

MHSA Prevention and Early Intervention (PEI) Taskforce Meeting #1

Friday, Oct. 27, 2017, 12 PM – 2 PM

264 Harbor Boulevard, Belmont, CA

Presenter: Doris Estremera, MHSA Manager and Toni DeMarco, Deputy Director, Child and Youth Services

Attendance: Please see sign-in sheet for a full list of attendees

- I. Why a PEI taskforce
 - a. New PEI guidelines have changed the programmatic requirements
 - b. PEI requires evidence-based and/or community best practices and the last time we convened a taskforce was in 2006, learnings and new best practices have emerged
 - c. We are currently underspending our required total amount for ALL PEI programming
 - d. About 51% of PEI programming is required to be dedicated to ages 0-25, if we need to increase our programming, it will need to be in the age 0-25 category.

- II. Goals and Objectives
 - a. The goal of this taskforce is to develop recommendations for prevention and early intervention programming for children, youth, and transition age youth (TAY) to present to the Mental Health Commission.
 - b. Today's objective is to provide taskforce members with information needed to make recommendations.
 - c. Today is also an opportunity for taskforce members to give input in terms of values for PEI programming. MHSA has some requirements, but also important for San Mateo County stakeholder values to be incorporated.
 - d. Focus of taskforce is not to determine if any current program needs to end, but rather set priorities for moving forward. Current programs and contracts are negotiated through a Request for Proposal process every two years and monitoring and decisions about what to move forward happens at that time.

- III. Frameworks
 - a. Continuum of Care Model: our strategy should include indicated, selective, and universal approaches to prevention
 - b. Prevention Institute's Spectrum of Prevention: approaches should also consider the spectrum of individual level, networks through changing organizational practices and policies
 - c. MHSA prevention goal is to reduce risk factors as well as build protective factors—this includes parents, caregivers, and individuals who are interacting with children and youth
 - d. Emily (First 5) added that if you approach an issue at multiple levels, you will have greater success at addressing that issue

- IV. Revenue and Expenses so far (please refer to PEI Programs and Funding handout)
 - a. We are projected to receive \$6-6.3 million in MHSA funding per year for the next two fiscal years; however, actual allocations are based on tax revenue received by the State, so these figures are only projections.
 - b. Working off of actual tax dollars received is what makes it hard to say with a high degree of certainty what the total budget is each year.

- V. New PEI guidelines separate activities for individuals ages 0-25 from those that target the general population
 - a. 51% of the whole budget must go to the 0-25 population, which includes parents, caregivers, and individuals who are interacting with children and youth
 - b. Programs that target the general population need to determine what percentage serves 0-25 specifically with general community prevention work being split 50/50

- VI. PEI Programs & Strategies (please refer to slide #10)
 - a. Note: PREP and ODE serve the general population, and not on listed on this table because including these programs would shift the percentages of funding away from the 0-25 age group
 - b. MHSAs requires that programs address certain strategies or “values”: Access and Linkage to Treatment, Timely Access, Stigma and Discrimination, and At-risk Communities
 - i. Seeking Safety and Teaching Pro-Social Skills are curricula-based strategies. While the curricula does not call for Access & Linkage or Timely Access strategies other aspects of program implementation may address these and will need to be accounted for and reported moving forward.
 - c. Additional values that were important to the 2006 PEI taskforce are included: Impact of Trauma, Juvenile Justice, Co-occurring
 - i. Joann (Puente) added that we now understand that Impact of Trauma informs so much of what we do that it comes before many of the other values
 - d. Srija (Family Health, Public Health, Health Coverage) added that it’s important to think about “0” to include pregnancy
 - i. Toni and Sarah (ECCT) said that ECCT does serve pregnant moms, and partners with Coastside clinic to reach at-risk moms.

- VII. MHSAs Three Year Plan – Stakeholder Input Process Findings
 - a. Findings from the MHSAs planning regarding gaps in services were shared. Further support was voiced by PEI Taskforce attendees for peer and family integration as well as low to moderate mental health resources—youth with low to moderate mental illness often don’t meet threshold for medical diagnosis and might not qualify for insurance, but cannot afford co-pays
 - i. Doris connected this to school crisis response services, which should be available to students regardless of insurance
 - ii. Toni echoed that many youth who have low to moderate mental illness cannot afford services—we wait for these individuals to become seriously mentally ill so that their insurance will cover services, and that is not acceptable.
 - iii. Molly (Crisis Coordination) pointed out that about 50% (from Child Death Review Team meeting) of youth in SMC are covered by Kaiser. Private providers and BHRS don’t take Kaiser insurance.
 - iv. Fernando (consumer) said that family partners are also important because doctors may miss mental health issues, and adolescents don’t always know how to describe the problems they are facing
 - v. Toni reaffirmed that when youth have a family partner (or older young adults have a peer partner), it makes it easier for them to access the help they want
 - vi. Ziomara (Coastside) spoke about community navigators in the Coast as a strategy.

vii. In terms of values, any strategies we recommend moving forward should include peer/family integration

