

PART II: PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

SECTION I: IDENTIFYING COMMUNITY ISSUES RELATED TO MENTAL ILLNESS AND RESULTING FROM LACK OF COMMUNITY SERVICES AND SUPPORTS

Question 1: Please list the major community issues identified through your community planning process, by age group. Please indicate which community issues have been selected to be the focus of MHSA services over the next three years by placing an asterisk (*) next to these issues. (Please identify all issues for every age group even if some issues are common to more than one group.)

Response 1: The leading issues identified in the public planning process are summarized in the table below.

Table 6: County/Community Issues Identified in the Public Planning Process

Children/Youth	Transition Age Youth	Adults	Older Adults
*1. Children/Youth in Community at-risk of hospitalization or out-of-home placement	*1. Inability to manage independence	*1. Inability to work	*1. Hospitalization due to untreated serious mental illness.
*2. Children/ Youth in Education System at-risk of School Failure	*2. Isolation	*2. Homelessness	*2. Institutionalization due to untreated serious mental illness.
*3. Children/ Youth in Child Welfare System	*3. Inability to work	*3. Frequent hospitalizations	*3. Social isolation due to the lack of wellness and recovery oriented programs.
*4. Youth in Juvenile Justice System	*4. Frequent hospitalizations	*4. Isolation	4. Lack of housing for older adults.
*5. Special Focus Areas: Improve Family/Youth Partnership, Cultural Competence, & Dual Diagnosis	*5. Youth leaving Foster Care	*5. Institutionalization	
		*6. Frequent emergency medical care	
		*7. Incarceration	

Question 2: Please describe what factors or criteria led to the selection of the issues starred above to be the focus of MHSA services over the next three years. How were issues prioritized for selection? (If one issue was selected for more than one age group, describe the factors that led to including it in each.)

Response 2:

A. Children

The MHSA requires that communities, 1) focus on identifying the local mental health issues and related needs of children and youth with serious emotional disturbances, and 2) specifically identify the following mental health related community issues for children, youth, and transition age youth:

- Involvement in the child welfare and juvenile justice systems;
- Out-of-home placement;
- Hospitalization;
- School failure and inability to be in a mainstream school environment; and
- Peer and family problems.

MHSA directs counties to work with clients, families and other community stakeholders to examine these issues, and others, in the context of our community—and to identify priority areas for focus. Towards this end, each of the four children’s committees (see below) reviewed the strengths and gaps in the current System of Care in order to identify key community issues in these areas. The rich array of needs assessment and data from the interagency initiatives (see below) painted a compelling picture of the community’s mental health successes and strengths, as well as areas of unmet need. We also engaged in efforts to infuse and refine our analysis with specialized focus groups and surveys with families, youth, and a wide variety of community stakeholders and partners. These included:

- Stakeholder Meetings;
- Phase I & II Surveys;
- Family Partnership Focus Groups;
- UCSC Youth Focus Groups (through Robert Wood Johnson project);
- Watsonville Digital Bridges Academy Surveys (focus on Latino population); and
- Barrios Unidos Surveys (focus on Latino population).

There were 1,691 total participants in the Children's planning process, with a positive balance of age, gender, ethnicity, and regional representation (please see color charts in appendix: Children's System of Care Overview of Community Response).

One of the primary factors, and related criteria, that led to the selection of the Children’s issues listed in Question 1, is the longstanding local System of Care for children, youth and their families. Santa Cruz County Children’s Mental Health has been an active interagency System of Care since 1989. The past 16 years have provided an ongoing context for interagency and community collaboration, needs identification, and system improvement.

These partnerships include Probation, Social Services, Substance Abuse, Education, and our Community partners (including our Family Partnership Program). Each of the partner agencies brought key reform efforts and opportunities/challenges to the System of Care “table”. These system/community values have shaped and focused our MHSA planning process, resulting in the particular target areas chosen above. Each partnership’s reform efforts proved applicable to our MHSA Prop 63 planning process, and have helped shape the selection of MHSA community issues and the mental health needs to be addressed, as follows:

- Child Welfare Redesign for Social Services, including a comprehensive Community Needs Assessment, and System Improvement Plan (SIP) to identify key areas of need;
- Probation and Substance Abuse Services, a Robert Wood Johnson Reclaiming Futures grant to assist with system change related to addressing the dual diagnosis mental health/substance abuse needs of Probation youth; collaborative efforts with Probation to institute Balanced and Restorative Justice (BARJ) approaches, and reduce Disproportionate Minority Confinement (DMC) in Juvenile Hall, as well as the overall population in detention, supported by increased community counseling services;
- Education:
 - Through the collaborative programs of AB 3632 mental health services for special education students, county mental health has worked with the schools to keep emotionally disturbed youth living at home in the community, and benefiting from their education, rather than placed in remote residential care; and
 - Partnership with the County Office of Education’s Court & Community Schools in System of Care has led to a variety of alternative school collaborations serving our shared youth.
- Other Community Partners Access to Medi-Cal EPSDT has been expanded to provide mental health services for vulnerable populations (particularly Latino youth, as identified in our Cultural Competence plan) through contracts with local non-profit agencies, as well as utilizing interagency funding support to sustain and expand our Family Partnership program.

