MENTAL HEALTH SERVICES ACT

FY 2020/21 – FY 2022/23

Three-Year Program & Expenditure Plan

MONTEREY COUNTY
BEHAVIORAL HEALTH

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Letter from the Behavioral Health Director

Dear Community Members:

We present this draft Mental Health Services Act (MHSA) FY21 – FY23 Three-Year Program & Expenditure Plan (Plan) to you at a time of great fiscal uncertainty. As our stakeholders know, Behavioral Health relies on sales tax revenue, vehicle license fees and personal income taxes to fund services. The MHSA is funded by personal income tax revenue. All projections for this revenue source for the next three years suggest significant decreases. We have developed this Plan based on our current revenue estimates but anticipate a need to make future reductions as we learn more about the long-term fiscal impact of COVID-19. These analyses will be part of the Annual Update process. As we make plans to adjust to the decrease in revenues, we also anticipate an increase in demand for services, as more residents of Monterey County become eligible for Medi-Cal due to the global economic downturn.

We are thankful to the community who robustly participated in our community stakeholder process. The community was very clear that accessible and timely mental health services is a key priority as we continue to address the disparities in our communities.

The MHSA is a vital funding source that keeps critical mental health services available in Monterey County. This Plan outlines services across the lifespan, serving children ages 0 to 5 and their families/caregivers, and providing supportive housing to individuals struggling with mental illness who have been formerly homeless. We are grateful for the contractors and county staff working hard every day to serve our community in new and innovative ways. Times like these highlight even more the importance of moving forward together.

Best regards,

Amie Miller, MFT, Psy.D.
Behavioral Health Director

Introduction

In 2004, California voters approved Proposition 63 to enact the Mental Health Services Act (MHSA) with the goal of transforming public mental health systems across the state. More than two million children, adults and seniors in California are affected by a potentially disabling mental illness each year. In Monterey County, it is estimated that 4.9% of the total population (20,000 individuals) need mental health services. Californians approved the MHSA to create a mental health system that can guarantee the same level of care already extended to those who face other kinds of disabilities. Failure to address and treat mental illness as a public health issue not only creates grief and emotional pain, but it undoubtedly imposes significant public costs from increased levels of hospitalizations, unemployment, homelessness, academic failure, and incarcerations. With the funding and regulatory support of the MHSA, counties can build capacity and implement robust systems of care, resulting in greater accessibility and effectiveness of treatment services across the continuum of prevention to recovery. MHSA funds can also be used to develop a skilled workforce that builds cultures of acceptance and awareness of mental health issues and resources throughout their communities. The MHSA can also fund capital projects and technological infrastructure.

The MHSA created a dedicated funding source by imposing a 1% tax on California residents with personal incomes greater than one million dollars. MHSA funds are accumulated by the State before being redistributed to each mental health jurisdiction (all 58 counties, and 2 cities) according to their population size and other factors. To receive MHSA funds, jurisdictions must produce and locally approve a stakeholder-informed plan describing how funds will be utilized. These MHSA program and expenditure plans are required in three-year cycles, with annual updates required in the interim years. This document fulfills this regulatory requirement.

MHSA plans must identify services for all ages, as well as programs specific to the age groups of children (0-16 years), transition age youth or TAY (16-25 years), adults (26-59 years) and older adults (60 years and older). MHSA plans must also identify programs according to these five (5) MHSA components: Community Services & Supports (CSS); Prevention & Early Intervention (PEI); Innovations (INN); Workforce, Education & Training (WET); and Capital Facilities & Technological Needs (CFTN). Descriptions of these components and their programs are described in their respective sections. Additionally, the most recent data (from FY 2018/19) for programs funded by the MHSA are reported in the Appendices III, IV and V, which follow this document.

This document was informed by stakeholder input and feedback received during the Community Program Planning Process (CPPP). Following a discussion on Monterey County's demographics and characteristics, the process, and results of the CPPP is shared to provide insights on local community needs and perspectives that helped shape our MHSA Plan.

Monterey County Demographics & Characteristics

Geographic & Economic Overview

Monterey County is located on the Central Coast of California, 106 miles south of San Francisco and roughly 250 miles north of Los Angeles. The region is well known for its iconic coastlines along Monterey Bay and Big Sur as well as its fertile Salinas Valley that is dubbed the "Salad Bowl of the World." With a total population of 435,594, and land mass area of 3,281 square miles, much of Monterey County is sparsely populated and rural, with most development being clustered at the northern end of the Salinas Valley and toward Monterey Peninsula on the coast. The City of Salinas is the County seat and its largest city, as well as the hub of the agricultural sector of the economy. Monterey County is the third largest agricultural county in California, supplying the second-most jobs in the county. Educational services, including healthcare and social assistance is the leading sector for employment in the county, with tourism-based services, professional, and construction industries also playing significant roles in the local economy. Monterey County is also home to three Army bases, a Coast Guard Station, the Defense Language Institute, and the Naval Postgraduate School.

The Four Regions of the County

Monterey County has four geographic regions: The Salinas Valley, the Coastal Region, North County and South County. The Salinas Valley region is comprised of the City of Salinas and immediately adjacent towns. The Coastal Region encompasses all cities on the coast from Marina to Big Sur and includes Carmel Valley. North County is made up of the small, rural, and/or agricultural towns and districts north of Salinas. South County is the expansive area of Monterey County south of Salinas. The South County region consists of several larger cities with populations ranging between 15,000 and 30,000 people, as well as several remote, sparsely populated rural districts.

Age & Gender

The median age in Monterey County is 34.7 years, trending a couple years younger than the state median. Adults ages 25-59 make up 46% of the population, with Older Adults ages 60 and above making up another 18%. Children under 5 years old represent less than 8% of the population, Youth ages 5-15 represent 15% of the population, and Transition Age Youth (TAY) ages 16-24 represent 14% of the population. Regarding gender, 51% of Monterey County residents are male and 49% are female.

Ethnicity, Race & Language

The majority of Monterey County residents are Hispanic/Latino, comprising 58% of the population. The remainder of the population is comprised of individuals self-identifying as White (31%), Asian (6%), African American (3%), Native Hawaiian and Other Pacific Islander (1%), and Native American and Other representing 1% of the population. Of the total population, an estimated 128,954 or 30% of the total population are foreign-born. Of this foreign-born population, 79% are of Hispanic or Latino origin, and 72% are not current U.S. citizens.

Spanish is the most common language spoken at home (48% of the households in Monterey County). English is the preferred language in 46% of households, while 4% prefer Asian or other Pacific Islander languages, 2% prefer an Indo-European language, and less than 1% speak an Other Language.

Housing, Income & Poverty

The total number of housing units in Monterey County is 150,548, with 51% being owner-occupied. Over the past three (3) years, the average home value in Monterey County has declined by 13% to $441,000 while the median household income has increased by 7% to $63,249. Although these trends bode well for housing affordability, like much of coastal California regions, Monterey County has a high cost of living relative to income levels. For nearly half (45%) of the 49% of county residents who are renters, their rental costs account for greater than 35% of their household income; while 32% of homeowners' mortgage costs are greater than 35% of their household income.

The total poverty rate in Monterey County is 15%, with 22% of all children in Monterey County living below the poverty level. The latest Monterey County Homeless Census conducted by Applied Survey Research found there are approximately 2,422 individuals who are homeless in the County.

Community Program Planning Process (CPPP)

MCBH engaged in a robust CPPP using multiple approaches to ensure that residents could provide input and feedback to guide the development of the MHSA FY21-23 Three-Year Program and Expenditure Plan. MCBH adopted two primary strategies which included in-person Community Engagement Sessions and a Needs Assessment conducted via surveys of providers and community members. Each strategy is described in detail below.

Community Engagement Sessions

A team of stakeholders comprised of consumers, contractors, MCBH staff and representatives from the County Board of Supervisors was convened to guide the development of the CPPP. Stakeholders provided input related to outreach for the sessions, key community leaders to invite, locations for meetings and other logistical details that would enhance community participation. MCBH contracted with a local consultant who has expertise in community engagement and prior experience with similar community planning processes in Monterey County to facilitate the CPPP sessions and to produce a report of the information and recommendations collected from participants to inform the development of this MHSA FY21-23 Three-Year Program and Expenditure Plan.

Ten Community Engagement Sessions were held between October 2019 to December 2019. Locations for each session were selected to provide convenient, broad access throughout Monterey County, with special attention to ensuring at least one (1) opportunity was offered in North County, Salinas, South County, and the Monterey Peninsula. The sessions were advertised

via mass email, County Board of Supervisors email lists, social media, at the Monterey County Free Libraries and on the Health Department webpage.

These Community Engagement Sessions were comprised of five (5) Regional Forums – one held in each District of the County and five (5) Focus Groups specific to the following State-identified Prevention and Early Intervention priority areas: Early Psychosis & Suicide Prevention; Mental Health Needs of Seniors; Childhood Trauma Prevention; Culturally Responsive Approaches; and Mental Health Needs of College Age Youth.

During the sessions, participants received an overview of the MHSA funding components and the CPPP requirements with an emphasis on how the current CPPP would be used to inform the development of Monterey County's MHSA FY21-23 3-Year Program and Expenditure Plan. Participants were also asked to complete a Community Member Survey to gather their specific insights as part of the Needs Assessment strategy, and a separate survey to provide feedback about their experience participating in the CPPP. Professional interpreters were engaged to provide Spanish and English translation and provided simultaneous translation in both languages at several of the sessions.

At each session, participants were offered the following prompts to guide their sharing and dialogue with others:

- What are current mental health assets in Monterey County you feel are especially helpful?
- What initial insights, recommendations, concerns, advocacy, or questions would you like to share?
- What is working regarding mental health in Monterey County?
- What is not working regarding mental health in Monterey County?
- What priorities do you recommend for strengthening mental health throughout Monterey County?

Findings from the Community Stakeholder Engagement Process

Core Themes for Priority Consideration

The following four (4) core themes for priority consideration emerged across the ten (10) Community Engagement Sessions:

1. Deepen and Expand Culturally Responsive, Trauma-informed Staffing, Approaches and Practices
2. Expand In-place, Embedded Culturally Responsive Care
3. Reduce Stigma Via Localized, Culturally Responsive, Tailored Outreach, Engagement, and Education
4. Foster Policy, Systems Change

Specific Recommendations Organized by Core Theme

Deepen and Expand Culturally Responsive, Trauma-Informed Staffing, Approaches & Practices

Participants advocated for staffing, approaches, and programs that honored people's individuality and cultural backgrounds. Participants reported services which work well and are effective do not take a one-size-fits-all approach; rather, they are designed to respond to and embrace people's various cultures and experiences, whether it be racial and ethnic backgrounds, languages used, experiences of trauma, other social identities and experiences. Participants advocated for continued implementation of services to expand effective culturally responsive approaches and practices to better address the assets, interests, needs, and realities of Monterey County residents, especially those services relevant to those with historically underrepresented, marginalized, and vulnerable identities, for example, low-income, racial/ethnic minorities, homeless, Veterans, Senior Citizens/Elders, farmworkers, children and youth, LBGTQ+, system-involved, undocumented residents.

Participants also advocated for the continuation of investments in a competent, relatable Workforce, reflective of the diversity of local residents with specific recommendations to:

1. Recruit and support the professional development of Peer Educators, Wellness Navigators, and Promotores as well as licensed mental health therapists and clinicians to expand the talent pool and grow the mental health workforce, including psychiatrists, with bi-cultural staff from our local communities with lived experience, cultural relevance, community rootedness, and reflective of the diverse people of Monterey County.
2. Train mental health care providers in trauma/healing-informed approaches, implicit bias, cultural responsiveness, connections between substance abuse and mental illness.
3. Provide training and support for locals with lived experience to provide tools for others in their local communities.
4. Increase access to bilingual, culturally relatable counselors, especially in South Monterey County.

Participants also advocated for investments in and promotion of services, programs, and policies that foster protective factors and resilience, especially social connectivity, interaction, and support specific to each age group across the lifespan as well as intergenerational programming, early childhood and youth development, and parent education. Specific examples include:

1. Expand access to mental wellness promoting activities, for example: meditation, yoga.
2. Expand services for homebound Seniors to reduce isolation, including initial in-home telecare assessments.

Participants in the CPPP also advocated for the expansion of equitable access to quality, effective mental health care, recommending the following potential strategies:

1. Reduce transportation barriers by increasing in-place, embedded care.
2. Expand client-friendly hours: Need for evening and weekend access, especially given most residents are hourly wage earners without flexibility to adjust schedules to access care during traditional 8AM- 5PM, Monday-Friday service windows.
3. Develop centralized points of information, referral, and care coordination embedded in the local communities with a "no closed door", universal access approach so when a resident does seek services, they experience seamless care and connection without being turned away from care due to affordability, insurance status, or other eligibility criteria.
4. Expand Spanish and English bi-lingual services, in addition to indigenous languages spoken (e.g. Triqui), as well as Tagalog and other languages reflective of the diverse population in Monterey County.
5. Provide access to quality childcare so parents and caregivers can participate in mental health care. Creative opportunities such as co-location within community recreation centers and schools were noted to support this recommendation.

Expand In-Place, Embedded Culturally Responsive Care

Participants advocated for expanded access and quality care throughout their local communities. Although stand-alone mental health facilities would be welcomed assets, participants noted resources could be invested by leveraging the social trust capital of key influencers and existing locations to expedite increased access to mental health care to serve more people quicker and more cost-effectively.

Participants pointed to existing promising examples of embedding mental health care professionals and paraprofessionals, including Licensed Mental Health Clinicians/Therapists, Wellness Navigators, Peer Educators, Promotores, etc., directly into local communities where community members already are comfortable visiting and have trusting relationships established. Participants noted this could also be a cost-effective way to address transportation barriers as well as destigmatize accessing mental health services when co-located in existing spheres of trust.

Reduce Stigma Via Localized, Culturally Responsive, Tailored Outreach, Engagement & Education

Participants consistently pointed to stigma and a lack of understanding of mental health as barriers to seeking mental health resources and services. Effective social marketing outreach, engagement, and education were noted as priority opportunities to reduce stigma, promote, and cultivate mental well-being, and increase access to existing services, programs, and resources. Participants highlighted the importance of mental health awareness-building and advocacy training for organizations, community members of all ages, and policymakers. They also asked for greater participation in, and transparency of, public mental health initiatives and agencies.

As with overarching culturally responsive staffing, approaches, and practices, participants cautioned against a one-size-fits-all approach, stressing the importance of social marketing, and messaging customized to the target audience featuring local trusted influencers, people, and programs from the community. Also, in alignment with the prior Core Themes, participants provided recommendations for where and how to embed anti-stigma campaigns in local

communities to take the campaign, materials, and outreach where people go about their daily lives.

Participants recommended leveraging word of mouth, social capital, and relationships with key community influencers to spread information and integrating outreach and education into existing community events and programs. To help reduce stigma and increase amount of culturally attuned supports, participants suggested expanding peer educators to include Promotores, Senior Companions and Youth Leaders, using local representatives in these roles. Additionally, participants noted specific trainings for professionals, such as law enforcement and educators, and youth-specific training to help educate different groups on mental health related topics. Parents and caregivers were also identified as a group that would benefit from education and training, such as Youth Mental Health First Aid.

Foster Policy, Systems Change

Participants consistently noted the need for increased communication and collaboration between stakeholders, i.e. consumers, providers, and policy makers, to continue making progress in policy and systems change. Also, participants consistently noted additional funding is needed above current MHSA and MCBH budgets.

Following are some of the specific recommendations brought forward by participants across the five (5) Regional Forums:

1. Improve cross-organizational collaboration and coordination of mental health care services.
2. Improve communication, coordination, and collaboration between MCBH and other county departments, for example, Adult Protective Services as well as external entities, for example, primary care doctors, emergency rooms, community-based organizations, private providers, and others.
3. Foster networking and relationship-building to aid "warm hand-offs" and "no closed doors" information and referral for residents.
4. Collaborate with policy makers and other decision-makers to cut through red tape for those in mental health crises to get timely follow-up care.
5. Continue offering and expanding MCBH-sponsored education and training that is open to staff of other agencies, organizations as well as residents.
6. Develop "one stop shops", hubs on-line and in trusted locations within communities where accurate information on services and access is available with "warm hand-offs" by knowledgeable, trusting, caring resource connectors/advocates available with a "no closed door" approach. Specific examples include:
    a. Integrating mental health awareness raising resources and services into existing trusted locations, for example: Schools, Family Resource Centers, Libraries, etc. in addition to other locations noted above;

b. Establishing a central call number noting therapists with their schedule/openings that potential clients or a main administrator can matchmake with the clients' day/time needs with available therapists;
c. Establishing a smart phone app enabling search for mental health resources and services, including clinicians with real-time appointment availability, characteristics such as cultural identity;
    i. Build upon what is working with Sam's Guide and 2-1-1 and address limitations of these resources; and
    ii. Innovate technology tools to help close mental health equity gaps (look for those created by historically underrepresented groups)

7. Build upon success of partnerships and co-location between MCBH and community organizations:
    a. Continue and expand partnerships with school districts to provide mental health therapists in the schools
    b. Mental health professionals continue to work with law enforcement and provide training such as Crisis Intervention Training.

Demographic Information from Community Engagement Sessions:

The following tables provide information regarding participants who attended each session including: total numbers that signed in per session, zip code of residence and stakeholder category. Additional demographic information such as: race, ethnicity, gender identity and sexual orientation, was not asked during the sign-in process due to participant level of comfort with sharing demographic information in a public meeting.

Regional Forum	# Signed-in
District 1	20
District 2	14
District 3	17
District 4	33
District 5	14
TOTAL	**98**

Focus Group	# Signed-in
Early Psychosis & Suicide Prevention	17
Mental Health Needs of Seniors	29
Childhood Trauma Prevention	16
Culturally Responsive Approaches	9
Mental Health Needs of College Age Youth	12
TOTAL	**83**

NOTE: Not all participants completed all information at sign-in , and some categories were checked more than once, twice, left blank, or illegible.

Community Engagement Sessions Participants' Zip Code of Residence			
City	**Zip Code**	**Total Participants by Zip Code**	**Percentage of Total Participants by Zip Code**
Salinas	93901	27	15%
Salinas	93905	11	6%
Salinas	93906	19	11%
Prunedale	93907	12	7%
Salinas	93908	3	2%
Carmel	93923	4	2%
Camel Valley	93924	3	2%
Gonzales	93926	15	9%
Greenfield	93927	5	3%
King City	93930	3	2%
Marina	93933	7	4%
Del Rey Oaks/Monterey	93940	8	5%
Pacific Grove	93950	1	1%
Sand City	93955	21	12%
Soledad	93960	7	4%
Aromas	95004	2	1%
Castroville	95012	6	3%
Gilroy	95020	1	1%
Hollister	95023	1	1%
Morgan Hill	95037	1	1%
Santa Cruz	95060	2	1%
Watsonville	95076	1	1%
Not stated		15	9%
TOTAL	**22**	**175**	100.0%

Community Engagement Sessions: Participant Representation by Stakeholder Category:

Session	Youth	Adult	Senior	Resident	Client	Practitioner	Com-Based Org	County Staff	MH Commissioner	Other	Both Practitioner and Resident	Both Client and Resident
RF - District 1	3	13	3	16	1	16	8	4	3	1	16	1
RF - District 2	0	8	1	11	0	0	2	0	0	0	0	0
RF - District 3	2	9	3	10	0	11	6	2	0	3	9	0
RF - District 4	2	22	9	32	4	10	4	2	4	0	10	3
RF - District 5	2	11	1	14	5	4	0	1	3	3	4	5
FG - Early Psychosis & Suicide Prevention	2	12	0	12	1	4	3	8	1	0	8	1
FG - Seniors	2	16	6	21	1	15	4	7	4	0	14	0
FG - Childhood Trauma Prevention	2	6	0	12	0	3	5	4	0	0	2	0
FG - Culturally Responsive Approaches	0	8	1	9	0	6	4	3	0	0	6	0
FG - College Age Youth	1	7	2	8	1	10	6	4	0	0	8	0
TOTAL NAMES ON SIGN UP SHEETS	**181**											
TOTAL PARTICIPANTS BY CATEGORY	**16**	**112**	**26**	**145**	**13**	**79**	**42**	**35**	**15**	**7**	**77**	**10**
TOTAL % BY CATEGORY	**8.8%**	**61.9%**	**14.4%**	**80.1%**	**7.2%**	**43.6%**	**23.2%**	**19.3%**	**8.3%**	**3.9%**	**42.5%**	**5.5%**
NOTE: Not all participants completed all sign-in catagories. Some catagories were double marked, left blank, or illegible.												

For additional information, please refer to the Report “Community Engagement Insights”, included in this document as Appendix I.

Behavioral Health Needs Assessment

To complete the Needs Assessment, the following two surveys were administered: A Provider Survey and a Community Member Survey. The Provider Survey was designed to gather feedback from a broad range of people, agencies, and systems working directly with individuals who are receiving or need mental health services. Respondents invited to take the survey represented multiple service sectors such as: education, law enforcement, hospitals, and other community service organizations. The Community Member Survey was designed to gather feedback from residents of Monterey County with mental health needs, as well as family members and other community members affected by mental health issues.

Both surveys were available for approximately two months, while MCBH conducted simultaneous, coordinated Community Engagement Sessions to gather feedback through regional forums and focus groups. Surveys were administered in English and in Spanish. The Provider Survey was distributed via email and posted on the Health Department website with a link to an online survey. The Community Member Survey was distributed on paper at the Community Engagement Sessions, as well as through an online link posted on the Health Department website. A total of 378 surveys were collected, consisting of 190 Provider Surveys and 188 Community Member Surveys.

Findings from both the Provider and Community Member Surveys indicate that there is very strong alignment in Monterey County across diverse stakeholders about the highest priority needs in mental and behavioral health and access to services. Nearly all providers agreed that there is unmet need for mental health care across sub-populations and age groups. Lack of knowledge about existing services, both among providers and community members, emerged as a key barrier to accessing services. Relatedly, providers identified outreach and education about available services and training for providers as a key recommendation.

Respondents to both the Provider and the Community Member Surveys were asked to identify barriers to accessing mental and behavioral health services. Notably, both providers and community members aligned on the top six barriers (out of a list of 15). *Lack of knowledge/information about services/where to get help* was the most highly prioritized barrier among both groups. Other top barriers identified include: *cost, stigma related to mental illness, service locations are too far away, lack of transportation and lack of health insurance*. Community members indicated that education about existing services is likely to be most effective if the information comes from a trusted professional such as a teacher, doctor, or social worker.

Both providers and community members agreed that *depression, anxiety, and trauma* are among their top three priorities for mental and behavioral health in terms of importance and, for providers, *resource allocation*. Suicide prevention was the least prioritized issue among both groups of survey-takers. There is also alignment on the identification of contributing factors to mental and behavioral health issues in the community. Both providers and community members identified *financial stress, stressful childhood experiences/Adverse Childhood Experiences, and homelessness*, as their top three contributing factors.

Demographic Information of Respondents to the Needs Assessment Surveys:

Percent of Community Member Respondents by City and Zip Code		
City	**Zip Code**	**%**
Salinas	**(total)**	**29%**
Salinas	*93901*	*14%*
Salinas	*93906*	*15%*
Salinas	*93938*	*1%*
Prunedale	93907	**12%**
Alisal	93905	**8%**
Gonzales	93926	**8%**
Sand City	93955	**7%**
Del Rey Oaks/Monterey	93940	**6%**
Soledad	93960	**5%**
Greenfield	93927	**4%**
Castroville	95012	**3%**
East Garrison	93933	**3%**
King City	93930	**3%**
Carmel	93923	**2%**
Corral de Tierra	93908	**2%**
Aromas	95004	**1%**
Carmel Valley	93924	**1%**
Corralitos	95076	**1%**
Hollister	95023	**1%**
Morgan Hill	95037	**1%**
Santa Cruz	95062	**1%**
Soquel	95073	**1%**
Total		**100%**

Providers' Sectors of Work (n=190)	
Service Sector	**% of Respondents**
Mental/Behavioral Counseling	39%
Pre-K through 12 Education	23%
Community-based Organization/Non-profit Service Provider	11%
Substance Use Prevention or Treatment Services Provider	6%
Public Health	5%
Medical Treatment/Healthcare Services	3%
Social Services	3%
College/Graduate Education	1%
Law Enforcement/Probation/Justice System	1%
Other	8%
Total	**100%**

Provider and Community Member Survey Findings

The Mental and Behavioral Health Needs Assessment "Community Stakeholder and System Partner Needs Assessment Report" is included in this document as Appendix II.

Additional Community Feedback

On an ongoing basis, MCBH collaborates and consults with two stakeholder groups that are representative of diverse community members, clients of MCBH, family members, peers, contract providers and MCBH staff. These groups are the Cultural Relevancy and Humility Committee (CRHC) and the Recovery Task Force (RTF). During the Community Program Planning Process (CPPP), members from both groups attended the Community Engagement Sessions and actively provided their input. The CRHC then reviewed the initial feedback from the CPPP, and subsequently recommended integrating information and strategies that were identified in prior work by the CRHC with the community feedback to inform the MHSA FY 21-23 Three-Year Program and Expenditure Plan. Recommendations from the CRHC related to better serving culturally specific and historically underserved populations are in alignment with the community feedback gathered during the CPPP. The RTF actively partners with MCBH in ensuring consumer and peer input and advocacy is incorporated in MCBH programs and this group also provided input during the CPPP.

30-Day Public Review and Comment Period

In accordance with MHSA regulations, the draft MHSA FY 21-23 Three-Year Program and Expenditure Plan was made available for public review and comment for a minimum 30-day period prior to approval by the Monterey County Behavioral Health Commission and Monterey County Board of Supervisors. Public comments were required to be submitted in writing via any of the following methods: the MCBH website, email to MHSAPublicComment@co.monterey.ca.us, regular mail or delivered to Monterey County Health Department, Behavioral Health Administration, 1270 Natividad Rd., Salinas, CA 93906, during the period from April 23, 2020 to May 22, 2020.

A summary of public comments/recommendations received, and county responses to these comments, is included in Addendum I and begins on page 40 of this document.

Public Hearing

The Behavioral Health Commission conducted a Public Hearing via ZOOM to review on Thursday, May 28, 2020 at 5:30PM.The Commission received the summary of comments received during the 30-Day Public Review Period and county staff responses to these comments. Staff also presented recommended modifications to the draft document to address errors in the naming and numbering of several of the strategies as well in the expenditures section of the Plan to bring the final version of the document in alignment with the established financial reporting system. Members of the public were offered the opportunity to provide face to face public comment and Spanish language interpretation services were available. Commissioners considered the comments received, offered their comments, and the Hearing concluded upon the Commission taking action to approve the MHSA FY 21-23 Three-Year Program and Expenditure Plan for forwarding to the County Board of Supervisors for adoption.

Please refer to the draft version of the May 28, 2020 Meeting Minutes of the Monterey County Behavioral Health Commission included in Addendum II and begins on page 42 of this document.

Community Service & Supports (CSS) Component: Program Descriptions

Seventy-six percent (76%) of MHSA funds received by counties must be allocated for the CSS component. MHSA funds may only be used to pay for those portions of the mental health programs/services for which there is no other source of funding available. CSS programs serve individuals affected by moderate to severe mental illness and their families. These services must be community based, recovery-oriented and culturally competent. Funding can only be used for voluntary services and no less than fifty-percent (50%) must be allocated to "full service partnerships" (FSPs). FSP services provide a "whatever it takes" level of services, also referred to as "wraparound" services, to support the most severely mentally ill clients and their families, twenty-four hours a day, seven days a week. These wraparound services include treatment, case management, peer support, transportation, housing, crisis intervention, family education, vocational training, and employment services, as well as socialization and recreational activities, based upon the individual's needs and goals to obtain successful treatment outcomes. The remaining funds in the CSS component are to be used for General System Development programs that provide a less-intensive level of mental health treatment and supportive services, and often consist of peer supports, family education, wellness centers, and assistance with access to educational, social, vocational rehabilitative and other community services.

Full Service Partnerships

1. Early Childhood and Family Stability FSP [CSS-01]

The Early Childhood and Family Stability FSP will support programs for children and families that are designed to improve the mental health and well-being of children and youth, improve family functioning, and prevent out-of-home placement of children and youth whose emotional, social, and/or behavioral problems create a substantial risk of placement in publicly funded care, such as foster homes, group homes, correctional institutions, or psychiatric facilities. The goal of these services are to improve the child's overall functioning within their family, school, peer group and community; reduce risk and incidence of mental health disability; and, improve family well-being and functioning. Children and youth who are at acute risk for disruption in home or school placement, or loss of access to extra-curricular activities, will receive a team based, "full service partnership" (FSP) approach that includes a Child & Family Therapist and Family Support Counselor, and with priority access, as needed, to psychiatric, psychological assessment and occupational therapy services. Adoption preservation is encouraged by integrating a parental component and additional mental health services in accordance with the FSP model.

Family Reunification Partnership, operated by MCBH, will offer a unique and innovative program model that integrates Children's Behavioral Health (CBH) therapists and Family and Children's Services (FCS/Department of Social Services) social workers into one cohesive program to help families in the reunification process. An intensive, short-term, in-home **Crisis Intervention and Family Education Program** will be provided to the same population where less intensive services are required along the continuum of care.

Additionally, **Outpatient Programs** operated by a contracted service provider will offer outpatient mental health services to eligible children and their families. Mental health services will consist of individual, family, or group therapies and interventions designed to promote the mental health of children whose social and emotional well-being has been negatively impacted by loss and trauma associated with poor family function, abuse, neglect, domestic violence, parental incarceration and parental substance abuse. Focus will be made on families with infants and children ages 0-5 who have been exposed to trauma and are exhibiting early signs of attachment disruption, poor attunement with their caregivers, and exhibiting trauma symptoms and related

behavioral dysregulation. Such services will improve the early attachment relationship, resolve trauma experiences for children as well as the impact of trauma on a child and his/her family, and reduce mental health symptoms.

2. Dual Diagnosis FSP [CSS-02]

The Dual Diagnosis FSP will include programs operated by a contracted service provider to support youth and young adults with co-occurring mental health and substance abuse disorders. This FSP strategy will include both an **Outpatient Program** that provides integrative co-occurring treatment through an evidence-based practice and strengths-based home-visitation model; and a **Residential Program** that will identify, assess and treat adolescent females in a residential facility who exhibit significant levels of co-occurring mental health and substance abuse needs. The goal of this FSP is to promote resiliency by reducing acute mental health and substance abuse symptoms, improving overall individual and family functioning, and reducing need for residential care.

3. Justice-Involved FSP [CSS-13]

The Justice-Involved FSP supports adolescents and adults with a mental health disorder who are involved with the juvenile/criminal justice systems. For adults, this FSP will include an **Adult Mental Health Court Program**, which is a collaborative effort between the Superior Court, Behavioral Health, Probation Department, District Attorney's Office, Public Defender's Office and the Sheriff's Office to reduce the repetitive cycle of arrest and incarceration for adults with serious mental illness by providing intensive case management, psychiatric care, Probation supervision and a therapeutic mental health court.

For transition age youth, MCBH will work in partnership with public agencies and community partners in providing the juvenile justice FSP's comprehensive programming for youth involved with MCBH, Juvenile Justice and/or the Department of Family and Children Services. These FSP programs will include a **Juvenile Mental Health Court Program** in which Probation, Juvenile Court and Behavioral Health provide supervision and support to youth and their families; and also the **Juvenile Sex Offender Response Team** (JSORT) program, which is a collaborative partnership between Monterey County Probation and MCBH to provide specialty mental health services to adolescents who have committed a sexually related offense. Their families/caregivers may also receive services by the program.

4. Transition Age Youth FSP [CSS-04]

Monterey County Behavioral Health will provide an intensive **Outpatient Program** for transition age youth (TAY) who are experiencing symptoms of serious mental illness. Services will be youth-guided, strength-based, individualized, community-based and culturally competent. Youth will receive a psychiatric assessment, case management and individual/group/family therapy based upon their mental health needs. TAY can also participate in skills groups, outings, and recognition events. Goals are tailored to each youth, ranging from achieving educational or vocational pursuits, acquiring a stable living situation, and engaging with peer and social supports while also reducing symptoms of mental illness.

5. Adults with Serious Mental Illness FSP [CSS-05]

The Adults with Serious Mental Illness FSP supports a range of services to Adults with a serious mental health diagnosis in reaching their recovery goals and live in the least restrictive environment as possible. This FSP is comprised of **Outpatient Programs** operated by MCBH and contracted services providers to serve this population of adults, including those with a co-occurring substance use disorder. Services within these outpatient programs will include outreach and engagement, employing a welcoming/engagement team, and

providing an intensive outpatient alternative to the array of residential treatment services and supportive housing-based FSP programs that often have long wait lists for entry to services.

6. Older Adults FSP [CSS-06]

The Older Adult FSP will offer a range of services and supports to older adults with a serious mental illness diagnosis in reaching their recovery goals and live in the least restrictive environment as possible. The FSP **Outpatient Program** operated by the MCBH will provide intensive and frequent services for older adults with serious mental illnesses and complex medical issues who are at risk of losing their community placement, hospitalization, institutionalization, and homelessness. Outpatient services are to be focused on reducing unplanned emergency services and admissions to inpatient psychiatric hospitals, as well as preventing out of county and locked placements.

The Older Adult FSP will also include a **licensed residential care facility** that serves older adults who have co-occurring mental health and physical health conditions. This residential program will assist residents with medication, medical appointments, daily living skills, money management, and provides structured activities daily.

7. Homeless Services and Supports FSP [CSS-14]

The Homeless Services and Supports FSP is an **Outpatient Program** to be operated by a contracted service provider, offering wrap-around services, and conducting outreach for adults with a psychiatric disability who are currently experiencing homelessness or who are at high risk of becoming homeless. Services will include mental health and psychiatry services, case management services, assistance with daily living skills, as well as supported education and employment services.

This FSP will also include **Supportive Permanent and Transitional Housing Programs** to vulnerable individuals over the age of 18 with a psychiatric disability who are currently experiencing homelessness or who are at risk of becoming homeless. Along with managing symptoms of mental health disorders and promoting recovery, the goals of these services are to prevent further homelessness, avoid costly hospitalization or use of short-term crisis residential programs, reduce the incidence of mental health crises, and avoid unnecessary institutionalization in residential care homes.

General System Development Programs

8. Access Regional Services [CSS-07]

The Access Regional Services strategy will support Monterey County Behavioral Health ACCESS walk-in clinics and community-based organizations who provide regionally based services to address the needs of our community. County **ACCESS clinics** function as entry points into the Behavioral Health system. These clinics are in Marina, Salinas, Soledad, and King City, providing reach in all four regions of the county. The clinics serve children, youth, and adults, and offer walk-in services and appointments to provide early intervention and referral services for mental health and substance use issues.

The clinical support offered through ACCESS clinics will be supplemented by community, education and therapeutic supports found at a **Wellness Center** now included as part of this CSS Strategy. Located in Salinas and serving TAY and Adult populations, the Center is a peer and family member operated facility that will assist participants in pursuing personal and social growth through self-help groups, socialization groups, and by providing skill-building tools to those who choose to take an active role in the wellness and recovery movement through various initiatives.

This CSS strategy to promote access to services will also support community-based providers in making **Outpatient Mental Health Services** accessible to children, youth, adults, and their families. This includes tailored supports for LGTBQ+ individuals, individuals affected by HIV/AIDS, individuals experiencing crisis and trauma, as well as supportive services for non-English speaking residents and those who are deaf or hard of hearing.

9. Early Childhood Mental Health Services [CSS-08]

The Early Childhood Mental Health Services strategy supports programs offering specialized care for families/caregivers with children ages 0-11. This will include **Outpatient Programs** operated by both the county and community-based contracted service providers that employ care coordination teams and therapists to provide culturally and linguistically appropriate behavioral health services for children and their caregivers/family members to support positive emotional and cognitive development in children and increase caregiver capacity to address their children's social/emotional needs. The outpatient teams collaborate with community-based agencies to provide services for infants, children and youth experiencing developmental delays and mental health problems caused by early childhood trauma, including neglect, abuse, violence, and/or prenatal exposure to alcohol and other drugs. The primary focus is to identify, assess, refer, and treat infants, children and youth affected by the broad spectrum of developmental, social, emotional, and neurobehavioral disorders utilizing evidence-based practices and trauma-informed services.

10. Supported Services to Adults with Serious Mental Illness [CSS-10]

The Supported Services to Adults with Serious Mental Illness strategy supports adults ages 18 years and older who are served by the various programs in our Adult System of Care. Programs will employ peer support specialists (i.e. those with lived-experience as a consumer or family member) as **Wellness Navigators** (WNs) stationed at each Adult Services clinic to welcome clients into the clinic, help support completion of intake screening tools, and help clients understand how to access the services available to them. The **Peer Partners for Health** Program will also offer voluntary training and supportive services focusing on creating a welcoming and recovery-oriented environment where clients accessing services at MCBH outpatient clinics can feel welcomed and supported by someone who may have a similar experience. With the assistance of the WN team, consumers will be connected by peers to community-based follow up services in a culturally sensitive manner.

This strategy will also support a **Benefits Counseling Program** for transition age youth, adults, and older adults with mental health disabilities. The goal of this program is to increase the number of consumers returning to the workforce and to increase independence by providing the following: problem solving and advocacy, benefits analysis and advising, benefits support planning and management, housing assistance, independent living skills training, assistive technology services and information, and referral services.

11. Dual Diagnosis Services [CSS-11]

Dual Diagnosis Services will serve those impacted by substance abuse and mental illness and provides intensive and cohesive supports. This **Outpatient Program** will be operated by a community-based contracted service provider to assist clients in developing dual recovery skills to maintain successful community living, and to promote a clean and sober lifestyle as they transition out of dual recovery residential programs.

12. Homeless Outreach & Treatment [CSS-15]

The Homeless Outreach and Treatment strategy will include **Shelter/Housing Supports** for vulnerable individuals with a psychiatric disability who are currently experiencing homelessness or at risk of becoming homeless. **Outreach and Outpatient Services** are also included in this strategy to assist those adults recently served in the Homeless Services and Supports FSP to continue to receive the appropriate level of services and

supports to maintain their recovery and their housing placement. The services include supported education and employment assistance, case management services, mental health services, and assistance with daily living skills. Outreach activities will be modified to address both youth and adult populations experiencing homelessness.

Additional feedback from the CPPP highlighted the importance of providing resources and help to individuals who are experiencing homelessness and offering them support in a location that is convenient and accessible in the community. There is an area known as "Chinatown" in Salinas, where individuals, who have been displaced from their homes, live in tents and other types of temporary shelters. This strategy will also support a **Resource Center in Chinatown** that will connect individuals to social services to address their individual circumstances related to their homelessness as well as other resources to assist them in addressing their behavioral health needs.

13. Responsive Crisis Interventions [CSS-16]

During the CPPP, residents identified the need to have responsive mental health services in a timely manner, particularly when an individual is experiencing a mental health crisis. The Responsive Crisis Interventions strategy will provide services to community members "where they are at" or otherwise provide services in a critical, time-sensitive manner. A **Mobile Crisis Team** will be deployed to help Monterey County residents when they are experiencing a mental health crisis. The mobile crisis team will work with law enforcement and emergency services in responding to individuals, youth, and families in crisis. They will intervene with individuals who are showing signs of psychiatric distress, initially assisting the individual to de-escalate and stabilize, and then provide available resources to help connect them with voluntary mental health and substance use disorder outpatient services and/or treatment as appropriate. Goals include avoiding unnecessary hospitalizations and diversion from emergency resources (hospital/jail), while providing the linkage to ongoing care as needed.

Additionally, for children who have been sexually assaulted, a county-operated **Forensic Outpatient Clinic** will be supported through this strategy, providing mental health assessments, referral, and therapy services. Crisis support services will also made available to the child's family/caregiver.

CSS Program Data for FY 2018-19

For CSS Program Data covering the Fiscal Year 2018-19 period, please refer to Appendix III.

Prevention & Early Intervention (PEI) Component: Program Descriptions

Nineteen percent (19%) of MHSA funds received by counties must be allocated for PEI services, designed to prevent mental illnesses from becoming severe and disabling. PEI services focus on preventing the onset of mental health issues and/or providing early intervention treatment and referral services. MHSA regulations require PEI plans to include at least one (1) program focused on delivering services for *each* of the following service categories: 1) Prevention, 2) Early intervention, 3) Stigma and discrimination reduction, 4) Recognizing early signs of mental illness, and 5) Promoting greater access and linkage to treatment. Suicide prevention programs also fit within the PEI component. All programs must employ strategies for promoting access and linkage to treatment, improving timely access to services for underserved populations, and utilizing non-stigmatizing and non-discriminatory practices. Counties must serve all ages in one or more programs funded by the PEI component. At least fifty-one percent (51%) of PEI funds must be allocated for serving individuals who are 25 years old or younger. Programs that serve parents, caregivers, or family members with the goal of addressing children and youth at risk of or with early onset of a mental illness can be counted as serving children

and youth. In addition, SB 1004 directs counties to focus on the following priority areas: 1) Childhood trauma prevention and early intervention; 2) Early psychosis and mood disorder detection and intervention; 3) Youth outreach and engagement strategies that target transition age youth; 4) Culturally competent and linguistically appropriate prevention and intervention; 5) Strategies targeting the mental health needs of older adults; and 6) Early identification programming of mental health symptoms and disorders, including but not limited to anxiety, depression, and psychosis.

The following provides an overview of proposed PEI funded programs and services that are reflective of the core themes and priority areas identified in the CPPP (see Community Program Planning Process section above).

Prevention

1. Family Support and Education [PEI-02]

Family members and caregivers who are living with and caring for loved ones with mental health conditions benefit from social connectedness and psycho-education that is provided in **family support groups**. Support groups will be offered regionally throughout Monterey County in community-based locations in languages that support the needs of family members and caregivers. Groups will be open and accessible to residents of Monterey County who would like to learn how to support their family member and gain support from others who are experiencing similar issues related to caring for a loved one with mental illness.

Parents and caregivers have expressed the need for **culturally relevant parenting classes** that address issues throughout a child's development from infancy through adolescence. Parents and caregivers will be offered options to choose a class that meets their family's needs as all children have unique strengths and challenges. Parenting classes will be provided in Spanish and English in community-based locations throughout Monterey County at times that are convenient for the families. Whenever possible, classes will provide childcare and meals to support families in addressing barriers to participation and to enhance their experience.

2. Prevention Services for Early Identification of Mental Health Symptoms Throughout the Lifespan [PEI-12]

Community based agencies will provide **outreach, education and referrals related to Behavioral Health Services** for individuals impacted by mental illness and their family members. **Anti-stigma campaigns and advocacy efforts** on behalf of consumers, family members, and friends of those living with mental illness will be supported and deployed in Monterey County to raise awareness and educate the community regarding mental health. **Professional training** will be provided to professionals, medical providers, faith leaders, educators, law enforcement and other key groups that interact with community members on mental health and related topics.

Community information sessions and presentations on mental health and related topics will be provided in all four regions of Monterey County by MCBH and community based organizations, focusing on underserved areas. Sessions will be provided in locations where community members feel comfortable and will be offered to existing groups and organizations building on trusted relationships in the community. Community information sessions will address the top barriers to care that were identified during the CPPP regarding the current lack of knowledge of available mental health resources and to increase understanding in the community regarding mental health.

MCBH will build upon proven **communication mechanisms** to provide information on mental health resources and programming to the community while developing new channels and mediums to respond to the preferred

methods diverse community members use to access information related to mental health. MCBH will also develop **marketing** materials to attract **diverse mental healthcare professionals** to work in our community.

During the CPPP, participants overwhelming identified the need for more community education on mental health, and specifically identified **Mental Health First Aid** (MHFA). MHFA is a proven educational program that teaches individuals how to identify, understand and respond to signs of mental illnesses and substance use disorders. MHFA teaches skills to help people reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or is experiencing a mental health crisis. Capacity will be developed to provide MHFA training in all categories relevant to Monterey County and could include: Adult, Youth, Public Safety, Fire/EMS, Veterans, Older Adults, Rural and Higher Education. MCBH will adopt **teen Mental Health First Aid** in accordance to timeframes from the National Council for Behavioral Health. MHFA programs are available in Spanish and English, the primary languages spoken in our County.

Veterans are a vulnerable population for mental health conditions and suicide risk and were identified as a priority population in SB 1004 and in our local CPPP. MCBH will partner with an organization that will provide education and awareness to veterans, their dependents, and survivors on entitled benefits to include mental health services available in the community. Additionally, this program will streamline the process of transitioning service members, veterans and their eligible dependents to healthcare, mental health services, education, employment, and other community-based services. This helps to promote resilience, social connectedness and other protective factors for veterans and their family members which helps to decrease risk for mental health conditions and suicide.

3. Student Mental Health [PEI-08]

MCBH has a very strong **partnership with the Monterey County Office of Education** and school districts throughout Monterey County. MCBH staff will provide **training, consultation, and support to schools** to develop positive school climates, understand and address behavioral health issues in students and implement state mandated district suicide prevention plans. MCBH staff located in the schools also will provide educational presentations to parents and caregivers on mental health related topics including common childhood mental health disorders and how to access Behavioral Health services.

Primary prevention programs that support student mental health and focus on students who are experiencing or are at-risk of experiencing mental health conditions will be provided. Individual and group therapy for children who have been exposed to trauma and Adverse Childhood Experience (ACES) will occur on school sites to minimize barriers to accessing care. Supports will be provided to parents and caregivers in meeting their child's social and psychological needs along with psycho-education in understanding ACES and how to support their children in building resilience. Wellness activities that assist children and youth in developing protective factors, such as social connectedness and emotional self-regulation skills, will be provided after the school day ends to support students who could benefit from positive interactions and supports to decrease risk for developing a mental health condition.

School-based Supportive Services will also be provided through this strategy, including individual and family counseling, group counseling, teacher consultation, psychiatric evaluation, and medication monitoring. Services will be provided primarily at the school site, as well as clinics in the community.

4. Maternal Mental Health [PEI-15]

Maternal Mental Health: To address childhood trauma prevention at the earliest possible point in time, MCBH will develop community-based supports to help mothers who are at-risk of or are experiencing mild to moderate Perinatal Mood and Anxiety Disorders. MCBH will offer **dyadic groups for mothers and infants/toddlers** in community locations, providing psycho-education and support with a focus on Spanish speaking, Latina mothers who do not have access to mental health services through their health insurance provider. These groups will increase opportunities for participants to have positive social interactions, develop support network and decrease stigma through shared experiences. A primary goal will be to increase group participants' knowledge and understanding of how being attuned with their child's cues positively impacts bonding and attachment. Additionally, the groups will incorporate culturally attuned healing practices that support women and families during the perinatal period. Peer support programs and therapeutic treatment for addressing Maternal Mental Health will be explored and incorporated based upon community capacity for implementation.

5. Stigma and Discrimination Reduction [PEI-04]

One of the top barriers to individuals receiving the mental health care they need is stigma related to mental illness. This was echoed during our CPPP as community members shared concerns about the prevalence of stigma, particularly in the Latino community. To address this, community presentations and trainings on **stigma and discrimination reduction** will be provided throughout Monterey County. These programs will be designed and implemented by individuals with lived experience and will include a diverse panel to address cultural considerations and issues throughout the lifespan. Presentations will help dispel myths associated with mental health conditions and provide opportunities for individuals with lived experience to share their stories to increase compassion and decrease negative assumptions for those living with mental health conditions.

The California Mental Health Services Authority (CalMHSA) administers **statewide projects** taking a population-based approach to **prevent mental illness** from becoming severe and disabling through **outreach to recognize the early signs** of mental illness, **reduce stigma** associated with mental illness and service seeking, and **reduce discrimination** against people with mental health challenges. Campaigns and activities developed with an emphasis on reaching Latino communities which is relevant in Monterey County will be continued. In addition, technical assistance, and support in developing comprehensive suicide prevention planning for counties is provided through CalMHSA's Each Mind Matters initiative. Monterey County participates in a Learning Collaborative supporting local efforts to develop a comprehensive suicide awareness and prevention plan.

6. Suicide Prevention [PEI-06]

Monterey County has seen an 18% increase in suicide related deaths over the last ten (10) years. MCBH is in the initial phase of developing a strategic plan to address **suicide awareness and prevention** in Monterey County. PEI funding will be utilized to support the development of the strategic plan and fund strategies identified by the Monterey County Suicide Prevention Coalition to reduce suicide related deaths and attempts, as well as to increase protective factors in Monterey County.

Supports and trainings will be provided to better address suicide prevention and awareness to decrease the suicide related death rate in Monterey County. High-risk individuals, families, and groups will be identified and provided with safe alternatives to suicidal behavior. An integrated method of service delivery including a 24/7/365 free, multi-lingual suicide crisis line, educational outreach and training, and bereavement support services for those who have lost a loved one to suicide will be provided. In addition, training will be offered for

MCBH staff and community groups on the following: Applied Suicide Intervention Skills Training ("ASIST"), and Suicide Alertness for Everyone ("SafeTALK").

Early Intervention

7. Prevention Services for Older Adults [PEI-05]

A continuum of supports will be provided for Seniors including:

Outreach and community education that is specific to seniors will be provided including: social marketing campaigns, community presentations, outreach events, and other promotional activities to engage seniors and older adults in mental health care and in programming to support their health and wellness. Activities that reduce isolation, promote resilience, recovery and social connectedness for seniors will be provided including individual and group supports. **Senior Peer Companions and Counselors** are a proven strategy, often the cornerstone of programs serving seniors and will be incorporated whenever possible in these activities.

Short-term therapeutic interventions will be provided to seniors and older adults who are suffering from depression, anxiety, grief, loss, adjustment to chronic illness, and other stressors that can occur in the latter third of life. Therapeutic interventions will be provided individually or in groups in non-clinical community based locations and homes to support home bound seniors and increase an individual's comfort level with receiving therapy.

8. Early Intervention Strategies for Adolescents, Transition Age & College Age Youth [PEI-13]

A continuum of supports will be provided for transition age youth including:

Outreach and community education that is specific to youth will be provided including: social marketing campaigns, community presentations, outreach events, and other promotional activities to **engage adolescents and transition age youth** (TAY) ages 16-25 in mental health care and in programming to **support their health and wellness**. Programming will focus on youth who have experienced trauma and/or have been involved with public agencies, such as Juvenile Probation and Child Welfare, in supporting their successful transition to adulthood. Positive, youth-friendly activities that reduce isolation, promote resilience, recovery and social connectedness for youth will be provided including individual and group supports. **Youth Mentors and Peers** are highly essential and proven to be effective in youth engagement and will be incorporated whenever possible in outreach efforts and programming. MCBH will partner with youth-serving organizations and local youth councils to develop effective outreach strategies and mental health programs for youth and young adults.

Short-term therapeutic interventions will be provided to TAY to address stressors associated with adolescence and young adulthood and to address mild to moderate mental health issues such as anxiety, depression, and adjustment disorders. Therapeutic interventions will be provided individually or in groups in non-clinical community based locations that are easily accessible for youth and young adults.

9. Culturally Specific Early Intervention Services [PEI-14]

A continuum of supports will be provided for vulnerable and historically underserved populations, such as: Latinos, African Americans, LGBTQ+*.

Outreach and community education that is specific to each cultural group will be provided including: social marketing campaigns, community presentations, outreach events, and other promotional activities to **engage historically underserved populations** (as noted above*) in mental health care and in programming to **support their health and wellness**. Holistic, wellness activities that reduce isolation, promote resilience, recovery and

social connectedness for each cultural group will be provided including individual and group supports. **Promotores and Peers** that are representative of diverse populations are highly essential and will be utilized as they are key elements in engaging and effectively supporting historically marginalized populations in accessing mental health care and other resources.

Short-term therapeutic interventions will be provided to address mild to moderate mental health issues and stressors associated with immigration related issues, institutional racism, discrimination, and trauma experienced over the lifetime related to one's cultural identity. Therapeutic interventions will be provided individually or in groups in non-clinical community based locations that are easily accessible and build upon trusted relationships in diverse communities.

10. Prevention and Recovery for Early Psychosis [PEI-10]

Early psychosis programs have demonstrated effectiveness in helping individuals to return to baseline levels of functioning and prevent future occurrences of psychotic episodes. This strategy consists of an integrated array of evidence-based treatments designed for remission of early psychosis among individuals ages 14-35 who are demonstrating symptoms and functional impairments related to early psychosis and/or diagnosis of Schizophrenia or Schizoaffective Disorder. Core services will include individual therapy using Cognitive Behavioral Therapy for Psychosis, strength based case management, algorithmic medication management, family support, educational and vocational support.

PEI Program Data for FY 2018-19

For PEI Program Data covering the Fiscal Year 2018-19 period, please refer to Appendix IV.

Innovation (INN) Component: Project Descriptions

Counties are required to allocate five percent (5%) of total MHSA Funds to INN projects. Innovation projects are defined as novel, creative, and/or ingenious mental health practices or approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative of unserved and underserved individuals. The Innovation Component allows counties the opportunity to "try out" new approaches that can inform current and future mental health practices/approaches. These projects are intended to contribute to learning about what approaches to providing mental health services can be effective, rather than having a primary focus on providing a service. Innovation projects can only be funded on a one-time basis and are time-limited. Innovation projects must also use quantifiable measurements to evaluate their usefulness.

Current Approved INN Projects

1. Micro-Innovation Grant Activities for Increasing Latino Engagement [INN-01]

The Micro-Innovation Grants for Increasing Latino Engagement project is intended on identifying and supporting community-driven responses to mental health related needs of Latino ethnicities, cultures, communities, neighborhoods, etc. Monterey County residents, community partners and mental health services staff are encouraged to apply for funds to deliver localized services to engage Latino communities in ways not currently employed through existing mental health services in Monterey County. The first application period began in March 2019, the second occurred in December 2019, with a final application period to be announced in the early Summer of 2020 .

2. Screening to Timely Access [INN-02]

The Screening to Timely Access project plans to develop a web-based assessment tool to screen for a broad spectrum of mental health disorders an individual may be experiencing and connect them directly to the most appropriate local resource. This project is being implemented in coordination with CalMHSA as part of the multi-county Tech Suite Collaborative project.

3. Transportation Coaching Project (formerly Transportation Coaching by Wellness Navigators) [INN-03]

The Transportation Coaching Project seeks to develop and test a transportation needs assessment tool that can inform transportation coaching strategies and measure the impact of those strategies. The goals of this project include improving consumer independence in accessing mental health treatment services and other activities contributing toward their wellness and recovery, as well as bring more efficiencies and identify best practices in the delivery of wellness coaching activities. MCBH staff has developed the transportation needs assessment tool, in partnership with Interim, Inc., our community partner employing the Wellness Navigators who provide transportation coaching services.

INN Program Data for FY 2018-19

For INN Program Data covering the Fiscal Year 2018-19 period, please refer to Appendix V.

Proposed INN Projects

In response to CPPP input and MCBH service data identifying needs that may be addressed through innovative methods, proposals are under development for the following projects. Detailed information concerning the implementation of each project, including vendor selection, will be included in the eventual proposal that will be submitted to the State Mental Health Services Oversight and Accountability Commission (MHSOAC) for approval, as required in INN regulations.

4. Residential Care Facility Incubator [INN-04]

This project will work to incentivize local Latino families to establish residential care facilities in three different regions within Monterey County. The goal of this project is to provide affordable, shared housing for adults with serious mental illness who have experienced homelessness or who are at risk of becoming homeless, who need additional supports for their daily living. These facilities will provide culturally responsive supports for individuals who are mono-lingual Spanish or bi-lingual. Prior to developing the proposal for submission to the MHSOAC, this project will require research to identify the costs and steps required to establish residential care facilities, as well as an evaluation of the need for licensed residential care facilities versus unlicensed room and board with in-home support services being provided. Significant collaboration must occur between local agencies, businesses, non-profits, families, and individuals to identify prospective individuals or families within three different regions who would be interested in operating a residential care facility as described above. Individuals selected for participation in the project will also be trained to operate and become certified as a residential care facility. This project has an anticipated timeline of five (5) years, with a total proposed budget of $2,000,000.

5. Psychiatric Advance Directives [INN-05]

The Psychiatric Advanced Directive project is a multi-county collaborative project supported by the MHSOAC focusing on deploying advanced directives to improve the response to individuals who are experiencing a mental health crisis by law enforcement, as well as physical health and behavioral health clinicians. A psychiatric advance directive (PAD) is a legal document that details a person's preferences for future mental health treatment, services, and supports, or names an individual to make treatment decisions, if the person is in a crisis

and unable to make decisions. Many people with mental illness, their families, and health professionals are not familiar with PADs. When a person has a PAD, proper care can be given, and involuntary treatment may be prevented. Individuals can also share their PADs with their local hospitals, providers, and police departments so their preference of care is clear and can be easily prioritized. And when family members are kept up to date on an individual's PAD, they can be better advocates for their loved one. This project has an anticipated timeline of two (2) years, with a total proposed budget of $500,000.

6. Center for Mind Body Medicine [INN-06]

The Center for Mind-Body Medicine (CMBM) project will support MCBH clinical staff through an evidenced-based practice group model to address trauma and build emotional wellness skills. Maintaining a steady workforce of mental healthcare providers is of critical importance, and MCBH will utilize this model to increase staff retention, reduce staff burnout and increase capacity in our community to provide effective culturally relevant supports to help community members cope with trauma, build resilience and protective factors. The model's approach is particularly useful for communities that lack enough mental health resources, such as MCBH clinical staff who are often managing a larger number of clients than is optimal due to the lack of a qualified mental health workforce. The model builds a long-lasting community resource for emotional wellness. Unlike a one-time workshop or training, once the facilitators are trained, that resource lives in the community for years to come, allowing people to join a group or attend a workshop when the time feels right to them. For this project, MCBH will contract with the CMBM to train two cohorts of participants and provide additional coaching and training to develop internal capacity within MCBH to sustain and grow the model. This project would be implemented over three (3) years with a total budget of $1,500,000.

Workforce Education & Training (WET) Component: Program Descriptions

WET programs are intended to develop a pipeline for increasing interest in community mental health careers, improving recovery oriented treatment skills for community mental health providers as well as retention strategies for qualified community mental health providers. Education and training programs are required to be consumer-centered, culturally competent, and driven by the values of wellness, recovery, and resiliency.

MCBH's WET Plan focuses on both the micro/individual and macro/systems levels as follows:

Supporting Individuals

- *Pipeline/Career Awareness* ($50,000)
  MCBH consistently has a clinical position vacancy rate of around 20%. MCBH engages in outreach activities to universities and professional programs to share information about community behavioral health careers in general, and with MCBH in particular. MCBH is also designing a "Grow Our Own" campaign to help Monterey County paraprofessional staff learn about advancement opportunities within MCBH.
- *Education and Training* ($700,000)
  A significant portion of the knowledge and skills clinical staff members need to provide effective mental health services are gained on the job through training and supervision, or before employment, during internship. To support staff development, MCBH is designing a robust curriculum focusing on core competencies and clinical intervention.
- *Retention* ($200,000)
  Monterey County's salary levels are not the highest in the greater Bay Area region. Left un-addressed, many employees, once trained, will continue to quickly move on to higher-paying jobs in other counties

nearby. To support staff retention, MCBH provides technical assistance to staff interested in applying for federal and state loan repayment programs and contributes funds to state loan repayment programs to increase the reach of funding.

Supporting Systems

- *Evaluation and Research* ($50,000)
  Efforts to assess and improve the effectiveness of course content and instruction methodology are critical to ensure that time clinicians spend in training, away from direct service, is worthwhile. To support effective programing, MCBH is developing tools and protocols to assess training and treatment outcomes and develop on-line instruction, when feasible.

Capital Facilities & Technological Needs (CFTN) Component: Project Descriptions

Capital Facilities funds allow counties to acquire, develop or renovate buildings to provide MHSA-funded programs. Technological Needs funds support counties in transforming and modernizing clinical and administrative information systems as well as increasing consumer and family member's access to health information within a variety of public and private settings.

Through facility assessments and community feedback gathered during the CPPP, these Capital Facilities projects have been identified to properly support MHSA programs:

- HVAC replacement at the Marina Clinic. The equipment has reached the end of its useful life and is unrepairable. Budget estimate: $2,500,000.
- Renovations on an East Salinas facility located directly behind the Monterey County Women, Infants & Children Program office on the corner of East Alisal Street and Pearl Street. This will enable and enhance mental health services for East Salinas residents of all ages. Budget estimate: $1,500,000.
- Development of a new facility on East Sanborn Road in Salinas. This facility will provide mental health services to children, youth, and their families. Budget estimate: $25,000.000.

The proposed transfers of nearly $14.5 million to the CFTN component during FY21-23 will be used to partially fund these projects. Additional funding streams will be required and sought.

Number of Clients to Be Served & Cost Per Client/Individual FY21-23

Community Services & Supports

STRATEGY	Projected # of Clients to Be Served Per Each Fiscal Year	Estimated Cost Per Client
Full Service Partnerships		
Early Childhood and Family Stability FSP [CSS-01] **MHSA Age Group:** Children & Youth (C&Y) (0-15 years)	224	$12,271
Dual Diagnosis FSP [CSS-02] **MHSA Age Groups:** C&Y; Transition Age Youth (16-25 yrs)	96	$11,263
Justice-Involved FSP [CSS-13] **MHSA Age Groups:** All age groups	137	$12,180
Transition Age Youth FSP [CSS-04] **MHSA Age Group:** Transition Age Youth	263	$8,492
Adults with Serious Mental Illness FSP [CSS-05] **MHSA Age Group:** Adults (26-59 years)	120	$12,471
Older Adults FSP [CSS-06] **MHSA Age Group:** Older Adults (60 years and older)	45	$39,466
Homeless Services and Supports FSP [CSS-14] **MHSA Age Groups:** Adults; Older Adults	141	$20,535
General System Development Programs		
Access Regional Services [CSS-07]	5,495	$1,091
Early Childhood Mental Health Services [CSS-08]	516	$7,753
Supported Services to Adults with Serious Mental Illness [CSS-10]	450	$969
Dual Diagnosis Services [CSS-11]	67	$10,921
Homeless Outreach & Treatment [CSS-15]	586	$624
Responsive Crisis Interventions [CSS-16]	596	$1,833

Prevention & Early Intervention

STRATEGY	Projected # of Individuals to Be Served Per Each Fiscal Year	Estimated Cost Per Individual
Prevention		
Family Support and Education [PEI-02]	278	$1,449
Prevention Services for Early Identification of Mental Health Symptoms Throughout the Lifespan [PEI-12]	11,911*	$93
Student Mental Health [PEI-08]	1,091	$715
Maternal Mental Health [PEI-15]	160	$1,256

Stigma and Discrimination Reduction [PEI-04]	1,116	$317
Suicide Prevention [PEI-06]	1,113	$235
Early Intervention		
Prevention Services for Older Adults [PEI-05]	447	$684
Early Intervention Strategies for Adolescents, Transition Age & College Age Youth [PEI-13]	1,086	$1,356
Culturally Specific Early Intervention Services [PEI-14]	1,207	$587
Prevention and Recovery for Early Psychosis [PEI-10]	55	$10,520

*includes information line phone calls and media impressions during outreach

Innovation

PROJECT	Projected # of Individuals to Be Served Per Each Fiscal Year	Estimated Cost Per Individual
Micro-Innovation Grant Activities for Increasing Latino Engagement [INN-01]	80	$8,500
Screening to Timely Access [INN-02]	N/A	N/A
Transportation Coaching Project [INN-03]	N/A	N/A
Residential Care Facility Incubator [INN-04]	TBD	TBD
Psychiatric Advance Directives [INN-05]	TBD	TBD
Center for Mind Body Medicine [INN-06]	TBD	TBD

N/A = not applicable TBD = to be determined

MHSA FY21-23 3-Year Plan Budget Narrative

This MHSA FY21-23 3-Year Program and Expenditure Plan ("Plan") reflects continued funding for previously approved CSS, PEI, and INN components. Additional programs have been added to this Plan to respond to the community needs as expressed and explored during our Community Program Planning Process. Expanded programs include: meeting the community where they are with expanded Mobile Crisis services and the expansion of supportive services to those individuals with mental illness who are at risk of or are currently experiencing homelessness.

In prior years, actual MHSA allocations have exceeded early conservative revenue estimates. This has enabled funds to be allocated to both the WET and CFTN components. This Plan details the intended uses of those funds.

During the initial development of this Plan, experts were advising counties that total MHSA revenues are expected to increase slightly each year during the course of this Plan. Over the last several years, the California economy has experienced unprecedented growth, and the positive tax revenue impacts are expected to briefly linger.

However, as of this writing, the international economic situation is very volatile, as the adverse financial effects of COVID-19 are impacting all aspects of the global economy. Should fiscal conditions change, resulting in disrupted revenue streams, planned expenditures will be adjusted accordingly.

Additionally, the State Legislature is currently re-evaluating the MHSA. Key requirements may be modified within this 3-Year Plan period. Should these changes occur, this Plan will be modified and updated through the Annual Update process.

FY 2020-21 Through FY 22-23 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Monterey Date: 6/3/20

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2020/21 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	26,454,542	1,213,753	4,246,079	1,000,000	6,201,772	
2. Estimated New FY2020/21 Funding	19,456,000	4,864,000	1,280,000			
3. Transfer in FY2020/21[a/]	(3,326,422)			1,000,000	2,326,422	
4. Access Local Prudent Reserve in FY2020/21						
5. Estimated Available Funding for FY2020/21	42,584,120	6,077,753	5,526,079	2,000,000	8,528,194	
B. Estimated FY2020/21 MHSA Expenditures	16,130,000	4,864,000	4,404,500	1,000,000	6,201,772	
C. Estimated FY2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	26,454,120	1,213,753	1,121,579	1,000,000	2,326,422	
2. Estimated New FY2021/22 Funding	19,845,120	4,961,280	1,305,600			
3. Transfer in FY2021/22[a/]	(3,636,662)			1,000,000	2,636,662	
4. Access Local Prudent Reserve in FY2021/22						
5. Estimated Available Funding for FY2021/22	42,662,578	6,175,033	2,427,179	2,000,000	4,963,084	
D. Estimated FY2021/22 Expenditures	16,452,600	4,961,280	1,322,500	1,000,000	4,963,084	
E. Estimated FY2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	26,209,978	1,213,753	1,104,679	1,000,000	0	
2. Estimated New FY2022/23 Funding	20,242,022	5,060,506	1,331,712			
3. Transfer in FY2022/23[a/]	(3,884,070)			1,000,000	2,884,070	
4. Access Local Prudent Reserve in FY2022/23						
5. Estimated Available Funding for FY2022/23	42,567,930	6,274,259	2,436,391	2,000,000	2,884,070	
F. Estimated FY2022/23 Expenditures	16,781,652	5,060,506	1,035,000	1,000,000	2,884,070	
G. Estimated FY2022/23 Unspent Fund Balance	25,786,278	1,213,753	1,401,391	1,000,000	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2020	4,795,236
2. Contributions to the Local Prudent Reserve in FY 2020/21	0
3. Distributions from the Local Prudent Reserve in FY 2020/21	0
4. Estimated Local Prudent Reserve Balance on June 30, 2021	4,795,236
5. Contributions to the Local Prudent Reserve in FY 2021/22	0
6. Distributions from the Local Prudent Reserve in FY 2021/22	0
7. Estimated Local Prudent Reserve Balance on June 30, 2022	4,795,236
8. Contributions to the Local Prudent Reserve in FY 2022/23	0
9. Distributions from the Local Prudent Reserve in FY 2022/23	0
10. Estimated Local Prudent Reserve Balance on June 30, 2023	**4,795,236**

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to CSS for the previous five years.

FY 2020-21 Through FY 22-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheets

County: Monterey Date: 6/3/2020

Fiscal Year 2020/21

	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
Family Stability FSP (CSS-01)	2,748,753	1,377,024	1,341,435	0	0	30,295
Dual Diagnosis FSP (CSS-02)	1,081,211	537,658	531,724	0	0	11,828
Justice Involved FSP (CSS-13)	1,668,667	1,175,201	467,611	0	0	25,854
Transition Age Youth FSP (CSS-04)	2,233,284	711,249	1,506,387	0	0	15,647
Adults with SMI FSP (CSS-05)	1,496,550	1,195,327	274,925	0	0	26,297
Older Adults FSP (CSS-06)	1,775,948	1,361,862	384,125	0	0	29,961
Homeless Services and Supports FSP (CSS-14)	2,443,632	1,397,607	1,015,277	0	0	30,747
Non-FSP Programs						
Access Regional Services (CSS-07)	5,993,794	2,196,407	3,783,624	0	0	13,763
Early Childhood Mental Health (CSS-08)	4,000,682	2,289,049	1,684,126	0	0	27,507
Supported Services to Adults with SMI (CSS-10)	436,066	334,953	101,113	0	0	0
Dual Diagnosis (CSS-11)	731,702	250,392	323,521	0	0	157,789
Homelessness Outreach and Treatment (CSS-15)	365,760	242,531	123,229	0	0	0
Responsive Crisis Interventions (CSS-16)	1,092,723	956,826	135,897	0	0	0
CSS Administration	2,103,913	2,103,913				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	28,172,685	16,130,000	11,672,996	0	0	369,690
FSP Programs as Percent of Total	55.3%					

Fiscal Year 2021/22

	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
Family Stability FSP (CSS-01)	2,803,729	1,404,564	1,368,264	0	0	30,295
Dual Diagnosis FSP (CSS-02)	1,102,835	548,411	542,359	0	0	11,828
Justice Involved FSP (CSS-13)	1,702,040	1,198,705	476,963	0	0	25,854
Transition Age Youth FSP (CSS-04)	2,277,950	725,474	1,536,515	0	0	15,647
Adults with SMI FSP (CSS-05)	1,526,481	1,219,234	280,424	0	0	26,297
Older Adults FSP (CSS-06)	1,811,467	1,389,099	391,808	0	0	29,961
Homeless Services and Supports FSP (CSS-14)	2,492,504	1,425,559	1,035,583	0	0	30,747
Non-FSP Programs						
Access Regional Services (CSS-07)	6,113,670	2,240,336	3,859,297	0	0	13,763
Early Childhood Mental Health (CSS-08)	4,080,696	2,334,830	1,717,808	0	0	27,507
Supported Services to Adults with SMI (CSS-10)	444,788	341,652	103,135	0	0	0
Dual Diagnosis (CSS-11)	746,336	255,399	329,992	0	0	157,789
Homelessness Outreach and Treatment (CSS-15)	373,076	247,382	125,694	0	0	0
Responsive Crisis Interventions (CSS-16)	1,114,577	975,962	138,615	0	0	0
CSS Administration	2,145,991	2,145,991				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	28,736,139	16,452,600	11,906,455	0	0	369,690
FSP Programs as Percent of Total	55.3%					

Fiscal Year 2022/23

	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
Family Stability FSP (CSS-01)	2,859,803	1,432,656	1,395,629	0	0	30,295
Dual Diagnosis FSP (CSS-02)	1,124,891	559,379	553,206	0	0	11,828
Justice Involved FSP (CSS-13)	1,736,081	1,222,679	486,502	0	0	25,854
Transition Age Youth FSP (CSS-04)	2,323,509	739,983	1,567,245	0	0	15,647
Adults with SMI FSP (CSS-05)	1,557,010	1,243,619	286,032	0	0	26,297
Older Adults FSP (CSS-06)	1,847,697	1,416,881	399,644	0	0	29,961
Homeless Services and Supports FSP (CSS-14)	2,542,354	1,454,071	1,056,294	0	0	30,747
Non-FSP Programs						
Access Regional Services (CSS-07)	6,235,944	2,285,142	3,936,483	0	0	13,763
Early Childhood Mental Health (CSS-08)	4,162,310	2,381,527	1,752,164	0	0	27,507
Supported Services to Adults with SMI (CSS-10)	453,683	348,485	105,198	0	0	0
Dual Diagnosis (CSS-11)	761,263	260,507	336,592	0	0	157,789
Homelessness Outreach and Treatment (CSS-15)	380,537	252,329	128,208	0	0	0
Responsive Crisis Interventions (CSS-16)	1,136,869	995,482	141,387	0	0	0
CSS Administration	2,188,911	2,188,911				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	29,310,862	16,781,652	12,144,585	0	0	369,690
FSP Programs as Percent of Total	55.3%					

FY 2020-21 Through FY 22-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheets

County: Monterey Date: 6/3/2020

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
Family Support and Education (PEI-02)	420,732	407,645	0	0	0	13,087
Symptoms & Disorders Throughout the Lifespan (PEI-12)	1,106,572	1,106,572	0	0	0	0
Student Mental Health (PEI-08)	780,190	779,739	0	0	0	451
Maternal Mental Health (PEI-15)	200,889	200,889	0	0	0	
Stigma and Discrimination Reduction (PEI-04)	353,746	291,855	0	0	0	61,891
Suicide Prevention (PEI-06)	261,155	261,155	0	0	0	0
PEI Programs - Early Intervention						
Early Intervention Services for Older Adults (PEI-05)	305,556	305,556	0	0	0	0
Early Intervention Services for Adolescents, Transition Age & College Age Youth (PEI-13)	406,902	279,674	124,094	0	0	3,134
Culturally Specific Early Intervention Services (PEI-14)	356,738	356,738	0	0	0	0
Prevention and Recovery for Early Psychosis (PEI-10)	578,583	276,222	286,709	0	0	15,652
PEI Administration	597,956	597,956				
PEI Assigned Funds	0	0	0	0	0	0
Total PEI Program Estimated Expenditures	5,369,018	4,864,000	410,803	0	0	94,215

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
Family Support and Education (PEI-02)	429,146	415,797	0	0	0	13,087
Symptoms & Disorders Throughout the Lifespan (PEI-12)	1,128,704	1,128,704	0	0	0	0
Student Mental Health (PEI-08)	795,793	795,333	0	0	0	451
Maternal Mental Health (PEI-15)	204,906	204,906	0	0	0	61,891
Stigma and Discrimination Reduction (PEI-04)	360,821	297,693	0	0	0	0
Suicide Prevention (PEI-06)	266,378	266,378	0	0	0	0
PEI Programs - Early Intervention						
Early Intervention Services for Older Adults (PEI-05)	311,667	311,667	0	0	0	0
Early Intervention Services for Adolescents, Transition Age & College Age Youth (PEI-13)	415,040	285,267	126,576	0	0	3,134
Culturally Specific Early Intervention Services (PEI-14)	363,873	363,873	0	0	0	0
Prevention and Recovery for Early Psychosis (PEI-10)	590,155	281,746	292,443	0	0	15,652
PEI Administration	609,915	609,915	0	0	0	0
PEI Assigned Funds	0	0	0	0	0	0
Total PEI Program Estimated Expenditures	5,476,398	4,961,280	419,019	0	0	94,215

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
Family Support and Education (PEI-02)	437,729	424,113	0	0	0	13,087
Symptoms & Disorders Throughout the Lifespan (PEI-12)	1,151,278	1,151,278	0	0	0	0
Student Mental Health (PEI-08)	811,709	811,240	0	0	0	451
Maternal Mental Health (PEI-15)	209,005	209,005	0	0	0	61,891
Stigma and Discrimination Reduction (PEI-04)	368,038	303,646	0	0	0	0
Suicide Prevention (PEI-06)	271,706	271,706	0	0	0	0
PEI Programs - Early Intervention						
Early Intervention Services for Older Adults (PEI-05)	317,900	317,900	0	0	0	0
Early Intervention Services for Adolescents, Transition Age & College Age Youth (PEI-13)	423,341	290,973	129,107	0	0	3,134
Culturally Specific Early Intervention Services (PEI-14)	371,150	371,150	0	0	0	0
Prevention and Recovery for Early Psychosis (PEI-10)	601,958	287,381	298,292	0	0	15,652
PEI Administration	622,113	622,113	0	0	0	0
PEI Assigned Funds	0	0	0	0	0	0
Total PEI Program Estimated Expenditures	5,585,926	5,060,506	427,399	0	0	94,215

FY 2020-21 Through FY 22-23 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheets

County: Monterey Date: 6/3/20

		Fiscal Year 2020/21					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs							
	Micro-Innovation Activities for Increasing Latino Engagement (INN-01)	700,000	700,000				
	Screening to Timely Access (INN-02)	1,300,000	1,300,000				
	Transportation Coaching by Wellness Navigators (INN-03)	680,000	680,000				
	Residential Care Facility Incubator (INN-04)	400,000	400,000				
	Psychiatric Advance Directives (INN-05)	250,000	250,000				
	Center for Mind Body Medicine (INN-06)	500,000	500,000				
INN Administration		574,500	574,500				
Total INN Program Estimated Expenditures		4,404,500	4,404,500	0	0	0	0

		Fiscal Year 2021/22					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs							
	Micro-Innovation Activities for Increasing Latino Engagement (INN-01)	0	0				
	Screening to Timely Access (INN-02)	0	0				
	Transportation Coaching by Wellness Navigators (INN-03)	0	0				
	Residential Care Facility Incubator (INN-04)	400,000	400,000				
	Psychiatric Advance Directives (INN-05)	250,000	250,000				
	Center for Mind Body Medicine (INN-06)	500,000	500,000				
INN Administration		172,500	172,500				
Total INN Program Estimated Expenditures		1,322,500	1,322,500	0	0	0	0

		Fiscal Year 2022/23					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs							
	Micro-Innovation Activities for Increasing Latino Engagement (INN-01)	0	0				
	Screening to Timely Access (INN-02)	0	0				
	Transportation Coaching by Wellness Navigators (INN-03)	0	0				
	Residential Care Facility Incubator (INN-04)	400,000	400,000				
	Psychiatric Advance Directives (INN-05)	0	0				
	Center for Mind Body Medicine (INN-06)	500,000	500,000				
INN Administration		135,000	135,000				
Total INN Program Estimated Expenditures		1,035,000	1,035,000	0	0	0	0

FY 2020-21 Through FY 22-23 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheets

County: Monterey Date: 6/3/20

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Pipeline/Career Awareness	50,000	50,000				
2. Education and Training	700,000	700,000				
3. Retention	200,000	200,000				
4. Evaluation and Research	50,000	50,000				
WET Administration	0					
Total WET Program Estimated Expenditures	1,000,000	1,000,000	0	0	0	0

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Pipeline/Career Awareness	50,000	50,000				
2. Education and Training	700,000	700,000				
3. Retention	200,000	200,000				
4. Evaluation and Research	50,000	50,000				
WET Administration	0					
Total WET Program Estimated Expenditures	1,000,000	1,000,000	0	0	0	0

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Pipeline/Career Awareness	50,000	50,000				
2. Education and Training	700,000	700,000				
3. Retention	200,000	200,000				
4. Evaluation and Research	50,000	50,000				
WET Administration	0					
Total WET Program Estimated Expenditures	1,000,000	1,000,000	0	0	0	0

FY 2020-21 Through FY 22-23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheets

County: Monterey Date: 6/3/20

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. HVAC Replacement - Marina	2,500,000	2,500,000	0	0	0	0
2. Pearl Street Renovations	1,500,000	1,500,000	0	0	0	0
3. East Sanborn St. Facility Construction	2,201,772	2,201,772	0	0	0	0
CFTN Programs - Technological Needs Projects						
CFTN Administration						
Total CFTN Program Estimated Expenditures	6,201,772	6,201,772	0	0	0	0

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. East Sanborn St. Facility Construction	4,963,084	4,963,084	0	0	0	0
CFTN Programs - Technological Needs Projects						
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	4,963,084	4,963,084	0	0	0	0

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. East Sanborn St. Facility Construction	2,884,070	2,884,070	0	0	0	0
CFTN Programs - Technological Needs Projects						
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	2,884,070	2,884,070	0	0	0	0

Summary of Public Comments/Recommendations

MONTEREY COUNTY MHSA FY 2020/21 – FY 2022-23 Three-Year Program & Expenditure Plan

Summary of Public Comments/Recommendations	County Response
Date Received: 5/10/2020 ***Method of Delivery:*** Wufoo form via website ***Individual's Name:*** Anonymous ***Affiliation/Role within Community Mental Health System:*** Other ***Comments:*** Asked if Hispanics receive 75% of funding and requested more than that for this population.	The Medi-Cal eligible population in Monterey County is approximately 75% Hispanic/Latino. Approximately 55% of clients to MCBH and their contracted service providers are Hispanic/Latino. Increasing services, and access to services, for Hispanic/Latino, Spanish speaking, and indigenous communities has been a prominent "health equity" goal for Monterey County Behavioral Health (MCBH) since 2017, with all programs and materials accommodating Spanish language, and several programs specifically addressing this diverse and underserved population, such the "Micro-Innovation Grant Activities for Increasing Latino Engagement".
Date Received: 5/11/2020 ***Method of Delivery:*** Wufoo form via website ***Individual's Name:*** Aidee Aldaco ***Affiliation/Role within Community Mental Health System:*** Family Member of Individual Living with Mental Health Condition ***Comments:*** Appreciated document being easier to read, the presentation of data, and new topics like Maternal Mental Health. Suggested all providers create a plan to provide services virtually, due to COVID-19.	MCBH appreciates the compliments to the plan. Regarding virtual mental health services, where feasible, both MCBH and contract providers have adapted to provide services via telehealth/video-conferencing during the Shelter in Place order. Any member of the public in Monterey County can access web- and telephone-based mental health services at this time.
Date Received: 5/22/2020 ***Method of Delivery:*** Wufoo form via website ***Individual's Name:*** David Pirochta ***Affiliation/Role within Community Mental Health System:*** Consumer / Peer Worker ***Comments:*** Advocated for continued support for permanent and transitional housing programs, the Homeless Services and Supports FSP, and the community wellness center.	MCBH notes and appreciates the community support for these programs.

