MHSA Prevention and Early Intervention (PEI) Taskforce Meeting #3
Friday, Dec. 8, 2017, 2 PM – 4 PM
225 37th Ave, San Mateo, CA

Presenters: Doris Estremera, MHSA Manager; Emily Roberts, First 5 SMC; Peter Ehrhorn, StarVista; Molly Henricks, BHRS; Jim Rutherford, BHRS
Attendance: Please see sign-in sheet for a full list of attendees

I. Review of previous meetings:
   a. At the first Taskforce meeting on Oct. 27th, prioritized needs/areas from MHSA three-year planning and Commission input and PEI program landscape were shared. Taskforce identified broad values/framework for PEI funding moving forward. Requests for additional data were taken.
   b. At the second meeting on Nov. 17th, we heard presentations from PEI programs currently funded by MHSA, shared data and started work on strategy development for priority needs/areas.
   c. Strategy development continued in the interim and were presented today. Important considerations will be discussed and prioritization across strategies and against PEI values and framework will be accomplished.
   d. We also received considerations from youth and parents, which Doris will share.

II. Strategy presentations (please refer to MHSA PEI Priority Issue summaries)
   a. Responding to youth mental health emergencies – Molly (BHRS)
      i. Recommendation: Mobile mental health crisis support and prevention for youth
      ii. Description/Desired Outcomes: This team would respond to transition age youth (age range not determined yet) in crisis, regardless of insurance. The team would not necessarily provide 24-hour support to begin with, instead being available throughout the school day until 8 or 9 pm (when parents are dealing with potential crises at home). The team would be comprised of two people (for safety reasons) who would have the ability to go out to the home, perform assessments, and provide care at home. The goal of this strategy would be to prevent youth from going to the hospital for non-5150 issues, avoid involving law enforcement and give parents what they need to care for their children in crisis at home. This strategy would be better and more cost effective than having police or ambulance transport youth to the hospital PES. The team would also help parents follow up with providers and the school, and eventually work with schools to identify signs of mental illness.
      iii. Research/Data: The need for prevention in this realm is evident in the fact that SMC has the highest rate per 100,000 youth of self-inflicted injury hospitalizations compared to neighboring counties (71.2% compared to 43.1% for the rest of CA).
      iv. EBP/Promising Practices: Safe Alternatives for Treating Youth (SAFTY) is Santa Barbara County's youth mobile crisis response service. It was noted that despite not having as many resources as SMC, SAFTY provides crisis intervention, in-home support, and linkage to services.
         1. Best practice: StarVista has one person who does outreach and offers presentations to schools, but many more presentations are requested than can be met. (Molly also does a training that is a gap-filler.)

2. EBPs: QPR (question/persuade/refer) is shorter in time, and can be incorporated into what Molly and StarVista do.
    - Other EBPs offered by the County include Youth Mental Health First Aid and Applied Suicide Intervention Skills Training.

v. Considerations:
1. Feedback from youth and parents:
    - parents and those around the youth who is experiencing the crisis need support too
    - Empathy of the staff who are responding was very important
    - A peer component or peer model should be integrated into the strategy.
2. What are the supports that could be articulated in the proposal, even if it is not part of the proposal itself? For example, is there a way to use the Neurosequential Model (NMT) team to identify the cohort of youth and make sure they get connected?
    - Regional mobile stabilization—counties are looking at this as a way to stabilize juvenile justice involved and foster youth
3. Parental education
    - For example, parents react with fear to cutting, which kids interpret as anger, leading to youth feeling fearful of telling their parents when they cut. Providing parents some psychoeducation about what cutting is and isn't would help.
4. Addressing barriers with specific groups, particularly ethnic minorities and immigrants
5. Insurance as noted in a previous meeting, about 50% of youth in SMC are covered by Kaiser, and this strategy would use public funds to absorb some of the cost that private insurance should be covering.
    - Molly spoke to the program manager of SAFTY in Santa Barbara, who said that they are working on developing contracts with private insurance companies like Anthem.
    - With private insurance companies, the start-up is daunting, but if we can show that we are serving a lot of Kaiser kids, we can get them to be part of the strategy.
    - Toni also pointed out that in SMC, a lot of completed suicides are private insurance kids, and there is no information on what happens post-suicide. We should engage those partners in conversation on better care and case management.
6. Age range - risk for child abuse starts as young as 3 or 4 years old. Providers often don't know what to do with children this young, and parents who children have behavioral issues often opt to medicate. This strategy needs to include some kind of prevention to help kids early on.
    - One way to do that is to embed family partners who could break down barriers within vulnerable communities.
    - On the upper end of age, we have young veterans who see mental health issues as a sign of weakness. The strategy should link parents of returning veterans to culturally appropriate services and supports.

b. Improving school and community connectedness – Jim (BHRS)

i. Recommendation: Community Schools for school and community connectedness

ii. Description/Desired Outcomes: Community Schools have Family Resource Centers on campus, which are hubs for parents and families that provide multiple benefits. They are often staffed by people who can speak the language of the parents. They build trust among parents because the Community School is where their kids go. They can be a first point of identification of mental health issues, and a place for parents to ask questions around behavioral health. HSA providers are also on hand to provide therapy. Community Schools also have parent groups, where the principal sits down with parents to discuss issues, creating a real opportunity for parents to become empowered in their children's education. Parents can also access resources for food, clothing, housing, and more—the point is to provide resources where they are, as opposed to in silos.

iii. Research/Data: School connectedness is the strongest protective factor to decrease substance use, school, absenteeism, early sexual initiation, violence, and risk of unintentional injury. School connectedness is second in importance, after family connectedness, as a protective factor against emotional distress, disordered eating, and suicidal ideation and attempts.

