Monterey County Mental Health Services Act

Community Services and Support

ANNUAL REPORT

FY 2021–2022

Prepared by
EVALCORP
Measuring What Matters

MONTEREY COUNTY
BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

TABLE OF CONTENTS

Acknowledgments 4
Introduction 5
- Overview 5
- MHSA CSS Regulations 5

Report Methodology 6
- Analytic Approach 6
- Data Sources 6
- Report Organization 6

CSS-02: DUAL DIAGNOSIS FSP 7
Integrated Co-Occurring Disorder FSP 8
Santa Lucia Short-Term Residential Treatment Program 9

CSS-6: OLDER ADULTS FSP 10
Older Adult FSP 11
Drake House FSP 12

CSS-07: ACCESS TO REGIONAL SERVICES 13
Access to Treatment – CalWORKs 14
Access to Treatment – Coastal Region 15
Access to Treatment – King City 16
Access to Treatment - Salinas 17
Access to Treatment – Soledad 18
Outpatient Mental Health 19
USC Telehealth 20
Wellness Recovery Center (Adults OMNI) 21

CSS-08: EARLY CHILDHOOD MENTAL HEALTH SERVICES 22
MCSTART 23

CSS-10: SUPPORTED SERVICES TO ADULTS WITH SERIOUS MENTAL ILLNESS 24
Peer Support Wellness Navigators 25
Return to WorK Benefits Counseling Program 26
Transportation Coaching Program 27

CSS-11: DUAL DIAGNOSIS 28
Academy Day Program 29
Bridge House 30
Co-Occurring Integrated Care/Keep It Real 31
Outreach & AfterCare 32

CSS-13: JUSTICE-INVOLVED FSP 33
Creating New Choices FSP 34
Juvenile Mental Health Court/ Collaborative Action Linking Adolescents 35
Juveniles Who Sexually Offend Response Team FSP 36

CSS-14: HOMELESS SERVICES AND SUPPORTS 37
MHSA Homeless FSP 38
Lupine Gardens FSP 39
Sandy Shores FSP 40
Sunflower Gardens 41

CSS-15: HOMELESS OUTREACH AND TREATMENT 42
MCHOME Homeless Outreach & Engagement 43
Rockrose Gardens 44
Shelter Cove 45
Street Outreach Program 46

CSS-16: RESPONSIVE CRISIS INTERVENTIONS 47
Manzanita House Salinas 48

CSS-18: MENTAL HEALTH SERVICES FOR ADULTS 49
ASOC Marina 50
ASOC Salinas 51
Community Housing 52

APPENDICES 53
Appendix A: List of CSS-Funded Programs 54

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INTRODUCTION

Overview

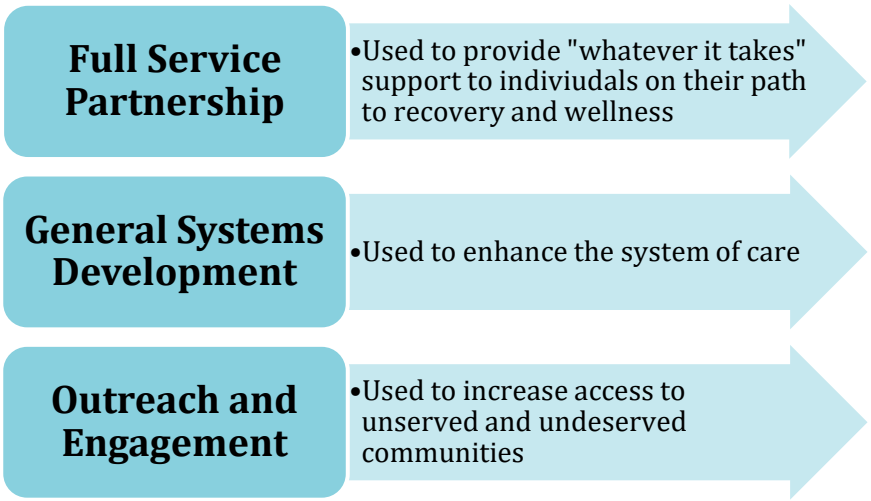
In 2004, California voters passed the Mental Health Services Act (MHSA) through Proposition 63. This act designated funding to improve mental health service systems throughout the state. Community Services and Supports (CSS) is one of several MHSA components and is intended to fund programs that provide mental health services to adults and older adults experiencing moderate to severe mental illness (SMI), as well as children and transitional-aged youth with serious emotional disturbance (SED). CSS is the largest of all the MHSA components.

Through MHSA funds, Monterey County Behavioral Health Bureau (MCBH) supports CSS programs that address the mental health needs of the county's culturally and regionally diverse communities. In fiscal year (FY) 21–22, Monterey County funded 54 programs, administered by both MCBH and contracted community service providers. This report details those programs, including descriptions of each, strengths, successes, and challenges in FY 21-22, along with goals for the upcoming year (FY 22-23).

MHSA CSS Regulations

CSS programs are intended to expand and transform services to individuals living with SMI, with a special focus on cultural competency and recovery orientation. Furthermore, these programs are driven by consumer and family needs, collaboration with the community, and integration of services. CSS programs include the following regulatory categories: full-service partnerships (FSPs), general systems development, and outreach and engagement.

In Monterey County, CSS programs are divided into categories based on the MHSA regulation and the individuals they serve. A list of CSS-funded programs in Monterey County by category is included for reference in **Appendix A**.



REPORT METHODOLOGY

Analytic Approach

MCBH contracted with EVALCORP Research & Consulting (EVALCORP) to develop this report, which summarizes data for CSS programs funded during FY 2021-2022. The evaluation utilized qualitative data provided to Monterey County by CSS-funded programs.

Data Sources

CSS programs provided narrative reports describing program activities for the fiscal year through an online survey. In FY 2021-2022, MCBH worked to enhance its data collection practices and build an evaluation infrastructure to ensure more robust data for CSS-funded programs.

