Presenters: Doris Estremera, MHSA Manager; Joann Watkin, Puente; Peter Ehrhorn, StarVista; Donovan Fones, Human Services Agency, Children and Family Services; Narges Dillon, StarVista; and Sarah Dobkin, StarVista
Attendance: Please see sign-in sheet for a full list of attendees

I. Taskforce Goal: Provide recommendations for funding and prioritization of prevention and early intervention strategies and programs for children youth and transition age youth.
    a. The goal of today's meeting is strategy development

II. MHSA Landscape – Current Programs
    a. Required of all PEI Programs: Access and Linkage to Treatment, Timely Access, Stigma and Discrimination, and At-Risk Communities
    b. San Mateo County Priorities: Impact of Trauma, Mental Health/Substance Use Integration, Juvenile Justice
        i. Added based on meeting #1: Family and Peer Partner Integration, System Continuity, Geographic Diversity

III. Program Presentations
    a. Project Success – Joann (Puente)
        i. Program summary: Now in its fourth year, Project Success is a SAMHSA-based prevention program serving students ages 9-18 in the Coastal region (rural, low-income). Groups are run by Licensed Clinical Social Workers, and conducted at lunch time (food is provided).

        The program teaches students information about drugs and alcohol, as well as refusal skills. At the 5th grade level, Project Success takes a universal approach (i.e. all 5th graders are enrolled into the eight-week program, although 4-5 parents refuse each year). It is important to start teaching refusal skills at 5th grade so that by the time students get to middle school, they have the skills to say no to marijuana, tobacco, and alcohol. (To the kids, it's about saving face and how to say no while still looking cool to their peers.) Students receive the curriculum again at 8th grade and in high school. At the high school level, the program is conducted for eight weeks back-to-back throughout the year. It addresses trauma, providing a space for kids to talk about their fears and what they see in the community in a safe way. High school students like to have the space to talk about drugs and alcohol, which is why the program runs continuously. By the time students are in high school, many have encountered Project Success previously; Project Success gets to know the kids and their families.

        In its first year, Project Success sought to maintain fidelity to the model, which was challenging because there was little baseline data. As a result of a recommendation from the Search Institute, Project Success used the Developmental Assets Model to capture pre- and post-data in later years.

        On top of groups, Puente also administers the Princess Project, which receives outside funding. The main draw of the Princess Project is that it takes girls to get prom dresses. The Princess Project emphasizes healthy dating with such topics/activities as: what to do if you go to the prom and your date brings alcohol; hormones, testosterone; movies and break-out sessions.

      ii.   Strengths: The main strength of Project Success is not the curriculum, but face time with students in a confidential, intimate, non-judgmental setting. It is not therapy, which relieves potential stigma. However, Project Success does have the ability to provide referrals, which is another strength.

     iii.   Needs or gaps: A major challenge early on was that there was very little buy-in from parents. Puente invited parents to come, and used Project Success as a starting point to talk about drug and alcohol prevention, peer pressure, and transitioning from elementary school to middle school, to high school.

     iv.   Future activities/goals: The biggest challenge for Project Success to manage right now is cell phones, so this year, they hope to address Internet and cell phone use.

b.   Seeking Safety – Joann (Puente)

      i.   Program summary: In its 2nd full year, Seeking Safety delivers a PTSD, trauma-related symptom toolkit to TAY ages 18-25 in 25 weekly sessions. Youth need to attend every group in order to maintain fidelity to the model, which is very difficult. (A stipend is offered to encourage attendance.)

      ii.   Strengths: Building community within their own age group is very valuable for participants.

     iii.   Needs or gaps: The biggest challenges are finding enough youth who are interested, finding the time for at least two participants to get together, and getting all of them to make all 25 sessions. Additionally, 18-to-25-year-olds are everywhere, and not necessarily in Pescadero or La Honda.

     iv.   Future activities/goals: This year, Puente is also trying to get 5 young moms in the group.

c.   Seeking Safety – Peter (StarVista)

      i.   Program summary: StarVista assumed administration of the Seeking Safety program when they merged with Pyramid Alternatives, which had been providing services at the Edgewood San Mateo Drop-In Center. StarVista's Seeking Safety focuses on harm reduction rather than a formal, clinical curriculum. It also provides space for youth to talk about their substance use and trauma, and links them to other services.

      ii.   Strengths: A strength of the program is that it covers a gap, as far as age and substance use related to trauma. The curriculum is also a strength.

     iii.   Needs or gaps: Continuity of care, data collection, and logistics

d.   Teaching Pro-Social Skills (TPS) – Donovan (HSA)

      i.   Program summary and strengths: Under the umbrella program of Aggression Replacement Training, TPS is an asset (versus deficit) program that focuses on social emotional learning (not therapy) in elementary school students. TPS targets kids who might not have been modeled pro-social skills in their upbringing, and addresses externalizing behaviors that affect their performance in school, as well as internalizing behaviors (kids who are withdrawn, not confident in approaching social situations).

