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MONTEREY COUNTY
BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

Mental Health Services Act
FY 2024-25
Annual Update

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Introduction

Monterey County Behavioral Health (MCBH) is pleased to present this Mental Health Services Act (MHSA) Fiscal Year 2024-25 (FY24-25) Annual Update. This is the first Annual Update to occur in the current 3-Year MHSA planning period. The primary function of the Annual Update is to update the budget information based on a changing fiscal reality and, if needed, note any changes to programs. The Annual Update also includes program data for the prior fiscal year period. In this year's document, FY 2023-24 data are included in Appendices II through V.

In June 2023, the Monterey County Board of Supervisors approved the FY 2023-24 – FY 2025-26 MHSA Three-Year Program and Expenditure Plan (MHSA Plan). This document can be found on our MHSA webpage at the following link:
https://www.countyofmonterey.gov/home/showpublisheddocument/124556/638345187572100000 (English)

https://www.countyofmonterey.gov/home/showpublisheddocument/124554/638430091602470000(Spanish)

Background on the MHSA

In 2004, California voters approved Proposition 63 to enact the Mental Health Services Act (MHSA) to transform 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 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. The State accumulates MHSA funds before redistributing them to each mental health jurisdiction (all 58 counties and two cities) according to their population size and other factors.

Recipients of MHSA funds 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 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

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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, FY 2023-24 data for programs funded by the MHSA are reported in Appendices II (CSS), III (PEI), IV (INN), and V (WET), 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 information collected during the CPPP are shared to provide insights on local community needs and perspectives that helped inform this FY24-25 Annual Update.

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 and its fertile Salinas Valley, dubbed the "Salad Bowl of the World." With a total population of 445,229 and a 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, are the leading sectors for employment in the county, with tourism-based services and 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 coastal cities from Marina to Big Sur and includes Carmel Valley. North County is made up of 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 and several remote, sparsely populated rural districts.

Age & Gender

The median age in Monterey County is 47 years, trending a couple of years younger than the state median. Adults ages 25-59 comprise 46% of the population, with Older Adults ages 60 and above making up 18%. Children under five years old represent 6.9% of the population, Youth ages 5-15 represent 15%, and Transition Age Youth (TAY) ages 16-24 represent 14% of the population. 51% of Monterey County residents are male and 49% are female.

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Ethnicity, Race & Language

Most Monterey County residents are Hispanic/Latino, comprising about 60% of the population. The remainder of the population is comprised of individuals self-identifying as White (29%), 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% are foreign-born, 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 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 another Language.

Individuals with Disabilities

Individuals with disabilities represent 8.8% of County residents.

Veterans

Veterans comprise 5.4% of the total population in the County.

Housing, Education, Income, Poverty, & Food Insecurity Data

The total number of housing units in Monterey County is 144,403, with 51.7% being owner-occupied. Over the past three (3) years, the average home value in Monterey County has increased from $441,000 to $596,400 (37% increase), while the median household income is $82,013. Regarding housing affordability, like much of the 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 12.15%, 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 that approximately 2,422 individuals are homeless.

Homelessness Data

The biennial 2022 Monterey County Homeless Census "Point in Time" (PIT) homeless count and survey found 2,047 persons experiencing homelessness during the 2022 count. The 2022 count is a 15% decrease from the 2019 PIT, the lowest PIT count in the previous decade. The majority (665) of the individuals experiencing homelessness were unsheltered, sleeping on the streets, in abandoned buildings, vehicles, and encampment areas, and in other places deemed unfit for human habitation. The remaining 34% of the population resided in emergency shelters or transitional housing. 78% of individuals have lived in Monterey County before becoming homeless, with 54% having resided in the County for ten or more years; 55% of survey respondents indicated their current episode of homelessness is their first, with 63% of respondents reported the duration of

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their current episode of homelessness at one year or longer. The next PIT was conducted in January 2024; the Report is unavailable now.

Community Program Planning Process (CPPP)

Introduction

Monterey County Behavioral Health (MCBH) conducted the Community Program Planning Process (CPPP), a collaborative initiative that ensured residents and stakeholders could actively contribute their input and feedback. This collective effort guided the development of the draft MHSA FY2023-2024 Annual Update. MCBH partnered with EVALCORP, an esteemed evaluation company, to assess the behavioral health needs of the Monterey County community as part of the CPPP. The goals of this assessment, where Community Members and Stakeholders shared their invaluable insights, were to enhance the effectiveness of the behavioral health system, improve access to care and services, and reduce health disparities for all communities across Monterey County.

EVALCORP, in its commitment to gather comprehensive insights based on diverse perspectives from across Monterey County, employed a robust mixed-methods strategy. This approach was designed to ensure that all community members and stakeholders, regardless of their background or role, could contribute to the assessment process. Community Members were engaged through a community survey and a series of community focus groups, while Stakeholders, defined as providers of behavioral health services and those who facilitate connection to those services, were engaged through a stakeholder survey and stakeholder focus groups. Listening sessions were then held across the county to report findings to the community and CPPP participants and to receive feedback on both the process and findings of the CPPP.

Community Engagement

Community engagement was achieved through two strategies: a community survey and community focus groups. Recognizing the critical role of community engagement in understanding and addressing behavioral health issues, the community survey was deployed through 48 distinct distribution channels established by partnering with local agencies and organizations in Monterey County to gather diverse perspectives. The distribution strategy described above resulted in 906 community responses in both English and Spanish that were included in the analysis. Additionally, the Community Focus Groups were designed to gather perspectives on the current state of mental and behavioral health services in Monterey County for underserved and underrepresented populations. Focus Group participants were recruited through system partners across Monterey County. Ultimately, eight priority populations were identified: 1) Unhoused, 2) African American Males, 3) Veterans, 4) LGBTQ+, 5) Individuals affected by the 2023 floods, 6) Early childhood caregivers, 7) individuals who live in South County, and 8) the Indigenous community. By coordinating with contacts at MCBH system partners, seven community focus groups were organized to ensure the representation of the above-priority populations. Four (4) focus groups were facilitated in English, two (2) in Spanish, and one (1) in Triqui. A system partner, such as a community-based organization, hosted in-person focus groups. Among these different focus groups, a wide array of community members participated, including parents, caregivers, veterans, individuals living with disabilities, individuals with a

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serious mental illness, family members of individuals with a serious mental illness, unhoused individuals, undocumented individuals, and individuals with substance use disorders.

The community survey and community focus groups helped reveal essential insights for MCBH. Surveyed community members identified substance use, anxiety, and alcoholism as the most critical issues in the County. Community members reported services were most lacking on matters related to fentanyl-laced fake prescription pills, intravenous drug use, and chronic stress. Additionally, community members identified the top five barriers they faced when accessing services: a lack of information about where to get help, appointment availability, a lack of convenient appointments, a lack of health insurance, and the cost of services. Finally, community members made several recommendations for improving the County's mental health and substance use care systems encompassing five significant themes: access and availability, comprehensive and integrated services, strengthening the behavioral health care workforce, community outreach and education, and culturally responsive and empathetic care.

The community focus groups also provided important insights. Findings show that, among focus group participants, there were a variety of understandings and usages of behavioral health language related to mental health. This language perception points to the need for more straight forwarded communication and education around mental health to foster a more unified, neutral, and destigmatized perspective. Participants also discussed social, environmental, and psychological risk factors for mental health issues that intersect with each other and cannot be treated in isolation, suggesting that services could be tailored to handle multiple factors and be sensitive to ways in which these factors compound their effects. Community members provided strong evidence of their desire to receive services and continued need for them. Finally, community members shared a passion for engagement strategies built on trust that create positive experiences with the community and provide safe spaces for everyone, especially the most vulnerable populations.

Stakeholder Engagement

Stakeholder engagement was achieved through the stakeholder survey and stakeholder focus groups. Monterey County Behavioral Health employed multiple survey distribution strategies to reach diverse stakeholders, ensuring the survey reached a broad and inclusive audience. The distribution strategy described above resulted in 95 responses included in the analyses. Second, EVALCORP collaborated with MCBH to purposefully recruit diverse stakeholders within the community for the focus groups. Four (4) four focus groups and one interview were conducted with 39 participants representing law enforcement, diversity and equity resources, and community-based organizations providing behavioral health prevention and treatment services. MCBH staff involved in the planning process were present during select focus groups to connect with stakeholders and ask follow-up questions that would be helpful to their planning.

The stakeholder survey provided valuable insights from a various providers and system partners, identifying key needs, barriers, and gaps in behavioral health services. In terms of community mental health and substance use service needs, stakeholders identified trauma, anxiety, and chronic stress as the most significant mental health issues, with alcoholism and prescription drug misuse, including opioids, as the top substance use concerns. There is a notable alignment between these issues and the services available, such as counseling and crisis response. However,

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a majority of stakeholders believe these services are insufficient for current needs. Regarding barriers to accessing care, staffing issues, such as shortages and long waitlists, were frequently cited as major barriers. There is also a knowledge gap in referring clients to services beyond Medi-Cal, indicating a need for more training in diverse insurance situations and a general skepticism about the effectiveness of referrals. Stakeholders also recognized MCBH's efforts to enhance accessibility, and quality, and provide a comprehensive approach to care. Stakeholder recommendations revolve around increasing collaboration, enhancing access to services, and improving staffing and training. The survey revealed that while MCBH has made strides in providing essential services, there is a clear call for expanded training on available resources, better system navigation, and enhanced coordination to fully address the community's mental health and substance use needs.

In the Stakeholder Focus Groups, stakeholders from various service areas shared valuable information regarding behavioral health, including prevalent issues, service needs, barriers to care, current initiatives positively impacting communities, and opportunities for improvement in Monterey County. Depression and anxiety were perceived as the most common behavioral health issues affecting communities in Monterey County. Identified contributors to poor behavioral health included psychological, social, and economic factors. Increased availability of behavioral health treatment options for underserved areas and populations was recommended. Stakeholders also emphasized how lessons from successful behavioral health services in the County showcase collaboration, cultural sensitivity, local outreach, and comprehensiveness as strategies for enhancing service engagement and improving outcomes. MCBH can leverage insights from stakeholders and capitalize on existing foundational elements to refine or develop initiatives to address priority behavioral health issues, fill gaps in services, and ensure resources are effectively allocated to increase service access and better meet community behavioral health needs.

Listening Sessions

One hundred ten community members participated in four listening sessions. Three were held in person, and one was virtual. All listening sessions were held in Spanish, with an English translation provided. The listening sessions took an informal and conversational approach. Community members were encouraged to share their feedback on all Community Program Planning Process activities, including ways MCBH and EVALCORP engaged with the community, additional barriers to accessing services, and additional recommendations for enhancing services.

Several key findings emerged from the Listening Sessions. Participants shared ideas for engaging the community, including enhancing accessibility and inclusion, increasing culturally sensitive communication and outreach, and tailoring communication strategies. Participants also discussed ideas for overcoming barriers, which included providing services outside of traditional working hours, funding dependent care during appointments, and providing translation services. Another theme that emerged was the systemic and institutional trust Issues that participants encountered. These issues included fear of repercussions from undocumented residents, lack of connected institutional response, concerns about the follow-up processes, structural racism, and system navigation challenges. Participants also revealed issues with insurance and finances that

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they feel they face alone. Ultimately, participants recommended increasing the number of system navigators who can support clients in finding services, determining eligibility, and managing payments.

Further Information

To review all findings from the CPPP needs assessment, please review the summaries for each engagement strategy incorporated into the appendices of the Annual Update.

Monterey County's CPPP also includes the following:

1. The draft FY24 Annual Update, thoughtfully prepared in both English and Spanish, is open for a minimum 30-day public review and comment period, ensuring your voices are heard and valued.

2. A public hearing with simultaneous Spanish language interpretation is to be conducted by the Monterey County Behavioral Health Commission.

3. Adopting the final FY23 Annual Update by the Monterey County Board of Supervisors.

Changes to MHSA Programs

The following changes to programs, as presented and approved in the FY 2023 – FY 2026 MHSA Three-Year Program & Expenditure Plan, have occurred during FY 2023-2024.

Innovation (INN) Component:

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

The Micro-Innovation Grant Activities for Increasing Latino Engagement has concluded the final evaluation report is attached in Appendix IV. No single micro-innovation activity has been sustained as a standalone program, however, promising practices as identified in the final evaluation report shall be referenced as needed.

Screening to Timely Access [INN-02]

The Screening to Timely Access project was created 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. The tool, which has been named "WellScreen Monterey", has been made available for public use. The project has concluded December 2023. Th final evaluation report is attached in Appendix IV.

PEI funds will sustain the WellScreen project for an additional 18 months (January to June 2025).

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

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The Transportation Coaching by Wellness Navigators project, also referred to as the "Transportation Coaching Project", concluded August 2023. The final evaluation report is attached in Appendix IV. Promising practices that were developed and identified in the Transportation Coaching Project have been incorporated by the Wellness Navigator program within CSS-10.

MHSA Annual Update FY2024-2025

Community Services & Supports (CSS) Program Descriptions

Seventy-six percent (76%) of the MHSA funds received by the County are allocated for CSS components. MHSA funds may only be used to pay for those portions of the mental health program/services for which no other funding source is available. CSS programs serve individual 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. No less than fifty percent (50%) must be allocated to "full service partnerships (FSP). FSP services provide a "whatever it takes" level of services – also referred to as "wraparound" services – 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, employment services, socialization, and recreational activities based on the individual's needs and goals for 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 support, family education, wellness centers, and assistance with access to educational, social, vocational rehabilitative and other community services.

Full Service Partnerships

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. These services aim to improve the child's overall functioning within their family, school, peer group, and community, reduce the 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 the 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 priority access to psychiatric, psychological assessment, and occupational therapy services as needed. Adoption preservation is encouraged by integrating a parental component and additional mental health services using 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

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Crisis Intervention and Family Education Program will be provided to the same population when less intensive services are required along the continuum of care. Contracted Partners will provide additional programs.

Additionally, 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. The focus will be made on families with infants and children 0-5 who have been exposed to trauma and are exhibiting early signs of attachment disruption, poor attunement with their caregivers, trauma symptoms, and related behavioral dysregulation. Such services will improve the early attachment relationship, reduce mental health symptoms, and resolve trauma experiences for children, as well as the impact of trauma on a child and their families.

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 consist of both an **Outpatient Program,** Integrated Co-Occurring Disorder, that provides integrative co-occurring treatment through an evidence-based practice and strengths-based home-visitation model and a **Residential Program,** Santa Lucia, 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 the need for residential care.

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 on their mental health needs. TAY can also participate in skills groups, outings, and recognition events. Goals are tailored to each youth and may include achieving educational or vocational pursuits, acquiring a stable living situation, and engaging with peer and social supports while reducing mental illness symptoms.

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 living in the least restrictive environment possible. This FSP is comprised of an **Outpatient Program** operated by a contracted service provider to serve this population of adults, including those with a co-occurring substance use disorder. Services within this outpatient program will include:

- Outreach and engagement.

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- Employing a welcoming/engagement team.
- 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.

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 living in

the least restrictive environment 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 and 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 and physical health conditions. This residential program will assist residents with medication, medical appointments, daily living skills, and money management and will provide daily structured activities.

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**. This program 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**, all in a bid to support adolescents and adults with a mental health disorder who are involved with the juvenile/criminal justice systems**.

For transition-age youth, MCBH will work in partnership with public agencies and community partners to provide a comprehensive range of services through the Justice-Involved FSP. These services are designed to support youth involved with MCBH, Juvenile Justice, and/or the Department of Family and Children Services. The FSP programs include a **Juvenile Mental Health Court Program,** where Probation, Juvenile Court, and Behavioral Health provide supervision and support to youth and their families. Additionally, the **Juveniles Who Sexually Offend Response Team** (JSORT) program, a collaborative partnership between Monterey County Probation and MCBH, provides specialty mental health services to adolescents who have committed a sexually related offense. Families/caregivers may also receive services from both programs.

Homeless Services and Supports FSP [CSS-14]

The Homeless Services and Supports FSP includes an **Outpatient Program** operated by a contracted service provider that will offer wrap-around services and will conduct outreach for adults with a psychiatric disability who are currently experiencing homelessness or who are at

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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** for 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

Access Regional Services [CSS-07]

The Access Regional Services strategy will support Monterey County Behavioral Health ACCESS walk-in clinics and community-based organizations that 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 the coastal region (i.e., Marina), Salinas, Soledad, and King City, and they provide reach in all four areas 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. Additional ACCESS clinics provide support for medication management and those enrolled in the Welfare to Work program with the Department of Social Services (DSS).

The clinical support offered through ACCESS clinics will be supplemented by community, education, and therapeutic support at a **wellness center**, the OMNI Resource Center, which is now funded 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 and 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.

Through a series of outpatient programs, this CSS strategy to promote access to services will also support community-based providers in making services accessible to children, youth, adults, and their families. These include tailored supports for LGTBQ+ individuals, individuals affected by HIV/AIDS, and individuals experiencing crisis and trauma. Programs also provide telehealth and in-person counseling services for individuals of all ages across the county, including services for non-English-speaking residents and those who are deaf or hard of hearing.

Early Childhood Mental Health Services [CSS-08]

The Early Childhood Mental Health Services strategy supports specialized programs for families/caregivers with children ages 0-11. This will include an **Outpatient Program** that employs care coordination teams and therapists to provide culturally and linguistically appropriate behavioral health services for children and their caregivers/family members. The program uses a family- and strengths-based approach to support positive emotional and cognitive

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development in children and increase caregiver capacity to address their children's socioemotional 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 prenatal exposure to alcohol and other drugs. The primary focus is identifying, assessing, referring, and treating infants, children, and youth affected by the broad spectrum of developmental, social, emotional, and neurobehavioral disorders by utilizing evidence-based practices and trauma-informed services.

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, support completion of intake screening tools, and help clients understand how to access the services available to them. The **Transportation Coaching Program** assists consumers' independence by helping them learn how to utilize public transit and rideshares to engage in day-to-day-activities. The **Primary Care Integration Program** will offer voluntary training and supportive services that focus 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.

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.

Dual Diagnosis Services [CSS-11]

Dual Diagnosis Services will serve those impacted by substance abuse and mental illness by providing intensive and cohesive supports. **Outpatient Programs** will be operated by a community-based contracted service provider to assist clients in developing dual recovery skills to maintain successful community living and promote a clean and sober lifestyle as they transition out of dual recovery residential programs. In addition, a **Residential Program** will provide a home-like environment in a structured, non-institutional, therapeutic community to support independent living skills and assist adults in their recovery.

Homeless Outreach & Treatment [CSS-15]

The Homeless Outreach and Treatment strategy will include **Shelter/Housing Programs** for vulnerable individuals with a psychiatric disability who are currently experiencing homelessness or are at risk of becoming homeless. Two **Outreach Programs** are also included in this strategy to provide case management to both youth and adult individuals experiencing homelessness in the county.

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Responsive Crisis Interventions [CSS-16]

County residents have identified the need for timely, responsive mental health services, 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 providing 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.
A county-operated **Forensic Outpatient Clinic**, the Archer Child Advocacy Center, will be supported through this strategy. This clinic will provide mental health assessments, referrals, and therapy services to children who have experienced sexual abuse. Crisis support services will also be available to the child's family/caregiver(s).

A **Residential Program** will offer crisis stabilization for adults with serious mental illness in a less traumatic environment, including support with daily living skills, personal hygiene, and treatment. Staff will work with residents to develop strategies to avoid the reoccurrence of crisis situations.

Mental Health Services for Adults [CSS-18]

The Mental Health Services for Adults strategy will provide specialty mental health care services to adults with severe and persistent mantal illness. **Outpatient Programs** will offer strengths-based services to individuals, such as case management, crisis intervention, therapy, medication management, and education and employment support. In addition, a **Supportive Housing Program**, Community Housing, will provide individual apartments and/or shared housing units to adults along with case management and mental health treatment services.

CSS Program Data for FY 2022-23

For CSS Program Data covering the Fiscal Year 2022-23 period, please refer to Appendix II

Community Services and Supports Annual Report FY 2022-2023

For CSS Program Data covering the Fiscal Year 2022-2023 period, please refer to Appendix II.

Prevention & Early Intervention Program Description

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 program focused on delivering services for each of the following service categories: 1) Prevention, 2) Early intervention, 3) Stigma and Discrimination Reduction, and 4) Suicide Prevention. All programs

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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 25 years old or younger. Programs that serve parents, caregivers, or family members to address 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 reflect the core themes and priority areas identified in the CPPP (see Community Program Planning Process section above).

Prevention

Family Support and Education [PEI-02]

Family members and caregivers living with and caring for loved ones with mental health conditions benefit from social connectedness and psychoeducation 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 and young adulthood. 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, and families come from different cultural backgrounds. Some families have added challenges related to being a teen parent, and they will be afforded programming and supports under this strategy. Parenting classes and programming will be provided in Spanish, English, and Indigenous languages 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 enhancing their experience.

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

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PEI funding will be used to provide outreach, education, and linkages to behavioral health care using culturally specific messaging campaigns aimed at decreasing stigma related to mental health for historically underserved communities, including Latinx, Black and African Americans, and LGBTQ+ communities. 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. This activity may include using bilingual and Spanish radio programming to provide information on behavioral health topics and how to access services.

Community information sessions and presentations on behavioral 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 identified during the CPPP regarding the current lack of knowledge of available behavioral health resources and to increase understanding in the community regarding behavioral health.

Participants identified stigma as a prominent barrier during the CPPP, focus group and listening session. They noted that language highlighting the term “mental health” can push individuals away from accessing services, especially in Latino and Indigenous communities. However, pivoting to language that highlights emotions, feelings, and behaviors associated with mental health was more accepted. Participants recommended leveraging trusted community members or organizations, especially train-the-trainer models. MCBH will explore opportunities to work with Community Health Workers (CHWs) and Promotoras to help bridge the gap between residents who are reluctant to engage in behavioral health care and local programs. The participants of one focus group stated, “Use Promotoras to help break the stigma among the Latino population. By vouching for them, they can help people trust service providers and county agencies.”

Additionally, during the CPPP, participants identified the need for more community education on mental health. MCBH would like to support Mental Health First Aid (MHFA) and the variations of this model, including Youth Mental Health First Aide and other variations that are relevant to Monterey County residents and meet the linguistic and cultural needs of our communities. 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. In prior fiscal years, MCBH was not able to build the capacity to provide MHFA training in all categories relevant to Monterey County, which could include Adult, Youth, Public Safety,

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Fire/EMS, Veterans, Older Adults, Rural, and Higher Education. MCBH will explore options for implementing MHFA programs in Spanish and English for the 3-year cycle of this current MHSA plan.

Professional training on mental health and related topics may also be provided to professionals, medical providers, faith leaders, educators, law enforcement, and other key groups that interact with community members.

MCBH may use PEI funding to support the maintenance and expansion of the Critical Incident Stress Management (CISM) Team. The CISM Team responds to residents and first responders in Monterey County who have experienced a traumatic event to address Critical Incident Stress (CIS) that if left untreated may result in Post-Traumatic Stress Disorder or other mental health conditions. The CISM Team also has staff from MCBH who can train other public agency staff and entities, such as law enforcement, to create their own internal CISM Teams.

Veterans are a vulnerable population for mental health conditions and suicide risk and were identified as a priority population in SB 1004 and 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 the risk of mental health conditions and suicide.

Student Mental Health [PEI-08]

MCBH has a solid 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 will provide educational presentations to parents and caregivers on mental health-related topics including, but not limited to, common childhood mental health disorders and how to access Behavioral Health services. MCBH staff will also respond to the emerging needs of the student population, which district administrators and other relevant educational staff identify. Psychoeducation and training will be provided to educational staff to support trauma-informed education practices and wellness for educators.

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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), including domestic violence, will occur on school sites to minimize barriers to accessing care. Support will be provided to parents and caregivers in meeting their child's social and psychological needs, along with psychoeducation on understanding ACES and how to support their children in building resilience. Bullying prevention programs and support for schools to address bullying will also be provided on school sites in coordination with other programming.

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 decrease the risk of developing a mental health condition.

Maternal Mental Health [PEI-15]

To address the prevention of childhood trauma at the earliest possible point in time, MCBH will develop community-based supports to help mothers/birthing people who are at risk of or are experiencing mild to moderate Perinatal Distress in the form of anxiety, depression, and mood concerns. MCBH will offer trauma-informed dyadic playgroups for families with children 0-5 in community locations, providing psychoeducation and support with a focus on Spanish-speaking Latina mothers who do not have access to mental health services through their health insurance provider. Groups will be offered in-person and online based on community needs and staffing capacity. These groups will increase opportunities for participants to have positive social interactions, develop support networks, and decrease stigma through shared experiences. A primary goal will be to increase group participants' knowledge and understanding of how being attuned to 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.

Additional support to address Perinatal Mood and Anxiety Disorder (PMAD) will be provided through the Maternal, Child and Adolescent Health (MCAH) nursing program. The MCAH Case Manager and team members are in a unique position to screen, intervene, and refer clients who are at risk or experiencing PMAD symptoms. Through building a therapeutic relationship, case managers can deliver person-centered, holistic, and trauma-informed care to support the client's health and well-being.

Community-based agencies will provide peer support programs and therapeutic treatment for addressing Maternal Mental Health through staff and peers who reflect the racial, ethnic, and cultural groups that makeup Monterey County. These supports will be provided 1:1 and in groups, in settings that support participation, including home visiting and community-based locations. Inclusion of partner involvement in interventions, such as fathers and co-parents, will be incorporated as capacity allows. Programs will also provide referrals to health and wellness resources through care navigation, concrete supports such as housing, and affiliation support that connects individuals with community resources like communal activities and events.

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PEI funding will be used to develop culturally attuned outreach materials that provide information on perinatal mental health and offer relevant resources. Materials will be designed to raise awareness of resources, decrease stigma, and build connections between individuals and families in our community. Participation in community events will create bridges to community members in natural settings who can benefit from service offerings and build relationships with other community agencies who serve parents and birthing people with other needed services to promote referrals and resources. Funding will also be used to support the Monterey County Maternal Mental Health Task Force in achieving the above goals: raising awareness, decreasing stigma, and building connections. Hence, families receive support to maximize wellness during pregnancy and throughout the early years of their children's lives.

Early Intervention
Prevention Services for Older Adults [PEI-05]

A continuum of supports will be provided for Seniors to engage seniors and older adults in mental health care and in programming to support their health and wellness. Activities include:

- Outreach and community education that is specific to seniors through social marketing campaigns, community presentations, outreach events, and other promotional activities.
- Activities that reduce isolation, promote resilience, recovery and social connectedness for seniors will be provided including individual and group support.
- Senior Peer Companions and Counselors, often the cornerstone of programs serving seniors, 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.

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 to engage adolescents and transition age youth (TAY) ages 16-25 in mental health care and in programming to support their health and wellness. Activities include:

- Social marketing campaigns, community presentations, outreach events, and other promotional activities
- A 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.
- Services for youth who have run away or are experiencing homelessness to connect them to programs to address risk factors and link youth to services that will meet their needs including, but not limited to, housing, substance abuse prevention, mental health counseling, benefits, health care, educational and employment opportunities.
- Case coordination as indicated with social services, probation, behavioral health, schools, law enforcement, and other service providers.

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Positive, youth-friendly activities that reduce isolation, promote resilience, recovery and social connectedness for youth will be provided including individual and group supports in a community-based setting that is youth led and informed by input from youth and young adults. 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 who have mental health conditions that are impacting their developmental trajectories for transitioning to adulthood and/or are placing them at risk for involvement with public agencies, such as Juvenile Probation. Therapeutic interventions will be provided individually or in groups in non-clinical community-based locations that are easily accessible for youth and young adults.

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+ individuals and communities*. 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 behavioral 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 behavioral 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.

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 and peer support, educational and vocational support.

In addition, outreach comprehensive community campaign providing education about early signs and symptoms of psychosis and the importance of early intervention, behavioral health wellness, psychosis and stigma. This may include individualized mental health consultation to caregivers

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and providers, including pre-screening of individuals for potential referral for early psychosis assessment and treatment or other behavioral health services, as indicated.
Outreach efforts will be focused on key stakeholders including medical providers, community health workers, educational partners and others who are connected to Medi-cal beneficiaries and residents in Monterey County.

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.
T
he 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. MCBH will provide funding as capacity allows to continue to participate in this statewide effort.

Suicide Prevention [PEI-06]

An integrated method of service delivery including a 24/7/365 free, multi-lingual suicide and crisis lifeline, educational outreach, and training, and postvention support services for those who have lost a loved one to suicide will be provided by a contract provider that is an Accredited Crisis Center through the American Association of Suicidology. High-risk individuals, families, and groups will be identified and provided with safe alternatives to suicidal behavior.

MCBH has developed a Roadmap to address suicide awareness and prevention in Monterey County and has formed a suicide prevention coalition named MC HOPES which stands for Monterey County: Helping One another to Prevent and Eliminate Suicide (Coalition). PEI funding will be utilized to facilitate the Coalition, make further progress on the Roadmap by creating workplans that include objectives and interventions identified by the 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. 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”).

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For PEI Program Data covering the Fiscal Year 2022-2023 period, please refer to Appendix III

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Innovation (INN) Projects

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 behavioral 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 underserved individuals. The Innovation Component allows counties the opportunity to "try out" new approaches that can inform current and future behavioral health practices and approaches. These projects are intended to contribute to learning about what approaches to providing behavioral 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. If any members of the public wish to identify a community need or suggest an innovative concept to improve the quality to, or access of, local behavioral health services, they are encouraged to contact MCBH at: MHSAinnovations@co.monterey.ca.us

Current Approved INN Projects

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

The Micro-Innovation Grant Activities for Increasing Latino Engagement project was created to **identify and support 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 were encouraged to apply for funds to deliver localized services to engage Latino communities in ways not currently employed through existing behavioral health services in Monterey County. The Innovation Plan is concluding the sixth and final cohort of micro-innovation activities on June 30, 2023, with the remainder of the Innovation funding timeline, ending August 22, 2023, being dedicated to evaluation activities. This Innovation project utilized the maximum 5-year timeline available to Innovation plans, and as evidenced in the FY21/22 Innovation

Evaluation Report included in Appendix IV

Several promising culturally and linguistically responsive approaches towards community engagement were identified. Promising practices originating from this Innovation project will be made relevant to any future planning discussions to create or modify programs intended to provide outreach to Latinx communities.

Screening to Timely Access [INN-02]

The Screening to Timely Access project was created 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 has been implemented in coordination with the California Mental Health Services Authority as part of the multi-county Tech Suite Collaborative "Help @ Hand" project. As discussed in further detail in the FY21/22 Innovation Evaluation Report included in Appendix IV, MCBH and CalMHSA have contracted with CredibleMind, who has developed the web-based screening and referral tool, along with supported the development

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and evaluation of a robust evaluation plan to assess the impact of this tool. Over the course of FY22/23, the tool, which has been named "WellScreen Monterey", has been made available for public use. Workflows for integrating user information for clinical use have been developed. Throughout the remainder of this Innovation plan 5-year funding timeline, ending December 31, 2023, continued marketing, implementation and evaluation activities will occur. Maintenance costs for supporting this tool beyond the Innovation funding timeline will be covered under the Prevention and Early Intervention component.

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

The Transportation Coaching by Wellness Navigators project, also referred to as the "Transportation Coaching Project", **developed and tested a transportation needs assessment tool capable of informing transportation coaching strategies for behavioral health services clients. and measuring the impact of those strategies on staff costs and client levels of independence**. 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 developed the transportation needs assessment tool, in partnership with Interim, Inc., our community partner employing the Wellness Navigators who provide transportation coaching services. As evidenced in the FY21/22 Innovation Evaluation Report included in Appendix IV, this project demonstrated successful outcomes related to clients' ability to attend and/or participate in the mental health services appointments and other preferred wellness activities. Beginning in FY22/23, Transportation Coaching Project services provided by Interim, Inc., were sustained under the Community Services and Supports component. The remainder of Innovation funds available through the conclusion of the 5-year term of this project, ending August 22, 2023, are dedicated to evaluation activities.

Residential Care Facility Incubator [INN-04]

The Residential Care Facility Incubator project aims to develop and enact a plan that will **incentivize local property owners to establish culturally and linguistically responsive residential care facilities in within Monterey County**.

Given the complexity and challenges associated with housing in Monterey County and California at-large, the Residential Care Facility Incubator projects is being carried out in two phases. Currently, MCBH has approval to support only Phase I of this project, which is to conduct the necessary research and planning required to support a successful implementation plan that will be carried out in a Phase II. 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.

During FY22/23, a Request for Proposal process was carried out, and a vendor was selected to assist MCBH in developing an actionable plan to incubate these residential care facilities. Initial research activities began in May 2023. Additional information on this Innovation

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project can be found in its FY2023- 2024 Innovation Evaluation Report included in Appendix IV.

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, when the person experiencing a psychiatric crisis is unable to make decisions. When a person has established a PAD, proper care can be provided, 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. Additionally, when family members are kept up to date on an individual's PAD, they can be better advocates for their loved one. MCBH is working collaboratively with the multi-county collaborative and its partners to support the created of the PAD template, technology platform on which it will be used and information can be shared, marketing and education materials, and policy advocacy. Locally, MCBH is working with Interim, Inc., in planning to pilot the use of PADs within two of their crisis stabilization programs beginning in late spring of FY23/24.

Rainbow connections [INN-07]

Rainbow Connections will increase interagency collaboration between MCBH, Monterey County Office of Education (MCOE), Monterey County Clinic Services (MCCS), Local Education Agencies (LEA's) and community-based organizations, to promote better health outcomes for the LGBTQ youth under 25 population in Monterey County. Integral to this interagency and community collaboration, Rainbow Connections will also be piloting an adapted version of an evidence-based practice to service LGTBQ youth and their families. In doing so, this Innovation project will create a new LGBTQ+ Continuum of Affirmative Care model, capable of improving the capacity of the adults, caregivers, providers, and systems responsible for the growth and well-being of LGBTQ youth to identify their mental health needs and promote their access to appropriate care.

Activities included within this proposed plan include the creation of dedicated staffing within MCBH to provide affirmative, integrated behavioral health and medical care for LGBTQ youth and their families. Staffing will include a team consisting of a Psychiatric Social Worker, Psychiatrist and Family Partner working in collaboration with or within MCCS to break down the silos that currently exist between the MCBH and MCCS systems. Additionally, a Social Worker III will be allocated to provide linkage to identified community resources and navigation of the various youth serving systems when specialized care is needed. The specialized services and supports that will be accessible to LGBTQ youth 24 and under in need will be provided through the MCBH LGBTQ Continuum of Affirmative Care for Learning Communities, an adaptation to the existing MCBH School-based Continuum of Care for Learning Communities that is currently being implemented in schools across Monterey County with high success rates and significant impact through a collaborative partnership with MCBH, MCOE and school districts. The LGBTQ

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Continuum of Affirmative Care is aligned with the Positive Behavioral Interventions and Supports (PBIS)/ Multi-Tiered System of Support (MTSS) frameworks to determine the various levels of care needed by LGBTQ youth. Additionally, local community-based organizations will deliver affirmative outreach and education programs to students, school staff, parents and service providers as part of this project. Meanwhile, the participating community-based organizations and clinical staff persons will receive specialized training to tailor their service offerings and delivery to directly address the barriers and challenges experienced by LGBTQ persons and their families.

The evaluation plan of this Innovation Plan will assess the impact of the adapted PBIS framework on client utilization of the allocated specialized staffing resources and other identified LGBTQ community resources, client satisfaction, decreased suicidal ideation and attempts, improvement in student behaviors and outcomes, and improvement in family functioning and other mental health outcomes.

This Innovation plan was approved by the MHSOA on May 2023, with activities set to begin in early FY23-24.

Workforce Education & Training (WET) Component: Program Descriptions

WET programs are intended to increase the number of well-trained public behavioral health providers who enter and remain in the field, serving underserve and hard to serve individuals. Strategies focus on increasing interest in public behavioral health careers, enhancing recovery-oriented treatment skills, and improving retention and career advancement opportunities. 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 [WET-01]

MCBH has a clinical position vacancy rate that consistently hovers around 20%. MCBH uses MHSA funds to **outreach to universities and professional programs** to share information about community behavioral health careers in general, and with MCBH, in particular.

MCBH has a **Psychiatric Social Work (PSW) Intern Program**. MCBH staff members mentor around thirteen Master of Social Work (MSW) or Marriage and Family Therapy (MFT) students each Academic Year. MHSA money is used to pay for an Intern Coordinator and mentor time recruiting, training and supervising PSW Interns. Starting in FY23, MCBH will use MHSA funds provide **stipends to PSW Interns** who are committed to pursuing a career in public behavioral health. MCBH encourages community members to seek higher education in the field of mental health; stipends allow students to work less and better focus on academics.

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Education and Training [WET-02]

A significant portion of the skills clinical staff members need to provide effective mental health services are gained on the job through training and supervision, as well as before employment during internship. To support staff development, MCBH has designed **a robust training curriculum focused on clinical competencies** in the areas of: Culturally Rooted Care; Trauma Informed Care; Clinical Fundamentals; Clinical Conceptualization; Treatment Interventions; Clinical Documentation; and Professional Development.

MCBH uses MHSA funds to pay for training and coaching. Core treatment strategies staff members are encouraged to master are Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy Skills (DBT Skills). In addition to attending foundation and advanced topic courses in MI, CBT and DBT, staff members can also have one-on-end and small group coaching and consultation to support skill development and mastery. Staff members also learn treatment strategies specific to the populations they serve (e.g., juvenile justice, transitional age youth, early childhood.)

MCBH also uses funds to pay for administrative support to manage advertising, enrollment, and attendance of the approximately 100 classes offered each fiscal year.

Retention [WET-03]

One reason for MCBH's high vacancy rate for clinical positions (20%), are historically low salaries, compared to salaries offered by other counties. Once trained, some staff members will move on to higher-paying jobs. Our Human Resources Department (HRD) increased salaries in 2021, after a lengthy analysis process; however, right around this time, a local hospital opened a children's behavioral health department and Kaiser opened a behavioral health clinic in Santa Cruz County, leading to a wave of resignations.

To support staff retention, MCBH provides technical assistance to staff interested in applying for federal and state loan repayment Starting in FY23, MCBH will, through the MHSA Greater Bay Area Collaborative, offer its own **loan repayment program**. MCBH will provide approximately $165,000 which will be leveraged to $570,000, with State Health Care Access and Information (HCAI) funds.

Supporting Systems

Evaluation and Research [WET-04]

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.

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WET Training Summary Report for FY 2020-21

For the WET Training Summary Report covering the Fiscal Year 2020-21 (07/01/2020-06/30/2021) period, please refer to **Appendix V**.

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.

The following Capital Facilities projects are included in our current MHSA FY21-23 Three-Year Program & Expenditure Plan:

Renovation of an East Salinas Facility

This facility is located directly behind the Monterey County Women, Infants & Children Program office on the corner of East Alisal and Pearl Streets in Salinas. These renovations will enable and enhance mental health services for East Salinas residents of all ages.

Development of a New Facility on East Sanborn Road in Salinas

This facility will provide mental health services to children, youth, and their families/caregivers. This project is underway, with groundbreaking having occurred in March of 2022.

This Capital Facilities project has been added for FY23-24 in response to local needs identified through the Community Program Planning Process:

Monterey Mental Health Rehabilitation Center (MHRC)

This facility will create 110 mental health treatment beds through converting a vacated county-owned facility at 1420 Natividad Road in Salinas. This MHRC will be a 24-hr program which provides intensive support and rehabilitative services designed to assist persons with serious mental disorders. Monterey County clients are best served locally; currently they are placed in a state hospital, or another mental health facility located outside Monterey County.

Planned transfers to CFTN are expected to continue in FY22-23. These transfers will not fully fund these planned projects. Additional funding streams will be required and sought.

FY 2023- 2024 Budget Narrative

This FY 2023-2024Annual Update reflects continued funding for previously approved Community Services & Supports (CSS), Prevention & Early Intervention (PEI), Innovations (INN), Workforce Education & Training (WET) and Capital Facilities & Technological Needs (CFTN) components.

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Estimated unspent funds from prior Fiscal Years will help augment estimated new MHSA annual allocations from the State of California to enable adequate funding for the first year of this FY2023-2024 through FY 2025-2026 Three-Year Program & Expenditure Plan.

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan

Funding Summary

County: Monterey Date: 4/30/2024

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. Estimate FY 2023/24 Funding							
1.	Estimated Unspent Funds from Prior Fiscal Years	0	5,735,577	6,872,530	797,049	5,846,652	
2.	Estimated New FY 2023/24 Funding	33,509,424	8,377,356	2,204,567			
3.	Transfer in FY 2023/24	(4,143,753)			1,000,000	3,143,753	
4.	Access Local Prudent Reserve in FY 2023/24						
5.	Estimated Available Funding for FY 2023/24	29,365,671	14,112,933	9,077,098	1,797,049	8,990,405	
B. Estimated FY 2023-24 MHSA Expenditures		31,510,283	6,450,664	3,423,896	1,648,122	5,500,000	
C. Estimate FY 2024/25 Funding							
1.	Estimated Unspent Funds from Prior Fiscal Years	(2,144,612)	7,662,270	5,653,202	148,927	3,490,405	0
2.	Estimated New FY 2024/25 Funding	27,415,927	6,853,982	1,803,679			
3.	Transfer in FY 2024/25	(2,629,731)			1,000,000	1,629,731	
4.	Access Local Prudent Reserve in FY 2024/25						
5.	Estimated Available Funding for FY 2024/25	22,641,584	14,516,251	7,456,881	1,148,927	5,120,136	
D. Estimated FY 2024/25 MHSA Expenditures		23,450,897	5,603,789	2,684,704	1,098,748	4,000,000	
E. Estimate FY 2025/26 Funding							
1.	Estimated Unspent Funds from Prior Fiscal Years	(809,313)	8,912,462	4,772,177	50,179	1,120,136	0
2.	Estimated New FY 2025/26 Funding	17,997,033	4,499,258	1,184,015			
3.	Transfer in FY 2025/26	(2,716,834)			1,000,000	1,716,834	
4.	Access Local Prudent Reserve in FY 2025/26						
5.	Estimated Available Funding for FY 2025/26	14,470,886	13,411,720	5,956,193	1,050,179	2,836,970	
F. Estimated FY 2025/26 MHSA Expenditures		14,457,014	5,615,619	2,428,570	1,098,748	3,000,000	
G. Estimated FY 2025-26 Unspent Fund Balance		13,872	7,796,102	3,527,622	(48,569)	(163,031)	0

H. Estimated Local Prudent Reserve Balance		
1.	Estimated Local Prudent Reserve Balance on June 30, 2023	4,795,236
2.	Contributions to the Local Prudent Reserve in FY 2023/24	
3.	Distributions from the Local Prudent Reserve in FY 2023/24	
4.	Etimated Local Prudent Reserve Balance ON June 30, 2024	4,795,236
5.	Contributions to the Local Prudent Reserve in FY 2024/25	
6.	Distributions from the Local Prudent Reserve in FY 2024/25	
7.	Etimated Local Prudent Reserve Balance ON June 30, 2025	4,795,236
8.	Contributions to the Local Prudent Reserve in FY 2025/26	
9.	Distributions from the Local Prudent Reserve in FY 2025/26	
10.	Etimated Local Prudent Reserve Balance ON June 30, 2026	4,795,236

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Community Services and Supports (CSS) Component Worksheet							
		Fiscal Year 2024/25					
		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							
	Early Childhood and Family Stability FSP (CSS-01)	4,783,768	2,790,180	1,732,461	0	0	261,127
	Dual Diagnosis FSP (CSS-02)	1,014,593	591,772	367,439	0	0	55,383
	Transition Age Youth FSP (CSS-04)	1,908,858	1,113,360	691,301	0	0	104,197
	Adults with Serious Mental Illness FSP (CSS-05)	5,076,410	2,960,866	1,838,443	0	0	277,102
	Older Adults FSP (CSS-06)	1,226,840	715,567	444,305	0	0	66,968
	Justice-Involved FSP (CSS-13)	1,460,244	681,758	528,833	0	0	249,652
	Homeless Services and Supports FSP (CSS-14)	2,889,250	1,685,183	1,046,354	0	0	157,713
Non-FSP Programs							
	Access Regional Services (CSS-07)	3,656,675	2,132,791	1,324,280	0	0	199,604
	Early Childhood Mental Health Services (CSS-08)	1,645,143	928,058	595,795	0	0	121,290
	Supported Services to Adults with Serious Mental Illn	577,760	336,984	209,238	0	0	31,538
	Dual Diagnosis Services (CSS-11)	1,410,170	822,495	510,699	0	0	76,976
	Homeless Outreach & Treatment (CSS-15)	1,105,134	644,580	400,229	0	0	60,325
	Responsive Crisis Interventions (CSS-16)	2,298,551	1,340,652	832,430	0	0	125,469
	Children's Mental Health Services (CSS-17)	1,331,800	776,785	482,317	0	0	72,698
	Mental Health Services for Adults (CSS-18)	4,922,425	2,871,052	1,782,676	0	0	268,696
CSS Administration		3,058,813	3,058,813				
CSS MHSA Housing Program Assigned Funds							
Total CSS Program Estimated Expenditures		38,366,433	23,450,897	12,786,799	0	0	2,128,737
FSP Programs as Percent of Total		51.68%					

Prevention and Early Intervention (PEI) Component Worksheet

Prevention and Early Intervention (PEI) Component							
		Fiscal Year 2024-25					
		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)	733,966	733,966	0	0	0	0
	Prevention Services for the Early Identification of MH Symptoms & Disorders Throughout the Lifespan (PEI-12)	676,262	676,262	0	0	0	0
	Student Mental Health (PEI-08)	630,108	430,559	175,169	0	0	24,380
	Maternal Mental Health (PEI-15)	459,671	459,671	0	0	0	0
	Stigma and Discrimination Reduction (PEI-04)	319,676	319,676	0	0	0	0
	Suicide Prevention (PEI-06)	406,872	406,872	0	0	0	0
PEI Programs - Early Intervention							
	Early Intervention Services for Older Adults (PEI-05)	384,409	384,409	0	0	0	0
	Early Intervention Services for Adolescents, Transition Age & College Age Youth (PEI-13)	205,223	128,746	76,477	0	0	0
	Culturally Specific Early Intervention Services (PEI-14)	1,187,432	1,187,432	0	0	0	0
	Prevention and Recovery for Early Psychosis (PEI-10)	248,934	57,397	168,136	0	0	23,401
	Prevention and Early Intervention for Substance Use Disorders (PEI-16)	87,870	87,870	0	0	0	0
PEI Administration		730,929	730,929				
PEI Assigned Funds		0	0	0	0	0	0
Total PEI Program Estimated Expenditures		6,071,353	5,603,789	419,782	0	0	47,782

Innovation (INN) Component Worksheet

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		Fiscal Year 2024-25					
		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	0	0	0	0
	Screening to Timely Access (INN-02)	0	0	0	0	0	0
	Transportation Coaching by Wellness Navigators (INN-03)	0	0	0	0	0	0
	Residential Care Facility Incubator (INN-04)	69,680	69,680	0	0	0	0
	Psychiatric Advance Directives (INN-05)	346,557	346,557	0	0	0	0
	Center for Mind Body Medicine (INN-06)	0	0	0	0	0	0
	Rainbow Connections (INN-07)	1,518,288	1,518,288	0	0	0	0
	Eating Disorder (INN-08)	400,000	400,000	0	0	0	0
INN Administration		350,179	350,179				
Total INN Program Estimated Expenditures		2,684,704	2,684,704	0	0	0	0

Workforce Education and Training (WET) Component Worksheet

		Fiscal Year 2024-25					
		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	207,739	207,739	0	0	0	0
2.	Education and Training	691,694	691,694	0	0	0	0
3.	Retention	0	0	0	0	0	0
4.	Evaluation and Research	56,000	56,000	0	0	0	0
WET Administration		143,315	143,315				
Total WET Program Estimated Expenditures		1,098,748	1,098,748	0	0	0	0

Capital Facilities/Technological Needs (CFTN) Component Worksheet

		Fiscal Year 2024-25					
		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.	MHRC Renovations	2,500,000	2,500,000	0	0	0	0
2.	BH Integrated Campus	0					
3.	Bridge Housing Development	1,500,000	1,500,000				
4.		0					
5.		0					
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
CFTN Administration							
Total CFTN Program Estimated Expenditures		4,000,000	4,000,000	0	0	0	0

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30-Day Public Comment Period and Behavioral Health Commission Approval

In accordance with MHSA regulations and procedures, the draft version of this FY2023-2024 Annual Update document was available for public input and review for the required minimum 30-day period prior to approval by the Monterey County Behavioral Health Commission (Commission) and Board of Supervisors.

Announcement of the 30-Day Public Comment Period was made via the Monterey County Health Department website, social media accounts, local media, and via emails to MCBH staff, community-based service providers and stakeholders who subscribe to the MCBH MHSA distribution list.

The 30-Day Public Comment Period began on May 16, 2024 and ended at 5:00 p.m. on June 16, 2024. All written comments received during the 30-Day review period, and MCBH response to these comments, were included in the final document that was presented to the Board of Supervisors for approval and adoption. Monterey County residents were encouraged to submit their comments using the following two methods:

email/link: MHSAPublicComment@countyofmonterey.gov;

OR

US Mail: MHSA Public Comment
Behavioral Health Bureau 1270 Natividad Road Salinas, CA 93906.

Following the close of the 30-Day Public Comment Period, the Commission conducted a Public Hearing to review the written comments received as well as receive additional comments on the FY2024-2025 MHSA Annual Update. This Hearing was conducted at 5:30 p.m. on Thursday, June 17, 2024, the County of Monterey Health Department, 1270 Natividad Road, Salinas CA. The public was invited to attend; Spanish language interpretation services were available. At the conclusion of this Hearing, with the consensus of the Commission, the FY2024-2025 MHSA Annual Update was put into final form and forwarded for adoption by the Monterey County Board of Supervisors, and then forwarded to the State Department of Health Care Services and the Mental Health Oversight and Accountability Commission.

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Appendix I: Community Needs Assessment

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Appendix II: Community Services & Supports FY2022-23 Program Updates & Client Demographic Data

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Appendix III: Prevention & Early Intervention FY 2022-23 Evaluation Report

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Appendix IV: Innovation FY 2023-24 Evaluation Reports

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Appendix V: Public Comments Received During 30-Day Public Review Period

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Appendix VI: Presentation for Public Hearing on draft FY23 MHSA Annual Update on May 30, 2024

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Appendix VIII: Monterey County Behavioral Health Commission Meeting Minutes from April 28, 2022

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MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

COMMUNITY PROGRAM PLANNING PROCESS
FY 2023-2024
COMMUNITY FOCUS GROUP SUMMARY

Prepared by:

EVALCORP

Measuring What Matters℠

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INTRODUCTION

In 2004, California voters passed the Mental Health Services Act (MHSA) through Proposition 63, which designated funding to improve mental health service systems throughout the state. To ensure effective utilization of these funds, the Mental Health Services Oversight and Accountability Commission (MHSOAC) requires counties receiving MHSA funds to develop a comprehensive Three-Year Program and Expenditure Plan outlining how funds will be used. This plan must be created in partnership with local stakeholders and community members through the Community Program Planning (CPP) Process.

Monterey County Behavioral Health Bureau (MCBH) contracted with EVALCORP, a professional evaluation company, to support an assessment of behavioral and mental health needs in communities throughout Monterey County. To gather comprehensive insights across the County, EVALCORP, engaged both Community Members (individuals from the community who may benefit from behavioral health services) and Stakeholders (those providing or facilitating access to services) in a mixed-methods approach including listening sessions, focus groups, and surveys. The purpose of these assessments, which are a part of the CPP Process, was to gather valuable insights from stakeholders and community members to enhance the effectiveness of behavioral health services in Monterey County, ensuring they meet the diverse needs of all communities.

This Community Health Survey report describes the needs, barriers to care, and gaps in behavioral health services identified by Community Members residing in Monterey County. Findings from other CPP Process data collection activities are also available:

- Community Member Focus Groups Summary of Findings
- Community Member Listening Sessions Summary of Findings
- Stakeholder Focus Groups Summary of Findings
- Stakeholder Survey Summary of Findings

MCBH will use this data to inform resource allocation and prioritization of programs, strategies, and initiatives funded under the Mental Health Services Act.

METHODOLOGY

Recruitment

The community focus groups were designed to gather perspectives on the current state of mental and behavioral health services in Monterey County for underserved and underrepresented populations in the county. Focus group participants were recruited through MCBH system partners across Monterey County. Ultimately, eight key populations were identified: 1) Unhoused, 2) African American Males, 3) Veterans, 4) LGBTQ+, 5) Individuals affected by the 2023 floods, 6) Early childhood caregivers, 7) individuals who live in South County, and 8) the Indigenous community.

Through coordinating with contacts at MCBH system partners, seven community focus groups were organized that ensured representation from each of the above priority populations. Four of the focus groups were facilitated in English, two in Spanish, and one in Triqui.

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Data collection

For each focus group, participants were hosted in person by a system partner, such as a community based organization. Four focus groups were facilitated virtually by a facilitator and three were facilitated in-person. A notetaker was present in each focus group and each group was recorded to verify the contents of the notes taken.

Focus groups lasted between 30 and 60 minutes. Demographic data were collected from consenting participants at the beginning of each focus group. Participants were each provided with a $40 gift card as an expression of appreciation for their time.

Data Analysis

All qualitative data were cleaned and prepared for analysis, which flowed through two phases. The first phase began with a content analysis for prominent themes. In the second phase of the analysis, results were synthesized within and across different focus groups to achieve a greater depth of understanding. Demographic data were analyzed for descriptive statistics.

RESPONDENT PROFILE

One hundred twenty-eight Community Members participated across the seven focus groups. Below represents a snapshot of demographic and background characteristics of participants:

- 70% were Hispanic/Latino, 16% were African American, and 11% were White (N=116)
- 64% were female (N=125)
- When asked what language they spoke most at home, 44% spoke Spanish and 35% spoke English (N=124)
- 85% were heterosexual or straight (N=87)
- 59% were covered by Medi-Cal, 24% were covered by Medicare, and 18% did not have insurance (N=114)

Table 1 provides a list of all the additional information participants wished to share about themselves.

Table 1. Additional Participant Information

Situation	Percentage*
Parent or Caregiver	51%
Veteran	13%
Individual Living with a Disability	12%
Individual with a Serious Mental Illness	11%
Family Member of an Individual with a Serious Mental Illness	10%
Unhoused	9%
Undocumented	7%
Individual with a Substance Use Disorder	6%
Caregiver of Adult	2%

*Percentages may sum to more than 100% because participants were able to choose more than one option. N=128

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FINDINGS

The focus groups were conducted in order to answer the following essential questions concerning mental health language, primary contributing factors to mental illness, experiences accessing and receiving services, suggestions for outreach, and suggestions for community engagement. The findings section will delve into the focus group findings for each topic. A conclusion will follow that synthesizes the findings at the end of the report.

The Language of Mental Health

Understanding the language that community members use when discussing mental health is foundational to creating effective, equitable, and supportive mental health environments and messaging that empowers individuals to seek care, reduce stigma, and promote overall well-being in the community. To explore how the community currently understands mental health, focus group participants were asked to talk about what the term meant to them. Conversations revealed a diverse range of perceptions of mental health and the varying language people use to talk about it. Many participants associated mental health with severe, negative states, encompassing emotional, cognitive, or physical distress. Conversely, others described mental health in positive terms, associating it with feelings of emotional well-being and physical relaxation. While a few participants recognized the integral link between mental health and overall health, the majority of the language reflected strong predispositions, casting mental health in either a distinctly positive or negative light. Multiple conversations also noted the difference in how service providers within the mental health continuum of care talk about mental health differently than how they, the community, understand it. These variations in understanding and language point to the need for clearer communication and education around mental health to foster a more unified and neutral perspective.

Primary Contributing Factors to Poor Mental Health

Uncovering the factors that contribute to poor mental health within the community from the perspective of the community can help the County pinpoint areas of need and better tailor interventions to meeting the nuanced and complex needs of residents. Findings reveal a variety of factors that stretch across psychological, environmental, and social influences that all affect the mental health of individuals within the County. The findings below offer insights into the mental health landscape of the community through lived experiences and observations of its members.

Psychological Factors

When asked about the issues that contribute to poor mental health outcomes in their community, groups brought up various stress-related conditions that many residents find themselves in. These various psychological states of mind pose a serious risk for individuals to develop severe mental health issues, if not addressed. For instance, financial strain was a common theme across several focus groups with conversations noting job insecurity, student loans, caregiving responsibilities, and the price of housing as a constant source of anxiety for many in the community. Additionally, attitudes against talking about mental health within minority populations were also identified as an issue that contributes to poor mental health. Focus group conversations noted that, within the African American and Hispanic cultures, there has been pressure to be strong and independent, causing a reluctance to openly discuss mental health issues. This reluctance, on top of a mistrust in the government and the medical community from historical neglect, can greatly impede the general willingness individuals in the

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community might have to talk openly about mental health, good or bad, and to seek early intervention services to prevent severe and disabling conditions. These psychological stressors that persist in the community, compounded by the loss of trust in the system, are important considerations for the County when expanding services and conducting community outreach. Notably, efforts to engage individuals in services should seek to understand the additional stressors an individual might be experiencing to provide a holistic form of care. Additionally, services may require additional efforts to hire individuals from minority populations and additional time that allows service providers to engage in trust building activities with and for minority populations. Such services would do well to collaborate with cultural organizations that are strongly connected to the communities of color to ensure services are culturally relevant and reflective of the community's beliefs, understandings, and values.

Environmental Factors

In discussing the impact of environmental factors on mental health, focus group participants notably highlighted the significant role of natural disasters, particularly emphasizing the psychological aftermath of floods in Monterey County. These conversations shed light on how experiences with natural disasters, such as the recent flooding, directly contribute to mental health challenges, including symptoms of anxiety and depression. For instance, a participant from the Flood Impacted Community focus group vividly illustrated the severe emotional toll, stating that the ordeal necessitated psychological intervention and medication to cope with the stress and anxiety induced by the disaster. Such personal accounts underlined the profound stress and ongoing anxiety about future disasters among the affected individuals. These findings from the community highlight the need to coordinate emergency relief efforts with immediate mental health services. Additionally, findings point to a need for long-term mental health services that continue even after the emergency services cease to help community members cope with the ongoing anxiety caused by the environmental trauma.

Social Factors

Community Members revealed several social factors that impact behavioral health outcomes in their communities, including social isolation, factors associated with migration, structural racism, and financial strain.

Discussing the impact that social factors have on mental health, community members highlighted the role of social isolation. Community members shared how different elements of social isolation, such as lack of social support, geographic isolation, experiencing loneliness, or being socially excluded can lead to poor mental health. For example, a participant shared the experience of how not having family made the holiday season difficult emotionally and wished there were "mental health barrier breakers" like concerts and community events to help combat the stress of being isolated during the holiday season. Other community members described the stress and anxiety they experienced that came with the social isolation of living in geographically remote areas. These findings suggest the need that community members have for support with expanding their social networks to combat feelings of isolation that contribute to poor mental health, particularly for those in geographically remote areas.

Members of multiple focus groups stressed that those who had migrated struggled with mental health issues because of factors linked to migration, such as migration status, not speaking English, and being away from friends and family in their home country. This conversation shed light on how experiences associated with migration can be risk factors for, or can exacerbate, community members' struggle with mental health issues. Community members described how undocumented people and non-English

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speakers, including migrants who speak Indigenous languages, were particularly at risk for mental health issues, such as depression and anxiety. These findings show a demand for services in Indigenous languages and the desire for further outreach to Indigenous communities. Community members also revealed the nuance of mental health needs of migrants, which could potentially be addressed through support groups tailored to the mental health issues that arise during the migration process. For example, a variety of support groups could be developed that are specific to the mental health needs of migrants, including not only stress, but also sadness that comes from missing friends and family.

Participants shared negative feelings from what they considered to be structural racism within the community. Particularly, participants attributed mental health concerns they or their community experienced to institutional practices, cultural representations, and other norms that perpetuate racial and ethnic inequities. Participants described how their communities were “hurting” due to “systemic racism” and described a number of mental health issues that were associated with these negative experiences, such as trauma. These findings reveal an opportunity to develop outreach programs and culturally sensitive services designed to help combat the negative impacts that structural racism has on individuals from these vulnerable racial and ethnic communities.

Community members provided a window into their mental health by opening up about the financial strain they faced, such as unemployment and lack of job opportunities. This discussion shed light on how financial strain can, in the eyes of community members, cause poor mental health. For instance, a participant explained that “financial issues” were linked to causing depression, anxiety, or poor mental health in their eyes. The participant described how “living in a shelter when you’re growing up, always worrying about whether you will have a home” was a major contributor to poor mental health. These results echo the 2022-2023 CPPP report, which show community survey results and provider survey results in which “Financial stress, unemployment, or lack of job opportunities” and “Homelessness” were two of the three “Top Contributing Major Factors to Mental and Behavioral Problems” for both data sources. Taken together, these findings show that financial strain continues to impact behavioral health outcomes in the County and that services may need to extend beyond traditional behavioral health assistance to include employment assistance, housing stability programs, and accessible educational opportunities.

Accessing and Engaging Services

Understanding how community members access and engage with mental health services can help the County improve community members’ experiences and increase access to services. Concerning accessing services, findings revealed that some community members did not consider themselves to be knowledgeable enough to access services and preferred to receive information through sources with which they had a personal connection. Community members also showed that they preferred local clinics. When talking about engagement with services, community members discussed how they valued cultural proficiency and timeliness of services, and preferred engagement strategies built on trust and relatability. These results help shed light on potential issues in the screening, assessment, and connection process, as well as provide ideas for how to engage unreached individuals and populations.

Accessing Services

In sharing their perceptions and experiences with the mental health care system, it was clear that many focus group participants lacked knowledge about available services and how to access services. When focus group participants spoke about not knowing about what services are available or how to access

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services, the conversation would turn to a resource sharing conversation where other participants would openly share about the resources they knew about. In these conversations, it was clear that participants wanted to know more and, for those that knew of services, that their experiences with the system were very positive.

Throughout several focus groups, community members highlighted the importance that mobile clinics could play in helping to provide services to unreached localities. The extent to which participants from different focus groups could travel to services varied. For example, many community members provided examples of how they could only walk or take the bus to mental health clinics. However, community members were hopeful that local clinics and mobile clinics could help them begin the process of seeking care. This reveals the interest that some community members have in using mobile clinics for their mental health care that would allow the County to reach geographically isolated populations.

Community members also underscored their desire to access knowledge about mental health services through sources they trust. For many participants, community-based organizations were an example of the type of source they trusted for information distribution. Participants discussed a variety of community based organizations that they engaged with and shared their positive experiences, revealing a special form of trust with caseworkers that they did not typically share with other providers. Additionally, participants talked about how schools and could be used to provide additional information about services in the community. The use of community-based organizations and schools reflects a need from community members to receive information from sources they trust and have established personal connections with. This underscores how important the relationship with the community is for outreach and education efforts to be successful.

Engaging Services

In discussing their experiences connecting with mental health services, community members described the importance of cultural proficiency. Participants discussed how cultural proficiency played a major role in determining whether they had a positive or negative experience. Participants shared the importance of different elements of cultural proficiency in their experience, such as seeing personal representation of themselves in staffing, being respected, and being offered services in their native languages, such as Spanish and Indigenous languages. One participant shared the importance of not only providing services in their own language, but also being sensitive of cultural norms in how services were provided. Community members across cultures also shared how empathy in service delivery was a critical element for engaging with a particular provider. Many community members wanted to feel understood and expressed that getting services from someone with comparable life experiences would help them feel understood. Participants' discussions of the need for cultural proficiency spanned race, ethnicity, and economic status, with the primary thread being the importance of having access to providers who empathize with, and relate to, their experiences. Findings demonstrate that cultural proficiency does not only concern race, ethnicity, or nationality, but revolves around life experience and relatability.

Community members also expressed a high value for timeliness of services. Conversations showed a sense of frustration with perceived "long" waiting times for services. These frustrations over timeliness also reflect the participants' desire to receive services and their enthusiasm to connect with mental health service providers.

When asked for recommendations on how MCBH can best engage with individuals who need mental health services, focus group participants encouraged continued outreach via community based

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organizations. In the trust and comfort that the participants described having with community-based organizations, community members revealed that there was already a successful open dialogue between community-based organizations and community members. A similar dialogue emerged for youth engaged in mental health services provided through programs in schools. Participants stressed the importance of providing safe spaces for the youth and educating them about mental health services. A peer outreach program was another key suggestion that emerged from the focus groups for establishing trust and comfort with unreached populations. For example, a participant shared their experience of fighting stigma around receiving mental health services in their community by doing presentations to share their story. Taken together, these findings show that community members value engagement strategies built on trust that create positive experiences with the community and provide safe spaces for everyone, and especially for vulnerable populations. These findings are important because they show that community members value engagement that is relatable and allows people to connect based on personal experiences.

Engagement Suggestions

Participants relayed preferences for more personal ways of community engagement:

1. *Outreach in Schools*
2. *Engagement through Community Based Organizations*
3. *Peer Engagement*

CONCLUSION

Community members shared an array of insights. Concerning the language of mental health, there is a distinct opportunity to engage with the community as more community members understand mental health terminology and use this terminology to describe their own conditions. The variation in language used reveals not only the progress that has been made in terms of behavioral health education, but also the need for a unified message about mental in various outreach and education events within the County.

In talking about factors that contribute to poor mental health, participants continually emphasized the role of social factors. Though the conversation, these social factors intersected within other social factors and other environmental or psychological factors. For example, those who are socially isolated can be more vulnerable to poor mental health when problems arise, such as natural disasters or stress from financial strain. The key takeaway here is that these factors often intersect and often cannot be treated in isolation. Services could be tailored to handle multiple factors and be sensitive to ways in which these factors compound their effects to more aggravated mental health issues.

For experiences accessing and receiving services, community members provided key insights into their desire to receive mental health services. Some participants discussed barriers that arose during their experiences of receiving or attempting to receive services, while others shared their perspectives on opportunities to overcome these barriers. However, across the board, participants were passionate about their mental health experiences. This passion provides evidence of community members' desire to receive services and their continued need for these services.

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APPENDIX

Table 2. Hispanic vs. Non-Hispanic

Hispanic vs. Non-Hispanic	Percentage
Hispanic/Latino	76%
Non-Hispanic/Non-Latino	24%

N=113

Table 3. Race and Ethnicity

Race and Ethnicity	Percentage
Latino/Hispanic	70%
Black or AA	16%
White	11%
Mixed Race	2%
Asian	1%

N=116

Table 4. Gender

Gender	Percentage
Female	64%
Male	29%
Genderqueer	2%
Questioning/unsure of gender identity	2%
Transgender	2%
Another	1%

N=125

Table 5. Language Most Spoken at Home

Language	Percentage*
Spanish	44%
English	35%
Another	19%
Both English and Spanish	11%

N=124

*Percentages may sum to more than 100% because participants were able to choose more than one option.

Table 6. Sexual Orientation

Sexual Orientation	Percentage
Heterosexual or Straight	85%
Bisexual	6%

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Another	5%
Queer	2%
Questioning	2%

N=87

Table 7. Additional Participant Identification

Situation	Percentage*
Parent or Caregiver	51%
Veteran	13%
Individual Living with a Disability	12%
Individual with a Serious Mental Illness	11%
Family Member of an Individual with a Serious Mental Illness	10%
Unhoused	9%
Undocumented	7%
Individual with a Substance Use Disorder	6%
Caregiver of Adult	2%

*Percentages may sum to more than 100% because participants were able to choose more than one option.
N=128

Table 8. Participant Insurance Status

Insurance Status	Percentage*
Medi-Cal	59%
Medicare	24%
None	18%
Private	8%

*Percentages may sum to more than 100% because participants were able to choose more than one option.
N=114

Table 9. Zip Code of Participants

Zip Code	Percent
95076	44%
93933	17%
93927	13%
93905	8%
93955	6%
93901	3%
93906	2%
93907	2%
9576	2%
92927	2%
93921	1%

N=125

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MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

COMMUNITY PROGRAM PLANNING PROCESS
FY 2023-2024
COMMUNITY HEALTH SURVEY SUMMARY

Prepared by:

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EVALCORP
Measuring What Matters℠

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INTRODUCTION

In 2004, California voters passed the Mental Health Services Act (MHSA) through Proposition 63, which designated funding to improve mental health service systems throughout the state. To ensure effective utilization of these funds, the Mental Health Services Oversight and Accountability Commission (MHSOAC) requires counties receiving MHSA funds to develop a comprehensive Three-Year Program and Expenditure Plan outlining how funds will be used. This plan must be created in partnership with local stakeholders and community members through the Community Program Planning (CPP) Process.

Monterey County Behavioral Health Bureau (MCBH) contracted with EVALCORP, a professional evaluation company, to support an assessment of behavioral and mental health needs in communities throughout Monterey County. To gather comprehensive insights across the County, EVALCORP, engaged both Community Members (individuals from the community who may benefit from behavioral health services) and Stakeholders (those providing or facilitating access to services) in a mixed-methods approach including listening sessions, focus groups, and surveys. The purpose of these assessments, which are a part of the CPP Process, was to gather valuable insights from stakeholders and community members to enhance the effectiveness of behavioral health services in Monterey County, ensuring they meet the diverse needs of all communities.

This Community Health Survey report describes the needs, barriers to care, and gaps in behavioral health services identified by Community Members residing in Monterey County. Findings from other CPP Process data collection activities are also available:

- Community Member Focus Groups Summary of Findings
- Community Member Listening Sessions Summary of Findings
- Stakeholder Focus Groups Summary of Findings
- Stakeholder Survey Summary of Findings

MCBH will use this data to inform resource allocation and prioritization of programs, strategies, and initiatives funded under the Mental Health Services Act.

ENGAGEMENT STRATEGY

Recognizing the critical role of community engagement in understanding and addressing behavioral health issues, the Community Health Survey was deployed through 48 distinct distribution channels established by partnering with local agencies and organizations in Monterey County to gather a diverse array of perspectives.

A coordinated distribution effort was engaged in by EVALCORP and MCBH. EVALCORP launched the initial request for each partner agency or organization to distribute the survey to their clients and other Community Members they might engage with. EVALCORP then conducted continuous monitoring of survey responses and solicited targeted online and hardcopy distribution to ensure the survey was inclusive of Monterey County's diverse population.

After data collection was completed, data was prepared for analysis. The distribution strategy described above resulted in 906 community responses that were included in the analyses.

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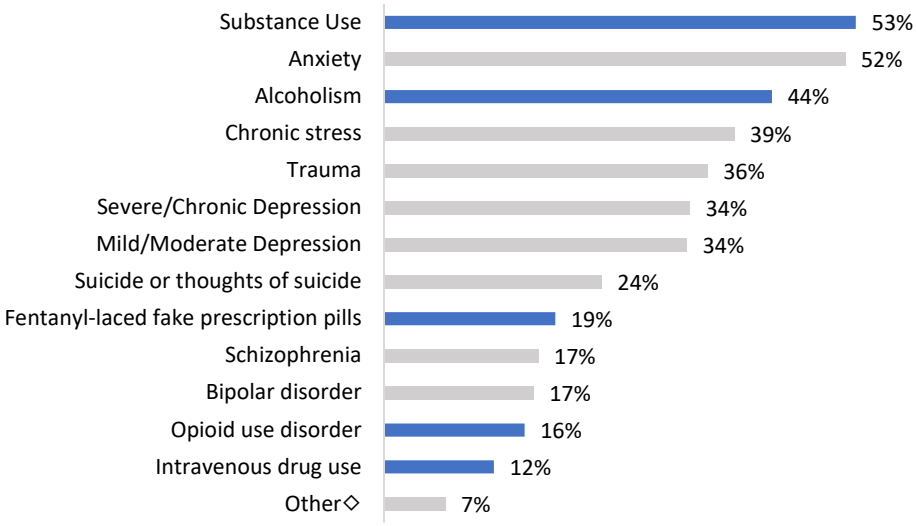
KEY THEMES AND FINDINGS

The findings below reflect the community's perspectives on key behavioral health issues and access to care. Respondents were asked to share their perceptions of significant behavioral health challenges, availability of services, barriers to accessing care, additional needs within the county, recommendations for improving behavioral health services, and mental health stigma. Findings offer insights into the current state of behavioral health services in Monterey County and suggest areas for improvement. Additionally, the survey collected essential demographic data to provide a complete picture of respondents' identities.

Prioritized Mental Health and Substance Use Issues

Respondents were asked to identify the most important mental health and substance use issues in their community.

Figure 1. Most Important Mental Health and Substance Use Issues*



*N=899 Community Responses. Percentages exceed 100% because respondents could select more than one issue. Issues related to mental health are shown in grey and substance use is shown in blue.
◇Other responses include youth, maternal, and senior mental health; homelessness and the co-occurrence of mental health issues; methamphetamine, poverty, human trafficking, cellphone addiction, and tenet abuse.

Overall, substance use and anxiety were rated as the most important issues to address within Monterey County. Chronic stress and trauma were the next highest-rated mental health issues in the community, followed closely by severe/chronic and mild/moderate depression. Alcoholism and Fentanyl-laced fake prescription pills were specifically identified as critical concerns related to substance use. These results showcase a wide and varied range of behavioral health issues within Monterey County that require diverse strategies.

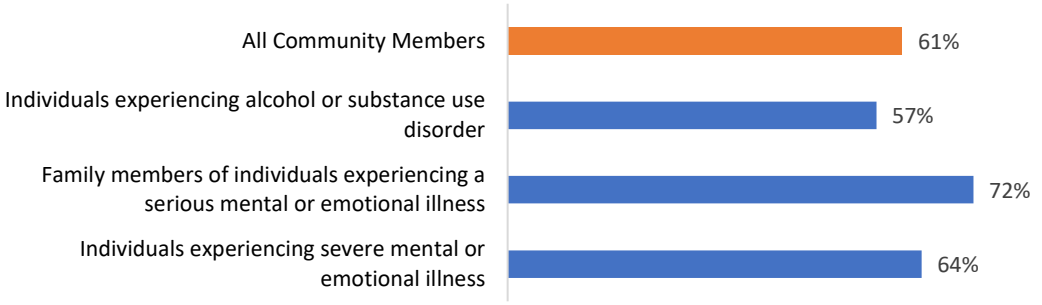
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Gaps in Behavioral Health Services

Community Members were asked several questions to understand if and how behavioral health issues are addressed in Monterey County. Responses to these questions provide insight into service gaps.

Availability of Services. Survey respondents were asked whether they believed there were sufficient services available to meet the needs of the behavioral health issues prevalent in their communities. Overall, almost two-thirds of Community Members reported mental health services were available but insufficient to meet the needs of the community. When looking at groups likely to engage with behavioral health services most often, individuals experiencing alcohol or substance use disorder (n=23) and severe mental and emotional illness (n=84) reported comparable views of service availability. Respondents who identified as a family member of someone experiencing a severe mental or emotional illness (n=209) reported higher views of service availability with 72% responding mental health services were available, but inadequate to meet the needs of the community (Figure 2).

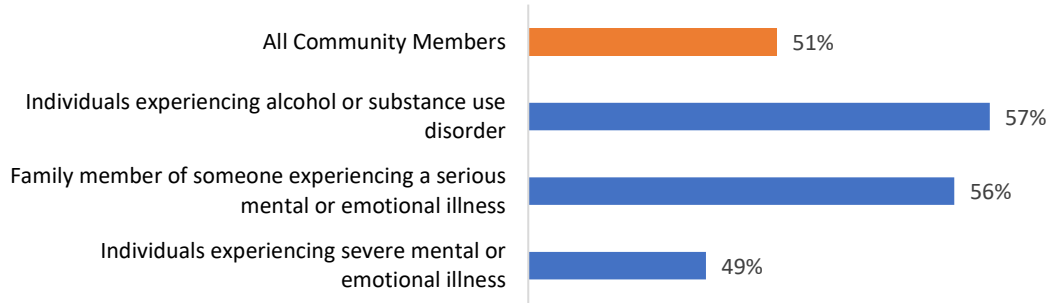
Figure 2. Perceptions of Available but Insufficient Mental Health Services *



* N=711 Community Responses. Percentages exceed 100% because respondents could select more than one identity.

Similarly, over half of Community Members felt substance use services in the County were available but insufficient to meet the community's needs. Individuals experiencing alcohol or substance use disorder (n=23) and family members of individuals experiencing a severe mental or emotional illness (n=209) reported slightly higher views of service availability while individuals experiencing severe mental and emotional illness (n=84) reported slightly lower views of service availability (Figure 3).

Figure 3. Perceptions of Available but Insufficient Substance Use Services *



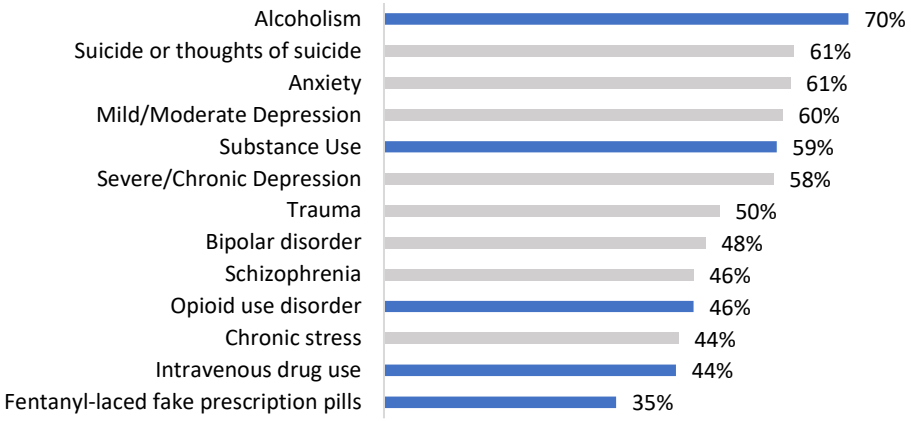
* N=674 Community Responses. Percentages exceed 100% because respondents could select more than one identity.

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Taken together these results suggest Community Members, including those most likely to engage with services, have some general awareness of behavioral health services in Monterey County. However, there are also perceived limitations to the support available with unmet service needs persisting in the community.

Additional questions provide greater insight into behavioral health service gaps. Community Members were asked to rate the availability of services in the County for specific behavioral health issues as either not available, somewhat available, available, or unsure (Figure 4; somewhat available and available were combined for this analysis). Responses highlighted Community Members' perceptions of what services are available in the County. Alcoholism was rated as the issue for which services were most available, while Fentanyl-laced fake prescription pills were rated as the issue for which services were least available. Results showcase that community members' views of service availability differ vastly by type of behavioral health issue, indicating a need for more tailored support.

Figure 4. Availability of Services for Behavioral Health Issues*



*N=679-711 Community Responses. Percentages exceed 100% because respondents could select more than one service category. Issues related to mental health are shown in grey and substance use is shown in blue.

Community Members were further asked to identify additional behavioral health services they feel are needed within Monterey County. Nearly half of responding Community Members (41%) provided write-in responses encompassing 5 themes: Behavioral Health Treatment, Crisis Intervention, Outreach and Education, Accessibility, and Integrated and Comprehensive Care.

Behavioral Health Treatment. Community Members noted a lack of adequate mental health and substance use services including the availability of inpatient and outpatient services including telehealth and in-person. Many desired services tailored to certain populations (e.g. justice-involved, youth, pregnant or postpartum women, families, caregivers, LGBTQ+, and veterans), and specific needs such as trauma, mild to moderate depression or anxiety, and eating disorders. Community Members noted a lack of personnel that reflects the diversity within Monterey County and a desire for care providers to deliver culturally responsive treatment. Community Member responses also suggested a need for greater mental health and substance use support in schools.

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"It is very important that we have mental health services available in our community, but to make sure the help is in our language and our culture because there could be a culture crash where most of the time we're not being understood with what we're going through."

Crisis Intervention. Community members expressed a desire for additional crisis intervention services such as a 24/7 hotline, crisis centers and shelters, as well as mobile crisis response teams.

"Additional crisis care as alternatives to hospital emergency rooms."

Outreach and Education. Across multiple responses, Community Members expressed a desire for mobile clinics and services to provide care where they live, work, and play. The unhoused, seniors, rural communities, and justice-involved individuals were identified as groups needing targeted outreach. Several respondents suggested deploying additional community health workers who understand the cultural variation of different communities.

"Public outreach to unhoused individuals so they have the opportunity to seek support or knowledge of where to go."

Community Member responses also suggest a need for greater education and advertisement about mental health promotion and substance use prevention throughout the County, as many stated they were unsure where to go or who to contact to find such information. The importance of tailoring information to the cultural needs of specific communities was emphasized as well. Youth, schools, Hispanic and Indigenous communities were specifically identified as groups who could benefit from educational efforts. Several Community Members also suggested behavioral health staff receive training on substance use trends in the County to better inform their care.

"I honestly would not know where to tell someone to go if they have substance abuse or mental health issues. We need more education, more outreach, and more resources."

Accessibility. Community members noted a need for affordable behavioral health services in more locations, particularly South County, as cost and transportation were often cited as barriers to care access. Timely access to services was also desired by Community Members with many responses noting long wait times of several months to a year before seeing providers due to a lack of available personnel. The need for translation services for non-English speakers and those deaf or hard of hearing was highlighted by multiple Community Members.

"There should be free or low-cost mental health and substance abuse services available to anyone at any time. Part of the problem is not being able to be seen when you are having an issue until an appointment is available, which could be months…."

Integrated and Holistic Care. Community Members shared views of insufficient holistic and integrated care in the County. Responses noted a lack of wraparound services addressing individuals' basic needs such as housing, including pet-friendly options, employment, transportation, health insurance, and childcare while concurrently addressing mental health and substance use issues.

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"…It's quite hard to focus on mental health or substances use when the main goal of each day and night is where am I going to sleep …".

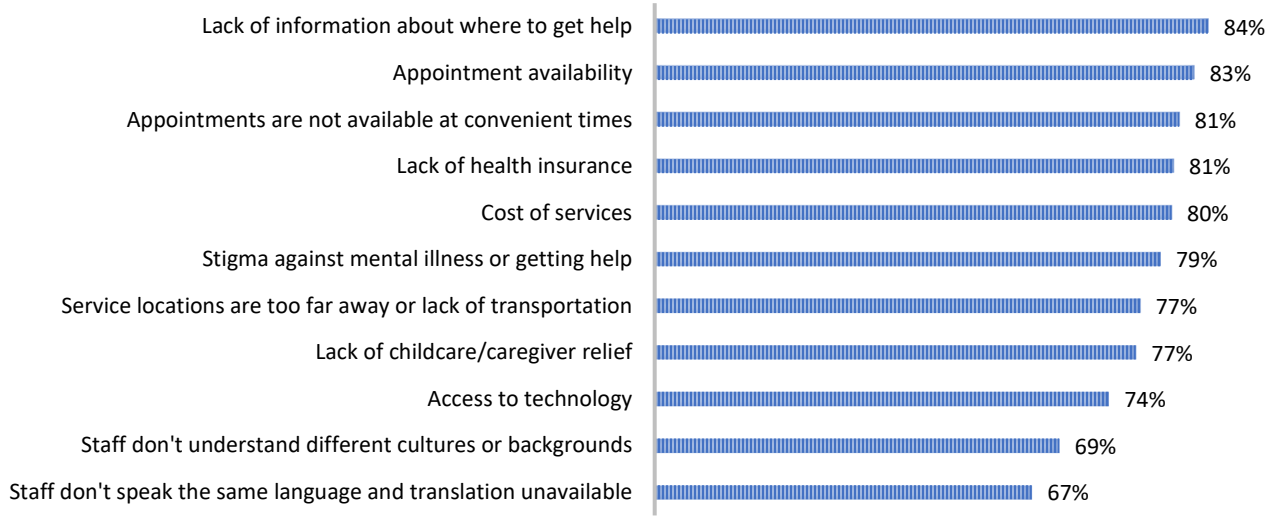
Community Members also expressed a need for follow-up support from case managers, social workers, and others to assist individuals as they navigate mental health and substance use care systems.

While the majority of Community Members acknowledge behavioral health services are available, they also perceive these services to be insufficient to meet the community's needs across various mental health and substance use issues. Community Members' suggestions for additional services in the County provide possible strategies for beginning to close behavioral health service gaps.

Barriers to Service

Additional questions aimed at understanding whether and how Community Members can access available behavioral health services. When asked what they believed were the greatest barriers faced when trying to access services, Community Members identified lack of knowledge about where to get help and appointment availability as the top challenges (Figure 5). Findings also show most respondents felt a lack of convenient appointment times, not having health insurance, and the cost of services can prevent service access. Mental health stigma, logistic challenges such as transportation or childcare, and cultural responsiveness were perceived as obstacles to accessing services by more than two-thirds of Community Members, suggesting barriers to care are prevalent throughout the County.

Figure 5. Barriers to Accessing Mental and Behavioral Health Services*



*N=681-703 Community Responses. Percentages exceed 100% because respondents could select more than one barrier.

Write-in responses from Community Members provide insight into the incongruency between the high levels of awareness of service availability described earlier in this report (35%-70%, Figure 4) and lack of information as the greatest barrier to service access. Community Members shared difficulty understanding what services and providers are covered under their insurance, the cost of services

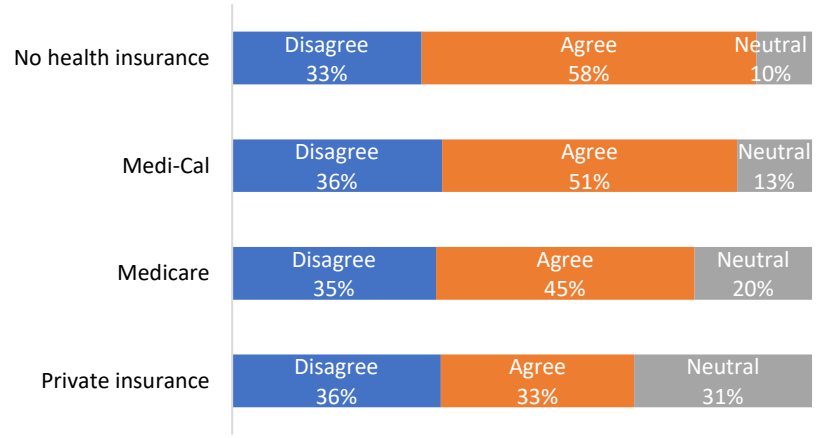
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including free or affordable if un- or under-insured, service sites, service eligibility requirements, or how to locate such information.

"I am not sure that the availability of services is the issue…I think advertising in the general locations of where people are to inform them of the availability and the cost/health insurance assistance they could receive for the services."

Additional questions sought to gain insight into specific barriers to accessing services in the County beginning with the challenge of lacking information about available services. When asked whether they agreed or disagreed that people with behavioral health needs can get help in their community, 41% of all respondents agreed (n=714). However, results differ by insurance type with those with no insurance (n=30) or Medi-Cal (n=59) reporting higher levels of agreement (Figure 6). Community Members with Medicare (n=33) reported similar levels of agreement while those with private insurance (n=112) agreed the least, reflecting a need for increased education regarding County services available to these populations.

Figure 6. Perceptions of Mental and Behavioral Health Service Access by Insurance Type



To better understand mental health stigma as a barrier to service access in Monterey County, survey respondents were asked to share their opinions (favorable vs unfavorable) about seeking help from a mental health professional should they have a mental health concern using the Mental Help Seeking Attitudes Scale (Hammer, Parent, & Spiker, 2018). Examination of the level of agreement with individual items provides insight into stigma related to seeking mental health support. General sentiment toward seeking mental health services was favorable. A look into particular priority populations reveals some isolated instances where a particular positive sentiment is less likely to be shared by that particular population. These instances are highlighted in Figure 7 below.

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Figure 7. Attitudes Toward Seeking Mental Health Support

	Useful	Important	Healthy	Effective	Good	Healing	Empowering	Satisfying	Desirable
All Responses (n = 283-322)	85%	89%	80%	76%	88%	88%	80%	79%	85%
Hispanic	82%	88%	71%	74%	87%	88%	78%	78%	82%
Non-Hispanic	91%	92%	93%	84%	92%	91%	89%	83%	94%
Parent/Caretaker of a child under 18	82%	87%	71%	73%	89%	90%	79%	79%	85%
Caretaker of an adult	88%	83%	83%	67%	81%	81%	74%	69%	81%
Veteran	87%	70%	74%	70%	83%	83%	83%	77%	74%
Individual with SMI	81%	91%	81%	75%	86%	88%	82%	83%	91%
Family of individual with SMI	87%	91%	85%	76%	87%	87%	83%	75%	87%
Individual with SUD	82%	91%	77%	68%	91%	82%	82%	68%	90%
Individual without or family of individual without immigration status	76%	91%	64%	73%	91%	91%	86%	68%	91%
Unhoused	92%	100%	67%	83%	100%	92%	92%	83%	83%

While most respondents may agree seeking mental health support is positive, write-in responses from multiple Community Members noted a strong belief that stigma towards mental illness continues to be a barrier to services, particularly in communities with unique cultures.

"More community outreach teams. Stigma is still so high because organizations just aren't prevalent or well-known in the community."

Collectively, these results showcase a variety of barriers that can significantly impede service access in Monterey County. There is a need for increased education and outreach about 1) services available for specific populations (i.e. uninsured community members and those with Medicare) and 2) focused efforts toward disrupting negative attitudes and beliefs about mental health support in diverse communities. Collecting community input and considering cultural nuances as these and other accessibility strategies are developed will ensure they are appropriate and relevant to community members.

RECOMMENDATIONS

In addition to providing insight into the issues within the community, service gaps, and barriers to accessing available services, Community Members shared recommendations for better meeting behavioral health needs in Monterey County.

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Approximately 50% of surveyed Community Members provided write-in recommendations encompassing 5 themes: Access and Availability, Comprehensive and Integrated Service, Strengthening the Behavioral Health Care Workforce, Community Outreach and Education, and Culturally Responsive and Empathetic Care.

Access and Availability. Community Members emphasized a need for simpler, affordable, and more widespread access to services across the County, especially in underserved and rural areas. Many respondents suggested greater appointment availability, including expanding to evenings and weekends as well as incorporating walk-in clinics to help reduce appointment wait times.

"Better access to services. Waiting lists are excessively long. Too many hoops to jump through to start services. Responses are not always timely."

Comprehensive and Integrated Service. Community Members' recommendations called for more whole-person approaches to behavioral health care, integrating medical care, mental health, and social support services.

"Transportation and childcare! Access to stable work, finances, and housing because lack of basic needs makes it harder to focus on mental health concerns."

A clear entry point for those desiring services along with consistent follow-up support was also highlighted by respondents as many felt the systems of care were complex and difficult to navigate on their own.

"Too many boxes to check or "restricted doors" to enter for the community as a whole."

Strengthening the Behavioral Health Care Workforce. Across multiple responses, Community Members called for increased funding in support of retaining current as well as hiring more care providers. Several respondents also noted the need for ongoing training for staff, financial support for therapeutic tools, and wellness days to prevent burnout.

"I work with children and have to buy many things out of pocket. Children's toys and books can be very expensive even when thrift shopping...Staff could benefit from more mental health days to prevent turnover."

Community Outreach and Education. Other Community Member recommendations highlighted the importance of increasing awareness and understanding of available services including targeted outreach, educational programming and events, and promotion via different communication channels (e.g. social media, MCBH clinics). Other education and outreach recommendations focused on reducing the stigma associated with mental or behavioral health issues as well as seeking help. Suggested strategies for sharing such information included a more comprehensive and functional website as well as partnering with trusted organizations or leaders in the local community.

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"It makes a world's difference hearing about mental and behavioral health services from someone who I already have a relationship with rather than a complete stranger."

Culturally Responsive and Empathetic Care. Community Members called for service providers that 1) acknowledge, respect, and understand individuals' cultural norms and backgrounds as part of their care, and 2) approach patients with compassion and non-judgement. Hiring diverse staff who understand local communities and providing cultural competence training to current staff were encouraged as strategies to consider. Many respondents also stressed the need for interpretation for all services (e.g. telehealth, crisis lines) and forms of communication (i.e. phone, in-person), especially in Indigenous languages.

"I would like to uplift the hiring and retention of culturally responsive personnel - individuals who not only speak Spanish or an indigenous language - but also are able to effectively engage with the community because they themselves are community members."

SURVEY RESPONDENT DEMOGRAPHICS

Characteristics of respondents were collected to ensure insights gained through the Community Health Survey were reflective of the distinct populations residing within Monterey County. A total of 656 Community Health Survey respondents provided demographic information. Community members represented diverse backgrounds with submissions from parents, family members of individuals living with behavioral health issues, veterans, and those experiencing severe mental or emotional illness.

Age. The average age of Community Members was 46 years, with a range of 15 – 84 years.

Table 1. Age of Surveyed Community Members*

Age Category (n = 571)	Percentage
Under 20 years old	2%
20 – 29 years old	13%
30 – 39 years old	21%
40 – 49 years old	24%
50 – 59 years old	22%
60+ years old	19%

Ethnicity and Race. Two-thirds of Community Members identified as Hispanic/Latino (67%) and just over one-fourth of Community Members identified as Caucasian (29%) (Table 2).

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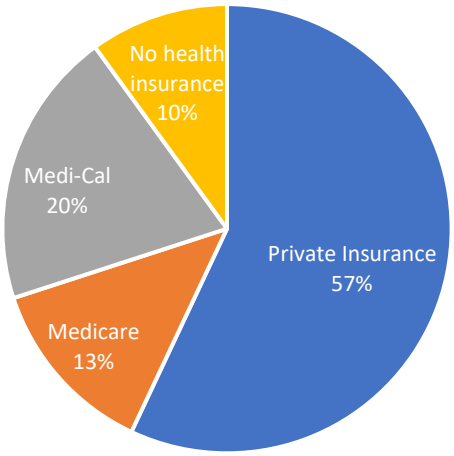
Table 2. Ethnicity and Race of Surveyed Community Members*

Ethnicity (n =581-647)	Percentage
Hispanic or Latino	67%
Non-Hispanic/Latino	33%
White	29%
Multiracial	6%
Asian	4%
Another Race/Ethnicity◇	3%
Black or African American	3%
American Indian or Alaska Native	3%
Native Hawaiian or Other Pacific Islander	1%

*Community Members could select more than one Race/Ethnicity. Percentages may exceed 100%.
◇Another Race/Ethnicity included Basque, Mexicana, Indigenous, Irish, Italian, French, Chinese, and German among others.

Health Insurance. Over half of respondents reported having private insurance (57%) (Figure 8).

Figure 8. Health Insurance Status of Surveyed Community Members



*N=588 Community Responses.

Gender. Over three-fourths of Community Members identified as female (Table 3).

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Table 3. Gender of Surveyed Community Members*

Gender (n = 612)	Percentage
Female	80%
Male	18%
Genderqueer	<1%
Questioning/Unsure of Gender Identity	<1%
Transgender	0%
A different Identity◇	<1%

*Percentages do not total 100% due to rounding.

◇A different Identity included agender, bigender, and non-binary

Sexual Orientation. More than three-fourths of surveyed Community Members identified as heterosexual or straight (90%).

Table 4. Sexual Orientation of Surveyed Community Members

Primary Language Spoken at Home (n = 506)	Percentage
Heterosexual or Straight	90%
Bisexual	4%
Gay or Lesbian	3%
Queer	1%
Another sexual orientation◇	2%

◇Another sexual orientation included asexual and pansexual.

Primary Language Spoken. Community Members were asked what language they primarily spoke at home to better understand the language they used most often to communicate. A little over one-fourth of Community Members reported speaking primarily Spanish at home (Table 5).

Table 5. Primary Language of Surveyed Community Members

Primary Language Spoken at Home (n = 665)	Percentage
English	49%
Spanish	27%
Both English and Spanish	18%
Another Language◇	5%

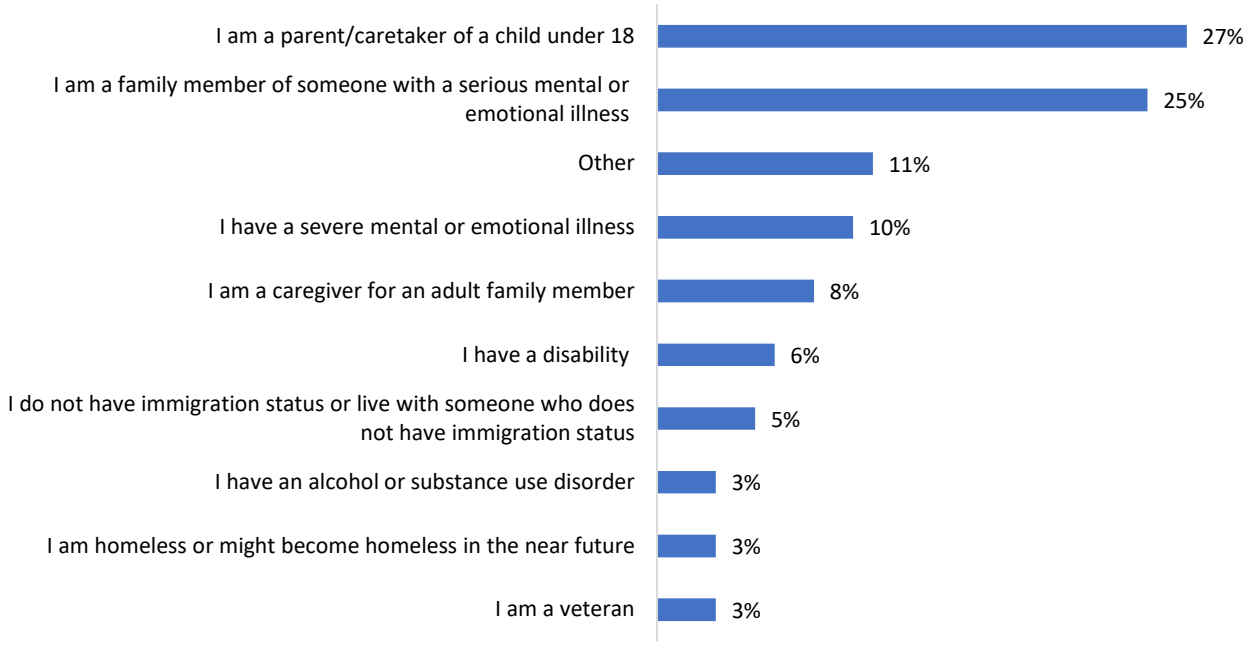
*Percentages do not total 100% due to rounding.

◇Another language included Triqui, Mixteco, Swedish, Japanese, Italian, American Sign Language, Russian, Haitian Creole, and German.

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Personal Identities. To further ensure the insights shared through the Community Health Survey were inclusive, surveyed Community Members were asked about additional personal identities they held. A quarter of respondents identified as a parent or caregiver of a child under 18 years old (27%) or a family member of someone with a serious mental or emotional illness (Table 6).

Figure 9. Personal Identities of Surveyed Community Members



*N=838 Community Responses. Community Members could select more than one identity. Percentages may exceed 100%.

Other identities included County employees, medical or mental health providers, family of someone with substance use disorder, and students among others. Respondents reported the following disabilities among others: Depression, Anxiety, PTSD, Schizophrenia, Bipolar Disorder, hearing impairment, and physical impairment.

SUMMARY

A diverse group of Community Members provided valuable insights into the needs, barriers to care, and gaps in behavioral health services in Monterey County. Substance use, anxiety, and alcoholism were identified by surveyed Community Members as the most important issues in the County. Community Members, including those most likely to engage with services, felt there were mental health and substance use services available in the County but the available services were insufficient to meet the community's needs. Expanding on this, Community Members reported services were most lacking for issues related to Fentanyl-laced fake prescription pills, intravenous drug use, and chronic stress. Community Members also shared a range of additional behavioral and mental health service needs through the following five themes: Mental Health and Substance Use Treatment, Crisis Intervention, Outreach and Education, Accessibility, and Integrated and Comprehensive Care.

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Community Members reported a lack of information about where to get help, appointment availability, lack of convenient appointments, lack of health insurance, and cost of services as the top five barriers faced when attempting to access services. Community Members provided additional insight into lack of information as a service barrier with under half of Community Members believing those with behavioral health issues can receive help within the County, though perceptions differed slightly by type of insurance. Community Members provided insight into mental health stigma as a barrier within the County as well. While a large majority of Community Members believed it was favorable to seek mental health support, many also felt that negative attitudes and beliefs about mental illness and seeking help continue to prevent access to care, particularly in communities with non-Western beliefs and views.

Finally, Community Members made several recommendations for improving the County's mental health and substance use care systems encompassing five major themes: Access and Availability, Comprehensive and Integrated Service, Strengthening the Behavioral Health Care Workforce, Community Outreach and Education, and Culturally Responsive and Empathetic Care.

Top Community Recommendations

Access and Availability	⇒ Offer more affordable services ⇒ Reduce long wait times to access appointments. ⇒ Expand appointment availability to include non-traditional hours (e.g. evenings, weekends).
Comprehensive and Integrated Service	⇒ Increase whole-person approaches to care, integrating medical care, mental health, and social support services. ⇒ Increase support for care initiation and coordination
Strengthening the Behavioral Health Care Workforce	⇒ Increase support and retention of current staff ⇒ Hire additional care providers
Community Outreach and Education	⇒ Provide education to Community Members about available services generally and based on unique needs (e.g. insurance type, location, cost, etc) ⇒ Provide education to reduce stigma associated with mental health issues and seeking help ⇒ Partner with trusted messengers to raise awareness and knowledge of services
Culturally Responsive and Empathetic Care	⇒ Increase consideration of individuals' culture throughout their care ⇒ Provide compassionate and nonjudgmental care ⇒ Provide interpretation and translation services consistently

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CITATIONS

Hammer, J. H., & Parent, M. C., & Spiker, D. A. (2018). Mental Help Seeking Attitudes Scale (MHSAS): Development, reliability, validity, and comparison with the ATSSPH-SF and IASMHS-PO. Journal of Counseling Psychology, 65, 74-85. doi: 10.1037/cou0000248

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MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSIONS
SUMMARY OF FINDINGS

Monterey County Behavioral Health (MCBH) works diligently to provide mental health and substance use services to Monterey County residents. Every year, MCBH solicits feedback from the community on the programs and services they offer, through an engagement strategy called the Community Program Planning Process.

The Community Program Planning Process consists of 2 main steps:

Step 1

Learning about the mental health and substance use needs of the community directly from community members through surveys and focus groups.

→ MCBH learned about these needs through survey and focus group data collected from community members who might benefit from the services MCBH provides and from stakeholders that directly provide or facilitate access to these services. Detailed reports on survey and focus group findings are available.

Step 2

Reporting these findings back to the community and offering an opportunity for community members to provide feedback and additional insights on the process. This summary highlights the feedback obtained through this part of the Community Program Planning Process.

MCBH contracted EVALCORP to conduct the Community Program Planning Process. After survey and focus group data were collected and analyzed, EVALCORP shared the findings with the community through a series of Listening Sessions. This summary reviews the rich insights community members shared through the Listening Sessions.

A total of **110 community members** participated in **4 Listening Sessions**.

3	In-person
1	Virtual

Language	Spanish with English translation
Approach	Informal and conversational

Community Members were encouraged to share their feedback on all Community Program Planning Process activities, including:

→ Ways MCBH and EVALCORP engaged with the community
→ Additional barriers to accessing services
→ Additional recommendations for enhancing services

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PARTICIPANTS

Fifty-three community members completed the demographics form. On average, participating community members were 46 years old (range = 23-81). Over half of participants identified as Hispanic/Latine (76%), female (87%), heterosexual (89%), and as a parent or caretaker of someone under 18 years of age (56%). Participants mostly spoke Spanish at home (70%); lived in zip codes 93905 (37%), 93930 (19%), and 93450 (19%); and had private insurance (47%).

Age Group	n = 48
30 – 39 years old	13 (27%)
40 – 49 years old	13 (27%)
50 – 59 years old	11 (23%)
60+ years old	7 (15%)
20 – 29 years old	4 (8%)
Race/Ethnicity*	**n = 50**
Hispanic or Latinx	38 (76%)
White (non-Hispanic)	7 (14%)
African American	3 (6%)
Another Race/Ethnicity	2 (4%)
Multi-racial	1 (2%)
Gender	**n = 52**
Female	45 (87%)
Male	7 (13%)

Health Insurance	n = 51
Private Insurance	24 (47%)
Medi-Cal	19 (37%)
Uninsured	5 (10%)
Medicare	3 (6%)
Language Spoken at Home*	**n = 53**
Spanish	37 (70%)
English	11 (21%)
Both English and Spanish	7 (13%)
Another Language	4 (8%)
Sexual Orientation	**n = 36**
Heterosexual	32 (89%)
Another Sexual Orientation	4 (11%)

Additional Identities*	n = 45
Parent/Caretaker of Someone Under 18	25 (56%)
Family Member of Someone with SMI	11 (24%)
Other	6 (13%)
Does not have immigration Status	6 (13%)
Unhoused	4 (9%)
Caretaker of an Adult Family Member	3 (7%)
Has SUD	2 (4%)
Veteran	1 (2%)
Living with Disability	1 (2%)

**Percentages may exceed 100% because respondents could select more than one option.*
53 total responses; 36 Spanish language submissions (70%)

IDEAS FOR ENGAGING THE COMMUNITY

Community members made several engagement recommendations, largely centered on inclusivity.

Enhancing Accessibility and Inclusion

Connecting with Underrepresented Populations: Prioritize outreach to indigenous, monolingual, and minority populations to ensure their access to services.

Visual and Audio Aids for Non-Readers: Use visuals and audio channels (like TV and radio) to reach individuals who cannot read or have limited literacy, especially in indigenous dialects for migrant workers.

Culturally Sensitive Communication and Outreach

Utilizing Cultural Public Spaces: Engage community members in places they frequent, such as grocery stores, laundromats, and churches, to foster a sense of familiarity and trust.

Adapting Language for Comfort: Replace clinical terms with everyday language (e.g., using "nervous" instead of "anxiety") to make discussions about mental health more approachable.

Tailored Communication Strategies

Text Messaging: Employ text messages and platforms like WhatsApp to reach individuals that may not have access to email or internet.

Population-Specific Messaging: Design informational materials specific to the needs and identities of various groups, including LGBTQIA+, youth, migrant workers, and the unhoused, to ensure messages are more approachable.

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IDEAS FOR OVERCOMING BARRIERS

Community members provided feedback on barriers they face when trying to access services. They also shared recommendations on how many of these barriers might be addressed. These barriers and their associated recommendations fall under one of four categories:

- → Access and Logistics
- → Cultural and Language Barriers
- → Systemic and Institutional Trust Issues
- → Insurance and Financial Barriers

Access & Logistics

Availability (of services and clients):
Community members shared that they have limited time to attend services on top of their work and home responsibilities. They expressed needing more appointment availability outside of working hours.

Recommendations: Services outside of traditional working hours

Dependent Care:
Community members experience challenges finding care for dependents (children and adults) while attending appointments.

Recommendations: Funding for dependent care during appointments; In-home care so clients do not need to leave home for appointments

Transportation:
Community members find it difficult to physically access services and pharmacies due to their locations. This is especially true for Indigenous women, who don't have cars and can only access local services during safe hours to be walking.

Recommendations: Home visits; Mobile services; Vouchers for public transportation

Culture & Language

Cultural Competency:
Community members shared experiences of feeling judged for engaging in cultural practices and staff being unaware of language-specific expressions, which has led to misunderstandings. They also expressed that clinical terminology carries a lot of stigma, making reaching out for help unapproachable.

Recommendations: Share mental health education and resources without using the term "mental health"; Use everyday terminology instead of clinical jargon, for example, sad instead of depressed or nervous instead of anxious

Language:
Community members noted that interpretations were often inaccurate, with interpreters not aware of cultural idioms and other culture-specific language features. They also shared that relying on friends and family for interpretation can interfere with seeking help due to stigma and shame.

Recommendations: Have more community groups help with interpretation; Hire staff that speak non-Spanish Indigenous languages

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Systemic & Institutional Trust Issues

Fear of Repercussions:
Community members expressed worries over potential negative outcomes from seeking help, such as having their child(ren) taken away.

Lack of Response:
Community members shared not receiving timely responses or assistance when seeking services, especially for children.

Referral and Follow-up Process:
Community members shared concerns about the follow-up process when schools make recommendations, citing experiences of being told to seek help from the County and receiving no additional assistance or follow-up from the school.

Structural Racism:
Community members expressed not knowing whether certain language or cultural practices would trigger institutional interventions and shared experiences of when such misunderstandings resulted in unwanted interactions with CPS or police.

System Navigation Challenges:
Community Members noted the system can be very complicated to navigate, especially for young adults.

Overall Recommendations:
Address potential interventions with clients before they share information; Implementation of WHO humanitarian intervention guidelines; Use of Community-Defined Evidence-Based Practices

Insurance & Finance

Challenges with Private Insurance:
Community members encountered difficulties when accessing services with private insurance, which may include coverage issues or additional costs.

Financial Challenges:
Community members shared being discouraged from seeking help, assuming they won't be able to afford the services. They also noted that it is challenging to determine whether they meet treatment eligibility based on their insurance coverage. Finally, community members shared experiences of income requirements making them ineligible even though they can't afford basic needs, let alone mental health services.

Overall Recommendations:
System navigators that support clients in finding services, determining eligibility, and managing payments.

Other Issues of Importance to the Community

Mental Health Crises Impact on Emergency Services:
Community members shared the toll of mental health crises on resource allocation in small cities in the County. In these small cities, one mental health crisis can significantly deplete available emergency services, such as law enforcement personnel and ambulances.

Substance Use Education:
Community members shared wanting more information on substances and substance use. In particular, they expressed interest in learning more about popular or trending drugs and how to talk to their children about how and why drugs look like kid-friendly foods (e.g., candy or brownies).

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MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

COMMUNITY PROGRAM PLANNING PROCESS
FY 2023-2024
STAKEHOLDER FOCUS GROUPS SUMMARY

Prepared by:

EVALCORP
Measuring What Matters℠

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INTRODUCTION

In 2004, California voters passed the Mental Health Services Act (MHSA) through Proposition 63, which designated funding to improve mental health service systems throughout the state. To ensure effective utilization of these funds, the Mental Health Services Oversight and Accountability Commission (MHSOAC) requires counties receiving MHSA funds to develop a comprehensive Three-Year Program and Expenditure Plan outlining how funds will be used. This plan must be created in partnership with local Stakeholders and community members through the Community Program Planning (CPP) Process.

Monterey County Behavioral Health Bureau (MCBH) contracted with EVALCORP, a professional evaluation company, to support an assessment of behavioral and mental health needs in communities throughout Monterey County. To gather comprehensive insights across the County, EVALCORP, engaged both Stakeholders (those providing or facilitating access to services) and Community Members (individuals from the community who may benefit from behavioral health services) using a mixed-methods approach including listening sessions, focus groups/interviews, and surveys. The purpose of these assessments, which are a part of the CPP Process, was to gather valuable insights from Stakeholders and community members to enhance the effectiveness of behavioral health services in Monterey County, ensuring they meet the diverse needs of all communities.

This Stakeholder Focus Group report describes the needs and barriers to behavioral health services identified by Stakeholders in Monterey County. Findings from other CPP Process data collection activities are also available:

- Stakeholder Survey Summary of Findings
- Community Member Health Survey Summary of Findings
- Community Member Focus Groups Summary of Findings
- Community Member Listening Sessions Summary of Findings

MCBH will use this data to inform resource allocation and prioritization of programs, strategies, and initiatives funded under the Mental Health Services Act.

ENGAGEMENT STRATEGY

EVALCORP collaborated with MCBH to purposefully recruit a diverse set of Stakeholders within the community. A total of 4 focus groups and 1 interview were conducted with 39 participants representing law enforcement, diversity and equity resources, and community-based organizations providing behavioral health prevention and treatment services. MCBH staff involved in the planning process were present during select focus groups to connect with Stakeholders and ask follow-up questions that would be helpful to their planning. After data collection was completed, data were prepped, reviewed, and coded into themes.

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FINDINGS

Stakeholders' perspectives on behavioral health issues and services in Monterey County are reflected below. Participants were asked to share insights into behavioral health challenges, populations needing additional support, barriers to accessing care, additional service needs within the county, and recommendations for improving behavioral health services. Results provide insight into the state of behavioral health services and identify opportunities for advancement.

Behavioral Health Issues

A deeper understanding of the most important behavioral health-related issues in the community sheds light on areas in need of additional resources, informing the focus and tailoring of interventions. Participants reported anxiety and depression as significant issues to address in Monterey County.

> ***"Some people call us and say that they haven't talked to anyone in four days."***

Factors thought by participants to be contributing to community behavioral health challenges included concerns related to basic needs (i.e. food, rent/housing), work, isolation, and loneliness. Missing family and deportation were specifically identified as contributing factors to behavioral health issues for immigrants. Stakeholders also expressed concern about conflict and substance use issues among youth leading to missed school and academic challenges. Post-traumatic stress, intimate partner violence, and the co-occurrence of mental illness and substance use were additional issues viewed as critical to address in the County.

Findings reveal an assortment of behavioral health issues within the County, often related to social, occupational, and psychological needs. Whole-person-centered approaches to behavioral health that consider individuals' overall well-being may help address the root causes of prevalent mental health and substance use issues.

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Behavioral Health Service Needs

Insights from Stakeholders regarding additional behavioral health service needs in Monterey County shed light on the specific community groups requiring the most assistance, as well as the types of support that are highly sought after but currently lack availability. Results are shared through three sub-themes: Priority Groups for Behavioral Health Services, Mental Health and Substance Use Services, and Coordinated and Comprehensive Behavioral Health Support.

Priority Groups for Behavioral Health Services

> ***"The veteran community has high incidents of suicides…there are individuals with PTSD and military sexual trauma."***

Stakeholders shared additional service needs for specific populations within the County. Veterans were described as a population with specific treatment needs resulting from their service. Participants called for more diverse substance use treatment options for Veterans including alternatives to traditional 12-step programs. One participant noted that some veterans are ineligible for assistance from the Military & Veterans Affairs Office, underscoring the necessity of community support for this demographic.

Focus group participants perceived the services available for individuals experiencing moderate-level mental health issues to be insufficient. While one participant noted mandates by some care systems to provide timely care to individuals experiencing moderate symptoms, many others described long appointment wait times often leading to delayed or no care for this population. Stakeholders emphasized that postponing treatment for moderate mental health concerns could create opportunities for future mental health emergencies. Individuals residing in South Monterey County and rural areas, older adults, and first responders were identified as other groups needing support.

> ***"It may not be a full-blown crisis, but it will lead to that and there is support needed before a crisis."***

Mental Health and Substance Use Services

Stakeholders desired more outpatient and residential services for individuals with mental illness and substance use disorders, especially for youth and the unhoused. Participants wanted more mobile crisis providers to ensure services are available daily. They also felt there were limited crisis stabilization options for children available in schools and the community, with required referrals often delaying care. Other participants perceived virtual appointments to be less effective for substance use treatment, particularly among adolescents, suggesting a need for additional in-person treatment options across age ranges. Focus group participants also emphasized a need for more indoor mental health support groups where individuals could receive help with their issues.

> ***"High overdoses in the county "because there is not a viable alternative for kids to go to. Outpatient is not sufficient to meet their needs.""***

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Coordinated and Comprehensive Behavioral Health Support

> ***"The approach seems to be to only deal with what's happening right now and not address what's happening in the long-term."***

Stakeholders emphasized the need for long-term support for behavioral health issues to prevent recurring cycles of homelessness, legal issues, and mental health crises. Focus group participants described an absence of post-discharge support critical for ensuring adherence to care plans (e.g., medication compliance, appointment attendance). Greater communication about the outcomes of referrals was desired to prevent individuals from "slipping through the cracks".

> ***"People who have been on the streets for years and years with Serious Mental Illness need a place to be housed."***

Focus group participants also desired more consistent and comprehensive support services to address the social needs of individuals experiencing mental health or substance use issues in the County. Many Stakeholders described a shortage of affordable housing in the community, including transitional options, generally and for specific populations experiencing behavioral health issues (i.e. men, those without immigration status, and older adults.) Participants described income, credit, and literacy as barriers to accessing stable living accommodations. Insurance, especially for those without immigration status, and transportation were other social needs prevalent throughout the County.

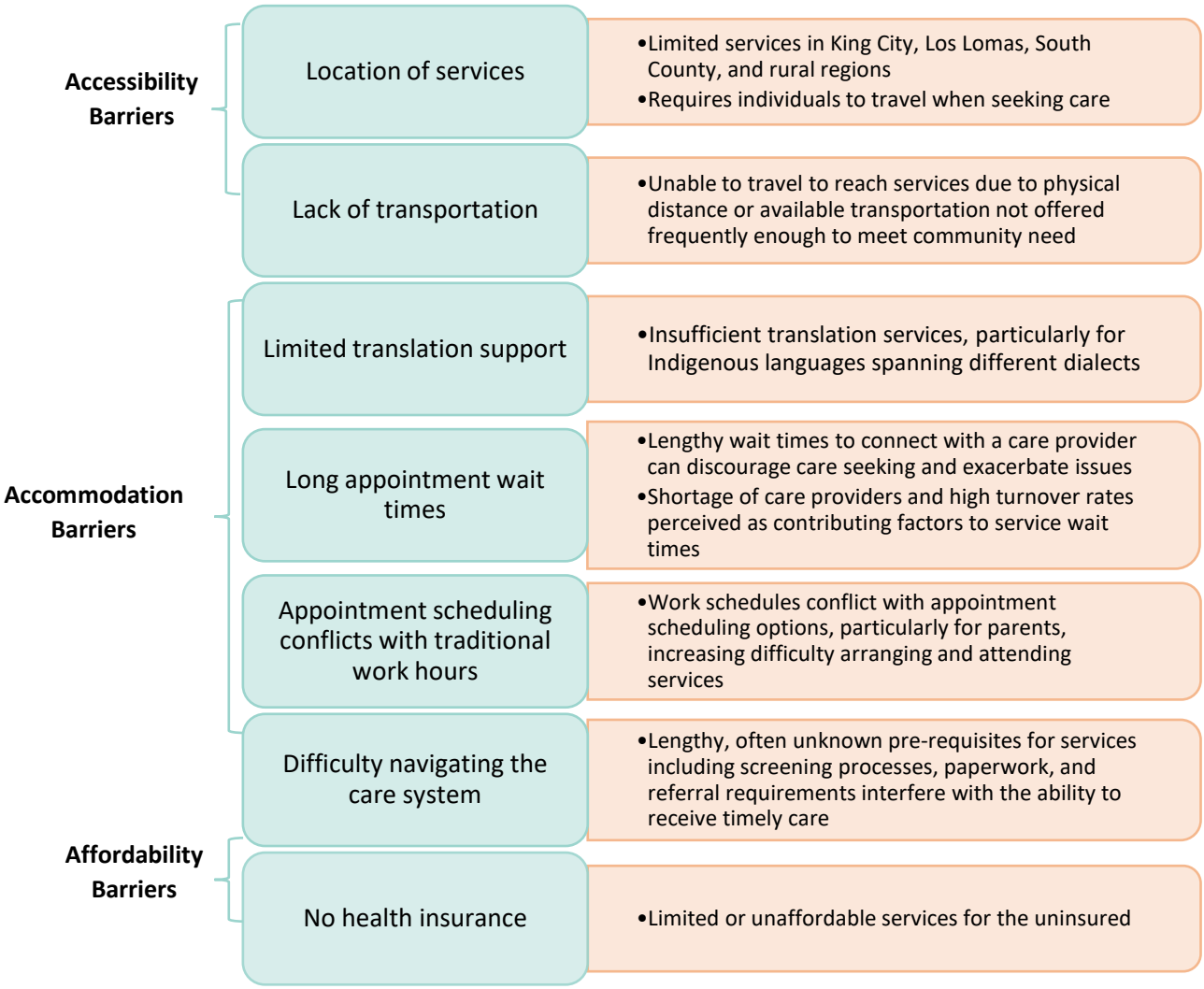
Results highlight a need for greater availability of comprehensive, behavioral health treatment services for the underserved areas and populations identified by Stakeholders. Stronger collaboration among organizations across the County can foster more integrated, support networks aimed at addressing service gaps and ensuring a holistic approach to care.

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Barriers to Accessing Care

Obtaining Stakeholder input on obstacles faced by community members when accessing behavioral health services can help the County customize programs and initiatives, effectively enhancing service accessibility for those who need care the most. Findings showcase barriers related to affordability (ability to pay for services), accessibility (distance to services), and accommodation (ability to be seen and treated) [1] can impair community members' ability to receive services in Monterey County (Figure 1).

Figure 1. Barriers to Accessing Care



Barriers to care can also intersect making it even more difficult for individuals to obtain care. For example, several Stakeholders noted the compound challenge of needing translation support along with having to travel to services outside their local community for those experiencing transportation issues.

[1] Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. Med Care. 1981;19(2):127-140. doi:10.1097/00005650-198102000-00001

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Results suggest services should apply comprehensive care approaches that consider the complex interactions of social, economic, cultural, and structural obstacles community members encounter when seeking help to improve service access.

Successful Behavioral Health Initiatives

Understanding behavioral health services that are positively impacting communities in Monterey County sheds light on strategies that are successfully addressing community needs. Focus group participants identified several interventions that can inspire and inform efforts to improve behavioral health outcomes.

Programs that were hosted locally and culturally tailored were celebrated for providing comfortable, safe spaces for individuals to receive mental health support and education. Stakeholders highlighted resources like WellScreen, MCHOPES, and the local 988 Suicide & Crisis Lifeline for increasing timely access to care. Collaboration between mental health professionals and law enforcement as part of mobile crisis intervention was also commended. The addition of a non-uniformed presence increased approachability, enabling individuals and families at various income levels to be well supported through behavioral health emergencies. Similarly, the Monterey Integrated System Transformation Initiative (MISTI) was praised for working to provide comprehensive services and create welcoming environments for groups typically ineligible for care (e.g. moderate mental illness, SUD, youth). Other successful services included court/legal programming for veterans, therapist-led support groups, and wellness navigators that support individuals throughout their care.

> ***"It is unique to Monterey County – the high level of collaboration between agencies and providers. They are willing to step out of silos to help the community."***

Findings highlight the importance of providing services that are: 1) available where individuals live, work, and play; 2) culturally responsive, 3) comprehensive in addressing behavioral health and other needs, and 4) integrated across organizations with patient navigation.

These principles establish a foundation for addressing the barriers to accessing services described earlier in this report, leading to improved engagement with care among community members.

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Recommendations

In addition to providing insight into behavioral health issues, service needs, and positive programming within Monterey County, Stakeholders shared recommendations for enhancing services to better meet the community's needs.

Assistance navigating care systems

- Addition of navigators to help guide individuals through healthcare systems during treatment such as assisting with understanding and fulfilling care requirements, scheduling appointments, accessing financial and social support, and following prescribed care plans.
- Peers with lived experience were viewed as ideal for such positions.

Community education

- More education to community members about mental health and available services to increase knowledge of resources as well as destigmatize mental illness and care seeking.
- Application of a person-centered approach to educational outreach efforts, customizing activities to the specific needs, preferences, and circumstances of different communities.
- Additional community health workers to assist with outreach as well as formal positions in the County responsible for staying up to date on available community resources, regularly sharing such information with Stakeholders.

Comprehensive and integrated care for behavioral health issues that includes social support services

- Greater collaboration between community organizations, care providers, and county agencies to increase awareness of services and care coordination throughout the community.

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SUMMARY OF KEY FINDINGS

Stakeholders from a variety of service areas shared valuable information regarding behavioral health including prevalent issues, service needs, barriers to care, current initiatives positively impacting communities, and opportunities for improvement in Monterey County.

Behavioral Health Issues

- Depression and anxiety are perceived as the most common behavioral health issues affecting communities in Monterey County.
- Identified contributors to poor behavioral health include psychological, social, and economic factors.

Behavioral Health Service Needs

- Increased availability of behavioral health treatment options for underserved areas and populations (i.e., rural cities, youth, unhoused, moderate symptoms, and veterans).
- More comprehensive and integrated services throughout the care continuum and across organizations

Barriers to Accessing Care

- Access to care is prevented by social, economic, cultural, and structural barriers that often intersect in community members' lives to further complicate care-seeking.

Successful Behavioral Health Initiatives

- Lessons from successful behavioral health services in the County showcase collaboration, cultural sensitivity, local outreach, and comprehensiveness as strategies for enhancing service engagement and improving outcomes.

Recommendations

- Assistance navigating care systems.
- Community education.
- Comprehensive and integrated care for substance use disorder and mental illness that includes social support services.

The County can leverage insights from Stakeholders and capitalize on existing foundational elements to refine or develop initiatives to address priority behavioral health issues, fill gaps in services, and ensure resources are effectively allocated to increase service access and better meet community behavioral health needs.

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MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

COMMUNITY PROGRAM PLANNING PROCESS
FY 2023-2024
STAKEHOLDER SURVEY SUMMARY

Prepared by:

EVALCORP

Measuring What Matters℠

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INTRODUCTION

In 2004, California voters passed the Mental Health Services Act (MHSA) through Proposition 63, which designated funding to improve mental health service systems throughout the state. To ensure effective utilization of these funds, the Mental Health Services Oversight and Accountability Commission (MHSOAC) requires counties receiving MHSA funds to develop a comprehensive Three-Year Program and Expenditure Plan outlining how funds will be used. This plan must be created in partnership with local Stakeholders and Community Members through the Community Program Planning (CPP) Process.

Monterey County Behavioral Health Bureau (MCBH) contracted with EVALCORP, a professional evaluation company, to support an assessment of behavioral and mental health needs in communities throughout Monterey County. To gather comprehensive insights across the County, EVALCORP, engaged both Community Members (individuals from the community who may benefit from behavioral health services) and Stakeholders (those providing or facilitating access to services) in a mixed-methods approach including listening sessions, focus groups, and surveys. The purpose of these assessments, which are a part of the CPP Process, was to gather valuable insights from Stakeholders and community members to enhance the effectiveness of behavioral health services in Monterey County, ensuring they meet the diverse needs of all communities.

This Community Health Survey report describes the needs, barriers to care, and gaps in mental health and substance use services identified by Community Members residing in Monterey County. Findings from other CPP Process data collection activities will also be available:

- Stakeholder Focus Groups Summary of Findings
- Community Member Survey Summary of Findings
- Community Member Focus Groups Summary of Findings
- Community Member Listening Sessions Summary of Findings

MCBH will use this data to inform resource allocation and prioritization of programs, strategies, and initiatives funded under the Mental Health Services Act.

ENGAGEMENT STRATEGY

Stakeholders who directly provide or facilitate access to mental health and substance use services were invited to complete a survey. Together with Monterey County Behavioral Health, EVALCORP employed multiple outreach strategies to reach a diverse range of Stakeholders, ensuring the survey reached a broad and inclusive audience.

Together, Monterey County Behavioral Health (MCBH) and EVALCORP implemented multiple engagement strategies to reach Stakeholders. After data collection was completed, data were prepared for analysis. The distribution strategy described above resulted in 95 responses that were included in the analyses.

KEY THEMES AND FINDINGS

The findings presented below reflect stakeholder and system partner perspectives on key behavioral health issues. Stakeholders were asked to share their perceptions of significant behavioral health service

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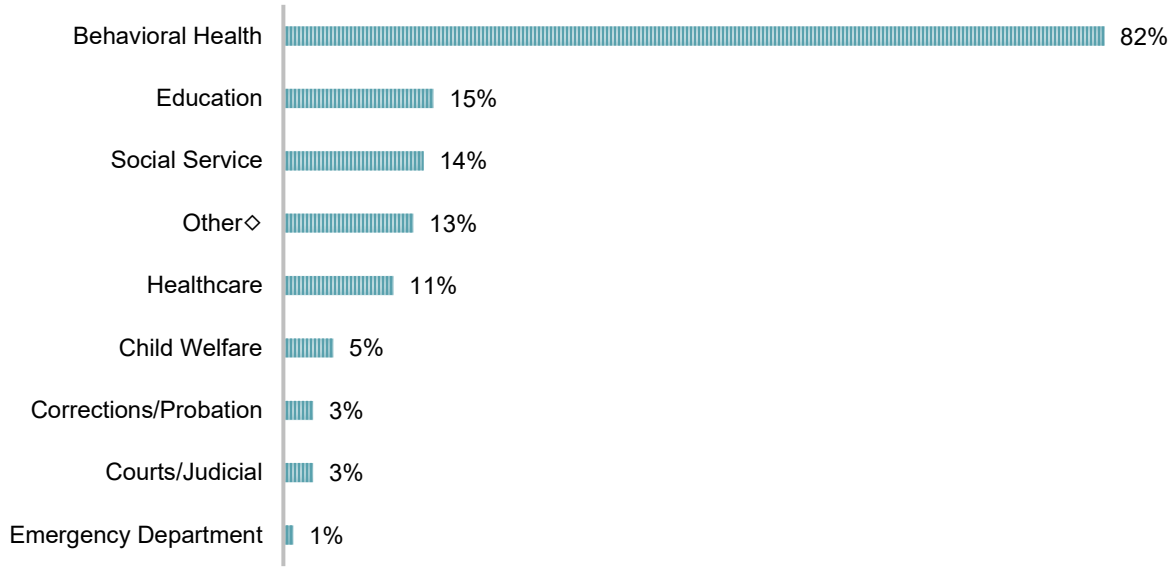
needs, availability of services, barriers to accessing care, strengths of the County's continuum of care, and recommendations for improving behavioral health services. Understanding Stakeholder perceptions related to these issues is critical in understanding issues related to service delivery and offer insight into both gaps in services and workforce education. The follows sections share a detailed analysis of related themes, underscoring their implications for MCBH.

Respondent Profile

To provide context to the survey findings, Stakeholders were asked a series of questions related to their role in the mental health or substance use service delivery system. The findings below share background information about respondents' professional engagement and personal identities, offering a deeper understanding of perspectives captured in this survey.

Sector. Stakeholders were asked to specify the sector of their professional engagement to improve the understanding of the diverse fields of expertise of respondents. More than 3/4 of Stakeholders (82%) reported working in Behavioral Health. This was followed by professionals in Education, Social Services, Other Sectors, and Healthcare. These findings, detailed in Figure 1, not only reflect the varied backgrounds of our Stakeholders but also underscore the broad scope of sectors engaged in our survey.

Figure 1. Sector of Professional Engagement of Engaged Stakeholders*



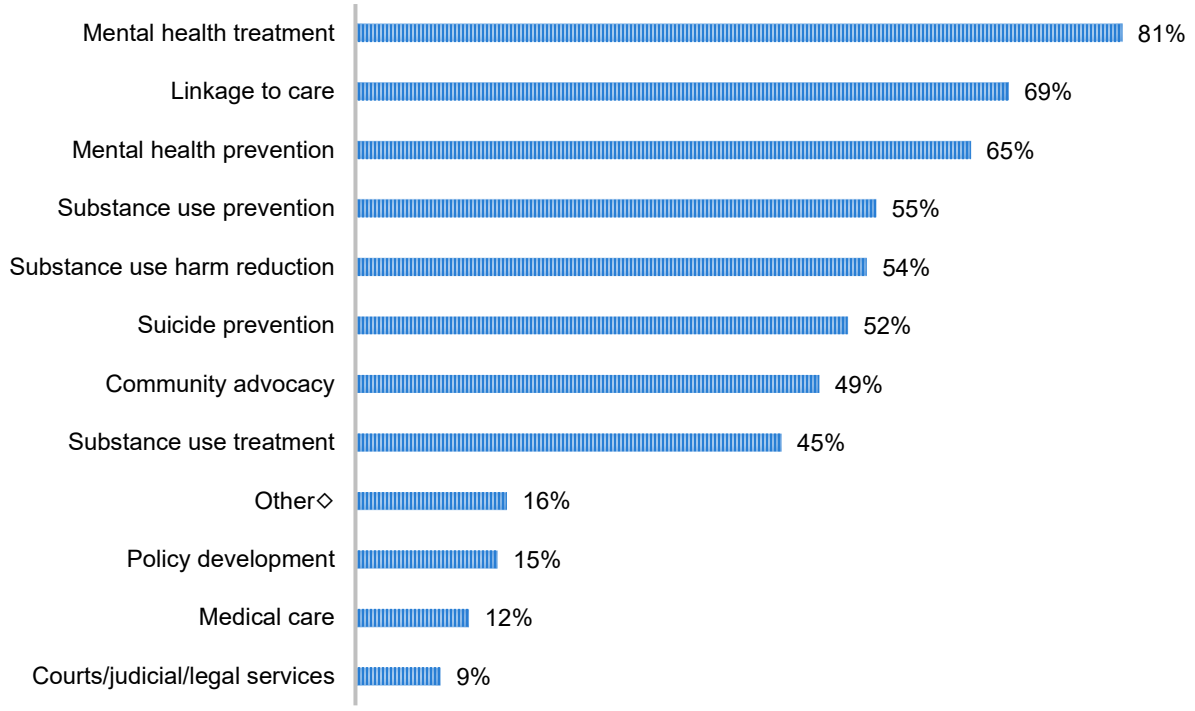
N=95
*Stakeholders could select more than one Sector.
◇12 respondents selected "Other", accounting for 13% of Respondents. Additional areas included Substance Use Disorder Treatment, Youth Development, Early Childhood Development, Resource Centers, Community Based Organizations, Public Health, Home Health, and Family Services.

Stakeholders were also asked about their affiliation to Monterey County Behavioral Health. Out of 92 responses, almost 2/3 of respondents were employees of MCBH (61%), with another 28% working at agencies that contract with MCBH. 8 Stakeholders (9%) had no affiliation with MCBH, and 2% worked at another Monterey County agency.

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Services Provided. Stakeholders were also asked to indicate the types of services provided through their professional engagement. In line with the top sector of professional engagement reported, over 3/4 of Stakeholders reported providing Mental health treatment (81%). As detailed in Figure 2, other services Stakeholders most frequently reported providing were Linkage to care (69%) and Mental health prevention (65%). Just over half of respondents reported providing substance use prevention services (55%) and substance use harm reduction services (54%).

Figure 2. Services Provided by Stakeholders' Agency*

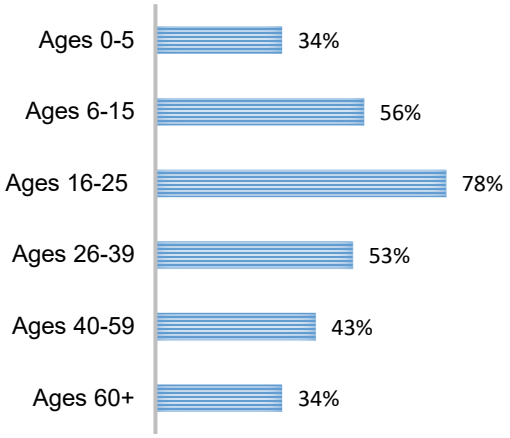


N=95
*Stakeholders could select more than one Service Provided. Percentages may exceed 100%.
◇15 Respondents selected "Other", accounting for 16% of Respondents. These other services included Linkages of Resources, Early Childhood Services, Collaboration, Case Management, Emergency Services, Recovery Services, Education and Youth Services, Housing Services, Eating Disorder Counseling, and Criminal Justice Services.

Ages & Population Served. Stakeholders were asked what populations they served through their professional engagement. Responses revealed that they served all ages and populations facing a diverse range of needs. See detailed ages and populations in Figures 3 and 4, respectively.

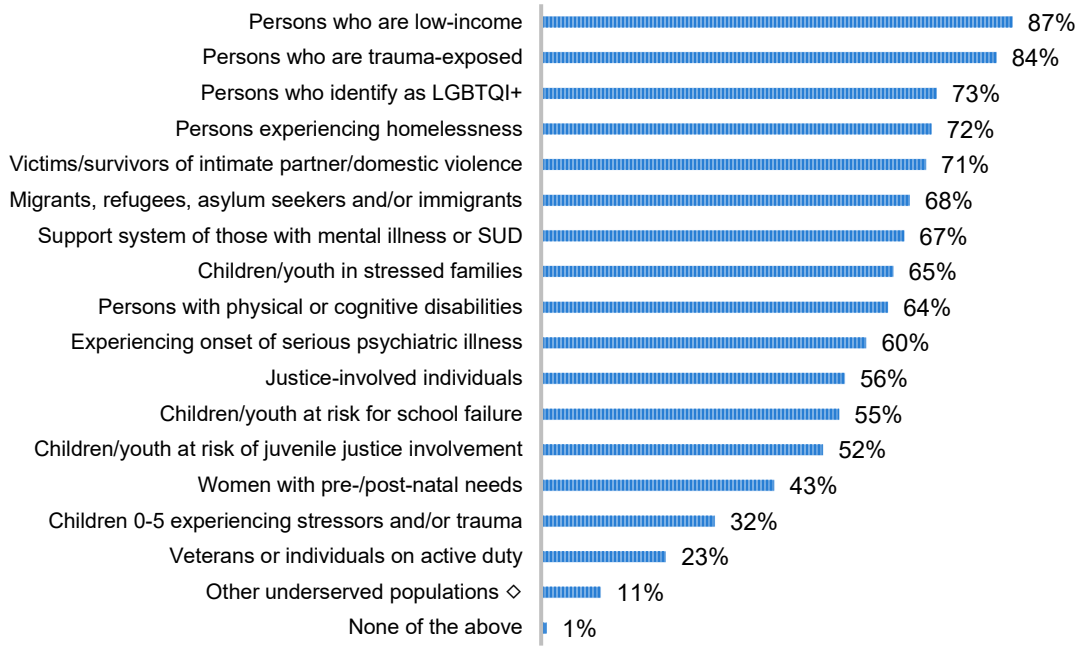
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Figure 3. Ages Served by Stakeholders through their Professional Engagement*



N=95
* Stakeholders could select more than one age group. Percentages may exceed 100%.

Figure 4. Populations and Needs Served through Stakeholders Professional Engagement*



N=95
*Stakeholders could select more than one population served. Percentages may exceed 100%.
◇ "Other" populations served include individuals with SUD, individuals living with disabilities, and indigenous populations.

Area Served. Stakeholders were asked about the areas of the county they serve. Of the 95 respondents surveyed, nearly 3/4 of the respondents (71%) reported serving the entire County, while just under 1/4 of Stakeholders reported that they only served South County (24%) or North County (23%), while the Coastal Regions were served by the fewest Stakeholders (19%). Stakeholders could select more than one area served, so percentages may exceed 100%.

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Demographics. Stakeholders were asked about their race and ethnicity, as well as their gender. As detailed in Table 2, just under half of Stakeholders identified as Hispanic (49%), close to half of Stakeholders identified as White (46%), and over 3/4 of Stakeholders identified as female (80%). 69% of Respondents reported speaking primarily English at home, with 27% speaking both English and Spanish, and 4% primarily speaking Spanish at home.

Table 2. Demographics of Engaged Stakeholders*

Race (N=82)*	Percentage
Hispanic or Latine	49%
White	46%
Multiracial	7%
Asian	5%
Native Hawaiian or Pacific Islander	4%
Another race/ethnicity	2%
American Indian or Alaska Native	1%
Black or African American	1%

Gender (N=85)	Percentage
Female	80%
Male	12%
A different identity	4%
Questioning/unsure	2%
Genderqueer	1%
Prefer not to answer	1%

Ethnicity (N=83)*	Percentage
Hispanic	54%
Non-Hispanic	49%

Primary Language (N=85)	Percentage
English	69%
Both English and Spanish	27%
Spanish	4%

*Stakeholders could select more than one option. Percentages may exceed 100%.

Overall, service providers in Monterey County span a range of sectors and provide diverse services to all age groups. Providers also have extensive experience working with mental health and substance use-involved individuals. Of the 95 respondents, nearly 1/2 of Stakeholders (46%) reported serving these populations for 10 or more years.

In characterizing the Respondent profile, we see that Respondents largely:

- Work in the behavioral health sector (82%)
- Provide mental health treatment services (81%)
- Engage with individuals aged 16-25 (78%)
- Engage with persons who are low income (87%)
- Serve the entire County (71%)
- Identify as Hispanic or Latine (54%)
- Identify as female (80%)
- Speak English (69%)

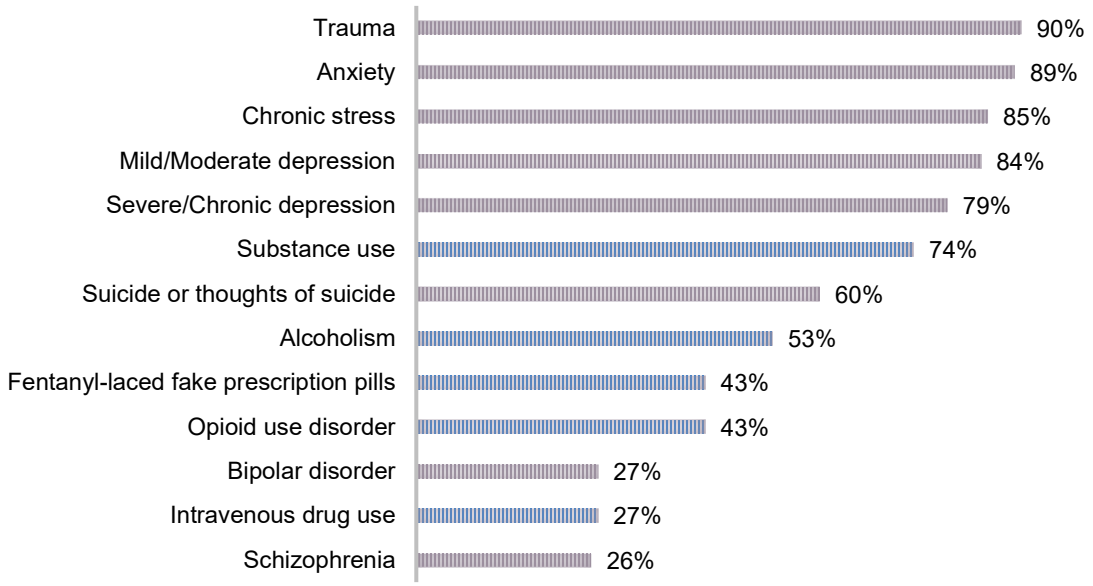
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Mental Health and Substance Use Service Needs

To better understand the community's behavioral health service needs, respondents were asked to share their perceptions of pressing issues facing the community. Specifically, they were asked about their knowledge and perceptions of community behavioral health needs in Monterey County, as well as issues regarding accessing such services.

Prevalence of Mental Health and Substance Use Issues. In order to understand the issues and needs of the community, Stakeholders were asked to rate the prevalence of various behavioral health issues across Monterey County, from "Not an Issue" to "A Major Issue." As seen in Figure 6, the top three issues, trauma, anxiety, and chronic stress, outpace the more severe and chronic mental health issues and substance use issues, suggesting a critical need for trauma-informed care and services addressing anxiety and stress within the community. It is important to note that 89% of respondents identified as part of the mental health continuum of care while on 69% of respondents identified as part of the substance use service system of care.

Figure 6. Prevalence of Issues Rated as "A Major Issue" by Engaged Stakeholders*

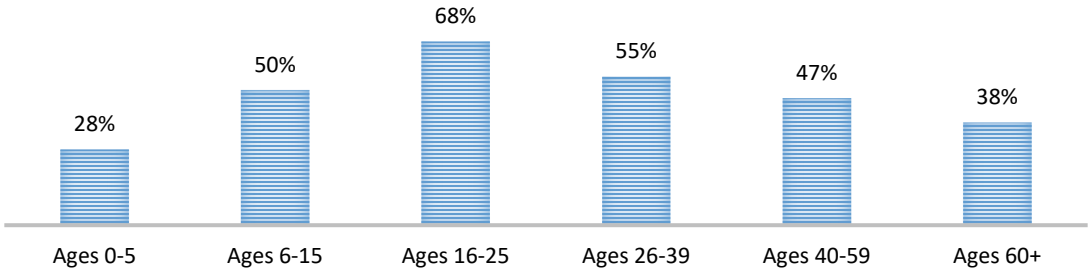


N: 91-94
*Respondents were asked to rank each issue listed on a scale from "Not an Issue" to "A Major Issue". There were no limits on how many issues could be ranked as "A Major Issue". Percentages may exceed 100%. Issues related to mental health are shown in grey and substance use are shown in blue.

Age Groups in Most Need of Additional Resources. Stakeholders were asked what populations were most in need of additional resources and services in the communities they served. As seen in Figure 7, half or more of the respondents identified age groups 6-15, 16-25, and 26-39 as most in need of additional resources.

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Figure 7. Age Groups in Most Need of Additional Resources *



N=94
* Stakeholders could select more than one age group. Percentages may exceed 100%.

Connection to Other Services. Stakeholders were asked to identify which services they could connect their clients to. Stakeholders reported being able to connect their clients to a range of other services, as detailed in Figure 8, such as Counseling, Crisis response, and Care related to substance use. This suggests that counseling is a more accessible resource available to the community while housing placement services or specialty resources, such as reentry services or hospice care, are less available.

Table 2. Services Stakeholders can Connect Clients to*

Resource	Percentage
Counseling	85%
Crisis response	74%
Care related to substance use	73%
Advocacy on behalf of persons experiencing mental health or substance use issues	64%
Support groups	63%
Transportation assistance	51%
Services for individuals who are homeless/unhoused	48%
Healthcare	45%
Short-term shelter	45%
Translation services	43%
System navigation assistance	36%
Financial assistance	30%
Home visitation services	29%
Legal services	25%
Insurance	21%
Long-term shelter/relocation	21%
Other mental health services◇	20%
Spiritual/Faith-based supports	18%
Reentry support services	12%
Other substance use services◇	12%
Hospice care	10%

N=89
*Stakeholders could select more than one Service Provided. Percentages may exceed 100%.
◇Stakeholders also were also able to openly add other mental health and substance use services they could connect their clients to. Some of the Other Mental Health Services added by Stakeholders included Peer-to-peer support, Eating Disorder Services/ Resources, Carelon, Domestic Violence support, Interim, Ohana, and Evidence based treatment. Some of the Other Substance Use Services added by Stakeholders included 12 Step Meetings, Other Agencies, SUD Wellness and Recovery, Door to Hope, and Gensis House.

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Availability of Mental Health Services and Substance Use Services. Stakeholders were asked whether mental health and substance use services were sufficiently available in the communities they serve. The findings show that most Stakeholders think that mental health and substance use services are available, but insufficient to meet the current need.

Table 2. Availability of Mental Health Services *

Mental Health Services (N=95)	Percentage
Available but insufficient to meet current needs	85%
Available to meet current needs	9%
Not available	4%
I don't know	2%

Substance Use Services (N=95)	Percentage
Available but insufficient to meet current needs	73%
Available to meet current needs	13%
Not available	5%
I don't know	9%

Together, findings related to Stakeholder perceptions of mental health and substance use services highlight that moderate mental health issues are the most frequently identified major issues and Stakeholders are most frequently able to refer clients to mental health services. Most Stakeholders agreed that while mental health and substance use disorder services are available, there are not enough of these services to address current need.