Report Organization

This report presents CSS data by program. The following information is included for each individual program where available:

- Program description
- FY 2021-2022 successes and strengths
- Challenges and growth opportunities in FY 2021-2022
- Goals for FY 2022-2023

CSS-02: DUAL DIAGNOSIS FSP

INTEGRATED CO-OCCURRING DISORDER FSP

Integrated Co-occurring Disorder FSP (ICT) utilizes evidence-based practices and strength-based clinical care to provide intensive outpatient services and supports for youth ages 12-25 experiencing co-occurring behavioral health problems. ICT meets with clients 2 times per week for therapy-based services, which include case management, therapy, peer mentoring, medication consult, and collaboration with other providers.

Strengths

- Offer flexibility in how, when, where we meet with families
- Offer around-the-clock communication
- Provide a sense of community to our clients via peer mentors and peer support group activities

Successes

- Increased client numbers
- Many successful graduations & completions of the program
- Successfully implemented utilization capacity building caring home-based services for youth and their families

Challenges & Growth Opportunities

This year, Integrated Co-Occurring Disorder FSP built hybrid service platforms, and worked to recruit and hire licensed therapists and peer support staff. As a result, ICT fostered more collaboration within the team to determine how to best engage clients, meet their needs, and increase collaboration with schools and outside providers. ICT also found new ways to engage families and build additional alliances that can support clients.

Goals for the Coming Year

1. Expand on services by adding more clinicians
2. Improve client satisfaction surveys
3. Offer more group programming and more peer-support services

SANTA LUCIA SHORT-TERM RESIDENTIAL TREATMENT PROGRAM

Santa Lucia Short-Term Residential Therapeutic Program (STRTP) is a program for female youth facing alcohol, substance use, and mental health disorders. Santa Lucia STRTP provides trauma-informed care to clients from highly trained psychiatrists and therapists.

Strengths

- Beautiful residential home to deliver compassionate clinical care
- Clients learn skills that serve them well when they return to their homes or start a life in new surroundings
- Staff goes beyond clinical care, and truly feel the pain, needs, and longings of our young clients

Successes

- Recruited and trained a diverse staff
- Created a nurturing environment for our clients and our staff
- Customized academic options to optimize client engagement and success

Challenges & Growth Opportunities

Santa Lucia STRTP faced difficulties with hiring and retention of qualified staff this fiscal year, in addition to experiencing high severity of client needs.

Goals for the Coming Year

1. Decrease staff turn-over
2. Improve client completion rates
3. Participate in robust evidence-based practice training

CSS-6: OLDER ADULTS FSP

OLDER ADULT FSP

The Older Adult FSP provides 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. Older Adult FSP also serves older adults with co-occurring mental health and physical health conditions by assisting residents with medication, medical appointments, daily living skills, money management, and structured daily activities.

Strengths

Older Adults FSP served the community by providing wraparound services to older adults with severe and persistent mental illnesses.

Successes

Clients were trained on Zoom, which allowed them to access treatment throughout the pandemic.

Challenges & Growth Opportunities

This year, the county has been short-staffed, particularly among psychiatric social workers (PSWs). Therefore, staff were not able to provide intensive services to the capacity that would be ideal for this population.

Goals for the Coming Year

1. Increase workforce by filling open positions
2. Keep clients engaged in services for longer periods

DRAKE HOUSE FSP

Drake House is an FSP program that provides on-site mental health services to residents and connects them to their psychiatrist and community providers. Drake House advocates for residents and helps them navigate care while also providing 1:1 and group mental health rehab services as well as other program activities.

Strengths

- Work closely with residents and providers to maintain stability and avoid crisis intervention or repeat psych hospitalization
- Provide residents a safe, supported home-like environment as they age and deal with their co-occurring mental health issues

Successes

- Consistently service between 50-55 residents, keeping them housed and supported.
- Advocating for clients to receive the help and services they need

Challenges & Growth Opportunities

One of the biggest challenges is the lack of available resources to support clients during pandemic times. A lot of providers are not providing services or are reducing hours, making it challenging to see specialists. Additionally, a lot of stigma still exists and some providers do not know how to interact with clients. For example, in the ER, often doctors, nurses, and techs are dismissive of clients; they do not get the full work up and evaluation that they deserve. We are there to help advocate for help and services.

Goals for the Coming Year

1. Continue to provide a safe and stable home for residents
2. Minimize need for repeat psychiatric or medical hospitalization
3. Provide activities and service that can enrich residents' lives

CSS-07: ACCESS TO REGIONAL SERVICES

ACCESS TO TREATMENT – CALWORKS

Access to Treatment – CalWORKs is a county-staffed program that works with the Department of Social Services (DSS) to act as the mental health provider for customers enrolled in the Welfare to Work program. The program offers mental health triage/assessment, therapy, and psychiatry for those who have identified mental health needs and who want to return to work. Services are offered to both children and adults.

Strengths

- Strong partnerships with community members to support clients' overall well-being
- Program is well-funded to support the needed staff
- Provides psychoeducation to DSS Staff

Successes

- Developed a Domestic Violence Behavioral Health Team
- Staffed a position for a Community Family Case Manager that works in the community to support families in acute crisis

Challenges & Growth Opportunities

Due to COVID and DSS restrictions, this team had to adapt quickly to having the entire building closed, working remotely, and then adopting a hybrid model in FY 2021-2022. This presented a challenge, given the in-person services and groups. A hybrid model was successfully implemented with a 'clinician of the day' in the office to support walk-ins or urgent cases. The team was adaptable and flexible, modifying workflows to meet current demands.

Goals for the Coming Year

1. Fill open positions to reach full staffing levels
2. Continue providing services to Welfare to Work clients
3. Expand children's services

ACCESS TO TREATMENT – COASTAL REGION

Access to Treatment Coastal Region provides triage and assessment services for community members seeking mental health (MH) and substance use disorder (SUD) services. Once an assessment is completed, an individual may receive referrals to community MH or SUD resources. If an individual requires MH services at a Specialty Mental Health level, then treatment is either provided through this program or the individual is referred to the appropriate team within the MCBH system. Treatment includes group and or individual therapy, medication support, case management, mental health rehabilitation, collateral treatment, and/or case management.