For MHSA planning, the Children’s Interagency System of Care framework and partnerships (per Welfare and Institutions Code 5850) were utilized to organize the community needs assessment and planning process.

Children’s committees were formed in the areas reflecting our System of Care partnerships:

- Probation;
- Child Welfare,
- Education, and
- Community.

Throughout the process, there was a commitment to integrate cross-cutting key areas of Cultural Competency, Family Partnerships, Dual Diagnosis Substance Abuse expertise/needs within the four subcommittees. Special attention was also paid to addressing Early Mental Health needs of children 0-5, and the needs of Transition-age youth aging out of the foster care system. Finally, there was a commitment to improve and expand service access in each of the four Children's committee areas (including Family Partnership) rather than identifying only one or two areas.

B. Transition Age Youth Populations: Transitional (SED) & Recovery (SMI)

Planning for Transitional Age Youth was divided between the Children's and Adult system's planning processes. The TAY population can be considered as one group by age (18-24), but actually includes 2 distinct subgroups as determined by developmental courses, age of onset of mental health needs, and diagnosis.

The first subgroup may be referred to as Transitional TAY (SED), age 18-20, and primarily include seriously emotionally disturbed individuals transitioning out of foster care into independent living. A smaller proportion of these individuals have serious mental illness and are similarly transitioning into the adult system of care.

The second subgroup may be referred to as Recovery TAY (SMI), age 18-24, and included individual with serious mental illnesses who are beginning their process of recovery. These individuals need intensive continued support with housing, employment, and illness management.

As mentioned in the previous Child/Youth section, the planning for the needs of Transition Age youth already identified and/or receiving services occurred within the context of the longstanding System of Care partnerships and ongoing needs assessment. (Please refer to that section for more detail.)

The Children's System of Care provides Transition Age Youth services and supports for foster youth aging out of the their System of Care. Community Support Services of the Santa Cruz Community Counseling Center is the non-profit agency contracted with by Social Services and Mental Health to run a Transitional Housing and support program for these foster youth. THPP, ILSP, and EPSDT funds support a variety of counseling, case management and related supports for identified youth. However, many more youth in our Children's System of Care make the transition to young adulthood without adequate assessment and supports as they turn 18 and are, therefore, unserved and underserved.

The Children's System of Care Steering Committee for Prop 63 decided to begin addressing these gaps by increasing assessment and case management supports to Transition Age youth served across our four major service "gates" of Probation, Child Welfare, Education, and Community, with an initial focus on foster youth. Particular attention will be paid to linkage and supports related to housing, jobs, college, as well as dual diagnosis mental health/substance abuse issues.

Community input with regards to meeting the needs of youth/young adults experiencing the onset of serious mental illness was gathered in the context of a larger discussion about overall adult system needs, and specifically analyzed within the TAY Sub-Committee. Stakeholders clearly identified the need for a dedicated service system that is sensitive and responsive to the unique needs of the population based on their age, developmental status, and the impact of the onset of mental illness.

C. Adults

The adult issues were determined through input from a broad range of individuals and organizations, including consumers, service providers, family members and other interested stakeholders. Interpreter services were offered at the stakeholder meetings for persons speaking our threshold language (Spanish). Contributions were gathered during Stakeholder Meetings, as well as through Surveys, Focus Groups, and Service Provider Meetings.

The Stakeholder Meetings consisted of 3 all day conferences and included 42 consumers, 26 family members, 146 service providers, and 31 other interested community stakeholders. In between the Stakeholder Meetings, various committees met as often as possible to discuss, detail and prioritize recommendations.

The individual adult committees (age 18 and older) focused on specific topic areas:

1. Mental Health Services;
2. Employment Services;
3. Older Adults (65+);
4. Housing and Supports;
5. Dual Diagnosis;
6. South County/Watsonville;
7. Criminal Justice;
8. Homelessness; and
9. Transition Age Youth -Recovery TAY (18-24).