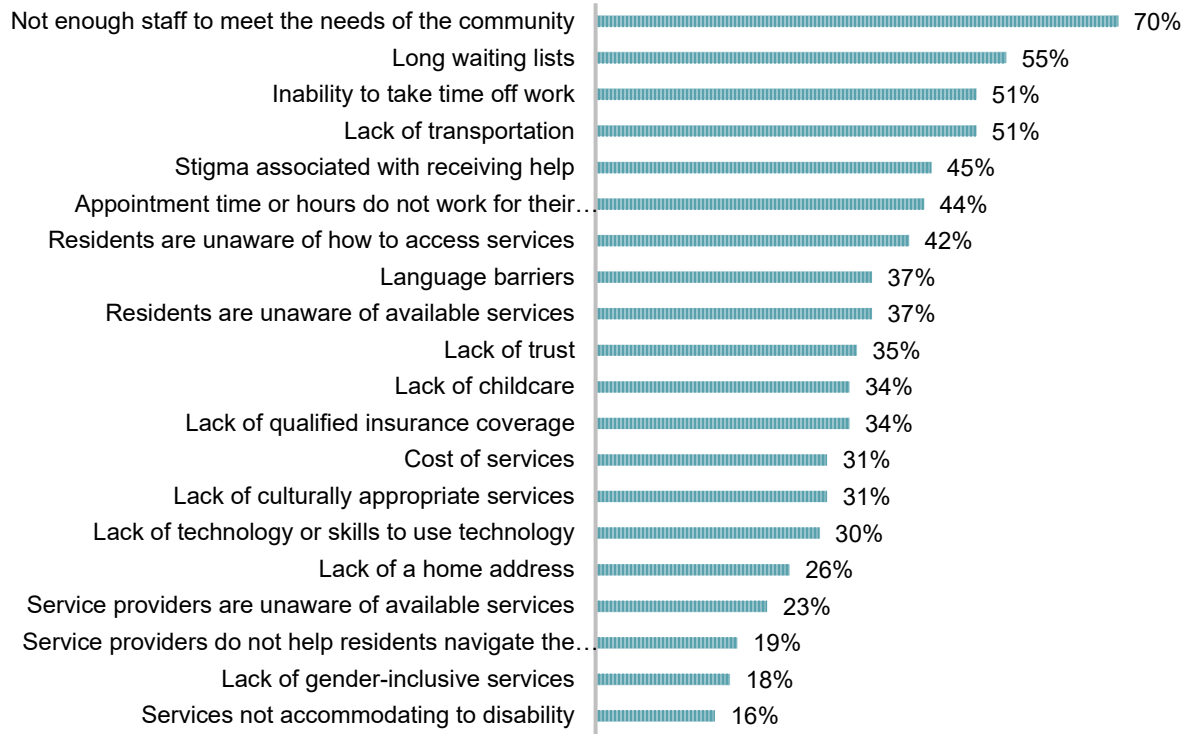
Stakeholder-Identified Barriers to Care

To understand the barriers preventing communities from accessing behavioral health services better, respondents were asked to share their perceptions of various factors that hinder or limit access. Additionally, they were asked to provide insights into their knowledge about care coordination processes, which are essential for facilitating services across the system of care.

System-Wide Barriers. Stakeholders were asked to identify barriers that community members face when trying to access services. To provide an overall view on barriers encountered by community members, respondents were asked to rate each barrier on a list of possible barriers from “Not a Barrier” to “Often a Barrier.” As detailed in Figure 11, issues regarding staffing, such as staff shortages and long wait lists, were the barriers most frequently identified as “Often Barriers” by Stakeholders.

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Figure 11. Issues Ranked by Stakeholders as "Often Barriers" to Community Members Receiving Services



N=82-84
Respondents could also write in other barriers. Write-in responses included the following: Cultural differences, Lack of enough services in south county all the way to Bradley, Lack of understanding of racism and historical persistent trauma, Limited Continuity and Communication between services, especially at discharge, Threat of abuse, Youth unwilling to seek services for themselves, and misleading service advertisement.

Referral Knowledge According to Insurance Source. Stakeholders also provided insight into their ability to make appropriate referrals for their clients regarding mental illness. Stakeholders were asked about their knowledge regarding what services clients can be referred to based on clients' condition and insurance status. As shown in Table 3, respondents displayed distinct strengths regarding knowledge of referrals for Medi-Cal. However, the respondents were not as confident for clients with other insurance statuses.

Table 3. Stakeholder Knowledge About Where to Refer Persons with Several Mental Health Conditions According to Insurance Source

"I know how/where to refer persons with **Severe Mental Health Conditions** for the services they need."	
Client Population	**Agree**
Persons who have Medi-Cal (N=85)	95%
Persons who have Medicare (N=85)	52%
Persons with private insurance (N=85)	51%
Persons who are uninsured (N=85)	61%

Respondents displayed similar patterns when asked about knowledge of referrals for Persons with Mild to Moderate Mental Illness. As shown in Table 4, respondents displayed distinct strengths regarding

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knowledge of referrals for Medi-Cal. However, the respondents were not as confident for clients with other insurance statuses.

Table 4. Stakeholder Knowledge About Where to Refer Persons with Mild to Moderate Mental Health Conditions According to Insurance Source

"I know how/where to refer persons with **Mild to Moderate Mental Illness** for the services they need."	
Client Population	**Agree**
Persons who have Medi-Cal (N=84)	89%
Persons who have Medicare (N=85)	49%
Persons with private insurance (N=85)	59%
Persons who are uninsured (N=85)	51%

Knowledge Regarding Where to Send Clients for Substance Use Disorder Services. Stakeholders also provided insight into their ability to make appropriate referrals for their clients regarding substance use. Stakeholders were asked about their knowledge regarding what services clients can be referred to based on clients' condition and insurance status. As shown in Table 5, respondents displayed distinct strengths regarding knowledge of referrals for Medi-Cal. However, respondents were not as confident for clients with other insurance statuses.

Table 5. Stakeholder Knowledge About Where to Refer Clients for Substance Use Services According to Insurance Source

"I know how/where to refer persons with **Substance Use Disorders** for the services they need."	
Client Population	**Agree**
Persons who have Medi-Cal (N=84)	82%
Persons who have Medicare (N=83)	40%
Persons with private insurance (N=84)	37%
Persons who are uninsured (N=83)	35%

Connecting to Care. Finally, when asked whether they agree with the statement "I am confident that when I make a referral to substance use services that it will result in treatment", about a 1/4 (27%) of the 82 respondents who answered the question agreed with the statement. Furthermore, when asked whether they agree with the statement "I am confident that when I make a referral to mental health services that it will result in treatment", about 1/4 (26%) of the 83 respondents who answered the question agreed with the statement. This shows an opportunity for MCBH to increase communication with Stakeholders regarding the outcomes of the referrals.

Findings from this section suggest a potential significant disconnect within the behavioral health system of care. Anywhere from 39-65% of stakeholders did not feel confident making referrals for individuals with mental health or substance use disorder needs who had an insurance status other than Medi-Cal.

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Areas of Effectiveness

To understand the strengths within the behavioral health system of care, Stakeholders were asked what they thought was most effective about Monterey County's current continuum of care for persons experiencing mental health issues. This question was also open-ended, allowing respondents to to share their views further in their own words. From these responses, three primary strengths emerged: 1) Accessibility of Care, 2) Quality of Care, and 3) Approach to Care.

Accessability of Care. Stakeholders clearly conveyed a sense that Monterey County's mental health continuum of care is accessible to the community. A key highlight is the effective use of a single entry point system (ACCESS), which simplifies the process of connecting individuals to mental health services. However, there's a noted need for clearer communication to assist the community in understanding and navigating this entry process. Additionally, the provision of flexible service hours, especially to accommodate the unique needs of the farmworker community, is highly valued. This includes options for extra shifts or flex time, allowing services to extend beyond the standard weekday hours. The presence of multiple access points further strengthens this theme, indicating a concerted effort to make mental health services reachable and adaptable to a diverse range of community needs, thereby enhancing overall service accessibility and flexibility in Monterey County.

"Offering current employees the ability to work an extra shift (per diem) or flex time to work on Saturdays or after hours to meet the needs of the community, particularly the farmworker community who are unable to access services Monday-Friday, 8-5 p.m."

Stakeholders also recognized the greater accessibility of services due to efforts by the County to decrease stigma in the community.

"Monterey County has supported with decreasing stigma in our community relating to mental health, which makes services more accessible to anyone who is interested in receiving mental health services."

Quality of Care. The feedback noted key strengths related to the quality of mental health services provided to the community. Findings indicate that the staff, praised for their care and knowledge, play a pivotal role, with their dedication and caring nature often highlighted. The commitment of staff was reflected in descriptions of a proactive approach to treatment and the collaborative approach across service providers in connecting people to resources. Stakeholder respondents indicated that individuals who engage with the services typically find staff that care, leading to the formation of a robust support system that enhances their outcomes. Moreover, the extensive knowledge of these health professionals was emphasized as a key factor in effectively addressing mental health needs. Responses noted that efforts by the County to improve staff retention through pay increases are positively influencing service quality, as consistent support staff is crucial for client satisfaction.

"There is a strong work ethic and drive to support clients on the part of the MH professionals. They are skilled and have a good breadth of knowledge."

Approach to Care. Finally, Stakeholders believed that Monterey County's current continuum of care was effective because of the quality of the approach that MCBH took to providing care. Broadly, Stakeholder responses reflected an appreciation for how MCBH leadership and staff approached mental health issues by advancing inclusivity and prioritizing improvement.

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Stakeholder Recommendations

To solicit recommendations to improve the behavioral health system of care, Stakeholders were asked for recommendations to improve coordination of the system of care for individuals needing mental health or substance use services. This question was also open-ended and findings bring to light actionable recommendations for improved collaboration and communication, navigation assistance, and workforce enhancements.

Increasing Collaboration. Stakeholder responses highlight their perception of a need for improved communication and information sharing among mental health and substance use service providers. Responses advocate for more frequent and structured interactions between program managers, suggesting quarterly meetings to discuss service availability, wait-lists, and processes. A significant recommendation is the creation of a centralized, web-based database, which would be regularly updated and accessible to all service providers, addressing the limitations of outdated resources like the SAMs Guide. This database would include information about various programs, their current status, and changes in service delivery methods. Enhancing communication channels and ensuring up-to-date information is accessible is seen as a critical step in fostering a more coordinated and efficient system of care.

"It would be beneficial for there to be a 'one-stop-shop' where the community can access mental and medical healthcare as well as services for other common needs (e.g., substance use treatment, probation, victim advocacy, social services)."

Navigation Assistance. Responses from the survey underscore the importance of improving access to and navigation of mental health and substance use services. A key suggestion is the establishment of a triage system to prioritize high-need clients, ensuring timely care even in the presence of wait-lists. Respondents also advocate for the implementation of more robust navigator-assisted programs, especially for families with children requiring mental health treatment, to help them understand and move through the system more effectively. The idea of a "one-stop shop" where clients can access a variety of services, including mental and medical healthcare, was also favored. This would simplify the process for clients, reducing the complexity and confusion often associated with accessing care.

"I would appreciate being able to use a web-based database that service providers would log into and maintain entries for their programs that would be searchable by service providers."

Workforce Enhancements. Survey findings reveal a critical need for enhancements in resources and staffing within the mental health and substance use service sectors. Stakeholders called for better strategies to retain and hire staff, such as offering more competitive pay and flexible schedules. There is a noticeable demand for increasing the diversity of service providers to better reflect the demographics of clients, along with the need for more training and education for existing staff. Expanding services to include, and training staff to provide, support to elements like housing and employment opportunities, particularly for those in the early stages of substance use disorder, is seen as crucial. Additionally, there's an emphasis on recruiting new, local staff, particularly from recent graduates, to address the challenges of long wait-lists and understaffing.

"It would help to have bilingual training to reduce translation struggles when explaining the system, the referral process, and what to do after for Spanish-speaking clients. It would also help to make

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more bilingual educational workshops about how the mental health system works, what to do if trying to seek services, challenging stigmas about substance abuse/mental health challenges."

SUMMARY

The Monterey County Behavioral Health Stakeholder Survey has gathered valuable insights from a diverse group of providers and system partners, identifying key needs, barriers, and gaps in behavioral health services. Findings related to service needs, barriers to care, areas of effectiveness, and recommendations are summarized below.

In terms of community mental health and substance use service needs, stakeholders identified trauma, anxiety, and chronic stress as the most significant mental health issues, with alcoholism and prescription drug misuse, including opioids, as the top substance use concerns. There is a notable alignment between these issues and the services available, such as counseling and crisis response, though a majority of stakeholders believe these services are insufficient for current needs. Regarding barriers to accessing care, staffing issues, such as shortages and long waitlists, were frequently cited as major barriers. There is also a knowledge gap in referring clients to services beyond Medi-Cal, indicating a need for more training in diverse insurance situations and a general skepticism about the effectiveness of referrals. Stakeholders also recognized MCBH's efforts in enhancing accessibility, quality, and a comprehensive approach to care. Stakeholder recommendations revolve around increasing collaboration, enhancing access to services, and improving staffing and training.

Overall, the survey reveals that while MCBH has made strides in providing essential services, there is a clear call for expanded resources, better system navigation, and enhanced coordination to fully address the community's mental health and substance use needs.

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APPENDIX

Mental Health Stakeholder Survey

Community Program Planning Process
Monterey County Behavioral Health

Thank you for participating in this survey. Your answers are very important to us and will better ensure that services meet the mental health and substance use needs of people throughout Monterey County. Please answer honestly based on your experiences. **All of your responses will be kept private.**

Part 1. Background

1. **Please select the field(s) or sector(s) you work in (check all that apply):**

- ❑ Child Welfare
- ❑ Corrections/Probation
- ❑ Courts/Judicial
- ❑ Education
- ❑ Emergency Department
- ❑ Faith-based Organization
- ❑ Healthcare
- ❑ Law Enforcement
- ❑ Mental/Behavioral Health
- ❑ Public Guardian
- ❑ Social Service
- ❑ Other (please specify): _____

2. **Please select the types of services provided at your agency (check all that apply):**

- ❑ Community advocacy
- ❑ Courts/judicial services
- ❑ Linkage to care
- ❑ Medical care
- ❑ Other: _____
- ❑ Mental health prevention
- ❑ Mental health treatment
- ❑ Policy development
- ❑ Public safety/Law enforcement
- ❑ Substance use prevention
- ❑ Substance use treatment
- ❑ Substance use harm reduction
- ❑ Suicide prevention

3. **Would you consider your agency part of Monterey County Behavioral Health (MCBH)?**

- ❑ Yes, I am an MCBH employee
- ❑ No, I do not work for MCBH or a contracted provider
- ❑ Yes, my agency contracts with MCBH
- ❑ No, I work at another Monterey County Department or Agency

4. **How long have you been working directly or indirectly with mental health or substance use-involved individuals?**

- ❑ Less than 1 year
- ❑ 1-4 years
- ❑ 5-9 years
- ❑ 10 or more years

5. **Which area(s) of the County does your agency primarily serve? (select all that apply)**

- ❑ North County
- ❑ South County
- ❑ Coastal Regions
- ❑ Countywide

6. **Which ages do you work with most often? (select all that apply)**

- ❑ Ages 0-5
- ❑ Ages 6-15
- ❑ Ages 16-25
- ❑ Ages 26-39
- ❑ Ages 40-59
- ❑ Ages 60+

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7. **Which of the following populations do you work with? (select all that apply)**

- ❑ Children 0-5 who have experienced early life stressors and/or trauma
- ❑ Children/youth in stressed families
- ❑ Children/youth at risk for school failure
- ❑ Children/youth at risk of juvenile justice involvement
- ❑ Family members, support persons, or caregivers of individuals with mental health conditions or substance use disorder
- ❑ Justice-involved individuals
- ❑ Persons experiencing homelessness
- ❑ Persons experiencing onset of serious psychiatric illness
- ❑ Persons who are low-income
- ❑ Persons who identify as LGBTQI+
- ❑ Persons who identify as migrants, refugees, asylum seekers and/or immigrants
- ❑ Persons with physical or cognitive disabilities
- ❑ Persons who are trauma-exposed
- ❑ Persons who are victims/survivors of intimate partner/domestic violence
- ❑ Veterans or individuals on active duty
- ❑ Women with pre-/post-natal needs
- ❑ None of the above
- ❑ Other underserved populations (please specify): _____

Part 2. Mental Health and Substance Use Services Needs

8. **Please rate the prevalence of the following issues in the communities you serve.**

	Not an issue	Somewhat of an issue	A major issue	I don't know
Alcoholism	○	○	○	○
Anxiety	○	○	○	○
Bipolar disorder	○	○	○	○
Chronic stress	○	○	○	○
Fentanyl-laced fake prescription pills	○	○	○	○
Intravenous drug use	○	○	○	○
Mild/Moderate depression	○	○	○	○
Opioid use disorder	○	○	○	○
Severe/Chronic depression	○	○	○	○
Schizophrenia	○	○	○	○
Substance use	○	○	○	○
Suicide or thoughts of suicide	○	○	○	○
Trauma	○	○	○	○
Other (please specify):_____				

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9. **Which age groups are most in need of additional resources/services in the communities you serve? (select all that apply**

- ❑ Ages 0-5
- ❑ Ages 6-15
- ❑ Ages 16-25
- ❑ Ages 26-39
- ❑ Ages 40-59
- ❑ Ages 60+

10. **Which of the following services would you be able to connect clients to, if needed? (select all that apply)**

- ❑ Advocacy on behalf of persons experiencing mental health or substance use issues
- ❑ Care related to substance use
- ❑ Counseling
- ❑ Crisis response
- ❑ Financial assistance
- ❑ Insurance
- ❑ Healthcare
- ❑ Home visitation services
- ❑ Hospice care
- ❑ Legal services
- ❑ Long-term shelter/relocation
- ❑ Reentry support services
- ❑ Services for individuals who are homeless/unhoused
- ❑ Short-term shelter
- ❑ Spiritual/Faith-based supports
- ❑ Support group
- ❑ System navigation assistance
- ❑ Translation services
- ❑ Transportation assistance
- ❑ Other substance use services: _____
- ❑ Other mental health services: _____
- ❑ Not applicable: I do not provide direct services

11. **Overall, how available are mental health services in meeting the needs of the communities you serve?**

- ❑ Available to meet current needs
- ❑ Available but insufficient to meet current needs
- ❑ Not available
- ❑ I don't know

12. **Overall, how available are substance use services in meeting the needs of the communities you serve?**

- ❑ Available to meet current needs
- ❑ Available but insufficient to meet current needs
- ❑ Not available
- ❑ I don't know

Part 3. Barriers to Accessing Mental Health and Substance Use Services

13. **How much do the following barriers prevent persons from accessing the services they need?**

	Not a barrier	Sometimes a barrier	Often a barrier	I don't know
Appointment time or hours do not work for their schedule	❑	❑	❑	❑
Cost of services	❑	❑	❑	❑
Inability to take time off work	❑	❑	❑	❑
Lack of a home address	❑	❑	❑	❑
Lack of childcare	❑	❑	❑	❑
Lack of culturally appropriate services	❑	❑	❑	❑
Lack of gender-inclusive services	❑	❑	❑	❑
Lack of qualified insurance coverage	❑	❑	❑	❑
Lack of technology or skills to use technology	❑	❑	❑	❑
Lack of transportation	❑	❑	❑	❑
Lack of trust	❑	❑	❑	❑

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13. **(cont.) How much do the following barriers prevent persons from accessing the services they need?**

	Not a barrier	Sometimes a barrier	Often a barrier	I don't know
Language barriers	❑	❑	❑	❑
Long waiting lists	❑	❑	❑	❑
Not enough staff to meet the needs of the community	❑	❑	❑	❑
Residents are unaware of available services	❑	❑	❑	❑
Residents are unaware of how to access services	❑	❑	❑	❑
Service providers are unaware of available services	❑	❑	❑	❑
Service providers do not help residents navigate the system	❑	❑	❑	❑
Services not accommodating to disability	❑	❑	❑	❑
Stigma associated with receiving help	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑

14. **Please indicate your level of agreement for each of the following statements:**

I know how/where to refer persons with **Severe Mental Illness** for the services they need for the following:

	Disagree	Unsure	Agree	N/A
• Persons who have Medi-Cal	○	○	○	○
• Persons who have Medicare	○	○	○	○
• Persons with private insurance	○	○	○	○
• Persons who are uninsured	○	○	○	○
I know how/where to refer persons with **Mild to Moderate Health Conditions** for the services they need for the following:				
• Persons who have Medi-Cal	○	○	○	○
• Persons who have Medicare	○	○	○	○
• Persons with private insurance	○	○	○	○
• Persons who are uninsured	○	○	○	○
I am confident that when I make a referral to mental health services that it will result in treatment	○	○	○	○

15. **Please indicate your level of agreement for each of the following statements:**

I know how/where to refer persons with **Substance Use Disorders** for the following:

	Disagree	Unsure	Agree	N/A
• Persons who have Medi-Cal	○	○	○	○
• Persons who have Medicare	○	○	○	○
• Persons with private insurance	○	○	○	○
• Persons who are uninsured	○	○	○	○
I am confident that when I make a referral to substance use services that it will result in treatment	○	○	○	○

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16. **What recommendations do you have to have a more coordinated system of care for individuals with mental health or substance use services?**

17. **What would you say is most effective about Monterey County's current continuum of care for persons experiencing mental health issues?**

Part 4. Demographics

18. **What language do you speak <u>most</u> at home?**

❑ English ❑ Spanish ❑ Both English and Spanish ❑ Another language: _____

19. **Which of the following best describes your current gender identity?**

❑ Female
❑ Genderqueer
❑ Male
❑ Questioning/unsure of gender identity
❑ Transgender
❑ A different identify: _____
❑ Prefer not to answer

20. **Which of the following best describes your ethnicity? (*select all that apply*)**

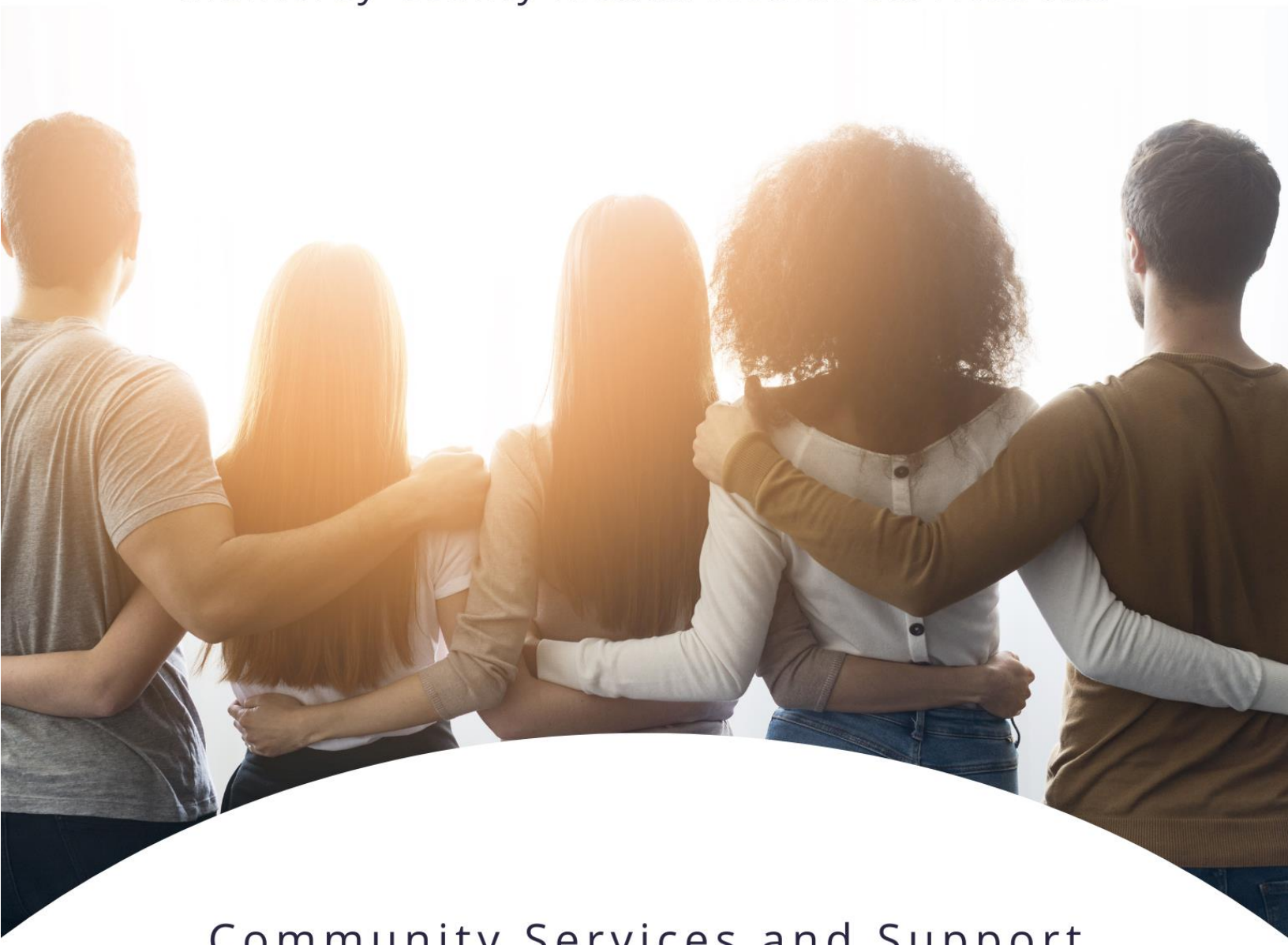
❑ Hispanic ❑ Non-Hispanic

21. **What racial/ethnic categories do you identify with? (check all that apply)**

❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Hispanic or Latino
❑ Native Hawaiian or Pacific Islander
❑ White
❑ Multiracial
❑ Another race/ethnicity (please specify):_____

Thank you for your time and responses.

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Community Services and Support

ANNUAL REPORT

FY 2022–2023

Prepared by
EVALCORP
Measuring What Matters

MONTEREY COUNTY
BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

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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; it is intended to fund programs that provide mental health services to adults and older adults experiencing moderate to severe mental illness (SMI), and children and transitional-aged youth with serious emotional disturbance (SED). CSS is the largest of all the components, with 76% of all MHSA funds received by counties being allocated to these programs.

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) 22-23, Monterey County funded 48 CSS programs administered by both MCBH and contracted community service providers. This report details those programs, including, program descriptions, successes, challenges, goals, or utilization information, based on available data sources.

MHSA CSS Regulations

CSS programs expand and transform services for individuals living with SMI, with a particular focus on cultural competency and recovery orientation. Furthermore, these programs are driven by client and family needs, collaboration with the community, and integration of various 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 categorized into 'strategies' based on the MHSA regulation and the individuals they serve. A list of CSS-funded programs in Monterey County by strategy is included for reference in **Appendix A**.

Full Service Partnership	• Used to provide "whatever it takes" support to indiviudals with SMI and their families
General Systems Development	• Used to enhance abd unorive the system of care for all clients and their families
Outreach and Engagement	• Used to identify and increase access for unserved and undeserved communities

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REPORT METHODOLOGY

Analytic Approach

MCBH contracted with EVALCORP to develop this report, which summarizes data for CSS programs funded during FY 22-23. The evaluation utilized qualitative and quantitative 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. Quantitative information about CSS programs was obtained by pulling data from the county's electronic health record system, Avatar.[1] Data reported from Avatar may contain total percentages that exceed 100% due to rounding and/or being able to select more than one response option.

Report Organization

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

- Program description
- FY 22-23 successes and strengths
- Challenges and action plans in FY 22-23
- Goals for FY 23-24
- Client information (demographics, service engagement, etc.)

[1] Not all CSS programs have data available in Avatar. Therefore, some programs do not have quantitative data for this report. For programs that did not complete the online survey, program descriptions were pulled from the FY 21-22 report where available.

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CSS-01: EARLY CHILDHOOD AND FAMILY STABILITY FSP

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FAMILY ASSESSMENT SUPPORT AND TREATMENT

The FAST Treatment Team offers mental health treatment and case management services to children and families involved in the Monterey County Dependency Court and Child Welfare system due to severe abuse and neglect. Therapy options include individual therapy, attachment work, group therapy, and family therapy. The FAST Team employs a systems perspective, with a team of therapists often providing therapy to multiple family members. This fosters a collaborative, cohesive, and stimulating approach to clinical work.

Successes and Highlights

- Delivered intensive support services to children and youth within the child welfare system.
- Successfully provided both in-person and telehealth services for children and families.
- Ensured that bilingual Spanish-speaking families could access the majority of services in their preferred language.

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FAMILY ASSESSMENT SUPPORT AND TREATMENT

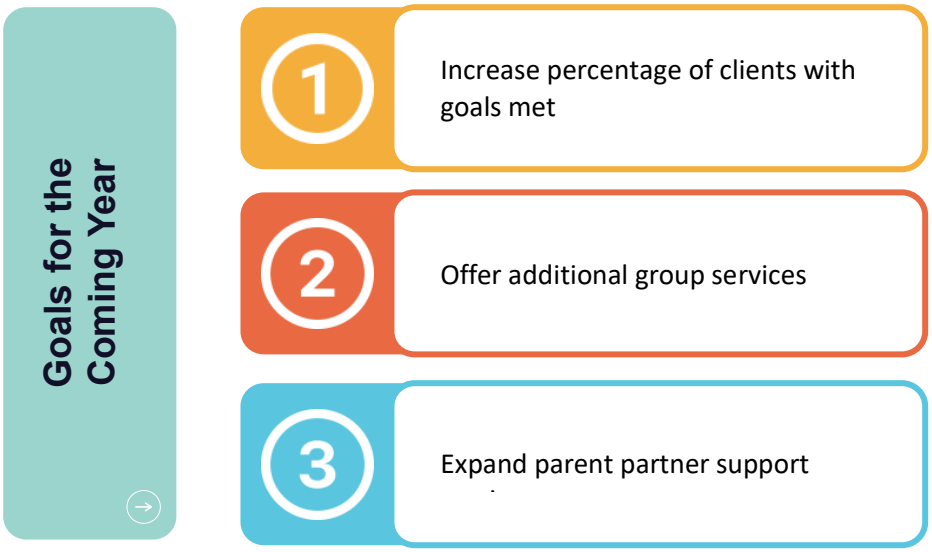
Challenges & Growth Opportunities

CHALLENGES: The FAST Team faced challenges this period.

- Ongoing coordination challenges due to the inability to meet the needs of youth with severe mental and behavioral challenges through local services, leading to their placement in residential facilities.

ACTION PLAN: The FAST Team developed an action plan to address these challenges.

- Conducted Child and Family team meetings to provide support and facilitate effective communication regarding the needs of the youth.
- Held clinical coordination meetings to enhance collaboration and address the challenges faced in meeting the needs of youth.



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FAMILY REUNIFICATION FSP

- **6 clients** served in FY 22-23
- On average, clients engaged in services for **530 days**

Housing

Housing Type Before Services (n=6)		Current Housing Type (n=7)
50%	Independent house or apartment	67%
0%	With friends/family	0%
0%	Shelter or temporary housing	0%
0%	Unhoused	0%
0%	Acute medical hospital	0%
0%	Acute psychiatric facility or hospital	0%
0%	Hospital	0%
0%	Assisted living facility	0%
0%	Residential treatment facility	0%
33%	Foster home	50%
0%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	0%
17%	Another housing status	0%
14%	Unknown/Declined to state	0%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 1 missing "housing type before services" status.

Employment and Education

Changes in Employment and Education

0% of clients
are currently employed or volunteering

compared to 0% before program engagement

67% of clients
are currently enrolled in or completed school

compared to 67% before program engagement

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FAMILY REUNIFICATION FSP

Emergency Events & Arrests

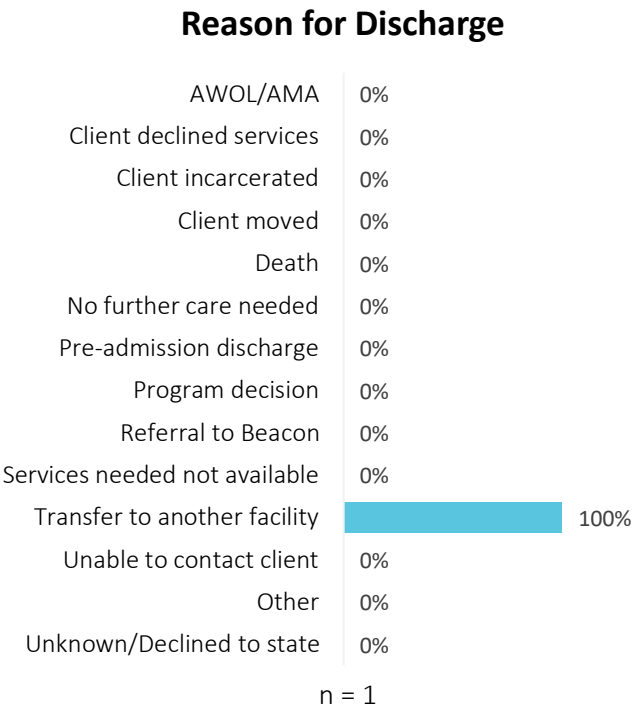
Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.

No clients were arrested or experienced physical health or mental health emergencies during either time point.

Discharge Information

5 clients were **discharged**.

80% had **achieved some to all of their goals**.



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FAMILY REUNIFICATION FSP

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	0%
Black / African American	33%
Native Hawaiian / Other Pacific Islander	0%
White	33%
Another	33%
Unknown/Declined to state	0%

n = 6

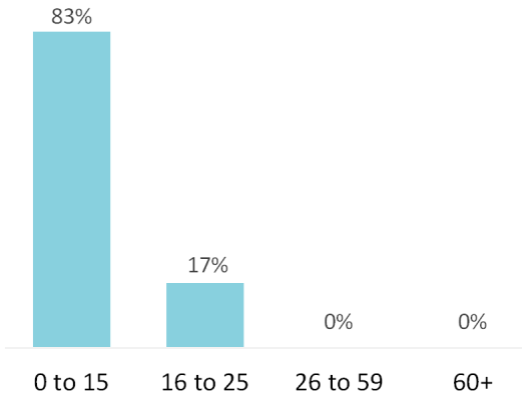
More than one race could be selected. Percentages may exceed 100%.

33% Hispanic/Latino
33% Not Hispanic/Latino

n = 6

33% Unknown/Declined to state.

Age



n = 6

0% of individuals did not answer this question.

Disability

Mental	17%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	83%
Unknown/Declined to state	0%

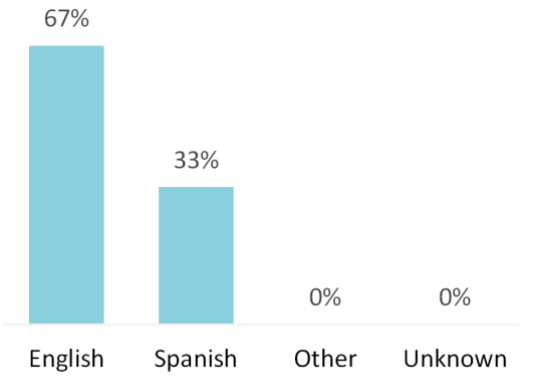
n = 6

More than one disability could be selected. Percentages may exceed 100%.

17% of individuals reported having one or more disabilities

n = 6

Primary Language



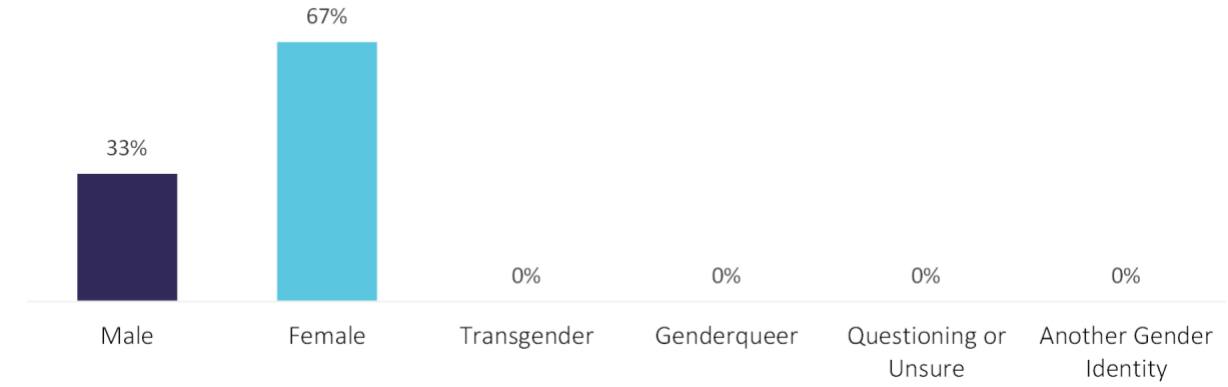
n = 6

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FAMILY REUNIFICATION FSP

Demographic Data

Gender Identity



n = 6

0% Unknown/Declined to State.

Sexual Orientation

Heterosexual or Straight	33%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	67%

n = 6

Sex at Birth

Male	33%
Female	67%
Another Sex	0%
Unknown/Declined to state	0%

n = 6

0% of individuals were veterans

n = 6

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KINSHIP CENTER, FIRST FIVE TRAUMA FSP

- **11 clients served** in FY 22-23
- On average, clients engaged in services for **148 days**

Housing

Housing Type Before Services (n=11)		Current Housing Type (n=8)
100%	Independent house or apartment	45%
0%	With friends/family	9%
0%	Shelter or temporary housing	0%
0%	Unhoused	0%
0%	Acute medical hospital	0%
0%	Acute psychiatric facility or hospital	0%
0%	Hospital	0%
0%	Assisted living facility	0%
0%	Residential treatment facility	0%
0%	Foster home	18%
0%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	0%
0%	Another housing status	0%
0%	Unknown/Declined to state*	27%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 3 missing "current housing type" statuses.

Employment and Education

Changes in Employment and Education

0% of clients
are currently employed or volunteering

compared to 0% before program engagement

55% of clients
are currently enrolled in or completed school

compared to 27% before program engagement

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KINSHIP CENTER, FIRST FIVE TRAUMA FSP

Emergency Events & Arrests

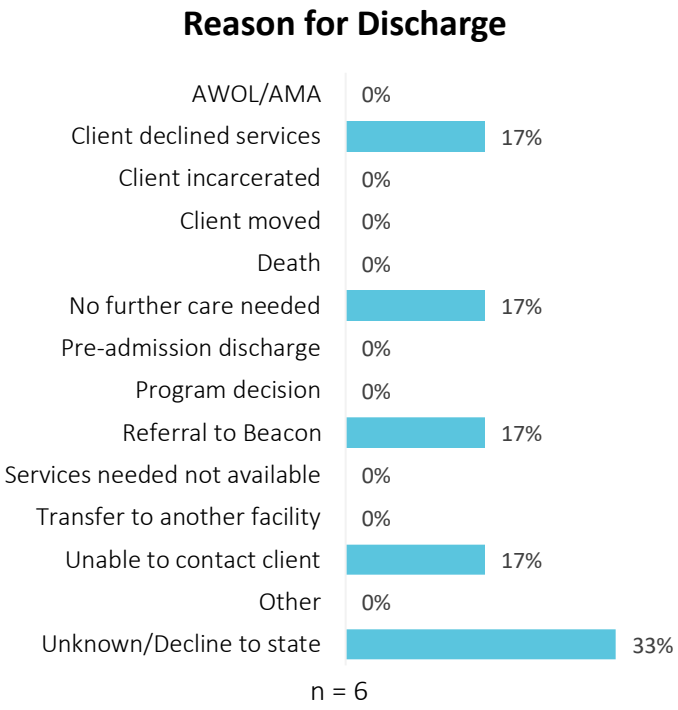
Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.

No clients were arrested or had a mental health emergency during either time point. 9% (n = 1) of clients experienced a physical health emergency during their enrollment in FY 22-23.

Discharge Information

7 clients were **discharged**.

14% had **achieved some to all of their goals**.



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KINSHIP CENTER, FIRST FIVE TRAUMA FSP

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	45%
Black / African American	27%
Native Hawaiian / Other Pacific Islander	0%
White	9%
Another	18%
Unknown/Declined to state	0%

n = 11

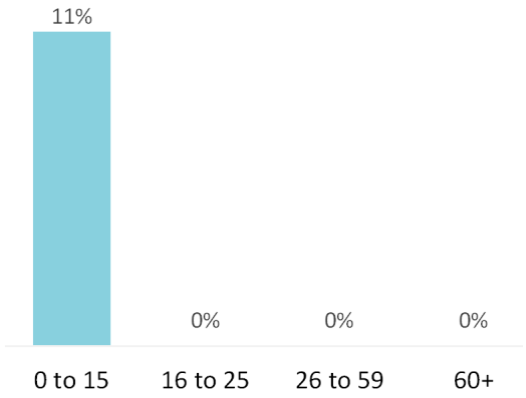
More than one race could be selected. Percentages may exceed 100%.

73% Hispanic/Latino
9% Not Hispanic/Latino

n = 11

18% Unknown/Declined to state.

Age



n = 11

0% of individuals did not answer this question.

Disability

Mental	0%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	100%
Unknown/Declined to state	0%

n = 11

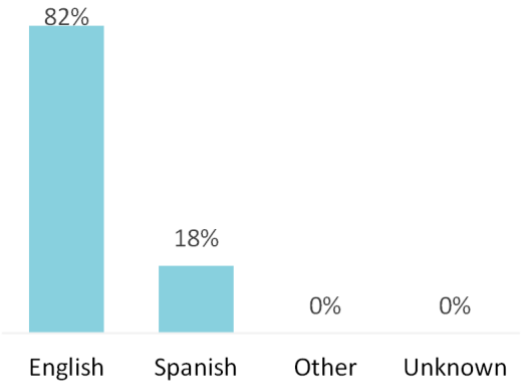
More than one disability could be selected. Percentages may exceed 100%.

0% of individuals reported having one or more disabilities

n = 11

0% Unknown/Declined to state.

Primary Language



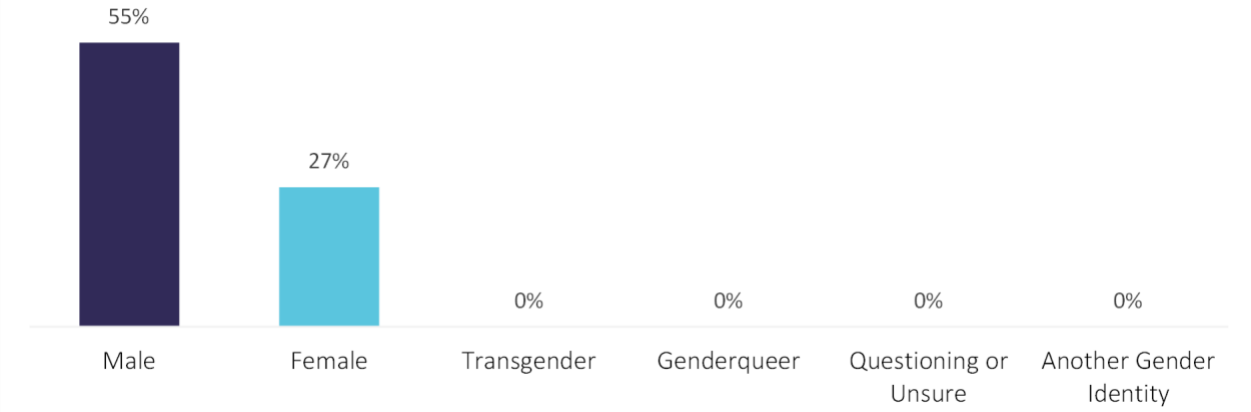
n = 11

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KINSHIP CENTER, FIRST FIVE TRAUMA FSP

Demographic Data

Gender Identity



n = 11
18% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	0%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	100%

n = 11

Sex at Birth

Male	73%
Female	27%
Another Sex	0%
Unknown/Declined to state	0%

n = 11

0% of individuals were veterans

n = 11
0% Unknown/Declined to state.

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KINSHIP CENTER, D'ARRIGO CHILDREN'S CLINIC

The Monterey Outpatient program offers Mental Health Services, Medication Support, and Case Management to eligible children, youth, and their families who require outpatient care. Additionally, Crisis services are provided in infrequent situations where a child/youth in a foster care home requires stabilization. These services aim to promote the mental health of children who have been negatively affected by loss and trauma resulting from poor family functioning, abuse, neglect, domestic violence, parental incarceration, and parental substance abuse.

Specializing in serving foster care, adoption care, and adoption preservation, the program utilizes their expertise in permanency, development, attachment, and trauma to support the well-being of the entire family. Children and youth who are at acute risk of disruption in home or school placement, or loss of community access to extra-curricular activities, receive a team-based approach. This approach includes a Child & Family Therapist and a Family Support Counselor. To encourage adoption preservation, the program integrates a parental course and additional mental health services.



- **102 clients served** in FY 22-23
- On average, clients engaged in services for **507 days**

Successes and Highlights

- Provided a range of evidence-based therapies, including trauma focused cognitive-behavioral therapy, play therapy, psychoeducation, and more, tailored to individuals' specific needs.
- Services made it easier for individuals to seek help without the need to seek higher levels of services such as hospitalization or residential care.
- Offered more individualized trainings for our mental health clinicians in order to serve the needs of our target populations.

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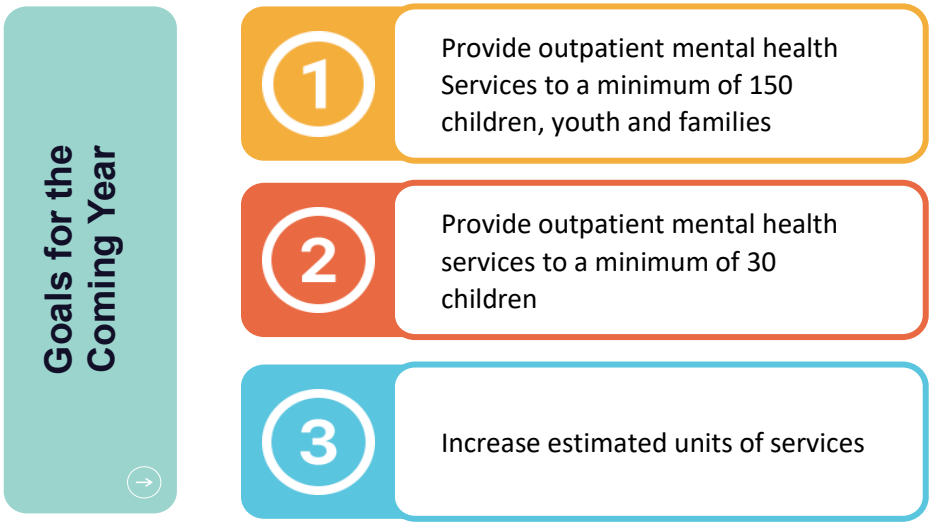
KINSHIP CENTER, D'ARRIGO CHILDREN'S CLINIC

Challenges & Growth Opportunities

CHALLENGES: Kinship Center, D'Arrigo Children's Clinic faced challenges this period.

- The mental health clinician shortage crisis affected our clinics due to insufficient staff.
- The constant demand to incorporate more clinical documents and screening tools, along with training requests and inconsistencies between counties, as well as the impact of CalMHSA, have negatively affected staff morale and retention.
- The short deadlines for completing new training or implementing changes, coupled with conflicting information from the state and county, have caused significant confusion, sometimes diverting attention from client care.
- It is important to acknowledge that this increased workload on our leaders can potentially lead to burnout.

ACTION PLAN: Kinship Center, D'Arrigo Children's Clinic tailored their goals for the coming year to address the challenges they've faced.



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KINSHIP CENTER, D'ARRIGO CHILDREN'S CLINIC

Housing

Housing Type Before Services (n=102)		Current Housing Type (n=96)
98%	Independent house or apartment	73%
0%	With friends/family	21%
0%	Shelter or temporary housing	0%
0%	Unhoused	0%
0%	Acute medical hospital	0%
0%	Acute psychiatric facility or hospital	0%
0%	Hospital	0%
0%	Assisted living facility	0%
0%	Residential treatment facility	0%
1%	Foster home	1%
0%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	0%
1%	Another housing status	0%
0%	Unknown/Declined to state*	6%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 6 missing "current housing type" statuses.

Employment and Education

Changes in Employment and Education

0% of clients
are currently employed or volunteering

compared to 0% before program engagement

88% of clients
are currently enrolled in or completed school

compared to 88% before program engagement

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KINSHIP CENTER, D'ARRIGO CHILDREN'S CLINIC

Emergency Events & Arrests

Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.

12 months prior to accessing services: No clients were arrested or experienced a physical or mental health emergency.

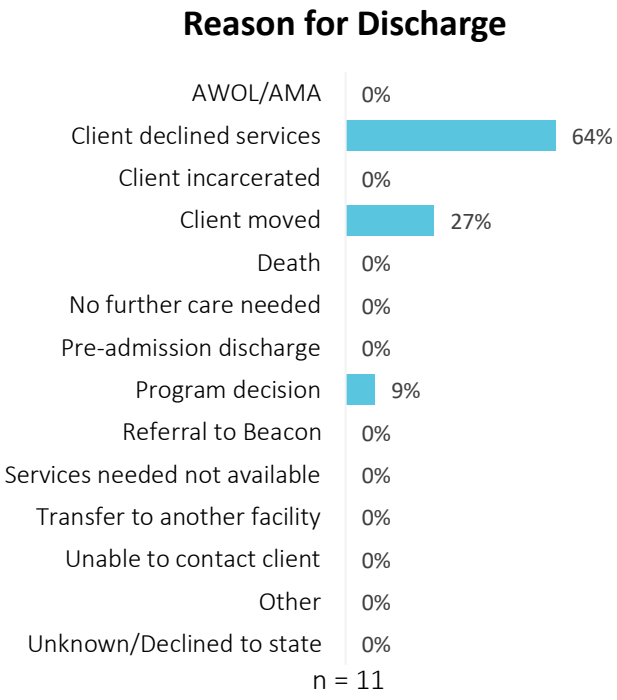
During FY 22-23 enrollment: 1% (n = 1) of clients were arrested. 3% (n = 3) of clients experienced a physical health emergency. 13% (n = 13) of clients experienced a mental health emergency.

Discharge Information

57 clients were **discharged**.



63% had **achieved some to all of their goals**.



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KINSHIP CENTER, D'ARRIGO CHILDREN'S CLINIC

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	15%
Black / African American	60%
Native Hawaiian / Other Pacific Islander	0%
White	10%
Another	16%
Unknown/Declined to state	0%

n = 102

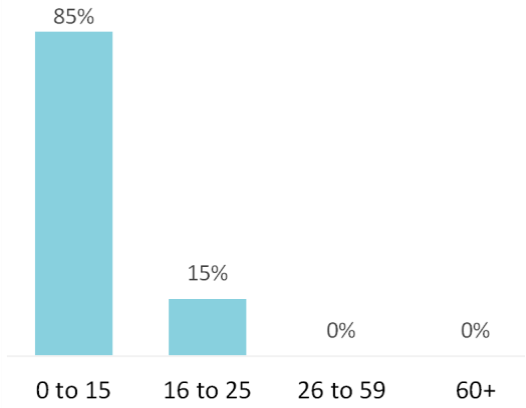
More than one race could be selected. Percentages may exceed 100%.

75% Hispanic/Latino
10% Not Hispanic/Latino

n = 102

16% Unknown/Declined to state.

Age



n = 102

0% of individuals did not answer this question.

Disability

Mental	0%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	100%
Unknown/Declined to state	0%

n = 102

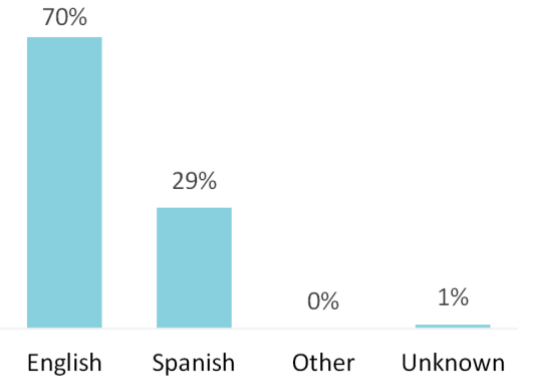
More than one disability could be selected. Percentages may exceed 100%.

0% of individuals reported having one or more disabilities

n = 102

0% Unknown/Declined to state.

Primary Language



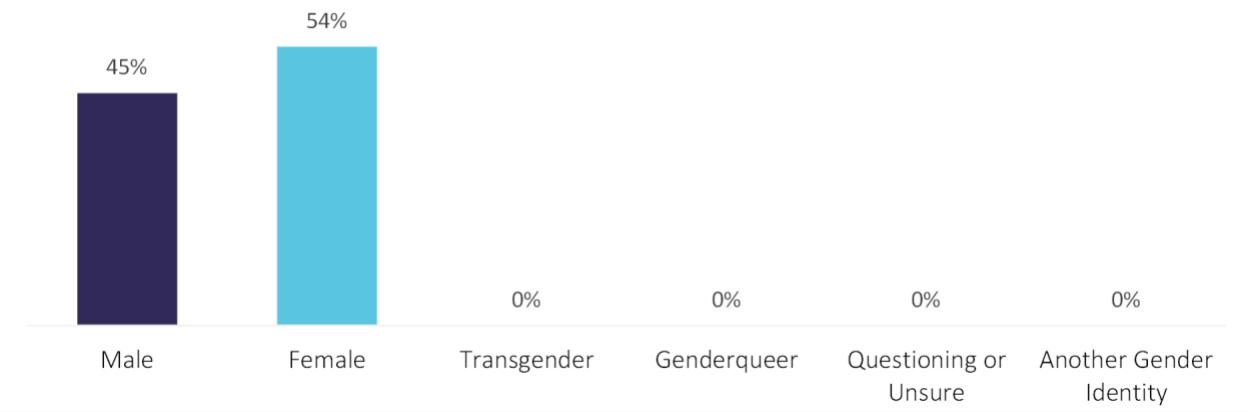
n = 102

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

KINSHIP CENTER, D'ARRIGO CHILDREN'S CLINIC

Demographic Data

Gender Identity



n = 102
1% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	6%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	1%
Unknown/Declined to state	93%

n = 102

Sex at Birth

Male	45%
Female	55%
Another Sex	0%
Unknown/Declined to state	0%

n = 102

0% of individuals were veterans

n = 102
0% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

SALINAS HOME PARTNERS FSP

- **13 clients served** in FY 22-23
- On average, clients engaged in services for **70 days**

Housing

Housing Type Before Services (n=13)		Current Housing Type (n=0)
85%	Independent house or apartment	0%
0%	With friends/family	0%
0%	Shelter or temporary housing	0%
0%	Unhoused	0%
0%	Acute medical hospital	0%
0%	Acute psychiatric facility or hospital	0%
0%	Hospital	0%
0%	Assisted living facility	0%
0%	Residential treatment facility	0%
15%	Foster home	0%
0%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	0%
0%	Another housing status	0%
0%	Unknown/Declined to state*	100%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 13 missing "current housing type" statuses.

Employment and Education

Changes in Employment and Education

0% of clients
are currently employed or volunteering

compared to 0% before program engagement

0% of clients
are currently enrolled in or completed school

compared to 69% before program engagement

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SALINAS HOME PARTNERS FSP

Emergency Events & Arrests

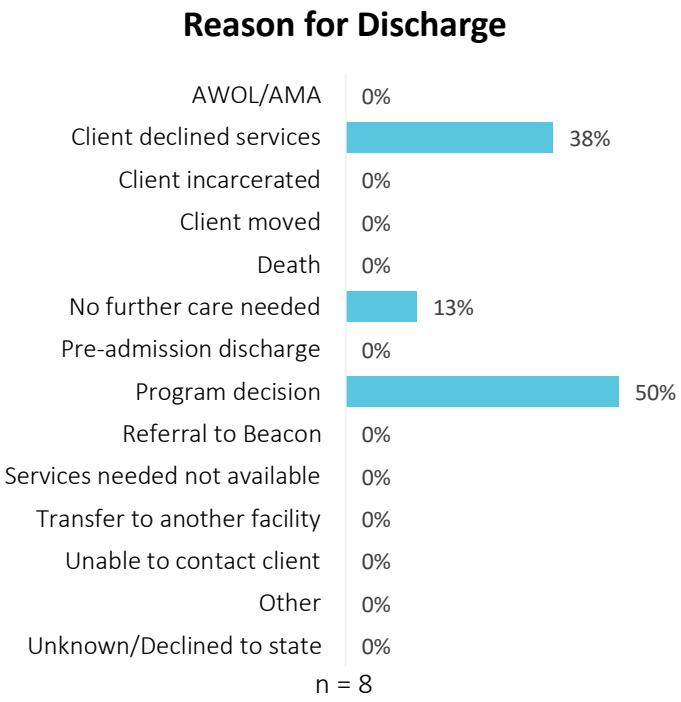
Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.

No clients were arrested or experienced physical or mental health emergencies during either time point.

Discharge Information

13 clients were **discharged**.

39% had **achieved some to all of their goals**.



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SALINAS HOME PARTNERS FSP

Demographic Data

Race

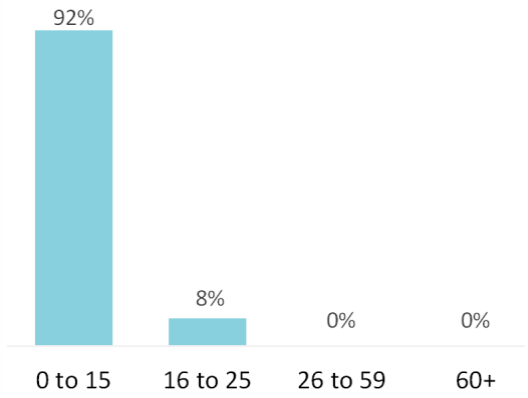
American Indian / Alaskan Native	0%
Asian	0%
Black / African American	31%
Native Hawaiian / Other Pacific Islander	0%
White	23%
Another	46%
Unknown/Declined to state	0%

n = 13
More than one race could be selected. Percentages may exceed 100%.

31% Hispanic/Latino
23% Not Hispanic/Latino

n = 13
46% selected Unknown/Declined to state.

Age



n = 13
0% of individuals did not answer this question.

Disability

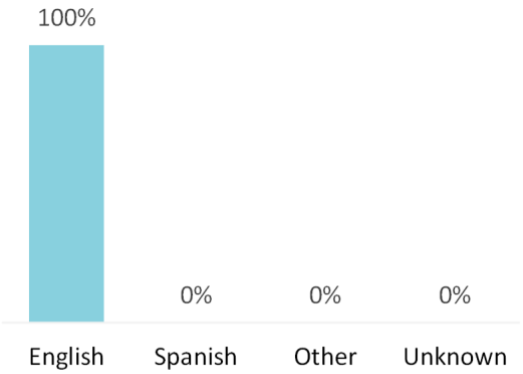
Mental	8%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	92%
Unknown/Declined to state	0%

n = 13
More than one disability could be selected. Percentages may exceed 100%.

8% of individuals reported having one or more disabilities

n = 13
0% selected Unknown/Declined to state.

Primary Language



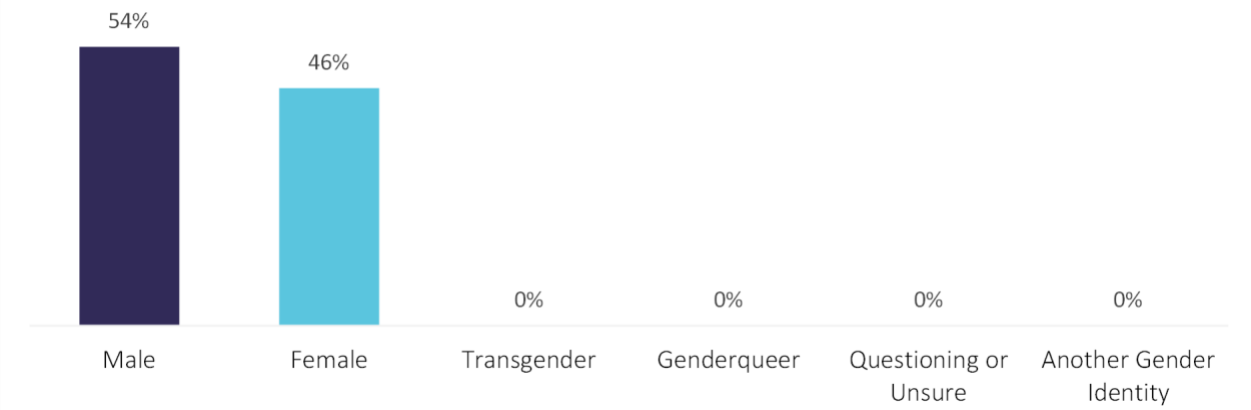
n = 13

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SALINAS HOME PARTNERS FSP

Demographic Data

Gender Identity



n = 13
0% selected Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	31%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	69%

n = 13

Sex at Birth

Male	54%
Female	46%
Another Sex	0%
Unknown/Declined to state	0%

n = 13

0% of individuals were veterans

n = 13
0% selected Unknown/Decline to state.

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CSS-02: DUAL DIAGNOSIS FSP

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INTEGRATED CO-OCCURRING DISORDER FSP

Integrated Co-Occurring Disorder FSP provides intensive mental health and substance use services on an outpatient basis. Therapy sessions are offered 2-3 times per week and encompass individual, collateral, and family therapy, along with case management, peer mentorship, and group sessions when available. Services are delivered both on-site and in the community.



- **54 clients served** in FY 22-23
- On average, clients engaged in services for **198 days**

Successes and Highlights

- Integrated group sessions to individual therapy, expanding on the ability to implement relationship building skills and opportunities to practice skills in the community and build peer support.
- Added occupational therapy on a trial basis in order to further meet the client's needs from a whole person approach.
- Continued increases in availability in South County, a community that often lacks access to mental health resources.

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INTEGRATED CO-OCCURRING DISORDER FSP

Challenges & Growth Opportunities

CHALLENGES: Integrated Co-Occurring Disorder FSP faced challenges this period.

- Transportation to services.
- Building trust with families and communities.
- Increasing client motivation and accountability.

ACTION PLAN: Integrated Co-Occurring Disorder FSP developed an action plan to address these challenges.

- Explored expansion of services and engagement methods, including incorporating art activities.
- Ensured clients have access to snacks and beverages.
- Provided flexibility in how services are offered.
- Accommodations and flexibility resulted in greater engagement and a sense of community for clients.



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INTEGRATED CO-OCCURRING DISORDER FSP

Housing

Housing Type Before Services (n=54)		Current Housing Type (n=61)
89%	Independent house or apartment	69%
0%	With friends/family	4%
0%	Shelter or temporary housing	2%
6%	Unhoused	2%
0%	Acute medical hospital	6%
0%	Acute psychiatric facility or hospital	13%
0%	Hospital	0%
0%	Assisted living facility	0%
2%	Residential treatment facility	2%
0%	Foster home	0%
0%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	17%
4%	Another housing status	0%
11%	Unknown/Declined to state*	0%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 7 missing "housing type before services" statuses.

Employment and Education

Changes in Employment and Education

9% of clients
are currently employed or volunteering

compared to 11% before program engagement

72% of clients
are currently enrolled in or completed school

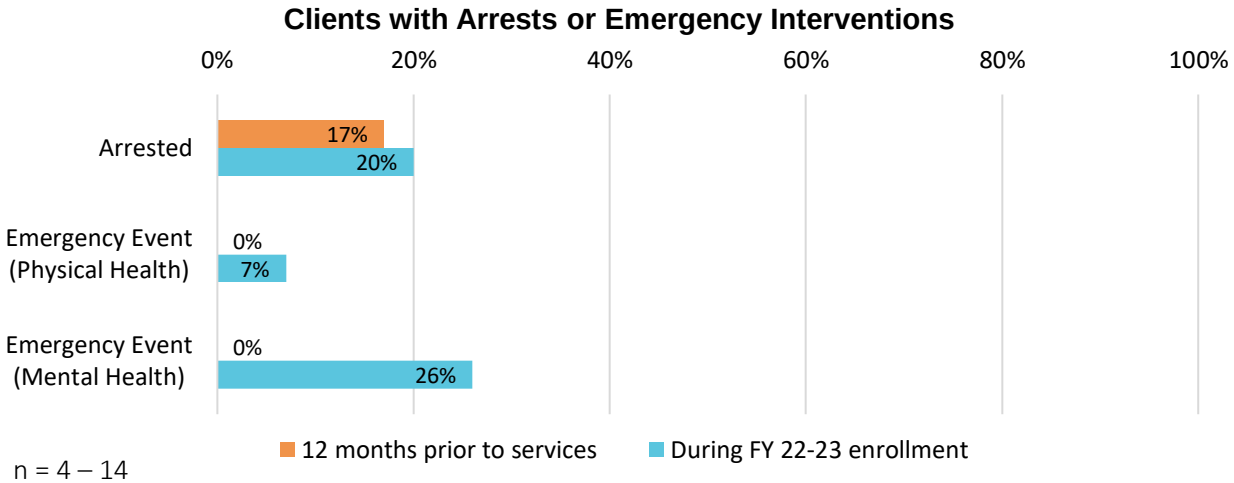
compared to 89% before program engagement

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INTEGRATED CO-OCCURRING DISORDER FSP

Emergency Events & Arrests

Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.



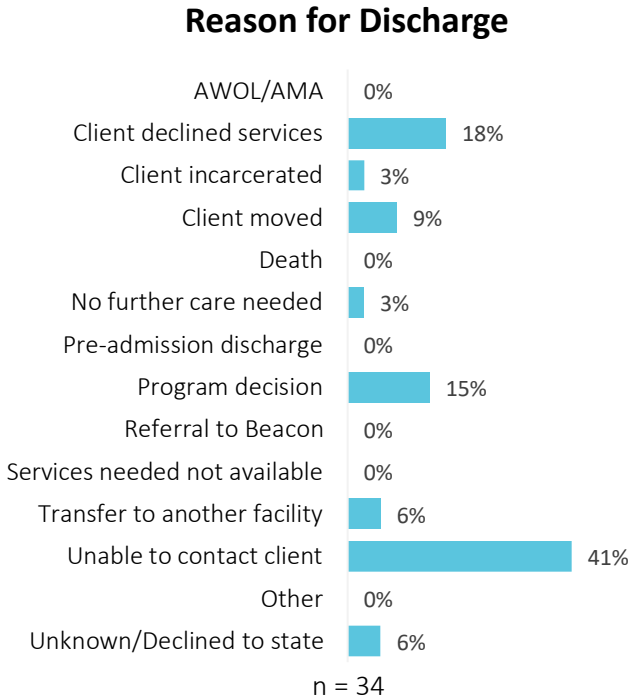
n = 4 – 14

0% for physical health and mental health emergency events in 12 months prior to services.

Discharge Information

49 clients were **discharged**.

31% had **achieved some to all of their goals**.



n = 34

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INTEGRATED CO-OCCURRING DISORDER FSP

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	6%
Black / African American	70%
Native Hawaiian / Other Pacific Islander	0%
White	13%
Another	11%
Unknown/Declined to state	0%

n = 54

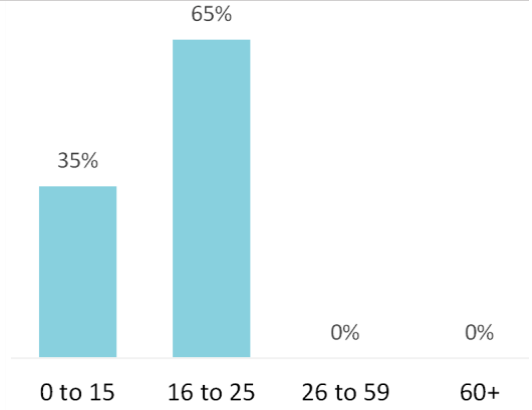
More than one race could be selected. Percentages may exceed 100%.

76% Hispanic/Latino
13% Not Hispanic/Latino

n = 54

11% Unknown/Declined to state.

Age



n = 54

0% of individuals did not answer this question.

Disability

Mental	19%
Visual	2%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	2%
Another Disability	0%
No Disability	78%
Unknown/Declined to state	0%

n = 54

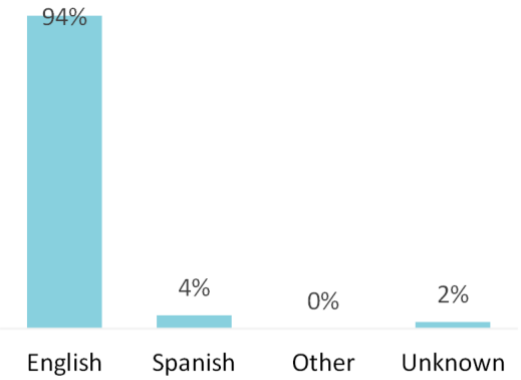
More than one disability could be selected. Percentages may exceed 100%.

22% of individuals reported having one or more disabilities

n = 54

0% Unknown/Declined to state.

Primary Language



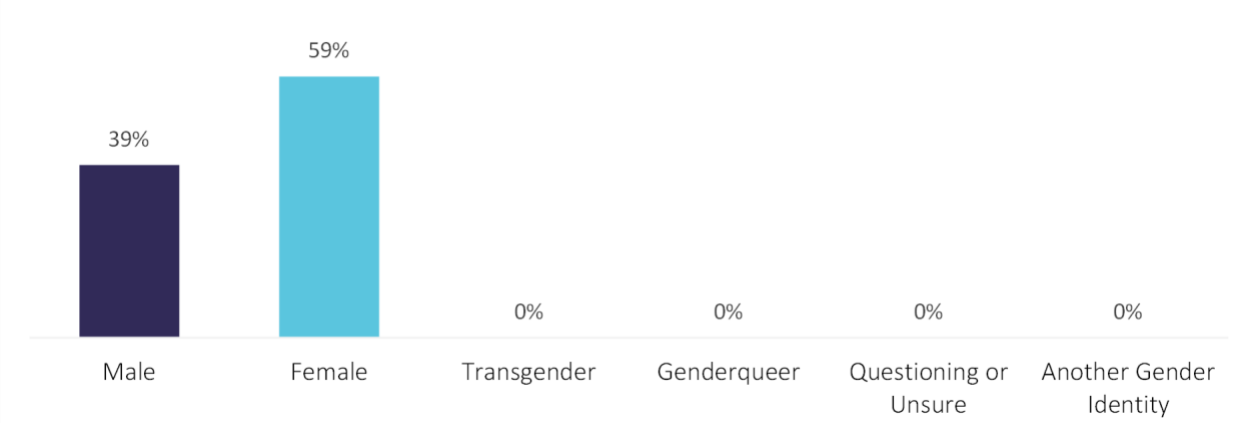
n = 54

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INTEGRATED CO-OCCURRING DISORDER FSP

Demographic Data

Gender Identity



n = 54
2% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	20%
Gay or Lesbian	2%
Bisexual	7%
Questioning or Unsure	0%
Another Sexual Orientation	2%
Unknown/Declined to state	69%

n = 54

Sex at Birth

Male	39%
Female	61%
Another Sex	0%
Unknown/Declined to state	0%

n = 54

0% of individuals were veterans

n = 54
0% Unknown/Declined to state.

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SANTA LUCIA SHORT-TERM RESIDENTIAL TREATMENT PROGRAM

Santa Lucia Short-term Residential Treatment Program (STRTP) is a 6-bed residential program for adolescent females ages 13 to 17 addressing mental health and substance use disorders. The program provides individual, group, and collateral therapeutic services to clients and works with families toward reunification and/or transitioning to adulthood.



- **12 clients served** in FY 22-23
- On average, clients engaged in services for **209 days**

Successes and Highlights

- Several graduations, resulting in clients either reunifying with family or transitioning to adulthood and independence.
- Working with clients to identify goals, develop, and implement strategies.
- Providing support to clients allowed clients to focus on their goals and make progress in meeting them.

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SANTA LUCIA SHORT-TERM RESIDENTIAL TREATMENT PROGRAM

Challenges & Growth Opportunities

CHALLENGES: Santa Lucia STRTP faced challenges this period.

- Difficulty retaining enough staff, leading to lowered client census due to inability to maintain ratio beyond 3 residents.
- Difficulties faced in hiring and training staff:
  - Not finding qualified staff.
  - Salary-related issues.
  - Lack of applicants.

ACTION PLAN: Santa Lucia STRTP tailored their goals for the coming year to address the challenges they've faced.



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SANTA LUCIA SHORT-TERM RESIDENTIAL TREATMENT PROGRAM

Housing

Housing Type Before Services (n=12)		Current Housing Type (n=0)
8%	Independent house or apartment	0%
0%	With friends/family	0%
0%	Shelter or temporary housing	0%
0%	Unhoused	0%
0%	Acute medical hospital	0%
0%	Acute psychiatric facility or hospital	0%
0%	Hospital	0%
0%	Assisted living facility	0%
25%	Residential treatment facility	0%
0%	Foster home	0%
58%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	0%
8%	Another housing status	0%
0%	Unknown/Declined to state	100%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 12 missing "current housing type" statuses.

Employment and Education

Changes in Employment and Education

0% of clients
are currently employed or volunteering

compared to 0% before program engagement

0% of clients
are currently enrolled in or completed school

compared to 92% before program engagement

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

SANTA LUCIA SHORT-TERM RESIDENTIAL TREATMENT PROGRAM

Emergency Events & Arrests

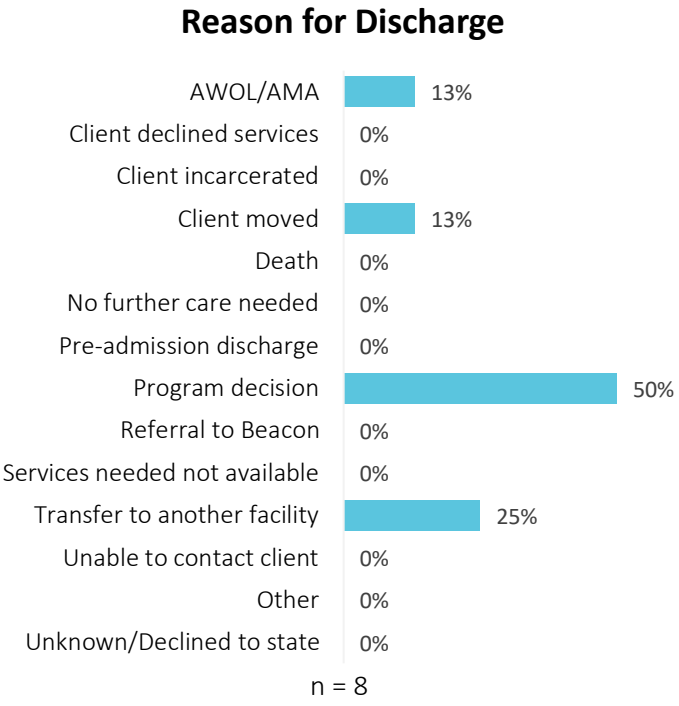
Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.

No clients were arrested or experienced physical or mental health emergencies during either time point.

Discharge Information

10 clients were **discharged**.

20% had **achieved some to all of their goals**.



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SANTA LUCIA SHORT-TERM RESIDENTIAL TREATMENT PROGRAM

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	25%
Black / African American	42%
Native Hawaiian / Other Pacific Islander	0%
White	17%
Another	17%
Unknown/Declined to state	0%

n = 12

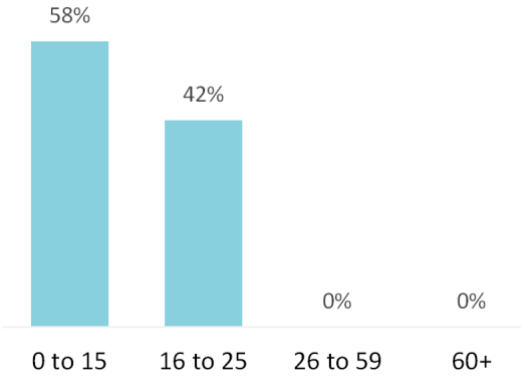
More than one race could be selected. Percentages may exceed 100%.

67% Hispanic/Latino
17% Not Hispanic/Latino

n = 12

17% Unknown/Declined to state.

Age



n = 12

0% of individuals did not answer this question.

Disability

Mental	8%
Visual	0%
Hearing	0%
Speech	8%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	83%
Unknown/Declined to state	0%

n = 12

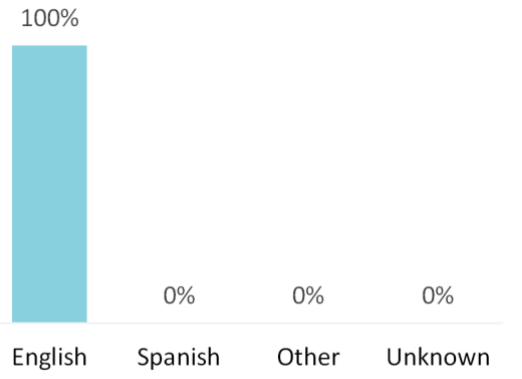
More than one disability could be selected. Percentages may exceed 100%.

17% of individuals reported having one or more disabilities

n = 12

0% Unknown/Declined to state.

Primary Language



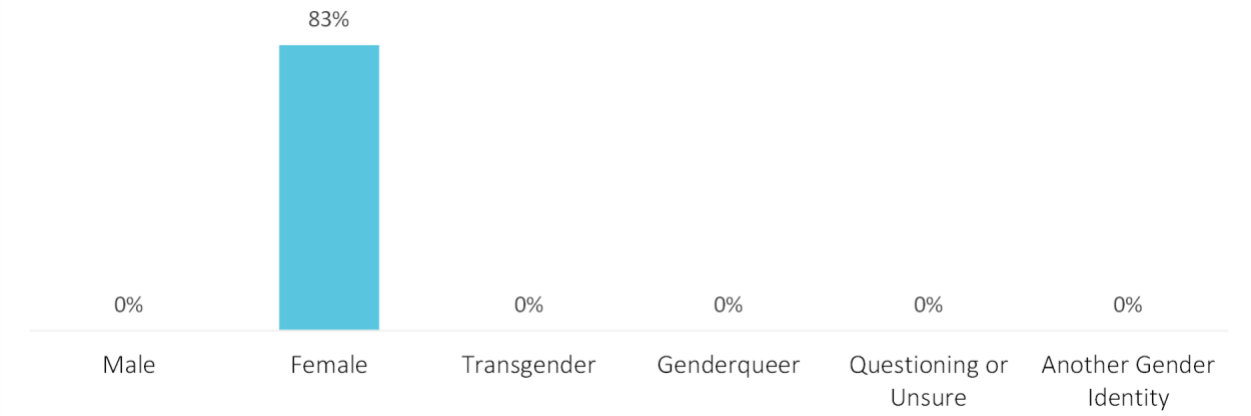
n = 12

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SANTA LUCIA SHORT-TERM RESIDENTIAL TREATMENT PROGRAM

Demographic Data

Gender Identity



n = 12

17% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	17%
Gay or Lesbian	0%
Bisexual	8%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	75%

n = 12

Sex at Birth

Male	0%
Female	100%
Another Sex	0%
Unknown/Declined to state	0%

n = 12

0% of individuals were veterans

n = 12

0% Unknown/Declined to state.

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CSS-04: TRANSITION AGE YOUTH FSP

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MHSA TIP AVANZA FSP

The Avanza program empowers youth and young adults aged 16 to 25 with mental health disorders through comprehensive case management, therapy, groups, and positive social interactions. It helps remove mental health-related barriers and supports youth in pursuing their goals in employment, education, independent living skills, and personal functioning. The program connects Transition Age Youth (TAY) with community resources, job opportunities, and education.

Psychoeducation and support are also extended to family members, recognizing their crucial role in a young adult's support system and success. Collaborative partners include TAY, family members, community-based youth organizations, juvenile probation, education, and social services.

Successes and Highlights

- Provided services to 204 clients throughout Monterey County.
- Introduction of a Peer Partner to assist with outreach, engagement, housing, employment, and life skills support.
- Integration and participation with the Early Psychosis Intervention- California (EPI-CAL TTA).

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

MHSA TIP AVANZA FSP

Challenges & Growth Opportunities

CHALLENGES: The Avanza program faced challenges this period.

- Staff shortages and high turnover in 2022-23.
- Clinician overwhelm due to high caseloads in 2022-23.
- Experienced an uptick in Post-Hospital referrals from both the Children's and Adult Post Hospital teams in 2022-23, necessitating staff education on addressing acute psychiatric emergencies and focusing on psychiatric stabilization.

ACTION PLAN: The Avanza program developed an action plan to address these challenges.

- To overcome staff shortages and high turnover a new manager was hired to the team and successfully filled most positions, including PSW/Clinician and SWIII positions.
- Addressed clinician overwhelm due to high caseloads by assigning support staff to every clinician, reducing the burden, and implementing a treatment team model.
- Provided training for staff on the CSSR-S and Stanley Brown to enhance client safety planning.
- Adapted creatively to tackle challenges and evolving client/community needs in 2022-23, maximizing available resources and fostering collaboration with partner programs/agencies to address needs as a team.



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CSS-05: ADULTS WITH SMI FSP

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ASSERTIVE COMMUNITY TREATMENT WELCOMING & ENGAGING TEAM

The Assertive Community Treatment (ACT) program, known as a Full-Service Partnership (FSP), is designed to serve 50 adults annually who have serious mental illnesses and/or serious functioning impairments and meet the ACT/FSP level of care.

The program aims to provide community-based mental health services and medication support to underserved individuals who face barriers in accessing or effectively utilizing clinic-based treatment for their mental health needs. In cases where Interim is unable to provide psychiatric services due to staff vacancies, Monterey County Behavioral Health (MCBH) steps in. Priority admission is given to Latino/a consumers who are housed or homeless and residing in Salinas Valley and South Monterey County.

ACT offers a range of services tailored to support consumers in their mental health recovery journey and help them develop the necessary skills to lead independent or interdependent, healthy, and meaningful lives in the community. The program focuses on increasing natural support systems by engaging, offering support, and providing psychoeducation to consumers and their family members.

Additionally, ACT assists consumers in finding and maintaining employment, reducing mental health symptoms, and addressing substance use issues to minimize the need for involuntary care and emergency room visits related to mental health and non-acute physical health problems. Services are provided in the community, available in both English and Spanish for consumers and their families.



- **59 clients served** in FY 22-23
- On average, clients engaged in services for **1,047 days**

Successes and Highlights

- 90% of consumers served by ACT were not hospitalized throughout the fiscal year.
- 88% of consumers served by ACT were not incarcerated throughout the fiscal year.
- ACT was able to provide and increase additional transportation resources to help our consumers be more independent (i.e. gas cards, taxi vouchers, MST passes, MST monthly passes).

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ASSERTIVE COMMUNITY TREATMENT WELCOMING & ENGAGING TEAM

Challenges & Growth Opportunities

CHALLENGES: ACT faced challenges this period.

- ACT has faced staffing challenges affecting program billing goals and consumer services.
- Unusual natural events, such as flooding and heat waves, limited in-person meetings with customers.
- Consumer incarcerations increased from 8% to 12% compared to the previous fiscal year.
- There was an increase in hospitalizations compared to previous years.

ACTION PLAN: ACT tailored their goals for the coming year to address the challenges they've faced.



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ASSERTIVE COMMUNITY TREATMENT WELCOMING & ENGAGING TEAM

Housing

Housing Type Before Services (n=59)		Current Housing Type (n=59)
76%	Independent house or apartment	64%
0%	Living with friends/family	7%
0%	Shelter or temporary housing	3%
8%	Unhoused	7%
0%	Acute medical hospital	17%
0%	Acute psychiatric facility or hospital	29%
0%	Hospital	0%
2%	Assisted living facility	5%
7%	Residential treatment facility	20%
2%	Foster home	0%
0%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	17%
5%	Another housing status	5%
0%	Unknown/Declined to state	0%

Clients may have more than one housing type. Percentages may exceed 100%.

Employment and Education

Changes in Employment and Education

5% of clients
are currently employed or volunteering

compared to 8% before program engagement

54% of clients
are currently enrolled in or completed school

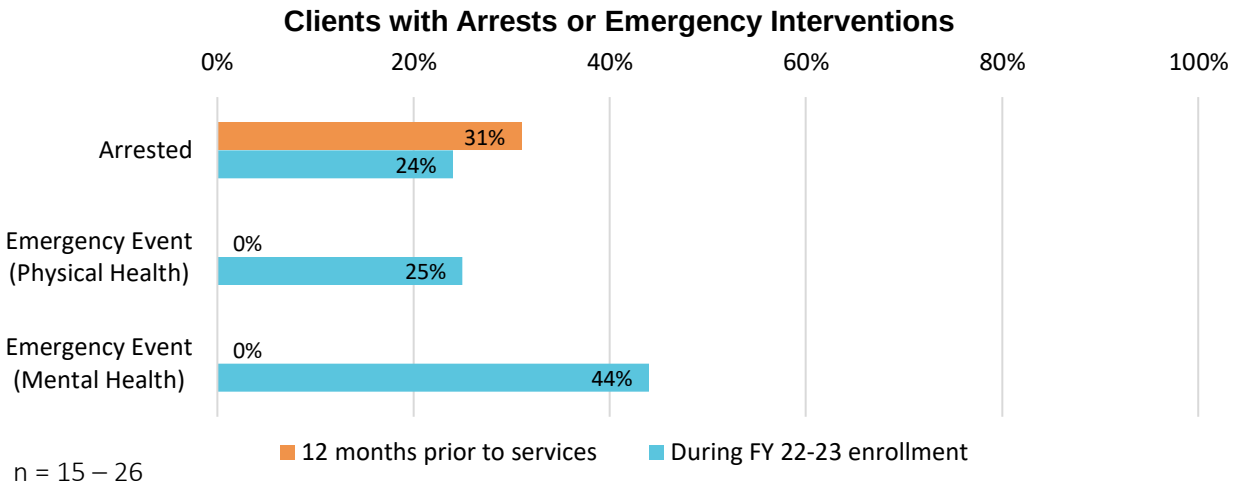
compared to 88% before program engagement

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ASSERTIVE COMMUNITY TREATMENT WELCOMING & ENGAGING TEAM

Emergency Events & Arrests

Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.



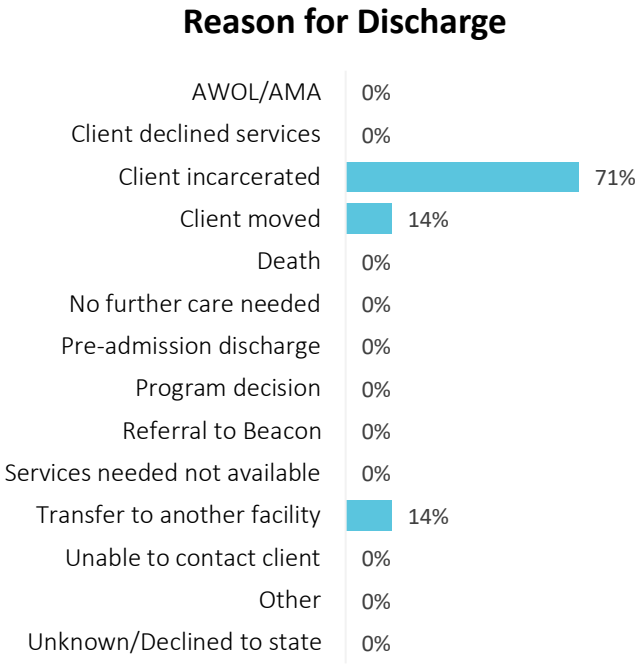
n = 15 – 26

0% for physical health and mental health emergency events in 12 months prior to services.

Discharge Information

22 clients were **discharged**.

55% had **achieved some to all of their goals**.



n = 7

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ASSERTIVE COMMUNITY TREATMENT WELCOMING & ENGAGING TEAM

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	24%
Black / African American	75%
Native Hawaiian / Other Pacific Islander	0%
White	0%
Another	2%
Unknown/Declined to state	0%

n = 59

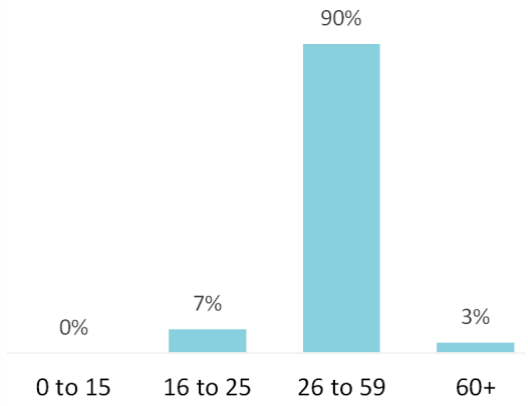
More than one race could be selected. Percentages may exceed 100%.

98% Hispanic/Latino
2% Not Hispanic/Latino

n = 59

0% Unknown/Declined to state.

Age



n = 59

Disability

Mental	76%
Visual	2%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	22%
Unknown/Declined to state	0%

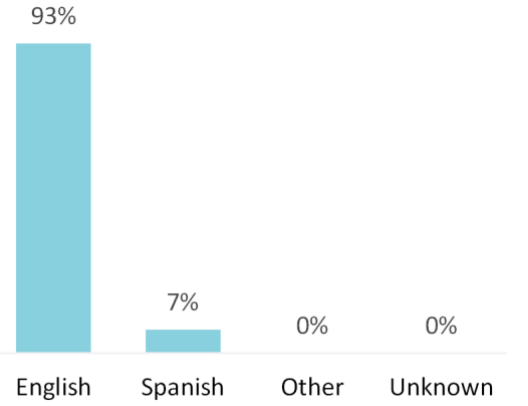
n = 59

More than one disability could be selected. Percentages may exceed 100%.

78% of individuals reported having one or more disabilities

n = 59

Primary Language



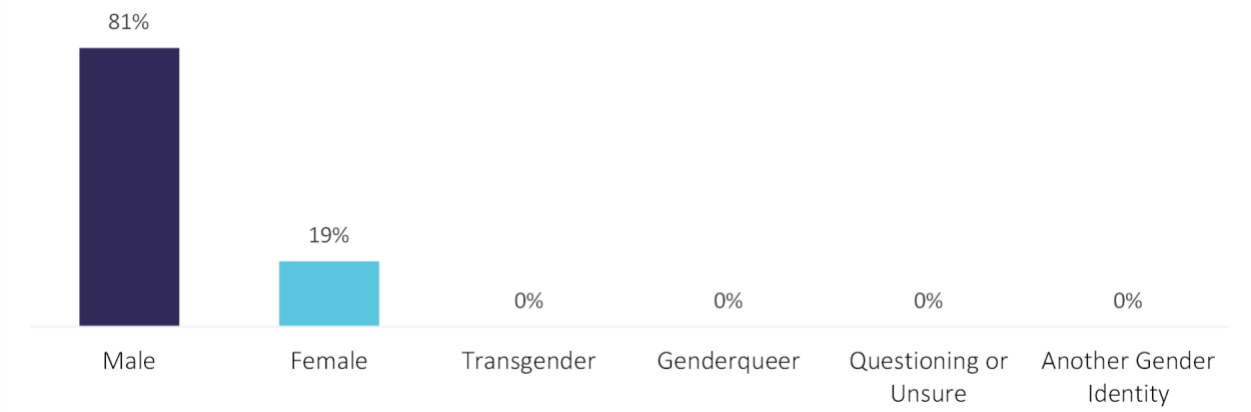
n = 59

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ASSERTIVE COMMUNITY TREATMENT WELCOMING & ENGAGING TEAMS

Demographic Data

Gender Identity



n = 59
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	39%
Gay or Lesbian	2%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	0%

n = 59

Sex at Birth

Male	81%
Female	19%
Another Sex	0%
Unknown/Declined to state	0%

n = 59

2% of individuals were veterans

n = 59
0% Unknown/Declined to state.

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CSS-06: OLDER ADULTS FSP

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OLDER ADULT FSP

- **7 clients served** in FY 22-23
- On average, clients engaged in services for **672 days**

Housing

Housing Type Before Services (n=7)		Current Housing Type (n=6)
57%	Independent house or apartment	14%
0%	With friends/family	14%
0%	Shelter or temporary housing	14%
29%	Unhoused	14%
0%	Acute medical hospital	0%
0%	Acute psychiatric facility or hospital	0%
0%	Hospital	0%
0%	Assisted living facility	0%
0%	Residential treatment facility	14%
0%	Foster home	0%
0%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	0%
0%	Another housing status	0%
14%	Unknown/Declined to state	29%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 1 missing "current housing type" status and 1 unknown/decline to state "current housing type" status from Avatar.

Employment and Education

Changes in Employment and Education

0% of clients
are currently employed or volunteering

compared to 0% before program engagement

71% of clients
are currently enrolled in or completed school

compared to 71% before program engagement

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

OLDER ADULT FSP

Emergency Events & Arrests

Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.

12 months prior to accessing services: 29% clients were arrested. No clients experienced a physical or mental health emergency.

During FY 22-23 enrollment: 1% of clients experienced a physical health emergency. No clients were arrested or experienced a mental health emergency.

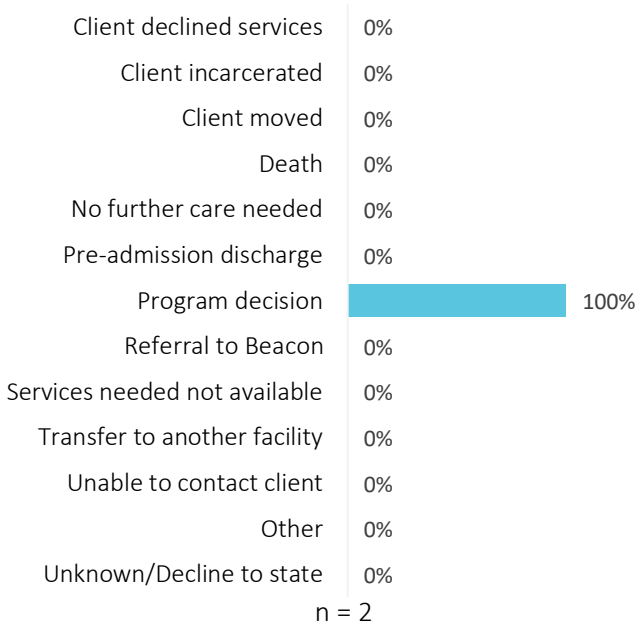
Discharge Information

3 clients were **discharged**.



0% had **achieved some to all of their goals**.

Reason for Discharge



Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

OLDER ADULT FSP

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	0%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	0%
White	86%
Another	14%
Unknown/Declined to state	0%

n = 7

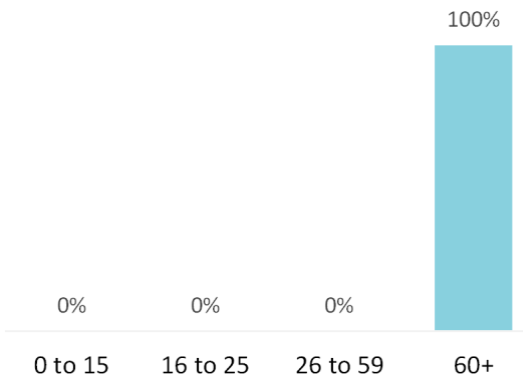
More than one race could be selected. Percentages may exceed 100%.

0% Hispanic/Latino
86% Not Hispanic/Latino

n = 7

14% Unknown/Decline to state.

Age



n = 7

0% of individuals did not answer this question.

Disability

Mental	43%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	14%
No Disability	43%
Unknown/Declined to state	0%

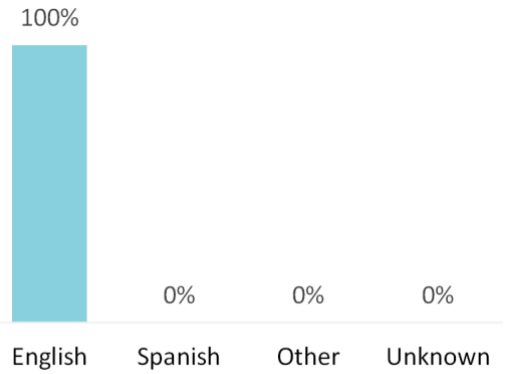
n = 7

More than one disability could be selected. Percentages may exceed 100%.

0% of individuals reported having one or more disabilities

n = 7

Primary Language



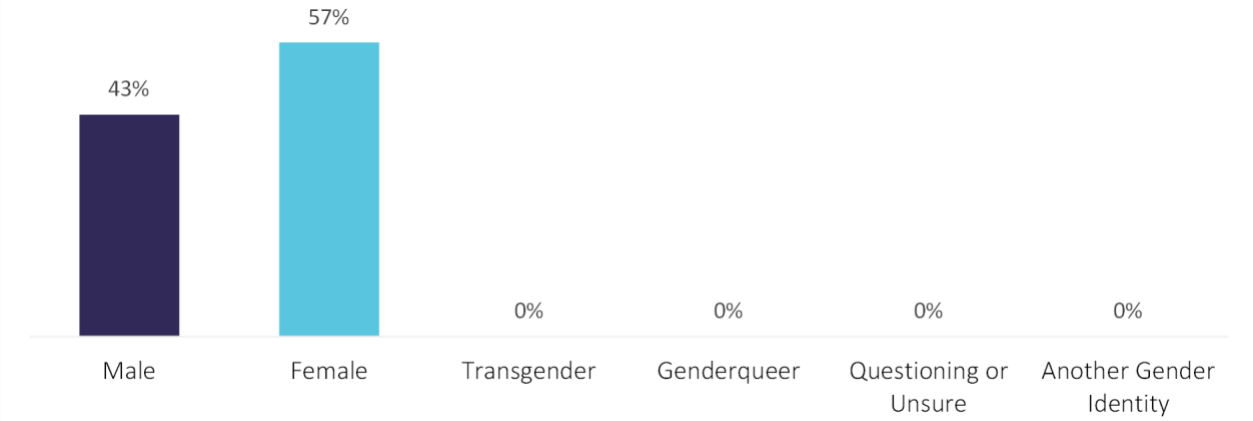
n = 7

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

OLDER ADULT FSP

Demographic Data

Gender Identity



n = 7

0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	0%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	100%

n = 7

Sex at Birth

Male	43%
Female	57%
Another Sex	0%
Unknown/Declined to state	0%

n = 7

0% of individuals were veterans

n = 7

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

DRAKE HOUSE FSP

Drake House provides residential care and mental health support services for 55 residents across several counties. Mental Health support services include individual and group sessions geared toward helping residents achieve their goals across many domains. This may include, but is not limited to, life skills, behavior management, symptom management, financial management, and independent living skills.



- **52 clients served** in FY 22-23
- On average, clients engaged in services for **2,802 days**

Successes and Highlights

- Perfect Community Care Licensing (CCL) annual report.
- Lower usage of inpatient psychiatric services.
- Increased use of technology to keep residents connected to family members.

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DRAKE HOUSE FSP

Challenges & Growth Opportunities

CHALLENGES: Drake House faced challenges this period.

- Overcoming staffing challenges while ensuring continuity of care and ongoing infection prevention.
- Entry-level positions with higher turnover.

ACTION PLAN: Drake House developed an action plan to address these challenges.

- Strategizing to maintain a qualified and passionate staff who can consistently deliver excellence.
- Streamlining infection prevention activities and integrating them into everyday staff tasks.



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DRAKE HOUSE FSP

Housing

Housing Type Before Services (n=52)		Current Housing Type (n=29)
2%	Independent house or apartment	0%
0%	With friends/family	0%
0%	Shelter or temporary housing	0%
0%	Unhoused	0%
0%	Acute medical hospital	0%
0%	Acute psychiatric facility or hospital	4%
0%	Hospital	0%
4%	Assisted living facility	29%
37%	Residential treatment facility	19%
0%	Foster home	0%
0%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	0%
58%	Another housing status	0%
0%	Unknown/Declined to state*	42%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 23 missing "current housing type" statuses and 2 unknown/decline to state "current housing type" statuses from Avatar.

Employment and Education

Changes in Employment and Education

0% of clients
are currently employed or volunteering

compared to 0% before program engagement

37% of clients
are currently enrolled in or completed school

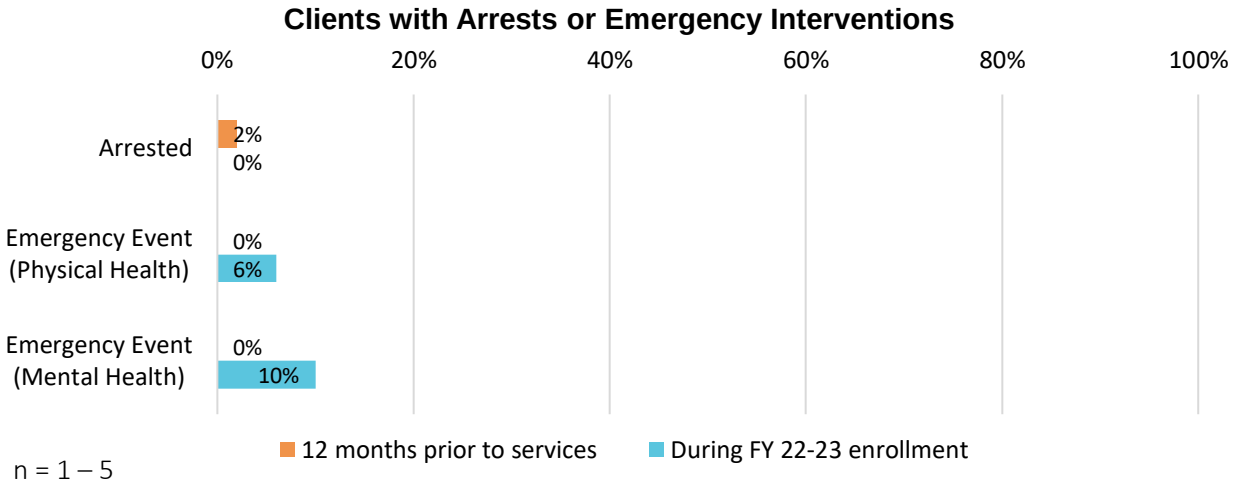
compared to 88% before program engagement

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

DRAKE HOUSE FSP

Emergency Events & Arrests

Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.



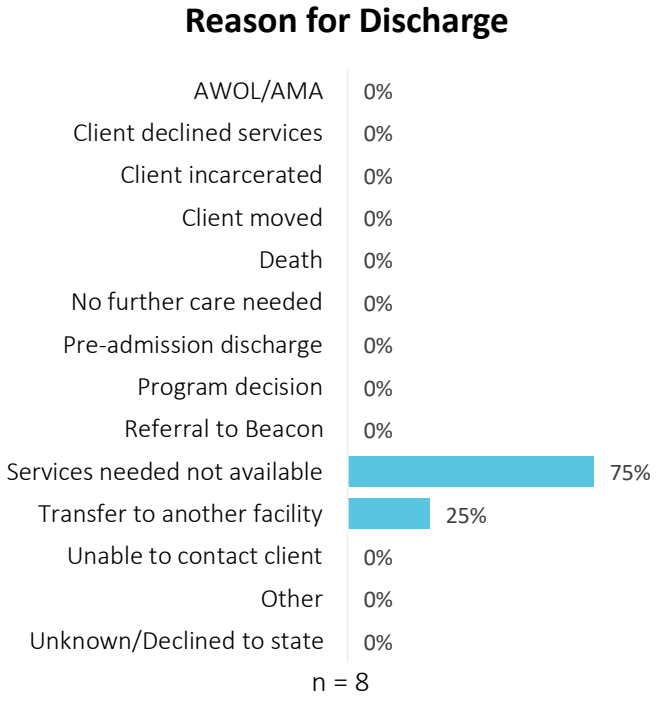
n = 1 – 5

0% arrested during FY 22-23 enrollment and 0% physical health and mental health emergency events in 12 months prior to services.

Discharge Information

8 clients were **discharged**.

0% had **achieved some to all of their goals**.



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DRAKE HOUSE FSP

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	0%
Black / African American	12%
Native Hawaiian / Other Pacific Islander	0%
White	77%
Another	12%
Unknown/Declined to state	0%

n = 52

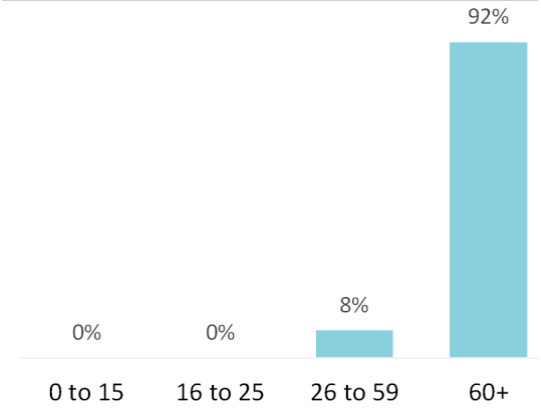
More than one race could be selected. Percentages may exceed 100%.

12% Hispanic/Latino
77% Not Hispanic/Latino

n = 52

12% Unknown/Declined to state.

Age



n = 52

0% of individuals did not answer this question.

Disability

Mental	81%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	2%
No Disability	17%
Unknown/Declined to state	0%

n = 52

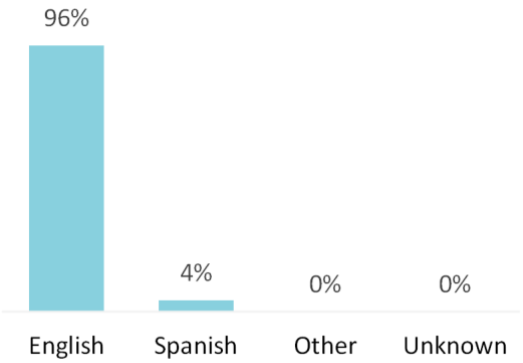
More than one disability could be selected. Percentages may exceed 100%.

83% of individuals reported having one or more disabilities

n = 52

0% Unknown/Declined to state.

Primary Language



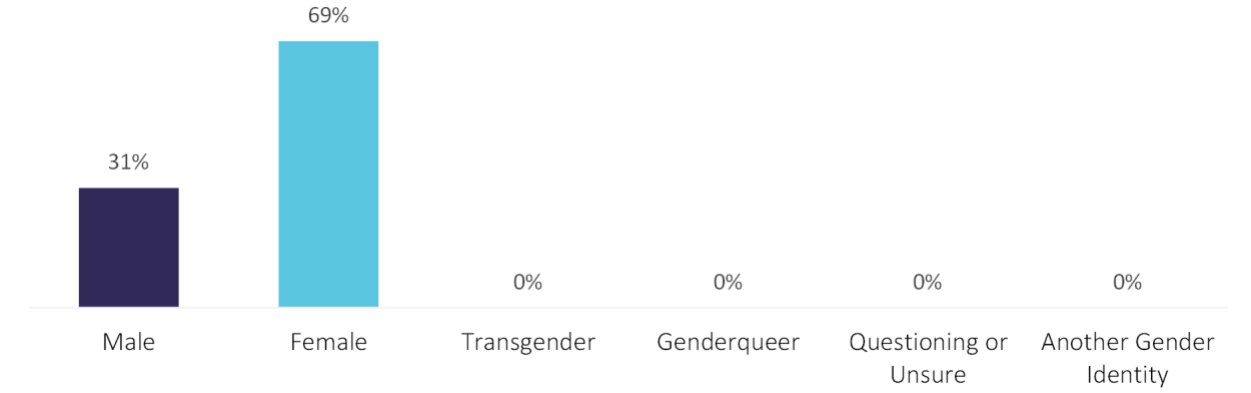
n = 52

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DRAKE HOUSE FSP

Demographic Data

Gender Identity



n = 52
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	12%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	88%

n = 52

Sex at Birth

Male	31%
Female	69%
Another Sex	0%
Unknown/Declined to state	0%

n = 52

4% of individuals were veterans

n = 52
35% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

CSS-07: ACCESS REGIONAL SERVICES

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ACCESS MEDICATION SUPPORT

Medication Support Services is a multidisciplinary program supervised by a licensed California Board of Behavioral Sciences supervisor in collaboration with a medical consultant. It offers medication and medical support services to consumers in various programs: Manzanita Crisis Residential, ACT, Homeless Services, Choices Day Treatment Intensive, and Supported FSP Housing (Sunflower Gardens only).

The program's team includes Interim, Inc. employed or contracted professionals, such as Psychiatrists (MD), Psychiatric Mental Health Nurse Practitioners (PMHNP-BC), Registered Nurses (RN), and Licensed Vocational Nurses (LVN). RN/LVN staff members are integrated into program staffing and supervised by an RN Nurse Administrator in collaboration with the Program Directors.

Medication Support Services actively encourages consumers to play an active role in making informed decisions about their mental health care and medication treatment options.



- **43 clients served** in FY 22-23
- On average, clients engaged in services for **281 days**

Successes and Highlights

- Increased longer-term retention of psychiatric providers, with up to two-year retention rates.
- Established long-term relationships with contracted Psychiatrists, incorporating a new Psychiatric Medical consultant.
- Provided In Service training available to all programs' staff in the areas of psychotropic medication and psychiatric symptomatology from social rehabilitation and medical perspectives.

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ACCESS MEDICATION SUPPORT

Challenges & Growth Opportunities

CHALLENGES: Access Medication Support faced challenges this period.

- Difficulty with RN/LVN recruitment: Local hospitals and some other agencies are offering higher salaries. However, increasing RN and possibly LVN salaries is not possible for Interim Inc. due to the salary schedule being set based on the CalAIM payment reform reimbursement method, which pays less for services performed by LVNs and RNs then the cost of these positions.
- Increase in consumers' physical/medical conditions, symptom and behavioral acuity, violence, and other types of behavioral incidents requiring additional staff attention, especially during psychiatric and medical injection appointments.
- Increase of consumer deaths due to self-injury, violence, and chronic medical conditions. Consumer deaths caused significant grief and stress for Psychiatric Services staff.

ACTION PLAN: Access Medication Support tailored their goals for the coming year to address the challenges they've faced.



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ACCESS MEDICATION SUPPORT

Housing, Employment, and Education

Housing Type at Intake (n=43)	
95%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
5%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
0%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
0%	Another housing status
0%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

23% of clients
were employed or volunteering at intake

(n = 10)

74% of clients
were enrolled in or completed school at intake

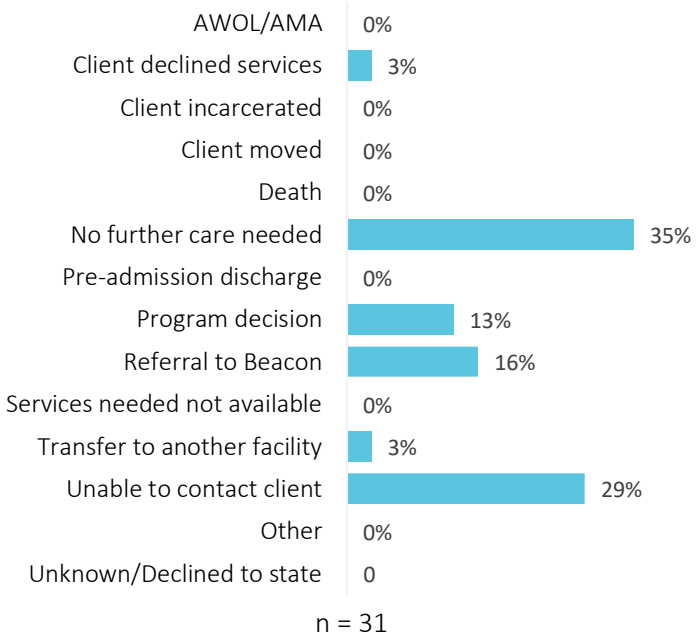
(n = 32)

Discharge Information

35 clients were **discharged**.

11% had **achieved some to all of their goals**.

Reason for Discharge



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ACCESS MEDICATION SUPPORT

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	7%
Black / African American	33%
Native Hawaiian / Other Pacific Islander	0%
White	28%
Another	33%
Unknown/Declined to state	0%

n = 43

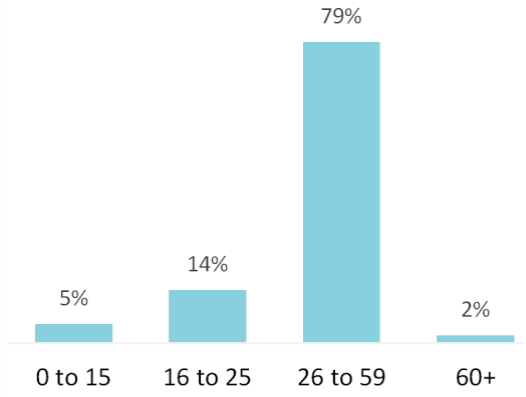
More than one race could be selected. Percentages may exceed 100%.

40% Hispanic/Latino
28% Not Hispanic/Latino

n = 43

33% Unknown/Declined to state.

Age



n = 43

0% of individuals did not answer this question.

Disability

Mental	63%
Visual	0%
Hearing	0%
Speech	0%
Mobility	2%
Developmental	0%
Another Disability	0%
No Disability	35%
Unknown/Declined to state	0%

n = 43

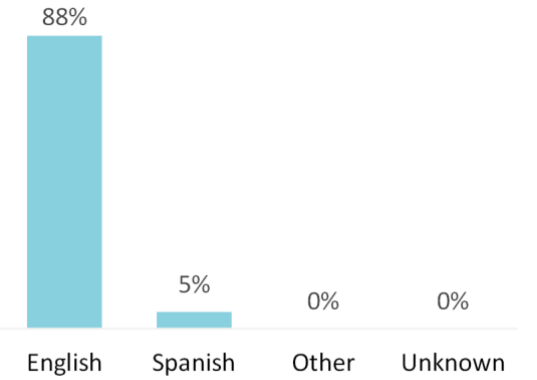
More than one disability could be selected. Percentages may exceed 100%.

65% of individuals reported having one or more disabilities

n = 43

0% Unknown/Declined to state.

Primary Language



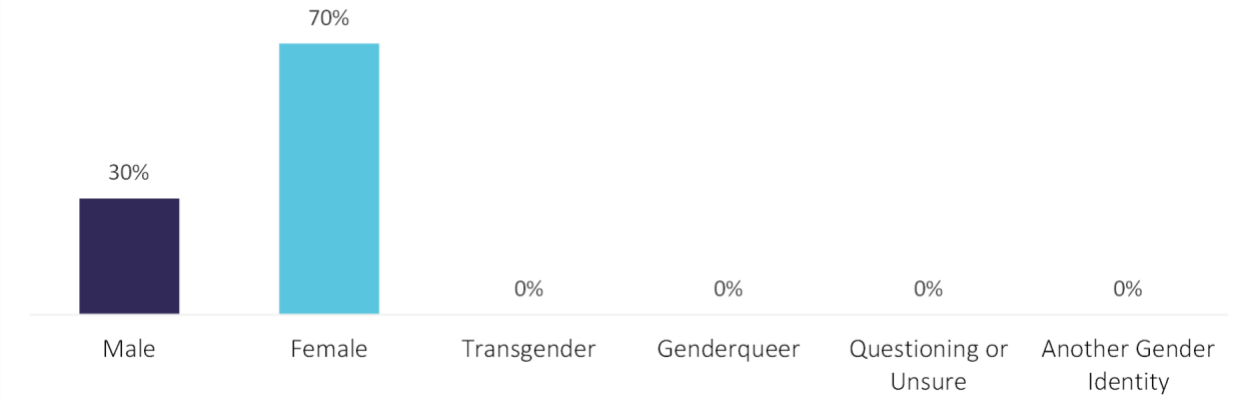
n = 43

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS MEDICATION SUPPORT

Demographic Data

Gender Identity



n = 43
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	28%
Gay or Lesbian	2%
Bisexual	5%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	65%

n = 43

Sex at Birth

Male	30%
Female	70%
Another Sex	0%
Unknown/Declined to state	0%

n = 43

2% of individuals were veterans

n = 43
5% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

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.



- **577 clients served** in FY 22-23
- On average, clients engaged in services for **246 days**

Housing, Employment, and Education

Housing Type at Intake (n=577)	
83%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
8%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
1%	Residential treatment facility
<1%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
4%	Another housing status
4%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

13% of clients
were employed or volunteering at intake

(n = 77)

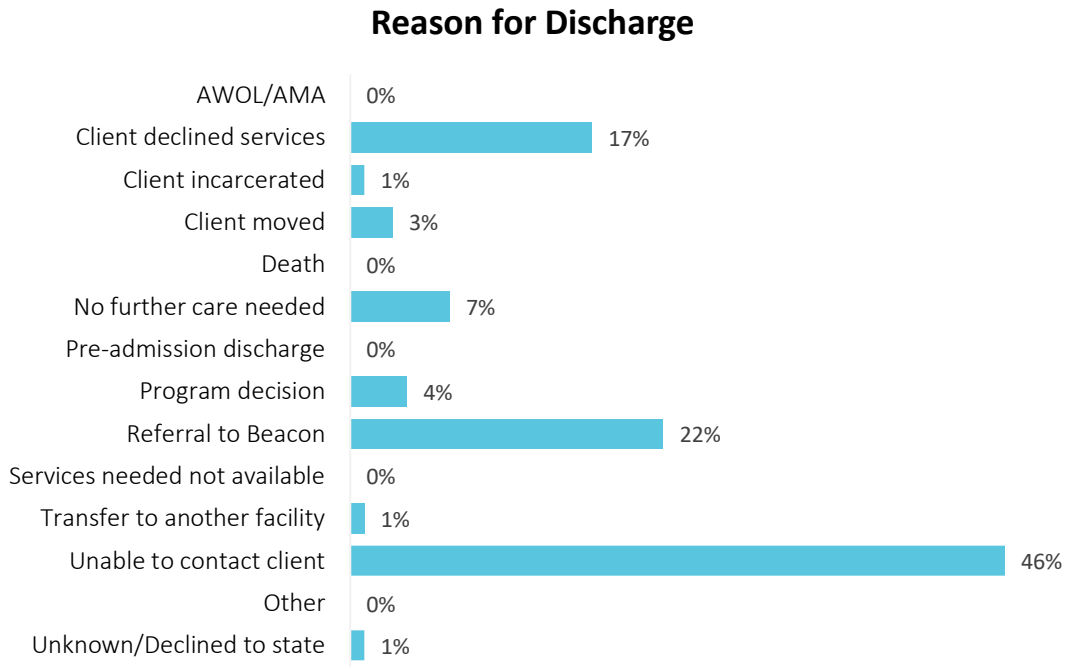
82% of clients
were enrolled in or completed school at intake

(n = 473)

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ACCESS TO TREATMENT CALWORKS

Discharge Information



n = 468

496 clients were **discharged.**

6% had
achieved some to all of their goals.

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ACCESS TO TREATMENT CALWORKS

Demographic Data

Race

American Indian / Alaskan Native	1%
Asian	17%
Black / African American	51%
Native Hawaiian / Other Pacific Islander	0%
White	13%
Another	19%
Unknown/Declined to state	0%

n = 577

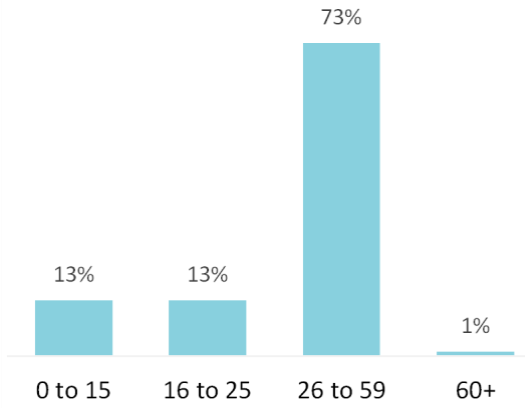
More than one race could be selected. Percentages may exceed 100%.

68% Hispanic/Latino
13% Not Hispanic/Latino

n = 577

19% Unknown/Declined to state.

Age



n = 577

0% of individuals did not answer this question.

Disability

Mental	10%
Visual	<1%
Hearing	<1%
Speech	<1%
Mobility	1%
Developmental	<1%
Another Disability	4%
No Disability	84%
Unknown/Declined to state	0%

n = 577

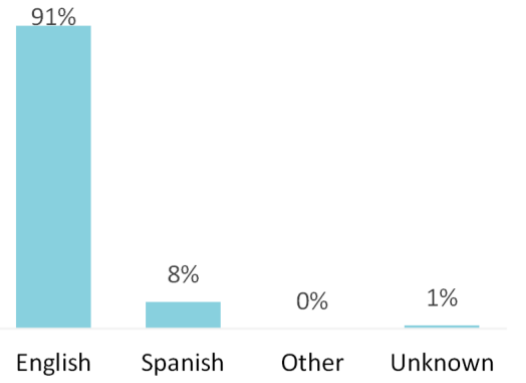
More than one disability could be selected. Percentages may exceed 100%.

16% of individuals reported having one or more disabilities

n = 577

0% Unknown/Declined to state.

Primary Language



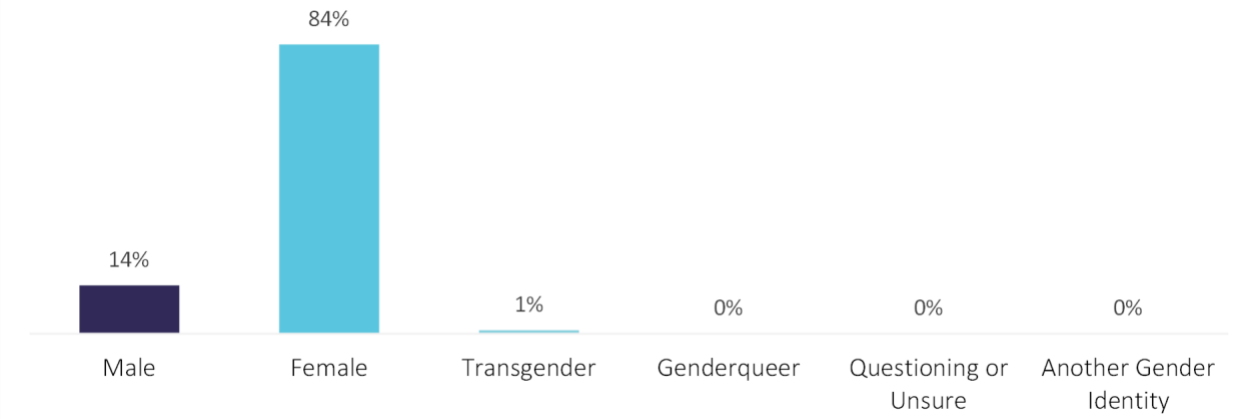
n = 577

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT CALWORKS

Demographic Data

Gender Identity



n = 577
<1% Transgender (n = 1).
2% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	15%
Gay or Lesbian	0%
Bisexual	1%
Questioning or Unsure	0%
Another Sexual Orientation	<1%
Unknown/Declined to state	84%

n = 577

Sex at Birth

Male	14%
Female	86%
Another Sex	0%
Unknown/Declined to state	<1%

n = 577

<1% of individuals were veterans

n = 577
4% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT COASTAL REGION

Access to Treatment Coastal Region provides triage and assessment services for community members seeking mental health and substance use disorder services. Once an assessment is completed, an individual may receive referrals to community mental health or substance use disorder resources.

If an individual requires mental health 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.



- **899 clients served** in FY 22-23
- On average, clients engaged in services for **120 days**

Housing, Employment, and Education

Housing Type at Intake (n=899)	
78%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
12%	Unhoused
0%	Acute medical hospital
<1%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
2%	Residential treatment facility
<1%	Foster home
<1%	Group home
0%	STRTP
<1%	Jail or juvenile detention facility
3%	Another housing status
5%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

13% of clients
were employed or volunteering at intake

(n = 117)

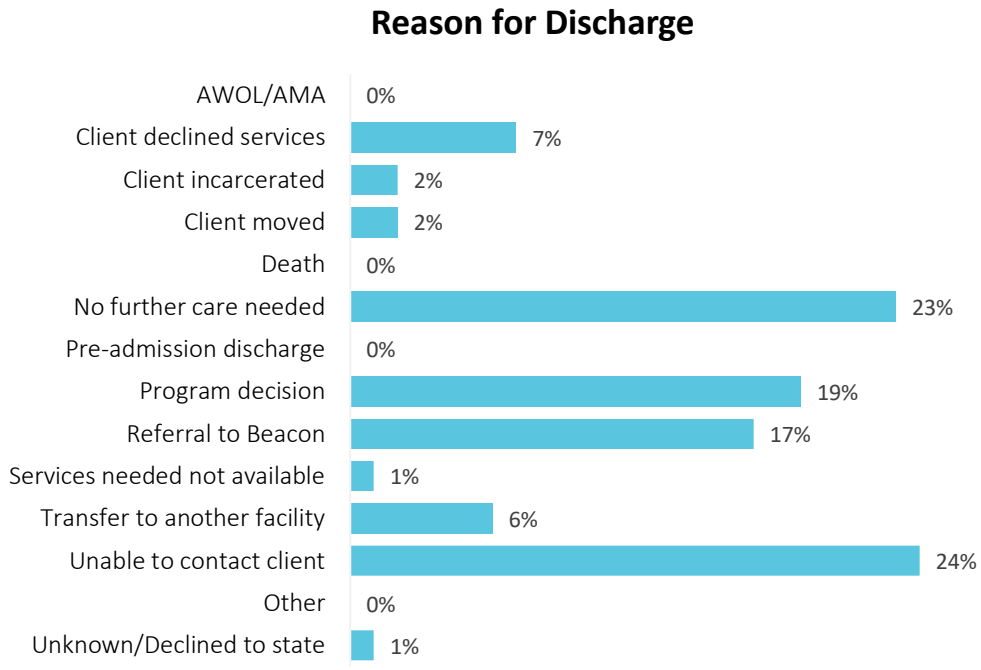
65% of clients
were enrolled in or completed school at intake

(n = 581)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT COASTAL REGION

Discharge Information



n = 849

<1% Services needed not available (n = 1).

871 clients were **discharged**.

2% had **achieved some to all of their goals**.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT COASTAL REGION

Demographic Data

Race

American Indian / Alaskan Native	<1%
Asian	10%
Black / African American	22%
Native Hawaiian / Other Pacific Islander	0%
White	34%
Another	33%
Unknown/Declined to state	0%

n = 899

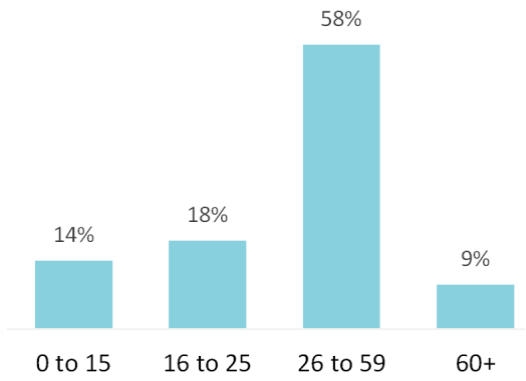
More than one race could be selected. Percentages may exceed 100%.

32% Hispanic/Latino
34% Not Hispanic/Latino

n = 899

34% Unknown/Declined to state.

Age



n = 899

0% of individuals did not answer this question.

Disability

Mental	30%
Visual	1%
Hearing	<1%
Speech	<1%
Mobility	1%
Developmental	<1%
Another Disability	5%
No Disability	63%
Unknown/Declined to state	0%

n = 899

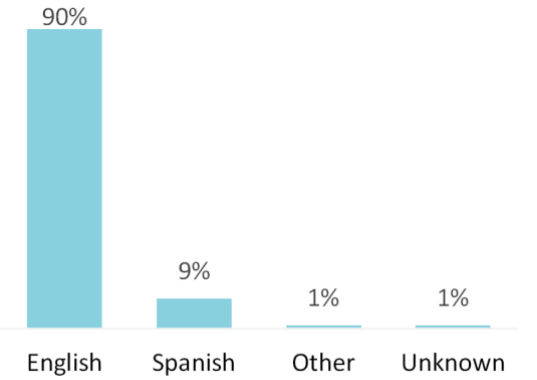
More than one disability could be selected. Percentages may exceed 100%.

37% of individuals reported having one or more disabilities

n = 899

0% Unknown/Declined to state.

Primary Language



n = 899

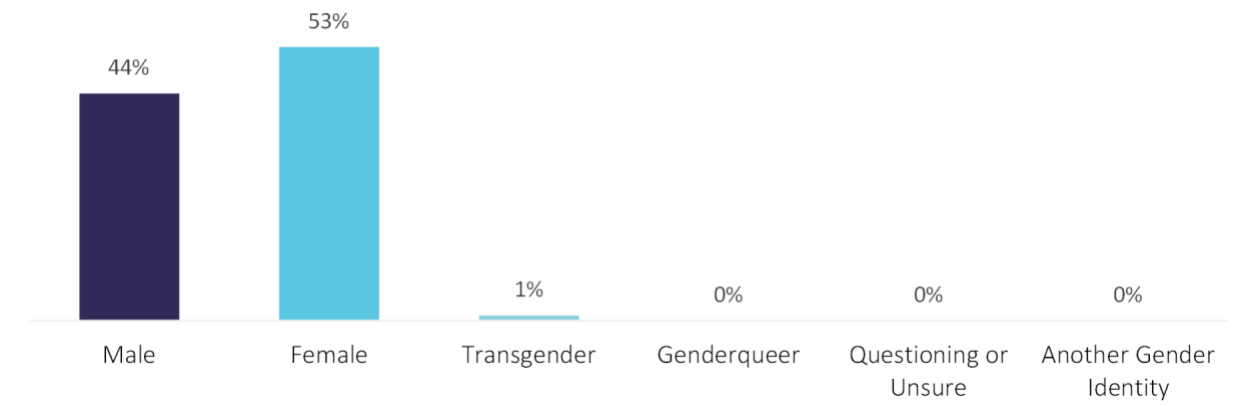
<1% Other (n = 1).

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT COASTAL REGION

Demographic Data

Gender Identity



n = 899
3% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	18%
Gay or Lesbian	1%
Bisexual	1%
Questioning or Unsure	0%
Another Sexual Orientation	1%
Unknown/Declined to state	80%

n = 899

Sex at Birth

Male	46%
Female	54%
Another Sex	0%
Unknown/Declined to state	1%

n = 899

1% of individuals were veterans

n = 899
6% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT KING CITY

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



- **462 clients served** in FY 22-23
- On average, clients engaged in services for **187 days**

Housing, Employment, and Education

Housing Type at Intake (n=462)	
45%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
2%	Unhoused
0%	Acute medical hospital
<1%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
<1%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
1%	Jail or juvenile detention facility
46%	Another housing status
6%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

7% of clients
were employed or volunteering at intake

(n = 33)

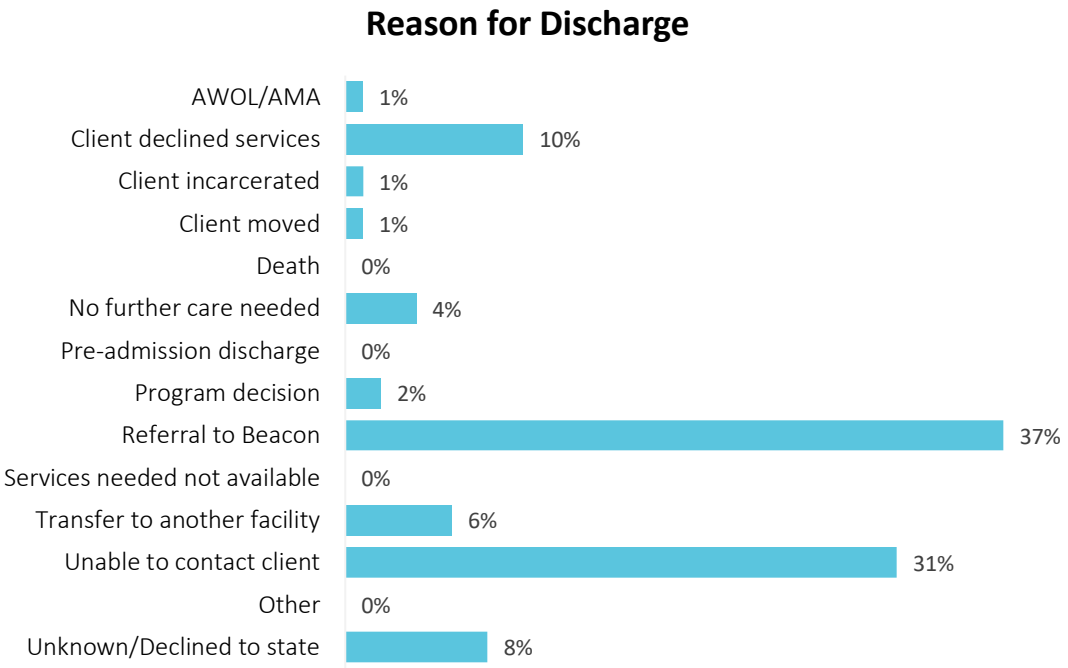
40% of clients
were enrolled in or completed school at intake

(n = 187)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT KING CITY

Discharge Information



n = 412

<1% AWOL/AMA (n = 1) and Incarcerated (n = 2).

429 clients were **discharged**.

3% had
achieved some to all of their goals.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT KING CITY

Demographic Data

Race

American Indian / Alaskan Native	1%
Asian	10%
Black / African American	71%
Native Hawaiian / Other Pacific Islander	0%
White	5%
Another	14%
Unknown/Declined to state	0%

n = 462

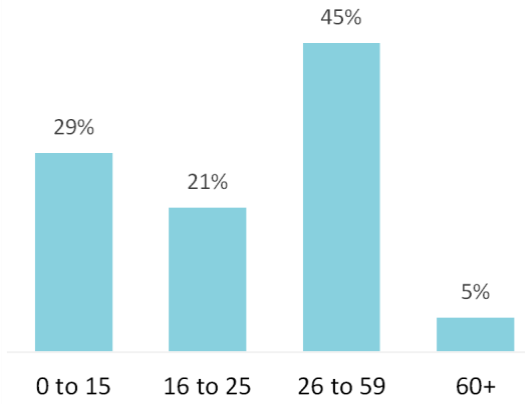
More than one race could be selected. Percentages may exceed 100%.

81% Hispanic/Latino
5% Not Hispanic/Latino

n = 462

15% Unknown/Declined to state.

Age



n = 462

0% of individuals did not answer this question.

Disability

Mental	8%
Visual	0%
Hearing	0%
Speech	0%
Mobility	1%
Developmental	0%
Another Disability	1%
No Disability	90%
Unknown/Declined to state	0%

n = 462

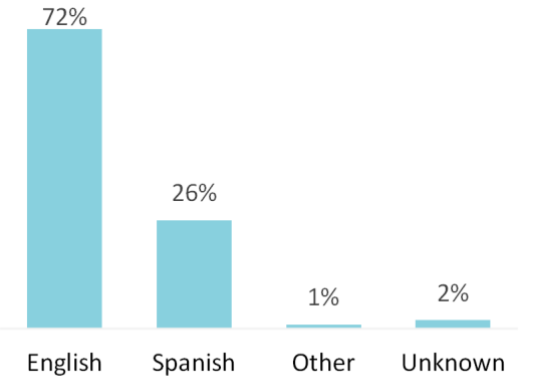
More than one disability could be selected. Percentages may exceed 100%.

10% of individuals reported having one or more disabilities

n = 462

0% Unknown/Declined to state.

Primary Language



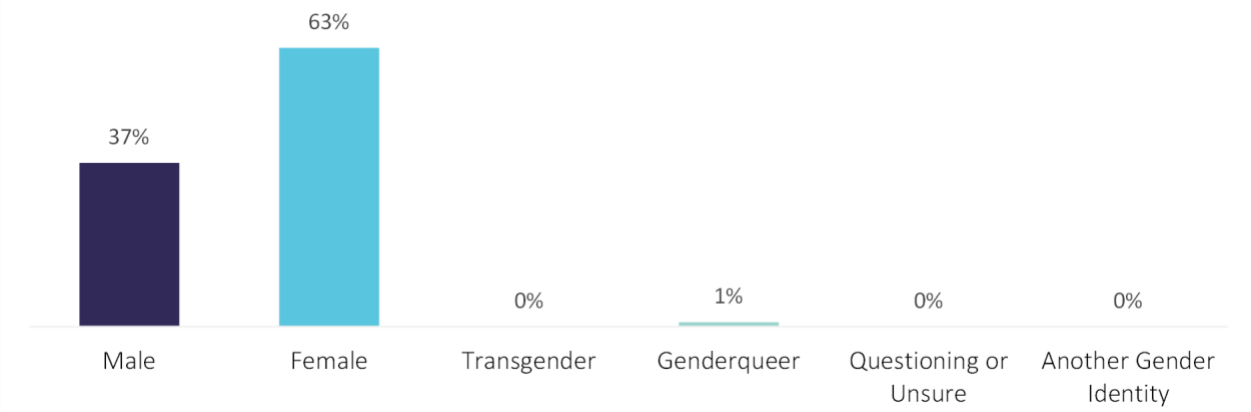
n = 462

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT KING CITY

Demographic Data

Gender Identity



n = 462
<1% Genderqueer (n = 1).
1% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	8%
Gay or Lesbian	0%
Bisexual	1%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	91%

n = 462

Sex at Birth

Male	37%
Female	63%
Another Sex	1%
Unknown/Declined to state	0%

n = 462

<1% of individuals were veterans

n = 462
1% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

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.



- **3,028 clients served** in FY 22-23
- On average, clients engaged in services for **86 days**

Housing, Employment, and Education

Housing Type at Intake (n=3,028)	
48%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
5%	Unhoused
0%	Acute medical hospital
<1%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
1%	Residential treatment facility
<1%	Foster home
<1%	Group home
0%	STRTP
1%	Jail or juvenile detention facility
33%	Another housing status
11%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

10% of clients
were employed or volunteering at intake

(n = 305)

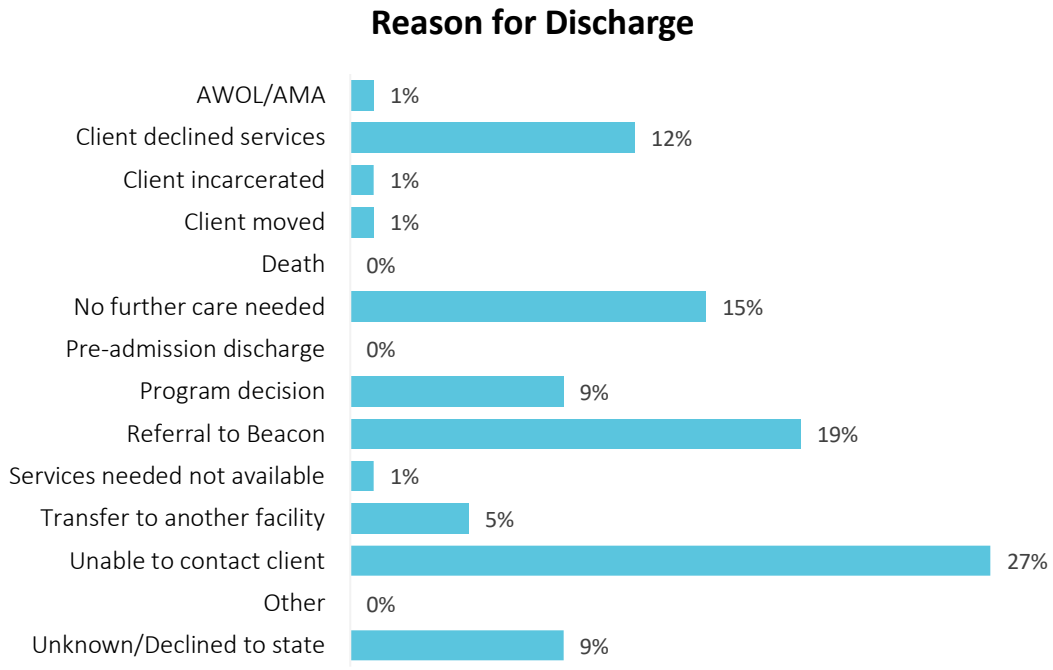
43% of clients
were enrolled in or completed school at intake

(n = 1,297)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT SALINAS

Discharge Information



n = 2,883

2,957 clients were **discharged**.

2% had
achieved some to all of their goals.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT SALINAS

Demographic Data

Race

American Indian / Alaskan Native	1%
Asian	8%
Black / African American	27%
Native Hawaiian / Other Pacific Islander	0%
White	9%
Another	54%
Unknown/Declined to state	0%

n = 3,028

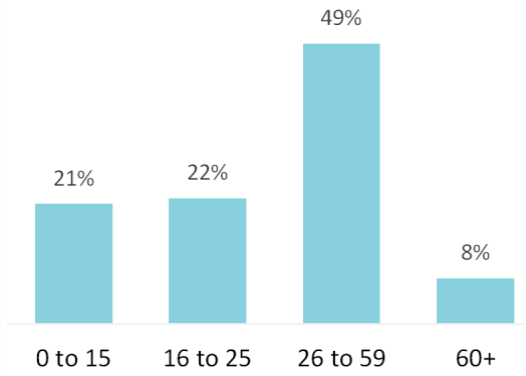
More than one race could be selected. Percentages may exceed 100%.

36% Hispanic/Latino
9% Not Hispanic/Latino

n = 3,028

55% Unknown/Declined to state.

Age



n = 3,028

0% of individuals did not answer this question.

Disability

Mental	10%
Visual	1%
Hearing	<1%
Speech	<1%
Mobility	1%
Developmental	<1%
Another Disability	2%
No Disability	85%
Unknown/Declined to state	0%

n = 3,028

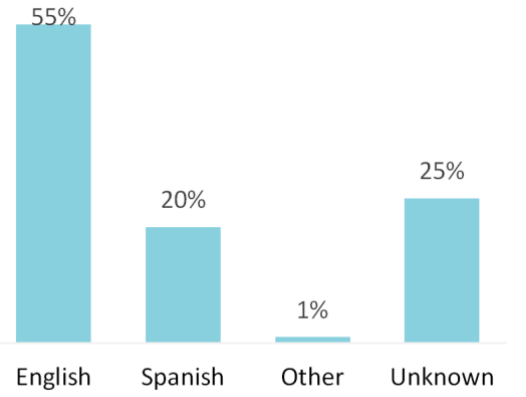
More than one disability could be selected. Percentages may exceed 100%.

15% of individuals reported having one or more disabilities

n = 3,028

0% Unknown/Declined to state.

Primary Language



n = 3,028

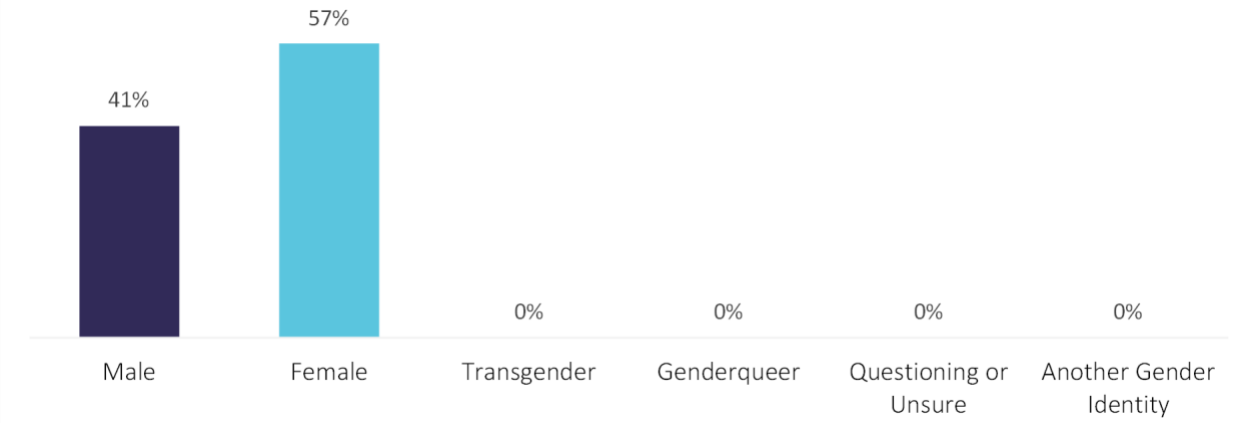
<1% Other (n = 8).

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT SALINAS

Demographic Data

Gender Identity



n = 3,028
2% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	12%
Gay or Lesbian	<1%
Bisexual	1%
Questioning or Unsure	0%
Another Sexual Orientation	<1%
Unknown/Declined to state	87%

n = 3,028

Sex at Birth

Male	42%
Female	57%
Another Sex	0%
Unknown/Declined to state	0%

n = 3,028

<1% of individuals were veterans

n = 3,028
12% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT SOLEDAD

Access to Treatment Soledad provides mental health and substance use 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.



- **931 clients served** in FY 22-23
- On average, clients engaged in services for **98 days**

Housing, Employment, and Education

Housing Type at Intake (n=931)	
96%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
2%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
<1%	Residential treatment facility
<1%	Foster home
0%	Group home
0%	STRTP
<1%	Jail or juvenile detention facility
2%	Another housing status
1%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

14% of clients
were employed or volunteering at intake

(n = 126)

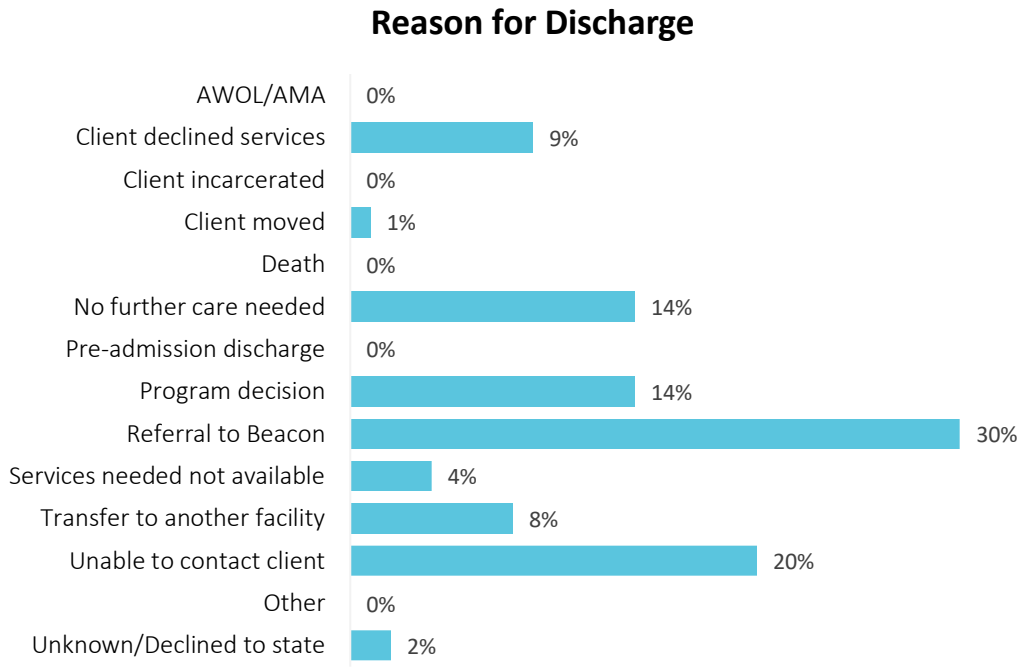
66% of clients
were enrolled in or completed school at intake

(n = 619)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT SOLEDAD

Discharge Information



n = 847

<1% Client moved (n = 2).