Strengths

- Provides a safe and emotionally warm place for community members to seek MH or SUD services.
- Offers follow-up and linkage to services based on individual assessments

Successes

- Increase in individuals receiving services
- Staff and clients adapted to utilizing both in-person and telehealth methods of both assessment and treatment

Challenges & Growth Opportunities

One of the greatest challenges this year was staffing shortages alongside increased community need. Access to Treatment Coastal Region overcame this obstacle by utilizing more frequent leadership and staff meetings, and by remaining flexible.

Goals for the Coming Year

1. Increase referrals to community resources to meet increased community needs
2. Reduce clients' length of stay in the program
3. Increase staffing to meet workload demand and community need

ACCESS TO TREATMENT – KING CITY

Access to Treatment King City provides triage and assessment services for community members seeking mental health (MH) and substance use disorder (SUD) services. Once triage/assessment is completed, individuals may be referred to community resources as needed. The program also provides MH treatment, including group and or individual therapy, medication support, case management, mental health rehabilitation, collateral treatment, and/or case management.

Strengths

This program provides community members a safe and emotionally warm place to seek services for SUD/MH needs, and to inquire about eligibility for these services. The community can receive follow-up services and linkage to other services based upon the outcome of their assessment.

Successes

The program sustained excellent client care while facing an increase in community need and significant staff shortages.

In-person and telehealth methods of providing both assessment and treatment to clients have been adopted.

Challenges & Growth Opportunities

To overcome obstacles such as low staffing and increased community demand, Access to Treatment King City held more frequent leadership and staff meetings, developing efficient solutions as a team.

Goals for the Coming Year

1. Refer individuals to community resources rather than providing direct services more often
2. Increase staffing levels to meet workload demands
3. Reduce the average time to complete the program

ACCESS TO TREATMENT - SALINAS

Access Salinas is a primary entry point for Medi-Cal-eligible community members seeking mental health services. Community members are screened for level of need and are then either referred to another program for services or receive services from the program directly. The program provides short-term therapy, psychiatry services, and case management to community members.

Strengths

- Because this program is not directed to one demographic, access is available to anyone, including those without Medi-Cal
- No appointments are needed to receive an assessment and a 24/7 call line is available for easy access
- We have strong relationships with other providers lead to strong support for clients across mental health and substance use concerns

Successes

- Clients are constantly successfully linked to the appropriate levels of care for their needs.
- Staff have adapted to a hybrid in-person and telehealth model of providing services due to the COVID pandemic.

Challenges & Growth Opportunities

Access to Treatment Salinas faced challenges regarding short-staffing, increased referrals, and COVID restrictions. Staff learned to be flexible, think 'out-of-the-box' and provide services using a hybrid model. Staff also worked more collaboratively to innovatively address obstacles and challenges.

Goals for the Coming Year

1. Adapt to any changes that are implemented regarding CalAim
2. Increase community resources pool for clients that do not meet the County level of care
3. Increase staffing and reduce length of stay for clients in services

ACCESS TO TREATMENT – SOLEDAD

Access to Treatment Soledad provides mental health (MH) and substance use (SU) triage and assessment for community members. Once a client completes a triage/assessment, a disposition of the client's individual needs is made. Treatment provided to clients includes group and/or individual therapy, medication support, case management, mental health rehabilitation, collateral treatment, and case management. If a client is determined to require mental health services at a Specialty Mental Health level, treatment can be provided through this program or referred to an appropriate team within MCBH.

Strengths

- Clients can access services in a safe and emotionally warm environment
- Program provides follow-up and linkage services upon the outcome of triage/assessment

Successes

- Increased the number of community members seeking services
- Adapted to using in-person and telehealth methods for assessment and treatment

Challenges & Growth Opportunities

Staffing shortages and the increased need of the community were two obstacles experienced by Access to Treatment Soledad. These challenges were overcome through frequent leadership and staff meetings to explore efficient ways to adapt to staffing shortages while meeting community needs.

Goals for the Coming Year

1. Increase community resource referrals
2. Decrease staff vacancies
3. Reduce length of programming

OUTPATIENT MENTAL HEALTH

The Outpatient Mental Health program offers individual and collateral therapy services for uninsured individuals since August 2021. Our services are provided in Salinas and Seaside for in-person sessions. Services are open to individuals of all ages in multiple languages.

Strengths

- We offer our services to individuals county-wide.
- We offer tele-health services to increase accessibility of our services.
- Our clinicians are trained in numerous evidenced based practices such as CBT, mindfulness, and DBT.

Successes

- We have serviced 69 clients over the course of 11 months.
- 37 out of the 69 clients served have exited the program with a 78% success rate in completing therapy services

Challenges & Growth Opportunities

The initial hurdle for our Outpatient Mental Health program was increasing community awareness of the availability of these services. We managed to promote our services through community events and local advertisements, resulting in an influx of community interest. This challenge taught us how our existing programs can benefit from one another and the importance of offering our programs in conjunction with one another (e.g., Parent Education).

Goals for the Coming Year

1. Learn what aspects of the therapy are helpful.
2. Learn how to better engage the community in our services.

USC TELEHEALTH

USC Telehealth provides online as well as face-to-face counseling and psychotherapy individual services to children, youth, adults, couples, and families. Providers and clients can virtually connect from separate locations via a computer, laptop, tablet, or smartphone. Services are provided in English and Spanish as weekly 50-minute appointments over 12 weeks or more.

Strengths

- Clients in treatment reach one or all of their goals
- Clients showed a decrease in anxiety and depression
- Mental health services are provided to rural residents

Successes

- Expansion of services to populations who access behavioral health services a lot less
- Services available to inaccessible areas in Monterey County

Challenges & Growth Opportunities

A challenge to accessing tele-behavioral health services was lack of technological literacy among clients. To overcome this obstacle, phone services during site closure were provided and led to creating more lines of communication for problem-solving.

Goals for the Coming Year

1. Allocating full services throughout the year
2. Improvement in referred clients
3. Better client outcomes for program completion

WELLNESS RECOVERY CENTER (ADULTS OMNI)

The Wellness Recovery Center (OMNI) provides peer support and counseling groups, individual peer support and counseling meetings, connection with community resources, leadership trainings, educational workshops, and socialization activities.