Date Received: 5/21/2020 ***Method of Delivery:*** Email ***Individual's Name:*** Barbara Mitchell ***Affiliation/Role within Community Mental Health System:*** Executive Director, Interim Inc. (Mental Health Service Provider) ***<u>Comments:</u>*** • Advocated for continued support of Homeless Services and Supports FSP, Community Wellness Center, and Stigma and Discrimination Reduction programs currently offered by Interim, Inc. • Provided construction comments regarding the "Residential Care Facility Incubator" Innovation project. • Advocated for WET funding to support peer workers, and loan forgiveness programs to include contract provider staffing. • Recommended to divert CFTN funding to fund supportive services instead.	MCBH notes and appreciates the community support for the programs mentioned. MCBH will evaluate feedback regarding the Residential Care Facility Incubator INN Project as staff develop a project plan. Regarding WET funding, MCBH recognizes the needs to develop peer workers and the contractor workforce and will assess possibilities as funding becomes available. Regarding the diversion of CFTN funding, funds allocated to the current CFTN plan may not be diverted at this time, as they will be subject to reversion. MCBH will reassess future allocations to the CFTN component when they become available.
Date Received: 5/22/2020 ***Method of Delivery:*** Email ***Individual's Name:*** Pamela Weston ***Affiliation/Role within Community Mental Health System:*** MCBH Cultural Relevancy & Humility Committee member / NorCal MHA Access Ambassador ***<u>Comments:</u>*** Requests the creation of an MHSA Steering Committee, that is representative of the diverse stakeholder groups in Monterey County, particularly of consumers, that may support the community planning process and inform decision-making regarding MHSA planning.	MCBH has expanded our CPPP process over the previous years, most recently doubling the number of community planning meetings to a total of 10, in preparation of this MHSA plan document. MCBH will continue to explore the potential of a dedicated MHSA steering committee as resources become available.

Monterey County Behavioral Health Commission Draft Meeting Minutes

Mark Lopez, Chairperson
Cathy Gutierrez, Chairperson Elect

Thursday, May 28, 2020 5:30 PM — Teleconference via Zoom
No Physical Location Provided

1. 5:30 P.M. - CALL TO ORDER

The meeting was called to order by Chair M. Lopez at 5:37 P.M.
All attendees appeared via teleconference.

2. INTRODUCTIONS

COMMISSIONERS

Present: Heather Deming; Maribel Ferreira; Linda Fosler; Cathy Gutierrez; Jesse Herrera; Anthony Ivanich; Supv. Christopher Lopez; Mark Lopez; Alma McHoney; Margie Sokotowski

Absent: Rosa Gonzalez-Rivas; Cortland Young (resigned); Hailey Dicken-Young (resigned)

Staff Present: Amie Miller, Behavioral Health Bureau Chief; Jon Drake, Behavioral Health Assistant Bureau Chief; Alica Hendricks, Management Analyst, Behavioral Health; Dana Edgull, Behavioral Health Services Manager, Marina Pantchenko, Deputy County Counsel; Stacy Saetta, Deputy County Counsel; Wesley Schweikhard, Management Analyst, Behavioral Health; Jill Walker, Training Manager, Behavioral Health; Michael Lisman, Deputy Director, Behavioral Health; Lucero Robles, Deputy Director, Behavioral Health; Andria Sumpter, Secretary, Behavioral Health

Announcement of the Interpreter: Spanish Interpreter present and announced Spanish interpreter services.

3. CORRECTIONS TO THE AGENDA

None.

4. PUBLIC COMMENT

Marisol Beas, Project Coordinator, California Youth Empowerment Network (CAYEN) submitted a public comment letter via email on behalf of CAYEN. Her statement was read out load and entered into the record.

Jorge, Central Coast Center for Independent Living (CCCIL) provided an update on CCCIL's work with consumers.

Theresa Comstock, Executive Director, CA Association of Local Behavioral Health Boards & Commissions (CALBHB/C) will be sharing information gained from local commission meetings with the CALBHB/C governing board and the MHS Oversight and Accountability Commission in a show of support for individual county's situations. She shared that CALBHB/C's website has a resource page for counties to report on their MHSA performance data and encouraged Monterey County to use this platform to share and learn.

Barbara Mitchell, Program Director, Interim Inc. provided an update on Interim's services and programs. The OMNI Resource Center is currently functioning solely as a warm line with plans to

reopen in the near future. She also asked the Commission to consider input from local providers during its decision-making process.

Daniel Gonzalez, Executive Director, Center for Community Advocacy (CCA) provided an update on CCA's interaction with the community and stressed the importance of the community's access to services during this pandemic.

5. ACCEPTANCE OF MINUTES

It was moved by Supv. C. Lopez, seconded by Commissioner Fosler to approve the April 30, 2020 meeting minutes. The motion passed unanimously by the following vote:

AYES:	McHoney; Sokotowski; Chair M. Lopez; Gutierrez; Ferreira; Herrera; Deming; Fosler; Ivanich; Supv. C. Lopez
NOES:	None
ABSENT:	Gonzalez-Rivas

6. ACTION: Public Hearing to review the Draft Mental Health Services Act (MHSA) FY 2020/21 to 2022/23 Three-Year Plan and recommend adoption by the Monterey County Board of Supervisors.

Amie Miller, Bureau Chief, presented referring to handout of power point:
FY20/21 to 2023/24 MHSA Three-Year Plan with Summary of Public Comments & Substantive Changes to Draft

Key points included:

- Funds can be withheld by the State if the MHSA plan is not approved by the Board of Supervisors by July 1, 2020.
- The final plan will have MHSA funding levels will be updated on page 35 of the plan, inadvertently omitted in the draft plan.

Identified Edits to Draft:

- Adjust numbering and title of Strategies to conform with fiscal structure.
  - Example: Change "CSS-04: Maternal Mental Health" to "4. [CSS-12] Maternal Mental Health"
  - This change to be reflected in narrative titles and budget worksheet

Public comments received at the meeting:

- Barbara Mitchell requested that the original public comment documents submitted during the 30-day comment period be provided in full to the commission for review, instead of just the summarized version of the comment to capture the full details. Also suggested a review of MSHA regulations to consider how to process public comment received moving forward at the local level.
- Theresa Comstock spoke towards the Welfare & Institution Code, regarding the commission and the MHSA plan. The process being the commission holds the public hearing but is not required to vote to approve the plan. She provided a reminder that documents shared with the commission also be provided to the public, and any substantive recommendations made for plans or updates be voted on by a majority of the commission's membership.

Commissioners comments received at the meeting:

- Comm. Deming raised the question if the original public comment statements are pertinent to view prior to the commission providing its decision at this meeting. She recognized that the current plan should move forward as is and that moving forward, she would like to be able to read public comments in their entirety.

- Comm. Ferreira recommended for this meeting, following the current regulations set forth and view public comments submitted in their summarized versions and forward onto the Board of Supervisors. Moving forward as a commission there can be discussion to have public comment presented in both summarized and original forms. However, there must be uniformity for processing all public comments received.
- Comm. Fosler recommended adhering to the current guidelines for this plan and accept the summarized versions of public comment submitted; discuss taking the initiative to provide the State with public comment in its entirety on an agenda at a later date but in advance of the next public hearing process. Also stated moving forward, she would like to review public comment received in their entirety.
- Comm. Sokotowski recommended viewing Barbara's original submission, however, the submission to the State contain the summaries only.
- Comm. Herrera recommended it is most respectful to the community to see their words in full included in the plan both presented to the commission and submitted to the State. For this meeting the summaries should stand with a reference to the original comment and the original comment document be submitted with the plan.
- Comm. McHoney recommended moving forward for this meeting with the summarized comments, however, have another discussion on the topic at a later date. She would also like to be able to read all comments in their entirety.

It was moved by Commissioner Ferreira, seconded by Commissioner McHoney to approve the Draft MHSA FY 2020/21 to FY 2022/23 Three-Year Plan to include the summary of substantive recommendations received during the 30-day public comment period and at the Public Hearing, as modified at the Public Hearing to identify full three-year Fiscal Year period and to include retitling and renumbering changes noted, for forwarding to the Board of Supervisors for adoption.
The motion passed with the following vote.

AYES:	**McHoney; Sokotowski; Chair M. Lopez; Gutierrez; Ferreira; Herrera; Deming; Fosler; Ivanich**
NOES:	**None**
ABSENT:	**Gonzalez-Rivas**
ABSTAIN:	**Supv. C. Lopez**

7. <u>INFORMATION:</u> Receive a Report from the Behavioral Health Director.
Dr. Amie Miller shared the following announcements:

- Monterey County Behavioral Health (MCBH) has been working on renewing contracts beginning July 1, 2020 which will include cuts in response to budget cuts.
- Many MCBH vacant staff positions have been frozen, which has resulted in increases of current staff's caseloads.
- It is important for MCBH to build out programs that bring in as much Medi-Cal as possible.
- Medi-Cal enrollment is rising and will continue to do so for the next several months. However, as enrollment increases, MCBH revenues decrease significantly, as there is no increase in match required for Medi-Cal reimbursement.

8. <u>INFORMATION:</u> Receive a Report from a Member of the Board of Supervisors
Supervisor Lopez shared the following announcements:

- The Board of Supervisors (BOS) budget hearings begin next week.
    - The data full impact of COVID-19 on our economy is still unknown

        - The gas tax, full impact from the State and other key budget numbers are still unknown
- The BOS submitted an attestation form on Tuesday, May 26, 2020 to the State to inform that Monterey County has met the criteria to move further into Stage 2 of the State's reopening plan.
    - A challenge the County is experiencing is very little notice given by State government when it moves items within the phases/stages (ex. religious services moved from stage 3 to early stage 2)
- The County's plan to navigate the COVID-19 pandemic has mechanisms in place to address should numbers exceed those predetermined in the plan.

9. INFORMATION: Receive the Commissioner's Reports/Updates

- Comm. McHoney thanked the BOS for their hard work. Reported that within the local VA clinic the older veteran population is struggling with shelter-in-place. The clinic moved all appointments to telehealth which will continue through August 15, 2020.
- Comm. Sokotowski acknowledged that telehealth appointments have been a challenge for the veteran community.
- Comm. M. Lopez reminded everyone to remain vigilant in following the hygiene guidelines for COVID-19.
- Comm. Gutierrez reported for South County, the MCBH-Access numbers remain high, and the Substance Use Disorders (SUD) program continues to see incoming requests for assistance. Thanked MCBH staff and contract providers for their continued hard work.
- Comm. Ferreira shared that the County juvenile court system pivoted quickly in coordination with MCBH-Children Services to adapt to the changes brought forth by COVID-19. Thanked MCBH for their efforts to provide stress relief for county staff and the community.
- Comm. Herrera asked MCBH for a future agenda item to provide clear criteria that will be used during decision making as reductions are made to county programs to address the issue of disparities (how will funding reductions impact the level of disparities). He also shared that CSUMB recently received an eight-year certification from the Council on Social Work Education and their MSW program graduated another cohort of students who are now working in the community in addition to students from the Physician's Assistant and Nursing programs. Noted focus needs to remain on prevention services especially as communities are struggling through this pandemic.
- Comm. Deming shared this is her last meeting as a commissioner and thanked everyone for their work and support. Her experience on this commission has affected her positively and deeply and she will continue to work to help work on hospital discharge planning programs and reduction of the recidivism rate.

ADJOURN

The meeting was adjourned at 7:02 p.m.

APPENDIX I

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

COMMUNITY PLANNING PROCESS:
REGIONAL FORUMS & FOCUS GROUPS

Community Engagement Insights:
FY 2021-2023 Mental Health Services Act
Program & Expenditure Plan

Prepared for Monterey County Behavioral Health
By Michelle Slade, Chief Strategist - C^4 Consulting
February 2020

C^4 CONSULTING
ACTIVATING TALENT. IGNITING RESULTS.

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INTRODUCTION

Report Purpose

This report provides an overview of key insights that surfaced from the Community Engagement Sessions component of the Monterey County Behavioral Health Community Planning Process. These Sessions were held to gain Monterey County stakeholder perspectives, especially residents, on *How Mental Health Can Be Strengthened Throughout Monterey County* to help shape the priorities, services, and resources related to the Monterey County Behavioral Health 2021-2023 Mental Health Services Act (MSHA) Program and Expenditure Plan. Additionally, an individual summary of insights for each Community Engagement Session is included in the digital Appendices along with access to photographs and other supporting information (e.g., participation and sign-in summary, outreach fliers, sign-in sheets, etc.).

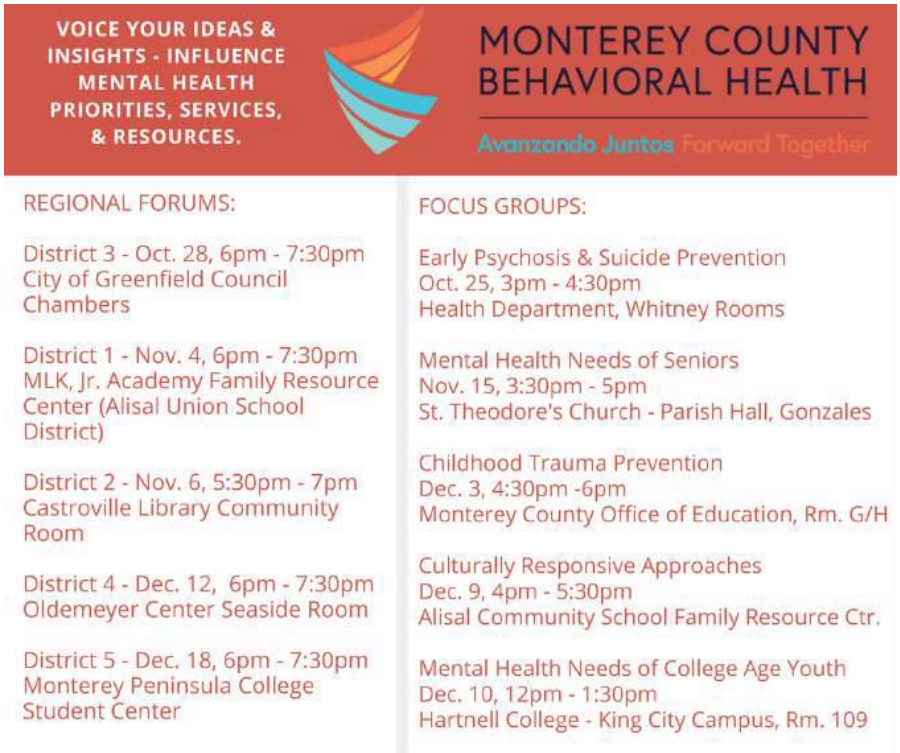
APPROACH & METHODOLOGY

Ten Community Engagement Sessions were held between October 2019 to December 2019. Locations for each Session were selected to provide convenient, broad access throughout the Monterey County, with special attention to ensuring at least one opportunity was offered in North County, Salinas, South County, and the Monterey Peninsula. Professional Interpreters were engaged to support Spanish and English translation.

These Community Engagement Sessions were comprised of five Regional Forums – one held in each District of the County and five Focus Groups specific to these critical Prevention and Early Intervention areas: Early Psychosis & Suicide Prevention, Mental Health Needs of Seniors, Childhood Trauma Prevention, Culturally Responsive Approaches, Mental Health Needs of College Age Youth.

At each Session, participants were offered the following prompts to guide their sharing and dialogue:

- What are current mental health assets in Monterey County you feel are especially helpful?
- What initial insights, recommendations, concerns, advocacy, or questions would you like to share?
- What is working regarding mental health in Monterey County?
- What is not working regarding mental health in Monterey County?
- What priorities do you recommend for strengthening mental health throughout Monterey County?



Core Themes for Priority Consideration:

Four core themes for priority consideration emerged across the 10 Community Engagement Sessions, continuing to:

1. Deepen and Expand Culturally Responsive, Trauma-informed Staffing, Approaches & Practices
2. Expand In-place, Embedded Culturally Responsive Care
3. Reduce Stigma Via Localized, Culturally Responsive, Tailored Outreach, Engagement, and Education
4. Foster Policy, Systems Change

Following are specific community recommendations organized by each core theme.

1. Deepen & Expand Culturally Responsive, Trauma-Informed Staffing, Approaches & Practices

Participants advocated for staffing, approaches, and programs that honored people's individuality and cultural backgrounds. Participants reported services that work well and are effective, do not take a one-size-fits-all approach; rather, they are designed to respond to and embrace people's various cultures and experiences, whether it be racial and ethnic backgrounds, languages used, experiences of trauma, other social identities and experiences. Participants advocated for continued implementation to expand effective culturally responsive approaches and practices to better address the assets, interests, needs, and realities of Monterey County residents, especially those relevant to Monterey County residents with historically underrepresented, marginalized, and vulnerable identities (for example, low-income, racial/ethnic minorities, homeless, Veterans, Senior Citizens/Elders, farmworkers, children and youth, LBGTQ+, system-involved, undocumented, etc.)

Specific priority opportunities noted in the Regional Forums include:

1. Ensure adoption and alignment to the Cultural Competency Plan of the Monterey County Health Department Behavioral Health Bureau to guide planning, implementation, evaluation, and continuous improvement.

2. Continue investing in a competent, relatable Workforce, reflective of the diversity of local residents:
   - 2.1. Recruit and support the professional development of Peer Educators, Wellness Navigators, and Promotores as well as licensed mental health therapists and clinicians to expand the talent pool and grow the mental health workforce (including psychiatrists) with bi-cultural staff from our local communities with lived experience, cultural relevance, community rootedness, reflective of the diverse people of Monterey County.
   - 2.2. Train mental health care providers in trauma/healing-informed approaches, implicit bias, cultural responsiveness, connections between substance abuse and mental illness.
   - 2.3. Provide training and support for locals with lived experience to provide tools for others in their local communities.
   - 2.4. Increase access to bilingual, culturally relatable counselors (especially in South Monterey County).

3. Continue expanding and deepening engagement of Monterey County residents in shaping equitable access to quality, effective mental health resources and services, including consumers of care across all aspects of Mental Health Services Act (MHSA) funding investments (for example, planning and program design, evaluation and assessment, funding decisions, etc. per MHSA regulations - cited by a participant as WIC sec 5813d CCR 9CCR3320).

4. Invest in and promote services, programs, policies that foster protective factors and resilience, especially social connectivity, interaction, and support specific to each age group across the lifespan as well as intergenerational programming, early childhood and youth development, and parent education. Specific examples include:
   4.1. Expand access to mental wellness promoting activities (for example, meditation, yoga, etc.).
   4.2. Expand services for homebound Seniors to reduce isolation (including initial in-home telecare assessments).

5. Provide alternatives to suspensions and expulsions for students as roots of behavior can be connected to mental health challenges (specific strategies such as Positive Behavioral Intervention Supports were noted as promising when implemented effectively).

6. Expand equitable access to quality, effective mental healthcare:
   6.1. Reduce transportation barriers by increasing in-place, embedded care.
   6.2. Expand client-friendly hours: Need for evening and weekend access, especially given most residents are hourly wage earners without flexibility to adjust schedules to access care during traditional 8am-5pm, Monday-Friday service windows.
   6.3. Develop centralized points of information, referral, and care coordination embedded in the local communities with a “no closed door”, universal access approach so when a resident does seek services, they experience seamless care and connection without being turned away from care due to affordability, insurance status, or other eligibility criteria.
   6.4. Expand Spanish and English bi-lingual services in addition to indigenous languages spoken (e.g., Triqui), Tagalog, and other languages reflective of the diverse population in Monterey County.
   6.5. Provide access to quality childcare so parents and caregivers are able to participate in mental healthcare - creative opportunities such as co-location within community recreation centers and schools were noted.

2. Expand In-Place, Embedded Culturally Responsive Care

Participants advocated for expanded access and quality care throughout their local communities. Although stand alone mental health facilities would be welcomed assets, participants noted resources invested in leveraging social trust capital of key influencers and existing locations to expedite increased access to mental healthcare could serve more people quicker and more cost-effectively than would major capital projects to expand services.

1. Participants pointed to existing promising examples of embedding mental health care professionals and paraprofessionals (including Licensed Mental Health Clinicians/Therapists, Wellness Navigators, Peer Educators, Promotores, etc.) directly into local communities where community members already are comfortable visiting and have trusting relationships established. Participants noted this could also be a cost-effective way to address transportation barriers as well as destigmatize accessing mental health services when co-located in existing spheres of trust.

2. Participants advocated for in-place, embedded care (from outreach, education & training, prevention to therapy) in specific locations including:
    1. Home Visits, especially for:
        1.1. Senior citizens/elders
        1.2. Parents/primary caregivers of zero to 5 years old
    2. K-12 Schools, for example:
        2.1. Behavioral health therapists/social workers at the schools
        2.2. Wellness centers at all Monterey County schools (elementary, middle, and high school levels; expanding upon successes such as within the Alisal Union School District and the Eagles Nest at Everett Alvarez High School and other sites in the Salinas Union High School District)
    3. Family Resource Centers, for example:
        3.1. Castroville Family Resource Center
        3.2. Alisal Family Resource Center
        3.3. Greenfield Union School District Family Resource Center
    4. Community Centers, for example:
        4.1. Alliance on Aging
        4.2. Boys & Girls Clubs
        4.3. CHISPA Community Centers (on-site within affordable housing)
        4.4. City Recreation, Community & Senior Centers
        4.5. Community Partnership for Youth
        4.6. Interim Omni Centers
        4.7. YMCAs
    5. Local Clinics offering other Health Services, for example:
        5.1. Clinica de Salud
        5.2. Seaside Clinic
        5.3. Taylor Farms Wellness Center
    6. Mobile Crisis Unit
        6.1. Expand service coverage and availability in all areas
    7. Community-based Organizations (especially those with proven effectiveness serving historically underrepresented, marginalized groups that experience oppression such as people with low-incomes, who are homeless, who are Veterans, who are racial/ethnic minorities, who are Senior Citizens/Elders, children and youth), for example:

7.1. Centro Binacional
7.2. Churches
7.3. Community Colleges & Universities
7.4. Epicenter
7.5. Libraries
7.6. Sunstreet Center
7.7. The Village Project
7.8. Veterans Transition Center
7.9. Local Government Spaces
    7.9.1. County Jail
    7.9.2. City Council Chambers, City Halls
7.10. Workplaces (including farm fields)

3. Reduce Stigma Via Localized, Culturally Responsive, Tailored Outreach, Engagement, & Education

1. Participants consistently pointed to stigma and a lack of understanding of mental health as barriers to seeking mental health resources and services. Effective social marketing outreach, engagement, and education were noted as priority opportunities to reduce stigma, promote, and cultivate mental well-being, and increase access to existing services, programs, and resources.

2. Participants highlighted the importance of mental health awareness-building and advocacy training for organizations, community members of all ages, and policymakers. They also asked for greater participation in, and transparency of, public mental health initiatives and agencies.

3. As with overarching culturally responsive staffing, approaches, and practices, participants cautioned against a one-size-fits-all approach, stressing the importance of social marketing and messaging customized to the target audience featuring local trusted influencers, people and programs from the community. Also, in alignment with the prior Core Themes, participants provided recommendations for where and how to embed an anti-stigma, mental health 101 campaign in local communities to take the campaign, materials, and outreach where people go about their daily lives, for example:
    3.1. Beauty Salons
    3.2. Bingo Halls (especially for Seniors)
    3.3. Churches
    3.4. Family Resource Centers
    3.5. Laundromats
    3.6. Schools (K-12 and post-secondary, higher education institutions)
    3.7. Trusted service providers, community-based organizations
    3.8. Waiting Rooms

4. Create a central on-line hub, including Community Calendar of Mental Health services, supports to improve awareness and access through more effective information and referral resources.

5. Leverage word of mouth, social capital, relationships with key community influencers to spread information.

6. Integrate outreach and education into existing community events, programs.

7. Promote the Mental Health Hotlines and resources in multiple languages in print, on the radio and television (tailor investment to "target market", for example, Spanish language radio for farmworker outreach).

8. Expand Peer Educators, for example:
   - 8.1. Promotores
   - 8.2. Senior Companions
   - 8.3. Youth-led Programs (for example, collaborate with existing Youth Councils/Advisories such as the Gonzales Youth Council, the Solead Youth Council, Girls Health in Girls Hands, Epicenter Youth Advisory, Center for Community Advocacy - Youth for Change Program, etc.)

9. Continue Mental Health Training, including accessibility to mental health professionals and community members – following are specific topics identified by participants:
   - 9.1. ACES Screenings (and response, information and referral)
   - 9.2. ASSIST (Keep Safe Now)
   - 9.3. Culturally Responsive Approaches and Practices
   - 9.4. Drug/Alcohol Use & Mental Health
   - 9.5. Early Warning Signs
   - 9.6. Mental Health 101 and First Aid
   - 9.7. Risk & Protective Factors
   - 9.8. Trauma/Healing-informed Approaches, Services, Programs

10. Continue Age-Span Specific Education and Training, for example:
    - 10.1. Youth Education
      - 10.1.1. Managing Stress & Anxiety
      - 10.1.2. Substance Abuse Impact on Healthy Brain Development
    - 10.2. Parent Education
      - 10.2.1. Infant, Family Training Series (for example, as offered by First 5)
      - 10.2.2. Maternal Mental Health
    - 10.3. Senior Education
      - 10.3.1. Addressing Aging, Loneliness, Isolation

11. Continue Profession-specific Education & Training, for example:
    - 11.1. Law Enforcement
      - 11.1.1. Crisis Intervention Training
    - 11.2. Teachers
      - 11.2.1. Adverse Childhood Experiences (ACES) - Risk and Protective factors
      - 11.2.2. Information & Referral Resources

11.2.3. Mental Health First Aid
11.2.4. Positive Behavior Interventions and Supports (PBIS)

4. Continue Policy, Systems Change

Participants consistently noted the need for increased awareness, communication, engagement at all levels and between stakeholders for consumers and providers to policy makers to continue making progress in systems change and policy. Also, participants consistently noted additional funding is needed above current MHSA and MCBH budgets.

Following are additional specific recommendations presented across the five Regional Forums:

1. Work to change policy to allow for insurance reimbursement, billing when services are delivered beyond traditional facilities and "in-place", for example, churches, community centers, schools, etc.

2. Align with Governor Newsom's newly created Council on Childhood Trauma as well as Master Plan on Aging, and make sure issues we have in Monterey are represented in future policy initiatives, with direct representation by local residents.

3. Continue to reduce equity gaps:
   3.1. Include left out organizations that are doing the various types of work but are not listed in the Behavioral Health Annual Update (or are listed but not for the full breadth of services they provide).
   3.2. Establish behavioral health committee within Behavioral Health Commission addressing 2017 Cultural Competence Blueprint and MHSA General Standards.
   3.3. Establish multicultural steering committee within Behavioral Health Commission for program planning and evaluation, outreach, engagement, assessment, transparency for equal access.
   3.4. Expand client and community-driven service planning and evaluation.

4. Improve cross-organizational collaboration and coordination of mental healthcare services:
   4.1. Improve communication, coordination, and collaboration between MCBH and other county agencies, departments (for example, Adult Protective Services) and external entities (for example, primary care doctors, emergency rooms, community-based organizations, private providers, etc.).
   4.2. Foster networking and relationship-building to aid "warm hand-offs" and "no closed doors" information and referral for residents.
   4.3. Collaborate with policy makers and other decision-makers to cut through red tape for those in Emergency Room, crisis to get timely follow-up care.
   4.4. Continue offering and expanding Monterey County Behavioral Health sponsored education and training that is open to Staff of other agencies, organizations as well as residents.
   4.5. Develop "one stop shops", hubs on-line and in trusted locations within communities where accurate information on services and access is available with "warm hand-offs" by knowledgeable, trusting,

caring resource connectors/advocates available with a "no closed door" approach. Specific examples include:

4.5.1. Integrating mental health awareness raising resources and services into existing trusted locations (for example: Schools, Family Resource Centers, Libraries, etc. in addition to other locations noted above);

4.5.2. Establishing a central call number noting therapists with their schedule/openings that potential clients or a main administrator can matchmake with the clients' day/time needs with available therapists;

4.5.3. Establishing a smart phone app enabling search for mental health resources and services, including clinicians with real-time appointment availability, characteristics such as cultural identity;

4.5.3.1. Build upon what's working with Sam's Guide and 211 and address limitations of these resources; and

4.5.3.2. Innovate technology tools to help close mental health equity gaps (look for those created by historically underrepresented groups)

5. Build upon success of partnership co-location between MCBH and community organizations and service providers:
   5.1. Continue and expand partnerships with School Districts to staff mental health therapists in the Schools, establishing a Wellness Center at each school site in Monterey County.
   5.2. Mental health professionals to continue to work with police (Crisis Intervention Training and Response).

6. Continue to work on changing laws to decriminalize mental illness.

Session Participants

In total, nearly 200 stakeholders participated (including predominantly residents along with service providers, including County Staff). Following is an overview of the number of participants who signed-in at each Community Engagement Session.

Regional Forum	# Signed-in		Focus Group	# Signed-in
District 1	20		Early Psychosis & Suicide Prevention	17
District 2	14		Mental Health Needs of Seniors	29
District 3	17		Childhood Trauma Prevention	16
District 4	33		Culturally Responsive Approaches	9
District 5	14		Mental Health Needs of College Age Youth	12
TOTAL	98		TOTAL	83

MONTEREY COUNTY BEHAVIORAL HEALTH

Mental and Behavioral Health Needs Assessment
Provider and Community Member Survey Findings
Fiscal Year 2019-2020

I. Introduction

Monterey County Behavioral Health Department (MCBH) contracted with EVALCORP, a professional evaluation company, to support an assessment of behavioral and mental health needs in communities throughout Monterey County.

II. Methodology

To complete the needs assessment, two surveys were administered, a Provider Survey and a Community Member Survey. The Provider Survey was designed to gather feedback from a broad range of people, agencies, and systems who work directly with persons who are receiving or are in need of mental health services. Respondents invited to take the survey represent multiple service sectors, such education, law enforcement, hospitals, and other community service agencies and organizations.

The Community Member Survey was designed to gather feedback from residents of Monterey County with mental health needs, as well as family members and other community members affected by mental health issues.

In order to gather detailed and robust feedback, both surveys included multi-item and open-ended responses options. Both surveys were in the field for approximately two months, while MCBH was conducting simultaneous, coordinated efforts to gather feedback through community forums and focus groups.

During this time, the Provider Survey was distributed via email with a link to an online survey in English and Spanish. The link to the survey was also posted to the MCBH website. Email invitations to the survey were sent to all of MCBH staff; the Maternal Mental Health Task Force, which includes service providers from medical, public health, community, and public agencies; mental and behavioral health service providers, and other stakeholders from the Mental Health Services Act Community Program Planning (CPP) process.

The Community Member Survey was administered on paper at the community forums and focus groups conducted throughout the County, as well as online through a link posted on the MCBH website.

Data Note: Providers who took the online Provider Survey were also given an option to take the Community Member Survey from their perspective as a community member and resident of Monterey County. However, quantitative analysis of the Community Member Survey revealed that providers tended to respond very similarly to related questions on both the Provider and Community Member Surveys. Therefore, in order to allow a meaningful comparison between community member and provider responses, the Community Member Survey analysis presented throughout the rest of this

report excludes responses given by survey-takers who identified as providers, except for open-ended/write-in responses.

III. Profile of Survey Respondents

This section presents the information gathered in both the Provider and Community Member Surveys to describe the respondents. A total of 378 surveys were collected from October 29, 2019 through January 2, 2020.

Table 1. Number of Surveys Collected by Survey Type

Survey Type	N
Provider Survey (online only)	190
Community Member Survey (paper and online)	188
Total	**378**

Provider Respondents

Providers were asked to give information about their professional roles/job titles; the sector they work in; whether they provide direct services; and the age groups, populations, and regions they serve.

Job Roles

Provider Survey respondents most commonly selected job titles of either Program Staff (41%) or Organizational/Agency Leadership (31%).

Table 2. Providers' Job Roles (n=190)

Job Title	%
Program Staff	41%
Organization/Agency Leadership (e.g., Executive, Principal, Chief, Director, or Manager)	31%
Admin/Office Support	12%
Other	16%
Total	**100%**

Among responses specified for "other," teachers, counselors, and medical/health providers were the most common titles. Table 12 in the Appendix contains a list of write-in responses grouped by common theme.

Work Sectors

The sectors best represented among the respondents to the Provider Survey were mental/behavioral health providers and educators.

Table 3. Providers' Sectors of Work (n=190)

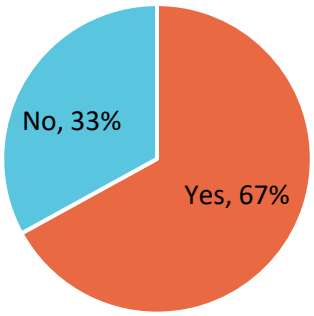
Sector	%
Mental/Behavioral Counseling	39%
Pre-K through 12 Education	23%
Community-based Organization/Non-profit Service Provider	11%
Substance Use Prevention or Treatment Services Provider	6%
Public Health	5%
Medical Treatment/Healthcare Services	3%
Social Services	3%
College/Graduate Education	1%
Law Enforcement/Probation/Justice System	1%
Other	8%
Total	**100%**

Among the responses specified under "other," Child Development, Special Education, and Administration were the most common sectors. Table 13 in the Appendix contains a list of write-in responses grouped by common theme.

Direct Services

Two thirds of respondents reported that they provide direct services either some or all of the time as part of their work. Among respondents who said they do not provide direct services, nearly all indicated that others in their organization/agency do provide direct services.

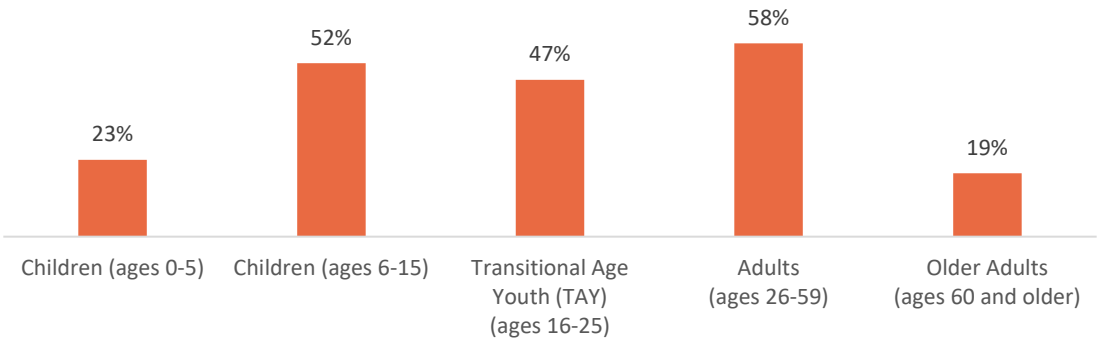
Chart 1. Do you provide direct services in your professional role? (n=190)



Age Groups Served

Respondents indicated that they work with a range of age groups, most often adults ages 26-59 (58%), followed by children ages 6-15 (52%) and transitional age youth (TAY) ages 16-25 (47%).

Chart 2. Which age groups do you work with most often? (n=184)



Total percentage exceeds 100% because respondents could select multiple options.

Population Groups Served

Below, Table 4 shows the top five population groups served by respondents. A strong majority of respondents serve populations who are low-income (80%), and more than half of respondents said they serve persons experiencing homelessness (55%).

Table 4. Population Groups Served by Providers (n=181)

Population Served	%
Persons who are low-income	80%
Persons who are trauma-exposed	70%
Immigrants	60%
Children/youth in stressed families	56%
Persons experiencing homelessness	55%

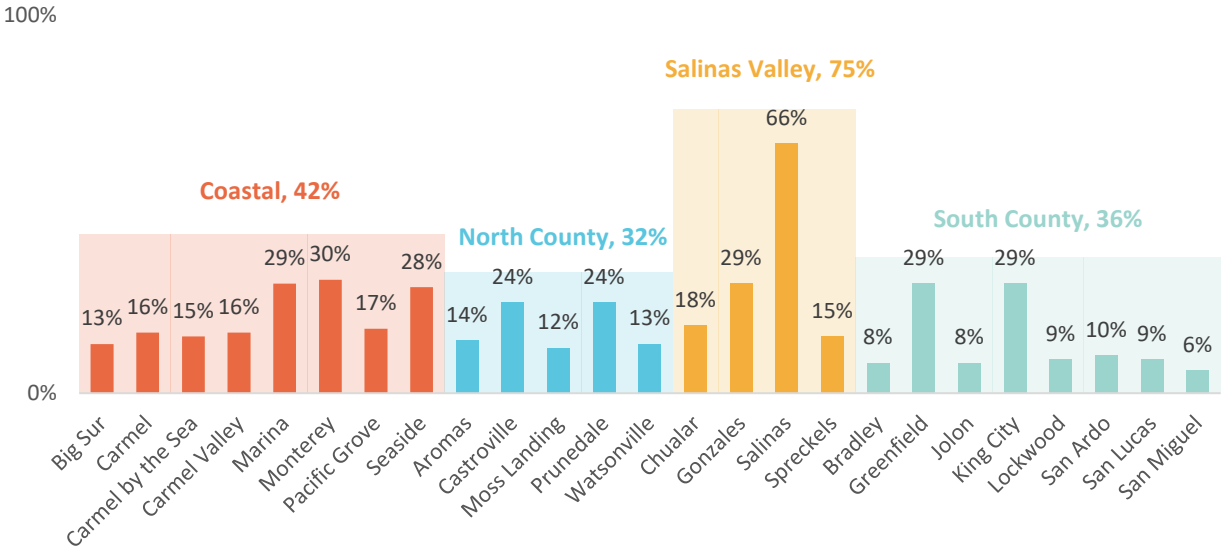
Total percentage exceeds 100% because respondents could select multiple options.

In addition, among respondents who indicated they served populations not listed, the most common group listed is people facing substance/alcohol use disorders. Tables 14 and 15 in the Appendix present a full list of populations served and a list of responses provided under "other," grouped by common theme.

Communities Served

Nearly half of respondents indicated that they provide services throughout Monterey County (48%). Among respondents who indicated the cities and regions in which they provide services, 75% of respondents said they provide services in the Salinas Valley, most often in the city of Salinas (66%).

Chart 3. Which geographic area(s) do you serve? (n=127)



Regional percentages reflect percent of respondents who selected one or more cities within the region. Total percentage of cities and total percentage of regions exceed 100% because respondents could select multiple options.

Notably, 16 respondents reported that they provide services in Soledad under the "other" option. Table 16 in the Appendix contains a full list of the cities written in under "other."

Community Member Respondents

Community Member Survey respondents were asked to give demographic information, including the zip code where they live, age, race/ethnicity, language, gender, sexual identity, disability status, and other information about themselves that may help give context to their responses on the survey (e.g., if they are a veteran, homeless, without immigration status, etc.).

Zip Code of Residence

Respondents most frequently selected zip codes in Salinas (29%), followed by Prunedale (12%).

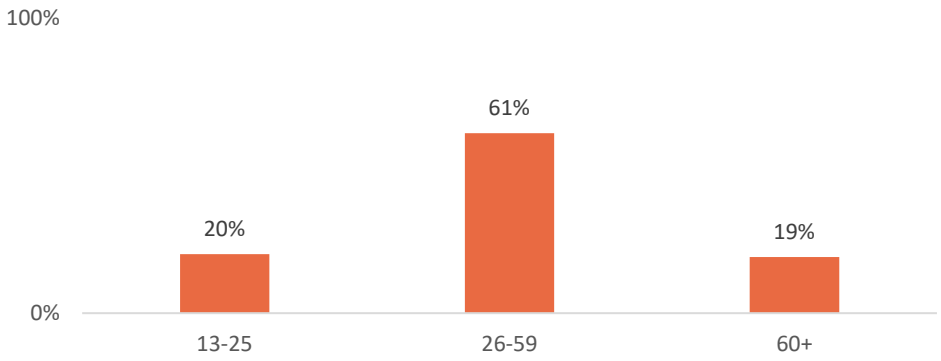
Table 5. Percent of Community Member Respondents by City and Zip Code (n=162)

City	Zip Code	%
Salinas	**(total)**	**29%**
Salinas	*93901*	*14%*
Salinas	*93906*	*15%*
Salinas	*93938*	*1%*
Prunedale	93907	**12%**
Alisal	93905	**8%**
Gonzales	93926	**8%**
Sand City	93955	**7%**
Del Rey Oaks	93940	**6%**
Soledad	93960	**5%**
Greenfield	93927	**4%**
Castroville	95012	**3%**
East Garrison	93933	**3%**
King City	93930	**3%**
Carmel	93923	**2%**
Corral de Tie	93908	**2%**
Aromas	95004	**1%**
Carmel Valley	93924	**1%**
Corralitos	95076	**1%**
Hollister	95023	**1%**
Morgan Hill	95037	**1%**
Santa Cruz	95062	**1%**
Soquel	95073	**1%**
Total		**100%**

Age

Ages of respondents range from 13 to 85 years old. The majority of respondents are ages 26 to 59 (61%).

Chart 4. How old are you? (n=161)



Race/Ethnicity

More than half of respondents to the Community Member Survey identify as Hispanic or Latino (52%).

Table 6. Percent of Community Member Respondents by Race/Ethnicity (n=170)

Race/Ethnicity	%
Hispanic or Latino	52%
White	34%
Black or African American	11%
Multiracial	6%
Asian	5%
American Indian or Alaska Native	3%
Native Hawaiian or Pacific Islander	3%
Another race/ethnicity	2%

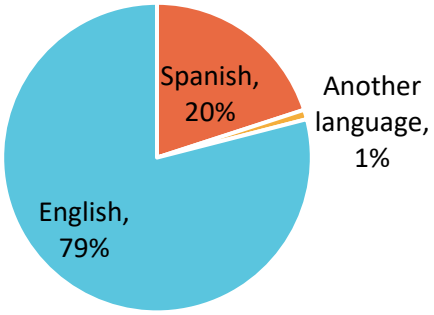
Total percentage exceeds 100% because respondents could select multiple options.

Write-in responses for “Another race/ethnicity,” include “Salinas” and “Latinx.” A list of write-in responses is presented in Table 21 in the Appendix.

Language

The majority of Community Member Survey respondents indicated that they speak English at home (79%).

Chart 5. What language do you speak most at home? (n=150)

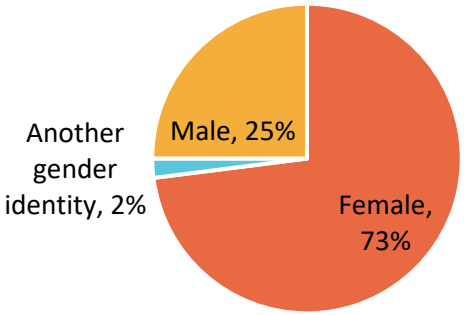


Responses specified under "another language" include "both English and Spanish." Other languages specified are Chicano, German, and Sign Language.

Gender

The majority of respondents to the Community Member Survey identify as Female (73%).

Chart 6. How do you describe your gender? (n=170)



Among respondents who selected "Another gender," non-binary or fluid was the most common write-in response. A grouped list of write-in responses is included in Table 22 in the Appendix.

LGBTQ+

Six percent (6%) of respondents to the Community Member Survey identify as LGBTQ+ (n=109). Respondents were able to write in information about their LGBTQ+ identity. The most common responses were gay, bisexual, and queer. A list of write-in responses is provided in Table 23 in the Appendix.

Disability

Nine percent (9%) of respondents to the Community Member Survey reported that they have a disability (n=112). When asked to specify their disability, the most common responses were types of mental health conditions, including depression. A list of write-in responses is provided in Table 24 in the Appendix.

Other Community Member Characteristics

Table 7. Percent of Community Member Respondents by Other Characteristics (n=77)

Characteristic	%
I am a caregiver for an adult family member	23%
I do not have immigration status or live with someone who does not have immigration status	12%
I am a veteran	8%
I am homeless or might become homeless in the near future	1%
Other	60%

Total percentage exceeds 100% because respondents could select multiple options.

Respondents wrote in a variety of additional characteristics about themselves under "Other," including information about respondents' lived experience and family, community, and professional roles. These Responses are summarized in Table 25 in the Appendix.

IV. Prioritized Mental and Behavioral Health Issues and Contributing Factors

Mental and Behavioral Health Issues

Respondents to both the Provider and Community Member Survey were asked to prioritize up to three mental/behavioral health issues that are most urgently in need of additional resources (Provider Survey) and most important in their community (Community Member Survey).

Notably, there was agreement among both providers (n=162) and community members (n=177) about their top three priorities. Both sets of respondents most frequently identified **depression**, **anxiety**, and **trauma** in their top three priorities. Suicide or thoughts of suicide was the least prioritized issue in both groups.

Respondents to both surveys wrote in additional issues under "other," most commonly including specific mental health diagnoses not included on the list such as psychosis, schizophrenia, and post-partum depression. Both Provider and Community Member write-in responses are summarized in Tables 17 and 26, respectively, in the Appendix.

Contributing Factors to Mental and Behavioral Health Issues

Respondents to the Provider and Community Member Survey were asked to identify factors most substantially contributing to mental and behavioral health needs. Again, there was agreement among both providers (n=165) and community members (n=176) about the top three contributing factors: **financial stress**, **stressful childhood experiences/ACEs**, and **homelessness**.

Respondents to both surveys wrote in additional contributing factors under "other." Respondents to the Provider Survey most commonly wrote about substance abuse disorders and family issues such as divorce and parenting challenges. Respondents to the Community Member Survey most commonly wrote about specific types of financial stressors such as low wages and lack of affordable housing. Both Provider and Community Member write-in responses are summarized in Tables 18 and 27, respectively, in the Appendix.

V. Availability of Mental and Behavioral Health Services and Barriers to Access

Provider Feedback on the Availability of Services

Respondents to the Provider Survey were asked to indicate the extent to which they think mental and behavioral health services are available to the communities and regions they serve, including specific populations and age groups. The Community Member Survey did not include these questions because these questions elicit feedback on the availability of services across multiple populations and groups and community members were asked to speak only to their personal experience with mental health needs and services.

General Availability of Services

Overall, **94% of respondents to the Provider Survey indicated that services are available to communities and regions they serve, but insufficient to meet the need.** Only 1% indicated that services are not available at all.

Specific Unserved and Underserved Populations

Respondents to the Provider Survey were asked to rate the availability of services for specific populations as either not available at all, available but insufficient to meet the need, sufficiently available to meet the need, or "I don't know."

Excluding those who selected "I don't know," at least 90% of respondents indicated there is unmet need for all but one category: persons who primarily speak Spanish (84%). Persons who are trauma-exposed is the population type most frequently selected by respondents as having insufficient or no available services (97%, excluding respondents who said they do not have knowledge of the availability services).

Table 8, below, lists each population type and the corresponding percent of respondents who rated services as either not available at all or insufficient to meet the need. Respondents who chose "I don't know" were excluded from this analysis.

Table 8. Availability of Services for Specific Populations

Population Type	Insufficient to meet the need or not available at all*
Persons who are trauma-exposed (n=135)	97%
Children/youth in stressed families (n=133)	96%
Persons experiencing onset of serious psychiatric illness (n=111)	95%
Immigrants (n=127)	95%
Family members, support persons, or caregivers of individuals with mental health conditions (n=113)	95%
Persons who are low-income (n=144)	94%
Persons who primarily speak a language other than English or Spanish (n=96)	94%
Persons experiencing homelessness (n=130)	94%
Persons with disabilities other than mental/behavioral health conditions (e.g., mobility, hearing, speech, learning, developmental, chronic health conditions like HIV or diabetes, etc.) (n=108)	94%
Persons who are victims/survivors of intimate partner/domestic violence (n=119)	94%
Children 0-5 who have experienced early life stressors and/or trauma (n=103)	93%
Children/youth at risk of juvenile justice involvement (n=112)	92%
Women with pre-/post-natal needs (n=90)	92%
Persons who identify as LGBTQ+ (n=98)	91%
Children/youth at risk for school failure (n=124)	90%
Veterans (n=88)	90%
Persons who primarily speak Spanish (n=139)	84%

* The n for each population type and calculated percent excludes respondents who selected "I don't know" for that population type.

Notably, 31% of respondents said that services are not available at all for persons who primarily speak a language other than English or Spanish (excluded those who selected "I don't know").

In addition, more than one third of respondents selected "I don't know" when asked to indicate the availability of services for:

- veterans (40%, n=146),
- women with pre-/post-natal needs (40%, n=149),
- persons who primarily speak a language other than English or Spanish (36%, n=149),
- persons who identify as LGBTQ+ (34%, n=149), and
- children 0-5 who have experienced early life stressors and/or trauma (33%, n=154)

When asked to identify any additional populations not listed, respondents most frequently wrote in specific immigrant populations, such as indigenous groups from Oaxaca, undocumented individuals, and DACA. A list of write-in responses is provided in Table 20 in the Appendix.

Age Groups

Similarly, respondents to the Provider Survey were asked to rate the availability of services by age group as either not available at all, available but insufficient to meet the need, sufficiently available to meet the need, or "I don't know."

Excluding those who selected "I don't know," at least 93% of respondents indicated there is unmet need for all age groups.

Table 9, below, lists each age group and the corresponding percent of respondents who rated services as either not available at all or insufficient to meet the need. Respondents who chose "I don't know" were excluded from this analysis.

Table 9. Availability of Services by Age Group

Age Group	Insufficient to meet the need or not available at all*
Children (age 0-5) (n=106)	95%
Children (age 6-15) (n=133)	95%
Transitional Age Youth (TAY) (age 16-25) (n=128)	94%
Adults (age 26-59) (n=123)	90%
Older Adults (age 60 and older) (n=101)	93%

* The n for each age group and calculated percent excludes respondents who selected "I don't know" for that age group.

There are notable gaps in knowledge among providers about the availability of services for two age groups, with 34% of respondents indicating "I don't know" for older adults age 26-59 (n=153) and 30% indicating "I don't know" for children age 0-5 (n=151).

Barriers to Accessing Mental and Behavioral Health Services

Respondents to both the Provider Survey and the Community Member Survey were asked to identify barriers to accessing mental and behavioral health services. Providers were asked to rate a list of barriers as either "a major barrier," "somewhat of a barrier," "not a barrier at all," or "I don't know." Community Members were asked to identify the top three biggest barriers to getting mental and behavioral health resources.

Notably, both providers (n=153) and community members (n=177) aligned on the top six barriers (out of a list of 15). **Lack of knowledge/information about services/where to get help** was the most highly prioritized barrier among both groups. This barrier was identified as "major" by the highest percentage of respondents to the Provider Survey (64%), excluding those who selected "I don't know." On the Community Member Survey, the highest percentage of respondents (63%) prioritized this barrier among their top three. Table 10 below shows the top six barriers from both the Community Member and Provider Surveys.

Table 10. Barriers to Accessing Mental and Behavioral Health Services

Barrier	Community Member Survey % prioritizing among top three barriers (n=177)	Provider Survey % indicating "major barrier" (n=153)
Lack of information about where to get help	63%	64%
Cost	46%	59%
Stigma related to mental illness	46%	58%
Service locations are too far away	37%	56%
Lack of transportation	35%	69%
Lack of health insurance	31%	57%

Respondents on both surveys wrote in additional issues under "other." Providers most commonly gave further explanation for their selections, such as transportation issues. Community Members most frequently wrote in more detail about a lack of services for specific populations and needs. Both Provider and Community Member write-in responses are summarized in Tables 19 and 28, respectively, in the Appendix.

"Clients have to go to behavioral health instead of directly to provider for assessment and authorization. It's too many hoops to jump through."

"Fragmented nature of services available, go here for this service, call that number, wait for that service, try calling them, navigating the process to find the right care is exhausting."

-Provider Survey Respondents

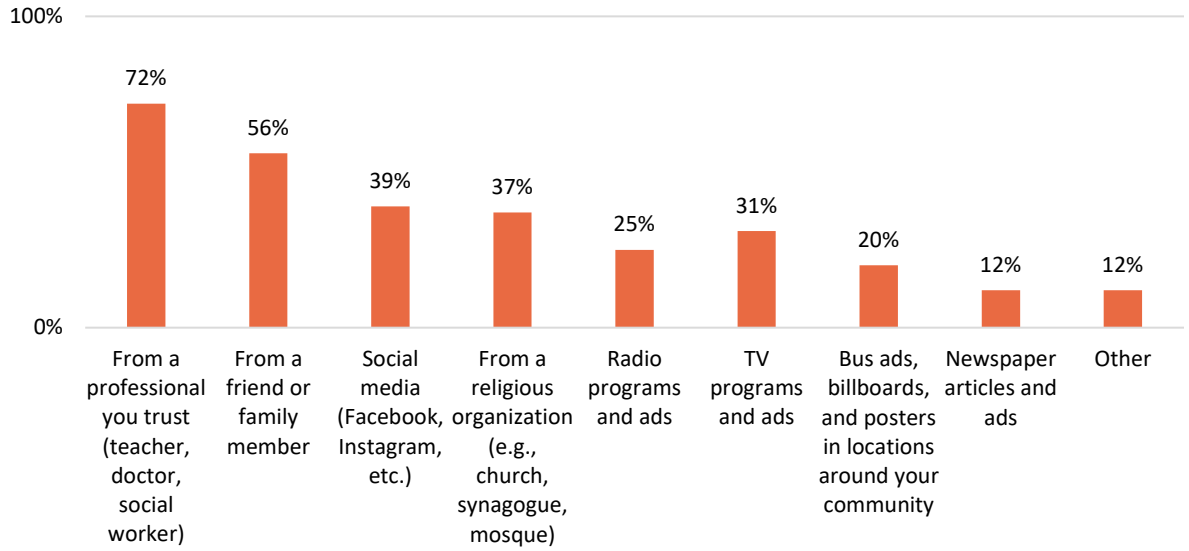
"Many people have insurance but [few] practitioners take insurance and [they are] always full."

-Community Member Survey Respondent

Outreach and Education about Available Services

Related to a lack of information about available services, when asked how they or their family members would be most likely to learn more about mental and behavioral health services, 72% of Community Member Survey respondents chose "from a professional you trust (e.g., teacher, doctor, social worker)."

Chart 7. Where would you/your family be most likely to learn about mental and behavioral health services? (n=177)



Top "other" responses include internet-related communication such as websites, and places such as school or work. Community Member write-in responses are summarized in Table 29 in the Appendix.

VI. Provider Recommendations

Respondents to the Provider Survey were given an opportunity to write in answers to an open-ended question asking for their recommendations or suggestions on how to better meet the mental/behavioral health needs in the communities that they serve. Their recommendations were grouped into the five themes described in Table 11, below.

Table 11. Provider Recommendations to Meet Mental/Behavioral Health Needs	**#**
Improve accessibility of services (e.g., expanded hours, mobile services, increased sites, increased services in underserved regions, cultural competence, easier access to services, increased insurance or payment options)	**80**
Offer more services and programs (e.g., more licensed mental health professionals, increased presence on school campuses, increased services for special populations, increased staff training for specific diagnoses, increased variety of service types, more prevention services)	**63**
Improve outreach and education about available services (e.g., increased community events explaining services available and how to access them, better engagement with community to understand needs, providing trainings such as mental health first aid)	**35**
Enhance program resources and infrastructure (e.g., staff retention through increased pay, reducing administrative burden, expanded efforts to seek funding, provision of laptops needed to better serve the community)	**19**
Improve quality of services (e.g., improved client collaboration/feedback, more coordinated care)	**6**

Below are more detailed highlights from two selected recommendations most pertinent to the needs and barriers identified in the Provider and Community Member Surveys: Improve accessibility of services and improve outreach and education about available services.

Improve accessibility of services

Providers frequently mentioned the lack of services available in South County, North County, and Salinas. In addition to opening additional sites, providers suggested offering mobile services to these areas and expanded hours such as evening and weekend appointments.

> "The majority of the population that resides in South County are farm workers. The schedule of a farm work varies from 3 am to 6-7 pm at times. There is a lack of time frames available for farm worker parents to tend to their own mental health needs and those of their children."
>
> -Provider Survey Respondent

Specific underserved populations were mentioned frequently, including agricultural workers, children 0-5, students, homeless individuals, and pregnant and postpartum mothers.

"There is a population of young adults in the city of Monterey who are homeless and living with untreated mental health conditions who do not want to leave the city of Monterey because of safety concerns and/or anxiety over traveling outside the city. They need the support of a shelter with linkages to a behavioral health center in Monterey similar to Marina and help establishing SSI benefits."

-Provider Survey Respondent

Improve outreach and education about available services

Respondents indicated a need to provide more outreach and education on mental health awareness and how to access services, as well as a better engagement with schools and existing communities and community-based organizations to gain an understanding of how to better serve those communities.

"[We need] greater collaboration with school districts to bring mental health services to school sites and district family resource centers/wellness centers. Parents are more willing to participate in services when they are closer to their place of living and connected to the school."

-Provider Survey Respondent

Enhance program resources and infrastructure

Many providers spoke to a systemic problem with and lack of funding, leading to overburdened staff and unmet community needs. The extensive documentation and administrative work currently required for billing drives the ratio of billable hours down; staff take on additional patients to bring the ratio of billable hours back up. Overwhelming caseloads and administrative work reduce clinicians' ability to provide high quality care and lead to burnout.

"There needs to be more money for more licensed staff to provide more direct services."

-Provider Survey Respondent

"Our service stats show the need is unmet and growing, yet our funding has been cut for three years in a row."

-Provider Survey Respondent

"We have a serious staffing issue. The need of accessing services continues to rise but the staff numbers do not …This leads to burnout and difficulty retaining employees long term."

-Provider Survey Respondent

VII. Summary of Findings and Implications for Prevention and Early Intervention Programs

Findings from both the Provider and Community Member Surveys indicate that there is very high alignment in Monterey County across diverse stakeholders about the highest priority needs in mental and behavioral health and access to services. Nearly all providers agreed that there is unmet need across sub-populations and age groups. Lack of knowledge about existing services, both among providers and community members, emerged as a key barrier to accessing services. Relatedly, providers identified outreach and education about available services and training for providers as a key recommendation, among other recommendations.

Robust Feedback

Nearly equal numbers of providers (n=190) and community members (n=188) responded to the surveys. Providers represented largely program staff and leadership from mental/behavioral health counseling, primary and secondary education, and community-based organizations, who provide direct services or work alongside colleagues who provide direct services. The large majority reported that they serve low-income people living in Monterey County (80%). In addition, at least half of the providers reported they serve persons who are trauma-exposed (70%), immigrants (60%), children/youth in stressed families (56%), an persons experiencing homelessness (55%).

Nearly one third or more of providers who responded to the survey said they served each county region: coastal (42%), North County (32%), Salinas Valley (75%), and South County (36%).

Outreach to community members about providing feedback through the survey, forums, or focus groups took place all five county districts. Most community members who took the survey are ages 26 to 59 (61%), and identify as female (73%) and Hispanic or Latino (52%). Other prevalent community member characteristics include respondents who are caregivers for an adult family member and with lived experience.

High Alignment on Mental Health Needs and Contributing Factors

Both providers and community members agreed that **depression**, **anxiety**, and **trauma** are among their top three priorities for mental and behavioral health in terms of importance and, for providers, resource allocation. Suicide prevention was the least prioritized issue among both groups of survey-takers. There is also alignment on the identification of contributing factors to mental and behavioral health issues: both providers and community members identified **financial stress**, **stressful childhood experiences/ACEs**, and **homelessness**, as their top three contributing factors.

Homelessness emerged as an area where more follow-up is indicated. Although homelessness was recognized as highly prioritized contributing factor, only two PEI programs explicitly include descriptions of services specifically for homeless individuals in their program and presentation descriptions: The Village Project's African American Community Partnership and Interim, Inc.'s Chinatown Learning Center.

Unmet Needs across Populations

When providers were asked about the availability of services to meet these needs and address these contributing factors, they generally indicated that **services are available in the communities and regions they serve, but insufficient to meet the need** (94%). This finding was echoed providers' rating of the availability of services for specific population and age groups; all but one population type received 90% or more of provider respondents indicating insufficient services to meet the need or no services at all. Eighty-four percent (84%) of providers indicated that there are insufficient services for individuals who primarily speak Spanish. Given the broad-based need for services indicated by providers, no one population group clearly emerged as a priority for addressing unmet needs.

Lack of Knowledge as a Barrier for Providers and Community Members

Lack of knowledge about existing services was identified as the top barrier to accessing services by both provider and community member respondents. Community members indicated that education about existing services is likely to be most effective if the information comes from a trusted professional such as a teacher, doctor, or social worker (72%). In alignment with this finding, providers recommended greater collaboration with school districts, wellness centers, and family resource centers to improve outreach and education about mental health services.

Among the MCBH PEI programs that tracked program outcomes, participants tended to agree that the services they received increased their knowledge of where to go for mental health services near them. However, programs that serve youth tended to receive lower ratings, including school-based counseling programs provided by Pajaro Valley Prevention and Student Assistance and Harmony at Home, as well as Silver Star Resource Center. These ratings may be lower due to the age of the individuals completing the outcome surveys, rather than the effectiveness of education about local services, and warrants further follow up. The Epicenter also serves youth and received one of the highest ratings for the same metric, so they may have strategies to share about educating youth on available services.

A parallel finding emerged among providers, with **more than one third of providers reporting that they do not know whether services were available to specific populations that MCBH currently serves through its PEI programming,** including veterans and persons who identify as LGBTQ+. This may indicate a need for education among providers about existing services in the county.

Appendix. Write-in Responses to Survey Questions

Provider Survey

Table 12. Providers' Job Roles Specified under "Other"

Job Title	#
Teacher/Educator	10
Counselor/therapist/social worker	5
Medical/Health Provider	4
SPED	2
Board/Commission member	2
Firefighter/ Public Safety	2
Community Outreach	1
Youth advocate	1
Community Consultant	1
Other (e.g., anonymous and "staff")	3

Table 13. Providers' Sectors of Work Specified under "Other"

Sector	#
Child Development	3
Special Education	2
Administration	2
Resource Center	1
Mental Health Administration	1
Emergency Medical Services	1
Disability, LGBTQ+ and foster youth communities	1
Peer Support	1
Medical Services	1
Other (e.g., Multi-tiered system of supports)	2

Table 14. Population Groups Served by Providers (n=181)

Sector	%
Persons who are low-income	80%
Persons who are trauma-exposed	70%
Immigrants	60%
Children/youth in stressed families	56%
Persons experiencing homelessness	55%
Children/youth at risk for school failure	48%
Persons who are victims/survivors of intimate partner/domestic violence	40%
Family members, support persons, or caregivers of individuals with mental health conditions	39%
Persons experiencing onset of serious psychiatric illness	33%
Persons with disabilities other than mental/behavioral health conditions (e.g., mobility, hearing, speech, learning, developmental, chronic health conditions like HIV or diabetes, etc.)	33%
Persons who identify as LGBTQ+	31%
Children/youth at risk of juvenile justice involvement	30%
Children 0-5 who have experienced early life stressors and/or trauma	23%
Women with pre-/post-natal needs	20%
Veterans	12%
None of the above	3%
Other underserved populations (please specify):	5%

Total percentage exceeds 100% because respondents could select multiple options.

Table 15. Population Groups Served by Providers Specified under "Other"

Population Served	#
Substance abuse and alcohol	3
Immigrants	2
Monterey County	1
Persons with mental/behavioral health conditions	1
College students	1
Intellectually Handicapped Students	1

Table 16. Cities Served by Providers Specified under "Other"

City	#
Soledad	16
Alisal	1
Chinatown	1
Gonzales	1
Las Lomas	1
Pajaro	1
Parkfield	1
Pebble Beach	1

Table 17. Most urgent Mental/Behavioral Health Issues Specified under "Other"

Mental/Behavioral Health Issue	#
Serious Mental Illness	4
Early Intervention	1
Teen drug use	1
Suicide	1
Homelessness	1
Victims of Abuse	1
Don't know	1
Substance abuse disorder	1

Table 18. Contributing Factors Specified under "Other"

Factor	#
Substance abuse disorder	3
Problems at home (e.g., divorce, parental challenges)	3
Limited availability of services	2
Housing	1
Don't know	1
Lack of transportation to services	1

Table 19. Barriers to Mental Health Services, identified by Providers

Barrier	#
Logistical difficulties with accessing services (e.g., difficulty beginning services, transportation)	6
Lack of service provisions for special populations (e.g., homeless, TAY, foster youth)	3
Lack of mental health staff and/or office space	3
Stigma and lack of community outreach and engagement	3
Inadequate discharge planning	1
Don't know	1

Table 20. Other Underserved Populations Identified by Providers

Underserved Population	#
Immigrants (e.g., indigenous groups from Oaxaca, undocumented, DACA)	5
Suicidal populations	1
Middle class who don’t qualify for Medi-Cal	1
Families who live in rural, isolated communities	1
First generation college students	1
People with ACES	1
High functioning individuals needing basic medication management	1
Youth and adults with developmental and behavioral needs	1
Families who live in labor camps	1

Table 21. Race/Ethnicity Specified under "Another race/ethnicity"

Races/ethnicities	#
"Salinas"	4
European (e.g., Irish, German)	3
Latinx	2
Chicano	1
Unspecified (e.g., "Decline," "all")	4

Table 22. Gender Specified under "Another gender Identity"

Gender	#
Non-Binary	4
Agender	1
Fluid	1
Decline to Answer	2

Table 23. Specified LGBTQ+ Identities

LGBTQ+ Identity	#
Gay	4
Bisexual	4
Queer	4
Asexual	1
Lesbian	1
Pansexual	1

Table 24. Specified Types of Disabilities

Type of Disability	#
Mental Health Condition	12
Cognitive Impairment or Learning disorder	3
Chronic Pain	2
Visual	1
Substance Abuse	1

Table 25. Additional Personal Characteristics Specified under "Other"

Characteristic	#
Descriptions of related professional roles	**32**
Policymaker and/or community advocate	8
Service provider/work with CBOs (e.g, work for a nonprofit; work with elders, at risk youth, early childhood; promotora de salud; community health outreach worker)	11
Public Council/Board member	3
Mental Health professional	3
Pastor	1
Teacher	1
Work in hospitality industry	1
Personal experience with mental health:	**14**
Currently experiencing stressor (e.g., isolation, bullying, chronic pain, housing-related financial stress)	4
History of trauma (e.g., trauma, poverty, domestic violence)	3
Diagnosed with mental health condition or substance user	3
Other personal interest in mental health issues (e.g., cares about mental health issues, general experience with mental health issues)	4
Lived experience with others' mental health:	**9**
Family member with mental health diagnosis, homelessness, or disability	**7**
Caregiver for someone with mental health diagnosis	2
Role as a family member:	**6**
Parent	5
Single parent	6
Grandparent	1
Population type	**6**
College student	2
Older adult	2
Senior	2

Table 26. Mental/Behavioral Health Issues Specified under "Other"

Mental/Behavioral Health Issue	#
Specific Mental Health Diagnosis (e.g., serious mental illness, post-partum depression)	4
Increased access (e.g., difficulty accessing services; not knowing how to access services)	2
Isolation	2
Financial Stress	1
Early Intervention	1

Table 27. Contributing Factors Specified under "Other"

Stressor	#
Financial Stress (e.g., low wages. lack of affordable housing)	7
Physical or mental abuse (e.g., Domestic Violence, Trauma/ ACES, Emotional Abuse)	3
Stress related to Political events	2
Immigration related Stress	2
School or Work Stress	2
Social pressure	1

Table 28. Barriers to Accessing Services Specified under "Other"

Barrier	#
Lack of Services or Providers (e.g., lack of services in area of need)	20
Stigma or Cultural barriers (e.g., mistrust of service providers)	7
Difficulty Starting Services (e.g., lengthy onboarding process, long wait times)	3
Insurance Not Accepted (e.g., lack of service providers who accept private or certain types of public insurance)	3
Other (e.g., lack of affordable housing; lack of transportation)	3

Table 29. Places Most Likely to Learn about Availability of Services Specified under "Other"

Place	#
Internet Search, Website, or Social Media	9
School or Work	8
Doctor or health clinic	6
Local community-based organizations	6
Professional Referrals	5

APPENDIX III

Community Services & Supports Data Report FY18/19

List of CSS Strategies (CSS-01 through 12) and Programs implemented in FY18/19:

CSS-01 - Family Stability FSP
- Kinship Center, Adoption Preservation FSP (p.1-2)
- Family Reunification FSP (p.3-4)

CSS-02 - Dual Diagnosis FSP
- Door to Hope, Co-occuring Disorder FSP (p.5-6)
- Door to Hope, Santa Lucia, Juvenile Justice Residential (p.7-8)

CSS-03 - Juvenile Justice FSP
- Juvenile Justice Mental Health Court, CS JJ CALA MH Court FSP (p.9-10)
- Juvenile Sex Offender Reduction Team (p.11-12)

CSS-04 - Transition Age Youth FSP
- Avanza FSP (p.13-14)

CSS-05 - Adults with SMI
- Mental Health Court, AS Creating New Choices FSP (p.15-16)
- Interim, MHSA Lupine Garden FSP (p.17-18)
- Interim, MHSA Homeless FSP (p.19-20)
- Interim, Sunflower Garden (p.21-22)
- Interim, Assertive Community Treatment (ACT) Welcoming & Engaging Team (p.23-24)

CSS-06 - Older Adults FSP
- Front St.-Drake House Supportive Housing (p.25-26)
- Integrated Care/Older Adult FSP (p.27-28)

CSS-07 - Access Regional Services
- Community Human Services, CHS MHS Outpatient (p.29-30)
- Kinship Center, Children's Clinic So. County (p.31-32)
- Community Human Services, CHS HIV/AIDS Com Partnership (p.33-34)
- Access to Treatment (p.35-36)

CSS-08 - Early Childhood Mental Health
- Door to Hope, MCSTART (p.37-38)
- Early Childhood, CS Secure Families (p.39-40)

CSS-09 - Transition Age Youth
- CS Transitional Aged Youth (p.41-42)

CSS-10 - Supports to Adults with SMI
- Interim, Rockrose (p.43-44)
- Interim, Peer Wellness Navigators & Peer Partners for Health (p.45-46)
- Central Coast Center for Independent Living, Workforce Support & Counseling (p.47-50)

CSS-11 - Dual Diagnosis
- Interim, Co-occurring Integrated Care (p.51-52)

CSS-12 - Family Stability
- Kinship Center, D'Arrigo Children's Clinic (p.53-54, 57-58)
- Family Preservation, CS Family Preservation (p.59-60)
- Family Preservation, CS Salinas Home Partners (p.61-62)
- Kinship Center, Outpatient Resolving Trauma Services for Children (p.55-56)

CSS-01 - Family Stability FSP

Program/Program Group: Kinship Adoption FSP Seneca

Services include the integration of a full service partnership model for some families and the inclusion of evidence based and evidence informed parent education programs.

Number of Clients Served: 3

Total Service Value: $116,950.73

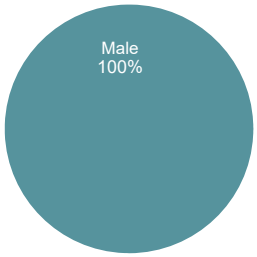
Average Service Value per Client: $38,983.58

Average Age: 10

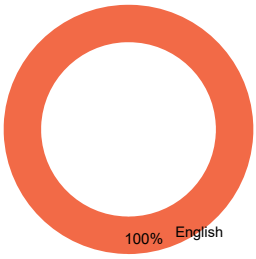
Number of New Clients: 0

Number of Clients Discharged: 3

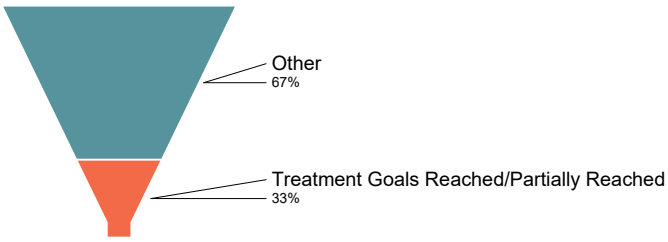
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	100 %

Of the Clients Served, **0** % had a Substance Use Diagnosis.

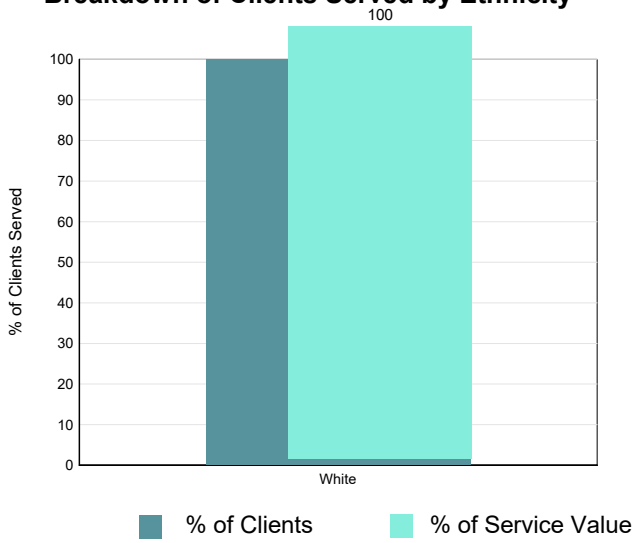
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	12	2 %	100%
Collateral/Family Therapy	85	18 %	100%
Linkage/Brokerage	127	20 %	100%
Medication Support	20	2 %	100%
Mental Health Counseling	214	58 %	100%
Total	458	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	62%
Private Insurance	38%

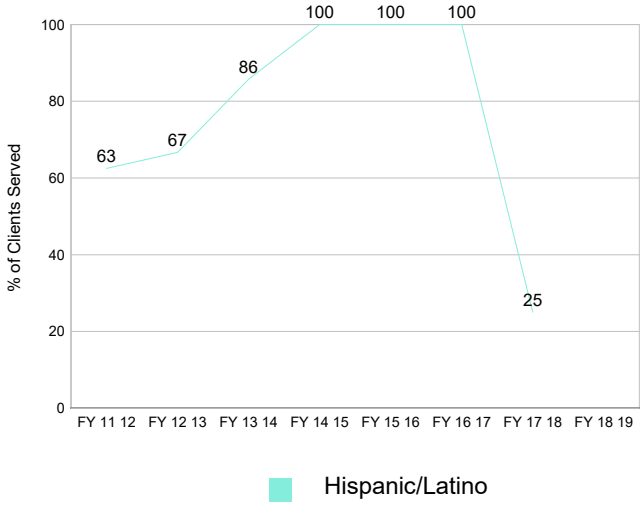
CSS-01 - Family Stability FSP

Health Equities

Breakdown of Clients Served by Ethnicity

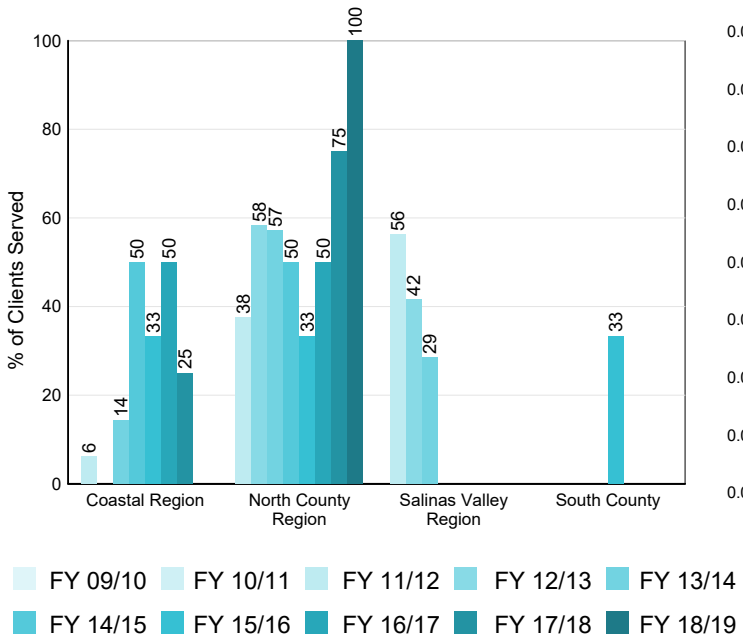


Percent of Hispanic / Latino Clients Served

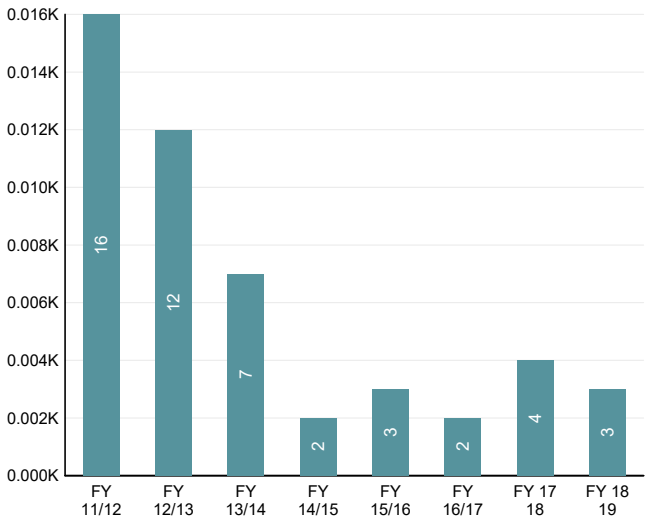


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



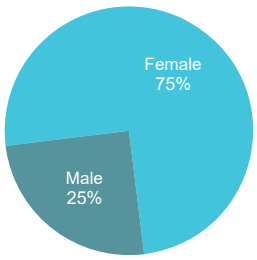
CSS-01 - Family Stability FSP

Program/Program Group: CS Family Reunification FSP

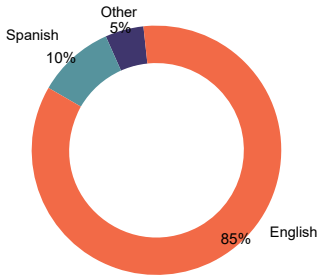
Family Reunification Program is a unique and innovative program model that truly integrates Children's Behavioral Health (CBH) therapists and Family and Children's Services (FCS/DSES) social workers into one cohesive service unit. The full FRP staff is co-located, co-supervised, and cross-trained to each other's jobs. At full staffing there are three FCS social workers, permanently teamed with three clinicians from CBH. Paired in teams of two for each FRP family, they share a caseload together and jointly provide services and case management to their families. They jointly share responsibility for case planning, provision of intensive therapeutic and support services, case monitoring, family team leadership, decision-making, and managing and leading orientation and other groups. The target population for the FRP program is: those families who are court-ordered to receive family reunification services from DSES after children have been removed from the home due to severe abuse or neglect and; have significant mental health needs and; face greater-then-normal challenges in safely reuniting and creating a stable home environment that will support the mental health and emotional needs of their children.