895 clients were **discharged**.

5% had **achieved some to all of their goals**.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT SOLEDAD

Demographic Data

Race

American Indian / Alaskan Native	1%
Asian	9%
Black / African American	74%
Native Hawaiian / Other Pacific Islander	0%
White	5%
Another	12%
Unknown/Declined to state	0%

n = 931

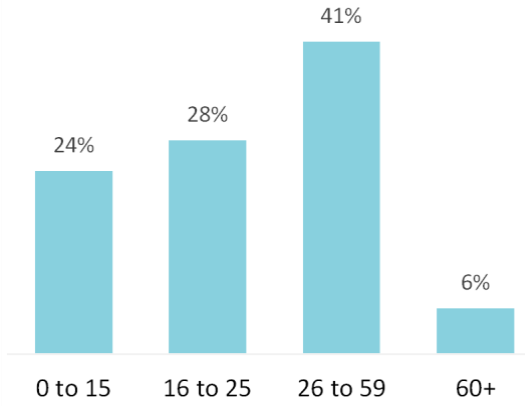
More than one race could be selected. Percentages may exceed 100%.

83% Hispanic/Latino
5% Not Hispanic/Latino

n = 931

12% Unknown/Declined to state.

Age



n = 931

0% of individuals did not answer this question.

Disability

Mental	9%
Visual	1%
Hearing	1%
Speech	1%
Mobility	1%
Developmental	0%
Another Disability	2%
No Disability	88%
Unknown/Declined to state	0%

n = 931

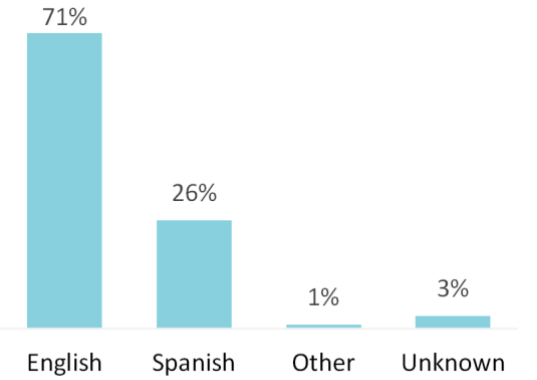
More than one disability could be selected. Percentages may exceed 100%.

12% of individuals reported having one or more disabilities

n = 931

0% Unknown/Declined to state.

Primary Language



n = 931

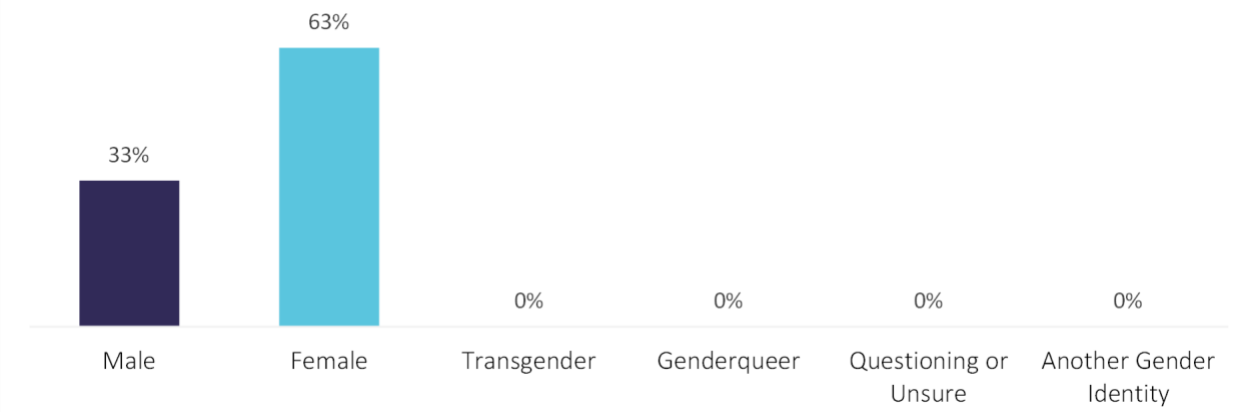
<1% Other (n = 3).

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ACCESS TO TREATMENT SOLEDAD

Demographic Data

Gender Identity



n = 931
4% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	8%
Gay or Lesbian	<1%
Bisexual	<1%
Questioning or Unsure	<1%
Another Sexual Orientation	<1%
Unknown/Declined to state	92%

n = 931

Sex at Birth

Male	34%
Female	66%
Another Sex	0%
Unknown/Declined to state	0%

n = 931

<1% of individuals were veterans

n = 931
<1% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

CHS SOUTH COUNTY

- **31 clients served** in FY 22-23
- On average, clients engaged in services for **290 days**

Housing, Employment, and Education

Housing Type at Intake (n=31)	
84%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
3%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
3%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
6%	Another housing status
3%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

13% of clients
were employed or volunteering at intake

(n = 4)

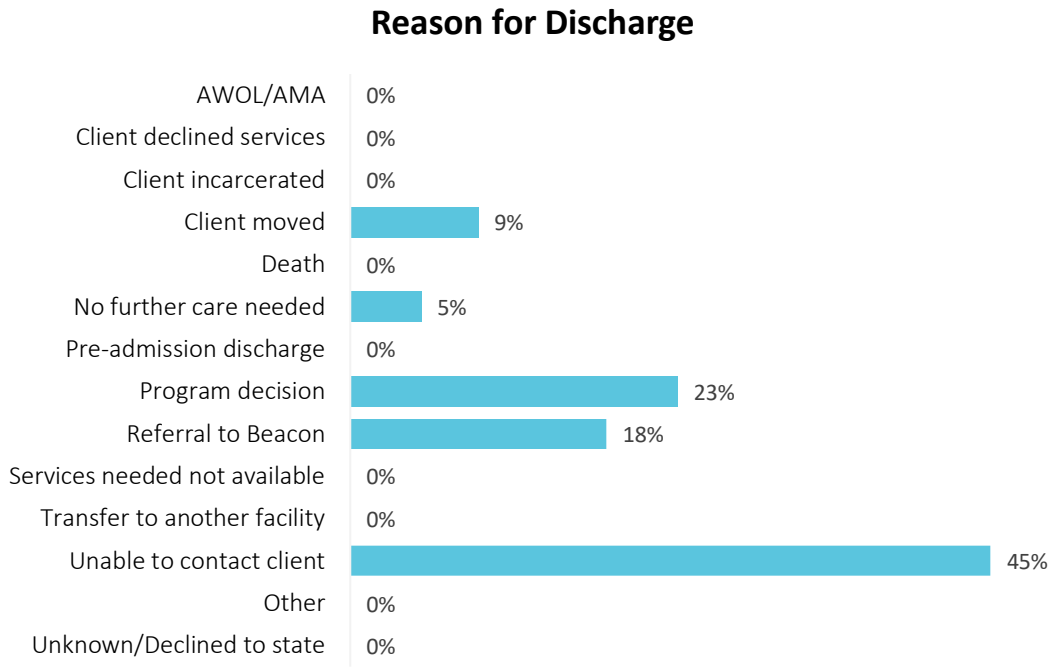
90% of clients
were enrolled in or completed school at intake

(n = 28)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

CHS SOUTH COUNTY

Discharge Information



n = 22

31 clients were **discharged**.

26% had
achieved some to all of their goals.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

CHS SOUTH COUNTY

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	6%
Black / African American	87%
Native Hawaiian / Other Pacific Islander	0%
White	0%
Another	6%
Unknown/Declined to state	0%

n = 31

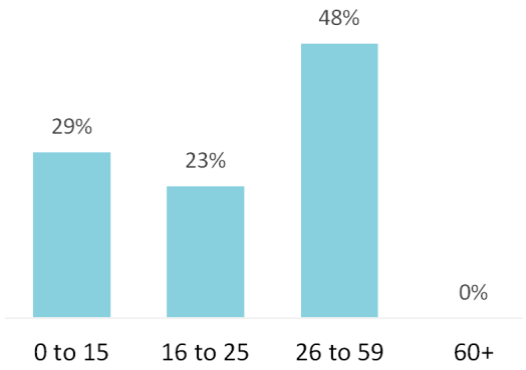
More than one race could be selected. Percentages may exceed 100%.

94% Hispanic/Latino
6% Not Hispanic/Latino

n = 31

0% Unknown/Declined to state.

Age



n = 31

0% of individuals did not answer this question.

Disability

Mental	45%
Visual	0%
Hearing	0%
Speech	0%
Mobility	3%
Developmental	0%
Another Disability	3%
No Disability	48%
Unknown/Declined to state	0%

n = 31

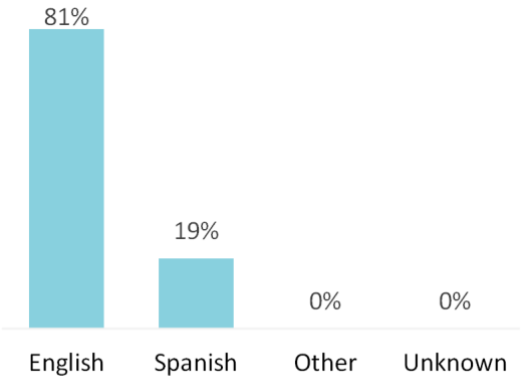
More than one disability could be selected. Percentages may exceed 100%.

51% of individuals reported having one or more disabilities

n = 31

0% Unknown/Declined to state.

Primary Language



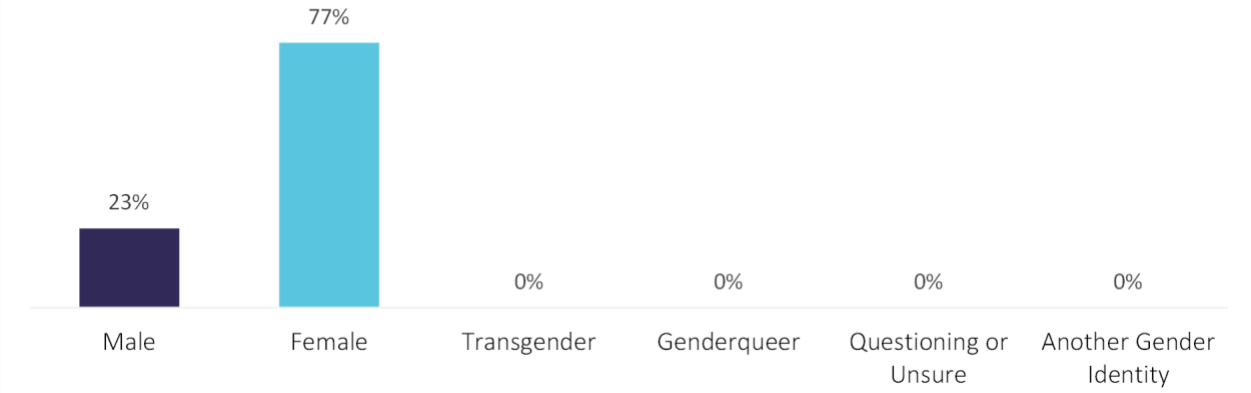
n = 31

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

CHS SOUTH COUNTY

Demographic Data

Gender Identity



n = 31
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	23%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	77%

n = 31

Sex at Birth

Male	23%
Female	77%
Another Sex	0%
Unknown/Declined to state	0%

n = 31

3% of individuals were veterans

n = 31
0% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

FAMILY COUNSELING SALINAS

- **200 clients served** in FY 22-23
- On average, clients engaged in services for **208 days**

Housing, Employment, and Education

Housing Type at Intake (n=200)	
90%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
4%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
1%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
4%	Another housing status
2%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

16% of clients
were employed or volunteering at intake

(n = 31)

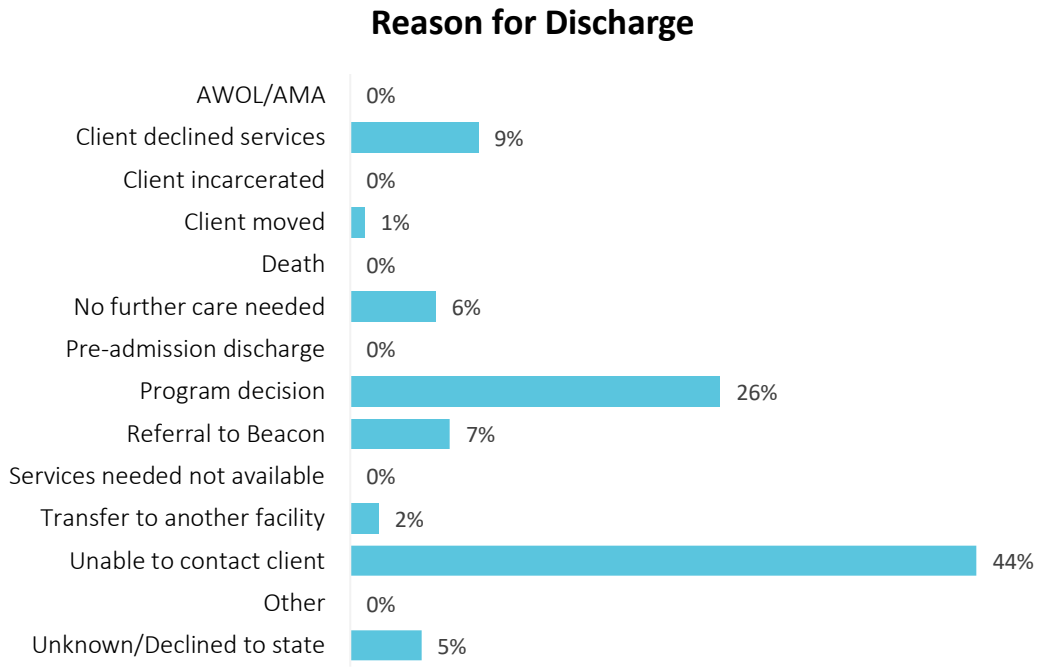
78% of clients
were enrolled in or completed school at intake

(n = 155)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

FAMILY COUNSELING SALINAS

Discharge Information



n = 155

155 clients were **discharged**.

19% had
achieved some to all of their goals.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

FAMILY COUNSELING SALINAS

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	13%
Black / African American	56%
Native Hawaiian / Other Pacific Islander	0%
White	8%
Another	23%
Unknown/Declined to state	0%

n = 200

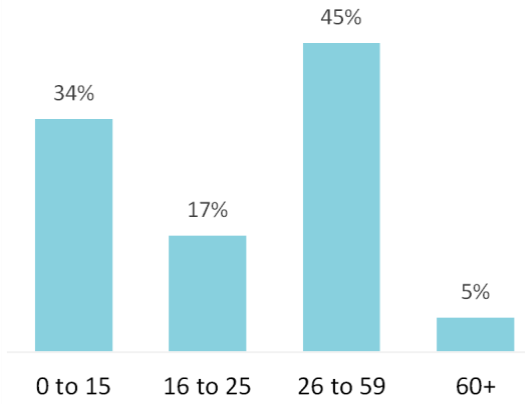
More than one race could be selected. Percentages may exceed 100%.

69% Hispanic/Latino
8% Not Hispanic/Latino

n = 200

23% Unknown/Declined to state.

Age



n = 200

0% of individuals did not answer this question.

Disability

Mental	24%
Visual	1%
Hearing	0%
Speech	0%
Mobility	3%
Developmental	2%
Another Disability	1%
No Disability	70%
Unknown/Declined to state	0%

n = 200

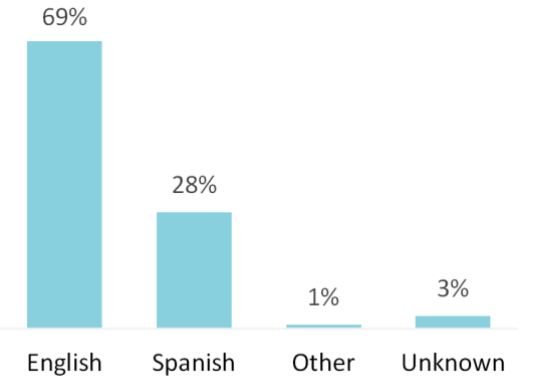
More than one disability could be selected. Percentages may exceed 100%.

31% of individuals reported having one or more disabilities

n = 200

0% Unknown/Declined to state.

Primary Language



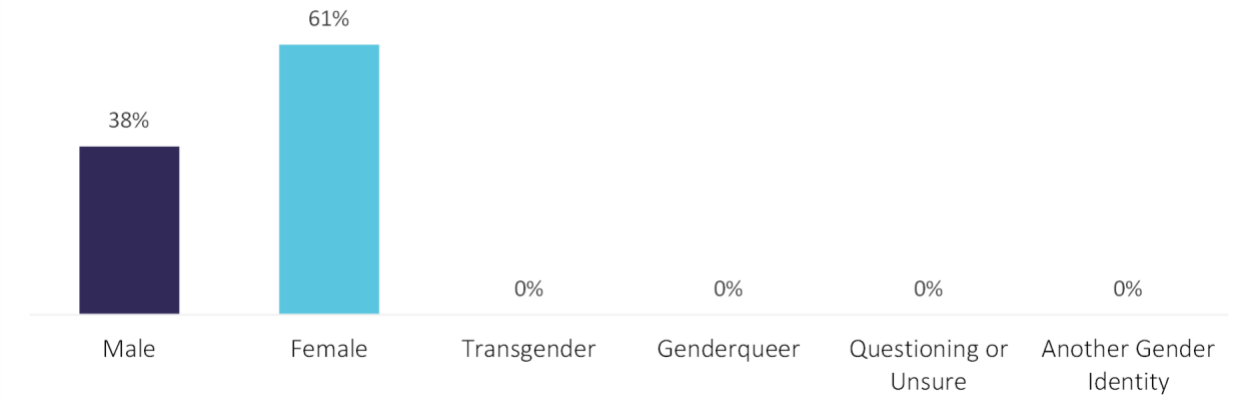
n = 200

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

FAMILY COUNSELING SALINAS

Demographic Data

Gender Identity



n = 200
2% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	21%
Gay or Lesbian	1%
Bisexual	2%
Questioning or Unsure	0%
Another Sexual Orientation	1%
Unknown/Declined to state	76%

n = 200

Sex at Birth

Male	39%
Female	61%
Another Sex	0%
Unknown/Declined to state	0%

n = 200

0% of individuals were veterans

n = 200
4% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

FAMILY COUNSELING SEASIDE

- **148 clients served** in FY 22-23
- On average, clients engaged in services for **244 days**

Housing, Employment, and Education

Housing Type at Intake (n=148)	
79%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
8%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
3%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
3%	Another housing status
7%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

23% of clients
were employed or volunteering at intake

(n = 34)

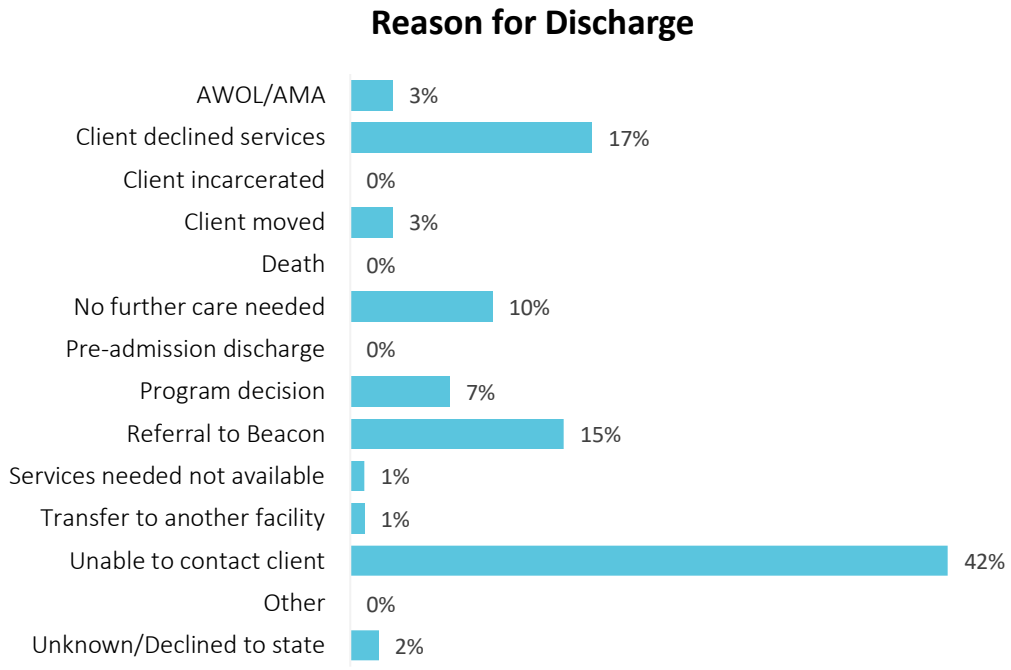
78% of clients
were enrolled in or completed school at intake

(n = 116)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

FAMILY COUNSELING SEASIDE

Discharge Information



n = 102

119 clients were **discharged**.

14% had
achieved some to all of their goals.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

FAMILY COUNSELING SEASIDE

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	12%
Black / African American	37%
Native Hawaiian / Other Pacific Islander	0%
White	32%
Another	19%
Unknown/Declined to state	0%

n = 148

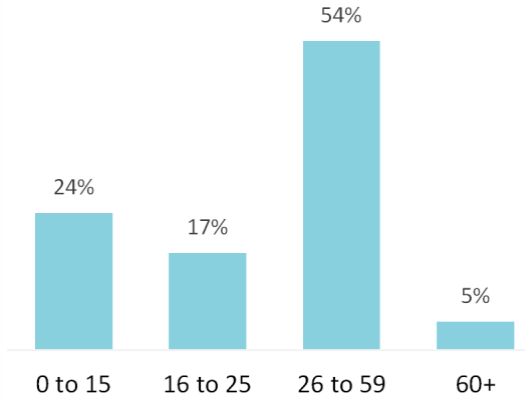
More than one race could be selected. Percentages may exceed 100%.

49% Hispanic/Latino
32% Not Hispanic/Latino

n = 148

19% Unknown/Declined to state.

Age



n = 148

0% of individuals did not answer this question.

Disability

Mental	22%
Visual	0%
Hearing	1%
Speech	1%
Mobility	2%
Developmental	1%
Another Disability	3%
No Disability	71%
Unknown/Declined to state	0%

n = 148

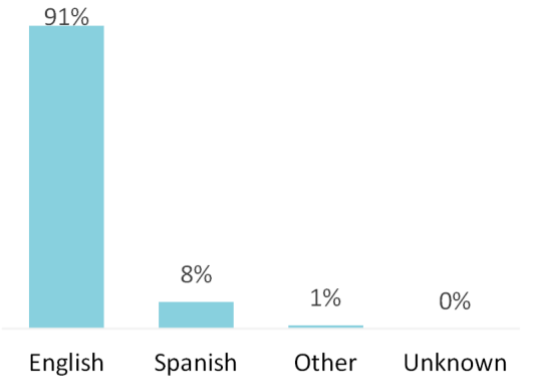
More than one disability could be selected. Percentages may exceed 100%.

30% of individuals reported having one or more disabilities

n = 148

0% Unknown/Declined to state.

Primary Language



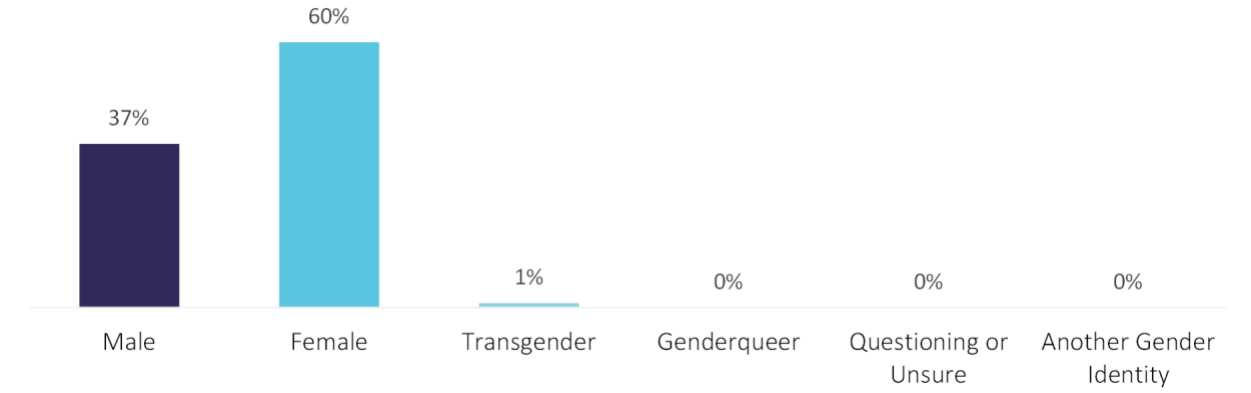
n = 148

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

FAMILY COUNSELING SEASIDE

Demographic Data

Gender Identity



n = 148
2% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	26%
Gay or Lesbian	1%
Bisexual	3%
Questioning or Unsure	0%
Another Sexual Orientation	1%
Unknown/Declined to state	70%

n = 148

Sex at Birth

Male	39%
Female	61%
Another Sex	0%
Unknown/Declined to state	0%

n = 148

1% of individuals were veterans

n = 148
11% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

OUTPATIENT MENTAL HEALTH

Community Human Services (CHS) provides moderate to severe levels of outpatient care services to clients who are referred to CHS by MCBH, as well as clients with Medi-Cal coverage who self-refer to CHS. These services are intended to help clients overcome impairments that affect their daily functioning. Services are offered in both English and Spanish, with additional language support available through translation services for clients.

Successes and Highlights

- CHS has developed practices to reduce wait time for individuals to be connected to and begin services. This was accomplished through collaboration with Monterey County Behavioral Health in the face of the unprecedented high need for outpatient mental health services for individuals Post Covid.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

OUTPATIENT MENTAL HEALTH

Challenges & Growth Opportunities

CHALLENGE: At the beginning of the 22-23 fiscal year, CHS had a waitlist of over 200 individuals waiting to be assigned to a clinician for intake and ongoing services.

ACTION PLAN: CHS developed an action plan to address these challenges.

- CHS clinical staff underwent refresher training to enhance their understanding of appropriate levels of care, length of stay, and treatment timelines. This training also emphasized the importance of transitioning and supporting clients effectively as they move between different levels of care, aligning with their unique needs.
- CHS adopted a client-centered approach by initiating these discussions with clients at the outset of treatment and maintaining them throughout. Additionally, CHS strengthened its collaboration with community partners to provide support for clients transitioning to lower levels of care programs.
- By the last quarter of the 22-23 fiscal year, CHS successfully reduced the waitlist to approximately 50 individuals, maintaining this number consistently. Wait times for individuals on the waitlist were reduced from 6 to 8 weeks down to 2 to 4 weeks.
- CHS has intensified its efforts to assess clients' suitability for moderate to severe levels of care. When appropriate, CHS staff collaborates with other community providers to facilitate client transfers to lower or higher levels of care as needed.



Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

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.



- **164 clients served** in FY 22-23
- On average, clients engaged in services for **162 days**

Housing, Employment, and Education

Housing Type at Intake (n=164)	
65%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
3%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
1%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
19%	Another housing status
12%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

12% of clients
were employed or volunteering at intake

(n = 20)

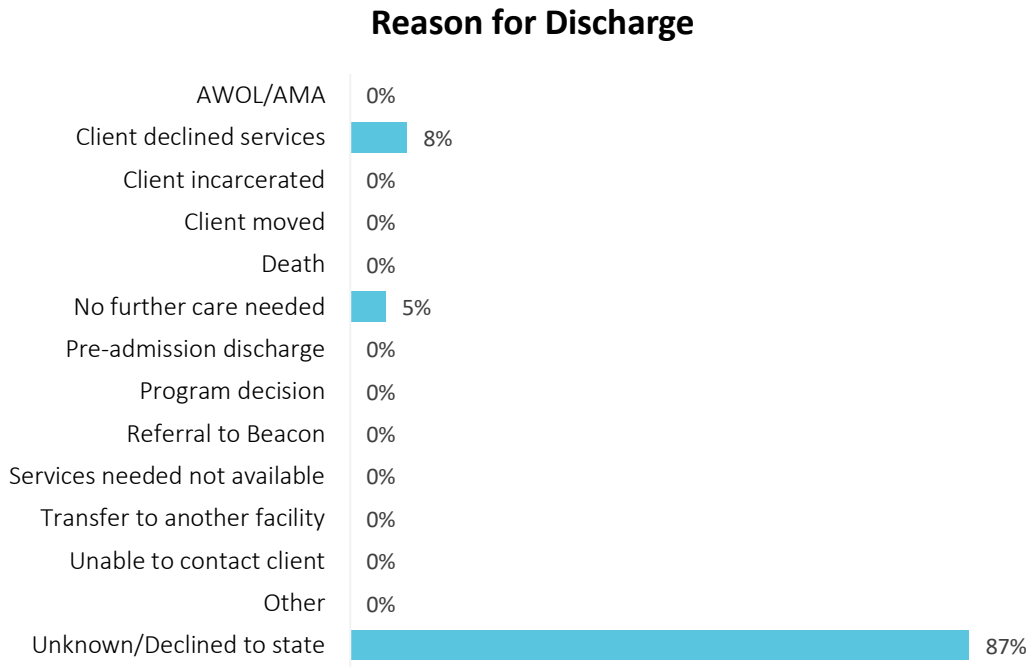
51% of clients
were enrolled in or completed school at intake

(n = 84)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

USC TELEHEALTH

Discharge Information



n = 38

112 clients were **discharged**.

65% had
achieved some to all of their goals.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

USC TELEHEALTH

Demographic Data

Race

American Indian / Alaskan Native	1%
Asian	11%
Black / African American	45%
Native Hawaiian / Other Pacific Islander	0%
White	10%
Another	34%
Unknown/Declined to state	0%

n = 164

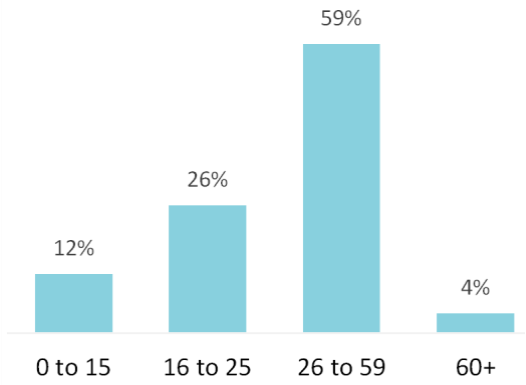
More than one race could be selected. Percentages may exceed 100%.

55% Hispanic/Latino
10% Not Hispanic/Latino

n = 164

35% Unknown/Declined to state.

Age



n = 164

0% of individuals did not answer this question.

Disability

Mental	91%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	9%
Unknown/Declined to state	0%

n = 164

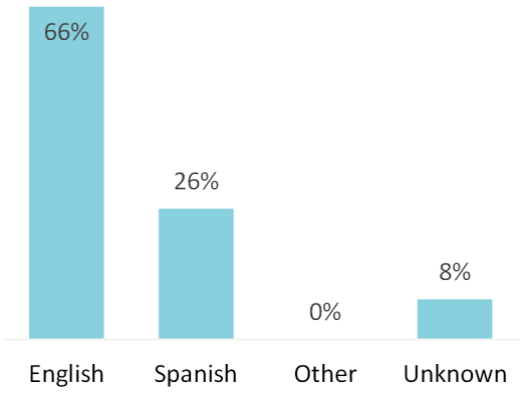
More than one disability could be selected. Percentages may exceed 100%.

91% of individuals reported having one or more disabilities

n = 164

0% Unknown/Declined to state.

Primary Language



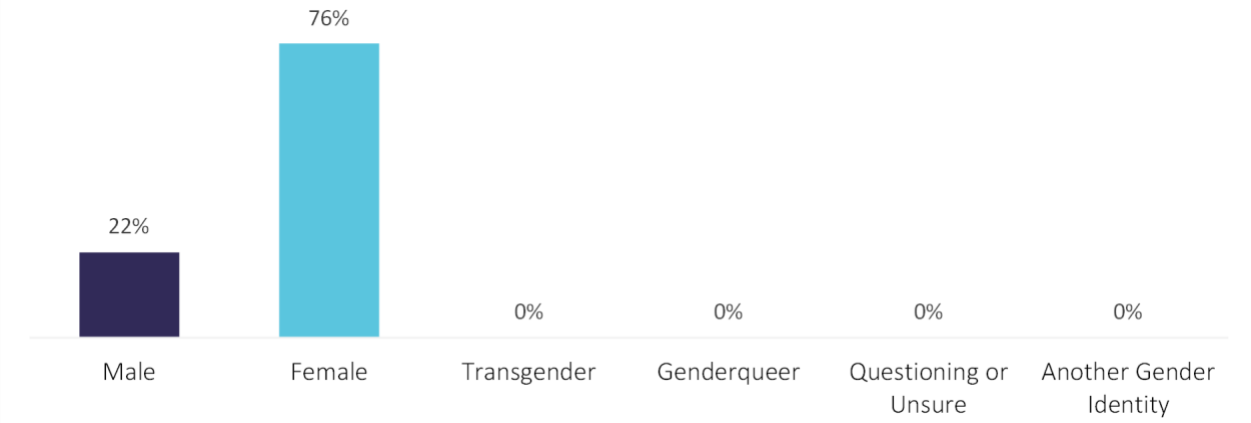
n = 164

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

USC TELEHEALTH

Demographic Data

Gender Identity



n = 164
2% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	5%
Gay or Lesbian	1%
Bisexual	1%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	94%

n = 164

Sex at Birth

Male	22%
Female	76%
Another Sex	0%
Unknown/Declined to state	2%

n = 164

2% of individuals were veterans

n = 164
6% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

WELLNESS RECOVERY CENTER (ADULTS OMNI)

OMNI's mission is to enhance mental health wellness through person-centered, trauma-informed, recovery-based services. The Center, operated by peers and family members, offers a range of support to promote personal and social growth. This includes peer counseling/support, community resources, recovery education, social skill development, social rehabilitation workshops, a peer-run warm line, and supported education services. These services are specifically designed for adults with serious mental illness, aiming to prevent isolation and withdrawal. The Pajaro Wellness Center provides services for diverse adult groups, focusing on recovery, interdependence, wellness, and empowerment.

Peer counseling groups teach communication skills, emotional regulation, and stress reduction. Individual support sessions are offered to improve mental health resilience and daily functioning.

Peer support groups and workshops enhance socialization, leadership skills, and resource connections. Weekly rides and monthly outreach activities are provided.

Supported education services assist adults with mental health challenges in pursuing education or vocational training. Staff support clients with registration, managing school environments, schedules, coursework, and provide mental health support for success. College support groups, campus tours, academic advising, and classroom accommodations are also facilitated.

Successes and Highlights

- An Administrative Assistant position was filled in October which has markedly improved staff capacity at the OMNI Center.
- OMNI has brought back numerous events and activities, such as an indoor, in-person awards presentation, and plans are underway for the return of the Agency Picnic and the Mental Health Banquet.
- Staff are planning a trip to go watch a San Francisco Giants ball game, participating in the Monterey Peninsula Pride Parade, and are hosting multiple workshops and activities throughout the upcoming year.

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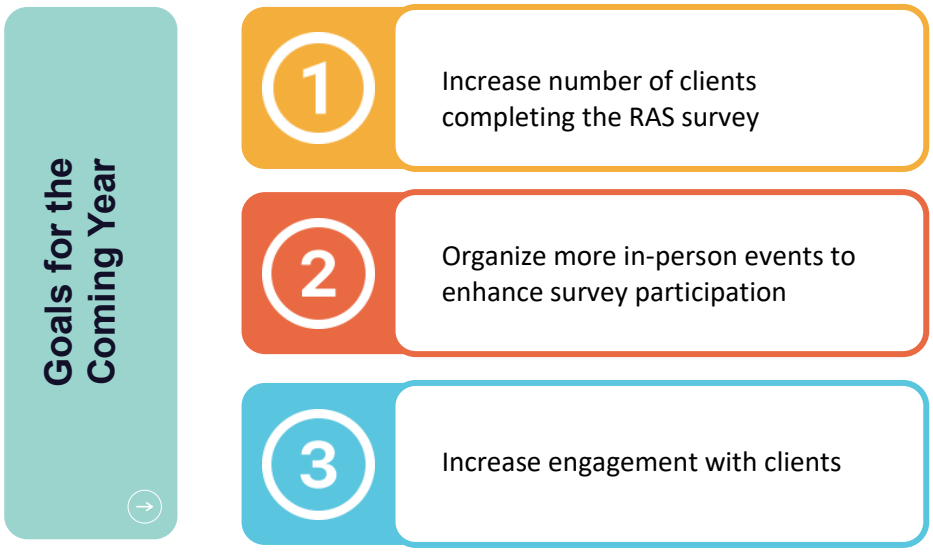
WELLNESS RECOVERY CENTER (ADULTS OMNI)

Challenges & Growth Opportunities

CHALLENGES: OMNI experienced challenges this period.

- OMNI has lost 20 clients since July 1st, 2022, with losses occurring as frequently as a few days apart.
- Staff shortages - Almost all staff members contracted COVID after an indoor event hosted by OMNI, resulting in reduced services such as pick up and drop offs. Some staff members have also assisted in other programs throughout the year.
- Pajaro has been without a janitor since November, causing the OMNI janitor to reduce coverage for OMNI in order to cover other programs and Pajaro.
- OMNI Wellness Navigators temporarily covered for both janitors for about a month when they were absent.
- There has been a significant increase in unsheltered clients at OMNI who are highly symptomatic and/or under the influence, requiring additional time and attention from staff for behavior management and resource connections.

ACTION PLAN: OMNI tailored their goals for the coming year to address the challenges they've faced.



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CSS-08: EARLY CHILDHOOD MENTAL HEALTH SERVICES

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

MCSTART

MCSTART provides family therapy, occupational therapy, rehabilitation, and case management services.

- **77 clients served** in FY 22-23
- On average, clients engaged in services for **331 days**

Successes and Highlights

- Worked more closely with DSS clients to provide attachment therapy and related rehabilitation.
- Provided occupational therapy services to families in the reunification process.
- Closer working relationship between our teams contributed to the success of those outcomes.

Challenges & Growth Opportunities

CHALLENGES: MCSTART faced challenges this period.

- Many cancellations occurred in the past year due to family illness.
- Lower billing.
- CalAIM billing reforms eliminated travel reimbursement to clients' homes, posing an obstacle.

ACTION PLAN: MCSTART developed an action plan to address these challenges.

- Organized a DTH therapeutic event for therapists to attend with their clients and families.
- More services have been provided in the office.

Goals for the Coming Year

1. Increase revenue
2. Serve more clients
3. Provide parenting classes

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

MCSTART

Housing, Employment, and Education

Housing Type at Intake (n=77)	
92%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
0%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
0%	Residential treatment facility
8%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
0%	Another housing status
0%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

0% of clients
were employed or volunteering at intake

(n = 0)

69% of clients
were enrolled in or completed school at intake

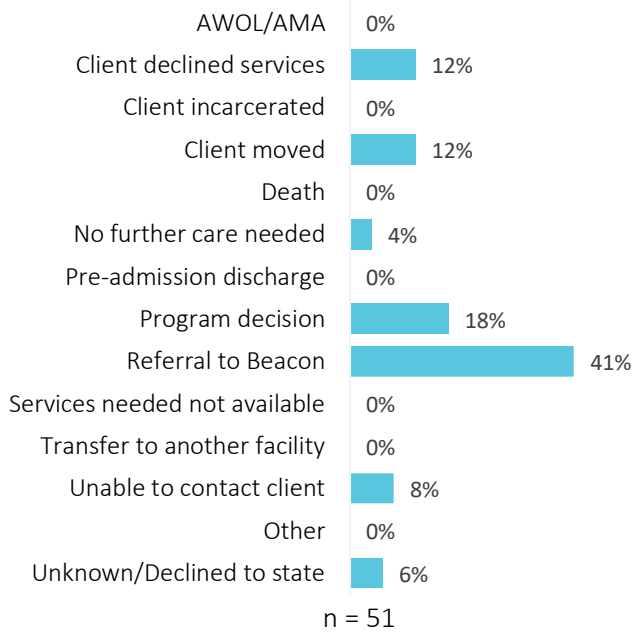
(n = 53)

Discharge Information

60 clients were **discharged**.

13% had **achieved some to all of their goals**.

Reason for Discharge



Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

MCSTART

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	9%
Black / African American	60%
Native Hawaiian / Other Pacific Islander	0%
White	19%
Another	12%
Unknown/Declined to state	0%

n = 77

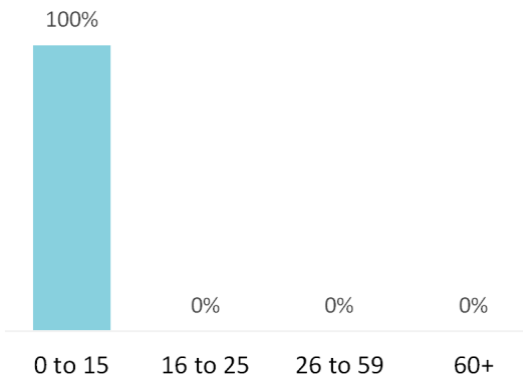
More than one race could be selected. Percentages may exceed 100%.

69% Hispanic/Latino
19% Not Hispanic/Latino

n = 77

12% Unknown/Declined to state.

Age



n = 77

0% of individuals did not answer this question.

Disability

Mental	16%
Visual	0%
Hearing	0%
Speech	1%
Mobility	0%
Developmental	1%
Another Disability	0%
No Disability	82%
Unknown/Declined to state	0%

n = 77

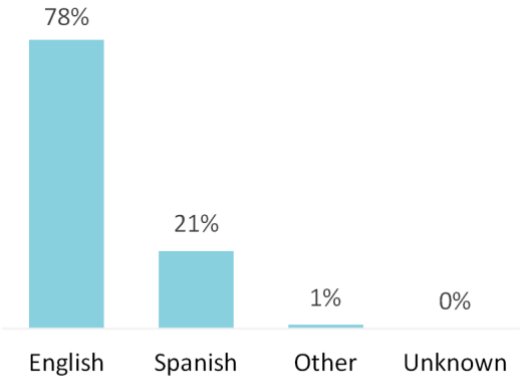
More than one disability could be selected. Percentages may exceed 100%.

18% of individuals reported having one or more disabilities

n = 77

0% Unknown/Declined to state.

Primary Language



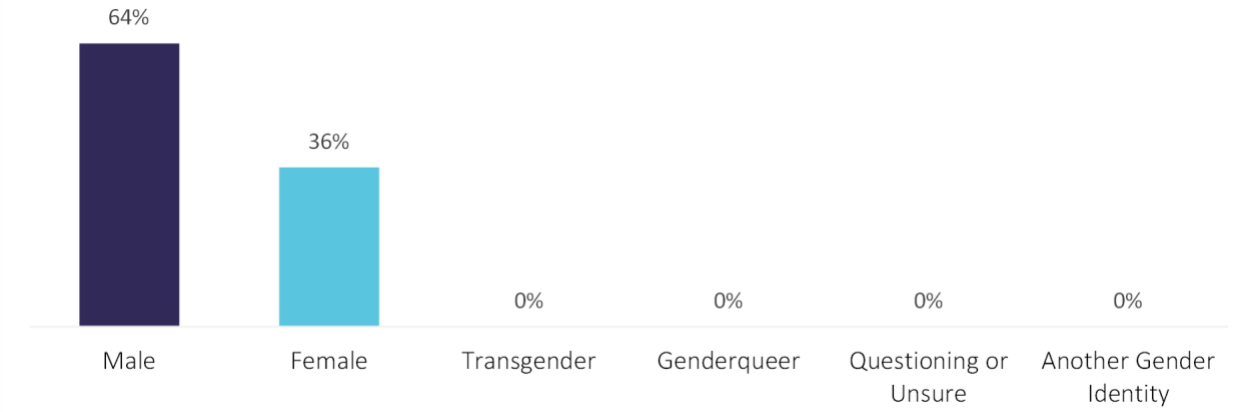
n = 77

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

MCSTART

Demographic Data

Gender Identity



n = 77
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	4%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	96%

n = 77

Sex at Birth

Male	65%
Female	35%
Another Sex	0%
Unknown/Declined to state	0%

n = 77

0% of individuals were veterans

n = 77
0% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

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

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PEER SUPPORT WELLNESS NAVIGATORS

Peer Support Wellness Navigators (PSWN) is a voluntary peer support program focusing on clients who are working with Monterey County Behavioral Health Adult System of Care. PSWN supports consumers to decrease the frequency of mental health crises by increasing support in areas including symptom management skills training, education on mental health, and connecting clients to community resources. The mission of the program is to assist consumers in accessing internal and community resources to maintain wellness.



- **60 clients served** in FY 22-23
- On average, clients engaged in services for **268 days**

Successes and Highlights

- Out of the 60 clients, 58% were linked to community resources.
- 84% of clients who completed the Recovery Assessment Scale survey reported maintaining or improving their wellness.
- 98% of clients who completed the survey reported satisfaction with the services received through PSWN.

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PEER SUPPORT WELLNESS NAVIGATORS

Challenges & Growth Opportunities

CHALLENGES: PSWN faced challenges this period.

- PSWN experienced staff turnover during the fiscal year.
- There were fewer referrals received during the fiscal year as some clients required longer service duration due to their needs.

ACTION PLAN: PSWN developed an action plan to address these challenges.

- Successfully transferred a previous Peer Support Wellness Navigator to ensure a smooth transition.



Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

PEER SUPPORT WELLNESS NAVIGATORS

Housing, Employment, and Education

Housing Type at Intake (n=60)	
77%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
2%	Unhoused
0%	Acute medical hospital
5%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
8%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
5%	Another housing status
3%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

13% of clients
were employed or volunteering at intake

(n = 8)

88% of clients
were enrolled in or completed school at intake

(n = 53)

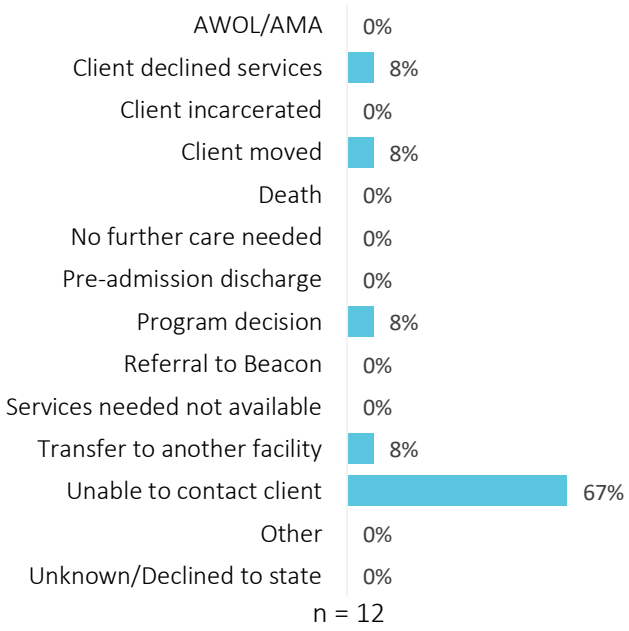
Discharge Information

49 clients were **discharged**.



63% had **achieved some to all of their goals**.

Reason for Discharge



Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

PEER SUPPORT WELLNESS NAVIGATORS

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	8%
Black / African American	42%
Native Hawaiian / Other Pacific Islander	0%
White	43%
Another	7%
Unknown/Declined to state	0%

n = 60

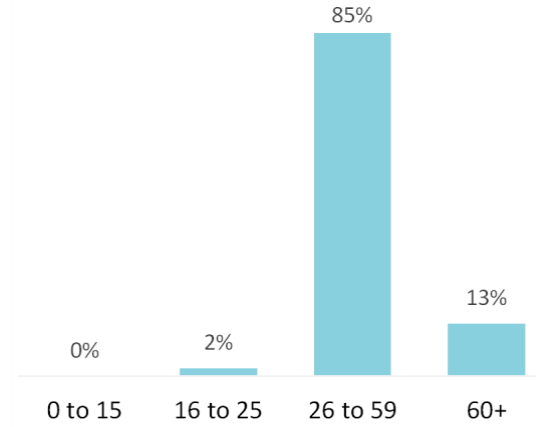
More than one race could be selected. Percentages may exceed 100%.

50% Hispanic/Latino
43% Not Hispanic/Latino

n = 60

7% Unknown/Declined to state.

Age



n = 60

0% of individuals did not answer this question.

Disability

Mental	70%
Visual	0%
Hearing	2%
Speech	0%
Mobility	2%
Developmental	2%
Another Disability	3%
No Disability	22%
Unknown/Declined to state	0%

n = 60

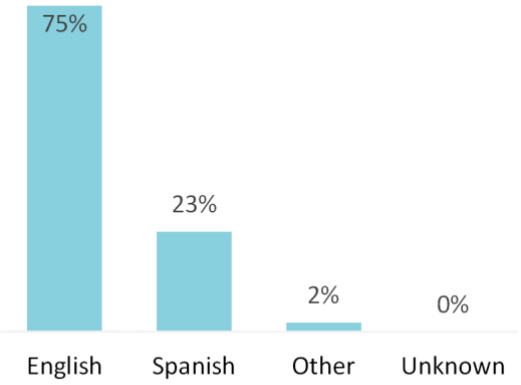
More than one disability could be selected. Percentages may exceed 100%.

78% of individuals reported having one or more disabilities

n = 60

0% Unknown/Declined to state.

Primary Language



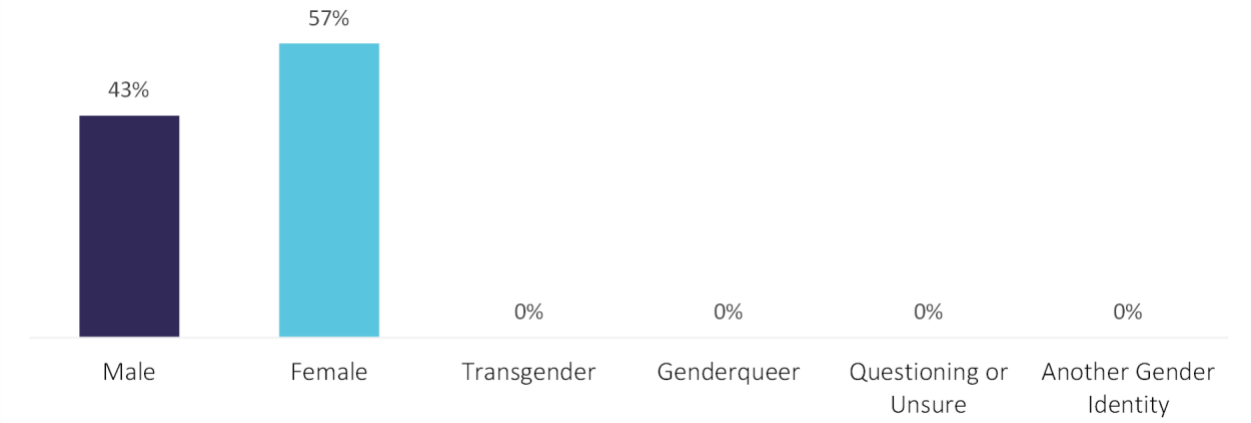
n = 60

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PEER SUPPORT WELLNESS NAVIGATORS

Demographic Data

Gender Identity



n = 60
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	15%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	85%

n = 60

Sex at Birth

Male	43%
Female	57%
Another Sex	0%
Unknown/Declined to state	0%

n = 60

0% of individuals were veterans

n = 60
7% Unknown/Declined to state.

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PRIMARY CARE INTEGRATION

Primary Care Integration (PCI) is a voluntary peer support program that provides one-on-one support to individuals working with Monterey County Behavioral Health (MCBH). The mission of the program is for clients to work together with a Wellness Navigator in order to gain access to primary healthcare clinics and attend appointments.



- **57 clients served** in FY 22-23
- On average, clients engaged in services **for 228 days**

Successes and Highlights

- PCI served 55 clients.
- Out of the 55 clients, 85% attended at least one PCP appointment.
- Staff were also able to link clients to many different Primary Care Physicians as well as other specialists to focus on treatment areas for the client.

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PRIMARY CARE INTEGRATION

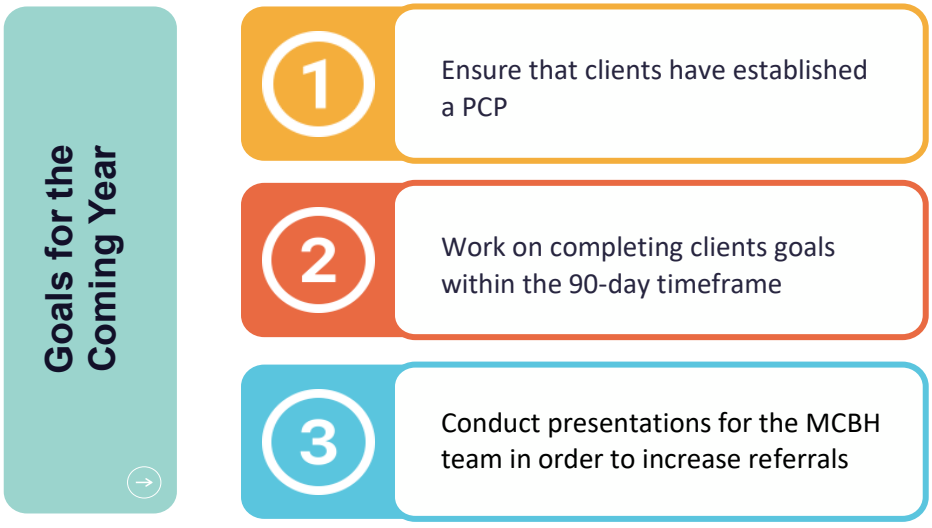
Challenges & Growth Opportunities

CHALLENGES: PCI faced challenges this period.

- PCI experienced staff turnover during the fiscal year.
- As it was PCI's first year, referrals were slower to come in as MCBH staff and clients became familiar with the program.
- Clients stayed in the program longer than anticipated due to individual needs or at the request of MCBH.

ACTION PLAN: PCI developed an action plan to address these challenges.

- Seamlessly filled vacancies by relocating new staff from ongoing hiring for Wellness Navigator positions.



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PRIMARY CARE INTEGRATION

Housing, Employment, and Education

Housing Type at Intake (n=57)	
79%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
11%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
0%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
7%	Another housing status
4%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

12% of clients
were employed or volunteering at intake

(n = 57)

79% of clients
were enrolled in or completed school at intake

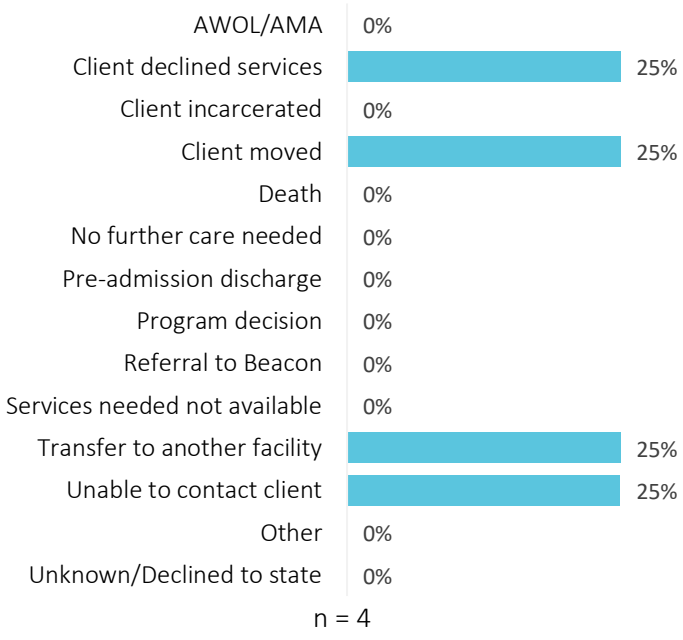
(n = 57)

Discharge Information

47 clients were **discharged**.

70% had **achieved some to all of their goals**.

Reason for Discharge



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PRIMARY CARE INTEGRATION

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	16%
Black / African American	39%
Native Hawaiian / Other Pacific Islander	0%
White	39%
Another	7%
Unknown/Declined to state	0%

n = 57

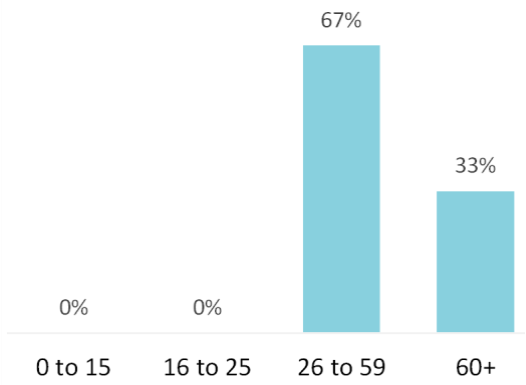
More than one race could be selected. Percentages may exceed 100%.

54% Hispanic/Latino
39% Not Hispanic/Latino

n = 57

7% Unknown/Declined to state.

Age



n = 57

0% of individuals did not answer this question.

Disability

Mental	61%
Visual	2%
Hearing	0%
Speech	0%
Mobility	2%
Developmental	2%
Another Disability	5%
No Disability	28%
Unknown/Declined to state	0%

n = 57

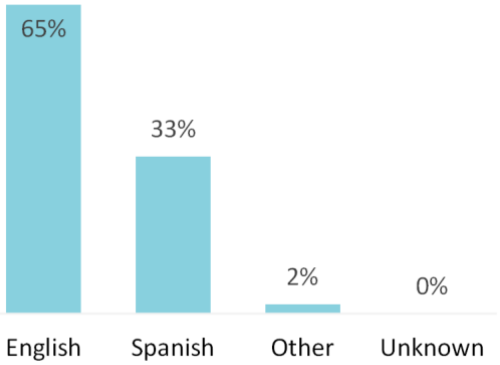
More than one disability could be selected. Percentages may exceed 100%.

72% of individuals reported having one or more disabilities

n = 57

0% Unknown/Declined to state.

Primary Language



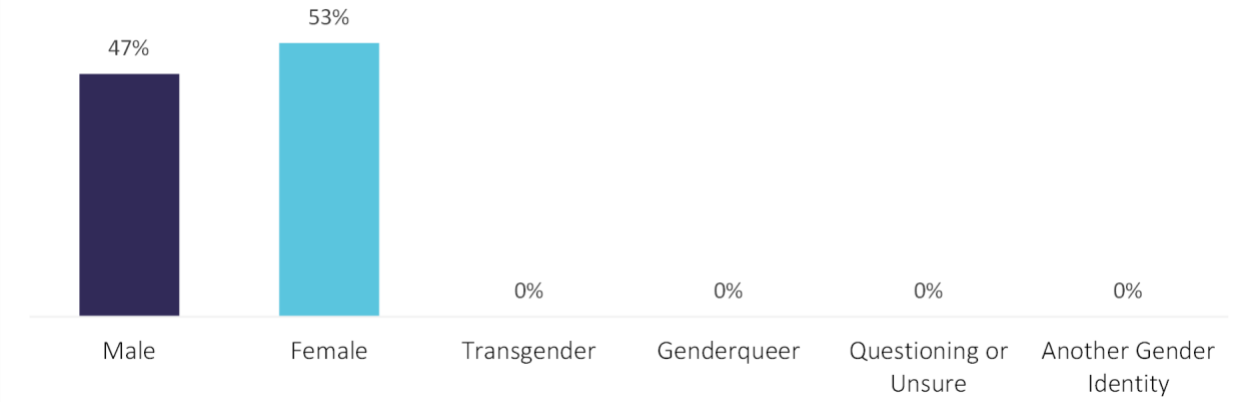
n = 57

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

PRIMARY CARE INTEGRATION

Demographic Data

Gender Identity



n = 57
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	19%
Gay or Lesbian	0%
Bisexual	2%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	79%

n = 57

Sex at Birth

Male	47%
Female	53%
Another Sex	0%
Unknown/Declined to state	0%

n = 57

0% of individuals were veterans

n = 57
0% Unknown/Declined to state.

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RETURN TO WORK BENEFITS COUNSELING

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.

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TRANSPORTATION COACHING

The Transportation Coaching Program (TCP) is funded by the MHSA Innovations Project and aims to help consumers of Monterey County Behavioral Health (MCBH) Adult System of Care (ASOC) gain independence by teaching them how to use public transit and rideshares. TCP supports consumers who are interested in acquiring these skills, enabling them to reintegrate into their community and fulfill their daily needs, including attending appointments, finding employment, pursuing education, and engaging in social activities.



- **32 clients served** in FY 22-23
- On average, clients engaged in services for **202 days**

Successes and Highlights

- Served a total of 32 clients, assisting clients with learning and navigating transportation resources in the community.
- 80% of clients who took the Transportation Needs Assessment Survey (TNAS) reported improving their knowledge and comfort with utilizing different means of transportation.

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TRANSPORTATION COACHING

Challenges & Growth Opportunities

CHALLENGES: TCP faced challenges this period.

- Low referrals throughout the year resulting in fewer clients being served than targeted.
- Turnover in staff.
- Difficult to maintain a steady flow in the program to reach our goal.

ACTION PLAN: TCP tailored their goals for the coming year to address the challenges they've faced.



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TRANSPORTATION COACHING

Housing, Employment, and Education

Housing Type at Intake (n=32)	
78%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
3%	Unhoused
0%	Acute medical hospital
3%	Acute psychiatric facility or hospital
0%	Hospital
6%	Assisted living facility
3%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
6%	Another housing status
0%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

9% of clients
were employed or volunteering at intake

(n = 3)

88% of clients
were enrolled in or completed school at intake

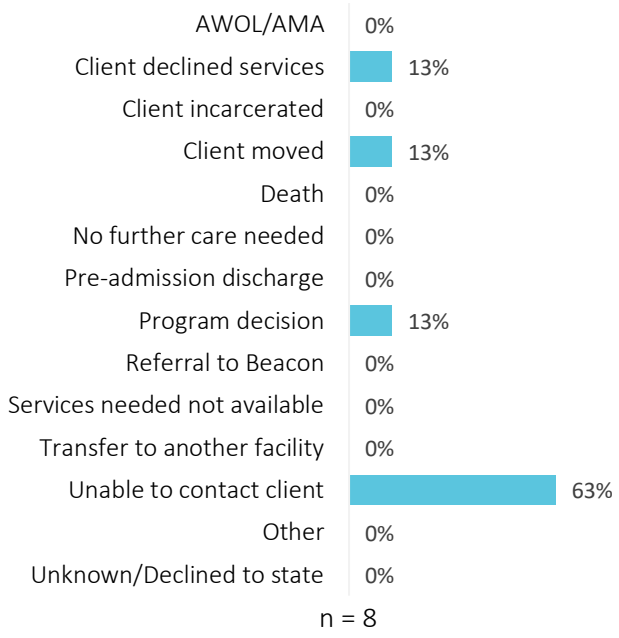
(n = 28)

Discharge Information

29 clients were **discharged**.

69% had **achieved some to all of their goals**.

Reason for Discharge



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TRANSPORTATION COACHING

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	6%
Black / African American	28%
Native Hawaiian / Other Pacific Islander	0%
White	56%
Another	9%
Unknown/Declined to state	0%

n = 32

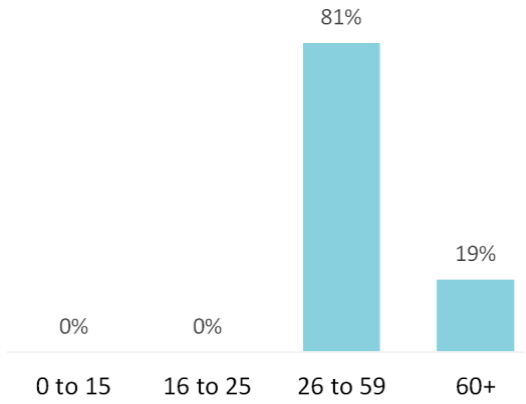
More than one race could be selected. Percentages may exceed 100%.

34% Hispanic/Latino
56% Not Hispanic/Latino

n = 32

9% Unknown/Declined to state.

Age



n = 32

0% of individuals did not answer this question.

Disability

Mental	81%
Visual	0%
Hearing	0%
Speech	0%
Mobility	3%
Developmental	6%
Another Disability	0%
No Disability	9%
Unknown/Declined to state	0%

n = 32

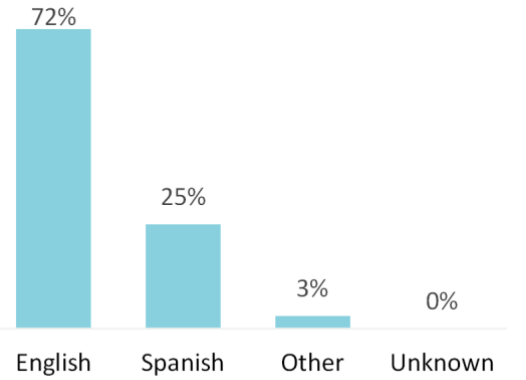
More than one disability could be selected. Percentages may exceed 100%.

91% of individuals reported having one or more disabilities

n = 32

0% Unknown/Declined to state.

Primary Language



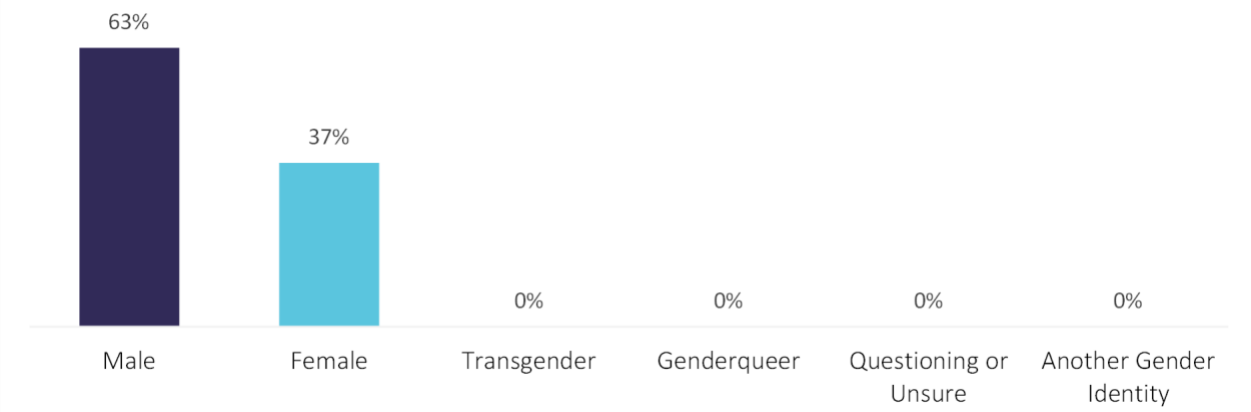
n = 32

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TRANSPORTATION COACHING

Demographic Data

Gender Identity



n = 32
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	13%
Gay or Lesbian	0%
Bisexual	6%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	81%

n = 32

Sex at Birth

Male	63%
Female	37%
Another Sex	0%
Unknown/Declined to state	0%

n = 32

0% of individuals were veterans

n = 32
3% Unknown/Declined to state.

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CSS-11: DUAL DIAGNOSIS

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ACADEMY DAY PROGRAM

The Wellness & Recovery Academy is certified by the State of California, Department of Healthcare Services, as a Full Day Rehabilitation Program for consumers dealing with serious mental illnesses and substance use disorders. Our program offers a range of services, including skills-building groups, group therapy, community meetings, process groups, therapeutic milieu, service plan development, community outings, and adjunctive therapies.

Our extended Day Rehabilitation program provides flexible, longer-term treatment options after residential care, with a maximum program duration of 2 years. The Wellness and Recovery Academy Day Rehabilitation program (Academy), guided by Harm Reduction principles, supports consumers in developing coping and recovery skills for successful community reintegration, improved functioning, and a higher quality of life.

We offer evaluation, rehabilitation, and mental health services aimed at maintaining or restoring personal independence and functioning. These services encompass psycho-educational groups, process groups, and individual therapy facilitated by dedicated clinicians within our program.

Successes and Highlights

- Reopened as a separate program from Bridge House, which provides participants with a safe and confidential space distinct from residential that enables participants to engage honestly about challenges without the concern of their housing being impacted due to a conflict of interest.
- Fully staffed with a Program Director, a Behavioral Health Clinician, two Counselor IIIs, an Administrative Assistant, and a Wellness Navigator.
- Current staff each have different facilitation styles and educational backgrounds, which aids in diversifying the skills and techniques provided to support and promote recovery.

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ACADEMY DAY PROGRAM

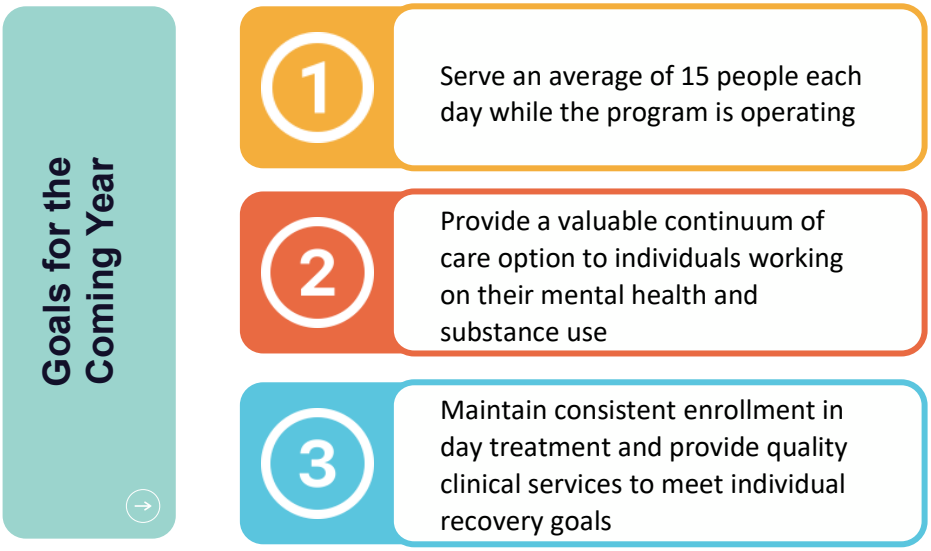
Challenges & Growth Opportunities

CHALLENGES: The Wellness & Recovery Academy faced challenges this period.

- Closure of the Academy during Q3 of 2020 due to the COVID-19 Pandemic.
- Rebuilding the client base beyond Bridge House residents after reopening for the 2022-2023 fiscal year.
- Initial staffing challenges, including having only one full-time facilitator and the Program Director upon reopening.
- Delays in hiring a new Program Director after the original one moved within the agency.
- Challenges arising from limited building space, leading to overcrowding, lower attendance, and engagement.

ACTION PLAN: The Wellness & Recovery Academy developed an action plan to addresses these challenges.

- The Program Director will initiate clear discharge planning conversations with clients at the beginning of enrollment, tailoring plans to outpatient versus Bridge House enrolled clients.
- Conduct individual meetings with clients to create and follow through with personalized discharge plans aligned with their treatment goals.
- Educate potential referral sources about Academy services to boost referrals and admissions.
- Attend staff meetings to promote awareness of the essential services provided by the Academy within the community.
- Implement the practice of splitting groups into smaller, more intimate sessions when they become too large to enhance client support.
- Foster better communication between Academy staff and Bridge House and Shelter Cove through meetings to improve service consistency for the shared.



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BRIDGE HOUSE

Bridge House ("Bridge") is a transitional residential treatment program for adults with co-occurring serious mental illnesses and substance use disorders. Staff utilizes Motivational Interviewing and Harm Reduction in providing counseling services and other activities. Clients' goals are focused on mental health wellness and substance use recovery principles. Clients work to improve symptom management, personal, social, and family functioning, and gain substance use recovery skills. Services are provided on an individual, group, and milieu basis. Therapeutic groups are offered during daytime hours, Monday to Friday. The program is licensed by the California Department of Social Services, Community Care Licensing as a social rehabilitation facility and certified by the Department of Healthcare Services for transitional residential treatment. Clients are referred by the Monterey County Behavioral Health Bureau or by Interim case coordinators.

Successes and Highlights

- Reached 96.7% of goal to maintain average monthly occupancy of 92%.
- 100% of consumers were discharged to a lower level of care.
- 81% of consumers remained abstinent from substances while receiving services.

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BRIDGE HOUSE

Challenges & Growth Opportunities

CHALLENGES: Bridge House faced several challenges this period.

- The program director's medical leave was extended until september 2022.
- Understaffing at the beginning of the fiscal year added pressure on current staff, impacting program operations.
- The Bienestar Clinic, an outstanding clinic connected to Monterey County Behavioral Health, closed its services to new patients. This negatively impacted consumers ability to establish a primary care physician, resulting in consumers using urgent care or emergency room services more frequently as their first approach for physical health needs.
- Challenges in obtaining collaboration from other medical professionals for Community Care Licensing (CCL) documentation.
- The need to increase nursing hours continues and is necessary to provide quality care and attention for physical health conditions/needs, primarily to support consumers with restricted health care conditions (such as asthma, sleep apnea, and diabetes).

ACTION PLAN: Bridge House developed plans to address these challenges.

- To address program occupancy, Bridge staff will collaborate with short-term crisis Manzanita programs for increased referrals to Bridge House, including monthly presentations, biweekly Program Director meetings, and outreach to MCBH and other referral sources.
- To increase consumer support as part of discharge planning and maintain their stability and abstinence after discharge, Bridge will actively collaborate with Shelter Cove to prepare clients for their semi-independent living setting starting two months before discharge. Bridge staff will also actively seek family members and such supporters for consumers, involving them in consumer care and inviting them to monthly support team meetings to increase consumer supportive networks outside of Interim, inc.



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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.

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CSS-13: JUSTICE-INVOLVED FSP

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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.



- **43 clients served** in FY 22-23
- On average, clients engaged in services for **203 days**

Housing

Housing Type Before Services (n=43)		Current Housing Type (n=20)
7%	Independent house or apartment	5%
0%	With friends/family	0%
0%	Shelter or temporary housing	2%
23%	Unhoused	7%
0%	Acute medical hospital	0%
0%	Acute psychiatric facility or hospital	0%
0%	Hospital	0%
0%	Assisted living facility	5%
9%	Residential treatment facility	12%
0%	Foster home	0%
0%	Group home	0%
0%	STRTP	0%
58%	Jail or juvenile detention facility	14%
0%	Another housing status	0%
2%	Unknown/decline to state*	58%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 23 missing "current housing type" statuses and 2 unknown/decline to state "current housing type" statuses from Avatar.

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CREATING NEW CHOICES FSP

Employment and Education

Changes in Employment and Education

0% of clients
are currently employed
or volunteering

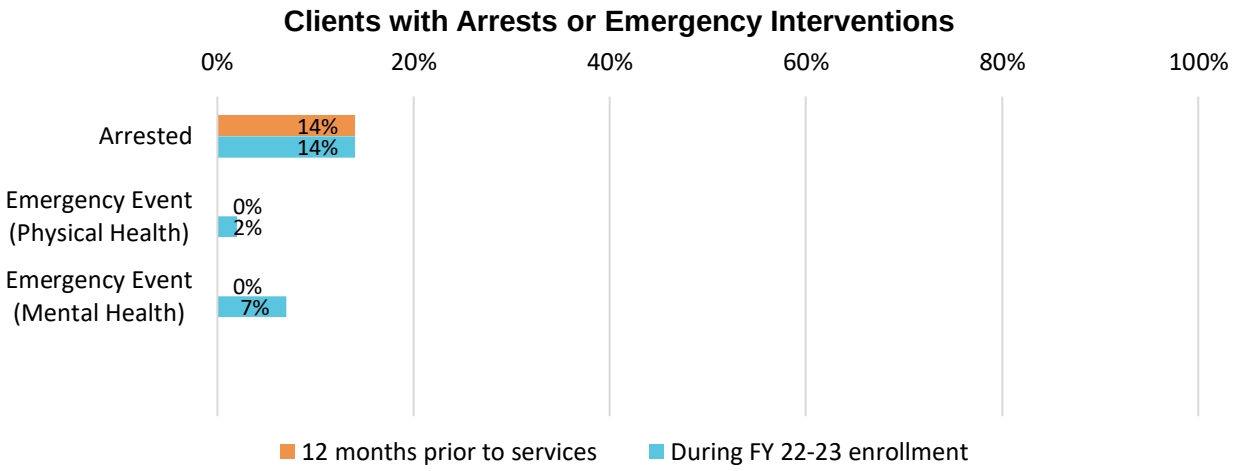
compared to 5% before
program engagement

12% of clients
are currently enrolled in
or completed school

compared to 86% before
program engagement

Emergency Events & Arrests

Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.



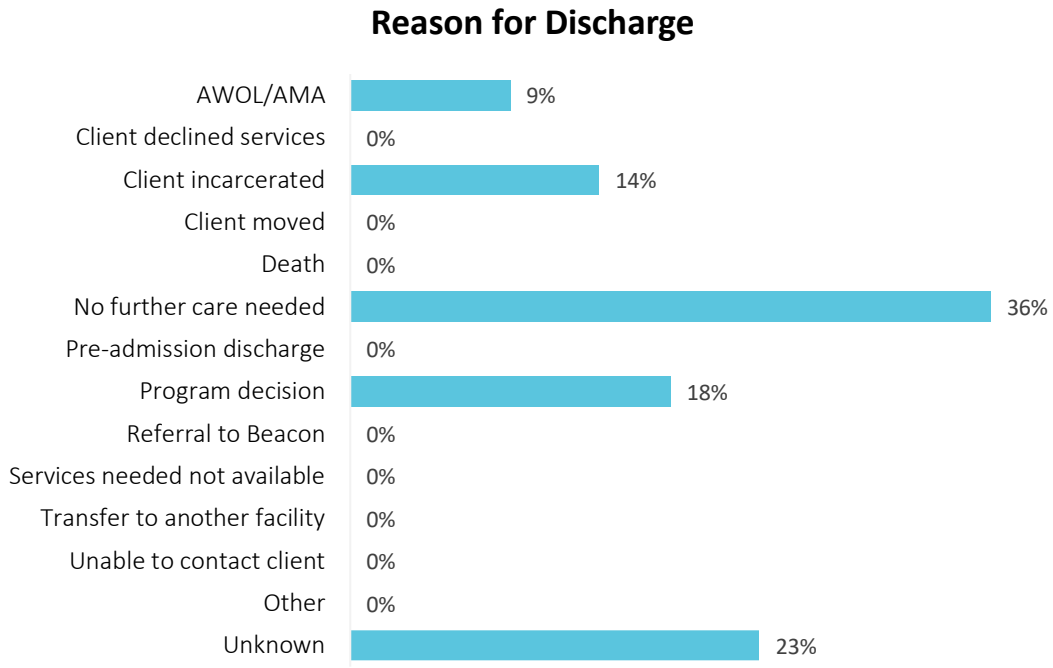
n = 1 – 6

0% for physical health and mental health emergency events in 12 months prior to services.

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CREATING NEW CHOICES FSP

Discharge Information



n = 22

36 clients were **discharged**.

39% had
achieved some to all of their goals.

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CREATING NEW CHOICES FSP

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	19%
Black / African American	23%
Native Hawaiian / Other Pacific Islander	0%
White	47%
Another	12%
Unknown/Declined to state	0%

n = 43

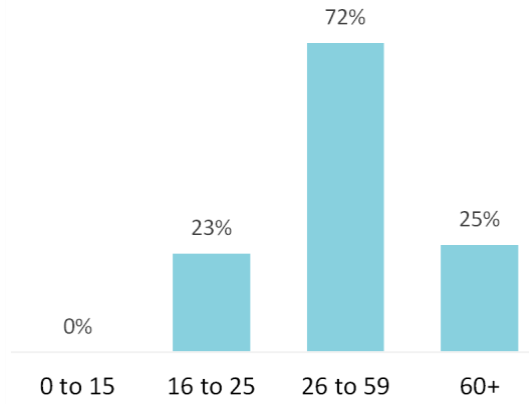
More than one race could be selected. Percentages may exceed 100%.

42% Hispanic/Latino
47% Not Hispanic/Latino

n = 43

12% Unknown/Declined to state.

Age



n = 43

0% of individuals did not answer this question.

Disability

Mental	91%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	9%
Unknown/Declined to state	0%

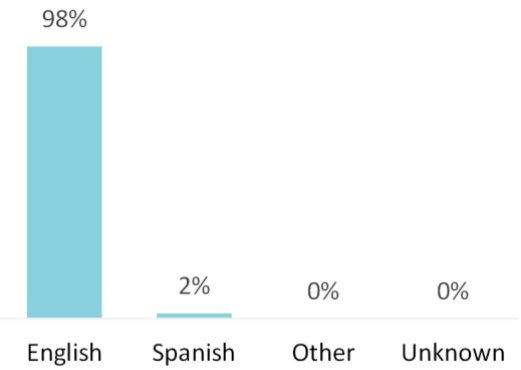
n = 43

More than one disability could be selected. Percentages may exceed 100%.

91% of individuals reported having one or more disabilities

n = 43

Primary Language



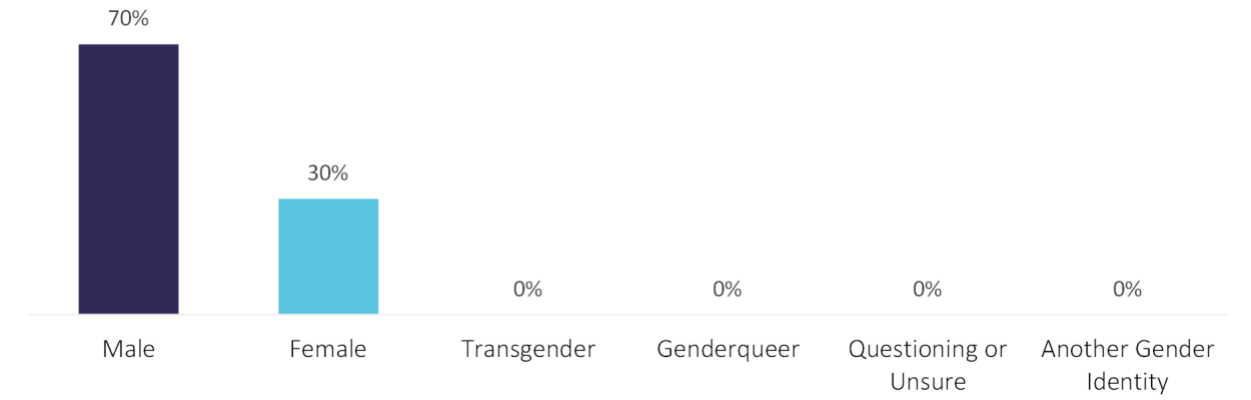
n = 43

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

CREATING NEW CHOICES FSP

Demographic Data

Gender Identity



n = 43
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	51%
Gay or Lesbian	5%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	5%
Unknown/Declined to state	40%

n = 43

Sex at Birth

Male	70%
Female	30%
Another Sex	0%

n = 43

0% of individuals were veterans

n = 39
14% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

JUVENILE MENTAL HEALTH COURT/COLLABORATIVE ACTION LINKING ADOLESCENTS FSP

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



- **32 clients served** in FY 22-23
- On average, clients engaged in services for **185 days**

Housing

Housing Type Before Services (n=32)		Current Housing Type (n=22)
88%	Independent house or apartment	25%
0%	With friends/family	0%
0%	Shelter or temporary housing	0%
0%	Unhoused	0%
0%	Acute medical hospital	9%
0%	Acute psychiatric facility or hospital	9%
0%	Hospital	0%
0%	Assisted living facility	0%
0%	Residential treatment facility	0%
0%	Foster home	0%
0%	Group home	0%
0%	STRTP	0%
13%	Jail or juvenile detention facility	22%
0%	Another housing status	0%
0%	Unknown/decline to state*	34%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 10 missing "current housing type" statuses and 1 unknown/decline to state "current housing type" status from Avatar.

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JUVENILE MENTAL HEALTH COURT/COLLABORATIVE ACTION LINKING ADOLESCENTS FSP

Employment and Education

Changes in Employment and Education

0% of clients
are currently employed
or volunteering

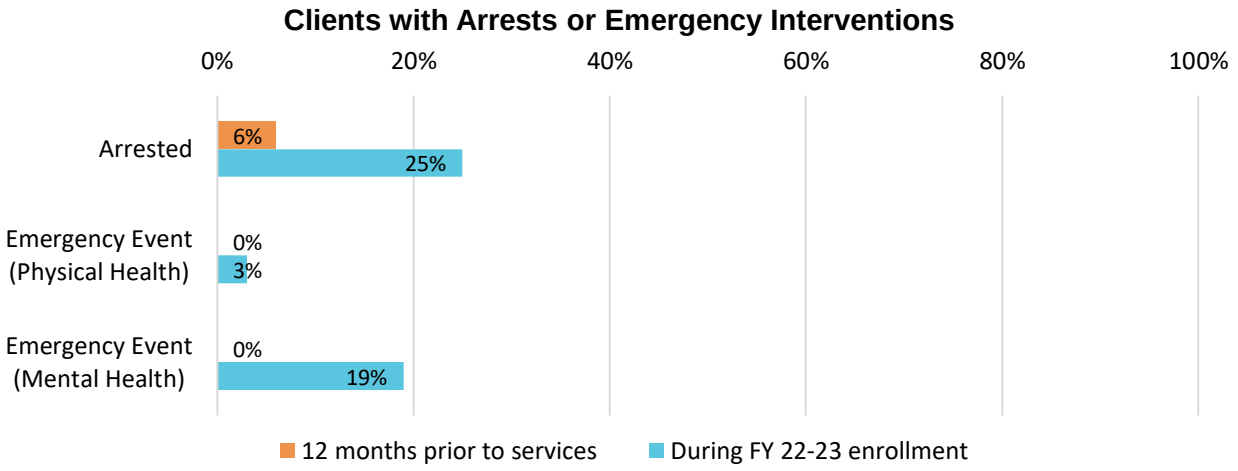
compared to 6% before
program engagement

25% of clients
are currently enrolled in
or completed school

compared to 97% before
program engagement

Emergency Events & Arrests

Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.



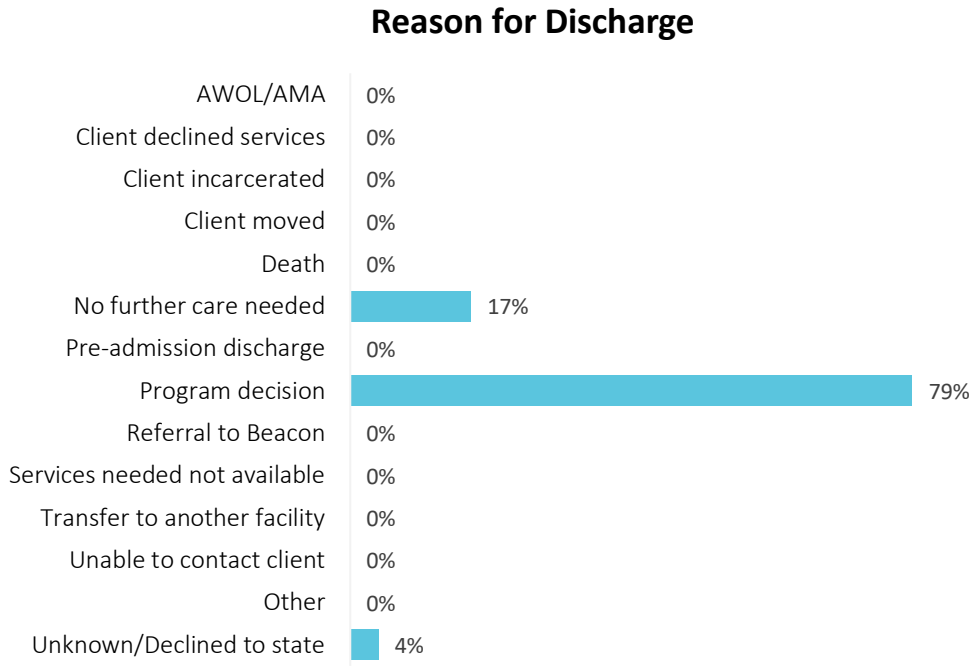
n = 1 – 8

0% for physical health and mental health emergency events in 12 months prior to services.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

JUVENILE MENTAL HEALTH COURT/COLLABORATIVE ACTION LINKING ADOLESCENTS FSP

Discharge Information



n = 24

26 clients were **discharged**.

<1% had **achieved some to all of their goals**.

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JUVENILE MENTAL HEALTH COURT/COLLABORATIVE ACTION LINKING ADOLESCENTS FSP

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	13%
Black / African American	56%
Native Hawaiian / Other Pacific Islander	0%
White	16%
Another	16%
Unknown/Declined to state	0%

n = 32

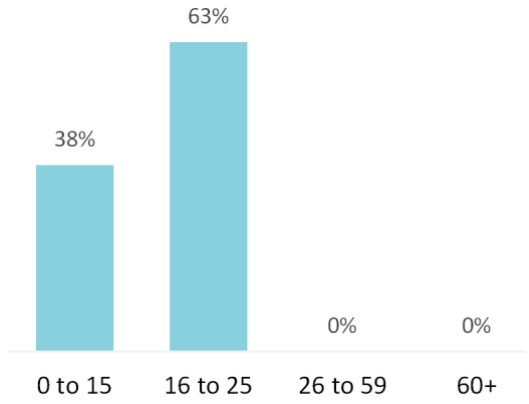
More than one race could be selected. Percentages may exceed 100%.

69% Hispanic/Latino
16% Not Hispanic/Latino

n = 32

16% Unknown/Declined to state.

Age



n = 32

0% of individuals did not answer this question.

Disability

Mental	22%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	78%
Unknown/Declined to state	0%

n = 32

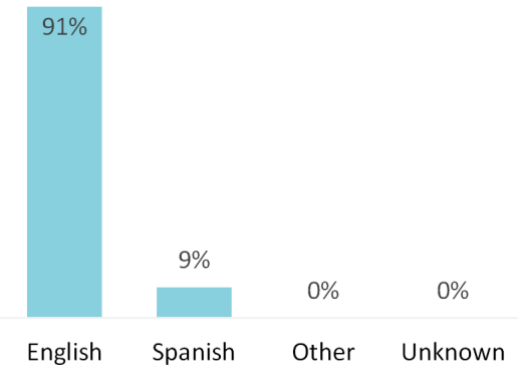
More than one disability could be selected. Percentages may exceed 100%.

22% of individuals reported having one or more disabilities

n = 32

0% Unknown/Declined to state.

Primary Language



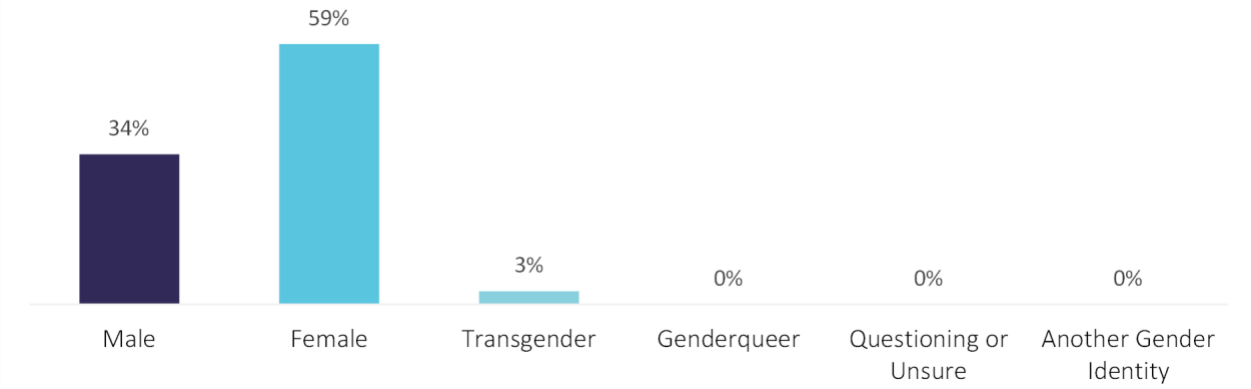
n = 32

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

JUVENILE MENTAL HEALTH COURT/COLLABORATIVE ACTION LINKING ADOLESCENTS FSP

Demographic Data

Gender Identity



n = 32
3% Unknown/Declined to state

Sexual Orientation

Heterosexual or Straight	53%
Gay or Lesbian	0%
Bisexual	3%
Questioning or Unsure	0%
Another Sexual Orientation	6%
Unknown/Declined to state	38%

n = 32

Sex at Birth

Male	34%
Female	66%
Another Sex	0%
Unknown/Declined to state	0%

n = 32

0% of individuals were veterans

n = 32
0% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

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.



- **37 clients served** in FY 22-23
- On average, clients engaged in services for **356 days**

Housing

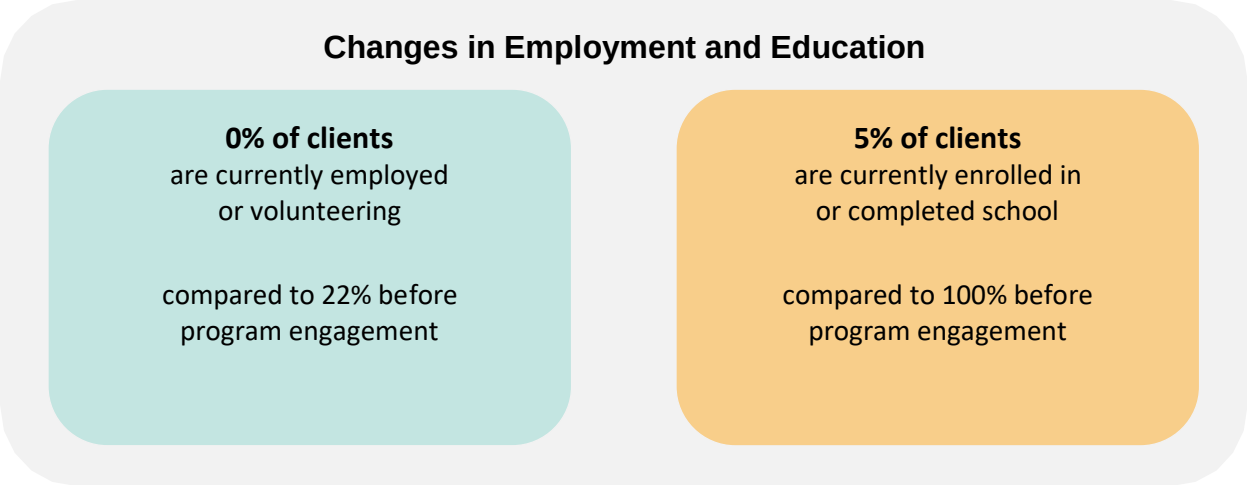
Housing Type Before Services (n=37)		Current Housing Type (n=2)
81%	Independent house or apartment	5%
0%	With friends/family	0%
0%	Shelter or temporary housing	0%
0%	Unhoused	0%
0%	Acute medical hospital	0%
0%	Acute psychiatric facility or hospital	0%
0%	Hospital	0%
0%	Assisted living facility	0%
0%	Residential treatment facility	0%
0%	Foster home	0%
0%	Group home	0%
0%	STRTP	0%
19%	Jail or juvenile detention facility	0%
0%	Another housing status	0%
0%	Unknown/Declined to state*	95%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 35 missing "current housing type" statuses.

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JUVENILES WHO SEXUALLY OFFEND RESPONSE TEAM FSP

Employment and Education



Emergency Events & Arrests

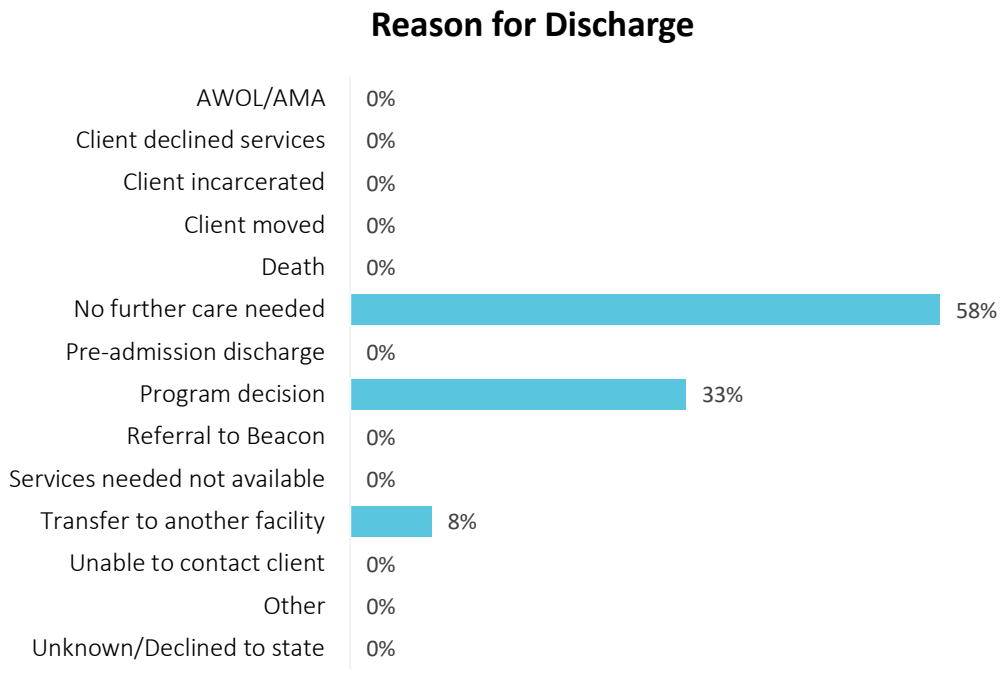
Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.

No clients were arrested or experienced a physical or mental health emergency during either time point.

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JUVENILES WHO SEXUALLY OFFEND RESPONSE TEAM FSP

Discharge Information



n = 12

26 clients were **discharged**.

50% had **achieved some to all of their goals**.

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JUVENILES WHO SEXUALLY OFFEND RESPONSE TEAM FSP

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	3%
Black / African American	76%
Native Hawaiian / Other Pacific Islander	0%
White	3%
Another	19%
Unknown/Declined to state	0%

n = 37

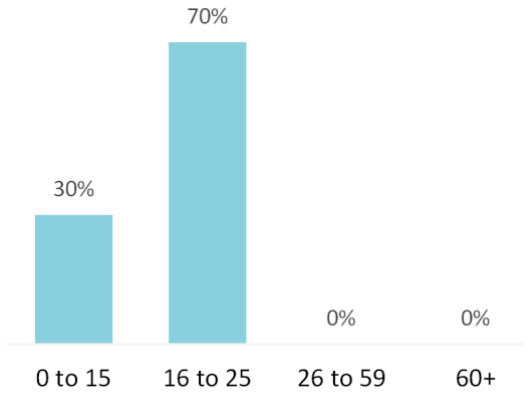
More than one race could be selected. Percentages may exceed 100%.

78% Hispanic/Latino
3% Not Hispanic/Latino

n = 37

19% Unknown/Declined to state.

Age



n = 37

0% of individuals did not answer this question.

Disability

Mental	3%
Visual	0%
Hearing	0%
Speech	3%
Mobility	0%
Developmental	3%
Another Disability	3%
No Disability	89%
Unknown/Declined to state	0%

n = 37

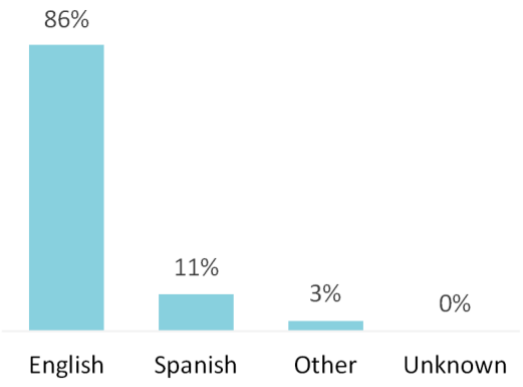
More than one disability could be selected. Percentages may exceed 100%.

11% of individuals reported having one or more disabilities

n = 37

0% Unknown/Declined to state.

Primary Language



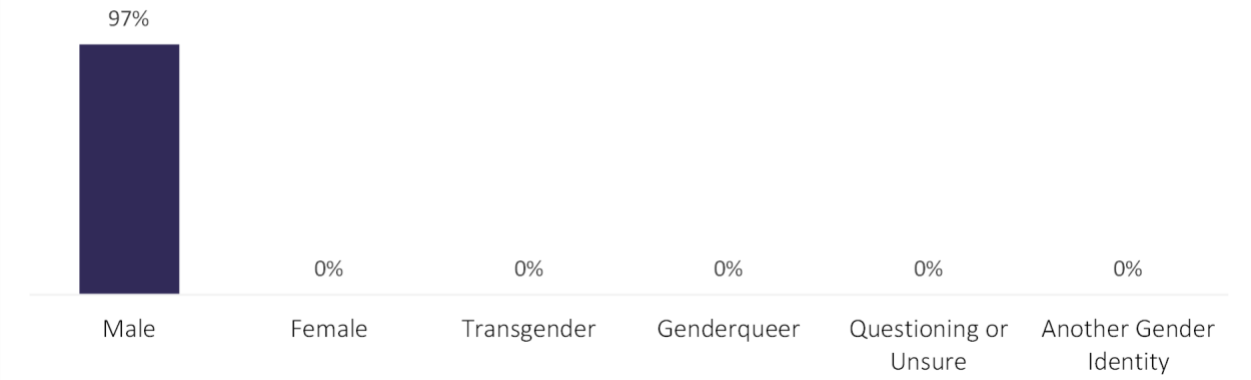
n = 37

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JUVENILES WHO SEXUALLY OFFEND RESPONSE TEAM FSP

Demographic Data

Gender Identity



n = 37
3% Unknown/Declined to state

Sexual Orientation

Heterosexual or Straight	32%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	68%

n = 37

Sex at Birth

Male	100%
Female	0%
Another Sex	0%
Unknown/Declined to state	0%

n = 37

0% of individuals were veterans

n = 37
0% Unknown/Declined to state.

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CSS-14: HOMELESS SERVICES AND SUPPORTS FSP

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MHSA HOMELESS FSP (FORMERLY MCHOME)

The MHSA Homeless program is a Full-Service Partnership (FSP) that offers comprehensive support and outreach to adults with a psychiatric disability who are homeless or at high risk of homelessness. The program's main objective is to assist adults with mental illness, including those already receiving care from the Adult System of Care and Access, in transitioning from the streets to stable housing and employment or benefits.

To achieve this, the program provides various services such as outreach, assessments, intensive case management, mental health services, and assistance with daily living skills. Medication Support Services are offered by a team consisting of an Interim psychiatrist, registered nurse, certified nurse specialist, licensed vocational nurse, nurse practitioner, Physician Assistant, or psychiatric technician. In the event of staff vacancies, MCBH will step in to provide psychiatric services.

This program empowers consumers to actively participate in decision-making regarding their mental health care. It ensures that individuals have the necessary information to make deliberate and informed choices about their treatment options and overall mental health care. The service array offered by MCHOME includes intensive case management and mental health services, which are provided in the FSP model as required by funding from the Mental Health Services Act. Additionally, independent living skills development is provided to assist residents in living self-sufficiently within the community.

One of the housing options available through MHSA Homeless is Wesley Oaks, an intensive permanent supportive housing program. Wesley Oaks caters to 4 very low-income individuals with a serious mental health diagnosis, all of whom are either homeless or at high risk of homelessness. This program provides a Full-Service Partnership level of services to support their needs.

MidPen's Moon Gate Plaza serves as a permanent housing facility where MHSA Homeless offers FSP level services to up to 20 low-income individuals who have a serious mental health diagnosis. All of the clients served by MCHOME are either homeless or at risk of homelessness. Clients who no longer require FSP level services are transitioned to CH scattered site housing, while those who still require this level of care remain in MCHOME Housing.

Sun Rose Housing, which is funded through No Place Like Home and other government funds, is currently under construction and is expected to be ready for occupancy in mid FY 2022-23. This housing facility will provide 8 transitional housing beds and 7 permanent housing units. It will serve as a central location that fosters positive peer support and provides consumers with the necessary tools to maintain housing.



- **124 clients served** in FY 22-23
- On average, clients engaged in services for **889 days**

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MHSA HOMELESS FSP (FORMERLY MCHOME)

Successes and Highlights

- 89% of consumers were shown to maintain or improve their mental health while in the MCHOME program, per the Reaching Recovery Assessment.
- 76% (10 of 15 consumers) were residing in transitional or permanent housing the day they were discharged from the MCHOME program.
- 92% of consumers who completed the Consumer Satisfaction Survey reported satisfaction with the quality of services provided.

Challenges & Growth Opportunities

CHALLENGES: MHSA Homeless faced challenges this period.

- Relationships with motels continue to be a challenge.
- Due to client behaviors/damages in the past during motel stays, MHSA Homeless is limited on which motels can be utilized.
- Communication with hospitals has been a challenge for the purposes of continuity of care.
- Staff have had difficulty connecting with hospital staff and developing a discharge plan.

ACTION PLAN: MHSA Homeless tailored their goals for the coming year to address the challenges they've faced.



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MHSA HOMELESS FSP (FORMERLY MCHOME)

Housing, Employment, and Education

Housing Type at Intake (n=124)	
12%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
71%	Unhoused
0%	Acute medical hospital
1%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
13%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
3%	Another housing status
0%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

7% of clients
were employed or volunteering at intake

(n = 9)

93% of clients
were enrolled in or completed school at intake

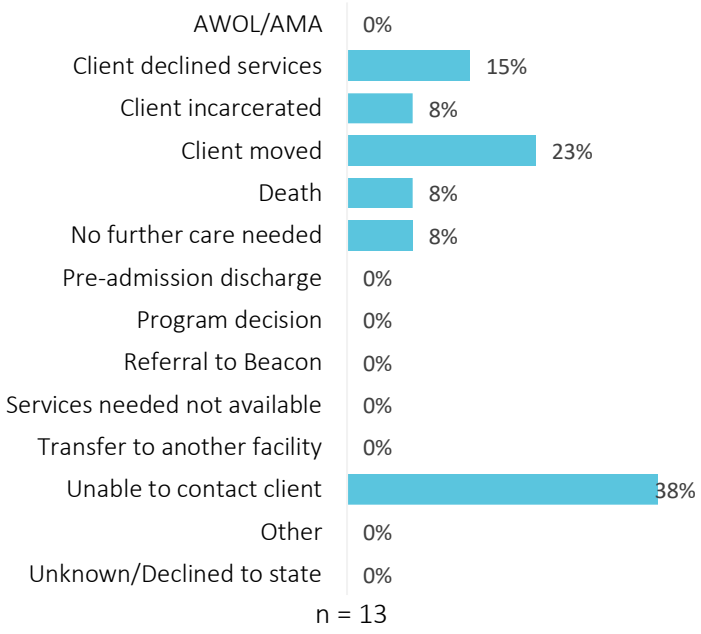
(n = 115)

Discharge Information

57 clients were **discharged**.

63% had **achieved some to all of their goals**.

Reason for Discharge



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MHSA HOMELESS FSP (FORMERLY MCHOME)

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	6%
Black / African American	16%
Native Hawaiian / Other Pacific Islander	0%
White	66%
Another	12%
Unknown/Declined to state	0%

n = 124

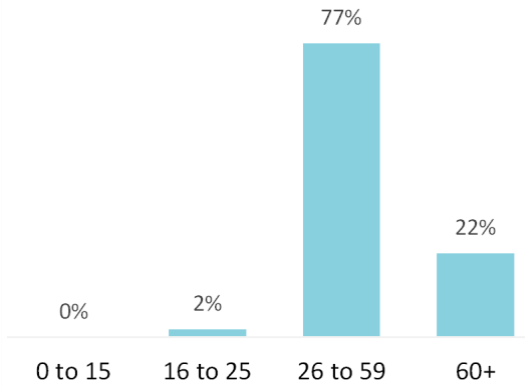
More than one race could be selected. Percentages may exceed 100%.

22% Hispanic/Latino
66% Not Hispanic/Latino

n = 124

12% Unknown/Declined to state.

Age



n = 124

0% of individuals did not answer this question.

Disability

Mental	87%
Visual	1%
Hearing	1%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	1%
No Disability	10%
Unknown/Declined to state	0%

n = 124

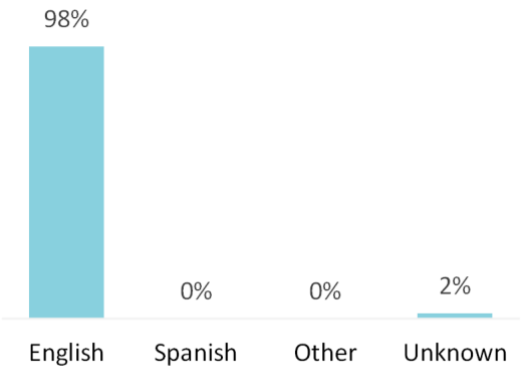
More than one disability could be selected. Percentages may exceed 100%.

90% of individuals reported having one or more disabilities

n = 124

0% Unknown/Declined to state.

Primary Language



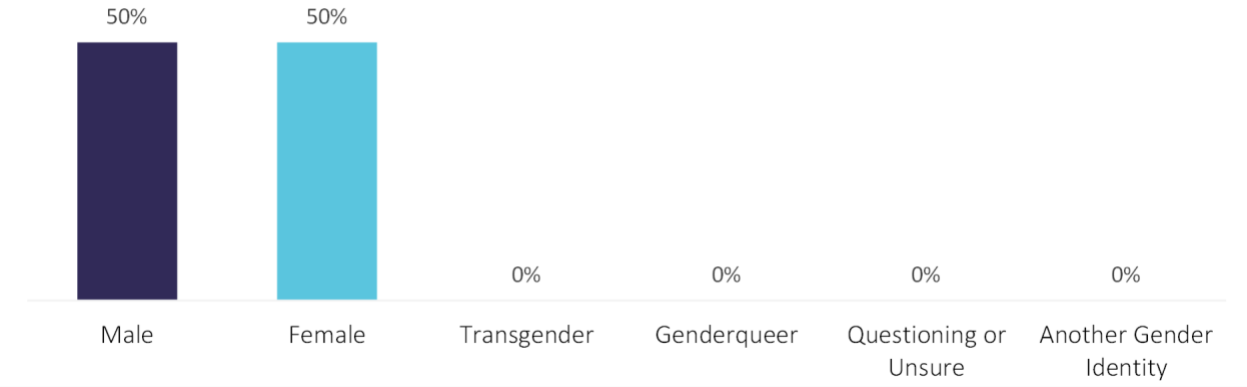
n = 124

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

MHSA HOMELESS FSP (FORMERLY MCHOME)

Demographic Data

Gender Identity



n = 124
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	32%
Gay or Lesbian	2%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	2%
Unknown/Declined to state	65%

n = 124

Sex at Birth

Male	50%
Female	50%
Another Sex	0%
Unknown/Declined to state	0%

n = 124

0% of individuals were veterans

n = 124
1% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

LUPINE GARDENS FSP

Lupine Gardens is an intensive permanent supportive housing program, which provides a Full Service Partnership (FSP) level of services to 20 very low-income individuals with a serious mental health diagnosis, all of whom are homeless or at high risk of homelessness.

The service array includes: intensive case management provided in the FSP model as required by Mental Health Services Act funding, and assistance with daily living skills i.e., meals, house cleaning, self-administration of medication, and laundry services in order to live independently in the community.



- **22 clients served** in FY 22-23
- On average, clients engaged in services for **2,929 days**

Successes and Highlights

- 94% of consumers surveyed reported satisfaction with the quality of services provided.
- 100% of consumers are engaged with their PCP.
- 82% of consumers served during this FY were not hospitalized.
- 100% of consumers were not incarcerated during this FY.

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LUPINE GARDENS FSP

Challenges & Growth Opportunities

CHALLENGES: Lupine Gardens faced challenges this period.

- Lupine has 10 clients who are under 56 years old.
- Cannabis use has increased at Lupine.

ACTION PLAN: Lupine Gardens developed an action plan to address these challenges.

- Staff will work on ways to incorporate more creative interventions, such as:
  - Guided conversations about cannabis use.
  - Collaborating with doctors to establish a plan to reduce unwanted symptoms.
  - Enlisting peers who don't use cannabis to support clients.
  - Implementing Cognitive Behavioral Therapeutic interventions.
  - Utilizing Motivational Interviewing techniques.
  - Developing different interventions to improve clients' ability to manage symptoms.
  - Exploring resources in the community to assist clients in having structure throughout their day.



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LUPINE GARDENS FSP

Housing

Housing Type Before Services (n=22)		Current Housing Type (n=45)
32%	Independent house or apartment	5%
0%	With friends/family	82%
0%	Shelter or temporary housing	5%
0%	Unhoused	0%
0%	Acute medical hospital	0%
0%	Acute psychiatric facility or hospital	5%
0%	Hospital	0%
0%	Assisted living facility	95%
9%	Residential treatment facility	14%
0%	Foster home	0%
0%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	0%
59%	Another housing status	0%
52%	Unknown/Declined to state*	0%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 23 missing "housing type before services" statuses.

Employment and Education

Changes in Employment and Education

0% of clients
are currently employed or volunteering

compared to 0% before program engagement

55% of clients
are currently enrolled in or completed school

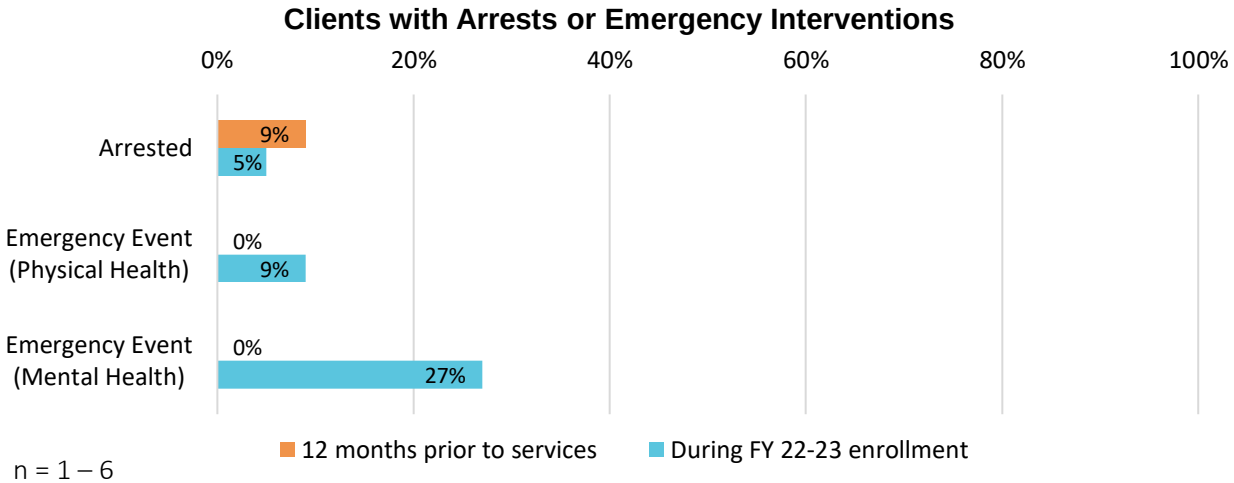
compared to 95% before program engagement

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LUPINE GARDENS FSP

Emergency Events & Arrests

Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.



n = 1 – 6

0% for physical health and mental health emergency events in 12 months prior to services.

Discharge Information*

3 clients were **discharged.**

100% had **achieved some to all of their goals.**

*Reasons for Discharge not available for this program.

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LUPINE GARDENS FSP

Demographic Data

Race

American Indian / Alaskan Native	5%
Asian	0%
Black / African American	23%
Native Hawaiian / Other Pacific Islander	0%
White	73%
Another	0%
Unknown/Declined to state	0%

n = 22

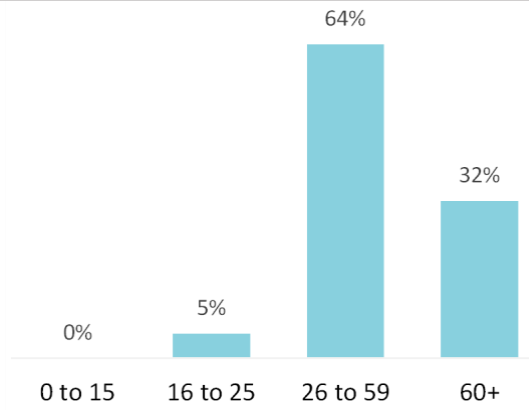
More than one race could be selected. Percentages may exceed 100%.

23% Hispanic/Latino
73% Not Hispanic/Latino

n = 22

5% Unknown/Declined to state.

Age



n = 22

0% of individuals did not answer this question.

Disability

Mental	86%
Visual	5%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	9%
Unknown/Declined to state	0%

n = 22

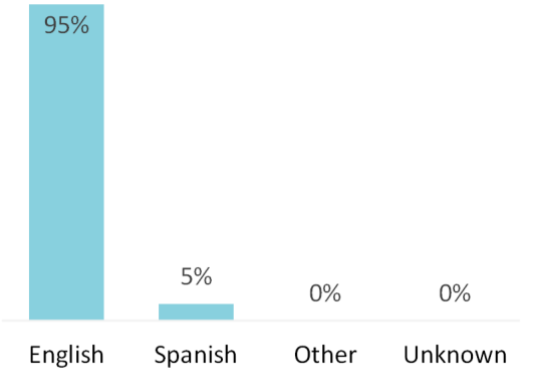
More than one disability could be selected. Percentages may exceed 100%.

91% of individuals reported having one or more disabilities

n = 22

0% Unknown/Declined to state.

Primary Language



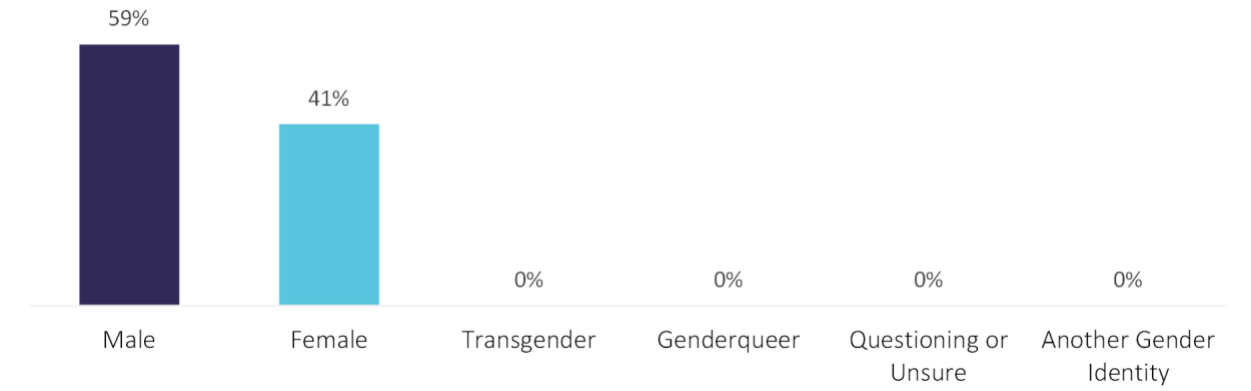
n = 22

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

LUPINE GARDENS FSP

Demographic Data

Gender Identity



n = 22
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	9%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	91%

n = 22

Sex at Birth

Male	59%
Female	41%
Another Sex	0%
Unknown/Declined to state	0%

n = 22

0% of individuals were veterans

n = 22
5% Unknown/Declined to state.

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SANDY SHORES FSP

Sandy Shores is an intensive permanent supportive housing program, which provides a Full Service Partnership (FSP) level of service for 28 very low-income individuals all of whom are homeless and have a serious mental health diagnosis that substantially interferes with their functional ability to carry out primary aspects of daily living in the community.

The service array includes intensive case management provided in the FSP model as required by Mental Health Services Act funding. All individuals receive case management, crisis intervention, mental health services, and housing services to assist individuals to live in the community.

- **34 clients served** in FY 22-23
- On average, clients engaged in services for **704 days**

Successes and Highlights

- 88% of consumers remained housed, with three out of seven discharges exiting to other permanent housing.
- 89% of residents maintained or improved their mental health recovery.
- 91% of residents actively engaged in medical services with their Primary Care Physician.

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SANDY SHORES FSP

Challenges & Growth Opportunities

CHALLENGES: Sandy Shores faced challenges this period.

- Only 15% of residents, out of a goal of 25%, attained employment, attended school, or attended a vocational training program.
    - Despite not meeting the goal, there was a 6% increase compared to the previous fiscal year.
- Some residents have expressed interest in work but face challenges, including:
    - Needing a vehicle for transportation to work.
    - Losing a previously provided bus route near the program.
    - Challenges related to psychiatric illness impacting motivation and energy.
- The change in bus routes has made it more difficult for residents with mobility and other health issues to access bus stops and be independent and involved in the community.

ACTION PLAN: Sandy Shores tailored their goals for the coming year to address the challenges they've faced.



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SANDY SHORES FSP

Housing

Housing Type Before Services (n=34)		Current Housing Type (n=42)
21%	Independent house or apartment	74%
0%	With friends/family	9%
0%	Shelter or temporary housing	3%
18%	Unhoused	9%
0%	Acute medical hospital	0%
3%	Acute psychiatric facility or hospital	6%
0%	Hospital	0%
0%	Assisted living facility	9%
29%	Residential treatment facility	15%
0%	Foster home	0%
0%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	0%
29%	Another housing status	0%
19%	Unknown/Declined to state*	0%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 8 missing "housing type before services" statuses.

Employment and Education

Changes in Employment and Education

12% of clients
are currently employed or volunteering

compared to 9% before program engagement

68% of clients
are currently enrolled in or completed school

compared to 94% before program engagement

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SANDY SHORES FSP

Emergency Events & Arrests

Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.

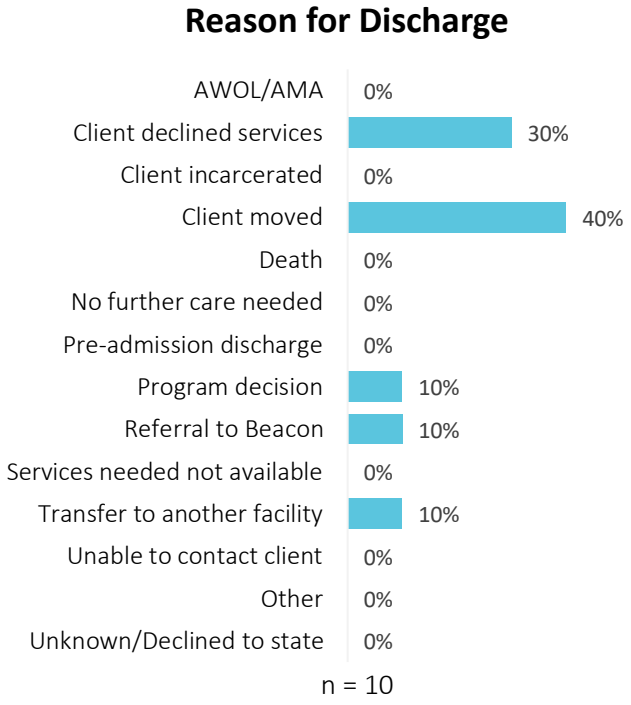
12 months prior to accessing services: No clients were arrested or experienced a physical or mental health emergency.

During FY 22-23 enrollment: No clients were arrested or experienced a physical health emergency. 12% (n = 4) of clients experienced a mental health emergency.

Discharge Information

12 clients were **discharged**.

8% had **achieved some to all of their goals**.



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SANDY SHORES FSP

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	3%
Black / African American	18%
Native Hawaiian / Other Pacific Islander	0%
White	79%
Another	0%
Unknown/Declined to state	0%

n = 34

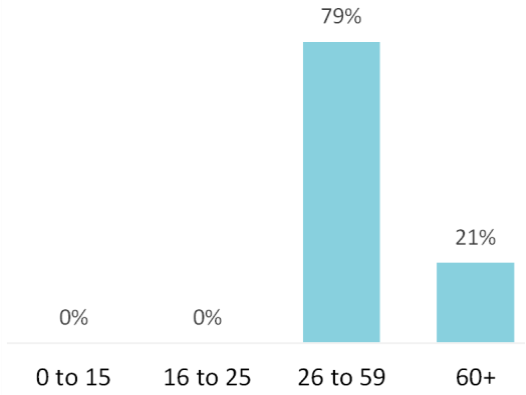
More than one race could be selected. Percentages may exceed 100%.

21% Hispanic/Latino
79% Not Hispanic/Latino

n = 34

0% Unknown/Declined to state.

Age



n = 34

0% of individuals did not answer this question.

Disability

Mental	94%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	6%
Unknown/Declined to state	%

n = 34

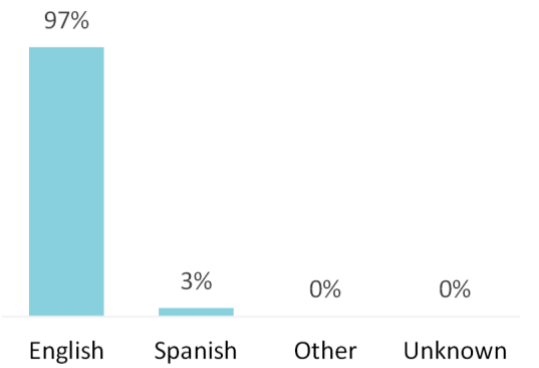
More than one disability could be selected. Percentages may exceed 100%.

94% of individuals reported having one or more disabilities

n = 34

0% Unknown/Declined to state.

Primary Language



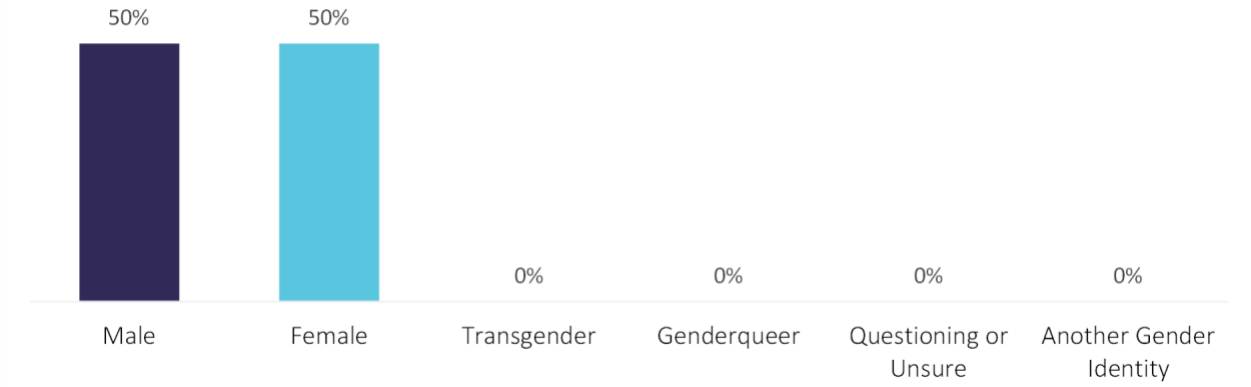
n = 34

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SANDY SHORES FSP

Demographic Data

Gender Identity



n = 34
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	68%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	32%

n = 34

Sex at Birth

Male	50%
Female	50%
Another Sex	0%
Unknown/Declined to state	0%

n = 34

0% of individuals were veterans

n = 34
0% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

SUNFLOWER GARDENS

Sunflower Gardens is an intensive permanent and transitional supportive housing program, which provides Full Service Partnership (FSP) level of services to 23 very low-income 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 provided in the FSP model as required by Mental Health Services Act funding, assistance in accessing benefits, and assistance with daily living skills in order to help consumers meet the terms of their lease and live independently in the community.



- **28 clients served** in FY 22-23
- On average, clients engaged in services for **1,347 days**

Successes and Highlights

- 82% of consumers remained housed during the operating year.
- 93% of consumers engaged with their primary care physician.
- 96% of consumers served did not experience incarceration, while in the program.

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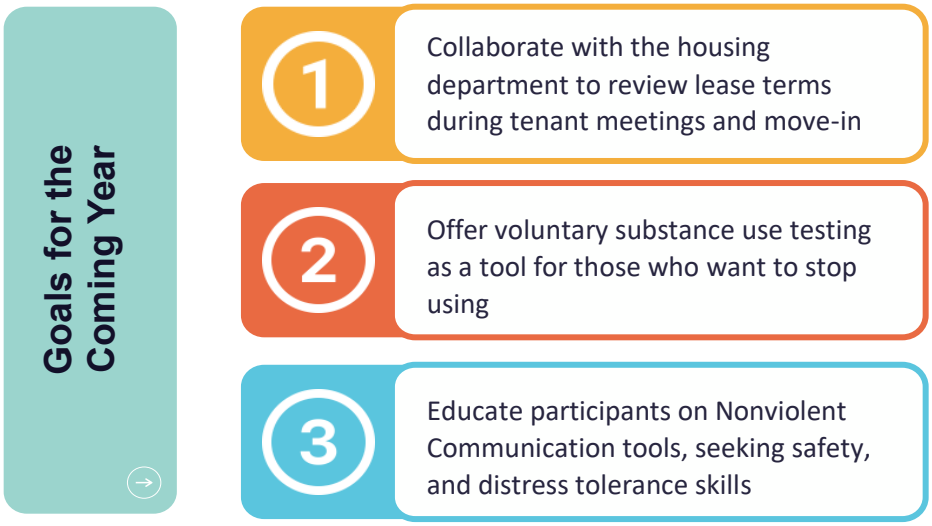
SUNFLOWER GARDENS

Challenges & Growth Opportunities

CHALLENGES: Sunflower Gardens faced challenges this period.

- Ongoing changes in support staff made it challenging for participants to engage and build trust.
- Challenges with participants meeting the terms of their lease due to non-payment of rent and severe substance use.
- 17 out of 28 participants had a co-occurring substance use diagnosis.
- Participants were at different stages of their recovery.
    - Co-occurring substance use exacerbated symptoms of mental illness.
    - Impact on engagement in services.
    - Increased interpersonal conflicts.
- The community's sense of safety was greatly impacted by an individual having weapons on the property.
    - The individual did not want to vacate their transitional unit.

ACTION PLAN: Sunflower Gardens tailored their goals for the coming year to address the challenges they've faced.



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SUNFLOWER GARDENS

Housing

Housing Type Before Services (n=28)		Current Housing Type (n=55)
46%	Independent house or apartment	50%
0%	With friends/family	29%
0%	Shelter or temporary housing	18%
18%	Unhoused	25%
0%	Acute medical hospital	11%
0%	Acute psychiatric facility or hospital	14%
0%	Hospital	0%
4%	Assisted living facility	18%
29%	Residential treatment facility	25%
0%	Foster home	0%
0%	Group home	0%
0%	STRTP	0%
0%	Jail or juvenile detention facility	0%
4%	Another housing status	7%
49%	Unknown/Declined to state*	0%

Clients may have more than one housing type. Percentages may exceed 100%.
*Unknown/Declined to state includes 27 missing "housing type before services" statuses.

Employment and Education

Changes in Employment and Education

4% of clients
are currently employed or volunteering

compared to 14% before program engagement

64% of clients
are currently enrolled in or completed school

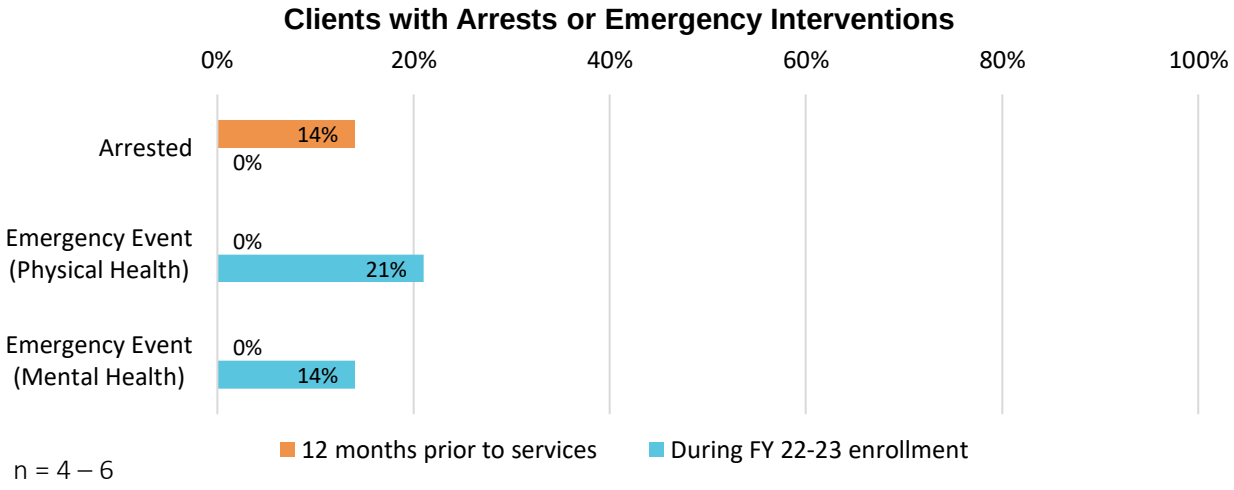
compared to 86% before program engagement

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SUNFLOWER GARDENS

Emergency Events & Arrests

Physical health emergency events, mental health emergency events, and arrests are reported for all clients in FSPs. These metrics are compared between 12 months prior to accessing services and the current year of engagement in the program.



n = 4 – 6

0% arrested during FY 22-23 enrollment. 0% for physical health and mental health emergency events in 12 months prior to services.

Discharge Information*

9 clients were **discharged.**

67% had **achieved some to all of their goals.**

*Reasons for Discharge are not available for this program.

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SUNFLOWER GARDENS

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	4%
Black / African American	18%
Native Hawaiian / Other Pacific Islander	0%
White	75%
Another	4%
Unknown/Declined to state	0%

n = 28

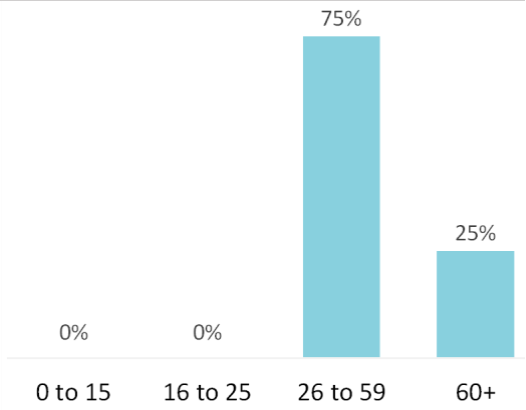
More than one race could be selected. Percentages may exceed 100%.

21% Hispanic/Latino
75% Not Hispanic/Latino

n = 28

4% Unknown/Declined to state.

Age



n = 28

0% of individuals did not answer this question.

Disability

Mental	93%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	2%
Unknown/Declined to state	0%

n = 28

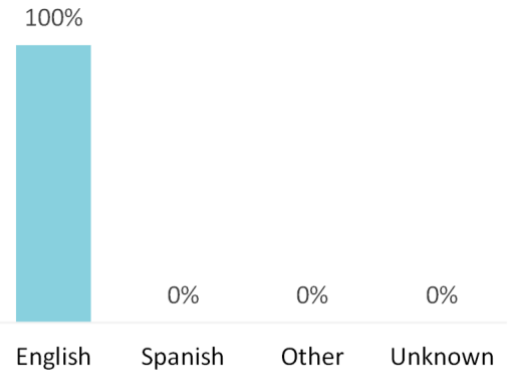
More than one disability could be selected. Percentages may exceed 100%.

93% of individuals reported having one or more disabilities

n = 28

0% Unknown/Declined to state.

Primary Language



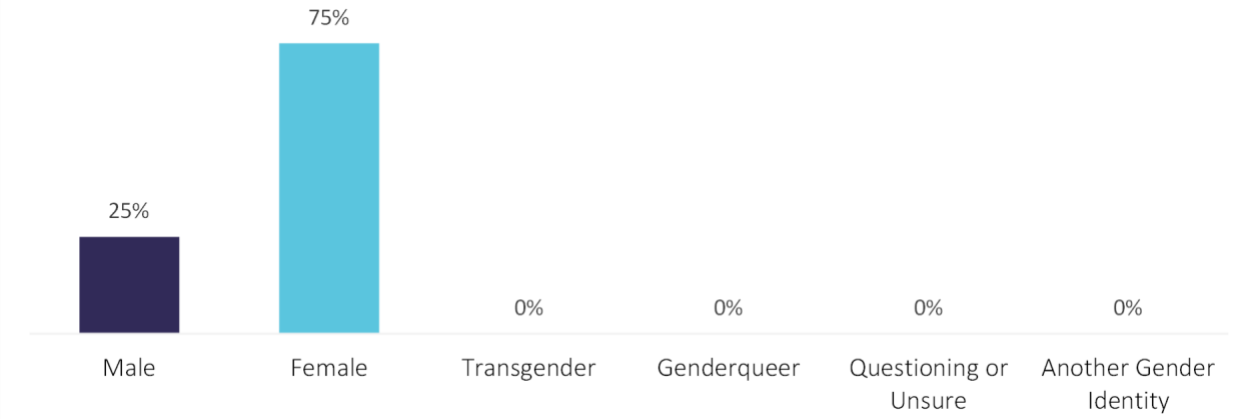
n = 28

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SUNFLOWER GARDENS

Demographic Data

Gender Identity



n = 28
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	32%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	68%

n = 28

Sex at Birth

Male	25%
Female	75%
Another Sex	0%
Unknown/Declined to state	0%

n = 28

0% of individuals were veterans

n = 28
0% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

CSS-15: HOMELESS OUTREACH AND TREATMENT

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MCHOME HOMELESS OUTREACH & ENGAGEMENT

The MCHOME Program, a Full-Service Partnership (FSP), offers comprehensive wraparound support and outreach to homeless or high-risk-of-homelessness adults with psychiatric disabilities. Our mission is to assist adults with mental illness, including those under the Adult System of Care and Access, in transitioning from homelessness to stable housing and employment or benefits. We achieve this through outreach, assessments, intensive case management, mental health services, daily living skills assistance, and Medication Support Services provided by qualified medical professionals.

Psychiatric services are offered by an Interim team, with backup support from MCBH if necessary. This approach empowers consumers to make informed choices about their mental health care and treatment options.

Within MCHOME, Wesley Oaks provides intensive permanent supportive housing for four very low-income individuals with serious mental health diagnoses who are homeless or at risk of homelessness. Services include intensive case management, mental health support, and independent living skills development.

At MidPen's Moon Gate Plaza, we offer permanent housing with FSP level services to up to 20 low-income individuals experiencing serious mental health issues and homelessness. Clients no longer requiring FSP services transition to CH scattered site housing, while those needing continued support remain in MCHOME Housing.

In mid FY 2022-23, Sun Rose Housing, funded through No Place Like Home and other government funds, will open, providing eight transitional housing beds and seven permanent housing units. This housing aims to foster positive peer support, equipping consumers with the tools needed to maintain stable housing.



- **124 clients served** in FY 22-23
- On average, clients engaged in services for **889 days**

Successes and Highlights

- 89% of consumers were shown to maintain or improve their mental health while in the MCHOME program, per the Reaching Recovery Assessment.
- 76% were residing in transitional or permanent housing the day they were discharged from the MCHOME program.
- 82% met with their primary care physician.

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MCHOME HOMELESS OUTREACH & ENGAGEMENT

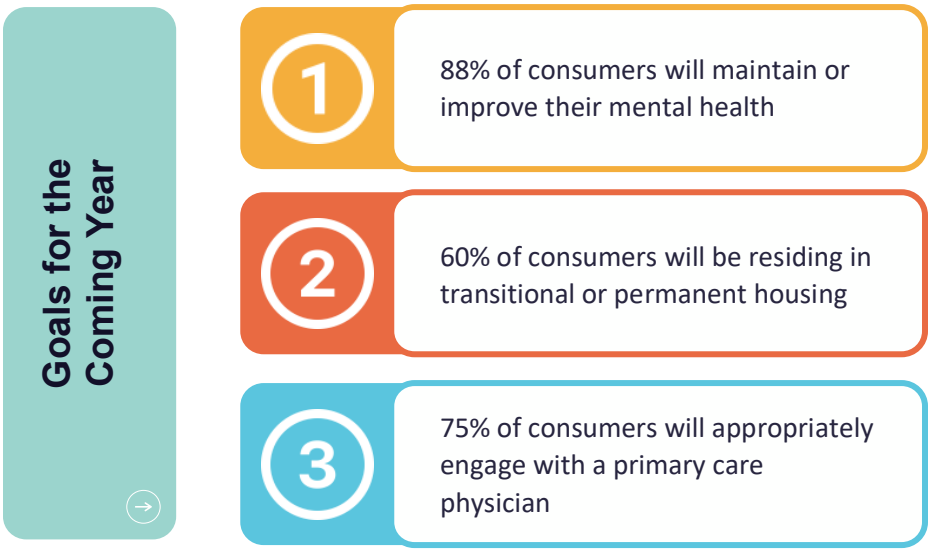
Challenges & Growth Opportunities

CHALLENGES: MCHOME faced challenges this period.

- Relationships with motels continue to be a challenge. Due to client behaviors/damages in the past during motel stays, MCHOME is limited on which motels can be utilized.
- Communication with hospitals has been a challenge for the purposes of continuity of care. Staff have had difficulty connecting with hospital staff and developing a discharge plan.

ACTION PLAN: MCHOME developed an action plan to address these challenges.

- MCHOME will continue to work towards accomplishing all of its goals by checking in with clients on a consistent basis to ensure they are meeting with a primary care physician.
- MCHOME will continue to work with motel staff to sustain a good relationship.
- Staff will work to identify points of contact at hospitals to improve the continuity of care upon discharge from hospitals. opportunities.



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ROCKROSE GARDENS

Rockrose Gardens is a permanent supportive housing program that offers housing to 20 individuals with a serious mental health diagnosis, of which 9 are homeless or at risk of homelessness. Interim, Inc. provides case management, crisis intervention, and mental health services to residents in compliance with state guidelines and MHSA funding regulations.

- **21 clients served** in FY 22-23
- On average, clients engaged in services **for 2,265 days**

Successes and Highlights

- 95% of consumers remained housed or exited to other permanent housing at the end of their opening year in the program.
- 100% of consumers maintained or improved their mental health recovery.
- 100% of consumers actively engaged in medical services with their Primary Care Physician.

Challenges & Growth Opportunities

CHALLENGES: Rockrose Gardens faced challenges this period.

- 10% of consumers attained employment (goal was 30%).
- Consumers are in different levels of their recovery.

ACTION PLAN: Rockrose Gardens tailored their goals for the coming year to address the challenges they've faced.

Goals for the Coming Year

1. Promote employment, volunteer, and educational opportunities
2. Enhance one-on-one counseling services to promote and foster community spirit
3. Facilitate on-site groups for wellness and recovery

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ROCKROSE GARDENS

Housing, Employment, and Education

Housing Type at Intake (n=21)	
86%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
0%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
10%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
5%	Another housing status
0%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

19% of clients
were employed or volunteering at intake

(n = 4)

95% of clients
were enrolled in or completed school at intake

(n = 20)

Discharge Information*

4 clients were **discharged.**



100% had
achieved some to all of their goals.

*Reasons for Discharge not available for this program.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ROCKROSE GARDENS

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	0%
Black / African American	14%
Native Hawaiian / Other Pacific Islander	0%
White	86%
Another	0%
Unknown/Declined to state	0%

n = 21

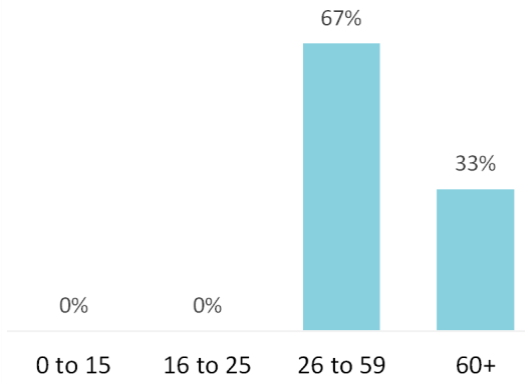
More than one race could be selected. Percentages may exceed 100%.

14% Hispanic/Latino
86% Not Hispanic/Latino

n = 21

0% Unknown/Declined to state.

Age



n = 21

0% of individuals did not answer this question.

Disability

Mental	20%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	1%
Unknown/Declined to state	0%

n = 21

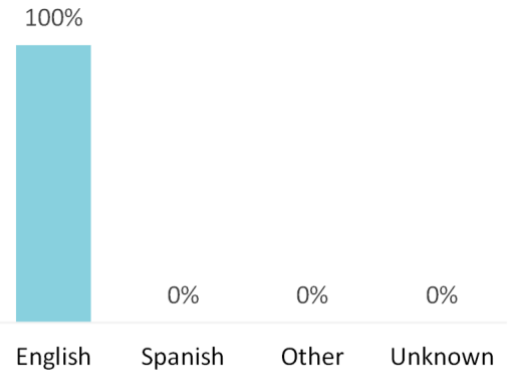
More than one disability could be selected. Percentages may exceed 100%.

95% of individuals reported having one or more disabilities

n = 21

0% Unknown/Declined to state.

Primary Language



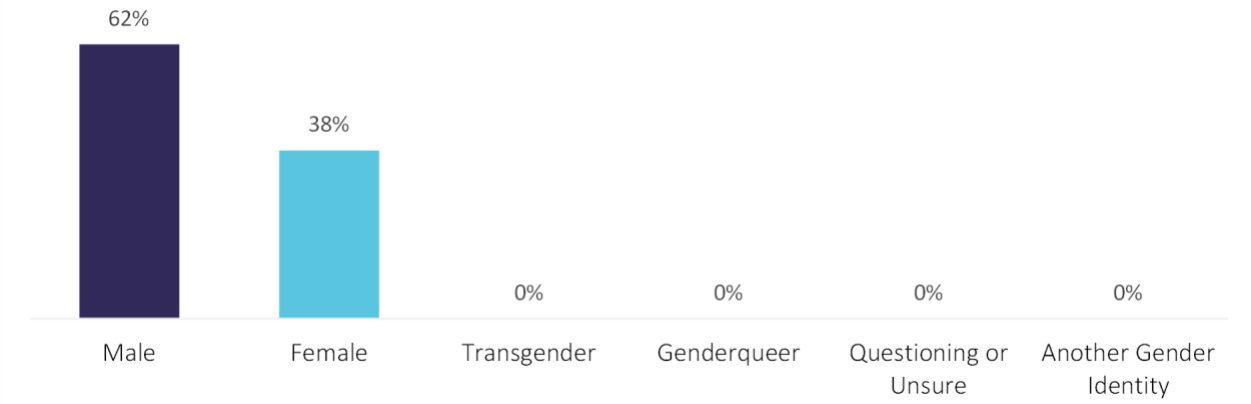
n = 21

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ROCKROSE GARDENS

Demographic Data

Gender Identity



n = 21
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	14%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	86%

n = 21

Sex at Birth

Male	62%
Female	38%
Another Sex	0%
Unknown/Declined to state	0%

n = 21

0% of individuals were veterans

n = 21
5% Unknown/Declined to state.