Strengths

- Staff have varied backgrounds, are strong, experienced, and use their lived experience to connect with clients.
- Staff are collaborative and work well with other programs and agencies.
- OMNI is easily accessible to anyone who needs our services.
- OMNI can easily refer clients to MCHOME Outreach or MCBH Access, and we can see anyone wherever they

Successes

OMNI began holding outdoor events at Pajaro and off-site. Clients have said they were happy that events were being held again, and that they missed seeing everyone having fun together. OMNI served 445 individual clients, meeting 178% of our annual goal, doubled our goal for the number of clients receiving Supported Education services, and exceeded the number of educational opportunities set as the goal for Success Over Stigma.

Challenges & Growth Opportunities

OMNI has been impacted by the labor shortage and COVID-19, leading to a decrease in off-site activities, staff shortages, and impacted SOS presentations. Most of the SOS presentations and Supported Education groups have been held via Zoom, which is a challenge for clients who do not feel comfortable with technology. SOS has also had difficulties recruiting clients to be panel speakers. Counselor positions have been vacant for most of the year, leading to shifts in who serves our clients. Individuals not receiving mental health services from MCBH or Interim have come to the center and exhibited aggressive and threatening behaviors. This trend appears to be increasing. Our number of volunteers has decreased, and of our current volunteers, few feel ready to run a group or assist in the kitchen. Many of OMNI's clients are those who are using a higher level of care and do not feel ready yet.

Goals for the Coming Year

1. Facilitate off-site groups
2. Increase the number of workshops and events
3. Introduce new people to OMNI services

CSS-08: EARLY CHILDHOOD MENTAL HEALTH SERVICES

MCSTART

MCSTART provides early intervention services to children aged 0-11 and their parents/caregivers with trauma, domestic violence, and prenatal substance exposure. Services include outpatient therapy, occupational therapy, screening, assessment, and case management services. MCSTART utilizes family-based strength-based behavioral improvements and diverse evidence-based practices to offer early treatment aimed at mitigating negative outcomes for our clients.

Strengths

- Offer unique early intervention services for children, families, and caregivers
- Offer an array of behavioral therapies and bilingual services

Successes

- Highly rated services and outcomes
- Recruited and trained child therapists and OTRs
- Received excellent family satisfaction surveys
- Successfully closed 75% of cases after child reached treatment goals

Challenges & Growth Opportunities

MCSTART experienced difficulties recruiting and hiring, particularly because of the COVID-19 pandemic. However, we were able to utilize hybrid interventions, developed family team meetings, and improved team case coordination to continue treatment during the pandemic.

Goals for the Coming Year

1. Continue to recruit and hire therapists
2. Successfully treat developmental delays, trauma, and other troubling behaviors.
3. Have our clients continue to meet their treatment goals

CSS-10: SUPPORTED SERVICES TO ADULTS WITH SERIOUS MENTAL ILLNESS

PEER SUPPORT WELLNESS NAVIGATORS

Wellness Navigation services are voluntary peer support programs focused on clients working with Monterey County Behavioral Health Adult System of Care. Wellness Navigators support in areas including symptom management, skills training, education on mental health, connecting clients to community resources, and teaching them how to navigate transportation services.

Strengths

Staff have a good working relationship with the Salinas and Marina MCBH clinics. Staff are also embedded into the clinics, meet with MCBH staff regularly, and attend regular trainings throughout the year. Group supervisions are held bi-weekly and are attended by Wellness Navigators, MCBH Supervisors and Program Directors.

Successes

Staff connected 80% of clients to community resources. Additionally, 70% of clients who completed the survey, reported maintaining or improving their wellness as determined by The Recovery Assessment Scale.

Challenges & Growth Opportunities

Challenges faced by the Wellness Navigation services programs include a turnover of staff during the fiscal year and a decrease in referrals as some clients were opened to services longer due to client needs. To resolve this challenge, staff worked to link clients to more than one service in the community.

Goals for the Coming Year

1. Increase the number of clients served during the year
2. Increase the number of clients connected to a resource
3. Facilitate groups to increase client's engagement

RETURN TO WORK BENEFITS COUNSELING PROGRAM

The Return to Work Benefits Counseling Program provides problem-solving and advocacy support by helping clients resolve issues with service providers and organizations related to employment (e.g., Social Security Administration, Department of Social and Employment Services, Medi-Cal, Department of Rehabilitation). The program also assists clients with understanding their options to return to work while keeping benefits, benefits analysis reports, and development of a plan to become self-sufficient by establishing an Independent Living Plan (ILP). The program also works in collaboration with clients to design, implement, monitor, and evaluate outcomes of the ILP.

Strengths

- Community members can understand how their disability benefits affect them if they go back to work.
- Clients can access additional services offered by the Central Coast Center for Independent Living, including Assistive Technology, Housing Application assistance, independent living skills and much more.

Successes

- Many of our Community Members who are managing Mental health disabilities also experience homelessness.
- Many of our consumers were able to move on from Homelessness to Housing.

Challenges & Growth Opportunities

This program and Central Coast Center for Independent Living (CCCIL) continued to operate remotely. We learned that our consumers who were willing to work with us were able to adapt to these service conditions. This led to us making the decision to ditch paper files and move toward an online storage solution.

Goals for the Coming Year

1. Many community members will be able to maintain their housing.
2. Many community members will be able to move into housing.
3. Many community members will receive Assistive Technology Services and other community supports.

TRANSPORTATION COACHING PROGRAM

The Transportation Coaching Program (TCP) is focused on assisting consumers who receive services from the Monterey County Behavioral Health (MCBH) Adult System of Care (ASOC) in gaining independence by helping them learn how to utilize public transit and rideshares. TCP provides support to consumers who are interested in gaining these skills thereby giving them the ability to integrate back into their community by attending to their day-to-day needs such as: attending appointments, joining the workforce, pursuing educational goals, and participating in social events.

Strengths

Staff have good working relationships with MCBH. Wellness Navigators are all stationed at MCBH clinics and attend bi-weekly group supervisions and weekly team meetings to discuss clients' progress and challenges. Staff have been provided with mobility training through MST and are able to travel train at no additional cost to staff on the bus. Staff attend regular agency and county trainings.