1. However, minority groups feel less connected: while 7.8% of all students felt a low level of agreement regarding school connectedness, 12.4% of African American, 10.3% of Hispanic/Latino, and 8.4% of Pacific Islander students felt a low level of agreement.

iv. EBP/ Promising Practices: Most Community Schools in Redwood City are elementary schools, and have already helped build a more robust community, especially with monolingual parents. The opportunities that they offer for parents in leadership and participation in their children's education has led to greater success in student achievement.

v. Considerations:

1. Feedback from youth and parents:
    - The Family Resource Center model has helped parents and kids feel more connected to their community, teachers and school administrators, and mental and behavioral health supports.
    - Parents expressed that it is very important to talk about cultural humility and the impact of racism and bias.
    - Parents asked that we keep in mind how connectedness affects youth from minority groups (minority groups feel less connected).
2. Molly reiterated that this disparity in feelings of connectedness is huge in the Coast (Hispanic vs. Caucasian)
3. Continuing this model in middle school and high school can also help with continuity: one parent talked about how resources were available to her at her child's elementary Community School, but when her child transitioned to middle school, all those resources were gone.
4. A potential strategy for Family Resource Centers is to function as a pipeline from pre-school to elementary school, to middle school, and to high school.

5. Sustainability relies on collaborative/diversified funding—Community Schools are proven to be an effective model in part because they have buy-in from different agencies/funding streams. This is a potential challenge because it would take more than just MHSA funds to sustain this strategy but, BHRS would not take lead
    - RWC2020 is an agency that advocated for and led this model. Redwood City has been successful at implementing the Community Schools model because RWC2020 provided a lot of resources, and had a lot of help from such agencies as HSA and StarVista.
    - If we were to move forward with this, MHSA could be part of it in terms of funding, but it is not an effort that BHRS could lead.
6. This strategy requires high readiness:
    - Daly City wanted to have a Community School, but some of the funding fell through.
    - San Bruno is not considered to have high readiness because the school and community have not been able to coordinate
    - Mary notes that there is readiness at Jefferson Union.
7. Would this funding be providing staff? (Not at that stage of planning yet.)
    - A pre-planning process looking specifically at readiness and need is clearly needed.

c. Prevention, early identification and treatment for children age birth-5 – Emily (First 5)

i. Recommendation: Centralized and coordinated system of care for children ages 0-5.

ii. Issues brought up before: pre-school expulsions; suicidal behavior among 3, 4, and 5 year olds; and a tendency among well-intentioned providers to say or hope that mental health issues in early childhood are a phase that will pass.
    1. Early childhood is an area where a lot of intergenerational trauma manifests
    2. 95% of the brain develops in this time
    3. Addressing this time period won't solve everything but will help prevent a lot of the problems down the road like youth crisis

iii. Description/Desired Outcomes: Help Me Grow is a national model that is not a stand-alone program, but the scaffolding that holds locally available programs and resources together. It helps parents who are struggling and do not know if their child has issues with mental health, behavior, or development. With the approach that everyone has questions, it provides an entry point for parents and providers alike. The entry point is the call center (some Help Me Grow models have a texting component), which is staffed by well-trained providers, and acts as a hub or communication point. Other important components of the program:
    1. Health provider outreach component: works directly with pediatricians
        - 95% of pediatricians surveyed would use this system to support families who need this—warm hand-off

2. Community provider outreach component: early education providers, faith-based community members, mothers' groups (a lot of outreach and psychoeducation go into this model).
3. Data piece: tracks referrals and helps us understand the fragmentation in the system

iv. Research/Data: Help Me Grow has a lot validity and promise—the national model, which was started in Connecticut, has been adopted by 25 states, and 18 counties in CA. It is successful because it does not supplant services, but rather, enhances access to services.
    1. Looking at the data, we know that parental mental health impacts children's mental health. There are already a lot of home visiting programs, as well as many programs that provide other early childhood services, but not a lot of coordination. Our impact could be the coordination.

v. Momentum/Stakeholder Support: First 5 is interested in this model, and is trying to bring together partners. While First 5 will be a funder, it cannot fund everything.