Committee membership was open to all interested persons. Every effort was made to include representation of consumers, providers, family members, and a topic expert. Final committee recommendations were prioritized in a multi-vote process by all stakeholders and the results are listed below in rank order.

Prioritized Recommendations of Combined Stakeholder Adult Committees:

1. Mental Health Services: integrated service teams, wellness centers, crisis services;
2. Employment Services: supported employment and education, employment specialists;
3. Older Adult Services (age 65+); mobile crisis, peer supports, housing supports;
4. Housing and Supports; rent plus, supported housing;
5. Dual Diagnosis; integrated dual diagnosis treatment;
6. South County/Watsonville; wellness center, increase access for Latino population;

7. Criminal Justice; jail discharge planner, crisis services, mental health court;
8. Homeless; wellness center, expand current AB2034, peer support; and
9. Transition Age Youth – Recovery TAY (age 18-24) integrated service teams.

There were 270 Surveys completed by consumers, family members, service providers, and other interested stakeholders. Surveys using various mediums and formats were provided and submitted in English and Spanish. Surveys were completed during meetings and focus groups on paper, on line at the county web site, and submitted via regular mail. (Refer to previous discussion in Part I: Section I, pages 1-9.) The surveys ranked the following areas as high priority needs to be addressed with MHSA funding.

Priority Rankings of Survey Data

1. Mental Health Services,
2. Housing and Supports,
3. Health Issues;
4. Illness Management;
5. Dual Diagnosis;
6. Employment Services; and
7. Consumer Run/Peer Services.

There were 8 Adult Focus Groups that consisted of consumers and family members. The Focus Groups ranked the following topics as priorities that should be addressed through MHSA planning and funding:

Focus Group Priority Rankings

1. Mental Health Services: smaller caseloads, more coordinators, peer counselors, integrated service teams, mobile crisis
2. Criminal Justice: jail crisis worker, additional nursing staff
3. Employment: supported employment and education, peer counselors,
4. Housing: supported housing, independent housing with supports, mobile crisis, and residential treatment.

There were 6 initial Provider Meetings that included a cross representation of all the major mental health service providers in the county. Efforts were made to involve direct service staff, supervisory staff, and various levels of management from each organization. Three (3) months after the first phase of the planning process was completed, additional meetings were held that included both provider meetings, as well as all County and Contract staff. (Detail regarding the number of attendees and composition for both planning phases is referenced in Tables 1-2 in Part I, pages 8-9.) The results of these Provider Meetings indicate general consensus with the above recommendations of the Focus Group, Stakeholders, and Surveys.

D. Older Adults

The Older Adult Committee that met throughout the public planning process represented a spectrum of individual and organizations involved with older adults in Santa Cruz County. The historical and current experience of each member was presented and discussed. Early in the planning process, it became strikingly apparent that there are significant barriers to older adults accessing mental health services.

Analysis of data suggested that many older adults with severe mental illness have not been served in Santa Cruz County. Equally significant is the lack of a mobile, integrated, and wellness-focused treatment program for older adults. These factors have led to a large number of unserved older adults in the community. Consequently, with current pressing needs and Wellness concepts in mind, the Older Adult issues listed in the above table were considered vital to address as the initial steps in developing an older adult treatment program.

Question 3: Please describe the specific racial/ethnic, and gender disparities within the selected community issues for each age group, such as access disparities, disproportionate representation in the homeless population and in county juvenile or criminal justice systems, foster care disparities, access disparities on American Indian rancherias or reservations, school achievement drop-out rates, and other significant issues.

Response 3:

A. Children

As indicated in Table 7 below (see Appendix A: Figure A.4 for more detail), of the 61,834 total children/youth in Santa Cruz County, approximately 25,166 are Hispanic/Latino (41%) compared to 31,934 White children (52%). Of the total child/youth population receiving services (1,451), the service data tends to indicate that Hispanic/Latino clients (644, or 44%) have fairly equitable access compared to the general population (as well as the 626 White children/youth, or 43% of clients served).

However, when comparing service delivery ethnicity data to the priority population of children/youth at or under 200% of poverty, the analysis changes. This total child/youth sub-population (20,661) is 66% Hispanic/Latino (13,543 children/youth), compared to 5,753 White children/youth (28%). While the “penetration rate” for Latino youth accessing mental health services is relatively good compared to the general population served, the data still shows that we must increase access opportunities for them, particularly for Latino children/youth at or under 200% of poverty.