          TPS provides a "menu" of 60 skills, and teachers who refer their students get to choose their top 10. During the 10-week program, groups focus on one skill per week. Skills fall into one of five categories:

        1.   Classroom survival: asking for help, bringing your materials to class, listening

        2.   Friendship making: a lot of kids have difficulties in their relationships with their peers

        3.   Dealing with feelings: empathy, how to express your feelings

        4.   Alternatives to aggression: conflict resolution, staying out of fights, dealing with losing

5. Dealing with stress: relaxation skills, basic mindfulness skills

       Groups are facilitated by a community worker, and consist of no more than 6-7 kids per group; groups are small because each child needs to be able to practice the skills in each session and give feedback about what they are learning. A psychiatric social worker (PSW) co-facilitates, managing classroom behaviors, keeping kids on track, identifying unmet mental health needs. The PSWs, who are funded by Measure A, ensure continuum of care and link into BHRS when a higher level of care is necessary. In the past, PSWs were from the schools, but were more recently moved out of school sites.

       Last year, HSA held 17 groups, with 5-6 students per group. The feedback from schools was that they wanted this program for all students, but referrals are from teachers for kids who have clear deficits. One clear impact of the program is that more teachers are now aware of TPS.

    ii. Needs or gaps: a previous evaluation conducted by Paul Gibson indicated that the program had a gap in communicating with parents and teachers about what students were working on. In the last few years, communication has been a main area of focus; Iliana (?) now sends letters home every week to let parents know what they're learning, and students return a signed copy for an incentive.

    iii. Future activities/goals: TPS is conducted at five schools, which were chosen based on where HSA already had family resource center programs. (Because of this, kids do not have to qualify for services.) Some of these schools also serve middle school students, and HSA would like to do this kind of prevention work with middle and high school students as well.

e. Crisis Center Youth Intervention Team – Narges (StarVista)

    i. Program summary: The Youth Intervention Team has a clinician available to conduct assessments for students with suicidal ideation, provide crisis counseling, or post-vention services to any school in San Mateo County. They take a collaborative approach with families, schools, and providers because contact with youth is very short-term.

       A major challenge for the Youth Intervention Team is the changing landscape, and increases in need. They have observed an increase in younger students needing crisis intervention services. This is in part because high schools are better equipped to deal with crisis on site, and in part because elementary school students are harder-to-assess clients. Another reason the Youth Intervention Team might get pulled in is that for teachers, it can be jarring to confront these issues in younger students. There has also been an increase in prevention education resulting in better identification of students in need (greater awareness has resulted in teachers being more likely to call Youth Intervention Team for assessments). Funding changes have also resulted in other similar services ending, and the Youth Intervention Team filling in the gaps.

       The recent increase in youth dying by suicide in SMC is mirrored in the drastic increase in crisis intervention demand. In FY 2016-17, the number of crisis intervention services delivered by StarVista far outpaced previous years (91, compared to an average of 26 in the previous three FYs). This FY, StarVista has already intervened in 22 crises, an alarming number considering that we are eight weeks into the school year.

    ii. Strengths: The suicide prevention presentations delivered by the Youth Intervention Team are a major community asset because the most successful suicide interventions have been when students were able to identify warning signs in their friends, and ask an adult for help. Peers are our primary allies, so classroom presentations ("tier 1"

prevention) are geared toward students. As with crisis intervention, the number of classroom presentations given in FY 2016-17 increased relative to previous years. The number of classroom presentations given this FY is likewise much higher than expected considering how early in the school year it is. StarVista also provides presentations to parents and guardians, trainings for school staff, and trainings for providers.

 iii. Needs or gaps: StarVista's primary gap is that they have no capacity for outreach. Ideally, the Youth Intervention Team would reach out to schools, alerting them of available services. Instead, they are reacting only to those who know about StarVista, and providing services to people who reach out to them.

 iv. Future activities/goals: As the Youth Intervention Team continues adapting to the changing landscape of what suicide prevention looks like in SMC, the ideal program would be a mobile crisis team not limited to schools.

 v. Crisis Hotline: There is currently no capacity for texting (there was a youth text line, but that program went away).