Successes

Staff successfully collaborated with MCBH and the Crisis Counseling Program, which focused on providing support with COVID related challenges. Additionally, staff served a total of 64 clients, assisting clients with learning and navigating transportation resources in the community. 85% of clients, who completed the Transportation Needs Assessment Survey, reported improving their knowledge and comfort with utilizing different means of transportation.

Challenges & Growth Opportunities

TCP had low referrals, resulting in only 17 clients served between the King City and Soledad MCBH clinics. Due to low referrals and county staff recommendations, TCP will be converted to Peer Partners for Health during FY22-23. TCP also received few referrals from the South County and Marina clinics as clients declined services or did not feel comfortable with travel training due to COVID-19. Staff found creative ways to train and support clients by following the bus route while clients were traveling. Staff were able to connect clients to the Crisis Counseling program for support with COVID-related challenges. Meetings with clients were primarily held outdoors to reduce the risk of COVID-19.

Goals for the Coming Year

1. Serve more clients in the next fiscal year
2. Engage more clients in the program
3. Increase transportation surveys to 100% participation

CSS-11: DUAL DIAGNOSIS

ACADEMY DAY PROGRAM

The Academy Day Program provides group therapy services five days a week for at least four hours a day to individuals living with co-occurring mental health and substance use disorders. The program groups offer and teach individuals skills to manage their mental health symptoms, ways to support goals related to substance use, and skills to promote improved functioning.

Strengths

The program provides a safe environment for community development and decreasing social isolation.

Successes

Program re-opened in July 2022 after being closed for two years during the pandemic. Since reopening, Academy Day Program has provided excellent continuum of care for individuals transitioning out of residential treatment settings.

Goals for the Coming Year

1. Serve an average of 15 people each day while the program is operating
2. Provide a valuable continuum of care option to individuals working on their mental health and substance use
3. Maintain consistent enrollment in day treatment and provide quality clinical services to meet individual recovery goals

BRIDGE HOUSE

Bridge House is a 13-bed transitional residential treatment program for adult residents who have a co-occurring mental health disability and a substance use disorder. The program provides a home-like environment in a structured, noninstitutional, therapeutic community that encourages interdependence as clients rebuild their lives. Bridge House helps clients identify and achieve their personal goals for symptom and medication management, as well as alcohol/drug recovery. Clients also learn to manage social and family relationships. In addition, goals are reviewed regularly as clients transition into more independent living.

Strengths

Bridge House helps improve clients' independent living skills, reduces rates of homelessness, and lowers the likelihood of clients entering jail.

Successes

Residents met their treatment goals, reduced their substance abuse, and transitioned to lower-level care housing.

Challenges & Growth Opportunities

Hiring and retaining staff was an obstacle that led to serving fewer clients because there were not enough counselors to manage client caseloads. The program overcame this challenge by continuing to serve clients.

Goals for the Coming Year

1. Increase staff occupancy
2. Discharge residents to lower level of care
3. Decrease in residents' substance use

CO-OCCURRING INTEGRATED CARE/KEEP IT REAL

Co-occurring Integrated Care/Keep It Real offers harm reduction group and individual counseling services for individuals with co-occurring mental health and substance use disorders.

Strengths

- Offers harm reduction skills training
- Creates a person-centered approach to substance use treatment and valuing self-determination

Successes

- Served over 85 individuals
- Expanded in-person groups
- Provided tele-health services to support individuals living throughout Monterey County

Challenges & Growth Opportunities

The program experienced a change of program directors during the beginning portion of the fiscal year and had some staffing shortages. Despite these challenges, the program was able to meet all goals set for FY 21-22.

Goals for the Coming Year

1. Serve at least 85 individuals
2. Reduce hospitalization and judicial recidivism rates
3. Provide harm reduction/mental health services to individuals living in south Monterey County

OUTREACH & AFTERCARE

The Outreach and Aftercare program provides community resources and treatment options to individuals struggling with co-occurring disorders, such as those offered by the harm reduction program, Keep It Real. Individuals are also able to access Monterey County Behavioral Health services such as group and individual counseling support.

Strengths

- Provides individual and group counseling services
- Connects individuals with community resources
- Serves as a steppingstone for initial treatment and continuum of care option

Successes

- Served 90 individuals
- 71 consumers reported 82% improvement rate
- All consumers received some form of referral to available resources within the county

Challenges & Growth Opportunities

The program had one staff member providing the Outreach and Aftercare Services to all of Monterey County. Thus, staff conducting outreach was needed to provide support to interagency program during the fiscal year due to staffing shortages, which created an obstacle in re-establishing community connections.

Goals for the Coming Year

1. Serve at least 40 consumers
2. Have 75% of consumers surveyed improve their mental health recovery
3. Connect 85% of consumers and community resources from additional providers

CSS-13: JUSTICE-INVOLVED FSP

CREATING NEW CHOICES FSP

The Creating New Choices (CNC) program is a collaborative court program for justice involved adults with a serious mental illness (e.g., schizophrenia, schizoaffective disorder, bipolar disorder) and often a co-occurring substance use disorder. CNC is a "whatever it takes" model that works to engage participants in treatment, stabilize them in the community in the least restrictive environment possible, and reduce recidivism.

Strengths

- The small multidisciplinary team of various behavioral health providers (peer, social worker III, clinician, psychiatrist, nurse, etc.) that works closely with probation daily.
- The FSP model provides continuity for our clients with after-hours on-call phone support as well.

Successes

Due to legislative changes, the number of referrals to this collaborative court program dwindled. As a result of our solid relationships with the justice partners and the willingness of the court to revisit the criteria for the program, we were able to revise the criteria to make more sense and increase referrals. The number of participants continues to rise.

Challenges & Growth Opportunities

With a court program, there are often factors outside the behavioral health partner's scope of control. CNC overcame obstacles with the court by having solid professional relationships with key partners and having tough conversations to advocate for the program, and to meet the needs of this segment of SMI justice involved individuals caught up in the legal system.