- Number of Clients Served: 20
- Total Service Value: $99,995.75
- Average Service Value per Client: $4,999.79
- Average Age: 10
- Number of New Clients: 7
- Number of Clients Discharged: 6

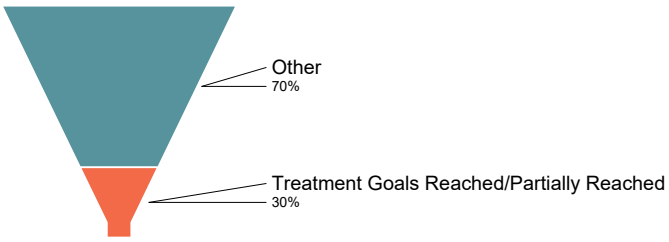
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	85 %
Mood Disorders	5 %

Of the Clients Served, **0** % had a Substance Use Diagnosis.

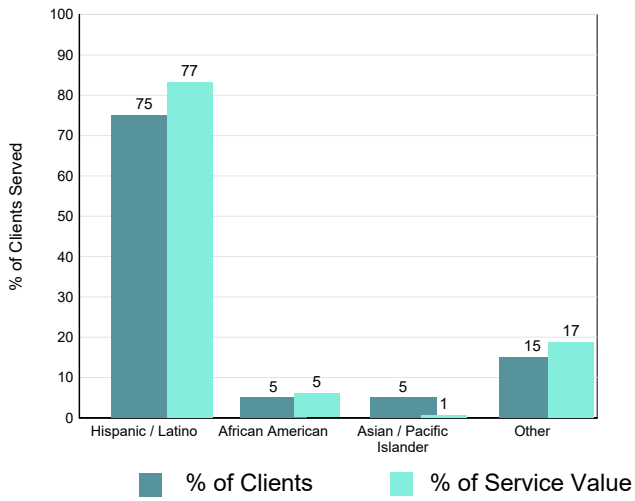
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	16	4 %	35%
Collateral/Family Therapy	6	2 %	10%
Linkage/Brokerage	357	63 %	85%
Mental Health Counseling	39	20 %	45%
Non Billable	47	12 %	50%
Total	465	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	100%

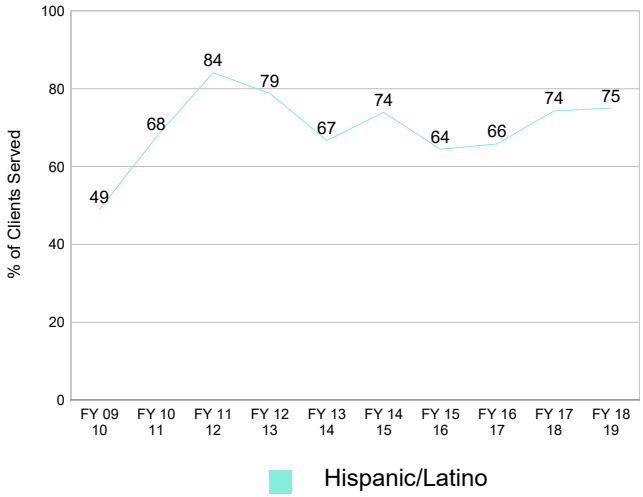
CSS-01 - Family Stability FSP

Health Equities

Breakdown of Clients Served by Ethnicity

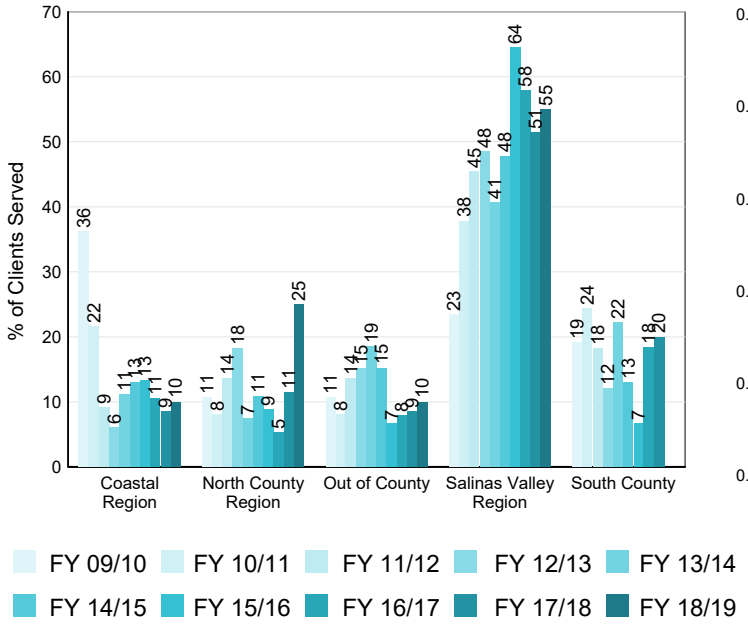


Percent of Hispanic / Latino Clients Served

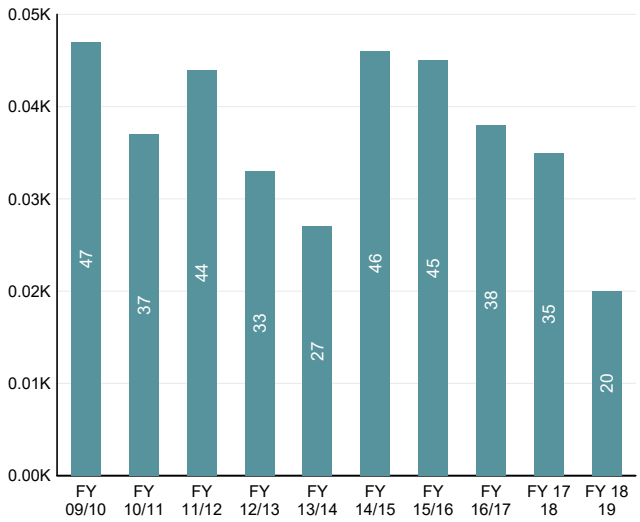


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



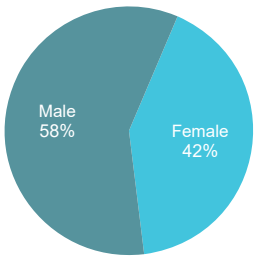
CSS-02 - Dual Diagnosis FSP

Program/Program Group: Co-Occurring Disorder

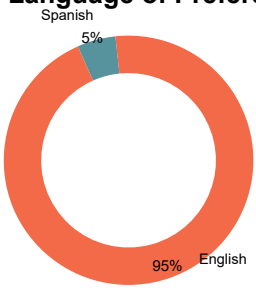
ICT is an MHSA program, a Full Service Partnership, (FSP), and a contract with Door to Hope. This team provides a high level of care to co-occurring youth and their families. ICT is designed to prevent youth from having to be placed out of the home, who may be struggling with a co-occurring disorder. It is offered to youth ages 12 -18, who meet the co-occurring criteria and are at risk of out of home placement. This team provides individual and family therapy, as well as peer mentor support.The desired outcomes include measuring success in education, decreasing recidivism, prevention of further involvement with the Juvenile Justice system, and providing treatment in a less restrictive setting. Success is measured by youth's ability to remain at home, in school, and in their community, with no new law violations.This is a Mental Health Services Act (MHSA) program, under the co-occurring strategy. It is one of the substance abuse programs designed to meet moderate to severe needs.

- Number of Clients Served: 79
- Total Service Value: $504,249.63
- Average Service Value per Client: $6,382.91
- Average Age: 16
- Number of New Clients: 41
- Number of Clients Discharged: 57

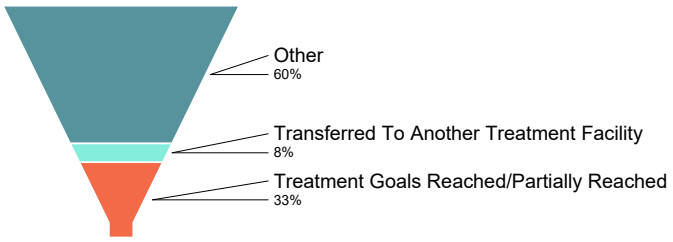
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Mood Disorders	57 %
Anxiety Disorders	25 %
Disruptive Behavior Disorders	8 %

Of the Clients Served, **96** % had a Substance Use Diagnosis.

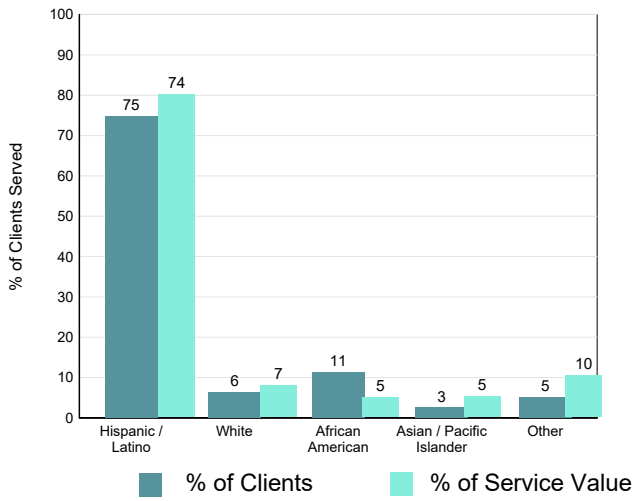
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	305	14 %	75%
Collateral/Family Therapy	317	9 %	48%
Group Counseling	5	0 %	4%
Linkage/Brokerage	1,000	26 %	96%
Mental Health Counseling	849	47 %	66%
Non Billable	105	2 %	51%
Others	24	1 %	4%
Total	2,605	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	79%
Private Insurance	11%
Self Pay/Other	10%

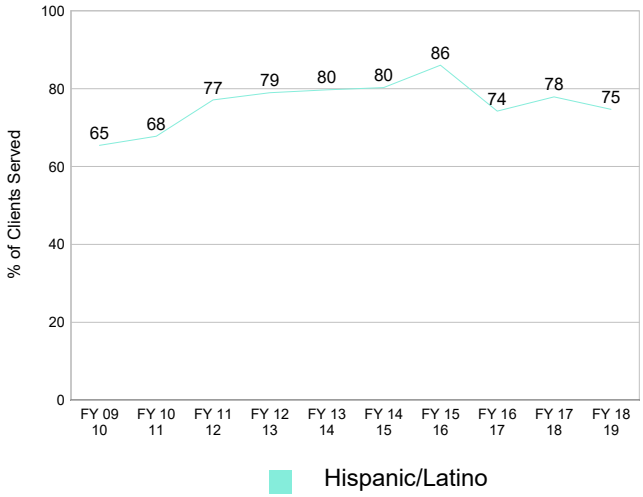
CSS-02 - Dual Diagnosis FSP

Health Equities

Breakdown of Clients Served by Ethnicity

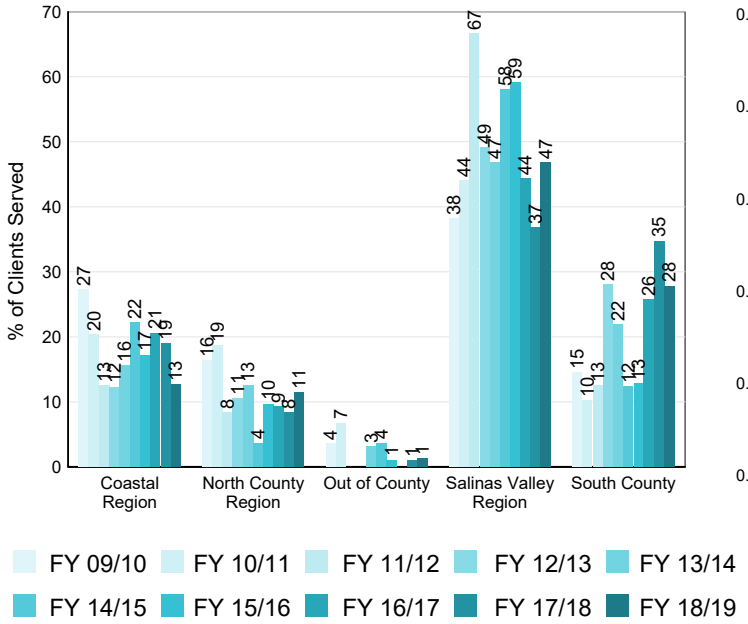


Percent of Hispanic / Latino Clients Served

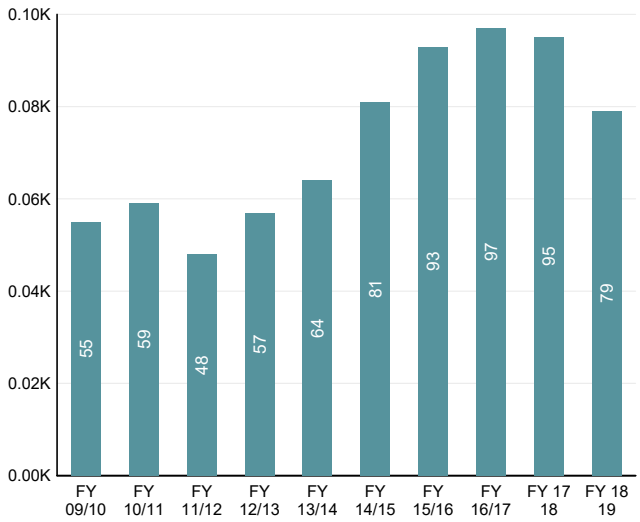


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



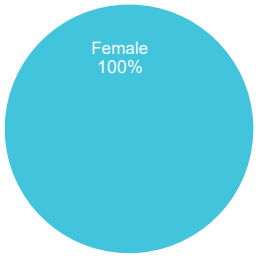
CSS-02 - Dual Diagnosis FSP

Program/Program Group: DTH Santa Lucia

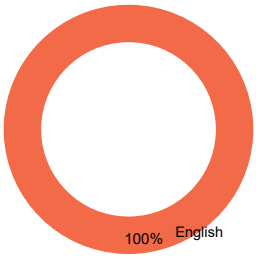
Santa Lucia/Door to Hope provides a 24 hour, Residential Care Level (RCL) 11, residential treatment program for adolescent females with co-occurring disorders. Door to Hope delivers a nine month, Intensive Treatment program, to at risk, female adolescent youth, with substance abuse issues, in a community setting. Youth are placed through Monterey County Probation or Monterey County Department of Social and Employment Services (DSES). Services delivered include individual, group, and family therapy. Substance abuse education and therapeutic community/milieu are also provided.

- Number of Clients Served: 15
- Total Service Value: $521,692.86
- Average Service Value per Client: $34,779.52
- Average Age: 15
- Number of New Clients: 9
- Number of Clients Discharged: 10

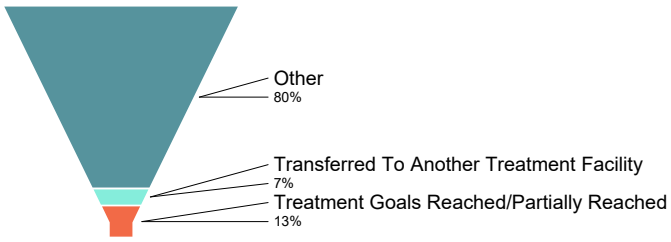
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Mood Disorders	53 %
Anxiety Disorders	47 %

Of the Clients Served, **100** % had a Substance Use Diagnosis.

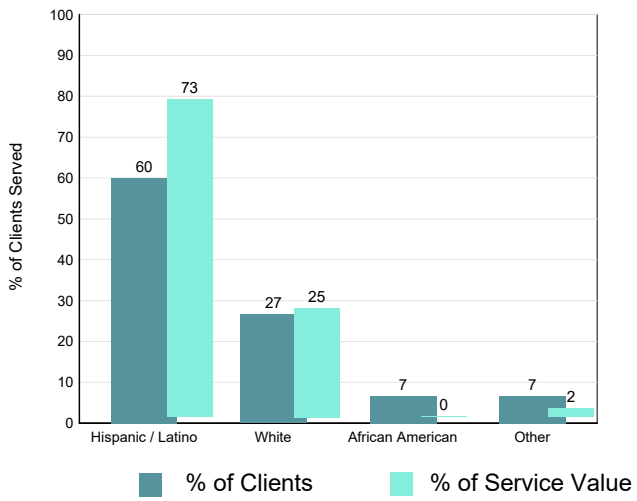
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	54	3 %	87%
Collateral/Family Therapy	73	3 %	87%
Group Counseling	741	11 %	93%
Linkage/Brokerage	477	20 %	100%
Mental Health Counseling	1,619	62 %	93%
Non Billable	10	0 %	33%
Total	2,974	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	100%

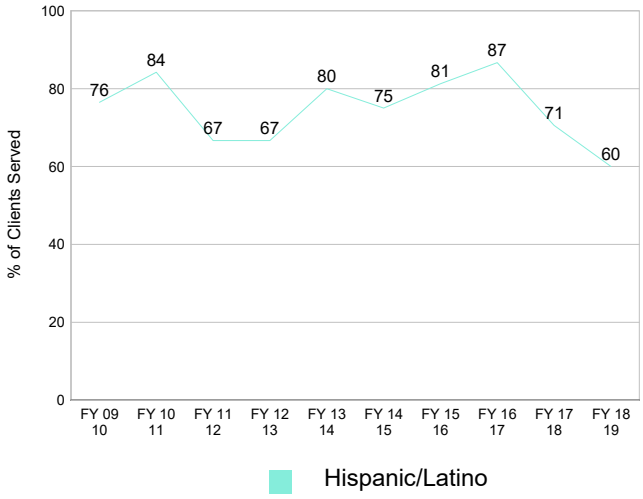
CSS-02 - Dual Diagnosis FSP

Health Equities

Breakdown of Clients Served by Ethnicity

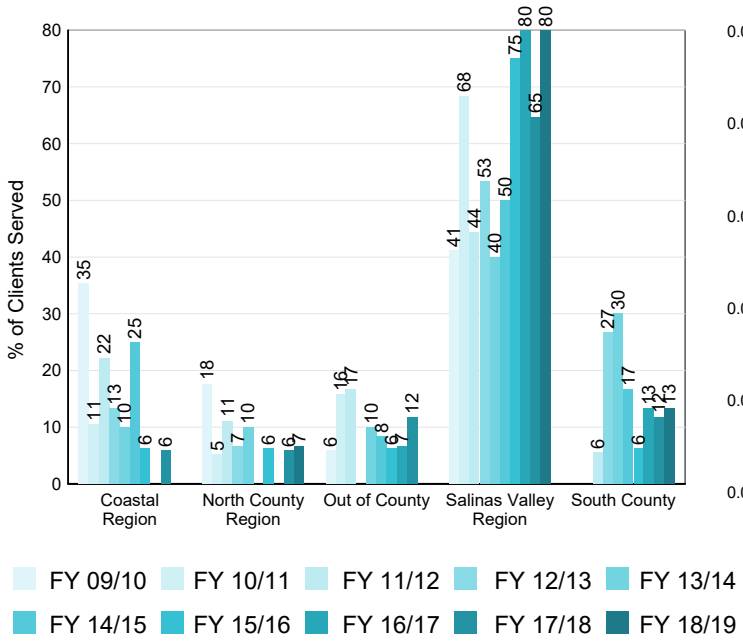


Percent of Hispanic / Latino Clients Served

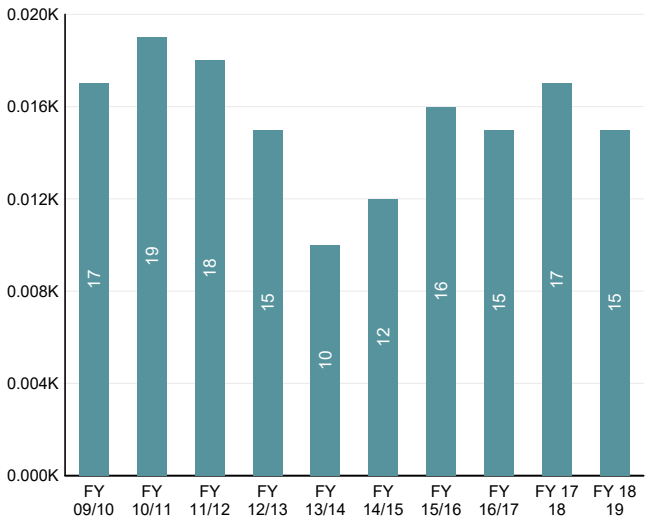


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



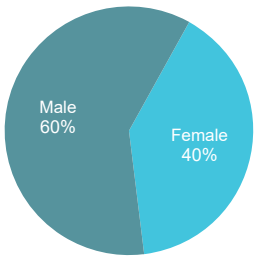
CSS-03 - Juvenile Justice FSP

Program/Program Group: CS JJ CALA MH Court

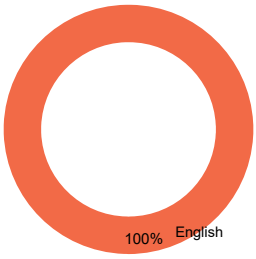
Community Action Linking Adolescents program provides intensive mental health services & case management for youth in the juvenile justice system. Probation, Juvenile Court and Behavioral Health collaborate to provide supervision and support to youth and their families. As an MHSA/Full Service Partnership (FSP) program, this team adopts a whatever it takes approach, in treating at risk youth and their families.The CALA Youth Program was a originally a combination of the Juvenile Mentally Ill Offender Criminal Reduction (MIOCR)Grant, and Mental Health Services Act (MHSA) funding. This funding made possible the development of a Juvenile Mental Health Court, and to serve the mental health needs of youth who come into contact with the Juvenile Justice system. This multidisciplinary team screens all youth who are in the field, and on Probation, with the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2), and also delivers Brief Strategic Family Therapy, as the Evidenced-Based Practice

- Number of Clients Served: 20
- Total Service Value: $147,484.01
- Average Service Value per Client: $7,374.20
- Average Age: 16
- Number of New Clients: 12
- Number of Clients Discharged: 10

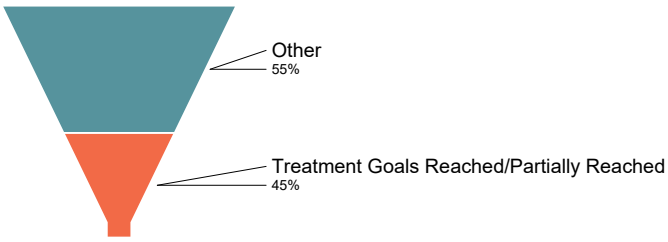
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Mood Disorders	35 %
Anxiety Disorders	20 %
Disruptive Behavior Disorders	5 %

Of the Clients Served, **15** % had a Substance Use Diagnosis.

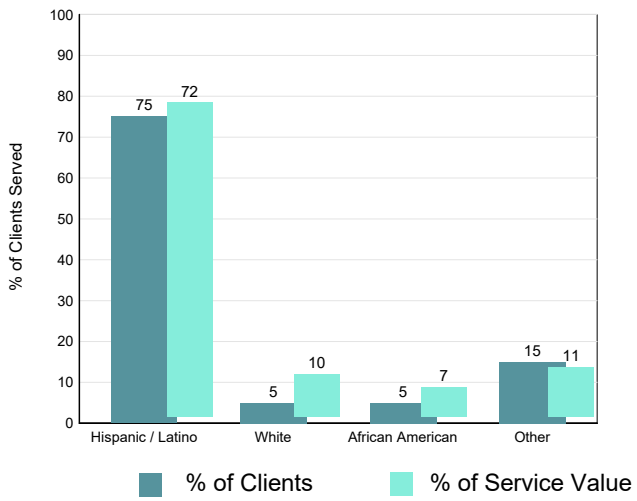
Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	53%
Private Insurance	30%
Self Pay/Other	17%

	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	66	18 %	75%
Collateral/Family Therapy	20	6 %	55%
Crisis Intervention	4	0 %	10%
Linkage/Brokerage	162	34 %	85%
Medication Support	13	2 %	40%
Mental Health Counseling	76	18 %	75%
Non Billable	156	21 %	95%
Others	2	0 %	5%
Total	499	100%	100%

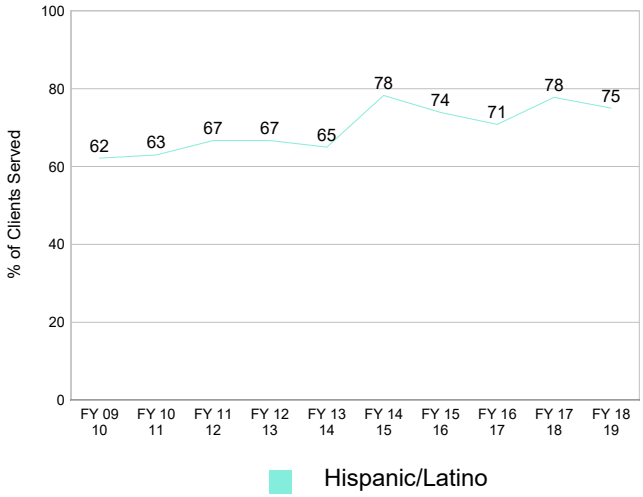
CSS-03 - Juvenile Justice FSP

Health Equities

Breakdown of Clients Served by Ethnicity

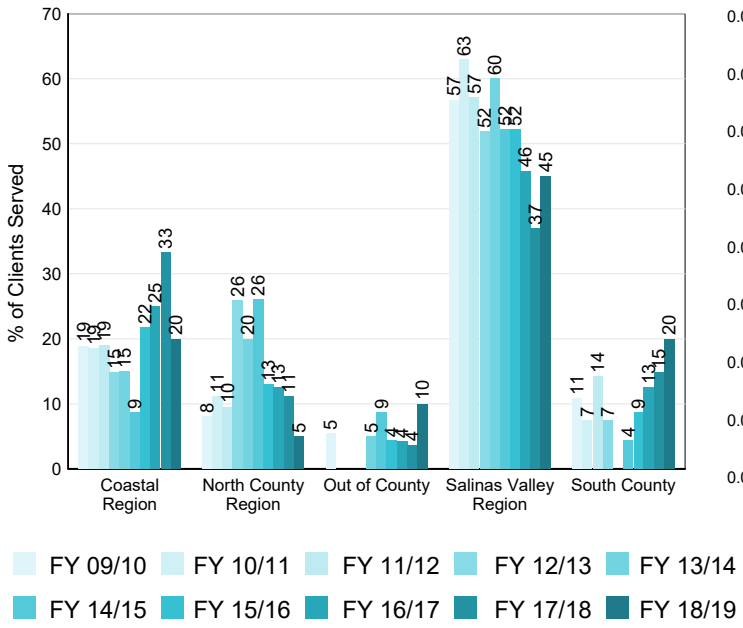


Percent of Hispanic / Latino Clients Served

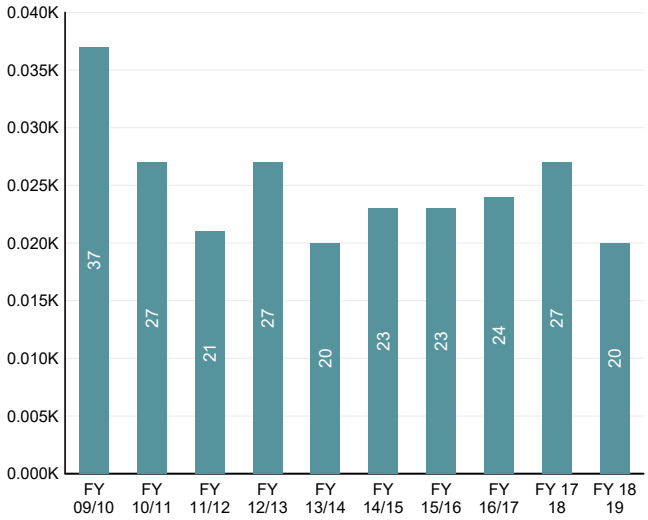


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



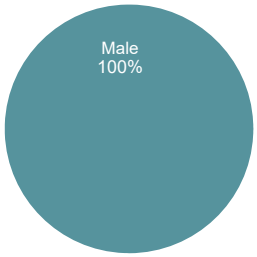
CSS-03 - Juvenile Justice FSP

Program/Program Group: CS JJ JSORT

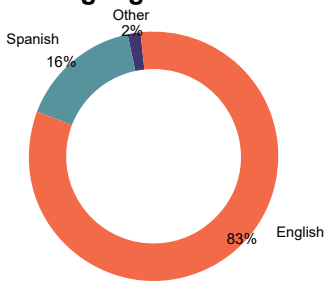
The Juvenile Sex Offender Response Team (JSORT) offers treatment to adolescents with sexual offender charges, in collaboration with the Probation Department. JSORT meets as a multidisciplinary team in order to meet the needs of the youth and family. Referrals are made through the Probation Department, and youth are assessed for the program. Services are implemented, in individual, group and family modalities. This team meets regularly to discuss the cases and treatment, and efforts are made to reduce the risk of re-offending and to plan reunification services for returning the offender to the home and community, with all safety factors considered.

- Number of Clients Served: 63
- Total Service Value: $522,144.60
- Average Service Value per Client: $8,288.01
- Average Age: 16
- Number of New Clients: 35
- Number of Clients Discharged: 32

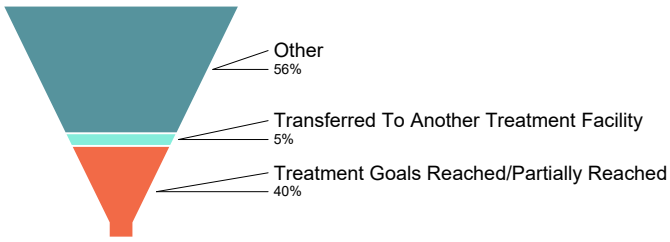
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	24 %
Disruptive Behavior Disorders	17 %
OTHER	11 %

Of the Clients Served, **5** % had a Substance Use Diagnosis.

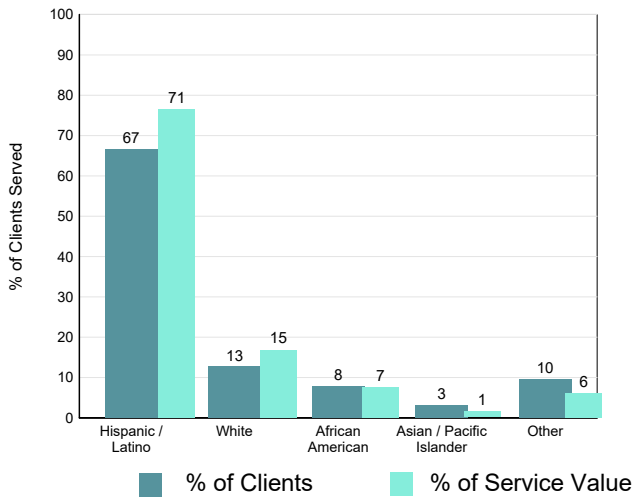
Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	64%
Private Insurance	9%
Self Pay/Other	27%

	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	253	19 %	81%
Collateral/Family Therapy	104	6 %	46%
Crisis Intervention	9	0 %	3%
Group Counseling	741	18 %	35%
Linkage/Brokerage	431	20 %	84%
Medication Support	10	0 %	10%
Mental Health Counseling	448	27 %	65%
Non Billable	341	9 %	90%
Others	16	1 %	6%
Total	2,353	100%	100%

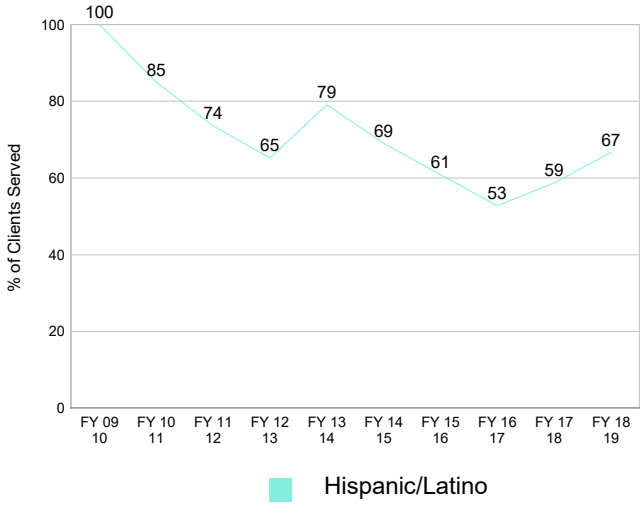
CSS-03 - Juvenile Justice FSP

Health Equities

Breakdown of Clients Served by Ethnicity

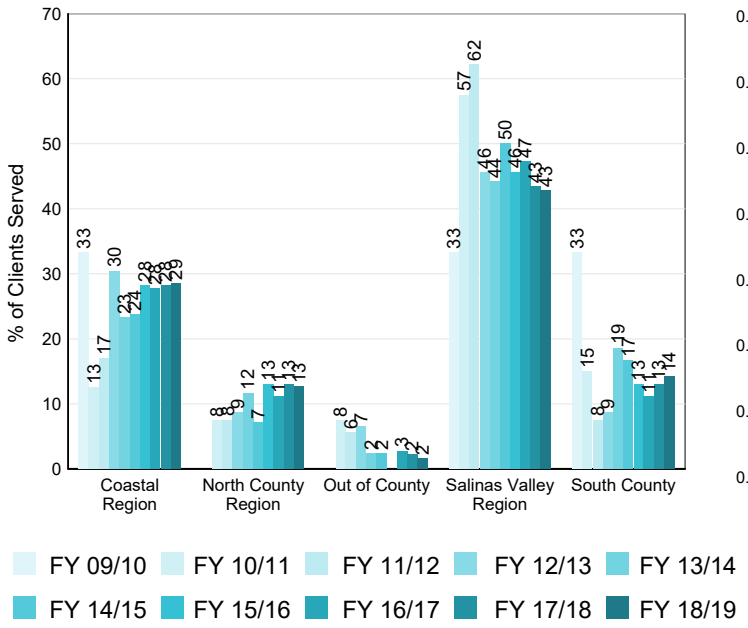


Percent of Hispanic / Latino Clients Served

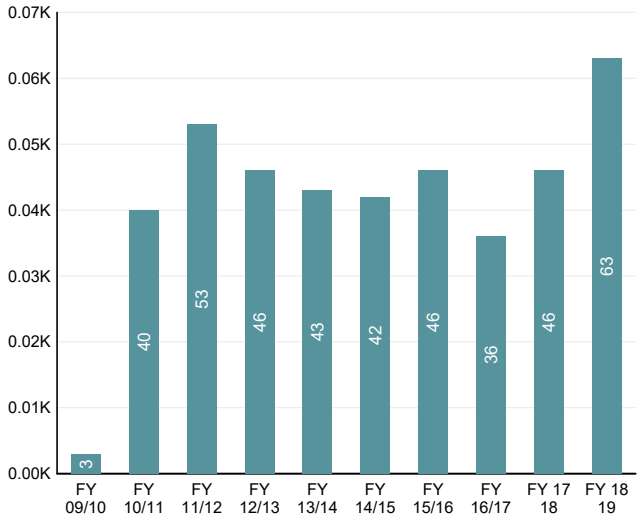


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



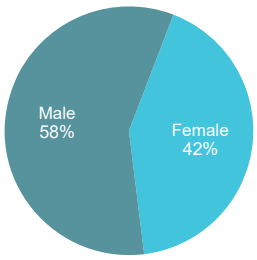
CSS-04 - Transition Age Youth FSP

Program/Program Group: TAY Avanza FSP

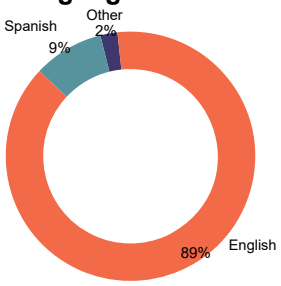
Avanza is a voluntary program for youth ages 16-25 and is based on the philosophy that services should be youth-guided, strength-based, individualized, community-based and culturally competent. We collaborate with other services providers, the youth and their family to provide services and supports to help the youth move forward in their life domains (Education, Employment, Living Situation, Personal/Community Engagement). Youth receive psychiatric assessment, case management and individual/group/family therapy based upon their mental health needs. Youth also can participate in skills groups, outings and recognition events.

- Number of Clients Served: 255
- Total Service Value: $749,497.14
- Average Service Value per Client: $2,939.20
- Average Age: 21
- Number of New Clients: 245
- Number of Clients Discharged: 35

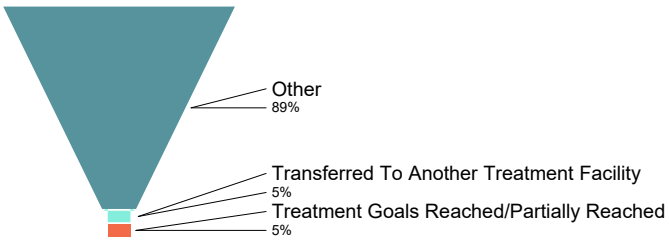
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Mood Disorders	26 %
Schizophrenia Spectrum	16 %
Anxiety Disorders	14 %

Of the Clients Served, **33** % had a Substance Use Diagnosis.

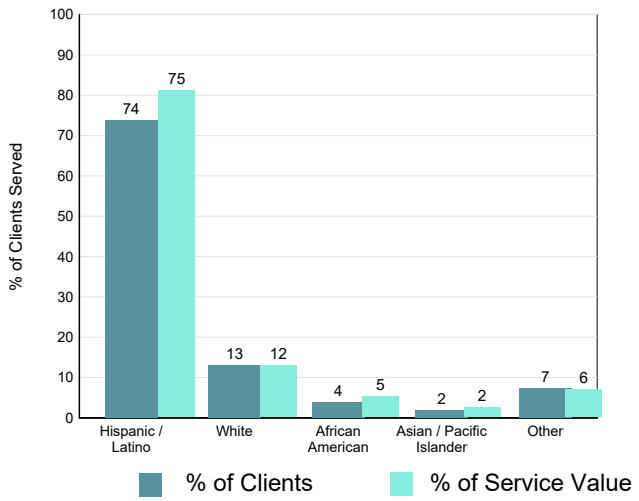
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	159	8 %	34%
Collateral/Family Therapy	90	4 %	18%
Crisis Intervention	58	1 %	8%
Group Counseling	162	3 %	9%
Linkage/Brokerage	1,626	45 %	94%
Medication Support	41	1 %	11%
Mental Health Counseling	405	21 %	47%
Non Billable	913	16 %	85%
Total	3,454	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	87%
Medicare B	1%
Private Insurance	10%
Self Pay/Other	3%

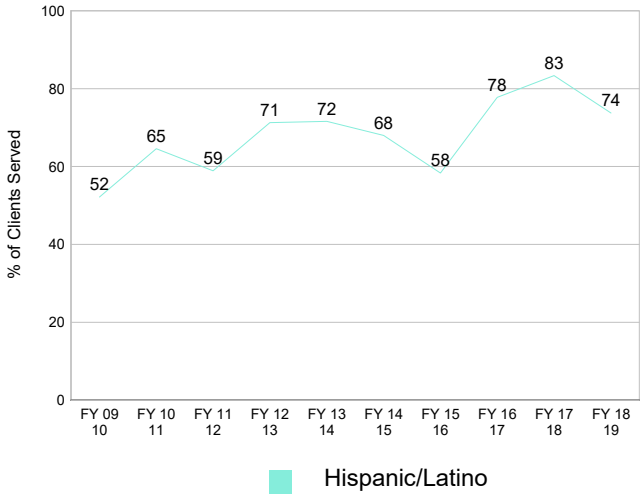
CSS-04 - Transition Age Youth FSP

Health Equities

Breakdown of Clients Served by Ethnicity

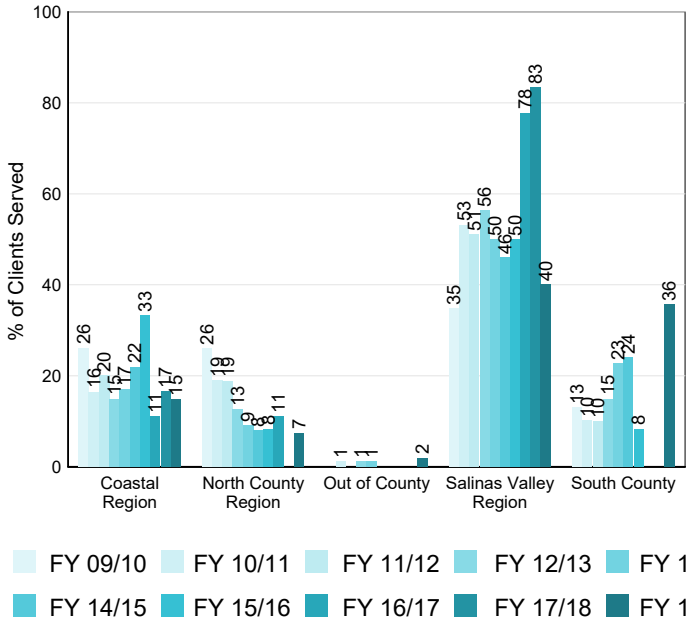


Percent of Hispanic / Latino Clients Served

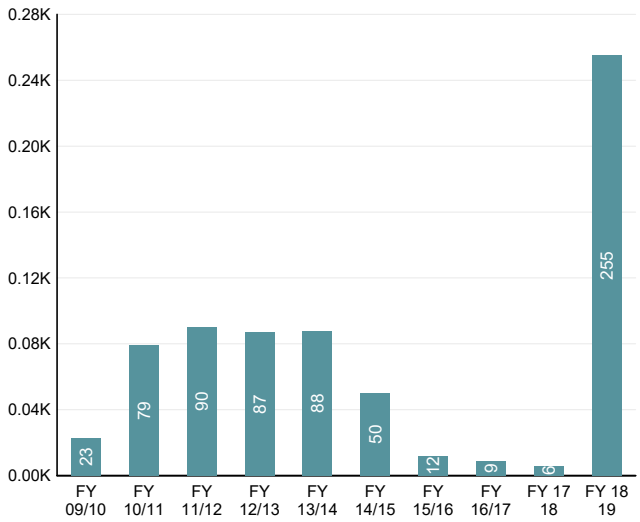


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



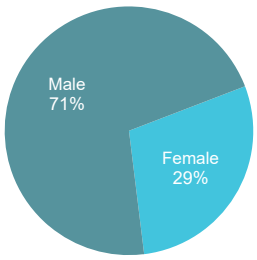
CSS-05 - Adults with SMI

Program/Program Group: AS Creating New Choices FSP

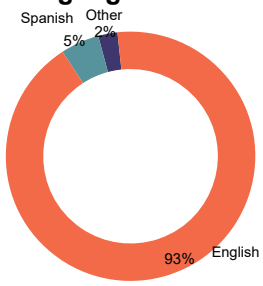
The Creating New Choices Program, or CNC is a collaborative effort between Behavioral Health, Probation, District Attorney, Public Defender and the Courts in Monterey County to provide intensive case management, psychiatric care, Probation supervision and therapeutic mental health court services to mentally ill offenders. CNC offers services in the Full Service Partnership or 'whatever it takes' model.Referral Process:Clients are referred to CNC through the court system. The court refers candidates to the CNC program either through a judge, public defender, district attorney or private counsel who believes a client meets the basic eligibility criteria.

- Number of Clients Served: 121
- Total Service Value: $613,255.07
- Average Service Value per Client: $5,068.22
- Average Age: 36
- Number of New Clients: 80
- Number of Clients Discharged: 82

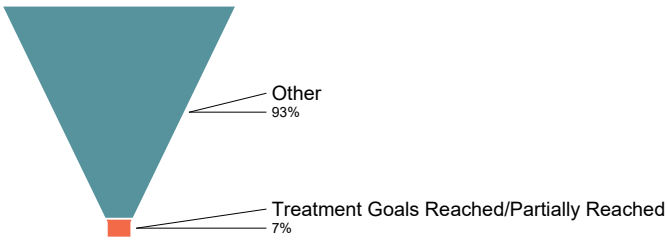
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Schizophrenia Spectrum	43 %
Mood Disorders	17 %
OTHER	12 %

Of the Clients Served, **68** % had a Substance Use Diagnosis.

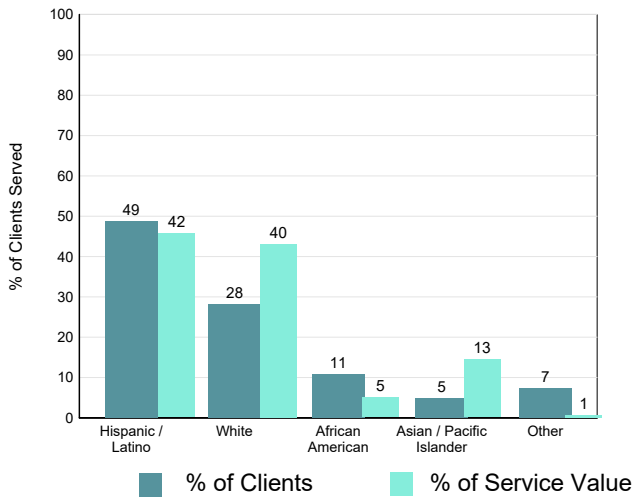
Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	54%
Medicare B	39%
Private Insurance	4%
Self Pay/Other	2%

	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	160	8 %	53%
Collateral/Family Therapy	5	0 %	3%
Crisis Intervention	4	0 %	2%
Group Counseling	1,800	19 %	21%
Linkage/Brokerage	1,325	40 %	48%
Medication Support	239	5 %	29%
Mental Health Counseling	45	2 %	16%
Non Billable	1,356	25 %	100%
Others	3	0 %	2%
Total	4,937	100%	100%

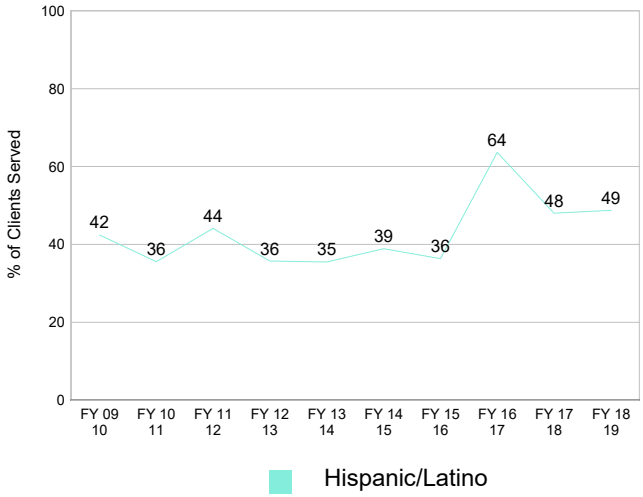
CSS-05 - Adults with SMI

Health Equities

Breakdown of Clients Served by Ethnicity

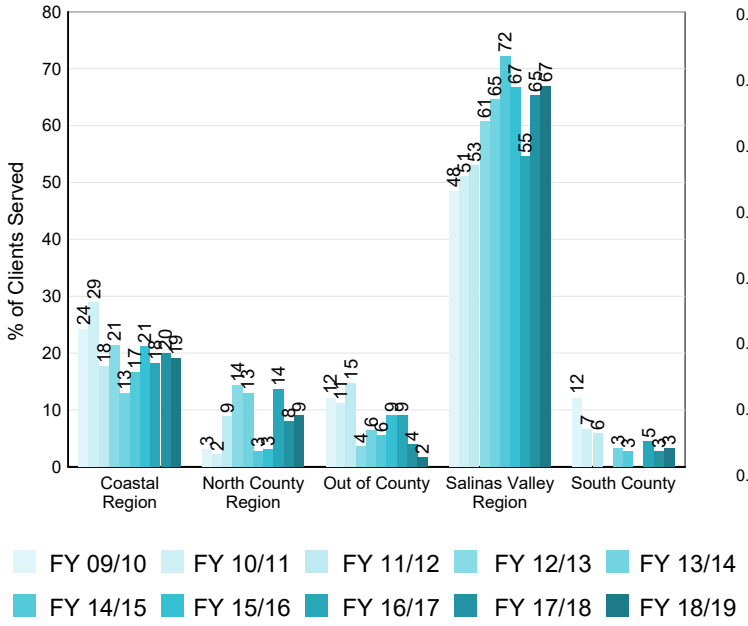


Percent of Hispanic / Latino Clients Served

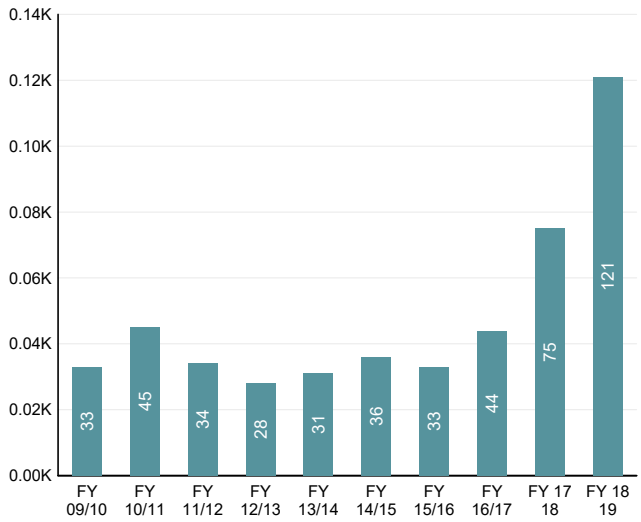


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



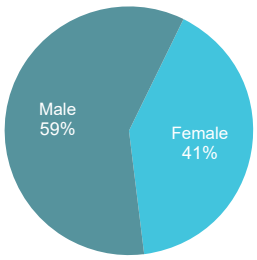
CSS-05 - Adults with SMI

Program/Program Group: Interim MHSA Lupine Garden FSP

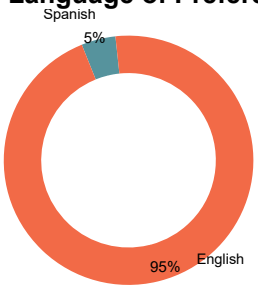
Lupine Gardens provides safe, affordable, quality permanent housing for 20 very low-income individuals with psychiatric disabilities, all of whom are homeless or at high risk of homelessness and require additional support necessary to live independently in the community. The service array includes: Intensive case management provided in the Full Service Partnership model as required by Mental Health Services Act funding, medication support and assistance with daily living skills, i.e., meals, house cleaning, and laundry services, in order to live independently in the community. These intensive support services are NOT available in Interim's other permanent housing projects.

- Number of Clients Served: 22
- Total Service Value: $395,893.34
- Average Service Value per Client: $17,995.15
- Average Age: 51
- Number of New Clients: 2
- Number of Clients Discharged: 4

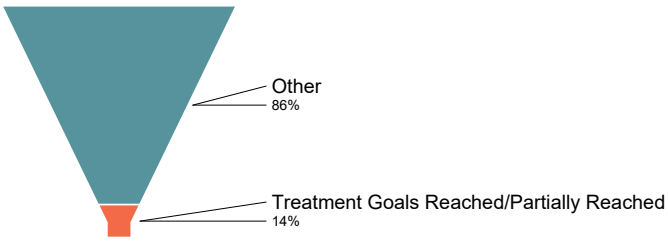
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Schizophrenia Spectrum	77 %
Mood Disorders	5 %

Of the Clients Served, **32** % had a Substance Use Diagnosis.

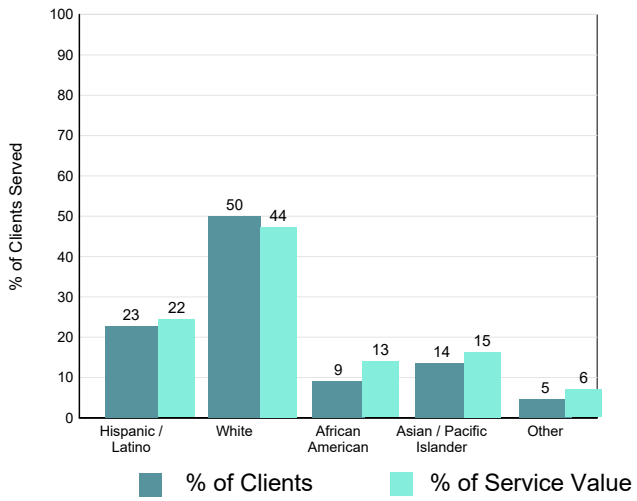
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	58	5 %	86%
Collateral/Family Therapy	4	0 %	9%
Linkage/Brokerage	674	41 %	100%
Mental Health Counseling	1,035	54 %	100%
Non Billable	8	0 %	32%
Total	1,779	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	33%
Medicare B	60%
Private Insurance	7%

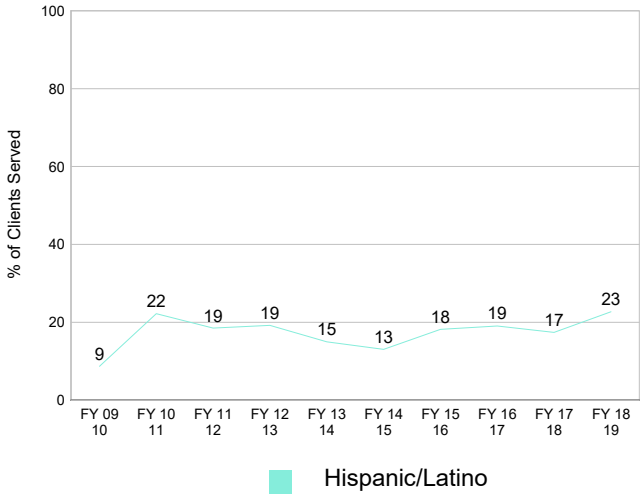
CSS-05 - Adults with SMI

Health Equities

Breakdown of Clients Served by Ethnicity

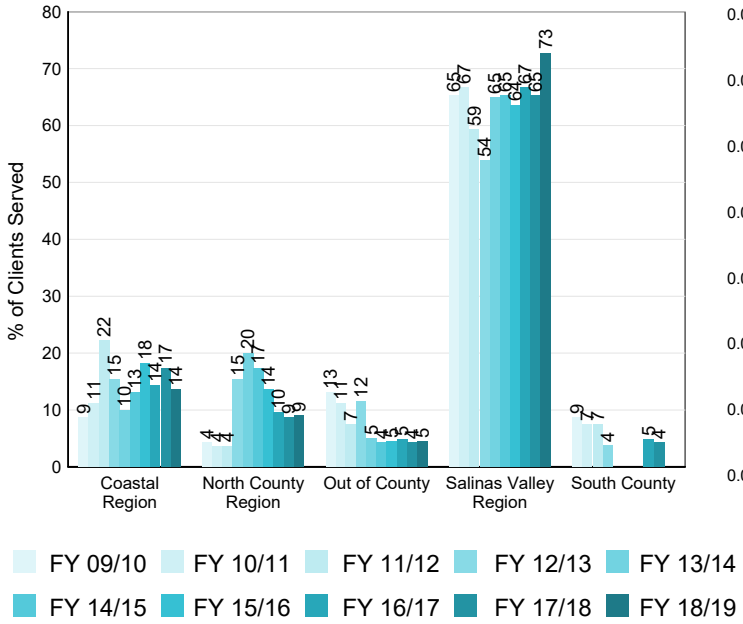


Percent of Hispanic / Latino Clients Served

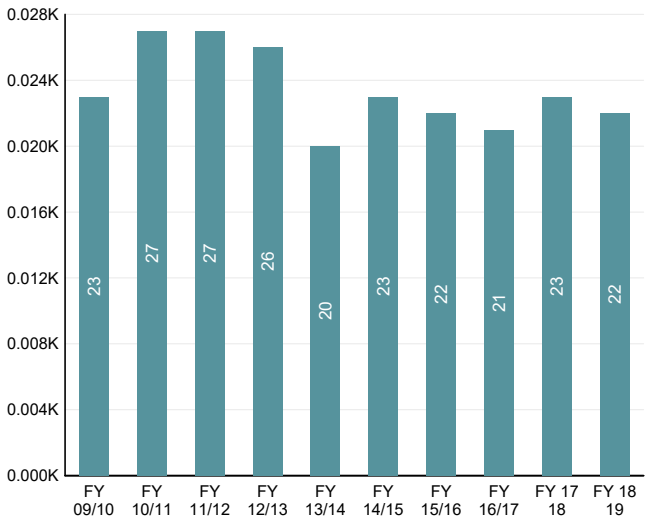


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



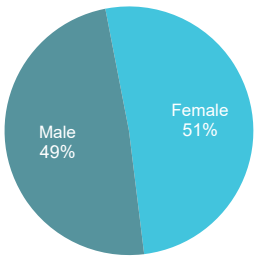
CSS-05 - Adults with SMI

Program/Program Group: Homeless FSP v2

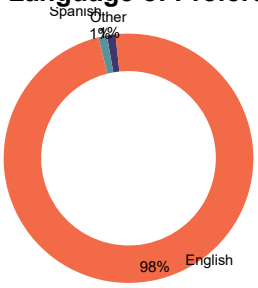
Safe, affordable, quality permanent housing for very low-income individuals with psychiatric disabilities, all of whom are homeless or at high risk of homelessness and require additional support necessary to live independently in the community. The service array includes: Intensive case management provided in the Full Service Partnership model as required by Mental Health Services Act funding, medication support and assistance with daily living skills, i.e., meals, house cleaning, and laundry services, in order to live independently in the community. These intensive support services are NOT available in Interim's other permanent housing projects.

- Number of Clients Served: 92
- Total Service Value: $1,062,707.50
- Average Service Value per Client: $11,551.17
- Average Age: 50
- Number of New Clients: 28
- Number of Clients Discharged: 27

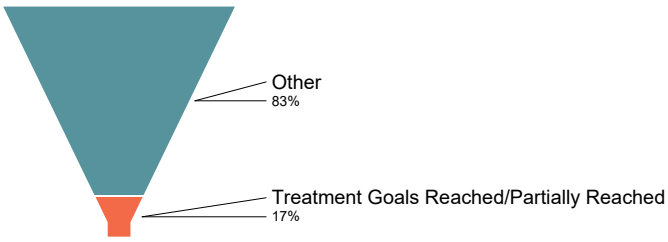
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Mood Disorders	25 %
Schizophrenia Spectrum	24 %
Anxiety Disorders	1 %

Of the Clients Served, **58** % had a Substance Use Diagnosis.

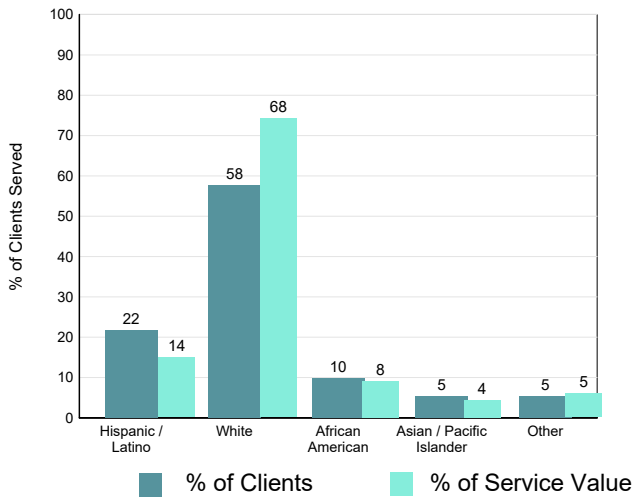
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	224	9 %	75%
Collateral/Family Therapy	33	0 %	20%
Group Counseling	468	7 %	25%
Linkage/Brokerage	1,387	35 %	97%
Mental Health Counseling	1,422	36 %	86%
Non Billable	1,644	12 %	96%
Others	2	0 %	1%
Total	5,180	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	67%
Medicare B	28%
Private Insurance	5%
Self Pay/Other	0%

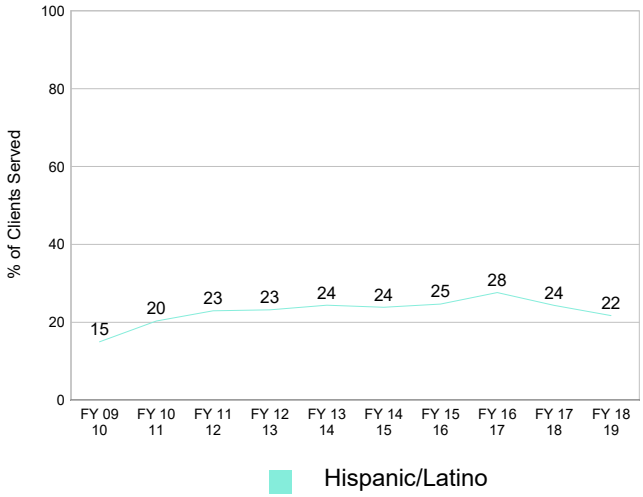
CSS-05 - Adults with SMI

Health Equities

Breakdown of Clients Served by Ethnicity

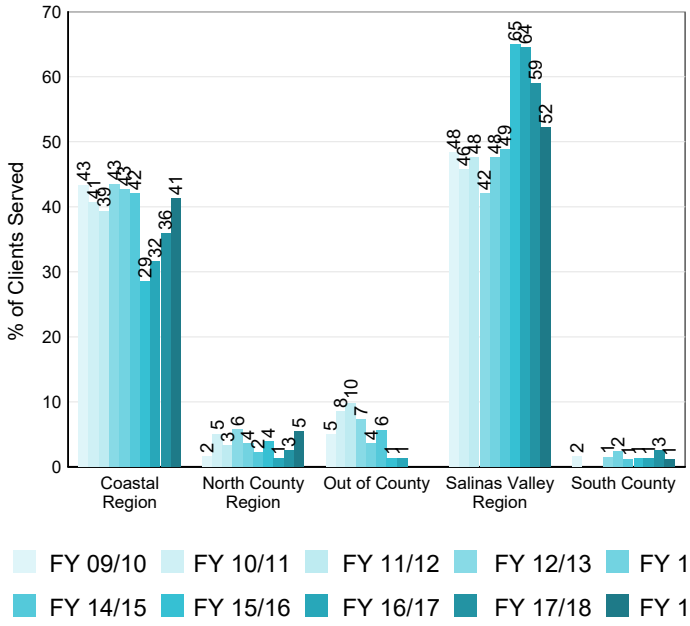


Percent of Hispanic / Latino Clients Served

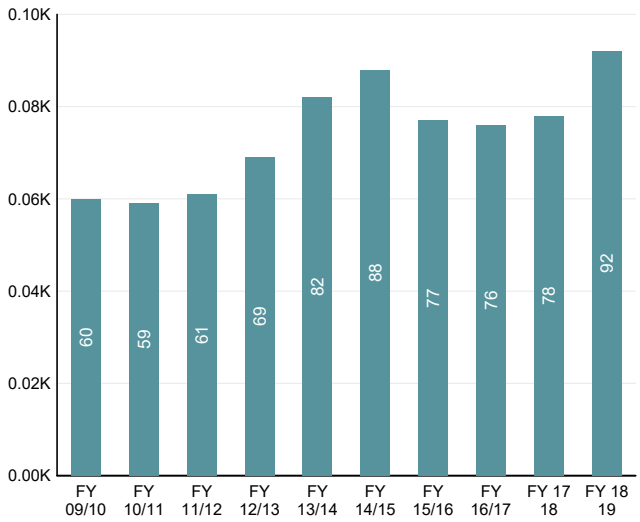


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



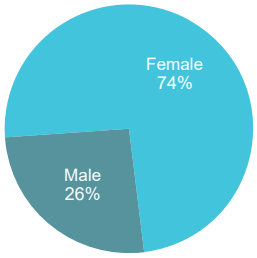
CSS-05 - Adults with SMI

Program/Program Group: Interim Sunflower Garden

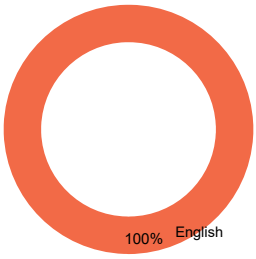
The Sunflower Gardens program provides supported housing services to individual with serious mental illness who are homeless or at risk of homelessness during a transition period whereby individuals are referred to this program by Monterey County Behavioral Health. The services provided to the consumers include assessments, evaluation, and assistance in accessing benefits, case management, with a major focus in helping consumers to be successful in housing by helping them to meet the terms of their leases. The intent is to ensure the challenges of maintaining housing for individuals with serious mental illness are addressed and the provision of independent living skills are provided in a collaborative environment whereby the County and Contractor collaborate in determining the individualized services needed for each consumer in working towards resiliency and self-sufficiency.

- Number of Clients Served: 27
- Total Service Value: $383,275.88
- Average Service Value per Client: $14,195.40
- Average Age: 48
- Number of New Clients: 7
- Number of Clients Discharged: 4

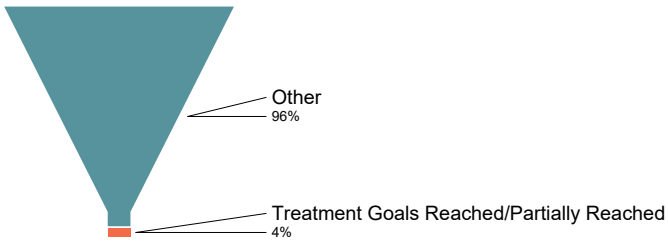
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Schizophrenia Spectrum	48 %
Mood Disorders	41 %

Of the Clients Served, **56** % had a Substance Use Diagnosis.

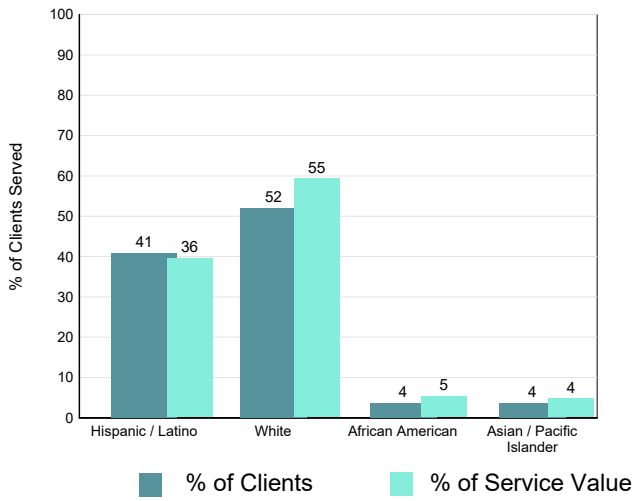
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	89	7 %	74%
Collateral/Family Therapy	17	1 %	44%
Group Counseling	139	4 %	74%
Linkage/Brokerage	566	32 %	100%
Mental Health Counseling	887	55 %	100%
Non Billable	81	1 %	85%
Total	1,779	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	79%
Medicare B	21%

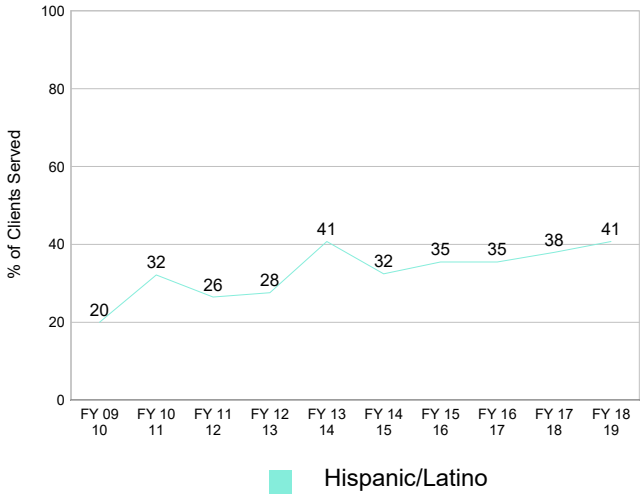
CSS-05 - Adults with SMI

Health Equities

Breakdown of Clients Served by Ethnicity

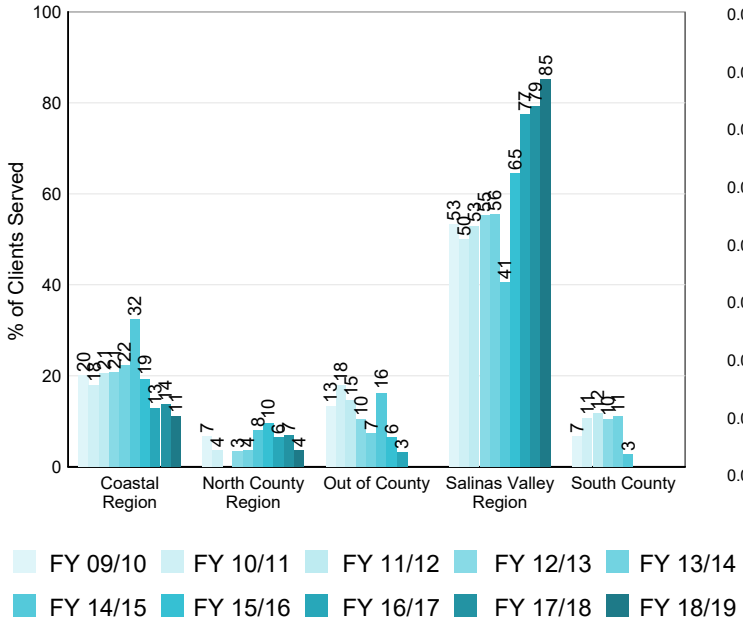


Percent of Hispanic / Latino Clients Served

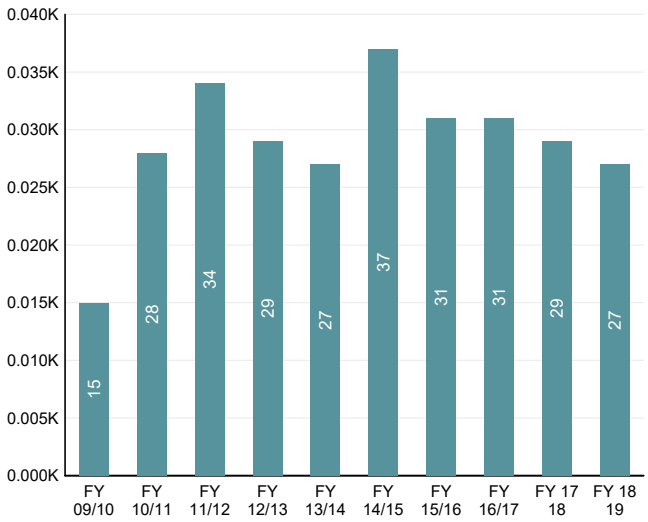


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



CSS-05 - Adults with SMI

Program/Program Group: Interim Assertive Comm Treat FSP

ACT assists consumers with their mental health recovery process and with developing the skills necessary to the lead independent or interdependent, healthy and meaningful lives in the community. This program increases natural support systems by engaging, offering support, and mental health information to consumers' family members. The program focuses on the Latino population who are frequent users of acute care services, and, yet, who are failing to engage in ongoing services in the Adult System of Care.

Number of Clients Served: 21

Total Service Value: $164,831.52

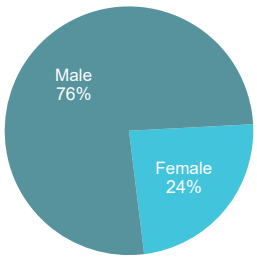
Average Service Value per Client: $7,849.12

Average Age: 35

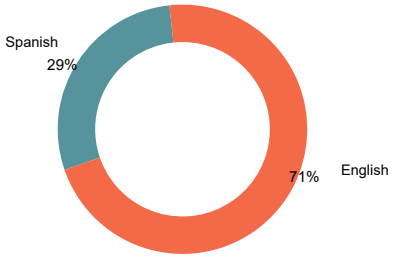
Number of New Clients: 21

Number of Clients Discharged: 1

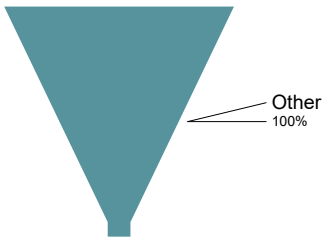
Gender



Language of Preference



Discharge Disposition/Outcome



Of the Clients Served, **52** % had a Substance Use Diagnosis.

Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Schizophrenia Spectrum	57 %
Mood Disorders	10 %
Organic Disorders	5 %

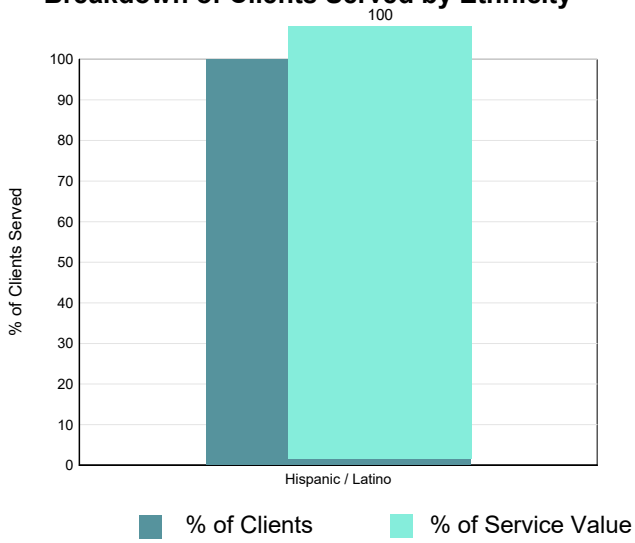
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	39	7 %	52%
Collateral/Family Therapy	19	3 %	29%
Linkage/Brokerage	156	29 %	90%
Medication Support	16	3 %	48%
Mental Health Counseling	229	51 %	95%
Non Billable	230	6 %	90%
Total	689	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	72%
Medicare B	25%
Self Pay/Other	3%

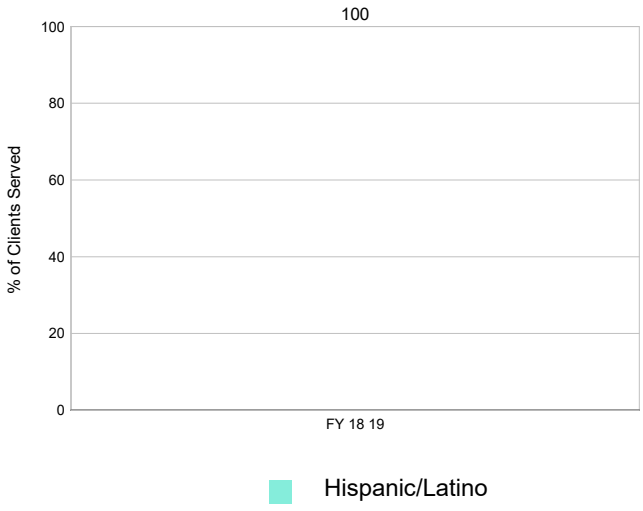
CSS-05 - Adults with SMI

Health Equities

Breakdown of Clients Served by Ethnicity

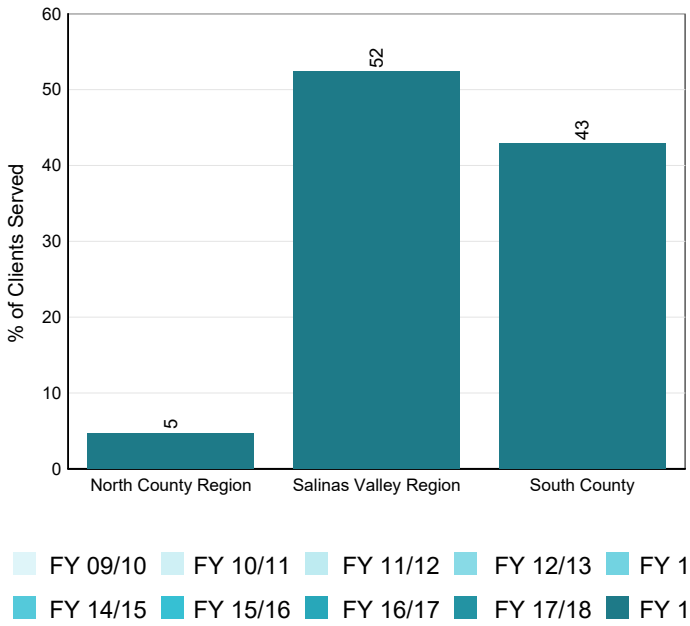


Percent of Hispanic / Latino Clients Served

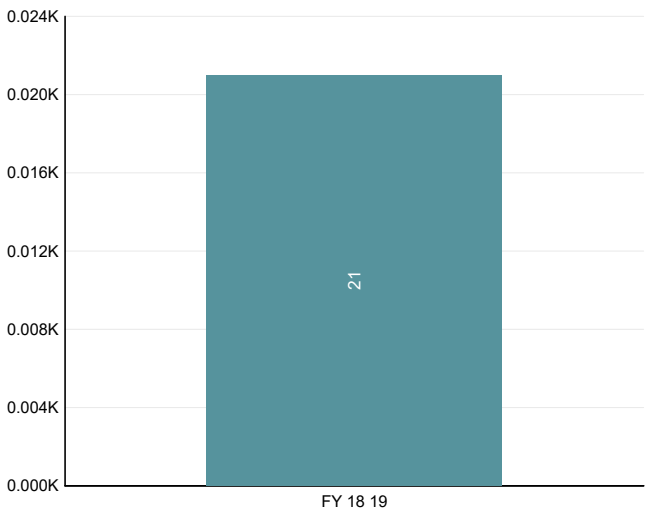


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



CSS-06 - Older Adults FSP

Program/Program Group: Drake House FSP

This is a full service partnership program providing services to adults 60 years + who have a serious and persistent mental illness with a co-occurring physical disorder that are risk of losing their community placement due to an ongoing chronic co-existing physical impairment. These older adult have had extensive histories of institutionalization or at high risk for a higher level of care, hospitalizations, unplanned emergency services and at high risk for skilled nursing care. Monterey County in collaboration with Drake House (Front Street) provides 24 hour residential care, intensive mental health and case management services. These older adults benefit from intensive case management preventing further deterioration of their condition and enhancing their capacity to remain in the least restrictive environment. The services are designed to maximize their participation in their recovery, and enhance their quality of life while living in their community.