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SHELTER COVE

Shelter Cove is a supported transitional housing program for 39 very low-income individuals. 20 of which meet HUD CoC definitions of homelessness, while 19 residents are non-CoC residents who must meet CA qualifications for homelessness or at-risk of homelessness. All residents must have a serious mental health diagnosis that significantly affects their ability to carry out daily living activities in the community. The program provides case management, crisis intervention, mental health services, and housing services to help residents develop the skills necessary for successful independent living. The program's philosophy is based on the Social Rehabilitation Model.

- **58 clients served** in FY 22-23
- On average, clients engaged in services for **405 days**

Successes and Highlight

- During the fiscal year, 13 out of 21 discharges went to permanent and independent housing.
- There was an increase in community activities and involvement helping the community become more stable.
- There were weekly groups and resident council, community dinners five nights a week, volunteer work with the kitchen coordinator, a community store, and holiday celebrations.

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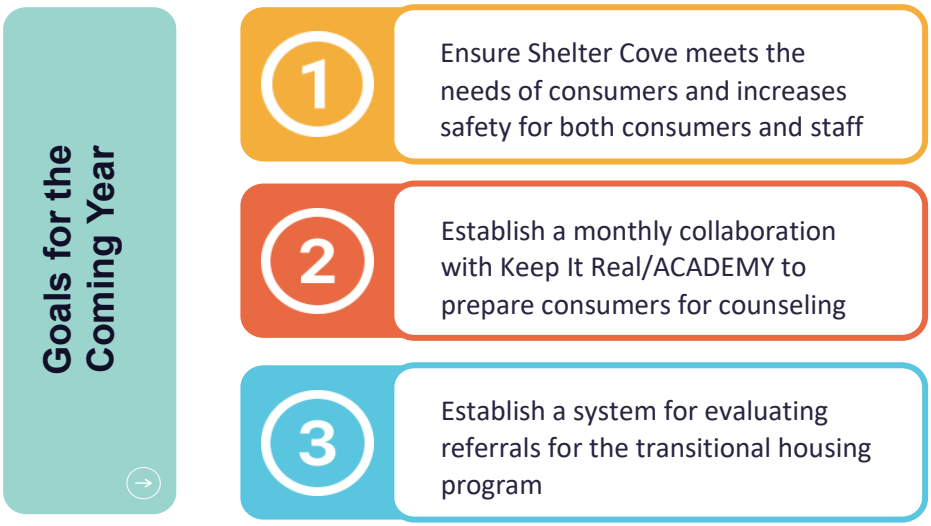
SHELTER COVE

Challenges & Growth Opportunities

CHALLENGES: Shelter Cove faced challenges this period.

- Severe staffing shortage: Only 2 out of 4 counseling positions filled for most of the year due to staff turnover and inability to hire new staff.
- Challenges in onboarding new staff: Supporting new counseling staff to gain proficiency in serving clients and meeting billing goals takes substantial time.
- Difficulty in serving and increasing community safety: Active methamphetamine use and dangerous behaviors by consumers make it challenging to engage with them.
- Lengthy eviction process: When consumers' leases are terminated due to non-engagement, the eviction process can take more than five months, impacting community safety as they continue to engage in illegal substances and harmful behaviors.

ACTION PLAN: Shelter Cove tailored their goals for the coming year to address the challenges they've faced.



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SHELTER COVE

Housing, Employment, and Education

Housing Type at Intake (n=58)	
14%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
29%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
57%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
0%	Another housing status
0%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

10% of clients
were employed or volunteering at intake

(n = 6)

86% of clients
were enrolled in or completed school at intake

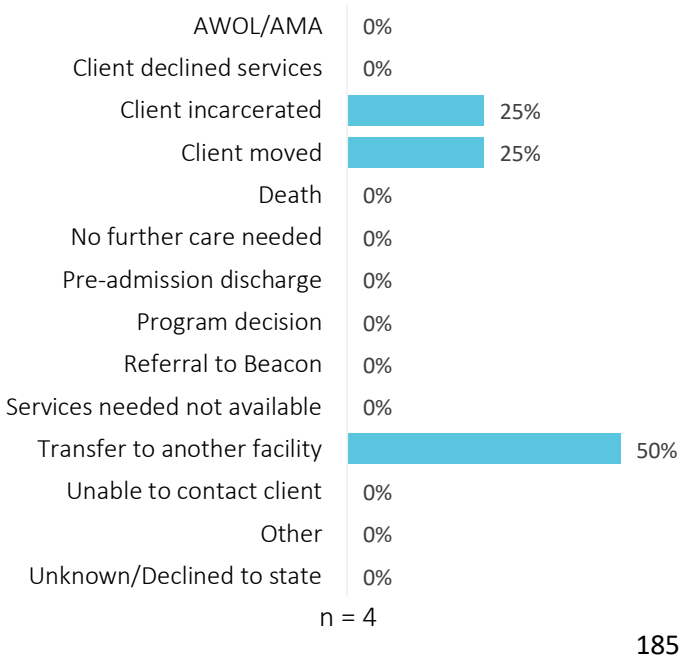
(n = 50)

Discharge Information

37 clients were **discharged**.

76% had **achieved some to all of their goals**.

Reason for Discharge



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SHELTER COVE

Demographic Data

Race

American Indian / Alaskan Native	0%
Asian	14%
Black / African American	22%
Native Hawaiian / Other Pacific Islander	0%
White	59%
Another	5%
Unknown/Declined to state	0%

n = 58

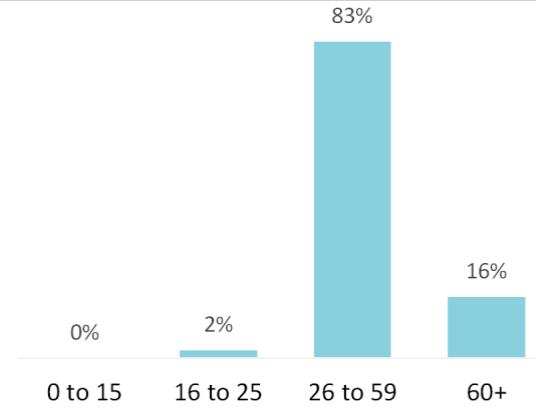
More than one race could be selected. Percentages may exceed 100%.

36% Hispanic/Latino
59% Not Hispanic/Latino

n = 58

5% Unknown/Declined to state.

Age



n = 58

0% of individuals did not answer this question.

Disability

Mental	84%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	0%
Another Disability	0%
No Disability	16%
Unknown/Declined to state	0%

n = 58

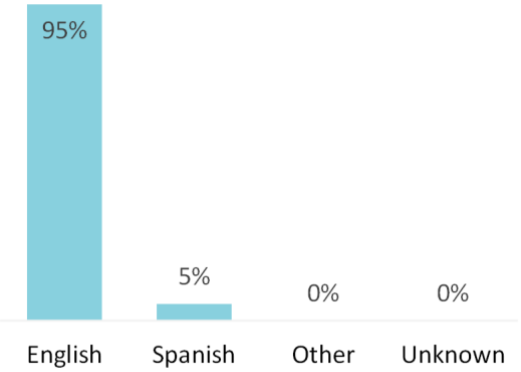
More than one disability could be selected. Percentages may exceed 100%.

84% of individuals reported having one or more disabilities

n = 58

0% Unknown/Declined to state.

Primary Language



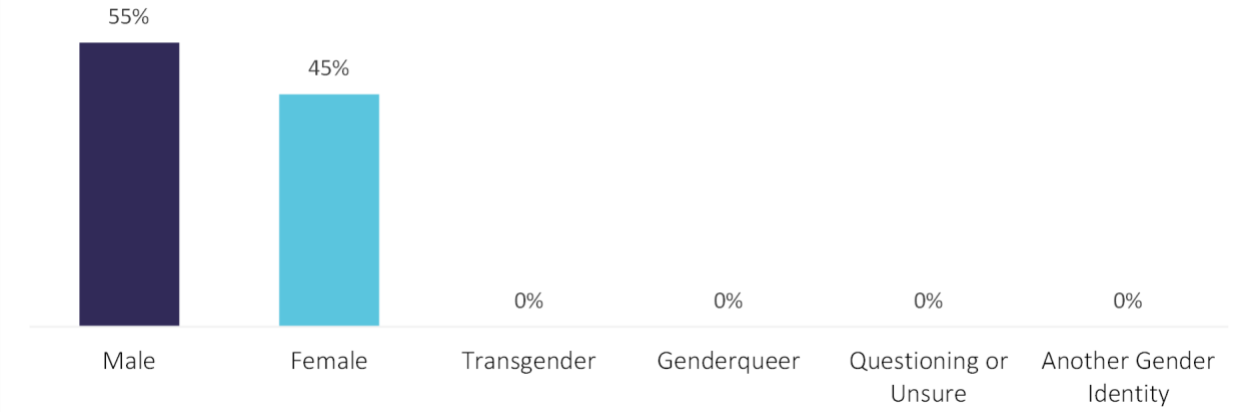
n = 58

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

SHELTER COVE

Demographic Data

Gender Identity



n = 58
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	43%
Gay or Lesbian	0%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Unknown/Declined to state	57%

n = 58

Sex at Birth

Male	53%
Female	47%
Another Sex	0%
Unknown/Declined to state	0%

n = 58

0% of individuals were veterans

n = 58
0% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

STREET OUTREACH (OUTREACH FOR YOUTH)

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.

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CSS-16: RESPONSIVE CRISIS INTERVENTIONS

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ARCHER CHILD ADVOCACY CENTER

- **215 clients served** in FY 22-23
- On average, clients engaged in services for **15 days**

Housing, Employment, and Education

Housing Type at Intake (n=215)	
96%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
0%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
0%	Assisted living facility
0%	Residential treatment facility
<1%	Foster home
0%	Group home
0%	STRTP
0%	Jail or juvenile detention facility
2%	Another housing status
1%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

<1% of clients
were employed or volunteering at intake

(n = 1)

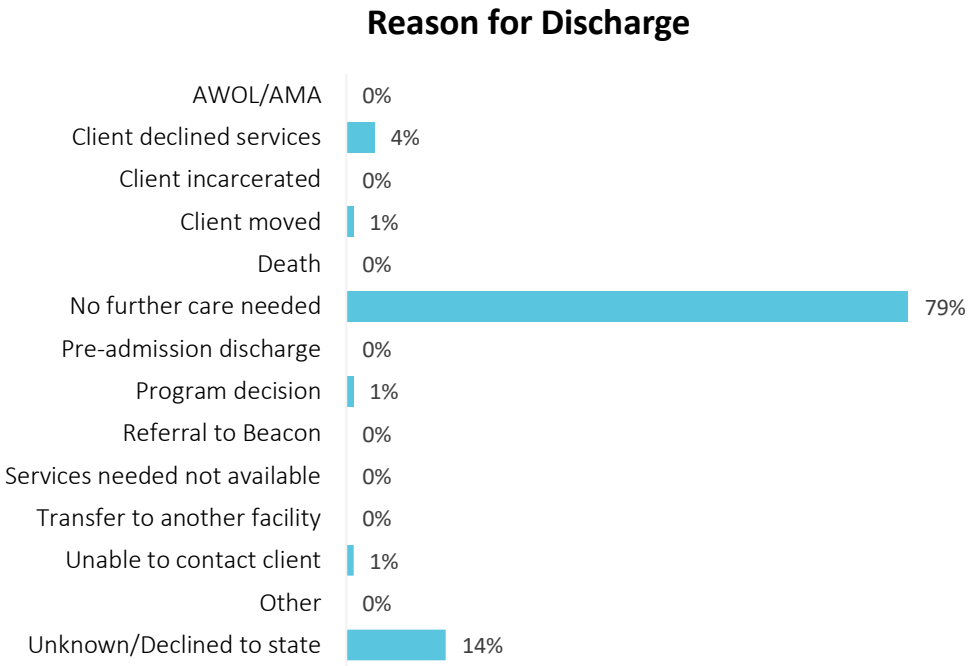
58% of clients
were enrolled in or completed school at intake

(n = 125)

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ARCHER CHILD ADVOCACY CENTER

Discharge Information



n = 214

<1% Client moved (n = 1).

215 clients were **discharged.**

0% had
achieved some to all of their goals.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ARCHER CHILD ADVOCACY CENTER

Demographic Data

Race

American Indian / Alaskan Native	1%
Asian	9%
Black / African American	39%
Native Hawaiian / Other Pacific Islander	0%
White	5%
Another	47%
Unknown/Declined to state	0%

n = 215

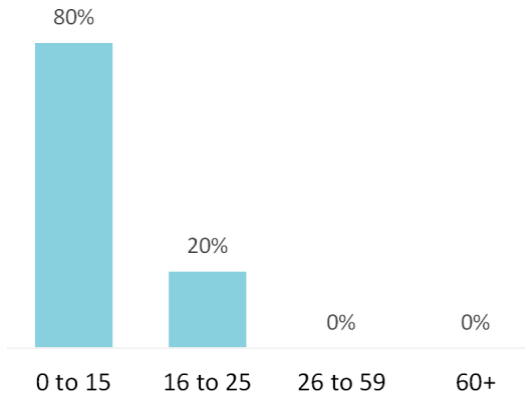
More than one race could be selected. Percentages may exceed 100%.

48% Hispanic/Latino
5% Not Hispanic/Latino

n = 215

47% Unknown/Declined to state.

Age



n = 215

0% of individuals did not answer this question.

Disability

Mental	13%
Visual	<1%
Hearing	0%
Speech	0%
Mobility	0%
Developmental	<1%
Another Disability	<1%
No Disability	93%
Unknown/Declined to state	0%

n = 215

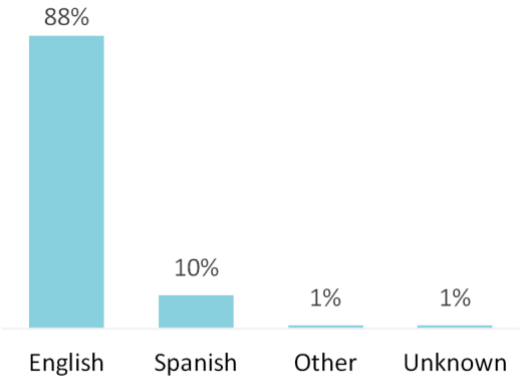
More than one disability could be selected. Percentages may exceed 100%.

6% of individuals reported having one or more disabilities

n = 215

0% Unknown/Declined to state.

Primary Language



n = 215

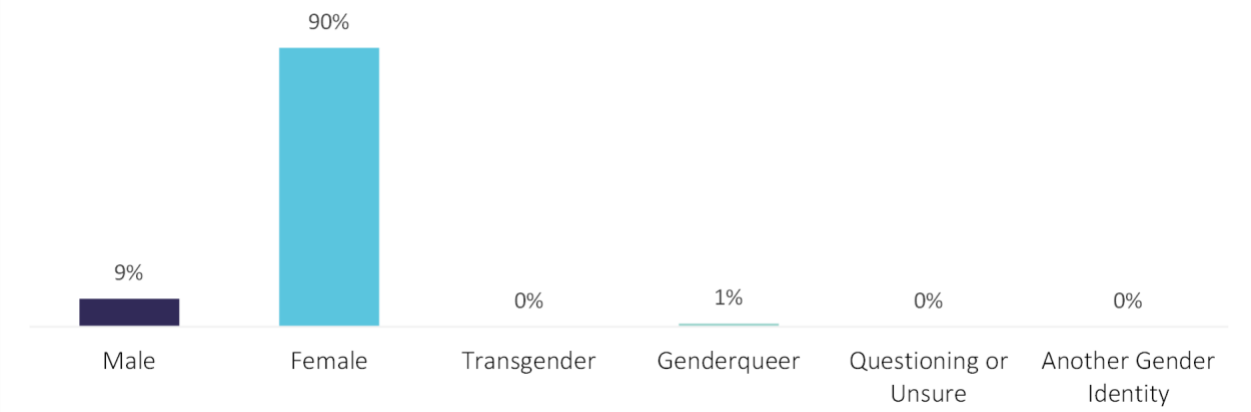
<1% Other (n = 1).

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

ARCHER CHILD ADVOCACY CENTER

Demographic Data

Gender Identity



n = 215
<1% Genderqueer (n = 1).
<1% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	2%
Gay or Lesbian	0%
Bisexual	1%
Questioning or Unsure	0%
Another Sexual Orientation	<1%
Unknown/Declined to state	96%

n = 215

Sex at Birth

Male	9%
Female	90%
Another Sex	<1%
Unknown/Declined to state	0%

n = 215

0% of individuals were veterans

n = 215
<1% Unknown/Declined to state.

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

MANZANITA HOUSE

Manzanita House is a short-term crisis residential treatment program that offers community-based rehabilitative services in a non-institutional residential setting. It serves as an alternative to inpatient psychiatric care for adult clients of the Monterey County Behavioral Health System who are experiencing an acute psychiatric episode or crisis but do not require in-patient psychiatric treatment or nursing care for medical complications.

The program and facilities are licensed by the State of California, Department of Social Services Community Care Licensing (CCL) as a "Social Rehabilitation Facility" and certified by the Department of Health Care Services as short-term Crisis Residential Treatment Service Facilities. The interventions provided focus on symptom reduction, medication, and functional stabilization. Services include behavioral health assessment, treatment planning, individual and group counseling, and the development of a community support system.

The psychiatric services team at Manzanita, led by Interim, provides care to clients, including medication support services delivered by qualified medical professionals. In the event that Interim is unable to provide services due to staff vacancies, MCBH will step in to ensure continuity of psychiatric care. This program empowers consumers to actively participate in decision-making regarding their mental health care and treatment options.



- **217 clients served** in FY 22-23
- On average, clients engaged in services for **36 days**

Successes and Highlights

- 97.59% of the program's annual occupancy goal of 6,790 bed days was met by having a total of 6,626 bed days.
- 85% of consumers reported crisis management and stabilization.
- 91% of consumers met or partially met their treatment goals.

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MANZANITA HOUSE

Challenges & Growth Opportunities

CHALLENGES: Manzanita House faced challenges this period.

- Staffing vacancies and shortages at Manzanitas pose a challenge, affecting program staffing ratios.
- Vacancies exist in various positions, including Program Director, Assistant Program Director, Counselor II, Counselor IB, Behavioral Health Clinician, and Counselor IC Overnight positions.
- Retaining employees is also a challenge for the programs.

ACTION PLAN: Manzanita House tailored their goals for the coming year to address the challenges they've faced.



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MANZANITA HOUSE

Housing, Employment, and Education

Housing Type at Intake (n=217)	
33%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
16%	Unhoused
0%	Acute medical hospital
26%	Acute psychiatric facility or hospital
0%	Hospital
1%	Assisted living facility
6%	Residential treatment facility
0%	Foster home
0%	Group home
0%	STRTP
6%	Jail or juvenile detention facility
11%	Another housing status
2%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

3% of clients
were employed or volunteering at intake

(n = 6)

86% of clients
were enrolled in or completed school at intake

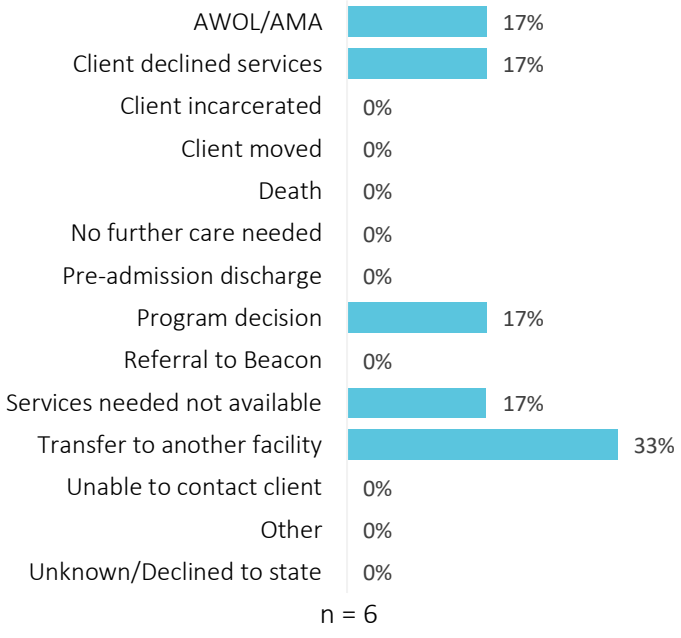
(n = 187)

Discharge Information

217 clients were **discharged**.

90% had **achieved some to all of their goals**.

Reason for Discharge



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MANZANITA HOUSE

Demographic Data

Race

American Indian / Alaskan Native	2%
Asian	14%
Black / African American	29%
Native Hawaiian / Other Pacific Islander	0%
White	48%
Another	7%
Unknown/Declined to state	0%

n = 217

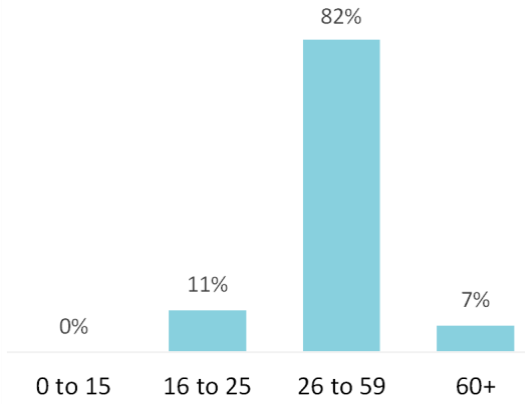
More than one race could be selected. Percentages may exceed 100%.

43% Hispanic/Latino
48% Not Hispanic/Latino

n = 217

9% Unknown/Declined to state.

Age



n = 217

0% of individuals did not answer this question.

Disability

Mental	90%
Visual	<1%
Hearing	0%
Speech	0%
Mobility	<1%
Developmental	0%
Another Disability	0%
No Disability	9%
Unknown/Declined to state	0%

n = 217

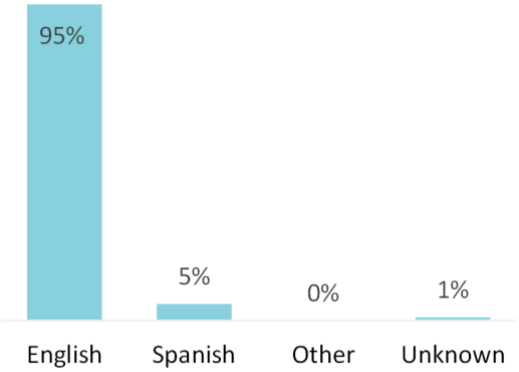
More than one disability could be selected. Percentages may exceed 100%.

91% of individuals reported having one or more disabilities

n = 217

0% Unknown/Declined to state.

Primary Language



n = 217

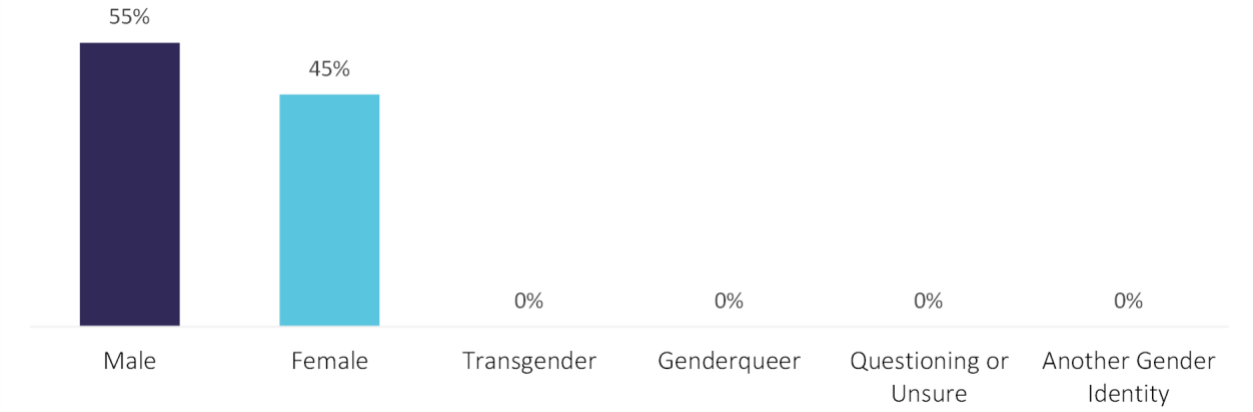
<1% Unknown/Declined to state (n = 1).

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MANZANITA HOUSE

Demographic Data

Gender Identity



n = 217
0% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	37%
Gay or Lesbian	0%
Bisexual	<1%
Questioning or Unsure	0%
Another Sexual Orientation	2%
Unknown/Declined to state	60%

n = 217

Sex at Birth

Male	56%
Female	44%
Another Sex	0%
Unknown/Declined to state	0%

n = 217

<1% of individuals were veterans

n = 217
1% Unknown/Declined to state.

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MOBILE CRISIS TEAM



- **391 clients served** in FY 22-23
- On average, clients engaged in services for **1 day**

Housing, Employment, and Education

Housing Type at Intake (n=391)	
84%	Independent house or apartment
0%	With friends/family
0%	Shelter or temporary housing
9%	Unhoused
0%	Acute medical hospital
0%	Acute psychiatric facility or hospital
0%	Hospital
<1%	Assisted living facility
4%	Residential treatment facility
0%	Foster home
<1%	Group home
0%	STRTP
1%	Jail or juvenile detention facility
1%	Another housing status
1%	Unknown/Declined to state

Clients may have more than one housing type. Percentages may exceed 100%.

10% of clients
were employed or volunteering at intake

(n = 39)

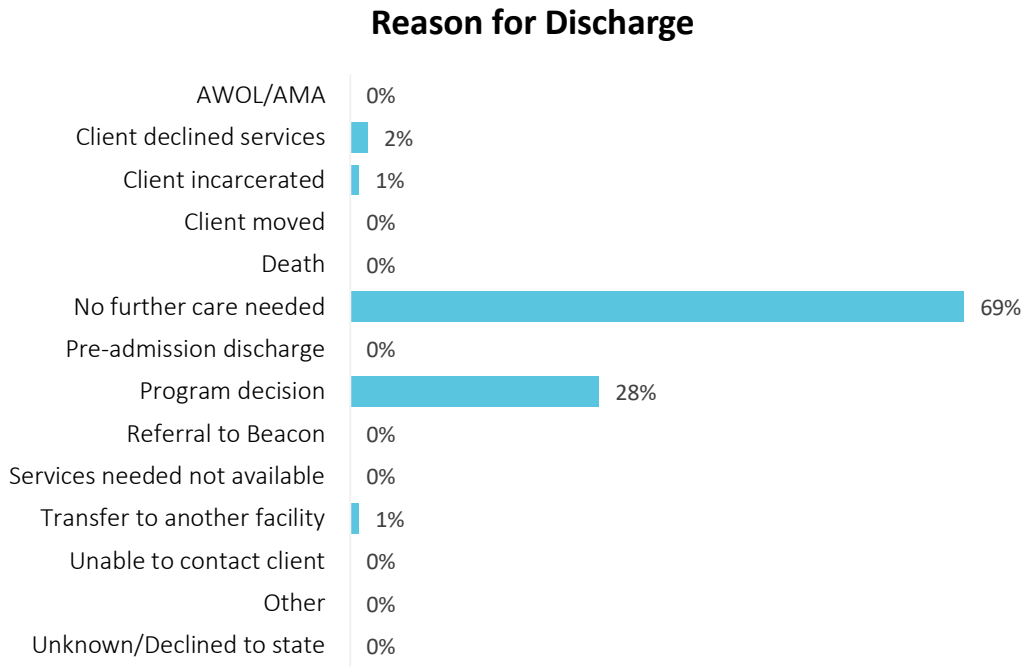
59% of clients
were enrolled in or completed school at intake

(n = 231)

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MOBILE CRISIS TEAM

Discharge Information



n = 391

391 clients were **discharged**.

0% had
achieved some to all of their goals.

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MOBILE CRISIS TEAM

Demographic Data

Race

American Indian / Alaskan Native	1%
Asian	8%
Black / African American	31%
Native Hawaiian / Other Pacific Islander	0%
White	22%
Another	37%
Unknown/Declined to state	0%

n = 391

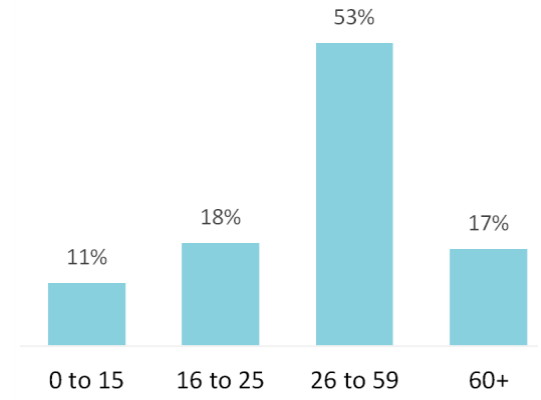
More than one race could be selected. Percentages may exceed 100%.

40% Hispanic/Latino
22% Not Hispanic/Latino

n = 391

38% Unknown/Declined to state.

Age



n = 391

0% of individuals did not answer this question.

Disability

Mental	29%
Visual	1%
Hearing	<1%
Speech	1%
Mobility	4%
Developmental	2%
Another Disability	4%
No Disability	59%
Unknown/Declined to state	0%

n = 391

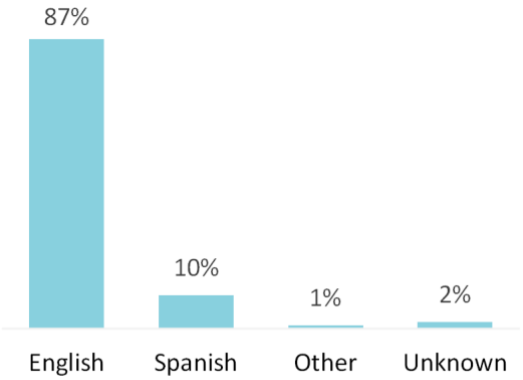
More than one disability could be selected. Percentages may exceed 100%.

41% of individuals reported having one or more disabilities

n = 391

0% Unknown/Declined to state.

Primary Language



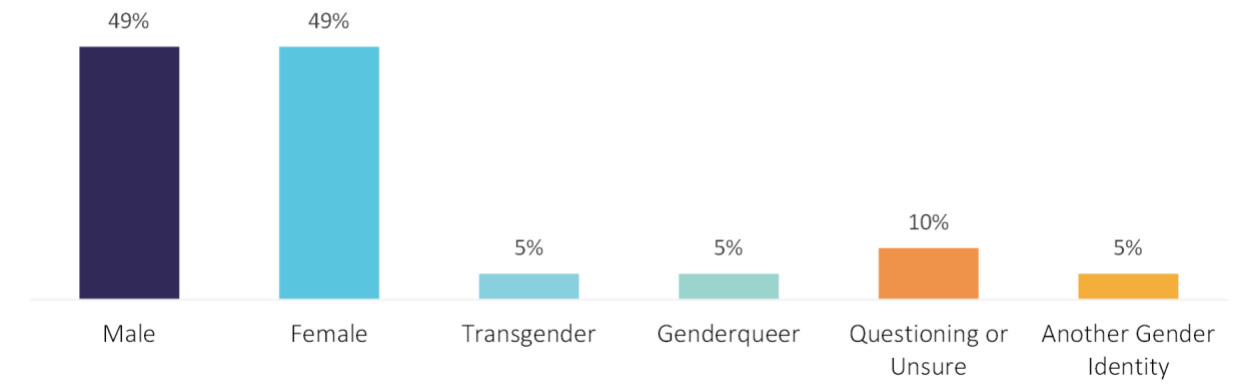
n = 391

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MOBILE CRISIS TEAM

Demographic Data

Gender Identity



n = 391
3% Unknown/Declined to state.

Sexual Orientation

Heterosexual or Straight	12%
Gay or Lesbian	<1%
Bisexual	0%
Questioning or Unsure	0%
Another Sexual Orientation	1%
Unknown/Declined to state	87%

n = 391

Sex at Birth

Male	50%
Female	50%
Another Sex	0%
Unknown/Declined to state	0%

n = 391

6% of individuals were veterans

n = 391
20% Unknown/Declined to state.

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CSS-18: MENTAL HEALTH SERVICES FOR ADULTS

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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.

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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.

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COMMUNITY HOUSING

Community Housing is a permanent supportive housing program that offers over 100 affordable housing placements for adults with serious and persistent, long-term psychiatric disabilities seeking independent living. These placements consist of individual apartments and cooperative group housing units. Interim, Inc. provides case coordination, case management, crisis intervention, and mental health treatment services to residents in all supported housing programs, in accordance with state guidelines established under the rehabilitation option.

Successes and Highlights

- 93% of consumers maintained or improved their mental health recovery.
- 98% of consumers engaged with a primary care physician.
- 91% of consumers surveyed reported satisfaction with the quality of services provided.

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COMMUNITY HOUSING

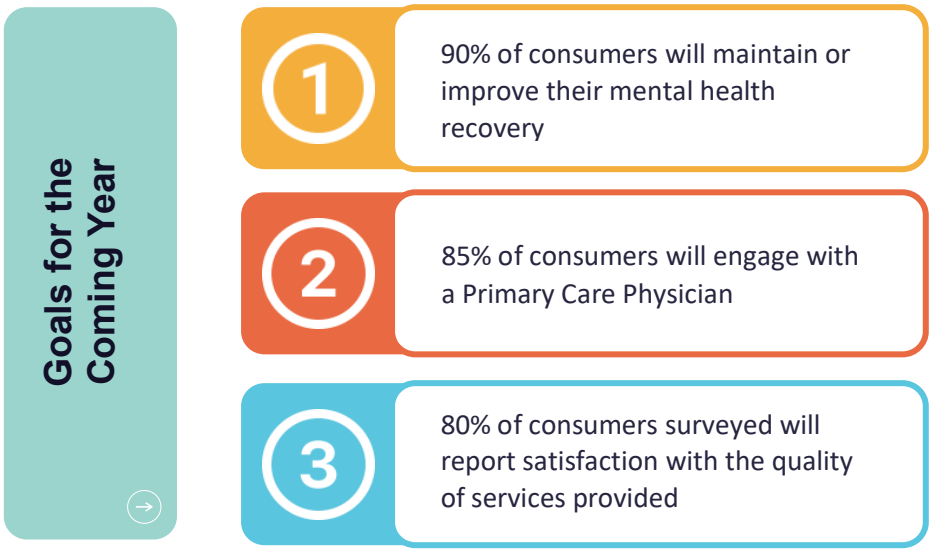
Challenges & Growth Opportunities

CHALLENGES: Community Housing experienced challenges this period.

- There continues to be limited resources in the community for low-cost housing for those clients who would like to move to a more independent setting.
- Some clients report wanting to move out of community housing but not being able to afford it.
- Staff have identified more than 5 clients who live in supportive housing and don't necessarily require supportive services. Those clients report that they enjoy the community they live in and that they would have access to support if necessary.

ACTION PLAN: To address these challenges, Community Housing developed an action plan.

- Staff will explore different interventions and resources (Housing Navigation Program, bringing up ideas during staff meetings/housing meetings, paying for deposits) on exiting or moving on strategies to assist clients who can move out into the community.
- These clients can potentially transition to the Community Housing Scattered Sites program. The program will continue to hold activities for socialization to combat loneliness (e.g., OMNI center, adult day rehabilitation center, local gyms, volunteer work, school, employment, SEES).



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APPENDIX A: LIST OF CSS-FUNDED PROGRAMS

CSS-01: Early Childhood and Family Stability FSP
- Family Assessment Support and Treatment
- 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

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
- Outpatient Mental Health
- USC Telehealth
- Wellness Recovery Center (Adults OMNI)

CSS-08: Early Childhood Mental Health Services
- MCSTART

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

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- Academy Day Program
- Bridge House
- 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)

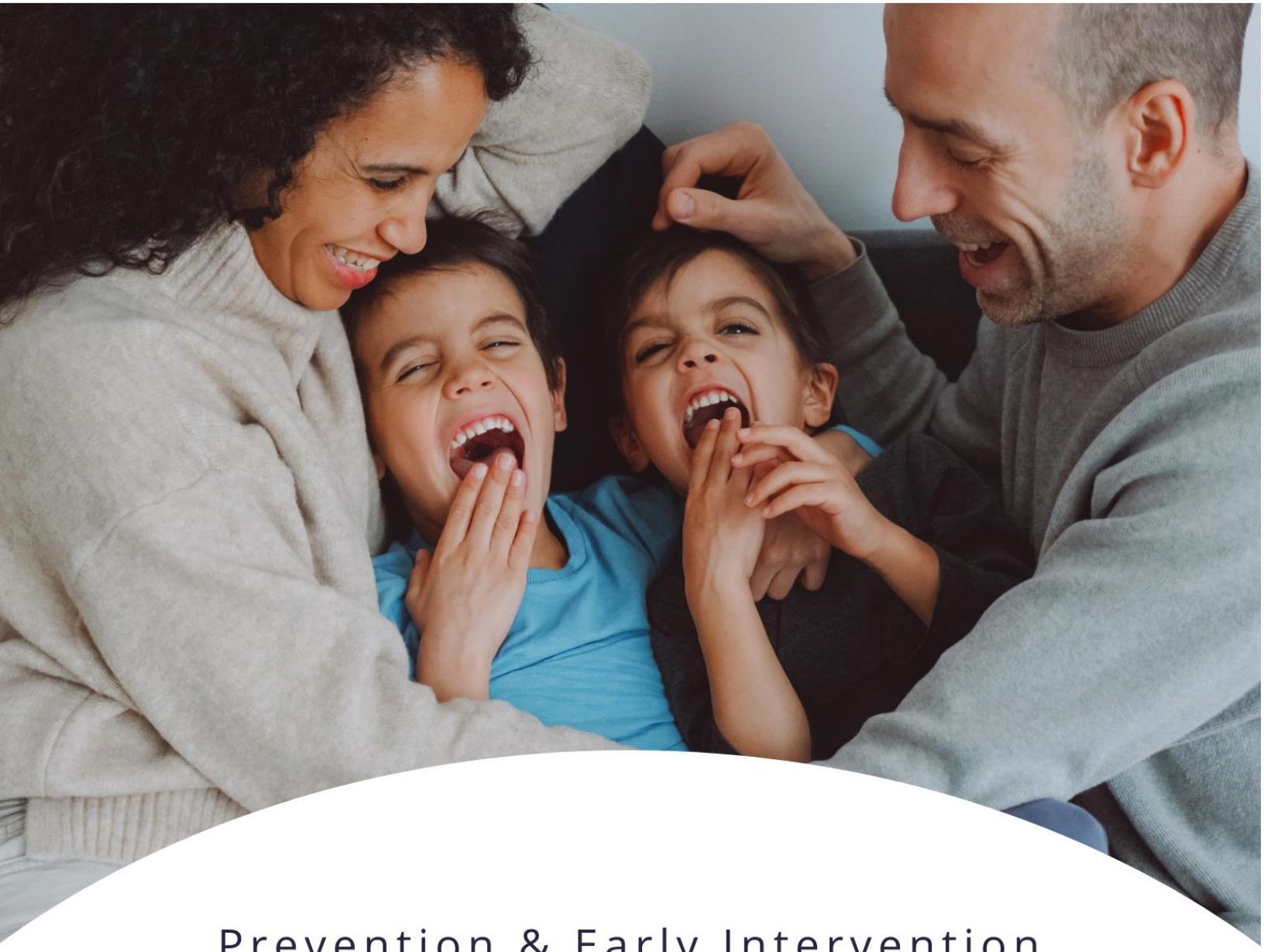
CSS-16: Responsive Crisis Interventions

- Archer Child Advocacy Center
- Manzanita House Salinas
- Mobile Crisis Team

CSS-18: Mental Health Services for Adults

- ASOC Marina
- ASOC Salinas
- Community Housing

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Prevention & Early Intervention

ANNUAL REPORT

FY 2022–2023

Prepared by
EVALCORP
Measuring What Matters

MONTEREY COUNTY
BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

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ACKNOWLEDGMENTS

EVALCORP would like to acknowledge a number of individuals for contributing their time and input to support the development of this report. To begin, we would like to thank Monterey County Behavioral Health for their partnership throughout the evaluation process. We particularly thank Monterey County Behavioral Health Bureau Director, Katherine Eckert; Assistant Bureau Chief, Jon Drake; Mental Health Services Act (MHSA) Prevention Manager, Dana Edgull; MHSA Innovation Coordinator, Wesley Schweikhard; and MHSA Coordinator, Shannon Castro. We greatly appreciate their collaboration and support. We would also like to thank all the funded providers for their hard work in collecting the data presented throughout this report. Lastly, we want to acknowledge the program participants for completing evaluation surveys and sharing their experiences, stories, and recommendations. This report would not be possible without them.

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INTRODUCTION

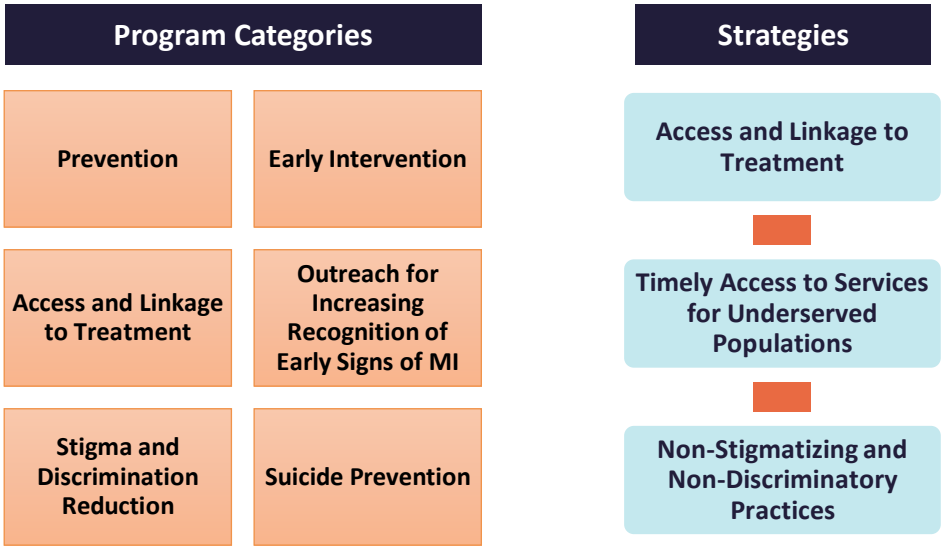
Overview

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 funded 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 Bureau (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 (FY) 22–23, MCBH funded 35 programs, administered by both MCBH and contracted community service providers. In addition, MCBH contributes to the CalMHSA (California Mental Health Services Authority) statewide PEI project, Each Mind Matters: California's Mental Health Movement.

MHSA PEI Regulations

Each of Monterey County's PEI programs are organized into one of six categories, as defined by state regulations. Additionally, each program must employ PEI strategies within the PEI activities they provide. 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's evaluator developed resources which were given to providers in FY 22–23 for online collection of process and outcomes data. This online system enabled a streamlined and consistent process in collecting important data that supports understanding of PEI programs' reach to Monterey community members and the impact in their lives.

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REPORT METHODOLOGY

Analytic Approach

MCBH contracted with EVALCORP Research & Consulting to develop this report, which summarizes data for PEI programs funded during fiscal year 2022–2023. The evaluation employed a mixed-methods approach, utilizing quantitative and qualitative data provided to Monterey County by PEI-funded programs.

The current 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 document presents available data in a standardized manner. In preparing this report, extensive data inspection and data cleaning were performed to ensure the highest level of data accuracy.

Data Sources

Data sources compiled to develop the fiscal year 2022–2023 report fall into five general categories:

1. **MHSA PEI Demographic Forms:** These forms were developed to collect demographic information required by MHSA PEI regulations (e.g., age group, race, ethnicity, primary language, sexual orientation, disability, veteran status, assigned sex at birth, current gender identity). 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 aged 13 or over
Parent	All parents of children aged 12 or under receiving services
Presentation	All presentation attendees

   Using these forms, PEI providers collected demographic data from program participants and then reported demographic data to MCBH both quarterly and annually.

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 two PEI programs in this report.

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3. **MHSA PEI Outcome Surveys:** These forms were developed to collect information about the impacts of program services as well as levels 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 CATEGORIES
Prevention	Prevention Programs
Early Intervention	Early Intervention Outreach for Increasing Recognition of Early Signs of Mental Illness Programs
Suicide Prevention	Suicide Prevention Programs
Stigma and Discrimination Reduction	Stigma and Discrimination Programs Outreach for Increasing Recognition of Early Signs of Mental Illness Programs

Surveys were meant to be collected during the fiscal year from every program participant who received services. At times, programs did not collect outcome surveys to minimize burden on program participants who were under emotional duress. The post-program surveys typically include both close-ended and open-ended questions to capture participant attitudes, knowledge, and behavioral intentions; participant risk and protective factors for mental illness; social-emotional well-being and functioning; symptoms of mental illness; participant satisfaction; and recommendations for improvements. Summaries of close-ended survey items are presented in this report as counts or percentages, while summaries of open-ended responses are presented as the most commonly-occurring themes from qualitative coding.

4. **Service Referrals:** When available, providers used an MCBH template to report the referrals made to MHSA-funded services by type, such as referral to mental/behavioral health treatment and referral to support services.

5. **Narrative Reports:** When available, narrative reports provided by the PEI programs to MCBH that described key activities, successes, and challenges were reviewed and included in the current report.

Data Notes

In fiscal year 2022–2023, MCBH continued to implement an enhanced data collection and evaluation infrastructure, allowing this year's report to provide more robust data for PEI programs. MCBH held a training for all PEI providers to introduce new data tools and quarterly reporting on case examples, successes, and challenges, to enhance data collection related to access to services and to offer more opportunities for programs to provide details about program activities.

Some considerations to keep in mind while reviewing this report are detailed below.

- **Unduplicated data:** PEI data are required to represent unduplicated individuals. The data reporting tools launched at the start of fiscal year 2018–2019 made it possible to provide an unduplicated count of individuals who completed demographic surveys. This number is reported

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as the number of completed demographic forms within each program section, and is an under-estimation of the true number of individuals each program has reached as, to reduce burdens for program participants who were under emotional distress, there were instances where programs did not collect demographic data. Additionally, 211, a program of United Way Monterey County, collects demographic data differently from other programs and it was not possible to provide unduplicated data for 211 in every circumstance.

- **Completeness of demographic data:**
    - **Differences in number of responses to demographic questions.** Some providers collected more than one type of Demographic Form, depending on their program activities. For example, a provider may have collected both Adult and Presentation Forms, meaning some respondents did not supply as much information because the Presentation Form has fewer questions. In those program sections, the number of respondents may vary from the overall number served and may also vary between different demographic questions.
    - **Skipped questions.** Program participants are free to skip any question they choose. As a result, some demographic questions have a lower number of responses than the total number of participants.

      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 PEI regulations. However, the Presentation Form is a shortened version of the Adult and Parent Forms 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 211 differed from the MHSA PEI Demographic Forms and therefore response options varied from those presented in other program sections where those forms were used.

- **Completeness of outcome survey data:** The number of survey responses collected is typically far less than the number of overall individuals served because survey administration may not always be feasible. Since participation in the survey process is voluntary, other individuals may choose not to complete the survey. In addition, the number of responses may vary between different questions within the same section if respondents skipped a question on the survey. In these cases, a range is provided for the number of responses (n) for the survey, indicating the lowest to highest number of responses to different questions within that survey.

- **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 not reporting the counts or details for unique or rare open-ended responses to changing responses to “other” for questions about race, ethnicity, and disability. Summarized data are not shown for any demographic or outcome survey with fewer than 10 total responses. In these instances, the section with low submissions has been removed from that particular program section.

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Report Organization

This report presents PEI data by program. Program sections are organized by six core PEI categories: Prevention; Early Intervention; Access and Linkage to Treatment; Suicide Prevention; Stigma and Discrimination Reduction; and Outreach for Increasing Recognition of Early Signs of Mental Illness.

The following information is included for individual programs where available:

- Program Highlights and Activities (which include overall number of individuals engaged by all programmatic activities and key program successes)
- Program Outcomes
    - Program Cultural Competency and Satisfaction
    - Participant Feedback
- Service Referrals
- Demographic Data
- Program Successes and Learnings

Additionally, **Appendix A** of the report contains a list of each program by PEI category, **Appendices B** and **C** 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, organized by particular outcome survey type.

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PREVENTION

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THE EPICENTER

The Epicenter is a youth-driven community-based agency that works towards empowering youth by providing them with a one-stop resource center. The Epicenter focuses on empowering transitional age youth (TAY) by working with the community to address the barriers that youth face, create a safe place for all youth to feel supported as they navigate the transition to adulthood, and build a network of support for youth representing marginalized communities, including LGBTQ+ TAY. The primary age group served is youth ages 16–24, with some activities also open to family members, supporters, and allies of the youth served. The Epicenter collaborates with staff from various community agencies to provide services that address housing, education, employment, and mental health and wellness.

Program Highlights



Population served: Transitional age youth (ages 16–24)

92 program events and activities

349 individuals engaged in program activities

Program Activities

Activities Hosted

Network of Affirmative Care Support Groups – 56 events were attended by 124 individuals. Events included Q-TURN drop-in hours, visits to school GSA programs, and community events like Zombie Prom and The Epicenter Pride Health Fair.

Brilliant Minds – 169 individuals accessed services through Brilliant Minds programming. 6 Brilliant Minds events took place, including listening sessions and mental health workshops.

Youth Development and Mental Health Support Program – 30 events or activities, including listening sessions on various health and wellness topics, life skills workshops, and a summer outdoor camp were attended by a total of 56 individuals.

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THE EPICENTER

Program Outcomes, Satisfaction, and Feedback

Because of this program… (n=13-15)	% Disagree	% Agree
I know a lot about the topic of this class.	0%	100%
I know where to go for mental health services near me.	0%	100%
I know when to ask for help with an emotional problem.	0%	100%
I feel good about myself.	0%	100%
I feel hopeful when I think about the future.	0%	100%



100% of respondents said that they were **more aware of when to ask for help** with an emotional problem after participating in this program.

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THE EPICENTER

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=14-15)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	0%	100%
The program was provided in the language that I speak best.	0%	100%
The materials provided were useful.	0%	100%
The program was practical and useful.	0%	100%
I would recommend this program to a friend or family member.	0%	100%



100% of respondents agreed or strongly agreed that the **program was practical and useful**.

"Learning the pros/cons of social media; how the algorithm works and how it can affect mental health."

"If it could get shared with more youth who use social media."

What was most useful or helpful about this program? (n=15)

- Learning about the influence of social media (6)
- Felt more educated (5)

What are your recommendations for improvement? (n=13)

- More resources to handle the technological aspects of the class (2)
- General positive feedback (5)

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THE EPICENTER

Referrals to Mental Health Services

Total Referrals Made

4 referrals were made to **mental/behavioral health treatment**

Types of Referrals Made*

2 referrals were made to clients with **serious mental illness**

2 referrals were made to clients from **underserved populations**

* More than one type of referral could be provided to clients and thus may exceed the total number of referrals.

Referrals for Individuals with Serious Mental Illness

Referred to County Treatment:

2 individuals confirmed to have engaged in treatment

5 days average interval between the referral and participation in treatment (standard deviation: 3)

Unavailable average duration of untreated mental illness prior to referral

Kinds of County Treatment Referred to:

Monterey County Behavioral Health ASOC

Referrals for Members of Underserved Populations

2 individuals confirmed to have engaged in treatment

5 days average interval between the referral and participation in treatment

Kinds of Treatment Referred to:

Monterey County Behavioral Health ASOC

Ways members of underserved populations were assisted in accessing services	
Bus Tokens	0
Transportation	0
Reminder Calls	2
Translation/Interpreter Services	0
Accompaniment	0
Other	0

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THE EPICENTER

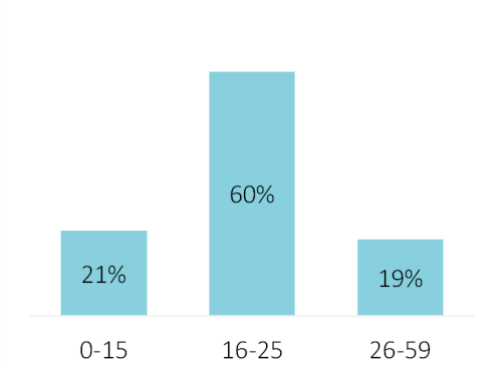
Demographic Data

Race

American Indian/Alaskan Native	2%
Asian	2%
Black/African American	4%
Native Hawaiian/Other Pacific Islander	0%
Latino	76%
White	16%
Another	0%
Declined to state	0%

n=55

Age



n=53

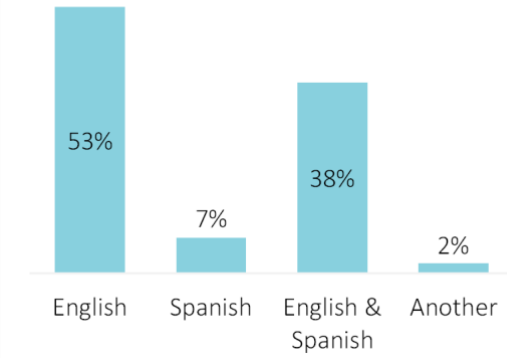
100% Hispanic/Latino
11% Non-Hispanic/Latino

Ethnicity*

Hispanic/Latino	
Caribbean	0%
Central American	0%
Mexican/Mex.-Am./Chicano	73%
Puerto Rican	0%
South American	8%
Other Hispanic/Latino	13%
Non-Hispanic/Latino	
African	0%
Asian Indian/South Asian	0%
Cambodia	0%
Chinese	0%
Eastern European	3%
European	5%
Filipino	3%
Japanese	0%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	0%
Unspecific Non-Hispanic/Latino	0%
More than one	0%
Declined to state	3%

n=40
15 individuals did not answer this question.

Primary Language



n=55
Another includes Mixteco.

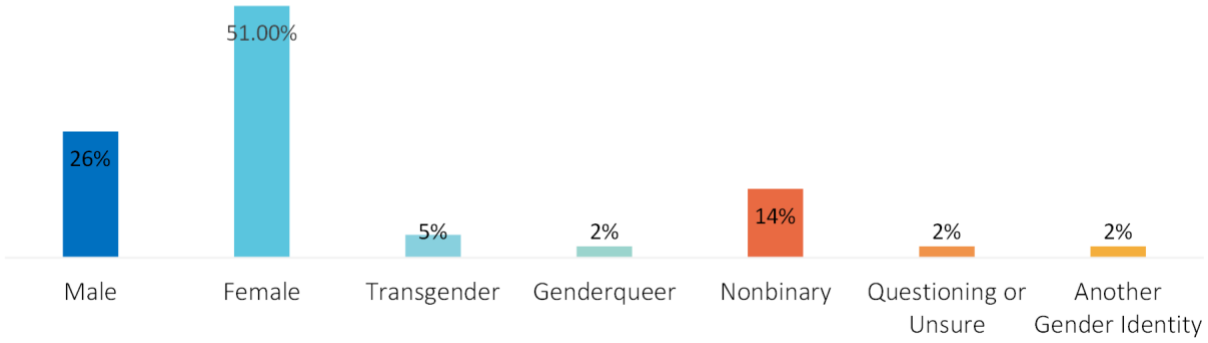
* Percentages may exceed 100% because participants could choose more than one response option.

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THE EPICENTER

Demographic Data

Gender Identity*



n=43*
Another gender identity includes "gender fluid."
1 individual selected "decline to state"

Sexual Orientation

Heterosexual or Straight	35%
Gay or Lesbian	16%
Bisexual	14%
Pansexual	9%
Queer	9%
Questioning or Unsure	5%
Another Sexual Orientation	2%
Decline to state	9%

n=43

Sex

Male	26%
Female	72%
Another Sex	0%
Decline to state	2%

n=43
1 individual selected "decline to state"

72% of individuals reported having one or more disabilities

n=43

Disability

Mental Domain	63%
Seeing	0%
Hearing	2%
Other Communication	0%
Physical	2%
Chronic Health Condition	2%
Another Disability	2%

n=43
Another disability includes Autism, Borderline Personality Disorder, Narcolepsy.

0% of respondents were veterans

n=43

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

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THE EPICENTER

Successes and Learning

Notable Strengths

- Creating and maintaining networks.
- Creating a culture of support between program staff, youth staff, and drop-in youth participants.
- Creating access to services for our target populations.

Challenges

It has been a struggle to engage with recurring and pre-shelter-in-place clients after moving to a new location. Youth staff experienced a lack of motivation due to this change.

Achievements

- Hosted several community health events centering on topics such as mental health strategies and services, MPox awareness, and HIV/AIDS awareness and risk reduction.
- An increase in youth leaders' confidence when tasked with planning and implementing social events with little to no guidance from program staff.
- Continued and strengthened collaboration with other community organizations and entities.

Case Example/Narrative

The younger cousin of a former program participant had become unhoused outside of the county late last year and was afraid for their safety while they figured out their living situation here in Monterey County. The uncertainty had bled into all other aspects of their life, and they were brought to the center to find community with other youth and support with academics and seeking employment. Through our programming, they found friends to lean on and a place where they could fully express their authentic self in an accepting environment. Since then, they have joined the Queer/Trans Youth Collective team, turned 18, finished all required credits to graduate high school, received mental health services through MCBH, are seeking independent housing, and have recently accepted our offer to be a full-time staff member under our new unhoused youth support program.

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PARENT EDUCATION PROGRAM
COMMUNITY HUMAN SERVICES (CHS)

Community Human Services (CHS) offers the Parent Education Program, which provides parenting programs in Spanish and English for parents and caregivers of children ages 0 to 12 years old. Specifically, CHS utilizes the Nurturing Parenting Program curriculum to teach families parenting skills with nurturing behaviors to promote healthy physical and emotional development and teach appropriate role and development expectations. The Nurturing Parenting Program is an evidence-based program that is designed for the treatment and prevention of child abuse and neglect. The program provides an educational approach in understanding the definition and effects of child abuse.

Program Highlights



Population served: Parents and caregivers of children ages 0–12

138 program events and activities

449 individuals engaged in program activities

Program Activities

Activities Hosted

Community Presentations – 305 individuals attended 1 community event.

Parenting Education Classes – 144 individuals attended 137 classes of the Nurturing Parenting Program. **served:** Parents of children ages 0 to 12

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PARENT EDUCATION PROGRAM

Program Outcomes, Satisfaction, and Feedback

Comparison of Before and After Knowledge (n=14–15)	Before (% Agree)	After (% Agree)	% Impacted
I knew a lot about the topic of this session/training/class.	60%	93%	33%
I knew where to go for mental health services.	60%	93%	33%
I knew when to ask for help with an emotional problem.	67%	93%	26%
I felt good about myself.	80%	87%	7%
I felt hopeful when I thought about the future.	93%	87%	-7%



33% of participants (5 individuals) **learned something new from the session/training/class**.

33% of participants (5 individuals) **learned where to go for mental health services**.

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PARENT EDUCATION PROGRAM

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=15)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	13%	87%
The program had services in the language that I speak best.	7%	93%
Materials provided were useful.	0%	100%
The program/training/course was practical and useful.	0%	100%
I would recommend this program/training/course to others.	7%	93%

"Everything I learned about how to discipline my son and how to maintain respectful communication."

"I feel like everything was excellent. I would like classes in Triqui."

What was most useful or helpful about this program? (n=15)

- Learning how to understand, help and care for children (n=10)
- Increased knowledge on parenting and child development (n=8)
- Information provided about self-care (n=4)
- Friendly/supportive staff (n=3)

What are your recommendations for improvement? (n=14)

- Nothing (n=8)
- Additional classes/services (n=4)
- Additional information and learning materials (n=2)
- Additional languages (n=2)

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PARENT EDUCATION PROGRAM

Referrals to Mental Health Services

Total Referrals Made

6 referrals were made to **mental/behavioral health treatment**

Types of Referrals Made*

2 referrals were made to clients with **serious mental illness**

5 referrals were made to clients from **underserved populations**

* More than one type of referral could be provided to clients and thus may exceed the total number of referrals.

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PARENT EDUCATION PROGRAM

Demographic Data

Race

American Indian/Alaskan Native	2%
Asian	1%
Black/African American	3%
Native Hawaiian/Other Pacific Islander	1%
Latino	71%
White	22%
Another	0%
Declined to state	2%

n=132

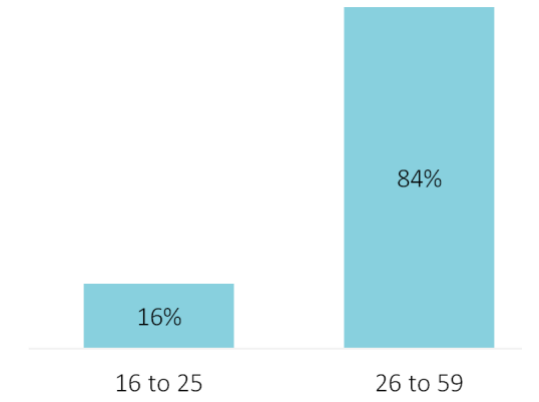
79% Hispanic/Latino
23% Non-Hispanic/Latino

Ethnicity*

Caribbean	0%	Hispanic/Latino
Central American	3%	
Mexican/Mex.-Am./Chicano	40%	
Puerto Rican	0%	
South American	1%	
Other Hispanic/Latino	35%	
African	0%	Non-Hispanic/Latino
Asian Indian/South Asian	1%	
Cambodia	0%	
Chinese	0%	
Eastern European	1%	
European	2%	
Filipino	1%	
Japanese	1%	
Korean	0%	
Middle Eastern	1%	
Vietnamese	0%	
Other Non-Hispanic/Latino	16%	
Declined to state	4%	

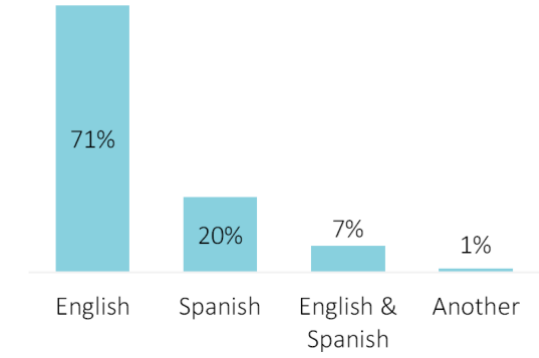
n=134

Age



n=136
3 individual selected "decline to state"

Primary Language



n=139
Another includes Q'anb'al.
1 individual selected "decline to state."

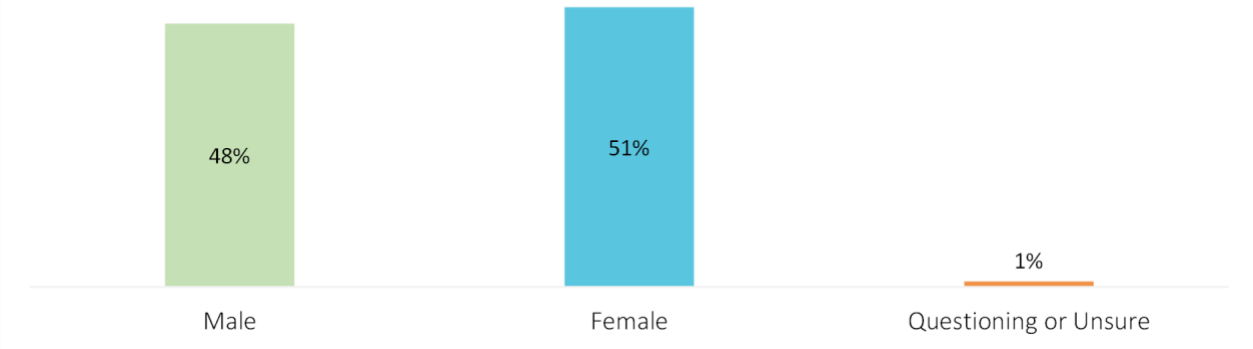
* Percentages may exceed 100% because participants could choose more than one response option.

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PARENT EDUCATION PROGRAM

Demographic Data

Gender Identity



n=136
1individual selected "decline to state."

Sexual Orientation

Heterosexual or Straight	88%
Gay or Lesbian	1%
Bisexual	2%
Pansexual	1%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	8%
Declined to state	1%

n=127

Sex

Male	48%
Female	51%
Another Sex	0%

n=139
1 individual selected "decline to state."

14% of individuals reported having one or more disabilities

n=133
2 individuals selected "decline to state."

Disability

Mental Domain	35%
Seeing	6%
Hearing	1%
Other Communication	2%
Physical	0%
Chronic Health Condition	0%
Another Disability	4%

n=133
Another disability includes Learning Disability.
2 individuals selected "decline to state."

1% of individuals were veterans

n=136
3 individuals selected "decline to state."

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

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PARENT EDUCATION PROGRAM

Successes and Learning

Notable Strengths

- The Nurturing Parenting Program equips participants with essential parenting skills, knowledge, and tools to create a healthier and more empathetic environment for their children. This fosters more functional households and happier parents and children within our community.
- The program provides a safe and welcoming space for community members to openly discuss their parenting concerns, learn new skills and share positive feedback.
- The program is delivered by culturally aware, bicultural instructors.

Challenges

The organization has faced challenges in offering planned courses due to a shortage of staff. Filling open positions has been particularly challenging. The organization remains committed to diligently filling the remaining positions.

Achievements

The organization successfully hosted its 6th Annual Parent University, attracting over 300 attendees. The dedicated leadership team, staff, and community partnerships enabled participation in resource events, reaching and providing information about their programs to numerous attendees.

Case Example/Narrative

We continue to receive positive feedback from our participants. The participants in our Nurturing Parenting Program Spanish class, that began on January 31, 2023, were very engaged in the curriculum. They shared examples of how they were applying at home the tools and skills that they were learning in class. They also shared many comments and asked questions. This class was a group of 10 men and 2 women. It was very interesting to see the dynamic of this group, as the fathers were very open, vulnerable, and willing to evolve.

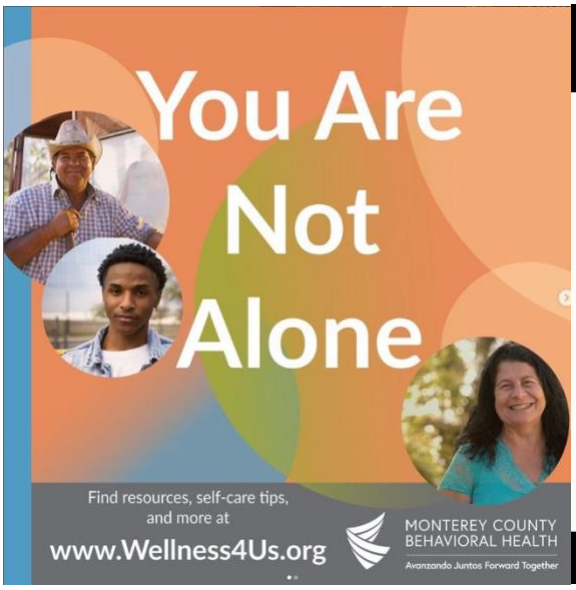
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CULTURALLY SPECIFIC OUTREACH AND ENGAGEMENT
COMMUNITY HUMAN SERVICES (CHS)

Community Human Services (CHS) partnered with Your Social Marketers (YSM) to develop and execute a plan of culturally specific outreach and community education strategies including social marketing campaigns, community presentations, outreach events, and other promotional activities to engage historically underserved populations (Latino, African American/Black, LGBTQ+) in identified priority geographic regions in mental health services to support their health and wellness.

Program Highlights

- PARTNERSHIP WITH LA PRECIOSA AND TRI COLOR RADIO ON 8 "EL MANANERO LUNCHES." Free lunch provided by local restaurants was delivered to contest-winning field worker crews along with multi-agency branded promotional items and bilingual outreach information about how to access free mental health services in the community. Items included lip balm, sunscreen, backpacks, water bottles and other "swag" selected specifically for the target populations.
- SPONSORSHIP OF THE CALIFORNIA RODEO SALINAS ON 2 NIGHTS. Community Human Services and Monterey County Behavioral Health branded items were distributed along with bilingual outreach information about how to access free mental health services in the community.





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Website Banner



Program Activities

Activities Hosted

Narrowcast Outreach Effort – 31,250 brochures were distributed at 267 venues specifically selected for the target populations.

Bilingual Mental Health-Specific Website – www.wellness4us.org / www.bienestarparati.org was launched.

Advertising Effort – Targeted radio and television advertising campaigns promoted free and low-cost mental health services to the target populations.

- Radio: 865 spots/2.4M impressions
- Television: 447 spots/1.5M impressions
- Social Media: 900,000 impressions over 3 months

Community Events – 10 targeted outreach events reached over 1,000 individuals.

Social Media Post



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CULTURALLY SPECIFIC OUTREACH AND ENGAGEMENT

Successes and Learning

Notable Strengths

The website promoted multiple service providers such as The Village Project, Inc., The Epicenter, NAMI, Central Coast Center for Community Advocacy and Pajaro Valley Prevention and Student Assistance, which expanded its reach and effectiveness.

Notable Learnings

Conducting outreach to agricultural workers in the fields brought useful information directly to individuals who may benefit from it.

Notable Successes

Local business that participated in narrowcasting efforts reported that interest in the information was high and information was regularly picked up by their visitors/clientele, and they requested more materials when supplies were exhausted. Multi-agency materials with the wellness4us and bienestarparati brands were developed and distributed in narrowcasting, promoting the mental health services of several participating providers to the target populations.

El Mananero Lunches



www.bienestarparati.org



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SENIOR COMPANION PROGAM
SENIORS COUNCIL OF SANTA CRUZ AND SAN BENITO COUNTIES

Senior Companion Program supports the achievement and maintenance of the highest level of independent living for their clients through various activities and by providing opportunities for their clients to interact socially. During client visits, senior companions may provide companionship and assist with activities fostering mental stimulation. They also participate in appropriate activities for social interaction (i.e., talking, listening, reading, gardening, playing games, assisting with hobbies). Senior companions may assist clients in food preparation, planning meals, and doing grocery shopping, provide grief support, assist in reality orientation and awareness, encourage clients' contacts with family and friends, and provide basic information about community services for seniors. They may take walks, encourage exercise, and provide information on exercise or recreation to clients. Many of their clients live in Southern Monterey County and find themselves needing rides to medical appointments outside of their community; thus, senior companions may also provide transportation for medical appointments and shopping.

Program Highlights

Population served: The local senior community

10 program events and activities

15 individuals engaged in program activities

Program Activities

Activities Hosted

Presentations – 10 individuals attended 9 presentations.

Community Events – 5 individuals were engaged in 1 community event.

Volunteer and Intern Trainings – 10 in-service trainings were held for volunteers.

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SENIOR COMPANION PROGAM

Successes and Learning

Notable Strengths

- Senior companion volunteers were allowed to visit their clients in person.
- Connections with Monterey County Behavioral Health were established again at the end of 2022.

Challenges

After the COVID-19 pandemic, we had lost a coordinator, our contract with MCBH in Salinas, and our contacts. Since then, we have a new contract and new contacts. This involved persistent calling and follow up—and it worked!

Achievements

- Created new pamphlets/data sheets with strong visual effects.
- Older adults were actively engaged with the program's outreach materials.
- Cultivated interest among potential volunteers.
- Senior companion volunteers continued outreach through their networks by sharing their own positive experiences.

Case Example/Narrative

In the last quarter, through ongoing communications as well as our in-service meetings, we saw a great need for our volunteers to obtain senior resources after the COVID-19 pandemic. The volunteers conveyed information about their needs and issues, such as challenges to pay rent, illegal evictions, and the necessity of fresh food and water. As more of these individuals regained their energy to volunteer again, we could see them become stronger citizens in our community.

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SENIOR PEER COUNSELING AND FORTALECIENDO EL BIENESTAR
ALLIANCE ON AGING

The Alliance on Aging provides two primary programs to seniors aged 55 and older in Monterey County (the **Senior Peer Counseling [SPC]** Program and the **Fortaleciendo el Bienestar [FEB]** Strengthening Wellness Program). SPC offers peer-to-peer counseling and support groups provided by trained volunteers. These program services are attuned to addressing the diversity of older adults in the community who are experiencing challenges that accompany aging, such as depression and anxiety, death of a spouse, stress of an illness, isolation from family or friends, and other life transitions. The Fortaleciendo el Bienestar Strengthening Wellness Program meets the unique needs of Latino elders residing in Salinas and Salinas Valley. Using a culturally competent approach focused on activities and conversations that address overall health and wellness, it is a natural complement to Alliance on Aging's Senior Peer Counseling (SPC) Program.

Program Highlights

Population served: Seniors (ages 55 and older)

430 individuals engaged in program activities

Program Activities

Activities Hosted

Peer Support Meetings – 790 hours of individual peer-to-peer support counseling was provided to 65 individuals.

Support Group Meetings – 163 individuals were engaged in 1,346 hours of support for both Spanish- and English-speaking older adults.

Volunteer and Intern Trainings – 28 volunteers who support the program and 3 bilingual interns received 876 supervision hours.

FEB Wellness Events – 15 events were held for 202 clients. Through Strengthening Wellness classes, the overarching goal is to combat isolation, loneliness, and life challenges—common incubators of anxiety and depression—through Spanish-facilitated discussions that honor Latino culture, spirituality, mysticism, and overall identity.

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SENIOR PEER COUNSELING AND FORTALECIENDO EL BIENESTAR

Program Outcomes, Satisfaction, and Feedback

Nearly all of the time… (n=20–102)	% After
Given my current physical condition, I am satisfied with what I can do.	38%
I have confidence in my ability to sustain important relationships.	71%
I feel hopeful about my future.	60%
I am often interested and excited about things in my life.	48%
I am able to have fun.	67%
I am generally satisfied with my psychological health.	43%
I am able to forgive myself for my failures.	57%
My life is progressing according to my expectations.	48%
I am able to handle conflicts with others.	43%
I have peace of mind.	62%



71% of respondents **felt confident in their ability to sustain their relationships nearly all of the time** after participating in this program.

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SENIOR PEER COUNSELING AND FORTALECIENDO EL BIENESTAR

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=22–27)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	0%	**100%**
The program was provided in the language that I speak best.	0%	**100%**
The program was right for me.	0%	**100%**
I was happy with this program.	0%	**100%**
I would recommend this program to a friend or family member.	0%	**100%**



100% of respondents agreed or strongly agreed that they **would recommend the program to a friend or family member**.

"The program had given me hope. I look forward to our meetings."

"We are happy with everything they taught us."

What was most useful or helpful about this program? (n=20)

- Feeling connected and supported (13)
- Having access to a counselor (2)

What are your recommendations for improvement? (n=16)

- Additional visits, times, days, and locations (4)
- General positive feedback (4)

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SENIOR PEER COUNSELING AND FORTALECIENDO EL BIENESTAR

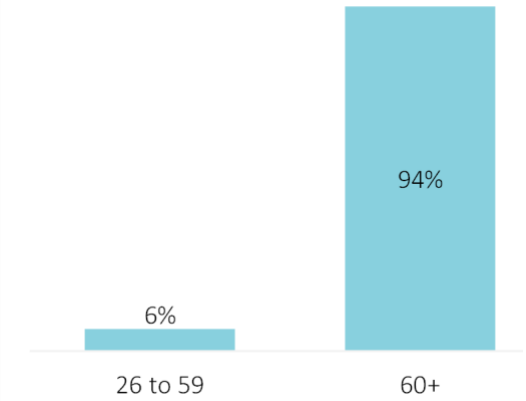
Demographic Data

Race

American Indian/Alaskan Native	0%
Asian	0%
Black/African American	1%
Native Hawaiian/Other Pacific Islander	0%
Latino	49%
White	50%
Another	0%
Declined to state	1%

n=171

Age



n=170
1 individual selected "decline to state."

51% Hispanic/Latino
51% Non-Hispanic/Latino

Ethnicity*

Hispanic/Latino

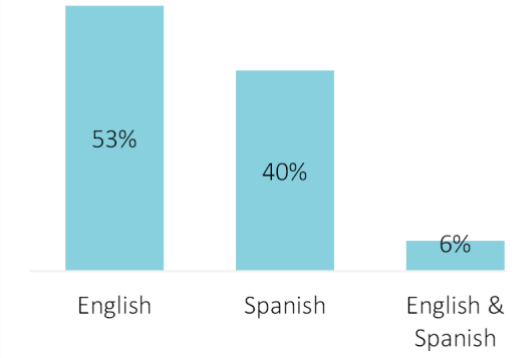
Caribbean	0%
Central American	1%
Mexican/Mex.-Am./Chicano	48%
Puerto Rican	0%
South American	1%
Other Hispanic/Latino	1%

Non-Hispanic/Latino

African	0%
Asian Indian/South Asian	0%
Cambodia	0%
Chinese	0%
Eastern European	1%
European	50%
Filipino	0%
Japanese	0%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	0%
Decliend to state	2%

n=171

Primary Language*



n=172

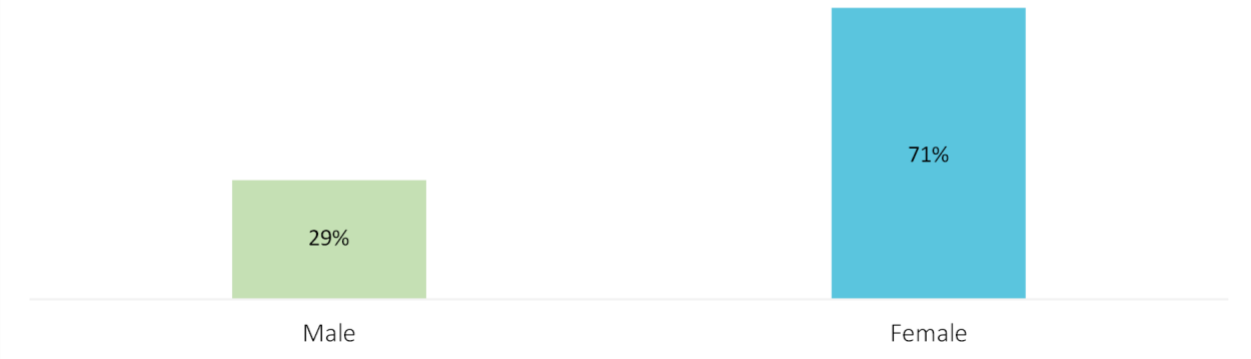
* Percentages may exceed 100% because participants could choose more than one response option.

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SENIOR PEER COUNSELING AND FORTALECIENDO EL BIENESTAR

Demographic Data

Gender Identity



n=172
1 individual selected "decline to state."

Sexual Orientation

Heterosexual or Straight	96%
Gay or Lesbian	1%
Bisexual	0%
Pansexual	0%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Declined to state	4%

n=168

Sex

Male	28%
Female	72%
Another Sex	0%

n=172

51% of individuals reported having one or more disabilities

n=172
1 individual selected "decline to state."

Disability

Mental Domain	9%
Seeing	13%
Hearing	4%
Other Communication	1%
Physical	26%
Chronic Health Condition	31%
Another Disability	1%

n=172
Another disability includes Asthma, Blind, Cancer, Diabetes, Hypertension, Kidney Failure, MS, Paraplegic, Parkinsons, Terminal Illness.

3% of individuals were veterans

n=171

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

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SENIOR PEER COUNSELING AND FORTALECIENDO EL BIENESTAR

Successes and Learning

Notable Strengths

- Effective partnership with California State University, Monterey Bay (CSUMB) master's program increases capacity.
- Agreement with three MSW interns offers better senior care.
- Adaptable team excels in handling unforeseen challenges.

Challenges

We had delays in launching Soledad due to challenges securing a site. The group met for the first time in February. Several support groups were canceled due to winter storms.

Achievements

- Pot painting and art therapy rekindled childhood creativity and memories for clients who hadn't experienced art before.
- Activities allowed members to tap into their creative sides and fostered engagement and discussions about their creations.
- Clients showcased their creations and shared the plants they had planted in their pots, highlighting the meaningful impact of the activity.

Case Example/Narrative

A trained Senior Peer Counselor had successfully assisted a first client, an 82-year-old navigating a housing crisis, leading to a more stable living situation. A second client, a fiercely independent 78-year-old former military woman with health problems, struggled with disconnected relationships with her adult daughters. Through counseling and reflective life review sessions, the client was able to reframe her perspective, acknowledging the benefits of her self-reliance. With the counselor's guidance, she overcame guilt and shame, and ultimately reached out to one of her daughters after 15 years of silence. Their positive reconnection marked a significant milestone in the client's life, and the counselor found immense personal fulfillment, feeling that they gained as much from the program as their clients did.

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CULTURALLY RELEVANT PARENTING CLASSES PARTNERS FOR PEACE

Partners for Peace (P4P) delivers three culturally relevant parenting classes and provides a continuum of prevention to intervention services for parents, families, and youth. Using an evidence-based/informed family skills training program and parenting training for high-risk youth and their parents, P4P seeks to improve social competencies, parenting skills, and the parent-child relationship. All family programs have their foundation in the five established protective factors: parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children. The programs are: **Loving Solutions** (prevention), for parents of 5–10-year-old children, **Strengthening Families Program** (prevention/intervention), for parents and their children ages 10–16 years, and **The Parent Project, Sr.** (intervention), for parents of youth ages 11–17 years.

Program Highlights



Population served: Children and youth receiving school-based services, their teachers, educational staff, and parents

823 program events and activities

5,632 individuals engaged in program activities

Program Activities

Activities Hosted

Community Presentations – 333 individuals attended 37 community presentations.

Community Events – 2,580 individuals attended 6 events.

Outreach Activities – 1,341 individuals participated in 24 outreach activities to help recruit and engage families.

Education/Training Sessions – 1,082 individuals and 525 families attended 720 parent education classes, and 152 individuals attended 9 family skills workshops. Parents also attended support groups at the conclusion of the class series.

Training of Potential Responders – 254 potential responders, including parents, youth, probation officers, and social workers, were trained on how to identify early signs of mental illness.

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CULTURALLY RELEVANT PARENTING CLASSES

Program Outcomes, Satisfaction, and Feedback

Because of this program… (n=39)	% Disagree	% Agree
I feel that I have better relationships with people.	4%	96%
I know where to go for mental health services.	6%	94%
I know when to ask for help with an emotional problem.	5%	95%
I am able to deal with problems better.	4%	96%
I feel less stress or pressure in my life.	5%	95%
I feel better about myself.	3%	97%
I feel good when I think about the future.	5%	95%
I feel less worried or afraid.	7%	93%
I feel I have more energy during the day.	13%	87%
I care about more things in my life.	10%	90%



95% of respondents said that they **were more aware of when to ask for help with an emotional problem** after participating in this program.

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CULTURALLY RELEVANT PARENTING CLASSES

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=136–150)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	8%	92%
The program was provided in the language that I speak best.	6%	94%
The program was right for me.	3%	97%
I was happy with this program.	4%	96%
I would recommend this program to a friend or family member.	5%	95%



97% of respondents agreed or strongly agreed that **the services were right for them** in this program.

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CULTURALLY RELEVANT PARENTING CLASSES

Demographic Data

Race

American Indian/Alaskan Native	1%
Asian	1%
Black/African American	2%
Native Hawaiian/Other Pacific Islander	0%
Latino	69%
White	12%
Another	1%
More than one race	3%
Declined to state	11%

n=769
81 individuals selected "decline to state."

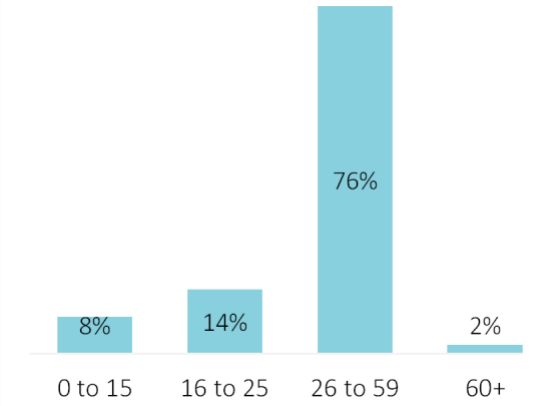
73% Hispanic/Latino
8% Non-Hispanic/Latino

Ethnicity

Hispanic/Latino	
Central American	2%
Mexican/Mex.-Am./Chicano	60%
Puerto Rican	0%
South American	1%
Other Hispanic/Latino	10%
Non-Hispanic/Latino	
African	1%
Asian Indian/South Asian	0%
Chinese	0%
Eastern European	0%
European	3%
Filipino	1%
Japanese	0%
Korean	0%
Middle Eastern	0%
Other Non-Hispanic/Latino	3%
More than one ethnicity	4%
Declined to state	14%

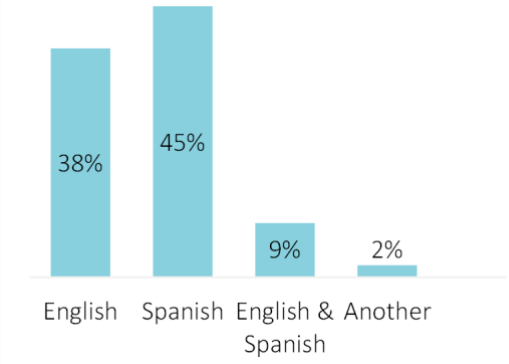
n=769

Age



n=767

Primary Language



n=769
39 individuals selected "decline to state."

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

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CULTURALLY RELEVANT PARENTING CLASSES

Demographic Data

Sexual Orientation

Heterosexual or Straight	66%
Gay or Lesbian	0%
Bisexual	1%
Queer	0%
Another Sexual Orientation	1%
Declined to state	32%

n=769

Sex

Male	24%
Female	68%
Another Sex	0%

n=769
54 individuals selected "decline to state"

1% of individuals were veterans

n=769
43 individuals selected "decline to state."

4% of individuals reported having one or more disabilities

n=769
63 individuals selected "decline to state"

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

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CULTURALLY RELEVANT PARENTING CLASSES

Successes and Learning

Notable Strengths

- Partners For Peace effectively addresses the concerns of parents and caregivers, including school absenteeism, vaping, fentanyl use, inappropriate media use, and levels of depression and anxiety in their children through prevention/intervention classes.
- 100% of families verbally express a willingness to recommend the programs to others. The Strengthening Families post-program evaluation shows positive outcomes, with 80% of families reporting increased youth adherence to family rules, increased family activities, improved school attendance, and enhanced youth-parent communication.

Achievements

- Partners For Peace has significantly increased the number of series conducted per quarter, resulting in 8.5% more parents, caregivers, and youth served by the third quarter of 2023 compared to all quarters in 2022.
- Despite challenges like atmospheric rivers, power outages, and class cancellations, the program scheduled a record 19-class series during the Winter quarter and successfully completed 8-to-10-week classes of that series. Both staff and parents/caregivers displayed resilience and dedication to family education.

Challenges

Partners For Peace faced challenges with the transition of their data system to Apricot Social Solutions, which was bought out by Bonterra. These challenges were overcome by purchasing consulting hours to address registration and report writing issues.

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CULTURALLY RELEVANT PARENTING CLASSES

Successes and Learning

Case Examples/Narratives

"We have a better structure now. My youth follows the rules, and I learned the value of positive reinforcement. I have also noticed that my youth keeps me informed now of anything I need to know. This program was Awesome to the T and super knowledgeable of everyday issues to help parents."

– Parent from Strengthening Families

"My son has been doing really good in his attendance and grades since we came to the program. We learned the importance of having fun family time and how to build a strong and healthy family. I would recommend this program to other parents!"

– Parent from Strengthening Families

“This class was really the instruction manual that we needed as parents. Our son was chronically truant and vaping. We did not know what to do. The support we received from our Facilitators and classmates gave us many new tools for our toolbox. We say "I love you" every day and make time for family meals and conversations. Our son’s grades and school attendance has improved. His behavior has improved, and so has ours!”

– Parent from The Parent Project, Sr.

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MATERNAL MENTAL HEALTH (MMH)
MONTEREY COUNTY BEHAVIORAL HEALTH (MCBH)

The Maternal Mental Health (MMH) program provides community-based support to help mothers at risk of or experiencing mild to moderate perinatal mood disorders and anxiety disorders. The program offers dyadic groups for mothers and infants/toddlers and provides psychoeducation and support with a focus on Spanish-speaking Latina mothers who do not have access to mental health services through their health insurance providers. These groups provide participants with opportunities to have positive social interactions, develop a support network, and decrease stigma through shared experiences. A primary goal of the program is to increase participants' knowledge and understanding of how being attuned to their child's cues positively impacts bonding and attachment. Additionally, the groups incorporate culturally attuned healing practices that support women and families during the perinatal period.

Program Highlights



Population served: Mothers who are at risk of or are experiencing perinatal distress

51 program events and activities

248 individuals engaged in program activities

Program Activities

Activities Hosted

Community Events – 114 individuals and 2 families attended 4 community events.

Maternal Health Individual Services – Perinatal individual services resulted in 7 referrals for mental health higher level of care, mental health early intervention, speech, and early childhood services.

Pop-up and Play Outreach – 134 individuals and 56 families attended Pop-up and Play outreach events with the goal of building connections between attendees, reducing isolation, and deepening social connectedness between the mothers who attended.

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MATERNAL MENTAL HEALTH (MMH)

Program Outcomes, Satisfaction, and Feedback





Comparison of Before and After Knowledge (n=9–15)	Before (% Agree)	After (% Agree)	% Impacted
I knew a lot about the topic of this session/training/class.	60%	73%	13%
I knew where to go for mental health services.	57%	67%	13%
I knew when to ask for help with an emotional problem.	80%	70%	-10%
I felt good about myself.	80%	80%	0%
I felt hopeful when I thought about the future.	89%	78%	-11%

13% of participants (2 individuals) **learned something new from the session/training/class**.

13% of participants (2 individual) **learned where to go for mental health services**.

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MATERNAL MENTAL HEALTH (MMH)

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=14–15)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	13%	87%
The program had services in the language that I speak best.	13%	87%
Materials provided were useful.	14%	86%
The program/training/course was practical and useful.	13%	87%
I would recommend this program/training/course to others.	13%	87%



87% of respondents agreed or strongly agreed that they **would recommend this program to others**.

"That my child learns to interact with other children."

"More promotion of the services on television and radio."

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

- The social skills their child(ren) learn (6)
- The parenting support received (3)

What are your recommendations for improvement? (n=8)

- Promoting services more widely (1)
- General positive feedback (4)

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MATERNAL MENTAL HEALTH (MMH)

Referrals to Mental Health Services

Total Referrals Made

10 referrals were made to **mental/behavioral health treatment**

Types of Referrals Made*

4 referrals were made to clients with **serious mental illness**

7 referrals were made to clients from **underserved populations**

* More than one type of referral could be provided to clients and thus may exceed the total number of referrals.

Referrals for Individuals with Serious Mental Illness

Referred to County Treatment:

1 individual confirmed to have engaged in treatment

2 days average interval between the referral and participation in treatment

1 year average duration of untreated mental illness prior to referral

Kinds of County Treatment Referred to:

Monterey County Behavioral Health ● Avanza ● Access

Kinds of Non-County Treatment Referred to:

Beacon ABA

Referrals for Members of Underserved Populations

3 individuals confirmed to have engaged in treatment

2 days average interval between the referral and participation in treatment

Kinds of Treatment Referred to:

Salinas City Elementary ● Access ● Early Childhood Services

Ways members of underserved populations were assisted in accessing services	
Bus Tokens	0
Transportation	0
Reminder Calls	0
Translation/Interpreter Services	0
Accompaniment	0
Other	2

Others include assistance with phone calls and emailing resources

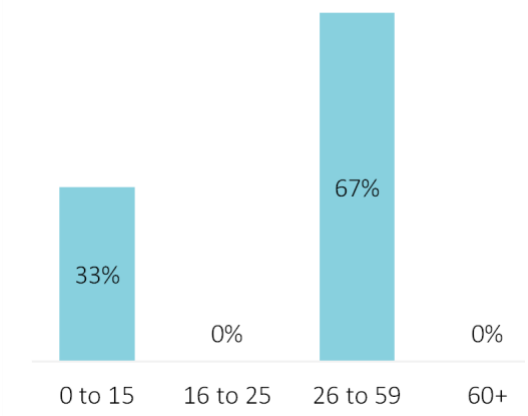
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MATERNAL MENTAL HEALTH (MMH)

Demographic Data†

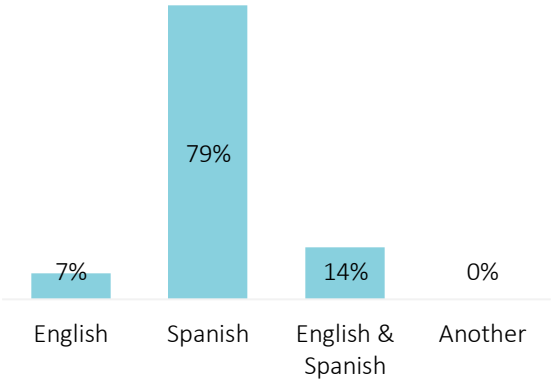
100% Hispanic/Latino
n=13

Age



n=12
2 individuals selected “decline to state.”

Primary Language



n=14

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MATERNAL MENTAL HEALTH (MMH)

Successes and Learning

Notable Strengths

- Community-based Pop-Up and Play groups that support at-risk mothers in improving mental health and reducing stigma.
- Active collaboration with WIC to reach out to new families to participate in playgroups.

Challenges

Obtaining demographic information has been a challenge since the first quarter. In addition, we had to cancel one Pop-Up and Play group due to limited staff capacity.

Achievements

- The team organized an event for participants to share birth stories and discuss pregnancy challenges.
- The team joined a community walk to raise awareness and provide resources for perinatal families.
- At the Birth and Baby Fair, the team promoted mental health resources during the perinatal period and infant massage benefits while offering a massage session.

Case Example/Narrative

A father who has been attending playgroup for about 9 months had difficulties engaging in play with his child. He would encourage his child to explore as he sat and watched her. This father also had difficulties in offering co-regulation to his child and would wait for facilitators to intervene when needed. This quarter, the father has been observed following the lead of his child, sitting on the floor with her to play, and making efforts to comfort her when she is crying. Further, the child is seeking her father for support, asking for help, and hugging him when she needs connection.

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM
PARENTING CONNECTIONS OF MONTEREY COUNTY

Parenting Connections of Monterey County's Maternal Mental Health Peer Navigation Program provides free services for Monterey County mothers, caregivers, and families to prevent perinatal mood and anxiety disorders from developing and provide early intervention mental health supports for mothers experiencing these disorders. The Maternal Mental Health Peer Navigation Program uses a three-tiered targeted outreach strategy intended to reach Salinas and South County low-income, Spanish- and Indigenous language-speaking residents.

Program Highlights



Population served: Mothers, caregivers, and families

61 program events and activities

350 individuals engaged in program activities

Program Activities

Activities Hosted

Maternal Mental Health Warmline – 34 individuals were helped through phone calls to the warmline.

Circle of Security – 6 individuals attended an 8-session class.

Family Circles – 48 support groups were held where 11 individuals attended.

Childbirth Education – 3 individuals attended a 2-session class.

Pop-up Support Services and Outreach – 11 events were held where 296 individuals attended.

Training of Peer-to-Peer Support Specialists – 2 4-session classes were facilitated via Zoom to train community members, activists, staff of nonprofit organizations and in-home nurses as support specialists.

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM

Program Outcomes, Satisfaction, and Feedback

Comparison of Before and After Knowledge (n=76–79)	Before (% Agree)	After (% Agree)	% Impacted
I knew a lot about the topic of this session/training/class.	71%	81%	10%
I knew where to go for mental health services.	88%	78%	10%
I knew when to ask for help with an emotional problem.	84%	81%	-3%
I felt good about myself.	83%	82%	-1%
I felt hopeful when I thought about the future.	87%	79%	-8%
I was able to recognize early signs of mental illness.	81%	94%	13%
I felt able to respond effectively to early signs of mental illness.	68%	90%	22%
I was likely to assist someone with a mental illness who needed help.	68%	94%	26%



9% of participants (7 individuals) **learned something new from the session/training/class**.

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=31–32)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	10%	90%
The program had services in the language that I speak best.	10%	90%
Materials provided were useful.	7%	93%
The program/training/course was practical and useful.	10%	90%
I would recommend this program/training/course to others.	10%	90%



90% of respondents agreed or strongly agreed that they **would recommend this program to others**.

"I learned how to be a better parent."

"My only wish is that they had playgroups every day. We love them so much!"

What are your recommendations for improvement? (n=45)

- Greater frequency/duration/locations (9)
- More topics (6)
- General positive feedback (10)

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM

Referrals to Mental Health Services

Total Referrals Made

52 referrals were made to **mental/behavioral health treatment**

Types of Referrals Made*

0 referrals were made to clients with **serious mental illness**

34 referrals were made to clients from **underserved populations**

* More than one type of referral could be provided to clients and thus may exceed the total number of referrals.

Referrals for Members of Underserved Populations

6 individuals confirmed to have engaged in treatment

7 days average interval between the referral and participation in treatment

Kinds of Treatment Referred to:

Lactation Support ● Mothers and Babies
Wellness Circles ● Birthing Support

Ways members of underserved populations were assisted in accessing services	
Bus Tokens	0
Transportation	0
Reminder Calls	1
Translation/Interpreter Services	0
Accompaniment	0
Other	4

Others include sharing resource information and Mothers and Babies participant handbook

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM

Demographic Data

Race*

American Indian/Alaskan Native	0%
Asian	5%
Black/African American	6%
Native Hawaiian/Other Pacific Islander	1%
Latino	56%
White	34%
Another	3%
Declined to state	1%

n=103
Another includes Arab.

72% Hispanic/Latino
32% Non-Hispanic/Latino

Ethnicity*

Hispanic/Latino

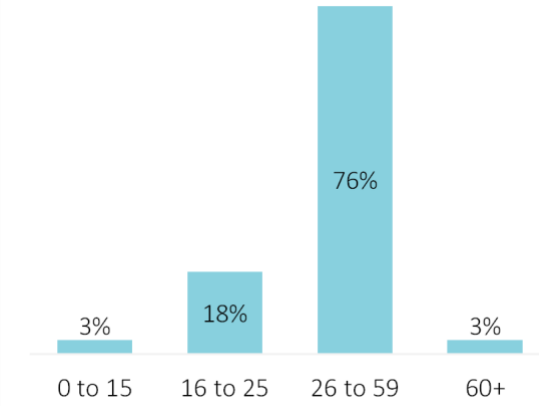
Caribbean	0%
Central American	0%
Mexican/Mex.-Am./Chicano	60%
Puerto Rican	1%
South American	3%
Other Hispanic/Latino	8%

Non-Hispanic/Latino

African	0%
Asian Indian/South Asian	1%
Cambodia	0%
Chinese	0%
Eastern European	1%
European	18%
Filipino	1%
Japanese	0%
Korean	0%
Middle Eastern	3%
Vietnamese	1%
Other Non-Hispanic/Latino	7%
Declined to state	7%

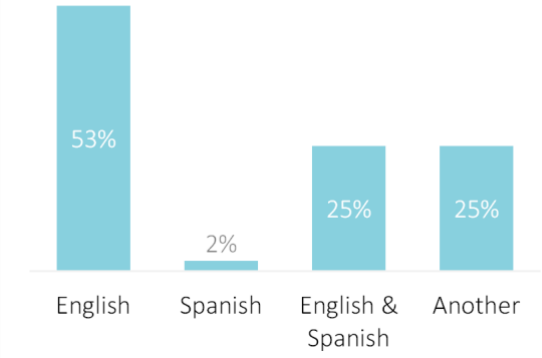
n=81
Other includes Triqui, Spanish.

Age



n=100
2 individuals selected “decline to state.”

Primary Language*



n=103
Another includes Arabic, Vietnamese.
2 individuals selected “decline to state”.

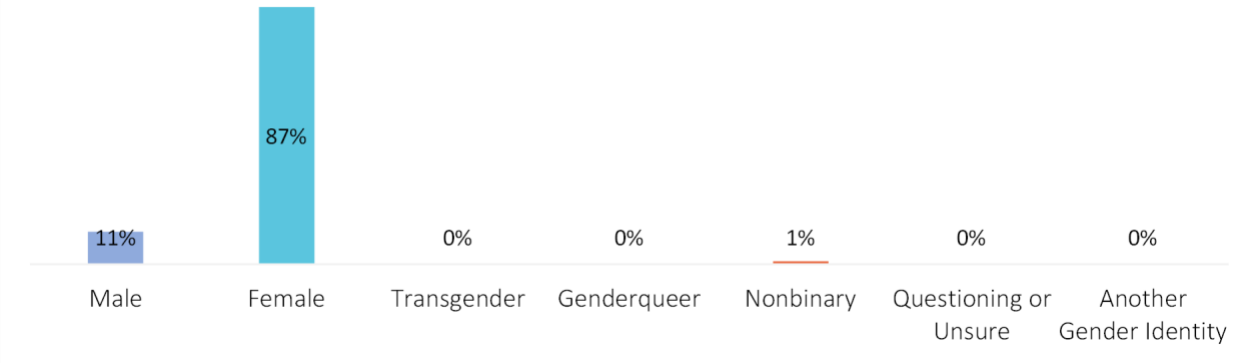
* Percentages may exceed 100% because participants could choose more than one response option.

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM

Demographic Data

Gender Identity



n=86
2 individuals selected "decline to state."

Sexual Orientation

Heterosexual or Straight	76%
Gay or Lesbian	1%
Bisexual	1%
Pansexual	1%
Queer	2%
Questioning or Unsure	1%
Another Sexual Orientation	0%
Declined to state	0%

n=82

Sex

Male	10%
Female	85%
Another Sex	0%

n=86
2 individuals selected "decline to state."

Disability

Mental Domain	41%
Seeing	2%
Hearing	0%
Other Communication	0%
Physical	0%
Chronic Health Condition	3%
Another Disability	1%

n=86
Another disability includes ADHD, Bipolar Personality Disorder.

30% of individuals reported having one or more disabilities

n=86
79 individuals did not answer this question.

2% of individuals were veterans

n=87
2 individuals selected "decline to state"

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

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM

Successes and Learning

Notable Strengths

- The organization has been successful in securing spaces and partnering with various organizations to offer Spanish-language Maternal Mental Health program services and Mothers and Babies Wellness Circles. These spaces are spread across different locations, enhancing community outreach.
- The organization has established a partnership with CSUMB, allowing them to have a master's student as an intern and staff member. This partnership is helping to build internship opportunities and increase staff capacity.

Achievements

- Partnerships were established with various entities, including the Alisal Family Resource Center, Hartnell, WIC, Greenfield Unified School District, and the Soledad Women's Clinic. These partnerships led to requests for Maternal Mental Health program presentations, program expansion beyond the main location in Salinas, and increased awareness of the organization's services.
- Successfully established a Mothers and Babies Wellness Circle at the Soledad Women's Clinic through outreach efforts at farmers markets. The organization serves as a referral agency for mothers facing barriers to accessing clinical support.

Challenges

- To address challenges related to parents' commitments, programming is modified to allow participants to drop into programs. This provides them with flexibility while allowing for tracking of program participation.
- The organization recognizes potential areas for growth related to cultural competencies and knowledge of Indigenous populations and impoverished farm worker communities. Partnerships and trainings are being sought to increase understanding of these underserved communities and their needs.

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM

Successes and Learning

Case Example/Narrative

During our outreach efforts in Soledad, we were approached by staff from the Soledad Women's Clinic which serves Hispanic/Latinx and Indigenous families in the greater South County region. The clinic provides comprehensive medical support for many families during their pregnancies and immediately postpartum; however, they had no mental health supports. When speaking with the leadership onsite, they conveyed a great need for accessible mental health support as they often saw birthing people exhibiting signs of anxiety and depression. Despite the current systems in place, they had low follow-up rates in regard to referrals to county behavioral health services due to distance, transportation barriers, and lack of familiarity with the system. The clinic was able to provide us space to create a weekly Mothers and Babies Wellness Circle. This was a win-win for both agencies. By offering postpartum circles in their neighborhood and in a location they are familiar with, many of the barriers that previously existed are being removed. Since August 2022, we have received 12 referrals from Soledad and have supported four women through our wellness circles.

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM
CENTRO BINACIONAL PARA EL DESARROLLO INDÍGENA OAXAQUEÑO (CBDIO)

The Maternal Mental Health Peer Navigation Program by Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) provides free services for Indigenous mothers, caregivers, and families to prevent Perinatal Mood and Anxiety Disorders from developing and provide early intervention mental health supports for mothers experiencing Perinatal Mood and Anxiety Disorders. CBDIO's Maternal Mental Health Peer Navigation program is the first and only program in Monterey County that specifically targets Indigenous communities. Currently, and especially in the South part of the county, there is no existing support for Perinatal Mood and Anxiety Disorders in Greenfield, Soledad, and King City, putting our Indigenous mothers at higher risk. Within CBDIO's team, the program is referred to as "Mamás Platicando y Sanando" (Mothers Talking and Healing) or "Mamás." Data presented below reflects data collected on services provided between July 1, 2022, and June 30, 2023.

Program Highlights



Population served: mothers experiencing Perinatal Mood and Anxiety Disorders

208 program events and activities

365 individuals engaged in program activities

Program Activities

Activities Hosted

Support Group Meetings – 87 "Pláticas" were held in three different Indigenous languages (16 in Mixteco, 40 in Triqui, 8 in Mixteco) and an additional 8 were held in Spanish. A total of 142 individuals participated.

Screenings – 208 screenings for Perinatal Mood and Anxiety Disorders were completed in Mixteco and Triqui.

Individual Therapy – 15 total individuals were provided one-on-one therapy services. Seven individuals received ongoing therapy while another 8 were referred to other services.

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM (CBDIO)

Program Outcomes, Satisfaction, and Feedback

To assess program outcomes, survey questions were asked to program participants verbally in their preferred language at the beginning of services and then again after receiving services. This approach aligns with cultural considerations, recognizing that many Indigenous mothers may face challenges in reading or writing, not only in Spanish but also in their specific Indigenous languages. Employing oral evaluations as a best practice not only ensures accessibility but also honors the diverse linguistic backgrounds of the participants, acknowledging the profound importance of oral traditions within many Indigenous cultures. By valuing and incorporating these oral practices, the assessment process becomes more culturally resonant, fostering a deeper connection and respect for the rich heritage of the participants. Results below reflect qualitative data captured during conversations regarding knowledge and attitudes about mental health and associated resources.

What does mental health mean to you?

Pre-survey responses (n=20) reflected a general lack of awareness and an associated negative stigma surrounding mental health. Only a limited number of responses expressed a positive connection to mental well-being or between mental health and the capacity to navigate emotions. This information underscores the importance of culturally sensitive mental health awareness initiatives, recognizing the unique perspectives and challenges within Oaxaqueñan Indigenous groups and emphasizing the need for positive narratives around mental health.

Of all Post survey responses (n=11), four made connections between mental health and emotions or feelings (4) or indicated that they have improved their understanding of mental health.

How do you feel when talking about your emotions?

CBDIO is working with mothers who are describing long-held stigmas and beliefs about mental health. Pre-survey/focus group for both platicas Triqui and Mixteco (n=21) showed that mamas felt shame and embarrassed to talk about their emotional health and well-being because they were afraid of what other community members would say. This survey/focused group also showed that it is not normal in the indigenous culture to talk about their feelings, and some mothers do not have words for some of their feelings. This pre-survey/focused group stated that it is difficult for the mamas to seek help because of the stigma, the not knowing where to go for help, and/or because they do not qualify for services due to their immigration status in this country.

Post survey responses (n=11) indicated that individuals were more comfortable discussing emotions or were learning how to have these discussions. Only one individual indicated that they were still embarrassed to discuss emotions.

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM (CBDIO)

Program Outcomes, Satisfaction, and Feedback (cont.)

How easy is it for you to ask for help for your emotional health?

Participants were asked to rate their comfort level on a scale of 0 to 10, with 0 being easy and 10 being hard. Of 19 responses on the pre-survey, the average response was 4.2. Of 12 responses on the post survey, the average response was 4.0. This does reflect a decrease in comfort talking about emotional help and reflects a strong cultural stigma that remains in the community at-large. This highlights the importance of the program for these mothers to have a safe place to explore their emotions and receive mental health services.

Is it embarrassing for you to think you have an emotional health problem?

Out of 20 responses to the pre-survey, 11 participants indicated that it was not embarrassing to think they have an emotional health problem and 7 responses suggested that they were growing in comfort with the idea. Of post-survey response (n=11), 8 indicated that it would not be embarrassing to think they had an emotional health problem and three indicated that it would be embarrassing. Three individuals indicated that they had a fear of criticism and judgement while only one response shared a similar sentiment on the post survey. Again, these results reflect the need for additional outreach and stigma and discrimination reduction efforts in the indigenous communities of Monterey County.

Did you know there were these mental health services here at the center?

Out of 19 responses to the pre-survey, 8 participants indicated they knew of the services at the center and 11 indicated they did not. Of post-survey response (n=12), 7 participants indicated that they knew the center had mental health services and 5 indicated that they did not know of the services.

Please choose how much you agree or disagree with each sentence below (n = 31-32)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	0%	**100%**
The program was provided in the language that I speak best.	0%	**100%**
The program was right for me.	0%	**100%**
I was happy with this program.	0%	**100%**
I would recommend this program to a friend or family member.	0%	**100%**

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM (CBDIO)

Referrals to Mental Health Services

Total Referrals Made

14 referrals were made to **mental/behavioral health treatment**

Types of Referrals Made*

0 referrals were made to clients with **serious mental illness****

14 referrals were made to clients from **underserved populations**

* More than one type of referral could be provided to clients and thus may exceed the total number of referrals.
**Due to staff turnover, referral data for mothers with high PHQ-9 scores were not retained for FY 22/23

Referrals for Members of Underserved Populations

13 individuals confirmed to have engaged in treatment

Kinds of Treatment Referred to:

Mamas Platicando y Sanando

Ways members of underserved populations were assisted in accessing services	
Bus Tokens	0
Transportation	0
Reminder Calls	14
Translation/Interpreter Services	14
Accompaniment	9
Other	7

Others include Therapy Consultation, Food Distribution, and Diaper Distribution

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM (CBDIO)

Demographic Data

Race

American Indian / Alaskan Native	2%
Asian	0%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	0%
Latino	73%
White	0%
Another	2%

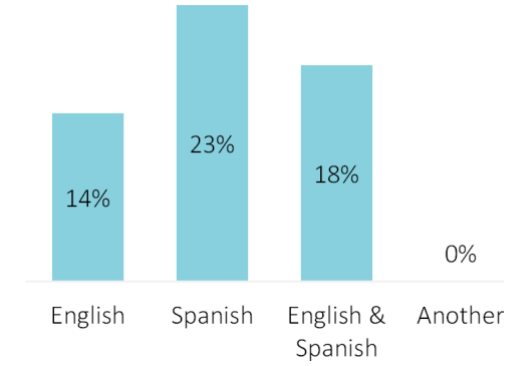
n=55
1 individual selected "decline to state."

Ethnicity

Caribbean	0%
Central American	2%
Mexican/Mex.-Am./Chicano	48%
Puerto Rican	0%
South American	0%
Triqui	44%
Mixteco	22%
Zapoteco	20%

n = 54
1 individual did not answer this question

Primary Language



n = 55

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

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MATERNAL MENTAL HEALTH PEER NAVIGATION PROGRAM (CBDIO)

Successes and Learning

CBDIO has been successful in addressing the unique mental health needs of Indigenous mothers, strongly committed to culturally sensitive and impactful interventions. Its strengths lie in creating a safe and supportive environment, providing vital education on maternal mental health, and effectively adapting content to the community's languages. These achievements, coupled with its emphasis on emotional support and the development of practical coping strategies, have made it a model for similar initiatives.

Notable Strengths

- Cultural Sensitivity and Relevance: In a culture that often views asking for help and sharing feelings as a sign of weakness, CBDIO has broken through these cultural barriers to provide a place for Indigenous mothers to receive support and education about mental health issues.
- Educational Impact: CBDIO is a primary source of knowledge for mothers from Indigenous populations about the development of their children. Mothers learn strategies to manage personal mental health, coping strategies, and knowledge about child development starting in the womb.
- Commitment to Safety: The office location for services has become a safe place for mothers to receive support outside of traditional therapy. CBDIO has worked with mothers to develop individualized support plan and emergency protocols to assist in managing their mental health. This level of interaction with clients would not be possible without the commitment to helping mothers feel safe and comfortable.

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Accomplishments

- Established the first Indigenous program in Monterey County
- Successfully engaged mothers from the Triqui and Mixteco communities and facilitated a significant transformation in their understanding and management of mental health issues.
- Built and strengthened relationships with regional and local organizations to enhance outreach and referrals.
- Increased participation and received positive feedback on cultural sensitivity.
- Respected and addressed the cultural needs of Indigenous mothers, including language, cultural norms, roles, and values.
- Delivered knowledge in an easily understandable and replicable manner.
- Empowered mothers to address mental health stigma and feel more confident discussing their well-being.

Despite its significant impact, CBDIO encountered several key challenges in its journey to support Indigenous mothers.

Challenges

- Staffing: It was key to hire and train Indigenous Community Workers who could navigate the cultural and linguistic nuances of the Indigenous community. Further recruitment hurdles were faced as the community exhibits stigma toward receiving mental health services, family roles are not conducive to supporting mothers, and the availability of workers in the community primarily rely on seasonal work.
- Curriculum and Training: CBDIO was committed to ensuring cultural and linguistic appropriateness of the curriculum used. This commitment faced hurdles due to the need to develop training materials and processes that were culturally sensitive and aligned with the unique needs of both the staff and the program participants. Staff than needed training that allowed them to navigate the cultural and linguistic nuances of the Indigenous community.
- Consistent Participation: Weather conditions, seasonal work, and cultural practices all impacted participant attendance as mothers had to overcome transportation difficulties during floods or full-time work and family duties to be able to participate.

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Case Example/Narrative

Throughout each quarter, we have seen a lot of growth in our participants. One specific mother who has demonstrated being a star participant reported that before the program she had a hard time processing her child's passing. Before learning about our program, she reported feeling sad, worried, and overwhelmed. In just a short time, this mother has reported that she feels equipped to learn how to identify her feelings and has the tools to manage them. The program has helped her integrate into her community and participate in different activities outside our program.

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TEEN SUCCESS, INC. PROGRAM
HARMONY AT HOME

Harmony at Home's Teen Success, Inc. (TSI) program provides a springboard for teenage mothers to be successful by helping them finish high school, supporting their social-emotional needs, and developing concrete goals and plans for their futures. Through individual coaching and peer support groups, teen mothers receive professional guidance and develop trusting, supportive relationships with their peers, which together inspire and empower them to reach their potential. Teen Success, Inc. participants also receive support focused on education navigation, reproductive and mental health, and child development. The mission of Teen Success, Inc. is to transform the lives of teen mothers and their children by helping them become educated, self-sufficient, valued members of society. The program is currently being offered virtually and in person across Monterey County and does not require insurance or collect fees from participants.

Program Highlights



Population served: Teenage mothers

103 program events and activities

124 individuals engaged in program activities

Program Activities

Activities Hosted

Education/Training Sessions – 89 individual coaching sessions given to 5 participants.

Support Group Meetings – 14 family support group meetings provided for 4 families.

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TEEN SUCCESS, INC. PROGRAM

Successes and Learning

Notable Strengths

- Engaging in community outreach.
- Forming new partnerships with similar agencies.
- Boosting expectant mothers' confidence and reducing postpartum fear.

Challenges

A significant obstacle the program faces is the need for more available childcare services. The Teen Success team is consistently looking for community programs that provide childcare services.

Achievements

- Prioritized professional development to support members on their education journeys.
- Connected with a local agency offering childbirth education.
- Focused on helping undocumented members navigate resources and overcome barriers.
- Attended a conference that provided valuable information on supporting undocumented individuals and accessing resources.

Case Example/Narrative

The Teen Success, Inc. program recently overcame a significant challenge when one of its members faced a housing crisis that had been ongoing since 2021. Despite this demanding situation, the member remained committed to completing her high school education while working part time to support herself and her unborn child. During this time, the member had to sleep at shelters or with friends and family—making it difficult for her to focus on her studies and maintain a stable living environment for herself and her family. Nevertheless, the program was able to provide the member with the support she needed to overcome this challenge. With the encouragement of program staff, the member was able to secure her very own apartment at the beginning of 2023—providing her with a stable and safe living environment for her and her child. The member is now attending college and is able to focus more fully on her studies and parenting while feeling secure and supported.

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BULLYING PREVENTION PROGRAM
HARMONY AT HOME

Harmony At Home has been implementing Bullying Prevention programs throughout Monterey County since 2012. Every year, approximately 11,000 children, parents, teachers, non-teaching staff, administrators and community partners are served. The goals of the program are to reduce existing bullying problems among students, to prevent the development of new bullying problems, and to achieve better peer relations at school. This school year, comprehensive social and emotional supports will also be introduced to all school partners. This model will include, in addition to bullying prevention, mental health support, mentoring, coaching and psychoeducation for children, school staff and families.

Program Highlights



Population served: Children, parents, teachers, non-teaching staff, administrators, and community partners

74 program events and activities

1,762 individuals engaged in program activities

Program Activities

Activities Hosted

Outreach Activities – 53 assemblies reached 1,673 students, 80 teachers, and 9 administrative staff.

Support Group Meetings – 21 group activities served 9 families.

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BULLYING PREVENTION PROGRAM

Successes and Learning

Notable Strengths

- Leading multiple schoolwide events.
- Coordinating “Pink Shirt Day” to raise anti-bullying awareness.

Challenges

Our program is currently supporting two middle schools. We have discovered that our approach to providing bullying prevention support in elementary schools should be different from the approach we use in middle schools.

Achievements

- Established strong partnerships with administration and staff at the assigned school sites throughout the school year.
- Supported schools with bullying prevention programs.
- Built the trust of staff, administrators, parents, and students.

Case Example/Narrative

Some of the school sites we are supporting in bullying prevention have severe issues with cyberbullying, physical bullying, and other serious bullying-related issues. Our Bullying Prevention Specialist has expressed the need for more support with bullying at one particular middle school with a high number of students. We are grateful to have meetings with leaders in this project who these recommendations can be relayed to. Due to our monthly meetings, consideration for more bullying prevention support at our school sites for the upcoming school year might be a possibility.

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AFTER SCHOOL ACADEMY
THE VILLAGE PROJECT, INC.

The Village Project, Inc. is an African American Family Resource Center which provides culturally affirming counseling, group therapy, and therapeutic programs and services to African Americans, other individuals and families of color, and the LGBTQ+ community. Services also include outreach, presentations, and workshops to increase mental health awareness, reduce stigma and provide timely access to mental health services among unserved and underserved communities. The Village Project, Inc. is a place where African Americans and communities 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



Population served: African Americans, other individuals and families of color, and the LGBTQ+ community

30 program events and activities

70 individuals engaged in program activities

Program Activities

Activities Hosted

Mental Health and Educational Services – 70 students engaged through 30 different activities and events.

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AFTER SCHOOL ACADEMY

Demographic Data

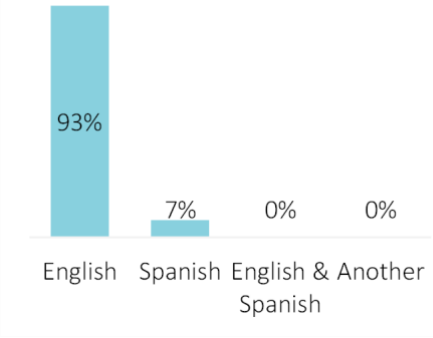
Race*

American Indian/Alaskan Native	0%
Asian	17%
Black/African American	93%
Native Hawaiian/Other Pacific Islander	7%
Latino	28%
White	14%
Another	3%
Declined to state	0%

n=29

100% Participants 4–17 years old

Primary Language



n=30

34% Hispanic/Latino
27% Non-Hispanic/Latino

Ethnicity*

Hispanic/Latino

Caribbean	3%
Central American	3%
Mexican/Mex.-Am./Chicano	21%
Puerto Rican	7%
South American	0%
Other Hispanic/Latino	0%

Non-Hispanic/Latino

African	76%
Asian Indian/South Asian	3%
Cambodia	0%
Chinese	0%
Eastern European	0%
European	0%
Filipino	0%
Japanese	21%
Korean	3%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	0%
Declined to state	0%

n=29

Sex

Male	50%
Female	50%
Another Sex	0%

n=30

10% of individuals reported having one or more disabilities

n=30

Disability

Mental Domain	30%
Seeing	0%
Hearing	0%
Other Communication	0%
Physical	0%
Chronic Health Condition	0%
Another Disability	0%

n=30

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

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AFTER SCHOOL ACADEMY

Successes and Learning

Notable Strengths

- Cultivating new partnerships.
- Engaging community members.
- Developing Youth Leaders.

Challenges

A challenge we have has been hiring qualified therapists so that we can serve more individuals and families who have been referred to our agency.

Achievements

- Collaborated with a variety of outside organizations and businesses.
- Created an Instagram docuseries.
- Conducted interviews that were nationally aired.
- Honored as the featured charity of the 2023 AT&T Pebble Beach Pro Am.

Case Example/Narrative

Our After School Academy wanted to keep providing enrichment opportunities throughout the school year to continue to help students build self-esteem and confidence, as well as empower them to keep making good decisions. Now, the After School Academy has enrichment opportunities at least once a week.

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OUTREACH AND ENGAGEMENT
THE VILLAGE PROJECT, INC.

The Village Project, Inc. is an African American Family Resource Center which provides culturally affirming counseling, group therapy, and therapeutic programs and services to African Americans, other individuals and families of color, and the LGBTQ+ community. Services also include outreach, presentations, and workshops to increase mental health awareness, reduce stigma and provide timely access to mental health services among unserved and underserved communities. The Village Project, Inc. is a place where African Americans and communities 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



Population served: African Americans, other individuals and families of color, and the LGBTQ+ community

39 program events and activities

13,365 individuals engaged in program activities

Program Activities

Activities Hosted

Lucille Hralima Mental Health Series Presentations – 11,187 individuals attended 2 presentation series where community members gained insight from Latinx, Native/Indigenous, and LGBTQ+ communities by learning about stigma reduction, effective mental health treatment, and available services.

Presentations at Schools and Parent Groups – 1,100 individuals attended 20 school presentations and/or parent groups. Parents and guardians learned how to help students who may need additional support.

Community Events – 900 individuals participated in 10 community events where members discussed available services and how to reduce stigma around mental health treatment.

Culturally Informed Training for Clinical Staff – 3 individuals, both internal and external staff, completed culturally informed training.

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OUTREACH AND ENGAGEMENT

Successes and Learning

Notable Strengths

- Cultivating new partnerships.
- Engaging community members.
- Developing Youth Leaders.

Challenges

A challenge we have has been hiring qualified therapists so that we can serve more individuals and families that have been referred to our agency.

Achievements

- Collaborated with a variety of outside organizations and businesses.
- Created an Instagram docuseries.
- Conducted interviews that were nationally aired.
- Honored as the featured charity of the 2023 AT&T Pebble Beach Pro Am.

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CULTURALLY SPECIFIC PREVENTION AND EARLY INTERVENTION THROUGH OUTREACH AND ENGAGEMENT
CENTER FOR COMMUNITY ADVOCACY (CCA)

Center for Community Advocacy's Culturally Specific Prevention and Early Intervention Through Outreach and Engagement program 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



Population served: Unserved and underserved Latino community

29 program events, classes, and activities

57 individuals engaged in program activities

Program Activities

Activities Hosted

Outreach Activities – 10 tabling events occurred.

Education/Training Sessions – 13 training or educational sessions were conducted, which resulted in 49 individuals trained.

Support Group Meetings – 6 support group events or activities were held, with 8 unduplicated participants served and a total of 57 attendees.

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CULTURALLY SPECIFIC PREVENTION AND EARLY INTERVENTION THROUGH OUTREACH AND ENGAGEMENT

Program Outcomes, Satisfaction, and Feedback

Comparison of Before and After Knowledge (n=77-343)	Before (% Agree)	After (% Agree)	% Impacted
I knew a lot about the topic of this session/training/class.	56%	90%	34%
I knew where to go for mental health services.	66%	91%	25%
I knew when to ask for help with an emotional problem.	72%	92%	20%
I felt good about myself.	71%	93%	22%
I felt hopeful when I thought about the future.	76%	95%	19%
I was able to recognize early signs of mental illness.	43%	79%	36%
I felt able to respond effectively to early signs of mental illness.	37%	78%	41%
I was likely to assist someone with a mental illness who needed help.	39%	82%	43%



34% of participants (116 individuals) **learned something new from the session/training/class**.

41% of participants (32 individuals) **learned how to effectively respond to early signs of mental illness**.

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CULTURALLY SPECIFIC PREVENTION AND EARLY INTERVENTION THROUGH OUTREACH AND ENGAGEMENT

Program Outcomes, Satisfaction, and Feedback

Because of this program… (n=74–87)	% Before	% After
I knew where to go for mental health services near me.	41%	90%
I thought people should share about their mental health struggles.	62%	80%
I would feel embarrassed about having personal mental health issues.	26%	19%
I thought the behavior of people with mental illness was unpredictable.	36%	42%
I was scared of people with mental illness.	19%	15%



90% of participants **knew where to go for mental health services** after participating in this program.

Program participants were asked to indicate their attitudes about seeking help for a mental health problem. Findings below shed light on important implications for efforts to promote a more open and supportive environment for individuals struggling with mental health issues.

If I had a mental health problem, seeking help would be… (n=87)	% Agree
Useful	71%
Important	68%
Healthy	60%
Effective	57%
Good	68%
Healing	60%
Empowering	51%
Satisfying	60%
Desirable	54%

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CULTURALLY SPECIFIC PREVENTION AND EARLY INTERVENTION THROUGH OUTREACH AND ENGAGEMENT

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=339–353)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	1%	99%
The program had services in the language that I speak best.	1%	99%
Materials provided were useful.	1%	99%
The program/training/course was practical and useful.	1%	99%
I would recommend this program/training/course to others.	1%	99%



99% of respondents agreed or strongly agreed that they **would recommend this program to others**.

"Now I know how to seek help and get ahead if the case arises."

"These groups should happen more often."

What was most useful or helpful about this program? (n=57)

- Information on mental health disorders (12)
- Information about drugs (8)
- Knowing that help is available (7)

What are your recommendations for improvement? (n=60)

- More time and more sessions (9)
- More examples and real-life stories (6)

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CULTURALLY SPECIFIC PREVENTION AND EARLY INTERVENTION THROUGH OUTREACH AND ENGAGEMENT

Referrals to Mental Health Services

Total Referrals Made

13 referrals were made to **mental/behavioral health treatment**

Types of Referrals Made*

0 referrals were made to clients with **serious mental illness**

13 referrals were made to clients from **underserved populations**

* More than one type of referral could be provided to clients and thus may exceed the total number of referrals.

Referrals for Members of Underserved Populations

1 individual confirmed to have engaged in treatment

Kinds of Treatment Referred to:

Access

Ways members of underserved populations were assisted in accessing services	
Bus Tokens	0
Transportation	0
Reminder Calls	0
Translation/Interpreter Services	0
Accompaniment	0
Other	0

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CULTURALLY SPECIFIC PREVENTION AND EARLY INTERVENTION THROUGH OUTREACH AND ENGAGEMENT

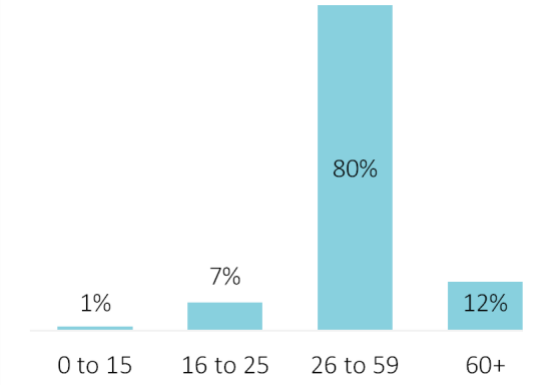
Demographic Data

Race

American Indian/Alaskan Native	0%
Asian	0%
Black/African American	0%
Native Hawaiian/Other Pacific Islander	0%
Latino	98%
White	0%
Another	2%
Declined to state	0%

n=219
Another includes Indigenous, Triqui.

Age



n=216
3 individuals selected "decline to state."

100% Hispanic/Latino
0% Non-Hispanic/Latino

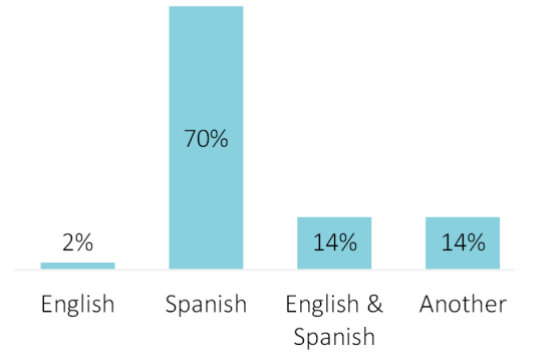
Ethnicity*

Hispanic/Latino	
Caribbean	1%
Central American	2%
Mexican/Mex.-Am./Chicano	93%
Puerto Rican	0%
South American	0%
Other Hispanic/Latino	4%

Non-Hispanic/Latino	
African	0%
Asian Indian/South Asian	0%
Cambodia	0%
Chinese	0%
Eastern European	0%
European	0%
Filipino	0%
Japanese	0%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	0%
Declined to state	0%

n=100

Primary Language



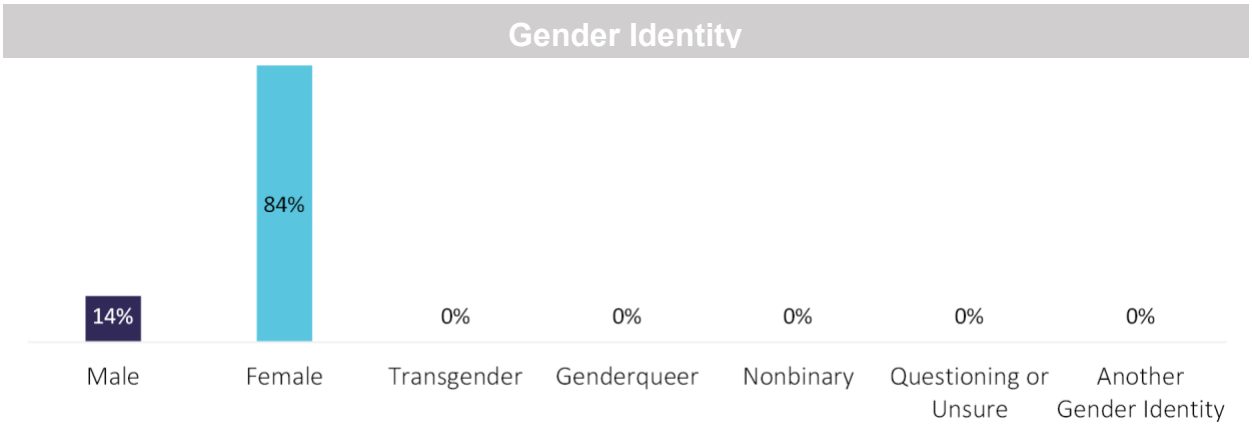
n=221
Another includes Mixteco, Triqui, Zapoteco.

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

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CULTURALLY SPECIFIC PREVENTION AND EARLY INTERVENTION THROUGH OUTREACH AND ENGAGEMENT

Demographic Data



n=96
2 individuals selected "decline to state."

25% of individuals reported having one or more disabilities

n=116
14 individuals did not answer this question.

Disability

Mental Domain	26%
Seeing	5%
Hearing	3%
Other Communication	1%
Physical	4%
Chronic Health Condition	6%
Another Disability	0%

n = 102
Another disability includes Depression.
1 individual selected "decline to state".

Sex

Male	10%
Female	69%
Another Sex	0%

n=116
2 individuals selected "decline to state"

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

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CULTURALLY SPECIFIC PREVENTION AND EARLY INTERVENTION THROUGH OUTREACH AND ENGAGEMENT

Successes and Learning

Notable Strengths

- The program excels in direct community engagement, resource distribution, and shifting care responsibility to providers.
- The program offers culturally relevant services in Spanish—fostering trust, confidence, and community engagement.

Challenges

Severe weather was one recent obstacle. Community members in our support groups were directly affected by the floods that destroyed their homes, properties, and jobs.

Achievements

- Gained 52 new participants.
- Established a new mental health support group in Salinas.
- Facilitated connections and peer support among neighbors, friends, and family members.
- Direct provision of resources and services was made in community members' homes and community spaces.
- Provided information in participants' main language for easy comprehension and implementation.

Case Example/Narrative

The example narrative is a direct experience of one of our participants in their words:

“I harmed my kids because I came to this country and I left them alone and I only had communication with my oldest daughter. I worked for my kids. I left them with my sister. I haven’t had time to tell them that I love them since I came 16 years ago. I have not stopped thinking about them, but they only come to me when they need money. They never ask me how I am. I feel like a bad mother because I left them and I wish I could hug them and feel their heartbeat. I am thankful for this space to be able to share my feelings.”

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PROYECTO CONTIGO AND SCHOOL-BASED COUNSELING
PAJARO VALLEY PREVENTION AND STUDENT ASSISTANCE

The mission of Pajaro Valley Prevention and Student Assistance (PVPSA) is to improve the quality of life of children, youth, and families of the greater Pajaro Valley by providing health education, mental health, and substance use services, and by advocating for public policies that protect the wellbeing of our community. By helping prevent criminal behavior, gang involvement, truancy, and drug, alcohol and tobacco use, PVPSA promotes student success and improves the quality of life in our community and its schools.

In its **School-Based Counseling** programs, PVPSA delivers outpatient mental health services to North Monterey County's children aged 0–5 years and school-age children attending schools in the Pajaro/Las Lomas area, and their Medi-Cal-eligible family members, addressing diverse mental health needs. **Proyecto Contigo** is a community program aimed at fostering resilience, reducing isolation, and strengthening social bonds among residents of Pajaro, Las Lomas, and Royal Oaks. A dedicated Promotora de Salud leads continuous outreach and engagement initiatives by actively participating in community activities and facilitating meaningful conversations.

Program Highlights



Population served: Children in North Monterey County receiving school-based services and their caregivers

15 program events and activities

580 individuals and 16 families engaged in program activities

Program Activities

Activities Hosted

Proyecto Contigo Presentations – 38 individuals and 15 families attended 5 presentations where they received information about mental health and how to access resources.

Proyecto Contigo Outreach – 540 individuals attended 7 outreach events that promoted self-care strategies (yoga, muscle relaxation, link between nutrition and mental health) and how to access mental health support.

Trainings – 2 individuals and 1 family attended 3 workshops where they learned about available services, signs and symptoms of when to seek help, and emotional support strategies that allowed them to express themselves.

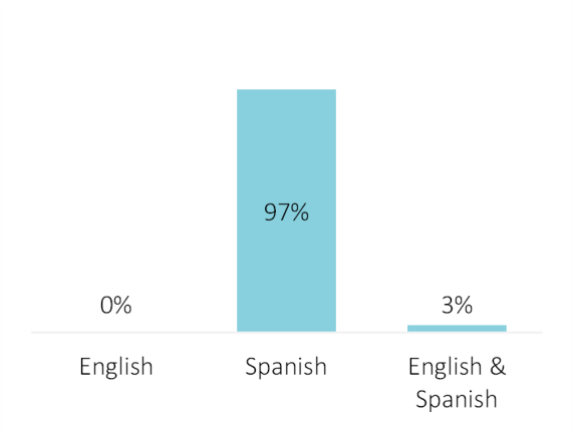
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PROYECTO CONTIGO AND SCHOOL-BASED COUNSELING

Demographic Data

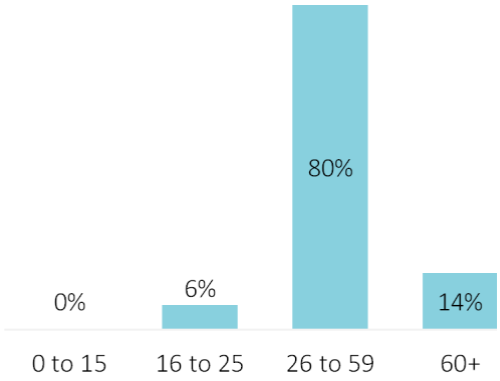
100% Hispanic/Latino

Primary Language



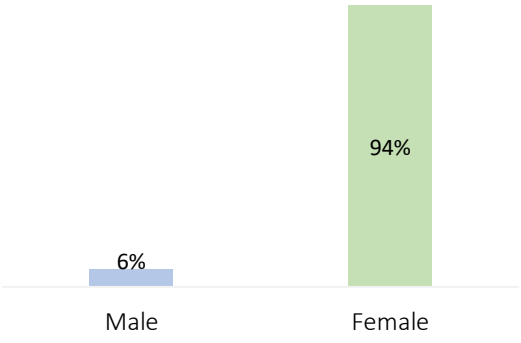
n=62

Age



n=65
2 individuals selected "decline to state."

Gender Identity and Sexual Orientation



n=18
100% of respondents identified as Heterosexual.

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

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PROYECTO CONTIGO AND SCHOOL-BASED COUNSELING

Successes and Learning

Notable Strengths

- Working diligently to continue building relationships with the community of Pajaro/Las Lomas via in-person presentations and outreach efforts.
- Being adaptable and flexible to meet the needs of the community.

Challenges

The families of Pajaro are working class and continue to struggle to make ends meet. A major barrier our community faced was the recent floods—this impacted their mental health tremendously.

Achievements

- Linked more individuals to mental health resources.
- Reached more participants through presentations.
- Presented mental health resources and information pertinent to community needs.
- Adapted program materials to be relevant to the immediate crises that community members faced.

Case Example/Narrative

Our staff has had a great experience in assisting the community of Pajaro with this program. A young woman was referred to PVPSA in April whose mental health had been affected by the floods. The client was linked to and started receiving mental health services. Her mother has mentioned that she is grateful to the staff and that she has seen a positive impact on her daughter. We also learned that the Pajaro/Las Lomas community is resilient. Considering the traumatic event they went through [the flood], these families were open to hearing and learning more about mental health and how to support each other as a community. We will continue to provide services for the clients, their families, and the community as whole.

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EARLY INTERVENTION

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FAMILY SUPPORT GROUPS
MONTEREY COUNTY BEHAVIORAL HEALTH (MCBH), ADULT SYSTEM OF CARE (ASOC)

Family Support Groups are facilitated by MCBH staff to provide support for family members of individuals living with mental health conditions. Family members get an opportunity to discuss their unique experiences and learn ways to cope from peers and, most of all, learn that they are not alone in their journey. Psychoeducation, resources, and opportunities for peer-sharing are provided through these groups. Family support groups are offered in English and in Spanish to all interested Monterey County residents.

Program Highlights



Population served: Family members of those with a mental illness

12 family support groups

11 individuals and 11 families engaged in family support groups

Program Activities

Activities Hosted

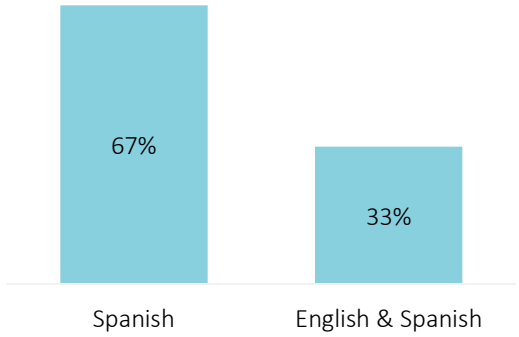
Support Group Meetings – 12 family support groups held in total, with groups meeting 4 times per month.

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FAMILY SUPPORT GROUPS

Demographic Data

Primary Language



n=15
6 individuals did not answer this question.

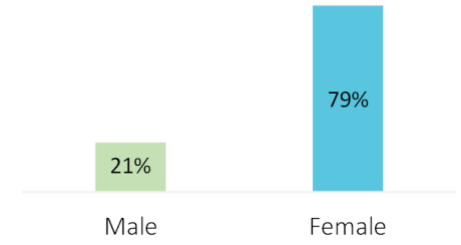
100% Respondents Aged 26–59

n=15
6 individuals did not answer this question.

100% of Respondents identified as Mexican/Mexican American/Chicano

n=19

Gender Identity and Sexual Orientation



n=14
100% of participants identified as Heterosexual .

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

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FAMILY SUPPORT GROUPS

Successes and Learning

Notable Strengths

- The family group meets weekly with a consistent attendance of 3–5 recurrent clients (about 95% attendance) in a rural area with limited mental health services.
- The group provides educational materials for clients, that teach coping skills and help participants access support for their loved ones.

Challenges

The greatest challenge the facilitator has is time. While the group is held weekly, it is difficult to keep up with the quarterly reports partly due to technology. The facilitator is not well-trained on how to submit the forms in a timely manner.

Achievements

- There is consistent group attendance by individuals who come seeking support during difficult times and return periodically to reset and manage their lives.
- Testimonials from group members indicate that the group provides a sense of belonging and understanding—helping them cope with challenges and not feel alone.
- The program has a positive impact on community members, offering valuable support and a sense of connection.

Case Example/Narrative

Most of the success of the groups is evidenced by client comments on how the groups help them. South Monterey County is a rural area where resources are very limited. There is a tremendous lack of information on mental health and mental illness. Some of the participants are parents or siblings of individuals who have a mental illness, and they are frequently frightened by the symptoms of someone who is going through a psychotic phase. They are often confused and have no idea how to react to their loved ones. These are the people who most appreciate, and usually bring others to, the family support group.

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(RE)MIND®
FELTON INSTITUTE

(re)MIND® is a program of Felton Institute to provide treatment and management of early psychosis with evidence-based, culturally competent assessment, diagnosis, and interventions. The mission of (re)MIND® 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 (re)MIND® program serves people ages 14–35 experiencing symptoms and functional impairments related to early psychosis and/or diagnosis of schizophrenia spectrum disorders with onset of symptoms within the previous five years.

Program Highlights



Population served: Individuals between 14–35 years old experiencing early psychosis

1,085 program events and activities

162 individuals and 55 families engaged in program activities

Program Activities

Activities Hosted

Presentations – 6 presentations were provided to the community that discussed psychosis, admission criteria, and resources that Felton provides.

Outreach Groups – 8 community stakeholder groups were hosted to increase awareness of mental illness and provide education on available services.

Family Psychoeducation – 55 families joined 295 psychoeducation events that addressed topics such as early signs and symptoms, the importance of early intervention, behavioral health wellness, and stigma.

Individual Therapy – Individual therapy services were provided to 66 participants across 299 sessions.

Case Management – Case management services were provided to 96 participants across 477 sessions.

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(RE)MIND®

Program Outcomes, Satisfaction, and Feedback

Nearly all of the time… (n=2–78)	% Before	% After
Given my current physical condition, I am satisfied with what I can do.	32%	100%
I have confidence in my ability to sustain important relationships.	32%	100%
I feel hopeful about my future.	21%	100%
I am often interested and excited about things in my life.	24%	100%
I am able to have fun.	30%	100%
I am generally satisfied with my psychological health.	20%	100%
I am able to forgive myself for my failures.	21%	100%
My life is progressing according to my expectations.	17%	100%
I am able to handle conflicts with others.	19%	100%
I have peace of mind.	28%	100%

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(RE)MIND®

Referrals to Mental Health Services

Total Referrals Made

12 referrals were made to **mental/behavioral health treatment**

Types of Referrals Made*

9 referrals were made to clients with **serious mental illness**

10 referrals were made to clients from **underserved populations**

* More than one type of referral could be provided to clients and thus may exceed the total number of referrals.

Referrals for Individuals with Serious Mental Illness

Referred to County Treatment:

7 individuals confirmed to have engaged in treatment

20 days average interval between the referral and participation in treatment (standard deviation: 21.5)

1.7 years and 1 month average duration of untreated mental illness prior to referral (standard deviation: 1.8 and 3, respectively)

Kinds of County Treatment Referred to:

Monterey County Behavioral Health Avanza

Kinds of Non-County Treatment Referred to:

OHANA

Referrals for Members of Underserved Populations

6 individuals confirmed to have engaged in treatment

29 days average interval between the referral and participation in treatment

Kinds of Treatment Referred to:

Monterey County Behavioral Health Avanza ● Private Insurance ● Monterey County Behavioral Health TAY

Ways members of underserved populations were assisted in accessing services	
Bus Tokens	0
Transportation	1
Reminder Calls	1
Translation/Interpreter Services	0
Accompaniment	0
Other	0

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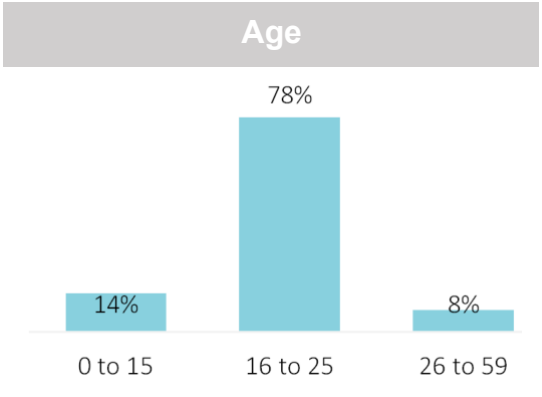
(RE)MIND®

Demographic Data

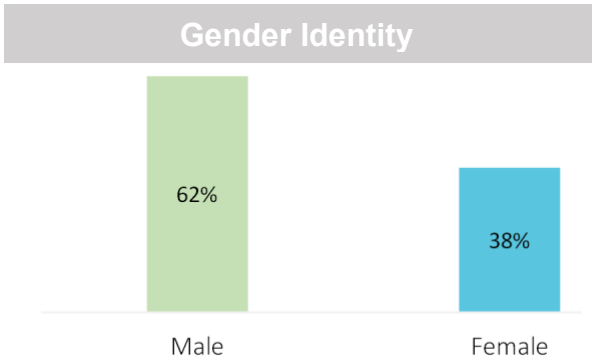
Race

Black/African American	62%
Latino	0%
White	14%
Another	24%

n=50†



n=50†



n=50†

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

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(RE)MIND®

Successes and Learning

Notable Strengths

- Commitment to utilizing evidence-based practices to support the lasting recovery of those served.
- The division's network of providers committed to the specialty of early psychosis.

Challenges

While we have received regular referrals from MCBH and other sources, not all referrals lead to participant engagement.

Achievements

- Numerous participant success stories.
- Filling a crucial role on the team that is a difficult position to fill. This vital position has allowed the program to expand the services it provides to participants and engage them on a more personal level.
- A specialist on the team started a Family Support Group, which provides crucial psychoeducation, information, and resources to participant caregivers/main support persons.

