for two hours; the first hour is combined as SUD/PEI Prevention and the second hour is separate. The group has developed a joint mission statement and the based on participant feedback, the joint effort seems to be beneficial to all.

#### Sutter-Yuba Counties

Integration of the Prevention and Early Intervention Program with the Mental Health Program began at the end of 14/15 fiscal year. In 15/16 the final integration will take place to include an increase in resource specialists, invention counselors and a coordinator.

Prevention programs and intervention are being implemented at various elementary and middle schools and PLUS Peer Leaders Uniting Students.

Other programs include: Strengthening Families, Bullying Prevention, Suicide Prevention, Yellow Ribbon program, Latino/Hispanic Community outreach center, upcoming Hmong outreach center, cutting information and intervention, 2nd step program, Mental Health First Aid, and the Assist Program.

Outreach in the community with First Onsets.

The integration of programs in substance abuse, behavioral and mental health including early intervention and substance use disorder prevention programs.

Overall, a better continuum of care is provided to our community and program participants.

**Trinity County**

Trinity County has an SUD prevention program for youth called Trinity Choices, which serves at risk youth who are on probation (informal, formal, and/or post incarceration). Youth participate in group or one-on-one or family support as needed. Youth with a mental illness are referred to the Mental Health program for an assessment and treatment as needed, with a signed release. Services are coordinated between SUD, Trinity Choices, and MH.

**Tulare County**

* The Alcohol and Other Drug (AOD) Division of the Tulare County Health and Human Services Agency (HHSA) Mental Health (MH) Branch provides prevention and harm reduction training and consultation with the local mental health housing programs.
* AOD also hosts an ongoing Substance Abuse Coalition which discusses substance use and abuse within the County, and how to best address. The Coalition is attended by AOD and MH staff, community and Agency partners, consumer and family members, and community at large.
* AOD attends many of the community events throughout the County with a Prevention Team that hosts booths and giving presentations to raise community awareness about prevention and treatment of substance abuse to include County services.
* Lastly, through Mental Health Services Act (MHSA) funds, the MH Branch has several programs that include substance use/abuse prevention as part of their curriculum or practice. These programs include Children of Promise Program which uses the evidence-based Reconnection Youth and C.A.S.T. curriculum, and Ending the Silence NAMI program.

**Ventura County**

Suicide Prevention: ADP staff have co-presented at community training such as Mental Health First AID.

Stigma Reduction: ADP has worked with Mental Health in community reduction campaigns to underserved populations in English and Spanish.

Student Mental Health: ADP with Mental Health and stakeholders works on specific projects such as bullying and cyber-bulling.

Universal Prevention: ADP works with the Mental Health staff and contract providers to develop, track and measure impacts of strategies such as web based messaging (see: wellnesseveryday.org).

MHSA Prevention Framework: ADP prevention staff provided input and direction in the formulation of PEI revisions in recent years.

\*\*\*NONE of these services are delivered with MHSA funds.

**Yolo County**

**Friday Night Live Alcohol and Drug Prevention Program (for Youth):** Friday Night Live (a program within Yolo County Health and Human Services) has an active partnership with the Yolo County School District to provide middle and high school youth with educational and leadership opportunities. School sites (with active Club Live, Friday Night Live and Friday Night Live Mentoring Chapters) send youth to this program to learn more about the effects of drug and alcohol abuse. SED youth (a) residing in Yolo County, or (b) attending Yolo County schools with or without full scope Medi-Cal are eligible to apply for this program.

**Victor Community Support Services Co-Occurring Treatment Program:** This program is for juvenile justice-involved adolescents (ages 12-18) suffering from co-occurring disorders (substance abuse and mental health disorders). The program is based on the harm reduction model. The agency seeks to meet the needs of these adolescents by: empowering teens, restoring family cohesiveness, and initiating recovery.

**Turning Point Free to Choose Program:** This program offers TAY (ages 18-25) with peer counseling/ group support also from a Harm Reduction perspective.