Number of Clients Served: 28

Total Service Value: $1,374,083.94

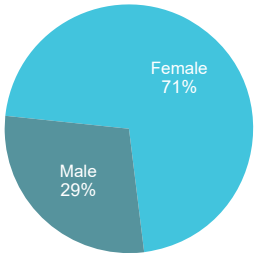
Average Service Value per Client: $49,074.43

Average Age: 69

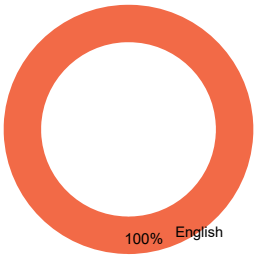
Number of New Clients: 6

Number of Clients Discharged: 5

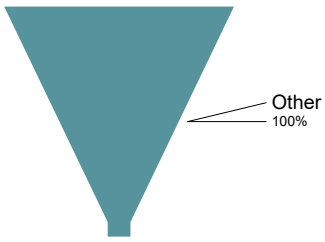
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Schizophrenia Spectrum	64 %
Mood Disorders	21 %

Of the Clients Served, **0** % had a Substance Use Diagnosis.

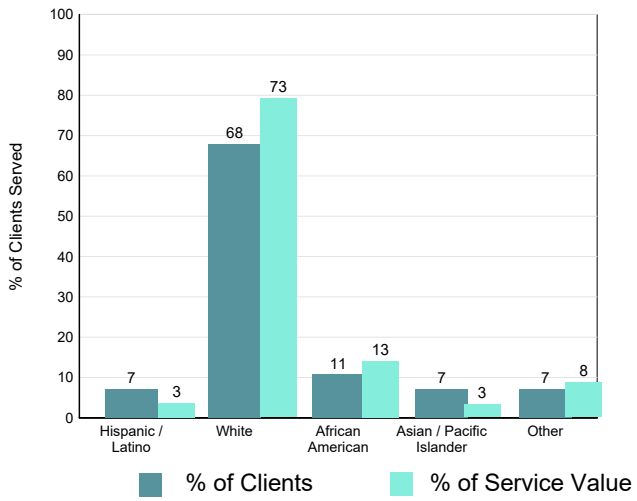
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	4	0 %	14%
Group Counseling	4,742	53 %	89%
Linkage/Brokerage	354	14 %	89%
Mental Health Counseling	1,294	28 %	89%
Non Billable	74	1 %	79%
Others	8,360	3 %	100%
Total	14,828	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	24%
Medicare B	76%

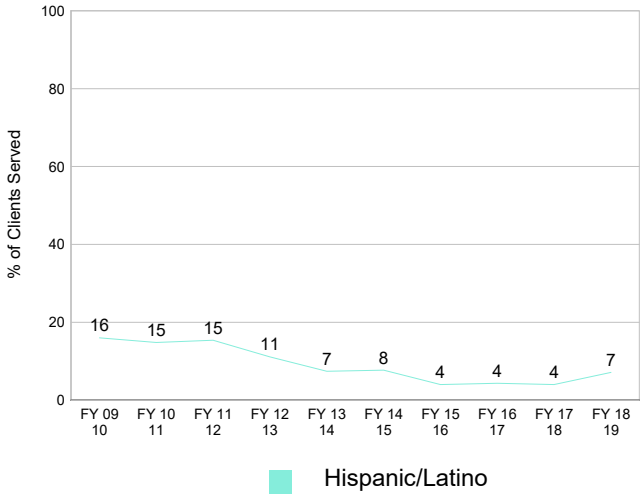
CSS-06 - Older Adults FSP

Health Equities

Breakdown of Clients Served by Ethnicity

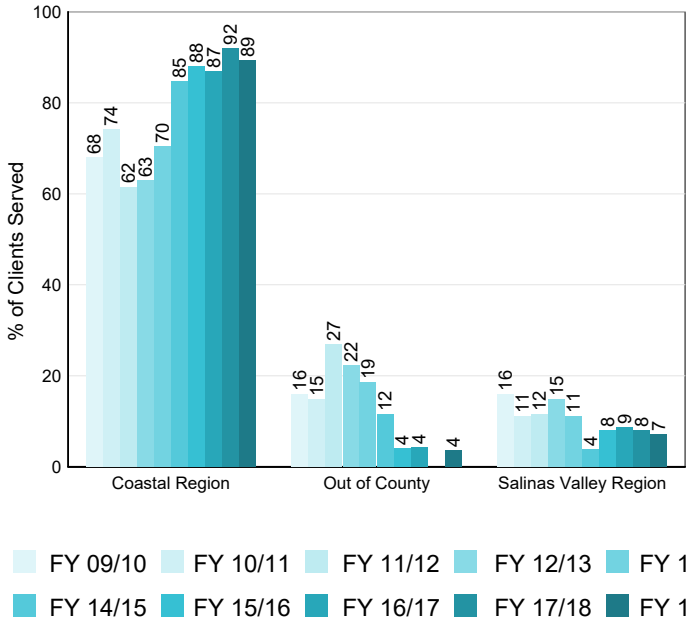


Percent of Hispanic / Latino Clients Served

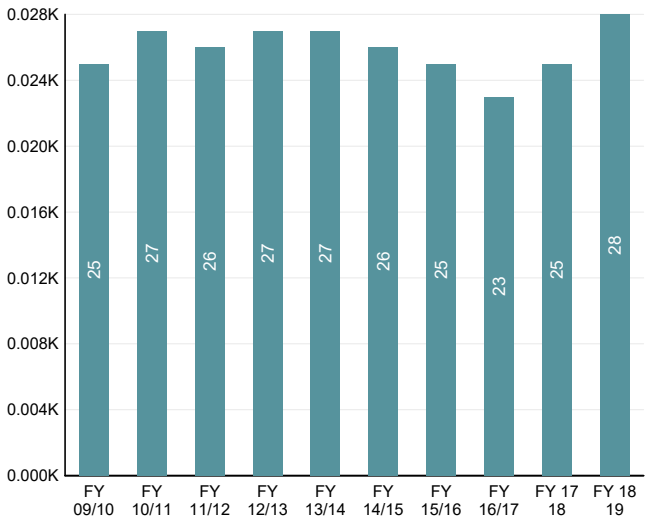


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



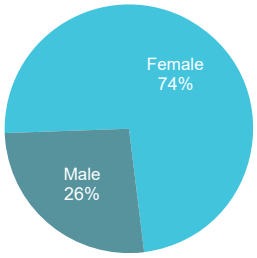
CSS-06 - Older Adults FSP

Program/Program Group: AS Older Adult FSP

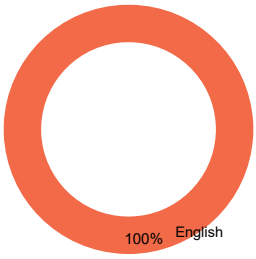
This is a full service partnership program providing services to adults 60 years + who have a serious and persistent mental illness with a co-occurring (physical and or/substance abuse) disorder who are risk of losing their community placement due to an ongoing chronic co-existing physical impairment. These adults are at risk of high utilization of unplanned emergency services and institutionalization requiring a higher level of care. These adults will benefit from intensive case management preventing further deterioration of their condition and enhancing their capacity to remain in the least restrictive environment. These services are designed to maximize their participation in their recovery and enhance their quality of life in the greater community.

- Number of Clients Served: 19
- Total Service Value: $152,296.49
- Average Service Value per Client: $8,015.60
- Average Age: 68
- Number of New Clients: 11
- Number of Clients Discharged: 8

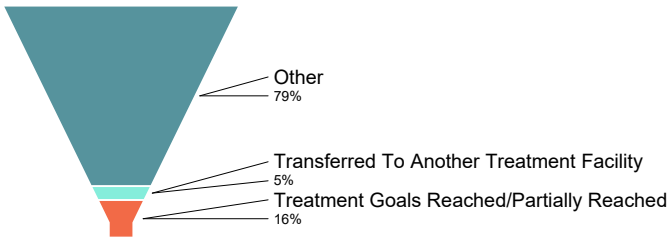
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Mood Disorders	47 %
Schizophrenia Spectrum	47 %

Of the Clients Served, **37** % had a Substance Use Diagnosis.

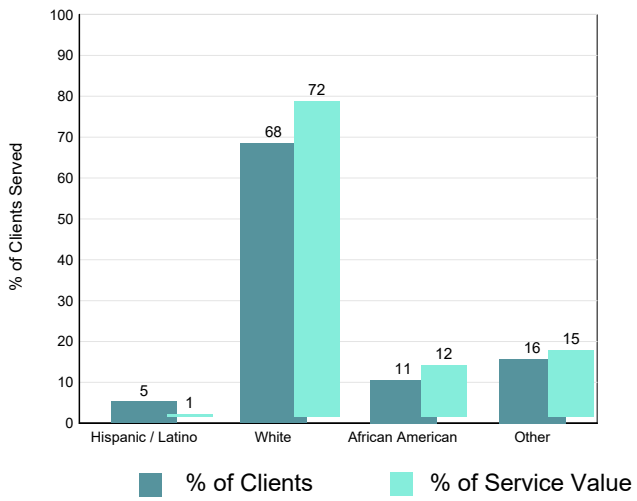
Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	26%
Medicare B	70%
Self Pay/Other	5%

	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	46	9 %	63%
Collateral/Family Therapy	5	0 %	16%
Crisis Intervention	36	4 %	26%
Group Counseling	23	2 %	11%
Linkage/Brokerage	332	66 %	95%
Medication Support	87	8 %	84%
Mental Health Counseling	25	5 %	42%
Non Billable	99	6 %	89%
Total	653	100%	100%

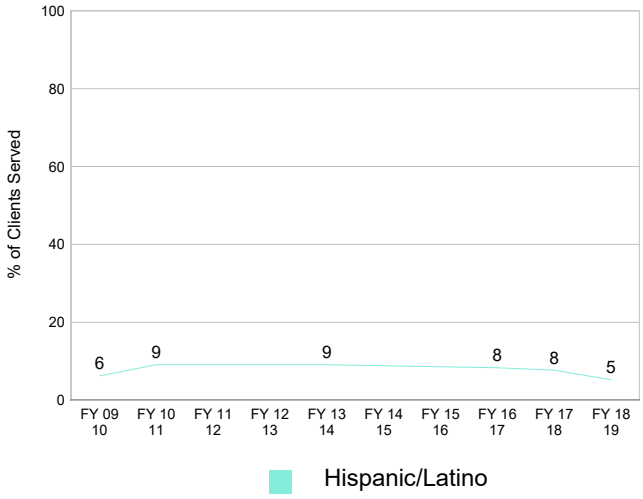
CSS-06 - Older Adults FSP

Health Equities

Breakdown of Clients Served by Ethnicity

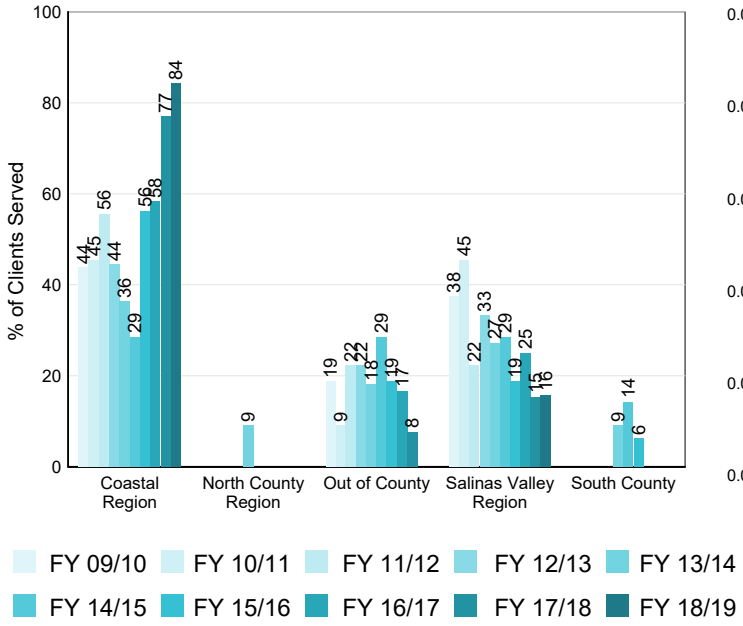


Percent of Hispanic / Latino Clients Served

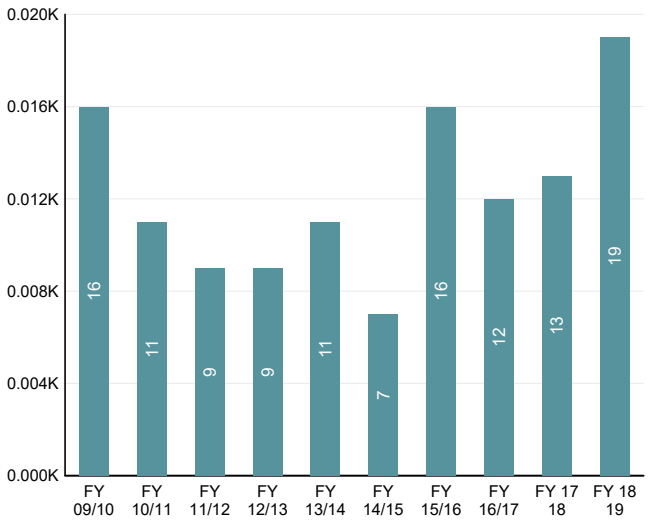


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



CSS-07 - Access Regional Services

Program/Program Group: Mental Health Services Outpatient

Community Human Services will provide outpatient mental health services to Monterey County Medi-Cal beneficiaries as authorized by the Monterey County Health Department, Behavioral Health Division

Number of Clients Served: 573

Total Service Value: $787,997.35

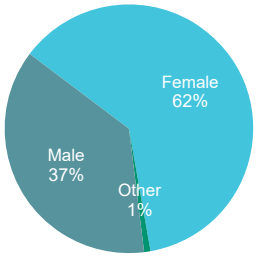
Average Service Value per Client: $1,375.21

Average Age: 28

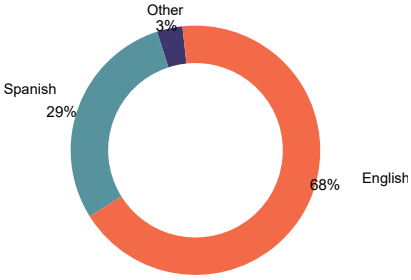
Number of New Clients: 229

Number of Clients Discharged: 499

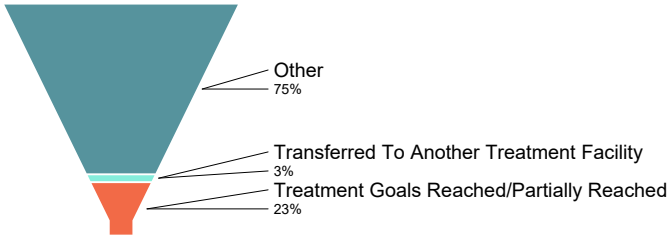
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	43 %
Mood Disorders	38 %
Disruptive Behavior Disorders	3 %

Of the Clients Served, **5** % had a Substance Use Diagnosis.

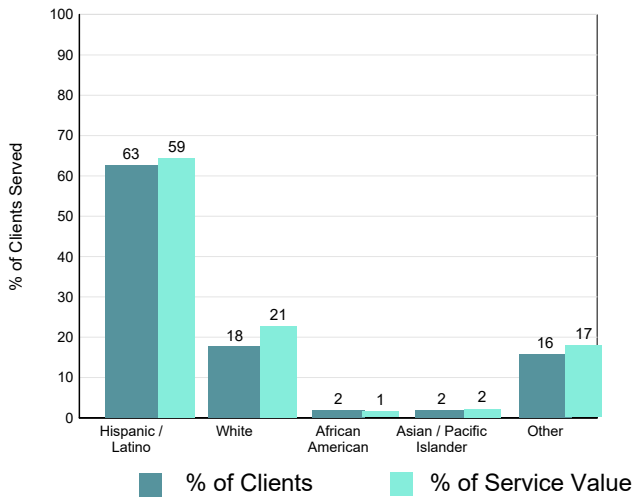
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	1,080	32 %	65%
Collateral/Family Therapy	558	14 %	24%
Group Counseling	546	5 %	13%
Linkage/Brokerage	882	11 %	85%
Mental Health Counseling	1,362	35 %	51%
Non Billable	586	2 %	34%
Total	5,014	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	80%
Medicare B	5%
Private Insurance	8%
Self Pay/Other	7%

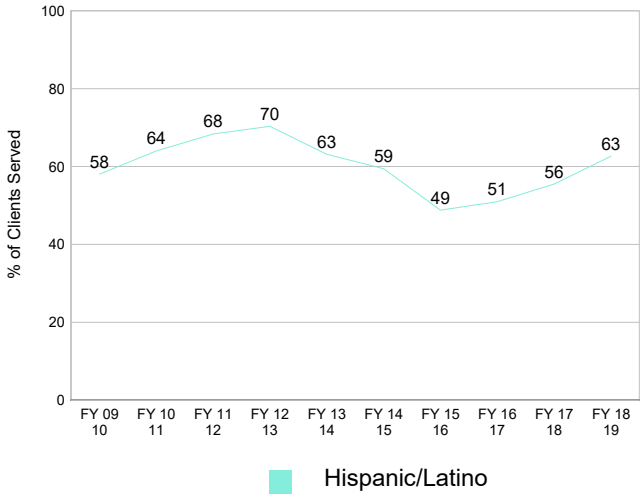
CSS-07 - Access Regional Services

Health Equities

Breakdown of Clients Served by Ethnicity

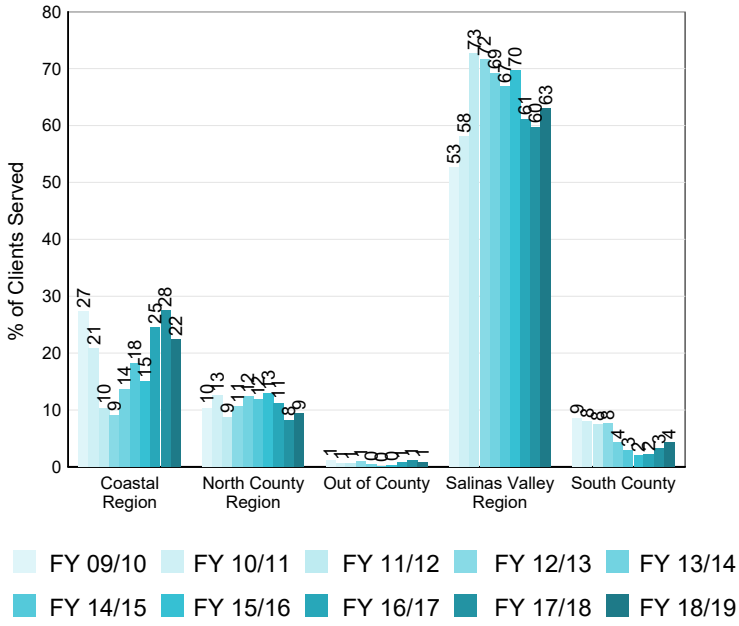


Percent of Hispanic / Latino Clients Served

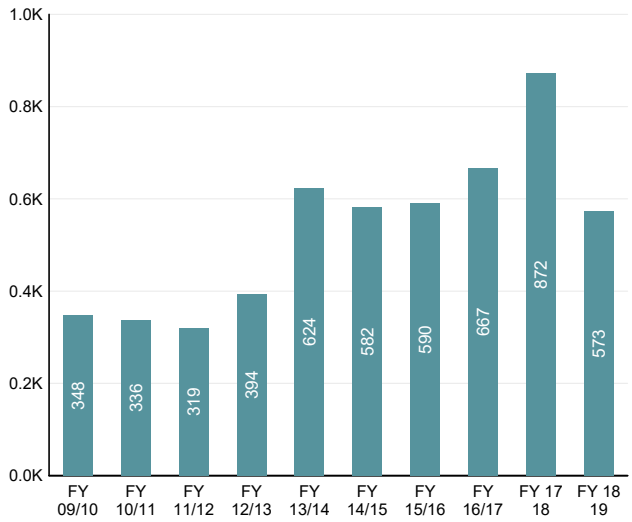


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



CSS-07 - Access Regional Services

Program/Program Group: CHS South County

Community Human Services will provide outpatient mental health services to Monterey County Medi-Cal beneficiaries as authorized by the Monterey County Health Department, Behavioral Health Division

Number of Clients Served: 10

Total Service Value: $6,603.30

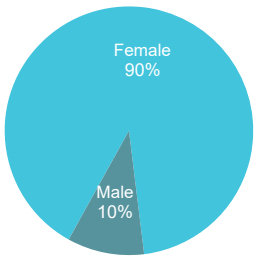
Average Service Value per Client: $660.33

Average Age: 32

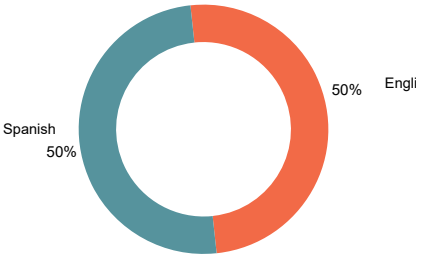
Number of New Clients: 12

Number of Clients Discharged: 5

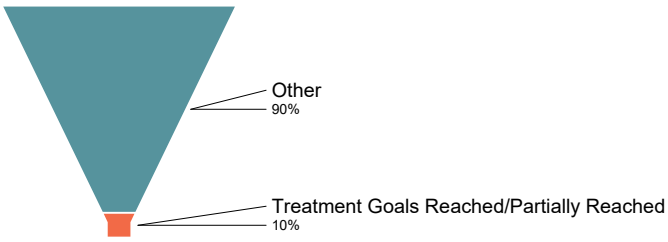
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	50 %
Mood Disorders	30 %

Of the Clients Served, **0** % had a Substance Use Diagnosis.

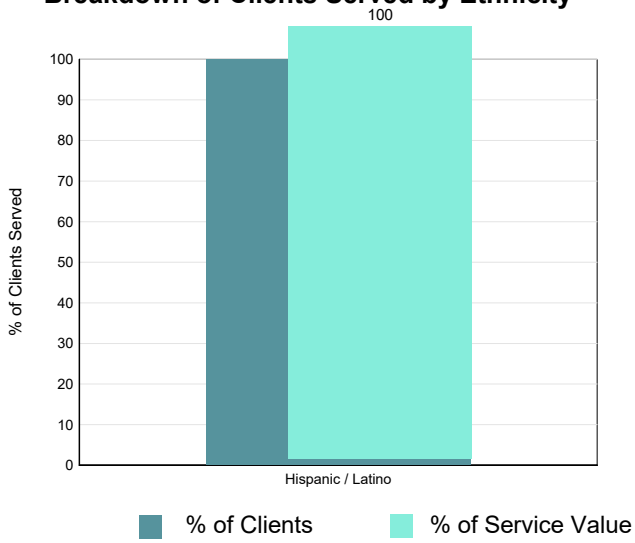
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	23	59 %	90%
Mental Health Counseling	14	34 %	20%
Non Billable	5	7 %	30%
Total	42	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	95%
Private Insurance	5%

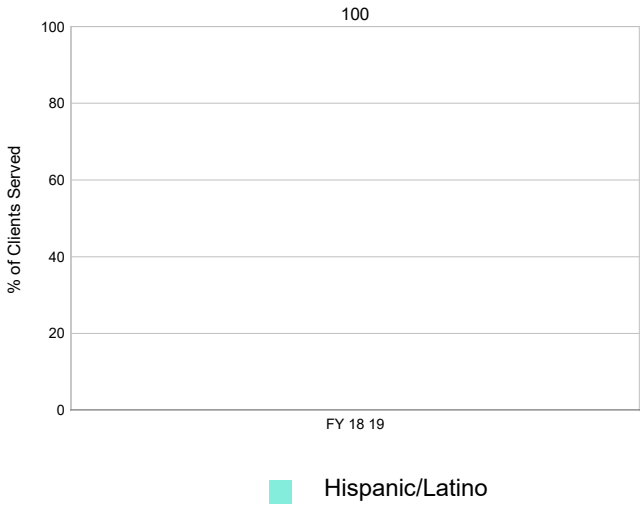
CSS-07 - Access Regional Services

Health Equities

Breakdown of Clients Served by Ethnicity

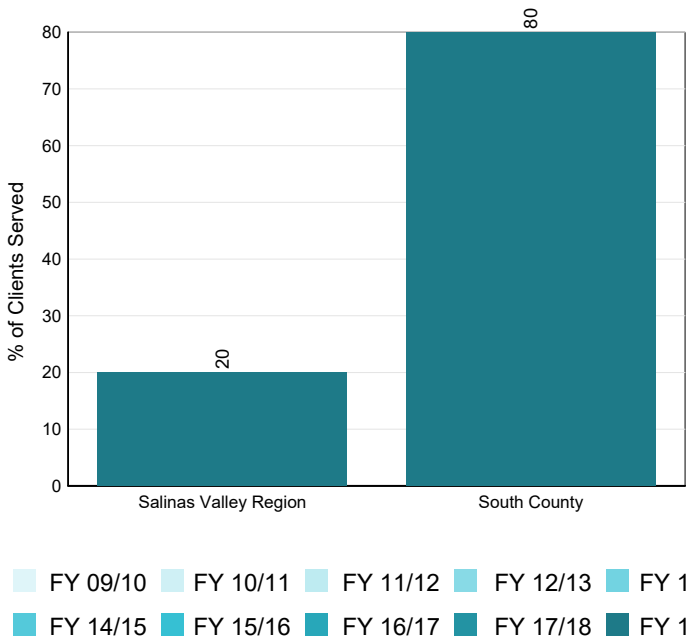


Percent of Hispanic / Latino Clients Served

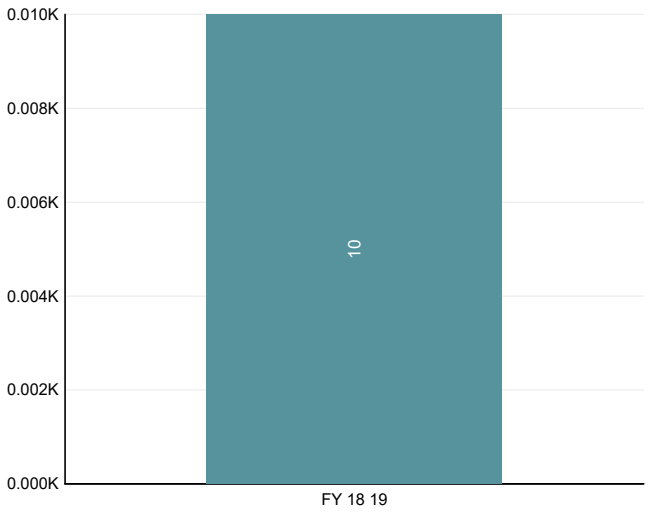


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



CSS-07 - Access Regional Services

Program/Program Group: CHS HIV/AIDS Com Partnership

This program works closely with John XXIII AIDS Ministry to reach out to the community and provide quality mental health services to individuals with HIV/AIDS or those at risk. This program expands mental health services provided to individuals with HIV/AIDS

Number of Clients Served: 5

Total Service Value: $4,137.89

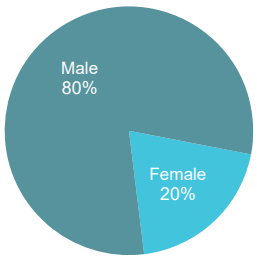
Average Service Value per Client: $827.58

Average Age: 35

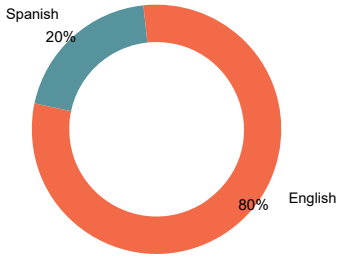
Number of New Clients: 1

Number of Clients Discharged: 5

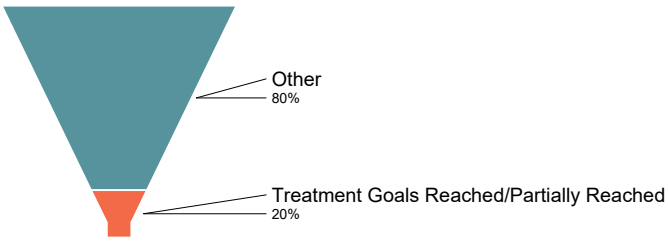
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Mood Disorders	80 %
Anxiety Disorders	20 %

Of the Clients Served, **20** % had a Substance Use Diagnosis.

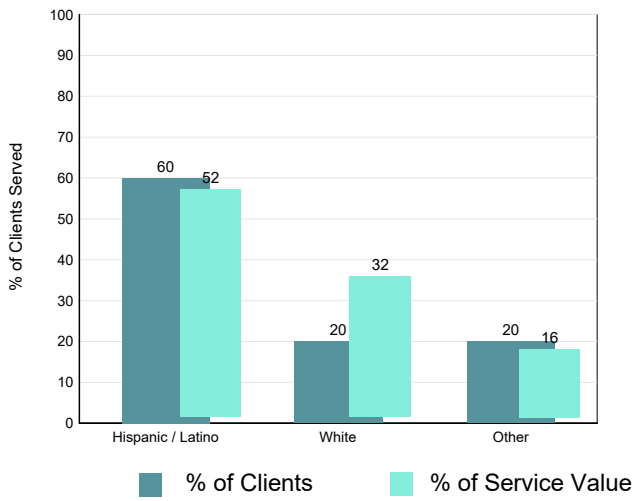
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	6	35 %	60%
Linkage/Brokerage	10	22 %	100%
Mental Health Counseling	9	42 %	60%
Non Billable	4	1 %	60%
Total	29	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	62%
Medicare B	28%
Self Pay/Other	10%

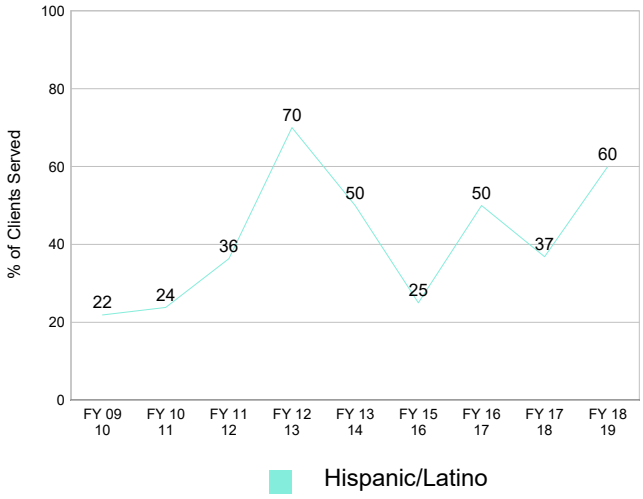
CSS-07 - Access Regional Services

Health Equities

Breakdown of Clients Served by Ethnicity

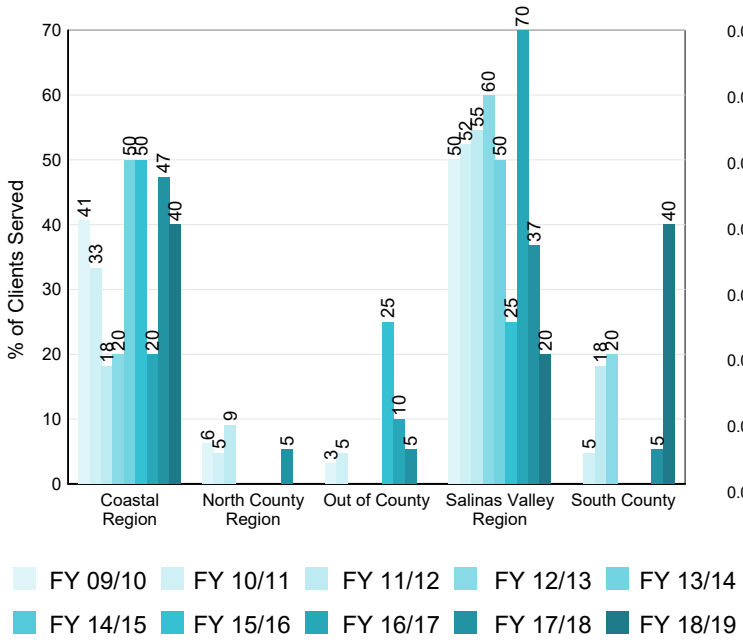


Percent of Hispanic / Latino Clients Served

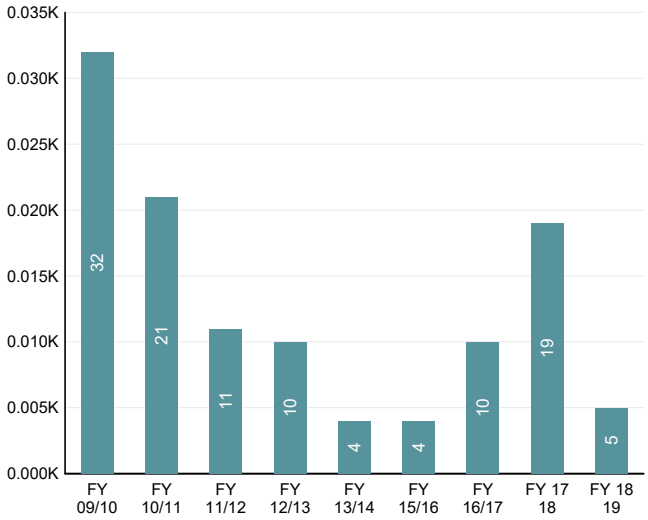


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



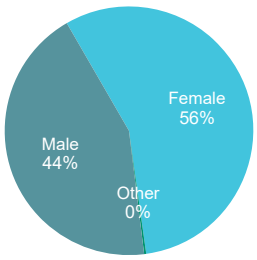
CSS-07 - Access Regional Services

Program/Program Group: Access to Treatment

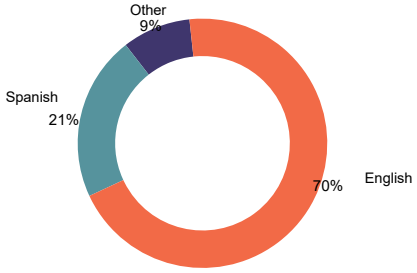
Access to Treatment programs are primary entry point for eligible county residents of Monterey County seeking mental health services. After an initial assessment, treatment services are typically provided in group settings and/or individual counseling sessionsthat focus on skill-building and support. In addition, specialty counseling services for LGBTQ, HIV/AIDS, and persons with cultural/linguistic needs, are provided by Behavioral Health and/or our community partners

- Number of Clients Served: 4,352
- Total Service Value: $6,645,537.72
- Average Service Value per Client: $1,527.01
- Average Age: 31
- Number of New Clients: 2,754
- Number of Clients Discharged: 3,464

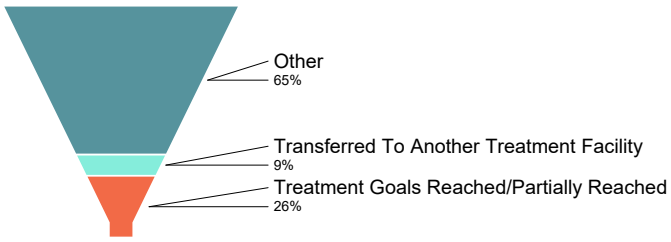
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Mood Disorders	34 %
Anxiety Disorders	26 %
Schizophrenia Spectrum	5 %

Of the Clients Served, **18** % had a Substance Use Diagnosis.

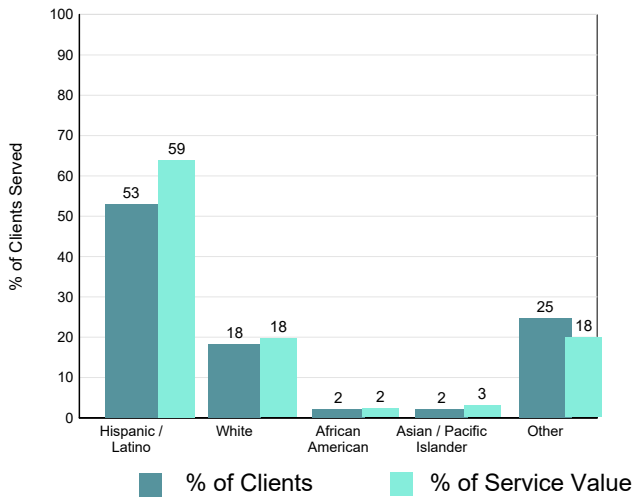
Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	77%
Medicare B	8%
Private Insurance	6%
Self Pay/Other	8%

	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	6,673	41 %	78%
Collateral/Family Therapy	137	0 %	2%
Crisis Intervention	325	1 %	3%
Group Counseling	424	1 %	2%
Linkage/Brokerage	7,893	17 %	60%
Medication Support	3,329	9 %	20%
Mental Health Counseling	3,146	16 %	11%
Non Billable	9,821	14 %	68%
Others	1	0 %	0%
Total	31,749	100%	100%

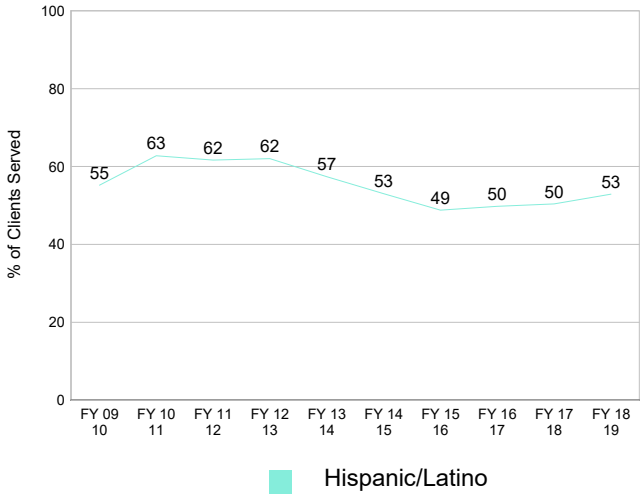
CSS-07 - Access Regional Services

Health Equities

Breakdown of Clients Served by Ethnicity

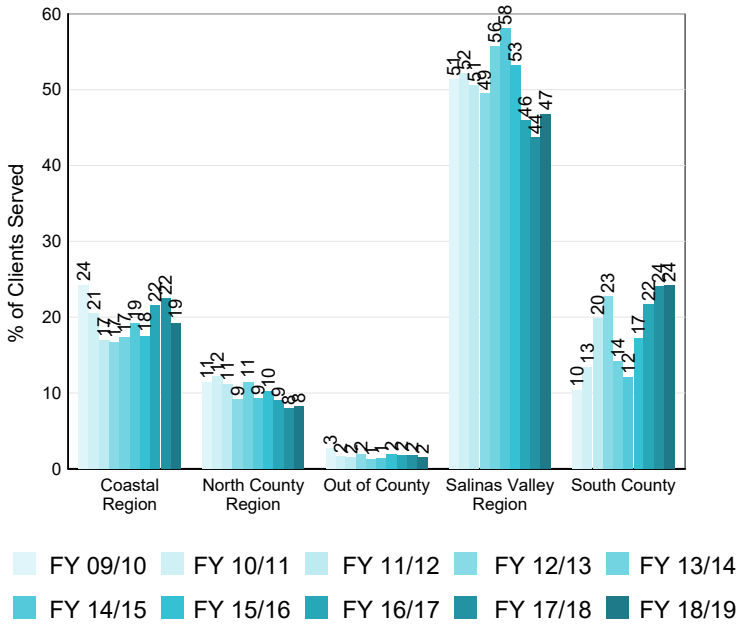


Percent of Hispanic / Latino Clients Served

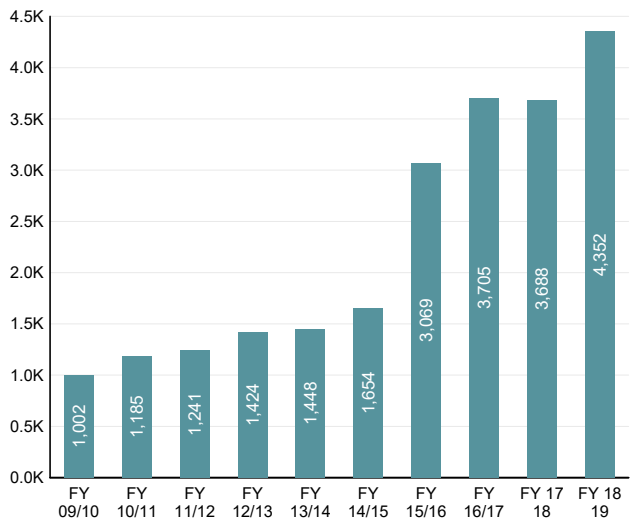


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



CSS-08 - Early Childhood Mental Health

Program/Program Group: DTH MCSTART

Provides Mental Health Services and Medication Support to eligible infants and children who require early intervention services. The primary focus of the program will be to identify, assess, refer, and treat children affected by the broad spectrum of developmental, social/emotional, and neurobehavioral disorders caused by perinatal alcohol and drug exposure. Such interventions will improve the child's development, improve the child's health, improve family functioning, and reduce the possibility of future residential care, out-of-the-home placement, and/or hospitalization

Number of Clients Served: 222

Total Service Value: $1,495,514.05

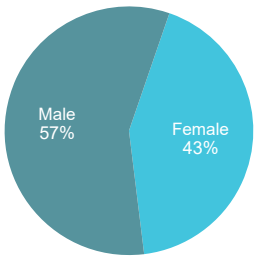
Average Service Value per Client: $6,736.55

Average Age: 5

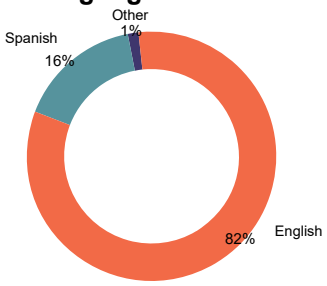
Number of New Clients: 58

Number of Clients Discharged: 143

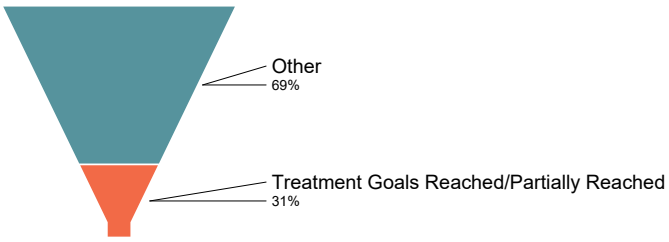
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	56 %
Disruptive Behavior Disorders	27 %
OTHER	2 %

Of the Clients Served, **0** % had a Substance Use Diagnosis.

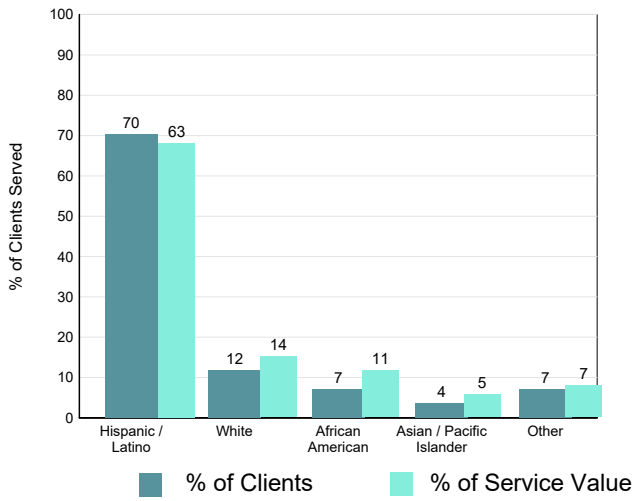
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	932	17 %	75%
Collateral/Family Therapy	1,335	18 %	66%
Group Counseling	198	3 %	7%
Linkage/Brokerage	2,730	32 %	92%
Mental Health Counseling	1,635	29 %	58%
Non Billable	334	1 %	53%
Others	5	0 %	1%
Total	7,169	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	89%
Private Insurance	6%
Self Pay/Other	4%

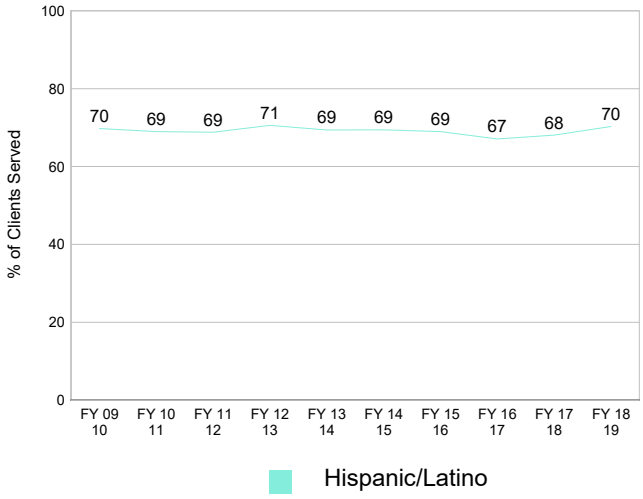
CSS-08 - Early Childhood Mental Health

Health Equities

Breakdown of Clients Served by Ethnicity

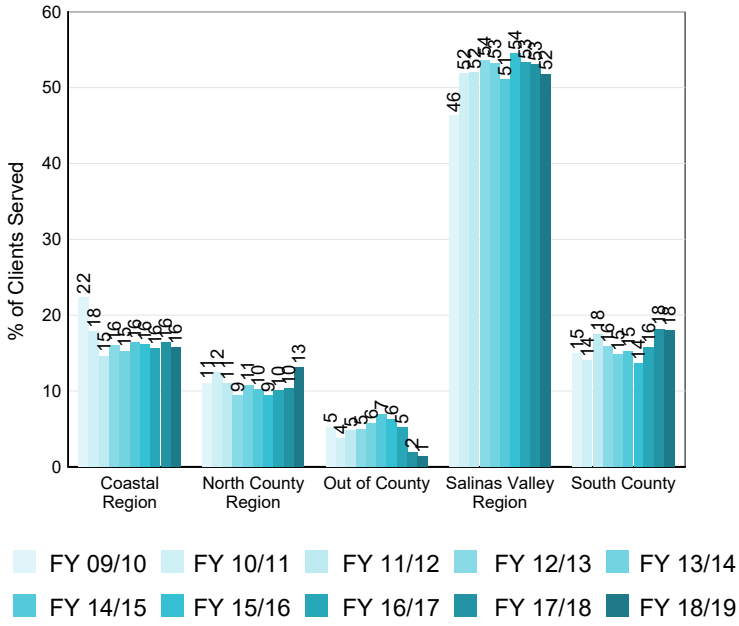


Percent of Hispanic / Latino Clients Served

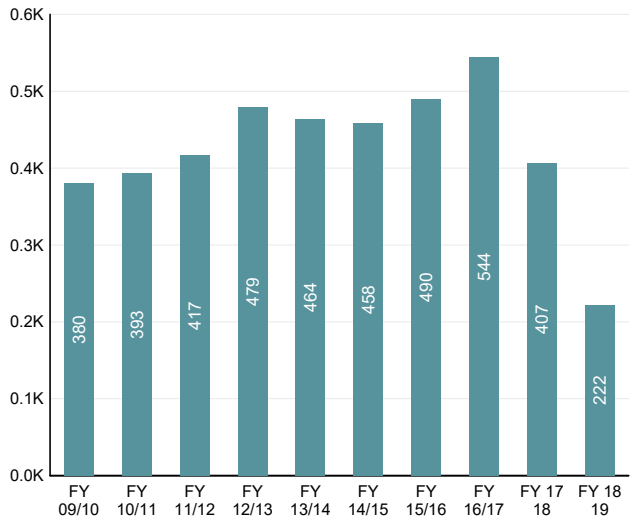


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



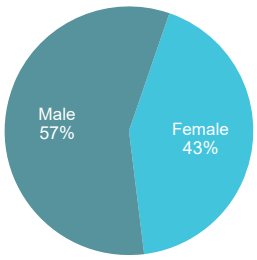
CSS-08 - Early Childhood Mental Health

Program/Program Group: CS School Readiness

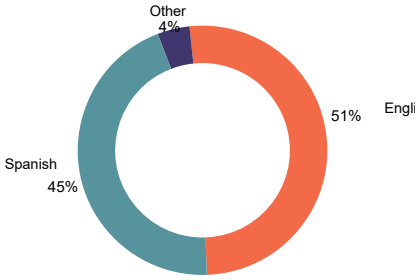
The Secure Families/Familias Seguras program has, as its core value, the provision of culturally and linguistically appropriate behavioral health services geared toward providing children ages 0-5 and the family with the necessary resources required to support positive physical, emotional and cognitive development. Services include:Dyadic Therapy (parent/caregiver and child). Mental Health Consultation. Developmental and Social-Emotional Screenings. Services are provided in conjunction with Family Resource Centers throughout Monterey County including King City, Salinas, Seaside and Castroville.

- Number of Clients Served: 302
- Total Service Value: $2,461,683.21
- Average Service Value per Client: $8,151.27
- Average Age: 7
- Number of New Clients: 175
- Number of Clients Discharged: 148

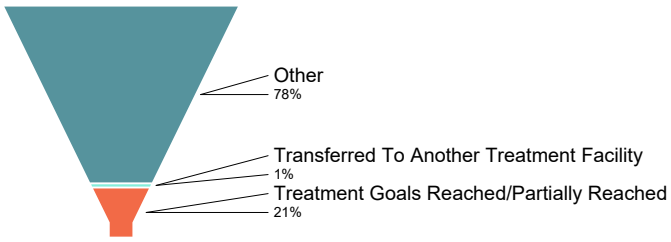
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	48 %
Disruptive Behavior Disorders	16 %
Mood Disorders	8 %

Of the Clients Served, **0** % had a Substance Use Diagnosis.

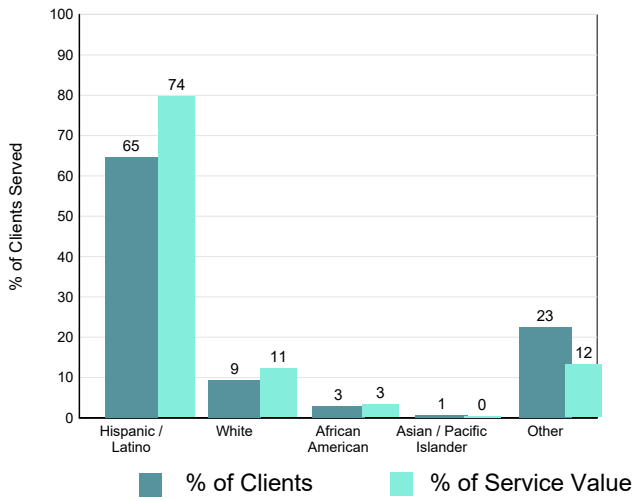
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	1,890	35 %	74%
Collateral/Family Therapy	1,656	30 %	50%
Crisis Intervention	1	0 %	0%
Group Counseling	263	3 %	8%
Linkage/Brokerage	1,248	15 %	80%
Medication Support	31	0 %	4%
Mental Health Counseling	349	6 %	13%
Non Billable	2,453	9 %	92%
Others	6	0 %	1%
Total	7,897	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	78%
Private Insurance	9%
Self Pay/Other	13%

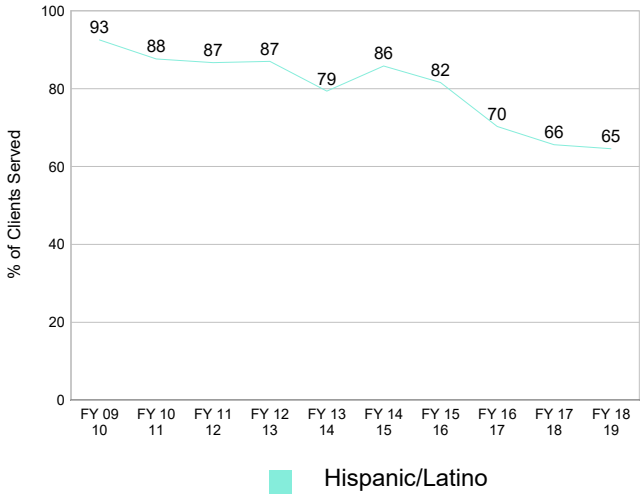
CSS-08 - Early Childhood Mental Health

Health Equities

Breakdown of Clients Served by Ethnicity

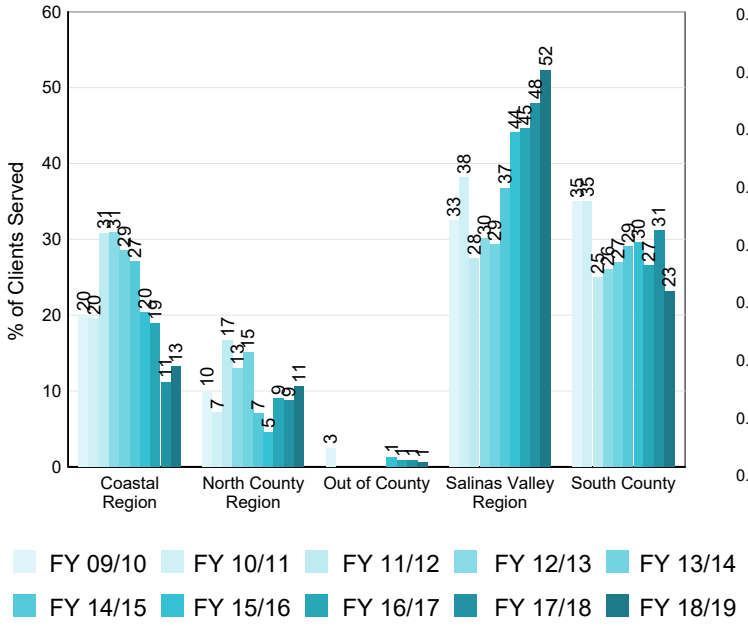


Percent of Hispanic / Latino Clients Served

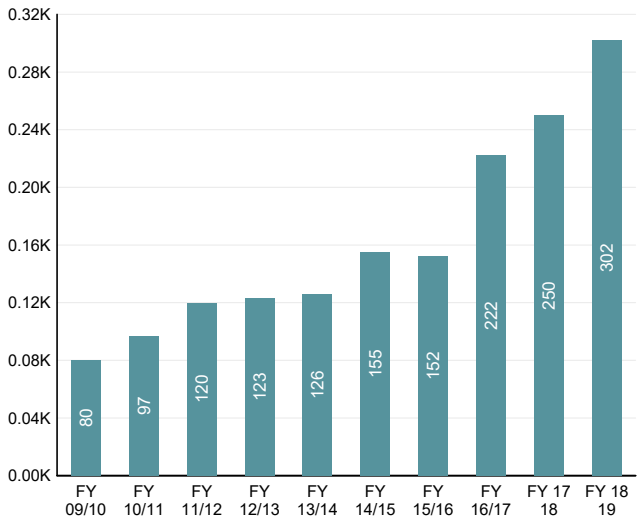


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



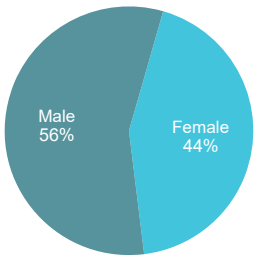
CSS-09 - Transition Age Youth

Program/Program Group: Transitional Aged Youth

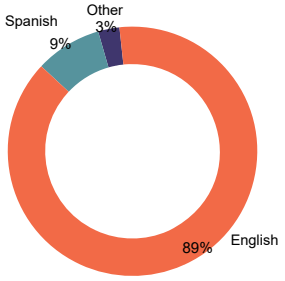
The Transitional Age program nurtures and empowers youth and young adults ages 16 through 25 who have mental health disorders by providing comprehensive case management, therapy, groups and opportunities for positive social interactions. The program provides assistance with removing barriers related to mental health issues and helps youth move forward in their goals related to employment, education, independent living skills, and personal functioning. The program connects Transition Age Youth (TAY) with community resources, jobs and educational opportunities. Psycho-education and support is also provided to family members as they are an important part of a young adult's support system and are critical in their success. Collaborative partners are: TAY, family members, community based youth serving organizations, juvenile probation, education, and social services.

- Number of Clients Served: 256
- Total Service Value: $1,631,316.32
- Average Service Value per Client: $6,372.33
- Average Age: 20
- Number of New Clients: 81
- Number of Clients Discharged: 254

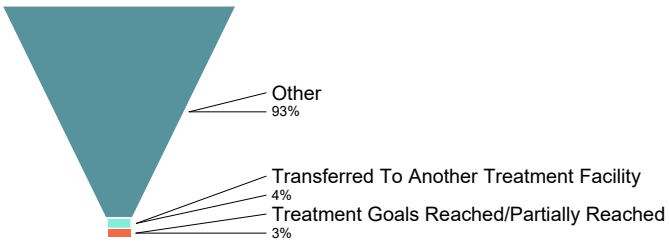
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Mood Disorders	45 %
Schizophrenia Spectrum	28 %
Anxiety Disorders	21 %

Of the Clients Served, **35** % had a Substance Use Diagnosis.

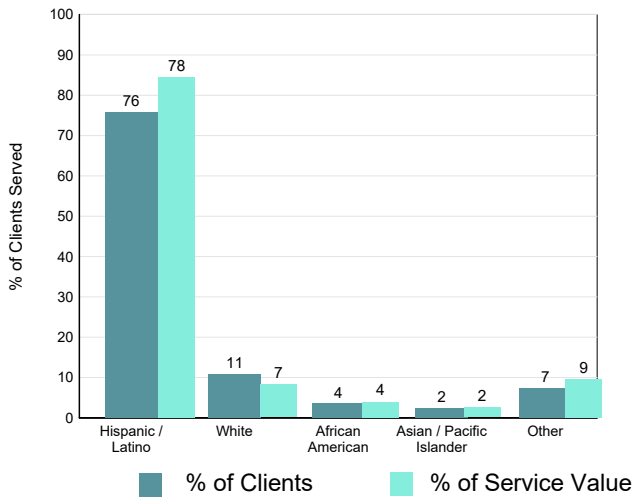
Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	84%
Medicare B	2%
Private Insurance	12%
Self Pay/Other	3%

	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	511	11 %	72%
Collateral/Family Therapy	141	3 %	23%
Crisis Intervention	77	1 %	6%
Group Counseling	86	1 %	9%
Linkage/Brokerage	2,914	43 %	92%
Medication Support	282	4 %	43%
Mental Health Counseling	940	27 %	59%
Non Billable	1,154	10 %	84%
Others	1	0 %	0%
Total	6,106	100%	100%

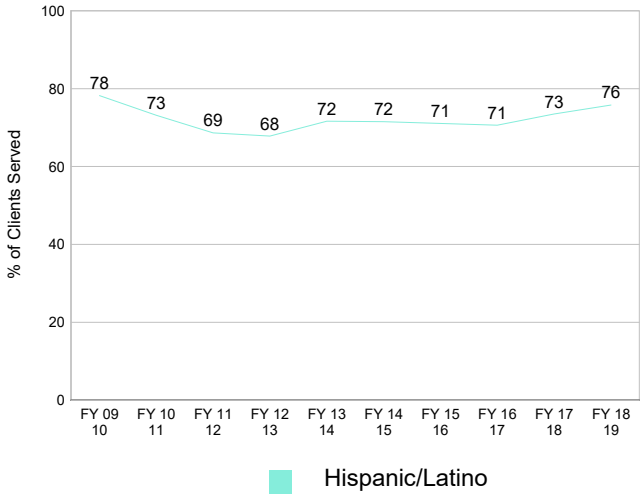
CSS-09 - Transition Age Youth

Health Equities

Breakdown of Clients Served by Ethnicity

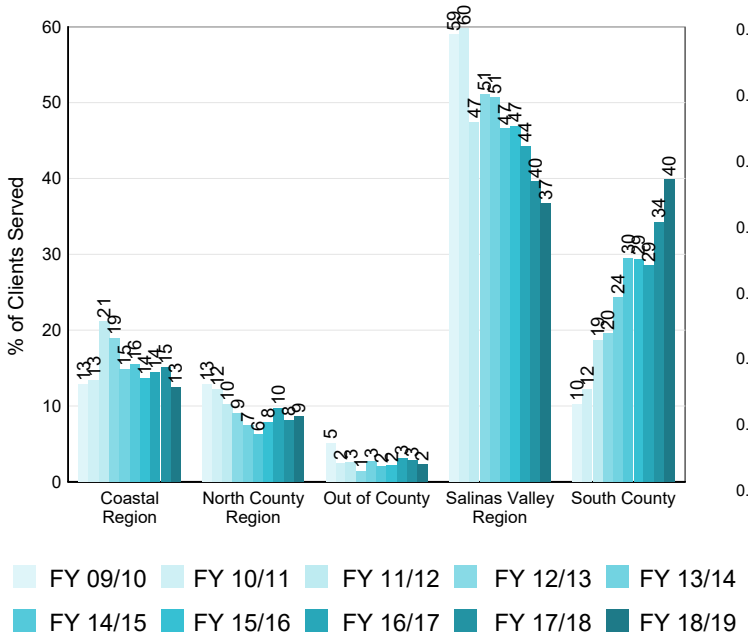


Percent of Hispanic / Latino Clients Served

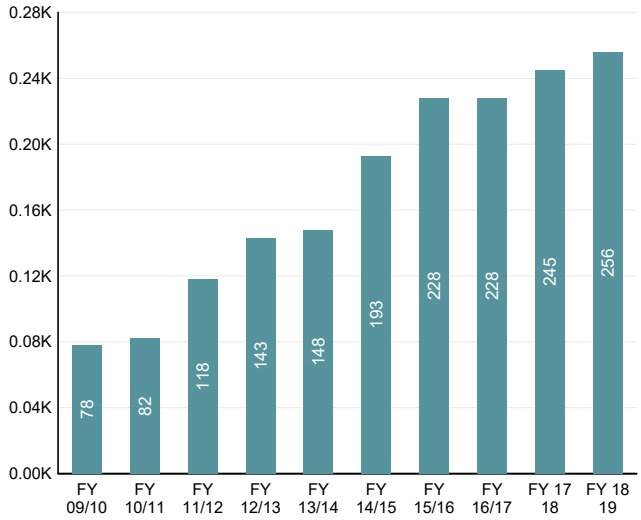


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



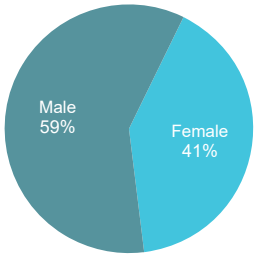
CSS-10 - Supports to Adults with SMI

Program/Program Group: Interim Rockrose Gardens

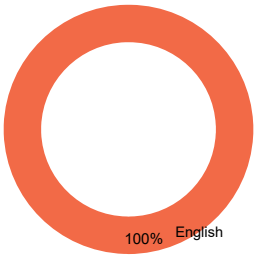
Interim Rockrose Gardens provides safe, affordable, quality permanent housing for 20 very low-income individuals with psychiatric disabilities, all of whom are homeless or at high risk of homelessness and require additional support necessary to live independently in the community. The service array includes: Intensive case management provided in the Full Service Partnership model as required by Mental Health Services Act funding, medication support and assistance with daily living skills, i.e., meals, house cleaning, and laundry services, in order to live independently in the community. These intensive support services are NOT available in Interim's other permanent housing projects.

- Number of Clients Served: 22
- Total Service Value: $281,970.73
- Average Service Value per Client: $12,816.85
- Average Age: 48
- Number of New Clients: 2
- Number of Clients Discharged: 2

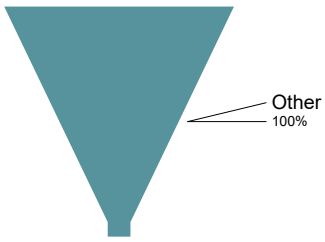
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Schizophrenia Spectrum	27 %
Mood Disorders	9 %

Of the Clients Served, **27** % had a Substance Use Diagnosis.

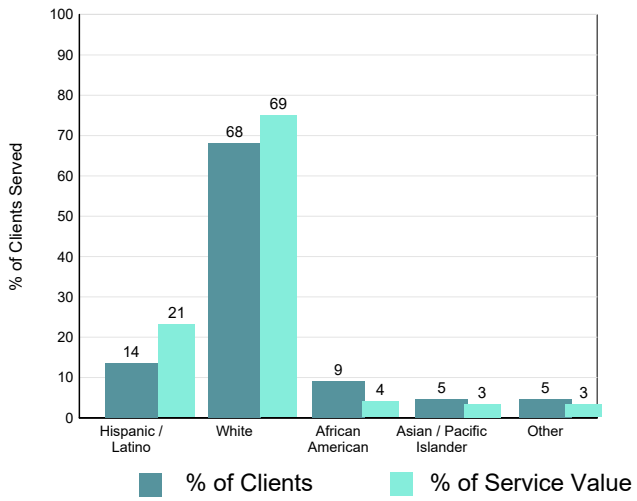
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	153	15 %	91%
Collateral/Family Therapy	6	1 %	23%
Group Counseling	76	4 %	5%
Linkage/Brokerage	166	12 %	95%
Mental Health Counseling	780	68 %	100%
Non Billable	93	1 %	55%
Total	1,274	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	31%
Medicare B	69%

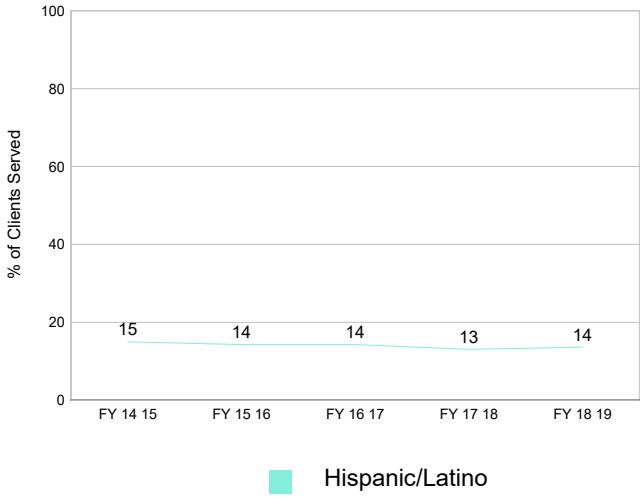
CSS-10 - Supports to Adults with SMI

Health Equities

Breakdown of Clients Served by Ethnicity

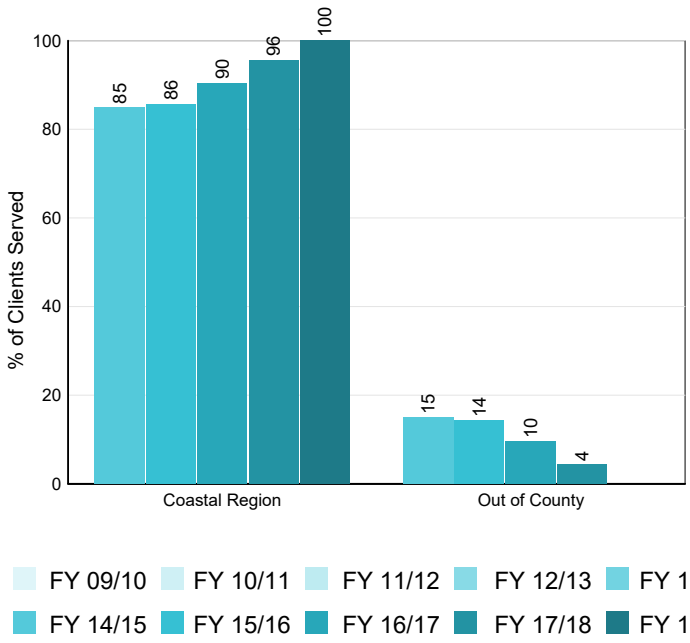


Percent of Hispanic / Latino Clients Served

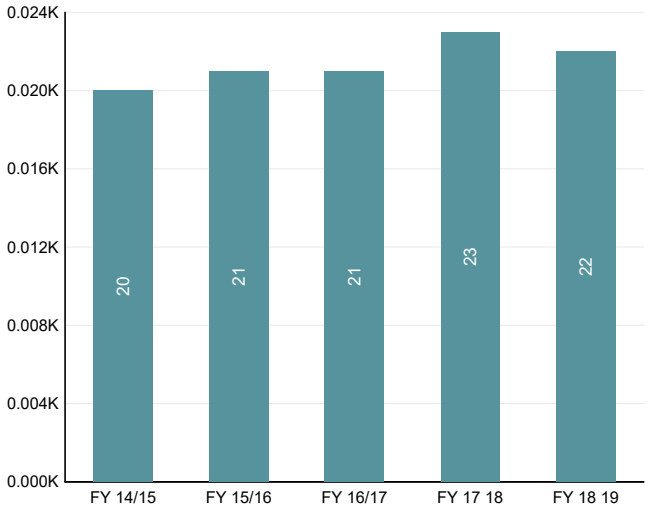


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



CSS-10 - Supports to Adults with SMI

Program/Program Group: Interim Wellness Navigator

Number of Clients Served: 79

Total Service Value: $181,709.76

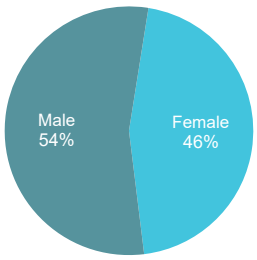
Average Service Value per Client: $2,300.12

Average Age: 44

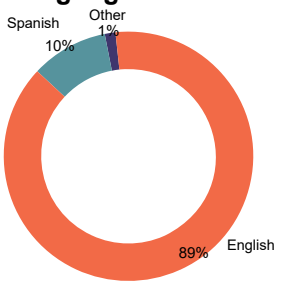
Number of New Clients: 59

Number of Clients Discharged: 59

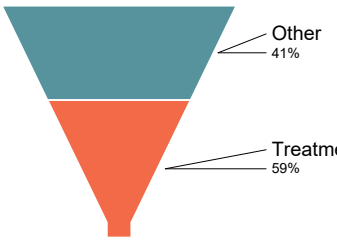
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Schizophrenia Spectrum	67 %
Mood Disorders	32 %
Personality Disorders	1 %

Of the Clients Served, **28** % had a Substance Use Diagnosis.

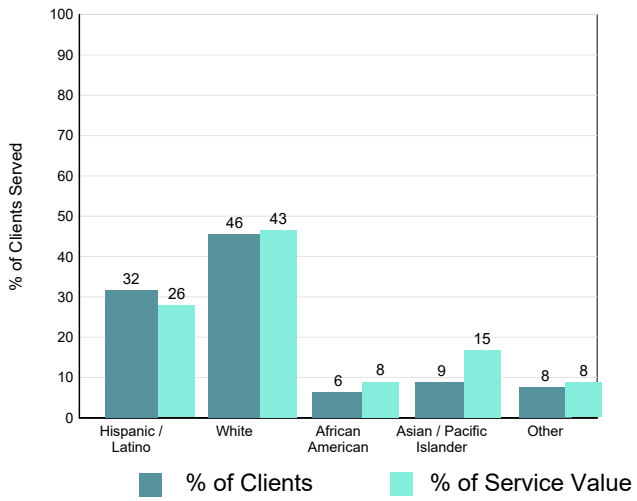
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Linkage/Brokerage	270	54 %	71%
Mental Health Counseling	182	37 %	62%
Non Billable	325	9 %	91%
Total	777	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	75%
Medicare B	19%
Private Insurance	2%
Self Pay/Other	3%

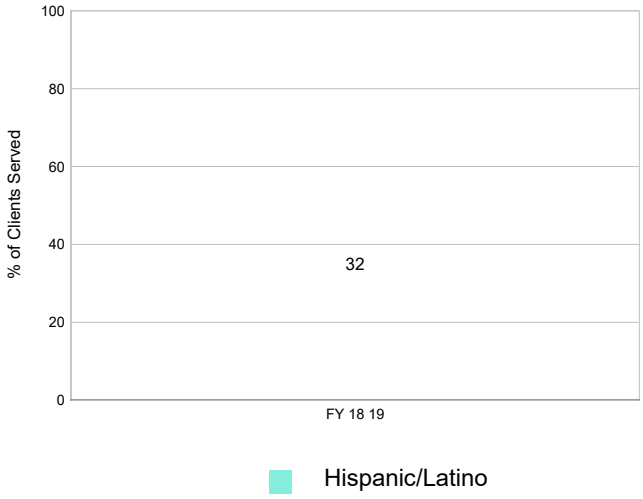
CSS-10 - Supports to Adults with SMI

Health Equities

Breakdown of Clients Served by Ethnicity

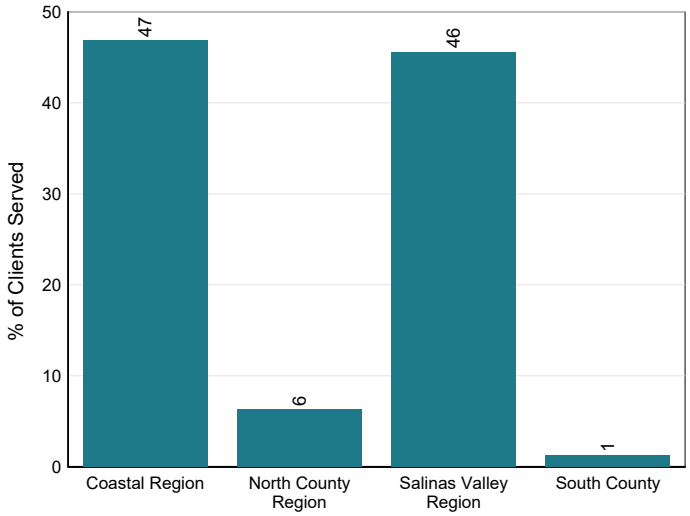


Percent of Hispanic / Latino Clients Served

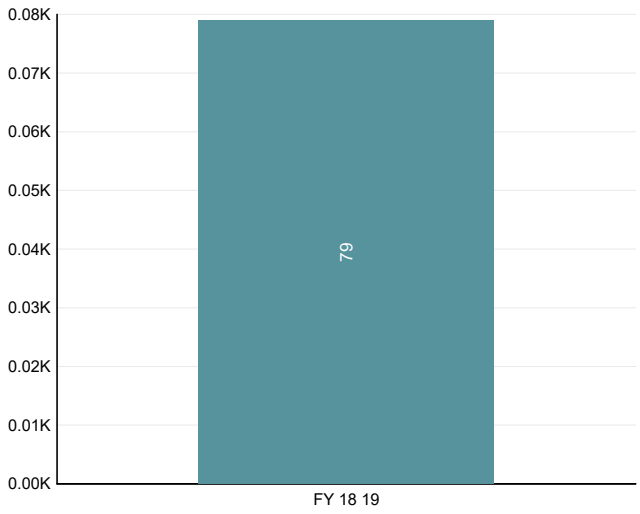


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



FY 09/10 FY 10/11 FY 11/12 FY 12/13 FY 13/14
FY 14/15 FY 15/16 FY 16/17 FY 17/18 FY 18/19

Central Coast Center for Independent Living (CCCIL)

Monterey County Behavioral Health: General System Development Programs Report

July 1, 2018 – June 30, 2019

Provider: Central Coast Center for Independent Living (CCCIL)

Population of Focus: Persons with disabilities:

Description: *Return to Work* Benefits Assistance: Problem Solving and Advocacy, Benefits Analysis and Advisement, Benefits Support Planning and Benefits Management.

Additional Services: Benefits Assistance, Housing Assistance, Independent Living Skills Training, Assistive Technology services & Information, Referral & Assistance services.

State Regulation Program Categories: Supported Services to Adults with Serious Mental Illness

State Regulation Program Strategies: Access and Linkage to Treatment & Improving Timely Access to Services for Underserved Populations

Data Collection Tools/Sources: CCCIL Data Management System/ CCCIL MCBH monthly reporting form

Service Location: Monterey County

Office Locations: Salinas & King City

Participants Demographics

Total Served - 238

Age:
Under 14 - 15
14-24 - 17
25-59 - 183
60 Plus - 23

Ethnicity:
Latino/Hispanic -118
White - 77
African American - 19
Native American/Alaskan Native - 3
Native Hawaiian/Pacific Islander - 2
Asian - 2
Two or more Races - 14
Unknown -3

Participant Residence: Monterey County

2017-2018

Salinas - 140

Greenfield - 8

Monterey - 12

Soledad - 8

Gonzales - 3

Marina –23

Seaside - 10

Pacific Grove - 9

Sand City -2

King City - 9

Castroville - 8

Royal Oaks - 3

Prunedale -2

San Ardo - 1

Zip codes	**Percentages**
93901 - 54	23%
93902 - 2	.008%
93905 - 20	8%
93906 - 46	19%
93907 - 16	7%
93908 -1	.004%
93912 - 8	.033%
93926 - 3	0.1%
93924- 2	.008%
93927 - 8	.034%
93930 - 8	.034%
93933 - 23	10%
93940 -11	.05%
93942 - 1	.004%

93950 - 9 .04%

93955 - 14 .06%

95039 -1 .004%

95076 – 1 004%

Total number of South Monterey County residents served – 29 (12%)

Services received	**Percentage**
Benefits Counseling - 69	29%
Benefits Assistance - 82	34%
Housing Assistance -136	57%
Independent Living Skills Training - 167	70%
Assistive Technology Services - 45	19%

Community Services:

Information & Assistance contacts - 51

Outreach Events - 67

Presentations - 24 -

Summary

During this reporting period CCCIL served 163 (38%) new consumers and 75 re-served consumers. 169 (71%) goals were set by MCBH consumers of those 169 goals set, 65 were met. 38% of consumers met their goal.