Case Example/Narrative

A young adult was experiencing their first psychosis episode and had been in a state of catatonia along with experiencing a slew of other psychosis-related symptoms. This individual has made such a vast turnaround from fully engaging in the services our program offers, doing the work in therapy, and really embracing the Early Psychosis Intervention model and treatment. Through this full engagement, they have now completed vocational school and are preparing to sit for the certification exam to be a Certified Nursing Assistant.

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STICKS & STONES® SCHOOL-BASED COUNSELING HARMONY AT HOME

The Sticks & Stones® school-based counseling program, sponsored by Harmony at Home, is a prevention and intervention program for children in grades K–12 exposed to violence and trauma in Monterey County. The program provides school-based psychoeducation, individual therapy, and group therapy for children who have been exposed to trauma and are displaying behaviors at school, home or in the community that suggest an underlying concern. The program also works to support parents and caregivers in meeting their children's academic, social, and psychological needs and enhance their conflict resolution skills. In addition, the Sticks & Stones® program provides outreach to community groups to promote the program and related services.

Program Highlights



Population served: Children who have experienced trauma and their families

8,916 program events and activities

782 individuals engaged in program activities

Program Activities

Activities Hosted

School-based Group and Individual Therapy – 782 individuals served through 8,916 sessions of school-based group and individual therapy.

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STICKS & STONES® SCHOOL-BASED COUNSELING

Program Outcomes, Satisfaction, and Feedback

Comparison of Before and After Knowledge (n=114–115)	Before (% Disagree)	After (% Disagree)	% Impacted
I knew a lot about the topic of this session/training/class.	67%	4%	63%
I knew where to go for mental health services.	55%	3%	52%
I knew when to ask for help with an emotional problem.	54%	4%	50%
I felt good about myself.	51%	8%	43%
I felt hopeful when I thought about the future.	50%	9%	41%



63% of participants (72 individuals) **learned something new from the session/training/class**.

52% of participants (60 individuals) **learned where to go for mental health services**.

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STICKS & STONES® SCHOOL-BASED COUNSELING

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=113–115)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	1%	99%
The program had services in the language that I speak best.	1%	99%
Materials provided were useful.	2%	98%
The program/training/course was practical and useful.	1%	99%
I would recommend this program/training/course to others.	4%	96%



96% of respondents agreed or strongly agreed that they **would recommend this program to others**.

"The most helpful thing about this program was talking about your feelings. Opening up to someone you trust."

"This program could be better by making the sessions longer or having more sessions."

What was most useful or helpful about this program? (n=99)

- Improved communication and the opportunity to share experiences with others (63)
- Felt more educated on how to manage emotions (43)

What are your recommendations for improvement? (n=89)

- More time and sessions (13)
- General positive feedback (61)

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STICKS & STONES® SCHOOL-BASED COUNSELING

Demographic Data

Race*

American Indian/Alaskan Native	0%
Asian	1%
Black/African American	3%
Native Hawaiian/Other Pacific Islander	2%
Latino	88%
White	13%
Another	1%
Declined to state	0%

n=419
Another includes Portuguese.

99% Hispanic/Latino
8% Non-Hispanic/Latino

Ethnicity*

Hispanic/Latino

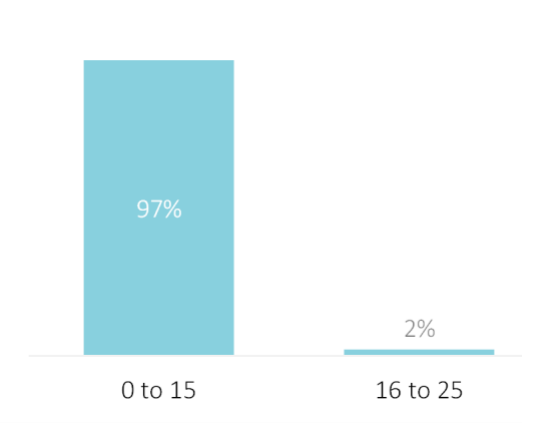
Caribbean	0%
Central American	2%
Mexican/Mex.-Am./Chicano	91%
Puerto Rican	1%
South American	1%
Other Hispanic/Latino	4%

Non-Hispanic/Latino

African	0%
Asian Indian/South Asian	0%
Cambodia	0%
Chinese	0%
Eastern European	1%
European	3%
Filipino	1%
Japanese	1%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	2%
Declined to state	2%

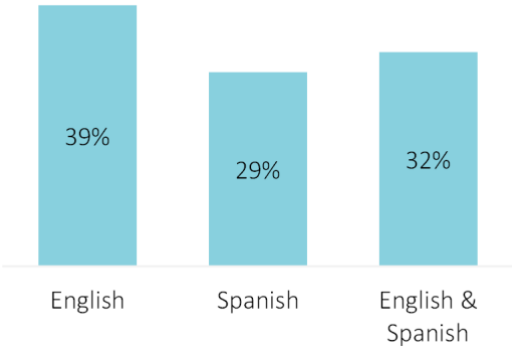
n=369
Other includes Afro-Mexican and Guerrero.

Age



n=439
6 individuals selected "decline to state."

Primary Language



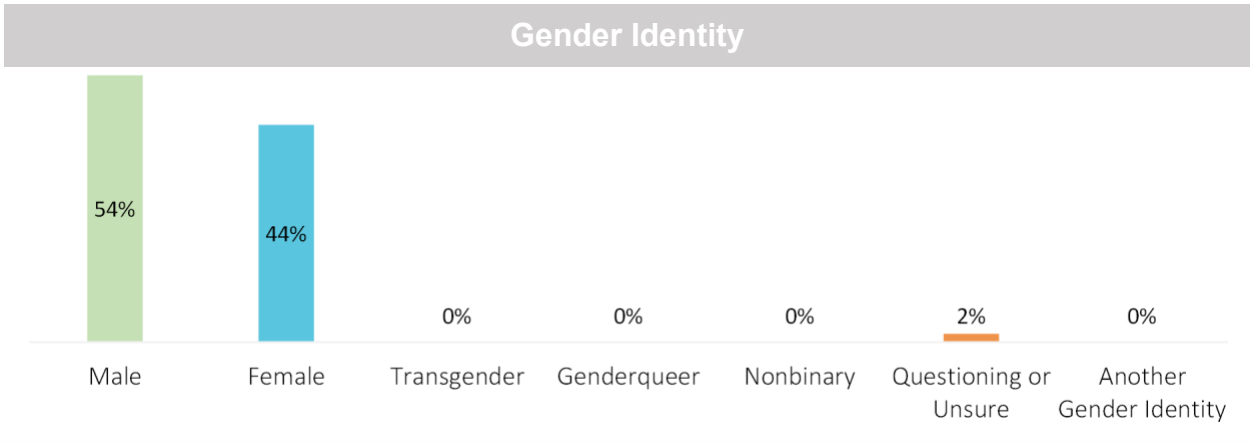
n=392

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

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STICKS & STONES® SCHOOL-BASED COUNSELING

Demographic Data



n=59

Sexual Orientation

Heterosexual or Straight	79%
Gay or Lesbian	0%
Bisexual	4%
Pansexual	2%
Queer	0%
Questioning or Unsure	6%
Another Sexual Orientation	0%
Declined to state	9%

n=47

Sex

Male	51%
Female	41%
Another Sex	0%

n=410

11% of individuals reported having one or more disabilities

N=366
5 selected "decline to state."

Disability

Mental Domain	13%
Seeing	1%
Hearing	1%
Other Communication	0%
Physical	0%
Chronic Health Condition	0%
Another Disability	1%

n=366
Another disability includes ADHD, Autism, Depression, Panic Attacks, Social Anxiety.

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

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STICKS & STONES® SCHOOL-BASED COUNSELING

Successes and Learning

Notable Strengths

- The curriculum is designed to work with students in small groups.
- The program is well known and accepted in the community.
- There is a low number of waitlisted students.

Challenges

For the past couple of years, staffing has been our greatest challenge. We are excited that this is the first time in a long time that we are fully staffed.

Achievements

- Served 10 school districts—for a total of 43 schools—throughout Monterey County and South County.
- Served most of the students that have been referred to the program.
- Achieved full staffing levels.
- Reduced the number of students on the waitlist.
- Cultivated high demand.
- Continued to grow.

Case Example/Narrative

One of the challenges that our program has had to overcome has been ensuring that our partners at the district level truly understand the impact of our work through data. It is very difficult to ensure that the data we collect reflects the impact of our work—especially as our program continues to expand. The success of our program therefore depends greatly on the continuous collaboration of each of our counseling staff within their assigned sites. We have learned what data we need to collect to help make sure that everyone has a clear understanding of our progress and that the data collected also helps us identify potential areas for growth. Data collection has also given us the opportunity to assist our partners in identifying what changes need to be implemented in order to help students. We continue to meet monthly with district partners to share our progress and discuss needs. Doing this has helped us establish closer working relationships and help students achieve academic success through mental health stability.

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SERVICES TO EDUCATION
MONTEREY COUNTY BEHAVIORAL HEALTH (MCBH)

MCBH has a very strong partnership with the Monterey County Office of Education and school districts throughout Monterey County. The Services to Education program staff provide training, consultation, and support to schools to develop positive school climates, understand and address student behavioral health issues and implement state-mandated district suicide prevention plans. MCBH staff located in the schools also 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.

Program Highlights

Population served: Children and youth receiving school-based services, their teachers, educational staff, and parents

135 program events and activities

210 individuals engaged in program activities

Program Activities

Activities Hosted

Outreach Activities – 50 individuals participated in 1 outreach activity.

Youth Support Group Meetings – 55 individuals participated in 22 support group meetings.

Coordination Meetings – 35 individuals participated in 46 coordination meetings.

Mental Health Consultations – 45 individuals were seen in a total of 62 mental health consultations.

Training Sessions – 25 individuals were trained in 2 training sessions.

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SERVICES TO EDUCATION

Program Outcomes, Satisfaction, and Feedback

Because of this program… (n=16)	% Before	% After
I knew where to go for mental health services near me.	88%	94%
I knew a lot about the topic of this training/class.	75%	94%
I was able to recognize early signs of mental illness.	88%	94%
I felt able to respond effectively to early signs of mental illness.	94%	81%
I was likely to assist someone with a mental illness who needed help.	81%	81%



94% of respondents said that they were able to recognize the early signs of mental illness after participating in this program.

"I appreciated learning about the positive effects of connecting with morning sun."

"It was helpful to learn ways to help with self-care that I can use."

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SERVICES TO EDUCATION

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=15-16)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	0%	100%
The program was provided in the language that I speak best.	0%	100%
The program was right for me.	0%	100%
I was happy with this program.	0%	100%
I would recommend this program to a friend or family member.	0%	100%



100% of respondents agreed or strongly agreed that they **would recommend the program to a friend or family member**.

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

- Leaning about tools that support my mental health (9)
- Receiving information about anxiety, depression, or suicide (2)
- General comments about enjoying the presentation (2)

What are your recommendations for improvement? (n=4)

- Have a more interesting, engaging, or interactive presentation (3)
- Have more examples, real-world applications (1)

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SERVICES TO EDUCATION

Demographic Data

Race*

American Indian/Alaskan Native	0%
Asian	4%
Black/African American	0%
Native Hawaiian/Other Pacific Islander	0%
Latino	82%
White	18%
Another	0%
Declined to state	0%

n=73

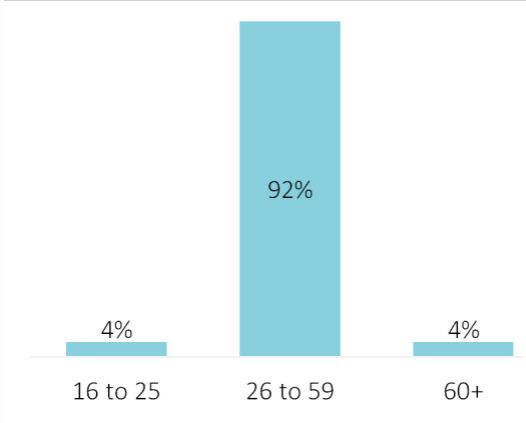
100% Hispanic/Latino
5% Non-Hispanic/Latino

Ethnicity*

Caribbean	0%	Hispanic/Latino
Central American	0%	
Mexican/Mex.-Am./Chicano	95%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	5%	
African	0%	Non-Hispanic/Latino
Asian Indian/South Asian	0%	
Cambodia	0%	
Chinese	0%	
Eastern European	0%	
European	0%	
Filipino	0%	
Japanese	0%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	5%	
Declined to state	10%	

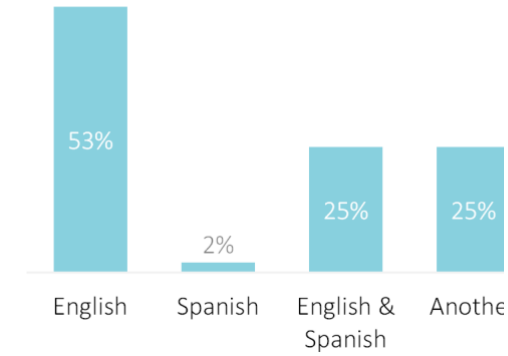
n=73

Age



n=71
2 individuals selected "decline to state."

Primary Language*



n=73
Another includes Mixteco.
2 individuals selected "decline to state."

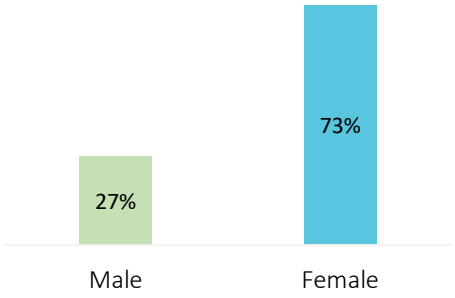
* Percentages may exceed 100% because participants could choose more than one response option.

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SERVICES TO EDUCATION

Demographic Data

Gender Identity



n=22

14% of individuals reported having one or more disabilities

n=21
3 individuals selected "decline to state."

Sexual Orientation

Heterosexual or Straight	82%
Gay or Lesbian	0%
Bisexual	0%
Pansexual	0%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Declined to answer	14%

n=22
3 individuals selected "decline to state."

Disability

Mental Domain	27%
Seeing	0%
Hearing	0%
Other Communication	0%
Physical	0%
Chronic Health Condition	0%
Another Disability	0%

n=21

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

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

SERVICES TO EDUCATION

Successes and Learning

Notable Strengths

- Collaborative partner with schools and other community agencies.
- Integrated into all levels of mental health services at schools.
- Available to triage on student needs to support in building capacity to address co-occurring needs in schools.

Challenges

Staffing challenges continue, so we have learned to utilize other supports within our agency like social workers. Another challenge is screening referrals to triage referrals and make efforts to not duplicate services.

Achievements

- Offered more training opportunities on Healing Centered Engagement, Trauma-Informed Care, Cultivating Relationships with Students, Mindfulness and Risk Assessments.
- Offered training specific to LGBTQ populations and developed the Rainbow Connections Program.
- Promoted inter-agency and community collaboration.
- Increased access to integrated affirming care.
- Built capacity across family, school, and community settings.

Case Example/Narrative

Our program assisted a school district in providing group services focused on skill building to support student re-entry rather than possible expulsion.

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SILVER STAR RESOURCE CENTER
MONTEREY COUNTY BEHAVIORAL HEALTH (MCBH)

Silver Star Resource Center is a multi-agency collaborative of prevention and early intervention services which are 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 Silver Star Resource Center 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



Population served: Youth at risk of juvenile justice system involvement and their families

115 program events and activities

210 individuals engaged in program activities

Program Activities

Activities Hosted

MDT Team Meetings – 25 MDT team meetings were conducted, serving 91 new referrals.

Individual Youth Client Services – 119 individuals received youth client services.

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SILVER STAR RESOURCE CENTER

Program Outcomes, Satisfaction, and Feedback

Comparison of Before and After Knowledge (n=37–40)	Before (% Disagree)	After (% Disagree)	% Impacted
I knew a lot about the topic of this session/training/class.	35%	8%	27%
I knew where to go for mental health services.	38%	0%	38%
I knew when to ask for help with an emotional problem.	28%	0%	28%
I felt good about myself.	40%	8%	32%
I felt hopeful when I thought about the future.	30%	5%	25%



38% of participants (15 individuals) **learned where to go for mental health services**.
28% of participants (11 individuals) **learned when to ask for help with an emotional problem**.

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SILVER STAR RESOURCE CENTER

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=37–39)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	0%	100%
The program had services in the language that I speak best.	0%	100%
Materials provided were useful.	0%	100%
The program/training/course was practical and useful.	0%	100%
I would recommend this program/training/course to others.	0%	100%



100% of respondents agreed or strongly agreed that they **would recommend this program to others**.

"Learning how to cope and understanding my emotions."

"Hearing from different generations, talking about mental health from their racial and cultural backgrounds."

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

- Connection with others and the opportunity to share experiences (11)
- Learning how to care for own mental health (11)

What are your recommendations for improvement? (n=31)

- Hearing from more diverse perspectives (3)
- General positive feedback (12)

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SILVER STAR RESOURCE CENTER

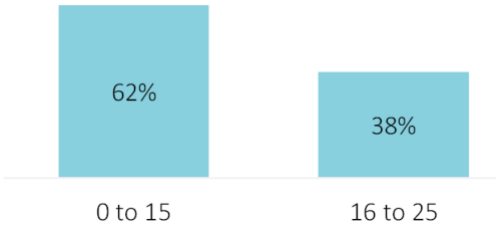
Demographic Data

Race

n=119†

Black/African American	2%
Latino	34%
White	1%
Another	64%

Age



n=119†

Sex

n=119†

Male	39%
Female	61%

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

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SILVER STAR RESOURCE CENTER

Successes and Learning

Notable Strengths

- Offering extensive engagement efforts for our new referrals.
- Linking families to community resources or other providers.
- Implementing a consent form to allow for collaboration to occur for court-ordered referrals.

Challenges

We are encouraging referring parties to ask if the family is already involved with MCBH prior to making a Silver Star Resource Center (SSRC) MCBH referral, and this is decreasing some duplicate referrals.

Achievements

- MCBH team collaborated multiple times per day with each other, which allowed for more in-depth processing of referrals.
- Even with severely short staffing, the waitlist has been eliminated.
- Most clients set an intake within 5–7 days.
- Most services occur in person at SSRC with SSRC PSW.

Case Example/Narrative

In order to refine and best use the MCBH team's time more effectively, MCBH streamlined a few program elements: 1) we utilize a live shared Excel spreadsheet to track referral status, triage, and prioritize cases, 2) MDT are held two Thursdays per month and, 3) on the immediate Friday after the MDT, the core MCBH SSRC team meets to review, process, and triage MCBH SSRC referrals. The end goal was to assign a Social Worker III to call for a symptom screener and set up an intake appointment for an onset packet, in prep for the PSW assignment. This led to faster turnaround, immediate contacts following MDT, and timelier appointments/intake interviews for clients.

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MATERNAL, CHILD AND ADOLESCENT HEALTH HOME VISITING PROGRAM
PUBLIC HEALTH BUREAU

The Maternal, Child and Adolescent Health (MCAH) Home Visting Program is committed to serving women, children, teens, and their families in Monterey County by improving access to comprehensive, quality health care, and focusing on prevention and early intervention strategies.

Program Highlights



Population served: Women, children, teens, and their families

64 program events and activities

65 individuals engaged in program activities

Program Activities

Activities Hosted

Screenings – 18 participants served through screenings.

Interventions – 45 individuals served through PMAD, SED, and client interventions.

Education/Training Sessions – 1 training held with 2 individuals trained.

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MATERNAL, CHILD AND ADOLESCENT HEALTH HOME VISITING PROGRAM

Successes and Learning

Notable Strengths

- Working to increase presence in the community to generate more referrals.
- Participating in outreach events.

Challenges

We continue to have challenges with filling the other MHSA vacancies. A PHN II Interview panel is tentatively scheduled for early May 2023 and Office Assistant III interviews were conducted in April.

Achievements

- Presented at WIC pregnancy classes to introduce the program to potential clients.
- Hired a PHN II at the end of quarter 3 who begin to see clients in quarter 4.
- Much work was done internally to spread the word of recruitment and hire the candidate.
- A PMAD onboarding training packet was put together to provide the new staff with the support and knowledge needed to start to see clients.

Case Example/Narrative

We successfully onboarded a PHN II at the end of the quarter. She quickly learned the SOC as well as the policies and procedures of MCAH. We are excited for her to begin to build her MHSA caseload and provide client-centered interventions around PMAD and infant growth and development.

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CULTURALLY SPECIFIC SHORT-TERM THERAPEUTIC SERVICES (CSSTS)
COMMUNITY HUMAN SERVICES (CHS)

Community Human Services (CHS) provides Culturally Specific Short-term Therapeutic Services (CSSTS) in English, Spanish and other languages to uninsured individuals experiencing mild to moderate mental health issues and stressors, including those associated with immigration-related issues, institutional racism, discrimination, and trauma experienced over the lifetime of one's cultural identity. Connections to community services and supports in a variety of settings are offered by the program to reduce access barriers.

Program Highlights



Population served: Adults and youth who are uninsured

142 individuals engaged in therapeutic assessment activities

Program Activities

Activities Hosted

Assessments – 142 individuals received 212 assessment sessions.

Initial Therapy Contacts – 138 initial therapy sessions were provided.

Individual Therapy Contacts – 606 individual therapy sessions were provided.

Case Management – 137 sessions of 15- to 30-minute case management services were held.

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CULTURALLY SPECIFIC SHORT-TERM THERAPEUTIC SERVICES (CSSTS)

Demographic Data

Race*

American Indian/Alaskan Native	0%
Asian	0%
Black/African American	0%
Native Hawaiian/Other Pacific Islander	0%
Latino	97%
White	6%
Another	1%
Declined to state	0%

n=88

99% Hispanic/Latino
1% Non-Hispanic/Latino

Ethnicity

Hispanic/Latino

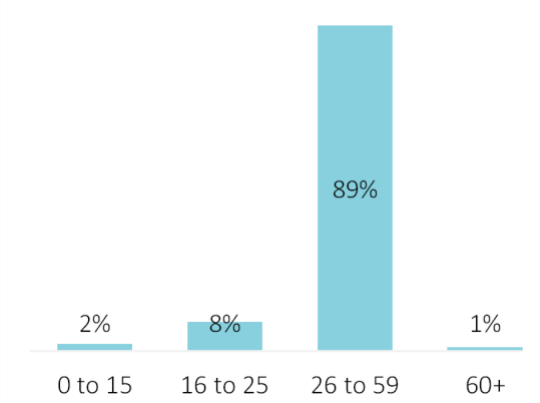
Caribbean	0%
Central American	3%
Mexican/Mex.-Am./Chicano	91%
Puerto Rican	0%
South American	0%
Other Hispanic/Latino	5%

Non-Hispanic/Latino

African	0%
Asian Indian/South Asian	0%
Cambodia	0%
Chinese	0%
Eastern European	0%
European	1%
Filipino	0%
Japanese	0%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	0%
Declined to state	3%

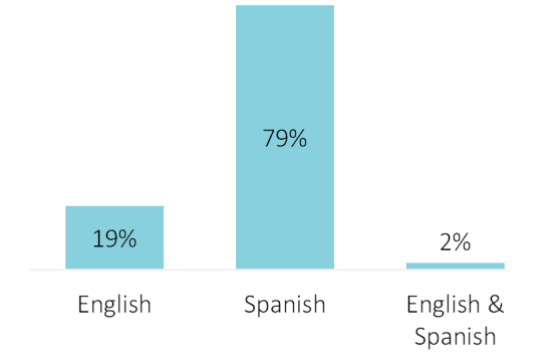
n=79

Age



n=93

Primary Language



n=90

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

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CULTURALLY SPECIFIC SHORT-TERM THERAPEUTIC SERVICES (CSSTS)

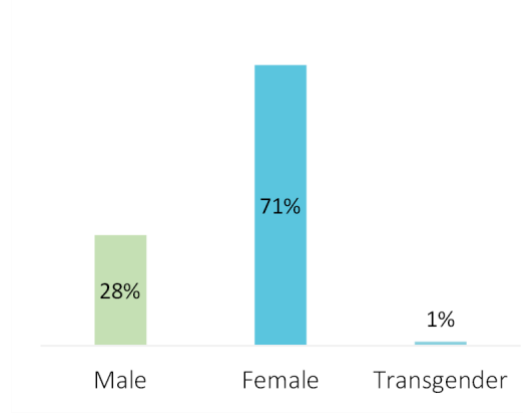
Demographic Data

Sex

Male	30%
Female	70%
Another Sex	0%

n=93

Gender Identity



n=92

Sexual Orientation

Heterosexual or Straight	78%
Gay or Lesbian	%
Bisexual	2%
Pansexual	0%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	4%
Declined to state	4%

n=93

11% of individuals reported having one or more disabilities

n=90
3 individuals selected “decline to state.”

Disability

Mental Domain	43%
Seeing	0%
Hearing	0%
Other Communication	0%
Physical	0%
Chronic Health Condition	0%
Another Disability	1%

n=90
Another disability includes Adjustment Disorder, Depression, Diabetes.

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

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CULTURALLY SPECIFIC SHORT-TERM THERAPEUTIC SERVICES (CSSTS)

Successes and Learning

Notable Strengths

- The program offers accessible mental health services for individuals without medical insurance, with a particular focus on underserved communities who might not otherwise have access.
- Providing services in both English and Spanish, with a focus on underserved communities, helps to reduce stigmas associated with mental health services and eliminate barriers to access for many individuals.

Achievements

- These programs have achieved success by meeting and exceeding utilization rates and expectations. Continued demand is evident through a current waitlist, showing the community's need for their services.
- A major achievement of the program is its outreach to historically underserved communities, raising awareness about the services offered. Services are also provided in various languages, including English, Spanish, and Oaxacan dialects, with professional language services for comprehensive support.

Challenges

- Challenges include addressing the negative stigmas associated with mental health services in underserved communities. More psychoeducation and outreach efforts are necessary to reduce these stigmas and make it easier for individuals to seek support.
- High demand for services has led to a current waitlist, and some individuals may complete services before feeling fully prepared, highlighting the challenge of balancing service demand with appropriate timing.
- Providing services in Indigenous languages remains a challenge. We currently have an agreement with at&t language line for this purpose.

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CULTURALLY SPECIFIC SHORT-TERM THERAPEUTIC SERVICES (CSSTS)

Successes and Learning

Case Example/Narrative

The program has supported several clients newly immigrated to the U.S. from other countries. These clients were suffering from mental health issues related to childhood trauma, domestic violence, and sexual identity. Several of these clients did not have legal residency status making it difficult to access services that typically require private insurance, state Medi-Cal coverage, or the ability to self-pay for these services. One of the clients served was experiencing active suicidal ideation and was able to receive timely services to address these issues. The clinician who worked with this client was able to create a safety and support plan that included connecting the client to other community resources. This client is now working to transition out of services and is participating in collateral sessions with their parent who is also providing vital support to the client in addressing their mental health care needs.

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DRUG AND ALCOHOL INTERVENTION SERVICES FOR YOUTH (DAISY)
COMMUNITY HUMAN SERVICES (CHS)

Community Human Services' (CHS's) Drug and Alcohol Intervention Services for Youth (DAISY) program provides services for substance-using, pre-delinquent youth (including status offenders, pre-court, probation without wardship, and first-time offenders). The program utilizes two evidence-based curricula: The Seven Challenges (for high-risk youth) and Brief Challenges (for youth at lower risk). Bilingual drug intervention and education services are offered for youth who are primarily in grades 7–12 or ages 13–18. Through individual and group counseling and interactive journaling, DAISY works to raise youths' consciousness, inspire hope, and motivate informed, internally driven, sincere decisions to change behaviors. DAISY also offers parent support groups to provide parents with information and tools to help them better understand and support their children in recovery. The program is located at Silver Star Resource Center in Salinas.

Program Highlights



Population served: Youth and parents

140 individuals engaged in counseling activities

Program Activities

Activities Hosted

Substance Use Counseling – Across 140 youth, individuals attended a total of 1,533 counseling sessions, for an average of 10–11 sessions per participant.

Parent Support Groups – Across 11 families, 115 sessions of support groups were held for an average of 10 sessions per family.

151 additional services were provided to clients, and a total of 1,968 units of service (including individual and group counseling) were provided to clients.

*These values do not include activities that took place in Quarter 1 of FY 22–23.

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DRUG AND ALCOHOL INTERVENTION SERVICES FOR YOUTH (DAISY)

Program Outcomes, Satisfaction, and Feedback

Comparison of Before and After Knowledge (n=11)	Before (% Agree)	After (% Agree)	% Impacted
I knew a lot about the topic of this session/training/class.	64%	82%	18%
I knew where to go for mental health services.	55%	91%	36%
I knew when to ask for help with an emotional problem.	64%	100%	36%
I felt good about myself.	64%	100%	36%
I felt hopeful when I thought about the future.	73%	100%	27%



36% of participants (4 individuals) **learned where to go for mental health services**.
36% of participants (4 individuals) **learned when to ask for help with an emotional problem**.

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DRUG AND ALCOHOL INTERVENTION SERVICES FOR YOUTH (DAISY)

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=11)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	9%	91%
The program had services in the language that I speak best.	0%	100%
Materials provided were useful.	0%	100%
The program/training/course was practical and useful.	0%	100%
I would recommend this program/training/course to others.	0%	100%

"Being able to learn more about myself and learning how to cope with my issues."

"They have a very good program and I like my counselor a lot."

What was most useful or helpful about this program? (n=10)

- Improved symptoms/behavior (n=4)
- Increased knowledge about mental health (n=3)
- Therapeutic communication (n=3)
- Other positive impacts (n=2)

What are your recommendations for improvement? (n=10)

- Nothing/unsure (n=7)
- Additional activities (n=2)

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DRUG AND ALCOHOL INTERVENTION SERVICES FOR YOUTH (DAISY)

Demographic Data

Race*

American Indian/Alaskan Native	2%
Asian	0%
Black/African American	0%
Native Hawaiian/Other Pacific Islander	2%
Latino	98%
White	2%
Another	0%
Declined to state	0%

n=55

98% Hispanic/Latino
2% Non-Hispanic/Latino

Ethnicity

Hispanic/Latino

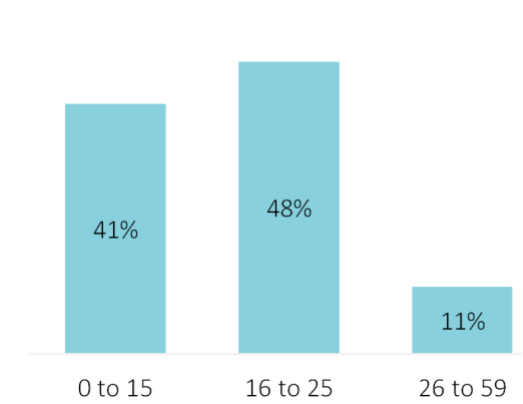
Caribbean	0%
Central American	6%
Mexican/Mex.-Am./Chicano	92%
Puerto Rican	0%
South American	0%
Other Hispanic/Latino	0%

Non-Hispanic/Latino

African	0%
Asian Indian/South Asian	0%
Cambodia	0%
Chinese	0%
Eastern European	0%
European	0%
Filipino	2%
Japanese	0%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	0%
Unspecific Non-Hispanic/Latino	0%
Declined to state	0%

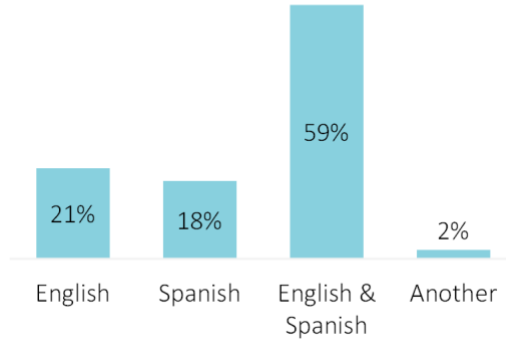
n=52

Age



n=56

Primary Language



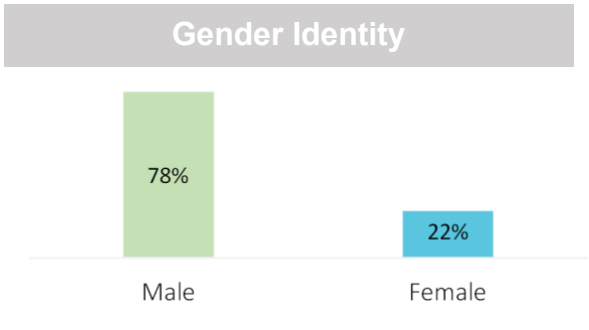
n=56
Another includes Tongan.

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

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DRUG AND ALCOHOL INTERVENTION SERVICES FOR YOUTH (DAISY)

Demographic Data



n=50

Sex

n=56

Male	71%
Female	29%
Another Sex	0%

Sexual Orientation

Heterosexual or Straight	98%
Gay or Lesbian	0%
Bisexual	2%
Pansexual	0%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Declined to state	0%

n=47

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

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DRUG AND ALCOHOL INTERVENTION SERVICES FOR YOUTH (DAISY)

Successes and Learning

Notable Strengths

- The program offers a non-judgmental, evidence-based curriculum, creating a supportive and effective environment for clients.
- The availability of bilingual staff enhances communication and support for clients.

Achievements

Flexible scheduling through Zoom sessions, dual curriculums tailored to individual assessment results, and a parent support group have all contributed to client successes, an increase in graduation rates, and program curriculum completion.

Challenges

A persistent challenge for the program is a lack of client commitment, often stemming from preconceptions about the program and a lack of motivation to continue.

Case Example/Narrative

At the beginning of program enrollment, one student presented as unstable and was actively engaging in high-risk behavior. After a couple of months of participating in The Seven Challenges curriculum, staff began to notice positive changes. The student's high-risk behavior decreased, and she was open to receiving more support to stabilize her mental health and home environment. This student has recently graduated from the program, increased her school credits, and has developed strong problem-solving and decision-making skills.

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OUTPATIENT MENTAL HEALTH SERVICES
THE VILLAGE PROJECT, INC.

The Village Project, Inc. is an African American Family Resource Center which provides culturally affirming counseling, group therapy, and therapeutic programs and services to African Americans, other individuals and families of color, and the LGBTQ+ community. Services also include outreach, presentations, and workshops to increase mental health awareness, reduce stigma and provide timely access to mental health services among unserved and underserved communities. The Village Project, Inc. is a place where African Americans and communities 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



Population served: African Americans, other individuals and families of color, and the LGBTQ+ community

254 program events and activities

60 individuals engaged in program activities

Program Activities

Activities Hosted

Culturally Specific Short-term Therapy for Mild to Moderate Mental Health Issues – 35 individuals and 25 families attended 209 presentations where they received therapy for mental health issues.

Group Sessions – 45 group sessions were conducted for mental health support.

Therapeutic Services – 121 individuals or families at risk for or with moderate mental illness received therapeutic services.

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OUTPATIENT MENTAL HEALTH SERVICES

Successes and Learning

Notable Strengths

- Cultivating new partnerships.
- Engaging community members.
- Developing Youth Leaders

Challenges

A challenge we have has been hiring qualified therapists so that we can serve more individuals and families that have been referred to our agency.

Achievements

- Collaborated with a variety of outside organizations and businesses.
- Created an Instagram docuseries.
- Conducted interviews that were nationally aired.
- Honored as the featured charity of the 2023 AT&T Pebble Beach Pro Am.

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ACCESS AND LINKAGE TO TREATMENT

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211
UNITED WAY MONTEREY COUNTY – TBD

211 is a free phone and digital network provided by United Way Monterey County that connects residents in need of assistance to community health and social services. The 211 network is available 24 hours per day, 7 days per week, in over 220 languages. Residents can access the service by dialing 2-1-1, texting their zip code to 898-211, or visiting 211montereycounty.org. **The Smart Referral Network (SRN)** is a referral platform that allows case managers, other front-line workers, and residents in need of services to identify resources and enroll in them through "closed-loop referrals." **The Hope and Help Network** is a collaborative of organizations working in the mental health, substance use disorder, and social determinants of health sectors committed to working together to more effectively connect residents to care.

Program Highlights



Population served: Individuals in need of health and social services

115 program presentations, events, and outreach activities

3,290 individuals engaged in program activities

Program Activities

Community and Partner Engagement

Presentations – 296 individuals were engaged in 23 total presentations at 211 events such as the Emergency Operations Center Briefings and the Access and Functional Needs Meetings. An additional 26 individuals benefited from 26 presentations about the Hope and Help Network.

Community Events – 1,355 individuals participated in 25 community events attended by 211. Additionally, 850 individuals engaged with the Hope and Help Network in 17 community events.

Outreach Activities – 113 individuals attended 11 outreach activities where 211 shared activities with Monterey County community members. Hope and Help Network information was shared with 650 individuals at 13 different outreach events.

Smart Referral Network – Quarterly meetings bring community organizations together to discuss partnerships and referrals through the SRN. There were 23 new social determinants of health referral partners in FY 22/23, 3 of which that are contracted Behavioral Health partners.

Hope and Help Network – The Hope and Help Network brings partners together quarterly as well. In FY 22/23, there were two additional referral relationships from the SRN referral network and four total partners with MOUs.

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211, SRN AND HOPE AND HELP NETWORK

Referrals to Mental Health Services

239 referrals were made to **mental/behavioral health treatment by 211.**

1,694 referrals were made through the Smart Referral Network. **53 that led to confirmed enrollment into services.** Three partners made more than 30 referrals: CCA, CHS, 211.

One of the most active partners in the Hope and Help Network and SRN, Sun Street Centers, engaged in 147 referral-based activities through the Smart Referral Network.

Referrals to Behavioral Health Treatment

Kinds of County Treatment Referred to:

Monterey County Behavioral Health ● Monterey County Rape Crisis Center

Kinds of Non-County Treatment Referred to:

Community Human Services ● Montage Health ● Shine a Light Counseling Center



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211, SRN, AND HOPE AND HELP NETWORK

Demographic Data of Residents Accessing 211†

Race

American Indian/Alaskan Native	1%
Asian	2%
Black/African American	5%
Native Hawaiian/Other Pacific Islander	1%
White	36%
Another	55%

n = 8,643
366 individuals did not answer and 1,418 were not asked this question.

Sex at Birth*

Male	27%
Female	73%
Another Sex	0%

n = 19,288
*Call specialist infers this information.

77% Hispanic/Latino

23% Non-Hispanic/Latino

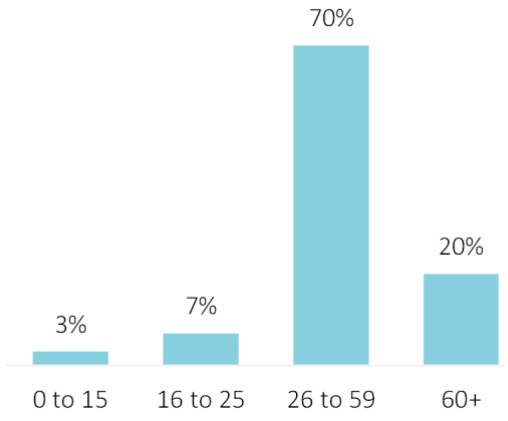
28% of individuals reported having one or more disabilities

n = 8,438
412 individuals did not answer and 443 were not asked this question.

2% of individuals were veterans

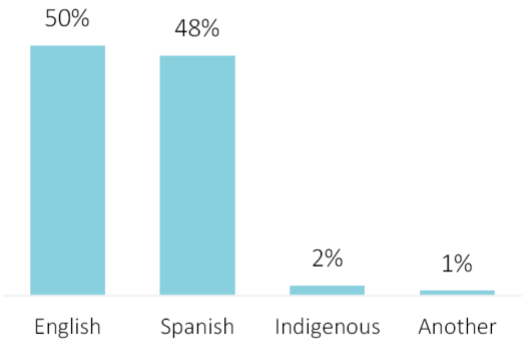
n = 8,516
406 individuals did not answer and 458 were not asked this question.

Age



n = 8,587

Primary Language



n = 8,578

314 individuals did not answer and 186 were not asked this question.

†Demographic data presented was from County residents accessing 211 during FY 22-23. Race, ethnicity, primary language, and veteran status questions were asked only of first-time callers.

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211, SRN, AND THE HOPE AND HELP NETWORK

Successes and Learning

Notable Strengths

- Increasing capacity to support and grow the Hope and Help Network.
- Bringing new mental health, substance use disorder, and SDOH partners onto the Smart Referral Network.

Challenges

A challenge that we continue to face is onboarding partners in the Smart Referral Network (SRN) who work in mental health and substance use disorder programs. In many cases, this is due to restrictions on how they can make and/or receive referrals.

Achievements

- Added a new staff member.
- Facilitated Hope and Help Network Meetings.
- Expanded participation in groups and with partners who serve residents in relation to mental health, substance use disorder, and SDOH.
- Socialized keyword texting and chatbot tools with partners and community members. Keyword texting allows community members to text to a designated phone number to receive resource information on suicide prevention, mental health, substance use disorder, and youth programs. The chatbot allows community members have a guided search and refer themselves directly to agencies for services on 211montereycounty.org.

Case Example/Narrative

United Way Monterey County, through the Smart Referral Network (SRN) and our Hope and Help program, has created a chatbot which is currently hosted on 211montereyounty.org. The chatbot provides the opportunity for residents to be guided through looking for resources in our community and send a referral on their own behalf to a service provider to get connected to resources. After launching the chatbot, we have continued to refine the tool to ensure it is a helpful tool for our community. Going into the project, our team knew that a chatbot would create access for many residents who may be hesitant to reach out for resources. Simultaneously, we also acknowledged that with technology there can be barriers that are created for many in our community. Therefore, we decided to hold focus groups to understand those barriers better and reduce them through improvements to the chatbot. An example of this is our first focus groups with Mujeres en Accion—where participants were able to test the chatbot, provide individual feedback, and discuss as a group their impressions and ways to improve the tool. We have processed that feedback and begun to incorporate it into the design of the chatbot.

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VETERANS REINTEGRATION TRANSITION PROGRAM COUNTY OF MONTEREY MILITARY & VETERANS AFFAIRS OFFICE

The Veterans Reintegration Transition Program provides education and awareness to veterans, their dependents, and survivors on entitled benefits that 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, legal assistance, 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



Population served: Local veterans, transitioning service members, and their families

49 program events and activities

1,135 individuals engaged in program activities

Program Activities

Activities Hosted

Community Events – 1,036 people attended 49 community events, including Veterans Issues Advisory Committee meetings, the Lotus Fair, the Monterey County Fair Senior, and Veteran Resource Expo.

Mental Health Outreach Activities – 197 individuals were reached through 14 mental health outreach activities. As part of these efforts, the Military & Veterans Affairs Office (MVAO) initiated a biweekly outreach program to homeless veterans at the Veterans Transition Center.

Incarcerated Veterans – 361 people attended 15 County of Monterey Veterans Treatment Court or Military Diversion Court sessions, to include meeting with Veterans Justice Outreach or County Behavioral Health, Peer Mentors, and MVAO staff. In addition, 5 incarcerated veterans were reached through 5 outreach sessions.

VA Services and Benefits Education – 572 individuals were reached through 45 briefings on benefits available to veterans, transitioning service members, dependents, and survivors.

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VETERANS REINTEGRATION TRANSITION PROGRAM

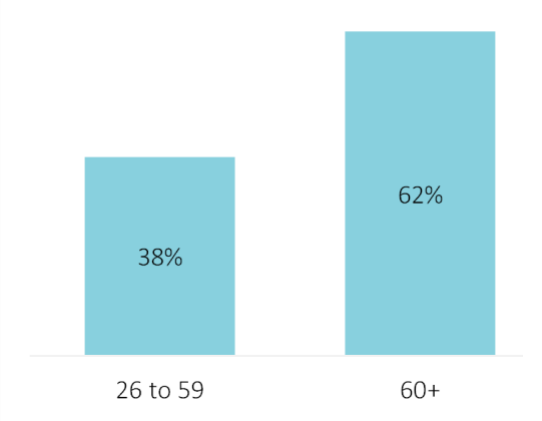
Demographic Data

Race*

American Indian/Alaskan Native	0%
Asian	10%
Black/African American	19%
Native Hawaiian/Other Pacific Islander	0%
Latino	5%
White	62%
Another	0%
More than one race	10%
Declined to state	0%

n=21

Age



n=21

12% Hispanic/Latino
101% Non-Hispanic/Latino

Ethnicity*

Hispanic/Latino

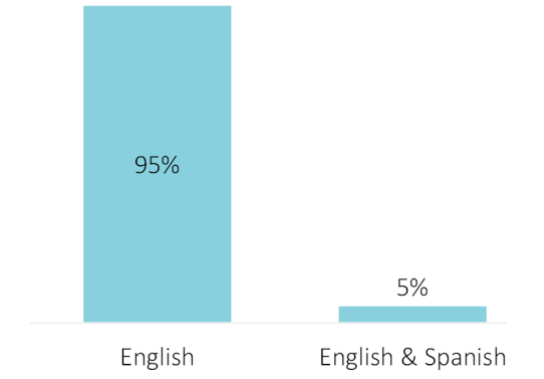
Caribbean	0%
Central American	0%
Mexican/Mex.-Am./Chicano	12%
Puerto Rican	0%
South American	0%
Other Hispanic/Latino	0%
Unspecified Hispanic/Latino	0%

Non-Hispanic/Latino

African	24%
Asian Indian/South Asian	0%
Cambodia	0%
Chinese	0%
Eastern European	12%
European	35%
Filipino	0%
Japanese	6%
Korean	0%
Middle Eastern	0%
Vietnamese	6%
Other Non-Hispanic/Latino	0%
Unspecific Non-Hispanic/Latino	18%
Declined to state	0%

n=19
Other includes Native American.

Primary Language



n=20

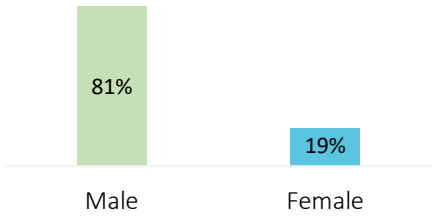
* Percentages may exceed 100% because participants could choose more than one response option.

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VETERANS REINTEGRATION TRANSITION PROGRAM

Demographic Data

Gender Identity and Sexual Orientation



n=21
100% of respondents identified as Heterosexual.

95% of individuals were veterans

n=20

76% of individuals reported having one or more disabilities

n=21
1 individual selected "decline to state."

Disability*

Mental Domain	105%
Seeing	0%
Hearing	24%
Other	0%
Communication	
Physical	38%
Chronic Health Condition	38%
Another Disability	5%

n=21
Another disability includes Depression, Hip Replacement, Insomnia.

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

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VETERANS REINTEGRATION TRANSITION PROGRAM

Successes and Learning

Notable Strengths

- Advocacy for increased benefits and services for veterans, service members, and their families.
- Collaboration with county agencies, the Department of Veterans Affairs, and local/regional elected officials to improve access, funding, and availability of veterans benefits and services.

Challenges

Staffing shortages continue. Our office is operating with four of six Veterans Service Representatives and the Management Analyst III has a dual role as the Interim Director. Staff have stepped up to fill multiple roles and responsibilities.

Achievements

- Despite continued reduced staffing, responded to 7,898 telephone/email inquiries and made 4,238 in-person or remote appointments to serve 3,040 unique veterans during FY 22–23.
- Filed 6,149 benefit claims which resulted in 3,040 VA disability compensation awards amounting to $4,671,975 in retroactive payments and $8,728,049 in recurring monthly benefit payments (annualized).

Case Example/Narrative

Our office made a concerted effort to increase outreach and services to South County veterans—specifically in Greenfield, King City and Ft Hunter-Liggett. Our office contacted seven veterans over three separate outreach events. While the outreach numbers remain low, this is noteworthy in that these areas are traditionally underserved and distant from the main population centers around Monterey and Salinas—including the VA Clinic in Marina.

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KEEP IT REAL INTERIM

The PEI-funded Keep It Real Community Outreach & Navigation team provides outreach to residents of Monterey County to facilitate advocacy and access to services. The target population for this team is the community at large, including transitional age youth (TAY) and other adults served by MCBH, and individuals who are exiting the emergency room or mental health unit. The team provides outreach to TAY and adults who have mental health and/or substance use problems that they or others have identified as interfering with their lives, such as creating barriers to employment, education, activities of daily living, other meaningful activities, and social and family relationships.

Program Highlights



Population served: Adults and transitional age youth with co-occurring mental health and substance use challenges

50 individuals engaged in program activities

Program Activities

Activities Hosted

Referrals – 50 individuals were referred to mental health and substance use services.

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KEEP IT REAL

Referrals to Mental Health Services

Total Referrals Made

82 referrals were made to **mental/behavioral health treatment**

Types of Referrals Made*

2 referrals were made to clients with **serious mental illness**

24 referrals were made to clients from **underserved populations**

* More than one type of referral could be provided to clients and thus may exceed the total number of referrals.

Referrals for Individuals with Serious Mental Illness

Referred to County Treatment:

0 individuals confirmed to have engaged in treatment

Kinds of County Treatment Referred to:

None

Kinds of Non-County Treatment Referred to:

MCHOME ● Bridge House

Referrals for Members of Underserved Populations

4 individuals confirmed to have engaged in treatment

5 days average interval between the referral and participation in treatment

Kinds of Treatment Referred to:

OMNI ● MCHOME ● Access

Ways members of underserved populations were assisted in accessing services	
Bus Tokens	0
Transportation	2
Reminder Calls	2
Translation/Interpreter Services	0
Accompaniment	2
Other	0

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KEEP IT REAL

Successes and Learning

Notable Strengths

- Increasing clients' confidence through outreach.
- Staff members supporting each other in reaching out to community resources and meeting with potential clients.

Achievements

- Staff members' confidence increased, which led to more client outreach.
- Improved linkages with additional community resources that can be provided to clients.
- Increased staff knowledge of community resources.

Challenges

We had one wellness navigator hired for most of the year instead of two individuals. In addition, providing services to South Monterey County locations can be difficult due to the remote location, transportation, and language barriers as our team did not have a bilingual PEI wellness navigator. Despite these challenges, we met our PEI goal and were able to outreach to new individuals through presentations during the Keep It Real group in South Monterey County (which is not PEI funded). Our team also looked at the program and what it could offer and began to develop a system that will allow us to continue to grow in the next fiscal year, adding additional PEI services including outreach group support for clients in all regions of Monterey County.

Case Example/Narrative

During the fourth quarter, we learned that our PEI program would be reduced to one wellness navigator position due to funding changes. When we informed the staff, one of our navigators put in their letter of resignation. At that time, we still had over 10 clients that we needed to outreach. Despite this challenge, we were able to meet our goal and provide additional follow-up services to many of our PEI clients including transportation to appointments, getting clients set up with cell phone services provided by the county, and connecting clients with the local foodbank. In addition, we were able to work collaboratively with the Methodist Church, which works with primarily homeless individuals, where we were provided access to an office as well as space to run outreach groups to the community. This space will eventually be used to follow up with clients, connecting them to other services in the county (appointments, food, mental health, dental and vision, call-the-car, MST Rides/courtesy cards, etc.) as well as providing group support services such as Seeking Safety, Substance Use Recovery, Symptoms Management, Harm Reduction and DBT groups such as Mindfulness and Art groups.

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FAMILY PARTNERS PROGRAM
SENECA CENTER

The Family Partners program provides peer support to family members of clients receiving mental health services. Family partners work individually with family members to engage them in the process of mental health services and assist them in achieving their individual/family goals. They can also support families in navigating the system of care, build engagement, and provide support to bridge communication between families and providers. Family partners are employed across multiple programs within the agency and will perform a wide range of activities to function as a member of the supporting team as well as provide individual support to parents. Family partners have personal experience as caregivers of a youth who has been the recipient of child welfare, probation and/or behavioral health services, and are practiced and/or interested in working with youth and families.

Program Highlights



Population served: Family members of youth receiving mental health services

10 program events and activities

8 individuals/families engaged in program activities

Program Activities

Activities Hosted

Supportive Services – 8 individuals/families received psychoeducation, parenting coaching, and emotional support and validation across 10 supportive service program activities.

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FAMILY PARTNERS PROGRAM

Successes and Learning

Notable Strengths

- Delivering family services.
- Ensuring comprehensive and consistent care.
- Excellent partnership with Monterey County.

Achievements

- Hired two bilingual family partners.
- Received first two referrals.

Challenges

Seneca did not receive any referrals until 3/30/23.

Case Example/Narrative

We coordinate and collaborate in care planning efforts with other child-serving agencies and institutions involved in delivering services to the child and family to ensure that comprehensive and consistent care is provided. Seneca Center's Family Partners program supported families in connecting to other community resources, coached parents through hard moments with their children, helped establish natural support networks and provided collaborative care with our county partners.

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STREET OUTREACH PROGRAM
COMMUNITY HUMAN SERVICES (CHS)

Community Human Services (CHS) provides street outreach services to homeless youth ages 18–24 throughout Monterey County (particularly Salinas Valley and Monterey Peninsula). This program improves the mental health of youth by addressing immediate crises, providing survival aid like food and water, and creating access to behavioral health services.

Program Highlights



Population served: Unaccompanied homeless youth ages 18–24

89 individuals served through program outreach activities

Program Activities

Activities Hosted

Outreach Activities – 89 homeless youth were provided street outreach services, case management and housing navigation services.

Referrals to Mental Health Services – 48 homeless youth were referred to mental health services.

Referrals to Substance Use Treatment – 23 homeless youth were referred to substance use treatment (which may include treatment for individuals with a dual diagnosis for mental illness).

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STREET OUTREACH PROGRAM

Referrals to Mental Health Services

Total Referrals Made

48 referrals were made to **mental/behavioral health treatment**

Types of Referrals Made*

34 referrals were made to clients with **serious mental illness**

29 referrals were made to clients from **underserved populations**

* More than one type of referral could be provided to clients and thus may exceed the total number of referrals.

Referrals for Individuals with Serious Mental Illness

Referred to County Treatment:

17 individuals confirmed to have engaged in treatment

15 days average interval between the referral and participation in treatment

3 years average duration of untreated mental illness prior to referral

Kinds of County Treatment Referred to:

Monterey County Behavioral Health

Kinds of Non-County Treatment Referred to:

CHS Inpatient ASAM ● CHS Genesis House ● CHS Outpatient

Referrals for Members of Underserved Populations

13 individuals confirmed to have engaged in treatment

14 days average interval between the referral and participation in treatment

Kinds of Treatment Referred to:

Monterey County Behavioral Health ● CHS Mental Health Counseling

Ways members of underserved populations were assisted in accessing services	
Bus Tokens	4
Transportation	8
Reminder Calls	12
Translation/Interpreter Services	2
Accompaniment	2
Other	4

Others include text message reminders, in-person reminders, advocacy, and phone calls to connected services

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STREET OUTREACH PROGRAM

Successes and Learning

Notable Strengths

- The program excels in collaborating with external agencies to meet clients' diverse needs and to provide access to services beyond its scope.
- The staff's resourcefulness, creative solutions, and determination in advocating for clients—whether for legal matters or housing—have resulted in positive outcomes.

Achievements

- The program has improved collaboration among regions and enhanced support for clients, including those who are undocumented.
- Notable accomplishments include helping clients secure housing in various programs and vocational schooling, thanks to staff availability, strong rapport, and increased funding support.

Challenges

- Advocating for clients initially excluded from Housing Authority referrals has successfully increased the number of referrals.
- The program has learned to provide proper notice to homeless encampments before sweeps to reduce trauma for residents and offers support during encampment visits, addressing a significant challenge.

Case Example/Narrative

Rose* was a mother of 3 young children and accompanied by her significant other. They were couch surfing and living primarily with their mother-in-law until they were kicked out and ended up living in their vehicle with their children. The client is the household’s main source of income. Our Salinas Valley Street Outreach Program (SVSOP) helped them and their family get an eligibility appointment with the Housing Authority, as well as conducted a housing search with them once they were approved for an emergency housing voucher. They and their family now have permanent housing. SVSOP was also able to provide rapid rehousing assistance for the first month's rent and security deposit, as well as some household items and food. (*Name changed to protect privacy.)

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SUICIDE PREVENTION

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

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 multilingual 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



Population served: Individuals at high risk for suicidal behavior and their families

156 program events and activities

2,303 individuals engaged in program activities

Program Activities

Activities Hosted

Presentations – 2,209 individuals were engaged through 98 presentations on suicide prevention, with 307 unduplicated providers.

Support Group Meetings – 31 individuals participated in 18 meetings to increase support and reduce isolation for survivors of suicide loss.

Responder Recruitment and Trainings – 63 individuals were trained through 40 classes. Thirty-nine of these individuals were new volunteers.

Suicide Crisis Line – 3,236 calls were answered.

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SUICIDE PREVENTION SERVICE

Program Outcomes, Satisfaction, and Feedback

Because of this program… (n=507)	% Before	% After
I knew where to go for mental health services near me.	59%	88%
I knew the warning signs of suicide.	65%	90%
I knew ways to help a person who is dealing with a mental problem or crisis.	56%	89%
I knew how to find someone who could help me with issues related to suicide.	60%	91%



91% of respondents said that they **knew how to find someone who could help them with issues related to suicide** after participating in this program.

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SUICIDE PREVENTION SERVICE

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=507) **between 15–498 individuals declined to respond*	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	4%	**96%**
The program was provided in the language that I speak best.	3%	**97%**
Materials provided were useful	0%	**100%**
The training/course was practical and useful.	5%	**95%**
I would recommend this program to a friend or family member.	5%	**95%**



91% of respondents agreed or strongly agreed that they **would recommend the program to a friend or family member**.

"The most helpful thing about this training was how to help someone who is having thoughts of suicide."

"Having more examples of how suicidal thoughts can look for different people."

What was most useful or helpful about this program? (n=480)

- Learning how to help people (111)
- Learning about the hotline phone number (105)
- Learning how to ask for help (53)

What are your recommendations for improvement? (n=229)

- More resources and information (e.g., on warning signs) (50)
- Greater accessibility (e.g., online and in more languages) (40)
- Making it more interactive (31)

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SUICIDE PREVENTION SERVICE

Demographic Data

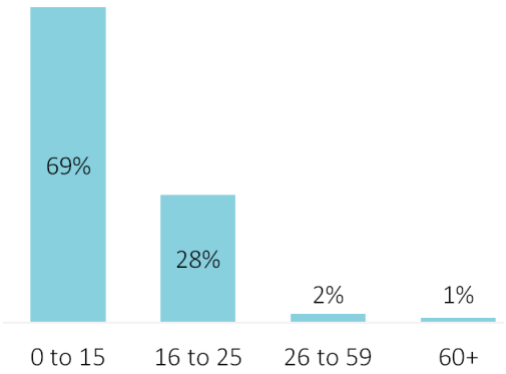
Race*

American Indian/Alaskan Native	2%
Asian	5%
Black/African American	3%
Native Hawaiian/Other Pacific Islander	1%
Latino	69%
White	18%
Another	1%
More than one race	7%
Declined to state	6%

n=1,033
Another includes Afro-Mexican, Arab.

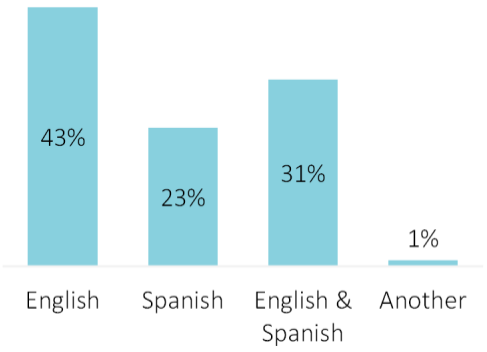
69% Hispanic/Latino

Age



n=950
67 individuals selected "decline to state."

Primary Language



N=1,023
Another includes Arabic, Korean, Mixteco.
30 individuals selected "decline to state."

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

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SUICIDE PREVENTION SERVICE

Successes and Learning

Notable Strengths

- Restructured service and program delivery.
- Restructuring resulted in the ability to handle increased call volume and improved "customer/caller" service and program/project efficiency.

Challenges

The storms, heavy rains, flooding, and wind the Central Coast experienced resulted in staff transportation/commute barriers and power/internet outages for our remote call responders.

Achievements

- Suicide Prevention Service (SPS) was an active participant in local, national and agencywide Suicide Prevention Month (September) campaigns and activities.
- SPS responded to requests for media interviews (English and Spanish) for print, radio and TV news outlets, spoke at community forums and gatherings, distributed press releases, and increased its social media outreach/engagement.
- Media activities included 9 interviews (KSBW, KION, Telemundo, Unison, Santa Cruz Sentinel and Santa Cruz Local Online newspaper).

Case Example/Narrative

The transition to 988 has been incredibly positive and impactful in terms of providing accessible, professional and compassionate support for people experiencing a mental health crisis themselves or who are concerned for someone else. An upward trajectory for program, as well as staff growth and expansion, are anticipated for months and years to come. The challenge we face is ensuring the positive mental health of our workforce (staff and volunteers). To this end, the SPS staff and management met as a team to explore and share the "why" of the work we do on a personal and professional level. This helped us to begin to look at our policies through a lens of equity, diversity and inclusion, and to rethink how we can take care of ourselves while delivering our vital services and programs.

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MONTEREY COUNTY HELPING ONE ANOTHER TO PREVENT AND ELIMINATE SUICIDE (MC HOPES) APPLIED CRISIS TRAINING AND CONSULTING, INC.

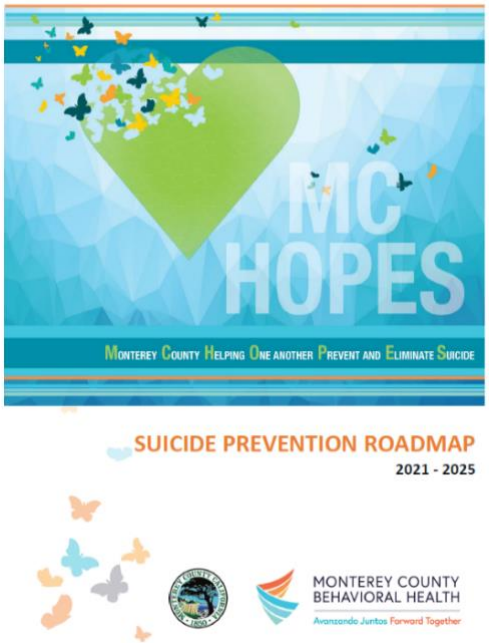
Monterey County Behavioral Health (MCBH) contracted with Applied Crisis Training and Consulting, Inc. to provide consultation and facilitation in the establishment of the Monterey County Helping One another to Prevent and Eliminate Suicide (MC HOPES) Coalition for suicide prevention, as well as training in suicide prevention.

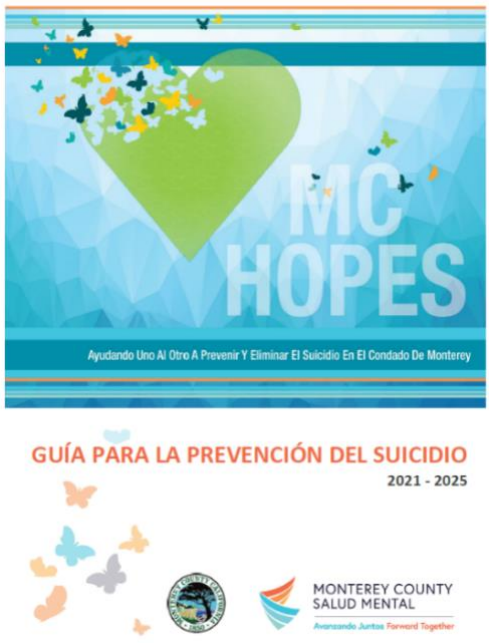
Coalition Highlights

78 individuals added to the MC HOPES Coalition

6 bi-monthly MC Hopes Coalition meetings were held

26 workgroup meetings were held that spanned three different areas (Postvention, Wellness and Prevention, Youth and Education) with an average attendance per meeting ranging from 5–8 individuals





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MONTEREY COUNTY HELPING ONE ANOTHER TO PREVENT AND ELIMINATE SUICIDE (MC HOPES)

Program Outcomes, Satisfaction, and Feedback

The Coalition… (n=13)	% Never	% Sometimes	% Most of the Time	% All of the Time
Meetings are aligned with the Community Agreements.	0%	0%	8%	92%
Offers opportunities for members to work collaboratively with one another in workgroups.	0%	9%	9%	82%
Monitors progress towards goals and on shared information on successes, challenges, etc.	0%	0%	17%	83%
Shares local suicide-related data for Monterey County.	0%	25%	25%	50%
Strives for inclusivity and language equity in meetings, presentations, and activities.	0%	0%	9%	91%
Increases my awareness of the individuals, groups, and networks working to prevent suicide in Monterey County.	0%	0%	0%	100%
Presents information on resources available in Monterey County to address suicide prevention.	0%	0%	0%	100%

Please share your feedback on coalition meetings that you have attended. (n=13)

- Useful and informative materials (38%)
- Facilitation and connection by training staff (23%)

Do you see areas for improvement? (n=13)

- More time to cover materials (15%)
- A system for sharing resources covered in workgroups (15%)

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MONTEREY COUNTY HELPING ONE ANOTHER TO PREVENT AND ELIMINATE SUICIDE (MC HOPES)

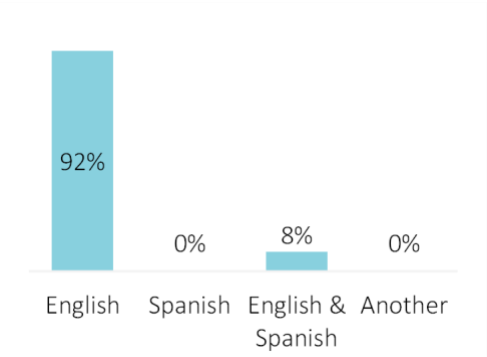
Demographic Data

Race*

American Indian/Alaskan Native	0%
Asian	15%
Black/African American	15%
Native Hawaiian/Other Pacific Islander	0%
Latino	46%
White	23%
More than one race	15%

n=13

Primary Language



n=13

Agencies and Systems Represented (n=13)*	%
An education-related organization	**46%**
Faith-based/Spiritual organization	**0%**
First-responder/Law enforcement	**8%**
Healthcare	**15%**
Monterey County Behavioral Health	**0%**
Personal or family experience with suicide or suicide loss	**8%**
LGBTQ+ community	**8%**
General community member	**23%**

*More than one category can be selected. Total may equal more than 100%.

Current Coalition Involvement (n=13)	%
I receive and read the emails.	69%
I attend most of all coalition meetings.	38%
I attend some coalition meetings.	31%
I am not involved in the coalition.	8%
Postvention workgroup member.	23%
Prevention/wellness workgroup member.	23%
Youth and education workgroup member.	38%

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

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MONTEREY COUNTY HELPING ONE ANOTHER TO PREVENT AND ELIMINATE SUICIDE (MC HOPES)

Successes and Learnings

Notable Strengths

- Implemented effective structures, processes, and interactive meetings to ensure long-term engagement and sustainability within the coalition.

Challenges

We continue to seek stronger representation from underserved and under-represented groups in our work. This includes individuals from our Hispanic/Latinx communities who are monolingual Spanish speakers and/or those who speak Indigenous languages. Additionally, we continue to work to identify appropriate strategies, messaging, and programs to reach adult males, who are statistically at highest risk for suicide death.

Achievements

- Broad participation in coalition meetings—including diverse representation—has facilitated collaboration and idea sharing.
- Active partnerships with key community organizations, such as Suicide Prevention Service and local schools, have been pursued.
- Achieved substantial engagement by promoting local and state mental health resources in order to reduce stigma.

Case Example/Narrative

While we have, as a group, succeeded in sharing community-wide suicide prevention messaging and resources in multiple ways, languages, and settings, we have been working to understand how to best approach groups that are either at disproportionate risk or for whom the typical community messaging is not traditionally effective. Our Wellness and Prevention Workgroup has been investigating resources, approaches, and strategies that are being used locally in other counties to understand what is or is not working, and to design an approach that will be successful with these various groups. We continued by exploring the application of the Cultural Model of Suicide for some of this work, acknowledging how some of these groups (e.g., first responders, BIPOC communities, LGBTQ+ youth, veterans, others) may display idioms of distress or warning signs in unique ways.

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STIGMA AND DISCRIMINATION REDUCTION

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FAMILY SELF-HELP SUPPORT AND ADVOCACY – NAMI SIGNATURE PROGRAMS
NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

National Alliance on Mental Illness (NAMI) Monterey County provides education, outreach, support, and resources to individuals and family members who have loved ones affected by mental illness. Program activities include community presentations, mental health educational programs, and peer-led support groups that are all free of charge. Family-to-Family, one of NAMI's signature programs, is an educational class that is taught in English and Spanish by trained volunteers with lived experience. The program is designed to help the family and friends understand and support their loved ones better. Peer-to-Peer, another of NAMI's signature programs, is an educational class that is also taught in English and Spanish by trained peers with lived experience. This class is designed to help adults who are affected by mental illness. The goal of Peer-to-Peer is to provide a better understanding of one's own mental health and their journey toward recovery in a safe environment.

Program Highlights



Population served: Individuals and family members of those experiencing mental illness

68 NAMI signature programs facilitated

2,875 individuals and 72 families engaged in program activities

Program Activities

Activities Hosted

Community Outreach – 2,875 individuals were engaged at 19 outreach events. Community members were introduced to NAMI programs and services and had the opportunity to register for upcoming programs and support groups.

Programs – 52 families participated in 4 Family-to-Family programs, which are designed to support family members who have loved ones with mental illness. Topics covered include treatment options, problem-solving techniques, and understanding symptoms associated with mental health conditions. The program also attempts to reduce discrimination, stigma, and biases toward mental illness. Another 10 participants participated in 3 Family to Family and Familia a Familia classes. An additional 20 families participated in 3 Peer-to-Peer programs, which are designed to support individuals along their mental health journeys.

Trainings – 18 individuals were trained as Peace Officers through 1 Crisis Intervention Team (CIT) session.

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FAMILY SELF-HELP SUPPORT AND ADVOCACY – NAMI SIGNATURE PROGRAMS

Program Outcomes, Satisfaction, and Feedback

Positive impact from before to after participation (n=17)	% Impact
Given my current physical condition, I am satisfied with what I can do.	35%
I have confidence in my ability to sustain important relationships.	29%
I feel hopeful about my future.	29%
I am often interested and excited about things in my life.	29%
I am able to have fun.	29%
I am generally satisfied with my psychological health.	35%
I am able to forgive myself for my failures.	29%
My life is progressing according to my expectations.	18%
I am able to handle conflicts with others.	29%
I have peace of mind.	29%



65% of participants **(11** individuals**) experienced some kind of positive impact on their lives** as a result of the program.

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FAMILY SELF-HELP SUPPORT AND ADVOCACY – NAMI SIGNATURE PROGRAMS

Program Outcomes, Satisfaction, and Feedback

Because of this program… (n=22)	% Before	% After
I knew where to go for mental health services near me.	41%	82%
I thought people should share about their mental health struggles	64%	95%
I would feel embarrassed about having personal mental health issues.	77%	91%
I thought the behavior of people with mental illness was unpredictable.	59%	86%
I was scared of people with mental illness.	73%	95%

Please choose how much you agree or disagree with each sentence below (n=17)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	11%	**89%**
The program was provided in the language that I speak best.	11%	**89%**
The materials provided were useful.	11%	**89%**
This program was practical and useful.	11%	**89%**
I would recommend this program to others.	11%	**89%**



89% of respondents agreed or strongly agreed that they **would recommend this program to others**.

"Meeting other individuals and having a safe space to talk about worries."

"More frequent support groups. Weekly and not just on Saturdays would be ideal."

What was most useful or helpful about this program? (n=15)

- The support group and feeling more connected to others (7)
- Felt more educated on the topic (4)

What are your recommendations for improvement? (n=13)

- Offered on different days and times (3)
- More structured and neutral facilitation (2)

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FAMILY SELF-HELP SUPPORT AND ADVOCACY – NAMI SIGNATURE PROGRAMS

Demographic Data

Race*

American Indian/Alaskan Native	2%
Asian	8%
Black/African American	2%
Native Hawaiian/Other Pacific Islander	3%
Latino	36%
White	55%
Another	2%
Declined to state	2%

n=130
Another includes Filipino, German, Guamanian.

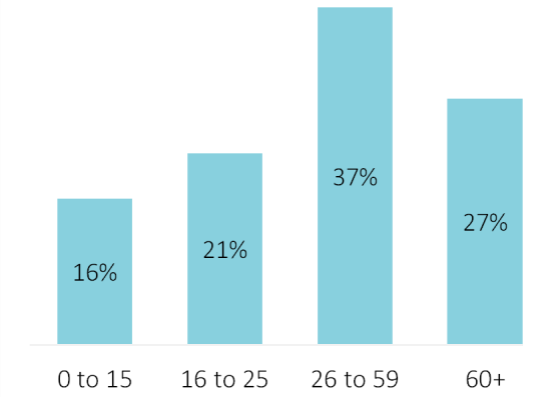
44% Hispanic/Latino
84% Non-Hispanic/Latino

Ethnicity*

Caribbean	1%	Hispanic/Latino
Central American	1%	
Mexican/Mex.-Am./Chicano	41%	
Puerto Rican	1%	
South American	0%	
African	0%	Non-Hispanic/Latino
Asian Indian/South Asian	2%	
Cambodia	0%	
Chinese	2%	
Eastern European	7%	
European	38%	
Filipino	7%	
Japanese	22%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	1%	
Other Non-Hispanic/Latino	5%	
Declined to state	8%	

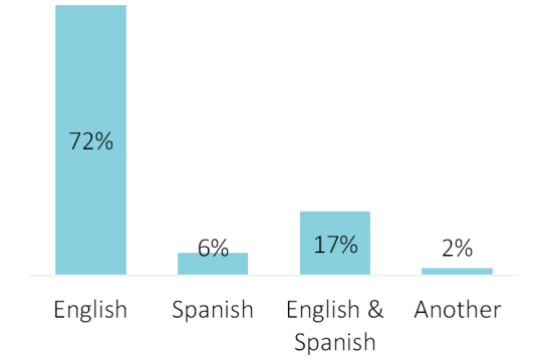
n=95
Other includes Chamorro, Portuguese.

Age



n=116
12 selected "decline to state."

Primary Language



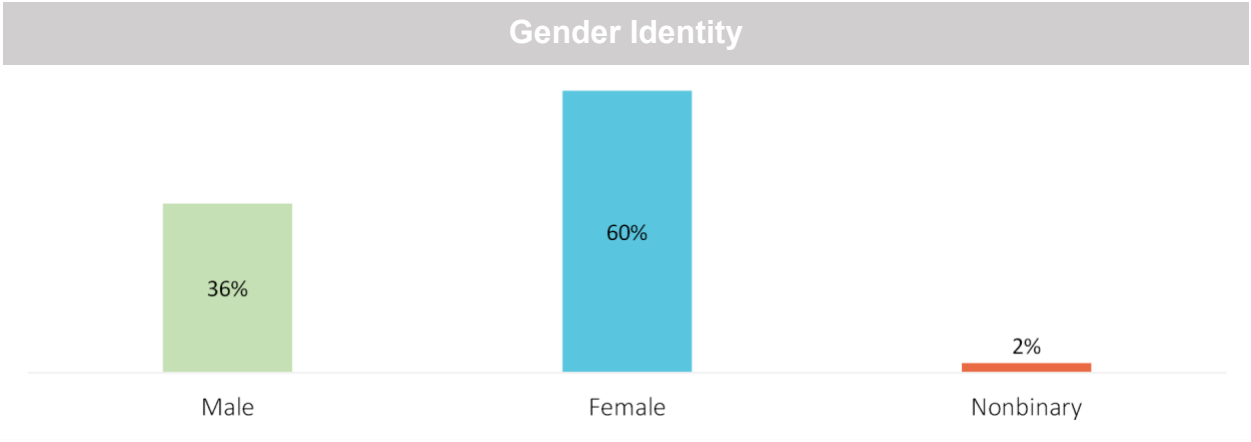
n=129
Another includes Portuguese.
3 individuals selected "decline to state."

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

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FAMILY SELF-HELP SUPPORT AND ADVOCACY – NAMI SIGNATURE PROGRAMS

Demographic Data



n=108
2 individuals selected "decline to state."

Sexual Orientation

Heterosexual or Straight	82%
Gay or Lesbian	2%
Bisexual	3%
Pansexual	2%
Queer	0%
Questioning or Unsure	1%
Another Sexual Orientation	1%
Declined to state	1%

n=108
Another sexual orientation includes Biromantic Asexual.

35% of individuals reported having one or more disabilities

n=107
7 individuals selected "decline to state."

Disability

Mental Domain	44%
Seeing	1%
Hearing	3%
Other Communication	1%
Physical	6%
Chronic Health Condition	8%
Another Disability	2%

n=107
Another disability includes Obstructive Sleep Apnea, Psychosis.

35% of individuals were veterans

n=103
4 individuals selected "decline to state."

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

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FAMILY SELF-HELP SUPPORT AND ADVOCACY – NAMI SIGNATURE PROGRAMS

Successes and Learning

Notable Strengths

- Capacity to serve families in English and Spanish is expanding.
- Developing a stronger network with state trainers to provide programs in Spanish.
- Building a sense of community.
- Expansion of services to South Monterey County communities.
- Establishing NAMI on high school campus clubs with the Salinas Union High School District.

Achievements

- Provided 55+ weeks of mental health education over 4 different programs.
- Facilitated over 25 support groups for family members, friends, and peers with lived experience.
- Conducted 38 presentations serving over 700+ participants.
- Participated in 19 community outreach events providing mental health resources to over 2,800 community residents.

Challenges

We currently have a shortage of English- and Spanish-speaking program and support group facilitators.

Case Example/Narrative

NAMI continues to strengthen its delivery of services to Monterey County residents despite the many obstacles that we encounter. There is a rejuvenation of excitement from NAMI board members and staff to provide quality services to those in need of our support. In addition, we are building stronger collaborations with prevention and early intervention providers in a joint effort to address youth mental health.

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SUCCESS OVER STIGMA (SOS) INTERIM

Success Over Stigma (SOS) is a consumer-driven, community advocacy and educational outreach program designed to combat the three most prevalent forms of stigma: community perception, internal stigma, and external stigma. This is accomplished by recruiting and training mental health clients to share their successful stories of recovery with others.

Program Highlights



Population served: Community members

18 program events and activities

14 individuals engaged in program activities as SOS speakers

Program Activities

Activities Hosted

Presentations – 18 stigma reduction presentations held for approximately 362 community members.

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SUCCESS OVER STIGMA (SOS)

Program Outcomes, Satisfaction, and Feedback

Because of this program… (n=123)	% Before	% After
I knew where to go for mental health services near me.	59%	90%
I thought people should share about their mental health struggles.	72%	84%
I would feel embarrassed about having personal mental health issues.	22%	6%
I thought the behavior of people with mental illness was unpredictable.	23%	6%
I was scared of people with mental illness.	3%	2%

Program participants were asked to indicate their attitudes about seeking help for a mental health problem. Findings below shed light on important implications for efforts to promote a more open and supportive environment for individuals struggling with mental health issues.

If I had a mental health problem, seeking help would be… (n=123)	% Agree
Useful	88%
Important	51%
Healthy	90%
Effective	84%
Good	49%
Healing	45%
Empowering	82%
Satisfying	44%
Desirable	50%



90% of respondents said that they were **more aware of where to go for mental health services** after participating in this program.

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SUCCESS OVER STIGMA (SOS)

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=109-118)	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	0%	**100%**
The program was provided in the language that I speak best.	0%	**100%**
Materials provided were useful.	0%	**100%**
Training/course was practical and useful.	0%	**100%**
I would recommend this program to a friend or family member.	1%	**99%**



92% of respondents agreed or strongly agreed that they **would recommend the program to a friend or family member**.

"Listening to others about their experiences was very helpful."

"Learning about more of the programs and opportunities at Interim!"

What was most useful or helpful about this program? (n=108)

- Hearing people's stories (67)
- The resources provided (14)

What are your recommendations for improvement? (n=108)

- Knowing help is available (14)
- General positive feedback (73)

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SUCCESS OVER STIGMA (SOS)

Demographic Data

Race*

American Indian/Alaskan Native	3%
Asian	5%
Black/African American	4%
Native Hawaiian/Other Pacific Islander	4%
Latino	43%
White	31%
Another	8%
More than one race	7%
Declined to state	11%

n=456
Another includes Chamorro, Middle Eastern, Portuguese.

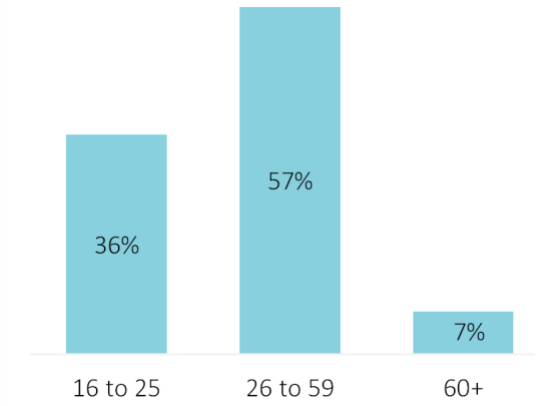
71% Hispanic/Latino
31% Non-Hispanic/Latino

Ethnicity*

Hispanic/Latino	
Caribbean	0%
Central American	0%
Mexican/Mex.-Am./Chicano	71%
Puerto Rican	0%
South American	0%
Other Hispanic/Latino	0%
Unspecified Hispanic/Latino	0%
Non-Hispanic/Latino	
African	0%
Asian Indian/South Asian	0%
Cambodia	0%
Chinese	0%
Eastern European	0%
European	13%
Filipino	8%
Japanese	0%
Korean	0%
Middle Eastern	5%
Vietnamese	0%
Other Non-Hispanic/Latino	5%
Declined to state	0%

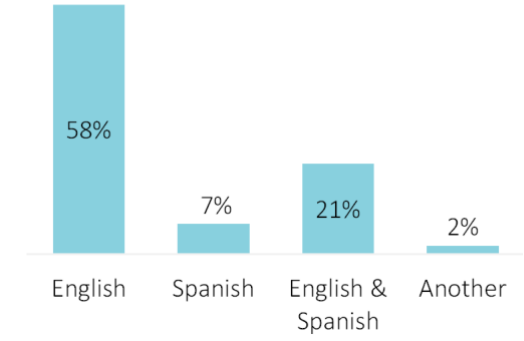
n=38
Other includes Pacific Islander, White.

Age



n=414
40 individuals selected "decline to state."

Primary Language



n=456
Another includes Indonesian, Tagalog, Vietnamese.
57 individuals selected "decline to state."

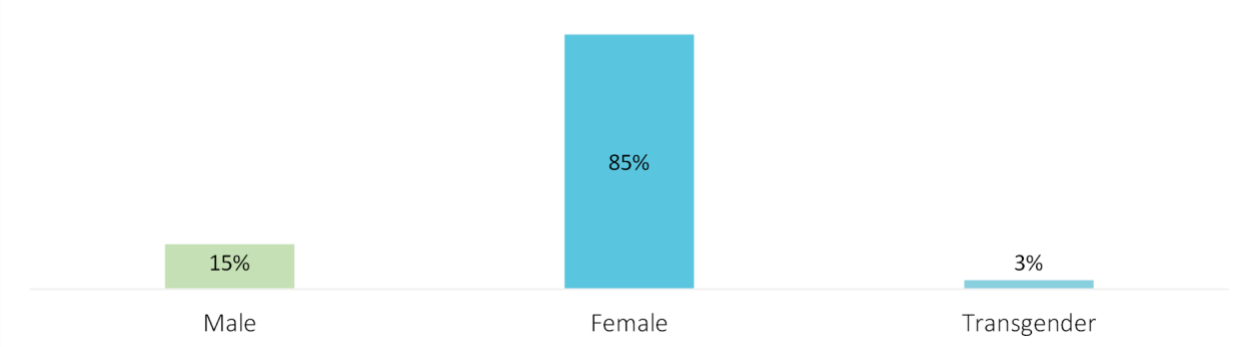
* Percentages may exceed 100% because participants could choose more than one response option.

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SUCCESS OVER STIGMA (SOS)

Demographic Data

Gender Identity*



n=40

Sexual Orientation

Heterosexual or Straight	83%
Gay or Lesbian	5%
Bisexual	8%
Pansexual	0%
Queer	5%
Questioning or Unsure	0%
Another Sexual Orientation	0%
Declined to state	0%

n=40

Sex

Male	13%
Female	88%
Another Sex	0%

n=40

Disability

Mental Domain	58%
Seeing	3%
Hearing	0%
Other Communication	0%
Physical	5%
Chronic Health Condition	8%
Another Disability	0%

n=40

33% of individuals reported having one or more disabilities

n=40

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

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SUCCESS OVER STIGMA (SOS)

Successes and Learning

Notable Strengths

- Ensuring that new speakers feel supported and share a collaborative spirit.
- Strong speaker training curriculum.
- Reducing stigma in the community around mental health.

Challenges

Between January and March 2023, there were extreme weather situations. Due to excessive rainfall and the threat of flooding, we had to reschedule two in-person presentations.

Achievements

- Trained 14 new speakers.
- Booked 18 presentations during the fiscal year.
- Started a monthly advocacy group.
- Increased appeal of the program for potential speakers.

Case Example/Narrative

SOS worked with a client, GD. GD had been a past speaker with SOS five years ago. Her strengths were that she was a great storyteller and that she used cartoons and anime in her stories to connect with young people. Her life changed after she married and attempted to work full time. She did not tell her current employer about her mental illness. Over several conversations, the SOS Peer Outreach & Advocacy Coordinator convinced her to advocate for herself and disclose her condition to her employer. They offered her support in a way that allowed her to flourish within the company. She was able to take control of her symptoms due to the support she received. She does not feel stigmatized at work, and she is happy and doing well.

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OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

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COMMUNITY PRESENTATIONS AND OUTREACH MONTEREY COUNTY BEHAVIORAL HEALTH (MCBH)

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. MCBH also offers psychoeducational workshops virtually using video conferencing and livestreaming via Facebook to accommodate a need for social distancing. Some of the virtual workshops have been conducted in partnership with community-based agencies.

Program Highlights



Population served: Community members of Monterey County

4 program events and activities

845 individuals engaged in program activities

Program Activities

Activities Hosted

End-of-Summer Celebration – Approximately 275 attendees were present at the event, which raised awareness of suicide prevention and provided resources on mental health and wellness to Monterey County residents.

Self-Care Workshop – Approximately 25 individuals attended a workshop on self-care and stress management to reduce staff burnout and promote wellness.

PostSecret Event – 500 individuals registered for an online event to provide clinical support and interpretation for Spanish-speaking participants in an online forum. The event highlighted the importance of addressing stigma and sharing secrets that keep people isolated from one another—including mental health and suicide.

Mental Health Summit – An estimated 45 individuals attended the summit where agency staff presented on topics such as understanding mental health, supporting children and youth mental health, suicide prevention, and how to access resources.

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COMMUNITY PRESENTATIONS AND OUTREACH

Program Outcomes, Satisfaction, and Feedback

"It was helpful to learn about the resources and direct contact numbers to partner agencies provided at the end of the presentation!"

" Each presenter spoke a different language and gave a lot of information. They were very clear in explaining each program."

Because of this program… (n=43)	% Before	% After
I knew where to go for mental health services near me.	40%	98%
I knew a lot about the topic of this training/class.	30%	67%
I was able to recognize early signs of mental illness.	70%	86%
I felt able to respond effectively to early signs of mental illness.	37%	81%
I was likely to assist someone with a mental illness who needed help.	56%	81%



86% of respondents said they were able to recognize the early signs of mental illness after participating in this program.

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COMMUNITY PRESENTATIONS AND OUTREACH

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n = 43) **between 1 – 2 individuals declined to respond*	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	7%	**93%**
The program was provided in the language that I speak best.	7%	**93%**
The program was right for me.	7%	**91%**
I was happy with this program.	5%	**91%**
I would recommend this program to a friend or family member.	5%	**91%**



91% of respondents agreed or highly agreed that the **services were right for them** in this program.

What was most useful or helpful about this program? (n=34)

- Learning about where to go for help or for more information (14)
- Receiving information about anxiety, depression, or suicide (7)
- Everything about the presentation was helpful (4)

What are your recommendations for improvement? (n=21)

- The community needs more services available for those that need help (8)
- Have more information that can be used right away (4)

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COMMUNITY PRESENTATIONS AND OUTREACH

Successes and Learning

Notable Strengths

- Staff that are knowledgeable about mental health and how to help residents access behavioral healthcare.
- Strong collaborative relationships with community agencies and programs that can be leveraged to reach community members.

Challenges

Challenges are limited availability of MCBH staff and no dedicated staff to conduct outreach and give presentations.

Achievements

- Collaborated effectively with partner agencies for a mental health summit in Soledad and a community event in September.
- The mental health summit provided information on mental health, warning signs, resources, and supportive programs that was well received by participants.
- The "End of Summer Celebration" event successfully promoted non-stigmatizing mental health awareness with a resource fair, entertainment, speakers, and a raffle.





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FAMILY SELF-HELP SUPPORT AND ADVOCACY – YOUTH LEADERSHIP AND EMPOWERMENT NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

National Alliance on Mental Illness of Monterey County (NAMI MC) provides education, outreach, support, and referrals to individuals affected by mental illness and their family members, loved ones, and professional providers. As part of its programming, NAMI MC facilitates youth leadership and empowerment regarding mental health in Monterey County. NAMI MC provides a Youth Program Coordinator and develops processes to empower high school students and transitional age youth (ages 16–25) to communicate information about mental health needs and the gaps in services, while stressing the importance of eliminating stigma. Connections amongst youth-centric organizations are also facilitated, and NAMI MC provides a lead role in coordinating efforts across Monterey County. In addition, youth leaders are sought and identified to be involved in these efforts, and develop and serve on a Youth Empowerment Council.

Program Highlights



Population served: Monterey County high school students and transitional age youth

38 community presentations on mental health awareness, suicide prevention awareness, and community-based mental health services

Program Activities

Activities Hosted

Community Presentations – 750 participants attended 38 community presentations that were conducted at several local high schools (Rancho San Juan, Everette Alvarez). Presentation topics included mental health statistics, warning signs, and where to find local help for mental health needs.

Youth Mental Health Summit – A Youth Mental Health Summit was organized and held on October 7, 2023 at California State University, Monterey Bay. NAMI MC collaborated with Monterey County Behavioral Health, NAMI California, and The Epicenter, The Village Project, Inc., Seneca, and Urban Arts Collaborative.

NAMI on Campus – Rancho San Juan High School finished its first year of being a NAMI on Campus club. NAMI MC held a closing ceremony for the academic year and presented awards to (?) the club advisors and student leaders for their commitment and dedication to reducing stigma associated with mental illness.

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FAMILY SELF-HELP SUPPORT AND ADVOCACY – YOUTH LEADERSHIP AND EMPOWERMENT

Program Outcomes, Satisfaction, and Feedback

"I appreciated learning about the types of conditions there are and how they affect people in their social and daily life."

"This program was helpful because you learn how to get help and that you are not alone."

Because of this program… (n=364)	% Before	% After
I knew where to go for mental health services near me.	54%	88%
I knew a lot about the topic of this training/class.	34%	74%
I was able to recognize early signs of mental illness.	46%	78%
I felt able to respond effectively to early signs of mental illness.	39%	68%
I was likely to assist someone with a mental illness who needed help.	46%	74%



88% of respondents said that they now **know where to go for mental health services** after participating in this program.

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FAMILY SELF-HELP SUPPORT AND ADVOCACY – YOUTH LEADERSHIP AND EMPOWERMENT

Program Outcomes, Satisfaction, and Feedback

Please choose how much you agree or disagree with each sentence below (n=351-364	% Disagree	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	2%	98%
The program was provided in the language that I speak best.	2%	98%
Materials provided were useful.	3%	97%
Training/course was practical and useful.	3%	97%
I would recommend this program to a friend or family member.	4%	96%



96% of respondents agreed or strongly agreed that they **would recommend the program to a friend or family member**.

"Learning about most/the main conditions of mental illness was most helpful because it helped me understand what that person is going through and maybe it can help me respond to them to help."

"The most helpful thing is learning where and how I can get resources to help myself or friends."

What was most useful or helpful about this program? (n=241)

- Learning about anxiety, depression, or suicide (77)
- Learning about the hotline when there is an emergency (54)
- Learning how to identify warning signs (53)

What are your recommendations for improvement? (n=68)

- More information to assist self or others with mental illness (22)
- Providing more examples and real-life scenarios (14)
- No improvements needed (15)

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FAMILY SELF-HELP SUPPORT AND ADVOCACY – YOUTH LEADERSHIP AND EMPOWERMENT

Demographic Data

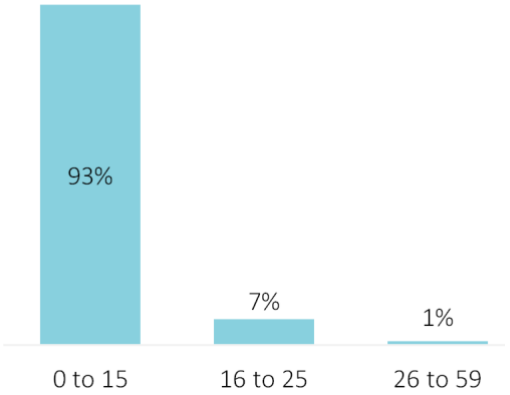
Race*

American Indian/Alaskan Native	2%
Asian	5%
Black/African American	2%
Native Hawaiian/Other Pacific Islander	1%
Latino	80%
White	12%
Another	0%
Declined to state	5%

n=668

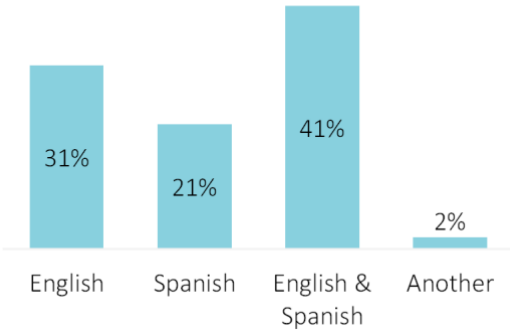
80% Hispanic/Latino

Age



n=581
69 individuals selected "decline to state."

Primary Language



n=668
Another includes Arabic, Filipino, Japanese, Korean, Mandarin, Nepali, Pashto, Portuguese, Russian, Tagalog, Telegu.
31 individuals elected "decline to state."

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

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FAMILY SELF-HELP SUPPORT AND ADVOCACY – YOUTH LEADERSHIP AND EMPOWERMENT

Successes and Learning

Notable Strengths

- Expanding capacity to serve families in both English and Spanish.
- Strengthening connections with state trainers for Spanish programs.
- Enhancing youth outreach through collaborations with local schools.

Challenges

We currently have a shortage of program and support group facilitators in English and in Spanish.

Achievements

- Reached contractual goal of facilitating 16 weeks of mental health educational material to community residents.
- Reached contractual goal of completing community presentation requirements.
- Completed a total of 38 presentations year to date. (Okay? P. 146 has 38 presentations…)

Case Example/Narrative

NAMI continues to strengthen its delivery of services to Monterey County residents despite the many obstacles that we encounter. There is a rejuvenation of excitement from NAMI board members and staff to provide quality services to those in need of our support. In addition, we are building stronger collaborations with prevention and early intervention providers in a joint effort to address youth mental health.

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APPENDIX A. FY 22–23 PEI PROGRAMS BY CATEGORY

Prevention

The Epicenter

Parent Education Program *(Community Human Services [CHS])*

Culturally Specific Outreach and Engagement *(Community Human Services [CHS])*

Senior Companion Program *(Seniors Council of Santa Cruz and San Benito Counties)*

Senior Peer Counseling and Fortaleciendo el Bienestar *(Alliance on Aging)*

Culturally Relevant Parenting Classes *(Partners for Peace)*

Maternal Mental Health (MMH) *(Monterey County Behavioral Health [MCBH])*

Maternal Mental Health Peer Navigation Program *(Parenting Connections of Monterey County)*

Maternal Mental Health Peer Navigation Program *(Centro Binacional para el Desarrollo Indígena Oaxaqueño [CBDIO])*

Teen Success, Inc. *(Harmony at Home)*

Bullying Prevention *(Harmony at Home)*

After School Academy *(The Village Project, Inc.)*

Outreach and Engagement Services *(The Village Project, Inc.)*

Culturally Specific Prevention and Early Intervention Through Outreach and Engagement *(Center for Community Advocacy [CCA])*

Proyecto Contigo and School-Based Counseling *(Pajaro Valley Prevention and Student Assistance)*

Early Intervention

Family Support Groups *(Monterey County Behavioral Health [MCBH], Adult System of Care [ASOC])*

(re)MIND® *(Felton Institute)*

Sticks & Stones® School-Based Counseling *(Harmony at Home)*

Services to Education *(Monterey County Behavioral Health [MCBH])*

Silver Star Resource Center *(Monterey County Behavioral Health [MCBH])*

Maternal, Child and Adolescent Health Home Visiting Program *(Public Health Bureau)*

Culturally Specific Short-term Therapeutic Services (CSSTS) *(Community Human Services [CHS])*

Drug and Alcohol Intervention Services for Youth (DAISY) *(Community Human Services [CHS])*

Outpatient Mental Health Services *(The Village Project, Inc.)*

Access and Linkage to Treatment

211 *(United Way Monterey County)*

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Veterans Reintegration Transition Program *(Monterey County Military & Veterans Affairs Office)*

Keep It Real *(Interim)*

Family Partners Program *(Seneca Center)*

Street Outreach Program *(Community Human Services [CHS])*

Suicide Prevention

Suicide Prevention Service *(Family Service Agency of the Central Coast)*

Monterey County Helping One another to Prevent and Eliminate Suicide (MC HOPES) *(Applied Crisis Training and Consulting, Inc.)*

Stigma and Discrimination Reduction

Family Self-help Support and Advocacy – Signature Programs *(National Alliance on Mental Illness [NAMI] Monterey County)*

Success Over Stigma (SOS) *(Interim)*

Outreach for Increasing Recognition of Early Signs of Mental Illness

Community Presentations and Outreach *(Monterey County Behavioral Health [MCBH])*

Family Self-Help Support and Advocacy – Youth Leadership and Empowerment *(National Alliance on Mental Illness [NAMI] Monterey County*

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APPENDIX B. FY 22–23 NUMBER OF INDIVIDUALS ENGAGED BY EACH PROGRAM

Prevention	**24,796**
The Epicenter	349
Parent Education Program *(Community Human Services [CHS])*	449
Culturally Specific Outreach and Engagement *(Community Human Services [CHS])*	1,000
Senior Companion Program *(Seniors Council of Santa Cruz and San Benito Counties)*	15
Senior Peer Counseling and Fortaleciendo el Bienestar *(Alliance on Aging)*	430
Culturally Relevant Parenting Classes *(Partners for Peace)*	5,632
Maternal Mental Health (MMH) *(Monterey County Behavioral Health [MCBH])*	248
Maternal Mental Health Peer Navigation Program *(Parenting Connections of Monterey County)*	350
Maternal Mental Health Peer Navigation Program *(Centro Binacional para el Desarrollo Indígena Oaxaqueño [CBDIO])*	365
Teen Success, Inc. *(Harmony at Home)*	124
Bullying Prevention *(Harmony at Home)*	1,762
After School Academy *(The Village Project, Inc.)*	70
Outreach and Engagement *(The Village Project, Inc.)*	13,365
Culturally Specific Prevention and Early Intervention Through Outreach and Engagement *(Center for Community Advocacy [CCA])*	57
Proyecto Contigo and School-Based Counseling *(Parajo Valley Prevention and Student Assistance)*	580
Early Intervention	**1,782**
Family Support Groups *(Monterey County Behavioral Health [MCBH], Adult System of Care [ASOC])*	11
(re)MIND® *(Felton Institute)*	162
Sticks & Stones® School-Based Counseling *(Harmony at Home)*	782
Services to Education *(Monterey County Behavioral Health [MCBH])*	210
Silver Star Resource Center *(Monterey County Behavioral Health [MCBH])*	210
Maternal, Child and Adolescent Health Home Visiting Program *(Public Health Bureau)*	65
Culturally Specific Short-term Therapeutic Services (CSSTS) *(Community Human Services [CHS])*	142
Drug and Alcohol Intervention Services for Youth (DAISY) *(Community Human Services [CHS])*	140
Outpatient Mental Health Services *(The Village Project, Inc.)*	60
Access and Linkage to Treatment	**4,572**
211 *(United Way Monterey County)*	3,290
Veterans Reintegration Transition Program *(Monterey County Military & Veterans Affairs Office)*	1,135
Keep It Real *(Interim)*	50
Family Partners Program *(Seneca Center)*	8

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Street Outreach Program *(Community Human Services [CHS])*	89
Suicide Prevention	**2,381**
Suicide Prevention Service *(Family Service Agency of the Central Coast)*	2,303
Monterey County Helping One another to Prevent and Eliminate Suicide *(Applied Crisis Training and Consulting, Inc.)*	78
Stigma and Discrimination Reduction	**1,112**
Family Self-help Support and Advocacy – Signature Programs *(National Alliance on Mental Illness [NAMI] Monterey County)*	2,875
Success Over Stigma (SOS) *(Interim)*	362
Outreach for Increasing Recognition of Early Signs of Mental Illness	**1,595**
Community Presentations and Outreach *(Monterey County Behavioral Health [MCBH])*	845
Family Self-Help Support and Advocacy – Youth Leadership and Empowerment *(National Alliance on Mental Illness [NAMI] Monterey County)*	750
Total	**36,238**

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PREFACE TO APPENDICES C AND D

Demographic and Outcome Data Across Programs

Appendix C presents aggregate PEI participant demographics across all programs and primary program categories. Demographic topics (e.g., race, ethnicity, age) and response options are shown in the rows. Rows with a dark grey background represent the total number of respondents who answered the question. The number of respondents who skipped the question are presented in the last row under each demographic topic. Demographic responses were collected by an MCBH PEI demographic form (adult, parent, or presentation version) or collected from Avatar.

Appendix D presents participant outcome survey data across programs and primary program categories. Data are organized by survey type. Questions from each survey type are presented in the rows. Columns with percentages of change are also provided to highlight positive or negative impact. The numbers or range of number of respondents who answered each question on the survey are presented in parentheses after each question.

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APPENDIX C. FY 22–23 PARTICIPANT DEMOGRAPHICS

Race	4,618
American Indian or Alaska Native	58
Asian	147
Black or African American	148
Hispanic/Latino	2,929
Native Hawaiian or Pacific Islander	55
White	870
Other	83
More than one race	164
Declined to answer/skipped	164
Ethnicity	1,453
Hispanic or Latino	1,100
Caribbean	6
Central American	22
Mexican/Mexican American/Chicano	935
Puerto Rican	6
South American	13
Other	118
Non-Hispanic or Latino	288
African	24
Asian Indian/South Asian	5
Cambodian	0
Chinese	3
Eastern European	15
European	157
Filipino	17
Japanese	13
Korean	2
Middle Eastern	5
Vietnamese	3
Other	44
More than one Ethnicity	26
Declined to answer/skipped	39
Primary Language	4,175
English	1,754
Spanish	1,146
English and Spanish	1,070
Other	79
Declined to answer/skipped	126
Veteran Status	1,066
Yes	47
No	1,010
Declined to answer/skipped	9

Age	4,165
0 to 15 years	1,759
16 to 25 years	631
26 to 59 years	1,028
60+ years	516
Declined to answer/skipped	231
Current Gender Identity	1,044
Female	671
Male	346
Transgender	4
Genderqueer	1
Non-Binary	9
Questioning or unsure	2
Another gender identity	2
Declined to answer/skipped	9
Sex Assigned at Birth	1,641
Female	976
Male	656
Another sex	0
Declined to answer/skipped	9
Sexual Orientation	1,239
Bisexual	21
Gay or Lesbian	14
Heterosexual or Straight	1,103
Pansexual	12
Queer	8
Questioning or unsure	7
Another sexual orientation	16
Declined to answer/skipped	58
Disability	1,400
Has a disability	328
No disability	1,046
Declined to answer/skipped	26
Type of Disability	649
Difficulty seeing	46
Difficulty hearing or having speech understood	26
Other communication difficulty	9
Mental domain disability	398
Chronic health condition	86
Physical disability	67
Another disability	17

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APPENDIX D. FY 22–23 OUTCOMES ACROSS PROGRAMS

Prevention and Early Intervention Program Survey

Percentage/number of respondents who selected "agree" or "strongly agree"	Before Services	After Services	% Change
I knew/know a lot about the topic of this session/training/class. (n=648 & 656)	52%	87%	35% ↑
I knew/know where to go for mental health services. (n=644 & 651)	60%	88%	28% ↑
I knew/know when to ask for help with an emotional problem. (n=645 & 646)	65%	88%	23% ↑
I felt/feel good about myself. (n=642 & 648)	64%	88%	24% ↑
I felt/feel hopeful when I thought/think about the future. (n=632 & 633)	68%	86%	18% ↑

Stigma and Discrimination Reduction Survey

Percentage/number of respondents who selected "agree" or "strongly agree"	Before Services	After Services	% Change
I knew/know where to go for mental health services. (n=225 & 221)	52%	87%	35% ↑
I thought/think people should share about their mental health struggles. (n=219 & 215)	70%	87%	17% ↑
I would feel embarrassed about having personal mental health issues. (n=218 & 217)	29%	19%	10% ↓
I thought/think the behavior of people with mental illness was/is unpredictable. (n=213 & 205)	32%	28%	4% ↓
I was/am scared of people with mental illness. (n=217 & 214)	16%	17%	1% ↓

If I had a mental health problem, seeking help would be…	% Agree
Useful (n=179)	88%
Important (n=174)	51%
Healthy (n=170)	90%
Effective (n=171)	84%
Good (n=172)	49%
Healing (n=169)	45%
Empowering (n=161)	82%
Satisfying (n=170)	44%
Desirable (n=167)	50%

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PEI Multi-Session Pre/Post Survey

Percentage/number of respondents who indicated higher level of health (4+ on a 7-point scale)	Before	After	% Change
Given my current physical condition, I am satisfied with what I can do. (n=197 & 52)	73%	73%	0%
I have confidence in my ability to sustain important relationships. (n=197 & 53)	81%	74%	7%
I feel hopeful about my future. (n=196 & 52)	75%	70%	5%
I am often interested and excited about things in my life. (n=197 & 53)	79%	78%	1%
I am able to have fun. (n=198 & 53)	77%	74%	3%
I am generally satisfied with my psychological health. (n=197 & 53)	68%	74%	6%
I am able to forgive myself for my failures. (n=197 & 53)	74%	69%	5%
My life is progressing according to my expectations. (n=195 & 53)	62%	68%	6%
I am able to handle conflicts with others. (n=197 & 53)	74%	75%	1%
I have peace of mind. (n=644 & 51)	76%	75%	1%

Suicide Prevention Survey

Percentage/number of respondents who selected "yes"	Before Services	After Services	% Change
I knew/know where to go for mental health services. (n=497 & 494)	59%	88%	29%
I knew/know the warning signs of suicide. (n=493 & 493)	65%	90%	25%
I knew/know the ways to help a person who is dealing with a mental problem or crisis. (n=497 & 494)	56%	89%	33%
I knew/know how to find someone who could help me with issues related to suicide. (n=493 & 496)	60%	91%	31%

Outreach Survey

Percentage/number of respondents who selected "yes"	Before Services	After Services	% Change
I knew/know where to go for mental health services. (n=528 & 523)	53%	90%	37%
I knew/know a lot about the topic of this training/class. (n=528 & 516)	32%	76%	44%
I was/am able to recognize early signs of mental illness. (n=527 & 519)	51%	82%	31%
I felt/feel able to respond effectively to early signs of mental illness. (n=524 & 517)	43%	74%	31%
I was/am likely to assist someone with a mental illness who needed/needs help. (n=524 & 518)	49%	79%	30%

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PEI Program Satisfaction

Percentage/number of respondents who selected "agree" or "strongly agree" across programs	% Agree
Staff respected my culture and background (e.g., ethnicity, beliefs, identity). (n=1,964)	97%
The program had services in the language that I speak best. (n=1,954)	97%
Materials provided were useful. (n=1,460)	98%
This training/course was practical and useful. (n=1,945)	97%
I would recommend this training/class to others. (n=1,936)	97%

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MONTEREY COUNTY
BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

MICRO-INNOVATION GRANT ACTIVITIES FOR INCREASING LATINO ENGAGEMENT INNOVATION PLAN
FINAL EVALUATION REPORT

Prepared by:

EVALCORP
Measuring What Matters℠

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Executive Summary

On August 30, 2018 the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the use of Mental Health Services Act Innovation Component funding for Monterey County Behavioral Health (MCBH) to implement the Micro-Innovation Grant Activities for Increasing Latino Engagement Innovation Plan (Micro-Inn) project. This report is the final evaluation report for the five-year project.

The Micro-Inn project was designed to uncover effective approaches to improving the outreach for and delivery of mental health services for the underserved Latino population in the county. The program intended to achieve this by enabling a diffuse network of micro-innovation grant-funded activities designed specifically by and for local communities, neighborhoods, niche cultural or ethnic sub-groups, etc. The grant activities could be a one-time activity or a sustained activity not to exceed 12 months. The maximum allowable amount for each mini-grant was $50,000.

MCBH accepted applications in six rounds. The applications were reviewed by the Micro-Innovation Grant Review Board. Thirty-two applications were received; 20 were approved, 14 were funded. The external evaluator, EVALCORP, used data submitted from the grantee's reports (n=13) and key informant interviews (n=6) with selected grantees to conduct the evaluation.

The program successes included reaching hundreds of Latino families, yet the exact number was not available. Programs, such as public service announcements, could not determine reach. Another success was the cultural relevancy of the programs. Programs included aspects of the Latino culture such as activities and traditions (e.g., dances). In addition, speakers and performances communicating stories and information about mental and behavioral health were Latino's from the community. During the programs, there were opportunities to share other resources such as food banks. Additionally, ideas, such as having a local text-based service for teens, were shared.

Challenges included collecting referral data as participants did not want to disclose that information (due to many reasons such as stigma, embarrassment). Program sustainability was limited as the grant money was needed to continuance. A couple of programs could possibly be sustainable. Data collection was difficult as the recipients of the mini-grants did not submit all information and it was not in a standized format.

In summary, the evaluation did not have ability to assess if referrals occurred from the available data, yet insights to lessons learned and recommendations were gained. The programs reached a large number of people, were culturally relevant, and a couple of potential promising programs were identified.

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Introduction

On August 30, 2018 the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the use of Mental Health Services Act Innovation Component funding for Monterey County Behavioral Health (MCBH) to implement the Micro-Innovation Grant Activities for Increasing Latino Engagement Innovation Plan (Micro-Inn) project. This report serves as the Final Evaluation Report as required by Title 9 California Code of Regulations – Division 1, Chapter 14, Article 5 Section 3580. The purpose of this Annual Evaluation Report is to update MCBH stakeholders and the MHSOAC on the implementation status of the Micro-Inn Project.

Project Overview

The Micro-Inn project is designed to uncover effective approaches to improving the outreach for and delivery of mental health services for the underserved Latino population in the county.

Background

The Micro-Inn project was created to address the problem of a relatively low number of Latinos utilizing behavioral health services in the county. The program intended to achieve this by enabling a diffuse network of micro-innovation activities designed specifically by and for local communities, neighborhoods, niche cultural or ethnic sub-groups, etc. The activities could be a one-time activity or a sustained activity not to exceed 12 months. To implement this Innovation project, MCBH created a grant application and scoring criteria (Appendix A) and the Micro-Innovation Grant Review Board scored the applications. MCBH created a referral tracking form for grantees to utilize in their programs (Appendix B).

Learning Goals

The primary learning goal of this 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:

- 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.

The evaluation questions for the Micro-Inn Program are aligned with the project learning goals established for the initiative (Table 1).

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Table 1. Evaluation Questions and Data Sources

Evaluation Questions	Data Source
For each micro-innovation, how many Latino individuals that have never engaged with mental health services received a referral for mental health treatment services?	Grantee Evaluation Reports
For each micro-innovation, how many Latino individuals followed through on a referral and received mental health treatment services?	Grantee Evaluation Reports
Did the total count of Latinos served increase during this Innovation project?	Grantee Evaluation Reports
Did any micro-innovation activities demonstrate capacity for sustainability in impact and/or funding?	Grantee Evaluation Reports and Interviews
How were cultural barriers addressed?	Grantee Evaluation Reports and Interviews

The grantees were required to maintain the following minimal records:

- 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

Thirty-two applications were received; 20 were approved, 14 were funded. An overview of funded projects that are included in this report are summarized in Table 2. Six projects were denied during FY 21/22 (Table 3). The reasons for denial included the activities being inconsistent with the intent or requirements of the Innovation Plan or due to several necessary components to explain the implementation and evaluation plan were not evident in the application. Full descriptions of approved and denied applications are in Appendix C.

Evaluation Methods

The Micro-Inn evaluation is designed to answer the learning and evaluation questions posed for the project and includes both qualitative and quantitative data collection strategies. Data

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utilized for the evaluation were from reports submitted by grantees who completed their projects (n=13) and key informant interviews (n=6). One grantee (MILPA /Rancho Cielo Youth Leadership Training) that completed the project did not submit a report.

Six 45-minute virtual key informant interviews were conducted with five grantees. The grantees were selected and interview questions created in consultation with MCBH. The programs that showed the greatest promise in terms of impact and sustainability were invited to participate in an interview. MCBH disseminated an email to introduce the grantee to the evaluators. The interview began with asking the grantee to describe the program followed by questions related to program implementation, impact, and sustainability.

Projects that showed to effectively engage and impact the Latino population were selected for the key informant interviews to explore in depth program details that led to successful engagement. More specifically, the evaluation uncovered the aspects of the programs that were most impactful and how the program was culturally tailored for the Latino population. The key informant interviews (see Appendix E for protocol) also engaged the program stakeholders in the evaluation and incorporated their ideas, experiences, and perspectives.

Limitations

As with any evaluation, the Micro-Inn assessment confronted limitations imposed by circumstances. The EVALCORP team was not involved in the evaluation for the first four years of the project. Only one of the grantees submitted referral data and two submitted demographic data. This is due to challenges in capturing the data. Some project impacts, such as those from PSAs, cannot provide information about the number reached or those who received services as a result of the program. Lastly, projects included in Micro-Inn may take time to influence the seeking out of mental health services and the impacts may show in longer-term evaluations.

Findings

Program Reach and Participant Demographics

Referrals to mental health services among the Latino population was one on the main goals of the Micro-Inn project. Door to Hope (n=32) was able to capture referral data to show that approximately one-third (38%, n=12) of participants were referred to mental health services; nine participants were successfully connected to mental health services and continue to see their therapist regularly. Other referrals were made as well, including parent education, food banks, financial assistance, etc. Three programs tracked demographic information and seven were able to track program reach (Table 4).

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Table 2. Reach and Demographics by Project

Rnd	Provider Name/ Program Cost	Reach	Demographics
1st	Community Human Services/$50,000	Approximately 2,000 participants across 19 events 35 individuals received triage services.	No demographic information was collected from participants
1st	Building Health Communities/$50,000	A total of 315 individuals participated in Culturally Rooted Holistic Health for Women Workshops and 223 referrals were provided to mental health services.	No demographic information was collected from participants
1st	Baktun 12/ $$48,279	Not fully implemented	Not fully implemented
1st	Center for Community Advocacy $50,000	Eight one-hour Spanish-language radio shows were delivered, with a community town hall following each. 98 individuals engaged in the town hall events. Five referrals to mental health services were provided	100% Hispanic/Latino Primary Language: Spanish: 83% Triqui: 10% English: 7%
1st	Michael Houston */$5750*	2878 attendees at eight events in a two-month period.	Activities were focused on engaging unhoused individuals and the Latino community of the Salinas Chinatown. Demographic information was not collected from participants.
4th	Michael Houston/ 6728	Unknown	Unknown
4th	Door to Hope/$50,000	32 participants	100% Hispanic/Latino/Indigenous

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4th	MILPA/ $50,000	Report Not Submitted	Report Not Submitted
4th	Precious Stone/ $50,000	Unknown	Unknown
5th	Monterey County Public Health Bureau/$36,166	For the Mind Matters program, 65 peer educators were trained and 77 presentations were completed; peer educators reached 1,740 unduplicated youth.	Unknown
5th	Community Human Services/$50,000	Estimated 208,760	Unknown
6th	Door to Hope/ $50,000	Number of individuals reached through monthly outreach activities: 194 Number of individuals receiving mental health screenings and services: 21 Number of mental health service referrals provided: 8	Information provided not complete
6th	Precious Stone/ $50,000	Unknown	Unknown
6th	United Way/ $50,000	1,440 received information or training. 30 individuals received mental health referrals.	Information provided not complete

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Summary of the Project Outcomes and Impacts of Selected Projects

Mi Via, Mi Arte, Mi Alegria. Located in south county, the grantee leveraged recognized community artists to combat mental health stigmas. Through live performances, these artists recounted their personal journeys with mental health challenges and recovery, advocating for mental health services within a secure and family-friendly environment. The initiative primarily catered to Oaxacan and Spanish-speaking farmworkers from Salinas, Greenfield, and King City in Monterey County.

These events were more than performances; they were platforms for open discussions on the therapeutic power of art, the joy inherent in dance, the significance of art-related activities for children, and the uplifting role of music in recovery. They showcased a mix of poetry, songs, and dances.

To gauge the impact, a survey was circulated among attendees. This survey, primarily in Spanish, aimed to help individuals determine if they or someone they knew might benefit from mental health service referrals. Of those who responded:

- 94% (n=141) expressed interest in attending future events.
- 29% (n=35 out of 121) acknowledged having friends or family experiencing unhappiness.
- All respondents (n=82) expressed a desire for assistance with social services in Spanish.

Evaluation Perspective. The program was a success in terms of attendance (n=285) and cost-effectiveness. Its culturally tailored approach, emphasizing the storytelling tradition prevalent in Latino culture, likely played a significant role in its resonance with the target audience. Furthermore, its potential for self-sustainability, combined with active community engagement, indicates a promising future for similar initiatives.

Door to Hope. Door to Hope facilitated the Circle of Security eight-week program in four separate sessions. Designed for group settings, approximately 10 parents engaged in two-hour virtual meetings each week for eight weeks. Each session had the consistent presence of two facilitators and a care coordinator.

In terms of actionable outcomes:

- 12 participants were referred to specialized mental health services, breaking down as:
    - 3 to the Access Line
    - 6 to the Community Human Services for uninsured individuals
    - 1 to Beacon Health
    - 1 to Door to Hope's Behavioral Health Integrated Program
    - 1 to a private insurance provider
- Out of these, 9 individuals successfully established a continued relationship with their therapist.

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- Additionally, referrals were made for parent education, food banks, financial aid, and more.

A statement from the Circle of Security Program Administrator emphasized the importance of the initiative:

> "Introducing Circle of Security classes to the unserved and underserved Latino communities laid the groundwork for delving into fundamental mental health themes. This initiative addresses a demographic that traditionally lacks easy access to mental health education or resources."

Participants provided feedback indicating introspection and application of the knowledge gained:

> “I’ve transitioned from yelling at my daughter, which only exacerbated her crying, to adopting a softer approach. This shift has improved our interactions.”
>
> “I initially misinterpreted my daughter’s curiosity as mischief. I now recognize her explorative nature as a keenness to learn.”
>
> “Past childhood traumas with my parents have left scars. At times, I fear repeating those patterns with my own children.”

Evaluation Perspective. The program demonstrated effectiveness in its referral process and maintained cultural relevance in its curriculum. It's evident that the program significantly impacts parental self-awareness and their relationships with their children. With a sustainable model in view, charging participants a reasonable fee could ensure the program's continuity without excluding low-income individuals.

Emeralda Owen/Public Service Announcements*.* Twelve monthly PSAs related to mental health were delivered in Spanish. No information was provided about the potential reach or impact of the announcements.

Evaluation perspectives. The program impact cannot be determined due to lack of data. The program is not expected to be self-sustaining even if the ads are delivered at no cost due to the expense of developing them.

Monterey County Public Health Bureau.
MCPHB introduced two key programs: Mind Matters and Postpone, sourced from The Dibble Institute.

- Mind Matters: Designed to bolster youth resilience, it has historically been deployed by various agencies to thwart violence, tackle chronic absenteeism, and nurture a wellness culture.
- Postpone: This teenage pregnancy prevention program delivered mental health education and resources alongside teen pregnancy prevention strategies.

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The program's goals and outcomes are in Table 5.

Table 5. Goals and Outcomes

Goals	Outcomes
Train a minimum of 30 high-school students at Alisal and Everett Alvarez High Schools and one college level student intern to serve as peer educators.	Sixty-five peer educators were trained.
Reach 1,030 students from Alisal and Everett Alvarez High Schools through classroom presentations.	Seventy-seven presentations were given to 1,740 students.
Refer into services 10% of youth reached (103 youth based on the original goal).	Unable to accurately track this number.

Successes associated with this project included initiating conversations and sharing information with youth about mental health and seeking mental health services. The programs provided a safe space for youth to hear about and normalize the topic of mental health. Some youth shared their own experiences, and this reminded other students that mental health issues are common, and that support is available.

Peer educators stated they really liked the Mind Matters content. The information they learned was shared with others via social media posts, and during one-on-one conversations with students. Peer educators also reported that they were using the information learned to help their siblings and friends. Peer educators learned to identify some of the signs, such as declines in school performance, poor grades, constant anxiety, social withdrawal, or aggression, which may indicate the need for mental health services. The Mind Matters curriculum assisted not only our Postpone peer educators but also facilitators and students across all our teen pregnancy prevention programs to clear away barriers. The curriculum helped to build skills in the educators that transferred to others through one-on-one interactions.

Postpone peer educators completed one-on-one outreach to their peers, documented their interactions, and posted positive messages about accessing mental health services, tips on mental health, and mental health resources to their personal social media accounts (e.g., Instagram, Snapchat). Posts were intended to reduce stigma and increase the understanding of mental health resources and services. Teens often go to other teens for help on topics such as reproductive health, homework, employment, etc. The Postpone program used a peer education model and students received accurate information and resources from their peers.

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Postpone peer educators were assigned to classrooms to speak on topics such as depression, anxiety, and mental health to normalize discussing mental health services and to increase the likelihood that the youth in the classrooms will seek mental health services.

Evaluation perspectives. The program engaged students in discussions about mental health and could potentially lead to greater help-seeking behavior among our youth. The cultural relevance is related to having the peer model. Peers have similar generational cultures and are from the same community. The cost of the curriculums would be a one-time fee, and there is a fee for the participant's journal. These items could be incorporated into the school budget, and the program could be sustained. The evaluator is uncertain if the journals are required to deliver the program.

***Community Human Services*.** The organization facilitated workshops about mental health in collaboration with Monterey County Office of Education's Migrant Education Program (MEP), disseminated materials, and delivered radio announcements. The topics were:

- No cost mental health services for uninsured or those with Medi-Cal (for parents)
- Tricolor Radio "Free Mental Health Counseling" Spots
- Workshops (five) on mental health topics for parents and students
- Tricolor radio stations in a "Lunchtime Giveaway" promotion to disseminate mental health information and free mental health services to Monterey County Latino/migrant families and farmworkers
- Mental health gift packs were disseminated at the Artichoke Festival on June 11, 2022, and during both days of the Salinas Rodeo on July 21 and 22, 2022.
- Facebook mental health and cross-promotional ads ran from June 1 through September 30, 2021; ad impressions: 539,000; ad reach: 151,000.

Their outreach for quarter one (when they shared materials about mental health) had an estimated reach of 600 people, the quarter two public radio announcement reached 55,400, quarter three workshops' (five) reach was estimated at 800, and for quarter four, the activities at festivals and events reached approximately 960 people. The grantee also ran Facebook ads that reached 151,000 people in four months.

Evaluation perspectives. The reach was high for these activities. The impact cannot be determined with the data that are available.

Discussion

In this section of the report, the topics of reach, referrals, sustainability, and culturally tailored programs are addressed. The grantee evaluation reports are in Appendix F.

Reach

The projects reached their intended audience, which was the Latino population, based on the limited demographic data available. The media and radio ads had a wide reach as well as the

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performing arts program. The Circle of Security classes for parents offered by Door to Hope had a smaller reach but resulted in several referrals to mental health and other services. The MCPHB programs had a significant reach to youth. The Community Human Services program had a significant reach as well.

Referrals

The data on the number of referrals for those that have never engaged with mental health services, the number who followed through with the referral, and the total count of Latinos served during this Innovation project is relatively unknown. There were 50 total referrals documented by three separate grants. It is possible that these projects had an impact on the mental health of the intended audience. The programs may have encouraged participants to engage in activities to assist with prevention or early intervention of mental health challenges. In addition, they may have opened the door to considering treatment in the future or engaging family and friends to participate in activities that promote mental health or seek help for themselves.

Sustainability

With regards to sustainability, the performing arts program was cost efficient in terms of dollars spent and reach. It has the potential to be self-sustaining. Tickets to the event could be sold at a reasonable cost, and it is possible to have the entertainers perform pro bono and possibly have venues donate or provide space at a low cost. More rigorous evaluation strategies are needed to assess their impact on the attendees in terms of perspectives on mental health, ability to implement improvement strategies, and service seeking. The Door to Hope Circle of Security classes, while appearing to be effective, were expensive ($50,000) for the number reached (n=32; average of eight per eight-week session course). The other programs had greater reach for the same amount or less money. It may be worth examining if the Circle of Security classes can be more cost efficient. The MCPHB programs are offered at schools and could be incorporated into the school budget. The cost is not prohibitive.

Cultural Responsiveness

The programs utilized a variety of methods to address cultural barriers, including language. The Mi Via, Mi Arte, Mi Alegria incorporated lived experiences of how Latinos overcame barriers and incorporated dialogue about mental health. The program included culturally rooted stories, poems, and music. The Door to Hope program explored what a person already knows or has experienced around positive relationships, so the organization was able to learn the different practices parents already use to process mental health challenges. For example, cultures and communities already have mental health ideas and rituals and now need spaces in their new communities in Monterey County to practice their native traditions that help them heal their mind and body. When people have resources in their communities that reflect who they are and where they come from, they are more willing to accept help and support when they need it.

> "…we learned that the Triqui community historically participates in 'sweat lodge' like

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> rituals when needing to heal their body and spirit. They also have leaders that guide a person through going back to painful memories or experiences that 'robbed' them of their positive spirit and process those negative experiences to bring their positive spirit back to them."
>
> – Circle of Security Program Administrator

The MCPHB programs were culturally relevant as they used a peer approach. The peers are of the same age, generational culture, school, and community. Being from the same school and community likely means that there are cultural similarities in terms of one or more of these factors: race, ethnicity, age, socio-economic status, and geography.

Focus Group Summary

The focus group participants shared ways in which the programs were tailored for the Hispanic population. This included having them in Spanish, speakers being from the region and Hispanic, the integration of Hispanic art and content (medicinal medicine, focus on women as they typically make health decisions for the family, use of peer educations, Hispanic communication channels, using a self-exploration approach).

Successes included the willingness of participants to share their thoughts and feelings, high participation, educating participants on how to access resources, and sharing resources that are available in the county. In addition, getting information to the public about mental health and its importance was of value.

A challenge was tracking referrals. Participants did not want to share this information, and some may have sought a referral after the activity. Also, getting school staff to participate was difficult due to staffing shortages and workloads.

Recommendations

Our recommendations encompass aspects such as tracking referrals, further evaluation of promising practices, examining the quality of the Behavioral Health referral number, and refining the school referral process. While MCBH may not have the capacity to implement all these changes, it's hoped that they can guide the relevant stakeholders.

<u>Tracking Referrals</u>

- ***Challenges.*** Tracking referrals was found challenging due to factors like shame, fear, embarrassment, and stigma. There are instances where participants either self-managed their mental health post-program or may seek services at a later stage – both scenarios making tracking difficult.
- ***Anonymity Concerns.*** Door to Hope emphasized that youth were hesitant to share information about accessing behavioral health services due to concerns about confidentiality. This mirrors concerns raised when staff made referrals to Family Pact clinics. Given these confidentiality

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worries, we recommend emphasizing education on privacy rights concerning behavioral health services.
- ***Recommendation.*** Referrals may not be the most reliable metric for evaluating program impacts due to tracking complexities. Alternative metrics should be considered.

Promising Practices

- Several programs including Mi Via, Mi Arte, Mi Alegria, Door to Hope Circle of Security, and Postpone and Mind Matters show promise. However, the limited data prevents a conclusive impact assessment. Future evaluations of these programs are recommended. Specifically, the Circle of Security program should undergo a cost analysis for its eight-week course.

Behavioral Health Referral Number

- ***Service Quality.*** Some youths reported hearing about "bad service" experiences from peers when calling the behavioral health referral number. This was partly attributed to students being asked for identifying details over the phone. However, others found the service helpful, though the timelines remain unclear.
- ***Communication Clarity.*** Confusion arose regarding the referral and intake process. Students were uncertain about follow-up procedures.
- ***Comfort Level.*** Peer educators from the Postpone program observed that students felt more at ease seeking on-campus services than calling a behavioral health clinic. The unfamiliarity of who might answer caused apprehension.
- ***Recommendation.*** A more immediate referral method, possibly a text-based system dedicated to teens, might prove more effective. While national and state crisis text lines exist, a local non-crisis text option is suggested.

School Referral Process

- ***Varying Procedures.*** Students noted inconsistencies in procedures across schools when trying to access behavioral health or counseling services. Additional concerns were raised about unnecessary barriers, like mandatory counselor meetings before accessing other services.
- ***Recommendation.*** A clearer outline and communication of the role of school guidance counselors and their referral process to behavioral health is essential. Also, addressing concerns such as the complexity of intake forms will enhance the process for students.

Program's Future and Dissemination of Results

MCBH will not be continuing to fund the projects, but some of them have created an infrastructure to be self-supporting. The reason for this decision is that none of the projects showed the ability to increase referrals to mental health services in the Hispanic community.

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Summary

Micro-Inn intended to lead to referrals to mental health services among the Latino population. For the most part, the evaluation did not have ability to assess if referrals occurred from the available data, yet insights to lessons learned and recommendations were gained. The programs reached a large number of people and a couple of potential promising programs were identified.

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MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

PSYCHIATRIC ADVANCE DIRECTIVES MULTI-COUNTY COLLABORATIVE INNOVATIONS REPORT FY 2022-2023

Prepared by:

EVALCORP

Measuring What Matters℠

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Introduction

This is the second Annual Innovation Project Report for the Monterey County component of the Multi-County Psychiatric Advance Directives (PADs) Innovation Project. On June 24, 2021, the Mental Health Services Oversight and Accountability Commissions (MHSOAC) approved the use of Mental Health Services Act Innovation Component funding for Monterey County Behavioral Health (MCBH) and four other counties to implement the PADs Innovation Project (two additional entities have since joined the project, Contra Costa County and Tri-City Mental Health Authority). This report pertains to activities that took place during FY 2022-2023.

In accordance with Title 9 California Code of Regulations (9 CCR § 3580.010), a report is to be submitted to the MHSOAC each year. This report has been developed to provide the MHSOAC and Monterey County stakeholders with a status update on this project. Per Title 9 California Code of Regulations (9 CCR § 3580.010), the contents of this Annual Innovation Report shall include updates on the following:

- 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 the number of participants and demographics of participants served.
- Any other data the County considers relevant.

Project Overview

The PADs Innovation Project is a multi-county collaboration that aims to improve the quality of mental health services by altering an existing practice in the mental health field. Specifically, the PADs Innovation Project is partnering with stakeholders, advocacy groups, peers, and others to develop training resources and a "toolkit" in multiple languages, a standardized Psychiatric Advance Directive (PAD) template, a PAD accessibility platform, and recommendations for statewide PAD legislation, policy, and procedures. Counties have identified priority populations to utilize PADS and are working towards implementation.

The Problem

Californians with mental illness face high recidivism rates, non-voluntary hospitalization, homelessness, and incarceration. In psychiatric emergencies, it may be challenging or impossible to engage with individuals in even the most basic conversations about symptoms, diagnosis, treatment, and care preferences. Psychiatric Advance Directives (PADs) are legal tools that may be used in these instances to ensure a person's preferences are honored and increase the quality of care within mental and physical health and justice-involved settings. A PAD allows a person in a mental health crisis to legally retain their decision-making capacity by choosing supporters to help advocate for their choices. PADs are legal documents in which a

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supporter is identified and entrusted with upholding the decisions and directions in the event the individual experiences a mental health crisis.

Despite the federal Center for Medicare and Medicaid Services recommendation that PADs be used as part of psychiatric care, California does not currently have a specific statute encouraging or recognizing PADs. There is no standardized PAD template, and PADs are often written with a focus on physical rather than mental health. Moreover, inconsistencies make the process confusing for consumers and pose challenges to compliance for providers.

The Solution

Since the 1990s, PADs have been implemented to various extents throughout the US and worldwide. This tool has been shown to improve outcomes, treatment satisfaction, and recidivism rates while also boosting community collaboration, increasing trust in mental health care services, and providing consumers with greater self-determination. However, PADs remain underutilized, and there are barriers to widespread adoption, including a general lack of awareness, perceptions of the process as cumbersome, skepticism that a PAD will be honored, and the absence of a central portal for PADs storage, access, and retrieval.

The PADs Innovation Project is a multi-county collaboration that expands a prior PADs project to address unmet needs across California. The project seeks to foster community collaboration, develop standardized training and templates, facilitate the creation and utilization of PADs, and lay the groundwork for legislative changes.

Project Goals

This multi-county collaborative project aims to establish the infrastructure for sustainable PADs usage in California. Project goals are described below:

- Engage the community, consumers, peers, families, consumer advocacy groups, law enforcement (LE), emergency departments, inpatient units, and the judicial system.
- Develop community-wide standardized training for understanding, accessing, recognizing, and implementing PADs within the Mental Health Plan, crisis centers, hospitals, LE, homeless services, and transitional-aged youth (TAY) services.
- Create a standardized PAD template.
- Train clinicians, community providers, peers, and others; and create standardized training for future use.
- Draft and advocate for legislation enabling PAD use, accessibility, adherence, and sustainability.
- Create a statewide PADs Technology Platform.
- Evaluate the impact of PADs on consumer outcomes.

Monterey County also identified project goals specific to the County's needs:

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- Increase consumers' individual wellness through the use of PADs.
- Reduce incarceration/criminal justice involvement resulting from a crisis.
- Reduce long-term hospitalization rates by increasing adherence to treatment plans.
- Reduce recidivism among clients by minimizing gaps in care.
- Reduce high utilization of services.
- Increase coordination of resources (e.g., warm hand-offs, clear communication).

Resources

The PADs Innovation Project plan indicates the following personnel will be used to execute the project in Monterey County:

Job Title	Responsibilities
Program Coordinator	Project coordination, PADs product development review, and project evaluation and reporting
Clinical Therapist	PADs Team implementation
Administrative Management Intern	Administrative support, evaluation, and reporting
Behavioral Health Bureau Administrator	Implementation planning, vendor procurement, and PADs project development review
Behavioral Health Services Manager	Implementation planning, clinical staff oversight, PAD product development review
Quality Improvement Services Manager	Implementation planning, technology integration coordination, and evaluation
IT Services Manager	Technology integration planning and oversight, and PAD product development review
Behavioral Health Unit Supervisor	Implementation planning, clinical staff coordination, and PAD product development review
Accountant	Fiscal accounting and reporting
Epidemiologist	Project evaluation

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Timeline

The PADs Innovation Project is planned to span four years, in accordance with the Title 9 California Code of Regulations (9 CCR § 3910.010). The original timeline for key phases is described below.

Year One	Year Two
Concepts Forward Consulting · Organize all counties' efforts · Identify Scope of Work tasks for all contractors to complete within year one · Interface with counties and contractors · Conduct and participate in all Stakeholder meetings · Mitigate challenges · Create Scope of Work, Performance Agreements and financial oversight as needed · Assist counties with decision making · Report out to counties, state, and stakeholders as needed	**Concepts Forward Consulting** · Organize all counties' efforts · Identify Scope of Work tasks for all contractors to complete within year two · Interface with counties and contractors · Conduct and participate in all Stakeholder meetings · Mitigate challenges · Enforce all scope of work and performance agreements. · Assist counties with decision making · Report out to counties, state, and stakeholders as needed
Laurie Hallmark (Hallmark Compass)[1] · Participate in statewide meetings · Lead the discussion to create a PAD template · Participate in discussion for "Informational Training Videos" · Assist in identifying PADs Teams · Present Statewide informational sessions · Present county-specific informational sessions · Assist in legislation advocacy · Training on how to obtain PADs clients · Participate in training material creation (Train the Trainer) · Assist with standardized training materials · Participate in data integration discussion	**Laurie Hallmark (Hallmark Compass)[1]** · Participate in statewide meetings · Lead the training of PAD Teams · Lead Train the Trainer for Peers/PADs Implementation · Continue county-specific informational sessions · Micro-train county-specific providers (peers, clinicians, contractors) to provide PADs · Assist in legislation advocacy · Provide 1:1 technical support to counties · Assist with data integration discussion

[1] Laurie Hallmark of Hallmark Compass resigned from the project in September 2022. Their work is instead divided among Painted Brain, CAMPHRO, and Concepts Forward Consulting. See the New Contractors and Collaborations section on page 9.

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Idea Engineering · Participate in statewide meetings · Assist with PADs Identity & Guidelines · Create Introductory Videos · Create Training Videos · Create Form Design	**Idea Engineering** · Participate in statewide meetings · Finalize Communications Package · Create PADs Identification Materials for consumers · Provide county-specific technical support
RAND · Participate in stakeholder meetings · Participate in statewide meetings · Provide 1:1 technical support to counties for evaluation priorities	**RAND** · Participate in stakeholder meetings · Participate in statewide meetings · Conduct focus groups with county implementors and Train the Trainer/Peers · Create an interim report · Provide technical support
Technology Platform · Engage in technology conversations and planning · Lead robust Stakeholder meetings · Identify interoperability, access needs · Identify what the platform backend, front end, and user interface will be · Provide additional information to all counties as requested	**Technology Platform** · Begin to build the PADs Platform · Identify PADs template and video upload needs

Year Three	Year Four
Concepts Forward Consulting · Organize all counties' efforts · Identify Scope of Work tasks for all contractors to complete within year three · Interface with counties and contractors · Conduct and participate in all Stakeholder meetings · Mitigate challenges · Assist counties with decision making · Report out to counties, state, and stakeholders as needed · Lead legislative efforts, working with interested agencies and community groups	**Concepts Forward Consulting** · Organize all counties' efforts · Identify Scope of Work tasks for all contractors to complete within year four · Interface with counties and contractors · Conduct and participate in all Stakeholder · meetings · Mitigate challenges · Assist counties with decision making · Report out to counties, state, and stakeholders as needed · Follow legislative efforts · Write Phase Two Innovations PADs Statewide Cloud-based Data project

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Laurie Hallmark (Hallmark Compass) [1] · Participate in statewide meetings · Provide 1:1 technical Support to counties · Assist in legislation advocacy	**Laurie Hallmark (Hallmark Compass)** [1] · Participate in statewide meetings · Provide 1:1 technical Support to counties · Participate in the final report development and statewide presentations
Idea Engineering · Provide county-specific technical support	**Idea Engineering** · Provide county-specific technical support · Create a Project Documentary video · Participate in the final report development and statewide presentations
RAND · Conduct focus group(s) with consumers · Conduct survey(s) to assess consumer experience · Aggregate data · Conduct analysis · Provide technical support · Participate in statewide meetings	**RAND** · Aggregate final data · Conduct final analysis · Provide final evaluation report · Participate in the final report development and statewide presentations
Technology Platform · Upload all templates and videos · Meet with consumer groups to discuss access and consent needs and parameters · Test Beta platform examples · Upload PADs on a pilot basis (Quarter 4)	**Technology Platform** · Continue to upload PADs on a pilot basis · Identify ongoing needs to complete statewide access · Pilot QR Code and webpage portal · Seek and/or obtain licensing fees/funding for sustainability

Budget

The PADs Innovation Project has a total approved budget of $16,515,147.00, with $1,978,237.00 approved in Monterey County specifically. The local county budget was allocated as follows:

Budget Category	Year 1	Year 2	Year 3	Year 4	*Total*
Personnel Salaries	$115,827	$119,302	$122,881	$126,568	*$484,578*
Direct Costs	$371,563	$357,706	$353,857	$353,427	*$1,436,552*
Indirect Costs	$12,455	$12,829	$13,214	$13610	*$52,107*
Equipment	$5,000				*$5,000*
Total	***$504,845***	***$489,837***	***$489,952***	***$493,605***	***$1,978,237***

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Project Updates in FY 2022-2023

The PADs Innovation Project made considerable progress across many goals this fiscal year. Described below are activities relative to new contractors and collaborations, marketing and branding, the PAD technology platform, and meetings and communication. Curriculum development, facilitator training, and legislative efforts are set to occur in FY 2023-2024.

New Contractors and Collaborations

Early in the fiscal year, it became apparent that The Hallmark Compass was not the right fit for the parameters of the Innovation project, and the subcontractor chose to resign. On September 1, 2022, an RFP was posted to identify a contract for a Peer SME to provide the statewide "Peer voice." Painted Brain and their subcontractor, CAMHPRO, were awarded the contract on October 14, 2022.

To meet the ethnic and cultural diversity requirement, the counties and subcontractors identified the need for ongoing translation and interpretative services that would fall outside of the scope of work and funding allocated by the counties. The project repurposed funding remaining from FY 2021-2022 to hire Alpha Omega to create multi-lingual documents, provide interpretation, and take part in interviews throughout the project. Alpha Omega ensures the ability to address the multiple threshold languages identified within the participating counties through professional translation services.

Marketing and Branding

In September 2023, the new project website, www.PADSca.org, was launched to provide the public with ongoing information on the project. In addition, Idea Engineering worked with the marketing workgroup, counties, and community members to create a PAD logo. This logo has been added to all print material and the public-facing website, providing a recognizable symbol for PADs.

PAD Technology Platform

In FY 2022-2023, much of the project was focused on building the PAD technology platform. Painted Brain and CAMPHRO completed a series of listening sessions, ongoing workshops, and cross-contractor collaborations to review the PADs template and provide guidance on important components. Workgroups were created with specific audiences in mind, including peers, family members and caregivers, and first responders and professionals. MCBH made continuous efforts to encourage the participation of these various audiences by outreaching to local providers and resource groups, such as Interim and NAMI, as well as to local hospitals and law enforcement agencies. Insights gained from these workgroups and workshops were submitted to Chorus Innovations for integration into the platform build. Chorus completed a mock design to show how the PAD could look in the digital format.

In addition to building the PAD technology platform, the flow of use and Terms of Services need to be developed. A county workgroup was created to identify appropriate language for these

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components. Monterey County participants include the core project team, County Counsel, Compliance Officer, and a Patient Services Representative. Meetings begin in FY 2023-2024.

Meetings and Communication

Frequent and ongoing meetings continued at multiple levels. Monthly participatory and community-centered stakeholder workgroups, continued throughout FY 2022-2023. Counties also met monthly, with bi-monthly workgroup for all participants, a monthly subcontractor meeting, and several meetings that included the collaboration between subcontractors, meetings with stakeholders, and one-on-one calls with the counties.

Throughout the project, the importance of in-person discussions, learning, and planning has been executed through bi-annual convenings. In FY 2022-2023, two in-person convenings were held. Fresno County hosted in August and Monterey County hosted in March. Both convenings were showcased on the project website, www.padsCA.org.

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Evaluation

RAND and the Burton Blatt Institute began work as the multi-site evaluators for this project. Monterey County continued working with Evalcorp to support county-specific evaluation needs. Evaluation activities for FY 2022-2023 are described next.

RAND

RAND developed and finalized an evaluation protocol and workflow for the Peer Specialists' training. This evaluation will use a two-level approach to assess Peer Specialists' knowledge, attitudes, and perceptions regarding the PADs, and obtain feedback on training satisfaction and acceptability:

- Level 1: Embedded in the PAD platform will be a mini-survey that collects demographic and satisfaction information. Then, the Peer Specialist can elect to be contacted in the future for participation at Level 2.
- Level 2: RAND will reach out to interested Peer Specialists to participate in a longer survey or a focus group.

The mini-survey has been developed and plans to be implemented in 2024, followed by a focus group(s) or lengthier survey with Peer Specialists that self-selected in to this option.

RAND also plans to collect quantitative data on PADs completion, and conduct focus groups with County implementors to assess barriers, facilitators, and lessons learned.

Burton Blatt Institute (BBI)

BBI is focused on the evaluation of the PADs web-based platform. They plan on taking a qualitative research approach to examine the overall organization and implementation of the PADs project, and the process of developing the PADs template, its content, and PADs branding and marketing. In FY 2022-2023, BBI:

- Conducted a comprehensive literature review to inform the evaluation
- Developed an evaluation plan
- Observed PADs project on-site, semi-annual, all-county, county-specific subcontractor, and workgroup meetings (in-person and virtually)
- Conducted a series of semi-structured interviews with county staff and community partners to gather perceptions on the web platform

Monterey County

Monterey County Behavioral Health staff developed a plan to collect important county-specific evaluation metrics. The county will try to work with NetSmart, the provider of the Avatar electronic health record system used in Monterey County, to include a field to signify that a client has completed a PAD. This will allow the county to pull information on clients with a PAD in the future (e.g., Reaching Recovery level, service utilization). Additional local evaluation strategies and tools are under development in collaboration with Evalcorp, to be deployed in 2024.

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MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

RESIDENTIAL CARE FACILITY INCUBATOR INNOVATIONS REPORT FY2022-2023

Prepared by:

EVALCORP

Measuring What Matters℠

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Introduction

This is the Second Annual Innovation Project Report for the Monterey County Innovation Project titled "Residential Care Facility Incubator" (RCFI). On November 1, 2021, the Mental Health Services Oversight and Accountability Commissions (MHSOAC) approved the use of Mental Health Services Act Innovation Component funding for Monterey County Behavioral Health (MCBH) to implement RCFI. This report pertains to activities that took place during FY 2022/2023.

Project Overview

The RCFI project aims to promote interagency and community collaboration regarding mental health services and supports by changing an existing practice in the field. Specifically, the RCFI project will increase the availability of residential care facilities for adults experiencing serious mental illness (SMI) in Monterey County and support those facilities in becoming culturally and linguistically responsive. To do this, MCBH will both seek out existing facility operators and engage new property owners that are interested in providing more culturally and linguistically responsive services. Across two phases, the project will develop and deliver the training and support needed to equip property owners to execute and maintain such services successfully.