  1. StarVista runs a youth chatroom, and trains young people to be on site and answer questions via chat.

  2. Narges noted that the number of youth callers to the crisis hotline has actually decreased over the years.

  3. Doris clarified that MHSA funds a clinician who supports the crisis line and Youth Intervention Team.

 f. Early Childhood Community Team – Sarah (StarVista)

  i. Program summary and strengths: ECCT serves children ages 0-5 as well as pregnant mothers in the Coastside and Half Moon Bay. Program goals include prevention, increasing parent knowledge, improved coordination among providers, and higher access to quality childcare. The team consists of a community outreach worker (provides case management and leads child-parent activity groups), an early childhood mental health consultant (provides on-site consultations to teachers), and a licensed clinician (provides therapy and receives referrals from the community outreach worker). The team provides wrap-around services using a coordinated care approach, working collaboratively (teams meet once or twice monthly) to ensure that each member is aware of cases and that the team is thinking together about how best to support families.

   Outreach ensures that services provided to each community are targeted, meeting the needs of that community. The impact of this close connection with the community was evident after a recent shooting happened, and the team was able to talk about it with the community. Noting that pre-school expulsions happen at three times the rate of K-12 expulsions, Sarah emphasized the importance of focusing on the 0-5 age group. ECCT received Measure K expansion funding to move into North Fair Oaks, South San Francisco, Daly City, and Pescadero/La Honda.

  ii. Needs or gaps: Many clients in Half Moon Bay do not meet the definition of medical necessity. Once children "age out" of ECCT, they are not eligible to receive other services, yet there is a huge need for mild-to-moderate mental health services in the Coast.

IV. Identifying Programs & Strategies

 a. Values: characteristics we want to consider every time we develop a program (e.g. trauma-informed, continuity, peer and family partners)

b. Priorities: at least one program should address each priority, but not all programs have to address all priorities (e.g. substance use, criminal justice)
c. Highlights of the data requested by the task force at last meeting:
    i. Compared to the rest of California, SMC scores low in **community connectedness** and **school connectedness** (i.e. youth do not feel supported in the community or at school).
    ii. Data on **social media** and **bullying** (including cyber bullying) are available today, and worth digging into more.
    iii. Geographic data: Probation, BHRS, and HSA looked at high-readiness (e.g. facilities) and high-need (e.g. juvenile probation "hot spots") areas, and mapped it out geographically based on high end usage by youth
        1. Communities that showed the highest scores for readiness: Daly City, SSF, HMB, Menlo Park, and EPA
        2. Srija said that the point of the mapping activity was to hone in on micro-communities (ideally 1.5 mile radius around an elementary school), so that County department could work with key stakeholders in that area, rather than whole cities.

V. Group Activity: attendees split into small group to discuss focus issues based on interest
a. Focus issues:
    i. School crisis response
    ii. Supportive services for TAY
    iii. School and community connectedness
    iv. Other topic: one group wanted to focus on early childhood
b. Prompts:
    i. Describe what the ideal program/service would look like to address the issue.
    ii. What is the ideal desired outcome?
    iii. Are there examples of similar efforts or programs elsewhere? Best practice models?
c. Data packets were provided to each group.
d. Please see small group discussion notes

VI. Next meeting will be prioritization
a. Opportunities/trends and other considerations will be discussed
b. Before the next meeting:
    i. We will have youth input from StarVista /Coastside and Edgewood youth provided input during the 3-year planning
    ii. Srija suggested inviting parents to give input as well

MHSA Prevention and Early Intervention (PEI) Taskforce Meeting #2
Small Group Discussion
Community and School Connectedness

Group members: Noelle Bruton, Jenei Littrell, Jessica Misslin, Ziomara Ochoa (point person), and Jim Rutherford (point person)

1. Describe what the ideal program/service would look like to address the issue.

Family Resource Centers at each school site
- Culturally appropriate
- Provide linkage and resources
- Navigators – family partners – parents w/ lived experience
- Universal screenings
    - Key questions at registration (SMUHSD)
- Staff trained on indicators
- Focus on marginalized communities

If not be each district, then by clusters
- Integrating mental health into centers to support mild-to-moderate

Mental health consultant on site w/ 0-5 specialty
- Community school model? (RWC 2020)

Continuum from 0-college
- More involvement with child development center and head start programs – earlier-on interventions ==NMT==
- Day treatment programs 0-5 (Richmond has a center)
- Supports for staff and adults ==NME==
- Seamless transitional process, creating a contimuum
- Increase awareness of 0-5 population in the schools