CCCIL continues to meet our contract deliverables for those consumers seeking independent living services. A bilingual (English/Spanish) CCCIL Case Manager remains stationed in the Behavioral Health Department's King City office serving South County consumers one day per week (Wednesday). This collaboration has facilitated our ability to serve South County residents unable to travel to our main office in Salinas.

Outreach Efforts

We attended meetings of South County Outreach Efforts (SCORE), a collaborative network of health, education and human service providers whose mission is to improve access and quality of services. We also attended meetings of the South County Services Subcommittee which disseminates information and is attended by members of the healthcare profession, schools, nonprofits and City leaders. Updates are provided on the status of mental health services in all of Monterey County including South County. Proposition 47 No Zip Code Left Behind: Addressing Inequalities through Community Advisory Panel is another collaborative we participate in. This group reports on the use of money generated through this proposition for services that will benefit persons with mental health disabilities.

CCCIL's Case Manager assigned to the King City office space, was appointed to the Housing Advisory Committee by Supervisor Simon Salinas and attends monthly committee meetings. The Housing Advisory Committee (HAC) is an appointed body that is charged with reviewing and considering housing related issues for Monterey County. Our participation allows us to address the housing needs of our consumers with disabilities living in South Monterey County.

To increase the number of consumers being served in South County, CCCIL is going to add a second day to our King City office, will conduct outreach to local schools, clinics, fait base organizations, public libraries and government and non-government entities. Our goal is to increase services to the Latino/farmworkers community by 10%.

Leveraging of Funds

CCCIL is also working on leveraging additional funds to continue or expand services, for example, CCCIL now has a contract with the Health Department to provide rapid re-housing services to consumers who are under the Whole Person Care (WPC) Program. Under this program CCCIL will be able not only to assist consumers to search for housing, apply for housing but will be able to assist consumers to secure affordable housing by providing temporary financial assistance to pay for the security deposit, first and last month.

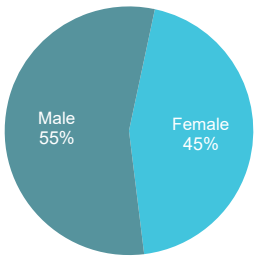
CSS-11 - Dual Diagnosis

Program/Program Group: Interim Co-occurring Integrated Care

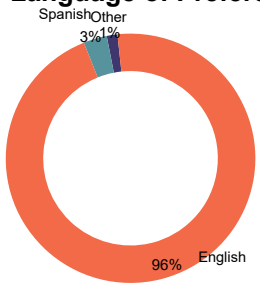
The purpose of these services is to reduce the length of stay at the Bridge House dual recovery residential program, to increase the support to consumers as they move into the next phase of their wellness and recovery treatment in the community, and to promote a clean and sober lifestyle for adults and transitional age youth in the MCBH Adult & TAY Systems of Care. Individual written service plans will be developed for each consumer moving into this phase of community based treatment and will help teach consumers how to avoid drug and alcohol use while strengthen healthy social supports using wellness and recovery principles.

- Number of Clients Served: 67
- Total Service Value: $534,216.16
- Average Service Value per Client: $7,973.38
- Average Age: 46
- Number of New Clients: 16
- Number of Clients Discharged: 27

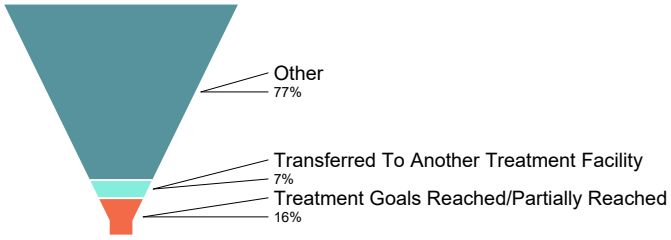
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Schizophrenia Spectrum	39 %
Mood Disorders	24 %
Anxiety Disorders	1 %

Of the Clients Served, **100** % had a Substance Use Diagnosis.

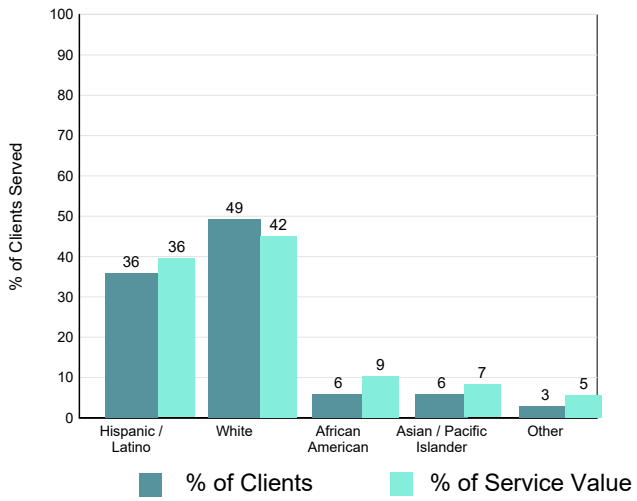
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	123	6 %	73%
Collateral/Family Therapy	2	0 %	3%
Group Counseling	2,112	50 %	81%
Linkage/Brokerage	124	2 %	57%
Mental Health Counseling	608	39 %	82%
Non Billable	373	3 %	88%
Total	3,342	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	57%
Medicare B	43%
Private Insurance	0%
Self Pay/Other	0%

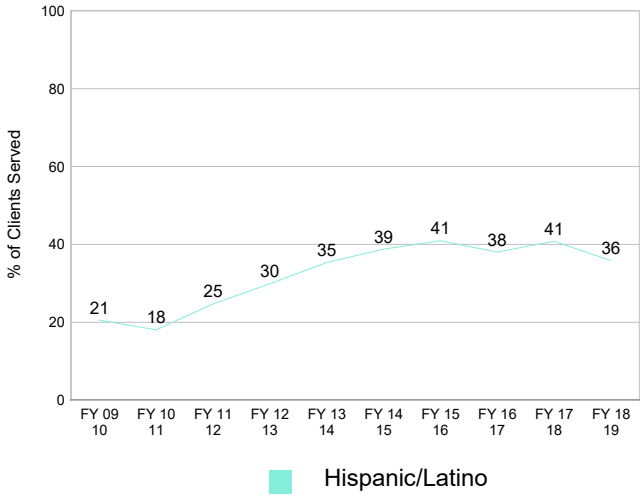
CSS-11 - Dual Diagnosis

Health Equities

Breakdown of Clients Served by Ethnicity

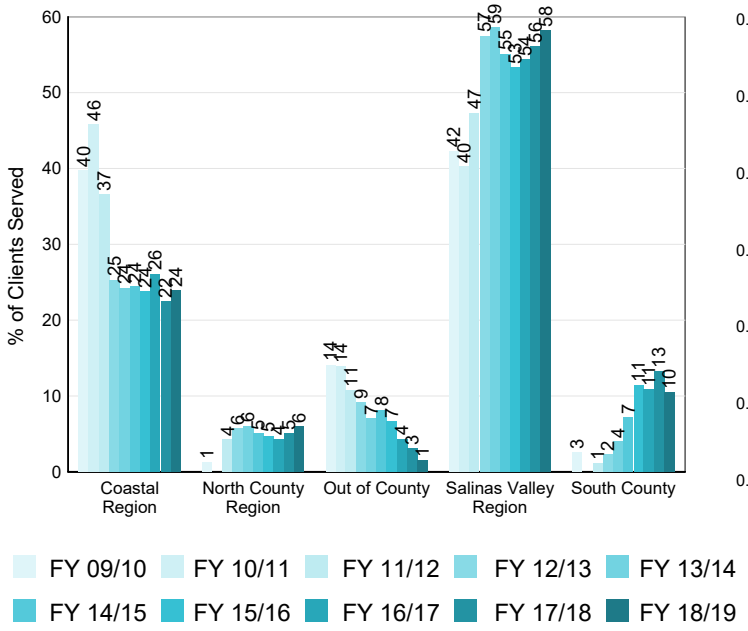


Percent of Hispanic / Latino Clients Served

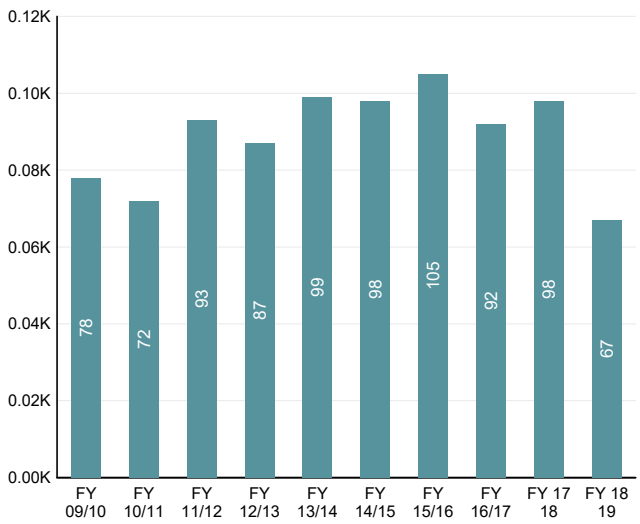


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



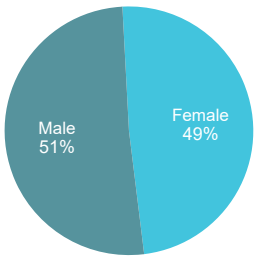
CSS-12 - Family Stability

Program/Program Group: Kinship Center Seneca

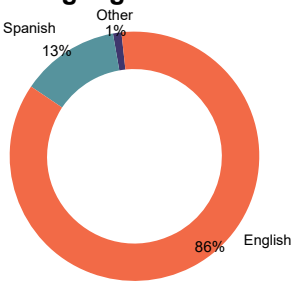
Kinship Center provides Mental Health Services and Medication Support to youth who require outpatient services. The focus of the program is permanency for children, the impact of adoption on a child and his/her family, and the impact on children being raised by a relative caregiver. Such services will reduce the possibility of future residential care, periodic inpatient hospitalization, placement at out-ofstate facilities, or placement in a juvenile justice facility.The D'Arrigo Children's Clinic provides outpatient mental health services to eligible children and their families. Mental health services refer to those individual, family or group therapies and interventions that are designed to provide reduction of mental disability and improvement and maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency.

- Number of Clients Served: 100
- Total Service Value: $1,060,602.46
- Average Service Value per Client: $10,606.02
- Average Age: 11
- Number of New Clients: 33
- Number of Clients Discharged: 100

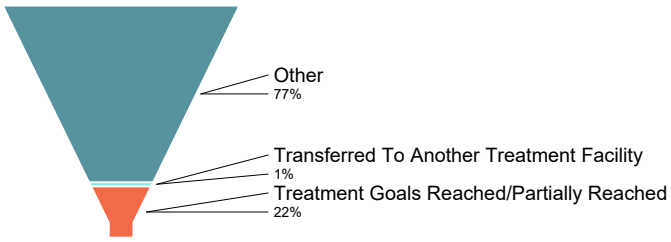
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	62 %
Disruptive Behavior Disorders	17 %
Mood Disorders	15 %

Of the Clients Served, **0** % had a Substance Use Diagnosis.

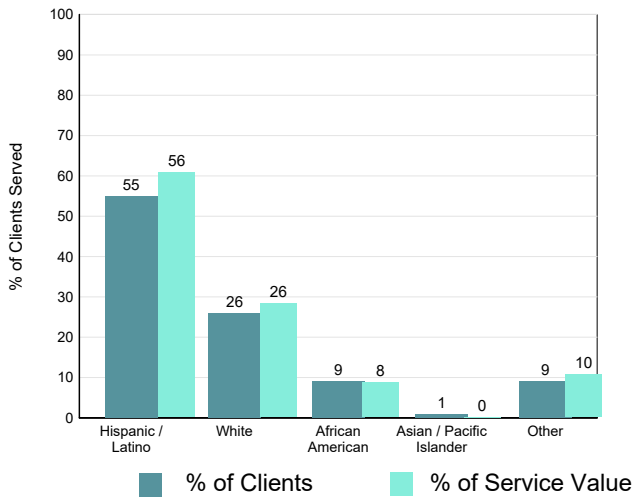
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	659	16 %	89%
Collateral/Family Therapy	658	12 %	71%
Crisis Intervention	21	0 %	2%
Group Counseling	237	5 %	35%
Linkage/Brokerage	972	14 %	88%
Medication Support	121	2 %	15%
Mental Health Counseling	2,024	51 %	82%
Total	4,692	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	91%
Private Insurance	6%
Self Pay/Other	3%

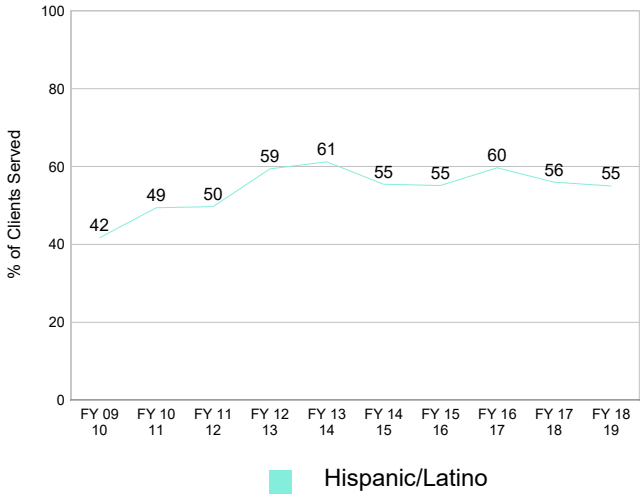
CSS-12 - Family Stability

Health Equities

Breakdown of Clients Served by Ethnicity

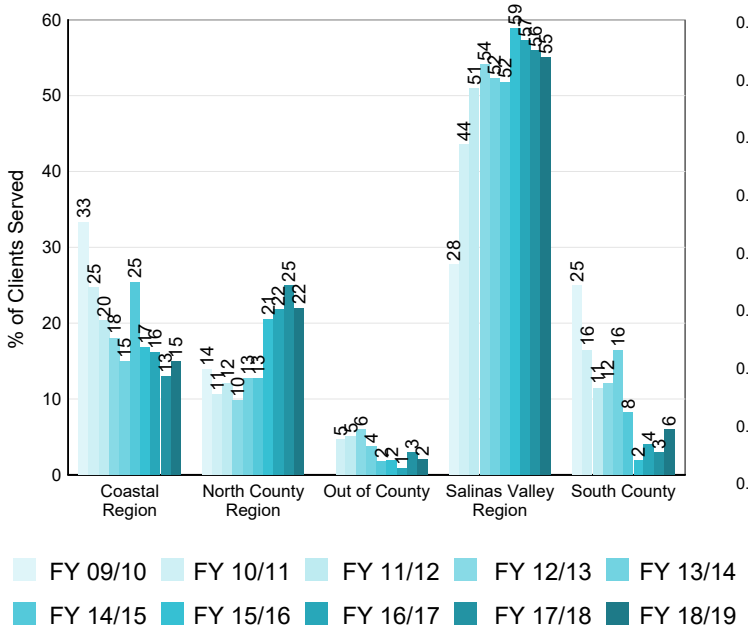


Percent of Hispanic / Latino Clients Served

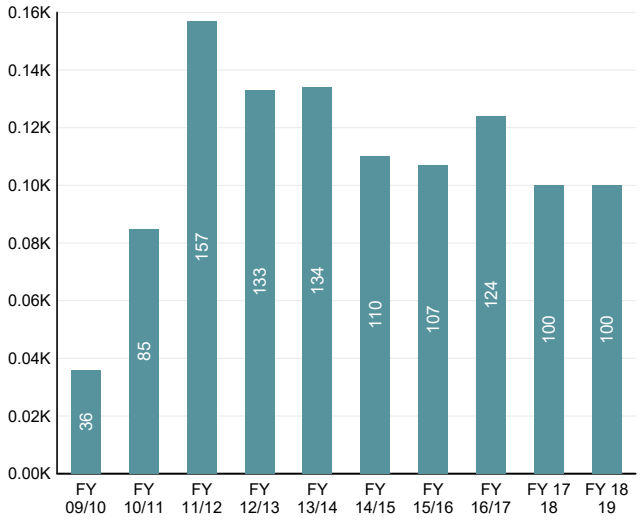


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



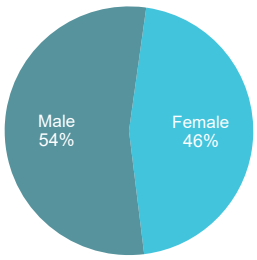
CSS-12 - Family Stability

Service Area: Kinship Center Seneca First Five Trauma

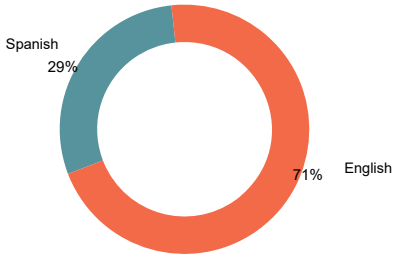
Kinship Center provides Mental Health Services and Medication Support to youth who require outpatient services. The focus of the program is permanency for children, the impact of adoption on a child and his/her family, and the impact on children being raised by a relative caregiver. Such services will reduce the possibility of future residential care, periodic inpatient hospitalization, placement at out-ofstate facilities, or placement in a juvenile justice facility. The D'Arrigo Children's Clinic provides outpatient mental health services to eligible children and their families. Mental health services refer to those individual, family or group therapies and interventions that are designed to provide reduction of mental disability and improvement and maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency.

- Number of Clients Served: 24
- Total Service Value: $220,799.18
- Average Service Value per Client: $9,199.97
- Average Age: 6
- Number of New Clients: 5
- Number of Clients Discharged: 14

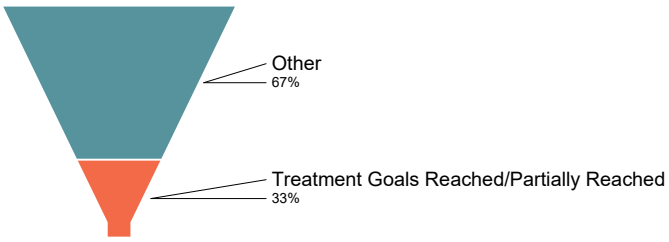
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	67 %
Mood Disorders	17 %
Disruptive Behavior Disorders	8 %

Of the Clients Served, **0** % had a Substance Use Diagnosis.

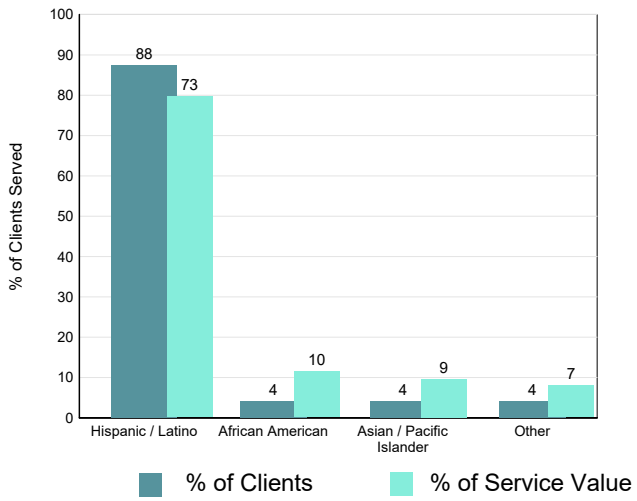
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	92	9 %	63%
Collateral/Family Therapy	262	28 %	92%
Group Counseling	9	1 %	13%
Linkage/Brokerage	153	10 %	79%
Medication Support	2	0 %	4%
Mental Health Counseling	437	52 %	96%
Total	955	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	81%
Private Insurance	17%
Self Pay/Other	3%

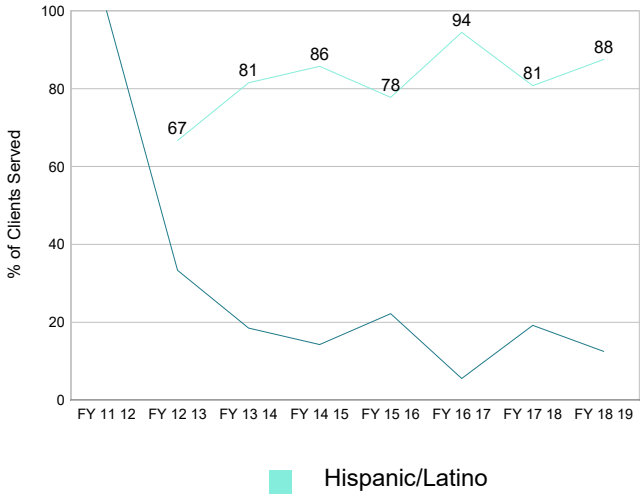
CSS-12 - Family Stability

Health Equities

Breakdown of Clients Served by Ethnicity

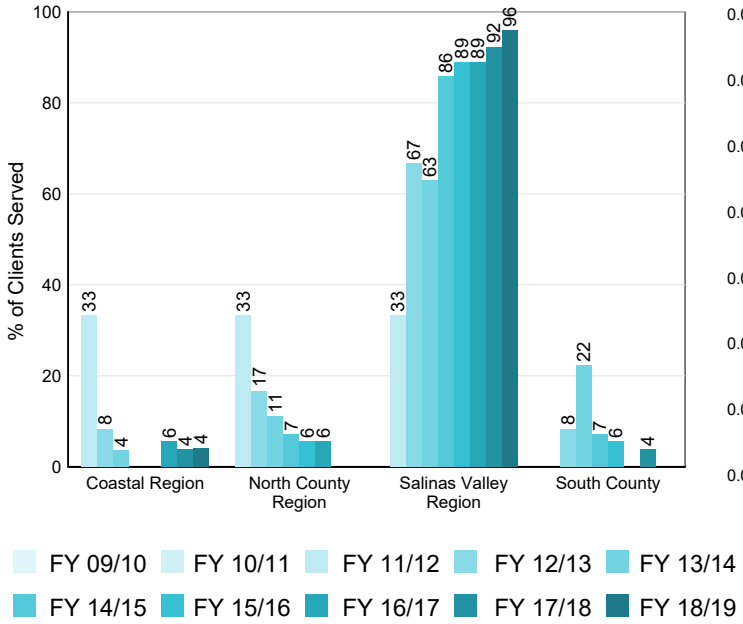


Percent of Hispanic / Latino Clients Served

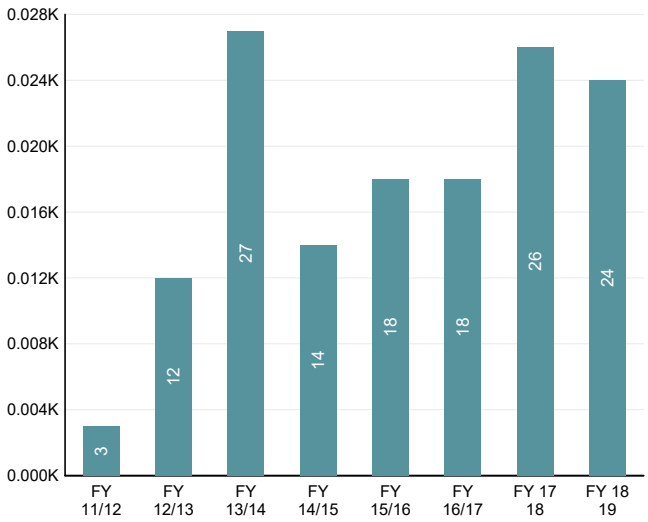


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



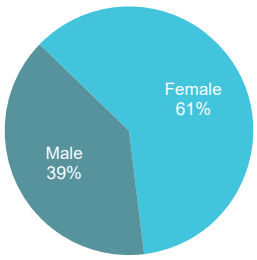
CSS-12 - Family Stability

Program/Program Group: Kinship Center Seneca FSP King City

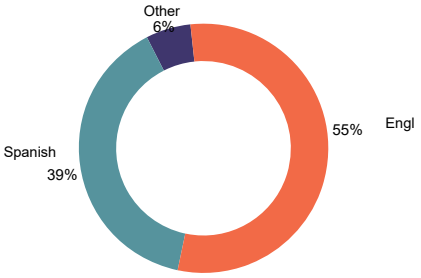
Kinship Center provides Mental Health Services and Medication Support to youth who require outpatient services. The focus of the program is permanency for children, the impact of adoption on a child and his/her family, and the impact on children being raised by a relative caregiver. Such services will reduce the possibility of future residential care, periodic inpatient hospitalization, placement at out-ofstate facilities, or placement in a juvenile justice facility.The D'Arrigo Children's Clinic provides outpatient mental health services to eligible children and their families. Mental health services refer to those individual, family or group therapies and interventions that are designed to provide reduction of mental disability and improvement and maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency.

- Number of Clients Served: 51
- Total Service Value: $478,085.84
- Average Service Value per Client: $9,374.23
- Average Age: 10
- Number of New Clients: 17
- Number of Clients Discharged: 22

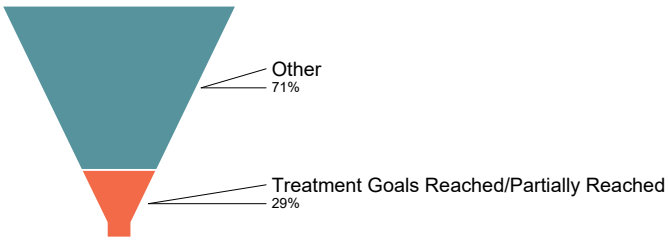
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	59 %
Mood Disorders	14 %
Disruptive Behavior Disorders	8 %

Of the Clients Served, **0** % had a Substance Use Diagnosis.

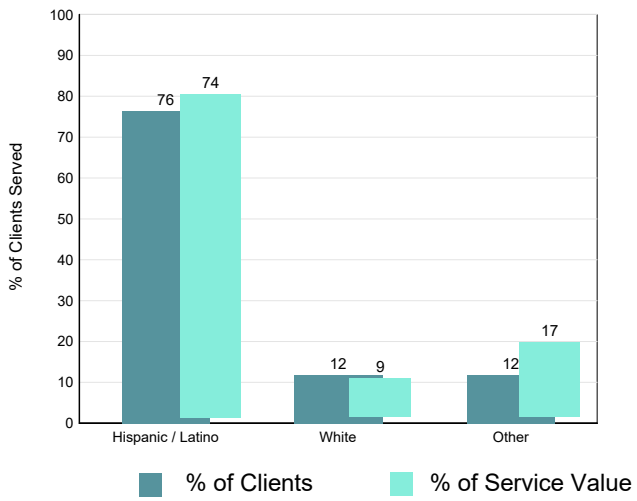
	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	335	22 %	73%
Collateral/Family Therapy	174	11 %	53%
Group Counseling	263	11 %	43%
Linkage/Brokerage	253	11 %	88%
Medication Support	2	0 %	2%
Mental Health Counseling	684	45 %	75%
Total	1,711	100%	100%

Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	100%

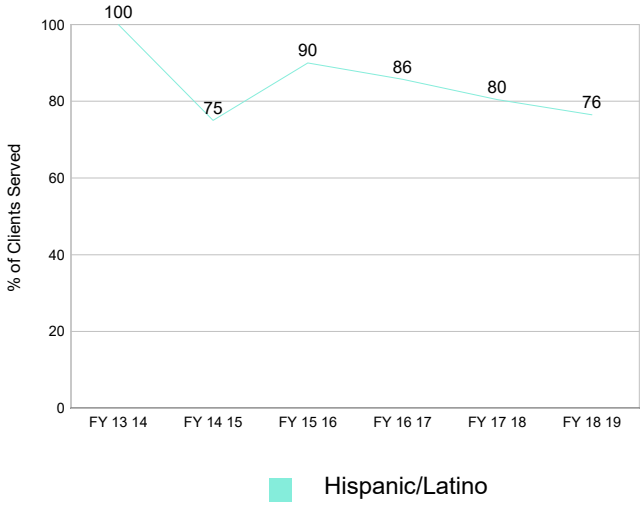
CSS-12 - Family Stability

Health Equities

Breakdown of Clients Served by Ethnicity

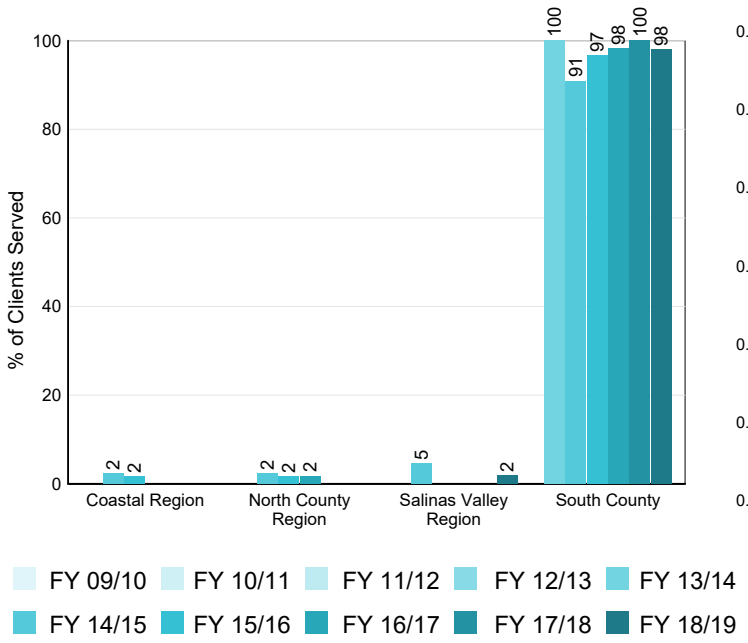


Percent of Hispanic / Latino Clients Served

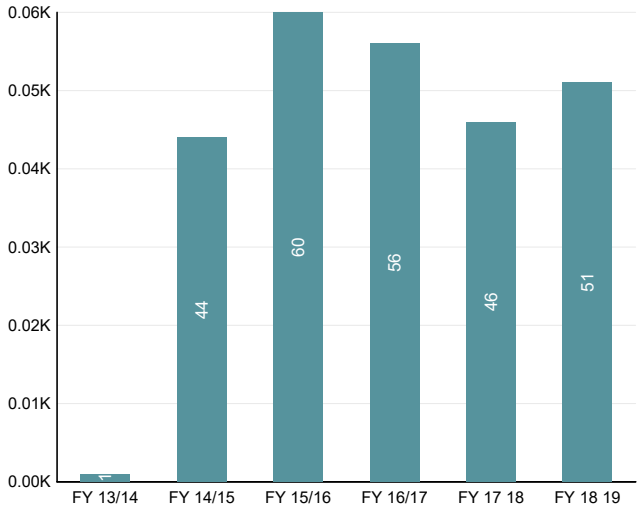


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count



Service Area: CS Family Preservation

This program provides intensive short term family based treatment in circumstances or situations where children are at eminent risk of removal from home. This program is designed to predominantly serve Spanish speaking families.

Number of Clients Served: 10

Total Service Value: $307,759.14

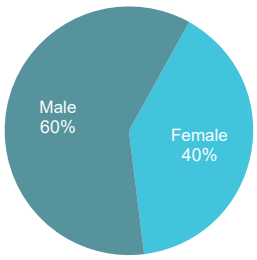
Average Service Value per Client: $30,775.91

Average Age: 11

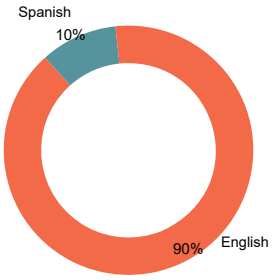
Number of New Clients: 8

Number of Clients Discharged: 7

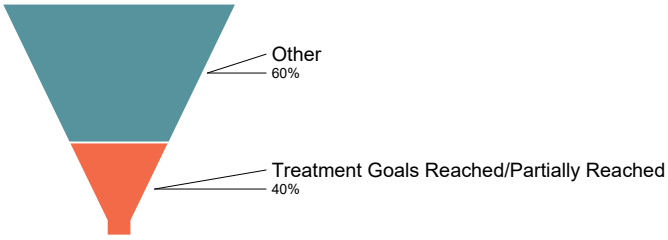
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	70 %
Disruptive Behavior Disorders	10 %
Mood Disorders	10 %

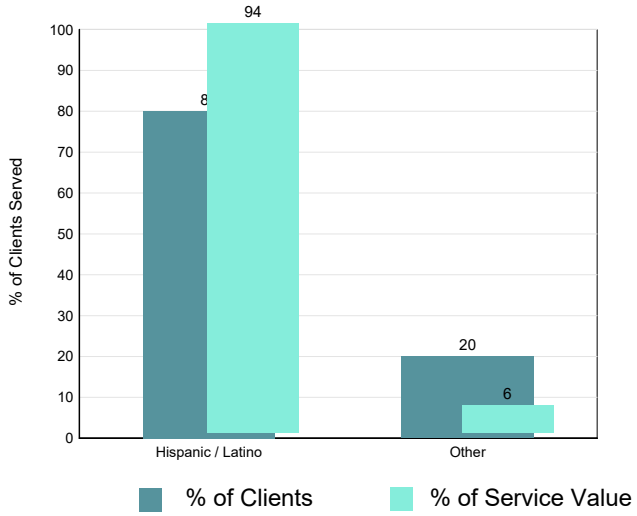
Of the Clients Served, **0** % had a Substance Use Diagnosis.

	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	34	15 %	90%
Collateral/Family Therapy	17	7 %	50%
Linkage/Brokerage	15	2 %	60%
Medication Support	1	0 %	10%
Mental Health Counseling	143	73 %	80%
Non Billable	12	3 %	50%
Total	222	100%	100%

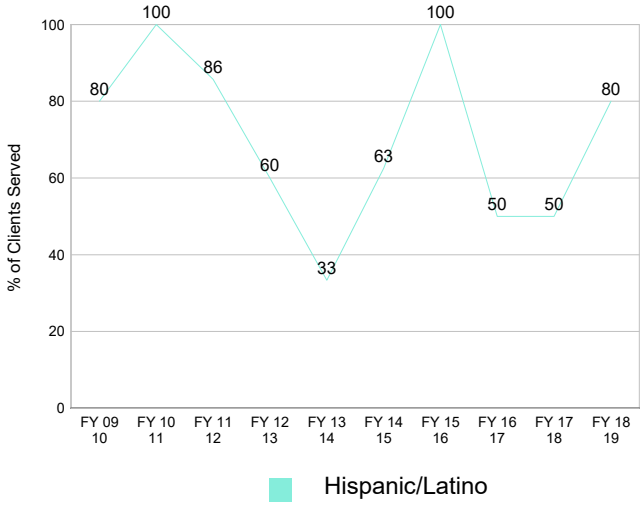
Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	81%
Self Pay/Other	19%

Health Equities

Breakdown of Clients Served by Ethnicity

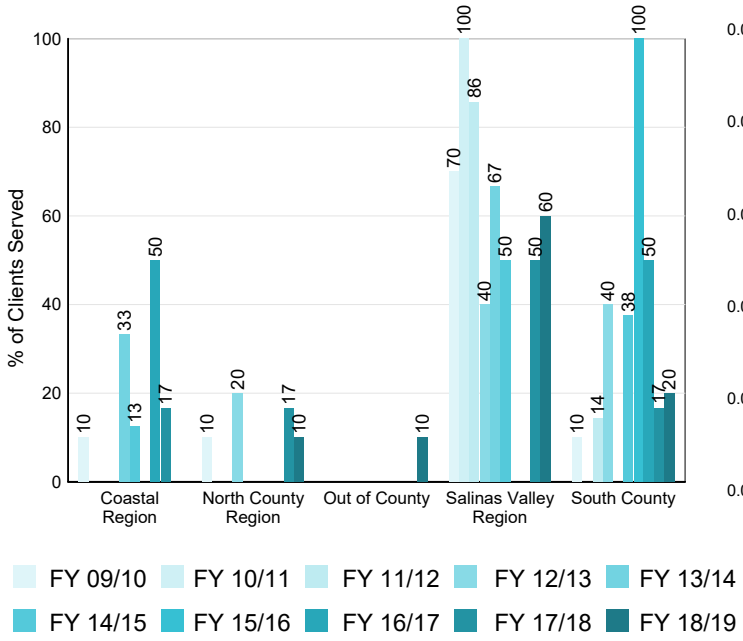


Percent of Hispanic / Latino Clients Served

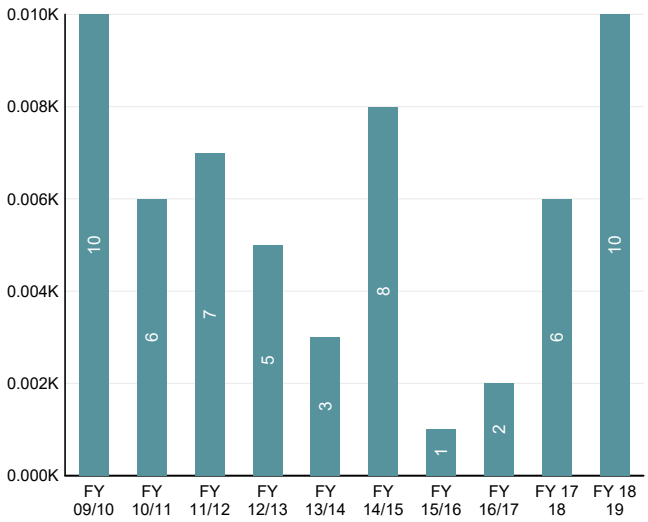


Ten Year Service Trend

Percent of Clients Served by Region of Residence



Total Client Count

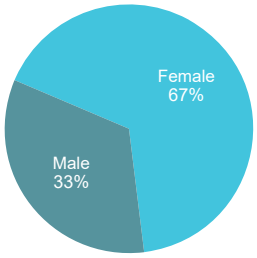


Service Area: CS Salinas Home Partners

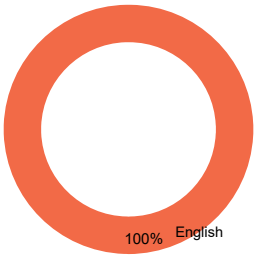
The Home Partners Program is an intensive, short-term, in-home crisis intervention and family education program. It is designed to prevent the out-of-home placement of children whose emotional, social, and/or behavioral problems create a substantial risk of placement in publicly funded care, such as foster homes, group homes, correctional institutions or psychiatric facilities. This program is designed to defuse the immediate crisis, stabilize the environment, and assist families to develop more effective parenting skills and coping abilities. The principal characteristics of this program include interventions at the crisis point, treatment in the client's environment, 24 hour therapist availability, treatment that is highly individualized and concrete services as needed. Services are provided intensively and as needed for up to 20 hours a week, over a 4-6 week period. Therapist only carry a caseload of two families at a time to allow for intensive, frequent contact in order to maximize learning opportunities and work on the basic concrete and hard services needs a family may have. Mental Health Services Act (MHSA) supports this program to ensure access by monolingual families. This part of the program is referred to as: MHSA Family Preservation Program.

- Number of Clients Served: 12
- Total Service Value: $333,284.53
- Average Service Value per Client: $27,773.71
- Average Age: 11
- Number of New Clients: 10
- Number of Clients Discharged: 10

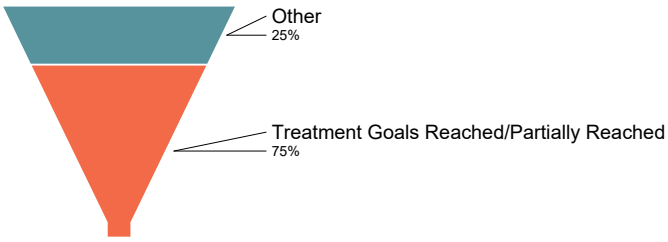
Gender



Language of Preference



Discharge Disposition/Outcome



Top 3 Primary Diagnosis	
Diagnosis Type	% of Clients with this Diagnosis Type
Anxiety Disorders	50 %
Mood Disorders	33 %

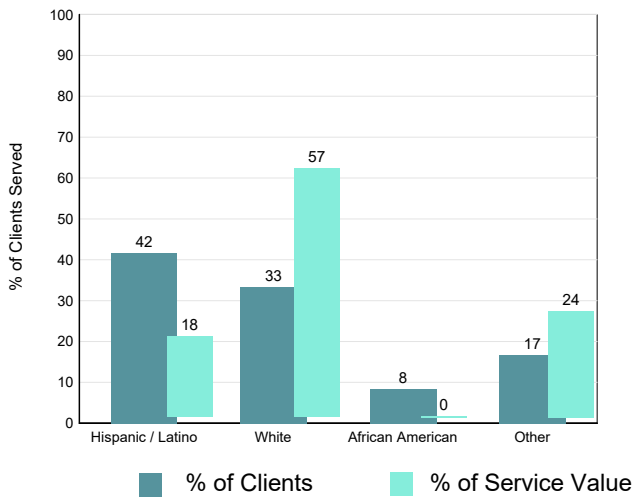
Of the Clients Served, **0** % had a Substance Use Diagnosis.

	Breakdown of Service Type		
	Number of Services	% of Total Service Minutes	% of Clients
Assessment/Evaluation	18	6 %	75%
Collateral/Family Therapy	20	5 %	58%
Linkage/Brokerage	45	5 %	67%
Mental Health Counseling	157	84 %	83%
Non Billable	15	1 %	83%
Total	255	100%	100%

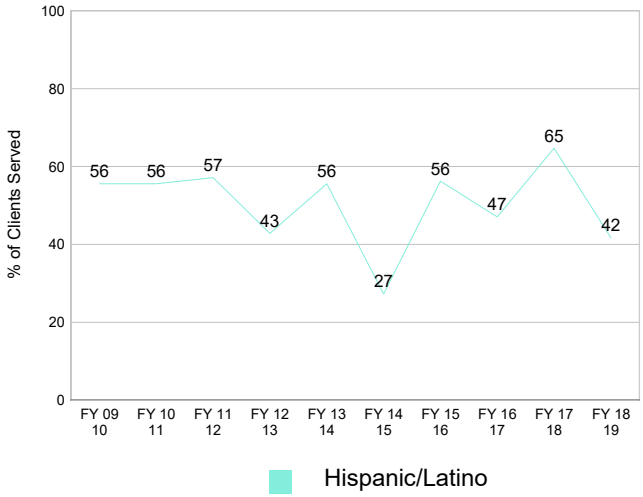
Primary Insurance Source of Clients Served	% of clients served
Medi-Cal	45%
Private Insurance	7%
Self Pay/Other	48%

Health Equities

Breakdown of Clients Served by Ethnicity

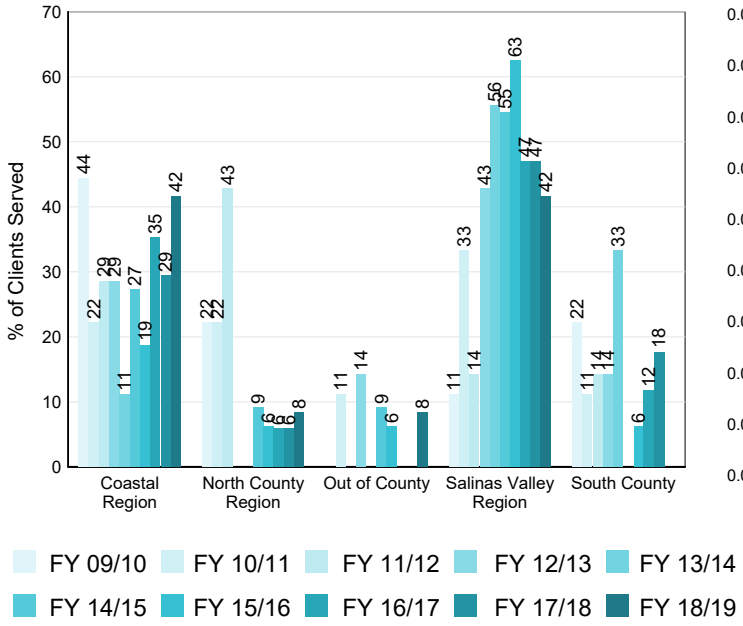


Percent of Hispanic / Latino Clients Served

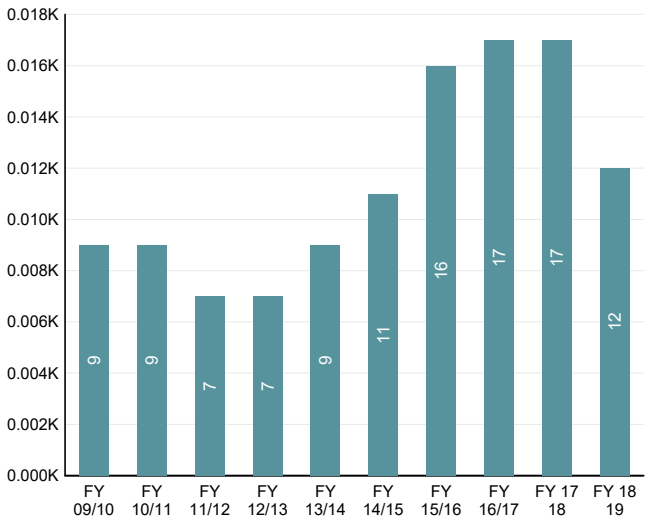


Ten Year Service Trend

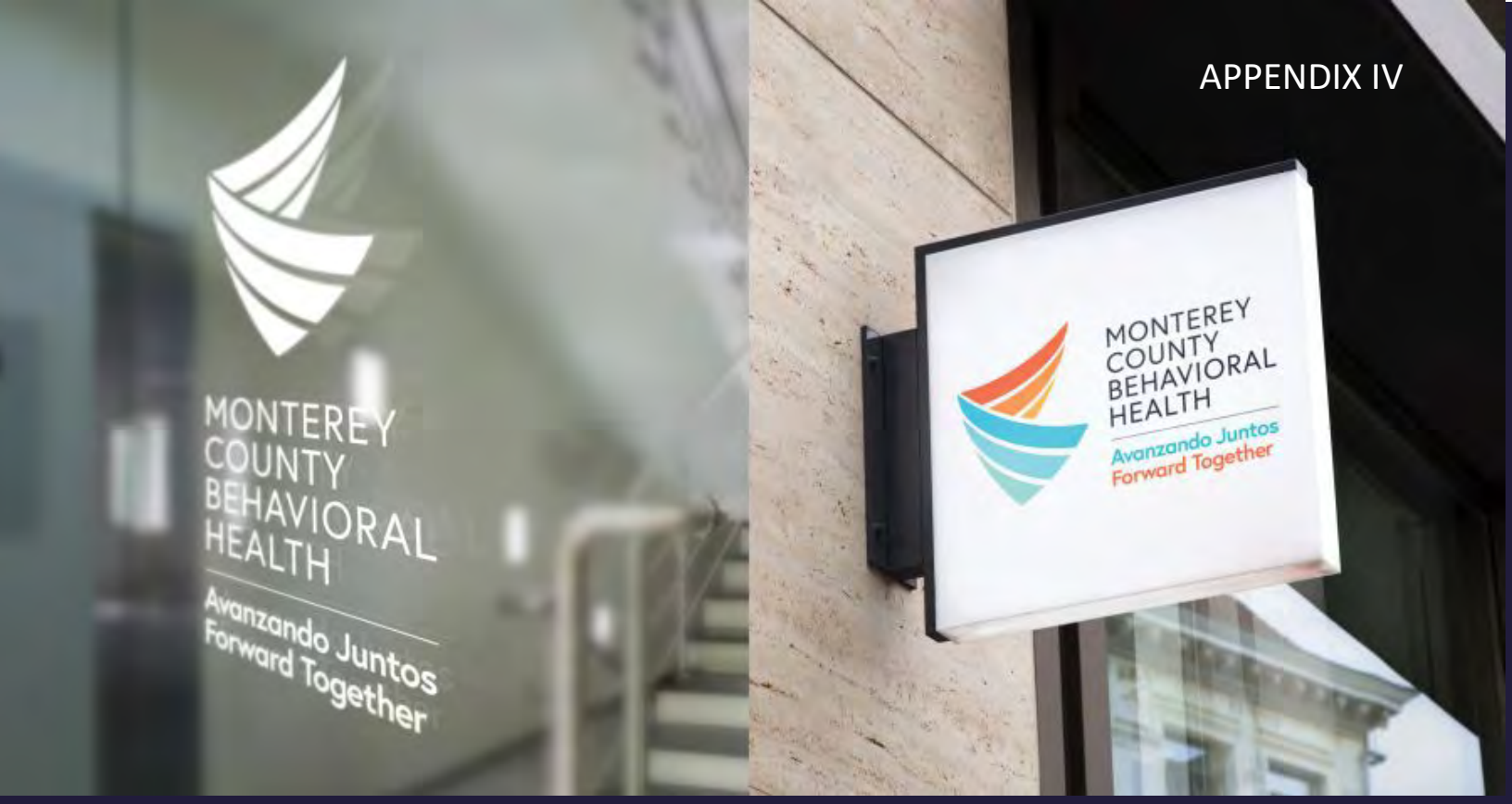
Percent of Clients Served by Region of Residence



Total Client Count



APPENDIX IV



Monterey County MHSA Prevention and Early Intervention FY 2018-2019 Report

Prepared by

EVALCORP
Research & Consulting

ACKNOWLEDGMENTS

This report was made possible through the collaborative effort of a number of individuals and agencies. EVALCORP extends our gratitude to Dr. Amie Miller, Monterey County Behavioral Health Bureau Director, for the opportunity to produce this report in partnership with the County. We also extend thanks to Alica Hendricks, Management Analyst III; Dana Edgull, MHSA Prevention Manager; and Wesley Schweikhard, Management Analyst II, for their significant contributions to building evaluation and data collection infrastructure. Additionally, we acknowledge the Prevention and Early Intervention program providers and participants for sharing their time, information, and experiences with us.

TABLE OF CONTENTS

INTRODUCTION

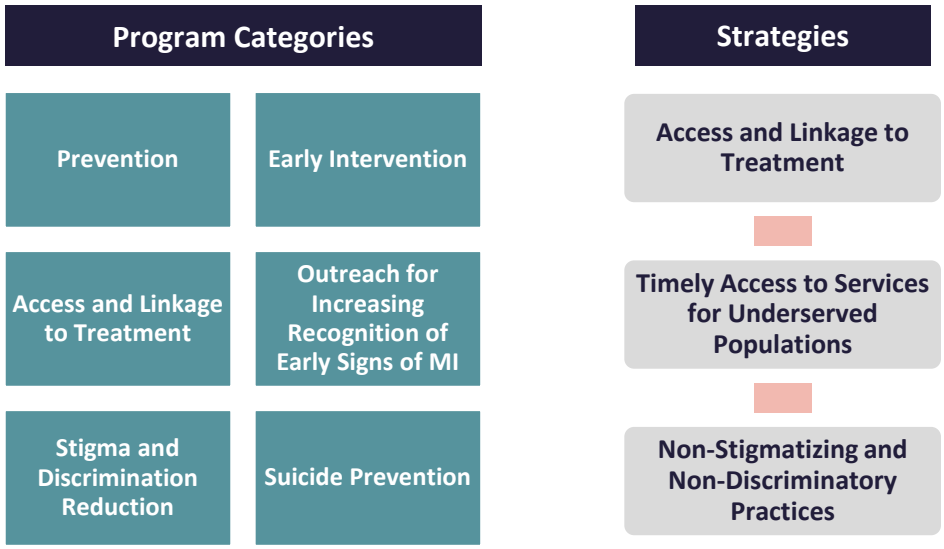
Overview

The Mental Health Services Act (MHSA) was passed by California voters in 2004 through Proposition 63, which designated funding to improve mental health service systems throughout the State. MHSA has several funding components, including Prevention and Early Intervention (PEI), which is intended to support programs that prevent mental illnesses from becoming severe and disabling.

Through MHSA funds, Monterey County Behavioral Health (MCBH) supports PEI programs that address the mental health prevention and early intervention needs of the County's culturally and regionally diverse communities. In fiscal year 2018–2019, MCBH funded 22 programs, administered by both the County and contracted community service providers. In addition, MCBH contributes to the CalMHSA statewide PEI project, Each Mind Matters: California's Mental Health Movement.

MHSA PEI Regulations

Each of Monterey County's PEI programs are organized into 1 of 6 categories, as defined by PEI regulations. Additionally, each program must employ PEI strategies within their program activities. A list of funded MCBH PEI programs by category is included for reference in **Appendix A**.



State regulations also require specific process and outcome evaluation metrics to be reported on an annual and three-year basis. MCBH has made continuous efforts over the last several years to build upon and improve data infrastructure, collection, and submission. During fiscal year 2018–2019, MCBH trained PEI programs to collect demographic and outcome data more uniformly. This has yielded an increased ability to demonstrate the reach of PEI services in the County and the impact on individuals served. Additionally, MCBH also launched a new method for tracking program referrals and follow-up, which will result in more detailed information about timely access to services and linkages to treatment.

REPORT METHODOLOGY

Analytic Approach

MCBH contracted with EVALCORP Research & Consulting to develop this report, which summarizes data for PEI programs funded during fiscal year 2018-2019. The current report employs a mixed-methods approach, utilizing quantitative and qualitative data provided to the County by PEI-funded programs.

This report provides a comprehensive review of programs, including:

- Program services and activities
- Service participation
- Participant demographics and populations served
- Program impacts/outcomes

Although the types of data provided by PEI programs varied in some cases, this report presents available data in a standardized manner. In preparing this report, extensive data cleaning, validation, and analytic procedures were performed to ensure the highest level of data accuracy and validity.

Data Sources

Data sources compiled to develop the fiscal year 2018-2019 report fall into five general categories:

1. **MHSA PEI Demographic Forms:** These forms were developed to collect demographic information required by the MHSA PEI regulations (e.g., age group, race, ethnicity, primary language, sexual orientation, disability, veteran status, assigned sex at birth, and current gender identity) and participant location of residence. Three types of forms were developed to be administered depending on participant age and the type of services received, as follows:

FORM TYPE	PARTICIPANTS
Adult	All participants age 13 or over
Parent	All parents of children age 12 or under receiving services
Presentation	All presentation attendees

   PEI providers used these forms to report demographic data from program participants both quarterly and annually to obtain an unduplicated count of participants. 16 of 22 PEI programs completed and submitted Demographic Forms to MCBH during fiscal year 2018-2019.

2. **Avatar:** The County's electronic health record system captures demographic information for some PEI-funded programs. Information regarding age group, race, ethnicity, primary language, veteran status, and gender are available, however ethnicity and gender categories are not currently in alignment with State PEI regulations. Avatar data were used for five PEI programs in this report.

3. **MHSA PEI Outcome Surveys:** These forms were developed to collect information about the impacts of program services as well as level of satisfaction and feedback from program participants. Four

types of outcome surveys were collected, depending on the primary PEI program category as follows:

SURVEY TYPE	PROGRAM CATEGORY
Prevention	Prevention Programs
Early Intervention	Early Intervention and Outreach for Increasing Recognition of Early Signs of Mental Illness Programs
Suicide Prevention	Suicide Prevention Programs
Stigma and Discrimination Reduction	Stigma and Discrimination Programs

Surveys were collected twice a year, in September 2019 and March 2019, from every unduplicated program participant who received services in those months. Programs primarily categorized under Access and Linkage to Treatment did not collect outcome surveys due to brevity of contact. Additionally, programs that provide crisis-oriented services, including Archer Child Advocacy Center and Mobile Crisis Team, did not collect outcome surveys in order to minimize burden on program participants who were under emotional duress.

4. **Data Driven Decisions (D3) Report:** Produced by MCBH, the D3 reports on program funding and populations served. The fiscal year 2017-2018 D3 report was referenced for information on program services. To view the D3 report for FY 17-18, click HERE.

5. **Other Program Reports:** 10 PEI-funded programs completed additional reports with information about progress toward specific program goals, key program activities, and quantitative program data. The format and these reports varied across providers, including logic models, narrative, and quantitative information about program services. In addition, 2-1-1 provided custom reports with demographic data.

Data Notes

In fiscal year 2018-2019, MCBH implemented an enhanced data collection and evaluation infrastructure, allowing this year's report to provide more robust data for PEI programs, including data on outcomes experienced by recipients of PEI services. Additionally, in June 2019, MCBH held a training for all PEI Providers to introduce new referral tracking tools and quarterly reporting on case examples, successes, and challenges, to enhance data collection about access to services and offer more opportunities for programs to provide details about program activities.

Below are some considerations to keep in mind throughout this report:

- **Unduplicated data:** PEI data are required to represent unduplicated individuals. The new data reporting tools launched at the start of fiscal year 2018-2019 made it possible to provide unduplicated demographic data. However, 2-1-1, a program of United Way Monterey County, collects demographic data differently from other programs and it was not possible to provide unduplicated data for 2-1-1 in every circumstance. These exceptions are noted in the 2-1-1 program section.

- **Completeness of demographic data:**

    - **Differences in number of responses to demographic questions:** Some providers collected more than one type of demographic form, depending on the program activity. For example, a provider may have collected both Adult and Presentation Forms, meaning some respondents did not give as much information because the Presentation Form has less questions. For those program sections, the number of respondents may vary from the overall number served and vary between different demographic questions. Notes are provided in each section where these circumstances apply.

    - **Skipped questions and "decline to answer":** Program participants are free to skip any question they choose and, for some demographic questions on the Adult and Parent Forms, respondents could affirmatively select an option indicating they "decline to answer" (the option reads, "I don't want to answer this question"). These questions include race and ethnicity on both forms, as well as gender identity, sex assigned at birth, and sexual orientation on the Adult Forms.

      As a result, some demographic questions have a lower number of responses than the total number of participants. Notes are provided in the body of each program's report section indicating how many respondents skipped a particular question and, of those, how many affirmatively selected "decline to answer." In a very small number of cases, respondents indicated that they "decline to answer" and also selected another option for a race or ethnicity. In these cases, a conservative approach was taken and responses were counted under "decline to answer." Presentation Forms do not include a "decline to answer" option and therefore all respondents who did not answer a question are reported as having skipped the question and "decline to answer" is not specified.

      Generally, when the rate of unanswered questions is high for a given program, data should be interpreted with caution, as they may not be representative of all individuals served by the program.

    - **Differences in response options to demographic questions:** Adult and Parent Forms collect all demographic data required by the PEI regulations. However, the Presentation Form is a shortened version of the Adult and Parent Form and only includes questions on zip code, age, race/ethnicity (combined into one question, and does not include sub-categories for ethnicity), and primary language. In addition, demographic data collection by programs using Avatar and by 2-1-1 differed from the demographic forms and therefore response options vary from those presented in other program sections where forms were used. For example, response options for race/ethnicity differed, and it was not always possible to indicate where a respondent skipped the question or declined to answer.

- **Completeness of outcome survey data:** The number of survey responses collected is typically far less than the number of overall individuals served and the number of respondents to demographic questions because surveys were only collected twice a year for one month each (September 2018 and March 2019). The number of responses may vary between different questions if respondents skipped a question on the survey. In this case, a range is provided for the number of responses (n) for the survey, indicating the lowest number of responses to a question and the highest.

- **Percentages versus counts:** In cases where the number of responses to a demographic or survey questions was less than 30, counts are presented instead of percentages.

- **Protection of identifying information:** In cases where responses to demographic questions were unique or rare enough to risk identifying the respondent, the responses were suppressed. This includes refraining from enumerating unique or rare open-ended responses to "other" options within questions about race, ethnicity, and disability. A note is provided wherever responses were suppressed to protect identifying information.

- **"Other" responses to questions about disability and race:** The demographic question about disability instructs respondents to indicate disabilities other than a mental illness. However, when asked to indicate if they have a disability that is not listed among the response options ("other"), approximately 1% of respondents wrote in types of mental illnesses. In response to this finding, an option for mental illness was added to the disability question for fiscal year 2019-2020.

  Additionally, of note, on the Parent Forms "ADHD/ADD" (attention deficit hyperactivity disorder/attention deficit disorder) was the most commonly written in disability for a child.

  - **A special note about Hispanic/Latino response options:** The demographic question about race on Adult and Parent Forms did not present an option Hispanic/Latino because the race options included were taken from the list provided by the MHSA PEI regulatory requirements. Therefore, the Hispanic/Latino option was only present in the question about ethnicity on those two forms. However, many people wrote in Hispanic options for race. In response to this finding, and to be inclusive of the community's point of view going forward, an option for Hispanic/Latino was added to the race question for fiscal year 2019-2020.

Report Organization

This report presents PEI data by program. Program sections are organized by PEI Category. The following information is included for programs where available:

- Program Highlights, including overall number of unduplicated individuals served and key program successes
- Program Outcomes
- Program Cultural Competency and Satisfaction
- Participant Feedback
- Demographic Data

Additionally, **Appendix A** contains a list of each program by PEI category, **Appendices B** and **C** of the report contain participant demographic data across all MCBH-funded programs where data were available, and **Appendix D** contains outcomes across all MCBH-funded programs where data were available.

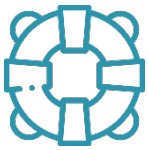
PREVENTION

THE EPICENTER

The Epicenter is a youth-led organization and one-stop resource center to connect youth to community services and resources with a focus on youth who have been involved with public agencies including the foster care system. The primary age group served is youth ages 16-24, with some activities being open to family members and natural supports of the youth served. The Epicenter hosts staff from various agencies at the center to provide services, including housing, education, employment, and mental health and wellness.

Program Highlights

209 individuals served



84% of respondents said they **know where to go for local mental health services** after participating in this program.

Program Outcomes

Because of this program… (n=36-37)	% Agree	% Neutral	% Disagree
I feel more connected to other people.	80%	17%	3%
I know where to go for mental health services near me.	84%	16%	0%
I know when to ask for help with an emotional problem.	78%	22%	0%
I am able to deal with problems better.	65%	35%	0%
I feel less stress or pressure in my life.	68%	27%	5%
I feel better about myself.	67%	30%	3%
When I think about the future, I feel good.	73%	27%	0%

Outreach Events

- **Latinx LGBTQ+ Film Festival**

THE EPICENTER

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=37)	% Agree	% Neutral	% Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	73%	13%	14%
The program had services in the language that I speak best.	92%	8%	0%
I got services that were right for me.	87%	13%	0%
I am happy with the services I received.	97%	3%	0%
I would recommend this program to a friend or family member.	92%	8%	0%

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=37)

- Building connections with staff and peers (17)
- Receiving emotional support (7)
- The caring staff (4)
- A nonjudgmental, safe space (3)

What are your recommendations for improvement? (n=36)

- General program enhancements (6)
- More events and activities (5)
- General positive feedback (e.g., “I like it the way it is.”) (25)

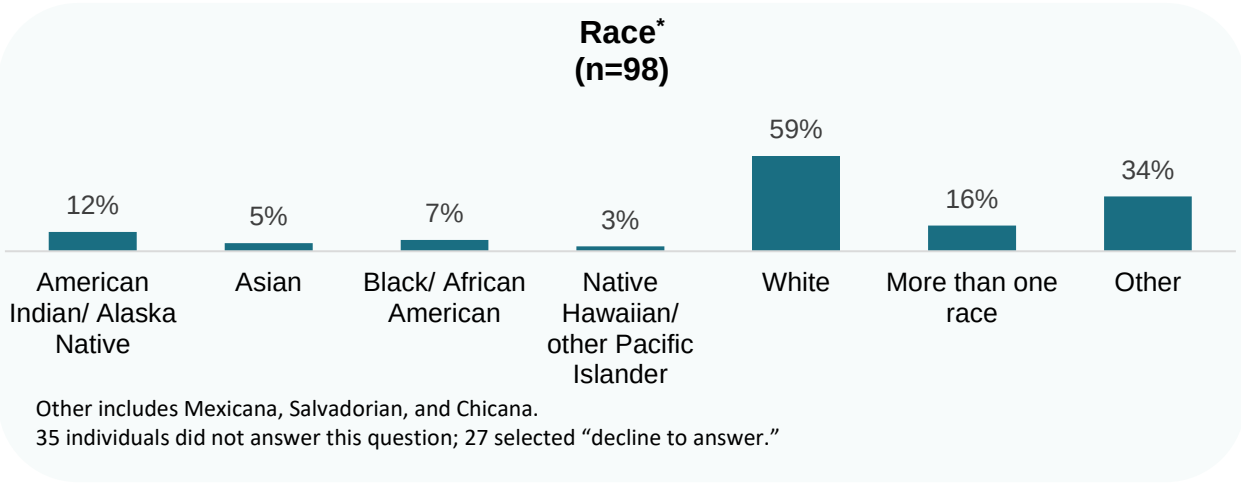
"I feel safe and more open to talk to people about my problems or just life."

"I like that the staff are friendly and are remarkable. They make me feel welcome and safe by respecting me and my identity."

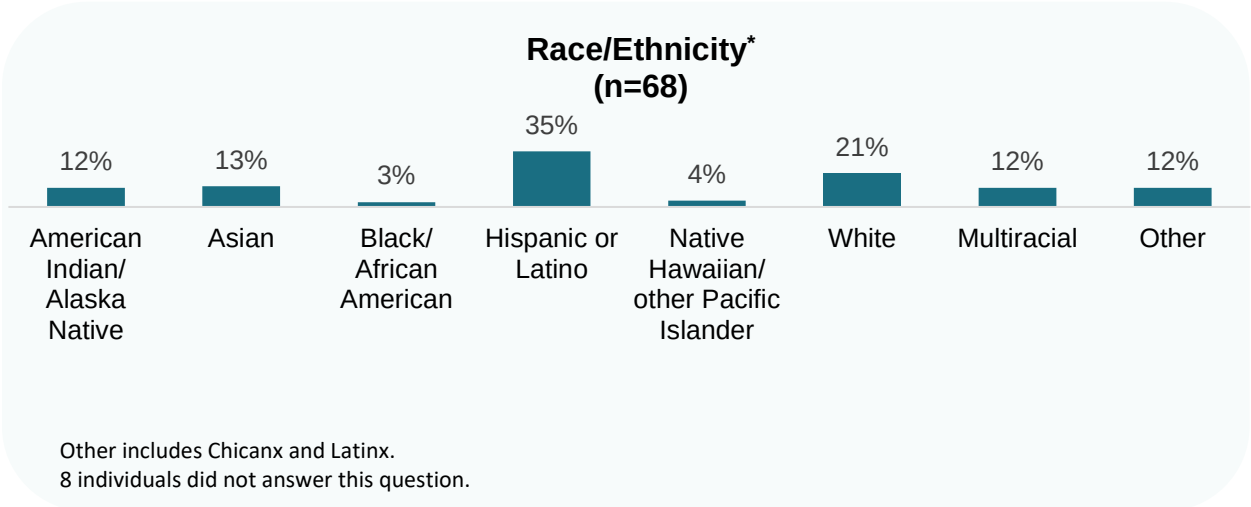
"They help with personal goals and also help you achieve them."

Demographic Data

Demographic data for this program was collected using both Adult Forms and shorter Presentation Forms. Presentation Form data presented below includes only Race/Ethnicity, Age, and Primary Language. Race and Ethnicity questions are combined on the Presentation Form and are therefore reported separately from Race and Ethnicity data collected from the Adult Form. Age and Primary Language data from the Presentation Form are combined with the Adult Form.



Other includes Mexicana, Salvadorian, and Chicana.
35 individuals did not answer this question; 27 selected "decline to answer."



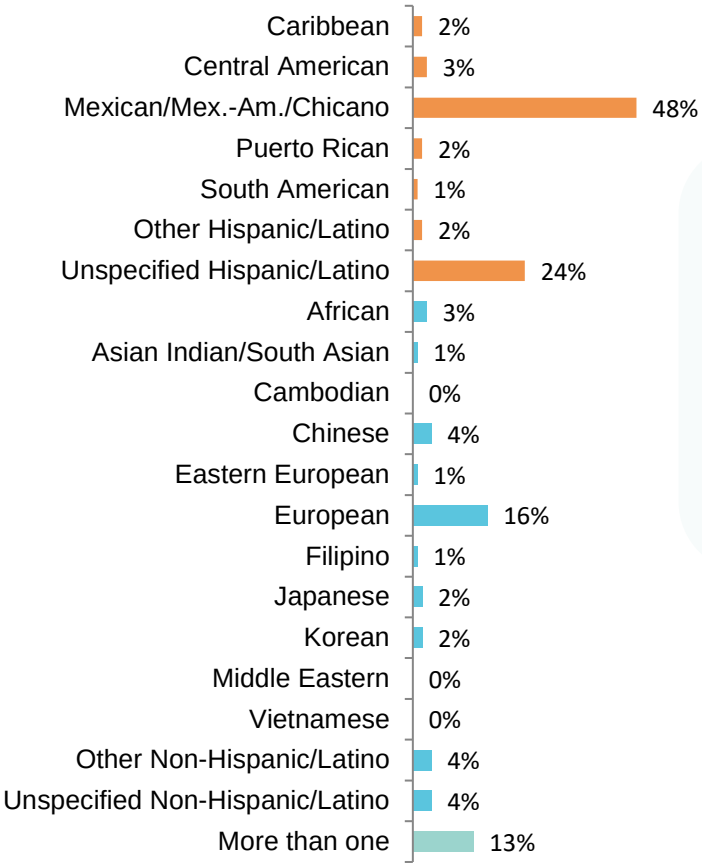
Other includes Chicanx and Latinx.
8 individuals did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

THE EPICENTER

Demographic Data

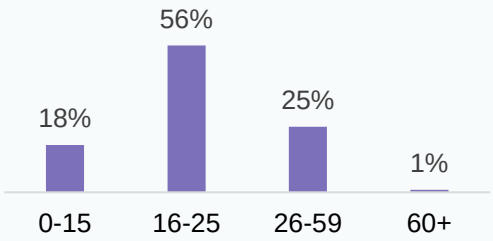
Ethnicity* (n=128)



Other ethnicities were not specified. 5 individuals did not answer this question; 4 selected "decline to answer."

80% Hispanic/Latino*
20% Non-Hispanic/Latino*

Age Groups (n=199)



10 individuals did not answer this question.

Primary Language (n=208)

English	64%
Spanish	27%
English & Spanish	6%
Other	3%

Other includes Chinese, French, and Japanese.
1 individual did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

THE EPICENTER

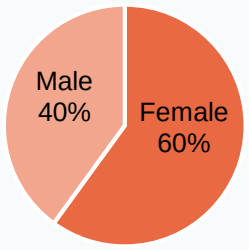
Demographic Data

Current Gender Identity (n=127)

Female	42%
Male	40%
Transgender	5%
Genderqueer	5%
Questioning or Unsure	5%
Another Gender Identity	3%

6 individuals did not answer this question, including 1 who selected "decline to answer."

Sex Assigned at Birth (n=127)



6 individuals did not answer this question, including 1 who selected "decline to answer."

Sexual Orientation (n=112)

Bisexual	21%
Gay or Lesbian	10%
Heterosexual or Straight	47%
Queer	10%
Questioning or Unsure	4%
Another Sexual Orientation	8%

21 individuals did not answer this question, including 11 who selected "decline to answer."

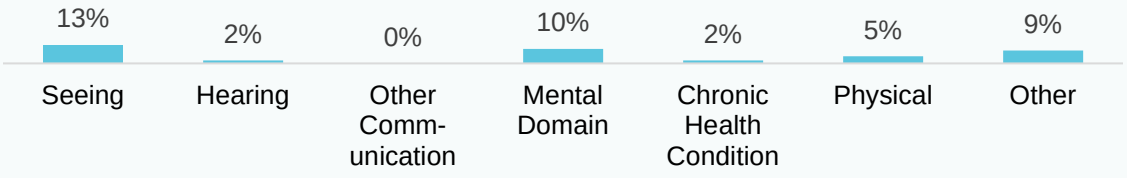
2% of individuals are veterans

n=133

27% of individuals reported having one or more disabilities

n=126; 7 individuals did not answer this question; none selected "decline to answer."

Disability* (n=126)



Other includes ADD, ADHD, PTSD, mood disorder, and Autism.
7 individuals did not answer this question; none selected "decline to answer."

* Percentages may exceed 100% because participants could choose more than one response option.

PARENT EDUCATION PROGRAM
COMMUNITY HUMAN SERVICES

Community Human Services (CHS) offers the Parent Education Program, which provides parenting programs in Spanish and English for parents and caregivers of children with emotional/behavioral challenges. CHS utilizes the evidence-based Triple P (Positive Parenting Program) to teach families communication and listening skills, safe and effective discipline methods, stress management, and how to resolve problems with respect and care. Triple P also helps build understanding of the stages of child development and the definition and effects of child abuse.

Program Highlights

250 individuals served

92% of respondents said they are **better able to deal with problems** after participating in this program.

Program Outcomes

Because of this program… (n=130-133)	% Agree	% Neutral	% Disagree
I feel more connected to other people.	82%	17%	1%
I know where to go for mental health services near me.	78%	21%	1%
I know when to ask for help with an emotional problem.	83%	17%	0%
I am able to deal with problems better.	92%	7%	1%
I feel less stress or pressure in my life.	78%	20%	2%
I feel better about myself.	89%	9%	2%
When I think about the future, I feel good.	90%	8%	2%

PARENT EDUCATION PROGRAM

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=130-134)	% Agree	% Neutral	% Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	88%	11%	1%
The program had services in the language that I speak best.	97%	1%	2%
I got services that were right for me.	91%	8%	1%
I am happy with the services I received.	95%	4%	1%
I would recommend this program to a friend or family member.	95%	4%	1%

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=128)

- Learning new parenting skills (86)
- Gaining knowledge on child development (18)
- Making connections with other parents and sharing experiences (11)

What are your recommendations for improvement? (n=114)

- More classes (11)
- Smaller class size (9)
- More convenient class times (4)
- Share resources and a workbook (4)
- General positive feedback (62)

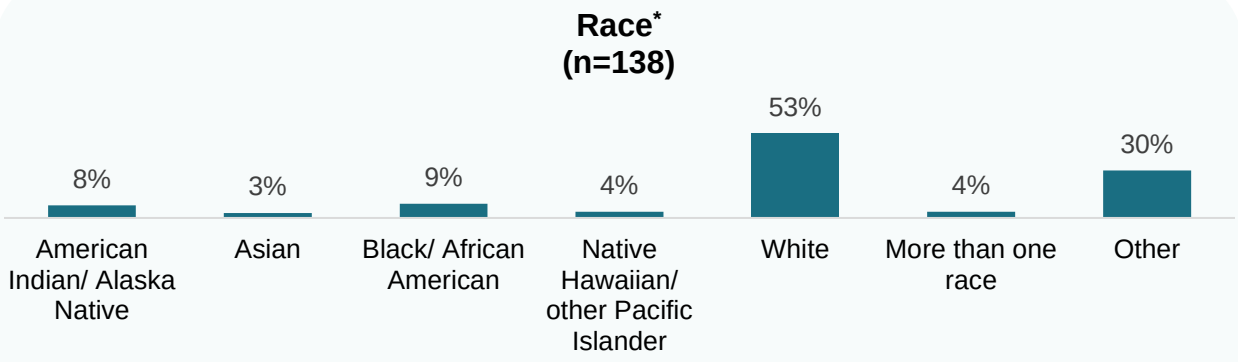
"That it helped me be a better father for my children."

"Learning how to positively parent my children and understand my child's social, emotional, and physical needs."

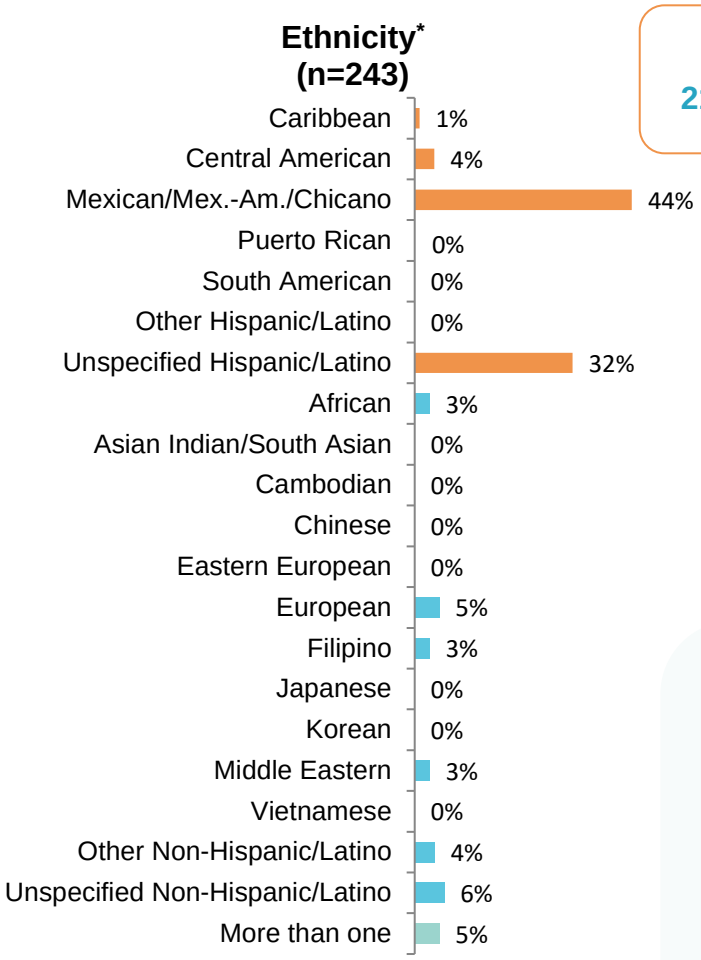
"[I learned ways to] be more open minded and try to control yourself when there is a problem at home and resolve it in the best way possible without hurting your children."

PARENT EDUCATION PROGRAM

Demographic Data

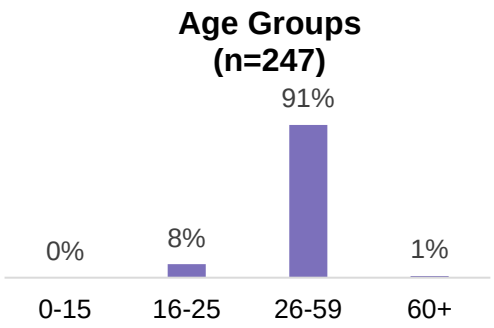


Other includes Hispanic, Mexican, and Latina. 112 individuals did not answer this question, including 58 who selected "decline to answer."