The Problem

The RCFI project was developed in response to community and consumer feedback citing a need for (a) programming that embraces individuals' cultures and experiences, (b) expanded access and quality care in local communities, especially for homeless adults experiencing SMI, and (c) systems-level change to address the housing crisis. In addition to this feedback from community members, an internal review of local resources showed insufficient beds for adults with SMI and a lack of culturally and linguistically responsive residential care services.

In recent years, at least three residential care facilities in Monterey County have closed, resulting in a loss of over 50 beds for adults experiencing SMI. When individuals experiencing SMI are released from higher levels of care but do not have suitable housing, this often leads to another mental health crisis and a return to high-level care, institutionalization, or homelessness. Common barriers to opening and maintaining adult residential care facilities include insufficient finances, lack of community buy-in, and staffing challenges.

In addition, an internal review of residential care facilities for adults experiencing SMI in Monterey County determined that these programs were not designed to respond to their residents' cultural and linguistic needs. For example, while Latinos make up 78% of Medi-Cal beneficiaries, no residential care facilities provide services embracing common Latino cultural traditions. MCBH managers estimate that an additional 150 Adults System of Care consumers would benefit from culturally and linguistically responsive residential care facilities.

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To address these issues, some counties have implemented programs that assist consumers in transitioning to a lower level of care or have directly addressed the problem of linking consumers to appropriate housing. However, no programs in California appear to have implemented culturally and linguistically relevant residential care facilities for adults experiencing SMI, and there is no readily available information on how to do so.

The Solution

To increase the availability of culturally and linguistically responsive residential care facilities for adults experiencing SMI, the RCFI project will repurpose residential and commercial properties to support residential care clients and rejuvenate existing facilities that are struggling to operate. The project has two phases:

> *Phase I: Research & Planning* – Identify and develop the necessary training and supports to equip property owners to operate residential care facilities that are culturally and linguistically responsive to the needs of the local SMI population.
>
> *Phase II: Implementation* – Educate property owners on how to integrate more culturally and linguistically responsive services into their facility. Provide property owners with training and technical assistance related to operating a small business.

Learning Goals

The RCFI project aims to establish culturally and linguistically responsive housing options for adults experiencing SMI in Monterey County. The current funding is for Phase I of the project; Phase I focuses on researching (a) the challenges facing residential care facility operators, and (b) the challenges facing individuals from particular cultural groups who are experiencing SMI. Results from this phase will inform materials and infrastructure to train and support property owners in operating successful culturally and linguistically responsive facilities (in Phase II). Learning goals for Phase I are described below.

1. Describe the attributes of and specific needs for culturally and linguistically responsive residential care facilities that serve the SMI population.

2. Ascertain barriers that prevent residential care facilities from being developed and remaining sustainable.

3. Determine the supports necessary to assist property owners who are already integrated into the community and are interested in turning their property into a residential care facility.

4. Outline the support needed to ensure residential care facilities are financially sustainable for property owners.

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5. Identify what materials and technical assistance will be required to support implementation in Phase II.

Resources

The RCFI project plan indicates the following personnel will be used to execute Phase I of the project (see section "Project Updates and Changes in FY2022/23" for updates on current resources):

Job Title	Responsibilities
Management Analyst II	Function as Innovation Coordinator to provide/support project management, service coordination, communications and outreach, vendor procurement, evaluation, and reporting activities.
Public Health Epidemiologist I	Participate and collaborate with vendor(s) and stakeholders in Phase I to develop an evaluation plan for Phase II implementation.
Behavioral Health Services Manager II	Monitor and approve vendor deliverables and provide technical assistance on service coordination and other matters as needed.
Behavioral Health Aide	Function as peer specialists to ensure Phase I and Phase II activities will be culturally competent and consumer-driven.
Consultant(s)	Provide subject matter expertise in residential care facility certification and management, supportive housing services, cultural and linguistic competency, marketing, and communications. Research and design a compelling and actionable Phase II implementation plan.

Timeline

The complete timeline for this project will not exceed five years, as required by Title 9 California Code of Regulations (9 CCR § 3910.010). Phase I will occur over a period of 2 years:

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- *3-6 Months*: Acquire the necessary consultant(s) and/or vendor(s) through a Request for Proposal (RFP) process.

- *12-18 Months*: Consultant(s) and/or vendor(s) will evaluate opportunities and barriers for implementation and create an actionable implementation plan (i.e., Phase II plan) for incubating cultural and linguistically responsive residential care facilities to mitigate housing instability concerns among the SMI population and positively impact mental health outcomes. Activities to be performed will generally include:

    - Identifying cultural/linguistic needs of the population of focus and identifying/informing corresponding tools and training for residential care facility providers to adequately respond to cultural/linguistic needs of the population of focus that may improve retention and outcomes

    - Investigating known and currently unknown challenges experienced by residential care facility operators in Monterey County and California that negatively impact their sustainability, and identifying solutions via technical assistance, training and/or policy change

    - Identifying and recruiting interested property owners

    - Planning with MCBH to establish a strategy for providing client placements and care coordination

Budget

Phase I of the RCFI project has a total approved budget of $792,130, allocated as follows:

Budget Category	**Year 1**	**Year 2**	***Total***
Personnel Salaries	$193,078	$193,078	*$386,155*
Direct Costs	$171,921	$171,921	*$343,842*
Indirect Costs	$31,066	$31,066	*$62,133*
Total	***$396,065***	***$696,065***	***$792,130***

Project Updates and Changes in FY 2022/23

After a delay in releasing the Request for Proposal (RFP) due to limited staff capacity within MCBH and the Monterey County Purchasing Department during FY 2021/22, RFP #10889 was

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released on February 2, 2023 (Appendix A). In December 2022, a no-cost extension of 18 months was awarded, extending funding through May 1, 2025 (Appendix B).

Housing Tools was selected, and their contract initiated on May 1, 2023. The remainder of FY 2022/23 focused on Project Setup, including:

- Facilitating a Kick-off Meeting with County staff to set scope of work, schedule, assignments, and coordination.
- Initiating the development of a Community Engagement Plan, including community stakeholders list and outreach strategies, and plans to involve existing residential care facility operators and local groups advocating for underrepresented populations.

There have also been changes to the Resources that will be utilized during Phase I. There will no longer be involvement of a Public Health Epidemiologist I or a Behavioral Health Aide. The project will now have support from a Management Analyst III, Deputy Director of Behavioral Health, and Assistant Bureau Chief.

Job Title	Responsibilities
Assistant Bureau Chief	Provide guidance and technical assistance on service coordination and other matters as needed.
Deputy Director of Behavioral Health	Monitor and approve vendor deliverables and provide technical assistance on service coordination and other matters as needed.
Management Analyst III	Function as MHSA Coordinator to provide/support project management, evaluation, and reporting activities.
Management Analyst II	Function as Innovation Coordinator to provide/support project management, service coordination, communications and outreach, vendor procurement, evaluation, and reporting activities.
Consultant(s)	Provide subject matter expertise in residential care facility certification and management, supportive housing services, cultural and linguistic competency, marketing, and communications. Research and design a compelling and actionable Phase II implementation plan.

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Evaluation Data

No individuals were engaged in this project, and no activities were conducted during FY 2022/23. Therefore, no evaluation data is available for this period.

Future evaluation data may examine:

- Specific needs of individuals experiencing SMI in Monterey County.
- The efficacy of the proposed model of culturally and linguistically responsive residential care facilities.
- The number and characteristics of property owners interested in participating in the project, and their identified needs.
- Consumers' experience and satisfaction as it relates to cultural and linguistic responsiveness of facilities
- Consumer improvement as identified by the number of homeless days, incarceration rates, emergency room visits, symptom management, substance use, interest in education, and other indicators.

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Appendix A – Request for Proposal

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COUNTY OF MONTEREY
CONTRACTS/PURCHASING DIVISION
1488 SCHILLING PLACE
SALINAS, CA 93901
(831) 755-4990

REQUEST FOR PROPOSALS #10889

For
Residential Care Facility Incubator Innovation Project for the County of Monterey

Proposals are due by 3:00 pm (PST) on March 6, 2023

Prepared by Angelica Ruelas
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SOLICITATION DETAILS SECTION

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1.0 INTENT

1.1 The County of Monterey Health Department – Behavioral Health Bureau, hereinafter referred to as "County", is soliciting proposals from qualified organizations, hereinafter referred to as "CONTRACTOR", to provide research, evaluation and program planning services for the creations and/or sustainability of residential care facilities supporting seriously mentally ill populations.

1.2 This solicitation is not intended to create an exclusive service AGREEMENT. Multiple agreement awards may be made as the discretion of the County. County retains the ability, at its sole discretion, to add qualified CONTRACTORS at any time.

2.0 BACKGROUND

2.1 The County of Monterey is located on the Central Coast of California, approximately 120 miles south of San Francisco. The County is approximately 3,350 square miles. There are approximately 75 locations throughout Monterey County at which services may be required. Locations include but are not limited to Pajaro, Castroville, Royal Oaks, Salinas, Monterey, Carmel Valley, Marina, Seaside, Prunedale, Aromas, Soledad, King City, and as far South as the San Luis Obispo County border.

2.2 Monterey County Behavioral Health Bureau (MCBH) has been awarded funding through the California Mental Health Services Act (MHSA) Innovations component to support the development of an implementation plan to foster the creation and/or sustainability of culturally and linguistically responsive residential care facilities for the unhoused severely mentally ill population within Monterey County. Under the MHSA Innovations component, California counties are encouraged to pilot novel projects capable of improving local mental health systems. The Innovation Project Plan that was awarded funding to support this RFP opportunity seeks to increase interagency collaboration to deliver improved mental health outcomes for adults experiencing serious mental illness (SMI) who are homeless or at-risk of homelessness.

2.3 In Monterey County, as with most of California counties, there is declining number of residential care facilities for adults experiencing serious mental illness (SMI), including Board and Care Homes (B&Cs) and Adult Residential Facilities (ARFs). This dwindling stock of supportive housing options for adults with SMI presents a significant challenge and burden on both the client and system as inadequate housing options for people experiencing SMI is linked to a "revolving door scenario" where individuals are released from higher levels of care, but then are unable to find suitable residential care or housing. This often leads to another mental health crisis and a return to high-level crisis programs, facilities, hospitals, jails/prisons, or homelessness. In recent years, 3 B&Cs in Monterey County have closed, resulting in the loss of over 50 beds for adults with SMI. There remains 13 B&Cs in Monterey County to offer a combined 169 total beds for adults experiencing SMI, which is insufficiently low for meeting the needs in the community.

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The MCBH Adults System of Care (ASOC), which delivers a spectrum of intensive wrap-around care services to adult SMI populations across Monterey County, currently has an estimated 100 clients under its care who are homeless and additional 50 clients housed in challenging situations who may be interested in and benefit from additional housing resources.

2.4 In addition to the need for supporting new and existing residential care facilities, during the community planning process to establish the approved Innovation Project Plan, MCBH community stakeholders also expressed an interest and desire to support residential care facilities that are culturally and linguistically responsive to the needs of Monterey County residents. MCBH stakeholders believed that placing an emphasis on the enhancement of cultural and linguistic responsiveness in residential care facilities will improve the consumer's experience and therefore lead to improved recovery outcomes. Additionally, property owners may be more inclined to open or continue operating a residential care facility for the SMI population if they are encouraged to embrace their cultural and linguistic identity when doing so, in addition to being offered logistical aids and supports via MCBH. Populations that may benefit from culturally and linguistically responsive residential care facilities include various racial and ethnic groups, gender specific groups, LGBTQ groups, transition age youth 18 -25, older adults, and adults with physical disabilities. Notably, while Latinos make up 78% of Medi-Cal beneficiaries, 59.4% of the overall population and 37% of the homeless population in Monterey County, there are no Latino owned and operated residential care facilities, or ones that provide services that embrace common Latino cultural traditions. This represents a major gap in the current viable housing options for Latino adults experiencing SMI.

2.5 To achieve the goal of supporting new and existing residential care facilities in Monterey County, and support their ability to be culturally and linguistically responsive to the diverse community members in need, MCBH proposed a two-phased project that will seek out motivated residential care facility operators interested in providing more culturally and linguistically responsive services, as well as engage new property owners interested in establishing new culturally and linguistically responsive residential care facilities. As a result of this project, MCBH hopes to increase the availability of culturally and linguistically appropriate housing for the adult SMI population by repurposing residential and commercial properties to support residential care clients. In addition, existing residential care facilities that are struggling to operate and provide adequate services will be rejuvenated. The two-phases of this Innovation project are:

2.5.1 Phase I: Research and Planning – Contractor will research, evaluate and provide program planning services for the creation and/or sustainability of residential care facilities supporting seriously mentally ill populations. _ This will include identifying the training and supports needed to equip property owners to operate a licensed or unlicensed residential care facility that is culturally and linguistically responsive to the local SMI population will be identified and developed.

2.5.2 Phase II: Implementation – Consultants, including peer providers, will educate and train property owners about how to integrate more culturally and linguistically responsive services into their facility. Property owners will also

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receive training and technical assistance related to operating a small business. Once established, eligible MCBH ASOC consumers will be referred to these facilities while continuing to receive services through MCBH to achieve their Reaching Recovery® goals.

2.6 MCBH currently possesses approval for the use of Innovation funds for Phase I only. Phase I will include in-depth research to better understand the housing challenges facing people with SMI within specific cultural groups in our community, as well as the challenges facing residential care facility operators. Results from the Phase I research will be used to develop the infrastructure and materials to support participating property owners in operating successful culturally and linguistically responsive residential care facilities during the implementation in Phase II

3.0 CALENDAR OF EVENTS

3.1	Issue RFP	February 2, 2023
3.2	Deadline for Written Questions	3:00 p.m., PT, February 16, 2023
3.4	Proposal Submittal Deadline	3:00 p.m., PT, March 6, 2023
3.5	Notifications of Finalist	March 2023
3.6	Estimated Notification of Selection	March 2023
3.7	Estimated AGREEMENT Date	April 28, 2023

This schedule is subject to change as necessary.

3.8 **FUTURE ADDENDA:** CONTRACTORs, who received notification of this solicitation by means other than through a County of Monterey mailing shall contact the person designated in the COUNTY POINTS OF CONTACT herein to request to be added to the mailing list. Inclusion on the mailing list is the only way to ensure timely notification of any addenda and/or information that may be issued prior to the solicitation submittal date. **IT IS EACH CONTRACTOR'S SOLE RESPONSIBILITY TO ENSURE THAT THEY RECEIVE ANY AND ALL ADDENDA FOR THIS RFP** by either informing the County of their mailing information or by regularly checking the County's Solicitation Center web page at https://www.co.monterey.ca.us/government/departments-a-h/administrative-office/contracts-purchasing/solicitation-center. Addenda will be posted on the website the day they are released.

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4.0 COUNTY POINTS OF CONTACT

4.1 Questions and correspondence regarding this solicitation shall be directed to:

Primary Contact for the County

Angelica Ruelas
Deputy Purchasing Agent
1488 Schilling Place
Salinas, CA 93901
PHONE: (831) 796-3035
FAX: (831) 755-4969
Email: ruelasa@co.monterey.ca.us

4.2 All questions regarding this solicitation shall be submitted in writing (E-mail or FAX is acceptable). The questions will be researched, and the answers will be communicated to all known interested CONTRACTORs after the deadline for receipt of questions.

4.3 The deadline for submitting written questions regarding this solicitation is indicated in the **CALENDAR OF EVENTS herein**. Questions submitted after the deadline will not be answered.

4.4 Only answers to questions communicated by formal written addenda will be binding.

4.5 Prospective CONTRACTOR shall not contact County officers or employees with questions or suggestions regarding this solicitation except through the primary contact person listed above. **Any unauthorized contact may be considered undue pressure and cause for disqualification of CONTRACTOR.**

4.6 OPTIONAL - Because of COVID-19, the County of Monterey allows electronic submissions as follows :

4.6.1 County has joined Negometrix, an e-procurement platform, to enhance the safety of our bidders and staff. Please submit your bids electronically at the following link: https://app.negometrix.com/buyer/585/tenders

4.6.2 ***PLEASE NOTE***: To use this option, CONTRACTORs are required to set up a free account prior to uploading proposals. This will take a few moments; therefore, set up your account at least 24 hours in advance of the bid deadline.

5.0 SCOPE OF WORK

5.1 Contractor Minimum Work Performance Percentage: CONTRACTOR shall perform with its own organization contract work amounting to not less than 50 percent of the original total contract price. However, any designated "Specialty Items" may be performed by subcontract and the amount of any such "Specialty Items" so performed may be deducted from the original total AGREEMENT price before computing the amount of work required to be performed by CONTRACTOR with its organization.

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5.2 The Scope of Work includes, but is not limited to the following:

Monterey is seeking one or more qualified consultants to assist in the development of an implementation plan for incubating culturally and linguistically responsive residential care facilities for adults experiencing serious mental illness (SMI) in Monterey County who are currently homeless or at-risk of homelessness.

MCBH will utilize one or more consultants, including peer providers, with expertise in residential care facilities, cultural competency, and small business operations, to research, define and make recommendations on the following elements (with preliminary research questions included in the bullets):

5.2.1 Attributes of a culturally and linguistically responsive residential care facility for the target population

5.2.1.1 What are the staffing requirements (how many bilingual/bicultural staff, etc.)?

5.2.1.2 How can programming respond to specific cultural and linguistic needs of various populations?

5.2.1.3 What cultural and linguistic attributes are missing in existing facilities?

5.2.1.4 What information is available through the California Reducing Disparities Project (CRDP) that may help identify these attributes?

5.3.1 Policies, protocols, and trainings for providing culturally and linguistically responsive residential care facility services to people with SMI in specific population groups.

5.3.1.1 What evidence-based approaches, including those identified by the CRDP or other studies, can be used to respond to the cultural and linguistic needs of specific population groups including Latinos, African Americans, Asian Americans, LGTBQ, Veterans, formerly institutionalized, formerly incarcerated, etc.?

5.4.1 Marketing and recruitment strategy to enroll qualifying property owners.

5.4.1.1 What is the current housing inventory for individuals with SMI relying on SSI?

5.4.1.2 Are there enough interested and willing property owners in Monterey County to enroll in this project and offer a residential care service, to warrant the pursuit of Innovation funds for Phase II?

5.4.1.2.1 Where are these properties located?

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5.4.1.2.2 Why are owners interested? What is their cultural background and capacity?

5.4.1.2.3 What incentives are available to create interest? How will this be communicated?

5.4.1.2.4 How can MCBH advertise and reach interested property owners?

5.5.1 Establishing and/or operating a licensed or unlicensed residential care facility manual.

5.5.1.1 What are the requirements, barriers, and solutions to the barriers for implementation, including:

5.5.1.1.1 Planning and building ordinances

5.5.1.1.2 Health and human safety

5.5.1.1.3 Security

5.5.1.1.4 Disability rights

5.5.1.1.5 Licensure requirements

5.5.1.1.6 Insurance requirements

5.5.1.1.7 Personnel management

5.5.1.1.8 Supply and logistics

5.5.1.1.9 Provision of care

5.5.1.1.10 Financial (both start-up and ongoing)

5.5.1.1.11 Addressing potential “not in my backyard” issues from neighbors

5.6.1 Policies, protocols and trainings relevant to operating a residential care facility and promoting interagency collaboration in the provision of referrals and services.

5.6.1.1 What supports are needed related to the consumer’s ability to pay or otherwise support the property owner to receive reimbursement for the provision of services?

5.6.1.1.1 How will clients know where and how to access SSI?

5.6.1.1.2 How will property owners be reimbursed or receive payment?

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5.6.1.2 What are the eligibility criteria for consumers and what is the referral process?

5.6.1.2.1 How can the process ensure consumers are matched to an appropriate residential care facility?

5.7 The completion of the above research and analysis will determine if and how implementation will be feasible, community-informed, and efficient.

5.8 Engagement and inclusion of community stakeholders in investigating and making recommendations on the above elements will be required.

6.0 CONTRACT TERM

6.1 The term of the AGREEMENT(s) will be for a period of 18 months.

6.2 If the AGREEMENT includes options for renewal or extension, CONTRACTOR must commence negotiations for any desired rate changes a minimum of 90 days prior to the expiration of the AGREEMENT.

6.2.1 Both parties must agree upon rate extension(s) or changes in writing.

6.3 The AGREEMENT shall contain a clause that provides that County reserves the right to cancel the AGREEMENT, or any extension of the AGREEMENT, without cause, with a 30-day written notice, or immediately with cause.

7.0 LICENSING/SECURITY REQUIREMENTS

7.1 CONTRACTOR shall ensure that all services, costs, and materials must, at minimum, meet the specifications for State of California and CAL/OSHA regulations, as applicable.

7.2 CONTRACTOR is to ensure that insurance and required licenses under both state and local jurisdictions are current during the full term of the AGREEMENT.

7.2.1 You may reference our Insurance Requirements for additional clarification and samples of required endorsements.

7.3 CONTRACTOR will be required to submit appropriate State level criminal background clearance(s) for all personnel required to work within County facilities that are deemed restricted or high security (if applicable).

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7.3.1 CONTRACTOR shall ensure that a California licensed investigator performed the required State level criminal background check(s) for all staff recommended to the County and must provide proof of such to County prior to the personnel being allowed to work within such County facilities. CONTRACTOR shall be responsible for the cost of these background checks unless otherwise agreed upon in writing by County.

7.3.2 A California licensed Investigator must perform the required State level criminal background check(s), which must then be submitted to the County prior to the personnel being allowed to work within such County facilities.

8.0 PROPOSAL PACKAGE REQUIREMENTS

8.1 CONTENT AND LAYOUT:

8.1.1 CONTRACTOR should provide the information as requested and as applicable to the proposed goods and services. The proposal package shall be organized as per the table below; headings and section numbering utilized in the proposal package shall be the same as those identified in the table. Proposal packages shall include, at a minimum, but not be limited to, the following information in the format indicated:

Proposal Package Layout; Organize and Number Sections as Follows:	
Section 1	COVER LETTER (INCLUDING CONTACT INFO)
	SIGNATURE PAGE
	RECEIPT OF SIGNED ADDENDA (IF ANY)
	TABLE OF CONTENTS
Section 2	PROPOSED APPROACH FOR PERFORMING THE SERVICES DESCRIBED IN SECTION 5.0 SCOPE OF WORK
Section 3	PRE-QUALIFICATIONS / LICENSING REQUIREMENTS
Section 4	PROJECT EXPERIENCE AND REFERENCES (**Attachment A**)
Section 5	PRICING (**Attachment B**)
Section 6	EXCEPTIONS
Section 7	APPENDIX

Section 1, Requirements:

Cover Letter: All proposals must be accompanied by a cover letter not exceeding two pages that provides the CONTRACTOR'S firm information and contact information as follows:

Contact Info: The name, address, telephone number, and fax number of CONTRACTOR'S primary contact person during the solicitation process through to potential contract award.

Firm Info: Description of the type of organization (e.g. corporation, partnership, including joint venture teams and subcontractors) and its age.

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Signed Signature Page and Signed Addenda (if any addenda were released for this solicitation). Any proposal packages submitted without this page will be deemed non-responsive. All signatures must be manual and in BLUE ink. All prices and notations must be typed or written in BLUE ink. Errors may be crossed out and corrections printed in ink or typed adjacent, and must be initialed in BLUE ink by the person signing the proposal.

Table of Contents

Section 2, Proposed Approach for Performing the Services Described in Section 5.0 Scope of Services:

2.1 CONTRACTOR shall provide detailed description of prior outcomes and successes with similar implementations including:

2.1.1 Examples or demonstrated experience in familiarity with residential care facilities

2.1.2 Housing constraints experienced by severally mentally ill homeless population

2.2 CONTRACTOR shall provide detailed outcome and success stories of prior work providing supports services to housing of mentally ill patients.

2.2.1 Performing meaningful research to support decision making on large-scale projects

2.2.2 Engaging community stakeholders, via in-person or virtually

2.2.3 Familiarity with cultural competency components

2.2.4 Ability to deliver project plan document

Section 3, Pre-Qualifications/Licensing Requirements:

3.1 CONTRACTOR must acknowledge in writing that it meets all the pre-qualifications and licensing requirements as set forth in Section 7.0 herein.

Section 4, Project Experience & References (Attachment A):

Key Staff Persons: CONTRACTOR shall identify key staff and their qualifications and experience proposed for the service identified herein.

Experience & References: CONTRACTOR shall describe at least 2 similar projects for which it provided services like the scope of work described herein. Please include phone number and email address if possible as the County will conduct reference checks using this information.

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Section 5, Pricing (Attachment B):

CONTRACTOR shall complete and submit pricing as per ATTACHMENT B – PRICING SCHEDULE attached hereto.

Warranty: CONTRACTOR shall specify the warranty period for the materials and guarantee the workmanship of all items proposed. After the award, the CONTRACTOR shall promptly remedy all defects without cost to the County that may appear within this period. CONTRACTOR shall also specify if extended warranty is available and submit the extended warranty term period and associated cost.

Section 6, Exceptions:

Submit all exceptions to this solicitation on separate pages, and clearly identify the top of each page with "EXCEPTION TO MONTEREY COUNTY SOLICITATION #10889" (indicate the applicable solicitation number). Each Exception shall reference the page number and section number, as appropriate. CONTRACTOR should note that the submittal of an Exception does not obligate the County to revise the terms of the RFP or AGREEMENT.

Section 7, Appendix:

Appendices: CONTRACTOR may provide any additional information that it believes to be applicable to this proposal package and include such information in an Appendix section.

8.2 **ADDITIONAL REQUIREMENTS:** To be considered "responsive," submitted proposal packages shall adhere to one of the two following options:

Option 1

Hardcopy and one electronic version of the proposal package:

8.2.1 Four sets of the proposal package (one original proposal marked "Original" plus three marked "copy") shall be submitted in response to this solicitation. Each copy shall include a cover indicating the company name submitting, and reference to "RFP #10889". **In addition**, submit one electronic version of the entire proposal package on a USB memory stick. Additional copies may be requested by the County at its discretion.

8.2.2 Proposal packages shall be prepared on 8-1/2" x 11" paper, preferably duplex printed bound with front and back covers. Fold out charts, tables, spreadsheets, brochures, pamphlets, and other pertinent information or work product examples may be included as Appendices.

8.2.3 Reproductions of the Monterey County Seal shall not be used in any documents submitted in response to this solicitation except for the Signature Page.

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8.2.4 CONTRACTOR shall not use white-out or a similar correction product to make late changes to their proposal package but may instead line out and initial in BLUE ink any item which no longer is applicable or accurate.

8.2.5 To validate your proposal package, **submit the SIGNATURE PAGE** (contained herein) **with your proposal**. Proposals packages submitted without that page will be deemed non-responsive. Proposal signature must be manual, in BLUE ink, and included with the original copy of the proposal. Photocopies of the Signature Page may be inserted into the remaining proposal copies. All prices and notations must be typed or written in BLUE ink in the original proposal copy as well. Errors may be crossed out and corrections printed in BLUE ink or typed adjacent, and must be initialed in BLUE ink by the person signing the proposal.

Option 2

OPTIONAL - Electronic Submission Package:

8.2.6 The County of Monterey has joined **Negometrix**, an e-procurement platform, to enhance the safety of our bidders and staff during the height of COVID-19.

8.2.6.1 Proposals may be submitted electronically using the following link: https://app.negometrix.com/buyer/585/tenders

8.2.6.2 ***PLEASE NOTE***: To use this option, CONTRACTORs and are required to set up a free account prior to uploading proposals. This will take a few moments; therefore, set up your account at least 24 hours in advance of the bid deadline.

8.3 **CONFIDENTIAL OR PROPRIETARY CONTENT:** Qualifications Packages submitted in response to this RFQ are not to be marked, in whole or in part, as confidential or proprietary and must not constitute or contain information that is confidential, proprietary, or trade secret, or subject to any other claim that it is not subject to public disclosure under applicable law. The County may refuse to consider any Qualifications Package so marked. Qualifications Package s submitted in response to this RFQ will become subject to public disclosure per the requirements of applicable law, including but not limited to the California Public Records Act, Government Code Section 6250 et seq, and the Ralph M. Brown Act, Government Code Section 54950 et seq. Please be advised that all information and documents submitted to County by CONSULTANT shall become non-confidential, non-proprietary, non-trade secret, public records without exception and subject to public disclosure by the County at any time without prior notice to CONSULTANT, whether pursuant to a request for disclosure or otherwise, including but not limited to disclosure in the course of County's normal procedures to post on the internet or otherwise make available to the general public documents of interest to the public. All interested CONSULTANTS are advised to consider, when deciding what information to include in their submitted Qualifications Package, that such inclusion will result in the information becoming a fully disclosable public record. The County shall not be liable in any way for disclosure of any such records or part thereof related to this RFQ or any Qualifications Package, including, but not limited to, evaluations, proposals, or any other information or records. In submitting the information and documents, the CONSULTANT is agreeing to the County's release of such information and documents under the Public Records Act or the Brown Act,

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without further notice to the CONSULTANT, and is agreeing to release, indemnify, and hold harmless the County from any harm that may result to the Proposer or any third party for release of such information and documents. This release and promise to defend and indemnify is given regardless of whether any exemption from disclosure may be available or might have been claimed under applicable law, and CONSULTANT's responding to this RFQ acknowledge that the decision whether to assert any such exemption will be made in the COUNTY'S sole discretion. Submission by an interested CONSULTANT constitutes a complete waiver of any claims whatsoever against the COUNTY, and/or its agents, officers, or employees, that the COUNTY has violated a vendor's right to privacy, disclosed trade secrets, or caused any damage by allowing the Proposal to be inspected.

Additionally, all Qualifications Packages received by COUNTY in response to this RFQ shall become the exclusive property of the COUNTY. The COUNTY reserves the right, without limitation, to make use of any information or ideas contained in the Proposals submitted. By submitting information and documents to the COUNTY as part of this RFQ, CONSULTANTS acknowledge and agree to the terms of this Section 15.1.

9.0 SUBMITTAL INSTRUCTIONS & CONDITIONS

9.1 Submittal Identification Requirements: ALL SUBMITTALS MAILED OR DELIVERED CONTAINING PROPOSAL OR QUOTATION PACKAGES MUST BE SEALED AND BEAR ON THE OUTSIDE, PROMINENTLY DISPLAYED IN THE LOWER LEFT CORNER: **THE SOLICITATION NUMBER RFP #10889 and CONTRACTOR'S COMPANY NAME.**

9.2 Mailing Address: Proposal packages shall be mailed to County at the mailing address indicated on the **Signature Page** of this solicitation.

9.3 Due Date: Proposal packages must be received by County ON OR BEFORE the time and date specified, at the location and to the person specified on the **Signature Page** of this solicitation. It is the sole responsibility of the CONTRACTOR to ensure that the proposal package is received at or before the specified time. Postmarks and facsimiles are not acceptable. Proposals received after the deadline shall be rejected and returned unopened.

9.4 Shipping Costs: Unless stated otherwise, the F.O.B. for receivables shall be destination. Charges for transportation, containers, packaging, and other related shipping costs shall be borne by the shipper.

9.5 Acceptance: Proposals are subject to acceptance at any time within 90 days after opening. Monterey County reserves the right to reject any and all proposal packages, or part of any proposal package, to postpone the scheduled deadline date(s), to make an award in its own best interest, and to waive any formalities or technicalities that do not significantly affect or alter the substance of an otherwise responsible proposal package and that would not affect a CONTRACTOR'S ability to perform the work adequately as specified.

9.6 Ownership: All submittals in response to this solicitation become the property of the County of Monterey. If a CONTRACTOR does not wish to submit a proposal package

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but wishes to acknowledge the receipt of the request, the reply envelope shall be marked "No Bid".

9.7 Compliance: Proposal packages that do not follow the format, content and submittal requirements as described herein, or fail to provide the required documentation, may receive lower evaluation scores, or be deemed non-responsive.

9.8 CAL-OSHA: The items proposed shall conform to all applicable requirements of the California Occupational Safety and Health Administration Act of 1973 (CAL-OSHA).

9.9 The award(s) resulting from this RFP will be made to the CONTRACTOR(s) that submit a response that, in the sole opinion of the county, best serves the overall interest of the County.

10.0 SELECTION CRITERIA

10.1 The selection of CONTRACTOR and subsequent contract award(s) will be based on the criteria contained in this Solicitation, as demonstrated in the submitted proposal. CONTRACTOR should submit information sufficient for the County to easily evaluate proposals with respect to the selection criteria. The absence of required information may cause the Proposal to be deemed non-responsive and may be cause for rejection.

10.2 The selection criteria include the following: **(100 points total).**

SCORING CRITERIA	Possible Points
Demonstrated experience in conducting research to support projects with a community-wide impact.	**10**
Provided a detailed research plan or approach for performing the necessary research to deliver a final implementation plan for this project.	**20**
Demonstrated familiarity or expertise with mental health services system(s), service delivery and/or program planning.	**10**
Demonstrated familiarity or expertise with Adult Residential Facilities for adults with serious mental illness in California	**15**
Demonstrated familiarity or experience with cultural and linguistic sensitivity and responsiveness	**10**
Description and/or examples of approach for communicating with clients	**5**
Description and/or examples of approach for communicating community stakeholders and/or public agencies	**5**
Description and/or examples of final project plan formatting	**5**
Pricing	**20**
TOTAL	**100**

10.3 AGREEMENT award(s) will not be based on cost alone.

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10.4 The award resulting from this RFP will be made to the CONTRACTOR that submits a response that, in the sole opinion of the County, best serves the overall interest of the County.

10.5 The award made from this RFP may be subject to approval by the County Board of Supervisors.

11.0 PRICING

11.1 CONTRACTOR(s) will complete **Attachment B – Pricing Schedule** for the provision of services as outlined within this RFP.

11.2 CONTRACTOR prices stated in **Attachment B – Pricing Schedule** shall be effective from the date the proposal is submitted to the day the AGREEMENT is awarded and through the initial term of the AGREEMENT.

11.3 Prior to the start of each project, the County department and CONTRACTOR(s) will mutually agree upon the budget for the project.

11.3.1 County will provide a defined scope

11.3.2 Pricing may be based upon an hourly rate or by the project, based upon the direction of the user department.

11.4 Prices quoted for work assignments must remain in effect for a minimum of thirty (30) days.

11.5 Invoicing by CONTRACTOR(s) will clearly itemize but is not limited to the following:
11.5.1 County Department receiving services,
11.5.2 Purchase order number under which the invoice is to be charged,
11.5.3 Services provided,
11.5.4 Dates of services,

11.6 Proposals should include any early discounts and/or incentives offered.

11.7 Travel/Mileage
11.7.1 Any travel/mileage must be agreed upon and approved by the County in writing prior to services being performed.
11.7.2 Travel/mileage must adhere to the current rate per mile at the time of service as provide by the US General Services Administration. Rates are listed at: https://www.gsa.gov/travel/plan-book/transportation-airfare-pov-etc/privately-owned-vehicle-pov-mileage-reimbursement-rates
11.7.3 Travel/mileage fees must be listed as a line-item within the corresponding invoice for associated services.
11.7.3.1 Travel/mileage fees more than the US GSA rate at the time services are provided will not be processed. CONTRACTOR must correct the

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invoice containing the incorrect fee to adhere to the current GSA rates at the time of service prior to processing of invoice.

12.0 PREFERENCE FOR LOCAL CONTRACTORS

12.1. General Requirements: Each local supplier funded in whole or in part by County funds, or funds which County expends or administers, shall be eligible for a local preference as provided in this section.

12.2. Rights of First Refusal: Each local supplier who is within five percent (5%) of the lowest responsible bid and who is otherwise responsive and responsible to the call for bids shall be provided the opportunity to reduce the local supplier's bid to the amount equal to the amount of the lowest responsible bid, if the lowest responsible bid is submitted by other than a local supplier. The opportunity to reduce the amount of the bid shall be provided first to the lowest eligible local supplier and, if not accepted by such local supplier within five (5) business days of the opening of bids, who is within five percent (5%) of the lowest responsible bid. In the event an eligible local supplier reduces the bid to the amount of the lowest responsible bid, the eligible local supplier shall be deemed to have provided the lowest responsible bid and shall be awarded the AGREEMENT.

12.3. The foregoing provisions apply only to competitive bids that require that contracts be awarded to the lowest responsible bidder. For contracts awarded pursuant to RFQs or requests for quotations, the awarding authority may consider, as one (1) of the factors in determining the most suitable proposal or quotation, whether or not a local supplier submits the proposal or quotation.

12.4. Definitions: For the purpose of this section, the following terms have the meanings indicated:

12.4.1. "Area" means Monterey County, San Benito County, and Santa Cruz County.

12.4.2. "Bid" includes any competitive bid, whether formal or informal.

12.4.3. "Local Supplier" shall mean a supplier doing business in the Area for not less than the past five (5) consecutive years.

12.4.4. "Supplier" shall mean a business or resident providing goods, supplies, or professional services.

12.4.5. "Local Vendor" means a Vendor for which all of the following criteria apply:
12.4.5.1. Vendor either owns, leases, rents or otherwise occupies a fixed office or other commercial building, or portion thereof, having a street address within the Area. Vendor possesses a valid and verifiable business license, if required, issued by a city within the Area or by one of the three counties within the Area when the address is located in an unincorporated area within one of the three counties as defined as “Area”; and

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12.4.5.2. Vendor employs at least one full time employee within the "Area", or if the business has no employees, the business shall be at least fifty percent (50%) owned by one or more persons whose primary residence(s) is located within the "Area"; and

12.4.5.3. Vendor's business must have been in existence, in Vendor's name, within the "Area" for at least two (2) years immediately prior to the issuance of either a request for competitive bids or request for qualifications for the County; and

12.4.5.4. Newly established businesses which are owned by an individual(s) formerly employed by a Local Vendor for at least two (2) years also qualifies for the preference; and

12.4.5.5. If applicable vendor must possess a valid resale license from the California Department of Tax and Fee Administration showing vendor's local address within the "Area" and evidencing that payment of the local share of the sales tax goes to either a city within the "Area" or to one of the three counties within the defined "Area".

12.5. Link to County's Local Preference Policy: *https://www.co.monterey.ca.us/home/showdocument?id=22313*

13.0 INSURANCE REQUIREMENTS

13.1 Evidence of Coverage:

13.1.1 Prior to commencement of an AGREEMENT, CONTRACTOR shall provide a "Certificate of Insurance" certifying that coverage as required herein has been obtained. Individual endorsements executed by the insurance carrier shall accompany the certificate. In addition, CONTRACTOR upon request shall provide a certified copy of the policy or policies.

13.1.2 This verification of coverage shall be sent to the County's Contracts/Purchasing Department, unless otherwise directed. The CONTRACTOR shall not receive a "Notice to Proceed" with the work under this Agreement until it has obtained all insurance required and the County has approved such insurance. This approval of insurance shall neither relieve nor decrease the liability of CONTRACTOR.

13.2 Qualifying Insurers: All coverages, except surety, shall be issued by companies that hold a current policy holder's alphabetic and financial size category rating of not less than A-VII, according to the current Best's Key Rating Guide, or a company of equal financial stability that is approved by the County's Purchasing Manager.

13.3 Insurance Coverage Requirements:

12.3.1 Without limiting CONTRACTOR'S duty to indemnify, CONTRACTOR shall maintain in effect throughout the term of an AGREEMENT a policy or policies of insurance with the following minimum limits of liability:

(i) Commercial general liability insurance including but not limited to premises and operations, including coverage for Bodily Injury and

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Property Damage, Personal Injury, Contractual Liability, Broad form Property Damage, Independent Contractors, Products and Completed Operations, with a combined single limit for Bodily Injury and Property Damage of not less than $1,000,000 per occurrence.

Note: any proposed modifications to these general liability insurance requirements shall be attached as an Exhibit hereto, and the section(s) above that are proposed as not applicable shall be lined out in blue ink. All proposed modifications are subject to County approval.

(ii) Automobile Insurance Threshold:

Agreement **Under $100,000** Business Automobile Liability Insurance: covering all motor vehicles, including owned, leased, non-owned, and hired vehicles, used in providing services under this Agreement, with a combined single limit for Bodily Injury and Property Damage of not less than $500,000 per occurrence.

OR
Agreement **Over $100,000** Business Automobile Liability Insurance: covering all motor vehicles, including owned, leased, non-owned, and hired vehicles, used in providing services under this Agreement, with a combined single limit for Bodily Injury and Property Damage of not less than $1,000,000 per occurrence.

Note: any proposed modifications to these general liability insurance requirements shall be attached as an Exhibit hereto, and the section(s) above that are proposed as not applicable shall be lined out in blue ink. All proposed modifications are subject to County approval.

(iii) Workers' Compensation Insurance, if CONTRACTOR employs others in the performance of this Agreement, in accordance with California Labor Code section 3700 and with Employer's Liability limits not less than $1,000,000 each person, $1,000,000 each accident and $1,000,000 each disease.

Note: any proposed modifications to these workers' compensation insurance requirements shall be attached as an Exhibit hereto, and the section(s) above that are proposed as not applicable shall be lined out in blue ink. All proposed modifications are subject to County approval.

(iv) Professional Liability Insurance: if required for the professional services being provided, (e.g., those persons authorized by a license to engage in a business or profession regulated by the California Business and Professions Code), in the amount of not less than $1,000,000 per claim and $2,000,000 in the aggregate, to cover liability for malpractice or errors or omissions made while rendering professional services. If professional liability insurance is written on a "claims-made" basis rather than an occurrence basis, the CONTRACTOR

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shall, upon the expiration or earlier termination of this Agreement, obtain extended reporting coverage (tail coverage) with the same liability limits. Any such tail coverage shall continue for at least three years following the expiration or earlier termination of this Agreement.

Note: any proposed modifications to these insurance requirements shall be attached as an Exhibit hereto, and the section(s) above that are proposed as not applicable shall be lined out in blue ink. All proposed modifications are subject to County approval.

13.4 Other Insurance Requirements:

13.4.1 All insurance required by an AGREEMENT shall be with a company acceptable to County and issued and executed by an admitted insurer authorized to transact insurance business in the State of California. Unless otherwise specified by an AGREEMENT, all such insurance shall be written on an occurrence basis, or, if the policy is not written on an occurrence basis, such policy with the coverage required herein shall continue in effect for a period of three years following the date CONTRACTOR completes its performance of services under an AGREEMENT.

13.4.2 Each liability policy shall provide that County shall be given notice in writing at least thirty days in advance of any endorsed reduction in coverage or limit, cancellation, or intended non-renewal thereof. Each policy shall provide coverage for CONTRACTOR and additional insureds with respect to claims arising from each subcontractor, if any, performing work under an AGREEMENT, or be accompanied by a certificate of insurance from each subcontractor showing each subcontractor has identical insurance coverage to the above requirements.

13.4.3 **Commercial general liability and automobile liability policies shall provide an endorsement naming the County of Monterey, its officers, agents, and employees as Additional Insureds** with respect to liability arising out of the CONTRACTOR'S work, including ongoing and completed operations, **and shall further provide that such insurance is primary insurance to any insurance or self-insurance maintained by the County and that the insurance of the Additional Insureds shall not be called upon to contribute to a loss covered by the CONTRACTOR'S insurance.** The required endorsement form for Commercial General Liability Additional Insured is ISO Form CG 20 10 11-85 or CG 20 10 10 01 in tandem with CG 20 37 10 01 (2000). The required endorsement form for Automobile Additional Insured endorsement is ISO Form CA 20 48 02 99.

13.4.4 Prior to the execution of an AGREEMENT by County, CONTRACTOR shall file certificates of insurance with County's contract administrator and County's Contracts/Purchasing Division, showing that CONTRACTOR has in effect the insurance required by an AGREEMENT. CONTRACTOR shall file a new or amended certificate of insurance within five calendar days after any change is made in any insurance policy, which would alter the information on the certificate then on file. Acceptance or approval of insurance shall in no way modify or

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change the indemnification clause in an AGREEMENT, which shall continue in full force and effect.

13.4.5 CONTRACTOR shall always during the term of an AGREEMENT maintain in force the insurance coverage required under an AGREEMENT and shall send, without demand by County, annual certificates to County's Contract Administrator and County's Contracts/Purchasing Division. If the certificate is not received by the expiration date, County shall notify CONTRACTOR and CONTRACTOR shall have five calendar days to send in the certificate, evidencing no lapse in coverage during the interim. Failure by CONTRACTOR to maintain such insurance is a default of an AGREEMENT, which entitles County, at its sole discretion, to terminate an AGREEMENT immediately.

You may reference our Insurance Requirements for additional clarification and samples of required endorsements.

14.0 CONTRACT AWARDS

14.1 No Guaranteed Value: County does not guarantee a minimum or maximum dollar value for any AGREEMENT(S) resulting from this solicitation.

14.2 Board of Supervisors: The award(s) made from this solicitation may be subject to approval by the County Board of Supervisors.

14.3 Interview: County reserves the right to interview selected CONTRACTOR before a contract is awarded. The costs of attending any interview are the CONTRACTOR'S responsibility.

14.4 Incurred Costs: County is not liable for any cost incurred by CONTRACTOR in response to this solicitation.

14.5 Notification: All CONTRACTORs who have submitted a Proposal Package will be notified of the final decision as soon as it has been determined.

14.6 In County's Best Interest: The award(s) resulting from this solicitation will be made to the CONTRACTOR that submit(s) a response that, in the sole opinion of County, best serves the overall interest of County.

15.0 SEQUENTIAL CONTRACT NEGOTIATION

County will pursue contract negotiations with the CONTRACTOR that submit(s) the best Proposal or is deemed the most qualified in the sole opinion of County, and which is in accordance with the criteria as described within this solicitation. If the contract negotiations are unsuccessful, in the opinion of either County or CONTRACTOR, County may pursue contract negotiations with the entity that submitted a Proposal that County deems to be the next best

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qualified to provide the services, or County may issue a new solicitation or take any other action which it deems to be in its best interest.

16.0 AGREEMENT TO TERMS AND CONDITIONS

CONTRACTOR selected through the solicitation process will be expected to execute a formal AGREEMENT with County for the provision of the requested service. The AGREEMENT shall be written by County in a standard format approved by County Counsel, similar to the *https://www.co.monterey.ca.us/home/showdocument?id=81980*. Submission of a signed bid/proposal and the **SIGNATURE PAGE** will be interpreted to mean CONTRACTOR HAS AGREED TO ALL THE TERMS AND CONDITIONS set forth in the pages of this solicitation and the standard provisions included in the **SAMPLE AGREEMENT** Section herein. County may but is not required to consider including language from the CONTRACTOR'S proposed AGREEMENT, and any such submission shall be included in the EXCEPTIONS section of CONTRACTOR'S proposal.

17.0 COLLUSION

CONTRACTOR shall not conspire, attempt to conspire, or commit any other act of collusion with any other interested party for the purpose of secretly, or otherwise, establishing an understanding regarding rates or conditions to the solicitation that would bring about any unfair conditions.

SAMPLE AGREEMENT SECTION

The COUNTY OF MONTEREY STANDARD AGREEMENTS with all terms and conditions (which are hereby incorporated by reference as though set forth entirely herein) may be viewed at: https://www.co.monterey.ca.us/home/showdocument?id=81980

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-- End of Sample Agreement Section –

ATTACHMENT A: PROJECT EXPIERENCE AND REFERENCES

Please provide at least two references as listed within section 2.

Business Name_____ Contact:_____

City: _____ Phone Number _____

Date of Service: _____

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Business Name_____ Contact: _____

City: _____ Phone Number _____

Date of Service: _____

Business Name_____ Contact: _____

City: _____ Phone Number _____

Date of Service: _____

Business Name_____ Contact: _____

City: _____ Phone Number _____

Installation Date of Service: _____

-- End of Attachment A –

ATTACHMENT B: PRICING SCHEDULE

Enter applicable pricing table/fee schedule here.

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-- End of Attachment B –

ATTACHMENT C: LOCAL BUSINESS DECLARATION FORM

COUNTY OF MONTEREY LOCAL BUSINESS DECLARATION FORM

If a business entity is claiming to be a "Local Vendor" as defined by the "Monterey County Local Preference Policy," adopted by the Monterey County Board of Supervisors on August 29, 2012, it must certify it meets the definition of "Local Vendor" as defined and in accordance with the adopted policy. Any business entity claiming to be a local business as defined by the policy, shall so certify, in writing herein, that it meets all of the criteria listed within the policy, which can be accessed online at the following link: ***https://www.co.monterey.ca.us/home/showdocument?id=22313***.

"Local Vendor" is defined as follows:

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1. Vendor either owns, leases, rents or otherwise occupies a fixed office or other commercial building, or portion thereof, having a street address within the Area. Vendor possesses a valid and verifiable business license, if required, issued by a city within the Area or by one of the three counties within the Area when the address is located in an unincorporated area within one of the three counties as defined as "Area"; **and**
2. Vendor employs at least one full time employee within the "Area", or if the business has no employees, the business shall be at least fifty percent (50%) owned by one or more persons whose primary residence(s) is located within the "Area"; **and**
3. Vendor's business must have been in existence, in Vendor's name, within the "Area" for at least two (2) years immediately prior to the issuance of either a request for competitive bids or request for qualifications for the County; **and**
4. Newly established businesses which are owned by an individual(s) formerly employed by a Local Vendor for at least two (2) years also qualifies for the preference; **and**
5. If applicable vendor must possess a valid resale license from the State Franchise Tax Board showing vendor's local address within the "Area" and evidencing that payment of the local share of the sales tax goes to either a city within the "Area" or to one of the three counties within the defined "Area".

County shall not be responsible or required to verify the accuracy or any such certifications and shall have sole discretion to determine if a bidder meets the definition of "local vendor" as provided herein.

Any business which falsely claims a preference pursuant to Monterey County Local Preference Policy shall be ineligible to bid on County purchases or contracts for a period of three (3) years from the date of discovery of the false certification(s).

Any business eligible for the local preference who desires to have the preference applied during the award selection process shall return this completed Local Business Preference Declaration form with its proposal or qualifications package response. Upon request, bidder agrees to provide additional information to substantiate this certification.

As per the policy: **"Area"** shall mean Monterey County, San Benito County, and Santa Cruz County.

Note: If applicable your organization must possess a valid resale license from the California Department of Tax and Fee Administration showing its local address within the "Area" and evidencing that payment of the local share of the sales tax goes to either a city within the "Area" or to one (1) of the three (3) counties within the defined "Area."

On behalf of my business entity (i.e., organization) I certify under penalty of perjury that I have both read and confirm that my business entity meets the requirements as outlined within the County's Local Preference Policy for the procurement in question.

Business Legal Name (and dba name if any):

Business Address: _____

City: _____ ***State:*** _____ ***Zip Code:*** _____

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Signature of Authorized Representative: _____ ***Date:*** _____

Title of Authorized Representative: _____

Telephone Number: (____) _____ ***E-Mail:*** _____

This form must be submitted within a bidder's proposal or qualifications package in order for the County to apply the applicable local preference.

Bidders who do <u>not</u> qualify as a local business as per the policy should <u>not</u> submit this form.

-- End of Attachment C –

SIGNATURE PAGE

COUNTY OF MONTEREY
CONTRACTS/PURCHASING DIVISION

RFP # **10889**
ISSUE DATE: February 2, 2023

RFP TITLE: RESIDENTIAL CARE FACILITY INCUBATOR INNOVATION PROJECT

PROPOSALS ARE DUE IN THE OFFICE OF THE CONTRACTS/PURCHASING OFFICER BY
3:00 P.M., LOCAL TIME, ON March 6, 2023

MAILING ADDRESS:
COUNTY OF MONTEREY
CONTRACTS/PURCHASING OFFICE
1488 SCHILLING PLACE
SALINAS, CA 93901

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QUESTIONS ABOUT THIS RFP SHOULD BE DIRECTED TO
RUELASA@CO.MONTEREY.CA.US, (831) 796- 3035

CONTRACTOR MUST INCLUDE THE FOLLOWING IN EACH PROPOSAL (1 original plus 3 copies):

☐ ALL REQUIRED CONTENT AS DEFINED PER SECTION 8.1 HEREIN

This Signature Page must be included with your submittal to validate your proposal.
Proposals submitted without this page will be deemed non-responsive.

☐ **CHECK HERE IF YOU HAVE ANY EXCEPTIONS TO THIS SOLICITATION.**

CONTRACTOR MUST COMPLETE THE FOLLOWING TO VALIDATE PROPOSAL
I hereby agree to furnish the articles and/or services stipulated in my proposal at the price quoted, subject to the instructions and conditions in the Request for Proposal package. I further attest that I am an official officer representing my firm and authorized with signatory authority to present this proposal package.

Company Name: _____ Date _____

Signature: _____ Printed Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: ( )_____ Fax: ( ) _____ Email: _____

License No. (If applicable): _____

License Classification (If applicable): _____

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Appendix B – No-Cost Extension

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MHSOAC
Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

MARA MADRIGAL-WEISS
Chair
MAYRA E. ALVAREZ
Vice Chair
TOBY EWING
Executive Director

December 21, 2022

Katy Eckert
Director-Monterey County
1270 Natividad Road
Salinas, CA 93906

Dear Ms. Eckert,

Thank you for your notification dated December 20, 2022, for the time extension of 18 months for Monterey County's ***Residential Care Facility Incubator***, which was originally approved on November 1, 2021, for $792,130 in Innovation funding for two (2) years.

Per your letter, you have informed us that the start date for this project was on November 21, 2021. With this time extension of 18 months the end date for this project will be no later than May 1, 2025, for a total period of three (3) years and six (6) months. No additional funding was requested.

On behalf of the Commission, I would like to thank you for all the work you do in your community.

If you have additional questions or need further assistance, feel free to contact me sharmil.shah@mhsoac.ca.gov or your county liaison vicque.kimmel@mhsoac.ca.gov.

Sincerely,

Sharmil Shah, Psy.D
Chief-Program Operations

Cc: Wesley Schweikhard, Innovation Coordinator
Shannon Castro, MHSA Coordinator

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Help@Hand: WellScreen Monterey Evaluation Final Report

Prepared for Monterey County Behavioral Health, Monterey, CA.

December 2023

Health Research for Action
University of California, Berkeley
1995 University Avenue, Suite 300
Berkeley, CA 94720-7358

Funded under a Subcontract from CredibleMind, Inc.

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Executive summary

Introduction
This report provides a mixed methods evaluation of Monterey County's behavioral health initiative to develop and implement Help@Hand (https://www.calmhsa.org/help-hand/) in Monterey County, CA. The purpose of the Help@Hand interactive, technology-based mental health demonstration project is to increase access to mental health care and promote early detection of mental health symptoms. Monterey County's Help@Hand demonstration project (2021-2023) is called WellScreen Monterey (https://wellscreenmonterey.crediblemind.com/). The WellScreen Monterey planning and development phase was from 2021-2022. The WellScreen Monterey website launched in November 2022.

University of California, Berkeley's Health Research for Action served as the local external evaluator for the Help@Hand Monterey County initiative, working closely with Monterey County Behavioral Health (MCBH), California Mental Health Services Authority (CalMHSA), and CredibleMind, Inc. on this Monterey County Help@Hand evaluation. This report summarizes the evaluation of the WellScreen Monterey website implementation and includes the following data sources, described below:

1) MCBH ACCESS program's de-identified data from the electronic health record (EHR) system (Avatar) to examine trends in the program's triage, assessment/evaluation, linkage/brokerage, and mental health services use before and following the launch of WellScreen Monterey;
2) The de-identified WellScreen Monterey user data set (dashboard, website data) to assess user demographic and behavioral health characteristics, how users learned about WellScreen Monterey, pages and links viewed by the users, and user satisfaction with the resources.
3) Key informant interviews that explored the process for the planning and development phases, the launch of WellScreen Monterey, what worked well, what were the challenges, and suggestions for the next steps.
4) Community member interviews that explored community perceptions of WellScreen Monterey website overall, its self-screening/assessment process, results page, resources page and information about how to access resources, and discussed community preferences for outreach and communication.

Data Sources and Key Findings
1) MCBH EHR data comparing pre-implementation to post-implementation data

MCBH EHR data from before and after the implementation date were analyzed using autoregressive integrated moving average (ARIMA) modeling to detect any deviations from predicted month-to-month trends based on EHR data from July 1, 2018 to November 15, 2022, in comparison to data from November 16, 2022 to June 30, 2023. This ARIMA technique allowed us to use the pre-post EHR utilization data to model the complex patterns of data occurring across time prior to the implementation of WellScreen Monterey. We then compared the predicted course of the time series from the pre-implementation period with the actual post-implementation course of the time series, assuming different potential impact patterns.

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We had several findings of interest using this ARIMA model that are suggestive of an association of changes with the implementation of the WellScreen Monterey as follows:

Service Provision Impacts

- Triage: There was a statistically significant, but short-lived rise in the proportion of services devoted to triage (90% confidence).
- Assessment/Evaluation: There was a statistically significant, but short-lived drop in the proportion of services devoted to assessment and evaluation (94% confidence).
- Linkage/Brokerage: There was a slight reduction in the proportion of services in the linkage/brokerage category (with approximately 90% confidence).
- High-Risk Clients There was a statistically significant rise in the proportion of services devoted to assessment and evaluation of high-risk clients (95% confidence).
- Prescribing and Non-prescribing providers: There was an increase in the proportion of licensed prescribing providers who provided services and a decrease in the proportion of unlicensed non-prescribing providers who provided services (95% confidence).

Average Cost per Patient

- Triage: There was a statistically significant, but slowly decaying decrease in the average cost of triage services (95% confidence).
- Assessment/Evaluation: There was a statistically significant, but slowly decaying decrease in the average cost of assessment and evaluation (95% confidence).
- Linkage/Brokerage: There was a statistically significant, but slowly decaying decrease in the average cost of linkage/brokerage services (95% confidence)
- All Services: There was a statistically significant, but short-lived decrease in the average cost of services when all services are included (95% confidence).

However, some expected or hoped for changes were not seen in either descriptive analysis of EHR data or by using the ARIMA modeling to look at change over time.

Referrals to Beacon/Carelon

- There was not a statistically significant change in referrals to Beacon/Carelon (95% confidence).

Non-billable Services

- There was not a statistically significant impact of the implementation on the proportion of non-billable services (95% confidence).

Additionally, other descriptive changes of potential interest include the following changes that may be of note:

Race Distribution

By race, the proportion of clients identifying as White showed a decrease from 33.2% in the pre-launch period to 28.8% in the post-launch period. The percentages for clients of "Other Race" and "Black/African-American" increased slightly, while "Asian," and other race categories experienced relatively minor fluctuations. Nevertheless, the change in Race distribution between pre-post-launch periods was statistically significant ($p<0.001$) in a bivariate/descriptive analysis..

Hispanic Ethnicity Distribution

The percentage of Hispanic clients remained relatively stable, slightly decreasing from 53.4% pre-launch period to 52.1% post-launch period. The pre-post-launch period change in Hispanic ethnic origin distribution was small but statistically significant ($p<0.001$).

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Source of Health Insurance
Overall, there were increases in client proportions covered by Medi-Cal and Medicare Part B insurance sources, while Self Pay and Private Insurance proportions decreased from pre- to post-intervention. The change in the insurance status distribution from pre- to post-intervention period was significant ($p<0.001$).

2) WellScreen Monterey user data set (dashboard, website data)

We also examined WellScreen Monterey website/application utilization data and metadata on use from CredibleMind. Data on WellScreen Monterey website events covered dates from the launch of the website on November 15, 2023, to July 31, 2023, and assessment data covered dates from the website launch to September 6, 2023.

Young User Pool
Many of those coming to the WellScreen Monterey website were under age 16 (though were not able to use the screeners). Nearly half of users were under the age of 18 (48.7%), followed by people between the ages of 18 and 34 years. There was a small percentage of users over the age of 65 utilizing the WellScreen tool, which could be due to older groups tending to have less digital literacy compared to younger groups.

Low Usage by Spanish-speakers
Based on the WellScreen Monterey website/platform data from CredibleMind, there were very few Spanish language users. However, CredibleMind noted there would be no way of knowing if people have set a browser to auto-translate websites into Spanish.

Most effective marketing approach
Multivariate regression models identified Google paid ads and referrals as the most effective marketing approaches to persuade individuals in Monterey County to complete mental health assessments.

Reaching the target audience for MCBH
Many WellScreen Monterey website users were from outside of Monterey County. Based on the Credible Mind Dashboard Data, 2,877 users were from within Monterey County. Our analysis of website data identified 552 potential new clients for MCBH. These were individuals who lived in Monterey County, had moderate-to-severe mental health conditions, were covered by Medi-Cal, and reported they were not currently being treated by MCBH.

3) Key informant interviews of planning and launch processes

We conducted interviews with 14 key stakeholders involved in the planning and launch phases of the Help@Hand project from Monterey County Behavioral Health, other community service agencies in Monterey County, and the Help@Hand Technology Development Partner. Interviews were conducted from May 26, 2023, to August 23, 2023.

Most key informants celebrated planning and launch successes. Some of these include: collaboration between teams working on the Help@Hand project, engagement and collaboration with community partners, intentional and extensive reviews and assessments, responsiveness to feedback, outreach efforts, transparent communication, adherence to timelines, and trust-building with community partners.

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Many key informants also reflected on planning and launch challenges, such as staffing shortages, the need for better outreach to Spanish-speaking communities, time frame delays for the website launch and marketing/outreach due to administrative or COVID-19 factors, communication difficulty between different service agencies and organizations or with community partners, and recruitment of users.

Key informants shared suggestions for improvements, for example, representatives from each team working on the Help@Hand project could improve collaboration, add community outreach by radio or in churches and local markets, and improve resource-sharing between agencies in the community and then sync these resources with WellScreen Monterey.

4) Community member interviews about WellScreen Monterey website

Two focus groups were conducted from August 8, 2023, to September 9, 2023. There were seven participants in the English language focus group. There were two participants in the Spanish language focus group. Participants in both focus groups shared details about WellScreen Monterey website functionality and ease of use.

Overall, focus group participants found the self-assessment, resources, and results as well as the English and Spanish language options on the WellScreen Monterey website to be very helpful. Many participants shared that the website was useful and effective for receiving mental health information and resources. Most participants found the website to be organized, easy to understand, and detailed. Some participants explained that the website was a convenient, private, and time-efficient method of gaining access to curated resources. Some participants complimented the photographs and animations on the website.

Some focus group participants commented on challenges of the website which included the long length of the self-assessment, reintroduction of trauma due to some of the questions in the assessment, and long wait times for the chats or phone lines that were linked as resources.

Several focus group participants discussed suggestions for improvements to the website, for example, more attention to the framing of questions to make the self-assessment more user friendly, reduction in the length of the assessment, and inclusion of additional resources available in Monterey County on the website.

Conclusion and Recommendations

The Help@Hand Monterey County initiative was a success in a number of ways. Overall, the project outcomes exceeded Monterey County Behavioral Health's expectations. During the course of a year, over 30,000 people visited the WellScreen Monterey website which greatly exceeded the last reported fiscal year's service count (F.Y. 2021-22, n=13,150). The project also highlighted a large need for more behavioral health resources among youth – nearly half of users who accessed the screener were 18 and under. As a result, MCBH is continuing the Innovative Project beyond the end of their involvement in the Help@Hand program using Prevention and Early Intervention funds at least until June 30, 2025. The principal reason for this is to continue to improve access and engagement to a free mental health resource that is available for community members in English and Spanish.

As documented under *Data Sources and Key Findings*, there were observable differences in impacts on service provision and average cost per patient that occurred after launch of the website in November 2022. In particular, a higher proportion of services were devoted to triage

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and a lower proportion of services were devoted to assessment and evaluation. One of MCBH's concerns at the beginning of the project was that the amount of time being devoted to assessment and evaluation was impacting productivity and efficiency of service delivery in the county, and this reduction in the proportion of time devoted to assessment and evaluation is a positive outcome.

Another observable difference is that the average cost per patient for all services decreased. While this is promising, this study design did not allow us to make a clear linkage or conclusion of causality. While this finding from the time series analysis suggests that WellScreen Monterey was likely one reason that these changes in service delivery and average cost occurred, there were other differences in which the project implementation may have had a clearer impact.

Overall, collaboration between teams on the Help@Hand project as well as with community partners including communities of color, outreach and communication efforts, and use of feedback-response cycles were strengths for the Help@Hand initiative. Recommendations include appointing a representative from each team to improve communication channels, increasing county staff working on the initiative, and engaging in more community-based outreach at local community gathering places.

Higher percentages of people of color suggested a positive effect of the implementation - this positive impact included a shift to more Medi-Cal recipients as MCBH had hoped. On the other hand, direction of change for triage was not consistent with expectations and no changes could be detected from the EHR data on Beacon referrals or on non-billable services. It is possible that this is due to either the low use noted for actually reading resources from the web platform, or the possible missing connections between the screening data from the website and the MCBH intake/triage processes.

Strengths of the WellScreen Monterey website include the calm, informative website design, straightforward assessment experiences, and functional, effective results page. Recommendations include having additional Monterey County specific resources, reducing the length of the assessment(s), and adjusting the user interface to improve ease of use. From the WellScreen Monterey site assessment data we identified 552 individuals who lived in Monterey County, were moderate-to-severe acuity for at least one or multiple (comorbidities) of the following conditions, were covered by Medi-Cal, and were not currently being treated by MCBH: Anxiety (354), Depression (367), PTSD (163), Bipolar (238), Eating Disorder (284), Substance Abuse Any (233) and Psychosis (26). In this initial period, several people brought in their screening results from Wellscreen Monterey site to ACCESS program visits, as indicated by the *Alias 10* field. As more people access Wellscreen Monterey site and this process becomes integrated in the ACCESS clinic workflow, there will be more linkages of screening results.

In conclusion, the key recommendation is the need for more seamless transfer of website screening data for people seeking services at MCBH. Interoperability of data across apps, devices, and EHRs is a persisting issue in the U.S. and there was no difference here from many other experiences in pre-screening of people on devices/internet who then seek services. However, the addition of tablets during intake that can go onto the WellScreen Monterey website to retrieve user data during that initial patient-provider process seems very valuable to pursue in the future. Having data called in through a RESTful API or other HIPAA-protected process for transfer of data could be a new pathway for importing screening data if MCBH chooses to work on that linkage. Automatically transmitting assessment information between WellScreen Monterey site and Avatar in an interoperable format (e.g., results can be added in a usable data format that can be accessed within the EHR) is an important suggestion.

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Introduction and background





Monterey County Behavioral Health (MCBH) and California Mental Health Services Authority (CalMHSA) are leading a Help@Hand Monterey County initiative in the development and implementation of an interactive technological, evidence-based Help@Hand virtual mental health screening app/tool, accessible through a website or smartphone, to expand the capacity and reach of MCBH to county residents in need of behavioral health services or seeking information and resources about mental health and wellbeing. The purpose of Help@Hand is to increase access to mental health care and support, and to promote early detection of mental health symptoms.

MCBH and CalMHSA collaborated with CredibleMind, Inc., a company that provides wellness-oriented digital platforms to support health organizations with client engagement, communication, and outreach, on this innovative county behavioral health initiative to develop and implement Help@Hand in Monterey County. University of California, Berkeley's Health Research for Action served as the external evaluator for the Help@Hand Monterey County initiative and worked closely with MCBH, CalMHSA, and CredibleMind, Inc. on this Monterey County Help@Hand evaluation.

The Help@Hand interactive technology-based mental health demonstration project in Monterey County is called "WellScreen Monterey" (https://wellscreenmonterey.crediblemind.com/) and is intended to increase the capacity and reach of the MCBH ACCESS program and behavioral health programs across Monterey County as well as to facilitate their screening and referral services. The WellScreen Monterey planning and development phase was from 2021-2022. The WellScreen Monterey website then launched in November 2022.

MCBH serves people of all ages in need across Monterey County, starting at pregnancy/early childhood services and going through senior years. MCBH works with children, youth, adults, and families to be able to screen for a broad array of mental health disorders, and to refer individuals to the appropriate levels of care within the local mental health services system or to the appropriate self-care resources for mental health and well-being. The WellScreen Monterey screening app/tool is intended to be easily accessible to individuals of age 16 years old and older seeking mental health services, as well as family, friends, or caregivers supporting individuals experiencing symptoms of mental health disorder(s). The app/tool maintains confidentiality standards, screens for a broad range of mental health conditions, and categorizes assessments as ranging from no risk/low risk to severe risk.

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The development of the evidence-based Help@Hand screening app/tool, WellScreen Monterey, included using existing, previously validated instruments for mental health screening (e.g., depression, anxiety, etc.), many of which had existing Spanish translations. Where that was not the case, they contracted with Spanish translation agencies and supervised the translation of the English version of the validated instruments into Spanish language. CredibleMind, Inc. developed the screening app/tool following validity checks and item-response theory. CredibleMind, Inc. also completed a community needs assessment and conducted usability testing during the developmental phase to collect input from local providers, clients, and community members.

The purpose of this evaluation was to assess the impact of the Help@Hand screening app/tool, WellScreen Monterey, on MCBH ACCESS program's screening and referral services. The evaluation plan consisted of process evaluation, outcome evaluation, economic evaluation, assessment of general functionality and ease of use of the tool, and impact evaluation pertaining to the development and implementation of WellScreen Monterey. The launch of WellScreen Monterey was in November 2022.

Evaluation plan components include:

1. Conduct process evaluation to establish a baseline evaluation and identify potential cost-effective and improvement areas via provider interviews and community member focus groups.
2. Conduct an outcome evaluation of the application to assess efficiency and accuracy of referral connections, in collaboration with a cohort of County staff, community-based service providers, and other key informants.
3. Conduct an economic evaluation to assess the cost associated with self-assessments pre-post implementation of the mental health screening application and comparing cost of existing in- person screening to the virtual approach of the screening application.
4. Conduct general functionality and ease-of-use study through web analytics, web-based self-administered surveys, community focus groups and user testing with those using the application to determine usefulness of application for connecting targeted audience to resources.
5. Conduct impact evaluation of application with participating agencies/clinics as well as a cohort of community members
6. Work collaboratively with CalMHSA and Monterey County to modify and refine the mental health screening application after input from the evaluation has been received.

Please see Appendix A for Methodology details.

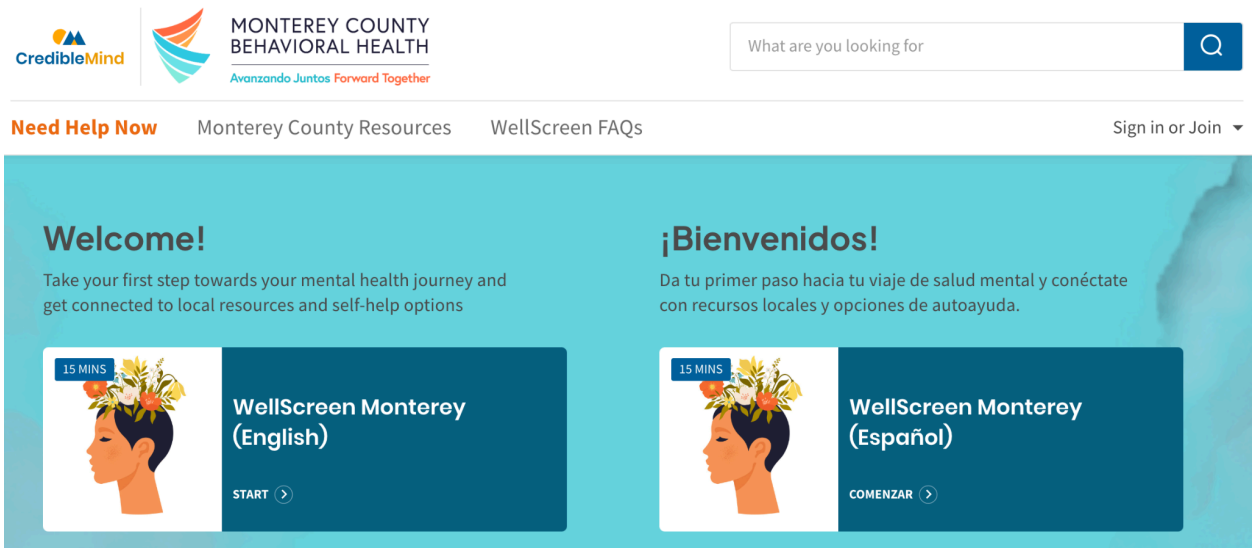
A key part of the evaluation report focuses on quantitative evaluation components of MCBH ACCESS program's de-identified data from the electronic health record (EHR) system (Avatar) and examined trends in the program's assessment/evaluation, linkage/brokerage, and mental health services and costs before and following the launch of WellScreen Monterey. Post-only de-identified WellScreen Monterey user data set (dashboard, website data) and the user demographic and behavioral health characteristics, how users learned about WellScreen Monterey, and the pages and links viewed by the users and their satisfaction with them were also examined.

The qualitative evaluation components with key informant interviews explored the process for the planning and developments phase, the launch of WellScreen Monterey, what worked well, what were the challenges, and suggestions for the next steps. The qualitative community member interviews explored community perceptions of the WellScreen Monterey website overall, its self-screening/assessment process and results page, its resources page and

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information about how to access resources, and community preferences for outreach and communication.

Process and impact of Help@Hand's WellScreen Monterey from planning to launch



This section reports on the key evaluation findings of the Help@Hand's behavioral health, innovative technology initiative, WellScreen Monterey, from the planning phase to the launch phase, and examined the process, outcome, economic, and impact evaluation components. These findings compare the Monterey County Behavioral Health ACCESS program's client demographic characteristics, screening services (triage, assessment/evaluation), referral services (linkage/brokerage), and mental health services (mental health counseling services) during pre-intervention and post-intervention periods of WellScreen Monterey. This section also reported on the successes, challenges, and suggestions for improvement during the planning and launch/intervention periods of WellScreen Monterey.

Pre-post-launch phase evaluation

Impact Assessment for WellScreen Monterey using data from MCBH Electronic Health Record System (Avatar)

To determine the impact of the WellScreen Monterey application, we applied interrupted time-series analysis (ITSA). The "interruption" in ITSA refers to a policy or program change that has a well-defined time of onset.[1] This approach was taken because we have no formal comparison group data, such as another County Behavioral Health organization that did not implement a similar website but was otherwise similar. The lack of comparison group data is a common occurrence in applied evaluation research and the particular ITSA method used here is designed to address the lack of a comparison group.

Since the population is the unit of interest (the population of individuals using various services at Monterey County Behavioral Health), and the interruption has a well-defined time of onset (we

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know the exact date that the WellScreen Monterey tool became available), we are able to model the time series prior to the implementation of the website in a statistically rigorous manner using the autoregressive integrated moving average (ARIMA) technique.[1] The ARIMA technique allows us to model the complex patterns of data occurring across time prior to the implementation of WellScreen Monterey. We then compare the predicted course of the time series with the actual post-implementation course of the time series, assuming different potential impact patterns (4 different patterns, including a pulse (an immediate pulse that then immediately returns to normal), decay (an immediate change that then decays over time back to normal), a step (an immediate change that is sustained), or smooth (a slower change that is sustained)). To the extent that the actual course of the time series differs from the predicted course of the time series, assuming any of the potential impact patterns, the well-defined interruption is likely the cause of the difference, assuming no other changes occurred at the same time. Thus, we expected a smooth pattern. Nevertheless, we examined all possible patterns for purposes of completeness.

In the current case, the evaluation is of the implementation of the website and accompanying dissemination strategy. Note that it is entirely possible that some proportion of any increase in the demand for MCBH services due to the implementation of the website and accompanying dissemination strategy may come from individuals exposed to the advertising for the website but who never used the website.

ARIMA requires us to have approximately 50 observations prior to the website introduction.[1] We obtained MCBH monthly electronic health record (EHR) data from July 2018 to July 2023 showing client services delivered over the pre-post time period. The WellScreen Monterey website was implemented November 15, 2022. Thus we have 52 months of client level data prior to implementation of the WellScreen Monterey website, and 8 months of client level data after the implementation of the website.

We examined the following outcomes using the MCBH monthly data:

I. *Service Provision*
   1. Mental Health Counseling (individual counseling, group rehabilitation counseling; in-person or telemedicine)
   2. Linkage/Brokerage Services (grouping: linkage/brokerage; in-person or telemedicine)
   3. Assessment/Evaluation (grouping: assessment and evaluation; in-person or telemedicine)
   4. Triage (grouping: triage assessment; in-person or telemedicine)
   5. Other Mental Health Services (grouping: assessment in lockout facility, case management in lockout facility, collateral, crisis intervention, family therapy, group psychotherapy, individual psychotherapy, psychotherapy, lockout, medication support, mental health rehabilitation, non-billable activity, plan development, telemedicine, other)

II. *Non-Billable Services*

III. *Risk Severity (definition: adults coded as high-severity by clinician)*

IV. *Costs for Service Provision (Inflation-adjusted to constant 2023 dollars)*
   1. Total Cost Per Patient
   2. Total Cost of Mental Health Counseling Per Patient
   3. Total Cost of Linkage/Brokerage Per Patient
   4. Total Cost of Assessment/Evaluation Per Patient
   5. Total Cost of Triage Per Patient

V. *Proportion of Visits Referred to Beacon/Carelon*

VI. *Proportion of Services Delivered by Licensed Prescribing Providers*

VII. *Proportion of Services Delivered by Licensed Non-Prescribing Providers*

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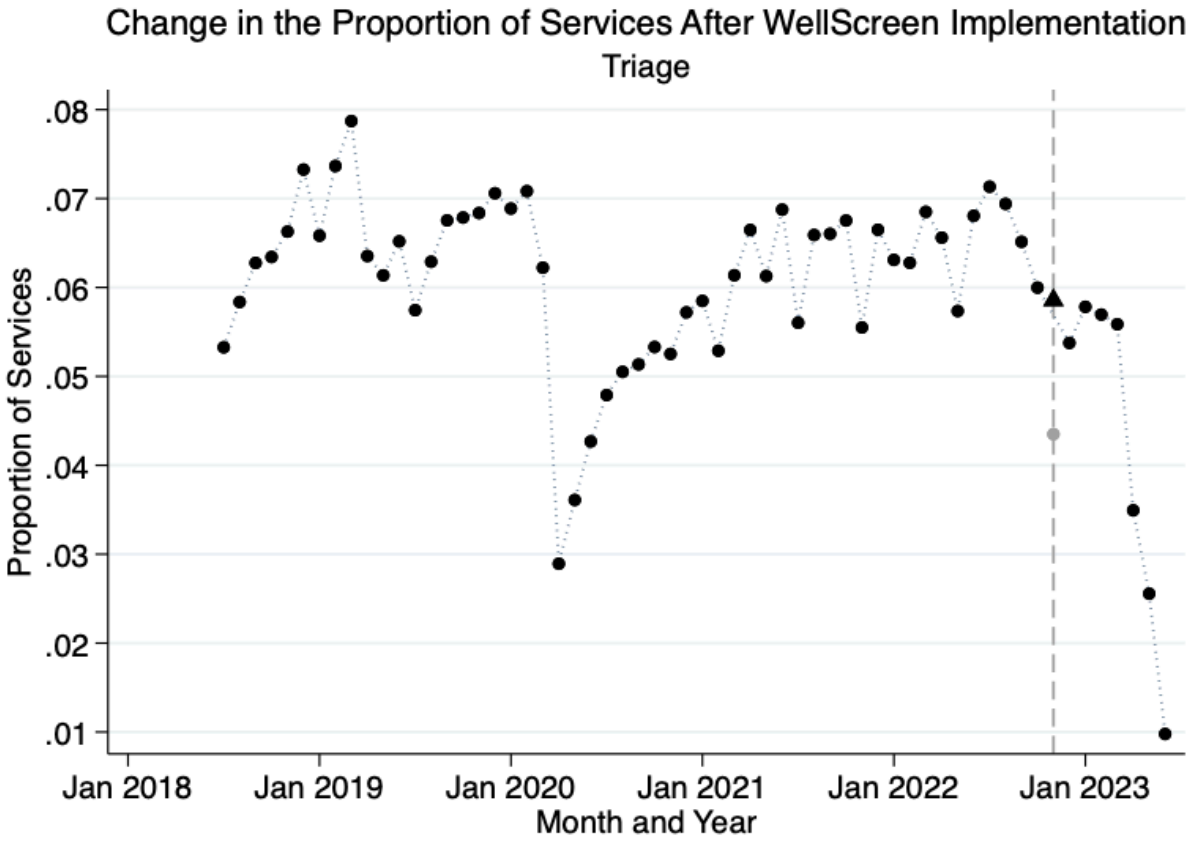
We show figures for results of each of these time series analyses, including the pre-implementation time series (actual time-series data); and the post-implementation time-series, including both the actual time-series data and the values predicted by the model. We also indicate the type of impact found in each case (pulse, decay, step, smooth) and whether there was a statistically significant difference between the actual post-implementation time series and the predicted post-implementation time series.

Triage and assessment/evaluation measures

Service Provision Impacts

There was a statistically significant, but short-lived rise (pulse) in the proportion of services devoted to triage (90% confidence).

FIGURE 1



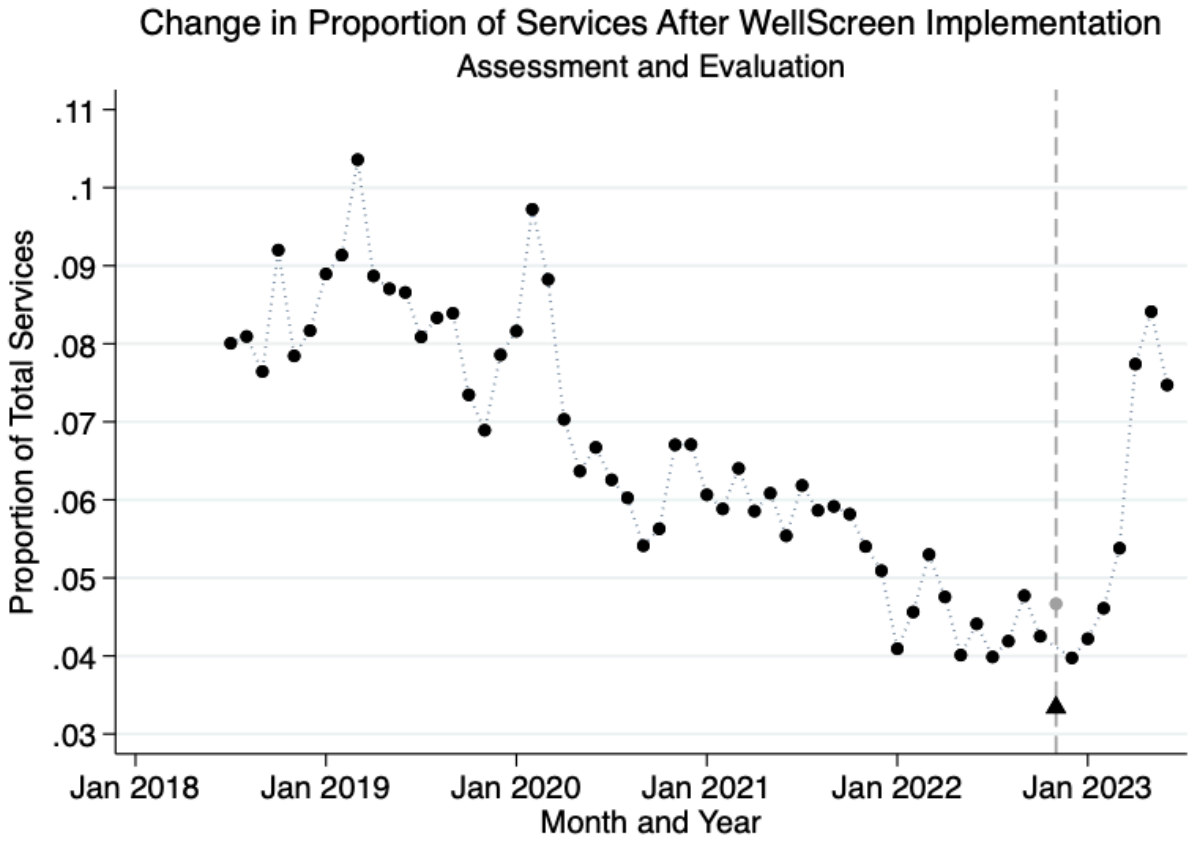
Notes: Data are from Monterey County Behavioral Health Electronic Health Record system. In the pre-intervention period, black circles represent actual data points. The gray dotted line represents the implementation of WellScreen (November, 2022). The black triangles present actual post-implementation data points. The gray circles represent expected data points based on the statistical modeling applied to pre-intervention data points.

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Service Provision Impacts

There was a statistically significant, but short-lived drop (decay) in the proportion of services devoted to assessment and evaluation (94% confidence).

FIGURE 2



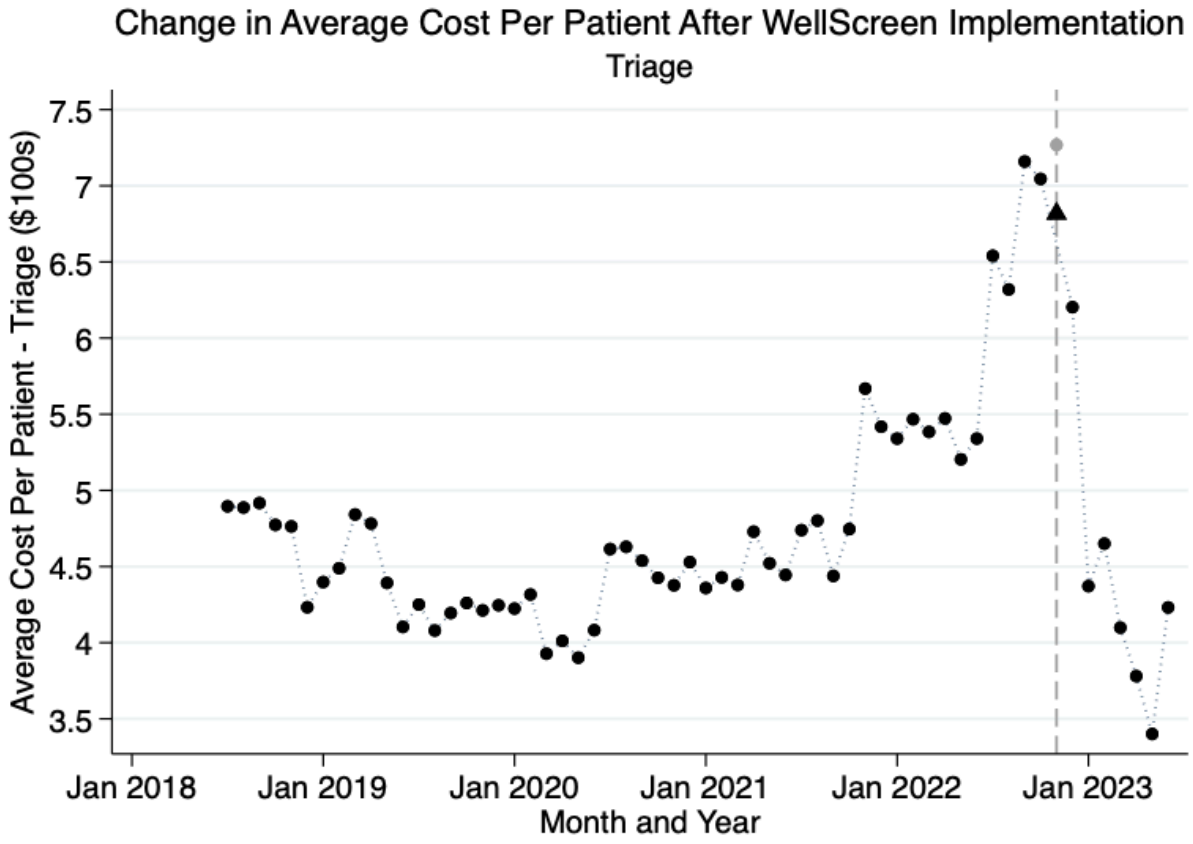
Notes: Data are from Monterey County Behavioral Health Electronic Health Record system. In the pre-intervention period, black circles represent actual data points. The gray dotted line represents the implementation of WellScreen (November, 2022). The black triangles present actual post-implementation data points. The gray circles represent expected data points based on the statistical modeling applied to pre-intervention data points.

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Service Provision Impacts

There was a statistically significant, but slowly decaying, decrease in the average cost of triage services (95% confidence).

FIGURE 3



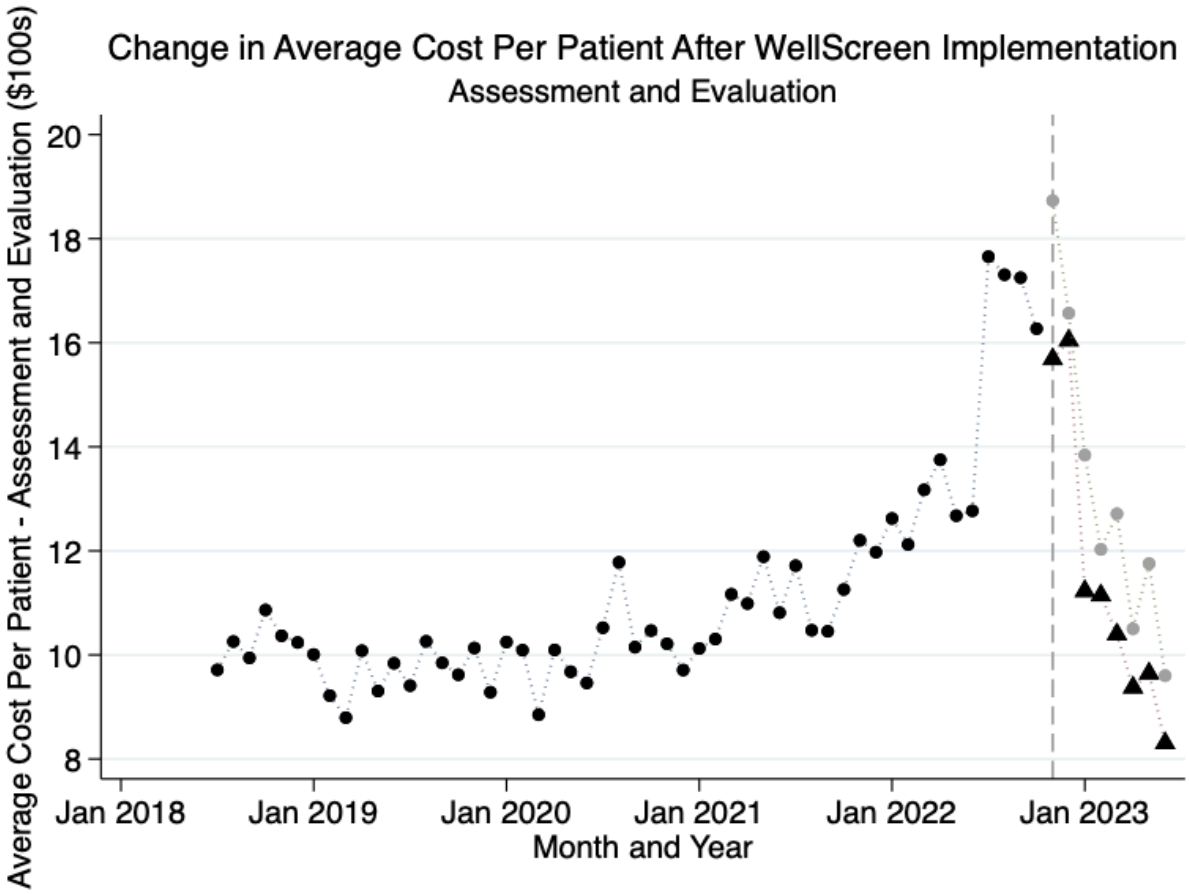
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Service Provision Impacts

There was a statistically significant, but decaying decrease in the average cost of assessment and evaluation services (95% confidence).

FIGURE 4



Notes: Data are from Monterey County Behavioral Health Electronic Health Record system. In the pre-intervention period, black circles represent actual data points. The gray dotted line represents the implementation of WellScreen (November, 2022). The black triangles present actual post-implementation data points. The gray circles represent expected data points based on the statistical modeling applied to pre-intervention data points.

Interpretation

Triage services increased consistent with a corresponding decrease in assessment and evaluation. The costs of triage, and assessment and evaluation, both decreased, likely driven by the increase in efficiency of triage activities.

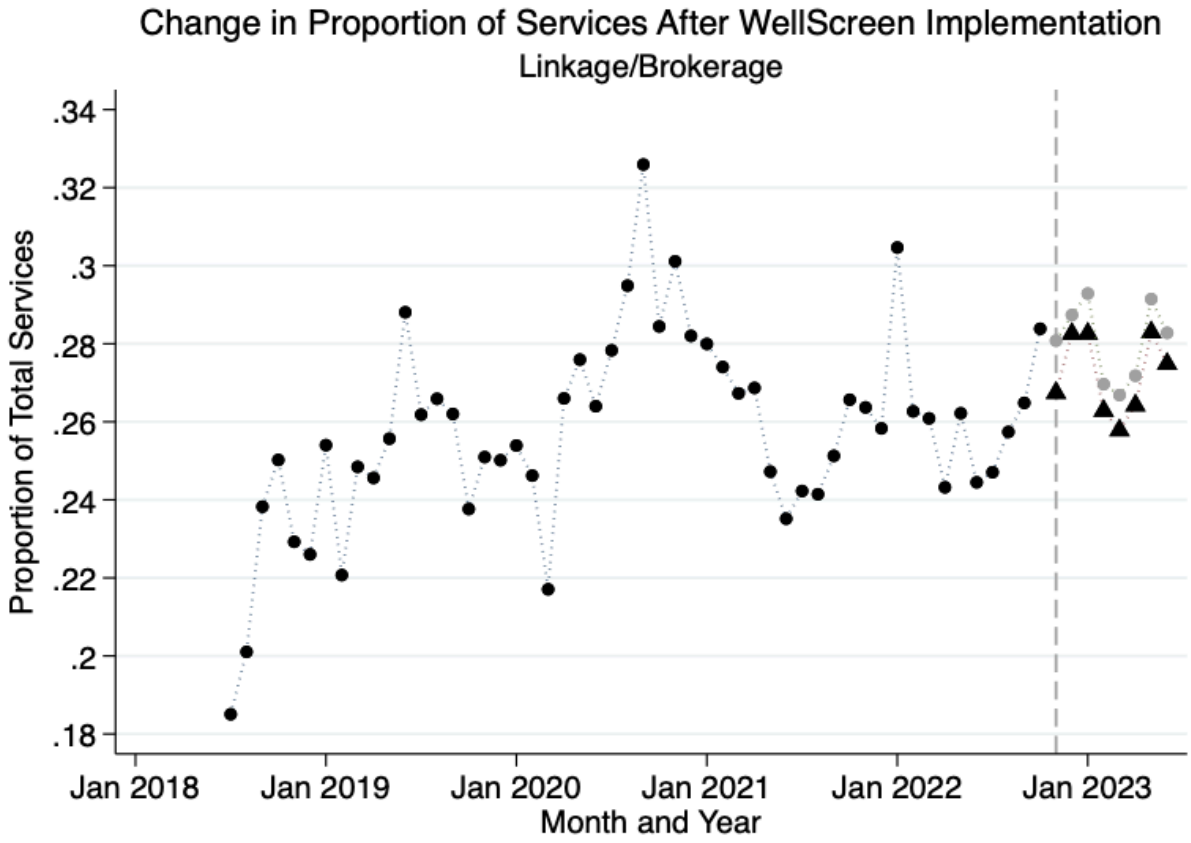
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Linkage/brokerage, referral measures

Service Provision Impacts

There was a smooth reduction in the proportion of services in the linkage/brokerage category (with approximate 90% confidence).

FIGURE 5



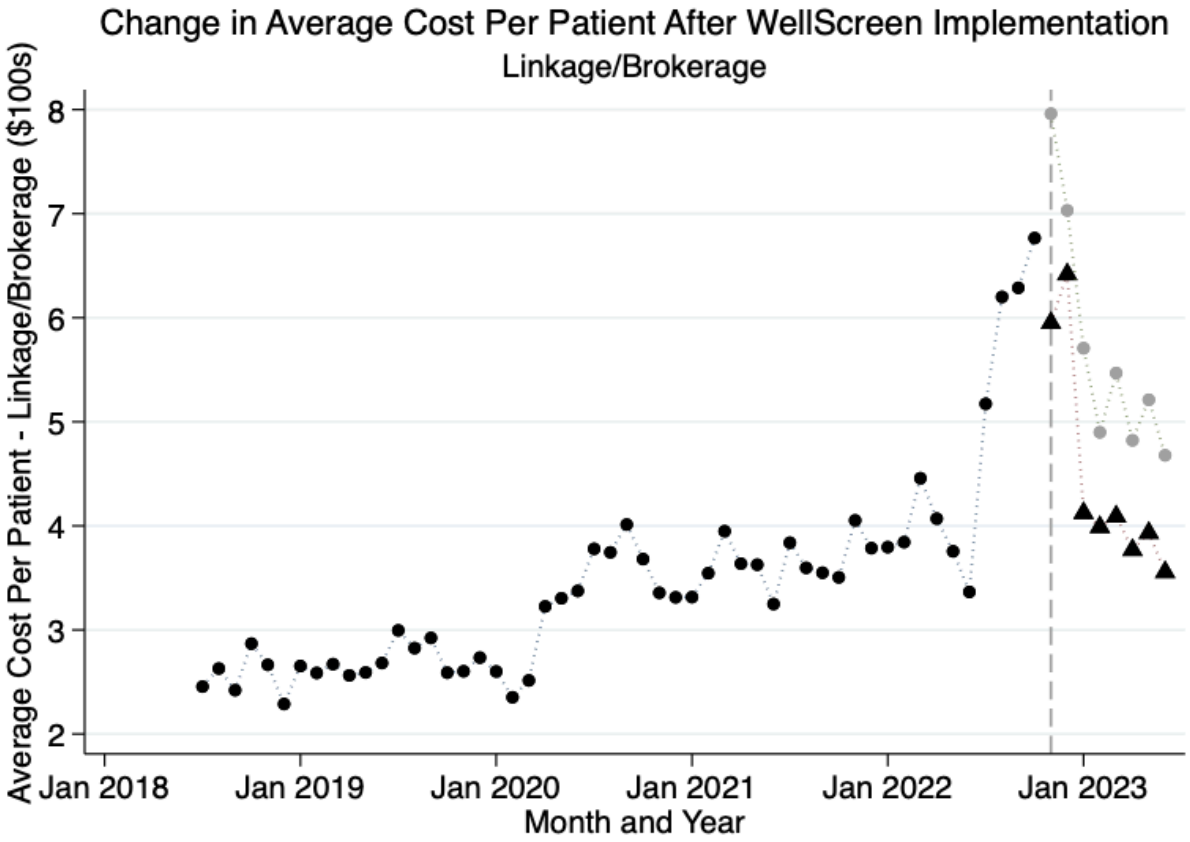
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Service Provision Impacts

There was a statistically significant, but slowly decaying decrease in the average cost of linkage/brokerage services (95% confidence).

FIGURE 6



Notes: Data are from Monterey County Behavioral Health Electronic Health Record system. In the pre-intervention period, black circles represent actual data points. The gray dotted line represents the implementation of WellScreen (November, 2022). The black triangles present actual post-implementation data points. The gray circles represent expected data points based on the statistical modeling applied to pre-intervention data points.

Interpretation

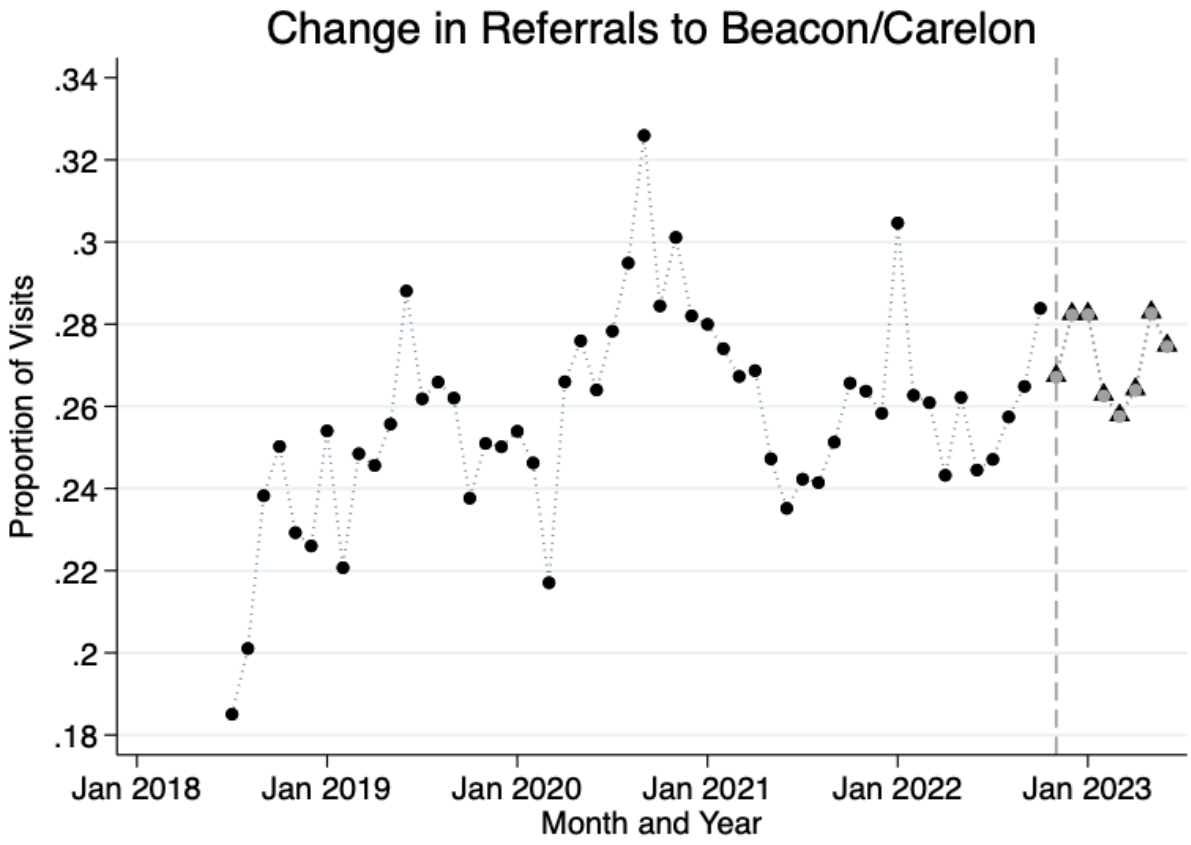
Linkage/brokerage services and costs decreased consistent with the corresponding decrease in assessment and evaluation services and costs.

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Service Provision Impacts

There was no statistically significant change in referrals to Beacon/Carelon (95% confidence).

FIGURE 7



Notes: Data are from Monterey County Behavioral Health Electronic Health Record system. In the pre-intervention period, black circles represent actual data points. The gray dotted line represents the implementation of WellScreen (November, 2022). The black triangles present actual post-implementation data points. The gray circles represent expected data points based on the statistical modeling applied to pre-intervention data points.

Interpretation

Referrals did not change, which simply means that the proportion of individuals inappropriately seeking care at MCBH rather than Beacon/Carelon did not change.

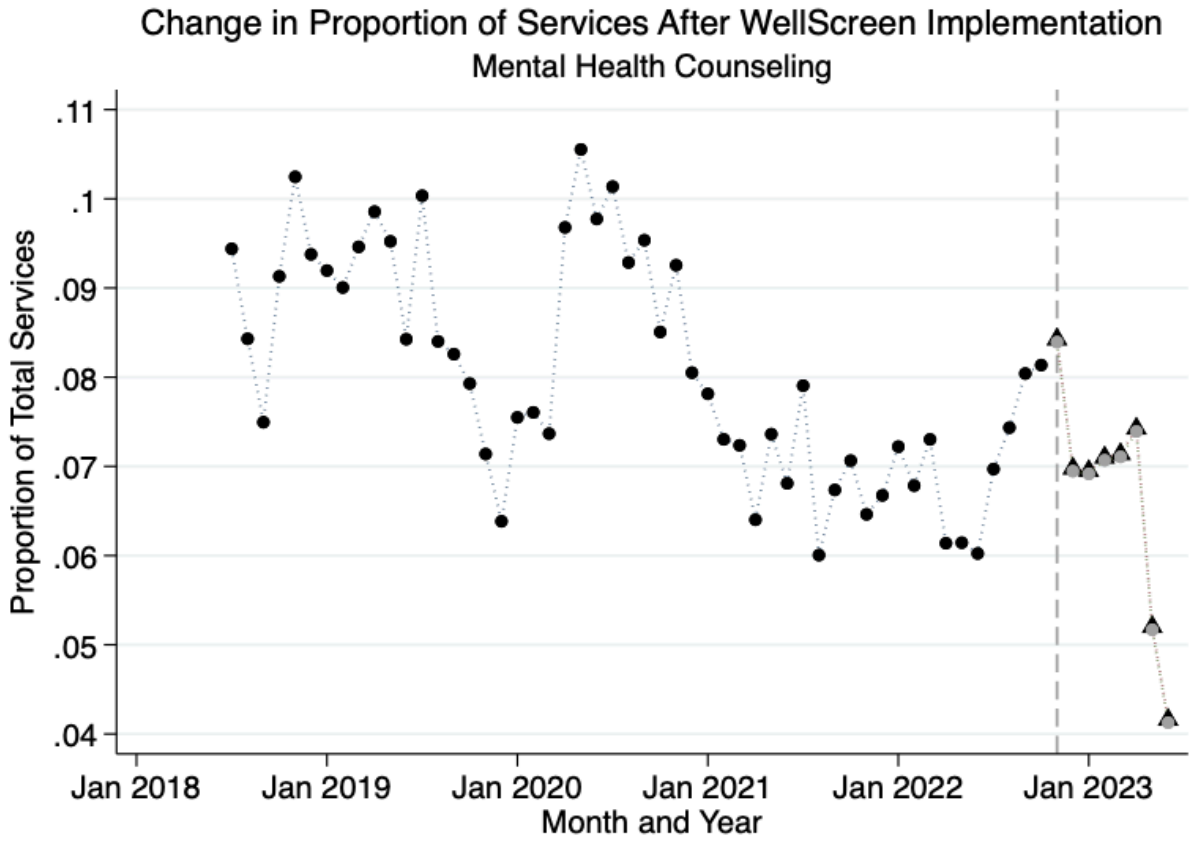
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Mental health counseling services

Service Provision Impacts

There was no statistically significant impact on the proportion of mental health counseling services.

FIGURE 8



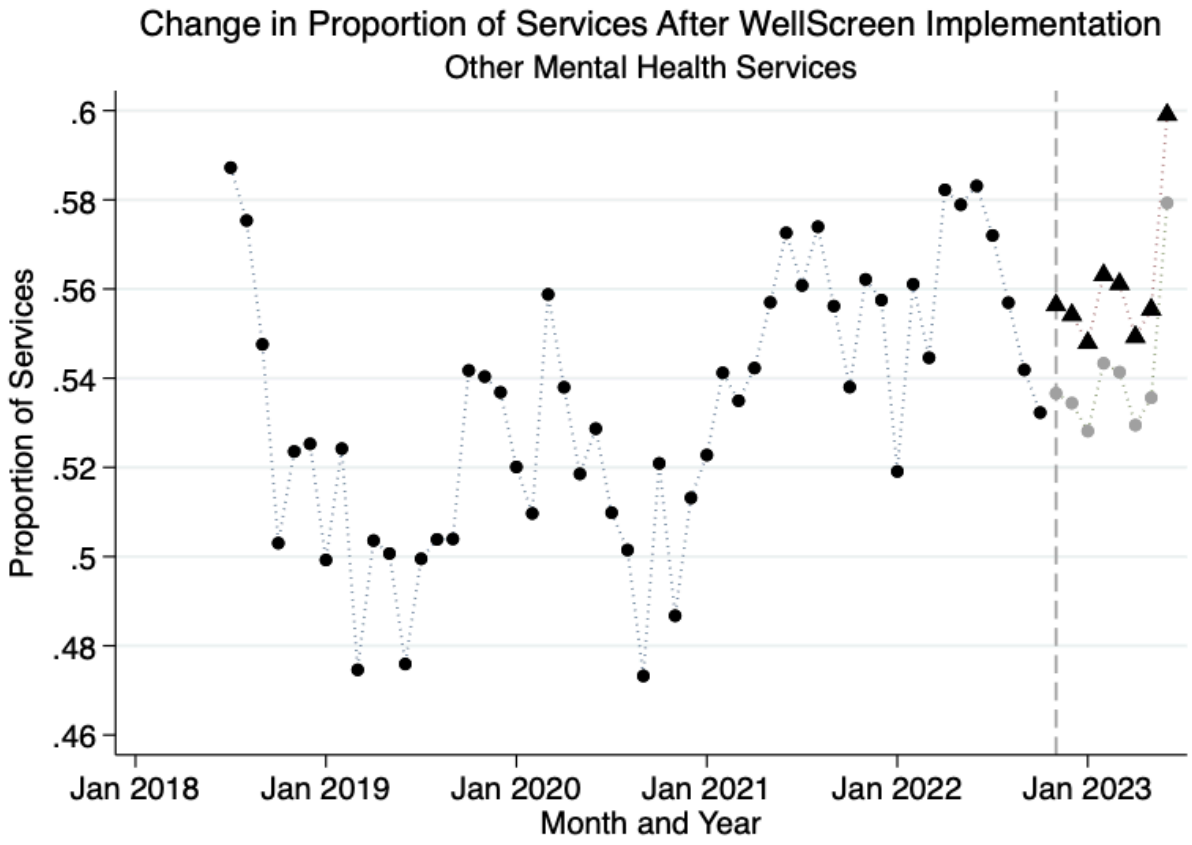
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Service Provision Impacts

There was no statistically significant impact on the proportion of other mental health services.

FIGURE 9



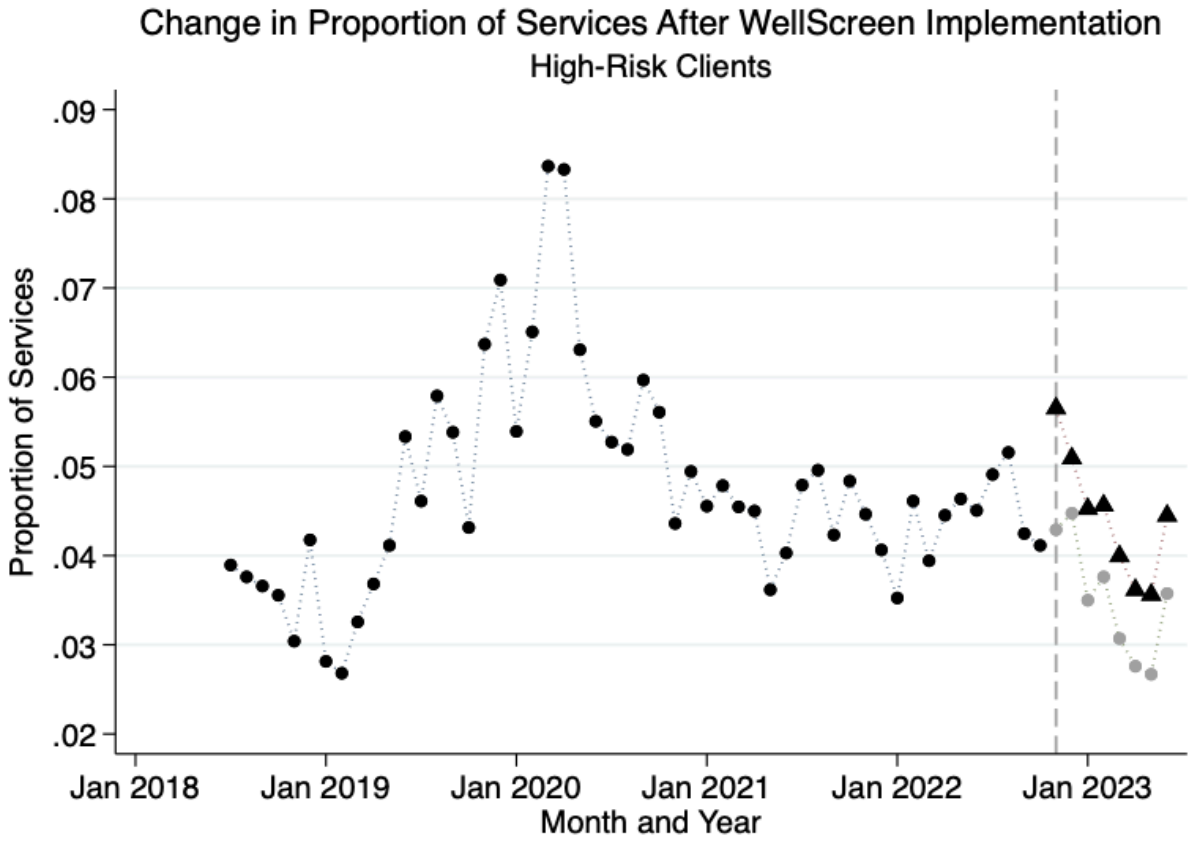
Notes: Data are from Monterey County Behavioral Health Electronic Health Record system. In the pre-intervention period, black circles represent actual data points. The gray dotted line represents the implementation of WellScreen (November, 2022). The black triangles present actual post-implementation data points. The gray circles represent expected data points based on the statistical modeling applied to pre-intervention data points.

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Service Provision Impacts

There was a statistically significant smooth rise in the proportion of services devoted to high-risk clients (95% confidence).

FIGURE 10



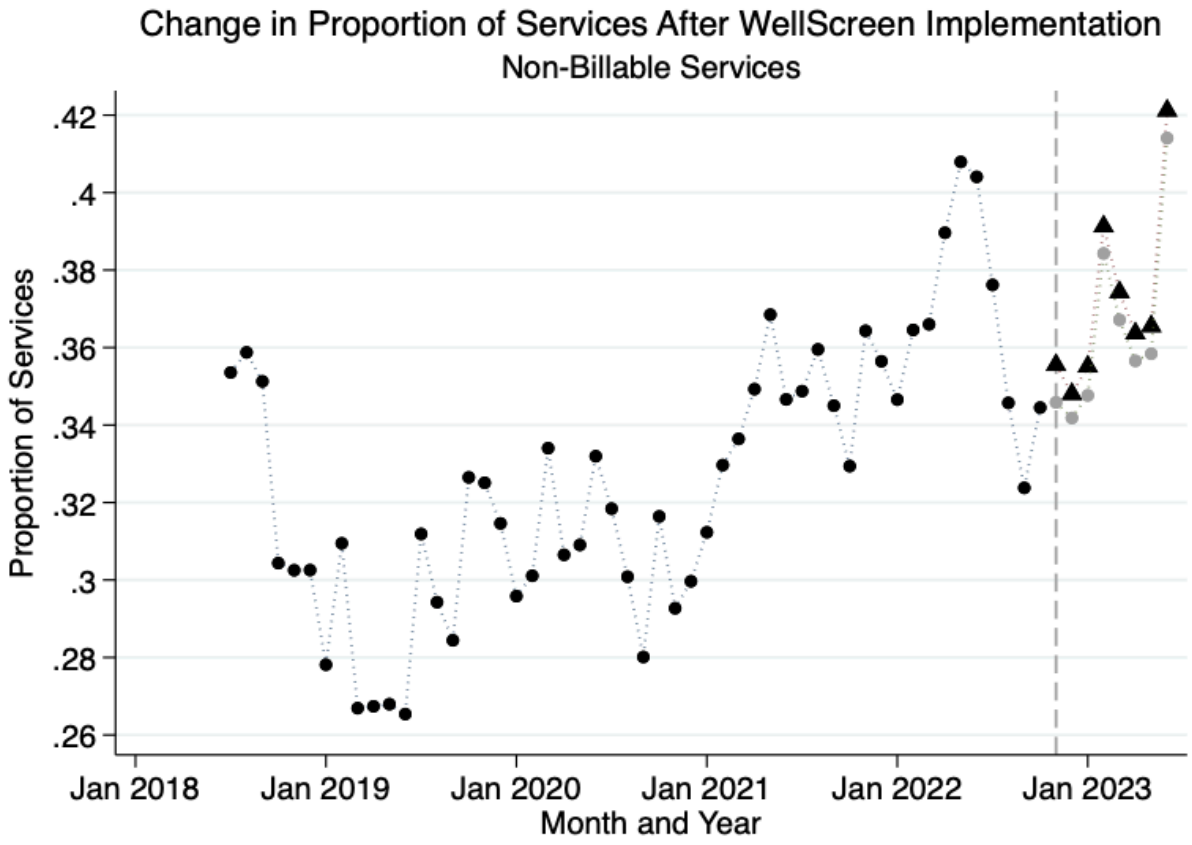
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Service Provision Impacts

There was no statistically significant impact on the proportion of non-billable services.

FIGURE 11



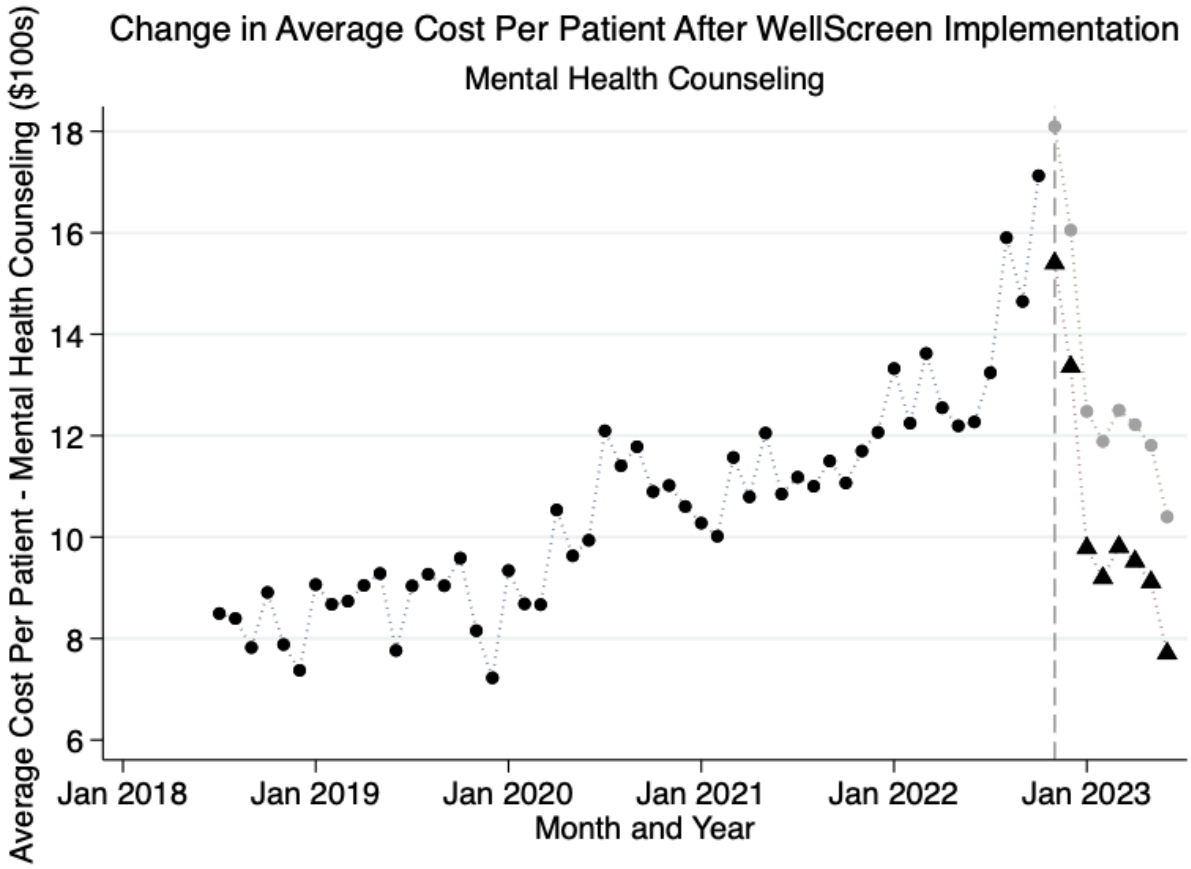
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Service Provision Impacts

There was a statistically significant, but seemingly permanent decrease (step) in the average cost of mental health counseling services (95% confidence).

FIGURE 12



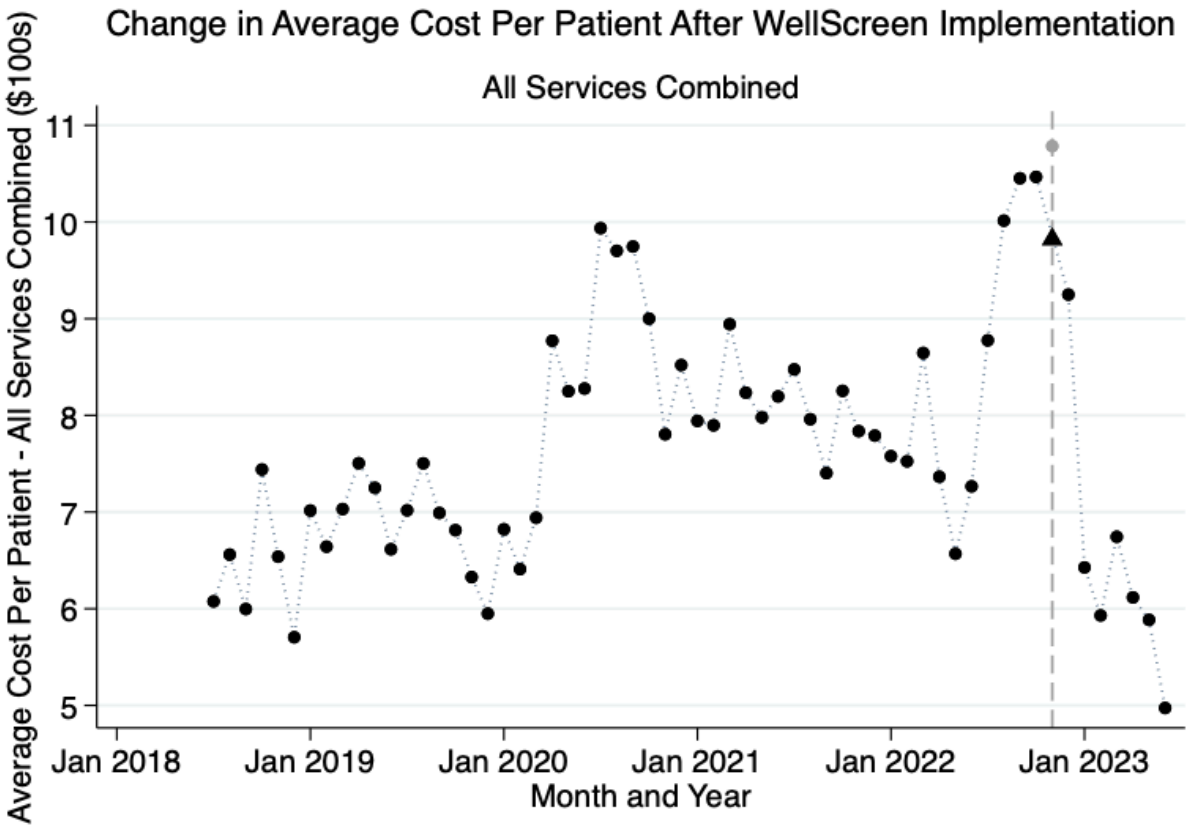
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Service Provision Impacts

There was a statistically significant, but short-lived decrease (decay) in the average cost of services when all services are included (95% confidence).

FIGURE 13



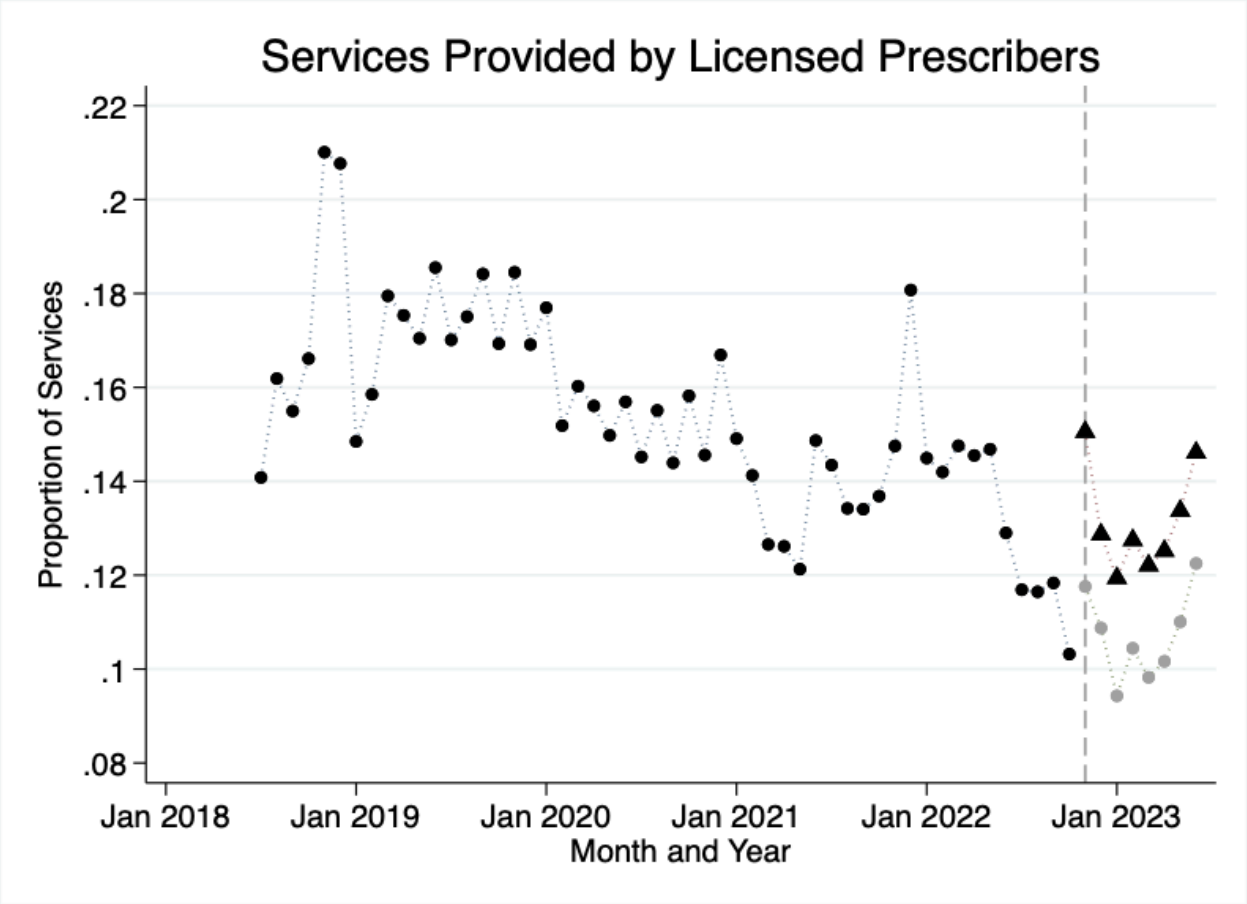
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Impact on Licensed Providers Providing Services by Prescribing Status

There was a statistically significant smooth increase in the proportion of licensed prescribing providers who provided services (95% confidence).

FIGURE 14



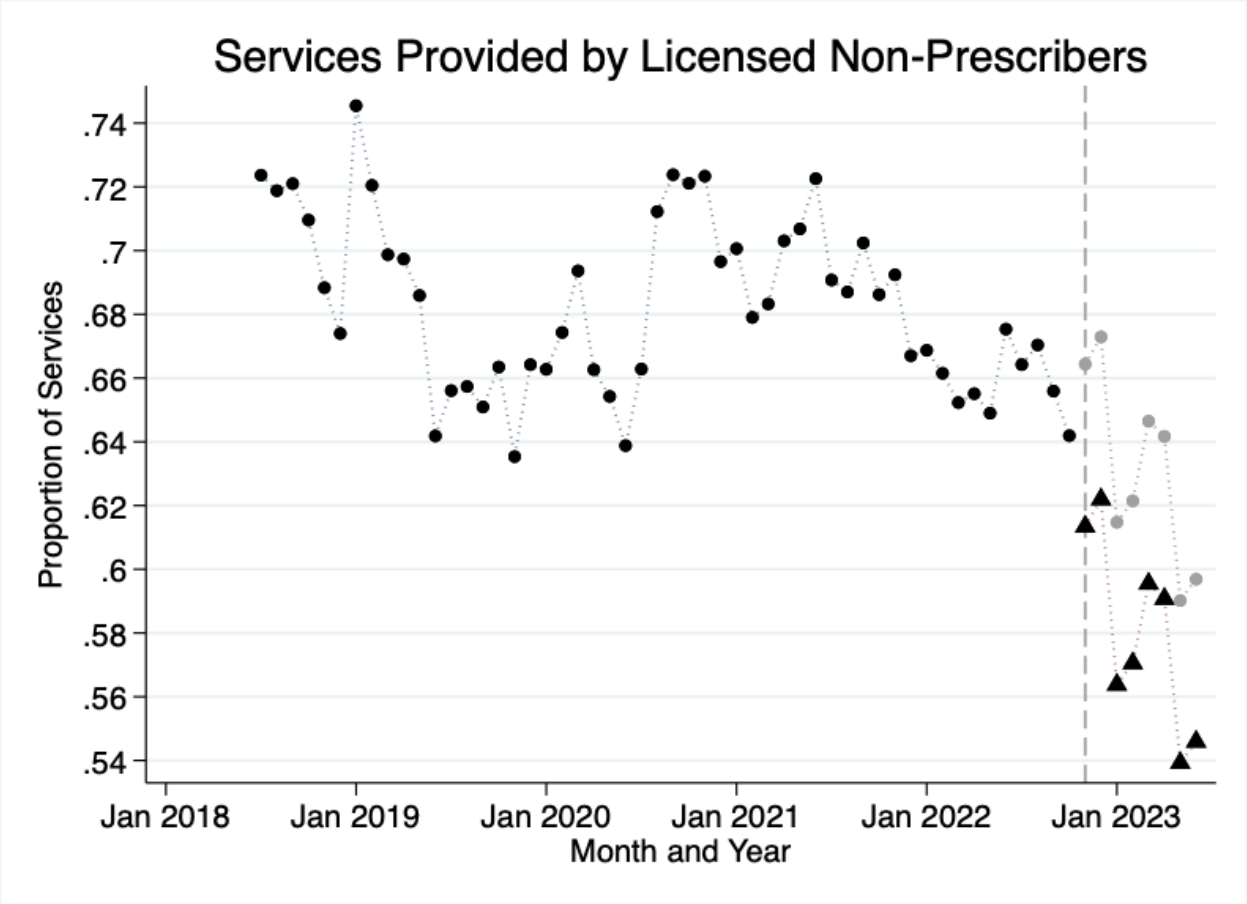
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Impact on Licensed Providers Providing Services by Prescribing Status

There was a statistically significant decrease (step) in the proportion of licensed non-prescribing providers who provided services (95% confidence).

FIGURE 15



Notes: Data are from Monterey County Behavioral Health Electronic Health Record system. In the pre-intervention period, black circles represent actual data points. The gray dotted line represents the implementation of WellScreen (November, 2022). The black triangles present actual post-implementation data points. The gray circles represent expected data points based on the statistical modeling applied to pre-intervention data points.

Interpretation

There was an increase in the proportion of high-risk patients, which is consistent with a change in the mix of providers away from non-prescribing providers and towards prescribing providers. The lack of a change in the mix of services allocated between mental health counseling services, other mental health services, and non-billable services, combined with an overall reduction in the average cost of the services, suggests that prescribing providers were able to efficiently serve these high-risk patients resulting in lower average costs.

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Mental Health Conditions Assessed by Help@Hand and Potential MCBH Clients

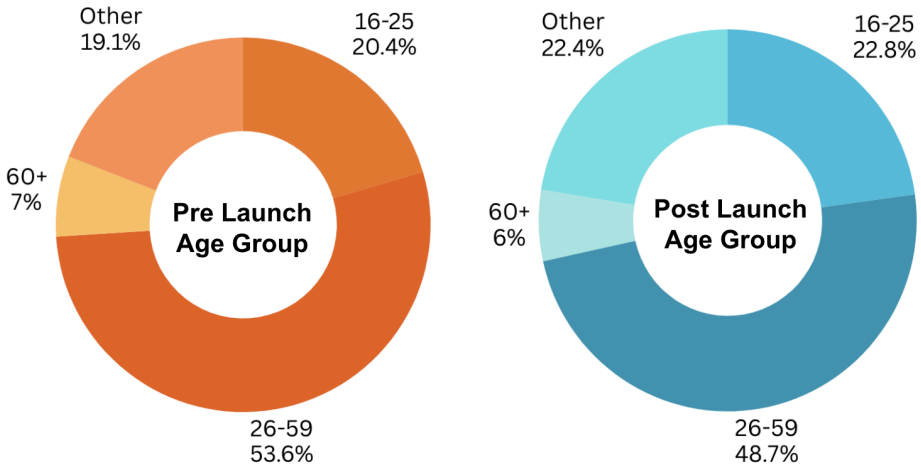
The following statistics are based on Help@Hand data from launch to September 7, 2023, and reflect 21,243 users of whom 9,509 lived in Monterey County and 2,228 completed an assessment. Multivariate logistic regression models found that Google paid advertisements and referrals were the most effective marketing strategies to attract Monterey County users (26.4% and 20.4% more effective than simple web search, respectively). Email and social media were no more effective than simple internet searching at bringing in individuals from Monterey County who go on to complete assessments.

Not all assessments were relevant for all individuals. Of the 2,228 individuals in Monterey who completed assessments (some individuals took tests more than once, which we accounted for), only a subset, 552, lived in Monterey County (based on their reported ZIP code), were rated moderate-to-severe for at least one of the following conditions, were covered by Medi-Cal, and were not currently being treated by MCBH: Anxiety (354, 64.1%), Depression (367, 66.4%), PTSD (163, 29.5%), Bipolar (238, 43.1%), Eating Disorder (284, 51.4%), Substance Abuse Any (233, 42.2%) and Psychosis (26, 4.7%).. This represents 552 different individuals when comorbid conditions are taken into account. Percentages do add to more than 100% due to comorbid conditions.

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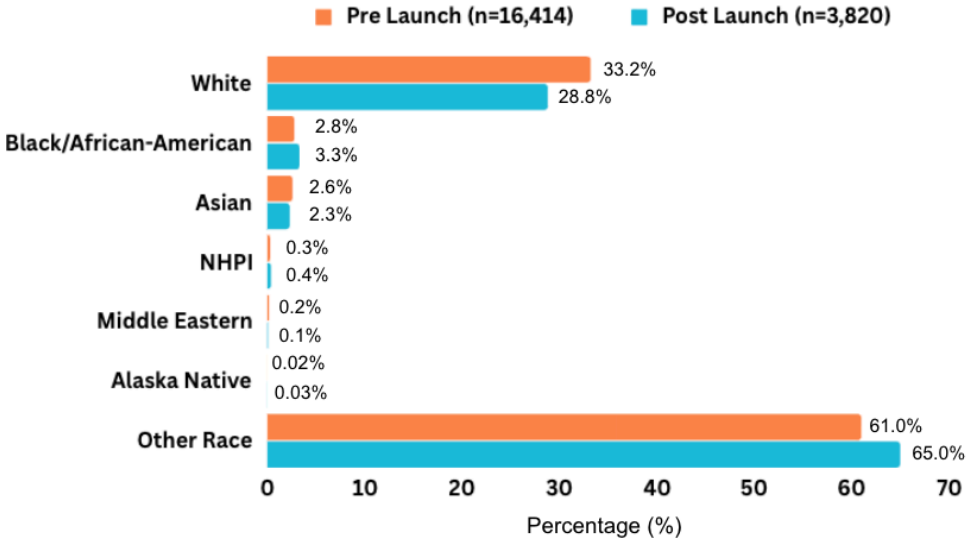
Monterey County Behavioral Health ACCESS Program demographic characteristics

FIGURE 16. Clients by Age Group



The percentage of clients in the 16-25 age category increased from 20.4% in the "pre" period to 22.8% in the "post" period. Conversely, the 26-59 age category experienced a decrease, with the percentage declining from 53.6% to 48.7%. The pre-post changes were not significant (p=0.187).

FIGURE 17. Clients by Race

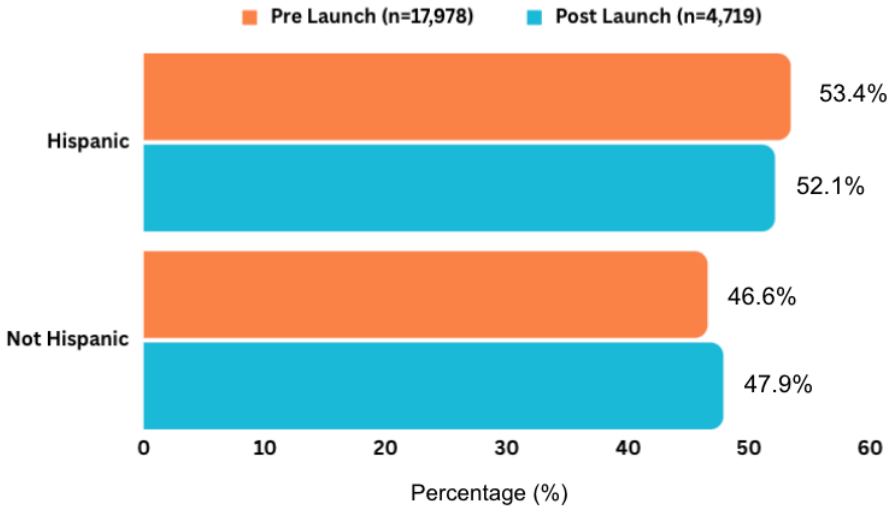


Note: Patients with No Entry responses were removed from this visualization.
(Number of clients with No Entry response - Pre: 3, Post: 1)

By race, the proportion of clients identifying as White showed a decrease from 33.2% in the pre-launch period to 28.8% in the post-launch period. The percentages for clients of "Other Race," "Black/African-American," "Asian," and other categories experienced relatively minor fluctuations. The change in Race distribution between pre-post-launch periods was significant (p<0.001).

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FIGURE 18. Clients by Ethnicity



Note: Patients with No Entry responses were removed from this visualization.
(Number of clients with No Entry response - Pre: 7, Post: 3).

The percentage of Hispanic clients remained relatively stable, slightly decreasing from 53.4% pre-launch to 52.1% post-launch. The pre-post-launch period change in ethnic origin distribution was significant ($p<0.001$).

FIGURE 19. Clients by Type of Health Insurance/No Insurance

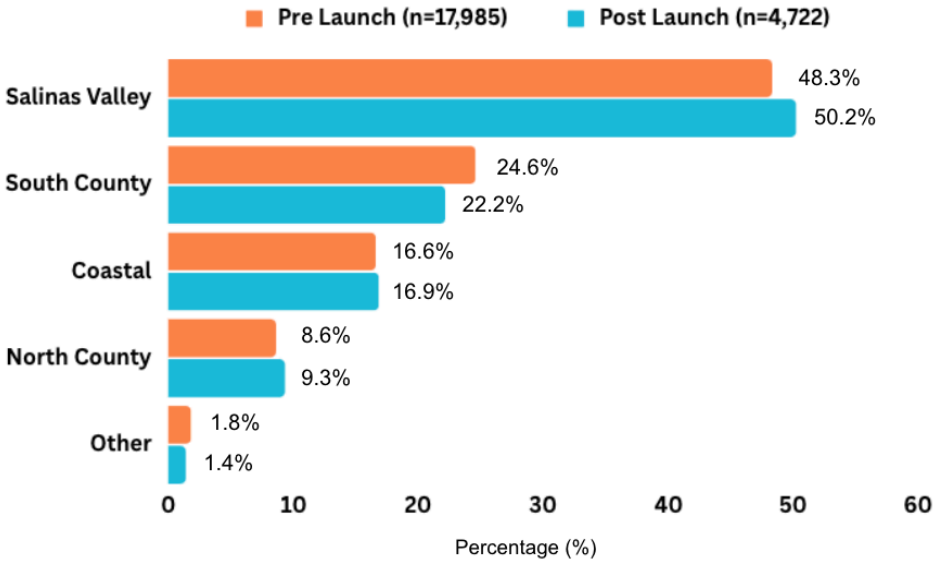
	Pre Launch (% of clients served)	Post Launch (% of clients served)
Medi-Cal (Medicaid)	73.5%	77.6%
Medicare Part B	5.4%	7.4%
Private Insurance	7.4%	6.6%
Self Pay/Other	13.3%	7.8%
Others	0.4%	0.6%

Data are from MCBH Electronic Health Record System.

The table displays the percentage of clients with different types of insurance coverage (or lack of insurance) in the pre- and post-intervention periods. Overall, there were increases in client proportions covered by Medi-Cal and Medicare Part B, while Self Pay and Private Insurance proportions decreased from pre- to post-intervention. The change in the insurance status distribution between the pre-post-intervention period was significant ($p<0.001$).

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FIGURE 20. Clients by Monterey County Regions



The above graph indicates that the proportion of clients from the Salinas Valley Region increased slightly from 48.3% in the pre-intervention period to 50.2% in the post-intervention period, while the South County region experienced a modest decrease from 24.6% in the pre-intervention period to 22.2% in the post-intervention period. The percentages for the Coastal, North County, and Other Regions remained relatively stable between the two time periods. The pre-post-change in the regional distribution was significant ($p<0.001$).

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Planning processes

Key informant interviews were conducted with 14 key stakeholders involved in the planning phase of the Help@Hand project and included informants from Monterey County Behavioral Health, other community service agencies in Monterey County, and Help@Hand Technology Development Partner. Interviews were conducted from May 26, 2023, to August 23, 2023. The following qualitative findings are organized into sections (successes, challenges, and suggestions), and then subsections (MCBH Key Informant Perspectives, Non-MCBH Provider Perspectives, or Help@Hand Technology Development Partner Perspectives).

Table 1. Key Informant Interview Participants (n=14)

Key Informant Agency Type (n)	Job Titles
Monterey County Behavioral Health (n=4)	Behavioral Health Services Manager, Assistant Bureau Chief, Services Manager II Over Quality Improvement, Management Analyst/Innovations Coordinator
Community Service Agencies in Monterey County (n=5)	Deputy Director, Social Services Manager, Peer Outreach/Advocacy Coordinator, Program Coordinator, CEO/Consultant
Help@Hand Technology Development Partner (n=5)	Customer Success Manager, Director of Content Operations, Research and Aata Coordinator, Chief Technology Officer, Senior Product Advisor

Successes

MCBH Key Informant (KI) Perspectives

“The planning went well and I think we had the right people in place to help support this. In particular, having our ‘ACCESS to Treatment’ managers available for the [planning and] implementation process, because a lot of times, our clients come through our ACCESS [program] doors.” - MCBH Administrator

“In the planning phase, I think what I feel really went well is the [digital technology development] team was very responsive to needing to be flexible and needing to hear from us about our community needs and then making those adjustments [to the design].” - MCBH Administrator

Monterey County Behavioral Health (MCBH) key informants shared that the key facilitators that made the planning phase for WellScreen Monterey digital platform/website successful included: (1) the partnership between the MCBH program managers and the mental health- and wellness-oriented digital technology development organization and evaluators in the planning and design process and the project team’s flexibility and responsiveness to the County stakeholders’ needs and priorities in the planning and design of the WellScreen Monterey website, (2) the community needs assessment which welcomed a variety of stakeholders input and identified the key community preferences for accessing and using the website content and format, (3) the testing and validation of the behavioral health assessment measures and scales

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to ensure their accuracy and usability, and (4) the full transparency and open communication of the planning team which cultivated the trust and facilitated the productivity in the planning and design process of the website between CalMHSA, MCBH administrators and providers, the digital technology development team, and the evaluation team.

"I think the [development] team, and really the [state] CalMHSA team, was good in keeping us on track and identifying weaknesses in our approach. So I think that was well done as well." - MCBH Administrator

Most MCBH KI participants shared that the collaboration between MCBH program managers/providers, state of California Help@Hand program (CalMHSA), and the Help@Hand partners (digital technology development and evaluation teams) was successful during the initial planning phase of WellScreen Monterey to facilitate the ongoing progress of this initiative. Half the participants also mentioned that the MCBH partners during the planning phase were very responsive and flexible to the needs of the county behavioral health agencies and community stakeholders. In addition, half of the participants indicated that each of the project collaborators brought the respective skills and capacities needed (e.g., mental health, program management, digital technology development, evaluation) which led to a well-developed initial technology innovation proposal that got awarded, team members being engaging and responsive to each other's feedback in the planning phase, and scope of work activities progressed in a productive manner and being fully executed. Further, one participant indicated that all design and development ideas and decisions were also openly discussed and transparent among all the team members during the planning phase and made the coordinated efforts more integrated and seamless. Another participant also indicated the planning phase process was productive.

"When myself and some other [MCBH] folks doing the work and really understanding the workflow and the needs of our community,…the feedback that we provided led to some adjustments from those initial impressions. And I always felt like that they were very responsive to that and wanted to make it make sense for the work and for the community. So I think that was a huge strength of the process." - MCBH Administrator

"I think [digital technology development team] did a really good job with their focus groups and all of that to kind of get more clinical and peer perspectives on what the tool should screen for." - MCBH Administrator

During the planning phase, the development team conducted a community needs assessment phase that included key informant interviews and focus groups with key stakeholders that included community, clinical, MCBH agency, and external provider perspectives. Half the MCBH participants stated that the key informant interviews from MCBH, other behavioral health serving agencies, and the mental health- and wellness-oriented digital technology development organization, were quite effective to inform the Help@Hand planning phase such as the design of the virtual screening measures and selection of the validated scales. One participant explained that the development team was very responsive to the feedback from Monterey County regarding the needs that the community stakeholders shared and validated scales that the Monterey County clinical team suggested to use in the self-assessment on WellScreen Monterey for the end users.

One participant also found the testing and review of mental health screening measures that occurred during the planning phase of WellScreen Monterey to be comprehensive and helped the accuracy of the assessment screening. Additionally, the participant explained that WellScreen Monterey became a community-facing screening tool to provide resources and

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better understanding of mental health needs for individuals, rather than a direct linkage to behavioral health services due to feedback from the MCBH administrative and clinical teams. This adjustment helped ensure WellScreen Monterey would supplement the work of a Monterey County clinical team to make the countywide assessment screening processes more efficient and be able to extend the reach to provide an earlier indication of mental health needs to address.

"I remember [technology development staff] did a really comprehensive dive into vetted assessments to try to use those assessments in the screener tool itself. To pinpoint the mental health issues that may be existing for somebody and for that to be accurately determined by the screening tool. And she did a really comprehensive dive into those various... What's the word? Validated measures." - MCBH Administrator

Non-MCBH Provider Perspectives

Among non-MCBH providers in the community, one participant shared that the planning phase was intentional in welcoming a variety of stakeholder perspectives and feedback, including youth perspectives.