2. What is the ideal desired outcome?

- Empowerment
- More representation on school boards
- Students of all backgrounds feel welcomed
- Higher success rate
- Increase trauma-informed services
- Higher level of engagement
- Reduce risk factors
- Improving parental participation
- Increasing equity around access to educational info
- Earlier detection
- Increase support for teachers
- Use social media to increase access

3. Are there examples of similar efforts or programs elsewhere? Best practice models?

- HAS- FRC
- RWS2020 – Community Schools
- Richmond Center- 0-5 Day Treatment Program
- UCSF- shadowing in the pre-schools – helping with social skills

MHSA Prevention and Early Intervention (PEI) Taskforce Meeting #2
Small Group Discussion
Early Childhood

Group members: Sarah Dobkin, Emily Roberts (point person), Eric Valladares

1. Describe what the ideal program/service would look like to address the issue.

- Attention to the youngest children – earliest point of prevention/intervention
- Looking at systems – how are "identified" children representative of challenges within a system (policies, etc.)
    - (Issues that systems are less comfortable responding to lead to more referrals)
    - Systematized developmental screening/health screening
- Who can be the champion?
    - Being more embedded at community clinics
    - Pediatrician in the "person"
        - Most children attend well child visits
        - Most trusted source of information is pediatrician
- At the health home:
    - Screening for trauma and developmental concerns
    - How to systematize other screenings
- Educating providers about bias and its impact on perceived challenges/needs of children and families
    - Coming from strengths – as opposed to deficits
- Social connectedness – addressing parent isolation
- Safe place to express concerns without worry about CPS involvement/repercussions
- Training opportunity for online group moderators
    - Someone who is connected to the resources – peer support

2. What is the ideal desired outcome?

- Parent connection – building parent networks as early as possible → pregnancy
- Early identification
- Universal screening – development, health, mental health
- Collaborative providers – ensuring providers are connected with each other
- Reflective, trauma-informed providers/systems
- Social media/accessible groups
    - How to facilitate these groups?
    - Peer mentors?
    - Connected to…?

3. Are there examples of similar efforts or programs elsewhere? Best practice models?

- Help Me Grow – general questions/concerns
    - Normalizing parents' questions
    - Anonymous
    - Back end is connected to services

- o Phone line
- Trauma-informed programs (focusing on collaboration)
- Reflective practice training/upervision for providers (peer mentors, medical providers, prenatal care providers)

MHSA Prevention and Early Intervention (PEI) Taskforce Meeting #2
Small Group Discussion
School Crisis Response

Group members: Nancy Chen, Narges Dillon (point person), Donovan Fones, and Molly Henricks

1. Describe what the ideal program/service would look like to address the issue.

Mobile crisis support 5-21 years
- 9 am – 9 pm Monday-Friday, 2-10 pm Saturday/Sunday
- Ability to go to house
- Transport to PES
- Work with family to link to services
- Counsel for 8-10 weeks while working with school or community resources
- Navigating range of services

Prevention
- Teachers need to be better equipped to deal with crisis, but this is a difficult demand given how much responsibility they already have
- Funding for teachers to be able to attend a full-day, eight-hour Mental Health First Aid training
  - Funding would pay for training as well as substitutes so that teachers can do the training on a regular work day (so that training does not take the place of another needed in-service training)

2. What is the ideal desired outcome?

3. Are there examples of similar efforts or programs elsewhere? Best practice models?

- Mateo Lodge – FAST mobile support
- Any youth mobile crisis in other counties

Additional, related resources (from Martin Fox):
- Los Angeles County Sheriff's Dept. Mobile Evacuation Team
- Sheriff's Dept. Psychiatric Emergency Response Team (only 8-5, 4 days/week)

MHSA Prevention and Early Intervention (PEI) Taskforce Meeting #2
Small Group Discussion
Support Services for TAY

Group members: Peter Ehrhorn (point person), Doug Fong, Martin Fox, Fernando Knight, Angela Powell, and Betty Saven

1. Describe what the ideal program/service would look like to address the issue.

A major theme of the discussion was around TAY who are entering the community as young adults upon discharge from foster care, military service and/or juvenile detention. It feels incredibly advantageous if these youth could have at least one caring, supportive adult that remained consistent in their lives over time. This personal connection could serve the youth as a mentor, or advisor, or therapist. Someone the youth could count on as a support and help them work through life's choices, if needed. While we are aware there are challenges in creating a service like this, it was a common, trauma-informed, theme that arose.