Other includes South American, Eastern European, and Chinese.
7 individuals did not answer this question, including 2 who selected "decline to answer."

80% Hispanic/Latino*
21% Non-Hispanic/Latino*



3 individuals did not answer this question.

Primary Language
(n=249)

English	43%
Spanish	49%
English & Spanish	5%
Other	3%

Other languages include Triqui and Mixteco.
1 individual did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

PARENT EDUCATION PROGRAM

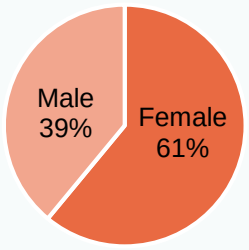
Demographic Data

Current Gender Identity* (n=243)

Female	61%
Male	39%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

7 individuals did not answer this question; none selected "decline to answer."

Sex Assigned at Birth (n=242)



8 individuals did not answer this question; none selected "decline to answer."

Sexual Orientation (n=202)

Bisexual	0%
Gay or Lesbian	1%
Heterosexual or Straight	96%
Queer	1%
Questioning or Unsure	1%
Another Sexual Orientation	1%

48 individuals did not answer this question, including 19 who selected "decline to answer."

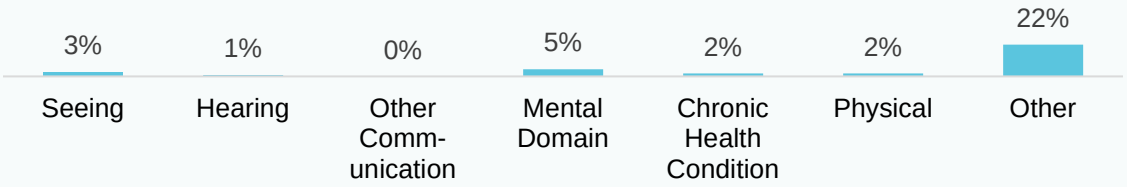
17% of individuals are veterans

n=241. 9 individuals did not answer this question.

30% of individuals reported having one or more disabilities

n=243. 7 individuals did not answer this question.

Disability* (n=243)



Other includes Depression, ADHD, Bi-polar Disorder, Diabetes, Substance Use, and Communication disorder.
7 individuals did not answer this question.

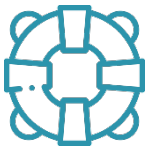
* Percentages may exceed 100% because participants could choose more than one response option.

SENIOR COMPANION PROGRAM
SENIORS COUNCIL OF SANTA CRUZ & SAN BENITO COUNTIES

Senior Companion Program recruits, trains, and places Senior Companions to assist in maintaining independent living and quality of life for older adults who are homebound, live alone, have chronic disabilities, have mental health issues, are visually or hearing impaired, or whose caregivers need respite. The goal of the program is to ease loneliness and social isolation for homebound seniors.

Program Highlights

13 individuals served



8 of 8 of respondents said they **felt more connected** to other people and **knew where to go for local mental health services** after participating in this program.

Program Outcomes

Because of this program… (n=8)	# Agree	# Neutral	# Disagree
I feel more connected to other people.	8	0	0
I know where to go for mental health services near me.	8	0	0
I know when to ask for help with an emotional problem.	7	1	0
I am able to deal with problems better.	5	3	0
I feel less stress or pressure in my life.	5	3	0
I feel better about myself.	5	3	0
When I think about the future, I feel good.	5	3	0

SENIOR COMPANION PROGRAM

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=8)	# Agree	# Neutral	# Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	8	0	0
The program had services in the language that I speak best.	7	1	0
I got services that were right for me.	8	0	0
I am happy with the services I received.	8	0	0
I would recommend this program to a friend or family member.	8	0	0

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=7)

- Having someone to talk to and emotional support (3)
- Support for medical needs (2)
- Learning emotional and social skills (2)

What are your recommendations for improvement? (n=6)

- General positive feedback (e.g., “I really like it, I hope nothing changes.”) (6)

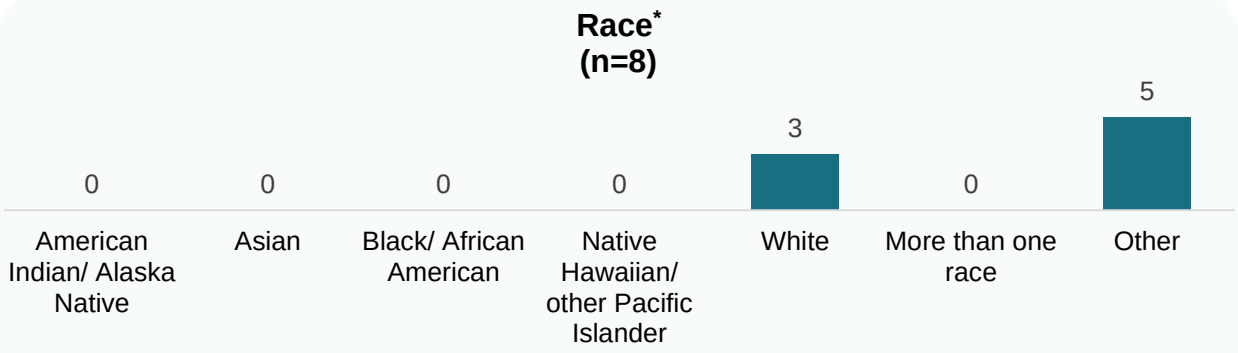
"I feel more accompanied and happy."

"I get to get out of the house and talk, and I can go to other places when I could not before and I get to talk to someone."

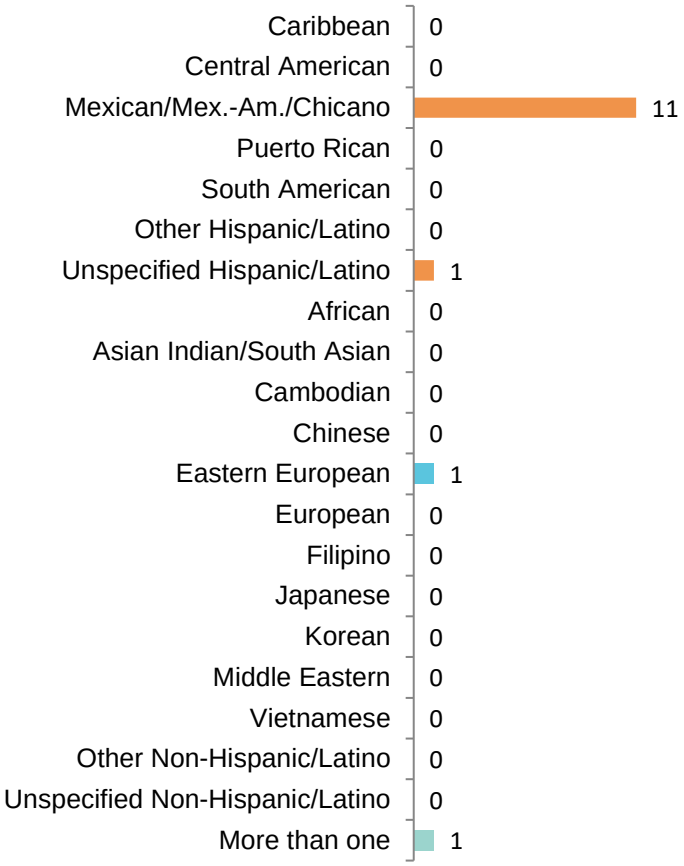
"I have learned to live together with everyone thanks to the program."

SENIOR COMPANION PROGRAM

Demographic Data

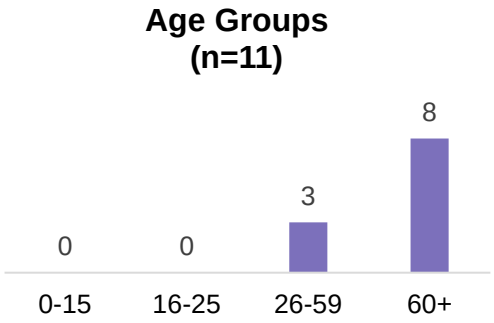


Other includes Hispanic and Mexican.
5 individuals did not answer this question, including 4 who selected "decline to answer."



1 individual did not answer this question, including 1 who selected "decline to answer."

12 Hispanic/Latino
1 Non-Hispanic/Latino



2 individuals did not answer this question.

Primary Language
(n=13)

English	2
Spanish	8
English & Spanish	3

* Counts may exceed number of individuals because participants could choose more than one response option.

SENIOR COMPANION PROGRAM

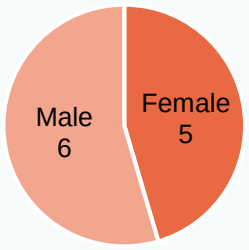
Demographic Data

Current Gender Identity (n=11)

Female	5
Male	6
Transgender	0
Genderqueer	0
Questioning or Unsure	0
Another Gender Identity	0

2 individuals did not answer this question; none selected "decline to answer."

Sex Assigned at Birth (n=11)



2 individuals did not answer this question; none selected "decline to answer."

Sexual Orientation (n=7)

Bisexual	0
Gay or Lesbian	0
Heterosexual or Straight	7
Queer	0
Questioning or Unsure	0
Another Sexual Orientation	0

6 individuals did not answer this question, including 5 who selected "decline to answer."

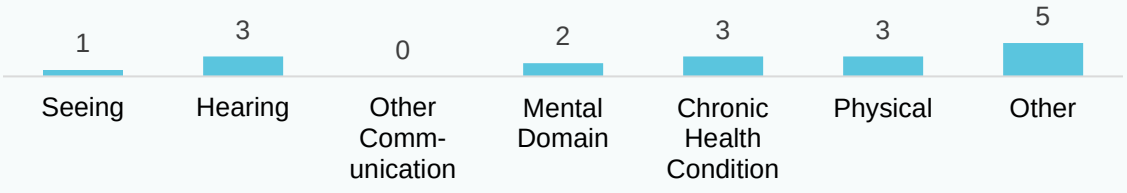
None identify as veterans

n=11; 2 individuals did not answer this question.

13 individuals reported having one or more disabilities

n=13

Disability* (n=13)



Other includes Bipolar and Schizophrenia.

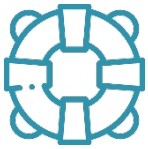
* Counts may exceed number of individuals because participants could choose more than one response option.

SENIOR PEER COUNSELING ALLIANCE ON AGING

The Alliance on Aging provides two primary programs to seniors age 55 and older in Monterey County, which include the Senior Peer Counseling Program (SPC) and Fortaleciendo el Bienestar. SPC offers Peer to Peer Counseling and support groups provided by trained volunteers and individual therapy provided by a bilingual licensed mental health professional. Fortaleciendo el Bienestar provides a series of Wellness seminars which serve the Latino community of elders. These components are attuned to address the diversity of older adults in our community who are experiencing challenges that accompany aging, such as depression and anxiety, the death of a spouse, the stress of an illness, isolation from family or friends, and other life transitions.

Program Highlights

434 individuals served



93% of respondents said they were **more aware of when to ask for help** with an emotional problem.

Program Outcomes

Because of this program... (n=154-158)	% Agree	% Neutral	% Disagree
I feel more connected to other people.	88%	11%	1%
I know where to go for mental health services near me.	88%	6%	6%
I know when to ask for help with an emotional problem.	93%	6%	1%
I am able to deal with problems better.	83%	14%	3%
I feel less stress or pressure in my life.	73%	21%	6%
I feel better about myself.	81%	17%	2%
When I think about the future, I feel good.	70%	23%	7%

SENIOR PEER COUNSELING

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=152-170)	% Agree	% Neutral	% Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	96%	3%	1%
The program had services in the language that I speak best.	97%	2%	1%
I got services that were right for me.	96%	3%	1%
I am happy with the services I received.	99%	1%	0%
I would recommend this program to a friend or family member.	100%	0%	0%

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=143)

- Building connections with others (54)
- Gaining knowledge and skills (32)
- Having someone to talk to (31)
- Emotional support (12)
- Knowing who to ask for help (10)

What are your recommendations for improvement? (n=122)

- Promote the program more and increase number of participants (16)
- Host classes at a better time (6)
- Facilitate classes more often and in more locations (7)
- General positive feedback (e.g., “It is already great!” (68)

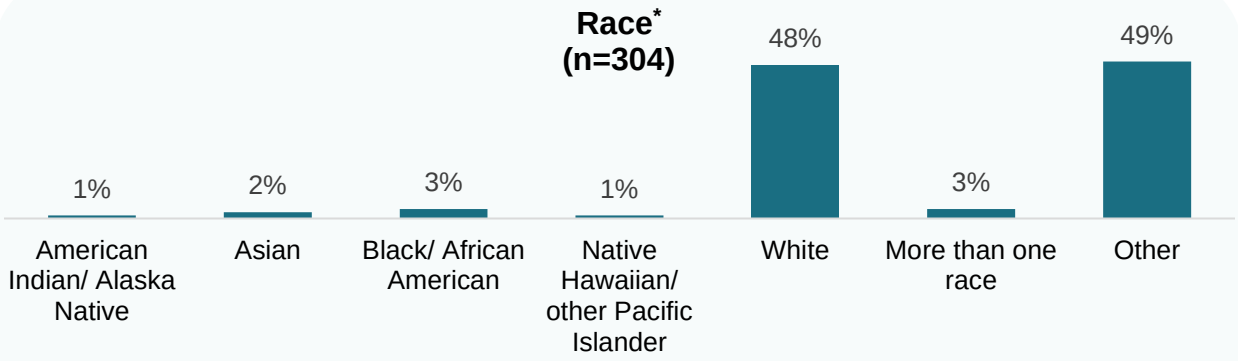
"The feeling of being able to express my thoughts and ongoing issues in my life."

"Having the Senior Peer Counselor come weekly which provides me with emotional support and stability."

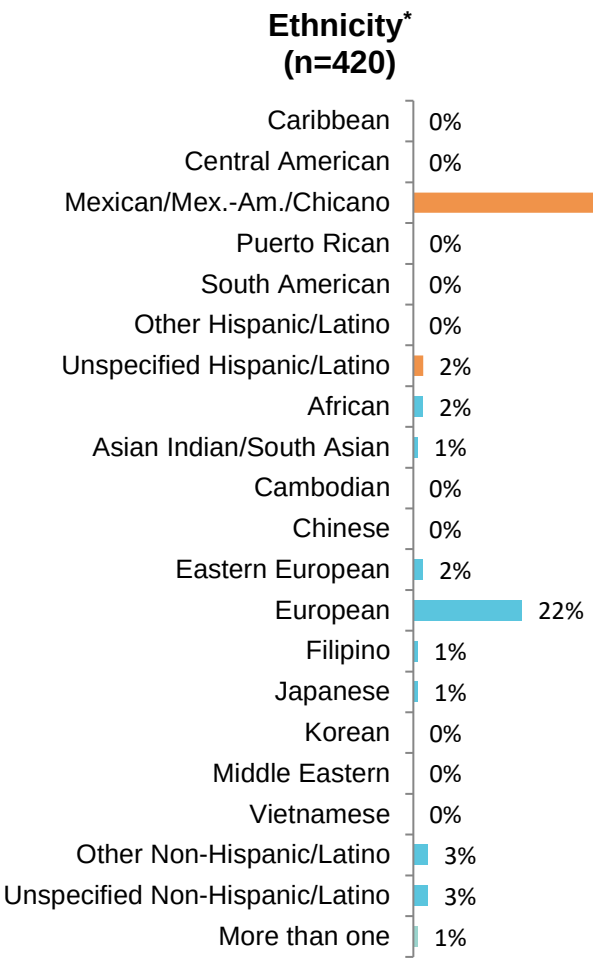
" I was very depressed because my wife died…I felt lost. I have claimed my life again and I don't feel so alone."

SENIOR PEER COUNSELING

Demographic Data

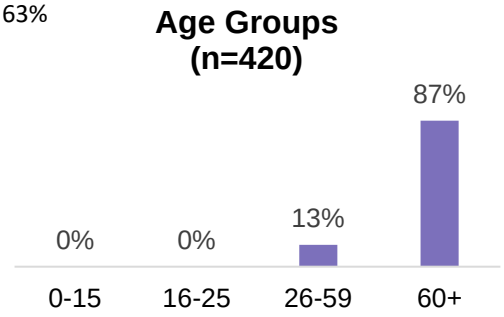


Other includes Mexican, Latino, and Middle Eastern.
130 individuals did not answer this question, including 30 who selected "decline to answer."



Other ethnicities were not specified. 14 individuals did not answer this question, including 2 who selected "decline to answer."

65% Hispanic/Latino
35% Non-Hispanic/Latino



14 individuals did not answer this question.

Primary Language (n=428)

English	36%
Spanish	58%
English & Spanish	6%
Other	1%

Other includes Tagalog, Italian, and Russian.
6 individuals did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

SENIOR PEER COUNSELING

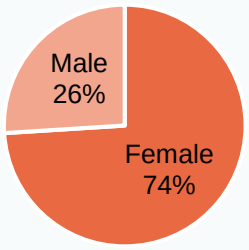
Demographic Data

Current Gender Identity (n=401)

Female	74%
Male	24%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	2%
Another Gender Identity	0%

33 individuals did not answer this question, including 8 who selected "decline to answer."

Sex Assigned at Birth (n=289)



145 individuals did not answer this question, including 85 who selected "decline to answer."

Sexual Orientation (n=224)

Bisexual	0%
Gay or Lesbian	1%
Heterosexual or Straight	94%
Queer	0%
Questioning or Unsure	5%
Another Sexual Orientation	0%

210 individuals did not answer this question, including 137 who selected "decline to answer."

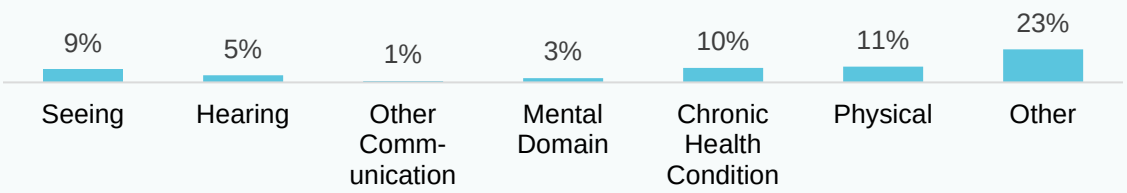
4% of individuals are veterans

n=412; 22 individuals did not answer this question.

51% of individuals reported having one or more disabilities

n=350; 84 individuals did not answer this question.

Disability* (n=350)



Other includes stroke, anxiety, bipolar, and diabetes.
84 individuals did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

EARLY INTERVENTION

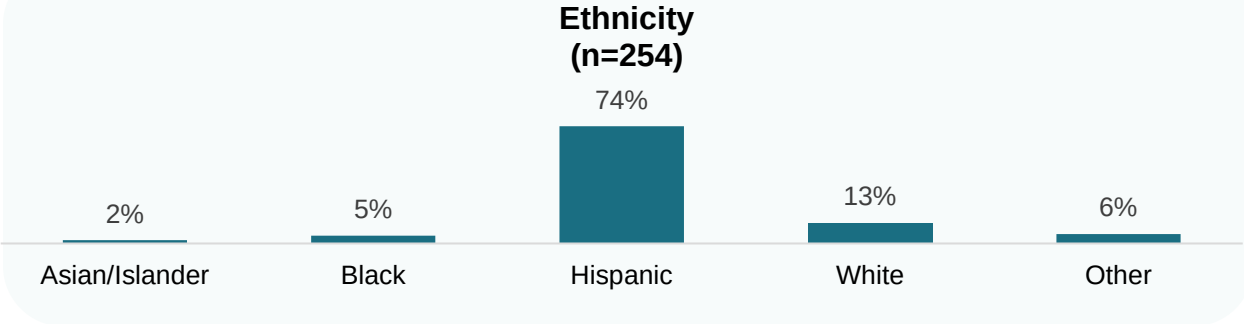
ARCHER CHILD ADVOCACY CENTER
MONTEREY COUNTY BEHAVIORAL HEALTH

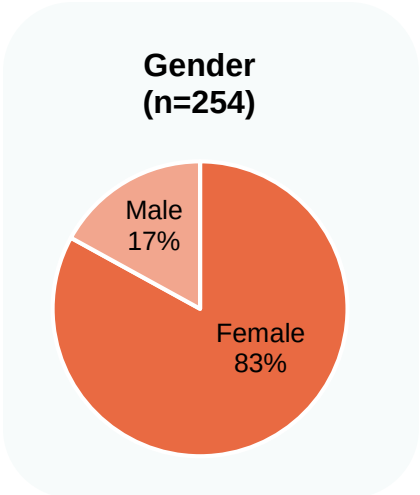
The Archer Child Advocacy Center is a Responsive Crisis Intervention program sponsored by MCBH to serve children with allegations of sexual exploitation, abuse, and/or neglect. The center provides mental health risk and treatment needs assessment, crisis stabilization, psychoeducation, mental health treatment, and linkage to other mental health services. Additionally, it serves as a child-friendly location for forensic interviews and offers crisis support services to the family/caregiver of the child. The Responsive Crisis Intervention program is a cluster of programs that offer trauma counseling, education, referrals, and crisis response team services.

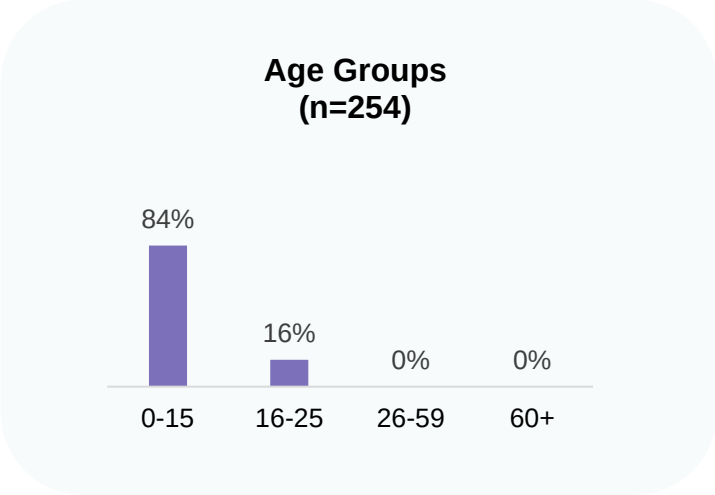
Program Highlights*

254 individuals served

Demographic Data†







* Only demographic information was collected for this program; outcome data was not collected.

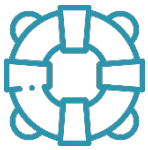
† Demographic data presented for this program was collected from Avatar. The number of individuals who skipped each question was not provided.

FAMILY SUPPORT GROUPS
MONTEREY COUNTY BEHAVIORAL HEALTH

Family Support Groups are sponsored by MCBH's Adult System of Care to facilitate regional support groups for family members of individuals living with mental illness. Psychoeducation, resources, and an opportunity for peer-sharing is provided during the support groups. There are four locations in Monterey County: Marina, Salinas, Soledad, and King City.

Program Highlights

28 individuals served



17 of 17 of respondents said they **cared more about the things happening in their life** after participating in this program.

Program Outcomes

Because of this program... (n=17-18)	# Agree	# Neutral	# Disagree
I feel more connected to other people.	14	3	0
I know where to go for mental health services near me.	18	0	0
I know when to ask for help with an emotional problem.	18	0	0
I am able to deal with problems better.	17	1	0
I feel less stress or pressure in my life.	13	3	1
I feel better about myself.	12	5	0
When I think about the future, I feel good.	14	4	0
I feel less worried or afraid.	15	1	1
I feel I have more energy during the day.	14	3	0
I care more about the things that are happening in my life.	17	0	0

FAMILY SUPPORT GROUPS

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=16-18)	# Agree	# Neutral	# Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	17	0	0
The program had services in the language that I speak best.	18	0	0
I got services that were right for me.	17	0	0
I am happy with the services I received.	16	0	0
I would recommend this program to a friend or family member.	17	0	0

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=14)

- Learning how to support self or others (5)
- Connection to local services or resources (5)
- Social support (4)

What are your recommendations for improvement? (n=11)

- More guest speakers (3)
- Host classes later in day (2)
- Increase community awareness (2)
- General positive feedback (e.g., “It was great”) (3)

The most helpful thing was…

"…talking to other parents who have the same problems."

"…learning more about what mental health means."

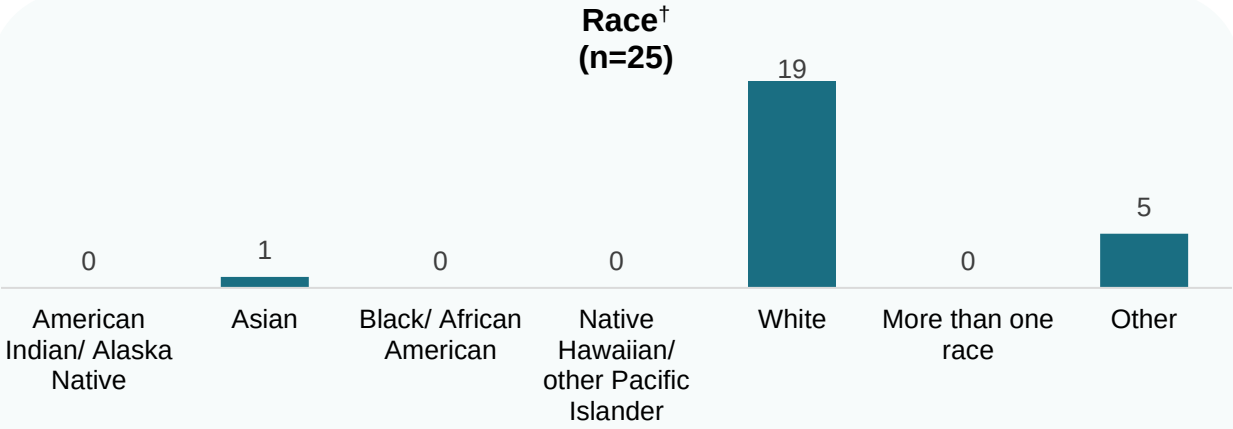
"…group problem solving, identifying county resources, understanding services BHS provides."

"The most useful thing I learned was how to help my son so that he doesn't hurt himself."

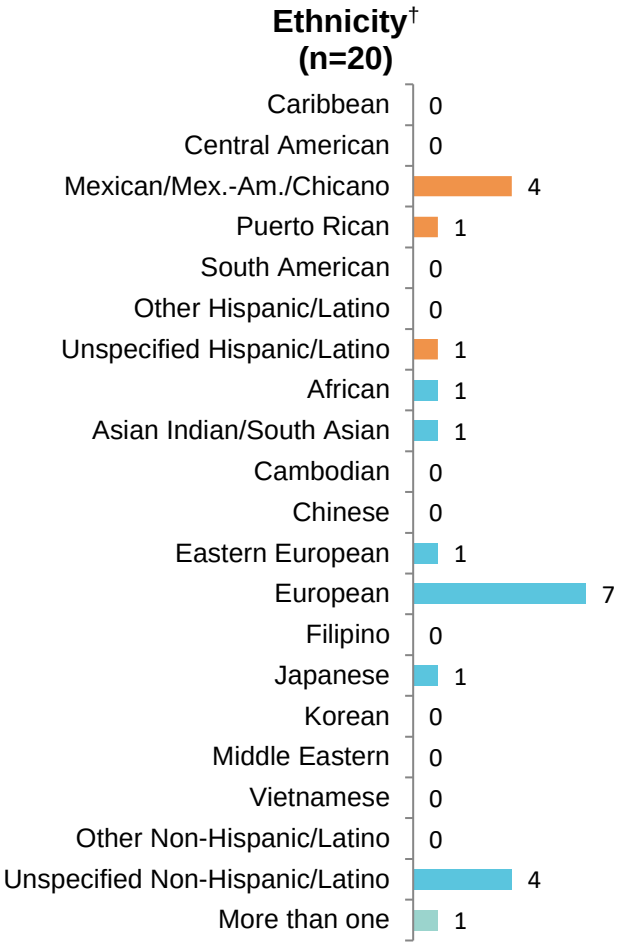
"They helped us with our doubts and gave us a lot of information about the health of our loved ones and how to help them."

FAMILY SUPPORT GROUPS

Demographic Data*

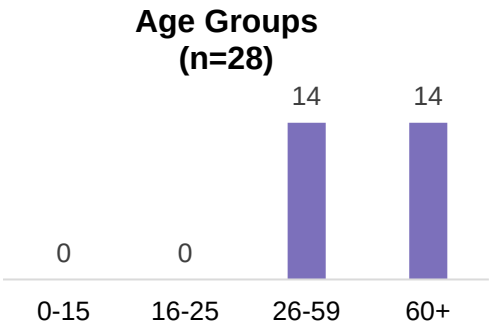


Other includes Hispanic. 3 individuals did not answer this question; none selected "decline to answer."



Other ethnicities were not specified.
6 individuals did not answer this question; none selected "decline to answer."

6 Hispanic/Latino†
14 Non-Hispanic/Latino†



Primary Language (n=28)

English	22
Spanish	4
English & Spanish	0
Other	2

Other languages are not listed to protect identifying information.

* 2 responses were from Presentation Forms and their data are included for Race, Age, and Primary Language.
† Counts may exceed the number of individuals because participants could choose more than one response option.

FAMILY SUPPORT GROUPS

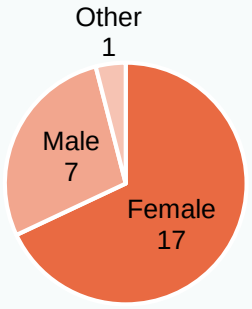
Demographic Data

Current Gender Identity (n=25)

Female	18
Male	6
Transgender	1
Genderqueer	0
Questioning or Unsure	0
Another Gender Identity	0

1 individual did not answer this question; none selected "decline to answer."

Sex Assigned at Birth (n=25)



1 individual did not answer this question; none selected "decline to answer."

Sexual Orientation (n=20)

Bisexual	2
Gay or Lesbian	0
Heterosexual or Straight	18
Queer	0
Questioning or Unsure	0
Another Sexual Orientation	0

6 individuals did not answer this question, including 3 who selected "decline to answer."

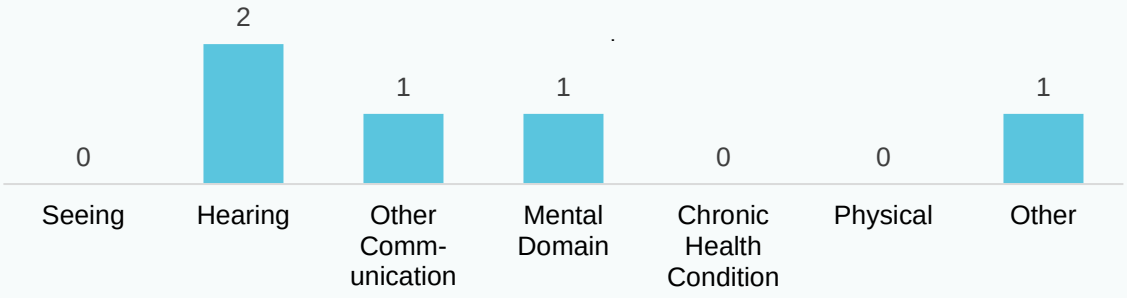
1 individual is a veteran

n=25; 1 individual did not answer this question.

5 individuals reported having one or more disabilities

n=25; 1 individual did not answer this question.

Disability* (n=25)



Other includes Depression. 1 individual did not answer this question.

* Counts may exceed number of individuals because participants could choose more than one response option.

FELTON EARLY PSYCHOSIS
FELTON INSTITUTE

Felton Early Psychosis is a program sponsored by the Felton Institute to provide treatment and management of early psychosis with evidence-based, culturally competent assessment and diagnosis. The mission of Felton Early Psychosis is to deliver comprehensive, conscientious and multi-faceted treatment grounded in wellness, recovery, and resilience to people experiencing signs and symptoms of psychosis, as well as their families. The Felton Early Psychosis program serves people ages 14-35 demonstrating symptoms and functional impairments related to early psychosis and/or diagnosis of schizophrenia or schizoaffective disorder.

Program Highlights

55 individuals served

95% of respondents said they got the services that were right for them.

Program Outcomes

Because of this program… (n=64-67)	% Agree	% Neutral	% Disagree
I feel more connected to other people.	64%	33%	3%
I know where to go for mental health services near me.	86%	12%	2%
I know when to ask for help with an emotional problem.	90%	8%	2%
I am able to deal with problems better.	85%	15%	0%
I feel less stress or pressure in my life.	70%	27%	3%
I feel better about myself.	82%	15%	3%
When I think about the future, I feel good.	80%	20%	0%
I feel less worried or afraid.	70%	28%	2%
I feel I have more energy during the day.	62%	35%	3%
I care more about the things that are happening in my life.	82%	18%	0%

FELTON EARLY PSYCHOSIS

Program Outcomes

Short-term performance goals for clients who were enrolled in treatment for at least 12 months were achieved in the following domains:

Well-Being
70% demonstrated improvements in family and social functioning, spiritual/religious and community connection, and optimism/hopefulness**.**

Symptoms
78% demonstrated improvements in psychosis, depression, anxiety, substance use, and/or adjustments to trauma.

Functioning
74% demonstrated improvements in residential stability, criminal behavior, acculturation stress, education, employment, and/or living skills.

Family Engagement
81% of clients had at least one family member engage in at least one session of either multi-family groups, case management, or family support and psychoeducation.

Reduced Hospitalizations
90% of clients who had at least one hospitalization episode within 1 year prior to treatment had a reduction in the number of hospitalization episodes.

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=64-67)	% Agree	% Neutral	% Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	82%	16%	2%
The program had services in the language that I speak best.	97%	3%	0%
I got services that were right for me.	95%	5%	0%
I am happy with the services I received.	92%	5%	3%
I would recommend this program to a friend or family member.	90%	8%	2%

FELTON EARLY PSYCHOSIS

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=62)

- Positive feedback about staff (e.g., caring, helpful, responsive) (20)
- Medical attention, therapy, and medication (15)
- Having someone to talk to and connecting with others (13)
- Feeling supported (5)

What are your recommendations for improvement? (n=51)

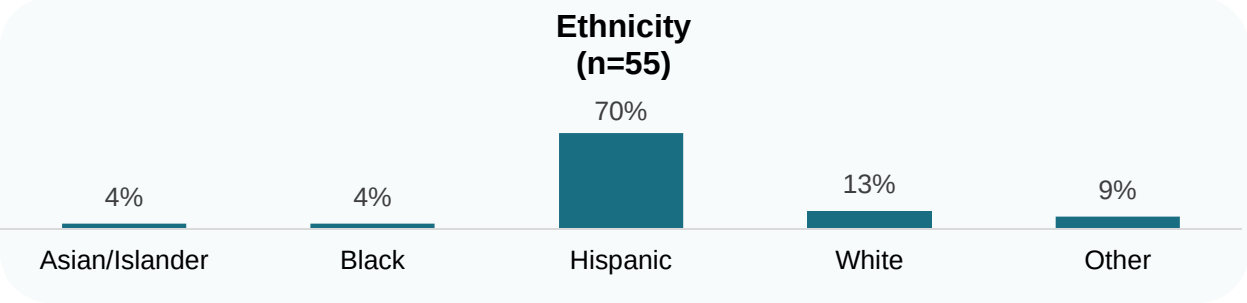
- Expand program (e.g., more accessible locations) (4)
- More group activities (3)
- More snacks (3)
- No recommendations, general positive feedback (e.g., "It's great just the way it is") (40)

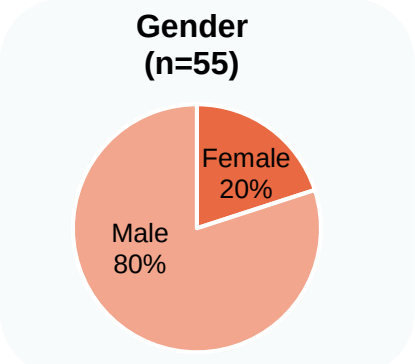
"Everyone here [is] always helping me with anything I need for my mental health"

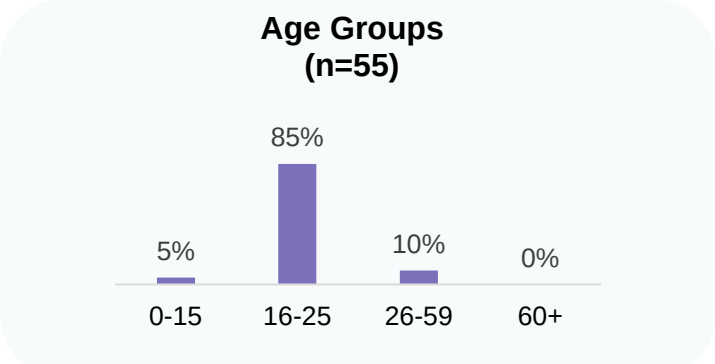
"The staff were really supportive and caring. They are fun to talk to and very helpful."

"Getting to talk to someone about what happened [was helpful]."

Demographic Data*







* Demographic data presented for this program was collected from Avatar. Other ethnicities listed, if any, and the number of individuals who skipped each question were not provided.

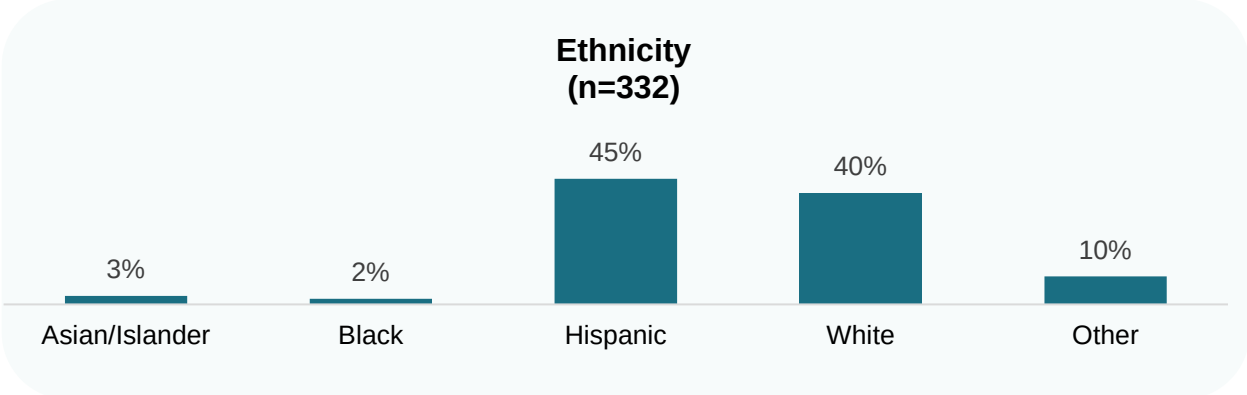
MOBILE CRISIS TEAM
MONTEREY COUNTY BEHAVIORAL HEALTH

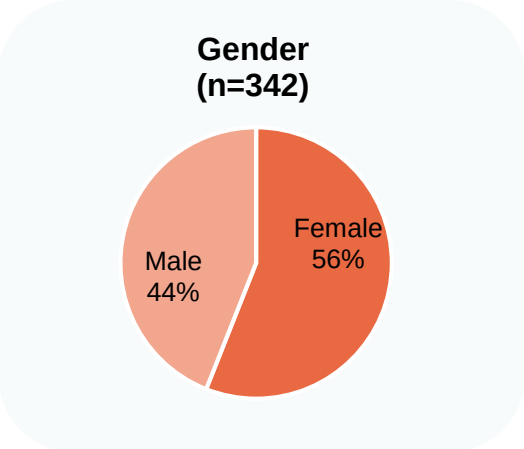
MCBH Mobile Crisis Team is a Responsive Intervention Program designed to partner with and support local law enforcement in responding to individuals in crisis. Dispatching law enforcement may request Mobile Crisis Team staff using county communications. Staff assist in identifying signs of psychiatric distress and work to avoid unnecessary hospitalizations by collaborating with law enforcement to de-escalate and stabilize situations. Additionally, Mobile Crisis Team assists with involuntary hospitalization and liaises with emergency personnel, hospitals, schools and jails to provide continuity of care. Mobile Crisis Team also offers linkage to outpatient services, and outreach and engagement services in the community. Mobile Crisis services were originally created to address needs in the adult population and under PEI the focus has increased to serve more children and youth.

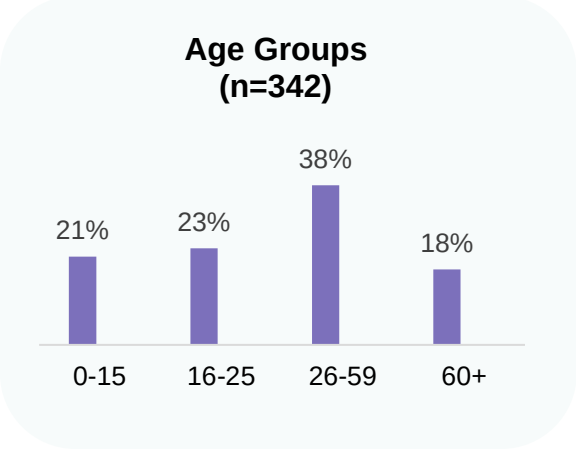
Program Highlights*

342 individuals served

Demographic Data†







* Only demographic information was collected for this program; outcomes data was not collected.

† Demographic data presented for this program was collected from Avatar. Other ethnicities listed, if any, and the number of individuals who skipped each question were not provided.

OMNI RESOURCE CENTER INTERIM, INC.

OMNI Resource Center (OMNI) is a program sponsored by Interim, Inc. to provide a neighborhood-based wellness center where community members can access resources and social support in non-stigmatizing settings. OMNI's mission is to increase mental health and wellness through wellness awareness and innovative programs. It is open to all adults, with special programs for Transition Age Youth (16-25) and Young Adults (25-30). OMNI offers peer-led programs to promote wellness and mental health recovery and hosts recreational and social opportunities. It assists community members to pursue personal and social growth through self-help, socialization, and peer support groups.

Program Highlights

482 individuals served

88% of participants would recommend this program to a friend or a family member.

Program Outcomes

Because of this program… (n=251-258)	% Agree	% Neutral	% Disagree
I feel more connected to other people.	75%	20%	5%
I know where to go for mental health services near me.	81%	14%	5%
I know when to ask for help with an emotional problem.	80%	16%	4%
I am able to deal with problems better.	76%	18%	6%
I feel less stress or pressure in my life.	66%	24%	10%
I feel better about myself.	80%	14%	6%
When I think about the future, I feel good.	67%	24%	9%
I feel less worried or afraid.	63%	27%	10%
I feel I have more energy during the day.	65%	22%	13%
I care more about the things that are happening in my life.	72%	22%	6%

Workshop Topics

• **Stigma Reduction** • **Nutrition** • **Diversity** • **Employment**

OMNI RESOURCE CENTER

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=257-258)	% Agree	% Neutral	% Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	77%	19%	4%
The program had services in the language that I speak best.	90%	8%	2%
I got services that were right for me.	78%	17%	5%
I am happy with the services I received.	84%	14%	2%
I would recommend this program to a friend or family member.	88%	9%	3%

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=231)

- Sense of community or social support (108)
- Programs and activities including groups, discussions, and guest speakers (96)
- Staff were caring, understanding, or helpful (83)
- The facility, including meals and safety (78)

What are your recommendations for improvement? (n=202)

- More services, activities, groups, speakers, and educational events (51)
- Bigger facility, increased hours, and additional staff (23)
- General positive feedback (e.g., “it was great”) (87)

“Great community feeling. Also, the groups help me interact more.”

"I feel so much like I finally have family. I'm no longer alone. I love the socializing and the groups/meals."

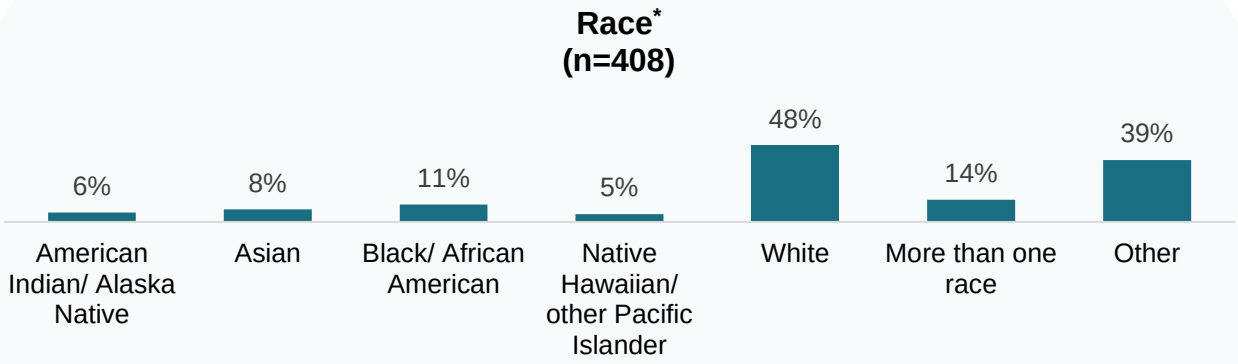
"Being around other people and not being judged for what I say and for who I am."

“[The most helpful thing about this program was] [a]ttending the groups, being able to speak freely + confidently, learning that many people have their issues with depression or addictions.”

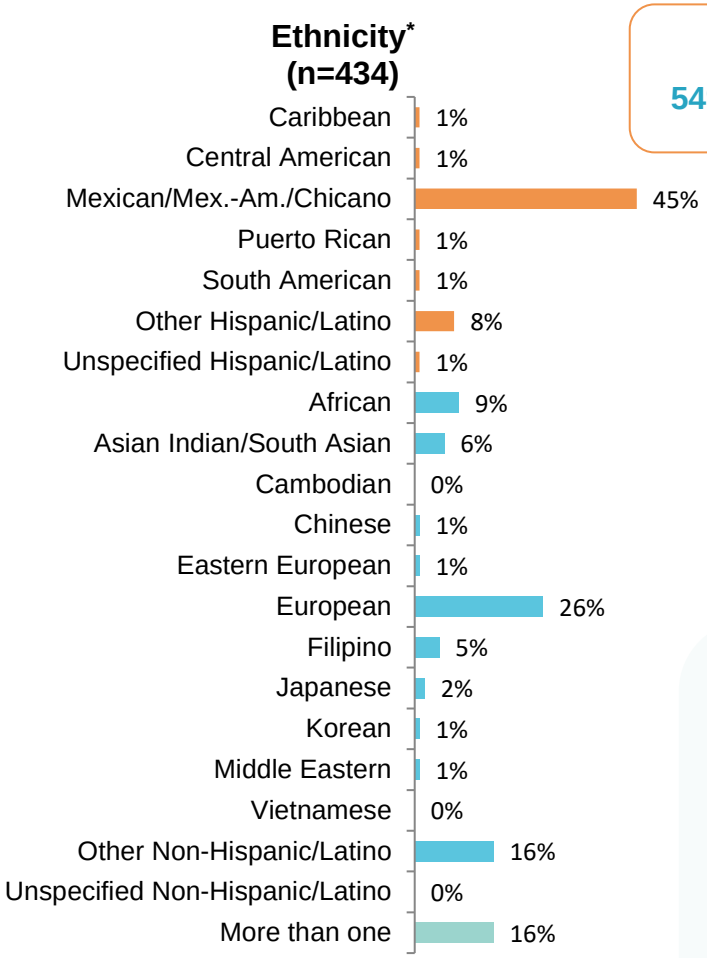
"OMNI has helped me understand what resources are available to me...[and] makes me feel happier.”

OMNI RESOURCE CENTER

Demographic Data

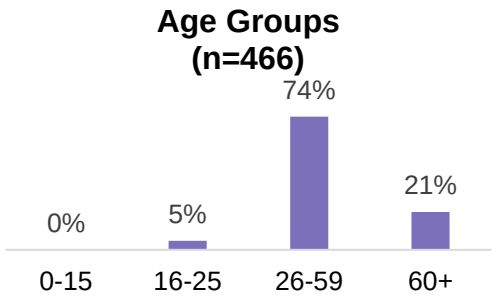


Other races are not listed not listed to protect identifying information. 74 individuals did not answer this question, including 72 who selected "decline to answer."



Other ethnicities are not listed to protect identifying information. 48 individuals did not answer this question, including 45 who selected "decline to answer."

54% Hispanic/Latino*
54% Non-Hispanic/Latino*



16 individuals did not answer this question.

Primary Language
(n=482)

English	89%
Spanish	11%
English & Spanish	0%
Other	1%

Other languages were not specified.

* Percentages may exceed 100% because participants could choose more than one response option.

OMNI RESOURCE CENTER

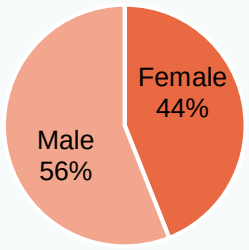
Demographic Data

Current Gender Identity (n=368)

Female	45%
Male	53%
Transgender	1%
Genderqueer	1%
Questioning or Unsure	0%
Another Gender Identity	0%

114 individuals did not answer this question; none selected "decline to answer."

Sex Assigned at Birth (n=479)



3 individuals did not answer this question, including 1 who selected "decline to answer."

Sexual Orientation (n=309)

Bisexual	5%
Gay or Lesbian	5%
Heterosexual or Straight	88%
Queer	1%
Questioning or Unsure	0%
Another Sexual Orientation	1%

173 individuals did not answer this question, including 42 who selected "decline to answer."

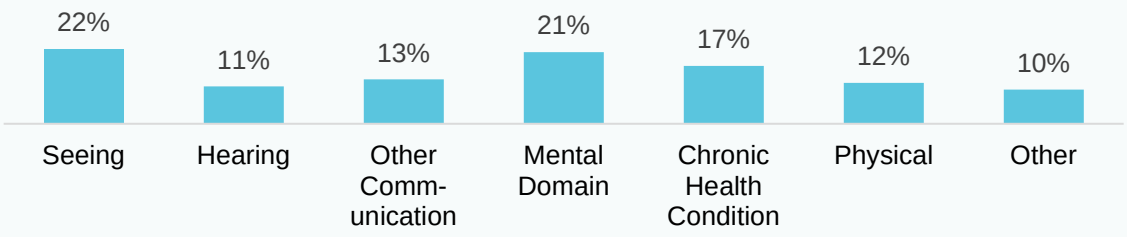
3% of individuals are veterans

n=481; 1 individual did not answer this question.

51% of individuals reported having one or more disabilities

n=481; 1 individual did not answer this question.

Disability* (n=481)



Other includes Autism, Depression, Epilepsy, and Learning Disabilities. 1 individual did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

SCHOOL-BASED COUNSELING
PAJARO VALLEY PREVENTION AND STUDENT ASSISTANCE

School-Based Counseling is a program sponsored by Pajaro Valley Prevention and Student Assistance to provide mental health services to children and their families in schools located in Northern Monterey County in the Pajaro/Las Lomas area. The program addresses a broad range of mental health needs and aims to help children develop coping skills and improve academic performance.

Program Highlights

121 individuals served

100% of respondents said they were **happy with the services they received** in this program.

Program Outcomes

Because of this program… (n=11-12)	# Agree	# Neutral	# Disagree
I feel more connected to other people.	8	4	0
I know where to go for mental health services near me.	11	1	0
I know when to ask for help with an emotional problem.	10	2	0
I am able to deal with problems better.	9	2	0
I feel less stress or pressure in my life.	9	1	1
I feel better about myself.	11	1	0
When I think about the future, I feel good.	8	4	0
I feel less worried or afraid.	10	1	1
I feel I have more energy during the day.	7	4	0
I care more about the things that are happening in my life.	11	0	1

SCHOOL-BASED COUNSELING

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=11-12)	# Agree	# Neutral	# Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	7	4	1
The program had services in the language that I speak best.	11	1	0
I got services that were right for me.	11	1	0
I am happy with the services I received.	11	0	0
I would recommend this program to a friend or family member.	12	0	0

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=10)

- Improved mood, self-esteem, or stress management (3)
- Talking about problems (2)
- Learning new skills (2)

What are your recommendations for improvement? (n=7)

- Continue to offer existing services, including therapy (2)
- Offer a counselor after school (2)
- Not sure (3)

"I get along with my mom."

"I feel better about myself."

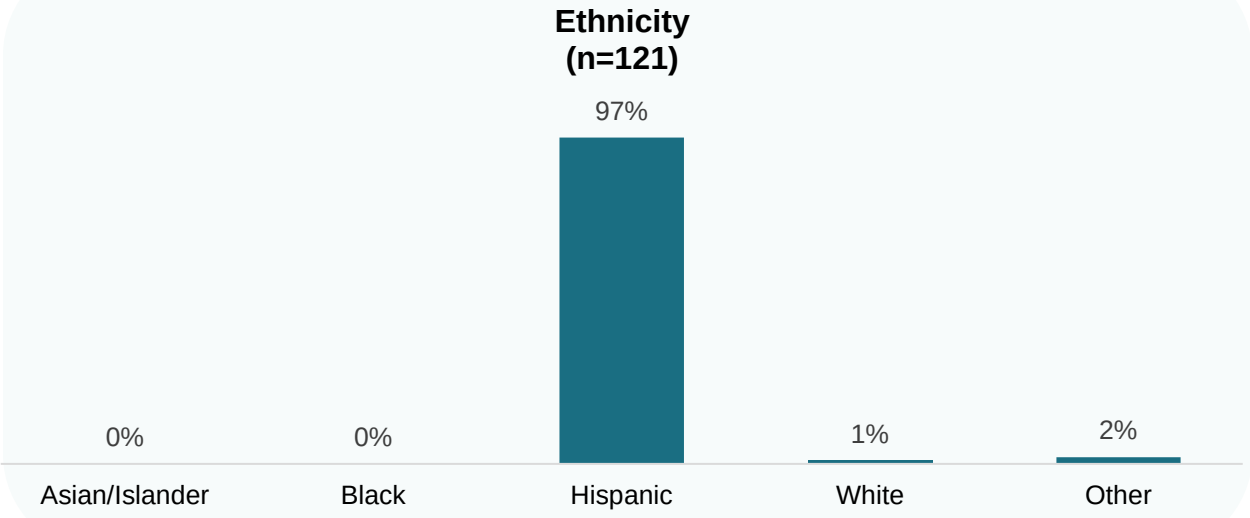
"This program is helpful for talking and venting."

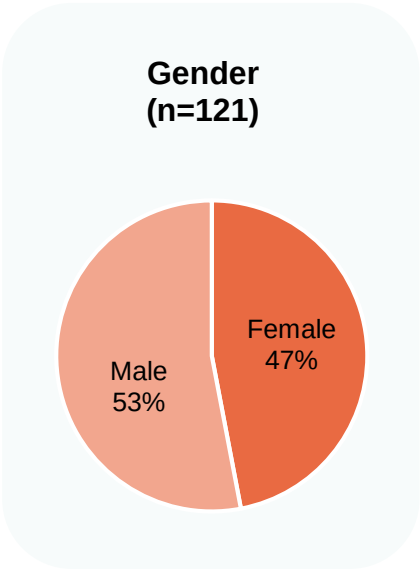
"I feel more connected to my peers."

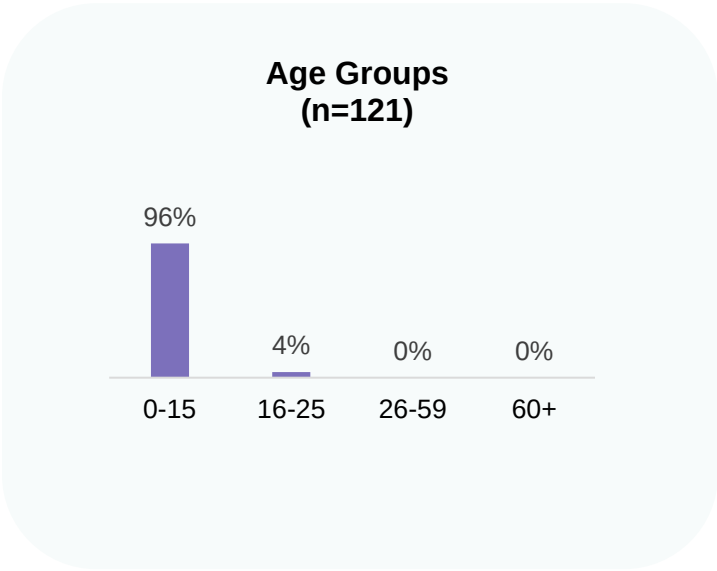
"I've gotten good recommendations for coping skills."

SCHOOL-BASED COUNSELING

Demographic Data*







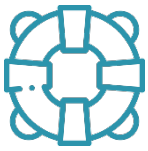
* Demographic data presented for this program was collected from Avatar. Other ethnicities listed, if any, and the number of individuals who skipped each question were not provided.

SCHOOL-BASED DOMESTIC VIOLENCE COUNSELING HARMONY AT HOME

School-Based Domestic Violence Counseling, sponsored by Harmony at Home, provides school-based psychoeducation, individual therapy, and group therapy for children who have been exposed to trauma and are at risk of school failure or juvenile justice involvement. The program also works to support parents and caregivers in meeting their child's academic, social and psychological needs and enhance their conflict resolution skills. In addition, the program outreaches to community groups to promote the program and related services.

Program Highlights

760 individuals served



73% of respondents said they were **more aware of when to ask for help** with an emotional problem after participating in this program.

Program Outcomes

Because of this program… (n=71-77)	% Agree	% Neutral	% Disagree
I feel more connected to other people.	43%	**47%**	10%
I know where to go for mental health services near me.	**55%**	32%	13%
I know when to ask for help with an emotional problem.	**73%**	22%	5%
I am able to deal with problems better.	**58%**	32%	10%
I feel less stress or pressure in my life.	40%	**45%**	15%
I feel better about myself.	**54%**	41%	5%
When I think about the future, I feel good.	41%	**51%**	8%
I feel less worried or afraid.	**43%**	42%	15%
I feel I have more energy during the day.	**44%**	43%	13%
I care more about the things that are happening in my life.	**62%**	34%	4%

SCHOOL-BASED DOMESTIC VIOLENCE COUNSELING

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=76-77)	% Agree	% Neutral	% Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	63%	21%	16%
The program had services in the language that I speak best.	81%	13%	6%
I got services that were right for me.	75%	16%	9%
I am happy with the services I received.	71%	21%	8%
I would recommend this program to a friend or family member.	64%	19%	17%

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=69)

- Talking about problems and self-expression (18)
- Learning to manage emotions (13)
- Getting help with problems (9)
- Being understood or listened to (8)

What are your recommendations for improvement? (n=50)

- More fun activities, especially outdoor activities and field trips (7)
- General positive feedback (e.g., “It was great”) (10)
- None or not sure (24)

"I can express my emotions a lot more."

"I learned how to manage my anger a little better."

"The program helped me deal with my problems and also helped me have more confidence in myself."

“They help us feel good when we are feeling down.”

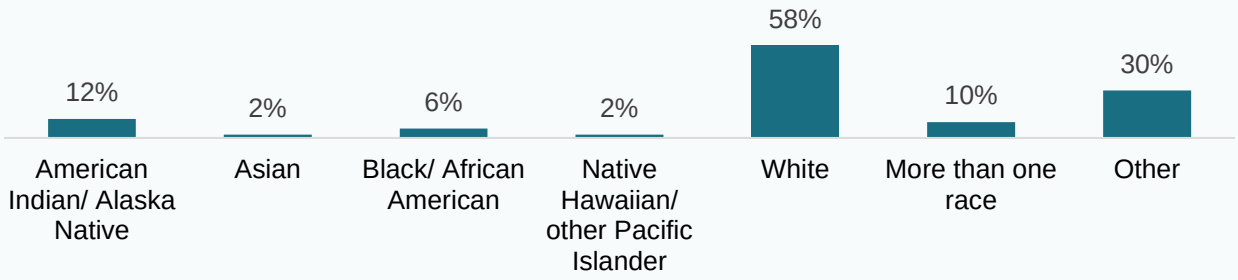
"[The most helpful part was] getting to talk to people about myself and being understood."

“I can talk to a counselor and the counselor won’t tell someone else.”

SCHOOL-BASED DOMESTIC VIOLENCE COUNSELING

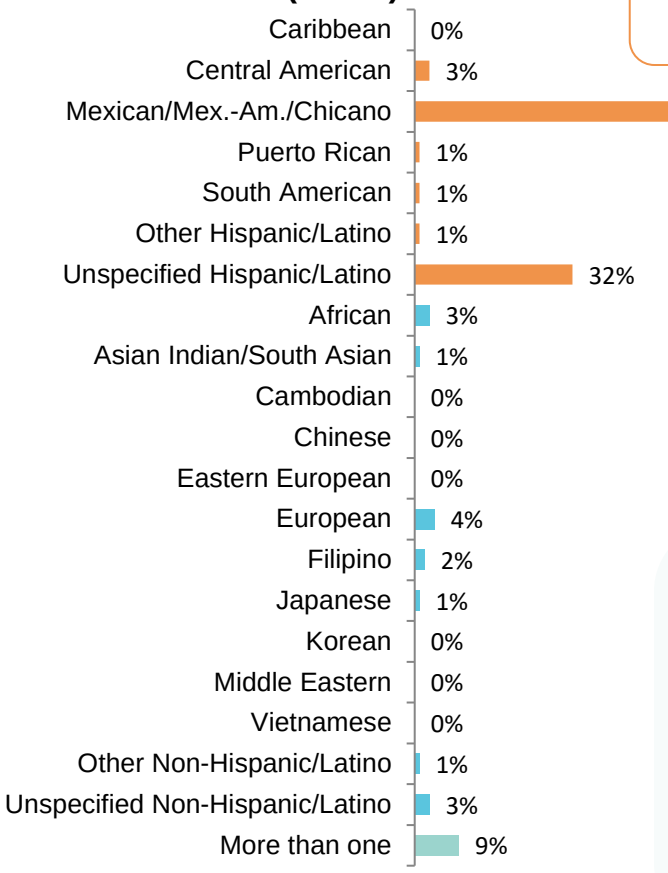
Demographic Data

Race* (n=431)



Other includes Latino/Hispanic and Mexican American.
329 individuals did not answer this question, including 142 who selected "decline to answer."

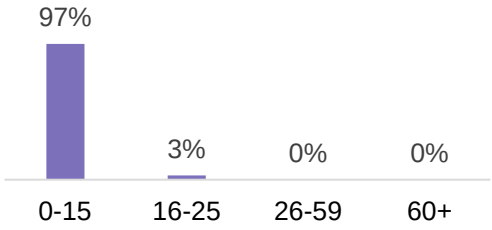
Ethnicity* (n=690)



Other ethnicities are not listed to protect identifying information.
70 individuals did not answer this question, including 37 who selected "decline to answer."

93% Hispanic/Latino*
14% Non-Hispanic/Latino*

Age Groups (n=679)



81 individuals did not answer this question.

Primary Language (n=744)

English	40%
Spanish	36%
English & Spanish	13%
Other	12%

Other includes Mixteco and Zapoteco. 16 individuals did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

SCHOOL-BASED DOMESTIC VIOLENCE COUNSELING

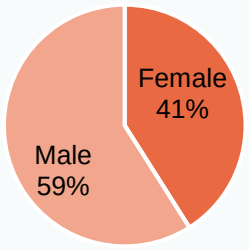
Demographic Data

Current Gender Identity* (n=76)

Female	42%
Male	58%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

1 response was suppressed to protect identifying information.

Sex Assigned at Birth* (n=756)



4 individuals did not answer this question, including 1 who selected "decline to answer."

Sexual Orientation* (n=72)

Bisexual	7%
Gay or Lesbian	0%
Heterosexual or Straight	87%
Queer	0%
Questioning or Unsure	3%
Another Sexual Orientation	3%

4 individuals did not answer this question; all 4 selected "decline to answer." 1 response was suppressed to protect identifying information.

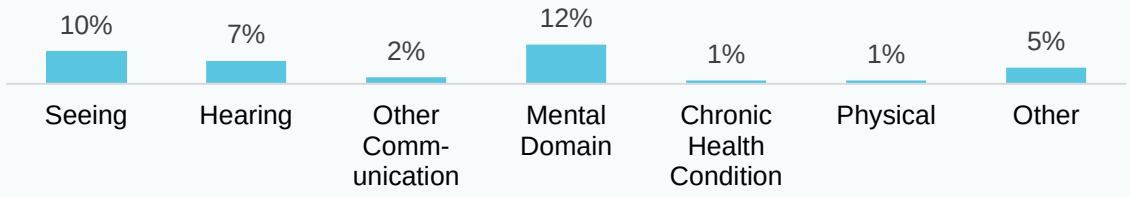
None identified as veterans*

n=77

28% of individuals reported having one or more disabilities

n=729; 31 individuals did not answer this question.

Disability† (n=729)



Other includes Learning, Developmental, ADHD, Asthma, Anxiety, Depression, and Seizures. 31 individuals did not answer this question.

* These questions were not asked of youth ages 12 and under; sex assigned at birth was asked as "is your child a boy or girl?"

† Percentages may exceed 100% because participants could choose more than one response option.

SILVER STAR RESOURCE CENTER
MONTEREY COUNTY BEHAVIORAL HEALTH

Silver Star Resource Center is a multi-agency collaborative of prevention and early intervention services, co-located to make resources easier to access for youth and families. This collaborative includes: MCBH, Monterey County Probation, Monterey County Office of Education, the District Attorney's Office, the Office of Employment Training, and community agencies such as Community Human Services and Partners for Peace. Behavioral Health services focus on youth who are demonstrating early signs of emotional/behavioral issues that are affecting their education, family, and/or social well-being and placing them at risk for involvement with the Juvenile Justice System. The purpose of the program is to identify and treat underlying mental health issues that can lead to more complex problems in youth, including involvement with the legal system.

Program Highlights

91 individuals served

94% of program participants said they were happy with the services they received and that they got the services that were right for them.

Program Outcomes

Because of this program… (n=16-17)	# Agree	# Neutral	# Disagree
I feel more connected to other people.	5	11	1
I know where to go for mental health services near me.	11	6	0
I know when to ask for help with an emotional problem.	12	5	0
I am able to deal with problems better.	10	5	1
I feel less stress or pressure in my life.	9	5	3
I feel better about myself.	8	8	1
When I think about the future, I feel good.	8	7	2
I feel less worried or afraid.	8	8	1
I feel I have more energy during the day.	7	7	3
I care more about the things that are happening in my life.	10	6	1

SILVER STAR RESOURCE CENTER

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=17)	# Agree	# Neutral	# Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	14	2	1
The program had services in the language that I speak best.	17	0	0
I got services that were right for me.	16	1	0
I am happy with the services I received.	16	1	0
I would recommend this program to a friend or family member.	15	2	0

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=16)

- Positive feedback about staff or program (e.g., caring staff, community spirit, feeling supported) (9)
- Talking to someone (6)
- Getting help with problems (4)

What are your recommendations for improvement? (n=16)

- More snack options (2)
- General positive feedback (e.g., “This program is good as it is”) (8)
- Not sure (5)

The most helpful thing about this program is…

"…Getting the help I need and talking about things."

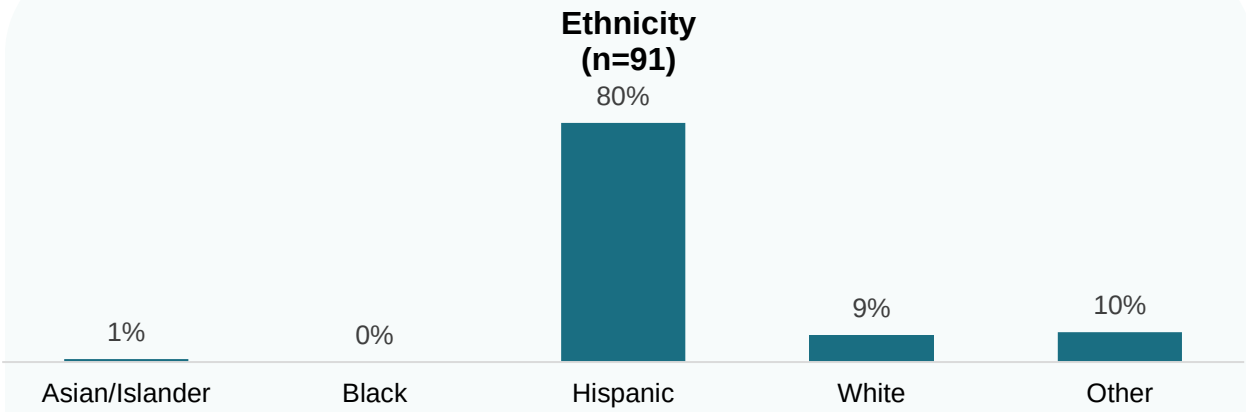
" …Talking to a person that understands you."

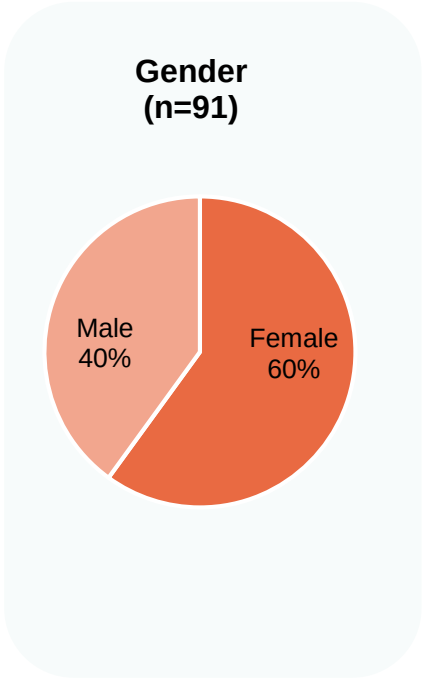
"…Knowing that I can talk to someone about my problems and how I am feeling."

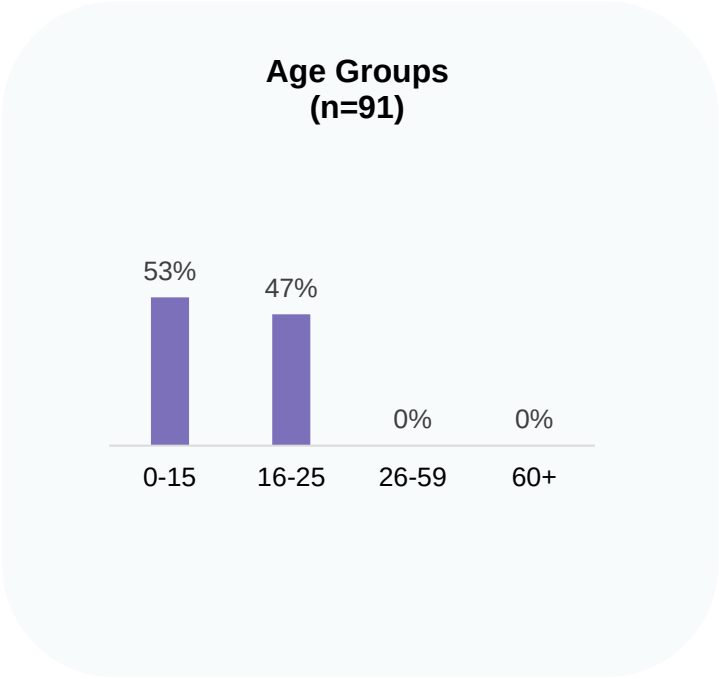
"…That I am able to talk about how I feel and it helps me cope with my problems better."

SILVER STAR RESOURCE CENTER

Demographic Data*







* Demographic data presented for this program was collected from Avatar. Other ethnicities listed, if any, and the number of individuals who skipped each question were not provided.

ACCESS AND LINKAGE TO TREATMENT

2-1-1
UNITED WAY OF MONTEREY COUNTY

2-1-1 is a phone and digital network that connects Monterey County residents in need of assistance to community health and social services. The 2-1-1 network is available 24 hours per day, 7 days per week, in 170 languages.

Program Highlights

9,695 calls completed*

52% were first-time callers

2,247 page views from 2-1-1 searches

Call Categories

Basic Needs • Consumer Services • Criminal Justice and Legal Services • Education
Environment and Public Health/Safety • Health Care • Income Support and Employment
Individual and Family Life • Mental Health and Substance Abuse Services
Organizational/Community/International Services • Target Populations

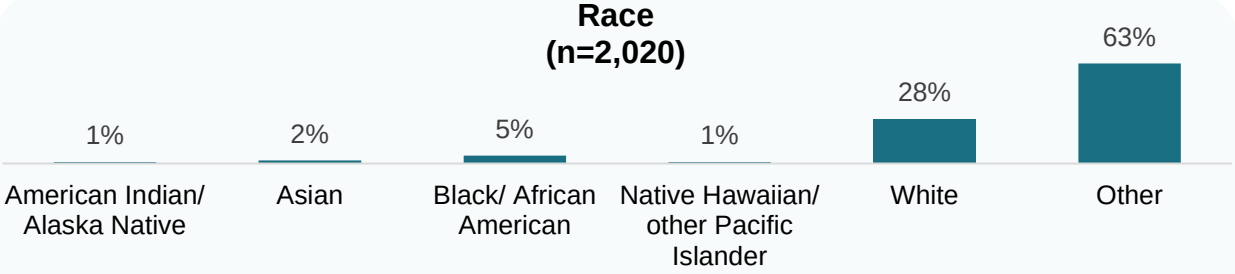
* Number of callers may be duplicated.

2-1-1

Demographic Data

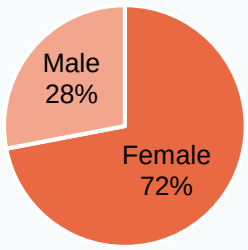
Demographic data presented for this program was collected from 2-1-1 custom reports. Some questions are collected only from first-time callers represent unduplicated data. The number of individuals who did not answer the question or declined to answer is indicated wherever possible. The number of responses may be less than the number of calls received if the call specialist did not retrieve the information from the caller.

Race (n=2,020)



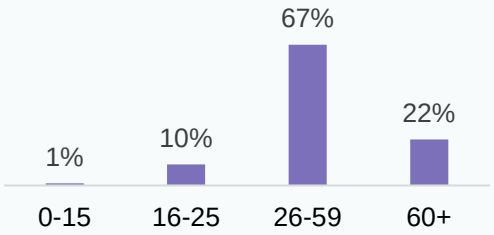
Other races were not specified. 411 individuals did not answer this question, including 48 who declined to answer. Only first-time callers were asked this question.

Gender of Caller (n=5,673)



Gender is inferred by call specialist.

Age Groups (n=5,407)



3% of individuals are veterans

n=2,466

73% Hispanic/Latino
27% Non-Hispanic/Latino

n=2,484; 131 individuals did not answer this question, including 8 who declined to answer. Only first-time callers were asked this question.

Primary Language (n=2,462)

English	55%
Spanish	43%
Other	2%

Other includes Trique and Mixteco. 50 individuals did not answer this question, including 6 who declined to answer. Only first-time callers were asked this question.

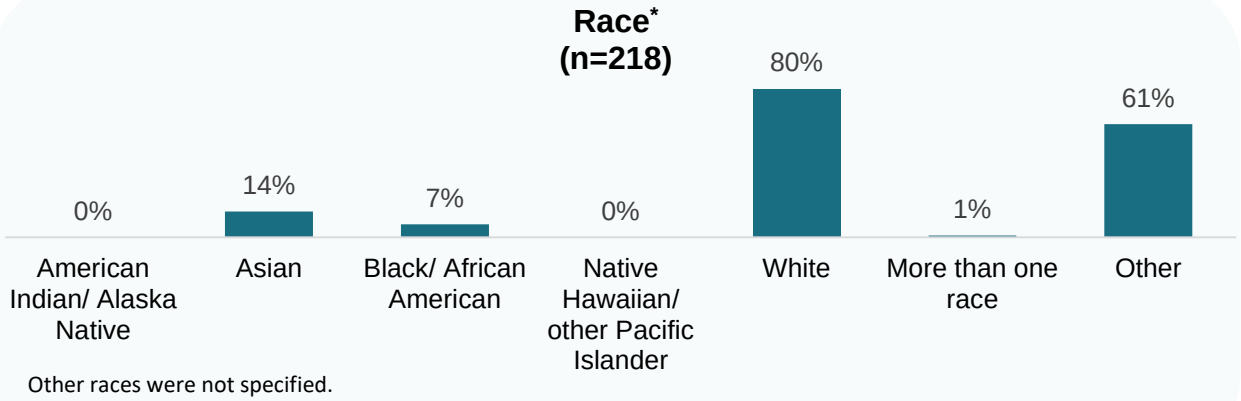
CHINATOWN LEARNING CENTER INTERIM, INC.

Chinatown Learning Center offers training experience for California State University, Monterey Bay, Master of Social Work candidates in supporting individuals experiencing homelessness, many of whom are also struggling with mental health and addiction issues, in the Chinatown neighborhood of Salinas and surrounding areas.

Program Highlights*

564 individuals served

Demographic Data



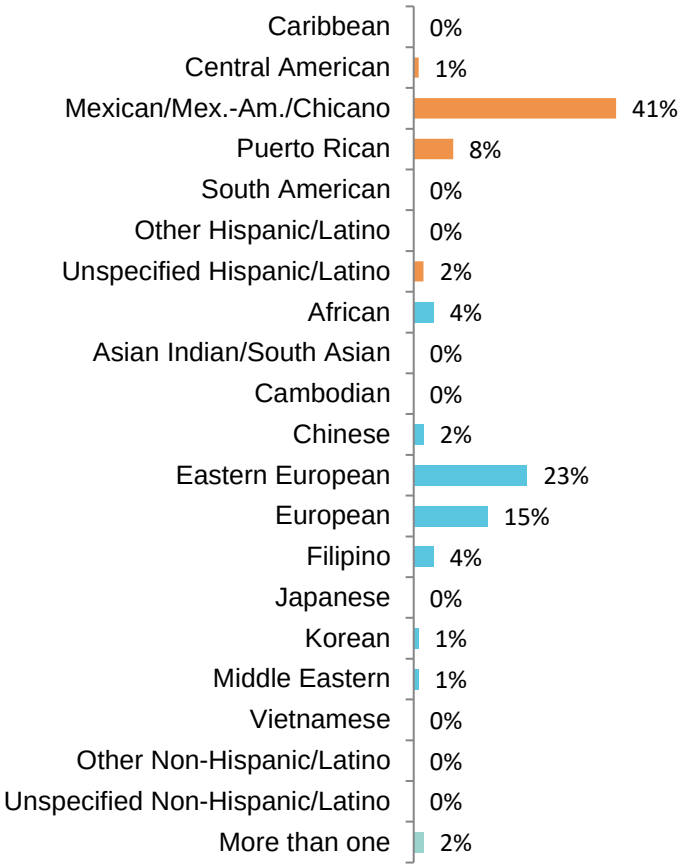
Other races were not specified.
346 individuals did not answer this question; none selected "decline to answer."