Help@Hand Technology Development Partner Perspectives

Help@Hand technology development partners key informants shared that key facilitators which made the planning phase for WellScreen Monterey digital platform/website successful included: (1) coordination and collaboration between project teams, (2) adherence to project timelines and responsiveness to any delays, (3) clear goals, measures, and outcomes for the project, (4) community needs assessment to gather important guidance and feedback from community members, (5) clinical site visits to engage and discuss with clients on-site at clinics in Monterey County clinics, (6) efficient administrative processes, and (7) marketing preparations and planning.

"We had a very open, [experienced] and informed team. [O]ur project management with [CalMHSA team] went really well. We also spent a lot of time collaboratively thinking about the problem[-solving], and from my perspective, trying to apply technical workflow or a user experience and workflow that would suit the constituents that we were trying to reach" - Help@Hand Technology Development Partner

Half of the Help@Hand technology development partners shared that the coordination between the collaborators Monterey County (MCBH), state of California (CalMHSA), and the technology development team were quite successful throughout the planning phase. Some of these participants commented on the success of the coordination between the various workgroups (e.g., research/evaluation, technology design, marketing) of the development team and MCBH that facilitated the technical development of WellScreen Monterey platform. A participant also mentioned that the CalMHSA was quite an effective mediator and made the joint planning between MCBH and the development team quite productive. Another participant highlighted the productive planning process was due to the abundance of professional experiences and expertise of individuals across the collaborating Help@Hand team of MCBH, CalMHSA, and the partners (development and evaluation teams).

"This is a seven-figure project, and every…deadline was actually met, except, I think we delayed the launch a little bit. But every major deadline along the way was met because there was a clear process in place, review, mock-up review, agile development process with sprints,

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and keeping things moving along. So I think, overall, I was very happy with the work of coordinating the original design, developing the product, and also just the flexibility of the team along the way…" - Help@Hand Technology Development Partner

Some participants shared that they stayed on track and met project deadlines throughout the planning phase. Almost every deadline was met due in part to a clearly set process with feasible tasks and associated timelines. For those project deadlines that were delayed, they were in part due to the need to await external feedback before being able to complete the set milestones. Some also mentioned that project management tools they used were quite useful and effective with setting milestones, tasks, and deadlines for the development team.

Some participants detailed that the scope of work parameters were clearly defined and realistic as they pertained to the goals, measures, and outcomes. This made each of the planning stage milestones set quite feasible to accomplish by the deadlines and led to the development team consistently making good progress.

"The most helpful information and also criticism of the system came from providers and community partners. Youth community members had a lot of good insight as well. It seems like the youth are a little more connected or…aware of what's available and what's not. They had some good feedback [about] the general state of mental health in the county." - Help@Hand Technology Development Partner

"Having the opportunity to actually interface with the people that might be impacted or interacting with the project. The final result of the project was really helpful. Going through a formal process of recruitment and interviewing, surveying, extracting our [community assessment] findings from that data reporting back out…that was positive." - Help@Hand Technology Development Partner

Some participants expressed the community needs assessment was quite useful for the planning process as it engaged and sought input from a variety of stakeholders about what they wanted and preferred for a new technology platform for mental health screening and resources. One participant shared that, in particular, mental health providers and community informants provided the most helpful guidance and feedback to the design of the Help@hand platform. In addition, this participant indicated that youth community members contributed very good insight as they were more connected and aware of mental health resources available to them and their general state of mental health. Another participant appreciated the comprehensive nature of the community assessment process which consisted of key informant interviews, focus groups, and surveys with mental health providers, community members, and MCBH partner organizations in the community.

"For validation [of the self-assessment tool] we did do a [MCBH clinic] site visit so that we could compare, so that we could reach people who were physically going into the ACCESS program clinics and then be able to compare the results of their [in-person] triage and intake process and our [virtual] screening process… it was definitely helpful to be there physically and be able to talk to people, explain to them directly what we're doing." - Help@Hand Technology Development Partner

One participant also indicated that the development team conducted MCBH ACCESS program clinical site visits to engage and discuss with actual clients on-site at the Monterey County clinics. During these site visits, the development team was able to compare the in-person triage and intake processes at the clinic to the virtual WellScreen Monterey self-assessment screening

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process. This participant also mentioned that it was quite helpful to be able to explain the new WellScreen Monterey website to clients of MCBH directly in the clinic and ask for their input on how to make the online self-assessment and the associated resource linkages easier to use. Most clients they reached out to in-person showed interest in sharing feedback on the usability of the WellScreen Monterey website.

In addition, one development team participant shared that the administrative process for the contracts were well-aligned with the proposed scope of work, and invoices were completed promptly by the accounting teams. Further, one participant commented that contract revisions or contract change requests were completed efficiently on all sides.

"I think what went well is that we were able to [prepare ahead of time to] get everything out there with some ads on the day of launch. And we did the initial ads internally and so we were able to put those together as a team and they did pretty well." - Help@Hand Technology Development Partner

One participant discussed the effectiveness of the preparations for the initial marketing and outreach process for the WellScreen Monterey launch during the planning phase. Discussions with online marketing strategies (e.g., Google, Facebook) and in-the-community outreach strategies (e.g., TV/radio, bus ads, flyers) occurred concurrently during the planning of the WellScreen Monterey launch.

"Google continues to be the best performing tactic based on conversions, and we are defining conversions by anybody who actually completes the survey." - Help@Hand Technology Development Partner

One participant shared that Google has been a very successful avenue for assessment screening completions, while Instagram and Facebook have been successful for overall impressions and views.

Challenges

MCBH Key Informant Perspectives

Monterey County Behavioral Health (MCBH) key informants shared that the key challenges for the planning phase for WellScreen Monterey digital platform/website included: (1) staffing transitions and need for more county staff, (2) earlier planning for marketing, (3) delays and task prioritization that affected timing, and (4) administrative processes and limitations of resources to prepare as well as integration of WellScreen Monterey results with the electronic health records.

"There's just a couple of us, myself included, trying to figure this out before the rubber met the road with CredibleMind. And then even once CredibleMind came on, they had lots of good input. So we're [considering that] would've been great to think about two years ago." - MCBH Administrator

One participant shared that the main challenge to the planning phase of WellScreen Monterey was related to staffing of Monterey County Help@Hand program. Transitions in county leadership and agreements between cross-county partners that varied in involvement affected the timeliness of the guidance from county leads about Help@Hand initiative to the county staff

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to work on this initiative and led to some delays during the planning phase. They also indicated that more county staff was needed to carry out the Help@Hand initiative before and after connecting with the development team, as well as more county staff to conduct training sessions before the WellScreen Monterey launch.

Two participants stated that earlier strategizing on marketing, as well as more outreach would be beneficial.

"...we had [another county] in the mix for a while. They were going to partner, they weren't really like an active partner, they're more fiscal…And then COVID hit, put a pause on everything. And then during the RFP process,...having this silent partner really slowed things down. And I feel like it put us into this current relative time crunch to pilot the project." - MCBH Administrator

Two participants discussed the timing challenges during the planning phase of WellScreen Monterey. Delayed start, task prioritization, and proposal and contract set up were aspects that impacted the timing. Determining county partnerships and adapting to COVID-19 also introduced challenges into the planning phase. One participant shared that ideally, the evaluation of WellScreen Monterey could be over three years rather than ten months.

"The failure to launch the project was more of an internal ability to provide the resources to get it done. And then the prioritization of those resources, there's always something that seems to come up that seems to be more important. And it wasn't until we finally prioritized this than other projects that it kind of shook everything loose and now we're going." -MCBH Administrator

Two participants described challenges from administrative processes including ability to provide resources during the planning phase to prepare for the launch phase, and limitations where the WellScreen Monterey assessment screening results could not be automatically entered into the electronic health records.

Non-MCBH Provider Perspectives

Non-Monterey County Behavioral Health (Non-MCBH) key informants shared that the key challenges for the planning phase for WellScreen Monterey digital platform/website included: (1) not reading the focus population due to education and language barriers, (2) need for more staff such as someone who had experience with being on air, and (3) timing challenges due to meeting coordination, budget discussions, and staffing.

"I just worry that [WellScreen Monterey website] might be a little bit too sophisticated for some people and actually very kind of middle class centric. What we have here is a giant population of people who do not have a bachelor's degree and who are working in the fields and who are typically Spanish speakers." - Non-MCBH Provider

One participant shared concerns that WellScreen Monterey is not reaching the focus population since many do not have college degrees and typically speak Spanish. Another participant discussed challenges of staffing, where a person could not be identified to do an on-air advertisement interview with a local radio station.

"There's one other component that we have everything set for, but it's just a matter of time and resource for the team, for the Monterey County team." - Non-MCBH Provider

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Two participants spoke about timing challenges, related to coordination of meetings, budget discussions, staffing. Difficulties finding meeting times that worked for everyone, as well as discussions about budget which introduced some delays. Additionally, due to lack of staff, there were delays in collecting advertisements and distributing in the communities.

Help@Hand Technology Development Partner Perspectives

Help@Hand technology development partners' key informants shared that the key challenges for the planning phase for WellScreen Monterey digital platform/website included: (1) collaboration challenges that could benefit from a designated representative from each team to improve communication, (2) need for more feedback especially from MCBH clinics on design of the website before launch, (3) challenges with recruitment for feedback from Monterey County communities, and (4) communication between teams and stakeholders as well as administrative challenges such as goals that were not as clear.

"One challenge…was that our main point of contact for [Monterey County] was not a clinical person. So when it got to determine…fit in the clinical workflow, we had to communicate,...get those people on the phone, or not on the phone. In meetings or through email…It definitely was a little more back and forth, not having a direct contact who was a clinician or a part of the clinical processes." -Help@Hand Technology Development Partner

Three participants discussed challenges related to team collaboration during the planning phase. Two participants shared that having a designated county representative would be helpful for the planning process. One participant commented that it was challenging to involve the large number of agencies and organizations that were part of the desired reach of WellScreen Monterey.

"There's so many different agencies and organizations we wanted to [reach]...the 800 number that people call, the actual MCBH clinics, making sure they were involved early on. We did an okay job at it, but it was a bit of a challenge because they're busy and they're seeing clients, and we had to come and intrude a bit." -Help@Hand Technology Development Partner

One participant shared that they would've liked to see more feedback on the design process prior to launching the website. Another participant discussed challenges with ensuring MCBH clinics were involved early on. Many of the clinics were so busy serving clients.

"Because [technology development partner] is completely virtual…and we don't live in Monterey County…[or] worked with Monterey County before, we didn't necessarily have the direct connections to the people that we needed to talk to…it was really on us from afar and virtually to do a lot of the recruitment [and create linkages] ourselves." -Help@Hand Technology Development Partner

Two participants brought up difficulties when recruiting and creating linkages. One participant described difficulty from usability recruitment and another participant discussed difficulties making direct connections and linkages with Monterey County. Everything was done through CredibleMinds from afar. The participant stated it would have been helpful to have a researcher reach out to the most visited clinics in the county.

"Some of the requirements from the statement of work were designed and developed at such an earlier date that there were some shifts and changes. And, while we were able to make some modifications along the way through mutual agreement, it was a little challenging to understand

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how to best suit [MCBH] based on what they had originally decided to position themselves to do. And then, what they might've wanted to do at the time we started to do our design work." -Help@Hand Technology Development Partner

One participant discussed timeline delays due to challenges with stakeholder communication; This resulted in the launch being delayed and not having enough time to fix website design before the launch. Another participant discussed challenges from requests and requirements made by Monterey County throughout the design process.

Two participants expressed administrative challenges. One participant discussed the challenges of understanding triage, specifically what happens when a person seeks services at clinics that have high demand and limited capacity and access Medi-Cal recipients but refer others out, and the difference between walk-in clients, and other clients. One participant shared that the goals were loosely defined, leading partners to create parameters.

Suggestions

MCBH Key Informant Perspectives

"Again, making sure that our Hispanic community have that resource, [WellScreen Monterey]. Sometimes it could be a QR code at their church or at our local carnicerías, or meat markets, where people go and are familiar with and not just a website that sometimes our families don't know how to navigate or our community doesn't know how to navigate…having more outreach efforts would still be beneficial for people to know about this tool." - MCBH Administrator

One participant suggested public announcements such as radio advertisements and QR codes in churches or local carnicerías (meat markets) would be helpful to reach Spanish-speaking communities and to reach people and families who may not be as familiar with navigating online resources.

Help@Hand Technology Development Partner Perspectives

One participant suggested having a clinician as a co-lead, and another participant suggested having a person dedicated as county-lead of WellScreen Monterey.

Launch processes

Key informant interviews were conducted with 14 key stakeholders involved in the launch phase of the Help@Hand project and included informants from Monterey County Behavioral Health, other community service agencies in Monterey County, and Help@Hand Technology Development Partner. Interviews were conducted from May 26, 2023 to August 23, 2023. The following qualitative findings are organized into sections (successes, challenges, and suggestions), and then subsections (MCBH Key Informant Perspectives, Non-MCBH Provider Perspectives, or Help@Hand Technology Development Partner Perspectives).

Successes

MCBH Key Informant Perspectives

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Monterey County Behavioral Health (MCBH) key informants shared that the key facilitators that made the launch phase for WellScreen Monterey digital platform/website successful included: (1) beta testing and gradual launch of WellScreen Monterey, (2) trust building between the community and the website, and (3) administrative success of no fiscal impacts from workflow changes in the MCBH ACCESS program.

"...This is a community facing screener…being on the ground for them and seeing that A, what our workflow is and B, what the waiting room or lobby experience for a client looks like. I think that was a good way to see things firsthand. I also think that helped." - MCBH Administrator

One participant shared successes from beta testing and the soft launch for WellScreen. Beta testing of the screener allowed CredibleMind to understand the workflow within MCBH ACCESS. Including a soft launch portion for WellScreen's launch allowed for an opportunity to hear community feedback and see how the community utilized the screener.

"The trust in the community [and] in our services in the community is a big part of why we're able to deliver services robustly in South Monterey County. It's taken years of us being present in South Monterey County to develop a relationship with the community…And a lot of why people continue to come through our doors is because they have heard that it's safe to do so. So they've heard from their neighbors, their family members, their church congregants, those types of things like these are good people and it's a safe place to go." - MCBH Administrator

One success for WellScreen is the trust between the community and the website. One participant explained how building trust between community members and MCBH ACCESS is what allows MCBH ACCESS to deliver its services so robustly in Monterey County. Currently, mostly younger users are accessing WellScreen Monterey.

"We had set up a process for if somebody were to self-identify in our offices, like, "Hey, I did this screener." We have a workflow in place for that…we have the ability to view those results and then utilize those results…So I don't know what the data says in terms of how many people in the community are going to the website and doing the screener, but we haven't seen it to the extent that I thought we would in our clinic sites." - MCBH Administrator

With the launch of WellScreen, some administrative successes include the integration of WellScreen results into MCBH ACCESS workflow and no negative fiscal impacts on programs. One participant shared that MCBH ACCESS has a system in place for clients who bring in WellScreen results. Additionally, since the launch of WellScreen, there have been no fiscal impacts on the program of workflow within MCBH Access.

Help@Hand Technology Development Partner Perspectives

Help@Hand technology development partners key informants shared that the key facilitators that made the launch phase for WellScreen Monterey digital platform/website successful included: (1) collaborations, training, and coordination between teams working on the launch, (2) product positioning and technical details of WellScreen Monterey website, (3) gradual launch of WellScreen Monterey, (4) sufficient funding and marketing.

"It was actually a very smooth release, and it worked out really well. I think that, what went well was that we were technically ready. And, we had product positioning ready and workflow, and we were also pretty well-trained and coordinated with the [MCBH] team. And so, all of those areas went really well." -Help@Hand Technology Development Partner

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Two participants discussed success in collaboration between all teams (county, state of California, technology development partner, and evaluator). One participant shared about satisfaction with the number of people taking the assessment and using the website during the early launch period. Moving forward, the county team is considering which aspect to prioritize first: website traffic, or the number of people who complete the assessment. One participant discussed the success of the technical side and product positioning of the website, as well as the training and coordination between teams throughout launch.

"I think the soft launch was…good…there was a little bit time to work out some kinks before there were too many eyes on it or before it got into too many public hands, there were things that it could live and exist and breathe a little bit and people could provide some feedback of those who were seeing it as before we really pushed it in a big way through marketing and things like that." -Help@Hand Technology Development Partner

One participant shared the positive impacts of having a soft launch for the WellScreen website. The soft launch allowed feedback opportunities and time to make improvements before reaching a wider audience.

"On the financial side, I think, it was coordinated through, from [development] side, our executive sponsor and so forth. And then, the piece where the financial money came in was through CalMHSA. And, Help at Hand was administering that. And then, also through Monterey County. And so, we had a couple of individuals at Monterey County that were responsible for the financing." -Help@Hand Technology Development Partner

Another success in the launch was the admin access portal and funding. One participant thought the project was financially well funded. Another participant noted that the financial side was coordinated through CredibleMinds and the executive sponsors. The funding came from CalMHSA which was administered through Help@Hand.

"Bringing on [marketing] was a success. It took a while. It took probably longer than it should have to go through all of the marketing things that Monterey wanted to do. And it was mostly on Monterey to figure out what's in the budget 'cause they wanted the word to get out…" -Help@Hand Technology Development Partner

The introduction of the marketing team aided in the launch of WellScreen. Two participants discussed how onboarding the Ku Collective took longer than expected and occurred after the launch of WellScreen. The onboarding process had discussions surrounding marketing ideas and budget details. Some marketing ideas include radio, bus, and TV ads.

Challenges

MCBH Key Informant Perspectives

Monterey County Behavioral Health (MCBH) key informants shared that the key challenges for the launch phase for WellScreen Monterey digital platform/website included: (1) need for more training and engagement with WellScreen Monterey website from providers, need for more bilingual staff in the county particularly staff who speak Indigenous languages, (2) trust building between the community and the website especially among older populations and

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Spanish-speaking communities, (3) time delays and administrative challenges from the need for more staffing, allocation of all the funding granted, and marketing contracts.

"An outstanding one is having all of our community providers fully aware of the tool. I think some more could be done there so they're all aware of it to use it as they wish or recommend it or just be aware in case somebody comes in with a results code…right now, we haven't heard anything from people, other agencies [if people have come in with a results code]. I just think that engagement across all the providers, I think that would be good." - MCBH Administrator

"There's a huge need in being able to speak Spanish and we're seeing an increased need to be able to speak Indigenous languages, particularly Triqui and…Indigenous languages from the state of Oaxaca, which we don't have the capacity to, and it's very hard to find good translation services for those languages as well. So that's an internal challenge that we have." - MCBH Administrator

One challenge discussed was the lack of training and engagement with the website from the providers. One participant shared that clinics are unable to adapt their workflows to integrate the new screening code due to a lack of training. Two participants also discussed the need for more bilingual staff in the county, especially those who speak Indigenous languages; There is currently miscommunication or lack of communication between clinical staff and community members. One participant shared that all teams collaborating on WellScreen Monterey are engaged in mitigating these challenges.

"There's a lot of undocumented folks out in South Monterey County, a lot of people that don't necessarily feel comfortable interacting with government agencies, which we are. And so it's taken a lot of time to really embed in a way that fosters trust. And so a lot of people come through the doors because they are seeking those individuals that they've heard are trustworthy." - MCBH Administrator

"A website might not have that level of trust for the older than the younger. So I don't mean older, but if younger people are interacting with the website, then those that are 30 plus or whatever the number is, they may be continuing to want to seek a person that they have heard is trustworthy or an agency that has actual human beings working there that they can trust." - MCBH Administrator

One participant discussed challenges interfacing with older populations and Spanish-speaking communities. They explained the technological difficulties the website may impose on older populations and those who are not as familiar with technology. Additionally, they explained the importance of building trust within Spanish-speaking communities. Building trust between WellScreen and older and Spanish-speaking communities will help to increase the usage of the screener.

"On the [MCBH] team at least, we are getting Q of I. …a lot of our clinical lead. They are so strapped for time as well because we just have a lot of vacancies and I feel like they're putting out fires a lot too with their jobs. So I think that's a barrier to get all of the people in the room that should be there and put their brains into it." - MCBH Administrator

"The timing lined up with CalAIM implementation across the state and with our county. And the CalAIM implementation includes a screening tool, adult and youth screening tool, which makes the determination of level of care." - MCBH Administrator

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Two participants discussed the difficulty with the timing of the launch. One participant shared how there are not enough staff, resulting in their clinical leads being strapped for time. Another participant shared that WellScreen Monterey's launch coincided with CalAIM's implementation.

"For the financial, I feel like it's kind of just all green lights with that, just innovation funding…at least at the county, we really feel a lot of pressure to spend innovation dollars. And so yeah, I just feel like it's easy to throw money at things. Because if we don't then we have to give it back to the state…at the end of the calendar year." - MCBH Administrator

"One of the financial goals…around launching the WellScreen was…to eliminate additional assessment time for our clinicians and be able to really use that as a tool to incorporate into their writeup or their assessment. So I don't know if that's been evaluated now,...[if] by having this tool response available to them so that [clinicians] can skip a portion, certain questions from the assessment and just use whatever was entered on the WellScreen." - MCBH Administrator

Administrative challenges discussed include spending budget, lack of staff, and marketing contracts. One participant shared that there is difficulty spending all the funds that were granted. If the funds are not spent, they will have to be returned to the state. Another participant stated that there was a lack of staff and providers on the administrative level. One participant shared that one of the goals of WellScreen was to eliminate additional assessment time done by MCBH clinicians. However, they do not know if this has been evaluated.

Help@Hand Technology Development Partner Perspectives

Help@Hand technology development partners key informants shared that the key challenges for the launch phase for WellScreen Monterey digital platform/website included: (1) integration of WellScreen Monterey with clinics, (2) collaboration between teams due to the amount of stakeholders and perspectives involved, (3) feedback was provided over long periods of time, (4) tight timelines for marketing and launch, and (5) budget considerations for different launch components and where to spend the funding granted.

"We thought that the project would also involve integrating the screener into the regular processes and we'd have tablets in the clinics and people could take it and then their provider would be able to see results and talk about their results alongside with the client. And that just hasn't happened… the whole kind of clinical integration, access integration has been very messy, complicated." -Help@Hand Technology Development Partner

One participant shared that the integration of the screener with clinics was messy and complicated, and did not go according to the original plan; They thought the screener would be integrated into the regular processes and tablets in the clinics–Clients would take the screener at the clinics and providers would see the results alongside the clients. Another participant discussed difficulty in the collaborative process between CredibleMind and Monterey County due to the amount of stakeholders and perspectives that had to be considered. The participant also noted that the county had many goals and gave feedback in pieces over long periods of time. They also suggested having a representative from Monterey County for CredibleMind that has expertise and connections to help better understand where information needs to go within the community.

The participants discussed challenges with the tight timeline for the marketing and launching WellScreen. One participant discussed having to add more scope and time due to having a two part launch and marketing process. They also noted that January was a big month for WellScreen users, but it has gone down since; in June the user activity went back up. Another participant, discussed

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how the team was still able to execute and deliver a site that gained good user traction and had a positive impact on specific populations despite the tight timeline.

"...There's been the challenge of figuring out how best to spend some of the marketing budget because you can pay money that's going to get people to come directly to the site and the screener, and that's great, but you can also pay money to get just brand awareness out there. So if, in the future, someone needs a screener, they know it's there. And that's much harder to measure the impact." -Help@Hand Technology Development Partner

The participants shared challenges with figuring out how to spend and divide the marketing budget for the two-part launch. One participant discussed how the two-part launch was not a part of the original contract, the budget had to be figured out as they went on with the planning process of WellScreen. Another participant stated how it was difficult to balance the budget while deciding the best advertising methods when targeting different communities. Two participants discussed the difficulties when keeping track of how much money was being spent, and how to spend the money on efforts that will have the biggest impact on the launch. One participant noted that although there were budgeting difficulties, the administrative side of the project went well.

Suggestions

MCBH Key Informant Perspectives

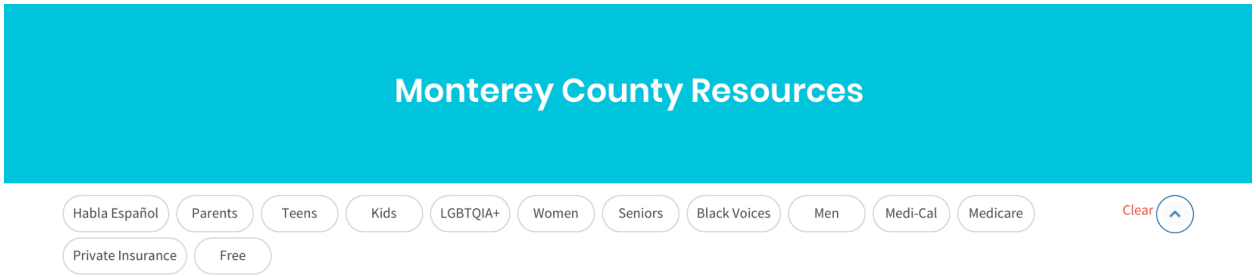
Suggestions from MCBH key informants included more training and engagement with the WellScreen Monterey website from providers, more bilingual staff in the county particularly staff who speak Indigenous languages, increased trust building between the community and the website especially among older populations and Spanish-speaking communities, and more efficient budget and funding decisions and administrative processes.

Help@Hand Technology Development Partner Perspectives

Suggestions from Help@Hand technology development partners key informants included integration of WellScreen Monterey with clinics, improved collaboration between teams especially with all stakeholders and perspectives involved, sharing feedback in a shorter timeframe to improve timeliness of the launch, and considering budget for different launch components.

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WellScreen Monterey website: functionality and ease of use



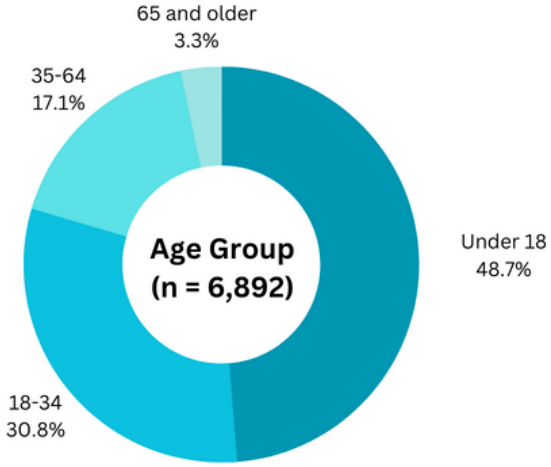
WellScreen Monterey demographic characteristics

These data were gathered from the dashboard which has been built for the screening app/tool, WellScreen Monterey, with the goal of assessing post-implementation usage to better serve providers, clients, and community partners. The WellScreen site was launched on November 15th, 2022, and the visualizations below are from the implementation date until October 24th, 2023. There have been a total of 28,879 users during this period with 35,998 sessions. A user is defined as a unique person, and a new session is counted each time a person interacts with the website (so cumulative visits to the site are counted with each new interaction counting as a new session after 2 hours have passed).

Traffic Changes and Traffic by Source

Google Paid ads were the most useful in increasing traffic to the WellScreen tool, as seen with implementation dates of ads and accompanying spikes in usage. Social media was the second most successful source for promoting traffic, with spikes in usage occurring shortly after Facebook and Instagram ads were implemented. Direct/Email methods were next after social media, and usage tended to rise and fall with social media traffic.

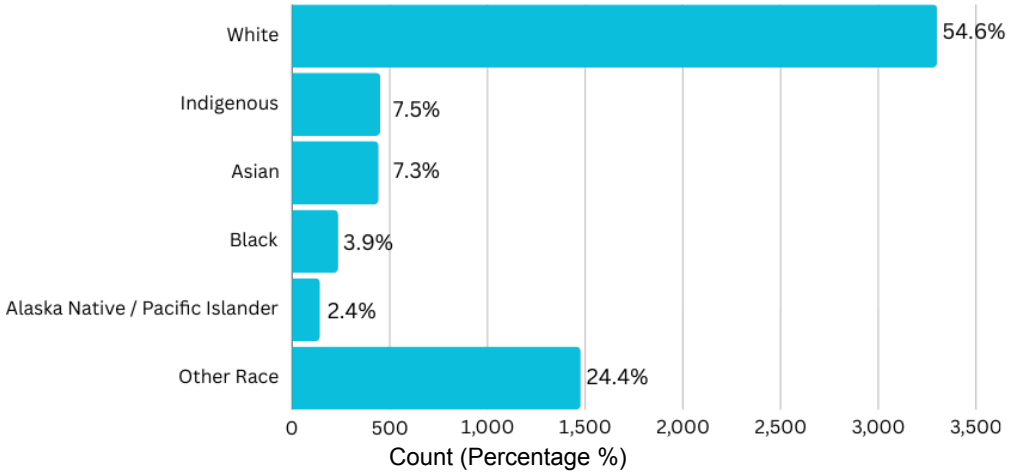
FIGURE 21. Mental Health Assessment Users by Age Group



Almost half of users are under the age of 18, followed by people between the ages of 18 and 34 years. There is a small percentage of users over the age of 65 utilizing the WellScreen tool, which could be due to older groups tending to have less digital literacy compared to younger groups.

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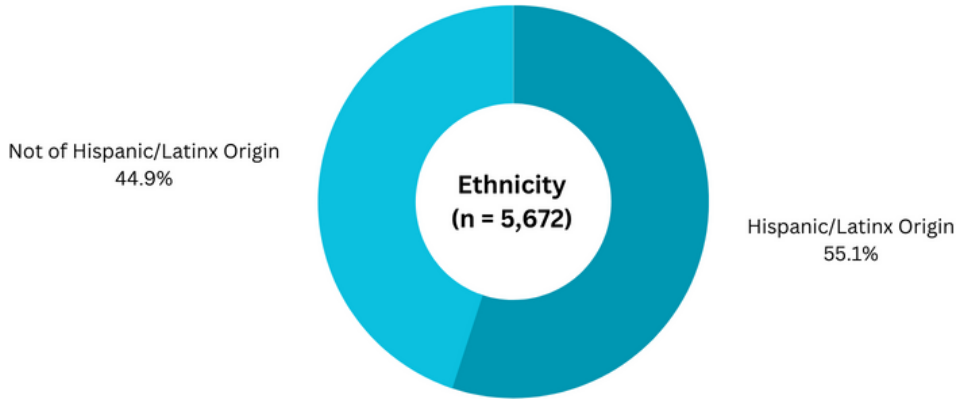
FIGURE 22. Mental Health Assessment Users by Race



Note: All racial groupings are shown as was given by the CredibleMind dashboard and WellScreen tool. Typically Indigenous may be Native American/Alaska Native, but here the pulldown mixed Alaska Native with Pacific Islander.

The majority of users identified as White, followed by “Other Race”. The races that fall into the “Other” category were not listed by the Credible Mind dashboard or WellScreen tool. The Indigenous category is the 3rd most common self-identified race through this tool.

FIGURE 23. Mental Health Assessment Users by Ethnicity

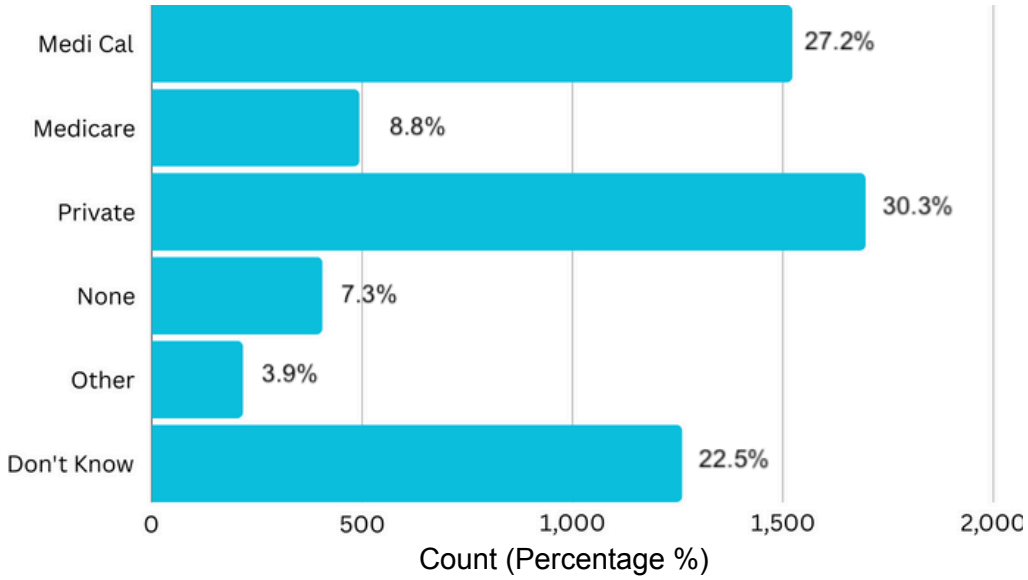


Note: Ethnicity options are shown as given on the WellScreen tool. We do not have a way of disaggregating which groups of hispanics are fluent spanish speakers vs. non-fluent spanish speakers.

The majority of users identified as being from Hispanic/Latinx origin.

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FIGURE 24. Mental Health Assessment Users by Type of Health Insurance/No Insurance

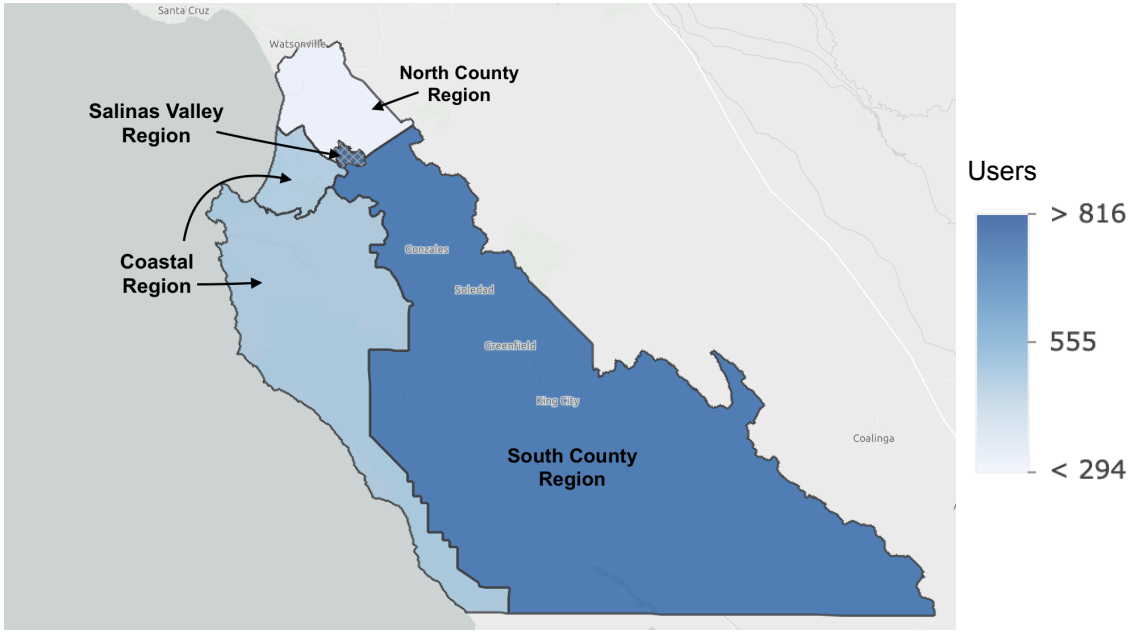


Note: Categories listed as presented on Credible Mind dashboard and WellScreen tool

The most common health insurance Help@Hand users had was private insurance followed by Medi-Cal. Another large percentage of users do not know their health insurance which could be due to the large number of younger users who used the tool, who may not know the source of their insurance (if any).

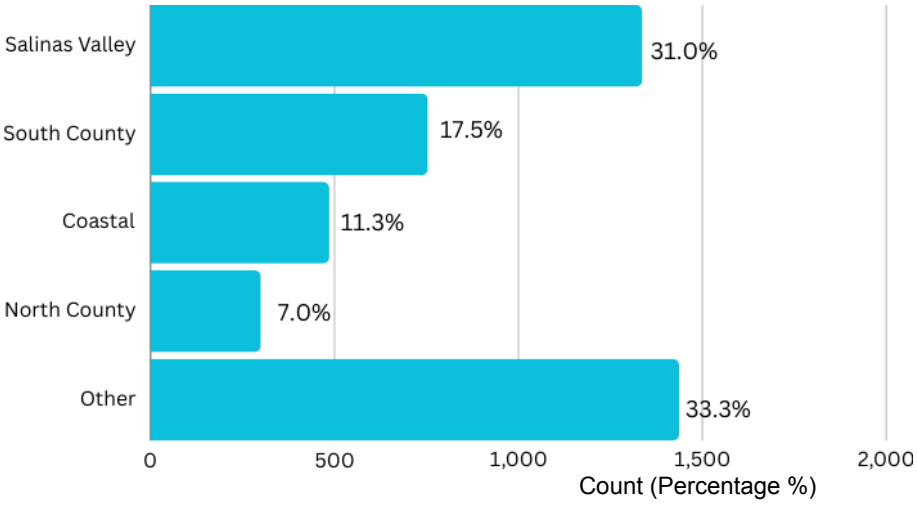
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FIGURE 25. Users by Monterey County Regions



Note: These are only the regions within Monterey County. The responses recorded and shown are only from those persons that are 16 years old and older.

FIGURE 26. Users by Region including Other Counties



Note: Other regions are regions that were outside of Monterey County. The largest contributors to “Other” were Santa Cruz County (users = 330), San Benito County (users = 278), and Santa Clara County (users = 267).

The largest region was in the “Other” category which included any users that were outside Monterey zip codes and region breakdowns. The largest contributors to this were Santa Cruz County, San Benito County, and Santa Clara County. The Salinas Valley region was the second most common reported region for users.

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Use of Help@Hand has been relatively steady, with a small increase occurring between the launch date of November 14, 2022 to present. The lowest traffic period was in the beginning of January 2023, but this picked back up after the implementation of Facebook Ads on January 11, 2023. Google ads were the most used source of traffic coming to the site, with the peak occurring in June 2023 after implementation of more Google Ads. The second most popular traffic source was from social media, followed by direct email. Those under 18 years of age make up almost half of the age distribution, with quite a lot of users reporting being 15 years or younger according to dashboard data. This indicates great need in this group but also the better digital literacy in younger cohorts of the population.

The greatest self-identified race group served was White, with the majority of users reporting their ethnicity as Hispanic or Latino/a/x origin. Most users identified their primary language as English, with a very small percent reporting a language other than English or Spanish. The most common health insurance type for Help@Hand users was private insurance. Most zip codes for users were within or nearby Monterey County, but there were some zip codes further out like Sutter and Los Angeles County.

Overall

Key informant interviews were conducted with key stakeholders involved in the WellScreen Monterey website of the Help@Hand project and included informants from Monterey County Behavioral Health, other community service agencies in Monterey County, and Help@Hand Technology Development Partner. Key informant interviews were conducted from May 26, 2023 to August 23, 2023. Two focus groups were conducted from August 8, 2023 to September 9, 2023. There were seven participants in the English language focus group. There were two participants in the Spanish language focus group. The following qualitative findings are organized into sections (overall, self-assessment, results, resources, and outreach and communication), and then subsections (content and design, and needs of vulnerable populations) by MCBH Key Informant Perspectives, Non-MCBH Provider Perspectives, Help@Hand Technology Development Partner Perspectives, English Focus Group Perspectives, and Spanish Language Focus Group Perspectives).

Table 2. Community Focus Group Participants

Focus Group Recruitment Source	Setting	Language	# Participants	Date of interviews
MCBH Listserv	Virtual	English	7	08/08/2023
MCBH Listserv	Virtual	Spanish	2	09/09/2023

Content and design

Successes

MCBH Key Informant (KI) Perspectives

“It's a good tool as a starting point to get clients quickly screened,...not necessarily assessed, but as far as their level of need, if it's mild, then they have some resources or some tools that they could use immediately. If it's moderate to severe, then they're prompted with the local

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clinics that are available based on their zip code or where they're at that moment. So it gives them an immediate resource based on their needs or level of needs." - MCBH Administrator

"...It's more of a community resource than it is for an informative screener for our work…for that individual being open to conversation or being able to have dialogue around something that they're truly coming in to look into." -MCBH Administrator

The participants discussed their experiences when using WellScreen Monterey. Two participants thought that the screener was easy to complete and navigate, and was reasonable in length. One participant emphasized the need for improvement when connecting clients to resources. Two participants pointed out that the tool is a good starting point for clients looking to get quickly screened and not assessed; It is a good resource to help clients become open to conversations surrounding their specific area of concern.

Non-MCBH Provider Perspectives

"...Love that it's user-friendly. I really appreciate that it explains things without any jargon…it really is straightforward and it has the linkage to resources. I really love that it had places where you can go. You can actually see a description. And just like immediate resources, even just hotlines that you can call directly and immediately get connected with some resources for your results… The summary portion at the end after the tool, after the test, it definitely was enlightening…to see the areas you're doing well and the areas of some concern, and…resources…to help." -Non-MCBH Provider

"The blue is a very welcoming color, a very calming color, so I thought that was good because if someone's in crisis or they're getting to that point, you want them to be calm as possible. The imagery is really nice…This part, where it has little icons, that's nice…it does help catch the eyes more, so people focus more on what's written. Same with above, too." -Non-MCBH Provider

One success from the launch of WellScreen was the positive reactions to the website. Three participants appreciated the website's user-friendliness, particularly favoring its consideration for monolingual Spanish speakers, the assessment question wording, the summary section, and the resources and recommendations. One participant shared the thought process behind the layout of the results and recommendations pages; originally, it was in the format of landing pages, but that decreased the number of people taking the survey.

Help@Hand Technology Development Partner Perspectives

Help@Hand technology development partners key informants shared that key facilitators that made the WellScreen Monterey digital platform/website successful included: (1) layout of the website and flow from home page to assessment to resources, (2) positive user experience, easy-to-understand language level, and simple navigation of the website on different types of devices.

"It's been a really powerful tool…I think someone pointed out that the screener has now served more people than MCBH clinics have in the same time period, way beyond. So we're able to get people to resources that were not before finding them. So I think that's a huge success, and I think we're finding it of value in the community, and the data we're getting back is also of high value as well." -Help@Hand Technology Development Partner

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Most participants discussed positive aspects of the layout of the WellScreen website. One participant discussed the importance of considering how the homepage directs users to the screener and resources. Two participants liked the resources that appear after the user completes the assessment. Additionally, two participants discussed the value of the data being reviewed from the activity occurring on WellScreen Monterey. The screener has now served more people than MCBH clinics in the same time span and 90% of users find value in using the tool. Looking at the data, one participant pointed out how analyzing the scores of users from the assessment can point us in a specific direction when looking for resources for community members. Additionally, they pointed out how it is less often that people taking the assessment actually click though the resources that are suggested to them.

"We did, I believe, try to make the reading level low enough so that most people can take the assessment and understand it." -Help@Hand Technology Development Partner

"The user experience, I think it's a pretty simple sort of interface to use. You go on the website,... you either take it or…explore resources or the "need help now" page. But otherwise the screener is the main call to action. I think the workflow could be better, but it isn't terrible. I think it works pretty responsively in mobile and we are actually improving the UX of our assessment questions…we don't have a lot of people falling off once they've started. So to me that kind of is a sign of, it's not that bad of an experience actually taking the assessment…" -Help@Hand Technology Development Partner

Many participants discussed positive user experience from the simplicity of WellScreen. Two participants noted that many people are taking and finishing the assessment. Three participants think that the tool is simple and easy to manage. Another participant discussed the thought process behind the creation of the assessment. The technology development partner tried to make the reading level of the assessment low and used adaptive testing and branching logic to keep the assessment as simple and organized as possible. One participant also pointed out that the screener works well on a mobile device and there are current improvements on the user experience of the assessment questions.

English Language Focus Group Participant Perspectives

"So I found resources slash phone numbers and chat very helpful as well besides the assessment, because assessment, you take it if you need the help, you have time to do it, you think there's an issue, but sometimes in case you need to contact somebody right away, you have all the contact information. So that was helpful for me." - English language focus group participant

Three participants reported accessing the WellScreen Monterey website using a computer, similarly, three participants used a smartphone or mobile device, and two participants did not share any information. About half of the participants' first instinct was to click on the WellScreen Monterey Assessment to learn more about Mental Health Resources. Many focus group participants found the resources and assessment helpful and a good way to seek immediate assistance during a crisis.

Spanish Language Focus Group Participant Perspectives

"[Participants] like it a lot because it is straightforward and [because] it gives you the exact information you need. [And] when you look at it using a computer or a phone, it always has the same outline and [functionalities]" - Spanish language focus group participant

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One participant reported accessing the WellScreen Monterey website via in person through a library, and one participant accessed WellScreen Monterey website online via Google searching/advertisement. Both found it to be a useful and effective tool for receiving mental health information and resources. Participants described it as a tool they could use for themselves and others to help them begin their mental health care.

Challenges

Non-MCBH Provider Perspectives

"...I do like this part, too, especially the share your results, because if I did take this…and it was saying, "Maybe you have something serious, like one of the serious mental illnesses," then I would definitely want to share that with my spouse. So sharing the code or copying the results link to let them know…" -Non-MCBH Provider

"I like the way that the results are done because it tells you what you're doing really well at that. Then it shows you what it is that you need to work on and how to work on it, who to go to…" -Non-MCBH Provider

One participant discussed challenges with delays in response time and dealing with the reintroduction of trauma. The participant stated that those using the chat may experience slow response times spending on the time of day they are seeking for help. Additionally, sometimes crisis lines may have delayed response times. The participant also pointed out how the screener may be difficult for some clients to complete because it asks about the trauma they may have experienced.

Help@Hand Technology Development Partner Perspectives

"There was a technical issue where, if you automatically have your site translated… using your browser…the design is a little weird…And so we didn't catch that until maybe a month or so after launch, but we did fix it. So now we can detect if your browser is translating and then switch it to our version of Spanish instead of the browser's attempt at translating the site. But we've gotten, so far, 9 to 10% of users are using the site in Spanish. Fewer are taking the assessment..." -Help@Hand Technology Development Partner

" …We did hope that these screening results would be more used in an intake process. So the user takes the screener, they see the 800 number, they call [MCBH ACCESS], they get an appointment, they show up at a clinic, they give their access code, and the clinician actually uses the results of the screener. That just has not happened very much…there's just workflow that people have been too busy and we haven't had the time to integrate it." -Help@Hand Technology Development Partner

There is difficulty when tracking the effectiveness of user activity on WellScreen due to automatic Google translations, having loose target populations, and lack of clients using results code with ACCESS clinics. Two participants discussed the lack of screener results being used in ACCESS clinics. One participant discussed how some websites are automatically translated to Spanish by Google, without using the toggle design; thus it cannot be tracked by CredibleMind. Another participant expressed how the large and loose population target of WellScreen makes it difficult to track the effectiveness of the website. Narrowing down the target population could aid in making the website more intentional.

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Needs of vulnerable populations

MCBH Key Informant (KI) Perspectives

Monterey County Behavioral Health (MCBH) key informants shared that the key challenges for the WellScreen Monterey digital platform/website included: (1) need for adaptations to the website for Spanish-speaking and Indigenous people such as an audio tool for navigating the assessment, (2) language and technology barriers, and (3) measurement of number of Spanish-speaking users.

"Sometimes if [WellScreen Monterey is] not translated into a language that that community speaks, then they can't complete it. If that particular community can only speak it but not write it, that's going to be an issue…so I don't know how some of our communities, especially our Indigenous community, would go about completing that if they don't have either an interpreter available physically completing it with them. We may be missing a chunk of our population." - MCBH Administrator

"If there's a way to create an audio tool so that it prompts them like what to complete, and then once they answer, it'll jot down their response." - MCBH Administrator

Three participants discussed the challenges Latino and Indigenous users face when accessing WellScreen Monterey. One participant shared concerns about the translation of the website for Indigenous speakers, and the adoption of an audio tool to better support this population. If the website was not translated into the language the community speaks, they will not be able to complete the assessment. Another participant commended the design of the website but noted that the website won't be able to reach communities who don't speak Spanish or don't have written languages.

"At least from our metric so far, we do see people who access the Spanish website is very low, a few people. But the people who access the English website, I think more than 40% are either Hispanic or bilingual Spanish speakers." - MCBH Administrator

Two participants expressed that the website has many barriers that make it hard to reach some clients. This includes language barriers, access to digital devices, and incompatibility with users who can only speak but not read Spanish or users who can only speak Indigenous languages. One challenge discussed was the difficulty in measuring the number of Spanish-speaking users. Participation from Spanish-speaking clients may be low because some may be bilingual speakers.

Non-MCBH Provider Perspectives

Non-Monterey County Behavioral Health (Non-MCBH) key informants shared that the key challenges for the WellScreen Monterey digital platform/website included: (1) language needs of Spanish-speaking and Indigenous people when accessing the website, (2) cultural stigma and prejudice around mental health, and (3) need for audio tools, cost and insurance information, and improved front page design.

"For Spanish speakers, again, I feel like it's…potentially too sophisticated. If it could be broken down into very more easier to understand I think would be good…Yes, terminology…Many people that we work with here at the hospital don't even have a basic understanding of that their heart is pumping blood around in their body." -Non-MCBH Provider

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A challenge raised by many key informants was increasing access to WellScreen Monterey for Latino and Indigenous individuals by accounting for language needs. One participant expressed concerns surrounding the terminology used on the website. The terminology may be too sophisticated. Some participants expressed mindfulness of language barriers. One participant suggested making the Spanish version more prominent on the website. Another concern was the comfort surrounding having a translator. One participant explained how some people may not be as open to answering questions through a family translator. Lastly, one participant mentioned that it was difficult to find WellScreen when browsing through the Monterey County Behavioral Health website due to the language barrier. The MCBH website does not have a Spanish translation.

"...One of the things that we thought about when creating the campaign and the language around the marketing campaign was that typically, especially in Spanish culture too, there's a stigma against mental health issues or anything, like reaching out for help is something that people have a hard time doing initially. So, getting them to get here in the first place is just such a huge step…" -Non-MCBH Provider

"A lot of people don't even know that there's access services that are available for free, but it's really buried. So, I know your evaluation is on the tool itself, but I think that that just contributes to the difficulty in getting people there." -Non-MCBH Provider

Challenges to the utilization of WellScreen Monterey include the visual format, language, and prejudice pose challenges for Latino/Indigenous clients to access WellScreen. Two participants discussed the challenges for Indigenous speakers (Mixteca and Oaxacan native speakers) and the stigma and prejudice surrounding mental health in Spanish culture. One participant suggested adjusting the visual format of the website. One participant mentioned difficulty accessing WellScreen Monterey directly through the MCBH website, noting that it is hard to find when browsing the MCBH Website.

"Some of my Spanish-speaking monolingual clients are not literate in Spanish. Everything they do is oral, so that might be an issue, too… maybe an option for an audio version." -Non-MCBH Provider

"[Users should be able to] go directly to the resource page without [the share information] popup. Having everything listed, that's awesome. Being able to select by category, that's great, too…On each little thumbnail, [add] the cost of the services, or basically how the person would pay for services…because a lot of the people here are concerned about cost. People who are receiving Medi-Cal are on low income. They're fixed income, people who are undocumented. Most of them have no income, and they need services. We're one of the few resources they can access at this point." -Non-MCBH Provider

Some suggestions for making WellScreen more user-friendly include incorporation of an audio tool, providing cost and insurance information, and improving on front page design. One participant expressed that having an audio version will make the website more accessible to those who may be visually impaired or are non-literate monolingual Spanish speakers. Another participant suggested keeping the terminology used on WellScreen as simple as possible. One participant suggested making improvements to the front page of the website. This includes, providing more context to the purpose of the assessment, moving information regarding the website to the top of the website, and editing the translate buttons to be larger and more apparent.

Help@Hand Technology Development Partner Perspectives

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Help@Hand technology development partners key informants shared that the key challenges to reach vulnerable populations regarding the WellScreen Monterey digital platform/website included: (1) budget and language constraints for increasing access to different types of communities, (2) identifying if the Spanish version of the website was being accessed by Spanish-speaking communities or if most users were bilingual and opted for the English-language version of the website, and (3) barriers to access including lack of internet and device access.

"I think that we could have gone a little further perhaps with a larger budget or with technology that may not have been available but might become available…to support other languages. We also could have involved more subject matter experts in that area...I know that there was some intention around that, and some exploration, but it does occur to me that we could have done more." -Help@Hand Technology Development Partner

The participants discussed budget and language constraints when serving Indigenous communities. One participant mentioned that when serving Indigenous communities, the language used should resonate with different types of communities. Another participant shared that although feedback regarding Indigenous Mexican languages was already discussed, CredibleMind only offered resources in Spanish; If the assessment were to be translated to Indigenous languages then that would require a change in the project scope. One participant stated that a larger budget would've allowed for more experts on the subject matter to help mitigate the language barrier. However, there is no cost-effective methodology allowing for Indigenous languages to be translated on WellScreen.

One participant discussed the efforts CredibleMind went through to ensure comfortability for Spanish-language speakers by manually translating everything on WellScreen Monterey to Spanish. Another participant acknowledged the attention to anonymity but was unsure if that factor affected Latino and Indigenous populations.

"55% of people who have taken the screener identified themselves as of Latino or Hispanic origin, but about 10% of people are using the [website] in Spanish. So I think that means…a lot of people they're just used to speaking English,...even though they're of Latino origin... But I think we've also found, with Google especially, it did not seem to reach a Spanish-speaking audience. It's hard to tell about the demographics there. So I think obviously a challenge with all the migrant workers and the other things, a lot of them share phones. They don't necessarily all have smartphones." -Help@Hand Technology Development Partner

The participants discussed the difficulty in identifying whether the Spanish version of the website is being accessed by Spanish-speaking communities. One participant shared that if users click on Spanish ads, they will be directed to the Spanish site. The participant also shared that Salinas is very bilingual compared to other cities in Monterey County and contains the majority of the Latino population. The participant noted that most bilingual users seem comfortable interacting in both English and Spanish versions.

"Some of the more rural populations that may not necessarily have access to internet 24/7, there are some barriers there. I think that's probably one of the biggest things. But [MCBH] is launching the [tablets] in the community so that if people don't have a cell phone or they don't have access, there are opportunities for people to be able to take the assessment on a shared device, which I think is going to be really helpful." -Help@Hand Technology Development Partner

Barriers to assessing WellScreen include the lack of broadband/internet access and lack of phone access 24/7. Two participants discussed the potential for community members to run into internet

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access and wifi issues; One of the participants mentioned difficulties with internet access for those living in rural populations. The other participant pointed out the importance of making sure WellScreen is also accessible using cellular reception and not just wifi. Another participant discussed the challenge of reaching migrant families because they usually all share phones and do not all have a smartphone. One participant commented that the introduction of community tablets would increase access and give people the opportunity to take the assessment on a shared device.

Suggestions

MCBH Key Informant (KI) Perspectives

Suggestions for improving Latino and Indigenous Communities' access to WellScreen include creating an audio tool and increasing access to digital devices. One participant discussed the possibility of creating an audio tool that allows users to listen to the assessment and jot down their responses. Another participant suggested partnering with health workers within Latino and Indigenous communities and equipping them with tablets, increasing digital access to WellScreen.

Non-MCBH Provider Perspectives

Some suggestions for improving access to WellScreen Monterey for Latino and Indigenous individuals include providing costs and insurance information for each resource, allowing for direct appointments from WellScreen, providing an audio version of the website, and having more outreach efforts. Two participants suggest making outreach and marketing efforts through social media platforms (Facebook, Instagram, Tiktok, etc)), public service announcements (TV, radio stations, etc), printed collateral, and ads on buses. Some participants suggested improving the WellScreen website to include more information regarding the assessment's purpose, making the Spanish version more prominent, and including an audio option of the website.

Help@Hand Technology Development Partner Perspectives

One participant shared some suggestions that would've helped to improve the productivity of the launch phase for CredibleMind. This includes Monterey County providing richer feedback and perspectives on the website earlier on, Monterey County having more narrow and precise goals, and Monterey County providing a representative from the county. The participant described how having a representative from Monterey County would've helped CredibleMind gain a better understanding of where information needed to be distributed within the community.

Self-Assessment

Content and design

Successes

Non-MCBH Provider Perspectives

"I thought it was a really good website. Great design…When I was taking it, I was thinking, "...What if I were super anxious…?" I thought the way it was laid out, very good, very simple. The results were really good, very clear. Having that contact information also helped."
-Non-MCBH Provider

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Four participants described the WellScreen assessment to be easy, straightforward, and easy to complete. They also liked the length of the assessment. Another participant shared that the website has a good design and is a good resource for those questioning their mental health.

English Language Focus Group Participant Perspectives

"I think that the design is really straightforward.....I'm actually using the [MCBH] services myself. And I've taken a lot of assessments online before. And so far this is the most understandable one. I've noticed that any other assessment I take, I'll sit here and spend 5 to 10 minutes wondering what the question exactly means and I think about it too much. But with this one it's really just straight to the point. I can answer it without thinking too hard about it and I find that super helpful." -English Language Focus Group Participant

Most participants found the website pleasant, clean, organized and easy to read and understand. According to many participants, the assessment contains an appropriate amount of necessary information. Several participants found the questions effective and comprehensive. They think the questions are well-crafted, thoughtful, and legible. Although a few participants in the group found the assessment slightly lengthy, according to two participants, the assessment's length is justifiable since diagnosis needs to be given upon learning about all the symptoms a person is experiencing. Both appreciated the multiple choice and lack of open-ended questions which could take longer to answer. Many participants shared that they would recommend the assessment or have family members take the assessment as well. Two other participants shared some concerns with the length of the assessment, stating that someone going through a crisis would not have the capacity to answer all questions effectively.

Spanish Language Focus Group Participant Perspectives

"The questions themselves are short, direct, and easy to understand…It doesn't make [users] read too much or understand everything to do the screening, as it's offering a screening where [people] can diagnose [themselves]." -Spanish Language Focus Group Participant

Many participants found the website's photographs, animations, and Spanish language options especially attractive. Additionally, the participants found the total time spent to complete the self-assessment adequate, even when the assessment took longer due to secondary follow-up questions. According to both participants, the questions are easy to understand and answer; they are relevant for people seeking mental health care.

"It's perfectly fine. I wouldn't improve anything about it. It's direct, it's easy to use. It's not too crowded. I think that when sites have a bunch of text and information, it may be too much for people who are trying to ask for help, especially when it comes to mental health." -Spanish Language Focus Group Participant

"When you are going through a mental crisis, sometimes you don't know if it is temporary or if you should look for a psychiatrist, a psychologist, or a specialist. [The self-assessment allows you to] know if your symptoms are serious because, since one is not a doctor, one can get pre-diagnosed, so to speak." -Spanish Language Focus Group Participant

Both participants explained that when a person is going through a crisis, the number of questions they need to answer and how the questions are framed matters. Additionally, they found that having access to the self-assessment privately is an excellent feature. They found the tool to be convenient, time efficient, and an easier method for sharing the results and

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resources with family members for their own use. One participant stated that currently the website:

"It's good, I like it because you can do it for someone else, for example, someone who doesn't know how to use the computer, let's say, my mom. If you are doing this survey about how you are feeling, you can do it privately at home without having to do it in public. I like it because we can have all kinds of mental problems. For example, I have a cousin who is schizophrenic. My sister is bipolar, I suffered from depression, and now anxiety for a while." -Spanish Language Focus Group Participant

One person reiterated liking the privacy of the websites and its option to allow registered participants to go through the questions for someone else who may not have access or knowledge on how to use a computer.

Challenges

MCBH Key Informant (KI) Perspectives

"...[WellScreen Monterey is] not a diagnostic tool…I've had a few requests to inquire with [technology development partner] to recalibrate those little meters on the results page, which I did. And [technology development partner] basically was like well that's kind of going off of the validated assessment so it is what it is. And I tend to agree with them on that." - MCBH Administrator

One participant asked about the recalibration of the self-diagnosis results. They shared that people have submitted requests that the online assessment may be too sensitive. Two participants believed that the screener was overly lengthy, noting that individuals completing it tend to respond thoughtfully initially but may become less thoughtful as they progress through it. Another participant suggested having a separate screening for those experiencing substance abuse disorders. They also suggested discontinuing the pop-up option "call behavior health" as the default resource. This resource can ultimately cost the client and clinical staff time and energy when they don't necessarily always need Monterey County Behavioral Health help. Instead, the participant would like to see a second option if a client gets mild or moderate results.

Help@Hand Technology Development Partner Perspectives

"I can speak to the overall user workflow. The length of the assessment is pretty long…We talked about from a user experience perspective, "Could the length be shortened even more…?" It does use branching logic and things like that to keep it as short as possible…So, I think that, there's some opportunities there." -Help@Hand Technology Development Partner

Some participants discussed the length and workflow of the WellScreen website. Three participants thought the length of the assessment was very long. Some people will start the assessment and not finish it. One participant added that those who are serious about seeking help will find the assessment length to be manageable. Two participants touched on the workflow of the website and emphasized the importance of constantly tuning the website.

Suggestions

English Language Focus Group Participant Perspectives

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One participant suggested that the developers add more animations or something “catchy” to attract new users or continue engaging current users. A few participants suggested shortening the assessments to accommodate people going through mental health crises, since, according to a few participants, the person is not capable of focusing in the same manner. One participant suggested the website contains an introduction message where the person learns about the effectiveness or usability of the website. In terms of the “What are you looking for..?” feature, one found it confusing since the participant was not sure what to ask in the blank.

Spanish Language Focus Group Participant Perspectives

“Once. Rarely, once a year. Sometimes, more than yearly to monthly--". Where it says, "Sometimes. more than yearly to monthly". Sometimes is occasionally. "More than yearly". I think that, if we are referring to the entire year, I would say, "Several times a year", without, "Monthly". It doesn't make sense at all in Spanish.” -Spanish Language Focus Group Participant

“Those parts weren't translated properly, in terms of translating and what they wanted to express. That was translated by a literal translation. It's not translated by the feel of what you wanted it to portray, what you wanted people to feel, or the point, to the point, if that makes sense.” -Spanish Language Focus Group Participant

Some plausible areas for improvement identified included the following, modifying the pronouns by using the word “Usted” since it is a gender-neutral word used for communicating with individuals in a formal manner. One participant suggested performing a secondary revision of the self-assessment questions to identify an appropriate translation since some questions have been translated using a literal translation. Additionally, a participant suggested using words understood by lower grade levels or more common vocabulary among the Monterey County communities since it could be difficult for some people to understand some words.

Needs of vulnerable populations

Help@Hand Technology Development Partner Perspectives

“...Create the linkages so…either [people helping] to translate for [community members] into Spanish or into English or just increasing their familiarity with the tool, so that they can either take [the assessment] on other people's behalf,...or they can just use the site as a way to either upload resources… and/or search for resources that are going to be relevant for that population. [While this is intended as] a community tool, it can be a real help to professionals who are interfacing with people as a way that they can look up information and the resources and local things that are available to the people that they're helping.” -Help@Hand Technology Development Partner

“We have seen that the number of people coming to the site that say that Spanish is their first or primary language or are finish taking the assessment in Spanish is pretty low.” -Help@Hand Technology Development Partner

Two participants discussed the low statistics of Spanish-speakers accessing the website and finishing the assessment. One participant shared that Indigenous and Latino populations currently do not see much benefit from using the WellScreen website. The participant suggested creating linkages within the community through translation, increasing familiarity with the tool, and providing resources that are relevant to Indigenous communities.

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Results

Content and design

Successes

MCBH Key Informant (KI) Perspectives

"…it does a good job with…linking the person to the appropriate level of resources…So I think that alone…is good to have to present immediately as soon as somebody's completing that information because sometimes if there's a delay..., then it might never get done later on. So if they're completing the screening now and then they get resources the following day, it might be too late. That person was really interested in getting screened and possibly help at that moment. So I think having that immediate feedback is important." - MCBH Administrator

The way results are reported on WellScreen gives users a good variety of resources depending on their results. Three participants think the description and language used in the results section is good. One participant pointed out that the results are meant to give users psychoeducation by providing descriptions of mental health risks and resources that may help users with self-help or link them to community organizations that could further make a diagnosis or risk determination. One participant liked how resources were suggested based on severity level. Mild results receive self-help resources, Moderate to severe results receive information on a local clinic based on their zip code. Another participant discussed the positive aspects of having a results code; it is a good place to start for a clinical visit.

Non-MCBH Provider Perspectives

Two participants complimented the design and layout of the website and results page. One participant liked how the results page pointed out areas a client is doing well in and areas they need help in. Another participant liked how the results are broken down into smaller sections making it less overwhelming. Additionally, the participant liked the ability to "share results."

Help@Hand Technology Development Partner Perspectives

"If someone records their score and we have a lot of prompts to say… "Remember to keep your results code or copy it or have it emailed to you, have it texted to you." I think that's great to encourage people to retain that information so that they can reference it again later. But again, I think the information can be overwhelming, but it's also about using it as a psychoeducational opportunity as well as a referral and linkage opportunity. So, we don't want to underplay it. So, it's tricky." -Help@Hand Technology Development Partner

There were overall positive reactions surrounding the way results are reported on the WellScreen website. Three participants pointed out positive aspects of the results code. They liked how it allows users to revisit their results at a later time with or without a provider and creating an account. Two participants liked how the results and resources are presented. Two participants discussed how the results may make the user feel like they are being diagnosed and may be overwhelming for some people, but this requires a careful balance of information and support. One participant appreciated how the results table allows people to click and jump through the results. Another participant liked the ability to filter through different county resources on the resources page.

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English Language Focus Group Participant Perspectives

"To be honest with you, I was impressed by the results page for so many reasons. First of all, let's say that I'm taking the assessment and I answer all the questions the correct way. It will give you detailed results about each condition. You have something about anxiety, you have something about depression, you have something about mania. So it's very detailed. And for me, maybe because I have a background, I would really like to see details about each one of these conditions. Especially people, who might have more than one case. So it's detailed, I like that." -English Language Focus Group Participant

"It's a really perfect design because I like the fact that it's visible. It shows... Immediately you get to the page, you see the whole screen and what it's all about. I think for me that's what really caught my attention and what I love about this particular page. And it has so many different icons that you can click on, you have the Planned Parenthood and I think for me having a wide range of options here is just what makes this page perfect." -English Language Focus Group Participant

Many participants are impressed with the results page and resources given within the results page. They find the results page effective and comprehensive. The results page according to most participants is perfect with only small modifications needed if the resources changed. Seven of eight participants had positive comments, stating that it does not need improvements in the design, content, and features. One participant suggested that more information is needed for the results page to be complete, however, the information given is good. The same participant found the addresses listed on the resource page useful for identifying the locations and distances from the client's home or current location.

Spanish Language Focus Group Participant Perspectives

"What I liked is that at the end of the survey, depending on whether you have private medical insurance, Medi-Cal, or you do not have insurance, it gives you options to seek help" -Spanish Language Focus Group Participant

Focus group participants found the results page particularly useful for identifying ways to improve their mental health. It allowed them to learn about different diagnoses and how to prevent further complications or how to seek immediate assistance for more severe cases. One participant stated using the results page for self-identifying their severity and seeking mental health using the resources page. The same participant found the "For more help" section very helpful. Although one participant was not able to receive care through Monterey County due to health insurance issues, the participant was able to continue to use the website for other family members in their home who qualified for Medi-Cal.

"When I did it, more than anything else, the results they gave me at the time revolved around depression. Depression and anxiety. What I found and what also helped me was, for example, socializing. They told me that depression is also caused by isolation, which happened to all of us with COVID when we were isolated and locked up at home, everything was virtual." -Spanish Language Focus Group Participant

"The format is great. I like that it has the categories on the top part, including the "Habla Español" one; that's huge for a lot of people. The colors are easy to look at; they're not too flashy but neutral, and the logos are there; everything is correctly laid out. None of it looks pixelated or anything like that." -Spanish Language Focus Group Participant

Spanish speaking participants found the results page especially helpful for identifying new or different ways to treat mental health symptoms at home and to find different ways to help themselves

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in conjunction with professional care as needed. The results page of the Wellscreen Monterey website allowed one participant to approach their mental health treatment plan with deep base knowledge. One participant appreciated the design of the results page because it gives specific results, definitions, and because survey respondents are not obligated to answer questions that do not apply to the person. Both participants liked the design of the resource page. It is visually easy to see and it includes a Spanish language, which is extremely helpful for people who do not speak English.

Challenges

MCBH Key Informant (KI) Perspectives

"One of the challenges…is around that disconnect with our systems where…the client completed it, but unless the client gets a printout or saves their QR code response so that they could look at later or the link to where it sends them the responses,...we won't have that information if the client comes in. Sometimes if our clients have pretty severe symptoms and didn't save the email or the link, it doesn't exist. We can't get to that screening that they completed already." - MCBH Administrator

Two participants discussed the disconnect between agency systems and WellScreen Monterey. Users have not been bringing the codes to the clinics. One participant believes this is due to the lack of printouts and information regarding the WellScreen Monterey code. Additionally, since both WellScreen Monterey and CalAIM are competing in all aspects (length, plan, implementation idea), the implementation of WellScreen is less applicable for MCBH ACCESS usage. Another participant discussed how the lack of WellScreen code usage may be due to the high number of incomplete assessments on WellScreen; if a client took the assessment but didn't save the email of the link then their results wouldn't exist.

Non-MCBH Provider Perspectives

"But I can imagine the anticipation of, oh, what are my results? And just anxiety of it all, like what is it going to... and it's not a diagnosis, but I can understand how some folks may feel like, oh, kind of worried about what is it going to say about me, that type of feeling." -Non-MCBH Provider

"When I got to the [question] about PTSD, like, "Have you experienced some trauma or whatever?" I did select yes. It was really the only question I ever saw with it. But then, at the end, it was like, "Hey, you may have PTSD," which is, I felt, a little too general. I don't know. I feel like if it's going to say, "Maybe there is PTSD,"...if there is PTSD, maybe there should have been more questions about it. I don't know." -Non-MCBH Provider

Four participants discussed the challenges with anticipation and oversimplification of results on the WellScreen website. One participant pointed out how some users may feel anticipation when taking the screen and waiting for their results. Another participant felt that the assessment deduced trauma symptom results based off only one trauma question and the end result was too general. Another challenge discussed were the resources that were not included on the resources page. This included OMNI/Interim and three digit resource numbers. One participant expressed that the current resource and results pages need to be reorganized and the size of resource buttons needs to be resized; The current format of the results page makes it difficult to focus on relevant information and to know what to do next with the results code. There were mixed reactions to the summary/results section. One participant disliked the design. Whereas another participant thought the results page was nice because it reassures the user that there is support. One participant pointed out how online resources

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may be accessed more than in-person resources depending on the time of day. The participant also suggested including friendly faces on WellScreen to encourage the youth to seek services.

Help@Hand Technology Development Partner Perspectives

"One of the things someone mentioned in a meeting was it's great that we have a number that you can call, but for some of the younger people who may be coming onto the site and taking it, there may be some hesitation to actually call a phone number. I think younger people tend to feel a little bit more comfortable if someone were to actually call them. So maybe adding in some capability for users to opt into having someone reach out to them might be something that could be helpful, rather than them having to take the action to call the phone number, which for some people could be hard to do that." -Help@Hand Technology Development Partner

One participant discussed the hesitation from youth to reach out for help. One participant pointed out the small number of people signing up for an account on WellScreen Monterey, even though there are many people accessing the website. Additionally, they mentioned how only 60% of users complete the assessment all the way through.

Spanish language focus group

"On the page, maybe give different options, for example, give you the option to enter your health insurance, perhaps with your membership number, and from there immediately redirect you to your provider. For example, provide the option to enter here, for example, I have UnitedHealthcare, and from there, redirect you to the pages. Ideally, they would send you to a psychiatrist or psychologist who is taking new clients. Because that is another obstacle, the problem is that you are unwell, you are anxious, depressed, and it is like a lot of work to still have to seek help." -FG3 - Participant 1

"I think that was a little confusing to me because I didn't know what to do after that. I didn't get it. I thought, "Okay, do I not feel well? Or do I feel well? Is this what I have? But what do I do after this?" -FG 2 - Participant 1

"I like [the resource page] because it also has, for example, Medi-Cal. If you have Medi-Cal, it takes you to the Medi-Cal page. Private medical insurance, it's good, because although maybe there aren't as many options, at least they give you options there." -FG3 - Participant 1

According to one participant, a challenge associated with the results page was the uncertainties about the next course of action. They recommended the website incorporate a section on the results page specifically dedicated to providing a clear set of *"next steps"* and include a description of how the *"results code"* is supposed to be used. One participant never reviewed the resources page because they did not see the tab at the top, it was visually difficult for them to see it. Upon reviewing the information, the participants felt it would have been useful when they were seeking treatment. One participant suggested expanding the website to include more sections or further capabilities to identify if there are any resources for people with other health insurance aside from Medi-Cal.

<u>Suggestions</u>

Non-MCBH Provider Perspectives

"...If you scroll down, areas you're doing well, areas of concern, what to do next, but I think there's just so much going on in that what to do next. It does have to come from here, but it's probably just has to be reorganized so it's very clear." -Non-MCBH Provider

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Some suggestions to improve the functionality and ease of use of WellScreen includes adding peer faces to the website, including more resources, and reorganizing the results page to be more clear and simple. One participant shared that adding peer faces to the website may increase the number of youth seeking services. The participant explained that for youth, an in-person connection may be needed as encouragement and support to make the next step towards receiving mental health services. Two other participants suggested adding three-digit resources and OMNI/Interim to the resource page. Another participant recommended reorganizing the results page. This will help the clients know what to do after taking the assessment.

Help@Hand Technology Development Partner Perspectives

"Ways to redesign our assessments broadly and one thing that has come up is having more collapsible sections. So, you might see the condition and your score on it, and then you'd have to press a carrot to open it and close it to see that section, instead of just having right now, again, in that table…Besides that, I'm not sure, because sometimes it's better to just show a lot of information, instead of forcing people to click on a lot of different things, because then the more times the person has to click, sometimes the less that they'll do so." -Help@Hand Technology Development Partner

One participant suggested adding an option for providers to reach out to the user. Another participant shared that the technology development partner had been working on collapsible sections in the website design to make WellScreen Monterey more organized. One participant shared the extensive process that went into deciding what outcomes made it onto the results page. Another participant wanted clinicians' point of view on WellScreen Monterey to learn if it is optimized for them.

Resources

Content and design

Successes

MCBH Key Informant (KI) Perspectives

"…just the community facing availability of individuals being able to look for their own resources and get a sense of their own possible severity of need…this could be complimentary in terms of helping people self-identify their actual severity of need and where is the right door to go to look for the help that they're seeking." - MCBH Administrator

"The work done by [technology development partner] and others to identify the resources that are available to the community at the end of the tool were good. It was pretty exhaustive. They kind of helped us organize our own self, in getting those resources lined up, getting the contact information correct." - MCBH Administrator

One of WellScreen Monterey's successes is its resources (self-help, community resources, psychoeducation) around mental health and wellness. One participant explained that MCBH ACCESS received many referrals who did not meet their level of care. WellScreen directs people toward resources that match their needs. Two participants commented that the website's design and questions are good and easy to navigate.

Challenges

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Non-MCBH Provider Perspectives

"There's just so many different reasons why people find themselves needing mental health services. And so I guess that is one of the things that I worry about, that if people take the screening, I'm looking at all of these resources that are up on the website, which are great, but then when people start calling around and trying to get help, they're often told, oh, your insurance won't work here. Or sorry, we have a four-month waitlist." -Non-MCBH Provider

There were challenges associated with accessing mental health providers. A participant mentioned that in cases where clients are referred to their clinic, they would need to reroute them due to the absence of a psychiatrist on site. Another barrier discussed was long wait times and difficulty getting people to the right services, resulting in many people in the county lacking a mental health provider. One participant also pointed out that some people won't have a provider in times of need because many clients typically reach out once they are in a crisis. Another challenge is getting clients to the right resources. One participant explained that a hospital is not a community organization or agency and that people should know when to access hospital services. To address the resources barriers, another participant suggested listing Interim as a top resource since Interim does not require referrals.

Help@Hand Technology Development Partner Perspectives

"A very small percentage of people have clicked on a resource. Part of it, as a team we've talked about maybe people just want to know what's going on with them and they don't really care about anything else. They know what's going on. They can read more about these conditions and…maybe that's all they wanted to do. So yeah, so we're just trying to see now that we're getting more eyes in this more robust marketing space. We'll see if behavior changes or anything like that." -Help@Hand Technology Development Partner

One participant shared that although they have not gotten experience feedback on what users are clicking on, they noted that very few users are utilizing the resources page after taking the assessment. The participant discussed that some users may only be interested in screening their symptoms, thus they are not clicking on the resources available. Additionally, the participant pointed out incorrect information on the WellScreen Website that was discussed during a linkage-feedback commissioners meeting.

<u>Suggestions</u>

MCBH Key Informant (KI) Perspectives

"After the screener, it narrows it down to what might be most appropriate for somebody…So I think this is going to take some pretty constant monitoring in order to ensure that the information is up to date and accurate and that the agencies still exist and that the programs that they're showing on here are applicable to that individual." - MCBH Administrator

In order to maintain the functionality of WellScreen, resources must be updated frequently. One participant discussed how frequent updates to resources will ensure that clients are directed to the correct resources. The outreach manager may be the appropriate person to be responsible for resource monitoring. Additionally, this will also help to narrow down resources based on what results the client gets. The participant also shared suggestions for which resources should be directed at which clients: local resources for users with eating disorders results even if mild,

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initially offering local help to clients with moderate results, initially offering self-help resources to clients with mild results, and including Carelon and Interim as a resource for those with Medi-Cal. One participant reported receiving requests to update the sensitivity of the meters on the results page. One participant recommended having a distinct screener for substance use disorder (SUD) and mental health. This may be helpful for those trying to gain a better understanding of SUD. Another participant suggested recalibrating the sensitivity of the meters on the results page.

Help@Hand Technology Development Partner Perspectives

One participant suggested adding the capability to have providers reach out to users about seeking services. Another participant recommended creating an exhaustive list of resources that highlights the most important information first, and if users are interested in psychoeducation, they can find that on another page. Additionally, the participant suggested prioritizing showing local community in-person resources on WellScreen.

English Language Focus Group Participant Perspectives

“Adding more languages. Another thing that may be helpful is adding something on there, some kind of link for those who may need help with reading the website or…pointing them to the nearest office or being able to translate it. I know most computers have something like that, like voice to text nowadays or text to voice. But if there's anything for visually impaired people or maybe taking into consideration colorblind people…Other than that I personally think that the website looks great, I think that it's well put together.” -English Language Focus Group Participant

The participants' suggestions included adding the costs of the services if there is a cost, labeling it as free, or adding the insurance eligibility. Another participant suggested adding the insurance eligibility in the resource page and/or sliding fee scale if available for the services. One participant mentioned adding a Spanish language capability, for the function to be visible since English speakers might be bilingual and could identify better in one of the various languages they speak. Additionally, if the resources listed could have the languages they speak at the location would be beneficial for the person seeking treatment. One participant followed up by suggesting that the website should include a visually impaired or technical assistance feature for people with disabilities. Lastly, one participant suggested the Seaside Village Project be added to the resource page.

Outreach and communication

Successes

MCBH Key Informant (KI) Perspectives

“Digital advertising has gone well and…social media…And…bus ads that have gone out…And then all the stuff that we're trying to do right now with getting tablets out into the world or I guess we've done the advertorials and other stuff. I just don't have the data to show if it's worked or not. Yeah, it's just hard to track. And the print materials are often hard to track. So most of us are on computers all the time, so I think the digital Google ads is pretty good.” - MCBH Administrator

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The digital marketing strategies were effective in fostering engagement and interaction on the website. Two participants shared that the current outreach efforts (GoogleAds, Bus ads, TV features, printed collateral) have been good. One participant made the distinction that since bus ads and printed materials are hard to track and most people use computers, digital ads are essential. One participant thought that the teams are very well-engaged and collaborative to better reach county residents.

"More could be done there so [community providers] are all aware of [WellScreen Monterey] to use it as they wish or recommend it or just be aware in case somebody comes in with a results code." - MCBH Administrator

"Part of the process is go on this countywide tour to all these agencies and drop off print materials and have that direct engagement would be good." - MCBH Administrator

"One thing that I was expecting to see that I didn't see would be some pamphlets or posters that we could put in our clinic lobbies…having some more visibility in our clinic sites, in primary care physician clinics, that's where I think that would be helpful in terms of visibility and actually getting the word out that this is something that's available to any community member." - MCBH Administrator

Four participants commented on engagement and outreach between Wellscreen Monterey with users, providers, and agencies. One participant shared that having community providers and agencies familiar with WellScreen one. He is very beneficial. Some concerns that arose included getting input from all providers since everyone's schedules were very busy, as well as getting all providers trained in the purpose and knowledge regarding Wellscreen Monterey. One participant they're giving out printed materials to different providers in agencies would be helpful for direct engagement, and posting pamphlets and posters in clinic lobbies since Wellscreen Monterey would have more visibility among community members in primary care clinic sites. The participant also recommended that better infrastructure for community planning processes would increase the audience of the website. For community residents, outreach is going well and the number of clients coming into clinics is increasing; this is ideal in terms of increasing opportunities for feedback and improvement of the website and resources. For individuals who are already clients, a participant suggested that they should still be made aware of Wellscreen Monterey. One participant shared concerns that some people may not know how to navigate the Internet or a smartphone, or read English or Spanish.

"We got trainings done with our clinical staff, our frontline staff at the desks and everything. We got that completed in time before the launch and we were all eager for it…I feel like that went pretty well of just getting it out there." - MCBH Administrator

One participant discussed the success of clinical staff engagement with WellScreen. The clinical and front desk staff received training and were eager to use the website.

Help@Hand Technology Development Partner Perspectives

"It's really nice to see all of the different types of outreach that we're doing beyond just some of the digital advertising, like Google Ads and Facebook, which I think is going to be really beneficial to reach some of the other community members that may not necessarily have access to a computer or internet. So it's exciting." -Help@Hand Technology Development Partner

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"We know Google Ads is going to bring people who want to take the screener, whereas Facebook is going to bring just more curious people. And now we've just started running bus ads and the other things." -Help@Hand Technology Development Partner

The participants discussed success in outreach and communication through the usage of GoogleAds and printed collateral in both English and Spanish. Four participants explained how using GoogleAds has increased the activity on WellScreen website. Prior marketing efforts through Facebook brought people who were curious about WellScreen, but did not intentionally search for mental health topics related to the county. One participant shared that onboarding the marketing team has expanded the marketing efforts beyond digital platforms. Two participants shared other marketing efforts such as mass emailing community providers and using bus ads. Another participant discussed the county efforts to minimize access and technological barriers to WellScreen through purchasing community tablets.

Challenges

MCBH Key Informant (KI) Perspectives

"In some of our outreach efforts, and peer groups, and some of the community engagement efforts I was surprised at the relatively small number that have been participating. It's really odd to me considering that the number that have been using the tool, or at least accessing the tool, in the thousands, is that's a high number. Yet in our outreach groups, in our peer groups, and all that stuff, it's often less than 10 people. And I don't know how you make that better, but I think that's something that could be improved upon, is the outreach to get the feedback." - MCBH Administrator

One challenge discussed was the need for more outreach and marketing efforts. One participant mentioned that marketing was not emphasized during the launch phase. Another participant pointed out that there are high numbers of users utilizing the tool yet, in outreach and peer groups, often less than ten people sign up and usually no community members attend.

Non-MCBH Provider Perspectives

"I think the more places we can have it visible, whether it's at bus stops or on buses, or in different local agencies, having a standard flyer that we can all promote at our agencies would be really neat to include." -Non-MCBH Provider

"I think we should have more public service announcements, I don't see many on TV anymore. I think we need to do more radio ads and utilize Instagram, utilize TikTok, utilize Facebook. Use what we have, media tools out there to get the word out." -Non-MCBH Provider

"We would love to have them so we can post them up, give them out, all that…Any program or agency that is an entry point to the system should have this information to hand out…If you can send the flyers out by email to the service providers directly, they could make their own copies and everything. It's the people on the ground who are going to be getting the word out for you." - Non-MCBH Provider

Challenges in communication and outreach include the need for increased marketing efforts in the community using various platforms. Many participants suggested the promotion of public health information through social media platforms (ex.- Facebook, Instagram, Tiktok, etc.). One

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participant suggested having more visible marketing efforts through the community through bus promotions, printed collateral for agencies, organizations, community centers, and college campuses to promote, and public service announcements through podcasts, radio stations, and TV ads. Another participant discussed the possibility of putting up community kiosks and computers that would allow those dealing with technological barriers to access WellScreen.

Help@Hand Technology Development Partner Perspectives

"What didn't go well…was knowing who to go to make it known throughout Monterey [County]; there's no general email list of all psychologists…or something so they could know that they could use this with their client." -Help@Hand Technology Development Partner

The participants discussed difficulty with outreach between agencies and the community. One participant expressed wanting to promote the screener through the 800 ACCESS number, but people within the agencies are too busy to create that kind of outreach. Another participant discussed not knowing who to go to when promoting in Monterey County; For instance, there are no generated lists of all the psychologists in the county.

Suggestions

MCBH Key Informant (KI) Perspectives

Three participants shared recommendations for enhancing user-friendliness in WellScreen, including audio capabilities and website format improvements to better streamline and simplify the information pages, along with effective outreach strategies tailored for Spanish-speaking communities and community feedback cycles.

Non-MCBH Provider Perspectives

Four participants discussed the marketing budget and recommendations for community outreach strategies, including the use of printed collateral, public announcements, and enhancing outreach efforts in Spanish-speaking communities. Two participants suggested incorporating an audio option, providing information on cost and insurance types, updating resources continuously, and indicating whether referrals are necessary would contribute to a more user-friendly website.

Help@Hand Technology Development Partner Perspectives

Three participants explained that the adoption of bus ads, posters, and use of audio and video websites were new approaches for increased community outreach. Utilization of Google Ads (Google AdWords) and the introduction of a marketing team was helpful, and recommendations include building brand awareness and setting priorities for marketing goals. Four participants recommended the enhancement of user-friendliness on all formats (laptop, mobile device, etc.) and the utilization of Facebook to promote WellScreen.

English Language Focus Group Participant Perspectives

"Go where people already go, YouTube, Instagram, Pinterest, and TikTok." -Spanish Language Focus Group Participant

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"I would say post it on the buses…,[c]ommunity wards, clinics,...doctor clinics. I mean, I do a lot of outreach myself, so I usually go to high traffic areas. Could be bakeries. I don't want to say Starbucks, but a lot of people go there." -English Language Focus Group Participant

"I agree with everybody with the flyer thing. People can read it everywhere, but having organized seminars in these places, like community centers, maybe churches, schools, and get a laptop with that so people can hear and can experience that…when I see really what it is and when somebody explain to me….So somebody who can guide you verbally, that will be helpful." -English Language Focus Group Participant

"Have [flyers] at the county offices, like here in Seaside, Salinas. Have somebody with a laptop or a tablet, and have a booth with material when it comes to behavioral health, like a tablecloth. And then have people come over and if they need help finding the resources, have someone who's bilingual, or trilingual, or have access to a language line, and people can come up and say, "Oh, I have a question." They could actually help people find resources that way." -English Language Focus Group Participant

"I was thinking about something right now, like public libraries, that will be good... People go there, especially to the computers, to look up things, basically. So maybe having something there for them beside the flyers. Could be a bookmark on these public computers for them." -English Language Focus Group Participant

"I'm telling all of my friends, colleagues here to know about this website, because it's a really great tool that we should all of know and use, basically. And spread the word." -English Language Focus Group Participant

Most participants suggested posting the WellScreen Monterey resources on bulletin boards in buses, supermarkets, community centers/other locations for the community, doctor clinics, libraries, churches, or any other place where there is a high volume of people or activity. One participant suggested that WellScreen Monterey should work with school therapists from all levels, especially with universities. Alternatively, one participant suggested having live seminars where people can use the tech (provided by staff) to learn and use the WellScreen Monterey services. Additionally, one participant mentioned incentives such as food as a method of attracting people to join seminars or workshops where people can learn about the services. A different participant followed up by suggesting that WellScreen Monterey partners with other organizations in the area that are interested in healthy lifestyles. Alternatively to having seminars, one participant suggested having a booth at different locations within Monterey County where people can learn more about the services through a one-on-one staff-guided introduction to the services on the webpage. A few participants suggested that this information be shared with close friends and family members. One participant who works with volunteers suggested posting the information on websites where low-income and Medi-Cal clients can see the information. Additionally, a participant suggested using apps. Overall, the website is serving focus group users well, most of them had positive comments and were very enthusiastic to share the tools with other people. Many participants have shared or will share the tool with immediate family members.

Spanish Language Focus Group Participant Perspectives

"For me there is no problem, I am used to copying it and putting it here, putting it there, because it is part of my job, it is what I do, I use the computer all day. I have to keep in mind that not everyone has, first, access to the internet, to begin with, access to a computer, access to a

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phone with internet. The easier it can be, the better. Especially if most people do not have a computer at home, then use their cell phone as a computer. Make it easier to navigate, make it easier to-- If there's going to be code, copy it somehow. See how to make it more accessible to everyone." -Spanish Language Focus Group Participant

"For example, with my providers I have an account that they make me create…, an account could be created with your name, address, and date of birth. On the page, you enter your health insurance, Medi-Cal, or whatever. From there, with that information, [MCBH] could send the information. Already having an account, they would already have access to the survey, and you could even enter your insurance information, and the member number." -Spanish Language Focus Group Participant

"Maybe at the César Chávez library,...And El Gavilán, too, where you can find more Spanish speakers and babysitters that go there with children after school, they go there with the kids and they can see the flyers there. Maybe you could have-- Not like a workshop, but like an informative timing to inform people of what's out there. "If you're feeling that you don't know what you have, you don't have this. Try this link out. Give it a try and see if you can-- If it's beneficial." -Spanish Language Focus Group Participant

"Sometimes it is good for a pop-up to appear so you can chat. There should be something in Spanish, because it goes, "Pop," that says, "Do you have any questions? Do you need help? Click here." It would be nice if there was a way to chat. I really like to chat." -Spanish Language Focus Group Participant

Focus group participants had many suggestions for disseminating the Wellscreen Monterey website, from making the information easier to understand, to asking healthcare providers to disseminate the information for Monterey County. One participant suggested the information be published via the primary clinics, posted in libraries, have information sessions, and distribute the information via the bilingual radio station. One participant suggested that there is better communication among medical and mental health providers, where they can share the results and relevant information via electronic health systems. Both participants suggested that this information be shared with close friends and family members, libraries, and supermarkets. One participant who works with volunteers suggested posting the information on websites where low-income and Medi-Cal clients can see the information. Additionally, a participant suggested using apps such as "Go where people already go, YouTube, Instagram, Pinterest, and TikTok." (FG3). In terms of usability, one participant suggested the website incorporate a chat feature in Spanish since it is helpful for identifying where to locate certain information.

Needs of vulnerable populations

Non-MCBH Provider Perspectives

"Not everybody has a fast internet connection or any internet connection. Yeah, not something you guys can fix, but maybe make it available on multiple platforms…I don't know if it's something that can be put on our Spanish TV stations, like little public service announcements or it could be made into half an hour, 20 minute segments. I think that would be helpful." -Non-MCBH Provider

"Yeah, on this website. So, once we had launched the campaign, I did provide them with a new banner to add here, which see, here it is. And they did have a banner before that was there, but it's difficult to read, it's difficult. Some of the other things that they have going on, it's hard to see

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where you want people to focus. And then, if you were to click on get help, maybe." -Non-MCBH Provider

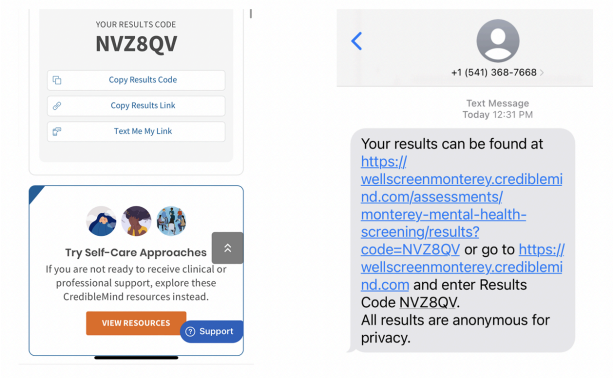
A challenge when increasing access to WellScreen Monterey for Latino and Indigenous individuals is the lack of outreach and marketing on different platforms. One participant suggested making the website announcements available on multiple platforms including Spanish TV stations and service announcements. Another participant suggested creating better banners and ads for the community.

Help@Hand Technology Development Partner Perspectives

"I think it's more about the avenues of marketing and not just the content of it that is going to be really important. Then something we talked about before during the needs assessment process is thinking about the population of monolingual Spanish speakers, you're likely looking at people who have less access to technology, smartphones, internet access, things like that."
-Help@Hand Technology Development Partner

One participant expressed emphasizing marketing WellScreen towards monolingual Spanish speakers since those who speak both English and Spanish face fewer barriers. Additionally, the participant pointed out the importance of considering different marketing avenues since the population of monolingual Spanish speakers may have more barriers when accessing WellScreen. Another participant noted that GoogleAd marketing efforts did not seem to reach the Spanish-speaking communities.

WellScreen Monterey website: linkage/brokerage effectiveness



Key informant interviews were conducted with 14 key stakeholders involved in the WellScreen Monterey website of the Help@Hand project and included informants from Monterey County Behavioral Health, other community service agencies in Monterey County, and Help@Hand Technology Development Partner. Key informant interviews were conducted from May 26, 2023 to August 23, 2023. The following qualitative findings are organized into sections (users and resources, results integration, users/clients and providers, additional resources), and then subsections by MCBH Key Informant Perspectives, Non-MCBH Provider Perspectives, and Help@Hand Technology Development Partner Perspectives.

Users and resources

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MCBH Key Informant (KI) Perspectives

"Well, [EHR System] integration doesn't really exist. I mean, we had to sort of land on a manual process, which is what it is. And I think what's also important for me to remember…is that this innovation project is to build this tool that could work in other counties and not all counties use Avatar for their electronic health record system…Manual stuff is easier to translate and do. Or just verbally share the information and then the receiving end looks it up and downloads it without any actual digital transfer of information. I think that's sufficient…" - MCBH Administrator

"I think [the resources are] effective. But right now, it's limited to what's in there and what's been uploaded by us and the [technology development] team. I think hopefully we can get some help from collaborating with United Way and their 2-1-1 database. And just having them be more of an active member to support this where the information is, basically we just have more resources listed and categorized. I think that would be good." - MCBH Administrator

One participant shared that the Avatar portal integration was not implemented and that potentially that may be sufficient since other counties do not use Avatar EHR System. Another participant liked that MCBH, Beacon, and Carelon are listed on the resources page. One participant shared thoughts on the resources that are offered depending on the user's results; People who score mild get coping skills and breathing exercises and those who fall under substance use disorder (SUD) get directed to local SUD services. Two participants think that WellScreen is easy to navigate and is good at linking users to immediate resources.

Help@Hand Technology Development Partner Perspectives

"We know the number of people who've taken the assessments. But we don't really know what they've done beyond that. We don't know if they've booked an appointment or called someone or took some type of action beyond taking the assessment, which in some ways, even just taking the assessment I think is a good step…But I think that is one of the challenges, is not knowing what people are doing after." -Help@Hand Technology Development Partner

"I think the biggest marker of success would be just people going to other agencies because we're trying to reduce the burden on MCBH and MCBH often is filtering people out to other agencies. So, if we can get people to go there by themselves and not have to take that extra step of MCBH, that would be great. So, the only way to know if we're doing that though is tracking. I think that's the tricky part." -Help@Hand Technology Development Partner

"We are finding users…give the assessment 90% plus thumbs up; they love it, but less than 20% of users are actually clicking on a resource,...it means they're happy just to have read their report, and it may be because they were low-risk or moderate-risk for everything…But I think there is still the challenge of how to do a better job of getting users to actually follow through with the resources." -Help@Hand Technology Development Partner

The participants expressed difficulty with gauging the effectiveness of the WellScreen website. One participant discussed that the effectiveness of WellScreen should be based on the amount of people going to other agencies with their results because the goal was to reduce the burden on MCBH. Two participants touched on portions of the website that are not used; One participant shared that the FAQ does not get used. Another participant stated that the users give the assessment a 90% thumbs up but less than 20% have clicked on a resource.

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Results integration

MCBH Key Informant (KI) Perspectives

"I don't know how good that is going to be, either now or ever. We don't have any example of somebody bringing the results in. And with all those visits to the site, and people actually took the screening tool, I would've thought just at some point somebody would have said, "Hey, I got this finding and here it is. And I need to talk to somebody."...I don't know if that has been the most effective component of the program." - MCBH Administrator

The effectiveness of the results code was discussed amongst the participants. One participant thought the results code was reasonable. However, another participant did not know how effective the results are. They have not heard of any clients bringing their results code to a provider. To date, only eight people have brought their results to clinic visits.

Non-MCBH Provider Perspectives

"You know what would be really excellent? Is if a person could do that result code and click to make an appointment with Behavioral Health, if that's what they could do. Straight from that website, straight from that result. Or something that leads them. So there's the phone number…Say if they clicked on it, it would give them appointments." -Non-MCBH Provider

"And so then a lot of the questions will be answered through their WellScreen. If they have a QR code, the staff at the office would be able to look at and see what's kind of going on. Have a summary of how this person is feeling and experiencing since they got such detail in the WellScreen tool." -Non-MCBH Provider

One participant expressed how they have no idea how to mitigate the problems surrounding finding a mental health provider in the county; There is a long wait-list to see a mental health provider and many people are in a crisis by the time they seek out a mental health provider. One participant discussed the possibility of sharing the received results from the self-assessment directly with an agency. Another participant pointed out the confidentiality topic concerning user results and questioned if users could opt out of confidentiality. One participant suggests including a button WellScreen that allows the user to send their results directly to a provider. Two participants suggested including action phrases so that users know what to do after receiving their results code.

Help@Hand Technology Development Partner Perspectives

"I think it would also really require more education of these organizations and MCBH professionals, because they're going to be the ones who need to actually request this information and create a language…of, "Hey, this is information that would be helpful for us." [This would help establish that] okay, this is something that we talk about, this is something that we seek out, this is something that we're prepared to receive. I think that would increase the user presenting with that information." -Help@Hand Technology Development Partner

Three participants discussed the lack of usage with the results code. They had no suggestions on how to increase the amount of people using the code. One participant suggested putting in more marketing efforts to explain the results code to the user, and also educating organizations on the purpose of the code. Another participant pointed out that the usage of the results code may be difficult for clinic admin because of the unusual workflow it introduces.

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Users/clients and providers

MCBH Key Informant (KI) Perspectives

"If…there's an area for improvement, it's still just connecting people to the right resource…specifically, there's kind of always a default on the results page to call Behavioral Health Access…there's always the icon to call behavioral health. If it's mild to moderate, maybe don't have that icon there to click…I think that's just important because part of the problem we've had is everybody coming to ACCESS and ACCESS having to then refer out to a lot of different directions and it just eats up their time." - MCBH Administrator

One participant pointed out that even though users are not bringing their results code to their providers, this does not mean that they are not taking the next steps to their wellness. Another participant suggested that MCBH providers ask for the results code in order to promote the usage of the code. Two participants suggested adjusting the resources recommended to users based on their results; One participant suggested those who have mild results to be directed towards self help resources and those who are moderate be directed to local resources; Another participant suggested that those who are moderate or mild not be directed to ACCESS but Carelon/Beacon instead.

"I wonder if, as soon as somebody completes it and…generated a resource of our ACCESS clinic, could WellScreen also send an email to our main access line and be like, "Hey, this person, John Doe, completed this WellScreen and indicated they have moderate symptoms for depression. Can you follow up with them within the next 24 hours?" And include the phone number…I think that's where it would start through our ACCESS entry point." - MCBH Administrator

To improve the connections between providers and users of WellScreen Monterey, one participant suggested including experience surveys for users to fill out. Another participant suggested that the screener be able to generate resources that are sent to ACCESS clinics from WellScreen Monterey when users have completed the WellScreen assessment.

Non-MCBH Provider Perspectives

"So from the provider side, I feel that need to set up for the QR code…Once someone calls and says 'I took the WellScreen,' or their QR code pops up or they give you their QR code. Once the provider gets the QR code, they can look at the results. And again, see what's going on with that person and they can then use what we have, what [is needed] to interface with that person where they're at." -Non-MCBH Provider

"...Providing them with a more clear way of getting in touch with somebody. And like you said, and having a more clear opportunity for providers to reach out to the people who have decided to take this to opt in to help potentially would be, is the missing piece." -Non-MCBH Provider

One participant suggested including information such as referral requirements, cost of service, and Spanish-speaking service availability under each resource to strengthen the connection between users and providers. Another participant pointed out that providers should know what to do if a client walks in with a WellScreen QR code. Another participant suggested creating a form that agencies can fill out when they want to update their agency information. Lastly, a participant expressed wanting a more clear way of allowing providers and services to get in touch with users after completing the questionnaire.

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"...For our youth, [providing] in-person connection,...let's say, they click on the OUR GENTE page, our LGBTQ youth support services program and they see a youth who is a peer and like, oh, visit The Epicenter on Thursdays, we have our drop-in hours, and seeing a face like, oh, this person looks like me, or this person may be able to provide that peer-to-peer support, it may be nice to have like a face to...can make it more personal, or personable." -Non-MCBH Provider

One participant suggested including testimonials and photos to encourage people to seek help. Another participant thought the current format of the results page makes it difficult to focus on relevant information. One participant stated that there are many resources on the MCBH website that are updated periodically and that it would be helpful if WellScreen Monterey could link back to that. They also pointed out that the Monterey County website does not include the WellScreen questionnaire.

Help@Hand Technology Development Partner Perspectives

"We've added that in [recently] for people to opt in to maybe be a part of some of those focus groups if they would like, which I know some people have started filling that out, which is great. So maybe we could continue doing things like that, if Monterey would like to speak to individual users." -Help@Hand Technology Development Partner

One participant suggested including options for opting in and out of things such as focus groups, and having someone reach out to users can aid in improving the connection between MCBH, Providers and users of WellScreen Monterey. Another participant suggested providing organizations with flyers and training to educate providers on WellScreen.

"...Even though the Help@Hand project will end, I think they want WellScreen to be intact for beyond that. So probably once a year training. I'm sure there's also a lot of turnover. So there's probably already new people since November who, I don't know if they learn about it during training or if they even know what's going on. So yeah, I'd say maybe once a year or twice a year even. Kind of refresher on it." -Help@Hand Technology Development Partner

"Well, again, it comes a little bit back to the workflow thing still. They need to integrate it in their workflow. If you arrive at the clinic and they're handed an [tablet] and said, "Go do this screener," that's going to make sure that they use it. I think also just general awareness of it…Even things just like little cards or something or flyers in the office, QR code posters that can be in the offices that are, "Scan this to assess your mental health," or things like that." Help@Hand Technology Development Partner

Five participants discussed improved linkages between the user and resources, as well as MCBH. For process improvement and continuation, two participants suggested conducting an annual training about WellScreen Monterey for new hires or as refreshers for providers. One participant explained that this would increase familiarity with the website among providers so that they can help users/clients take the assessment. The participant also suggested that MCBH complete an annual review to ensure that resources are active or updated accordingly. Another participant recommended that providers should be allowed to upload resources or search for resources within the website, as this would enable them to look up information about local organizations. One participant shared that the county may consider an end-user survey of users who registered at the end of the year to assess effects of WellScreen Monterey, including how the user felt when using the website, if the user learned anything new, and if the user used a resource. One participant discussed several approaches to integration and collaboration. They

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suggested working with United Way 211 to maintain a database (on what? Check transcript) as well as sharing resources that WellScreen Monterey does not yet have listed. The participant also suggested integrating Wellscreen Monterey results with MCBH Electronic Health Record System, so that results can be automatically uploaded to clinic systems, including MCBH clinics. They commented that the tablets for clients to take the screener, as well as cards, flyers, and QR codes in offices, were helpful to users. The participant also recommended increased follow-up with users who have completed the assessment to ensure that users know what actions they can take after completing the assessment. The participant shared that it would be helpful to highlight resources that are specific to user demographics and to help users under age 16 to access resources. Another participant reiterated that a better online workflow, connecting Wellscreen Monterey with clinics, would build trust and a better connection with community members and would increase the number of people coming in for support.

Additional resources

MCBH Key Informant (KI) Perspectives

"I am pretty sure it's on there, but the Carelon, I think that should be highlighted more just because they're a mild to moderate provider for Medi-Cal people. And so I think making them more prominent would be good. Besides that, it's more niche based on people's needs and demographics. So it's hard to say highlight one over the other." - MCBH Administrator

"That's going to be Monterey County team that's going to have to do [update resources]...Because phone numbers change, and people change, and things change. So yeah, I don't know. Monterey County, what frequency? I would think every six months…putting that on somebody's calendar to make sure it gets done, we haven't done that." - MCBH Administrator

One participant gave suggestions on updating the resources list; The MCBH team should be responsible for updating the resources every six months. Another participant recommended that local resources for users with eating disorders be added to the resources page. Additionally, another participant pointed out that Carelon should be added to WellScreen as well.

Non-MCBH Provider Perspectives

"Listing of the food bank would be good on here for people that are struggling with food insecurity and then also an updated listing of all the places that people could receive a hot meal in our community, in our county. I think the other thing that's missing in terms of mental health for younger people is school districts across our region now have mental health professionals, licensed mental health professionals providing care for students in high schools, in all our comprehensive high schools. And it would be actually really good to list out all of the different schools and how to reach the licensed mental health professional on those school campuses for parents who are having issues with their kids." -Non-MCBH Provider

"Maybe if you have an option for someone who, if they're on low bandwidth or their data plan's pretty low on their phone, maybe just a straight-up list that they can click on if they need that option instead." -Non-MCBH Provider

One participant suggests including DoortoHope, all-inclusive resources, BrilliantMinds, and including testimonials and pictures of peers on WellScreen. Another participant suggested including a list of various resources available at community colleges, school districts, food banks, clubhouses, resource centers, etc. One participant recommended having a cohesive list of all the resources on

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WellScreen available in the case that someone loses their internet access and can no longer see the resources online.

Help@Hand Technology Development Partner Perspectives

"There are a lot of resources that we've developed nationally and internationally on our site, and they haven't been necessarily integrated fully. But they haven't been excluded either. There are self-help resources that are videos, and podcasts, and things like that. But, there are some larger virtual agencies that might be important to integrate a little bit more strongly."
-Help@Hand Technology Development Partner

"I think maybe a good idea is to do an annual review to make sure, oh, if there's any new ones or maybe something closed down or to update the information as well. I think we wanted to push put that on Monterey to do the updating and I'm not sure if they've designated someone to do that, but it's definitely a lot to have to go through every year." -Help@Hand Technology Development Partner

One participant expressed that national and international virtual resources should be included on the WellScreen resource page. Another participant advocated for constantly updating information on local resources. One participant shared the idea of highlighting resources from the start of the assessment rather than after you finish the assessment.

Conclusion and recommendations

The Help@Hand Monterey County initiative was a great success in a number of ways. Higher percentages of people of color suggested a positive effect of the implementation - this positive impact included a shift to more Medi-Cal recipients as MCBH had hoped. On the other hand, direction of change for triage was not consistent with expectations and no changes could be detected from the EHR data on Beacon referrals or on non-billable services. It is possible that this is due to either the low use noted for actually reading resources from the web platform, or the connections between the screening data from the website and the MCBH intake/triage processes.

From the WellScreen Monterey site assessment data we identified 552 individuals who lived in Monterey County, were moderate-to-severe acuity for at least one or multiple (comorbidities) of the following conditions, were covered by Medi-Cal, and were not currently being treated by MCBH: Anxiety (354), Depression (367), PTSD (163), Bipolar (238), Eating Disorder (284), Substance Abuse Any (233) and Psychosis (26). In this initial period, several people brought in their screening results from Wellscreen Monterey site to ACCESS program visits, as indicated by the *Alias 10* field. As more people access Wellscreen Monterey site and this screening process becomes integrated in the ACCESS clinic workflow, more people will bring their screening results to ACCESS clinic visits.

Strengths of the planning and launch phases included collaboration between teams working on the Help@Hand project as well as with community agencies and partners, outreach and communication efforts, and feedback-response cycles. In the perspectives of the key informants, the facilitators that brought success in the planning phase include strong partnerships between MCBH program managers and mental health technology development organizations, a well-developed community needs assessment, good testing and validation of behavioral health assessment measures and scales, and transparent and open communication

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between the technology development teams in the evaluation team. Challenges in the planning phase include having limited staff when preparing for launch, facing language barriers between clients and providers, and timing issues such as delays in deadlines and coordination between teams. In regards to the launch phase, successes from the key informants' perspectives include having a gradual launch (soft and hard launch), beta testing, building trust between the community and website, collaboration between the teams, and having a good budget. Challenges that were encountered during the launch phase include a lack of integration of screeners within clinics due to lack of training and engagement amongst providers, lack of trust between the older population and using an online platform, timing delays, and administrative challenges.

Strengths of the WellScreen Monterey website include the calm and informative website design, straightforward assessment experiences, and functional access to results as well as effective presentation of the results page. Participants in key informant interviews and focus groups found the website feasibility and ease of use to be a success overall, in the self-assessment, results page, resources page, and for outreach and communication. Key informants discussed successes which include positive user experience, improvements to connecting clients with resources, the use of the website as a starting point, and the thoughtful layout and easy-to-understand content of the website. Focus group participants found the website to be a helpful tool for receiving mental health information and resources, to be effective and comprehensive, and to be well-designed. Key informants commented that challenges include timing delays, linkages of users using results codes at clinics, and disconnect and communication difficulties between agencies. Focus group participants discussed challenges that include needing more information on the results page, improving language access.

From the user's perspectives and experiences to the developer's feedback, in linkage/brokerage, we see the successes and challenges associated with the WellScreen Monterey website implementation. Informants feel a sense of connection and relief by having access to a tool that can guide them through their symptoms and diagnoses. Although much work is needed to create a clear path from the MCBH Assessment to the MCBH providers, users are seeing positive outcomes from using the website for themselves or their family members and friends. At this moment, it is uncertain why users are not leveraging all the website content, however, changes will be implemented to guide the users to find the resources within the website.

The key recommendation is a more seamless transfer of website results data if someone seeks services at MCBH. Interoperability of data across apps, devices, and EHRs is a persisting issue in the U.S. and there was no difference here from many other experiences in pre-screening of people on devices/internet who then seek services. However, the addition of tablets during intake that can go onto the WellScreen Monterey website to retrieve user data during that initial patient-provider process seems very valuable to pursue in the future. Having data called in through a RESTful API or other HIPAA-protected process for transfer of data could be a new pathway for importing the screening data if MCBH chooses to work on that linkage. In the qualitative findings, many participants discussed the benefits of results integration between WellScreen Monterey website and MCBH Avatar system. Automatically transmitting assessment information between WellScreen Monterey site and Avatar in an interoperable format (e.g., results can be added in a usable data format that can be accessed within the EHR) is an important suggestion.

Recommendations for the planning and launch phases are to appoint a representative from each team working on the Help@Hand project to improve communication channels, and to

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engage in more community-based outreach at local community gathering places. Suggestions from key informants regarding the planning phase include having public announcements in areas where the communities gather (e.g., meat markets and churches) and having more people in leadership positions (co-lead) to provide more perspectives. Suggestions from the key informants for the launch phase include providing more training and integration within clinics using the screener, having more bilingual providers, building trust among Spanish-speaking and older communities, and receiving more feedback from stakeholders regarding the screening tool.

Recommendations for the WellScreen Monterey website are to include additional Monterey County specific resources, consider the length of the assessment, and make adjustments to the user interface to improve ease of use. Suggestions from participants in key informant interviews and focus groups include having an audio version of the website and additional language translation to better support language needs of different populations, increasing internet and device access, and reducing the reading level of the assessment. Additional suggestions include working inter-agency to update resources listed on WellScreen Monterey, adding information such as distances of locations and costs to the results and resources page, and increasing community-based marketing for better engagement and outreach (clinics, bakeries, churches, schools, county office community events, public libraries, word-of-mouth, and more social media).

Next steps

Summary of learnings and achievement of intended outcomes of the Innovation Project

“That's one thing where we didn't necessarily achieve that outcome….The project has shifted too. From the time we got the plan approved to now, a lot of the world has changed.” - MCBH Administrator

“...Personally, I still think this tool's done a lot of good, because it gets a lot of education out there. A lot of people are using it. It's just…hard to measure.” - MCBH Administrator

WellScreen Monterey has contributed greatly to educating the community. While measuring outcomes has been difficult, e.g. direct linkage is difficult to track, people using WellScreen Monterey to find services may not share their results code, the project has adapted successfully to the changing world with shifting expectations and external challenges such as COVID-19. One additional outcome that may be considered is measuring the preventive effects of WellScreen Monterey.

Continuation of the Innovation Project: plans, funding, stakeholder involvement

“Our public health department [is a] stakeholder in essence too. Our director [has] expressed interest in expanding the scope of [WellScreen Monterey], beyond behavioral health services…[and we will] factor that into our MHSA planning processes, because that's really our opportunity window each year to assess needs, and talk to stakeholders to…let them know what's going on, and then also to invite them to contribute to the decision making.” - MCBH Administrator

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"We have a contractual relationship with United Way for other services, but that keeps us close, and so we'll be in touch with them at that level. But then in terms of if we were to look to ever modify the product at all, we can leave room for this in our annual MHSA planning processes" - MCBH Administrator

"We're going to continue [WellScreen Monterey], but likely under PEI funds…at this point we view the tool as developed and now it's just a matter of maintenance…Currently we don't have plans, concrete plans, to really modify significantly the product, we just want to maintain it." - MCBH Administrator

The Innovation Project continuation plan has been considered throughout the CalMHSA planning process and will continue under funding from CalMHSA for Prevention and Early Intervention Services (PEI). WellScreen Monterey, now fully developed, will require maintenance over time. There are currently no plans to make significant modifications. The county will continue to contract with United Way for different services and may reach out for support in maintaining WellScreen Monterey. County leadership has expressed interest in expanding the scope of WellScreen Monterey beyond behavioral health services.

Dissemination of Innovation Project results from County to stakeholders

"Throughout the process of this, with our annual Innovation Reports, that's always been included in our MHSA annual updates, or three-year plan." - MCBH Administrator

"There's 15 counties total, so 14 other counties. Then I know [State Admin 1] and I [have] done at least two or three presentations to that group." - MCBH Administrator

"The…conference presentation [could also be included] as communication to stakeholders." - MCBH Administrator

"...With the MHSOAC, they've tried a couple iterations of posting all the Innovation Projects, and PEI and CSS. But for Innovation alone, they've done a couple of iterations of trying to create a clearinghouse of information on their website, where you can search, see what's been done. Because a part of this is with Innovation Projects, you don't want to duplicate, and OAC doesn't want people to duplicate what's already been done." - MCBH Administrator

CalMHSA annual updates will disseminate information and results from the Innovation Project. MCBH will submit the final report to the Mental Health Services Oversight and Accountability Commission (MHSOAC), and MHSOAC will share the results with other counties. Each county may experience different benefits from the projects compared to other counties. The dissemination of it will also include presenting findings to other counties, including conference presentations with stakeholders. MHSOAC also posts all of the Innovation Projects on PEI and other platforms for people to read. The intention is so that other counties do not duplicate what has already been completed. MHSOAC has put efforts to share information, although more frequent updates and consistent information between state and county entities would be helpful. Considering previous evaluations that were not widely disseminated, a suggestion moving forward is to create an executive summary for each evaluation that discusses pieces of the evaluation that can be more easily disseminated and understood.

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Appendices

Appendix A: Methodology

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- Quantitative Methodology: pg 82
- Qualitative Methodology: pg 86

University of California, Berkeley's Health Research for Action served as the local external evaluator for the Help@Hand Monterey County initiative, working closely with Monterey County Behavioral Health (MCBH), California Mental Health Services Authority (CalMHSA), and CredibleMind, Inc. on this Monterey County Help@Hand evaluation. This report summarizes the evaluation of WellScreen Monterey website implementation and includes the following data sources:

1) MCBH ACCESS program's de-identified data from the electronic health record (EHR) system (Avatar) to examine trends in the program's assessment/evaluation, linkage/brokerage, and mental health services before and following the launch of WellScreen Monterey;
2) The de-identified WellScreen Monterey user data set (dashboard, website data) to assess user demographic and behavioral health characteristics, how users learned about WellScreen Monterey, pages and links viewed by the users, and user satisfaction with the resources.
3) Key informant interviews that explored the process for the planning and development phases, the launch of WellScreen Monterey, what worked well, what were the challenges, and suggestions for the next steps.
4) Community member interviews that explored community perceptions of WellScreen Monterey website overall, its self-screening/assessment process, results page, resources page and information about how to access resources, and discussed community preferences for outreach and communication.

Quantitative Methods

Pre-Post Comparison

ARIMA Methods

Dataset
The Electronic Health Record System (Avatar) dataset, de-identified EHR data from MCBH, covers the period from July 1, 2018, to June 30, 2023.

Variables
We re-coded a few variables as follows:

- **Number of Patients**

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    - The total number of new clients was calculated by determining the distinct Patient Order Number count in the dataset.
- **Pre-Post Launch Dates**
    - The 'dates of service' designated before 2022-11-15 were classified as *Pre-intervention* and the rest of the data as *Post-intervention* period..
- **Race Value**
    - Asian: This category includes individuals identified as Asian Native, Chinese, Filipino, Japanese, Korean, Laotian, Vietnamese, Other Asian, and Cambodian. There is also a blended category called American Indian/South Asian. This appears to be an error in the system after checking with MCBH but for the purpose of categorizing data, we chose to call this the South Asian category, as it is more likely to represent South Asians as the higher number of people in the county.
    - NHPI - Native Hawaiian/Guamanian/Samoan: This category includes individuals identified as Native Hawaiian, Guamanian, and Samoan.
    - The rest of the categories remain unchanged (Alaska Native, Black/African-American, Hispanic, White, Middle Eastern, and Other Race). Typically American Indian would be grouped with Alaska Native populations as Indigenous people in the US. There did not appear to be a way to disaggregate from another category.
- **Ethnicity**
    - Hispanic: This category includes individuals identified as Cuban, Mexican/Mexican American, Other Hispanic/Latino, and Puerto Rican.
    - The rest of the ethnicity categories remain unchanged (Not Hispanic and Unknown)
- **Primary Language**
    - Other Non-English: This category includes individuals who reported their primary language as Arabic, Farsi, Japanese, Korean, Mandarin, Other Non-English, Portuguese, Samoan, Sign Language, Tagalog, and Vietnamese.
    - English and Spanish categories remain unchanged
    - Unknown: This category includes Unknown / Not Reported or No Entry responses

WellScreen Monterey Website Data Methods

Dataset
De-identified data from WellScreen Monterey user data (dashboard, website data) was examined to assess user demographic and behavioral health characteristics, how users learned about WellScreen Monterey, pages and links viewed by the users, and user satisfaction with the resources.

- Dashboard Data: WellScreen Website Dashboard data were examined from 11/15/22 to 10/23/23.
    - Sample
        - Number of Users: 28,879
        - Number of Sessions: 35,998
    - Variables: We re-coded a few variables as follows:
        - Primary Language:
            - Other Non-English: This category includes individuals who reported their primary language as Indigenous languages (e.g.

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Mixteco, Triqui, Chatino), Korean, Tagalog, or was referred to as "Other language" by the Credible Mind dashboard
- English and Spanish categories used their original groupings

- Gender:
  - Other: This category includes individuals who reported their gender as Questioning/Unsure, Transgender, Genderqueer, I prefer not to say, Other gender identity
  - Female and Male categories used their original groupings

- Website Event Data: WellScreen Website Event data were examined from 11/16/22 to 7/31/2023
  - Sample
    - Number of Users: 21,243
    - Number of Website Events: 165,670
  - **Variables**: We re-coded a few variables as follows:
    - **The topic associated with the event**
      - **Addiction and Recovery:** Addiction & Recovery, Alcohol Use, Cannabis, Loved One with Addiction, Gaming for Wellbeing
      - **Anxiety and Stress:** Anxiety, Stress, Ansiedad, Estrés
      - **Mental Health Awareness:** Mental Health, Depresión, Psicosis, Psychosis
      - **Mindfulness and Meditation:** Mindfulness, Mindfulness of the Senses, Body Scan Meditation, Meditation
      - **Mood Disorders:** Depression, Bipolar Disorder, Seasonal Affective Disorder, Postpartum Depression, Depression and Young Adults, Trastorno bipolar
      - **Personal Development:** Personal Development, Leadership, Happiness, Hope, Positive Thinking, Positive Psychology
      - **Relationships and Social Support:** Friendships & Social Support, Romantic Relationships, Loved One with a New Diagnosis, Loss of a Loved One, Grief & Loss
      - **Therapy and Mental Health Support:** Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Therapy & Support Groups, Online Therapy, Mindfulness-Based Stress Reduction
      - **Wellness and Self-Care:** Self-Care, Physical Health, Nutrition, Exercise & Body Movement, Healthy Social Media Use, Sleep, Tai Chi, Yoga
      - **Other Themes:** 12-Step Alternatives, ADHD, Aging & Longevity, Anger Management, Attachment Style, Autism, Body Image, Borderline Personality Disorder, Boundaries, Bullying, Caregiving, Caring for Aging Loved Ones, CBD, Communication Skills, Community Building, Compassion, Compassion-Focused Therapy, Compassionate Behavior, Concentration & Focused Attention, Crianza de hijos, Dance, Death & Dying, Diversity, Equity, and Wellbeing, Doctors & Medication, Domestic Violence, Eating Disorders, Empathy, Enneagram, Fear, Financial Wellness, Flourishing or Languishing, Gratitude, Habilidades de comunicación, Humor, Hypnosis, Incarceration & Reentry, Living with Chronic Pain, Loneliness, Narcisismo, Narcissism, Naturaleza y al aire libre, Nature & The Outdoors, Neuroscience, OCD, Parenting, Personality Types, Relaciones Románticas, Resilience, Resiliencia, Retirement, Salud física, Salud mental,

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Schizophrenia, Self-Esteem, Service & Volunteering, Sex & Intimacy, Sexuality, Spirituality, Trastorno bipolar, Trauma, Vulnerability, Work-Life Balance, Working From Home

- **Region**
  - California
  - International
  - Other (Includes all other US States)
  - Not Reported

Impact Assessment for WellScreen Monterey using data from MCBH Electronic Health Record System (Avatar)

To determine the impact of the WellScreen Monterey application, we applied a set of quantitative methods that includes use of interrupted time-series analysis (ITSA). The "interruption" in ITSA refers to a policy or program change that has a well-defined time of onset.[1] This approach was taken because we have no formal comparison group data, such as another County Behavioral Health organization that did not implement a similar website but was otherwise similar. The lack of comparison group data is a common occurrence in applied evaluation research and the particular ITSA method used here is designed to address the lack of a comparison group.

Since the population is the unit of interest (the population of individuals using various services at Monterey County Behavioral Health), and the interruption has a well-defined time of onset (we know the exact date that the WellScreen Monterey tool became available), we are able to model the time series prior to the implementation of the website in a statistically rigorous manner using the autoregressive integrated moving average (ARIMA) technique.[1] The ARIMA technique allows us to model the complex patterns of data occurring across time prior to the implementation of WellScreen Monterey. We then compare the predicted course of the time series with the actual post-implementation course of the time series, assuming different potential impact patterns (4 different patterns, including a pulse (an immediate pulse that then immediately returns to normal), decay (an immediate change that then decays over time back to normal), a step (an immediate change that is sustained), or smooth (a slower change that is sustained)). To the extent that the actual course of the time series differs from the predicted course of the time series, assuming any of the potential impact patterns, the well-defined interruption is likely the cause of the difference, assuming no other changes occurred at the same time.

In the current case, the evaluation is of the implementation of the website and accompanying dissemination strategy. Thus, we expect a smooth pattern. Nevertheless, we examine all possible patterns for purposes of completeness.

ARIMA requires us to have approximately 50 observations prior to the website introduction.[1] We obtained MCBH monthly electronic health record (EHR) data from July 2018 to July 2023 showing client services delivered over the pre-post time period. The WellScreen Monterey website was implemented November 15, 2022. Thus we have 52 months of client level data prior to implementation of the WellScreen Monterey website, and 8 months of client level data after the implementation of the website.

We examined the following outcomes using the MCBH monthly data:

II. Service Provision

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6. Mental Health Counseling (individual counseling, group rehabilitation counseling; in-person or telemedicine)
7. Linkage/Brokerage Services (grouping: linkage/brokerage; in-person or telemedicine)
8. Assessment/Evaluation (grouping: assessment and evaluation; in-person or telemedicine)
9. Triage (grouping: triage assessment; in-person or telemedicine)
10. Other Mental Health Services (grouping: assessment in lockout facility, case management in lockout facility, collateral, crisis intervention, family therapy, group psychotherapy, individual psychotherapy, psychotherapy, lockout, medication support, mental health rehabilitation, non-billable activity, plan development, telemedicine, other)

II. *Non-Billable Services*
III. *Risk Severity (definition: adults coded as high-severity by clinician)*
IV. *Costs for Service Provision (Inflation-adjusted to constant 2023 dollars)*

6. Total Cost Per Patient
7. Total Cost of Mental Health Counseling Per Patient
8. Total Cost of Linkage/Brokerage Per Patient
9. Total Cost of Assessment/Evaluation Per Patient
10. Total Cost of Triage Per Patient

V. *Proportion of Visits Referred to Beacon/Carelon*
VI. *Proportion of Services Delivered by Licensed Prescribing Providers*
VII. *Proportion of Services Delivered by Licensed Non-Prescribing Providers*

We show figures for results of each of these time series analyses, including the pre-implementation time series (actual time-series data); and the post-implementation time-series, including both the actual time-series data and the values predicted by the model. We also indicate the type of impact found in each case (pulse, decay, step, smooth) and whether there was a statistically significant difference between the actual post-implementation time series and the predicted post-implementation time series.

Qualitative Methods

The qualitative evaluation in this report focused on the process evaluation and assessment of planning process, launch process, and website functionality and effectiveness. The data collection included 14 key informant interviews with Monterey County Behavioral Health (MCBH) administrators/providers, non-MCBH providers, and technology development partners. We also conducted two community focus groups in English and Spanish languages with 9 participants.

Sampling plan

Inclusion criteria for the key informant interviews included: adults aged 18 years old or older and work as professionals to serve mental health clients and community members in Monterey County. Key informants were chosen from organizational contact lists and word-of-mouth via purposive and snowball sampling. Inclusion criteria for the focus groups with community members included: Spanish-speaking and adults aged 18 years old or older who have used WellScreen Monterey. Community focus group participants were recruited from a contact list generated from an interest survey on WellScreen Monterey website.

Data collection protocol

Qualitative data were collected through virtual semi-structured in-depth individual interviews and focus groups conducted by the evaluation team. The interview instrument included the following domains and indicators: provider experiences with mental health screening and referrals,

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barriers, facilitators, and suggestions for improvement with mental health screening and referrals, community mental health needs, overall suggestions with accessing mental health services, perceptions and concerns about the new virtual mental health screening tool. Community focus groups were conducted with youth and adult community members using an interview guide and included the following domains: experiences with mental health screening and referrals, barriers, facilitators, and suggestions for improvement with mental health screening and referrals, community mental health needs, overall experiences and suggestions for improvement with accessing mental health services, preferences for mental health information, perceptions and concerns about the new virtual mental health screening tool. Analyses included in this report were based on de-identified verbatim transcripts provided to HRA by CredibleMind, Inc.

Table 1. Key Informant Interview Participants

Key Informant Agency Type (n=14)	**Job Titles**
Monterey County Behavioral Health (n=4)	Behavioral Health Services Manager, Assistant Bureau Chief, Services Manager II Over Quality Improvement, Management Analyst/Innovations Coordinator
Community Service Agencies in Monterey County (n=5)	Deputy Director, Social Services Manager, Peer Outreach/Advocacy Coordinator, Program Coordinator, CEO/Consultant
Help@Hand Technology Development Partner (n=5)	Customer Success Manager, Director of Content Operations, Research and Aata Coordinator, Chief Technology Officer, Senior Product Advisor

Table 2. Community Focus Group Participants

Focus Group Recruitment Source	**Setting**	**Language**	**# Participants**	**Date of interviews**
MCBH Listserv	Virtual	English	8	08/08/2023
MCBH Listserv	Virtual	Spanish	3	09/09/2023

Data analysis plan

Interview transcripts and notes were compiled and organized by interview type (key informant interviews, community focus groups) for qualitative analysis. The constant comparative method was used as a technique for the qualitative thematic analysis. This method develops codes, examines relationships and interactions across descriptive and thematic codes, and compares the major themes that emerged from the coding categories. Qualitative analysis probed for parallel themes regarding planning process, launch process, and website functionality and effectiveness. The final codebook consisted of descriptive and thematic codes common across the key informant interviews and community focus groups. Four research team members conducted the qualitative analysis and four research team members independently coded and then discussed together the coding for each of the transcripts from the key informant interviews

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and community focus groups. Inter-rater agreement for the first two key informant interview transcripts and the first focus group interview transcript was determined to ensure consistency in coding. For each interview transcript, if 80% agreement in coding consistency was not reached, the researchers discussed potential issues that arose and reached consensus about these coding issues until consistency was reached. The coding of the transcripts was an iterative process with new codes added as they emerged. The codebook was updated with new codes as each subsequent transcript was coded. Coding consistency was recalibrated as part of this iterative coding process. Code categories were connected and grouped through thematic coding, and as the researchers identified major themes from the codes. The codebook was organized into thematic categories: planning process, launch process, and website functionality and effectiveness; each included subcategories organized by successes, challenges, and suggestions; and themes organized by key informant organizational affiliation (MCBH, Non-MCBH, and Technology Development Partner). Google Workspace software was used for qualitative data analysis.

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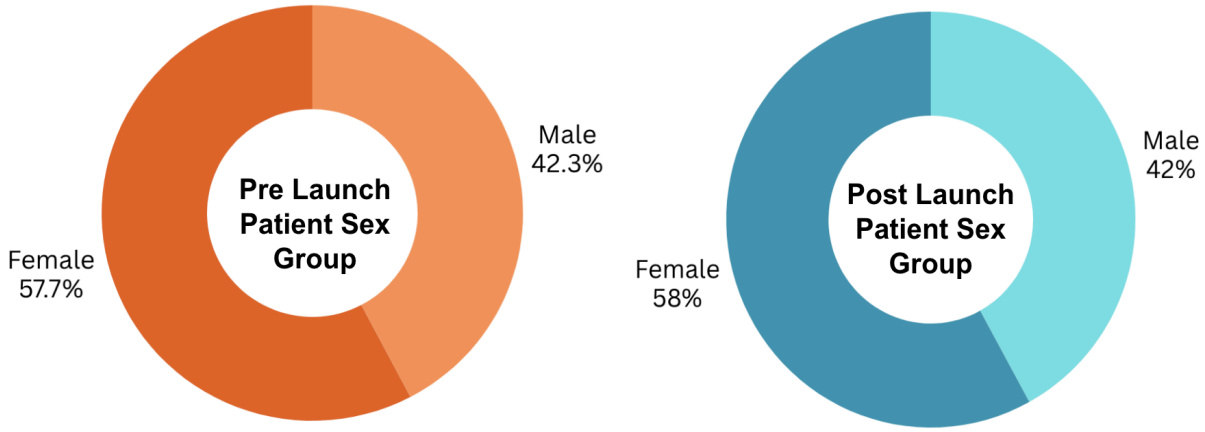
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- Website Event Data: pg 115
- Outcome Assessment: pg 120

Overview of Monterey County Behavioral Health ACCESS Program Demographic Characteristics

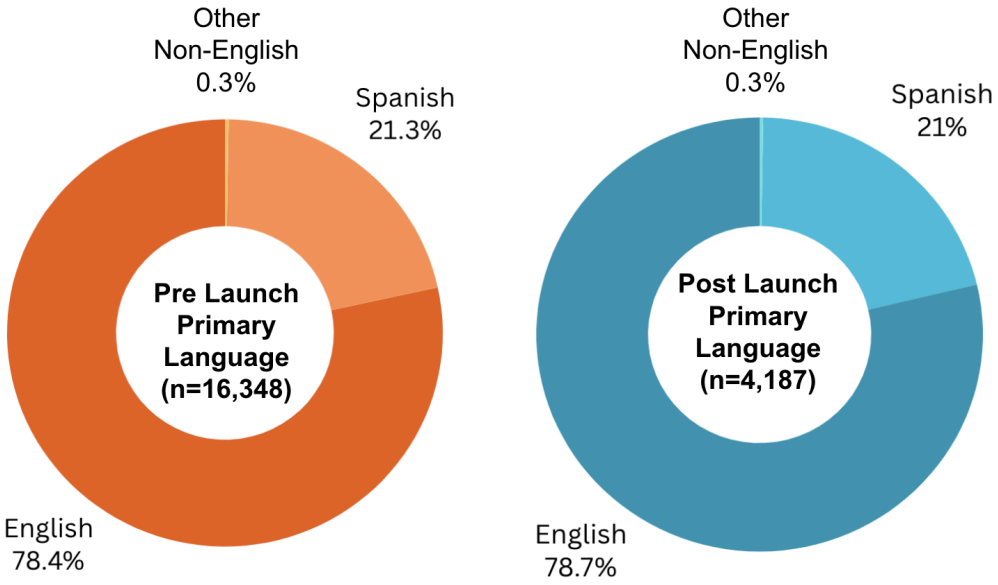
Clients by Sex Group



The proportion of female clients remained relatively stable, slightly increasing from 57.7% in the pre-launch period to 58.0% in the post-launch period. Conversely, the percentage of male clients demonstrated a minor decline. Overall, the client sex group distribution exhibited only subtle shifts between pre-post launch. However, it was statistically significant ($p<0.001$).

Clients by Primary Language

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Note: Patients with Unknown responses were removed from this visualization. (Number of clients with Unknown response - Pre: 1637, Post: 535)

Most clients reported English as their primary language, slightly increasing from 78.4% in the pre-launch period to 78.7% in the post-launch period. Conversely, the percentage of clients preferring Spanish decreased slightly, dropping from 21.3% to 21.0%. The proportion of clients with other non-English language preferences remained constant at 0.3% in both periods. Overall, language preferences exhibited minimal changes between the two time periods. However, the pre-post-launch change was significant ($p<0.001$).

Clients by top 3 Mental Health Diagnosis Codes (exclusive of non-specific Z codes)

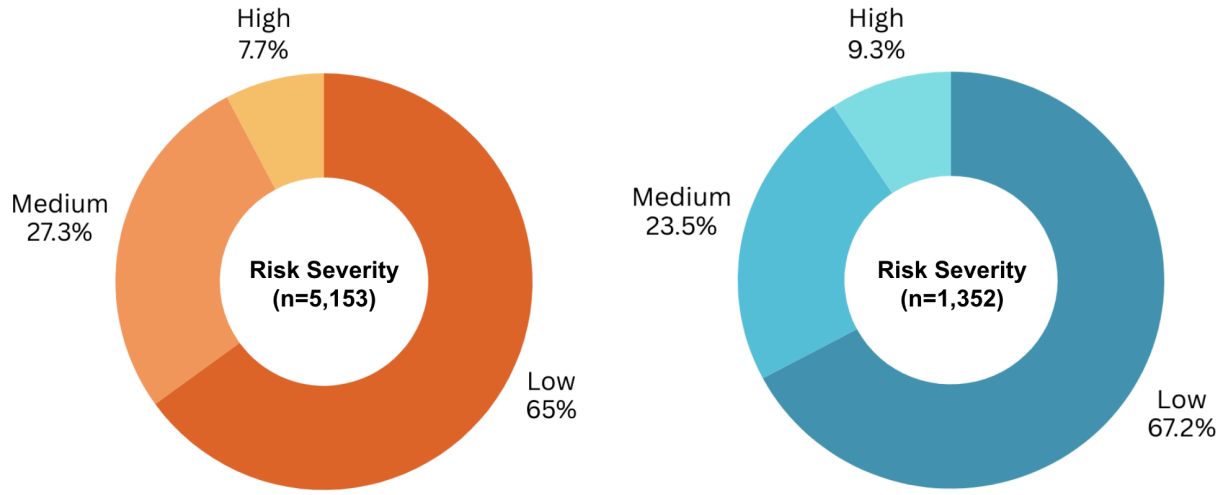
	Pre Launch (% of clients)		Post Launch (% of clients)
F30-F39: Mood [affective] disorders	26%	F10-F19: Mental and behavioral disorders due to psychoactive substance use	26%
F40-F48: Neurotic, stress-related and somatoform disorders	24.7%	F30-F39: Mood [affective] disorders	24.7%
F10-F19: Mental and behavioral disorders due to psychoactive substance use	24%	F40-F48: Neurotic, stress-related and somatoform disorders	24.7%

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

Note: Data are from the MCBH Electronic Health Records. The code is designed to filter rows where any of the three diagnosis codes (prim_combined_icd10_code, sec_combined_icd10_code, and ter_combined_icd10_code) start with "F." If there are multiple occurrences of "F" codes in a row, only the first one encountered will be selected.

The table compares the top 3 mental health diagnosis codes between the pre- and post-launch periods. Notably, the percentage of clients diagnosed with mental health and behavioral disorders due to psychoactive substance use (F10-F19) remained relatively consistent, with a slight increase from 24.0% in the pre-launch period to 26.0% in the post-launch period, while its ranking changed from third to first. Additionally, there was similar stability in the diagnosis of mood affective disorders (F30-F39) and neurotic, stress-related and somatoform disorders (F40-F48) codes, with percentages going down only slightly, even though ranking numbers changed. The pre-post-change in the mental health diagnosis distribution was not significant (p=0.163).

Clients by Risk Severity

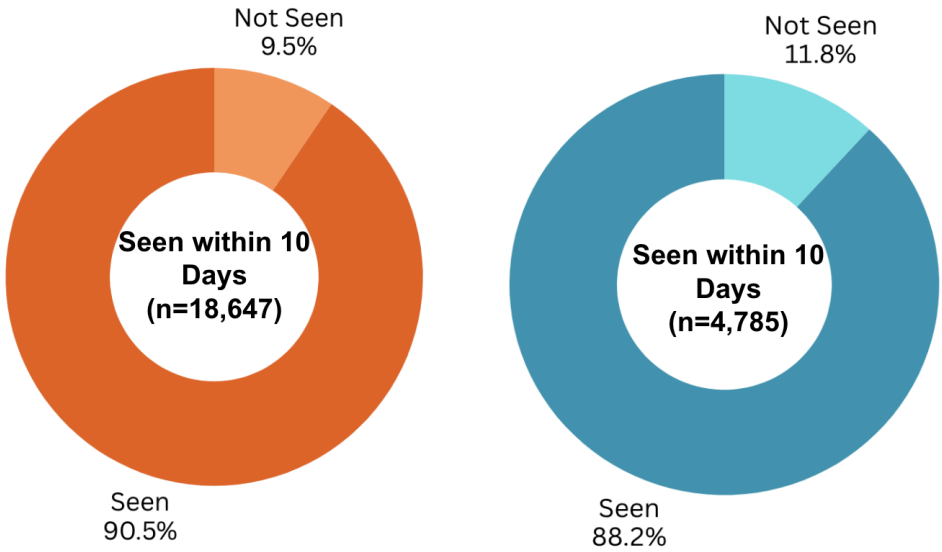


Note: Data are from MCBH Electronic Health Records. Missing values were removed from this visualization. (Number of clients with Missing response - Pre: 12,832, Post: 3,370)

The above plot indicates that the percentage of clients with low-risk severity increased slightly from 65.0% in the pre-intervention period to 67.2% in the post-intervention period. Clients with high-risk severity also showed a slight increase, rising from 7.7% in the pre-intervention period to 9.3% in the post-intervention period. Conversely, there was a decrease in the percentage of clients with medium risk severity, dropping from 27.3% to 23.5%. Overall, these changes suggest subtle shifts in the distribution of risk severity levels between the two time periods. The change in the risk severity distribution was significant (p<0.001).

Clients by Seen within 10 days after Referral

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The plot indicates a slight increase in the percentage of clients not seen by a behavioral health provider within 10 days after the initial referral, rising from 9.5% in the WellScreen Monterey pre-launch period to 11.8% in the post-launch period. Conversely, the percentage of clients seen decreased from 90.5% (pre-launch) to 88.2% (post-launch). The change was significant ($p<0.001$).

Mental Health Service Type (Total Clients Pre: 17,985 Post: 4,722)

	Pre Launch (n=45,044)			Post Launch (n=9,511)		
	Number of Services	% of Total Service Minutes	% of Clients	Number of Services	% of Total Service Minutes	% of Clients
Triage	13,705	9.2%	23.6%	1,350	6.9%	13.3%
Assessment/Evaluation	14,882	17.7%	14.8%	1,862	17.9%	12.5%
Linkage/Brokerage	58,300	20.9%	25.2%	8,697	24.6%	29.8%
Mental Health Counseling	18,170	15.9%	3.4%	2,080	13.3%	3.7%
Other	120,161	36.3%	33%	17,901	37.3%	40.8%

Note: Data are from MCBH Electronic Health Record System. Case Management Service Type is not included in the above table due to small sample size (Number of Services (Pre-Launch) = 2, Number of Services (Post-Launch) = 0)

The "Linkage/Brokerage" service category demonstrated a significant increase in the percentage of total service minutes, rising from 20.9% in the pre-launch period to 24.6% in the post-launch period. Moreover, there was a notable uptick in the percentage of clients served for this category, increasing from 25.2% before the launch to 29.8% after the launch. Conversely, the "Assessment/Evaluation" services experienced a slight decline in the percentage of clients served, dropping from 14.8% to 12.5% from the pre-launch period to the post-launch period. The pre-post change in the service type distribution was significant ($p<0.001$).

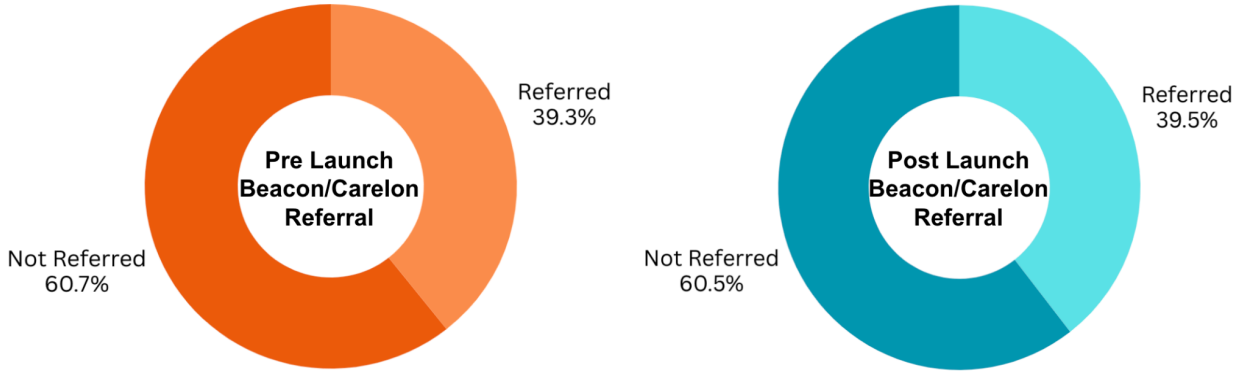
Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

Overview of Costs

	Overall	Pre Launch	Post Launch
Number of Clients	20,453	17,985	4,722
Total Service Value	$ 58,288,407	$ 51,085,324	$ 7,203,083
Average Service Value per Client	$ 2,850	$ 2,840	$ 1,525

The table provides an overview of client statistics, comparing data from the pre- and post-launch periods. The average service value per client decreased, dropping from $2,840 in the pre-launch period to $1,525 in the post-launch period.

Beacon/Carelon Referral (Data from MCBH Electronic Health Record System)



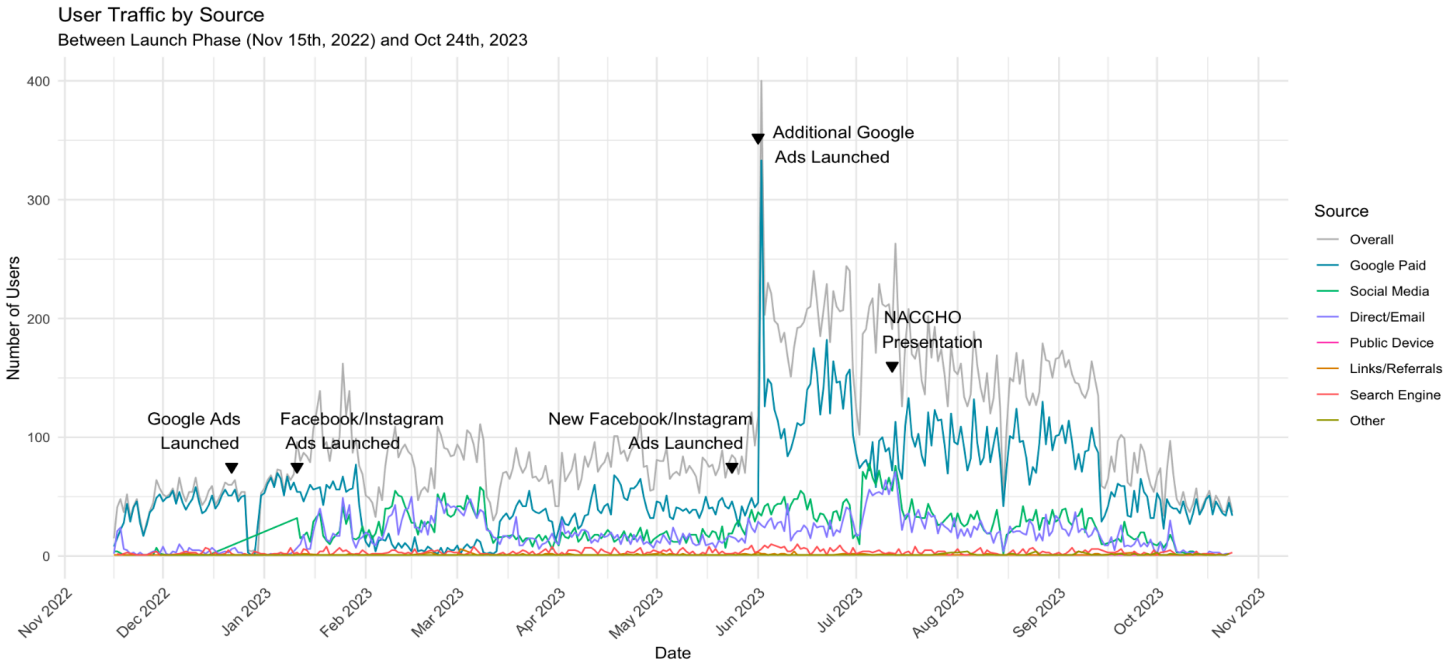
Overall, the distribution of client referrals from Beacon experienced only minor changes between the pre-post launch, which was significant ($p<0.001$).