Goals for the Coming Year

1. Stabilize staffing
2. Admit new participants to return to pre-pandemic levels of client participation
3. Strive for a 90% successful program completion rate

JUVENILE MENTAL HEALTH COURT / COLLABORATIVE ACTION LINKING ADOLESCENTS

Intensive outpatient collaborative court program for youth on probation with serious mental health concerns and/or significant family dysfunction.

Strengths

- Highly collaborative team
- Has the capacity to see clients multiple times per week in different environments
- Offers holistic care

Successes

Program is finally staffed

Challenges & Growth Opportunities

The most significant challenge has been staffing for this intensive program. We overcame it by having the supervisor and other qualified staff take on cases. Having several players required significantly more communication and is not necessarily ideal when working so closely with the court and attorneys.

Goals for the Coming Year

1. Maintain staffing
2. Build program numbers (with appropriate referrals)
3. Look for opportunities to support parents more

JUVENILES WHO SEXUALLY OFFEND RESPONSE TEAM FSP

The Juveniles Who Sexually Offend Response Team (JSORT) FSP is an intensive outpatient collaborative court program focusing on juveniles who sexually offend. JSORT provides individual and group treatment, as well as treatment team meetings to incorporate families/support systems.

Strengths

- Unique program ability to address topics not typically addressed in the outpatient setting
- Keeping families together/kids in the community when outpatient care is indicated rather than sending youth to STRTPs

Successes

Hired one staff, who is bilingual/bicultural.

Challenges & Growth Opportunities

The most significant challenge has been staffing – hiring staff who are qualified and willing to work with this specific population. Supervisors and other qualified staff have supported the program to maintain treatment levels; however, due to the specialty of work, staff who provide services need to participate in additional training workshops and supervision to ensure continuity of care, as well as to address any areas of training.

Goals for the Coming Year

1. Fully staff the program
2. Continue to work on building out the program and diversifying the curriculum to include parents more
3. Look at how to provide some early intervention material about safe boundaries and the law

CSS-14: HOMELESS SERVICES AND SUPPORTS

MHSA HOMELESS FSP

MHSA Homeless FSP (formerly MCHOME) provides mental health services for those who are experiencing homelessness and have a diagnosis of a severe mental illness and/or substance use disorder. MHSA Homeless FSP provides case management, linkage to services, case coordination, therapeutic interventions, and psychiatric services.

Strengths

- Meeting individuals in the community where they are at and providing services to support their well-being despite not having a permanent residence.
- MCHOME has positive outcomes in client recovery and treatment, including reduced recidivism in the hospital and incarceration.

Successes

We met all our goals and for the first time, we met our PCP goal of getting 75% of our clients to meet their PCP or get connected to a new one.

Challenges & Growth Opportunities

Challenges include the decrease in inventory of available apartments and increasing rents. MHSA Homeless FSP continued collaboration with other agencies to identify housing in the county.

Goals for the Coming Year

1. Designate one Wellness Navigator to follow up with clients in the FSP monthly about seeing their PCP.
2. Build relationships with motels to support some of our homeless clients in accessing shelter.

LUPINE GARDENS FSP

Lupine Gardens FSP is a 20-unit studio apartment complex that provides permanent housing for adults with serious mental illness who need intensive case management, medication support, and assistance with daily living skills in order to live independently in the community. Lupine Gardens FSP focuses on preventing further homelessness for a vulnerable population, avoid costly hospitalization or use of short-term crisis residential programs, hospital crisis teams, and unnecessary institutionalization in residential care homes. Case managers and community support workers meet as often as twice a day with residents to monitor daily medications, re-order medications, and discuss and review doctors' appointments. Case managers also work individually with residents to encourage participation in vocational and educational resources in the community in addition to other structured activities.

Strengths

- Client engagement in Lupine Gardens' services (medication support, tenant meetings, weekly meetings)
- Client participation in activities, employment, and volunteering

Successes

- Ability to maintain housing
- Low hospitalization rate
- Treatment compliance: 100% of consumers reported showing improvement, 96% of consumers are engaged with their PCP, 87% of clients were successfully housed

Challenges & Growth Opportunities

Lupine Gardens had challenges with the aging population and faced difficulty finding ways to serve clients who require higher levels of care. Support from nurses was incorporated and helpful with physical challenges clients faced.

Goals for the Coming Year

1. Maintain permanently housed clients
2. Engage clients in treatment with psychiatrist and PCP
3. Encourage more client participation in employment, education, and volunteer work

SANDY SHORES FSP

The Sandy Shores permanent supportive housing offers an array of services through a Full-Service Partnership (FSP) model as required by the Mental Health Services Act funding. Services include case management, crisis intervention, mental health, and housing to assist individuals with a psychiatric disability who are unhoused.

Strengths

- Program provides intensive mental health services
- Permanent housing is also provided for the unhoused

Successes

- 94% of clients had housing and were not hospitalized
- 89% of clients had improved mental health
- 84% of clients engaged with primary care physician

Challenges & Growth Opportunities

Sandy Shores FSP had a strong community of residents in FY 2021-2022

Goals for the Coming Year

1. Increase employment
2. Promote education
3. Active participation

SUNFLOWER GARDENS

Sunflower Gardens is a permanent and transitional supportive housing program serving 23 individuals with a serious mental health diagnosis, all of whom are homeless or at high risk of homelessness. The service array includes assessments, evaluation, case coordination, intensive case management, assistance in accessing benefits, and assistance with daily living skills to help consumers meet the terms of their lease and live independently.

Strengths

The program receives direct services from an Interim psychiatrist who is available once a week to review medications and support with symptom management. Additionally, consumers receive support from Interim nurses who provide education on nutrition, physical health concerns, and support with linkage to medical providers. The program also offers a variety of weekly groups that help with creating a sense of community and build independent living skills.

Successes

The program had 3 discharges, and all participants discharged from the program reached their treatment goals. Two individuals moved to their own apartment and one individual moved to a long-term facility where they have access to more support for physical health challenges. Sunflower staff collaborated with the housing team to fill vacancies, as a result, the program maintained an annual 99% occupancy rate.