Another idea is to integrate Mindfulness work in serving TAY in foster care and juvenile detention. This work can be taken home and done on their own and has the potential to serve them for the duration of their lives. Dr. Sam Himelstein has created an evidence-based practice and written two books based on his work providing Mindfulness-based therapeutic interventions for high-risk adolescents at Camp Glenwood. One of the books is integrating Mindfulness-based approaches for addressing substance use concerns. Sam is a former StarVista employee and while he was working toward is doctorate, he served as a group therapist at Camp Glenwood. Sam now provides training all over the country. This type of service (and/or training) could be provided at Camp Kemp, Camp Glenwood and the Youth Services Center as well as various community based organizations (which would satisfy almost all of the priorities listed: Access and Linkage to Tx, Timely Access, At Risk Communities, Impact of Trauma, MH/Substance Use Integration, Juvenile Justice Involvement).

2. What is the ideal desired outcome?

- Decrease in recidivism amongst youth.
- Decrease in homelessness post military, foster care, justice system.
- Increase in youth's knowledge and ability to navigate community resources.
- Continuity of care (positive adult connections) - remaining the youth's advocate for an extended period of time.
- Fewer behaviors while incarcerated

3. Are there examples of similar efforts or programs elsewhere? Best practice models?

- Transitional Housing Placement Plus (THP+) for former juvenile justice and foster youth.
- CASA
- StarVista's clinicians continue to provide therapeutic services post release from Camp Kemp and Camp Glenwood to provide continuity of care.
- Fresh Lifelines for Youth (FLY) provides re-entry services for youth about to be discharged back in to their communities.

MHSA Prevention and Early Intervention Task Force

Date: Friday, Nov. 17, 2017   Start Time: 2:00 PM   End Time: 4:00 PM

Last Name	First Name	Attended 1st Mtg	Signature	Organization/Agency or Client/Consumer	E-mail or phone number (optional)
Bruton	Noelle	x		BHRS	nbruton@smcgov.org
Chen	Nancy	x		BHRS-ODE	nchen@smcgov.org
Cornejo	Rocio	x		NAMO/MHSARC	(650) 544-1698
Demarco	Toni	x		BHRS	
Dillon	Narges	x		Star Vista	
Dobkin	Sarah	x		Star Vista	sarah.dobkin@star-vista.org
Ehrhorn ~~Ehron~~ :)	Peter	x		Star Vista	peter.ehrhorn@star-vista.org
Fones	Donovan	x		HSA CFS	dfones@smcgov.org
Fong	Doug	x		BHRS	dfong@smcgov.org
Fox	Martin	x		SMC Veterans Coalition	martyfox@juno.com
Henricks	Molly	x		BHRS	(415) 342-2610
Hong	Susan	x		Edgewood	susanh@edgewood.com
Hughes	Suzanne	x		One Life	suzie@onelifecounselingservices.com
Knight	Fernando	x		Life Moods	(650) 771-6925
Lui	Kristie	x		BHRS	
Marroquin	Cindy	x		RTS	cindy@rapetraumaservices.org
Misslin	Jessica	x		Sand Hill Foundation	jmisslin@pfs-llc.net
Ochoa	Ziamara	x		BHRS	(650) 573-2174

MHSA Prevention and Early Intervention Task Force

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Last Name	First Name	Attended 1st Mtg	Signature	Organization/Agency or Client/Consumer	E-mail or phone number (optional)
Richard	Hope	x		MHA	(650) 281-8981
Roberts	Emily	x		First 5 SMC	eroberts@smcgov.org
Rutherford	Jim	x		BHRS	jrutherford@smc.gov.us
Saven	Betty	x	Betty Saven	MHSARC	bettysaven@yahoo.com
Scott	Raynard	x		Life Moods	
Srinivasan	Srija	x		Health System	ssrinivasan@smcgov.org
Staurt	Darren	x		MHA	(650) 274-5195
Stoll	Michael	x		El Centro	mistoll@comcast.net
Valdivias	Luis	x		El Centro de Libertad	(650) 599-9955
Vehsha	Sorooshian	x		Telecare	
Watkin	Joann	x		Puente	jwatkins@mypuente.org
Young	David	x		BHRS	
Keene	Hertrudez	1	Hertruda Keene	Life moves	Hertrudez.Keene.7@Gmail.com
Littrell	Jamie	NO		SMCOE	jlittrell@smcoe.org
Torrijos	Geardy	No		SMC BOS D1	gtorrijos@smcgov.org
Valladares	Eric	No		Star Vista	eric.valladares@star-vista.org
Powell	Angelo	No		Star Vista	Angelo.Powell@star-vista.org
Espinoza	Jason	No		OHS	jason.r.espinoza@mhn.com