Overview of WellScreen Monterey Demographic Characteristics

These data were gathered from the dashboard which has been built for the screening app/tool, WellScreen Monterey, with the goal of assessing post-implementation usage to better serve providers, clients, and community partners. The WellScreen site was launched on November 15th, 2022, and the visualizations below are from the implementation date until October 24th, 2023. There have been a total of 28,879 users during this period with 35,998 sessions. A user is defined as a unique person, and a new session is counted each time a person interacts with the website (so cumulative visits to the site are counted with each new interaction counting as a new session after 2 hours have passed).

Traffic Changes and Traffic by Source

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Note: Data are from WellScreen Monterey. A user is defined as a unique person, and a session is the number of times a person interacts with the website, with each new interaction counting as a new section after 2 hours have passed. NACCHO means National Association of County and City Health Officials. Since NACCHO is a national conference, usage may have increased due to increased trial by attendees, but not from actual users.

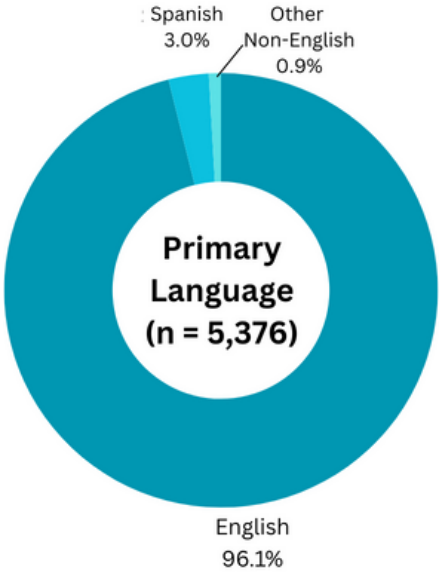
Google Paid ads were the most useful in increasing traffic to the WellScreen tool, as seen with implementation dates of ads and accompanying spikes in usage. Social media was the second most successful source for promoting traffic, with spikes in usage occurring shortly after Facebook and Instagram ads were implemented. Direct/Email methods were next after social media, and usage tended to rise and fall with social media traffic.

Mental Health Assessment Usage by Groups

Users by Primary Language

- Other Non-English: This category includes individuals who reported their primary language as Indigenous languages (e.g. Mixteco, Triqui, Chatino), Korean, Tagalog, or was referred to as “Other language” by the Credible Mind dashboard
- English and Spanish categories used their original groupings

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

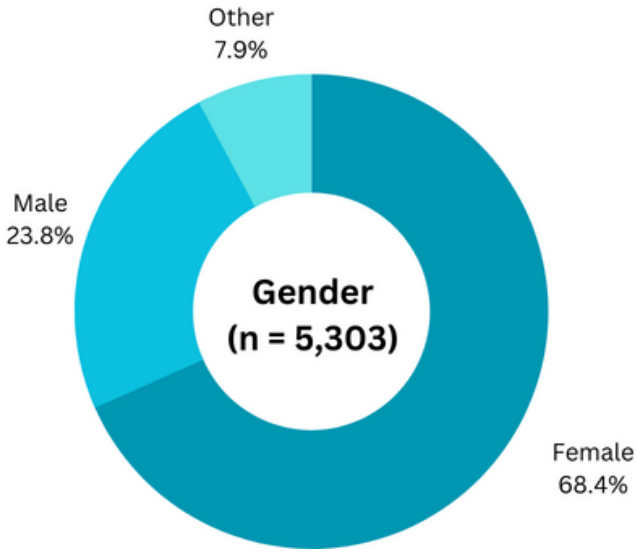


Note: "Other Non-English" languages are listed above

English was the majority of users' reports of primary language, with not many users identifying Spanish as their primary language. This was quite different from the MCBH pre-post comparison results. However, it is important to note that some users may have their browser automatically translate the WellScreen assessment into Spanish, which would not be picked up by the metadata. This is a limitation of these data percentages.

Users by Gender

- Other: This category includes individuals who reported their gender as Questioning/Unsure, Transgender, Genderqueer, I prefer not to say, Other gender identity
- Female and Male categories used their original groupings



Note: "Other" was grouped based on the gender identities listed above

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

Users identifying as Female made up the largest percentage of users (68.4%), followed by those identifying as Male (23.8%).

Summary Tables
Source: The WellScreen Monterey assessment data from 11/15/22 to 9/6/2023

	Overall (N=6,327)
Year_month	
2022 November	204 (3.2%)
2022 December	600 (9.5%)
2023 January	719 (11.4%)
2023 February	146 (2.3%)
2023 March	474 (7.5%)
2023 April	691 (10.9%)
2023 May	714 (11.3%)
2023 June	787 (12.4%)
2023 July	916 (14.5%)
2023 August	901 (14.2%)
2023 September	175 (2.8%)
Age	
15 or younger	1,818 (28.7%)
16-17 years old	1,085 (17.1%)
18-20 years old	835 (13.2%)
21-24 years old	586 (9.3%)
25-34 years old	829 (13.1%)
35-44 years old	517 (8.2%)
45-54 years old	238 (3.8%)
55-64 years old	234 (3.7%)
65 or over	185 (2.9%)
Anxiety	
Mild	482 (7.6%)
Minimal	1,542 (24.4%)
Moderate	1,059 (16.7%)
Severe	1,427 (22.6%)
Missing	1,817 (28.7%)
Depression	
Mild	255 (4.0%)
Minimal	1,630 (25.8%)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

Moderate	607 (9.6%)
Moderately severe	1,371 (21.7%)
Severe	647 (10.2%)
Missing	1,817 (28.7%)
Are you pregnant or were you pregnant within the last 18 months?	
No	6,016 (95.1%)
Yes	311 (4.9%)
Postpartum_depression	
Not currently pregnant or recently been pregnant	6,022 (95.2%)
None to Mild	42 (0.7%)
Moderate to Severe	263 (4.2%)
PTSD Screener **Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. Have you ever experienced this kind of event?**	
No	2,264 (35.8%)
Yes	2,241 (35.4%)
Missing (Definition)	1,822 (28.8%)
PTSD	
No traumatic event experience	4,074 (64.4%)
None (No PTSD)	140 (2.2%)
Low to Moderate	991 (15.7%)
Moderate to Severe	1,122 (17.7%)
Bipolar	
None to Mild	2,833 (44.8%)
Moderate to Severe	1,677 (26.5%)
Missing	1,817 (28.7%)
Psychosis	
None to Mild	4,295 (67.9%)
Moderate to Severe	214 (3.4%)
Missing	1,818 (28.7%)
Eating_disorders	
None to Mild	2,370 (37.5%)
Moderate to Severe	2,139 (33.8%)
Missing	1,818 (28.7%)
Substance_use_General	
Under 21	3,738 (59.1%)
No use of any substances	1,027 (16.2%)

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Use of substances in past 12 months	1,562 (24.7%)
Substance_use_Tobacco	
No use in past 12 mos	5,784 (91.4%)
Low	185 (2.9%)
Moderate	239 (3.8%)
High	119 (1.9%)
Substance_use_Alcohol)	
No use in past 12 mos	5,211 (82.4%)
Low	328 (5.2%)
Moderate	256 (4.0%)
High	532 (8.4%)
Substance_use_Drugs	
No use in past 3 mos	88 (1.4%)
No use in past 12 mos	5,450 (86.1%)
Low	299 (4.7%)
Moderate	123 (1.9%)
High	367 (5.8%)
Substance_use_Prescription_medications	
No use in past 3 mos	123 (1.9%)
No use in past 12 mos	6,082 (96.1%)
Low	44 (0.7%)
Moderate	25 (0.4%)
High	53 (0.8%)
Youth_substance_use_General	
21+	4,408 (69.7%)
Low	930 (14.7%)
Medium	314 (5.0%)
High	675 (10.7%)
Youth_substance_use_Nicotine	
21+ OR No nicotine use	5,821 (92.0%)
No to Low Risk	190 (3.0%)
Some Risk	281 (4.4%)
Missing	35 (0.6%)
genderHelpAtHand	
Female	3,011 (47.6%)
Male	1,060 (16.8%)
Genderqueer	54 (0.9%)
I prefer not to say	202 (3.2%)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

Questioning/Unsure	60 (0.9%)
Transgender	65 (1.0%)
Missing	1,875 (29.6%)
Are you of Hispanic, Latino, or of Spanish origin?	
No	2,020 (31.9%)
Yes	2,487 (39.3%)
Missing	1,820 (28.8%)
Race	
Asian	208 (3.3%)
Black	95 (1.5%)
Indigenous/American Indian/Alaska Native	197 (3.1%)
Native Hawaiian or Other Pacific Islander	37 (0.6%)
Multi Race	1,531 (24.2%)
Other Race	3 (0.0%)
Not Reported	2,088 (33.0%)
White	2,164 (34.2%)
Missing	4 (0.1%)
What health insurance do you have?	
Medi-Cal or Medicaid	1,016 (16.1%)
Medicare	236 (3.7%)
More than one type of insurance	2,521 (39.8%)
No insurance	271 (4.3%)
Other	2 (0.0%)
Unsure	761 (12.0%)
Missing	1,520 (24.0%)
What is your language of preference?	
English	4,346 (68.7%)
Indigenous languages (e.g. Mixteco, Triqui, Chatino)	2 (0.0%)
Korean	6 (0.1%)
Spanish	122 (1.9%)
Tagalog	9 (0.1%)
Missing	1,842 (29.1%)
Are you currently receiving treatment or services for mental health or substance use?	
No	3,896 (61.6%)
Yes	606 (9.6%)
Missing	1,825 (28.8%)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

Are you currently taking any medications for mental health or substance use?	
No	3,870 (61.2%)
Yes	636 (10.1%)
Missing	1,821 (28.8%)
Are you currently receiving services or have you ever received services from Monterey County Behavioral Health?	
No	4,269 (67.5%)
Yes	228 (3.6%)
Missing	1,830 (28.9%)

Summary of Assessment Data

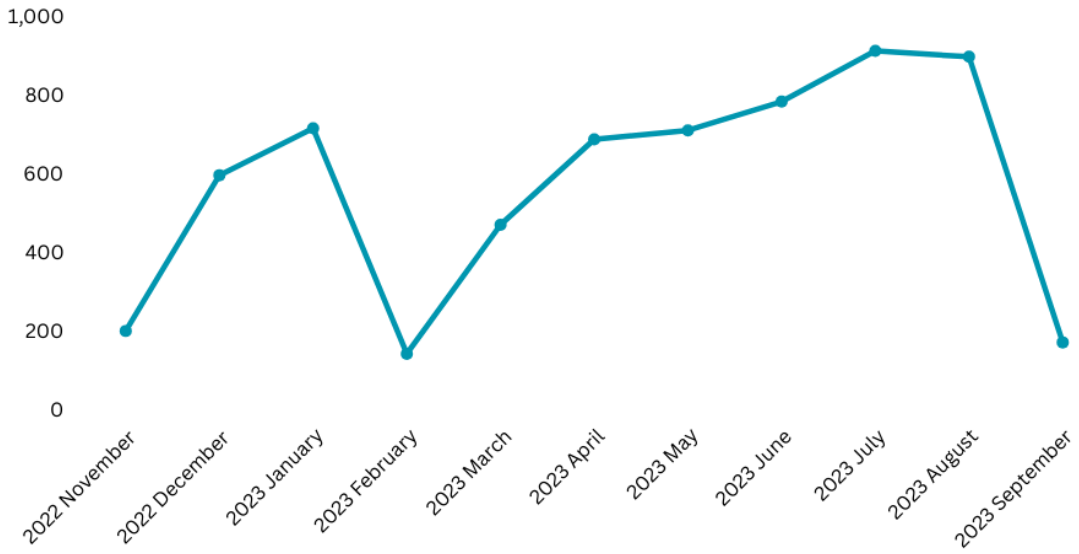
1. **Demographic Overview:**
    - The survey included 6,327 completed assessments between 2022 and 2023.
    - Notably, 14.5% of the respondents were from July 2023, followed by 14.2% from August 2023.

- **Age Distribution:**
    - The age distribution shows a diverse range, with the largest group being 15 or younger (28.7%), followed by 16-17 years old (17.1%).
- **Mental Health Conditions:**
    - Anxiety levels varied, with 31.6% reporting severe anxiety and 23.5% reporting moderate anxiety.
    - Depression levels showed 30.4% experiencing moderately severe depression, while 14.4% reported severe depression.
- **Pregnancy and Postpartum Depression:**
    - A small percentage (4.9%) reported being pregnant or recently pregnant, while 86.2% of this group experienced moderate to severe postpartum depression.
- **Substance Use Patterns:**
    - Among those 21 and older, 59.1% reported no substance use in the past 12 months.
    - Notably, for alcohol, 82.4% reported no use in the past year, while 86.1% reported no drug use in the past 12 months.
- **Gender and Ethnicity:**
    - Gender distribution varied, with 70.8% female and 24.9% male.
    - Almost 55% identified as Hispanic or Latino.
    - More than half (51.1%) identified as White, followed by 36.2% as Multi Race and 4.9% as Asian.
- **Health Insurance and Language Preference:**
    - The majority (96.9%) preferred English as their language, followed by Spanish (2.7%).
    - In terms of health insurance, 52.4% reported having more than one type, while Medi-Cal or Medicaid covered 21.4%.
- **Mental Health Services:**
    - A significant portion (86.5%) were not currently receiving mental health services.
    - Similarly, 85.9% were not taking medications for mental health or substance use.
- **Monterey County Behavioral Health Services:**

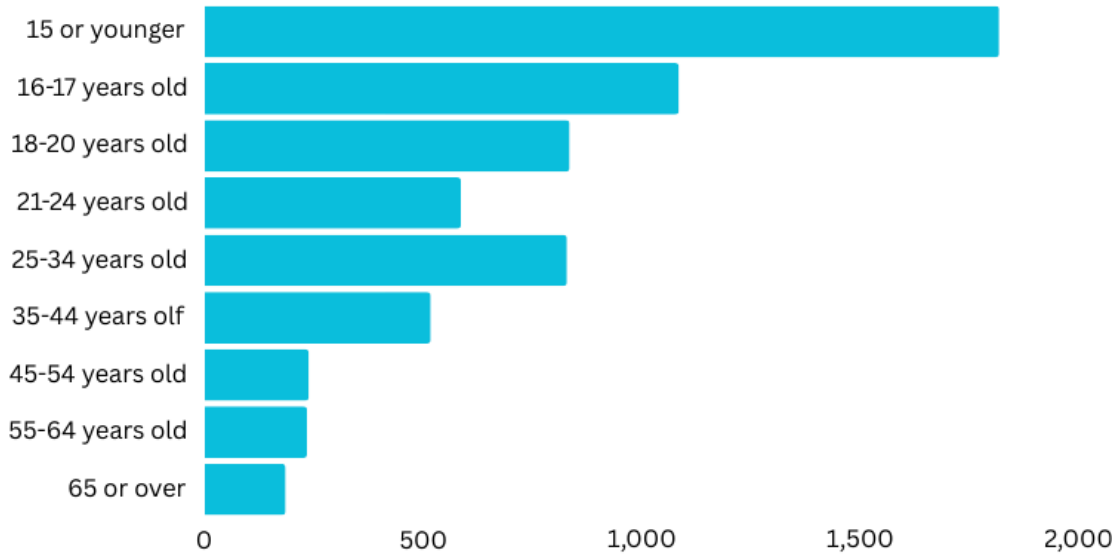
Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

- A majority (94.9%) had not received services from Monterey County Behavioral Health.

Year-Month Usage

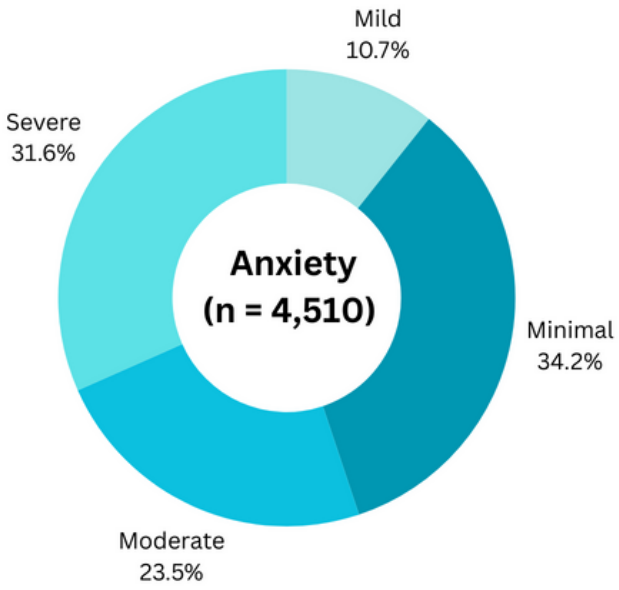


Age Groups



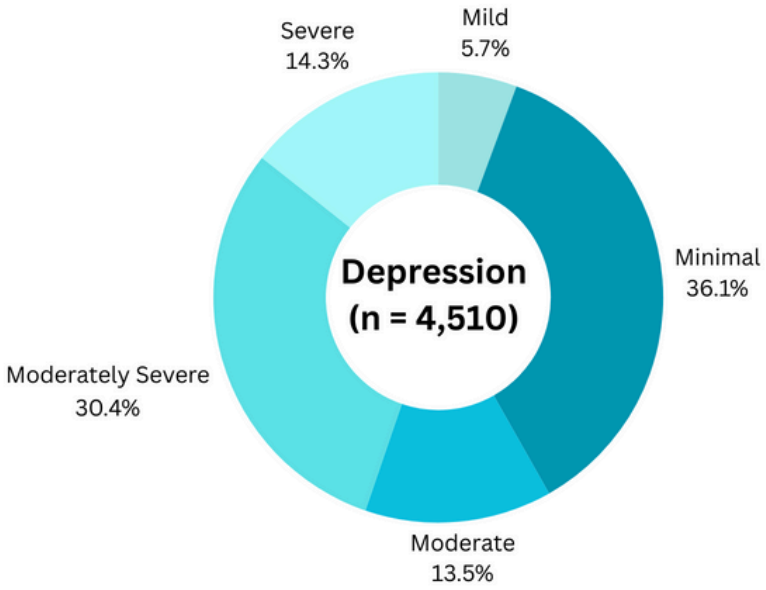
Users by Anxiety

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4



Note: Missing values were removed from this visualization (Number of userss with Missing response - 1,817)

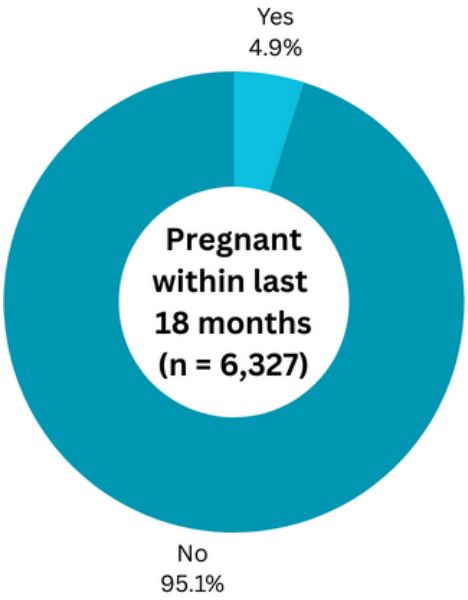
Users by Depression



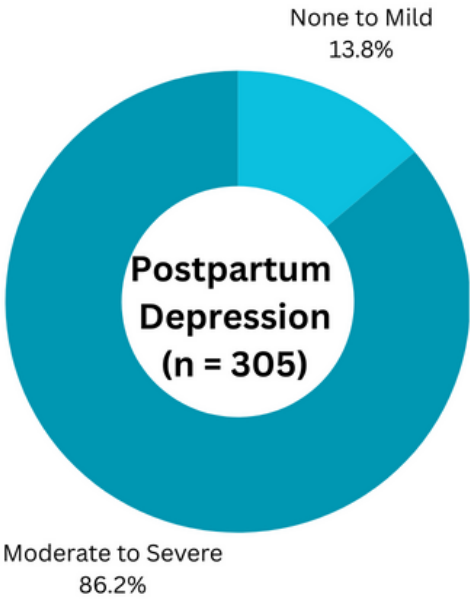
Note: Missing values were removed from this visualization (Number of userss with Missing response - 1,817)

Userss by Pregnancy Status

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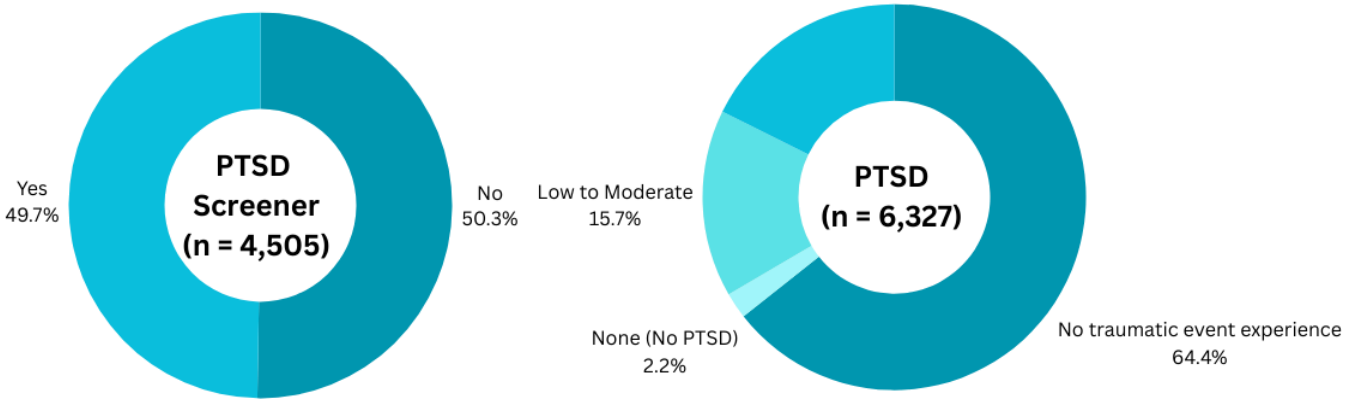
Users by Postpartum Depression



Note: Values indicating no past or recent pregnancy were removed from this visualization (Number of userss with no current or recent pregnancy - 6,022)

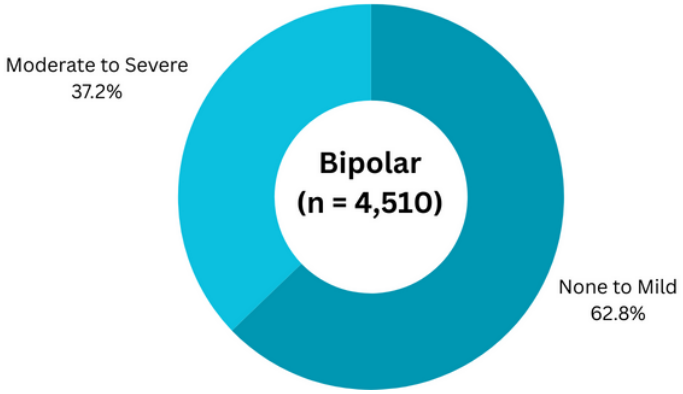
Users by PTSD Severity

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4



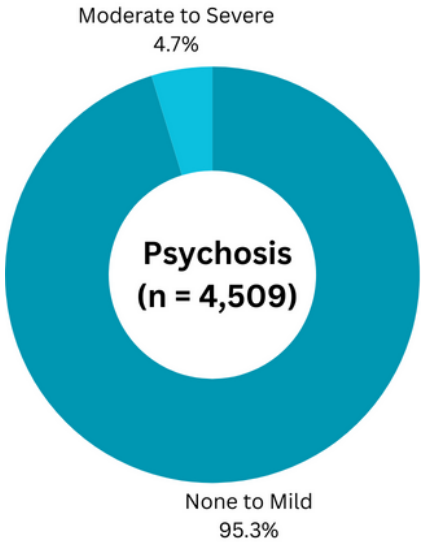
Note: Missing values were removed from the PTSD Screener Visualization (Number of users with Missing response - 1,822)

Users by Bipolar



Note: Missing values were removed from the Bipolar Visualization (Number of users with Missing response - 1,817)

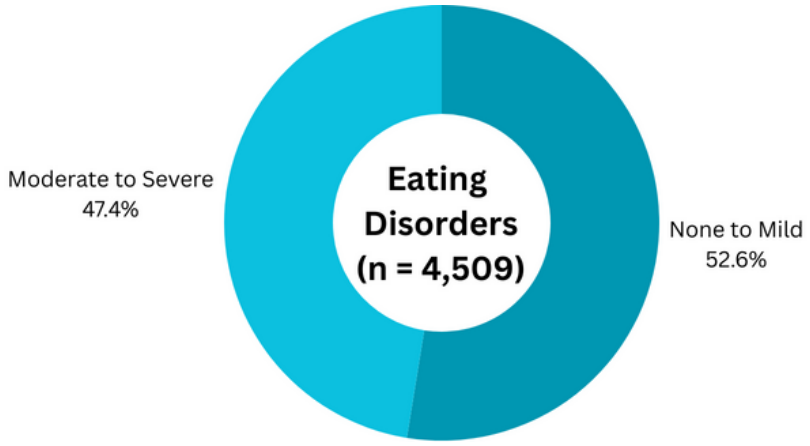
Users by Psychosis



Note: Missing values were removed from the Psychosis Visualization (Number of users with Missing response - 1,818)

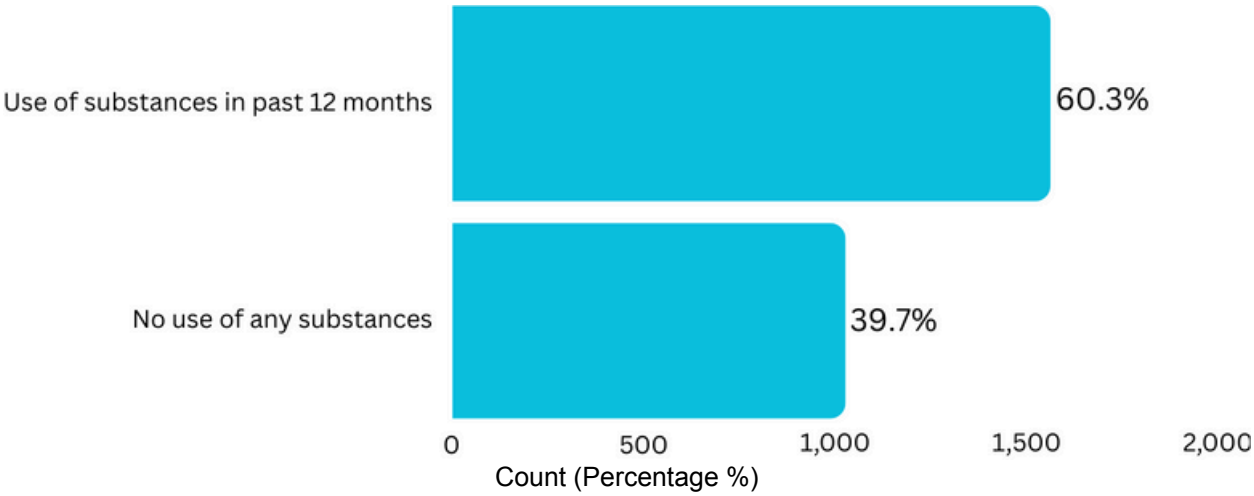
Users by Eating Disorder

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4



Note: Missing values were removed from the Eating Disorder Visualization (Number of users with Missing response - 1,818)

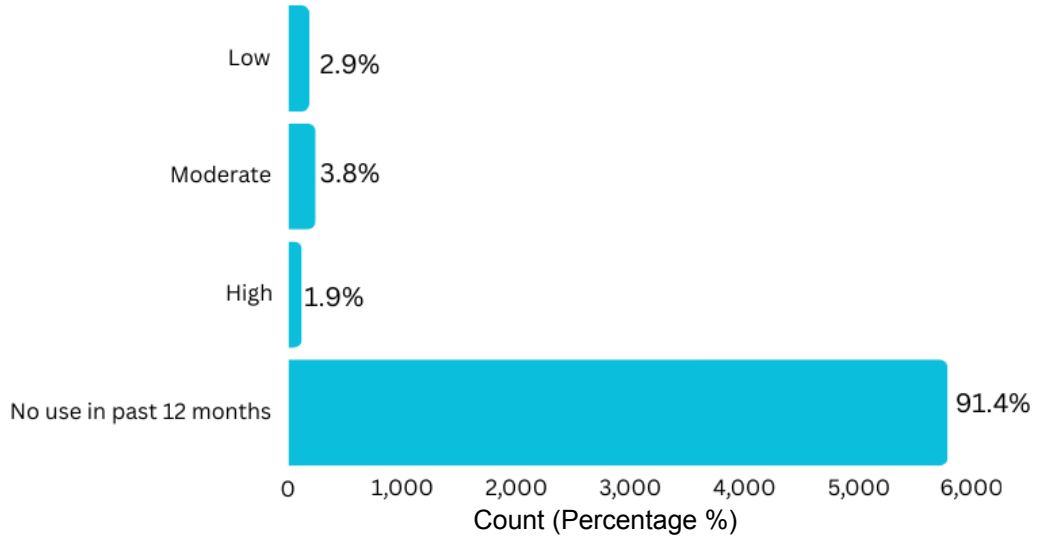
Users by General Substance Use



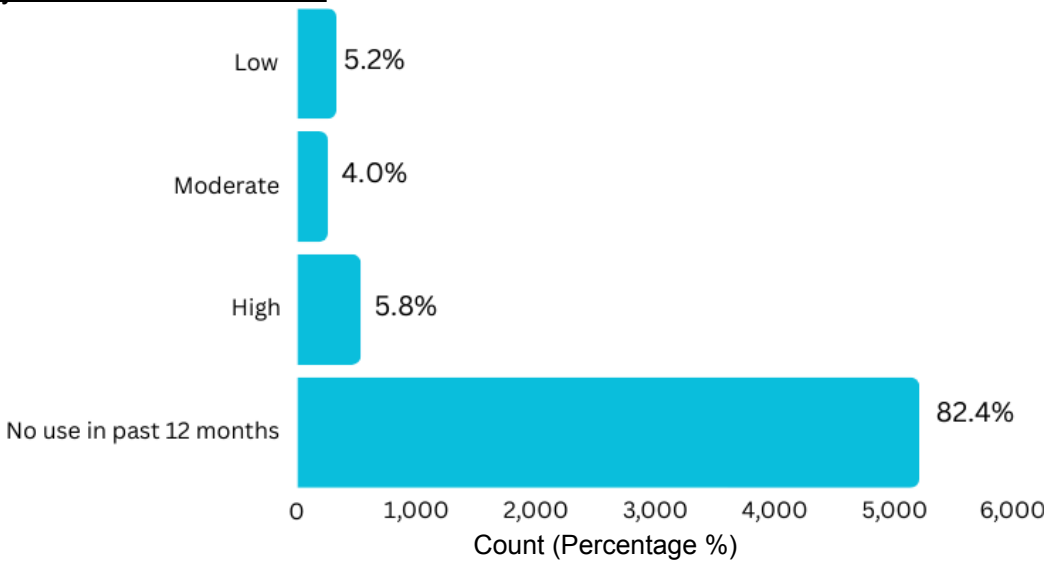
Note: Under 21 responses were removed from the General Substance Use Visualization (Number of users with Under 21 response - 3,738)

Users by Tobacco Substance Use

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

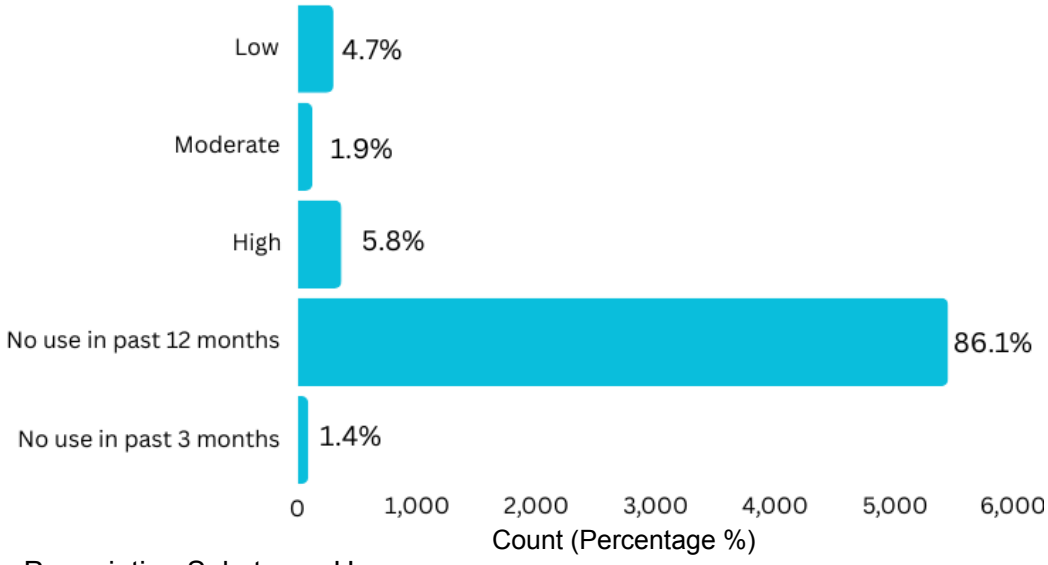


Users by Alcohol Substance Use

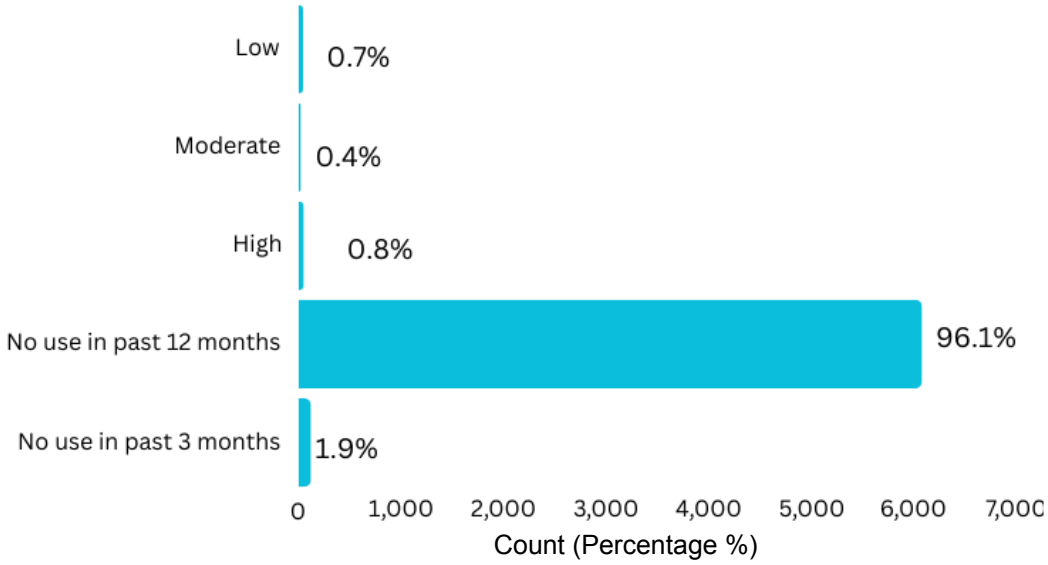


Users by Drug Substance Use

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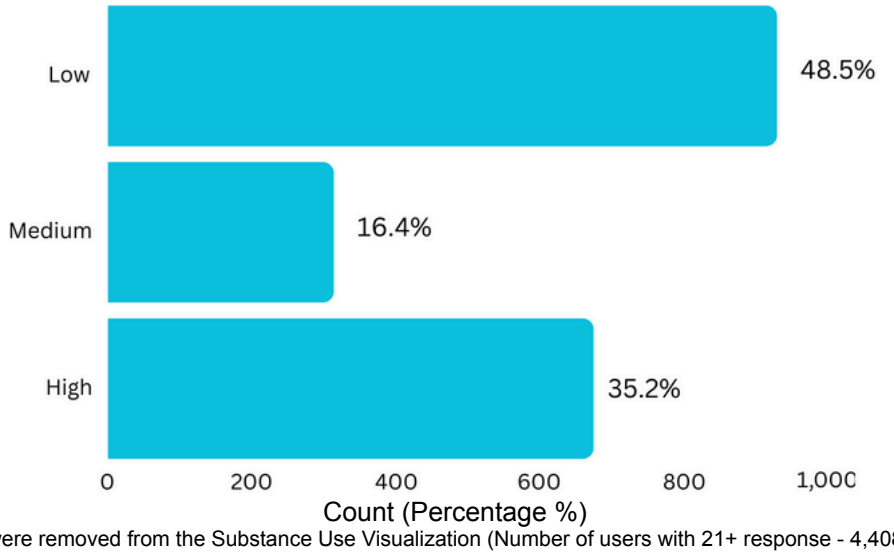


Users by Prescription Substance Use



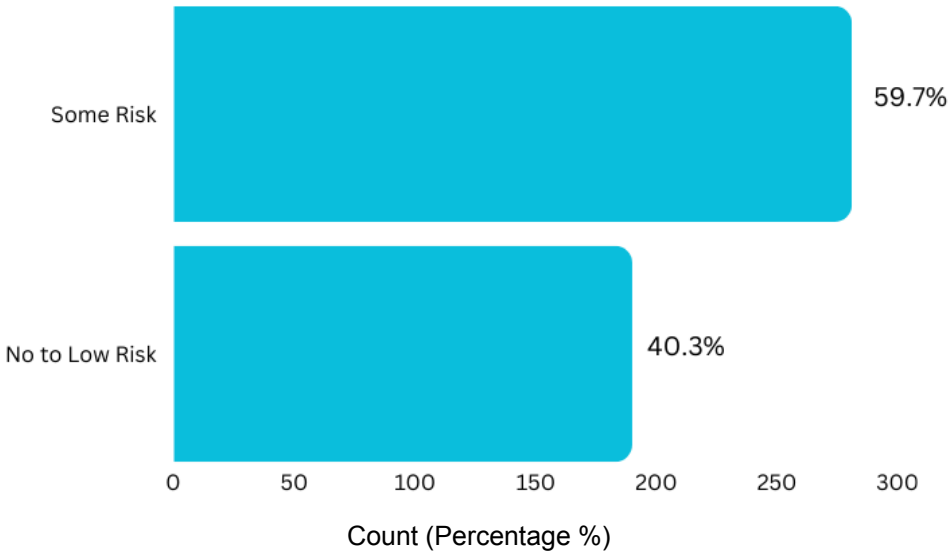
Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

Youth Users by General Substance Use



Note: 21+ values were removed from the Substance Use Visualization (Number of users with 21+ response - 4,408)

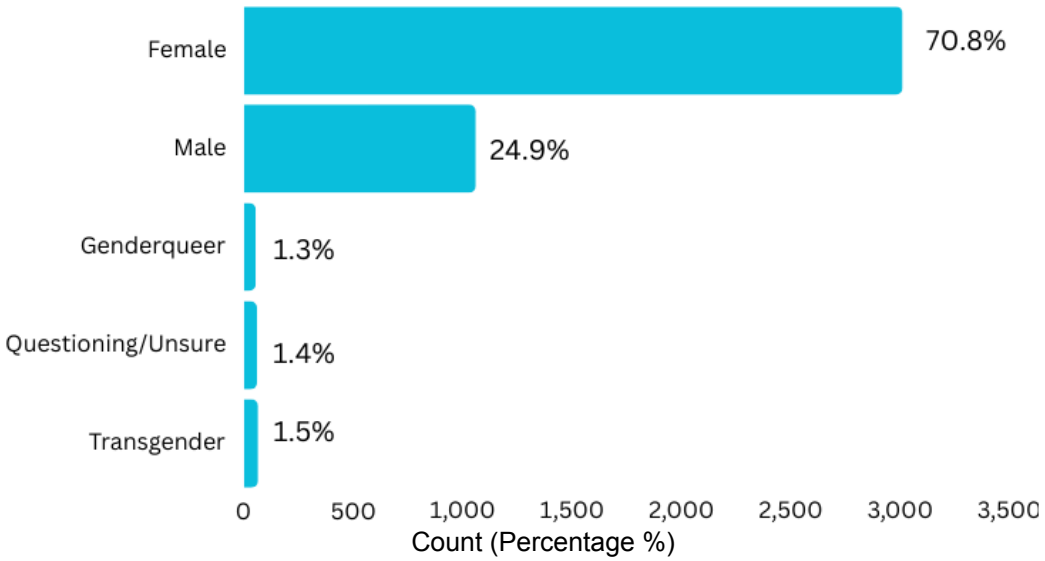
Youth Users by Nicotine Substance Use



Note: 21+ and missing values were removed from the Nicotine Use Visualization (Number of users with 21+ and Missing response - 5,856)

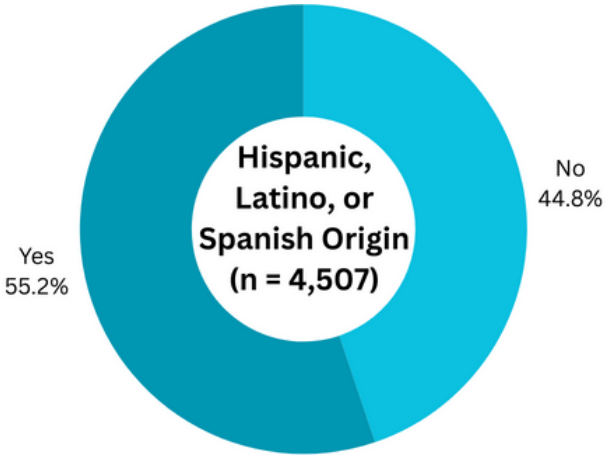
Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

Users by Gender



Note: Missing, unknown, and nondisclosed values were removed from the Gender Visualization (Number of users with no response - 2,077)

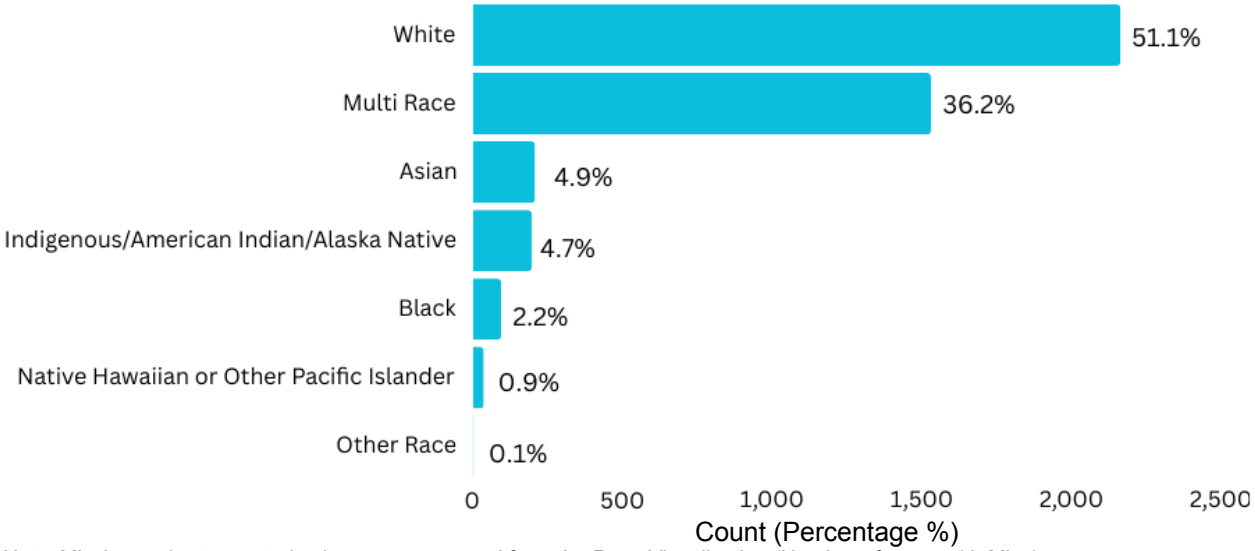
Users by Hispanic, Latino, or Spanish Origin



Note: Missing values were removed from the Hispanic, Latino, or Spanish origin Visualization (Number of users with Missing response - 1,820)

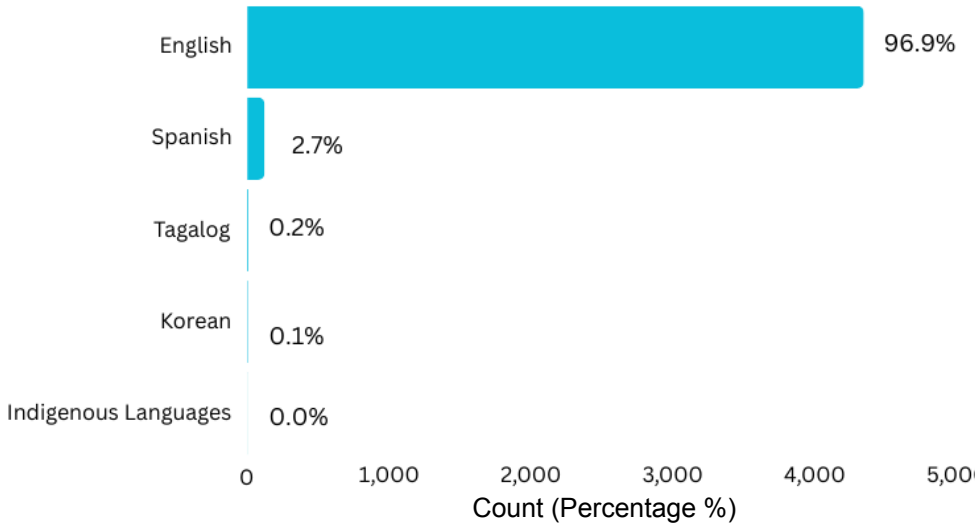
Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

Users by Race



Note: Missing and not reported values were removed from the Race Visualization (Number of users with Missing or non response - 2,092)

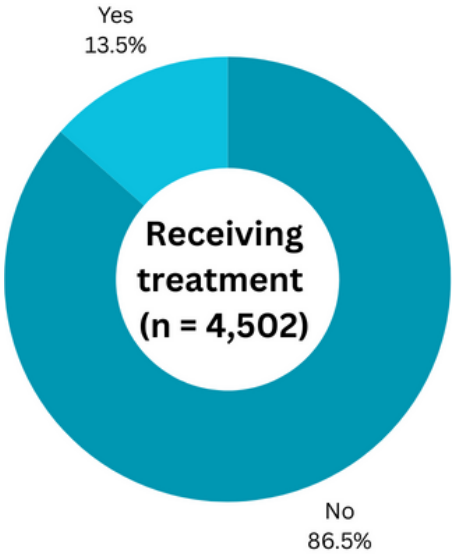
Users by Preferred Language



Note: Missing values were removed from the Preferred Language Visualization (Number of users with Missing response - 1,842)

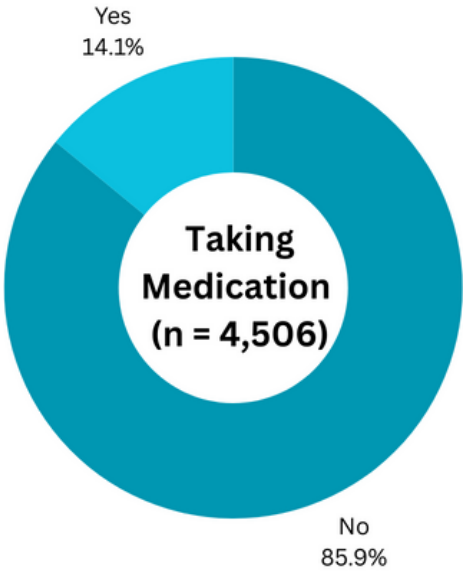
Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

Users Who Are Receiving Treatment for Mental Health or Substance Use



Note: Missing values were removed from the Treatment Visualization (Number of users with Missing response - 1,825)

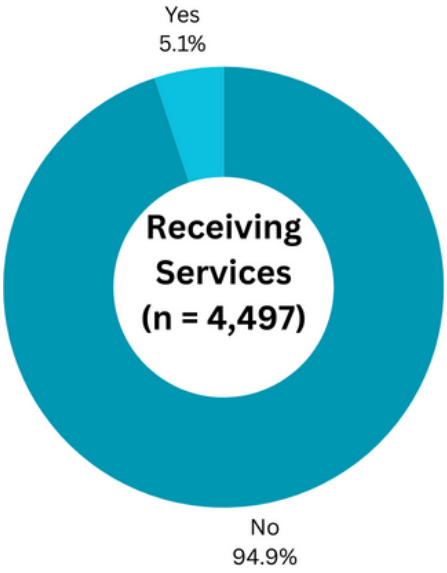
Users Who Are Taking Medications for Mental Health or Substance Use



Note: Missing values were removed from the Medication Visualization (Number of users with Missing response - 1,821)

Docusign Envelope ID: F90AF6C1-0DC8-40D8-A555-82EB31AE0CE4

Users Who Have Received Services from Monterey County Behavioral Health



Note: Missing values were removed from the Services Visualization (Number of clients with Missing response - 1,830)

Website data

Mental Health Diagnosis

Source: The assessment data from 11/15/22 to 9/6/2023

Multiple response ones

Have you been diagnosed for any of the conditions below by a professional, whether currently or in the past? Please check all that apply.	Counts of Users	Percentage (%)
Anxiety disorder	1,612	17.8%
Depression	1,520	16.8%
Bipolar disorder	202	2.2%
Postpartum or perinatal depression	102	1.1%
Eating disorder	387	4.3%
Personality disorder	109	1.2%
Post-traumatic stress disorder (PTSD)	440	4.9%
Substance use disorder	134	1.5%
Schizophrenia	32	0.4%
I prefer not to say	329	3.6%
None of the above, I've never been diagnosed with a mental health condition	3,634	40.2%
Other mental health condition	541	6.0%

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Total Number of Responses (Includes Multiple Responses)	**9,042**	

Social Determinants Challenges
Source: The assessment data from 11/15/22 to 9/6/2023

Are you currently having any significant challenges with the following items? Please check all that apply.	Counts of Users	Percentage (%)
Housing (homelessness, being able to pay rent, or being able to stay in your current home)	497	5.7%
Physical health (chronic illness, pain, or disability)	805	9.2%
Job/employment (unemployment, finding a job, or keeping a job)	720	8.3%
School (missing school, being late to school, or maintaining good grades)	1,066	12.2%
Food insecurity (being able to pay for food or having access to healthy food options)	527	6.0%
Transportation	316	3.6%
Immigration	64	0.7%
Family instability	822	9.4%
None of the above	2,084	23.9%
Missing	1,818	20.9%
Total Number of Responses (Includes Multiple Responses)	**8,719**	

County Program Status
Source: The assessment data from 11/15/22 to 9/6/2023

Do you receive or are you a client of any of the following services or programs? Please check all that apply.	Counts of Users	Percentage (%)
Foster care or child welfare services	43	0.7%
The justice system	26	0.4%
CalWORKS	118	1.8%
Cal Fresh	442	6.9%
Other open case with the Department of Social Services	149	2.3%
None of the above	3,855	59.8%
Missing	1,818	28.2%

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Total Number of Responses (Includes Multiple Responses)	**6,451**	

Health Insurance Status
Source: The assessment data from 11/15/22 to 9/6/2023

What health insurance do you have? Please check all that apply.	Counts of Users	Percentage (%)
Medi-Cal or Medicaid	1,281	18.5%
Medicare	421	6.1%
Private insurance (either from your job, through Covered California, or as a dependent on someone else's insurance)	1,374	19.9%
No insurance	323	4.7%
Unsure	1,097	15.9%
Other	608	8.8%
Missing	1,818	26.6%
Total Number of Responses (Includes Multiple Responses)	**6,922**	

How Did You Hear About WellScreen
Source: The assessment data from 11/15/22 to 9/6/2023

How did you find out about WellScreen? Please check all that apply.	Counts of Users	Percentage (%)
A provider, counselor, or therapist who works for Monterey County Behavioral Health	51	0.73%
A mental health or substance use provider who does not work for Monterey County Behavioral Health	32	0.46%
Social media	794	11.39%
The Monterey County website	115	1.65%
An advertisement, flyer, or billboard in the community	70	1%
Friend or family member	152	2.18%
My primary care physician or other doctor or nurse	14	0.20%
School or work	45	0.65%
Google search	3137	45.01%
Other	2560	36.73%

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Total Number of Responses (Includes Multiple Responses)	6970	

MCBH Practitioner Categories

Num	Category
1	AMFT (Associate MFT)~INACTIVE
2	APCC (Associate PCC)~INACTIVE
3	ASW (Associate Social Worker)~INACTIVE
4	BHA (Behavioral Health Aide)~INACTIVE
5	LCSW~INACTIVE
6	LMFT~INACTIVE
7	LPCC~INACTIVE
8	LPHA
9	LPHA - Intern
10	Licensed Vocational Nurse
11	MFT (Marriage and Family Therapist)~INAC
12	MFT Trainee~INACTIVE
13	MFTI~INACTIVE
14	MHRS or equivalent~INACTIVE
15	MHS (Mental Health Specialist)~INACTIVE
16	MSW Intern~INACTIVE
17	Medical Assistant~INACTIVE
18	Mental Health Rehabilitation Specialist
19	Nurse Practitioner
20	Other Qualified Provider
21	Physician
22	Physician Assistant
23	Psychiatrist~INACTIVE
24	Psychiatry~INACTIVE
25	Psychologist
26	Psychologist (Waivered)~INACTIVE

MDpsy	Categories 1 to 19, excluding 20, 21, and 22 to 26
PhDpsy	Categories 1 to 24, excluding 25 and 26
MApsy	Categories 1 to 3, 5 to 9, 11 to 13, 14 to 16
NPPApsy	Categories 1 to 18, 19 to 20, excluding 21 and 22 to 26
BApsy	Categories 4, 10, 17, 18
HSpsy	Categories 2, 3, 6 to 9, 12 to 16, 19 to 26

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	Pre Launch (% of clients served)	Post Launch (% of clients served)
MDpsy	17.2%	12.9%
PhDpsy	3.0%	2.3%
MApsy	60.4%	53.2%
NPPApsy	8.1%	10.2%
BApsy	35.2%	42.1%
HSpsy	0.9%	0.9%

Website Event Data

Summary Table

	Website Events (N=165670)
Year-Month	
2022-11	5946 (3.6%)
2022-12	16753 (10.1%)
2023-01	22824 (13.8%)
2023-02	7091 (4.3%)
2023-03	13515 (8.2%)
2023-04	19210 (11.6%)
2023-05	20164 (12.2%)
2023-06	29479 (17.8%)

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2023-07	30688 (18.5%)
If an email campaign, the assigned UTM source.	
adwords	132755 (80.1%)
email	284 (0.2%)
facebook	21485 (13.0%)
Missing	11146 (6.7%)
If an email campaign, the assigned UTM content.	
Anxiety	7616 (4.6%)
Depression	3277 (2.0%)
General	5346 (3.2%)
Postpartum	867 (0.5%)
Substance Use	866 (0.5%)
Missing	147698 (89.2%)
Whether the user is logged in when the event occurred.	
Yes	9553 (5.8%)
No	156117 (94.2%)
The user-selected language	
English	159300 (96.2%)
Spanish	6366 (3.8%)
Missing	4 (0.0%)
Whether the user is on mobile, desktop, or other device.	
Desktop	18701 (11.3%)
Mobile	146965 (88.7%)
Other device	4 (0.0%)
The most common sources of traffic, e.g. Google, Facebook, etc.	
Bing	261 (0.2%)
Direct/Email	14952 (9.0%)
DuckDuckGo	31 (0.0%)
Facebook	12966 (7.8%)
Google Organic	2917 (1.8%)
Google Paid	132755 (80.1%)
Instagram	115 (0.1%)

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Linkedin	34 (0.0%)
Links/Referrals	1542 (0.9%)
Other	4 (0.0%)
Twitter	82 (0.0%)
Yahoo	11 (0.0%)
High level categories of traffic	
Direct/Email	14952 (9.0%)
Google Paid	132755 (80.1%)
Links/Referrals	1542 (0.9%)
Other	4 (0.0%)
Search Engine	3220 (1.9%)
Social Media	13197 (8.0%)
The user's region (state), from the IP address.	
California	155757 (94.0%)
International	42 (0.0%)
Other US States	8948 (5.4%)
Not Reported	923 (0.6%)
Found some kind of resource	
Yes	16499 (10.0%)
No	149171 (90.0%)
The topic associated with the event.	
Addiction and Recovery	79 (0.0%)
Anxiety and Stress	8860 (5.3%)
Mental Health Awareness	222 (0.1%)
Mindfulness and Meditation	39 (0.0%)
Mood Disorders	57 (0.0%)
Personal Development	12 (0.0%)
Relationships and Social Support	9 (0.0%)
Therapy and Mental Health Support	16 (0.0%)
Wellness and Self-Care	31 (0.0%)
Other Themes	524 (0.3%)
Missing	155821 (94.1%)
The user selected a client (external) resource or service	

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Yes	555 (0.3%)
No	165115 (99.7%)
The user found a resource	
Yes	15104 (9.1%)
No	150566 (90.9%)
The user completed the Wellscreen assessment	
Yes	5319 (3.2%)
No	160351 (96.8%)
The user found something useful	
Yes	15695 (9.5%)
No	149975 (90.5%)
The user played a video or podcast / audio	
Yes	486 (0.3%)
No	165184 (99.7%)
The user read something (article, etc.)	
Yes	90 (0.1%)
No	165580 (99.9%)
The user used the search to find a resource	
Yes	30 (0.0%)
No	165640 (100.0%)
The user registered or signed in to the site	
Yes	656 (0.4%)
No	165014 (99.6%)
The user viewed a list of resources	
Yes	15746 (9.5%)
No	149924 (90.5%)
The user navigated using the navigation menu	
Yes	818 (0.5%)
No	164852 (99.5%)

Summary Website Events Data

- **Website Events Overview:**
  - A total of 165,670 website events were recorded.
  - The data spanned across different months (Nov 2022 to July 2023), with June 2023 having the highest event count (29,479).
- **Traffic Sources:**

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    - Most events (80.1%) originated from Google Paid, while Facebook contributed 13.0%.
    - Direct/Email and Search Engine traffic accounted for 9.0% and 1.9%, respectively.
- **User Engagement:**
    - About 5.8% of events occurred when users were logged in, and 96.2% preferred English as their language.
    - Mobile devices were the predominant platform, constituting 88.7% of events.
- **Geographical Distribution:**
    - Most events (94.0%) were from California, with Other US States events comprising only 5.4%.
- **Interaction with Resources:**
    - Users found something useful in 9.5% of the events.
    - During most events (90.9%), users did not register or sign in to the site.
- **User Behavior and Interaction:**
    - Notably, during 9.5% of the events, users navigated using the navigation menu.
    - Only during 0.3% of events were users recorded playing a video or podcast, and during 0.1% of events did users read an article.
- **Wellscreen Assessment:**
    - A relatively small percentage (3.2%) of events recorded users who completed the Wellscreen assessment.
- **Topic Association and Themes:**
    - Anxiety and Stress-related events constituted 5.3%, while other themes collectively formed 0.3%.
    - Most events (94.1%) had no specific topic or theme.

The following models measure the association of marketing modes (compared to simple internet search): Google paid ads, social media ads, e-mail, and referrals. The models look at the primary outcome of interest–a completed mental health assessment.

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Outcome Assessment Completed (All Users)

Logistic regression — Number of obs = 21,243; LR chi2(16) = 4154.65; Prob > chi2 = 0.0000; Log likelihood = -8984.6513; Pseudo R2 = 0.1878

outcome_completed_assessment_mx	Odds Ratio	Std. Err.	z	P>|z|	[95% Conf.	Interval]
spanish_mx	.2208677	.0302069	-11.04	0.000	.1689344	.2887662
cellphone_mx	.9509166	.0557529	-0.86	0.391	.8476879	1.066716
email_mx	1.07955	.2112945	0.39	0.696	.7356	1.584323
google_paid_mx	11.66643	2.078244	13.79	0.000	8.228221	16.54131
referrals_mx	4.855779	1.387682	5.53	0.000	2.77334	8.501877
soc_media_mx	.7429618	.1480321	-1.49	0.136	.5027686	1.097905
dec22_mx	1.095655	.0984607	1.02	0.309	.9187148	1.306672
jan23_mx	.925461	.076811	-0.93	0.351	.7865213	1.088945
feb23_mx	.9660268	.1115937	-0.30	0.765	.7703	1.211486
mar23_mx	1.524313	.1395167	4.61	0.000	1.273989	1.823822
apr23_mx	1.556197	.1319238	5.22	0.000	1.31797	1.837484
may23_mx	1.585951	.1342481	5.45	0.000	1.343498	1.872158
jun23_mx	.4203168	.0335156	-10.87	0.000	.3595033	.4914175
jul23_mx	.7536741	.0602111	-3.54	0.000	.6444378	.8814266
Calif_mx	1.416645	.1193182	4.14	0.000	1.201069	1.670915
Monterey_County_mx	.9199631	.0351788	-2.18	0.029	.8535344	.9915619
_cons	.0402197	.0079493	-16.26	0.000	.0273024	.0592485

Note: **_cons** estimates baseline odds.

Outcome Assessment Completed (Monterey Users Only)

Logistic regression — Number of obs = 9,509; LR chi2(14) = 1847.59; Prob > chi2 = 0.0000; Log likelihood = -3838.9648; Pseudo R2 = 0.1940

outcome_completed_assessment_mx	Odds Ratio	Std. Err.	z	P>|z|	[95% Conf.	Interval]
spanish_mx	.2493198	.0467921	-7.40	0.000	.1725854	.3601715
cellphone_mx	.9162604	.0800867	-1.00	0.317	.7720025	1.087475
email_mx	.8050178	.2473758	-0.71	0.480	.4407961	1.470189
google_paid_mx	7.544664	2.120251	7.19	0.000	4.349403	13.0873
referrals_mx	4.793384	1.920762	3.91	0.000	2.185528	10.51303
soc_media_mx	.5866721	.1767784	-1.77	0.077	.3250184	1.058968
dec22_mx	1.060939	.1454686	0.43	0.666	.8109229	1.388038
jan23_mx	.9797968	.1231796	-0.16	0.871	.765814	1.25357
feb23_mx	.8468118	.1462345	-0.96	0.336	.6036627	1.187899
mar23_mx	1.565917	.2125607	3.30	0.001	1.20012	2.043207
apr23_mx	1.427309	.1799524	2.82	0.005	1.114809	1.82741
may23_mx	1.598951	.2068871	3.63	0.000	1.240792	2.060495
jun23_mx	.2810925	.033717	-10.58	0.000	.2222018	.3555911
jul23_mx	.5871701	.070653	-4.42	0.000	.4638105	.7433397
_cons	.0943026	.028375	-7.85	0.000	.052288	.1700766

Note: **_cons** estimates baseline odds.

Among all users, Google paid ads were the most effective, with referrals being effective, but less effective than Google paid ads. Among Monterey users, the findings were the same, however, we cannot measure a statistical difference between the effectiveness of Google paid ads relative to the effectiveness of referrals..

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Appendix C: Qualitative interview guides

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- CredibleMind Key Informant Interview Guide: pg 127
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- MCBH Spanish Language Focus Group Interview Guide: pg 138

KI ID#: _____

WellScreen Monterey Screening Website Post-Implementation
MCBH Key Informant (KI) Interview Guide

Date of interview: _____
Start time: _____ End Time: _____
Interview ID: _____
KI organization and job title: _____

File Name: WellScreen Monterey_KI#_MCBH_Date

INTRODUCTION AND INFORMED CONSENT

My name is [NAME] and I am with UC Berkeley Health Research for Action. I am a member of the evaluation team for the Monterey County Behavioral Health Help@Hand initiative and the WellScreen Monterey website.

WellScreen Monterey (https://wellscreenmonterey.crediblemind.com/) is a new virtual mental health screening website launched by Monterey County Behavioral Health (MCBH) in November 2022. The website allows individuals residing in Monterey County to self-screen themselves for mental health conditions, in the privacy of their own homes or community, and provide individuals information and resources about local mental health services or self-care resources available to them. MCBH has partnered with CredibleMind, Inc., a company that provides a wellness-oriented digital platform, to develop this website as part of the CalMHSA Help@Hand initiative. This website is intended for individuals ages 16 or older or for caregivers supporting those experiencing symptoms of mental health.

The purpose of this interview is to help inform and provide feedback on the planning and implementation of the WellScreen Monterey mental health screening and resources website and to help improve this new website to increase the reach of MCBH to support the growing needs of the Monterey County community.

We have invited you to participate in this interview today because of your MCBH expertise and experiences. We believe you can help share your experiences with the

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planning and implementation of WellScreen Monterey, identify some of the challenges and successes MCBH experienced to facilitating the mental health assessment process and linkage to mental health services subsequent to the launch of the WellScreen Monterey website, and give suggestions moving forward for improving WellScreen Monterey outreach and communication to facilitate the mental health assessments and linkage to mental health services for clients across Monterey County.

Do you have any questions about the study before we begin? [If yes, answer questions.]

[Briefly go over the main points of informed consent.]

- Just a reminder, you can refuse to answer any questions and you can discontinue the interview at any time.
- We will make every effort to make sure that your name or other identifying information such as your job title and ethnicity is not associated with anything you say. Your name and other identifying information will not appear on the interview document or any written reports. However, there may be some risk that you could be identified.
- There is no direct benefit to you from taking part in the interview, but you may benefit others in the future.
- The interview will take approximately 45-60 minutes.

Now I would like to begin the interview.

Key informant background
[We will first ask a few questions about your job.]

1. What is your current job title?

2. What are your primary roles and responsibilities at your current position?

Experiences with WellScreen Monterey planning and launch
[Next, we will ask you questions about your perspectives and experiences with the WellScreen Monterey planning and launch.]

3. What are your thoughts about the planning phase for the WellScreen Monterey website?
    a. What went well?
    b. What were the challenges?

4. What do you think of the launch for the WellScreen Monterey website?
    a. For the launch, what went well for that? And what were the challenges?
        i. What are the major financial or administrative facilitators and challenges in supporting the launch of WellScreen Monterey?
        ii. What are the major facilitators and challenges with MCBH interfacing with potential clients directed from WellScreen Monterey?

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b. Are there unique challenges (issues) for potential Latino or Indigenous clients to access WellScreen Monterey?

Perceptions about WellScreen Monterey's self-assessment process and linkage to mental health services
[We will next ask you questions about your perspectives about WellScreen Monterey's self-assessment tool and information about the website's mental health resources]

5. What are your thoughts about WellScreen Monterey's self-assessment tool?
    a. What are your thoughts on the user experience for taking the self-assessment tool?
    b. What are your thoughts on how the self-assessment results and the conditions are reported on Wellscreen Monterey?

6. What are your thoughts about the effectiveness of the WellScreen Monterey website (e.g., code for viewing assessment results; Monterey resources page; Avatar portal integration) in linking users to mental health services and self-care resources?
    a. What do you think are some ways that can help get the users to share their WellScreen Monterey assessment results to MCBH providers?
    b. What do you think are some ways that can make it easier for MCBH providers to be able to interface with users of WellScreen Monterey?
    c. What are the most important mental health resources not yet on the WellScreen Monterey website that should be included on the WellScreen Monterey resources page?
    d. Do you have additional suggestions for improving the linkage between users of WellScreen Monterey and MCBH providers?

WellScreen Monterey outreach and communication

7. What did you think of the outreach and communication strategies for WellScreen Monterey?
    a. What went well thus far?
    b. What are some challenges?
    c. What can we do to address these challenges?
    d. Are there additional suggestions you have for improving outreach and communication of the WellScreen Monterey website to county residents?
    e. Are there additional suggestions you have to make it more user friendly?

8. That is all the questions we have. Do you have any other comments you would like to share?

<u>Interview Notes</u>

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KI ID#: _____

WellScreen Monterey Screening Website Post-Implementation
Non-MCBH Key Informant (KI) Interview Guide

Date of interview: _____
Start time: _____ End Time: _____
Interview ID: _____
KI organization and job title: _____

File Name: WellScreenMonterey_KI#_NonMCBH_Date

INTRODUCTION AND INFORMED CONSENT

WellScreen Monterey (https://wellscreenmonterey.crediblemind.com/) is a new virtual mental health screening website launched by Monterey County Behavioral Health (MCBH) in November 2022. The website allows individuals residing in Monterey County to self-screen themselves for mental health conditions, in the privacy of their own homes or community, and provide individuals information and resources about local mental health services or self-care resources available to them. MCBH has partnered with CredibleMind, Inc., a company that provides a wellness-oriented digital platform, to develop this website as part of the CalMHSA Help@Hand initiative. This website is intended for individuals ages 16 or older or for caregivers supporting those experiencing symptoms of mental health.

The purpose of this interview is to help inform and provide feedback on the implementation of the WellScreen Monterey mental health screening and resources website and to help improve this new website to increase the reach of MCBH to support the growing needs of the Monterey County community.

We have invited you to participate in this interview today because of your expertise and experiences. We believe you can help share your experiences with the planning and implementation of WellScreen Monterey, identify some of the challenges and successes in facilitating the mental health assessment process and linkage to mental health services for potential clients subsequent to the launch of the new WellScreen Monterey website, and give suggestions moving forward for improving WellScreen Monterey outreach and communication to facilitate the mental health assessments and linkage to mental health services for potential clients across Monterey County.

Do you have any questions about the study before we begin? [If yes, answer questions.]

[Briefly go over the main points of informed consent.]

- Just a reminder, you can refuse to answer any questions and you can discontinue the interview at any time.
- We will make every effort to make sure that your name or other identifying information such as your job title and ethnicity is not associated with anything you

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say. Your name and other identifying information will not appear on the interview document or any written reports. However, there may be some risk that you could be identified.
- There is no direct benefit to you from taking part in the interview, but you may benefit others in the future.
- The interview will take approximately 45-60 minutes.

Now I would like to begin the interview.

Key informant background

1. What is your current job title?

2. What are your primary roles and responsibilities at your current position?

Experiences with WellScreen Monterey planning and launch

3. Were you a part of the planning phase for the WellScreen Monterey website? (yes/no) [*If yes, go to 3a. If no, go to 3b.*]
    a. What did you think of the planning phase for the WellScreen Monterey website?
        i. What went well?
        ii. What were the challenges?
    b. How did you first learn about the WellScreen Monterey Website?

4. In general, what do you think of the new WellScreen Monterey website?
    a. What do you like the most about it? And what can be improved?
    b. What are the barriers or limitations of WellScreen Monterey to support potential users to understand mental health symptoms and resources?
    c. What are the major facilitators and challenges with your organization/agency interfacing with potential clients directed from WellScreen Monterey?
    d. What are the challenges for potential Latino or Indigenous clients to access WellScreen Monterey?

Perceptions about WellScreen Monterey's self-assessment process and linkage to mental health services (walk through the self-assessment page by page with the KI for a few minutes)

5. What are your thoughts about WellScreen Monterey's self-assessment tool?
    a. What are your thoughts on the user experience for taking the self-assessment tool?
    b. What are your thoughts on how the self-assessment results and the conditions are reported on Wellscreen Monterey?

6. What are your thoughts about the effectiveness of the WellScreen Monterey website (e.g., results code for viewing the self-assessment results; Monterey

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resources page) in linking users to mental health services and self-care resources?

a. What do you think are some ways that can help get the users to share their WellScreen Monterey assessment results to mental health providers?
b. What do you think are some ways that can make it easier for mental health providers to be able to interface with users of WellScreen Monterey?
c. What are the most important mental health resources not yet on the WellScreen Monterey website that should be included on the WellScreen Monterey resources page?
d. Do you have additional suggestions for improving the linkage between users of WellScreen Monterey and mental health providers?

WellScreen Monterey outreach and communication

7. Are there suggestions you have for improving outreach and communication of the WellScreen Monterey website to county residents?
    a. Are there suggestions you have to make the Website more user friendly?

8. What do you think WellScreen Monterey could do to help its users learn more about and access your organization's/agency's services?

9. That is all the questions we have. Do you have any other comments you would like to share?

Interview Notes

KI ID#: _____

WellScreen Monterey Screening Website Post-Implementation
CredibleMind Key Informant (KI) Interview Guide

Date of interview: _____
Start time: _____ End Time: _____
Interview ID: _____
KI organization and job title: _____
(Credible Mind Staff)

File Name: WellScreenMonterey_KI#_CredibleMind_Date

INTRODUCTION AND INFORMED CONSENT

WellScreen Monterey (https://wellscreenmonterey.crediblemind.com/) is a new virtual mental health screening website launched by Monterey County Behavioral Health (MCBH) in November 2022 by your organization, CredibleMind. As you know, the

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website allows individuals residing in Monterey County to self-screen themselves in the privacy of their own home or community for mental health conditions and provide individuals information and resources about the local mental health services or self-care resources available to them. This website is intended for individuals 16 or older or for caregivers supporting those experiencing symptoms of mental health.

The purpose of this interview is to help inform and provide feedback on your experiences with the planning and implementation of the WellScreen Monterey mental health screening and resources website and how to continue to improve the website to meet the needs of MCBH and the community.

We have invited you to participate in this interview today because we believe you can help us identify some of the challenges and strategies in the screening and referral processes on the website and its linkages to resources and services as well as provide important recommendations for improving screening assessments and referrals for clients in Monterey County.

Do you have any questions about the study before we begin? [If yes, answer questions.]

[Briefly go over the main points of informed consent.]

- Just a reminder, you can refuse to answer any questions and you can discontinue the interview at any time.
- We will make every effort to make sure that your name or other identifying information such as your job title and ethnicity is not associated with anything you say. Your name and other identifying information will not appear on the interview document or any written reports. However, there may be some risk that you could be identified.
- There is no direct benefit to you from taking part in the interview, but you may benefit others in the future.
- Each interview will take approximately 45-60 minutes.

Now I would like to begin the interview.

Key informant background
[We will first ask a few questions about your job.]

1. What is your current job title and organizational affiliation?

2. What are your primary roles and responsibilities at your current position?

Experiences with WellScreen Monterey planning and launch
[Next, we will ask you questions about your perspectives and experiences with the WellScreen Monterey planning and launch.]

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3. What are your thoughts about the planning phase for the WellScreen Monterey website?
    a. What went well?
    b. What were the challenges?

4. What do you think of the launch for the WellScreen Monterey website?
    a. For the launch, what went well for that?
        i. What are the major financial or administrative facilitators in launching WellScreen Monterey?
        ii. What are the major facilitators with MCBH interfacing with potential clients directed from WellScreen Monterey? (After community members that may be potential clients are directed from WellScreen Monterey Assessments, how does MCBH connect with them?)
    b. And what were the challenges?
        i. What are the major financial or administrative challenges in launching WellScreen Monterey?
        ii. What are the major challenges with MCBH interfacing with potential clients directed from WellScreen Monterey? (After community members that may be potential clients are directed from WellScreen Monterey Assessments, how does MCBH connect with them?)
    c. Are there unique challenges (issues) for potential Latino or Indigenous clients to access WellScreen Monterey?

Perceptions about WellScreen Monterey's self-assessment process and linkage to mental health services
[We will next ask you questions about your perspectives about WellScreen Monterey's self-assessment tool and information about the website's mental health resources]

5. What are your thoughts about WellScreen Monterey's self-assessment tool for users?
    a. What are your thoughts on the user experience for taking the self-assessment tool?
    b. What are your thoughts on how the self-assessment results and the conditions are reported on Wellscreen Monterey?

6. What are your thoughts about the effectiveness of the WellScreen Monterey website (e.g., code for viewing assessment results; Monterey resources page; Avatar portal integration) in linking users to mental health services and self-care resources?
    a. What do you think are some ways that can help get the users to share their WellScreen Monterey assessment results to MCBH or other providers? (Why was the rationale behind the design of the codes for viewing the assessment results.)

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b. What do you think are some ways that can make it easier for MCBH or other providers to be able to interface with users of WellScreen Monterey?
c. What are the most important mental health resources not yet on the WellScreen Monterey website that should be included on the WellScreen Monterey resources page? (What specific resources on the resources page should be highlighted?)
d. Do you have additional suggestions for improving the linkage between users of WellScreen Monterey and MCBH or non-MCBH providers?

WellScreen Monterey outreach and communication

7. What did you think of the outreach and communication strategies for WellScreen Monterey (e.g., Google, Facebook)?
    a. What went well thus far?
    b. What are some challenges?
    c. What can we do to address these challenges?
    d. Are there additional suggestions you have for improving outreach and communication of the WellScreen Monterey website to county residents?
    e. Are there additional suggestions you have to make it more user friendly?

8. That is all the questions we have. Do you have any other comments you would like to share?

<u>Interview Notes</u>

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WellScreen Monterey Screening Website Post-Implementation MCBH English Language Focus Group (FG) Interview Guide

Date of interview: _____
Start time: _____ End Time: _____
of participants: ____
Language: _____

Introduction and Informed Consent	**Introduction and Informed Consent** (15 minutes)
As participants log into the group video call, greet them. After an initial welcome, the moderator will briefly describe the purpose of the focus group. [The participant's copy of the consent form was emailed/mailed before the focus group session.] Next, verbal informed consent will be obtained. **Read the consent form out loud.** [The preceding instruction is site-specific, depending on literacy and language anticipated for the group members.] After reading the form, emphasize the following points:	*WellScreen Monterey (https://wellscreenmonterey.crediblemind.com/) is a new virtual mental health screening website launched by Monterey County Behavioral Health (MCBH) in November 2022. The website allows individuals residing in Monterey County to self-screen themselves in the privacy of their own home or community for mental health conditions and provide individuals information and resources about the local mental health services or self-care resources available to them. MCBH has partnered with CredibleMind, Inc., a company that provides a wellness-oriented digital platform, to develop this website. This website is intended for individuals 16 or older or for caregivers supporting those experiencing symptoms of mental health.* *The purpose of this interview is to help inform and provide feedback on the implementation of the WellScreen Monterey mental health screening and resources website and to make sure we are meeting the needs of the Monterey community.* *We have invited you to participate in this interview today because we believe you can help us identify some of the challenges and strengths of this website for mental health screening and referral processes and provide important recommendations for improving screening assessments and referrals for clients in Monterey County.*

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At this point, ask participants if they have any questions. Once all questions have been answered, ask the participants to agree to the verbal consent form. Remind the participants that a copy of the consent form for their records was emailed/mailed to them prior to the focus group. Point out that should they have a question at any time following the focus group, they may contact the persons listed on the consent form. After obtaining informed consent, give each participant a participant demographic survey link to complete. Depending on the group participants' characteristics, it may be desirable to have each participant complete the demographic survey as you read it aloud.	*We will be recording the session. We don't want to miss any of your comments. Only members of the evaluation team will have access to the recordings. If anyone is uncomfortable with being recorded, please say so. You are free to turn off your camera or leave the group video call if you would prefer. The recordings will be typed-up (transcribed) without any names or other identifying information and will be kept in a locked cabinet. Once the recordings have been typed-up, they will be destroyed. The typed versions will also be kept in a locked cabinet or password protected online server/computer. In any reports of the findings, we will not use anyone's name. We also ask that each of you keep what others say in this group confidential. Also, please do not identify any of our participants outside of this group. What is said here, should stay here.*
Ground Rules Following the introductions, the moderator will describe what is expected of participants in terms of the group discussions (e.g., the ground rules): **Introduction** Welcome & Thanks for coming General information about focus groups Audio and video recording Housekeeping - bathrooms, food, drinks, break Time - 1 to 1.5 hours **Honest opinion** No right or wrong answers You do not have to answer a question if you don't want to All opinions welcome Anonymity - your first name or an alias Confidentiality Moderator role - make sure everyone gets heard	**Ground Rules** *Before we get into our discussion, let me make a few requests of you. First, speak up so that everyone can hear you and let's try to have just one person speak at a time. Please say exactly what you think. Don't worry about what I think or others in the group might think. There are no right or wrong answers. Everyone's ideas and experiences are important. Everyone does not have to agree; we are interested in hearing all opinions.*

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Can talk or respond to others in the room, not only me Speak clearly and loudly enough - hands up signal Speak one at a time Time out signal (when multiple people speak at the same time) - give the floor to person who first had the floor and work around room to all the people that want to speak Questions?	
Introductions To facilitate group interaction, the moderator will ask each participant to introduce him or herself using a name he or she prefers to be called. The moderator will also emphasize that they can use any name they choose (e.g., nickname, alias, initials, etc.). Each participant may choose to leave video off if preferred.	**Introductions** *1. Please tell us your first name or the name you prefer to use. Please also tell us if you know a family member or friend who is feeling healthy and happy and why you think this family member or friend is feeling healthy and happy. (If you do not know anyone, please let us know why you are interested in health and wellness).*
Introduce WellScreen Monterey Website To facilitate group discussion, the moderator will ask the participants to review the WellScreen Monterey website on their own via their device for 5-10 minutes, sharing the main webpage link with them via Chat. The moderator will then take 5-10 minutes to go over step-by-step the major components of the WellScreen Monterey Website and how to navigate them using the Zoom Share Screen option. The moderator will walk through the homepage, the self-assessment screener, the results page with the assessment results summary and details with recommended resources for each condition, and the resources webpage.	**Introduce WellScreen Monterey Website** *Before we discuss the new WellScreen Monterey Website, we want to ask you to please go onto the WellScreen Monterey website (share website homepage link in Chat) to review for 5-10 minutes . After that, we will also use Share Screen and go over the WellScreen Monterey Website together with you for a few minutes.*
Focus Group Questions	**Focus Group Questions** *Next, I would like to ask you a few questions about the WellScreen Monterey Website. (Share home page)*

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2. How did you first learn about the WellScreen Monterey Website?

PROMPT: What device did you use to access the Website (e.g., mobile phone, computer)?

3. What do you think of the new WellScreen Monterey website in general?

PROMPT: What was the first thing you saw and clicked on when you got onto the main homepage on the website?

PROMPT: What have you found to be the most helpful or easy to use on the website?

PROMPT: What are the challenges you encountered with using the website?

PROMPT: What can be improved?

4. What are your thoughts about taking the WellScreen Monterey's self-assessment tool? (1st page of self-assessment, select random questions)

PROMPT: What are your thoughts about the design and length of the self-assessment tool?

PROMPT: What are your thoughts about the self-assessment questions? Were there any particular questions or sections you found that were hard to understand or respond to?

PROMPT: What are your thoughts on how the self-assessment results, the summary of the conditions, and the suggested resources are reported on Wellscreen Monterey results page? (go to Results Page and show them the Results Page)

PROMPT: Were the suggested resources easy to browse and understand on the results page?

PROMPT: What can be improved?

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5. What are your thoughts about the results code for you or the provider to be able to view the self-assessment results? (Go to results code on results page on a separate tab)

PROMPT: What do you think you or other users can do with the results code on the results page?

PROMPT: What do you think are some ways that can help get you or other users to share their WellScreen Monterey assessment results with mental health providers?

PROMPT: What do you think are some ways that can make it easier for mental health providers to be able to connect with you or other users of WellScreen Monterey?

PROMPT: Do you have additional suggestions for connecting the users of WellScreen Monterey and mental health providers?

6. What are your thoughts about the WellScreen Monterey resources page? (Go to Resources Page)

PROMPT: What are your thoughts about the design and format of the resources page?

PROMPT: What have you found to be most helpful or easy to use on the resources page?

PROMPT: What are the challenges you encountered with browsing through the resources page?

PROMPT: What are the most important resources not yet on the WellScreen Monterey website that should be included on the WellScreen Monterey resources page?

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	7. Are there suggestions you have for getting the message out about the new WellScreen Monterey website to county residents that may need it? PROMPT: *What venues should the information about WellScreen Monterey be posted or presented (e.g., Google ads, Bus ads, Grocery Store bulletin board, churches, health clinics,...)?* PROMPT: *How can one make the WellScreen Monterey website more easily available? (e.g., social media, in-person via tablet,...)* *8. Are there suggestions you have to make the information on the Website more user friendly?* PROMPT: *What specific information have you found to be most helpful?* PROMPT: *What information were you not able to find?*
OTHER TOPICS	*9. Is there anything else you would like to talk about?* PROMPT: *Are there additional suggestions you would like to share about your experiences with using the WellScreen Monterey Website?* PROMPT: *Are there any other suggestions you have for improving mental health services in Monterey County that you would like to share?*
Wrap-up	**Wrap-up** *Before we end our group discussion, I'd like to know if there is anything you would like to add. Are there things that we didn't discuss that you think are important for us to know about how [WellScreen Monterey] can better serve your community?*

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	Thank you very much for taking the time to talk with us. Your input will be very helpful. Again, if you have questions at any time about this project, please feel free to contact the persons listed on your consent form.

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WellScreen Monterey Screening Website Post-Implementation MCBH Spanish Language Focus Group (FG) Interview Guide

Fecha de Entrevista: _____
Hora de Inicio: _____ Hora de Terminar: _____
de participantes: ____
Idioma: _____

Introducción y Consentimiento Informado	**Introducción y Consentimiento Informadot** (15 minutos)
Cuando los participantes inicien sesión en la videollamada grupal, salúdelos. Después de una bienvenida inicial, el moderador describirá brevemente el propósito del grupo focal. [La copia del formulario de consentimiento del participante se envió por correo electrónico/correo postal antes de la sesión del grupo focal.] A continuación, se obtendrá el consentimiento informado verbal. **Lea el formulario de consentimiento en voz alta.** [La instrucción anterior es específica del sitio, dependiendo de la alfabetización y el idioma anticipado para los miembros del grupo.] Después de leer el formulario, enfatice los siguientes puntos:	*WellScreen Monterey (https://wellscreenmonterey.crediblemind.com/) es un nuevo sitio web virtual y evaluación de salud mental lanzado por Monterey County Behavioral Health (MCBH) en noviembre de 2022. El sitio web permite a las personas que residen en el condado de Monterey autoevaluarse en él privacidad de su propio hogar o comunidad para las condiciones de salud mental y proporcionar a las personas información y recursos sobre los servicios locales de salud mental o los recursos de autocuidado disponibles para ellos. MCBH se ha asociado con CredibleMind, Inc., una empresa que proporciona una plataforma digital orientada al bienestar, para desarrollar este sitio web. Este sitio web está destinado a personas mayores de 16 años o para cuidadores que brindan apoyo a quienes experimentan síntomas de salud mental.* *El propósito de esta entrevista es ayudar a informar y proporcionar comentarios sobre la implementación del sitio web de recursos y evaluaciones de salud mental WellScreen Monterey y asegurarnos de que estamos satisfaciendo las necesidades de la comunidad de Monterey.* *Lo hemos invitado a participar en esta entrevista hoy porque creemos que puede ayudarnos a identificar algunos de los desafíos y fortalezas de este sitio web para los procesos de evaluación y referencias de salud mental y brindar recomendaciones importantes para mejorar las evaluaciones y las referencias para clientes en el condado de Monterey.*

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En este punto, pregunte a los participantes si tienen alguna pregunta. Una vez que se hayan respondido todas las preguntas, pida a los participantes que acepten el formulario de consentimiento verbal. Recuerde a los participantes que se les envió por correo electrónico/correo postal una copia del formulario de consentimiento para sus registros antes del grupo de enfoque. Indique que si tienen una pregunta en cualquier momento después del grupo de enfoque, pueden comunicarse con las personas que figuran en el formulario de consentimiento. Después de obtener el consentimiento informado, entregue a cada participante un enlace de encuesta demográfica para que lo complete. Dependiendo de las características de los participantes del grupo, puede ser conveniente que cada participante complete la encuesta demográfica mientras la lee en voz alta.	*Estaremos grabando la sesión. No queremos perdernos ninguno de tus comentarios. Solo los miembros del equipo de evaluación tendrán acceso a las grabaciones. Si alguien se siente incómodo con ser grabado, por favor dígalo. Puede apagar su cámara o abandonar la discusión si lo prefiere. Las grabaciones se transcribirán sin ningún nombre u otra información de identificación y se mantendrán en un gabinete cerrado con llave. Las grabaciones serán destruidas. Las versiones transcritas también se mantendrán en un gabinete cerrado con llave o en un servidor/computadora en línea protegido por contraseña. En cualquier reporte, no utilizaremos el nombre de nadie. También pedimos que cada uno de ustedes mantenga confidencial lo que digan los demás en este grupo. Además, no identifique a ninguno de nuestros participantes fuera de este grupo. Lo que se dice aquí, debe quedarse aquí.*
Reglas Después de las presentaciones, el moderador describirá lo que se espera de los participantes en términos de las discusiones grupales (por ejemplo, las reglas básicas): **Introducción** Bienvenido y gracias por venir Información general sobre los grupos focales Grabación de audio y video Limpieza: baños, comida, bebidas, descanso. Tiempo - 1 a 1,5 horas **Opinión honesta** No hay respuestas correctas o incorrectas	**Reglas** *Antes de entrar en nuestra discusión, permítanme hacerles algunas peticiones. Primero, hable para que todos puedan escucharlo e intentemos que solo hable una persona a la vez. Por favor, diga exactamente lo que piensa. No se preocupe por lo que yo pienso o lo que otros en el grupo puedan pensar. No hay respuestas correctas o incorrectas. Las ideas y experiencias de todos son importantes. No todos tienen que estar de acuerdo; nos interesa escuchar todas las opiniones.*

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No tienes que responder una pregunta si no quieres Todas las opiniones son bienvenidas Anonimato: su nombre de pila o un alias Confidencialidad Rol de moderador: asegúrese de que todos sean escuchados Puede hablar o responder a otras personas en la habitación, no solo a mí Hable claramente y lo suficientemente alto - señal de manos arriba Hablar uno a la vez Señal de tiempo de espera (cuando varias personas hablan al mismo tiempo): dé la palabra a la persona que primero tuvo la palabra y trabaje alrededor de la sala para todas las personas que quieran hablar ¿Preguntas?	
Introducciones Para facilitar la interacción del grupo, el moderador le pedirá a cada participante que se presente usando el nombre que prefiera que lo llamen. El moderador también enfatizará que puede usar cualquier nombre que elija (por ejemplo, apodo, alias, iniciales, etc.). Cada participante puede optar por dejar el video apagado si lo prefiere.	**Introductions** Moderator shares first - *1. Díganos su nombre o el nombre que prefiere usar. Díganos también si conoce a un familiar o amigo que se sienta saludable y feliz y por qué cree que este familiar o amigo se siente saludable y feliz. (Si no conoce a nadie, háganos saber por qué está interesado en la salud y el bienestar).*
Presentar el sitio web de WellScreen Monterey Para facilitar la discusión grupal, el moderador les pedirá a los participantes que revisen el sitio web de WellScreen Monterey por su cuenta a través de su dispositivo durante 5 a 10 minutos, compartiendo el enlace de la página web principal con ellos a través del chat. Luego, el moderador tomará de 5 a 10 minutos para repasar paso a paso los principales componentes del sitio web de WellScreen Monterey y cómo navegar por ellos usando la opción Zoom Share Screen. El moderador recorrerá la página de inicio, el	**Introduce WellScreen Monterey Website** *Antes de hablar sobre el nuevo sitio web de WellScreen Monterey, queremos pedirle que visite el sitio web de WellScreen Monterey (comparta el enlace de la página de inicio del sitio web en el chat) para revisarlo durante 5 a 10 minutos. Después de eso, también usaremos Share Screen y revisaremos el sitio web de WellScreen Monterey junto con usted durante unos minutos.* **(Put link to website in chat)** **https://wellscreenmonterey.crediblemind.com/**

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el autoevaluación, la página de resultados con el resumen de los resultados de la evaluación y los detalles con los recursos recomendados para cada condición, y la página web de recursos.	
Preguntas de el grupo focal	**Preguntas de el grupo focal** *A continuación, me gustaría hacerle algunas preguntas sobre el sitio web de WellScreen Monterey.* **START AT HOME PAGE, Click through options on home page** *2. ¿Cómo se enteró por primera vez del sitio web de WellScreen Monterey?* *AVISO: ¿Qué dispositivo (electronic device) usó para acceder al sitio web (por ejemplo, teléfono móvil, computadora)?* *3. ¿Qué opina del nuevo sitio web de WellScreen Monterey en general?* *AVISO: ¿Qué fue lo primero que vio y en lo que hizo clic cuando visitó la página principal del sitio web?* *AVISO: ¿Qué ha encontrado que es más útil o fácil de usar en el sitio web?* *AVISO: ¿Cuáles son los desafíos que encontró al usar el sitio web?* *PROMPT: ¿Qué se puede mejorar?* *4. ¿Qué piensa acerca de tomar la autoevaluación de WellScreen Monterey?* **(Go to the 1st page of questions on self-assessment, select answers to a few questions and move through a few pages of the self-assessment)**

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	AVISO: ¿Qué opina sobre el diseño y la duración del autoevaluación? *AVISO: ¿Qué opina sobre las preguntas de la autoevaluación? ¿Hubo alguna pregunta o sección en particular que encontró que fue difícil de entender o responder?* *AVISO: ¿Qué piensa sobre cómo se informan los resultados de la autoevaluación, el resumen de las condiciones y los recursos sugeridos en la página de resultados de Wellscreen Monterey?* **(Go to results page here, it will also include some resources)** *AVISO: ¿Los recursos sugeridos fueron fáciles de explorar y comprender en la página de resultados?* *PROMPT: ¿Qué se puede mejorar?* *5. ¿Qué opina sobre el código de resultados para que usted o el proveedor puedan ver los resultados de la autoevaluación? (***Go page where you will enter results code, also the home page, scroll down)** *AVISO: ¿Qué cree que usted u otros usuarios pueden hacer con el código (clave) de resultados en la página de resultados?* *AVISO: ¿Cuáles cree que son algunas formas que pueden ayudar a que usted u otros usuarios compartan los resultados de su evaluación WellScreen Monterey con los proveedores de salud mental?* *AVISO: ¿Cuáles cree que son algunas formas que pueden facilitar que los proveedores de salud mental puedan conectarse con usted u otros usuarios de WellScreen Monterey?* *AVISO: ¿Tiene sugerencias adicionales para conectar a los usuarios de WellScreen Monterey y los proveedores de salud mental?*

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6. ¿Qué opina sobre la página de recursos de WellScreen Monterey? **(Go to resource page)**

AVISO: ¿Qué piensa sobre el diseño y el formato de la página de recursos?

AVISO: ¿Qué ha encontrado más útil o fácil de usar en la página de recursos?

AVISO: ¿Cuáles son los desafíos que encontró al navegar por la página de recursos?

AVISO: ¿Cuáles son los recursos más importantes que aún no están en el sitio web de WellScreen Monterey y que deberían incluirse en la página de recursos de WellScreen Monterey?

7. ¿Tiene alguna sugerencia para difundir (extender) el mensaje sobre el nuevo sitio web de WellScreen Monterey a los residentes del condado que puedan necesitarlo?

AVISO: ¿En qué lugares se debe publicar o presentar la información sobre WellScreen Monterey (por ejemplo, anuncios de Google, anuncios de autobuses, tablón de anuncios de supermercados, iglesias, clínicas de salud,...)?

AVISO: ¿Cómo se puede hacer que el sitio web de WellScreen Monterey esté más fácilmente disponible? (por ejemplo, redes sociales, en persona a través de una tableta,...)

8. ¿Tiene alguna sugerencia para que la información del sitio web sea más fácil de usar?

AVISO: ¿Qué información específica ha encontrado más útil?

PROMPT: ¿Qué información no pudo encontrar?

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OTROS TEMAS	*9. ¿Hay algo más de lo que le gustaría hablar?* *AVISO: ¿Hay sugerencias adicionales que le gustaría compartir sobre sus experiencias con el uso del sitio web de WellScreen Monterey?* *AVISO: ¿Hay alguna otra sugerencia que tenga para mejorar los servicios de salud mental en el condado de Monterey que le gustaría compartir?*
Envolver	**Envolver** *Antes de terminar nuestra discusión grupal, me gustaría saber si hay algo que le gustaría agregar. ¿Hay cosas que no discutimos que cree que es importante que sepamos sobre cómo [WellScreen Monterey] puede servir mejor a su comunidad?* *Muchas gracias por tomarse el tiempo para hablar con nosotros. Su entrada será muy útil. Nuevamente, si tiene preguntas en cualquier momento sobre este proyecto, no dude en comunicarse con [nosotros] las personas que figuran en su formulario de consentimiento.*

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Appendix D: Qualitative quotes and summaries

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- Results: pg 152
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Planning processes

Successes

MCBH Key Informant Perspectives

"I always have the sense that things were happening, action items were being addressed, feedback was being listened to and responded to. And I think, and this goes back to the strengths of the process." - MCBH Administrator

"The planning phase? Well, I think going way back, I thought the RFP that was developed was well done. That was in consultation with the CalMHSA team. I think we developed pretty good scope of work and some pretty good parameters within the RFP." - MCBH Administrator

Help@Hand Technology Development Partner Perspectives

"And so I think having consistent meetings was great and good to help us move forward and make sure that we were on track." - Help@Hand Technology Development Partner

"We had an abundance of experience and expertise related to planning all the pieces out and making sure that we were meeting our milestones correctly. And we had some regular meetings…Things really went swimmingly, in terms of a large-scale project." - Help@Hand Technology Development Partner

"And so for the most part, every deadline we had planned, we met. The times where we didn't meet our deadline, it was usually due to, we were still waiting for feedback or something from stakeholders." - Help@Hand Development Partner

"I think we had a very intentional needs assessment process that tried its best to involve community members in comprehensive ways. So, we had focused groups, surveys. We had a validation process that happened on the ground. We had one-on-one interviews and that was with people who were just lay people within Monterey County residents, but also with some of the organizations that we thought might be interfacing with the tool once it was created." - Help@Hand Technology Development Partner

Challenges

Non-MCBH Provider Perspectives

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“I think it's difficult to get everyone at the table to give their... So, I think just doing the meetings or finding a time where everyone can make it. Of course, those are challenges that can come up along with planning and making sure we get everyone, but I think that was one of the things that I've seen.” -KI 3

Help@Hand Technology Development Partner Perspectives

“I also think that Monterey County Behavioral Health had very loose goals. So, whereas that is a positive in some sense, it is a challenge in others because there is less direction around what exactly we are looking for, striving towards, and having to create those parameters for ourselves.” -Help@Hand Technology Development Partner

“For the design, I think one thing we're kind of dealing with now after launching is we wished there had been a little more feedback on the design. I think it seemed like they were happy that we got something out there and it looks fine, but it definitely, there's some UX UI things that I pointed out before, but we just didn't really have time to fix them.” -Help@Hand Technology Development Partner

“I think one thing that would've helped is if we could have had another researcher. So there were two of us and there are four clinics and so we were only able to be at most two…it still would've been nice to just have a third person be able to get as many people as we could.” Help@Hand Technology Development Partner

“So the usability stuff, that was difficult. Getting names and people, just recruiting people. We got some information from, they do an annual survey and so some of the contacts we received came from that, but we also had to do our own recruiting through Craigslist. It's hard to know if the people that we reached out to would've been interested in something like this or they're just interested in participating in research and getting compensated and all of that.” -Help@Hand Technology Development Partner
“And so for the most part, every deadline we had planned, we met. The times where we didn't meet our deadline, it was usually due to, we were still waiting for feedback or something from stakeholders.” -Help@Hand Technology Development Partner

“I don't think we were too far behind. I think the original launch date was in September maybe. So we were only a couple months delayed, which compared to other delays we had throughout the project, I think that was pretty good.” -Help@Hand Technology Development Partner

Launch Processes

Successes

MCBH Key Informant Perspectives

“So I think that was smart to do a softer launch and then see what the community response would be and how it's utilized or if it's utilized by the community. And then if it is, then what community members are then bringing that to us in Monterey County Behavioral Health to see, to follow-up from after they've been screened.” - MCBH Administrator

“And a website might not have that level of trust for the older than the younger…if younger people are interacting with the website, then those that are 30 plus or whatever the number is,

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they may be continuing to wanting to seek a person that they have heard is trustworthy or an agency that has actual human beings working there that they can trust." - MCBH Administrator

"I mean the tool would be a facilitator if people would go through the tool and decide to contact us." - MCBH Administrator

Help@Hand Technology Development Partner Perspectives

"But I would say I was very impressed with how many users and assessment completions we got even during that initial soft launch. From my perspective, I think the Monterey team was really happy with the numbers that we initially got and are continuing to get. …So it's really nice to see how many people are finding the site and taking the assessments." -Help@Hand Technology Development Partner

"I mean, financially, it was well funded, and I think there's been the challenge of figuring out how best to spend some of the marketing budget because you can pay money that's going to get people to come directly to the site and the screener, and that's great, but you can also pay money to get just brand awareness out there. So if, in the future, someone needs a screener, they know it's there." -Help@Hand Technology Development Partner

Challenges

MCBH Key Informant Perspectives

"...I feel like the barriers would again be more on the county side to be sure to adapt their workflows to ask for the results code. Because I know we've tested it a couple times where we call the clinics and say we have a results code and the person on the other line is kind of like, "What? What results code?" So that's not good. So I think just the frequent training of people and reminders…" - MCBH Administrator

"The trust in the community is a big part, or the trust in our services in the community is a big part of why we're able to deliver services robustly in South Monterey County. " - MCBH Administrator

Help@Hand Technology Development Partner Perspectives

"Yeah, I think on Monterey's side, even though it's obviously been an extremely collaborative process with them, I guess the stakeholding, if that can be a word, is a lot more dispersed for them as opposed for us. CredibleMind is a fairly small team and we all have eyes on the project. For them, there's a lot of different people who have different perspectives or might have some weight to play in the different elements of it." -Help@Hand Technology Development Partner

"I think it's similar to just the barriers that have been common throughout this process where the Monterey County representatives don't always have the expertise or connections that are needed to get to the people that we're trying to get to. So, I think we've created a lot of the material that will be helpful, but we really need to have someone from Monterey County know where that information needs to go, where the posters need to be posted, where the business cards need to be populated, things like that." -Help@Hand Technology Development Partner

"I think one thing that we ran into was kind of the idea of a soft launch and phase two launch because Monterey wasn't ready to go out and we didn't have all the marketing stuff yet. And so

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yeah, the idea of a two-part launch wasn't part of the original contract. And so it was something that we had to figure out as we went, but it ended up working out okay. I think it's just how do we define the first part and then how do we define the second part. What else?" -Help@Hand Technology Development Partner

"...I think we were a little delayed on possibly legal and insurance reasons, but we were pretty close to our dates, and we were running up against some backend dates, we really wanted to get it into place. So, these are pieces that are around the edges a little bit. And, certainly understandable. So overall, I'd say, it was pretty successful in terms of getting people to the site, and then also spinning up some great Google AdWord outreach and so forth, so that we really had some traffic on the site and some usage. And ultimately, we're helping some specific populations at pretty high volumes in the county. And that felt pretty good to see it utilized as well." -Help@Hand Technology Development Partner

"It's a challenge, but there's only so much money that's available. Obviously, the more money you have, the better, and the more you can spend on a lot of different types of outreach…I think there's been a great budget to work with, but I think it's just figuring out what makes the most sense for targeting different communities and different types of marketing collateral or digital advertising…It was more of just figuring out what makes the most sense with the budget that we do have. You're always going to have to work with the budget, so just making sure that it's all balanced and using the budget in the right way." -Help@Hand Technology Development Partner

"We've had conversations about do we want the number of people coming to the site to increase, or are we really focused…" If they're not taking an assessment, maybe that's not necessarily what we want. Maybe we should be focusing trying to get the people to come to the site and taking the assessment. So there's a balance." -Help@Hand Technology Development Partner

Website

Overall

Non-MCBH Provider Perspectives

"I like the way it was written. I like the types of words used to express what you guys were trying to say. It wasn't using the psychobabble that we have to use for billing. It's more when you're feeling this, how are you feeling this? So I know what it's leading to, but the questions are simple." -Non-MCBH Provider

Help@Hand Technology Development Partner Perspectives

"I think it's pretty simple. It's a question and handful of options, and you just hand-select. I think people are pretty used to taking questionnaires in this type of format, so I don't really see many issues with the way that it's laid out. We did, I believe, try to make the reading level low enough so that most people can take the assessment and understand it." -Help@Hand Technology Development Partner

Challenges

Needs of vulnerable populations

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MCBH Key Informant (KI) Perspectives

"...I think the product is done well to be fluent in Spanish and our marketing is equally Spanish as it is English. The Indigenous groups though, I think they'd be restricted. I know to my understanding, they don't necessarily speak Spanish and their languages aren't written languages. So that's definitely a hard-to-reach demographic." - MCBH Administrator

Non-MCBH Provider Perspectives

"I would suggest, maybe,...to have a primarily Spanish version of this website with everything translated, not just the Bienvenidos part there. If you've already completed it… I would make that a little more prominent. Instead of a dropdown menu, maybe buttons so someone can see it clearly and just click there." -Non-MCBH Provider

Help@Hand Technology Development Partner Perspectives

"When we did our assessment, we did get feedback on what about other Indigenous Mexican languages. And basically what we said was, "Well, we have some resources for that population, but the assessment itself won't be in those languages 'cause we're contracted for English and Spanish only". And so if Monterey wanted us to add another language, then we could, it would just be a change in scope." -Help@Hand Technology Development Partner

"I would say, for Latino and Indigenous clients, certainly we did some research into languages beyond Spanish, like Indigenous languages like Triqui and so forth. And, we didn't find a cost-effective methodology for allowing for additional Indigenous languages." -Help@Hand Technology Development Partner

"...We're unsure whether if someone has their browser set to Spanish already. We're not able to tell. If someone has their browser set to Spanish, I believe that any website that they visit that can be translated is automatically translated. So, that means they're still getting an automatic translation experience of our website and not the human translation experience of our website. I do believe that our developers have been doing work to read if someone's browser is set to Spanish to make sure that they see our human-translated version of this website in Spanish. I think that's something we've achieved already, but I'm not 100% sure." -Help@Hand Technology Development Partner

"So, one thing we've noticed is that we've done a lot of work to human translate the website into Spanish, and the homepage has separate buttons for starting the screener in English and Spanish to really overemphasize and encourage that you can access this website in a language that feels more comfortable for you." -Help@Hand Technology Development Partner

"...we've had a lot of conversations about brand awareness and how the more often people are seeing the ads, whether they're digital or in person, they're constantly being reminded that that resource is there. So they may not need it in that moment. So they may not scan the QR code or click on the link, but the more they see it, they will remember that that's a resource for them when they are feeling in need of something like WellScreen." -Help@Hand Technology Development Partner

" I think just continuing to improve on and add some of the physical collateral to different partners and different areas of the community is going to be helpful and beneficial. We have the

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bus ads that just started running, and I know we have business cards and rack cards and flyers that Wes just got in the mail. So just making sure that those are being distributed and people are being educated on what WellScreen is and how to talk about it so when they are handing out some of that physical collateral, people know what it's for and how to use it." -Help@Hand Technology Development Partner

"...having non-online opportunities within the county as well can be quite important. I think that, there are many other groups that could be reached, like seniors and people who are a little less likely to be on web tools and a little more likely to just be communicating with agencies at the county, or texting, or things like that." -Help@Hand Technology Development Partner

"So we were able to implement different sort of landing pages, catered to specific needs. So we have an anxiety one, depression, one postpartum depression one. So we could see what's getting the most hits or the most visits. But in terms of adjusting, I think there's still a little bit of learning that we're still doing…" -Help@Hand Technology Development Partner

"I know we've tried to make more amendments to the process on the mobile experience, but from my understanding, I would imagine most people would be taking this on the phone. That hasn't always been our focus, so there's probably some improvements that we could do there." -Help@Hand Technology Development Partner

"I am in favor of constantly tuning. So, I would assume that there's some things that could be done there. And certainly, when you think about a mobile phone experience, or certain experiences, you might give someone an alternative. So you might even consider two workflows. So there's a lot that you could do from a workflow and technology perspective as well, where you would just allow for people to choose into their experience a little bit more." -Help@Hand Technology Development Partner

Self-assessment

Content and design

Successes

Non-MCBH Provider Perspectives

"I believe I saw in there that it was around 50 or so questions, and depending on your response to... I think one of them, if it was related to any traumatic event, then, there would be additional questions. I think it's very thorough. I don't remember it being too long of a process to take, because it was multiple choice, so it was pretty straightforward." -Non-MCBH Provider

Challenges

MCBH Key Informant (KI) Perspectives

"... at what point do you just start answering questions to get done and start... You might start thinking about things very considerably taking your time and how you're going to answer it. And at what point do you start jumping through it quicker so you can get to the end?" -MCBH Administrator

Help@Hand Technology Development Partner Perspectives

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"I think it's pretty self-explanatory. I think the only barrier may be just the number of questions. We see there are some people who start the assessment and may not finish it. That could be for a variety of reasons. But I think this day and age, people have short attention spans. So maybe that is a slight barrier. But we've seen a large number of people coming to the site and finishing the assessment, so it doesn't seem like that's that big of an issue for people." -Help@Hand Technology Development Partner

"I know it can be long, but I think if someone is at a place where they're feeling pretty serious about finding mental health support, then I think it is also a manageable length. It's not excessive and it's not something you're going to have to sit down and take an hour to do, though it might take a person that amount of time if they're really being thoughtful about their answers and they're also not digitally savvy, but otherwise, someone who has digital savvy and is being thoughtful can probably get through it in 20 minutes and some people get through it in less than 10 minutes. So, I think there is a barrier to the length of it, but I think the benefits outweigh that barrier so that people can actually get the information that they need. There's a lot of work done to narrow down and decide what screeners were going to be used, what scales were going to be used, and whether it's comprehensive enough or too short or too long. So, I think we struck the balance that was best for the setting." -Help@Hand Technology Development Partner

"I can speak to the overall user workflow. The length of the assessment is pretty long. And so, that's something that we were aware of, and we talked about from a user experience perspective, "Could the length be shortened even more than it was?" It does use branching logic and things like that to keep it as short as possible. If you're not a woman, or you're not pregnant, there are certain sections of questions that you don't have to answer. So, I think that, there's some opportunities there." -Help@Hand Technology Development Partner

Results

Content and design

Successes

MCBH Key Informant (KI) Perspectives

"So if the results are saying you're at higher risk of depressive disorder, then here's what that means and here's the resources that might help you be that self-help, be that psychoeducation or be that linkage to a community organization that could further make that determination or provide some support around that." - MCBH Administrator

"I like the balance that we were able to come up to…Community resources and availability of those resources change a lot. And so I think for the health of the website and of the screening tool, being able to add accurately and adequately direct somebody to where they can go, especially if they want to follow up with some actual help. So if they're not wanting to just use self-help resources or just learn more about their diagnosis, but where if they want to go to us or go to a community-based organization." - MCBH Administrator

Help@Hand Technology Development Partner Perspectives

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"Well, I was highly involved in the design of it. And so, part of it is trying to step away and say, "Could this have been done differently or better? Or could it be done differently or better over time?" I think the number of resources available within the county and the ability to filter on them is quite impressive. It's a really nice set of resources. And it's really well organized from my perspective. But, it may or may not always be provided to the user at the right time…if there's any way to potentially look at what information is made available to users and try to simplify it down." -Help@Hand Technology Development Partner

Challenges

MCBH Key Informant (KI) Perspectives

"And so every individual that's coming through our doors…anybody coming into initiating services with us is given this screening tool that the state has implemented, which very quickly scores the client and makes a determination whether or not the assessment should be followed up through the mental health plan, which is us or through the managed care plan, which is not us. So it lined up with something from that was being implemented by the state. And so I think that in some ways made it, the screener a little even less applicable to our workflow. Still a good use of for the community to have something community facing again, that points people on the direction of self-help resources or community resources or just psychoeducation around mental health and wellness. But in terms of our own practical usage of the results of the screening tool made it a little less applicable." - MCBH Administrator

Non-MCBH Provider Perspectives

"...if you scroll down, areas you're doing well, areas of concern, what to do next, but I think there's just so much going on in that what to do next. It does have to come from here, but it's probably just has to be reorganized so it's very clear." -Non-MCBH Provider

Help@Hand Technology Development Partner Perspectives

"I think the area, and this is something we're going to do in general at CredibleMind, which will help with this, is the questionnaires themselves are a little old school; the radio buttons and the things could be a little more Typeform-like, if you've ever done a Typeform survey, where things just float up and you answer them and they keep floating. Anyway, I think the UI could be improved there, but I don't think that's been a blockage to it being used." Help@Hand Technology Development Partner

Suggestions

Non-MCBH Provider Perspectives

"We have so many three letter numbers. Not three, help with three letters or digits… But we're not telling people what these numbers are for…I think that stuff should be also included on here somewhere." -Non-MCBH Provider

"Yeah. It's hard to say because it's very difficult... I think it might be difficult for our youth, like if they don't have that in-person connection, if they're taking a quiz, and then, seeing the resources, it may take some kind of like, I guess some encouragement to go and make that step, that next step. I think the first step is very difficult to receive mental health services, or to acknowledge that something, we may need some support." -Non-MCBH Provider

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Resources

Content and design

Successes

MCBH Key Informant (KI) Perspectives

"I think the questions, the series, the way it was set up, it was easy to navigate. And I like how, based on the responses, it generated immediate resources for somebody to use…I think it was pretty accessible." - MCBH Administrator

Challenges

Non-MCBH Provider Perspectives

"Well, most people don't have a mental health provider and it's really hard to get one in this county. Actually, in most counties, it's very, very difficult." -Non-MCBH Provider

"Actually, for my program in particular, Interim has a lot of programs, but mine is one of the few that does not require a referral to get in. We have a drop-in component. I think listing us as a resource on that final page that tells you the results, like, "Maybe you have this. This is the number you can call for access. Here are some community resources." I think that might be helpful." -Non-MCBH Provider

"Well, we're a hospital, so I think people know when to access the services. We're not a community provider, we're a hospital, so I don't think there's anything that they could do." -Non-MCBH Provider

Help@Hand Technology Development Partner Perspectives

"...other than that we don't, like some people are clicking on things but we don't really know what. No one has really let us know how the experience has been or if people are using it to look up services and stuff in their community." -Help@Hand Technology Development Partner

Suggestions

MCBH Key Informant (KI) Perspectives

"...I like the balance that we were able to come up to. One of the things that I think is... community resources and availability of those resources changes a lot. And so I think for the health of the website and of the screening tool, being able to add accurately and adequately direct somebody to where they can go, especially if they want to follow up with some actual help." - MCBH Administrator

"... In my view, I don't know if it needs to be improved. I was looking at one thing today though where there was a lot of, it's like 50% of people that have taken it have kind of signified having a mild risk for an eating disorder. I was like, that seems really high. But then again, I don't know. I'd have to look back at the questions. But in America, we're known for eating a lot. So maybe. Again that's the thing where it's like I'm considering myself relatively fit and healthy, but my BMI is above where it should be. So it's like, I don't know. Who am I to challenged the validated

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scale? I don't know. If as a group we wanted to say, "Hey let's recalibrate this to push that risk scale up higher so not so many people trigger being at risk for something that they feel are not." Sure, if it's a team decision, but I don't know. Yeah, I just don't know how much weight to put in those critiques." - MCBH Administrator

"It might be interesting to think about do we separate the SUD from the mental health? And I know we're not supposed to do that as we're moving towards more integration between substance use disorder and mental health treatment. But in terms of what somebody might want to get information on. Usually people that are using substances know that they are and they'll know what they're using and they'll know why they're using it. Now, if you were filling this out on behalf of somebody else, maybe that might be helpful for you to get an understanding… But for yourself, you tend to know what your problems are, whether or not you're willing to admit them or not. So it may be worth-" - MCBH Administrator

"What should be there is for Medi-Cal recipients should be what used to be called Beacon Health Strategies, which links to the managed care plan provider network. They're now called Carelon…" - MCBH Administrator

Outreach and communication

MCBH Key Informant (KI) Perspectives

"The Google ads were surprisingly good. And in our last data review, we saw when they were turned down and then they got turned back up. It'll be interesting to hear the reaction of this other level of promotion." -MCBH Administrator

"Well, what I like about our approach is we're asking the experts to come up with their ideas. I'm not. So that's why it's good to talk to the communications and the outreach people. They know how to reach people better than I do. And so I like that part of the project, as we're asking the clinicians for clinician input, and we're asking the marketing people for marketing input. It's important to, not keep everybody in their lane, but listen to those who have the expertise over others." -MCBH Administrator

"It seems like the digital advertising has gone well and I guess the social media. And then that's kind of the extent of what's happened. And there's also the bus ads that have gone out…And then all the stuff that we're trying to do right now with getting tablets out into the world or I guess we've done the advertorials and other stuff. I just don't have the data to show if it's worked or not. Yeah, it's just hard to track…So most of us are on computers all the time, so I think the digital Google ads is pretty good." -MCBH Administrator

"In my view, I think the user consumption of the tool was pretty good. The user count just in that first month and a half was really good." - MCBH Administrator

"Well, part of it is we have the stock pile of print materials that need to go out and dropped off. And so I've been working with our prevention manager and getting input from others on where to drop those off. And I need to come up with basic communication plan for it too and do that like asap. But again, it's hard just because there's so many competing priorities. It's been hard me to get out the door and go do that. But I think that's probably part of the process is go on this countywide tour to all these agencies and drop off print materials and have that direct engagement would be good." - MCBH Administrator

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"One thing that I was expecting to see that I didn't see would be some pamphlets or posters that we could put in our clinic lobbies. So again, we're not advertising that somebody do it that's already our client, right? Or somebody that's already come in the door, but that doesn't mean that these individuals don't, shouldn't be made aware that it is available to them or to people that they may know. And so I think having some more visibility in our clinic sites, in primary care physician clinics, that's where I think that would be helpful in terms of visibility and actually getting the word out that this is something that's available to any community member." - MCBH Administrator

Help@Hand Technology Development Partner Perspectives

"...things seem to be going very well with the different marketing that has been going on. It seems to be starting to really take life within the community. A lot of people are using it. A lot of people who go to the site are actually going through the screener. I think it's really successful that we've been able to do marketing in both English and Spanish and use a lot of different avenues to present that information." -Help@Hand Technology Development Partner

Challenges

MCBH Key Informant (KI) Perspectives

"I think possibly not having the marketing dialed in yet, because we're going to do a two-phase approach. And I thought everything was going to be in place to do that… And so when I came back, nothing had happened. I was like, oh, thought we were going to have our hard launch by now. So I think if anything had gone wrong, I think it just would've been the marketing wasn't totally figured out yet." - MCBH Administrator

Needs of vulnerable populations

Help@Hand Technology Development Partner Perspectives

"Also, I think a big thing is about marketing to people who are monolingual Spanish speakers, because at least the data shows, especially from my experience in Monterey County for a couple weeks during the validation process, there are a lot of Hispanic people that speak English there. So, that may be less of a barrier to them." -Help@Hand Technology Development Partner

Users and resources

MCBH Key Informant (KI) Perspectives

"Some people, if this is their early step, they may not be ready to talk to somebody, but they'll go ahead and watch a video to try and help them through what they're dealing with." - MCBH Administrator

Help@Hand Technology Development Partner Perspectives

"We are finding users…give the assessment 90% plus thumbs up; they love it, but less than 20% of users are actually clicking on a resource, I think it's higher in the separate resource area, but coming out of the screener. So it means they're happy just to have read their report, and it may be because they were low-risk or moderate-risk for everything…But I think there is still the

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challenge of how to do a better job of getting users to actually follow through with the resources, so not only just click on them but call the phone number or whatever's needed there."
-Help@Hand Technology Development Partner

Results integration

MCBH Key Informant (KI) Perspectives

"I don't know if anybody's going to walk in with their code number and say, "Hey, I'm here." We haven't heard it yet. You would think we would've heard it by now." - MCBH Administrator

Help@Hand Technology Development Partner Perspectives

"It would be nice if, I think, the Access Clinics were using the codes that people have a little bit more. I think that's been one of the challenges, is I think we expected that piece of it to go a little bit smoother than I think it has." -Help@Hand Technology Development Partner

"So I think we tell users they could share their results code and that could be a way for whoever they're sharing with to see their results on their own time. So yeah, I think maybe it's a little tool tip help things… we don't really know what people are doing, what their results or what they're doing after. And so for the people who are sharing them, it would be good to hear how that process is and what made them want to share their results." -Help@Hand Technology Development Partner

Users/clients and providers

MCBH Key Informant (KI) Perspectives

"I think if anything, if there's an area for improvement, it's still just connecting people to the right resource. I think that's still something we hopefully can iron out better before the time is up. And specifically, there's kind of always a default on the results page to call Behavioral Health Access… It seems like it's almost like a default thing of just there's always the icon to call behavioral health. If it's mild to moderate, maybe don't have that icon there to click…I think that's just important because part of the problem we've had is everybody coming to Access and Access having to then refer out to a lot of different directions and it just eats up their time and sort of stresses them. And so I feel like somebody goes through this thing and basically nothing comes up is moderate to severe and yet they're told to call Behavioral Health Access. I feel like it'd be nice if that wasn't the case." - MCBH Administrator

"This is just my opinion, but I think if it's indicating anything above moderate, maybe there's a way to have it show the local help. But for where it's mild to or none to mild, maybe it should just show the self-help resources, if that makes sense." - MCBH Administrator

"I think it would be fascinating for some of our user group, if you're able to talk to them, if they have some suggestions about what the experience is like at the end of the survey." - MCBH Administrator

Non-MCBH Provider Perspectives

"...Too many popups at this point. Sorry. I know it's very helpful for you guys, but yeah, I'm thinking about my clients trying to get to something…" -Non-MCBH Provider

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"if you scroll down, areas you're doing well, areas of concern, what to do next, but I think there's just so much going on in that what to do next. It does have to come from here, but it's probably just has to be reorganized so it's very clear." -Non-MCBH Provider

"There's so many resources that are listed on the Monterey County Behavioral Health website. There's so many opportunities where we could continually link back to this that just need to be updated." -Non-MCBH Provider

Help@Hand Technology Development Partner Perspectives

"I think it would require more of a needs assessment around with those people and determining either what from our results page is the most relevant information to you. How can we get that to you more directly, or again, is it more just about you're happy that we're getting people to your front door and that's it and the results are not as relevant once they get there?" -Help@Hand Technology Development Partner

"We do have that thing that we've added recently for the focus groups, so we've added that in for people to opt in to maybe be a part of some of those focus groups if they would like, which I know some people have started filling that out, which is great. So maybe we could continue doing things like that, if Monterey would like to speak to individual users. We don't want people to like...Yeah, we want people to come to the site and be able to use it anonymously." -Help@Hand Technology Development Partner

"... outreach is a really big part, certainly in education around the availability of this piece, the potential that someone could come across their doorway or call them and have already been using it. Or, someone could be given access to it on an [tablet] or something like that within that agency area." -Help@Hand Technology Development Partner

"... I think it's just always about improving user experience as technology modernizes and making sure that we are just staying on top of new capabilities and ways that people use technology." -Help@Hand Technology Development Partner

Additional resources

MCBH Key Informant (KI) Perspectives

"At the end of the day, end of the year, whatever, that's going to be Monterey County team that's going to have to do that. We talked about that way back when, at the early part of the project…Because phone numbers change, and people change, and things change. So yeah, I don't know. Monterey County, what frequency? I would think every six months. I think that's what we said before. But putting that on somebody's calendar to make sure it gets done, we haven't done that." - MCBH Administrator

Non-MCBH Provider Perspectives

"...I think just an all-inclusive, not only it meets the needs of mental health services, but it can also help with housing or it could also help with other areas." -Non-MCBH Provider

"I like the way that the results are done because it tells you what you're doing really well at that. Then it shows you what it is that you need to work on and how to work on it, who to go to. We

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have so many three letter numbers. Not three, help with three letters or digits…But we're not telling people what these numbers are for…I think that stuff should be also included on here somewhere." -Non-MCBH Provider

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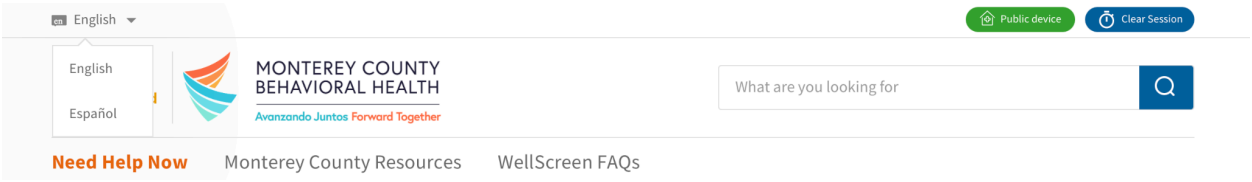
Appendix E: WellScreen Monterey website photos and marketing materials

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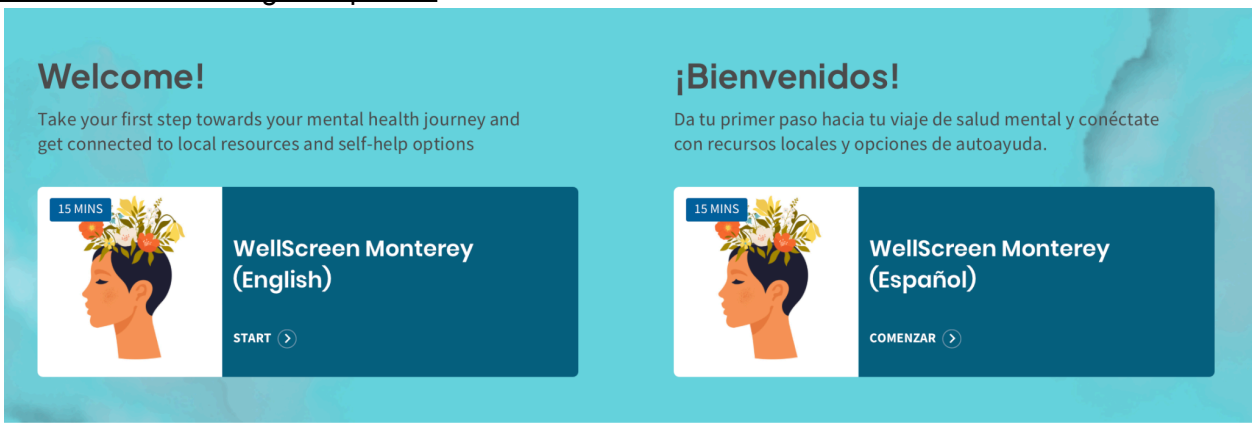
- WellScreen Monterey website: pg 160
- Marketing materials: pg 163
- Social media materials: pg 166

WellScreen Monterey website photos

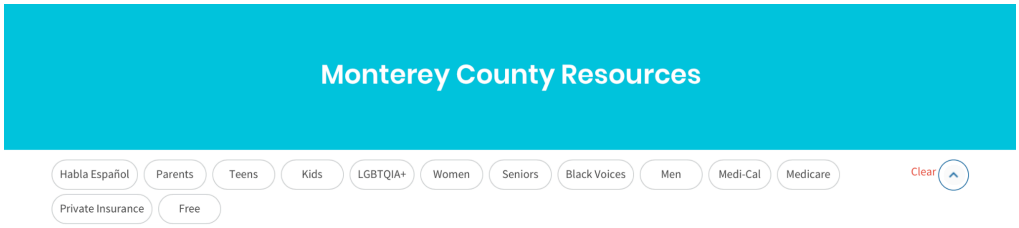
Welcome screen header: English & Spanish Option, Public Device, and Clear Session



Welcome screen English/Spanish

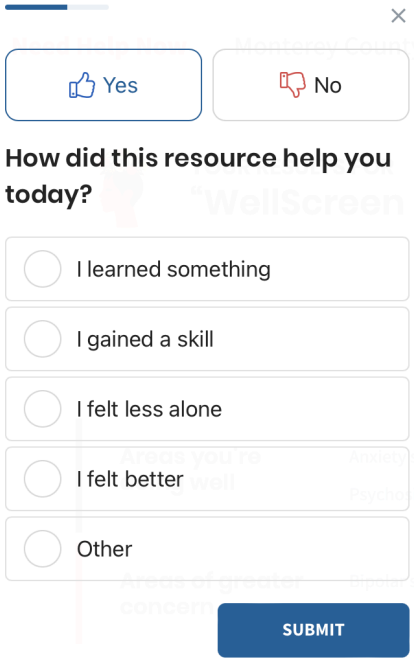


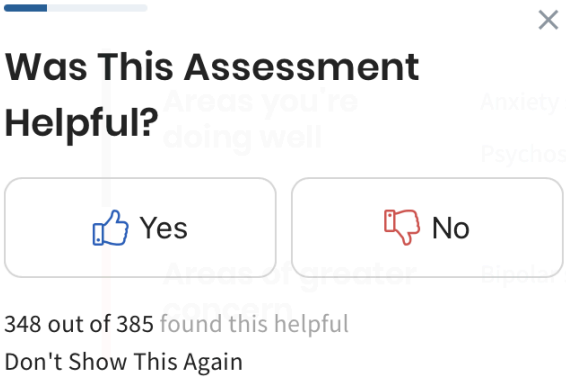
Resource filters



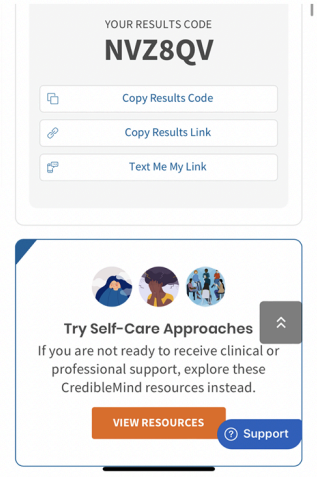
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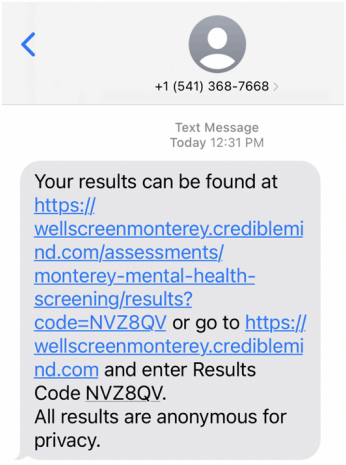
Feedback pop-ups on Results page





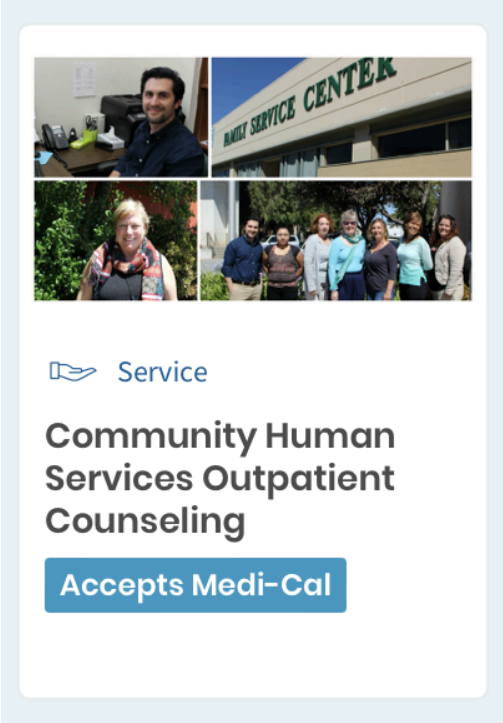
Text message example



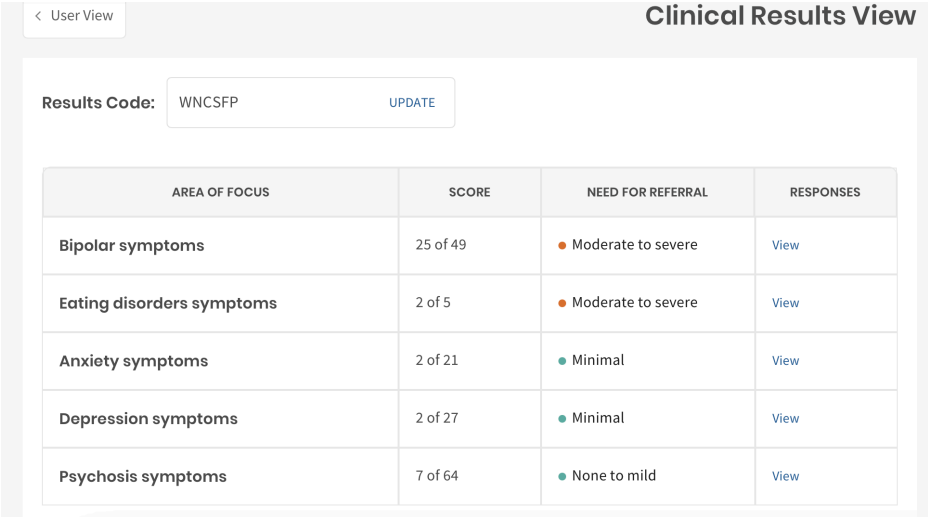


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Accepts Medi-Cal Example



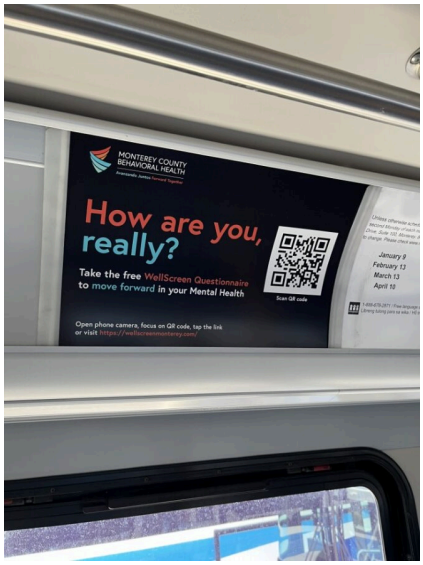
Clinical Results View Example



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Marketing materials

Bus advertisements



Mock-up advertisements



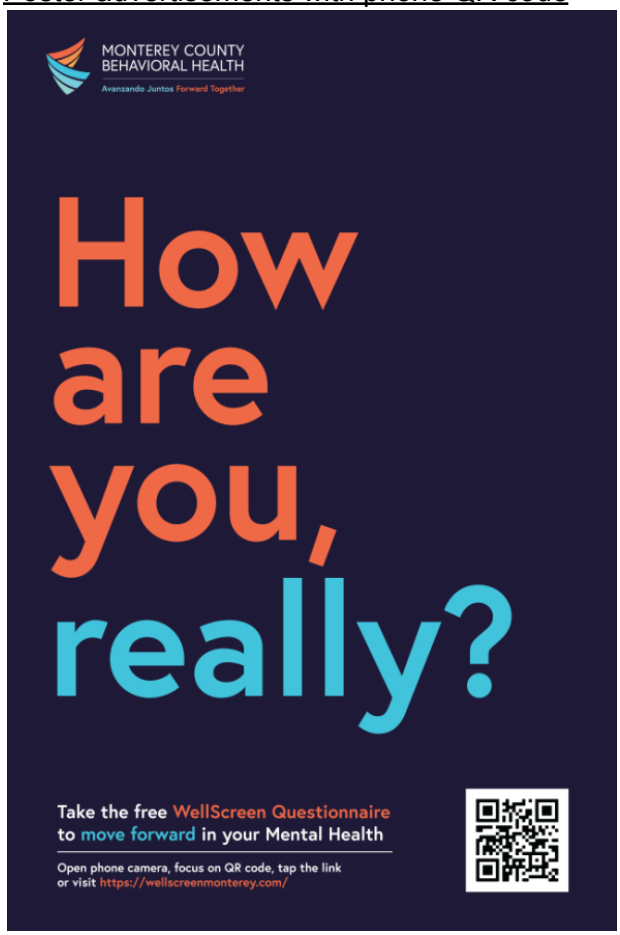


Business card with QR code



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Poster advertisements with phone QR code





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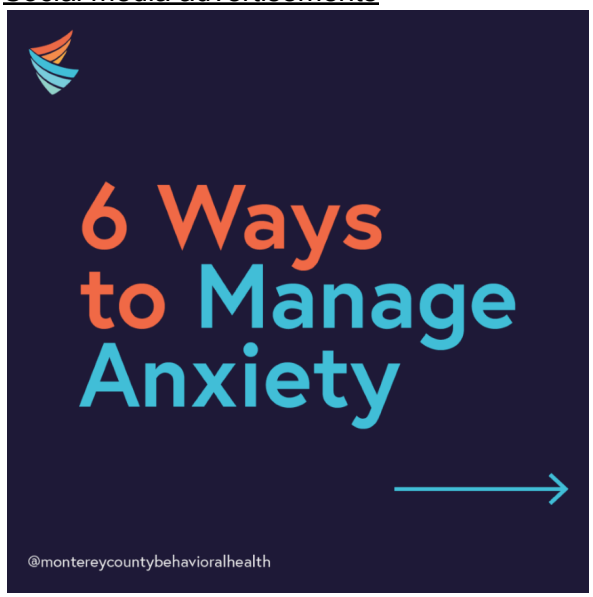
County website advertisements





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Social media advertisements







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Social media advertisements



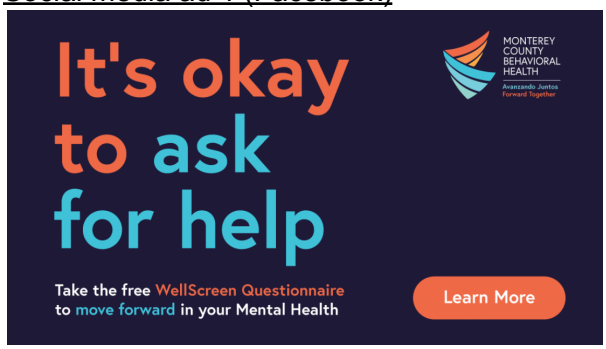






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Social media ad 1 (Facebook)



Social Media ad 2 (Facebook)



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MONTEREY COUNTY BEHAVIORAL HEALTH

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Appendix VI:
MONTEREY COUNTY MENTAL HEALTH SERVICES ACT FY 2024-25 DRAFT ANNUAL UPDATE

PUBLIC COMMENTS

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Public Comments Received

No.	Comment
1	**Good afternoon Shannon,** **My name is Kalyssa King and I am the Community Impact Director of Information, Referral, and Partner Development at United Way Monterey County. I wanted to reach out to thank you for Monterey County Behavioral Health Department's past support of 211 Monterey County and the Smart Referral Network. These programs are critical for information and referral, getting community members connected to the services they need. We look forward to future collaboration.** **Best Regards,** **Kalyssa King**

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MONTEREY COUNTY BEHAVIORAL HEALTH

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Appendix VII:
THE COUNTY OF MONTEREY MENTAL HEALTH SERVICES ACT FY 2024-25 DRAFT ANNUAL UPDATE

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Monterey County Behavioral Health Commission
Public Hearing to Approve

DRAFT
Mental Health Service Act (MHSA)
FY 2024-25 Annual Update and Expenditure Plan

MONTEREY COUNTY BEHAVIORAL HEALTH COMMISSION

JUNE 17, 2024

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MONTEREY COUNTY BEHAVIORAL HEALTH
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Monterey County's MHSA Team

Shannon Castro, MHSA Coordinator

Fabricio Chombo, Finance Manager II

Isaura Zamora, Accountant III

Wesley Schweikhard, Innovation Coordinator

and

EVALCORP

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MONTEREY COUNTY BEHAVIORAL HEALTH
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Introduction

The Mental Health Service Act (MHSA) is one of several funding sources supporting Monterey County Behavioral Health.

MHSA programs comprise nearly one-third of the Bureau's total annual expenditures.

The MHSA requires 3-Year Program & Expenditure Plans and subsequent Annual Updates for the second & third years.

Monterey County's currently approved 3-Year Plan covers the fiscal years of 2023-24, 2024-25, and 2025-26.

This Annual Update covers the fiscal year period beginning July 1, 2024, through June 30, 2025.

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30-Day Public Review Period

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Posting and Announcement for public review on May 16, 2024

→

Public Comment will close on June 16, 2024**, at 5 pm**

→

Posting: Health Department, 1270 Natividad Rd., Salinas CA

Public Announcements via: County of Monterey **website, and mass e-mail to community partners and stakeholders.**

→

Received Public Comments: No Public comments have been received. If any public comments are received MCBH will share with the BH Commission .

- The Commission will review the FY 24-25 Annual Plan for approval during the June Special Meeting.

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Annual Community Program, Planning Process (CPPP)

Between October 2022 and March 2024 Provider and Community Member Outreach (English/Spanish)

Printed & Online Surveys Stakeholders and Community Members

48 distinct distribution channels
906 community responses
95 stakeholder responses

Focus Groups Community Members

Eight populations:
1) Unhoused, 2) African American Males,
3) Veterans, 4) LGBTQ+,
5) Individuals affected by the 2023 floods,
6) Early childhood caregivers,
7) individuals who live in South County, and
8) the Indigenous community.

Focus groups and Interviews Stakeholders

4 focus groups and 1 interview were conducted with 39 participants

Listening Sessions

A total of 110 community members participated in 4 Listening Sessions.

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Summary of Findings and Implications for Prevention and Early Intervention Programs

- There is a high need for mental health services for anxiety, chronic stress, depression, and alcohol and substance misuse.
- There is a substantial impact from financial insecurity, childhood trauma, and homelessness on residents' mental and behavioral health.
- There are continued challenges to accessing services including stigma, lack of knowledge about available services, transportation, and limited services in rural regions.

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The Annual Update was written based on all input received

Adopted general trends and details as received during the Community Program Planning Process

- Supporting currently successful MHSA programs
- Applying public input into new or existing programs where applicable

Incorporated specific programmatic guidelines as detailed by the State regulations

Funding amounts are based on forecasted budget levels made at the time of plan generation



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MHSA Component Overview

MONTEREY COUNTY BEHAVIORAL HEALTH
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Community Services & Supports (CSS)

- 76% allocated to CSS
- Up to 20% of the five-year average can be transferred to WET, CFTN, and PR.
- 3 years to spend funds before they are reverted to the State
- Funds must be spent in accordance with Three-Year Plan

Prevention & Early Intervention (PEI)

- 19% allocated to PEI
- 3 years to spend funds before they are reverted to the State
- Funds must be spent in accordance with Three-Year Plan

Innovation (INN)

- 5% allocated to INN
- 3 years to encumber funds with project and the life of the project to spend funds before they are reverted to the State
- Funds must be spent in accordance with Three-Year Plan

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Community Services & Supports (CSS)

Changes to the Three-Year Plan

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Three-year Plan Total CSS Program Estimated Expenditures: $87,478,930
(FY 23-24 $39,359,846; FY 24-25 $23,667,581 - $38,366,433; and FY 25-26 24,451,503)

- Serve individuals with severe mental health illness and their families.
- Services must be community-based, recovery-oriented, culturally competent, and **voluntary.**
- **50%** of CSS funds must be allocated to Full-Service Partnerships.

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Prevention & Early Intervention (PEI)

No Significant Changes to the Three-Year Plan

Three-year Plan Total PEI Program Estimated Expenditures $21,814,902

(FY 23-24 $7,963,782; FY 24-25 $6,918,258 – $6,701,353; and FY 25-26 $6,932,862)

- Designed to prevent mental illnesses from becoming severe and disabling
- Must include at least one program focused on: **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
- **51%** of PEI funds must be allocated to serving individuals 25 years old or younger

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Innovation (INN)

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No changes to the Three-Year Plan

Three-year Plan Total INN Program Estimated Expenditures $8,537,170

FY 23-24 $3,423,896; FY 24-25 $2,684,704; and FY 25-26 $2,428,570

- Novel, creative, and/or ingenious projects
- Designed to contribute learning about effective approaches to providing mental health services
- Can only be funded on a one-time basis and are time limited.

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Other components

Capital Facilities and Technological Needs

- Can be used to fund technological and capital facilities.
- Can be used to fund the acquisition and development of land and buildings.

Workforce Education and Training

- Can be used to fund education and training programs for prospective and current Public Mental Health System employees as well as contractors and volunteers.

Prudent Reserve

- A requirement to ensure services can be provided at current levels in the event of an economic downturn.

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Public Comments Received

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

06/13/24	**Good afternoon Shannon,** **My name is Kalyssa King and I am the Community Impact Director of Information, Referral, and Partner Development at United Way Monterey County. I wanted to reach out to thank you for Monterey County Behavioral Health Department's past support of 211 Monterey County and the Smart Referral Network. These programs are critical for information and referral, getting community members connected to the services they need. We look forward to future collaboration.** **Best Regards,** **Kalyssa King**

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Questions?

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MONTEREY COUNTY
BEHAVIORAL HEALTH

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Appendix VIII:
The County of MONTEREY
MENTAL HEALTH SERVICES ACT
FY 2024-25
DRAFT
ANNUAL UPDATE

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Monterey County Behavioral Health Commission (BHC)
Draft Action Meeting Minutes

Jeff Wardwell, Chairperson
Derrick Elder, Chairperson-Elect

Thursday, June 17, 2024 5:30 PM Health Department – Whitney Rooms
1270 Natividad Rd, Salinas, CA

Quorum Met: ☒ Yes ☐ No *Excused Absence

District	Commissioner	Commissioner	Commissioner
1 – *Alejo*	☒ Jeff Wardwell	☐ Carissa Purnell	☐ *VACANT*
2 – *Church*	☒ Alma McHoney	☒ Terri Larson	☐ *VACANT*
3 – *Lopez*	☒ Claudia Gomez	☒ Mark Lopez	☒ Cathy Gutierrez
4 – *Askew*	☒ Derrick Elder	* Regina Palmer	☐ *VACANT*
5 – *Adams*	☒ Linda Fosler	☐ *VACANT*	☐ *VACANT*
Law Enforcement	☐ *VACANT*		
BOS Member	☐ Luis Alejo, District 1	☒ **Alt**: Wendy Askew, District 4	

Staff:	Shane Strong, Katy Eckert, Shannon Castro, Wesley Schweikhard, Isaura Zamora, Melanie Rhodes, Jessica M. Ramirez, Lara Clayton,
Guests:	Sara Cervantes Weber (Spanish Interpreter), Jill Allen, Kalyssa King, Charles Carman, Colleen Beye, Francine Rodd, Kontrena McPheter

1. CALL TO ORDER

Meeting was called to order by Chairperson Wardwell at 5:35 PM.

2. ANNOUNCEMENTS

Attendance was taken to determine quorum — Quorum established, *see above*.

Spanish Interpreter present and announced Spanish interpreter services.

3. ADDITIONS AND CORRECTIONS TO THE AGENDA

Call for Additions/Modifications to the Agenda — *None*

4. PUBLIC COMMENT

None.

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5. PUBLIC HEARING AND APPROVAL OF THE DRAFT FY 2024-25 MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL UPDATE AND EXPENDITURE PLAN

Public hearing held on the Draft FY 2024-25 MHSA Annual Update and Expenditure Plan, presented and led by Shannon Castro, MHSA Coordinator.

Motion to approve by Comm. Lopez; Seconded by Comm. McHoney — *Approved*

Aye: Wardwell, McHoney, Larson, Gomez, Lopez, Gutierrez, Elder, Fosler, Askew
Nay: None
Abstain: None

Public comment was opened and received.

6. ADJOURN

The meeting was adjourned at 6:45 PM.

DRAFT