Table 7: Child/Youth Prevalence & Service Data by Ethnicity

[State Dept. of Finance Population Estimates vs Santa Cruz County FY 03-04 Data]

Ethnicity	2004 Child Census (% of Total)	2004 Child Census <200% Poverty	Unduplicated Children Served
White/Caucasian	52%	28%	43%
Latino/Hispanic	41%	66%	44%
African American	<1%	1.7%	3%
Native American	<1%	<1%	<1%
Asian	2%	1.5%	<1%
Pacific Islander	<1%	<1%	<1%
Multi-Ethnic	4%	2%	6.6%
Other/Unknown	<1%	<1%	<1%
Total	61,834	20,661	1,451

In addition, it is evident (see Appendix A: Figure A.4) that we serve a higher proportion of adolescents in our system. Indeed, through our participation in the California Institute for Mental Health (CIMH) Outcome Development Team with 7 other counties, we discovered that Santa Cruz serves a significantly higher proportion of adolescents than all the other counties. We view this as both a strength and a gap: evidencing a strong service array for adolescents, but also pointing to the need for increased outreach to Latino children between the ages of 0-11.

The proportion of male/females served is fairly close, but weighted (as is often the case) towards identification of more issues among boys. Hence, tailoring services to better identify the mental health needs of girls across our subcommittee recommendations will be important.

Because of the interagency System of Care, there is a well-established linkage and referral processes set up with Probation and Child Welfare, who do a good job of identifying the mental health needs of children and youth across racial, ethnic and gender categories. We know that, historically, children and youth from “minority” groups (soon to become the “majority” in California) are often over-represented in Probation and Child Welfare due to various risk factors (poverty, crime, institutionalized racism). The strong interagency case management and referral processes help assure access to needed services for this population. While we view these targeted interagency referral links as a strength, we are concerned that these youth have not received services prior to reaching the level of Probation and Child Welfare involvement.

Therefore, for children and youth with serious emotional disturbances (SED) in the schools and general community, who do not rise to the severity level of Probation and Child Welfare clients (and are not AB 3632 I.E.P. identified), we must do a better job of outreach, with increased service provision, to Latino youth in particular.

B. Transition Age Youth (Transitional/SED 18-20)

The racial/ethnic analysis in the previous Child/Youth section is applicable to this section on Transition Age (SED) foster youth as well, as there are no unique disparities amongst individuals transitioning out of children’s system of care based on ethnicity.

Available census and other data did not support an analysis of the TAY Recovery population as a specific subgroup. It is assumed for planning purposes that racial/ethnic and gender disparities as they may exist for this group are the same as for the general adult population and decisions about program development, and resource allocation for TAY Recovery were based upon data for the general adult population.

C. Adults (18+) (Ref. Appendix B: Figure B.11.)

Racial/Ethnic Disparities in Accessing Services

As indicated in the table below, when comparing the State Department of Finance population estimates to the FY 03-04 utilization data, the Adult Latino population is accessing services at a rate that is not proportional to the presence of this cohort within the community. Data indicates that while 25% of the population is Latino, the percentage of all services provided includes only 13.1% for Latinos. Unduplicated eligible Latino Adults receiving services were 16.8% of all unduplicated adults.

The other ethnic group underutilizing service and under-represented was Asian, with 4% representation in the population compared to 2% of the services accessed, and 1.2% of the unduplicated client total. Adult White individuals are over-represented both in numbers of services accessed (69% vs. 77.8%) and unduplicated client count (69% vs. 72.9%). The Latino population, the largest potentially unserved ethnic group, will be the priority population and receive the most attention from MHSA strategic planning.

Table 8: Adult Prevalence & Service Data by Ethnicity

[State Dept. of Finance Population Estimates vs Santa Cruz County FY 0304 Data]

Ethnicity	2004 Adult Census % of Total	Services Accessed % of Total	Unduplicated Clients % of Total
White/Caucasian	69%	77.8%	72.9%
Latino/Hispanic	25%	13.1%	16.8%
African American	<1%	1.3%	2.6%
Native American	<1%	<1%	<1%
Asian	4%	2.0%	1.2%
Pacific Islander	<1%	<1%	<1%
Multi-Ethnic	<1%	3.0%	2.5%
Other/Unknown		1.5%	2.4%
Total	198,368	226,400	2974

Racial/Ethnic Disparities: Homeless Population

The ethnic breakdown of the homeless population, as determined by the 2005 Santa Cruz County Homeless Census and Survey project analysis, consists of fewer than expected White/Caucasian individuals, while there is an over representation of several other ethnic groups; including Latino/Hispanic, African American, Native American, and Multi-Ethnic individuals. Non-white ethnic groups are more likely to have higher unemployment, more physical health issues, and lower family income and these factors may contribute to an increased incidence of homelessness for those individuals.