- b. School-based services: think about extending integrated systems down to preschool and child care
 - i. Training/services for school-based providers: Sarah (ECCT) said that training should ensure that providers receive the prevention and support that they need
 - 1. Ziomara (Coastside) mentioned hubs that help teachers get the level of support they need
 - ii. Doris shared that Darrell Steinberg, the author of MHSA who remains very influential, will be advocating for school-based models
 - iii. Molly (Crisis Coordination) added that often the expectation is that schools will pay for services, but when a state mandate comes out saying that schools need to provide mental health services, that mandate does not necessarily come with funding. That means that schools are taking funding away from art, music, after-school care, etc. to meet the state demands
 - iv. Schools also have different confidentiality rules
 - 1. The Family Educational Rights and Privacy Act (FERPA) is the education-equivalent of Health Insurance Portability and Accountability Act (HIPAA), data privacy provisions in health. FERPA gives parents certain protections with regards to their children’s educational records. It is not as strict as HIPAA, and we have sharing agreements with schools for information on students.
 - 2. When outsourcing mental health services to school sites, the staff providing services are covered under FERPA.
 - 3. However, most providers (including those in the room) are covered under HIPAA. For example, when StarVista goes to a school to offer services, those staff are covered under HIPAA.
 - 4. Important that parents/students understand that confidentiality is respected and a 5150 won’t be on file or shared for college admissions
 - v. A question was asked regarding fund dissemination: Is there a provisional level of services being offered? E.g. Can it be a student earning clinical hours?
 - 1. Services may be provided by a trainee getting licensing hours
 - 2. Schools have to comply with who is getting mental health (e.g. students, not teachers)
 - 3. The only provision is related to individuals incarcerated or parolees in state/federal prisons

VIII. Further discussion on values (what values does the group want to raise?)

- a. Toni raised “artificially imposed transition points”—e.g. pre-to-three transitioning to kindergarten
 - i. Before TAY services, systems would fall away after kids turned 18—systems and services were created specifically to address that gap
 - ii. Some providers observed that preschoolers are being kicked out of pre-school—expecting them to go to kindergarten presents them with new issues
 - 1. ECCT is able to go to some schools, not all
 - 2. Additional challenges: difficult to bring children to services; school-based services aren’t always there; summer-time gap

iii. **In terms of values, strategies moving forward should consider Continuity of Care and system integration**

- b. Question was asked: who identifies children who have needs?
 - i. Velicia (consumer) brought up that parents are afraid to have their kids evaluated because they fear having their kids taken away. Where can parents take their children to get help without fear that CPS will be at your door?
 - ii. Noelle (BHRS Pre-to-Three) Pre-to-Three partners with Black Infant Health: public health nurses identify babies who may have challenges early on
 - 1. If mom is facing issues (e.g. depression, homelessness) partner agencies will also refer them to Pre-to-Three
 - c. Question was asked: how are we addressing stigma in our programs/events?
 - i. Pre-to-Three are home visitors; someone suggested their presence at stigma reduction events might be beneficial to community members
 - ii. Srija (Family Health, Public Health, Health Coverage) also felt that this discussion re-emphasized the importance of family and peer partners—if the family feels distrustful of us, we are not going to be able to help them.
 - iii. Joann (Puente) said that family engagement is essential to breaking stigma, and shared some of Puente’s strategies:
 - 1. Puente employs community navigators who help families with information on substance abuse, food, etc.
 - 2. Puente also provides a bus to bring families to events
 - 3. Family nights, movie nights, etc.
 - iv. A possible Value is to prioritize strategies in certain communities (?)
 - d. Stigma reduction: Emily (First 5) suggested making the conversation around all parents having questions, and creating safe spaces for anonymous question-asking
 - i. Normalizing questions is a communication strategy
 - ii. Most parents are looking for tools
 - iii. CAP Line from StarVista (Child/Adolescent line) was intended for this, but its funding was reallocated
 - iv. This is about having an equity lens
 - v. Honoring points of contact (e.g. home visits)
 - e. Quality of services (encompassed by “timely access”)
 - f. Doris suggested **defining all values and required strategies** to include concepts important to the taskforce. For example serving “At-risk populations,” an MHSa requirement, should include concepts of health equity; “Timely Access” should include social media strategies.
- IX. What **additional information** would the taskforce like to see?
- a. Geography: we don’t know the lay of the land of where our programs are. Mapping out where prevention services are being provided would be helpful.
 - b. What’s the latest in Evidence-Based Practice for crisis?
 - i. A potential resource is the Lucile Packard Foundation, which used to have prevention strategies for 0-3 and 9-12 (considered times of vulnerability)
 - ii. Headspace model
 - c. Molly (Crisis Coordination) would like to see data from kids.org on feelings of connectiveness, bullying, rates of suicide, self-hospitalizations due to self-injury, etc.
 - i. Feelings of connectiveness are the strongest protective factor

- ii. What are other protective factors and risk factors we want to focus on?
 - iii. Kids.org data can be pulled out by schools
 - d. Joann (Puente) would like to see data on social media access, use, and impact(s)
 - i. *From a harm reduction and prevention lens*
 - ii. Pediatric recommendations on screen time (parents are asking how much media time is too much)
 - iii. Violence prevention and developmental concerns around social media
 - iv. As far as harm reduction, what do we need to be talking to parents AND kids about?
 - v. Narges (StarVista) pointed out that while we're talking about social media, our intervention also has to be on social media. This is an issue of access.
 - e. The taskforce would also like to see data on specific communities
 - i. CA Healthy Kids survey (youth-reported): district data are online, but we can ask schools for specific data
 - 1. Nancy (ODE) also wants to see data on community and family systems
 - ii. Srija (Family Health, Public Health, Health Coverage) mentioned HSA and Probation mapped out most-impacted communities for planning purposes
- X. Future meetings/interim tasks
 - a. Youth input – Doris will follow up with the Youth Commission and other partners (StarVista, Edgewood)
 - b. We did not cover program summaries today, but we would like to include 10 minute presentations from the 5 programs (Donovan/HSA –Teaching Pro-Social Skills; Narges/StarVista – Crisis Hotline and Intervention; Joann/Puente – Project SUCCESS; Luis/El Centro – Seeking Safety; Sarah/StarVista – ECCT)
 - c. Taskforce members were asked to please send any resources, follow up leads to Doris



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End Time: 2:00 PM



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