Challenges & Growth Opportunities

Due to the pandemic, in-person interactions were limited and resulted in individuals not feeling comfortable meeting with providers using technology to disclose their personal information. The program assigned an area in the community to provide consumers an opportunity to meet with their provider for case management support. The program also used the space to connect participants to an online chair yoga class that has been successful.

Goals for the Coming Year

1. 70% of consumers will remain housed at SFG as of the end of the operating year or exit to other permanent housing destinations during the operating year
2. 75% of consumers served during the FY will eliminate all psychiatric hospitalizations, while in the program
3. 20% of consumers will attain employment, attend a school/vocational training program or volunteer

CSS-15: HOMELESS OUTREACH AND TREATMENT

MCHOME HOMELESS OUTREACH & ENGAGEMENT

MCHOME offers outreach services to the homeless population in Monterey County. Our outreach counselors provide basic case management while identifying clients with severe mental illness.

Strengths

We have successfully been able to meet the needs of the population because:

- We are a flexible team who respond to referrals in a quick manner.
- We are reliable and always ready to serve our homeless population.
- We are a team who lean on each other for guidance and support.

Successes

Street outreach and intensive case management were provided to 21 homeless individuals this year, as well as 190 nights of motel accommodation. Under our COVID grant, the outreach team provided street outreach to 32 individuals in unincorporated areas. We also provided 32 outreached homeless individuals with disposable masks and hand sanitizer to help stop the spread of COVID. The program provided street outreach to 33 Salinas residents under the HCD grant. Additionally, the outreach team provided intensive case management and successfully linked clients to other services. The program also provided these homeless residents with 173 motel nights.

Challenges & Growth Opportunities

The program had major staffing changes and being short staffed was a huge challenge. MCHOME outreach had to work together to meet our grant numbers and keep adapting to staff absences due to COVID-19 illness or exposure.

Goals for the Coming Year

1. Be fully staffed
2. Overachieve our grants
3. Connect with south county agencies through our COVID/PATH grant

ROCKROSE GARDENS

Rockrose Gardens is a supportive 20-unit housing complex designated for low-income individuals with disabilities. Services include case management and mental health rehabilitation.

Strengths

- Provides low-income housing and support for activities of daily living (ADL)
- Helps individuals connect to community resources

Successes

- Connect clients to needed services (in-patient, crisis house, government programs)

Challenges & Growth Opportunities

The pandemic was an obstacle given it caused a shift to using technology, which was challenging for some clients. Rockrose Gardens established ways around these obstacles by providing education and access to resources that were difficult to obtain.

Goals for the Coming Year

1. Better communication with outside providers
2. More opportunities for client social events
3. Meet billing requirements and ensure services are provided

SHELTER COVE

Shelter Cove provides case management, crisis intervention, mental health services and housing services to help residents learn the skills they will need to successfully transition to independent living. The program's philosophy is based on the Social Rehabilitation Model.

Strengths

Shelter Cove provides clients with case management services that help them prepare for independent living and help them develop goals that improve their life in the areas of health, education, employment, and daily living skills.

Successes

- 90% of clients reported satisfaction with the program
- 95% of clients engaged with a primary care physician
- Regarding the percentage of clients involved in education and employment services, program goals were exceeded

Challenges & Growth Opportunities

Despite the pandemic and short fall in staff, many clients exited to permanent housing in the community, and most clients maintained or improved their mental health. We also successfully established sober living environments within the community.

Goals for the Coming Year

1. Increase number of clients exiting to permanent housing
2. Increase leadership within the community
3. Increase active engagement and independence with resources in the larger

STREET OUTREACH PROGRAM

Street Outreach Programs (SOP) engage with homeless youth up to the age of 24 to provide them with emergency aid, such as food, water, and essential clothing. In addition, SOP offers linkages to housing, social services benefits, mental health and/or substance use disorder services. SOPs collaborate closely with partner agencies, like CHE, Interim Inc., Sun Street Centers, Door to Hope, Dorothy's Place, Housing Authority, CCCIL, among others. The programming participates in Coordinated Entry and utilizes CARS, so counselors coordinate within Monterey County's Continuum of Care (CoC) to link homeless youth with appropriate housing referrals.

Strengths

- Assists clients with motel and weather vouchers during extreme circumstances
- Promotes the utilization of the Emergency Housing Voucher program

Successes

- Increased food donations
- Supported housing and transition among youth throughout the year
- Increased involvement with CoC and police departments

Challenges & Growth Opportunities

There was an increase in displacement encampments, employed clients not being able to meet their hygiene needs, and limited essentials. As a result, SOP communicated with CoC as well as police departments, donated to Monterey Sports Center so clients could meet their hygiene needs, and collaborated.

Goals for the Coming Year

1. Obtain permanent outpost site in south county to provide outreach and drop-in services for homeless youth
2. Hire permanent Case Manager/Housing Navigator
3. Increase access to rapid rehousing services for homeless youth

CSS-16: RESPONSIVE CRISIS INTERVENTIONS

MANZANITA HOUSE SALINAS

Manzanita House is a structured crisis residential program environment for adults with serious mental illness where staff support residents with daily living skills, personal hygiene, and daily house maintenance. In addition, staff work with residents to develop strategies to avoid the reoccurrence of crisis situations through individual and group counseling. Medication support is provided by staff assisting residents with self-administration of medications, symptom awareness, and education. Each resident meets with a psychiatric prescriber once a week (or as needed), in person or through telemedicine. An onsite structured day program is offered consisting of weekend activities and groups 5 days a week for 4 hours a day.

Strengths

- Offers crisis stabilization in a less traumatic environment
- More cost-effective than acute hospital services

Successes

- Almost all clients surveyed were satisfied with services
- Manzanita met or exceeded all their recovery goals for clients

Challenges & Growth Opportunities

One challenge was the logistics of the new Client Services Specialist position. To overcome this obstacle, agency counselors were trained as backup staff to fill vacancies and provide relief to Manzanita staff team and meet staffing.