Table 9: County Adult Population and Homeless Estimates

[Santa Cruz Homeless 2005 Project Estimates
vs State Department of Finance Population Estimates]

Category	2005 Homeless	2004 Adult Census
White/Caucasian	58%	69%
Latino/Hispanic	28%	25%
African American	4%	<1
Native American	4%	<1
Asian	1%	4%
Pacific Islander		<1
Multi-Ethnic/Other	5%	<1
Total	804	198,368

Racial/Ethnic Disparities: Criminal Justice System (Ref. Appendix B: Figure B.10)

Individuals incarcerated in the County jail system are under-represented by the White population (70% vs. 59%) and the Asian population (4% vs. <1%), and over represented in the Latino (22% vs. 34%) and African American population (<1% vs. 4%).

Table 10: County Adult Population and Jail Census

[2004 Santa Cruz County Jail Census vs
State Department of Finance Population Estimates]

Category	2004 Jail Census	2004 Adult Census
White/Caucasian	59.0%	70%
Latino/Hispanic	34%	22%
African American	4%	1%
Native American	<1	<1
Asian Pacific Islander	1%	4%
Multi-Ethnic	<1	<1
Other	<1	3%
Total	9104	198,368

Racial/Ethnic Disparities: American Indian Rancheria or Reservation

No federally acknowledged Native American Indian Reservation exists in Santa Cruz County.

Gender Disparities for Accessing Services (Ref. Appendix A: Figures A.4 & A.5)

As indicated in the table below, the proportion of males receiving services is very comparable to the County population, with the unduplicated client utilization within the County mental health system evenly split between males and females (49.2% compared to 50.8%). Prevalence data to be examined later may yet challenge this apparent equitable service allocation.

Table 11: Adult Population and Services by Gender

[State Department of Finance Population Estimates vs
 Santa Cruz County FY 03-04 Data]

Gender	2004 Adult Census	Unduplicated Clients
Male	50%	51%
Female	50%	49%

Age/Gender Disparities: Homelessness

The 2005 Santa Cruz County Homeless Census and Survey project analysis indicated that the homeless population in Santa Cruz consists of 96.5% Adults and 3.5% Children, compared to the total population for Santa Cruz County of 76% Adults and 24% Children. There are fewer homeless Children than the general population data would suggest, and more Adults. Santa Cruz has a highly effective AB 2034 program that targets homeless mentally ill adults and their families. There is a new shelter for homeless families in the county. These programs may help to explain the lower than expected number of homeless children.

Table 12: County Census and Homeless Adults/Children

[Santa Cruz Homeless 2005 Project Estimates vs
 State Department of Finance Population Estimates]

Category	2005 Homeless	2004 Census
Adult	96.5%	76%
Child	3.5%	24%
Total	3371	260,203

The study found that 61% of the homeless were male and 39% were female, compared to the County population of 50% male and 50% female. There is a much higher incidence of homelessness among males than what the County population suggests.

Table 13: County Census and Homeless by Gender

[Santa Cruz Homeless 2005 Project Estimates vs
 State Department of Finance Population Estimates]

Category	2005 Homeless	2004 Census
Male	61%	50%
Female	39%	50%
Total	3371	260,203

Gender Disparities: Criminal Justice System (Ref. Appendix B: Figure B.10)

Individual incarcerated in the County jail system are predominately male (80% vs. 20%) and over-represented in the jail census when compared to the general population. Population data would suggest an even distribution of males and females.

Table 13: Adult Jail and Population Census by Gender

Gender	Jail Census	2004 Census
Male	80%	50%
Female	20%	50%

Gender Disparities: American Indian Rancheria or Reservation

No federally acknowledged Native American Indian Reservation exists in this County.

D. Older Adults

Information was not available to analyze racial, ethnic and gender disparities of the Older Adult population. The Adult sections above include all individuals age 18 and older. Available census and other data did not support an analysis of the Older Adult population as a specific subgroup. It is assumed for planning purposes that racial/ethnic and gender disparities as they may exist for this group are the same as for the general adult population and decisions about program development, and resource allocation for Older Adults were based upon data for the general adult population.

Question 4: If you selected any community issues that are not identified in the “Direction” section above, please describe why these issues are more significant for your County/community and how the issues are consistent with the purpose and intent of the MHSA.

Response 4: No community issues were selected which were not previously identified in the Direction section.