* Only demographic information was collected for this program; outcome data was not collected.

CHINATOWN LEARNING CENTER

Demographic Data

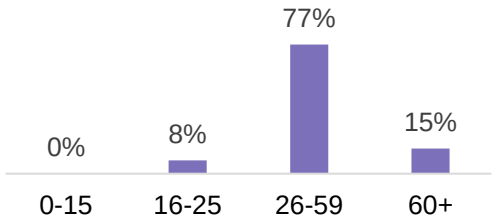
**Ethnicity*
(n=458)**



Other ethnicities were not specified. 106 individuals did not answer this question; none selected "decline to answer."

51% Hispanic/Latino
49% Non-Hispanic/Latino

**Age Groups
(n=454)**



110 individuals did not answer this question.

**Primary Language
(n=490)**

English	70%
Spanish	30%
Other	1%

Other includes Japanese, Korean, and Tagalog.
74 individuals did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

CHINATOWN LEARNING CENTER

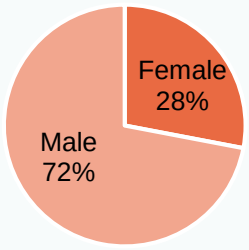
Demographic Data

Current Gender Identity (n=467)

Female	26%
Male	74%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

97 individuals did not answer this question, including 1 who selected "decline to answer."

Sex Assigned at Birth (n=467)



97 individuals did not answer this question, including 1 who selected "decline to answer."

Sexual Orientation (n=468)

Bisexual	10%
Gay or Lesbian	4%
Heterosexual or Straight	85%
Queer	0%
Questioning or Unsure	1%
Another Sexual Orientation	0%

96 individuals did not answer this question, including 1 who selected "decline to answer."

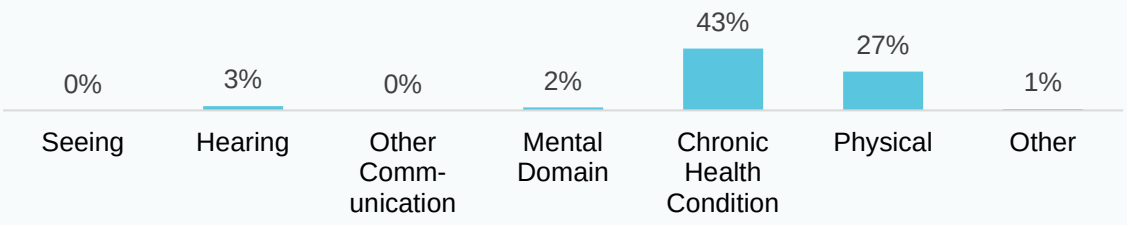
5% of individuals are veterans

n=460; 104 individuals did not answer this question.

64% of individuals reported having one or more disabilities

n=472; 92 individuals did not answer this question.

Disability* (n=472)



Other includes Bipolar Disorder and Heart Conditions.
92 individuals did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

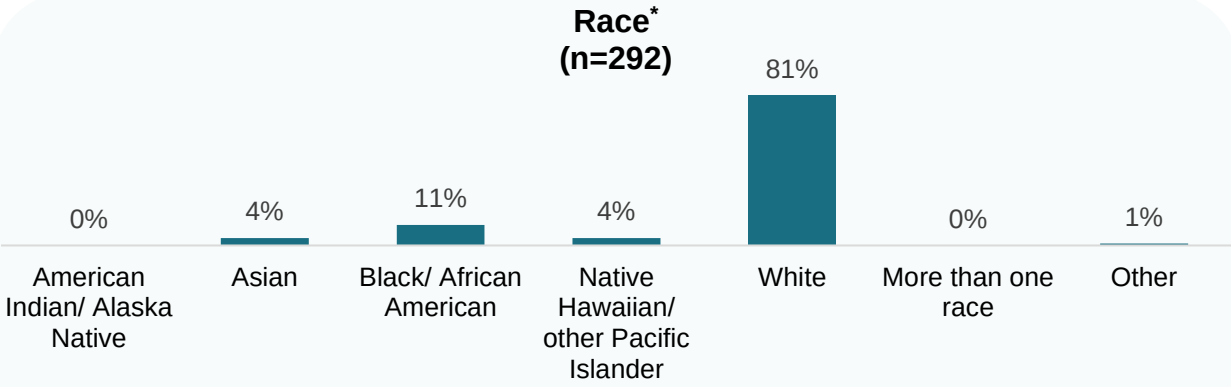
VETERANS REINTEGRATION TRANSITION PROGRAM MONTEREY COUNTY MILITARY & VETERANS AFFAIRS OFFICE

The Veterans Reintegration Transition Program provides education and awareness to veterans, their dependents and survivors on entitled benefits to include mental health services available in the community. Additionally, this program seeks to streamline the process of transitioning service members, veterans and their eligible dependents to healthcare, mental health services, education, employment and other community-based services. By assisting those transitioning service members, veterans, and their dependents who are eligible for Veterans Administration (VA) health care to connect with the VA, the program aims to preserve the local safety net funds for those unserved and underserved populations who are not eligible for VA benefits.

Program Highlights*

319 individuals served

Demographic Data



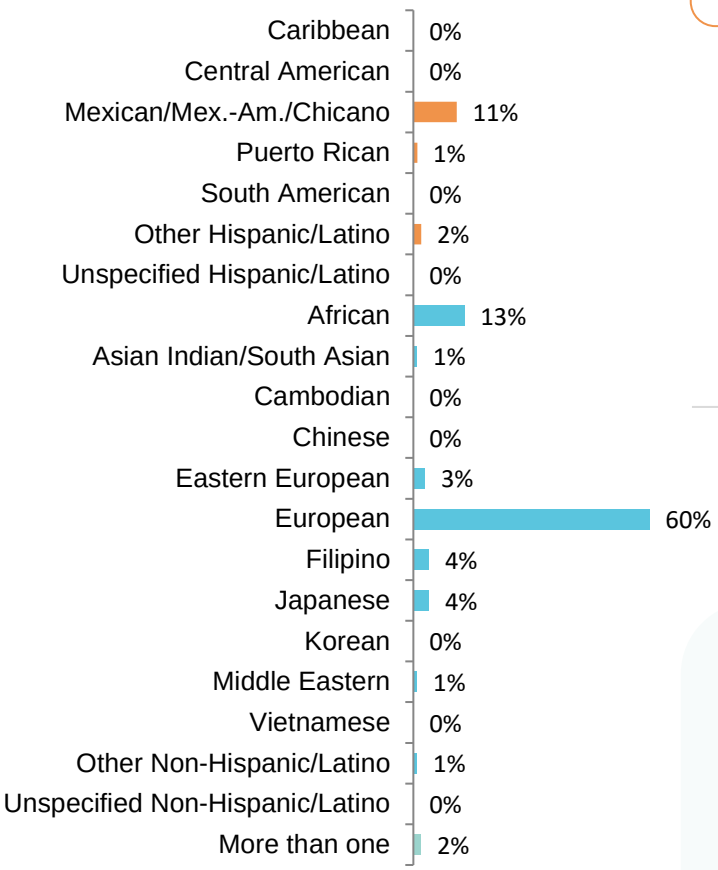
Other races were not specified.
27 individuals did not answer this question, including 5 who selected "decline to answer."

* Only demographic information was collected for this program; outcome data was not collected.

VETERANS REINTEGRATION TRANSITION PROGRAM

Demographic Data

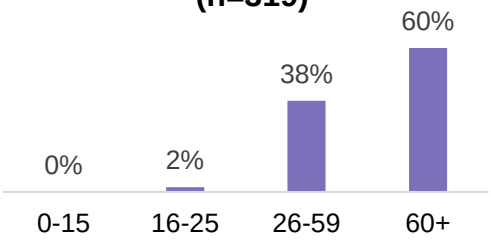
Ethnicity* (n=250)



Other ethnicities were not specified. 69 individuals did not answer this question, including 5 who selected "decline to answer."

14% Hispanic/Latino
87% Non-Hispanic/Latino

Age Groups (n=319)



Primary Language (n=316)

English	97%
Spanish	1%
Other	3%

Other languages were not specified. 3 individuals did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

VETERANS REINTEGRATION TRANSITION PROGRAM

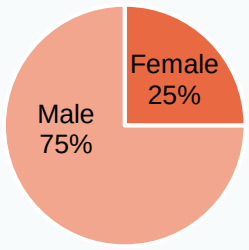
Demographic Data

Current Gender Identity (n=318)

Female	25%
Male	75%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

1 individual did not answer this question, including 1 who selected "decline to answer."

Sex Assigned at Birth (n=318)



1 individual did not answer this question, including 1 who selected "decline to answer."

Sexual Orientation (n=312)

Bisexual	1%
Gay or Lesbian	1%
Heterosexual or Straight	98%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

7 individuals did not answer this question, including 7 who selected "decline to answer."

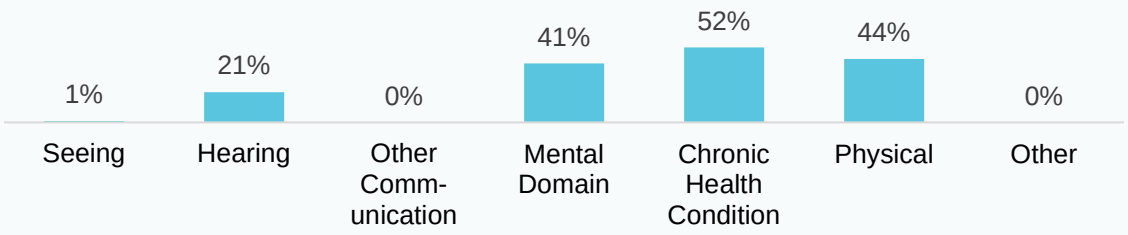
83% of individuals are veterans

n=319

88% of individuals reported having one or more disabilities

n=319

Disability* (n=319)



* Percentages may exceed 100% because participants could choose more than one response option.

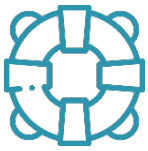
SUICIDE PREVENTION

SUICIDE PREVENTION SERVICE
FAMILY SERVICE AGENCY OF THE CENTRAL COAST

Suicide Prevention Service is a program of Family Service Agency of the Central Coast. The primary mission is to identify high-risk individuals, families, and groups and provide them with safe alternatives to suicidal behavior. The program's integrated method of service delivery includes a 24/7/365 free, multi-lingual suicide crisis line, educational outreach and training, and bereavement support services for those who have lost a loved one to suicide. Outreach personnel are also trained to offer a variety of training programs for community groups including: ASIST, safeTalk, and Mental Health First Aid.

Program Highlights

1,133 individuals served



82% of respondents said they would **know when to ask for help with an emotional problem** after attending a training/class from this program.

Program Outcomes

Because of coming to this training/class… (n=143-144)	% Agree	% Neutral	% Disagree
I know where to go for mental health services near me.	76%	18%	6%
I know when to ask for help with an emotional problem.	82%	16%	2%
I believe people with mental illness can get better and have healthy lives.	78%	19%	3%
I believe people are generally caring and sympathetic to people with mental illness.*	63%	30%	7%
I would be more likely to help someone in need who has a mental illness.†	93%	7%	0%
I learned more about the warning signs of suicide.	80%	16%	4%
I learned ways to help a person who is dealing with a mental health problem or crisis.	84%	15%	1%

* This question was only asked in September 2018; n=129
† This question was only asked in March 2019; n=15

SUICIDE PREVENTION SERVICE

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=139-145)	% Agree	% Neutral	% Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	64%	22%	14%
Information was given in the language that I speak best.	87%	12%	1%
I will use what I learned in this training/class.	75%	23%	2%
This training/class helped me.	82%	17%	1%
I would recommend this training/class to a friend or family member.	78%	20%	2%

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=120)

- Learning how to spot warning signs of suicide (35)
- Learning how to help someone else (27)
- Hearing about available resources (17)

What are your recommendations for improvement? (n=112)

- More examples and videos (7)
- I don't know (9)
- The class was good as is, no suggestions for improvement (57)

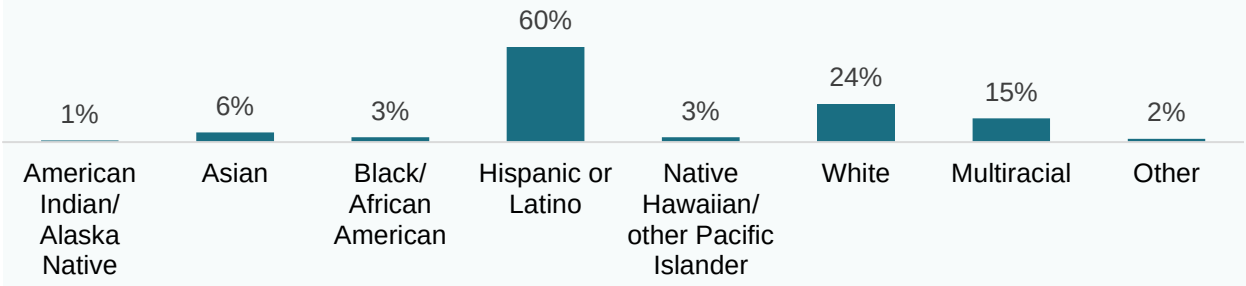
"I really just liked listening to what [the trainer] had to say: knowing someone is there for me really helps."

"The most useful part was learning about places you can go for help and how to help others going through this."

SUICIDE PREVENTION SERVICE

Demographic Data

Race/Ethnicity* (n=1,114)



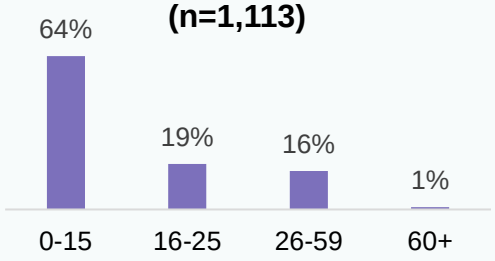
Other races/ethnicities included Middle Eastern, European, and African. 19 individuals did not answer this question.

Primary Language (n=1,128)

English	7%
Spanish	91%
English & Spanish	1%
Other	1%

Other languages include Arabic, Chinese, Japanese, and Korean. 5 individuals did not answer this question.

Age Groups (n=1,113)



20 individuals did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

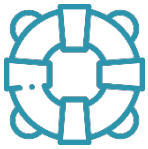
STIGMA AND DISCRIMINATION REDUCTION

SUCCESS OVER STIGMA INTERIM, INC.

Success Over Stigma (SOS) promotes consumer involvement in advocating for public policies that aim to support and empower people with psychiatric disabilities. The program focuses on consumer involvement in planning and executing mental health services and anti-stigma messaging in the community. SOS provides peer consultation to service providers, including increasing peer involvement in developing and strengthening mental health services both locally and at the state level. SOS also aims to teach consumers how to better advocate for themselves by providing reciprocal peer support and advocacy in their community. A goal of this initiative is to give clients the opportunity to share their behavioral health experience and impact policy regarding their services.

Program Highlights

1,116 individuals served



87% of respondents said they were **more aware of when to ask for help** with an emotional problem and **believe treatment can help people with mental illness lead normal lives** after participating in this program.

Program Outcomes

Because of coming to this training/class… (n=210-215)	% Agree	% Neutral	% Disagree
I know where to go for mental health services in my community.	76%	20%	4%
I know when to ask for help with a personal or emotional problem.	87%	12%	1%
I believe treatment can help people with mental illness lead normal lives.	87%	11%	2%
I believe people are generally caring and sympathetic to people with mental illness.	66%	27%	7%

SUCCESS OVER STIGMA

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=211-214)	% Agree	% Neutral	% Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	60%	24%	16%
Information was given in the language that I speak best.	87%	12%	1%
I will use what I learned in this training/class.	83%	16%	1%
This training/class helped me.	86%	14%	0%
I would recommend this training/class to a friend or family member.	83%	15%	2%

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=201)

- Hearing other people's personal stories about mental illness (44)
- Help is available when needed (20)
- Everything (14)

What are your recommendations for improvement? (n=179)

- More time (e.g., to hear speakers talk) (18)
- No suggestions, the class is great as is (105)

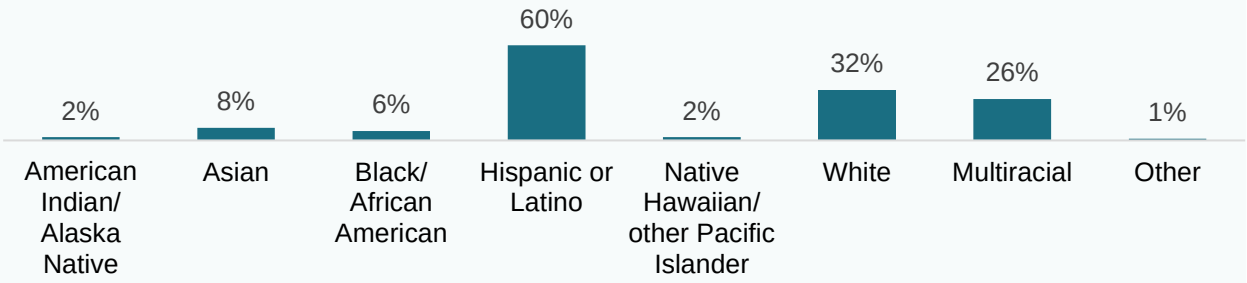
"The most helpful thing about this class was learning that most people with mental illness can live normal, healthy lives."

"I was glad that they tined in the local drunk driving issue with everything else, it made the stories feel more personal and real. Everyone was personable and honest, so it made the connection feel stronger."

SUCCESS OVER STIGMA

Demographic Data

Race/Ethnicity* (n=1,109)



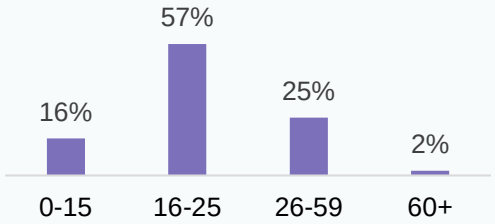
Other races/ethnicities include Middle Eastern and Egyptian. 7 individuals did not answer this question.

Primary Language (n=1,113)

English	64%
Spanish	25%
English & Spanish	8%
Other	3%

Other languages include Farsi and Tagalog.
3 individuals did not answer this question.

Age Groups (n=1,105)



11 individuals did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

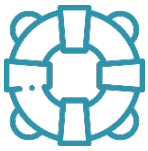
OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

AFRICAN AMERICAN COMMUNITY PARTNERSHIP
THE VILLAGE PROJECT, INC.

The Village Project, Inc. offers the African American Community Partnership program, which provides culturally competent counseling, group therapy, and related services to African Americans and other individuals and families of color. Services also include outreach, presentations, and workshops to increase mental health awareness and timely access to mental health services among unserved and underserved low-income communities. The Village Project is a place where people of color can go to work through challenges with the help of trusted practitioners in the community who look like them and understand their cultural dynamics.

Program Highlights

469 individuals served



91% of respondents said they **knew where to go for local mental health services** after participating in this program.

Program Outcomes

As a result of participating in this training/class… (n=22-46)	% Agree	% Neutral	% Disagree
I know where to go for mental health services near me.	91%	7%	2%
I know when to ask for help with an emotional problem.	87%	11%	2%
I believe people with mental illness can get better and have healthy lives.	91%	7%	2%
I believe people are generally caring and sympathetic to people with mental illness.	58%	25%	17%
I have a better understanding of mental illness.*	100%	0%	0%
I would be more likely to help someone in need who has a mental illness.*	100%	0%	0%

Outreach Events and Presentations

Community Partners Fair • CSUMB - Psychology Class • Fall Festival Resource Fair • Homeless Youth Planning Group • Jewish Film Festival • Mental Health Education Series • Monterey Rotary Club • MPC - In Service Day • NAMI Focus Group Presentation • National Night Out - Seaside • Open House - Dual Language Academy MP

* This question was only asked in March 2019 survey version; n=22.

AFRICAN AMERICAN COMMUNITY PARTNERSHIP

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=44-46)	% Agree	% Neutral	% Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	94%	2%	4%
Training/class materials were available in my preferred language.	100%	0%	0%
I plan to use what I learned in this training/class.	93%	7%	0%
Overall, this training/class was helpful to me.	98%	2%	0%
I would recommend this training/class to a friend or family member.	98%	2%	0%

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=33)

- Gaining knowledge about mental health issues (19)
- Gaining mental health skills (4)
- The staff/presenters (4)
- Cultural competency (3)

What are your recommendations for improvement? (n=25)

- More classes and more time (4)
- More participants (3)
- Increase discussion time (3)
- General positive feedback (e.g., “Everything was great.”) (11)

" I learned that it is ok to seek mental health therapy."

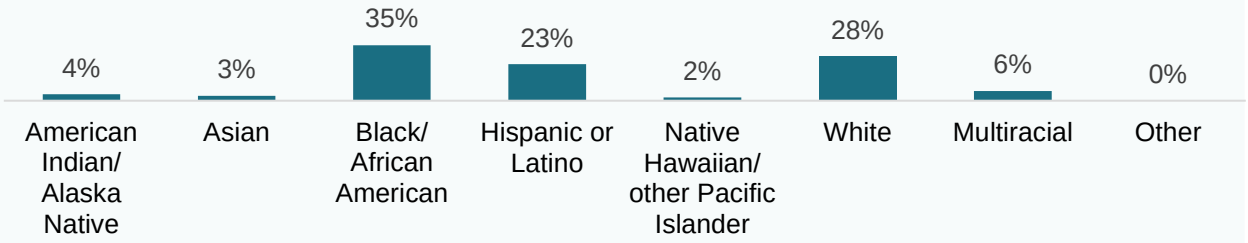
" Information on suicide rates for blacks going up, especially black youth. How best to be helpful, how to detect (strategies). Resources and what to do, how to refer, where to refer."

" The training was helpful because it gave me more insight on mental illness."

AFRICAN AMERICAN COMMUNITY PARTNERSHIP

Demographic Data

Race/Ethnicity* (n=465)



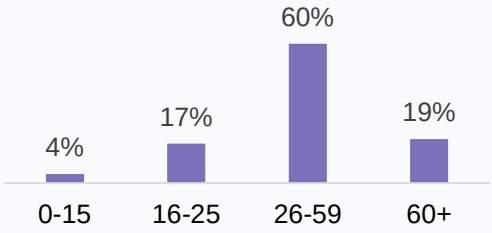
Other races/ethnicities were not specified. 4 individuals did not answer this question.

Primary Language (n=468)

English	76%
Spanish	8%
English & Spanish	16%
Other	0%

1 individual did not answer this question.

Age Groups (n=467)



2 individuals did not answer this question.

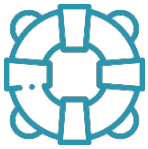
* Percentages may exceed 100% because participants could choose more than one response option.

FAMILY SELF-HELP SUPPORT AND ADVOCACY NATIONAL ALLIANCE ON MENTAL ILLNESS

National Alliance on Mental Illness (NAMI) provides education, outreach, support, and referrals to individuals affected by mental illness and their family members, loved ones, and professional providers. Program activities include community presentations, support groups, and trainings for potential responders. Family to Family educational workshops are taught in Spanish and English by families who have experienced mental illness and are designed to help the whole family understand and support loved ones living with a mental disorder without neglecting the well-being of the family circle. Peer to Peer educational workshops are taught by trained peers to help adults with mental illness better understand their conditions and journeys toward recovery.

Program Highlights

357 individuals served



100% of respondents said they **know where to go for local mental health services** after participating in this program.

Program Outcomes

Survey for Workshop Trainees*

Because of this program… (n=10)	# Agree	# Not Sure	# Disagree
I know where to go for mental health services in my community.	10	0	0
I am more aware of when I need to ask for help with a personal or emotional problem.	10	0	0
I believe treatment can help people with mental illness lead normal lives.	10	0	0
I believe people are generally caring and sympathetic to people with mental illness.	10	0	0

Presentation Topics

Anxiety, Stress, and Depression • Anxiety in Teens • Depression and Anxiety in Youth • La Salud Mental y el Estigma (Mental Health and Stigma) • Stigma and Depression

* This survey was collected only in March 2019.

FAMILY SELF-HELP SUPPORT AND ADVOCACY

Program Outcomes

Survey for Participants of Support Groups and Other Programs*

Because of this program… (n=20-22)	# Agree	# Not Sure	# Disagree
I feel more connected to other people.	20	1	0
I know where to go for mental health services near me.	22	0	0
I know when to ask for help with an emotional problem.	21	1	0
I am able to deal with problems better.	21	1	0
I feel less stress or pressure in my life.	13	6	1
I feel better about myself.	19	3	0
When I think about the future, I feel good.	18	4	0
I feel less worried or afraid.	16	6	0
I feel I have more energy during the day.	12	9	0
I care more about the things that are happening in my life.	21	1	0

Program Cultural Competency and Satisfaction

Survey for Workshop Trainees†

Please choose how much you agree or disagree with each sentence below (n=8-10)	# Agree	# Not Sure	# Disagree
The leaders of this training/class were sensitive to my cultural background (e.g., ethnic/ religious beliefs).	9	0	0
Training/class materials were available in my preferred language.	10	0	0
I plan to use what I learned in this training/class.	10	0	0
Overall, this training/class was helpful to me.	10	0	0
I would recommend this training/class to a friend or family member.	8	0	0

* This survey was collected only in September 2018.
† This survey was collected only in March 2019.

FAMILY SELF-HELP SUPPORT AND ADVOCACY

Program Cultural Competency and Satisfaction

Survey for Participants of Support Groups and Other Programs*

Please choose how much you agree or disagree with each sentence below (n=23)	# Agree	# Not Sure	# Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	22	0	1
The program had services in the language that I speak best.	23	0	0
I got services that were right for me.	23	0	0
I am happy with the services I received.	22	1	0
I would recommend this program to a friend or family member.	23	0	0

Participant Feedback

Participants who received services, including both trainees and support groups participants, were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=26)

- Building connections with others (11)
- Learning new skills, such as coping and support (6)
- Gaining knowledge about mental illness symptoms and experience (5)
- Learning about existing resources and where to ask for help (5)

What are your recommendations for improvement? (n=20)

- Increase number of participants (4)
- More time for discussion and learning (4)
- More activities and information shared (2)
- General positive feedback (e.g., “It was fantastic.”) (7)

"Knowing I am not alone."

"The classes were very clear and they made me understand the symptoms of schizophrenia and being able to help my daughters and spend time in their shoes to understand their illness."

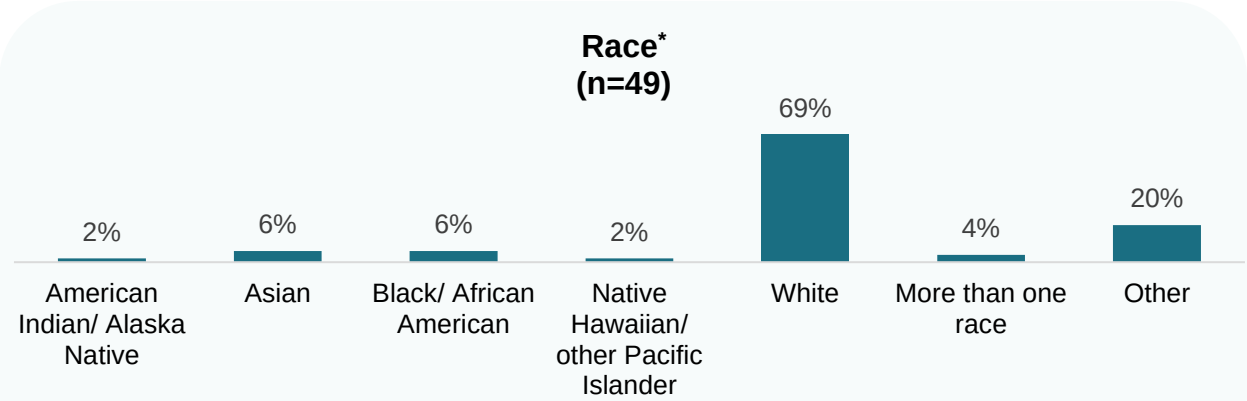
"[Staff] made me feel safe and helped me understand my illness and how to make a plan."

* This survey was collected only in September 2018.

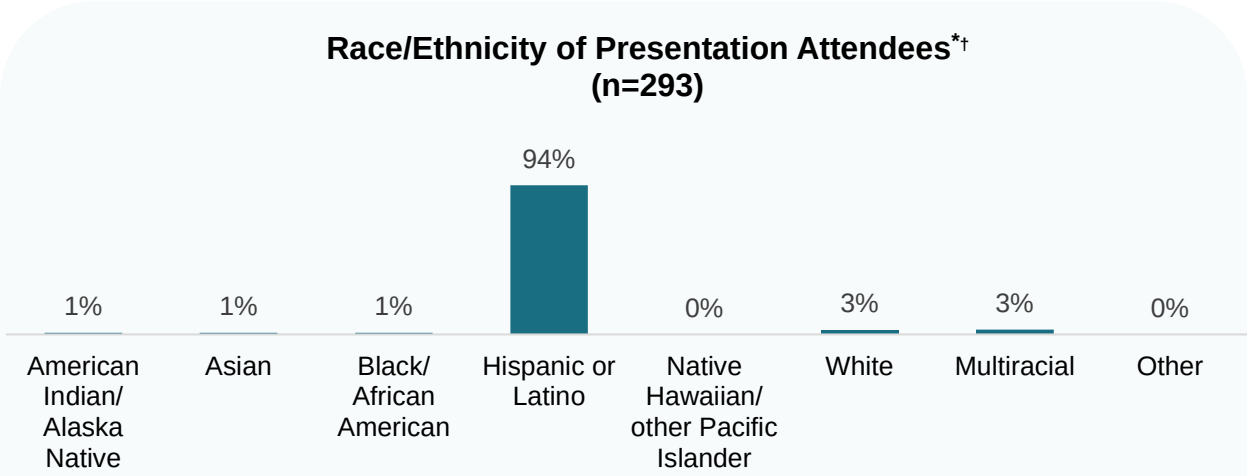
FAMILY SELF-HELP SUPPORT AND ADVOCACY

Demographic Data

Demographic data for this program was collected using both Adult Forms and shorter Presentation Forms. Presentation Form data presented below includes only Race/Ethnicity, Age, and Primary Language. Race and Ethnicity questions are combined on the Presentation Form and are therefore reported separately from Race and Ethnicity data collected from the Adult Form. Age and Primary Language data from the Presentation Form are combined with the Adult Form.



Other includes Hispanic, Latino, and Mexican American.
15 individuals did not answer this question, including 4 who selected "decline to answer."



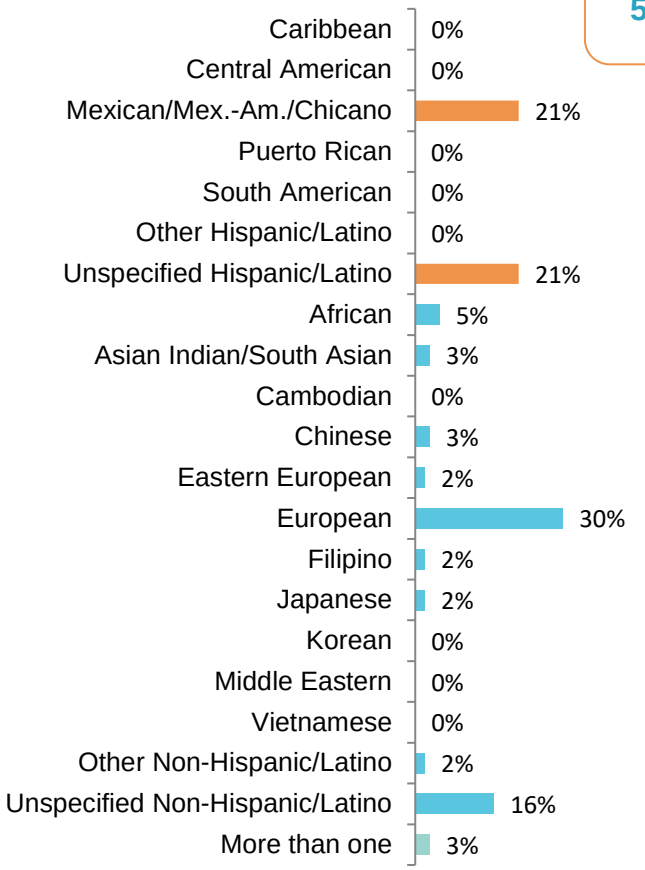
All individuals answered this question.

* Percentages may exceed 100% because participants could choose more than one response option.
† Responses were collected from a shorter demographic form administered at presentations that combines race and ethnicity into one question.

FAMILY SELF-HELP SUPPORT AND ADVOCACY

Demographic Data

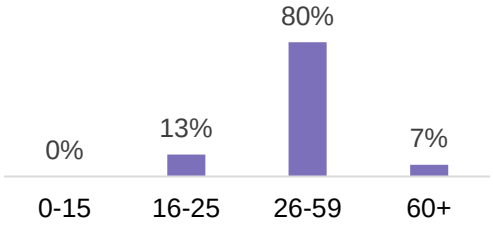
Ethnicity* (n=61)



Other ethnicities are not listed to protect identifying information.
3 individuals did not answer this question; none selected "decline to answer."

43% Hispanic/Latino
57% Non-Hispanic/Latino

Age Groups (n=344)



13 individuals did not answer this question.

Primary Language (n=357)

English	23%
Spanish	76%
English & Spanish	1%
Other	0%

* Percentages may exceed 100% because participants could choose more than one response option.

FAMILY SELF-HELP SUPPORT AND ADVOCACY

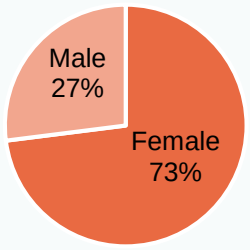
Demographic Data

Current Gender Identity (n=56)

Female	73%
Male	27%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

8 individuals did not answer this question; none selected "decline to answer."

Sex Assigned at Birth (n=56)



8 individuals did not answer this question; none selected "decline to answer."

Sexual Orientation (n=47)

Bisexual	2%
Gay or Lesbian	0%
Heterosexual or Straight	98%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

17 individuals did not answer this question, including 6 who selected "decline to answer."

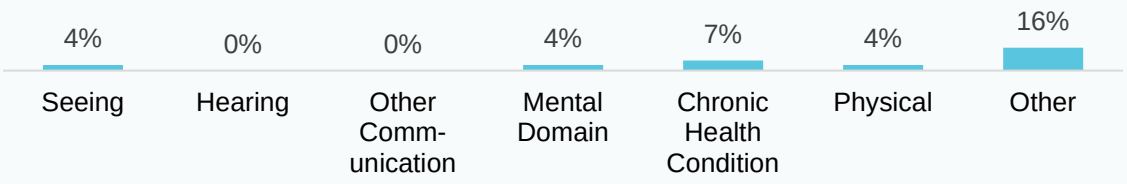
5% of individuals are veterans

n=64; all individuals answered this question.

27% of individuals reported having one or more disabilities

n=55; 9 individuals did not answer this question.

Disability* (n=55)



Other includes PTSD, Anxiety, and Schizophrenia.
9 individuals did not answer this question.

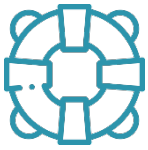
* Percentages may exceed 100% because participants could choose more than one response option.

LATINO COMMUNITY PARTNERSHIP
CENTER FOR COMMUNITY ADVOCACY

The Center for Community Advocacy uses Promotores de Salud (Health Promoters) to educate the Latino community about mental health issues and remove the stigma associated with seeking mental health services. The Promotores de Salud also provide information, linkages, and referrals to services, programs, and mental health care.

Program Highlights

139 individuals served



91% of respondents said they **knew where to go for local mental health services** after participating in this program.

Program Outcomes

As a result of participating in this training/class... (n=32-36)	% Agree	% Neutral	% Disagree
I know where to go for mental health services near me.	91%	6%	3%
I know when to ask for help with an emotional problem.	84%	16%	0%
I believe people with mental illness can get better and have healthy lives.	94%	3%	3%
I have a better understanding of mental illness.	76%	24%	0%
I would be more likely to help someone in need who has a mental illness.	73%	24%	3%

Presentation Topics

Depression • Stress • Emotional Balance • Health Resources • Resilience • Mental Health • Mental Health and Stress • Trauma and Pain

LATINO COMMUNITY PARTNERSHIP

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=33-37)	% Agree	% Neutral	% Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	92%	8%	0%
Training/class materials were available in my preferred language.	94%	6%	0%
I plan to use what I learned in this training/class.	97%	3%	0%
Overall, this training/class was helpful to me.	100%	0%	0%
I would recommend this training/class to a friend or family member.	97%	3%	0%

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=32)

- Learning about mental illness and health (17)
- Gaining skills to cope with stress (5)
- Knowing where to ask for help (3)
- Everything (6)

What are your recommendations for improvement? (n=23)

- More activities, workshops, and classes (5)
- Teach about additional topics (3)
- Share materials to take home (2)
- General positive feedback (e.g., “Everything was good”) (10)

"Knowing that we should ask for help before the problem becomes larger."

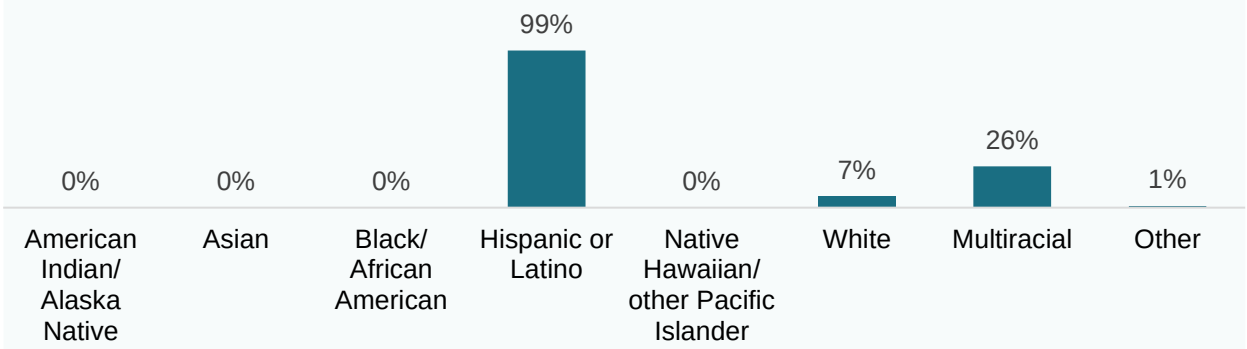
"Knowing how to recognize when a person has depression and [beyond] something normal. It's a problem and it has a solution and talking about it is important."

"Learned how to manage stress and manage my self-esteem and advice on how to do it with family."

LATINO COMMUNITY PARTNERSHIP

Demographic Data

Race/Ethnicity* (n=138)



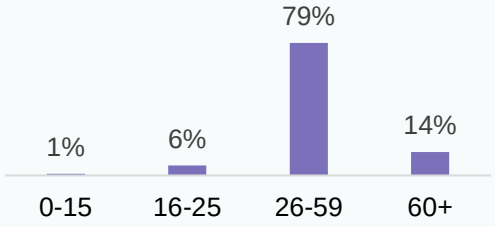
Other races/ethnicities were not listed by respondents. 1 individual did not answer this question.

Primary Language (n=139)

English	7%
Spanish	91%
English & Spanish	1%
Other	1%

Other languages not listed to protect identifying information.

Age Groups (n=138)



1 individual did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

MCBH COMMUNITY PRESENTATIONS AND OUTREACH MONTEREY COUNTY BEHAVIORAL HEALTH

MCBH staff provide community-based psychoeducational workshops and presentations to advance awareness and knowledge of mental health and related topics across Monterey County. MCBH partners with local non-profits, schools, churches, and other community entities to reach community members in accessible locations.

Program Highlights

1,540 individuals reached*

50% of activities in Spanish

17 community presentations **13** outreach events
2 community workshops

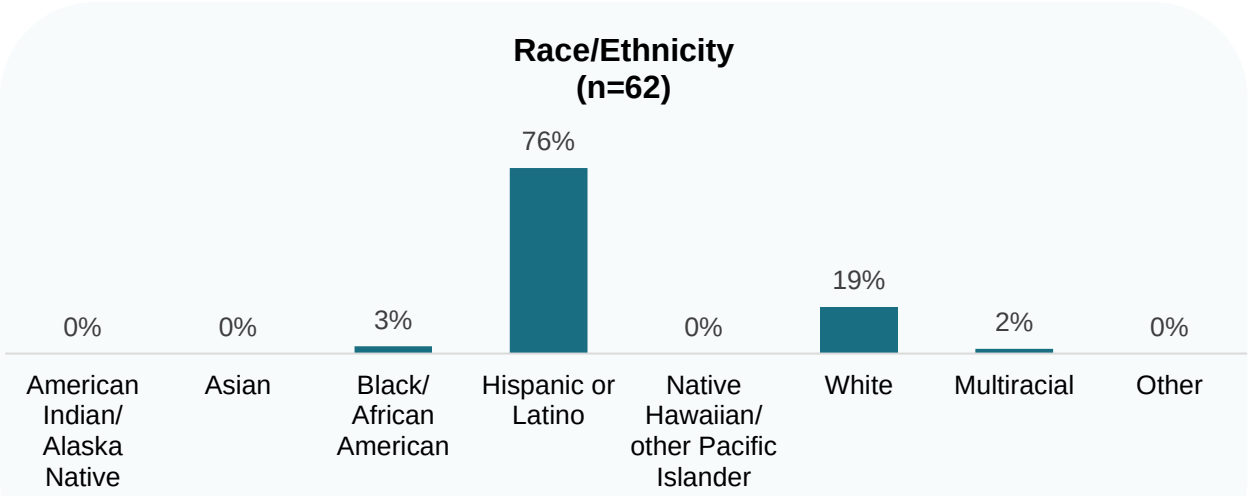
Presentation Topics

Behavioral Health Services and Locations • Early Intervention • Mental Health 101 • Stress, Anxiety and Depression • Urgent Mental Health Issues among the Undocumented Community • Mental Health Awareness Month • Building Resilience: Mental Health in the Latinx Community • LGBTQ • Maternal Mental Health • Early Childhood • Suicide Prevention • Behavioral Health • Mental Health and Careers in Mental Health Understanding Trauma

* Number of individuals reached may be duplicated. Unduplicated demographic forms were collected from 63 individuals.

MCBH COMMUNITY PRESENTATIONS AND OUTREACH

Demographic Data

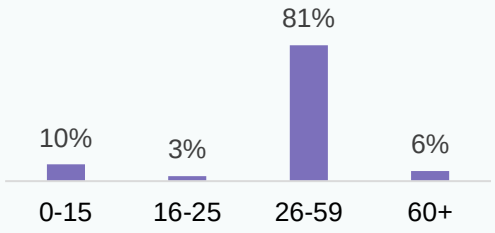


1 individual did not answer this question.

Primary Language (n=62)

English	31%
Spanish	51%
English & Spanish	18%
Other	0%

1 individual did not answer this question.



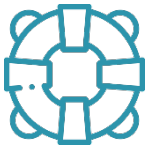
All individuals answered this question.

PROMOTORES MENTAL HEALTH PROGRAM
CENTRAL COAST CITIZENSHIP PROJECT

The Promotores Mental Health Program uses Promotores de Salud (Health Promoters) to educate the unserved and underserved Latino community about mental health issues and remove the stigma associated with seeking mental health services. The program also provides information and referrals to mental health prevention and care services and offers mental health counseling sessions free-of-charge.

Program Highlights

599 individuals served



10 of 11 of respondents said they **knew where to go for local mental health services** after participating in this program.

Program Outcomes

Because of this program... (n=11)	# Agree	# Neutral	# Disagree
I feel more connected to other people.	9	2	0
I know where to go for mental health services near me.	10	1	0
I know when to ask for help with an emotional problem.	6	5	0
I am able to deal with problems better.	6	5	0
I feel less stress or pressure in my life.	7	4	0
I feel better about myself.	10	1	0
When I think about the future, I feel good.	7	4	0
I feel less worried or afraid.	10	1	0
I feel I have more energy during the day.	10	1	0
I care more about the things that are happening in my life.	10	1	0

Presentation Topics

Services Provided by Central Coast Citizenship Project • **Family Café Mental Health Discussion**

PROMOTORES MENTAL HEALTH PROGRAM

Program Cultural Competency and Satisfaction

Please choose how much you agree or disagree with each sentence below (n=10-11)	# Agree	# Neutral	# Disagree
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	10	1	0
The program had services in the language that I speak best.	11	0	0
I got services that were right for me.	8	3	0
I am happy with the services I received.	8	2	0
I would recommend this program to a friend or family member.	10	0	0

Participant Feedback

Participants who received services were asked to provide feedback through open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response theme is shown in parentheses.

What was most useful or helpful about this program? (n=11)

- Receiving mental health support (4)
- Learning skills to manage stress and life challenges (4)
- Having someone to talk to (3)

What are your recommendations for improvement? (n=10)

- Teach additional communication skills (1)
- Have more available hours (1)
- Provide additional services (1)
- General positive feedback (e.g., “I think it’s fine how it is.”) (7)

"I have learned coping strategies for my life problems."

"[The most useful part was] having someone who can listen to me."

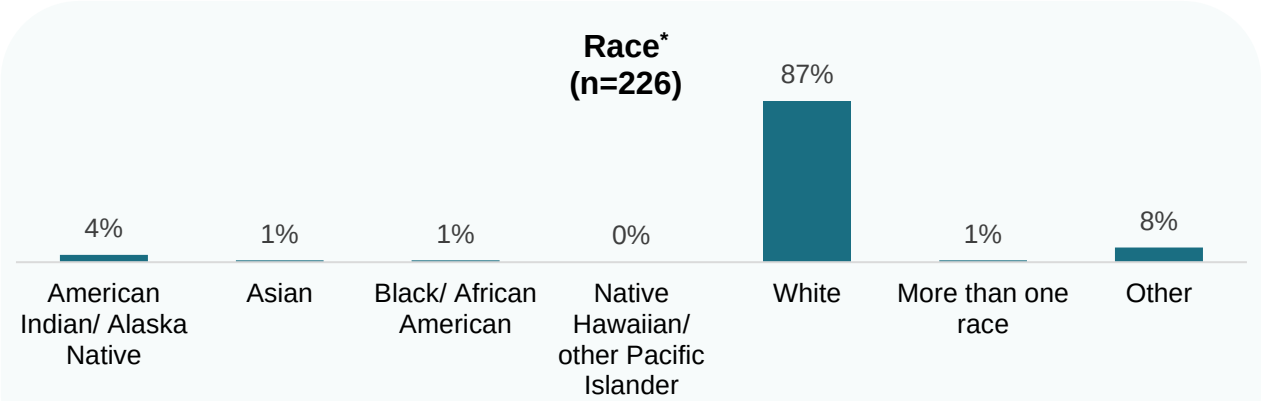
"It helped with my stress."

"It helped me find a better way to act."

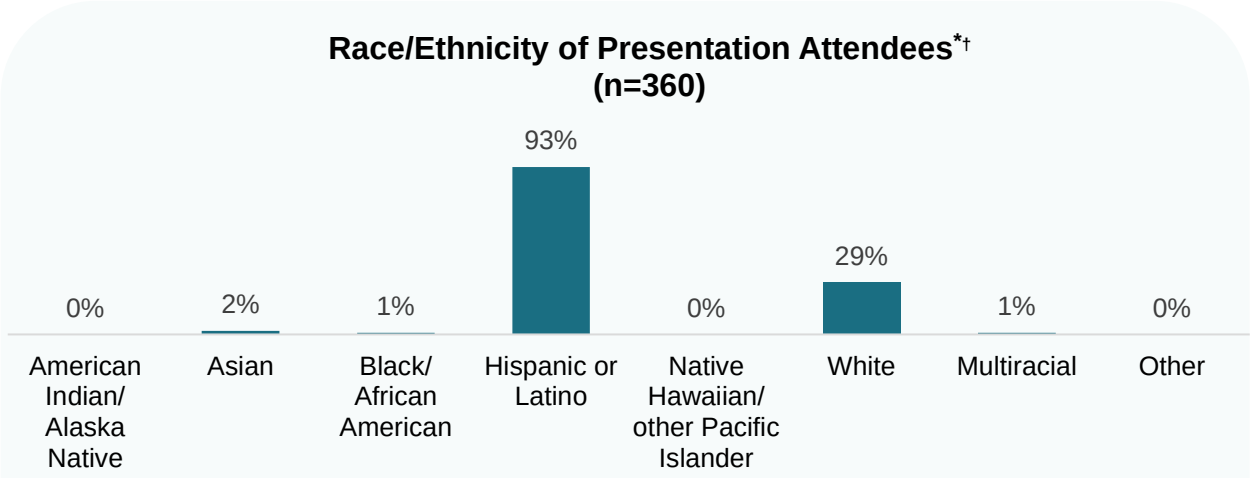
PROMOTORES MENTAL HEALTH PROGRAM

Demographic Data

Demographic data for this program was collected using both Adult Forms and shorter Presentation Forms. Presentation Form data presented below includes only Race/Ethnicity, Age, and Primary Language. Race and Ethnicity questions are combined on the Presentation Form and are therefore reported separately from Race and Ethnicity data collected from the Adult Form. Age and Primary Language data from the Presentation Form are combined with the Adult Form.



Other includes Mexican and Hispanic.
13 individuals did not answer this question, including 6 who selected "decline to answer."



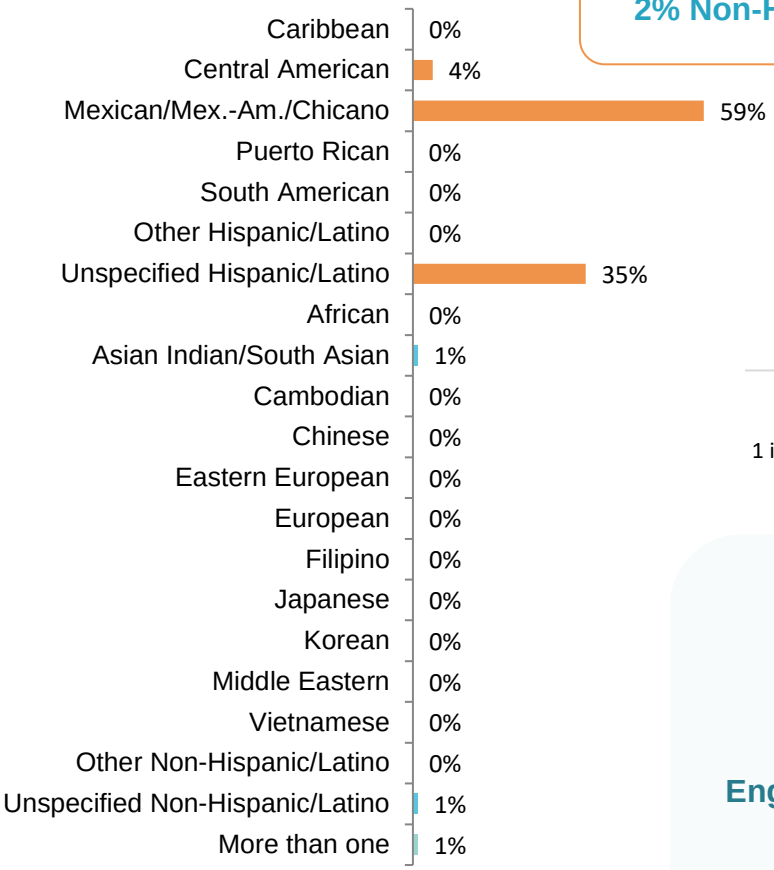
All individuals answered this question.

* Percentages may exceed 100% because participants could choose more than one response option.
† Responses collected from a shorter demographic form administered at presentations that combines race and ethnicity into one question.

PROMOTORES MENTAL HEALTH PROGRAM

Demographic Data

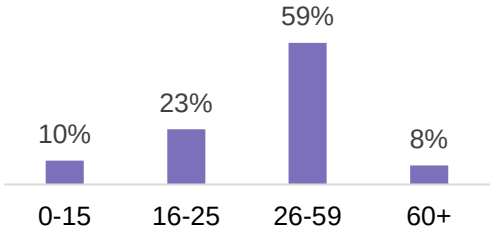
Ethnicity* (n=237)



Other ethnicities were not specified.
2 individuals did not answer this question; none selected "decline to answer."

98% Hispanic/Latino
2% Non-Hispanic/Latino

Age Groups (n=598)



1 individual did not answer this question.

Primary Language (n=594)

English	31%
Spanish	64%
English & Spanish	2%
Other	3%

Other includes Mixteco, Tarasco, and Urdu.
5 individuals did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

PROMOTORES MENTAL HEALTH PROGRAM

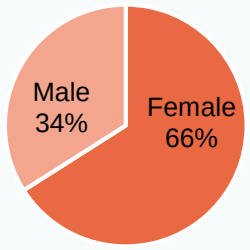
Demographic Data

Current Gender Identity (n=234)

Female	68%
Male	32%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

5 individuals did not answer this question, including 1 who selected "decline to answer."

Sex Assigned at Birth (n=235)



4 individuals did not answer this question; none selected "decline to answer."

Sexual Orientation (n=223)

Bisexual	2%
Gay or Lesbian	0%
Heterosexual or Straight	98%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

16 individuals did not answer this question, including 6 who selected "decline to answer."

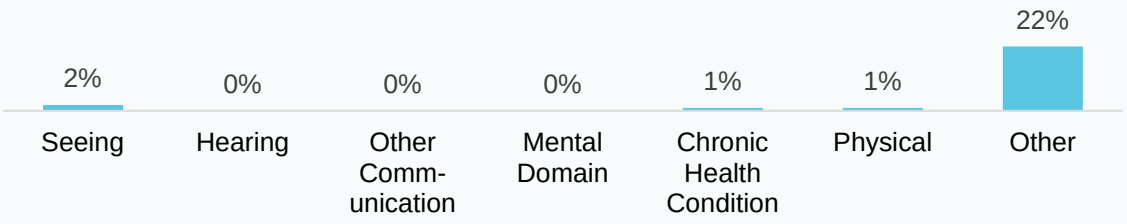
None identify as veterans

n=238; 1 individual did not answer this question.

26% of individuals reported having one or more disabilities

n=235; 4 individuals did not answer this question.

Disability* (n=235)



Other disabilities were not specified.
4 individuals did not answer this question.

* Percentages may exceed 100% because participants could choose more than one response option.

APPENDIX A. FY 18-19 PEI PROGRAMS BY CATEGORY

Prevention

The Epicenter *(The Epicenter)*

Parent Education Program *(Community Human Services)*

Senior Companion Program *(Seniors Council of Santa Cruz and San Benito Counties)*

Senior Peer Counseling *(Alliance on Aging)*

Early Intervention

Archer Child Advocacy Center *(Monterey County Behavioral Health)*

Family Support Groups *(Monterey County Behavioral Health)*

Felton Early Psychosis *(Felton Institute)*

Mobile Crisis Team (*Monterey County Behavioral Health)*

OMNI Resource Center *(Interim, Inc.)*

School-Based Counseling *(Pajaro Valley Prevention and Student Assistance)*

School-Based Domestic Violence Counseling *(Harmony at Home)*

Silver Star Resource Center *(Monterey County Behavioral Health)*

Access and Linkage to Treatment

2-1-1 *(United Way of Monterey County)*

Chinatown Learning Center *(Interim, Inc.)*

Veterans Reintegration Transition Program *(Monterey County Military & Veterans Affairs Office)*

Suicide Prevention

Suicide Prevention Service *(Family Service Agency of the Central Coast)*

Stigma and Discrimination Reduction

Success Over Stigma *(Interim, Inc.)*

Outreach for Increasing Recognition of Early Signs of Mental Illness

African American Community Partnership *(The Village Project, Inc.)*

Family Self-Help Support and Advocacy *(NAMI Monterey County)*

Latino Community Partnership *(Center for Community Advocacy)*

MCBH Community Presentations and Outreach

Promotores Mental Health Program *(Central Coast Citizenship Project)*

APPENDIX B. FY 18-19 NUMBER OF PARTICIPANTS SERVED BY PROGRAM AND CATEGORY

Prevention	**906**
The Epicenter *(The Epicenter)*	209
Parent Education Program *(Community Human Services)*	250
Senior Companion Program *(Seniors Council of Santa Cruz and San Benito Counties)*	13
Senior Peer Counseling *(Alliance on Aging)*	434
Early Intervention	**2,133**
Archer Child Advocacy Center *(Monterey County Behavioral Health)*	254
Family Support Groups *(Monterey County Behavioral Health)*	28
Felton Early Psychosis *(Felton Institute)*	55
Mobile Crisis Team (*Monterey County Behavioral Health)*	342
OMNI Resource Center *(Interim, Inc.)*	482
School-Based Counseling *(Pajaro Valley Prevention and Student Assistance)*	121
School-Based Domestic Violence Counseling *(Harmony at Home)*	760
Silver Star Resource Center *(Monterey County Behavioral Health)*	91
Access and Linkage to Treatment	**883**
2-1-1 *(United Way of Monterey County)*	9,695*
Chinatown Learning Center *(Interim, Inc.)*	564
Veterans Reintegration Transition Program *(Monterey County Military & Veterans Affairs Office)*	319
Suicide Prevention	**1,133**
Suicide Prevention Service *(Family Service Agency of the Central Coast)*	1,133
Stigma and Discrimination Reduction	**1,116**
Success Over Stigma *(Interim, Inc.)*	1,116
Outreach for Increasing Recognition of Early Signs of Mental Illness	**1,627**
African American Community Partnership *(The Village Project, Inc.)*	469
Family Self-Help Support and Advocacy *(NAMI Monterey County)*	357
Latino Community Partnership *(Center for Community Advocacy)*	139
MCBH Community Presentations and Outreach	63†
Promotores Mental Health Program *(Central Coast Citizenship Project)*	599
Total	**7,798**

* 2-1-1 number of participants served is not included in the overall total as some callers may be duplicated.

† MCBH Community Presentations and Outreach number reached (1,540) is not included in the overall total because some individuals may be duplicated. Demographic forms were collected from 63 unduplicated individuals and this number is included in the total.

PREFACE TO APPENDICES C AND D

Demographic and Outcome Data Across Programs

Appendix C presents PEI participant demographics for each program, organized by primary program category. An overall summary of demographic totals across programs is also included. Each program category is presented in a separate table. Overall totals across all program categories are presented in the last table. The demographic topic (e.g., race, ethnicity, age, etc.) and response options are shown in the rows. Rows highlighted in green represent the number of respondents who answered the question. The number of respondents who skipped the question or selected decline to answer are presented in the last row under each demographic topic. The program names are represented in each column. Totals from each program within a program category are presented in the totals column. Cells that are highlighted in grey represent demographic questions that were not asked by a particular program. Demographic responses were collected by a MCBH PEI demographic form (adult, parent, or presentation version) or collected from Avatar.

Appendix D presents participant outcome surveys across programs, organized by primary program category. Access and Linkage to Treatment programs do not administer outcome surveys (2-1-1, Chinatown Learning Center and Veterans Reintegration Program). Additionally, some programs do not collect outcome surveys due to the crisis or brief nature of services (Archer Child Advocacy Center, Mobile Crisis Team, and MCBH Community Presentations and Outreach). Questions from each survey are presented in the rows, with the columns presenting the percentage or number of respondents who selected “Agree” on the scale, which included “Agree,” “Neutral,” and “Disagree.” Surveys with less than 30 respondents are reported as values and not percentages. The range of number of respondents who answered each question on the survey are presented at the header of each column, under individual program names. Cells with dashes mean this question or survey was not administered to this program.

APPENDIX C. PEI PARTICIPANT DEMOGRAPHICS BY PROGRAM CATEGORY

Prevention

Prevention Programs Demographics	TOTALS	The Epicenter	Parent Education Program	Senior Companion Program	Senior Peer Counseling
Race	(n=653)	98	243	8	304
American Indian/Alaska Native	25	12	11	0	2
Asian	16	5	4	0	7
Black/African American	28	7	12	0	9
Native Hawaiian/other Pacific Islander	12	3	6	0	3
White	279	58	73	3	145
More than one race	32	16	6	0	10
Another race	227	33	41	5	148
Declined to answer/skipped	*282*	*35*	*112*	*5*	*130*
Ethnicity	(n=803)	128	243	12	420
Hispanic/Latino	586	102	195	12	277
Non-Hispanic/Latino	232	36	50	1	145
More than one Ethnicity	34	17	11	1	5
Declined to answer/skipped	*27*	*5*	*7*	*1*	*14*
Hispanic/Latino Ethnicities					
Caribbean	7	3	3	0	1
Central American	13	4	9	0	0
Mexican/Mexican-American/Chicano	446	62	107	11	266
Puerto Rican	3	3	0	0	0
South American	3	1	2	0	0
Unspecified Hispanic/Latino ethnicity	120	31	78	1	10
Another Hispanic/Latino ethnicity	4	2	1	0	1
Non-Hispanic Ethnicities					
African	21	4	8	0	9
Asian Indian/South Asian	3	1	0	0	2
Cambodian	1	0	0	0	1
Chinese	1	0	1	0	0
Eastern European	11	1	2	1	7
European	125	20	13	0	92
Filipino	13	1	6	0	6
Japanese	6	2	1	0	3
Korean	3	2	0	0	1
Middle Eastern	1	0	0	0	1
Vietnamese	0	0	0	0	0
Unspecified Non-Hispanic/Latino ethnicity	32	5	15	0	12
Another Non-Hispanic/Latino ethnicity	27	5	9	0	13

Prevention Programs Demographics	TOTALS	The Epicenter	Parent Education Program	Senior Companion Program	Senior Peer Counseling
Race/Ethnicity (Presentations)	(n=68)	68			
American Indian/Alaska Native	8	8			
Asian	9	9			
Black/African American	2	2			
Hispanic or Latino	24	24			
Native Hawaiian/other Pacific Islander	3	3			
White	14	14			
More than one race	20	20			
Another race/ethnicity	8	8			
Declined to answer/skipped	*8*	*8*			
Primary Language	(n=898)	208	249	13	428
English	397	134	108	2	153
Spanish	433	56	123	8	246
English and Spanish	51	12	12	3	24
Other	17	6	6	0	5
Declined to answer/skipped	*8*	*1*	*1*	*0*	*6*
Age	(n=877)	199	247	11	420
0 to 15 years	35	35	0	0	0
16 to 25 years	134	113	19	0	2
26 to 59 years	331	50	225	3	53
60 years+	377	1	3	8	365
Declined to answer/skipped	*29*	*10*	*3*	*2*	*14*
Current Gender Identity	(n=782)	127	243	11	401
Male	248	51	94	6	97
Female	503	54	148	5	296
Transgender	7	6	1	0	0
Genderqueer	6	6	0	0	0
Questioning or unsure	14	6	0	0	8
Another gender identity	4	4	0	0	0
Declined to answer/skipped	*48*	*6*	*7*	*2*	*33*
Sex Assigned at Birth	(n=669)	127	242	11	289
Male	228	51	95	6	76
Female	440	76	146	5	213
Another sex	1	0	1	0	0
Declined to answer/skipped	*161*	*6*	*8*	*2*	*145*
Sexual Orientation	(n=545)	112	202	7	224
Gay or Lesbian	16	11	2	0	3
Heterosexual or Straight	464	53	195	7	209
Bisexual	26	24	1	0	1
Questioning or unsure	16	4	1	0	11
Queer	12	11	1	0	0
Another sexual orientation	11	9	2	0	0
Declined to answer/skipped	*285*	*21*	*48*	*6*	*210*

Prevention Programs Demographics	TOTALS	The Epicenter	Parent Education Program	Senior Companion Program	Senior Peer Counseling
Veteran Status	(n=797)	133	241	11	412
Yes	59	2	42	0	15
No	738	131	199	11	397
Declined to answer/skipped	*33*	*0*	*9*	*2*	*22*
Disability	(n=606)		243	13	350
No Disability	435	92	170	0	173
Has a disability	297	34	73	13	177
Disability Types					
Difficulty seeing	56	16	7	1	32
Difficulty hearing or having speech understood	26	3	2	3	18
Other communication difficulty	6	3	1	0	2
Mental domain disability	37	12	13	2	10
Chronic health condition	43	2	4	3	34
Physical disability	52	6	4	3	39
Another disability	88	10	18	3	57
Unspecified disability	63	1	35	2	25
Declined to answer/skipped	*98*	*7*	*7*	*0*	*84*

Early Intervention

Early Intervention Programs Demographics	TOTALS	Archer Child Advocacy Center	Family Support Groups	Felton Early Psychosis	Mobile Crisis Team	OMNI Resource Center	School-Based Counseling	School-Based DV Counseling	Silver Star Resource Center
Race	(n=864)		25			408		431	
American Indian/Alaska Native	76		0			26		50	
Asian	42		1			31		10	
Black/African American	68		0			44		24	
Native Hawaiian/other Pacific Islander	31		0			21		10	
White	465		19			195		251	
More than one race	97		0			56		41	
Another race	292		5			157		130	
Declined to answer/skipped	*406*		*3*			*74*		*329*	
Ethnicity	(n=1,144)		20			434		690	
Hispanic/Latino	879		6			234		639	
Non-Hispanic/Latino	349		14			236		99	
More than one Ethnicity	136		1			71		64	
Declined to answer/skipped	*124*		*6*			*48*		*70*	
Hispanic/Latino Ethnicities									
Caribbean	5		0			3		2	
Central American	25		0			5		20	
Mexican/Mexican-American/Chicano	591		4			194		393	
Puerto Rican	16		1			6		9	
South American	8		0			4		4	
Unspecified Hispanic/Latino ethnicity	223		1			2		220	
Another Hispanic/Latino ethnicity	40		0			35		5	

Early Intervention Programs Demographics	TOTALS	Archer Child Advocacy Center	Family Support Groups	Felton Early Psychosis	Mobile Crisis Team	OMNI Resource Center	School-Based Counseling	School-Based DV Counseling	Silver Star Resource Center
Non-Hispanic Ethnicities									
African	64		1			41		22	
Asian Indian/South Asian	32		1			27		4	
Cambodian	1		0			1		0	
Chinese	4		0			2		2	
Eastern European	9		1			6		2	
European	147		7			112		28	
Filipino	37		0			21		16	
Japanese	12		1			7		4	
Korean	6		0			5		1	
Middle Eastern	5		0			2		3	
Vietnamese	1		0			1		0	
Unspecified Non-Hispanic/Latino ethnicity	27		4			1		22	
Another Non-Hispanic/Latino ethnicity	77		0			70		7	
Ethnicity (Avatar)	(n=853)	254		55	332		121		91
Asian/Islander	20	6		2	11		0		1
Black	23	13		2	8		0		0
Hispanic	567	188		39	149		118		73
Other	62	14		5	32		2		9
White	181	33		7	132		1		8
Primary Language	(n=1,254)		28			482		744	
English	748		22			428		298	
Spanish	319		4			51		264	
English and Spanish	94		0			0		94	
Other	93		2			3		88	
Declined to answer/skipped	*16*		*0*			*0*		*16*	

Early Intervention Programs Demographics	TOTALS	Archer Child Advocacy Center	Family Support Groups	Felton Early Psychosis	Mobile Crisis Team	OMNI Resource Center	School-Based Counseling	School-Based DV Counseling	Silver Star Resource Center
Age	(n=2,036)	254	28	55	342	466	121	679	91
0 to 15 years	1,113	214	0	3	73	0	116	659	48
16 to 25 years	258	40	0	47	79	24	5	20	43
26 to 59 years	493	0	14	5	131	343	0	0	0
60 years+	172	0	14	0	59	99	0	0	0
Declined to answer/skipped	*97*	*0*	*0*	*0*	*0*	*16*	*0*	*81*	*0*
Gender (Avatar)	(n=862)	254		55	341		121		91
Male	337	42		44	151		64		36
Female	535	222		11	190		57		55
Current Gender Identity*	(n=469)		25			368		76	
Male	245		6			195		44	
Female	218		18			168		32	
Transgender	3		1			2		0	
Genderqueer	2		0			2		0	
Questioning or unsure	1		0			1		0	
Another gender identity	0		0			0		0	
Declined to answer/skipped	*115*		*1*			*114*		*0*	
Sex Assigned at Birth	(n=1,260)		25			479		756	
Male	722		7			270		445	
Female	534		15			208		311	
Another sex	2		1			1		0	
Declined to answer/skipped	*8*		*1*			*3*		*4*	
Sexual Orientation*	(n=401)		20			309		72	
Gay or Lesbian	16		0			15		1	
Heterosexual or Straight	354		18			273		63	
Bisexual	23		2			16		5	
Questioning or unsure	3		0			1		2	
Queer	2		0			2		0	
Another sexual orientation	4		0			2		2	
Declined to answer/skipped	*183*		*6*			*173*		*4*	

* School-Based Domestic Violence Counseling had responses suppressed from this category to protect identifying information.

Early Intervention Programs Demographics	TOTALS	Archer Child Advocacy Center	Family Support Groups	Felton Early Psychosis	Mobile Crisis Team	OMNI Resource Center	School-Based Counseling	School-Based DV Counseling	Silver Star Resource Center
Veteran Status	(n=583)		25			481		77	
Yes	13		1			12		0	
No	570		24			469		77	
Declined to answer/skipped	*2*		*1*			*1*		*0*	
Disability	(n=1,235)		25			481		729	
No Disability	781		20			234		527	
Has a disability	454		5			247		202	
Disability Types									
Difficulty seeing	174		0			105		69	
Difficulty hearing or having speech understood	101		2			51		48	
Other communication difficulty	80		1			63		16	
Mental domain disability	190		1			99		90	
Chronic health condition	87		0			82		5	
Physical disability	66		0			57		9	
Another disability	87		1			49		37	
Unspecified disability	4		2			0		2	
Declined to answer/skipped	*33*		*1*			*1*		*31*	

Access and Linkage to Treatment

Access and Linkage to Treatment Programs Demographics	TOTALS	2-1-1*	Chinatown Learning Center	Veterans Reintegration Transition Program
Race	(n=510)		218	292
American Indian/Alaska Native	0		0	0
Asian	42		31	11
Black/African American	46		15	31
Native Hawaiian/other Pacific Islander	11		0	11
White	410		175	235
More than one race	3		3	0
Another race	4		0	4
Declined to answer/skipped	*373*		*346*	*27*
Ethnicity	(n=708)		458	250
Hispanic/Latino	272		236	36
Non-Hispanic/Latino	440		222	218
More than one Ethnicity	13		9	4
Declined to answer/skipped	*175*		*106*	*69*
Hispanic/Latino Ethnicities				
Caribbean	0		0	0
Central American	3		3	0
Mexican/Mexican-American/Chicano	217		189	28
Puerto Rican	39		36	3
South American	0		0	0
Unspecified Hispanic/Latino ethnicity	9		9	0
Another Hispanic/Latino ethnicity	5		0	5
Non-Hispanic Ethnicities				
African	49		17	32
Asian Indian/South Asian	5		2	3
Cambodian	0		0	0
Chinese	7		7	0
Eastern European	115		107	8
European	219		69	150
Filipino	30		20	10
Japanese	10		1	9
Korean	5		4	1
Middle Eastern	8		6	2
Vietnamese	1		1	0
Unspecified Non-Hispanic/Latino ethnicity	0		0	0
Another Non-Hispanic/Latino ethnicity	3		0	3
Primary Language	(n=806)		490	316
English	648		343	305
Spanish	146		143	3

* 2-1-1 caller demographic information is not included here as individuals may be duplicated. Refer to 2-1-1 Program section in this report for demographic information of callers.

Access and Linkage to Treatment Programs Demographics	TOTALS	2-1-1*	Chinatown Learning Center	Veterans Reintegration Transition Program
English and Spanish	0		0	0
Other	12		4	8
Declined to answer/skipped	*77*		*74*	*3*
Age	(n=773)		454	319
0 to 15 years	0		0	0
16 to 25 years	41		36	5
26 to 59 years	472		350	122
60 years+	260		68	192
Declined to answer/skipped	*110*		*110*	*0*
Current Gender Identity	(n=785)		467	318
Male	583		344	239
Female	202		123	79
Transgender	0		0	0
Genderqueer	0		0	0
Questioning or unsure	0		0	0
Another gender identity	0		0	0
Declined to answer/skipped	*98*		*97*	*1*
Sex Assigned at Birth	(n=785)		467	318
Male	574		335	239
Female	211		132	79
Another sex	0		0	0
Declined to answer/skipped	*98*		*97*	*1*
Sexual Orientation	(n=780)		468	312
Gay or Lesbian	19		17	2
Heterosexual or Straight	709		402	307
Bisexual	49		46	3
Questioning or unsure	3		3	0
Queer	0		0	0
Another sexual orientation	0		0	0
Declined to answer/skipped	*103*		*96*	*7*
Veteran Status	(n=779)		460	319
Yes	287		21	266
No	492		439	53
Declined to answer/skipped	*104*		*104*	*0*
Disability	(n=791)		472	319
No Disability	339		300	39
Has a disability	452		172	280

* 2-1-1 caller demographic information is not included here as individuals may be duplicated. Refer to 2-1-1 Program section in this report for demographic information of callers.

Access and Linkage to Treatment Programs Demographics	TOTALS	2-1-1*	Chinatown Learning Center	Veterans Reintegration Transition Program
Disability Types				
Difficulty seeing	5		2	3
Difficulty hearing or having speech understood	79		12	67
Other communication difficulty	0		0	0
Mental domain disability	140		8	132
Chronic health condition	370		203	167
Physical disability	267		127	140
Another disability	3		3	0
Unspecified disability	59		59	0
Declined to answer/skipped	*92*		*92*	*0*

* 2-1-1 caller demographic information is not included here as individuals may be duplicated. Refer to 2-1-1 Program section in this report for demographic information of callers.