vi. Considerations:
    1. Feedback from youth and parents:
        - Services are not just about mental health—what causes stress is lack of basic needs
        - In addition to continuity (feeling like services disappear after children transition to a new development stage), parents felt that there is a lot out there, but they don't know how to access.
    2. Sarah's experience is not that there is a lot out there, and many do not meet eligibility for services, e.g. families whose children do not meet medical necessity, families in which the parents are under-insured, and services where a diagnosis is required.
        - There is also a bias in diagnosis, and thus a need to educate providers in diagnosis and screening.
    3. Implementation concerns
        - How will Help Me Grow be different from 211 and the StarVista Parent Line, which have not been sustainable, and have had poor reach?
            i. So much of what services people are able to receive is driven by insurance—having a call center or access point does not change that.
            ii. Emily noted that a feasibility study showed that previous call centers did not actually do what Help Me Grow does Additionally, other CA counties noted that they had high utilization, but that it depends a lot on outreach.
    4. How will this strategy work with the Access Call Center?
    5. The feedback that First 5 received from parents is that they feel isolated, depressed, lonely, and don't know where to go for supports—Help Me Grow addresses those issues.

d. Supportive services for high-risk Transition Age Youth (TAY) – Peter (StarVista)

i. Trends: bridging gaps—TAY is broadly considered to be ages 13-25, but services for youth ages 13-18 can look different from services for those who are 18-25.
   1. Continuity of care is really important for this population
      - Having one caring, supportive adult has been shown to be really important for ensuring continuity—this person could be a mentor or case manager.
      - Trust and consistency are also very important to this population.

ii. Recommendation #1: Drop-in support services for high-risk TAY.
   1. Support services include educational, vocational, mindfulness and other skill development.
      - Feedback from Camp Glenwood: mindfulness really helps with mental health and behavior
   2. Other services available: AB12 (non-minor dependent service), THP+ (transitional housing services)

iii. **Recommendation #2: Support services for TAY involved in Juvenile Justice or** Foster Care System.
   1. What makes this strategy unique is that it would serve juvenile justice youth who have been diagnosed with a mental illness, starting when they are incarcerated and following them out.

iv. Gaps in the system:
   1. Many youth who are first time offenders are sentenced to weekend detention, but services are not provided on weekends—this is potentially a key place to intervene, and reduce the likelihood of recidivism.
   2. Post-incarceration, some youth lose their medical insurance: having support services with which they are already familiar and that can follow them out is another important place to intervene.

v. Considerations:
   1. Feedback from youth and parents:
      - Parents wanted to be involved, saying that including parents of 18-25-year-olds is important too.
      - What's unique is that parents of adult children do not have the same rights as parents of minors, yet they often still support their young adult children.
   2. 13-18-year-olds cannot be in the same DIC as 18-25-year-olds (this was a concern that parents raised as well)
   3. Navigating the Tides: StarVista hosted a community panel discussion for parents and community members to discuss the challenges facing children and adolescence and strategies for nurturing healthy children, promoting resiliency, and providing resources for children and families

III. Prioritizing PEI Strategies

a. Activity: Fist to Five – Attendees were asked to respond with how they felt about each of the strategies that were discussed with a show of hands, using the "Fist to Five" rating, in which a fist or 0 represents no support for the strategy ("No way! Lots of

changes needed"), and a 5 represents full support ("Love it! Wildly enthusiastic about it").

i. A. Centralized and coordinated system of care for children ages 0-5: 1s, 2s, and 3s
ii. B. Drop-in support services for high-risk TAY: 3s and 4s
iii. C: Support services for TAY involved in Juvenile Justice or Foster Care System: 3s, 4s and 5s
iv. D: Mobile mental health crisis support and prevention for youth: 4s and 5s
v. E: Community Schools for school and community connectedness: 2s, 3s, 4s, and 5s
vi. Attendees were also asked to write their level of support on scoring sheets, which were collected.

b. Planning for the next 3 fiscal years 16/17 – 18/19
   i. We need to increase our spending to meet guidelines (51% of PEI programming must be dedicated to ages 0-25).
   ii. At the same time, we need to be conservative so that we do not have to cut programs later on.
   iii. The strategies discussed today would be the priorities—we can fund one proposal now, but we have to see what our real funding is in 17/18 and 18/19 (the figured presented are projections).
   iv. Every three years we do a planning process—considerations that were left out in this process can be brought up
c. Activity: Priority Matrix Scoring – Attendees were asked to score the proposed strategies by selecting the two strategies that best fit each of the following alignment principles:
   i. Impact Alignment Principles:
      1. Upstream Prevention
      2. Research-Driven (need, promising practice)
      3. MHSA Requirements: Access and Linkage to Treatment, Timely Access, Stigma and Discrimination, At Risk Communities
      4. SMC MHSA Values: Impact of Trauma, Mental Health/Substance Use Integration, Juvenile Justice Involvement, Family and Peer Partner Integration, System Continuity, Geographic Diversity
   ii. Effort Alignment Principles:
      1. Diverse Agencies Involved
      2. Momentum – current initiatives, investments
      3. High Stakeholder Support
      4. Low Cost/Resources
   iii. Due to time constraints, these scores will be plotted based on impact vs. effort and distributed after the meeting.

IV. Strategy development—What's next? Is there room for details? How does this work??
a. A Request for Proposals (RFP) for PEI programming, in which we can specify details.
b. Next step: the recommendations and prioritization that came out of this series of meetings will be emailed and presented to the Commission (most likely in February)

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WELLNESS · RECOVERY · RESILIENCE

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