Goals for the Coming Year

1. 70% of consumers reported crisis management and stabilization
2. 75% of consumers will discharge to a lower level of care
3. 80% of consumers will report satisfaction with quality of services

CSS-18: MENTAL HEALTH SERVICES FOR ADULTS

ASOC MARINA

ASOC Marina provides specialty mental health services to adults with severe and persistent mental illness. Many clients have co-occurring substance use disorders, are homeless, and are justice-involved. ASOC Marina provides case management, crisis intervention, some individual and group therapy, collateral, and medication services. The staff is a multidisciplinary team of masters- and bachelors-level social workers, Behavioral Health Aides, Wellness Navigators, interns, medical assistants, psychiatrists, a nurse, and a Transportation Coach.

Strengths

- Supervisors provide clinical training to staff to meet community needs
- Staff are highly trained in crisis intervention and risk assessments to ensure the safety of the community
- The program is highly involved with Interim Inc. to provide education and employment services to people interested in gaining job skills and/or obtaining their education

Successes

- Continued to navigate providing services to the community with the ongoing pandemic
- Provided services to the community while facing significant staff shortages
- Clients in the program obtained employment

Challenges & Growth Opportunities

Due to lower staffing levels, ASOC Marina utilized staff from all different levels of care to provide services to clients. Staff are extremely flexible and willing to adapt and pivot in an ever-changing environment.

Goals for the Coming Year

1. Reach full staffing to best meet the needs of clients
2. Obtain Social Worker III positions to support staffing

ASOC SALINAS

ASOC Salinas offers outpatient mental health services such as case management and therapy support for adults over age 26 with serious mental illness who may or may not also have a co-occurring substance use disorder. Services for ages 18-26 are provided by the transitional age youth (TAY) team.

Strengths

- ASOC Salinas offers 1:1 case management support for the community's most vulnerable population.
- ASOC utilizes a strength-based approach to connect clients with community resources and help mentally ill populations live meaningful lives.

Successes

- Fully incorporated Wellness Navigators as part of the ASOC team to provide unique interventions and connections with clients.
- Continued accepting clients and offering outpatient mental health services despite COVID.
- Migrated the vast majority of psychiatrist and therapy groups into a telehealth format, which increased compliance.

Challenges & Growth Opportunities

ASOC suffers from a serious issue of short staffing at the direct line level. The current line staff has been asked to take on heavier caseloads. To accomplish this, clinic leadership offered the necessary flexibility, such as hybrid schedules and resources to effectively offer a tele-health option.

Goals for the Coming Year

1. Increase internal clinic line staff and lower overall vacancy rate.
2. Streamline workflows such as referral process to various community partners
3. Restructure team layout while maintaining key aspects of the Reaching Recovery model

COMMUNITY HOUSING

Community Housing (CH) is a permanent supportive housing that provides 100 affordable community independent living for adults with serious and persistent, long term psychiatric disabilities. These placements are provided as individual apartments and/or shared housing units. In addition, Interim Inc. provides case coordination, case management, crisis intervention, and mental health treatment services for residents in all supported housing programs. Residents also utilize a variety of resources within Monterey County and behavioral health.

Strengths

CH staff received additional training on using Reaching Recovery model to help support residents' mental health wellness, purpose, and safety through recovery.

Successes

90% of consumers engaged with primary care physicians and maintained or improved their recovery.

Challenges & Growth Opportunities

Limited resources for low-cost housing, serving a senior citizen population, resident monitoring, and student nurse placements were challenges experienced by Community Housing.

Goals for the Coming Year

1. Adapting current housing for senior citizen population
2. Explore interventions to provide health and wellness education
3. Expand agency collaboration for housing resources

APPENDICES

APPENDIX A: LIST OF CSS-FUNDED PROGRAMS

CSS-01: Early Childhood and Family Stability FSP
- Family Assessment Support and Treatment^
- Family Preservation FSP^
- Family Reunification FSP^
- Kinship Center, First Five Trauma FSP^
- Kinship Center, D'Arrigo Children's Clinic^
- Salinas Home Partners FSP^

CSS-02: Dual Diagnosis FSP
- Integrated Co-Occurring Disorder FSP
- Santa Lucia Short-Term Residential Treatment Program

CSS-04: Transition Age Youth FSP
- MHSA TIP AVANZA FSP^
- Transitional Aged Youth FSP^

CSS-05: Adults with SMI FSP
- Assertive Community Treatment Welcoming & Engaging Team^

CSS-06: Older Adults FSP
- Older Adult FSP
- Drake House FSP

CSS-07: Access Regional Services
- Access Medication Support^
- Access to Treatment CALWORKS
- Access to Treatment Coastal Region
- Access to Treatment King City
- Access to Treatment Salinas
- Access to Treatment Soledad
- CHS South County^
- Family Counseling Salinas^
- Family Counseling Seaside^
- HIV/AIDs Community Partnership^
- Kinship Center, Children's Clinic South County^
- Outpatient Mental Health
- USC Telehealth
- Wellness Recovery Center (Adults OMNI)

CSS-08: Early Childhood Mental Health Services
- MCSTART
- Secure Families^

CSS-10: Supported Services to Adults with Serious Mental Illness

- Peer Support Wellness Navigators
- Primary Care Integration^
- Return to Work Benefits Counseling
- Transportation Coaching

CSS-11: Dual Diagnosis

- Academy Day Program
- Bridge House
- Co-occurring Integrated Care (Keep It Real)
- Outreach and Aftercare

CSS-13: Justice-Involved FSP

- Creating New Choices FSP
- Juvenile Mental Health Court/Collaborative Action Linking Adolescents FSP
- Juvenile Sex Offender Response Team FSP

CSS-14: Homeless Services and Supports FSP

- MHSA Homeless FSP (formerly MCHOME)
- Lupine Gardens FSP
- Sandy Shores FSP
- Sunflower Gardens

CSS-15 Homeless Outreach and Treatment

- MCHOME Homeless Outreach & Engagement
- Rockrose Gardens
- Shelter Cove
- Street Outreach (Outreach for youth)

CSS-16: Responsive Crisis Interventions

- Archer Child Advocacy Center^[1]
- Manzanita House Salinas
- Mobile Crisis Team^

CSS-18: Mental Health Services for Adults

- ASOC Marina
- ASOC Salinas
- Community Housing

^ No data were available for FY21-22.