Suicide Prevention & Stigma and Discrimination Reduction

Suicide Prevention & Stigma and Discrimination Reduction Demographics	TOTALS	Suicide Prevention Service	Success Over Stigma
Race/Ethnicity (Presentations)	(n=2,223)	1,114	1,109
American Indian/Alaska Native	35	15	20
Asian	155	67	88
Black/African American	100	37	63
Hispanic or Latino	1,336	671	665
Native Hawaiian/other Pacific Islander	55	30	25
White	622	266	356
More than one race	336	168	168
Another race/ethnicity	27	17	10
Declined to answer/skipped	*26*	*19*	*7*
Primary Language	(n=2,241)	1,128	1,113
English	1,357	640	717
Spanish	646	363	283
English and Spanish	193	108	85
Other	45	17	28
Declined to answer/skipped	*8*	*5*	*3*
Age	(n=2,218)	1,113	1,105
0 to 15 years	885	714	171
16 to 25 years	849	215	634
26 to 59 years	453	172	281
60 years+	31	12	19
Declined to answer/skipped	*31*	*20*	*11*

Outreach for Increasing Recognition of Early Signs of Mental Illness

Outreach for Increasing Recognition of Early Signs of Mental Illness Demographics	TOTALS	African American Community Partnership	Family Self-Help Support and Advocacy	Latino Community Partnership	MCBH Community Presentations and Outreach	Promotores Mental Health Program
Race	(n=275)		49			226
American Indian/Alaska Native	9		1			8
Asian	5		3			2
Black/African American	6		3			3
Native Hawaiian/other Pacific Islander	1		1			0
White	231		34			197
More than one race	5		2			3
Another race	29		10			19
Declined to answer/skipped	*28*		*15*			*13*
Ethnicity	(n=298)		61			237
Hispanic/Latino	256		26			230
Non-Hispanic/Latino	43		35			8
More than one Ethnicity	4		2			2
Declined to answer/skipped	*5*		*3*			*2*
Hispanic/Latino Ethnicities						
Caribbean	0		0			0
Central American	9		0			9
Mexican/Mexican-American/Chicano	152		13			139
Puerto Rican	1		0			1
South American	0		0			0
Unspecified Hispanic/Latino ethnicity	95		13			82
Another Hispanic/Latino ethnicity	0		0			0

Outreach for Increasing Recognition of Early Signs of Mental Illness Demographics	TOTALS	African American Community Partnership	Family Self-Help Support and Advocacy	Latino Community Partnership	MCBH Community Presentations and Outreach	Promotores Mental Health Program
Non-Hispanic Ethnicities						
African	4		3			1
Asian Indian/South Asian	4		2			2
Cambodian	0		0			0
Chinese	2		2			0
Eastern European	2		1			1
European	19		18			1
Filipino	1		1			0
Japanese	2		1			1
Korean	0		0			0
Middle Eastern	0		0			0
Vietnamese	0		0			0
Unspecified Non-Hispanic/Latino ethnicity	12		10			2
Another Non-Hispanic/Latino ethnicity	1		1			0
Race/Ethnicity (Presentations)	(n=1,318)	465	293	138	62	360
American Indian/Alaska Native	22	17	4	0	0	1
Asian	22	14	2	0	0	6
Black/African American	169	161	3	0	2	3
Hispanic or Latino	898	106	274	137	47	334
Native Hawaiian/other Pacific Islander	10	9	0	0	0	1
White	266	129	10	9	12	106
More than one race	74	27	8	36	1	2
Another race/ethnicity	0	0	0	0	0	0
Declined to answer/skipped	*6*	*4*	*0*	*1*	*1*	*0*

Outreach for Increasing Recognition of Early Signs of Mental Illness Demographics	TOTALS	African American Community Partnership	Family Self-Help Support and Advocacy	Latino Community Partnership	MCBH Community Presentations and Outreach	Promotores Mental Health Program
Primary Language	(n=1,620)	468	357	139	62	594
English	651	358	81	9	19	184
Spanish	849	37	271	128	32	381
English and Spanish	107	73	5	1	11	17
Other	13	0	0	1	0	12
Declined to answer/skipped	*7*	*1*	*0*	*0*	*1*	*5*
Age	(n=1,610)	467	344	138	63	598
0 to 15 years	85	19	0	1	6	59
16 to 25 years	272	77	45	8	2	140
26 to 59 years	1,072	284	276	109	51	352
60 years+	181	87	23	20	4	47
Declined to answer/skipped	*17*	*2*	*13*	*1*	*0*	*1*
Current Gender Identity	(n=290)		56			234
Male	91		15			76
Female	199		41			158
Transgender	0		0			0
Genderqueer	0		0			0
Questioning or unsure	0		0			0
Another gender identity	0		0			0
Declined to answer/skipped	*13*		*8*			*5*
Sex Assigned at Birth	(n=291)		56			235
Male	95		15			80
Female	196		41			155
Another sex	0		0			0
Declined to answer/skipped	*12*		*8*			*4*

Outreach for Increasing Recognition of Early Signs of Mental Illness Demographics	TOTALS	African American Community Partnership	Family Self-Help Support and Advocacy	Latino Community Partnership	MCBH Community Presentations and Outreach	Promotores Mental Health Program
Sexual Orientation	(n=270)		47			223
Gay or Lesbian	2		0			2
Heterosexual or Straight	266		46			220
Bisexual	1		1			0
Questioning or unsure	0		0			0
Queer	0		0			0
Another sexual orientation	1		0			1
Declined to answer/skipped	*33*		*17*			*16*
Veteran Status	(n=302)		64			238
Yes	3		3			0
No	299		61			238
Declined to answer/skipped	*1*		*0*			*1*
Disability	(n=290)		55			235
No Disability	213		40			173
Has a disability	77		15			62
Disability Types						
Difficulty seeing	7		2			5
Difficulty hearing or having speech understood	1		0			1
Other communication difficulty	0		0			0
Mental domain disability	2		2			0
Chronic health condition	7		4			3
Physical disability	4		2			2
Another disability	4		4			0
Unspecified disability	57		5			52
Declined to answer/skipped	*13*		*9*			*4*

Overall PEI Totals

Demographics Across PEI Programs

Race	**(n=2,302)**
American Indian/Alaska Native	110
Asian	105
Black/African American	148
Native Hawaiian/other Pacific Islander	55
White	1,385
More than one race	137
Another race	552
Declined to answer/skipped	*1,089*
Ethnicity	**(n=2,953)**
Hispanic/Latino	1,993
Non-Hispanic/Latino	1,064
More than one Ethnicity	187
Declined to answer/skipped	*331*
Hispanic/Latino Ethnicities	
Caribbean	12
Central American	50
Mexican/Mexican-American/Chicano	1,406
Puerto Rican	59
South American	11
Unspecified Hispanic/Latino ethnicity	447
Other Hispanic/Latino ethnicity	49
Non-Hispanic Ethnicities	
African	138
Asian Indian/South Asian	44
Cambodian	2
Chinese	14
Eastern European	137
European	510
Filipino	81
Japanese	30
Korean	14
Middle Eastern	14
Vietnamese	2
Unspecified Non-Hispanic/Latino ethnicity	71
Other Non-Hispanic/Latino ethnicity	108

Primary Language	**(n=6,819)**
English	3,801
Spanish	2,393
English and Spanish	445
Other	180
Declined to answer/skipped	*116*
Age	**(n=7,514)**
0 to 15 years	2,118
16 to 25 years	1,554
26 to 59 years	2,821
60 years+	1,021
Declined to answer/skipped	*284*
Gender (Avatar)	**(n=862)**
Male	337
Female	535
Current Gender Identity	**(n=2,326)**
Male	1,167
Female	1,122
Transgender	10
Genderqueer	8
Questioning or unsure	15
Another gender identity	4
Declined to answer/skipped	*274*
Sex Assigned at Birth	**(n=3,005)**
Male	1,619
Female	1,381
Another sex	3
Declined to answer/skipped	*279*
Sexual Orientation	**(n=1,996)**
Gay or Lesbian	53
Heterosexual or Straight	1,793
Bisexual	99
Questioning or unsure	22
Queer	14
Another sexual orientation	16
Declined to answer/skipped	*604*

Demographics Across PEI Programs

Race/Ethnicity (Presentations)	**(n=3,609)**
American Indian/Alaska Native	65
Asian	186
Black/African American	271
Hispanic or Latino	2,258
Native Hawaiian/other Pacific Islander	68
White	902
More than one race	430
Another race/ethnicity	35
Declined to answer/skipped	*40*
Ethnicity (Avatar)	**(n=853)**
Asian/Islander	20
Black	23
Hispanic	567
Other	62
White	181

Veteran Status	**(n=2,461)**
Yes	362
No	2,099
Declined to answer/skipped	*140*
Disability	**(n=2,922)**
No Disability	1,768
Has a disability	1,280
Disability Types	
Difficulty seeing	242
Difficulty hearing or having speech understood	207
Other communication difficulty	86
Mental domain disability	369
Chronic health condition	507
Physical disability	389
Another disability	182
Unspecified disability	183

APPENDIX D. OUTCOMES ACROSS PROGRAMS

Prevention

Percentage/number of respondents who selected Agree, by program	Epicenter	Parent Education Program	Senior Companion Program	Senior Peer Counseling
Because of this program…	**(n=36-37)**	**(n=130-133)**	**(n=8)**	**(n=154-158)**
I feel more connected to other people.	80%	82%	8	88%
I know where to go for mental health services near me.	84%	78%	8	88%
I know when to ask for help with an emotional problem.	78%	83%	7	93%
I am able to deal with problems better.	65%	92%	5	83%
I feel less stress or pressure in my life.	68%	78%	5	73%
I feel better about myself.	67%	89%	5	81%
When I think about the future, I feel good.	73%	90%	5	70%
Please choose how much you agree or disagree with each sentence below:	**(n=37)**	**(n=130-134)**	**(n=8)**	**(n=152-170)**
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	73%	88%	8	96%
The program had services in the language that I speak best.	92%	97%	7	97%
I got services that were right for me.	87%	91%	8	96%
I am happy with the services I received.	97%	95%	8	99%
I would recommend this program to a friend or family member.	92%	95%	8	100%

Early Intervention

Percentage/number of respondents who selected Agree, by program

Because of this program…	Family Support Groups (n=17-18)	Felton Early Psychosis (n=64-67)	OMNI Resource Center (n=251-258)	School-Based Counseling (n=11-12)	School-Based DV Counseling (n=71-77)	Silver Star Resource Center (n=16-17)
I feel more connected to other people.	14	64%	75%	8	43%	5
I know where to go for mental health services near me.	18	86%	81%	11	55%	11
I know when to ask for help with an emotional problem.	18	90%	80%	10	73%	12
I am able to deal with problems better.	17	85%	76%	9	58%	10
I feel less stress or pressure in my life.	13	70%	66%	9	40%	9
I feel better about myself.	12	82%	80%	11	54%	8
When I think about the future, I feel good.	14	80%	67%	8	41%	8
I feel less worried or afraid.	15	70%	63%	10	43%	8
I feel I have more energy during the day.	14	62%	65%	7	44%	7
I care more about the things that are happening in my life.	17	82%	72%	11	62%	10
Please choose how much you agree or disagree with each sentence below:	**(n=16-18)**	**(n=64-67)**	**(n=257-258)**	**(n=11-12)**	**(n=76-77)**	**(n=17)**
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	17	82%	77%	7	63%	14
The program had services in the language that I speak best.	18	97%	90%	11	81%	17
I got services that were right for me.	17	95%	78%	11	75%	16
I am happy with the services I received.	16	92%	84%	11	71%	16
I would recommend this program to a friend or family member.	17	90%	88%	12	64%	15

Suicide Prevention & Stigma and Discrimination Reduction

Percentage/number of respondents who selected Agree, by program

Because of coming to this training/class…	Suicide Prevention Service (n=143-144)	Success Over Stigma (n=210-215)
I know where to go for mental health services near me.	76%	76%
I know when to ask for help with an emotional problem.	82%	87%
I believe people with mental illness can get better and have healthy lives.	78%	87%
I believe people are generally caring and sympathetic to people with mental illness.*	63%	66%
I would be more likely to help someone in need who has a mental illness.†	93%	-
I learned more about the warning signs of suicide.	80%	-
I learned ways to help a person who is dealing with a mental health problem or crisis.	84%	-
Please choose how much you agree or disagree with each sentence below:	**(n=139-145)**	**(n=211-214)**
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	64%	64%
Information was given in the language that I speak best.	87%	87%
I will use what I learned in this training/class.	75%	75%
This training/class helped me.	82%	82%
I would recommend this training/class to a friend or family member.	78%	78%

* This question was only asked in September 2018 survey version.

† This question was only asked in March 2019 survey version.

Outreach for Increasing Recognition of Early Signs of Mental Illness

Percentage/number of respondents who selected Agree, by program	African American Community Partnership	Family Self-Help Support and Advocacy	Latino Community Partnership	Promotores Mental Health Program
As a result of participating in this training/class…	**(n=22-46)**	**(n=10)**	**(n=32-36)**	
I know where to go for mental health services near me.	91%	10	91%	-
I know when to ask for help with an emotional problem.	87%	10	84%	-
I believe people with mental illness can get better and have healthy lives.	91%	10	94%	-
I believe people are generally caring and sympathetic to people with mental illness.	58%	10	76%	-
I have a better understanding of mental illness.*	100%	-	73%	-
I would be more likely to help someone in need who has a mental illness.*	100%	-	91%	-
Please choose how much you agree or disagree with each sentence below:	**(n=44-46)**	**(n=8-10)**	**(n=33-37)**	
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	94%	9	92%	-
Training/class materials were available in my preferred language.	100%	10	94%	-
I plan to use what I learned in this training/class.	93%	10	97%	-
Overall, this training/class was helpful to me.	98%	10	100%	-
I would recommend this training/class to a friend or family member.	98%	8	97%	-
Because of this program…		**(n=20-22)**		**(n=11)**
I feel more connected to other people.	-	20	-	9
I know where to go for mental health services near me.	-	22	-	10
I know when to ask for help with an emotional problem.	-	21	-	6
I am able to deal with problems better.	-	21	-	6
I feel less stress or pressure in my life.	-	13	-	7
I feel better about myself.	-	19	-	10
When I think about the future, I feel good.	-	18	-	7
I feel less worried or afraid.	-	16	-	10
I feel I have more energy during the day.	-	12	-	10
I care more about the things that are happening in my life.	-	21	-	10

* This question was only asked in March 2019 survey version.

Percentage/number of respondents who selected Agree, by program **Please choose how much you agree or disagree with each sentence below:**	**African American Community Partnership**	**Family Self-Help Support and Advocacy (n=23)**	**Latino Community Partnership**	**Promotores Mental Health Program (n=10-11)**
Staff respected my culture and background (e.g., ethnic/ religious beliefs).	-	22	-	10
The program had services in the language that I speak best.	-	23	-	11
I got services that were right for me.	-	23	-	8
I am happy with the services I received.	-	22	-	8
I would recommend this program to a friend or family member.	-	23	-	10

APPENDIX V

MONTEREY COUNTY BEHAVIORAL HEALTH

MENTAL HEALTH SERVICES ACT

INNOVATION COMPONENT

FY 2018-19

EVALUATION REPORTS

INN-01: Micro-Innovation Grant Activities for Increasing Latino Engagement

INN-02: Screening to Timely Assessment

INN-03: Transportation Coaching Project

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

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MONTEREY COUNTY
BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

INN-01: Micro-Innovation Grant Activities for Increasing Latino Engagement

First Annual Innovation Project Report – FY 2018/19

MONTEREY COUNTY HEALTH DEPARTMENT BEHAVIORAL HEALTH BUREAU | DIVISIÓN DE SALUD MENTAL | 1270 NATIVIDAD ROAD, SALINAS, CA 93906

Program Name: **Micro-Innovation Grant Activities for Increasing Latino Engagement**

Introduction

This is the First Annual Innovation Project Report for the Monterey County Innovation Project titled "Micro-Innovation Grant Activities for Increasing Latino Engagement". This report is to be submitted to the Mental Health Services Oversight and Accountability Commissions (MHSOAC) prior to December 31st following the conclusion of the first fiscal year of project implementation, in accordance with Title 9 California Code of Regulations – Division 1, Chapter 14, Article 5, Section 3580. The MHSOAC approved use of Mental Health Services Act Innovation Component funding for Monterey County Behavioral Health (MCBH) to implement this Innovation Project on August 23, 2018. Therefore, this report only pertains to activities taken place during FY 2018/19.

The intent of this report is to provide the MHSOAC and Monterey County stakeholders with a status update on this Innovation project. Per Title 9 California Code of Regulations – Division 1, Chapter 14, Article 5, Section 3580, the contents of this First Annual Innovation Report shall include updates on:

- Whether and what changes were made to the Innovation Project during the reporting period and the reasons for changes.
- Available evaluation data, including outcomes of the Innovation Project and information about which elements of the Project are contributing to outcomes.
- Program information collected during the reporting period, including number of participants and demographics of participants served.
- Any other data the County considers relevant.

Innovation Project Overview

The purpose of this Innovation Project is to increase access to mental health services to underserved groups by applying promising community driven practices that have been successful in a non-mental health setting to the mental health system. Specifically, by supporting small-scale community-driven innovative projects to address unique challenges and characteristics of certain demographics, languages, neighborhoods, communities, etc., the Micro-Innovation Grant Activities for Increasing Latino Engagement project may uncover effective approaches to improving the outreach for and delivery of mental health services to our most underserved populations in Monterey County.

The Problem

The primary problem to be addressed by this Innovation project is the relatively low number of Latinos utilizing Behavioral Health services in Monterey County. MCBH functions as the "safety net" mental health service provider in the county, and therefore sets the demographic profile of the local Medi-Cal eligible population as the benchmark for who mental health services should be designed for and accessed by. In FY 2016/17, Latinos made up 75% of the Medi-Cal eligible population in Monterey County, yet comprised roughly only 53% of MCBH mental health service consumers. This rate has even been on a slight decline over the prior 4 years. Not only has this persistent gap in

adequate service provision to Latinos and Spanish-speaking communities been observed in Monterey County, but a review of data from other counites suggests this is a statewide challenge.

The Solution

This Innovation project seeks to increase the number of Latinos receiving mental health services in Monterey County by enabling a diffuse network of micro-innovation activities designed specifically by and for local communities, neighborhoods, niche cultural or ethnic sub-groups, etc. These activities may be a one-time activity, or a sustained activity not to exceed 12 months. To implement this Innovation project, MCBH will first create a grant application. Next, MCBH will establish a Micro-Innovation Grant Review Board comprised of MCBH administrative staff, including staff that support Leadership and Civic Engagement programming and Cultural Competency, and a community stakeholder representative (who will not be applying for a mini-grant). The Review Board will additionally include the Monterey County Behavioral Health Epidemiologist, who will ensure all funded projects have a method to measure impact. Once established, the Review Board will refine and establish the criteria for awarding micro-innovation grants.

Criteria and/or information required of each grant applicant includes:

- How the activity will either a) introduce a new practice or approach to engage Latinos into mental health services, b) make a change to an existing practice in the field of mental health to better apply to Latino populations, or c) apply a promising community driven practice or approach from Latino communities/cultures that has been successful in a non-mental health context or setting to the mental health system.
- The staffing and material needs of the activity
- The budget for implementing and evaluating the activity
- A timeline for the activity
- The characteristics and culture of the community/individuals/neighborhood to be served
- A hypothesis for why the target community may not be engaged and how the activity will address this specific need (i.e. micro-innovation activity learning goals)
- A plan for how this activity can be scaled up to reach a broader population or geographic region
- How participant demographics will be recorded
- How referral to services will be recorded
- How other relevant data will be recorded

It is anticipated that MCBH will award 9 to 15 micro-innovation grants per fiscal year. Micro-innovation grants will range in size from $1,000 to $50,000. Portions of the grant may be supplied upfront to initiate the grant activities, with installment payments made upon completion of deliverables/benchmarks as set forth in the agreements with each grantee.

Dissemination of the micro-innovation grant opportunity occurs through several channels, including sharing with Monterey County boards and commissions, and shared across county websites, social media accounts, and email. At the conclusion of the application window, the review board will evaluate all received proposals and invite those who submitted promising concepts to in-

person interviews prior to awarding grant funds. In-person interviews are to be used for clarifying any additional questions by review board or proposer, and confirm an evaluation plan. Service Agreements will be negotiated to include a timeline for completion of each deliverable, and finalize reporting, project evaluation methods and communication requirements. MCBH will also utilize a local organization that will serve as "fiscal agent" for those individuals/groups who do not meet the County's insurance requirements, thereby mitigating the potential barrier for applicants not affiliated with an established organization.

Throughout the duration of this project and micro-innovation activities, MCBH Innovation staff is available to provide technical assistance related to documenting learning and outcome data that is required for conducting meaningful evaluation.

Learning Goals

This Innovation Project aims to increase the number of Latinos served by mental health services in Monterey County. Therefore, the main learning goal of this Innovation Project is to determine if any of these micro-innovation activities are effective in engaging Latino populations with needed mental health services. Specific learning goals of this project are to:

- For each micro-innovation, identify how many Latino individuals that have never engaged with mental health services received a referral for mental health treatment services.
- For each micro-innovation, identify how many Latino individuals followed through on a referral and received mental health treatment services.
- Identify if the total count of Latinos served increased during this Innovation project.
- Identify if any micro-innovation activities demonstrate capacity for sustainability in impact and/or funding.
- Identify if and how cultural barriers were addressed.
- Additional learning goals unique to target populations will be established in the development and approval of micro-innovation activities.

As this Innovation Project will support several diverse small-scale approaches and/or practices to engage specific communities, Latino sub-ethnicities, etc., it is anticipated that a variety of unique and novel learning goals will be developed, and both quantitative and qualitative evaluation methodologies will be used. At a minimum, to evaluate the learning goals stated above, each activity will maintain records on:

- Total Client Count
- Demographics
- Count of individuals that have not previously received mental health services
- Number of referrals
- Type of referrals
- Number of referrals where individuals followed through on an appointment

MCBH will provide technical assistance, as needed, to assist individual and organizations in recording valid data, including referral and process data. Service data will be aggregated and

evaluated in conjunction with the MCBH electronic medical record system (Avatar) to assess the net impact on service penetration rates by Latinos. In addition to evaluation of activities, MCBH will document the process of implementing this project and provide qualitative assessment of challenges and successes experienced.

At the conclusion of this Innovation project, MCBH plans to hold an exit summit, providing all grantees the opportunity to present and share their results. Additional evaluation will be conducted by MCBH staff to assess the mini-grant project model, and synthesize observed impacts of micro-innovation projects for potential implementation with other sources of funding as may be available.

Resources

The Micro-Innovation Grant Activities for Increasing Latino Engagement project plan indicates MCBH to assign partial staff time of an Analyst and Epidemiologist for purposes of project coordination, evaluation, and reporting. MCBH will contract with a community based organization to act as fiscal agent responsible for distributing mini-grant funds in certain cases. Given the potential volume and variety of mini-grant applicants (community organizations, members of the public, county staff member, etc.), the burden of County purchasing procedures and requirements presented too significant of a challenge to implementation of this project in a timely manner. Therefore, the partnership with a qualified local agency to serve as fiscal agent is critical. MCBH will solicit and award bids to perform work, and provide administration oversight of this project. The fiscal agent will only be used to distribute funds.

Timeline

The total timeframe (duration) of this Innovation project is 3 years. The timeline for key phases / deliverables is as follows:

- January 2019 – March 2019 (3 months): Form Micro-Innovation Grant Review Board and establish Micro-Innovation Grant application criteria. Establish agreement with county purchasing department and Action Council of Monterey County for issuing grant payments.
- April 2019 – June 2019 (3 months): Issue announcement requesting first round of Micro-Innovation Grant proposals for in October 2018. Perform review process, awarding grants before end of calendar year.
- July 2019 – June 2020 (1 year): Cohort #1 implements micro-innovation activities.
- October 2019 – December 2019 (3 months): Issue announcement requesting second round of Micro-Innovation Grant proposals. Perform review process, awarding grants before end of June 2019.
- January 2020 – December 2020 (1 year): Cohort #2 implements micro-innovation activities.
- April 2020 – June 2020 (3 months): Issue announcement requesting third round of Micro-Innovation Grant proposals. Perform review process, awarding grants before end of December 2019.
- July 2020 – June 2021 (1 year): Cohort #3 implements micro-innovation activities.
- July 2021 – December 2021 (6 months): Review evaluation findings and hold 'Exit Summit' to share results and lessons learned.

Budget

This Innovation Project has a total approved budget of $1,240,000.

The budget allocates funding accordingly:

Budget Category	FY 2018/19	FY 2019/20	FY 2020/21	*Total*
County-Operated Program Expenses	$66,239	$67,030	$67,731	$201,000
Consultant Costs/Contracts	$346,334	$346,333	$346,333	$1,039,000
Total	$412,573	$413,363	$414,064	$1,240,000

Innovation Project Updates and Changes in FY 2018/19

This Innovation is currently on track with the activities and timeline as specified in the project plan. A micro-innovation grant application was developed by MCBH staff and disseminated/posted to the public from March 8, 2018 to April 15, 2018. The application was available in both Spanish and English (Appendix A). This was the first application period. The announcement was made via email to county staff and community partners, the county MHSA and Public Health websites, social media accounts, and by presentation at the County Behavioral Health Commission.

A Review Board was also assembled during this period. The Review Board included: MCBH staff, including the Prevention and Early Intervention Coordinator, Quality Improvement Manager, Cultural Competency Coordinator, and Chronic Disease Health Coordinator (Civic Leadership Manager); and, members of the Monterey County Behavioral Health Commission. An application scoring criteria and score sheet was created and provided to Review Board members (Appendix B).

MCBH received a total of six (6) applications during the first application period. Applicants included one (1) county staff member, one (1) community member, and four (4) local community service providers. All six (6) projects were approved for funding by the Review Board. Two (2) applicants subsequently postponed their projects, resulting in four (4) applicants moving forward towards funding and implementation. The four (4) applicants that received agreements to proceed with their micro-innovation activity planned to implement the following projects:

1. Working with a local homeless resource clinic, a community member planned to host culturally significant meals and artistic performances by individuals with lived experience. This applicant expressed the need to provide culturally significant Mexican food to the homeless clientele, that is predominately of Hispanic/Latino descent, in order to build foundational trust. The artistic performances consisted poetry and painting performed live to the audience. The performers are all individuals with lived experience dealing with homelessness and mental health disorders. An open dialogue on mental health would follow the meal and performances, with the opportunity for service referrals to be provided by an attending Social Worker.
2. A local community advocacy group proposed to hold ten (1) hour-long radio programs on a local Spanish language radio station, covering a variety of mental health topics. Following

each radio show, the applicant would then host a community workshop on the topic presented during the show, with the ability to provide resource referrals as needed.

3. A local community-based service provider proposed to host numerous mental health workshops throughout the county, particularly in more remote areas of the county, with the ability to provide triage and referral services. Of note, these workshops will be provided in Spanish-language.
4. A local community-based service provider proposed to facilitate a sequence of events focused on serving Latino women. The project will consist of numerous workshops open to Latino women, with the intent to develop a resource guide that includes a variety of culturally relevant, indigenously based and/or alternative mental health care practices and approaches to aid women; particularly mothers. The series of workshops will culminate in a women's retreat in which the practices will be utilized.

To aid each applicant in providing referrals and to track clients, MCBH staff provided them with a referral sheet and formatted Excel workbook (Appendix C). Applicants were directed to use these documents as needed, or otherwise test their own methods. Applicants were also directed to provide their lessons learned on the efficacy of their micro-innovation to generate completed referrals at the conclusion of their project.

All four(4) projects currently moving forward with funding and implementation have a start date of July 1, 2019. Expenditures to be incurred by the four projects will not be processed for reimbursement until FY 2019/20.

In FY 2018/19, the total expenditures for the Micro-Innovation Grant Activities for Increasing Latino Engagement project fell below the anticipated budget presented in the approved plan, as reflected here:

Funding Category	**FY 2018/19 Budget**	**FY 2018/19 Estimated Expenditures**	***Estimated Remaining Balance***
County-Operated Program Expenses	$66,239	$16,865	$47,363
Consultant Costs/Contracts	$346,334	$0	$346,334
Total	$412,573	$16,865	$393,697

The large discrepancy between budget projections and expenditures is primarily due to the delay in receiving funding approval by the MHSOAC. The budget table included in the approved project plan reflects an anticipated start date of July 1, 2018. However, delays in the inclusion of Monterey County's proposed Innovation project on the MHSOAC meeting agenda set back the Micro-Innovation Grant Activities for Increasing Latino Engagement project start date to January 1, 2019.

Evaluation Data

No Micro-Innovation Grant Activities for Increasing Latino Engagement projects were implemented during FY 2018/19, in accordance with the approved workplan, and therefore no evaluation data is available for this review period.

Appendix A: Micro-Innovation Grant Application

Application for Micro-Innovation Grant Activities to Increase Latino Engagement

Monterey County Behavioral Health (MCBH) is currently offering a funding opportunity for one-time projects that may increase the engagement of Latino communities with our local mental health services system. For several years, health record data for Monterey County has indicated Latino communities to be the most underserved in our county. Extensive community feedback has indicated this may be due to current services not resonating with the various Latino ethnicities, languages and dialects, and cultural norms that exist across our large county. In response to this feedback, MCBH has obtained Mental Health Services Act (MHSA) Innovation funding to support individuals and organizations across Monterey County to try out their own unique approach to promoting mental health services in ways that better reach their Latino ethnicity, culture, language, city, neighborhood, etc. As a result, it is hoped that more culturally appropriate and impactful mental health service delivery and communication methods will be uncovered.

MHSA Innovation funding is intended for testing out new "out-of-the-box" ideas that can improve our mental health system. These projects can test out a new practice or approach the delivering mental health services, adapt an existing mental health service to better serve a group of people, or promote better communication and collaboration between agencies and organizations to make services more accessible and/or provide better quality services. It is not necessary for these projects to demonstrate success (although that's desirable!); but rather, it is most important to learn from the successes and failures of the ideas to better inform the mental health services community on best practices.

Micro-Innovation Application Requirements:

1. All activities must be new! Innovation funds are dedicated for testing new and novel concepts, and may not be used to supplement existing programs or activities.
2. Eligibility: All members of our community are encouraged to apply, including members of the public, past and current clients, affected family members, students, community partners and service providers.
3. Budget: Activities may be small or large in scope, with budgets ranging from $500 to $50,000. Please note that funds received must be reported to the IRS as personal income and recipients will receive a 1099 tax form at the end of the year to assist in tax preparation.
4. Timeline: Activities may be a one-time event or a continuous activity lasting up to one year. Timelines should account for planning for the activity, implementing the activity, and organizing activity information for evaluation efforts.

Applications Rating Criteria:

A. Level of Innovation – Creativity and unique solutions to address community-specific needs is encouraged.
B. Evaluability – Being able to articulate the work to be done and the anticipated results of that work is very important, as it allows evaluation to occur on impact and cost-effectiveness.
C. Scalability – It is desirable for projects to be able to support an increased number or clients/participants
D. Population to be served – Projects will be awarded additional points for serving communities identified as most in-need, including zip codes with the majority of residents being Latino, Spanish-speaking individuals, and Latino adults and older adults.

To assist in developing a strong application, the following documents can be referenced on the Monterey County Behavioral Health MHSA webpage (http://www.co.monterey.ca.us/government/departments-a-h/health/behavioral-health/mental-health-services-act):

- 'Scoring criteria'
- 'Monterey County Behavioral Health Bureau Health Equity Report FY17/18'
- 'Innovation Plan: Micro-Innovation Grant Activities to Increase Latino Engagement'

Successful applicants will be contacted by MCBH and scheduled to meet with the Micro-Innovation Grant Review Board to refine project details as needed, prior to approval of funding.

The current deadline for submitting applications is April 15, 2019. Applications received after this date may be considered for the next application period to be held in Fall 2019

Questions may be sent to MHSAinnovation@co.monterey.ca.us

---

1. Contact Information

Name:_____ Phone Number:_____

E-mail Address:_____

2. Population of Interest

a. Who do you plan to serve? (i.e. specific Latino/Hispanic ethnicity, language, culture, neighborhood, etc.)

_____

_____

_____

_____

b. What issue do you hope to address?

_____

_____

_____

_____

c. How many individuals to you expect to serve?

_____

_____

3. Project Methodology

d. What idea do you want to test?

e. How will you do this? (i.e. what work will be involved, who will do it, where and when will it happen, etc.)

4. Evaluation

f. What would it look like if your project was successful? How will you know?

5. Budget

Please list the costs and explanation of costs associated with this project:

	Cost ($)	Explanation of Costs
Estimated Labor Costs		
Estimated Materials Costs		
Other costs		
Total Request		

6. Timeline

g. What is the timeline for carrying out this project ?

_____
_____
_____
_____
_____

Appendix B: Scoring Criteria

Scoring Criteria

for Applications for Micro-Innovation Grant Activities to Increase Latino Engagement

Applications will be scored across four criteria. The first three criteria will be scored by the review board on a scale of 1 – 9, where a higher score signals a stronger application. The fourth criteria will receive a set number of points (5) for satisfying that criterions' requirement.

The first three criteria will be scored on a scale of 1-9, where 1 = poor and 9 = exceptional (See Table1).

Table 1: Criteria Scoring Guide

Overall Impact or Criterion Strength	Score	Descriptor
Low	1	Poor
	2	Marginal
	3	Fair
Medium	4	Satisfactory
	5	Good
	6	Very Good
High	7	Excellent
	8	Outstanding
	9	Exceptional

1. Level of Innovation
    a. MCBH is looking for new, unique, and truly innovative ideas to address gaps in the mental health system that may be preventing Latino populations from being adequately served. As current services are falling short, MCBH is not looking for more of the same. Instead, it will be the "out of the box" ideas that have not been seen or tried in Monterey County

2. Evaluability
    a. As a requirement of receiving MHSA Innovation funding, activities must be evaluated for some outcome. This means that applications must identify what the activity will do to address a problem, and what factor will be tracked to determine if an impact was made. For example, an activity where a video on signs and symptoms of mental illness is shown, with the goal of increasing viewers' awareness and knowledge of mental illness, the impact of this activity can be measured by asking the viewers if they better understand mental illness and its signs and symptoms after they have viewed the video. Evaluating an activity for impact is critical for helping that activity turn into a more permanent program.

3. Scalability

a. Scalability means that an activity has the ability to be replicated in another setting or environment, and/or can grow in response to meeting additional demand. For example, an activity that involves a single person going door-to-door to inform the public about mental health programs may be effective, but is limited in its potential impact. One person going door-to-door is not scalable, as that person can only contact a single household at a time. A more scalable approach to reaching households with this information is to have a team of individuals going door-to-door, or having a resource phone line available to call and promoting that phone number through flyers or social media. These approaches are more scalable because they can make a bigger impact with only a bit more efforts and materials, and those methods can be applied in multiple areas at the same time.

The fourth criterion will receive a score of 5 points if satisfied:

4. Population To Be Served
    a. While this focus of this funding opportunity is to improve access to, and quality of, services to Latino populations, there remain subsets of this population that are even more underserved. The MCBH Health Equities report highlights data that indicates the following Latino population subsets being underserved:
        i. Women
        ii. Older Adults
        iii. Disabled
        iv. South County and North County

        Projects that aim to serve at least one of the above groups will receive an additional 5 points in their application score.

Appendix C: Referral Sheet

Micro-Innovation Referral Form

Client Name:_____

Contact Information:_____

Date of Referral: _____

What racial/ethnic categories do they identify with?:	○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Hispanic or Latino ○ Native Hawaiian or Pacific Islander Native Hawaiian or Pacific Islander ○ White ○ Multiracial ○ Another race/ethnicity: _____
What language do you speak at home?:	○ English ○ Spanish Another language: _____

Please list name of agency/programs referred to: *(if more than one, list all)*	**Did this person participate at least once in the services of the agency/program that you referred them to?** *(mark 'X' on applicable response)*		
	Yes	**No**	**Unable to Determine**
1.			
2.			
3.			
4.			

Tear off below line for client:

Behavioral Health Resource Referrals

Agency/Program	Contact Information

MONTEREY COUNTY
BEHAVIORAL HEALTH

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INN-02: Screening to Timely Assessment

First Annual Innovation Project Report – FY 2018/19

Program Name: Screening to Timely Access

Introduction

This is the First Annual Innovation Project Report for the Monterey County Innovation Project titled "Screening to Timely Access". This report is to be submitted to the Mental Health Services Oversight and Accountability Commissions (MHSOAC) prior to December 31st following the conclusion of the first fiscal year of project implementation, in accordance with Title 9 California Code of Regulations – Division 1, Chapter 14, Article 5, Section 3580. The MHSOAC approved use of Mental Health Services Act Innovation Component funding for Monterey County Behavioral Health (MCBH) to implement this Innovation Project on September 27, 2018. Therefore, this report only pertains to activities taken place during FY 2018/19.

The intent of this report is to provide the MHSOAC and Monterey County stakeholders with a status update on this Innovation project. Per Title 9 California Code of Regulations – Division 1, Chapter 14, Article 5, Section 3580, the contents of this First Annual Innovation Report shall include updates on:

- Whether and what changes were made to the Innovation Project during the reporting period and the reasons for changes.
- Available evaluation data, including outcomes of the Innovation Project and information about which elements of the Project are contributing to outcomes.
- Program information collected during the reporting period, including number of participants and demographics of participants served.
- Any other data the County considers relevant.

Innovation Project Overview

The Screening to Timely Access project aims to increase access to mental health services by introducing a new practice into the mental health system. This practice includes developing a web-based screening tool that will assess users for a wide spectrum of potential mental health disorders and that will provide education resources and linkage to the appropriate local mental health service.

The Problem

The primary problem addressed by this Innovation project is demand for mental health services outpacing the capacity of the mental health services system to appropriately screen and refer individuals to treatment. The demand for services at MCBH open access mental health clinics has seen a significant increase in recent years, with the number of clients served over the three-year period (FY2015-17) increasing by more than 100% (2,521 to 5,087). Meanwhile, the level of staff capable of responding to these community needs remained unchanged. The result is a bottleneck occurring at the client assessment entry point, with less clinical staff time being available for more intensive therapy services.

The MCBH community planning processes also revealed both a lack of knowledge in the community about mental health, available mental health services, and a persistent stigma associated with

mental health issues, particularly among Latino communities. Therefore, MCBH believes demand for services will only continue to increase over time.

The Solution

To better meet the increased demand for services, the Screening to Timely Access project will develop a comprehensive web-based mental health assessment application that can screen for a broad spectrum of mental health disorders and refer individuals to the appropriate level of care within the MCBH system. This tool will have additional benefits of educating individuals on their potential condition(s), expediting client assessments in clinical settings, and minimizing the detrimental effects of stigma towards seeking information and help for mental health issues.

To build this tool, MCBH successfully applied for Innovation funding under the multi-county Technology Suite Collaborative (Help@Hand). This collaborative is facilitated by the California Mental Health Services Authority (CalMHSA), whereby CalMHSA serves as the agent for procuring technology, marketing and evaluation vendors to assist participating counties in incubating technology-based Innovation Projects. The Screening to Timely Access tool will be built independently of any existing MCBH or Technology Suite applications, only potentially linking with Technology Suite applications at a future date where feasible and applicable.

The tool will be developed around the core criteria of:

- Being able to screen for a broad range of disorders, from low-risk with mild need to severe with urgent need.
- Being easily accessible for use by community based providers to help individuals understand the need for treatment.
- Maintaining confidentially standards.
- Interfacing with MCBH's Avatar electronic medical record system to provide more seamless transitions into care.
- Working fluidly in Spanish. The Screening tool will incorporate perspectives from the Latino community and will include cultural nuances that reflect how Latinos understand and relate to mental health.
- Build upon current evidence based screening tools with proven validity and utilize item response theory to minimize the number of questions required in the assessment.

By using the web-based screening tool, the type and severity of mental health concerns will be identified along with the corresponding MCBH treatment program that best fits the individual's needs. The user will be provided the option to view the appropriate referral contact information or transmit health information to MCBH for review and a callback by MCBH staff.

The deployment of this application will occur in several phases:

1. MCBH will engage CalMHSA to identify an appropriate vendor(s) with experience to develop the screening tool and application, comply with all information security regulations and concerns, and support evaluation efforts. MCBH will also partner with other interested counties to ensure this meets the needs of many diverse populations.
2. A prototype of the application will be developed and a cohort of MCBH staff and community based service providers will be trained in its use. These trained individuals will pilot

screenings in the field, using the application with a small number of clients to ensure its applicability within our local communities, and assess functionality and user experience.

3. After testing indicates the application is capable of accurately determining the level of care and services needed by the user, MCBH will make the application available for download on the MCBH website (or online "app store") and enlist additional participation by staff and community partners in using the application. This application will be tested in batches of 100 clients at a time as we conduct initial user acceptance testing and make modifications. During this Innovation project, we anticipate at least 5,000 screenings will be conducted.

Learning Goals

This program aims to increase access to mental health treatment services in Monterey County. To assess the relationship between use of this application and greater accessibility to services, and its value to consumers/users more generally, the following learning goals will be evaluated:

1. Determine if this screening tool accurately gauges type and severity of mental illness.
2. Determine if this application provides meaningful and accurate referral connections to the appropriate service / resource as efficiently as possible.
3. Assess whether this web-based screening tool reduces the hours and cost associated with in-person assessments.
4. Assess the impact the implementation of this application has on the total volume of clients entering ACCESS services, including its effect on the demographics of clients served.
5. Assess whether individuals (staff, community provider, peer, etc.) using this application to assist a person in need find this application useful for connecting that person to resources. Many local agencies expressed interest in testing this, including local law enforcement who hope to use this to link community members to care.

To evaluate the impact and value of the application proposed in this project, quantitative and qualitative methodologies with be used. Through evaluation efforts, application data on user demographics, assessment data and referral data will be assessed and utilized for various evaluation strategies. To measure if the application accurately gauges type and severity of mental illness, follow-up surveys and/or cross-reference with Avatar service data will be conducted. A similar methodology will be used to assess the efficacy of referral/linkage functions of the application. To measure for any reduction in staff hours spent on assessment/evaluation of clients, the corresponding staff hours spent on these service activities as reflected in Avatar data will be analyzed. Avatar data will also be referenced to assess the aggregate impact that use of this application may have on increasing total number of clients served. Finally, qualitative information will be gathered to assess user experience. This information will be requested from the spectrum of users, including clinical and law enforcement staff, community providers, consumers, peers and family members.

Resources

The Screening to Timely Access project plan indicates MCBH to assign partial staff time of an Analyst and Epidemiologist for purposes of project coordination, evaluation, and reporting. Implementation of the Screening to Timely Access project, including facilitation of the vendor

procurement process, product development and testing, and marketing and evaluation services, is to be performed by CalMHSA and contracted service providers.

Timeline

The total timeframe (duration) of this Innovation project is 3 years. The timeline for key phases / deliverables is as follows:

- January 2019 – June 2019 (6 months): Work with CalMHSA to identify and enter contracts with web developers.
- July 2019 – December 2019 (6 months): Establish specifications and develop application.
- October 2019 – December 2019 (3 months): Beta test application with community partner.
- January 2020 – December 2021 (2 years): Support countywide access and use of applications.
- October 2021 – December 2021 (3 months): Perform evaluation activities

Budget

The Screening to Timely Access project has a total approved budget of $2,526,00.

The budget allocates funding accordingly:

Budget Category	FY 2018/19	FY 2019/20	FY 2020/21	*Total*
County-Operated Program Expenses	$64,228	$65,046	$65,725	$195,000
Consultant Costs/Contracts	$806,000	$760,000	$760,000	$2,326,000
Total	**$875,227**	**$825,047**	**$825,726**	**$2,526,000**

Innovation Project Updates and Changes in FY 2018/19

The Screening to Timely Access project has experienced significant delays in implementation and is currently behind the anticipated timeline. It was expected by the end of FY 2018/19, CalMHSA would have entered into agreements with appropriate vendors to develop both the assessment survey and technology components of the project. However, as of this writing, the RFP document still under development and not yet made publicly available.

There are two primary reasons for the delay in project implementation. CalMHSA was delayed in assigning contract procurement specialists to assist MCBH staff in creating an RFP document to procure vendors. CalMHSA eventually contracted with Cambria Solutions to facilitate vendor procurement processes. The project implementation was further delayed while MCBH made efforts to recruit additional counties into this project. MCBH perceives value in the addition of other county partners to increase the available funding and validate the eventual product in other environments and languages in addition to what Monterey County can offer. The effort to obtain a commitment from additional counties has led to delays in drafting language in the RFP document, as the participation of such partners in this phase of the process is highly-desired.

In FY 2018/19, the total expenditures for the Screening to Timely Access project fell below the anticipated budget presented in the approved plan, as reflected here:

Funding Category	FY 2018/19 Budget	FY 2018/19 Estimated Expenditures	*Estimated Remaining Balance*
County-Operated Program Expenses	$64,228	$16,865	$47,363
Consultant Costs/Contracts	$806,000	$387,506	$418,494
Total	**$875,227**	**$404,371**	**$470,856**

The large discrepancy between budget projections and expenditures is primarily due to the delay in receiving funding approval by the MHSOAC. The budget table included in the approved project plan reflects an anticipated start date of July 1, 2018. However, delays in the inclusion of Monterey County's proposed Innovation project on the MHSOAC meeting agenda set back the Screening to Timely Access project start date to January 1, 2019.

Evaluation Data

No clients participated in the Screening to Timely Access Project in FY 2018/19, in accordance with the approved workplan, and therefore no evaluation data is available for this report.

MONTEREY COUNTY BEHAVIORAL HEALTH

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INN-03: Transportation Coaching by Wellness Navigators

First Annual Innovation Project Report – FY 2018/19

Program Name: Transportation Coaching Project (formerly Transportation Coaching by Wellness Navigators)

Introduction

This is the First Annual Innovation Project Report for the Monterey County Innovation Project titled "Transportation Coaching Project" (TCP). This report is to be submitted to the Mental Health Services Oversight and Accountability Commissions (MHSOAC) prior to December 31st following the conclusion of the first fiscal year of project implementation, in accordance with Title 9 California Code of Regulations – Division 1, Chapter 14, Article 5, Section 3580. The MHSOAC approved use of Mental Health Services Act Innovation Component funding for Monterey County Behavioral Health (MCBH) to implement the TCP (under the original title "Transportation Coaching by Wellness Navigators") on August 23, 2018. Therefore, this report only pertains to activities taken place during FY 2018/19.

The intent of this report is to provide the MHSOAC and Monterey County stakeholders with a status update on this Innovation project. Per Title 9 California Code of Regulations – Division 1, Chapter 14, Article 5, Section 3580, the contents of this First Annual Innovation Report shall include updates on:

- Whether and what changes were made to the Innovation Project during the reporting period and the reasons for changes.
- Available evaluation data, including outcomes of the Innovation Project and information about which elements of the Project are contributing to outcomes.
- Program information collected during the reporting period, including number of participants and demographics of participants served.
- Any other data the County considers relevant.

Innovation Project Overview

The TCP aims to increase access to mental health services by introducing a new practice into the mental health system. This practice includes the development and use of a Transportation Needs Assessment Tool (TNAT) to inform and guide the transportation coaching activities of peers who function as Wellness Navigators (WN's). The intended result of the coaching activities prescribed by TNAT results is to promote greater independence and capability of consumers to participate in both clinical and non-clinical activities that support their wellness and recovery.

The Problem

The TCP was developed in response to consistent community and consumer feedback citing transportation challenges as a major barrier to receiving the mental healthcare they or their loved ones need. Some of the cited transportation challenges include a consumers' inability to obtain a license and/or vehicle, limited or no driving experience, timely access to transportation via family and friends, and inexperience navigating public transit and rideshare systems. MCBH has previously responded to meet some of these challenges by allocating staff resources to provide transportation. However, demand for transportation services continually exceeded the capacity MCBH.

The negative consequences of this strained system are then two-fold. First, transportation needs of existing and potential consumers of mental health services going unmet means they are experiencing prolonged suffering and/or delayed progress in their recovery. Second, to alleviate these transportation barriers and promote accessibility to services, qualified mental health professionals traditionally spend an inordinate amount of time in providing transportation services instead of providing more meaningful therapeutic services.

The Solution

To support and promote the independent transportation skills of mental healthcare consumers, the TCP introduced a TNAT protocol to standardize a review of transportation-related barriers and consumer goals. TNAT results are then used to prescribe targeted WN coaching activities. The intended result of the project is to support enhanced consumer independence as part of their wellness and recovery plan, as well as aid in the efficient use of clinical resources.

The TCP plan identified the following five (5) phases for project implementation:

1. Develop the transportation needs assessment tool
2. Hire and train Wellness Navigators
3. Enroll consumers in the program
4. Implement transportation coaching activities
5. Evaluate program impacts

Learning Goals

This Innovation project aims to increase the independent transportation skills of MCBH consumers by employing a transportation coaching program that is informed by a new TNAT. While the service goals in the project are to increase access to services and improve rates of recovery, the primary Innovation learning goals of this project are focused on measuring the impact and value of the TNAT. By creating a valuable tool and identifying best practices for promoting consumer independence, this Innovation project may offer valuable knowledge to the broader mental health services community. Specifically, the lessons learned through the TCP may aid mental health service agencies to more effectively plan and implement wellness navigation and transportation coaching services.

Specific learning goals of this project are to:

1. Assess whether the use of the transportation needs assessment tool and subsequent transportation coaching lead to greater levels of independence and recovery reported by participating consumers.
2. Identify which transportation coaching activities correspond to improved levels of independence and recovery.
3. Quantify the staffing costs/investment associated with improving a consumer's level of independence (i.e. observe a "step-down" in level of transportation coaching needs).

The scores observed on the TNAT are central to evaluating the learning goals of this project. The level of change between pre- and post-intervention TNAT scores indicates the level of improvement a consumer has experienced, and aids in identifying coaching activities that may have contributed to that success. Additionally, analysis of staff time allocated towards activities and consumers demonstrating success is used to evaluate TCP learning goals.

Resources

The TCP project plan indicates MCBH to assign partial staff time of an Analyst and Epidemiologist for purposes of project coordination, evaluation, and reporting. Implementation of the TCP, including hiring and management of WN's, and administration of the TNAT, WN coaching activities and data collection, is performed by a contracted service provider.

Timeline

The total timeframe (duration) of this Innovation project is 3 years. The timeline for key phases / deliverables is as follows:

- January 2019 – March 2019 (3 months): MCBH will develop Transportation Needs Assessment Tool, and sequence vetting and approval of a final product through the Behavioral Health Commission, Cultural Relevancy and Humility Committee and Recovery Task Force.
- January 2019 – March 2019 (3 months): Source vendor, negotiate contract terms, and process contract through county purchasing procedures.
- April 2019 – June 2019 (3 months): Develop transportation coaching curriculum for Wellness Navigators. Complete trainings before end of calendar year.
- July 2019 – June 2021 (2 years): Begin assessments of new and existing consumers in Adult System of Care programs. Continue providing assessment and re-assessments through June 2021. Collect assessment data and provide technical assistance throughout implementation timeline.
- July 2021 – December 2021 (6 months): Conduct evaluation, including evaluation of assessment data and gathering qualitative data from staff and participants

Budget

The TCP has a total approved budget of $1,234,000.

The budget allocates funding accordingly:

Budget Category	FY 2018/19	FY 2019/20	FY 2020/21	*Total*
County- Operated Program Expenses	$64,228	$65,046	$65,725	***$195,000***
Consultant Costs/Contracts	$346,334	$346,333	$346,333	***$1,039,000***
Total	***$410,562***	***$411,379***	***$412,058***	***$1,234,000***

Innovation Project Updates and Changes in FY 2018/19

The TCP is currently on-track with the activities and timeline proposed in the Innovation Project Plan. Throughout the winter and spring of 2019, the following accomplishments and changes were made:

1. MCBH entered into an agreement with Interim, Inc. as the contracted provider of TCP related services, including hiring and management of WN's, and administration of the TNAT, WN coaching activities, and data collection.

   a. Service provisions within the contract include hiring four (4) WN's (to be stationed out of MCBH clinical facilities in each region of the county). All four (4) WN's were hired prior to FY 2019/20.
   b. The 4 WN's have a combined goal of serving eighty (80) consumers in the TCP (twenty (20) per region), with all consumers completing the TNAT a minimum of two (2) times.
      i. The original plan states re-assessments every three (3) months. This change to a focus on a minimum of two (2) assessments was primarily made due to the reality that consumers may participate in the TCP for weeks to years, and it is most critical to have at least one (1) assessment in the beginning and end of their participation.
   c. In preparation of launching the TCP, MCBH and Interim, Inc. staff conducted several meetings to establish a referral workflow from MCBH clinical staff to WN's, review TCP related documents such as the TNAT and coaching activities guide and identify strategies for data collection.
   d. Additionally, it was determined that WN's would log consumer TCP activities into Monterey County's Avatar electronic medical record system to allow for an easier transition to potential Medi-Cal billing in future iterations of this project, should the TCP project be determined as successful.
      i. A change resulting from these meetings was the renaming of the project from "Transportation Coaching by Wellness Navigators" to "Transportation Coaching Project." The reason for this change was to support easier communication between MCBH, Interim Inc., and stakeholders with more simple terminology.
2. The TNAT was developed (Appendix A).
   a. The TNAT was developed in draft form by MCBH staff and subsequently reviewed and refined staff of Interim Inc. and a total of 18 current consumers in Adult System of Care programs.
3. A TCP Intervention Guide (coaching curriculum) was created for use by WN's in determining appropriate activities to use in response to a consumer's TNAT results, along with resources to deal with Critical Incidents and De-escalation Techniques (Appendix B).
4. A TCP Client Handbook was created to provide consumers with information (Appendix C).
5. A TCP Client Referral Form was created, to be provided by clinical staff to the TCP Coordinator (Appendix D).
6. A formatted Excel workbook was created to assist TCP staff in maintaining records of TNAT scores.
7. New service codes were created in Avatar to reflect the operation performed out of each of the four (4) MCBH clinical facilities.

Per the TCP plan, enrollment and participation of consumers in the project is planned to begin at the beginning of FY 2019/20. At the conclusion of FY 2018/19, WN's were hired, trained and located in MCBH clinical facilities, and MCBH staff was oriented to the referral process in order to begin referring consumers in July 2019.

In FY 2018/19, the total expenditures for the TCP fell below the anticipated budget, as reflected here:

Funding Category	FY 2018/19 Budget	FY 2018/19 Estimated Expenditures	*Estimated Remaining Balance*
MCBH Personnel	$64,228	$16,865	$47,363
Consultant Costs/Contracts	$346,334	$103,900	$242,434
Total	$410,562	$120,765	$289,797

The large discrepancy between budget projections and expenditures is primarily due to the delay in receiving funding approval by the MHSOAC. The budget table included in the approved project plan reflects an anticipated start date of July 1, 2018. However, delays in the inclusion of Monterey County's proposed Innovation project on the MHSOAC meeting agenda set back the TCP start date to January 1, 2019.

Evaluation Data

No consumers were enrolled in the TCP in FY 2018/19, in accordance with the approved workplan, and therefore no evaluation data is available for this period.

Appendix A: Transportation Needs Assessment Tool

Transportation Needs Assessment Survey

MHSA Innovations Project

Avatar#:_____ ***Date***: _____

1. How often do you miss your health appointments due to transportation issues?
☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

2. How often do you get to your appointment on your own, without the help of another person?
☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

3. How often do you go out for other activities that support your wellness and recovery?
☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

3a. Which types of activities would you like to do/attend on your own? *(select all that apply)*
- ☐ Errands/Shopping (grocery store, bank, etc.)
- ☐ Religious
- ☐ School
- ☐ Work/Volunteering
- ☐ Sports/Leisure Activities
- ☐ Social Outings
- ☐ Other (Please specify:_____)

4. How do you currently get around?
(select all that apply)
- ☐ Walk
- ☐ Bike
- ☐ Drive myself
- ☐ Driven by friend/family
- ☐ Driven by mental healthcare worker
- ☐ MST
- ☐ MST Rides
- ☐ CCAH (Medi-Cal Transportation Benefit)
- ☐ Taxi
- ☐ Rideshare app (Uber, Lyft)
- ☐ Other (Please specify:_____)

5. How would you like to get around?
(select all that apply)
- ☐ Walk
- ☐ Bike
- ☐ Drive myself
- ☐ Driven by friend/family
- ☐ Driven by mental healthcare worker
- ☐ MST
- ☐ MST Rides
- ☐ CCAH (Medi-Cal Transportation Benefit)
- ☐ Taxi
- ☐ Rideshare app (Uber, Lyft)
- ☐ Other (Please specify:_____)

6. What prevents you from traveling, or makes travel difficult for you?
(select all that apply)
- ☐ Motivation to get out of the house
- ☐ Physical Limitations
- ☐ Keeping a schedule for myself
- ☐ Safety concerns (Please specify:_____)
- ☐ Understanding public transit system (schedules, routes)
- ☐ Cost of bus and/or taxi fares
- ☐ Availability/Accessibility of public transportation
- ☐ Mental health symptoms (Please specify: _____)
- ☐ Other (Please specify:_____)

7. Are you aware of low or no-cost rideshare programs? ☐ Yes ☐ No
(If yes, please specify:_____)

8. Are you interested in using low- or no-cost rideshare programs? ☐ Yes ☐ No

Scoring questions:

- Potential scores from summing scores from questions 1,2,3,5,6 and 7 ranges from 0 – 37, with 37 being most severe need.

Evaluation:

- A t-test of pre- and post-test scores can measure for statistical significance in this project / coaching activities being effective in promoting client independence.
- For clients that demonstrate significant improvement (for example, drop from 20 to 10), a review of coaching activities they received will inform us of promising practices – especially if found across several client experiences.
- Separate evaluation can be made for #4 and #5, where we can see if post test score for #4 corresponds to pre-test score for #5.
- Separate evaluation can be made for #6, where we can see if average number of barriers dropped from pre- to post-test.
- Separate evaluation can be made for question #7, to see if number of client aware of rideshare programs increased as a result of project.

Requirements for Evaluation:

- Maintain paper copies of all TNAT's
- Maintain records of coaching activities used with each client

Use of TNAT to inform coaching curriculum:

- Use questions 1 – 3 to understand if client needs help attending health and/or non-health appointments. 3a helps understand which non-health activities clients want to do.
- Use question 5 to determine which transportation methods to focus on. Curriculum would have prescribed activities for each.
- Use question 6 to determine which barriers to address. Curriculum would have prescribed activities for each.
- Use question 8 to determine whether client wants to learn of or use rideshare programs. Curriculum would have prescribed activities for each.

Appendix B: Coaching Guides

Sample Interventions for Transportation Coaching Program

What prevents me from traveling:

- Obstacle: No motivation to get out of the house
  - Wellness Navigator will:
    - Utilize a strengths-based assessment process to determine the client's strengths and needs to encourage participation in out-of-home activities.
    - Build in rewarding opportunities for travel training; such as seeing a friend or family member, attending social events with peers, rewarding self for completing a task.
    - Reduce the effort needed to complete a traveling task by breaking tasks down, creating to-do-list, setting reminders, etc.
    - Offer clients meaningful choice wherever possible.
- Obstacle: Keeping a schedule for myself
  - Wellness Navigator will:
    - Collaborate with client in developing reminders (i.e. on phone, in calendar) in order to leave house on time for health care appointments, social events, etc.
    - Assist client in creating a calendar in order to help client remember to attend appointments.
    - Work with client to determine barriers to scheduling including identifying mental health symptoms that may be interfering with client's ability to make and keep a schedule.
- Obstacle Symptoms: Depression
  - Wellness Navigator will:
    - Develop with client positive affirmations, in order to reduce symptoms of depression so that client may attend outside events/activities.
    - Teach mindfulness techniques (i.e. self-compassion, meditation, five senses exercise, etc.) to support clients in managing depressive symptoms.
    - Assist client in establishing a routine, by incorporating activities such as increasing physical activity outside of the home, attending healthcare

appointments, signing up for educational classes, attending social events, attending support groups, socializing with peers in a public setting.

- Teach and practice using Opposite Action with clients to support clients in "acting opposite" to the thoughts and behaviors that are leading to isolation (i.e. lack of self-care, focus on negative thinking, inactivity, etc.).

- Obstacle Symptoms: Anxiety
  - Wellness Navigator will:
    - Provide support and empathy to encourage the client to feel safe in expressing his/her symptoms.
    - Ask the client to describe his/her past experiences of anxiety and their impact on functioning with day-to-day tasks.
    - Support clients in listing specific behaviors they would need to practice in order to overcome anxiety with completing tasks and encourage clients to take action on those behaviors.
    - Practice grounding techniques (i.e. reality checking, breathing techniques, focus on texture, focus on environment).
    - Expand positive coping skills (i.e. practice relaxation strategies, listening to music, state the emotion, recite positive affirmations, check in with a friend, review travel plan).
- Obstacle Symptoms: Auditory/Visual hallucinations
  - Wellness Navigator will:
    - Engage the client by showing interest in the voices. Ask questions such as the following: "When did the voices start? Where are they coming from? Can you bring them on or stop them?"
    - Normalize the hallucination. List scientifically plausible "reasons for hearing voices," including sleep deprivation, isolation, dehydration and/or starvation, extreme stress, strong thoughts or emotions, fever and illness, and drug/alcohol use.
    - Ask which methods worked previously and have clients build on that list, if possible.
    - Suggest coping strategies, such as: humming or singing a song several times, listening to music, utilizing distraction techniques such as reading (reading forward starting at the beginning of a page and reading

backwards starting with the last word on a page), talking with others, and medication compliance (important to discuss).

- Use "in-session voices" to teach coping strategies. Ask the client to hum a song with you. Reading a paragraph together forwards or backwards. Have the client practice exercises at home and notice if the voices stop for longer periods.
- Provide client with Hearing Voices handbook to support their own self-study in coping and living with voices.

- Obstacle Symptoms: Paranoia
  - Wellness Navigator will:
    - Lead client to recognize symptoms by identifying red flags and triggers to address onset of symptoms by practicing positive coping skills.
    - Assist client in examining his/her worries by reviewing probability of the negative events occurring, the real consequences of it occurring, his/her ability to control the outcome, the worst possible outcome, and his/her ability to accept it.
    - Teach clients about perspective taking and support clients in seeing other perspectives and the middle ground in between perspectives in order to support clients in reality-testing paranoid thoughts.
- Obstacle Symptoms: Mania
  - Wellness Navigator will:
    - Develop with client a written behavioral plan that clearly states behavior limits they want to set for themselves.
    - Identify with client what are possible warning signs for manic episode in order to use grounding techniques before onset (i.e. describe your environment, how many windows on the bus, 5 senses exercise).
    - Teach and practice distress tolerance and emotional regulation skills to learn ways to manage symptoms before, during, and after a manic episode in order to support client to remain engaged in services and supports.

- Obstacle: Safety concerns
    - Wellness Navigator will:
        - Develop a travel plan with client that incorporates clients concerns for safety in order to support client's individualized needs.
        - Support client in developing a plan that includes alternative routes to take in case one becomes unavailable.
        - Work with client to develop a list of safe people to call if needed to reinforce sense of safety and support.
        - Assist the client in identifying and scheduling travel during times in which they feel safer in order to not put self at risk.
        - Assist client with identifying which seat on public transportation vehicle would be the safest to them and why (i.e. sitting at the back of the bus, sitting near the driver, sitting near the isle, etc.).
        - Review safe travel procedure with clients (i.e. be cautious when getting on and off the bus, use grounding techniques when feeling symptomatic, communicate with the vehicle driver to establish safe connection).
- Obstacle: Understanding Public Transit system (Schedule routes)
    - Wellness Navigator will:
        - Create detailed guide for specific routes for clients (i.e. identify arrival location, time to leave the house, scheduling transportation in a timely manner ahead of time if needed, identify correct transportation vehicle, recognize landmarks to associate with correct destination).
        - Teach clients to access resources via phone or online for new route information and/or scheduling new rides.
        - Develop with client a travel plan to carry as a reference and reduce risk of getting lost or overwhelmed.
        - Provide in-person assistance to clients utilizing the public transportation system by accompanying clients on routes they will need to utilize to get to appointments and other important places in their lives.

- Obstacle: Cost of Bus and taxi fares
    - Wellness Navigator will:
        - Assist client by linking to traveling resources to help with options that are more affordable.
        - Help client with obtaining courtesy card for additional discounts.
        - Link client to transportation assistance through insurance companies that are free of charge.
        - Connect client to rideshare services that offer affordable rates.
        - Support client in identifying and applying for all benefits they may be eligible for to ensure they are receiving all available resources.
- Obstacle: Other
    - Wellness Navigator will:
        - Identify possible challenges such as accessibility and work towards possible solutions with client in their area (i.e. linking to MST RIDES, connecting with Support Network, identifying a travel plan).
        - Develop organizational skills (i.e. calendar, phone reminders) that will assist in meeting travel training goals.
        - Teach and model appropriate communication skills for client to communicate with transportation staff (i.e. communicating with driver if you are lost, confirm with driver if it is correct route, or confirming destination before boarding transportation vehicle).

Interim, Inc.

Transportation Coaching Program
De-escalation Techniques

When a potentially violent situation threatens to erupt on the spot and no weapon is present, verbal de-escalation techniques are an appropriate strategy. Reasoning with an enraged person is not possible. The first and only objective in de-escalation is to reduce the level of arousal so that discussion becomes possible.

De-escalation techniques are abnormal in these situations. We are adrenally driven to fight, flight or freeze when scared or threatened. However, to effectively de-escalate a situation, we can do none of these. We must appear centered and calm even when we are scared. Therefore, these techniques must be practiced before they are needed so that they can become 'second nature.'

The staff members are in control of themselves

1. Appear calm, centered and self-assured even though you don't feel it. Anxiety can make the client feel anxious and unsafe which can escalate aggression.
2. Use a modulated, low monotonous tone of voice (our normal tendency is to have a high pitched, tight voice when scared).
3. Do not be defensive-even if the comments or insults are directed at you, they are not about you.
4. Do not defend yourself or anyone else from insults, curses or misconceptions about their roles.
5. Be aware of any resources available for back up. Know that you can always leave, or seek additional support as needed, should de-escalation not be effective.
6. Be very respectful even when firmly setting limits or calling for help. The agitated individual is very sensitive to feeling shamed and disrespected. We want him/her to know that it is not necessary to show us that they should be respected. We automatically treat them with dignity and respect.

The physical stance

1. Never turn your back for any reason.
2. Always be at the same eye level. Encourage the client to be seated, but if he/she needs to stand, you stand up also.
3. Allow extra physical space between you – about four times your usual distance. Anger and agitation fill the extra space between you and the client.

4. Do not maintain constant eye contact. Allow the client to break his/her gaze and look away.
5. Do not point or shake your finger.
6. Do not touch –Cognitive disorders in agitated people allow for easy misinterpretation of physical contact as hostile or threatening.
7. Keep hands out of your pockets, up and available to protect yourself. It also demonstrates a non-verbal ally, that you do not have a concealed weapon.

The de-escalation discussion

1. Remember that there is no content except trying to calmly bring the level of arousal down to a safer place.
2. Do not get loud or try to yell over a screaming person. Wait until he/she takes a breath; then talk. Speak calmly at an average volume.
3. Respond selectively; answer only informational questions no matter how rudely asked, e.g. "Why do I have to follow these stupid rules anyway?" This is a real information-seeking question). DO NOT answer abusive questions (e.g. "Why are all you counselors such jerks?") This question should get no response whatsoever.
4. Explain limits and rules in an authoritative, firm, but always respectful tone. Give choices where possible in which both alternatives are safe ones (e.g. Would you like to continue this discussion calmly now or would you prefer to stop now and we'll discuss this at another day when things can be more relaxed?).
5. Empathize with feelings but not with the behavior (e.g. "I understand that you have every right to feel angry, and it is not okay for you to threaten me or other clients.)
6. Do not solicit how a person is feeling or interpret feelings in an analytic way.
7. Wherever possible, tap into the client's cognitive mode: DO NOT ask "Tell me how you feel." But instead: "Help me to understand what you are saying to me." People are not attacking you while they are explaining to you what they want you to know.
8. Do not argue or try to convince the individual.
9. Suggest alternative behaviors where appropriate e.g. "Would you like to take a break from this assignment now and work on your resume instead?"
10. Give the consequences of inappropriate behavior without threats or anger.
11. Represent external controls as institutional rather than personal.

Adapted from Verbal De-Escalation Techniques for Defusing or Talking Down an Explosive Situation; prepared by National Association of Social Worker's Committee for the Study and Prevention of Violence Against Social Workers.

Interim Inc
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Transportation Coaching Program
Critical Incidents Procedures

Mental Health Crises: Hospitalization or immediate crisis team evaluation is assessed as not immediately necessary

Wellness Navigators contact clients' MCBHB or Interim, Inc. Case Coordinators to coordinator, provide information, and obtain consultation, as necessary. Staff members assist clients with problem solving and consult with clients and case coordinators or other support person designated by the client related to referral in efforts to assist clients with other services. In a non-crisis situation, staff members consult with support persons or referral sources for which the client has provided written release of information in accordance with HIPAA.

Mental Health Crisis Protocol

Clients are assessed for safety, by MCBHB or Interim, Inc. Case Coordinators as needed. If a client reports ideation, intention or plan to self-harm or harm others, staff member will initiate a risk safety assessment, consult with supervisory staff, call and speak to the client's Case Coordinator or Officer of the Day at Behavioral Health offices, provide necessary crisis support for the client, and refer to appropriate services as needed.

Risk Assessment will include asking the client if they feel safe. If having suicidal ideations, if they have a plan, if they have the means to carry their plan, and help them connect with the crisis team at (831) 755-1111 (ask to be connected to the Crisis Tam at Hospital). Stay with the client until additional assistance arrives, if there is a need for hospitalization.

- Staff will consult with supervisors MCBHB or Interim Case Coordinators, as needed, during all mental health crisis.
- Staff members will call 9-1-1 and request public safety and ambulance assistance for clients, initiating assessment and transportation by ambulance to emergency rooms. Request a CIT trained officer, if possible.
- After the client is safety with police or ambulance personnel, staff will contact the crisis teams and provide any "need to know" information about the client's condition and situation or provide the necessary "need to know" client information to police/ambulance upon arrival.
- Staff will call MCBHB or Interim, Inc. Case Coordinator and provide information about the incident.

Appendix C: Client Handbook

INDIVIDUAL AGREEMENTS

The *key to the success of your treatment* is your willingness to participate in all aspects of the program. We hope you will partner with us in doing the following:

Be Engaged and learn from the treatment program we designed for your benefit. Utilize all of the resources that are made available to you. We ask that you will be open-minded about the information presented to you and seek a positive attitude about your treatment.

Be Solution Oriented. We encourage people to set reasonable goals and to work on reaching them. If you have questions or concerns about your treatment, talk with your Transportation Coach and Case Coordinator, the staff want to be a source of support. Open communication benefits everyone.

- I agree meet with my Transportation Coach as scheduled
- I agree to participate in the program to the best of my ability.
- I agree to be sober when I am in the program.
- I agree to be on time for all meetings
- I agree to be respectful of everyone, and their gender, race, ethnicity, age, religion, sexual orientation, geographic area of origin, physical size or ability, political affiliation and profession.
- I agree to inform my Transportation Coach of any problems that may interfere with services being provided by the Transportation Coaching Program.

Interim, Inc.
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TRANSPORTATION COACHING PROGRAM

CLIENT HANDBOOK

DAYS AND HOURS OF OPERATION
Monday – Friday 8:00 AM – 5:00 PM

Transportation Coaching Program Staff

Donna Gonzales
Location: Monterey County Behavioral Health
1441 Constitution Blvd. Salinas Ca. 93906 Building 400
Cell: (831)

Tatyana Hardy
Location: Monterey County Behavioral Health
IHC Building - 299 Twelfth St. Marina Ca. 93933
Cell: (831)

Joseph Ruiz
Location: Monterey County Behavioral Health
200 Broadway, Suite 88 King City, Ca. 93930
Cell: (831)

Wellness Navigator Name
Location: Monterey County Behavioral Health
359 Gabilan Dr. Soledad, Ca. 93960
Cell: (831)

Sandra Peña B.A.
WE&T Program Coordinator
spena@interiminc.org

Idalia Matthews, B.A., CPRP
Program Director
Supported Education & Employment Services
imatthews@interiminc.org

CLIENT COMPLAINT PROCEDURE: Interim is committed to providing you with services of the highest possible quality. To insure this, it is our policy you have the right to state and seek assistance in resolving complaints associated with our services, policies or other practices that may affect you while you are receiving agency services. Interim, Inc. guarantees there will be no negative consequences/retaliation as a result of your filing a complaint/grievance.

In order to provide you with assistance in resolving your specific problems or complaints about services received and to ensure proper handling of your request for assistance please follow these instructions. It is important to know that you may ask a friend to assist you during your complaint process.

Step 1. You may discuss your complaint/grievance with one of Interim staff. After meeting with Interim staff if you are not happy with the outcome you can ask to meet with the Program Director.

Step 2. Schedule a meeting to discuss your complaint/grievance. The Program Director shall arrange a time to meet with you and try to resolve the problem that led to your complaint. If you are not satisfied with Step 2 resolution (or no resolution is reached), then you may arrange to meet with Interim's Deputy Director.

Step 3. Call or write the Deputy Director, Jane Odegard, P.O. Box 3222, Monterey, CA 93942; telephone no. 831/646-2220 x304. The Deputy Director shall arrange to meet with you and try to find a solution to your complaint/grievance that is satisfactory to you. The decision of the Deputy Director is final and shall be in writing. In informing you about the final decision, the Deputy Director will also inform you of your right to appeal the decision to:

Monterey County Patient's Rights Advocate
Perla Calvario
1270 Natividad Road, Room 140
Salinas, CA 93906
(831) 755-4518

Modified 5/10/2019

PERSONAL RIGHTS

It is the policy of INTERIM to promote the rights of clients. Clients are informed of their rights upon entering a program.

All clients are entitled to:

- Respectful treatment by Interim staff
- Services provided in a safe environment
- Informed consent for services
- Confidential care and record keeping
- Change of Interim service provider when requested
- Participation in planning their services
- Access to their file
- Authorize a person to act on their behalf during the grievance process
- Patient's Rights Advocate available to assist with grievance, appeal on request
- Be free of discrimination or any other penalty for filing a grievance or appeal
- Acknowledgement and inclusion of their cultural beliefs and values in planning and delivery of their services
- Freedom from abuse, financial or other exploitation, retaliation, humiliation, and neglect

Welcome to The Transportation Coaching Program (TCP). We hope you will have a successful and rewarding experience while working with our staff. We are providing you with this handbook to give you information about the program and how it works. Together, you and your Transportation coach, will review and identify your goals to provide you with ongoing support to ensure success in reaching established goals. Transportation coaches are stationed at Monterey County Behavioral Health (MCBH) Adult System of Care (ASOC) Clinics in order to create a welcoming & recovery-oriented environment where individuals accessing services at the outpatient clinics can feel welcomed & supported by someone who may have a similar experience.

Your opinion about the services that you receive is important to us. If you have any suggestions or comments, please share them with your Transportation coach. Your Transportation coach will ensure that your comments are directed to the Program Coordinator.

Our Mission:

Transportation Coaching Program provides one-on-one support to individuals working with MCBH. Clients will work hand-in-hand with a Transportation Coach in order to complete goals established by the client and their Case Coordinator.

Modified 5/10/2019

HOW WE CAN HELP YOU

Transportation Coaching Program (TCP) is a program developed to assist individuals in gaining their independence by learning how to utilize public transit system.

Individuals work one-on-one with a Transportation Coach to develop a customized plan to better assist individuals in learning these skills.

Your Transportation Coach can assist with:

- Providing peer support services to encourage increased recovery activities and connections to community resources.
- Education on how public transit works and assistance in reducing fears associated with using the public system.
- Assisting clients in articulating personal goals for recovery and whole health through the use of one-on-one meetings
- Assist clients in working with their case worker and/or psychiatrist to determine steps to take in order to achieve goals.
- Wellness Navigators provide client-centered services, that are trauma informed, focusing on the present.

REFERRAL

Clients receiving TCP services must be eligible to receive or receiving services from Monterey County Behavioral Health/ Adult Services Division (MCBH). Clients must be at least 18-years-old and must want our services. Referrals are submitted by client's MCBH Case Coordinator. Clients are opened to services and are contacted by their Transportation Coach to schedule an intake appointment to review and establish personal goals.

Modified 5/10/2019

Appendix D: Referral Form

Interim, Inc.

Transportation Coaching Program - Wellness Navigator Referral
Completed referrals provided to Senior PSW for linkage to services.

CLIENT'S NAME:	PHONE #	MEDICAL RECORD #
ADDRESS:	CITY:	
Is the client conserved? Yes ☐ No ☐	If Yes, NAME:	PHONE #:
Case Coordinator:		PHONE #:

Describe the reason for referral:

☐ Teach how to utilize public transportation/travel training:
- ☐ Link to MST public transit
- ☐ Assist with learning Taxi Voucher procedure
- ☐ Assist with mobility barriers - Please indicate barriers: _____
- ☐ Link to Ride Share - Please indicate the name of ride share: _____

☐ Provide Peer Counseling and coaching to assist with: _____

☐ Other Travel Training Needs: _____

Estimated Completion/End Date: _____

Does client have any natural supports participating in their recovery? Yes ☐ No ☐

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

Psychiatrist Name:	Phone Number:

Does client *currently or in the past* has the client abused drugs/substances? Yes ☐ No ☐

List Active Substance/s:

1.	2.	3.

Does client have active suicidal ideations? Yes ☐ No ☐ Describe plan, intent, means:

History of suicide attempts? Yes ☐ No ☐ Describe plan, intent, means:

Does the client currently have thoughts of harming others? Yes ☐ No ☐ Describe:

Does client have a history of anger control problems or striking out? Yes ☐ No ☐ Describe:

Is client on parole/probation? Yes ☐ No ☐	Name of PO:	Phone Number:

Treatment Plan Intervention:

Special Client Considerations:

Case Coordinator: _____ Authorizes services beginning: _____
Signature Date

CONFIDENTIAL CLIENT INFORMATION SEE CALIFORNIA WELFARE & INSTITUTIONS CODE SECTION 5328

Interim, Inc.
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Transportation Coaching Program
Client Information

Name: _____ Client ID: _____

Address: _____

Phone: _____ Email: _____

Admit Date: _____

Emergency Contact: _____ Relation: _____

Address: _____ Phone Number: _____

☐ Release of Information obtained for Emergency Contact

1. What are your strengths?

_____

2. What are some of your challenges?

_____

3. What are your long-term goals?

_____

4. What, if anything, worries you about transportation?

_____

5. What are some signs that you are not doing well?

_____

6. What are some coping skills that have worked for you in the past?

_____

CULTURAL BACKGROUND

1. What is important to you in terms of your cultural background (i.e. race, ethnicity, color, gender, economic status, etc.)?

_____

2. What different languages do you speak?

_____

3. What special events or holidays do you celebrate? Are there family traditions that you still practice?

_____

MENTAL HEALTH

1. How do your symptoms affect you?

_____

2. What are the first signs that you may be experiencing a symptom flare-up (Example: Feeling depressed, unmotivated, hearing voices, drinking or using substances, feeling stressed)?

_____

3. How do you cope with your symptoms?

_____

INTERPERSONAL SKILLS

1. How well do you get along with other people?

_____

2. Who do you spend time with? How often do you see or talk to them?

_____

Monterey County
Board of Supervisors

168 West Alisal Street,
1st Floor
Salinas, CA 93901
831.755.5066
www.co.monterey.ca.us

Board Order

A motion was made by Supervisor John M. Phillips, seconded by Supervisor Luis A. Alejo to approve Consent Calendar Item Numbers 8 through 34 excluding Item No. 34.1 to:

Adopt the Monterey County Fiscal Year 2021-2023 Mental Health Services Act Three-Year Program and Expenditure Plan.

PASSED AND ADOPTED on this 30th day of June 2020, by roll call vote:

AYES: Supervisors Alejo, Phillips, Lopez and Parker
NOES: None
ABSENT: Supervisor Adams (excused)
(Government Code 54953)

I, Valerie Ralph, Clerk of the Board of Supervisors of the County of Monterey, State of California, hereby certify that the foregoing is a true copy of an original order of said Board of Supervisors duly made and entered in the minutes thereof of Minute Book 82 for the meeting June 30, 2020.

Dated: July 2, 2020
File ID: 20-527
Agenda Item No.: 17

Valerie Ralph, Clerk of the Board of Supervisors
County of Monterey, State of California

Joel Pablo
_____
Joel G. Pablo, Deputy

MHSA COUNTY COMPLIANCE CERTIFICATION

County: **Monterey**

■ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	Program Lead
Name: Amie Miller, Psy.D, MFT	**Name:** Alica Hendricks, MHSA Coordinator
Telephone Number: 831-755-4580	**Telephone Number:** 831-796-1295
E-mail: MillerAS@co.monterey.ca.us	**Email:** hendricksa@co.monterey.ca.us
County Mental Health Mailing Address: Monterey County Health Department, Behavioral Health Administration 1270 Natividad Road Salinas, CA 93906	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this *"**MHSA FY 2020/21 – FY 2022/23 Program & Expenditure Plan**"*, including stakeholder participation and nonsupplantation requirements.

This *"**MHSA FY 2020/21 – FY 2022/23 Program & Expenditure Plan**"* has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft *"**MHSA FY 2020/21 – FY 2022/23 Program & Expenditure Plan**"* was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health commission. All input has been considered with adjustments made, as appropriate. The *"**MHSA FY 2020/21 – FY 2022/23 Program & Expenditure Plan**",* attached hereto, was adopted by the County Board of Supervisors on June 30, 2020.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached "***MHSA FY 2020/21 – FY 2022/23 Program & Expenditure Plan***" are true and correct.

DocuSigned by:
Amie Miller
3AD61307413F4AD...

Amie Miller, Psy.D MFT
Local Mental Health Director

Signature

7/8/2020 | 2:19 PM PDT
Date

County: Monterey

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County/City: Monterey

■ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	**County Auditor-Controller**
Name: Amie Miller, Psy.D, MFT	Name: Rupa Shah
Telephone Number: 831-755-4580	Telephone Number: 831-755-5040
E-mail: MillerAS@co.monterey.ca.us	E-mail: shahr@co.monterey.ca.us
Local Mental Health Mailing Address: Monterey County Health Department, Behavioral Health Administration 1270 Natividad Road Salinas, CA 93906	

I hereby certify that the *"**MHSA FY 2020/21 – FY 2022/23 Program & Expenditure Plan**"* is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached ***"MHSA FY 2020/21 – FY 2022/23 Program & Expenditure Plan"*** is true and correct to the best of my knowledge.

Amie Miller, Psy.D, MFT
Local Mental Health Director (PRINT NAME)

DocuSigned by: Amie Miller 3AD81307413F4AD...
Signature

7/8/2020 | 2:19 PM PDT
Date

I hereby certify that for the fiscal year ended June 30, 2019, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated June 30, 2019 for the fiscal year ended June 30, 2019. I further certify that for the fiscal year ended June 30, 19, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and *if* there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Rupa Shah
County Auditor Controller (PRINT NAME)

DocuSigned by: Gary Gikonyo D3834BFEC1D84B...
Signature

7/9/2020 | 9:05 AM PD
Date

1 Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)