MONTEREY COUNTY
BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

Mental Health Services Act
FY 2025-26
Annual Update

FINAL

Table of Contents

Introduction

Monterey County Behavioral Health (MCBH) is pleased to present this Mental Health Services Act (MHSA) Fiscal Year 2025-26 (FY25-26) Annual Update. This is the second 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 2024-25 data are included in Appendices II through VII.

In June 2023, the Monterey County Board of Supervisors approved the FY23 – FY 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 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 FY25-2 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 as well as its fertile Salinas Valley that is dubbed the "Salad Bowl of the World." With a total population of 445,229, and land mass area of 3,281 square miles, much of Monterey County is sparsely populated and rural, with most development being clustered at the northern end of the Salinas Valley and toward Monterey Peninsula on the coast. The City of Salinas is the County seat and its largest city, as well as the hub of the agricultural sector of the economy. Monterey County is the third largest agricultural county in California, supplying the second-most jobs in the county. Educational services, including healthcare and social assistance are the leading sectors for employment in the county, with tourism-based services, professional, and construction industries also playing significant roles in the local economy. Monterey County is also home to three Army bases, a Coast Guard Station, the Defense Language Institute, and the Naval Postgraduate School.

The Four Regions of the County

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

Age & Gender

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

Ethnicity, Race & Language

Most Monterey County residents are Hispanic/Latino, comprising of 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, and estimated 128,954 or 30% of the total population are foreign-born population, 79% are of Hispanic or Latino origin, and 72% are not current U.S. citizens.

Spanish is the most common language spoken at home (50.4% of households in Monterey County). English is the preferred language in 43.4% of households, while 3.3% prefer Asian or other Pacific Islander languages, 2.3% prefer an Indo-European language, and less than .6% speak an Other Language.

Individuals with Disabilities

Individuals with disabilities represent 9.7% of County residents.

Veterans

Veterans comprise 4.6% of the total population in the County.

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

Monterey County has a total of 144,403 housing units, with 51.7% owner-occupied. The housing market in Monterey County has seen dramatic increases, making homeownership and long-term housing stability unattainable for many residents. The average home value rose by 44.5%, from $569,068 in 2018 to $822,837 in 2023, and then surged by 56.6% to $1,289,000 in March 2024. During the period from 2019 to 2023, the median income in the county was $94,500.

In terms of housing affordability, like many coastal regions in California, Monterey County has a high cost of living relative to income. Nearly half (45%) of the county's 49% of renters spend more than 37% of their household income on rental costs. Additionally, 32% of homeowners face mortgage costs that exceed 35% of their 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 The Coalition of Homeless Services Providers found there are approximately 2,436 individual who are homeless in the County.

Homelessness Data

The biennial 2024 Monterey County Homeless Census “Point in Time” (PIT) homeless count and survey found 2,436 persons experiencing homelessness during the 2024 count. The 2024 count is a 19% increase from the 2022 PIT. The majority 77% (1,883) 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 24% (533) of the population resided in either 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; 23% of survey respondents indicated their current episode of homelessness is their first, with 77% of respondents reported the duration of their current episode of homelessness at one year or longer. The next PIT will be conducted in January 2026; the Report is not available at this time.

Community Program Planning Process (CPPP)

Introduction

Monterey County Behavioral Health (MCBH) conducted the Community Program Planning Process (CPPP), a collaborative initiative that allowed residents and stakeholders to actively share their input and feedback. This collective effort guided the development of the draft Mental Health Services Act (MHSA) fiscal year 2025-2026 Annual Update.

To assess the behavioral health needs of the Monterey County community as part of the CPPP, MCBH partnered with EVALCORP, a respected evaluation firm. The objectives of this assessment, which

included invaluable insights from community members and stakeholders, were to enhance the effectiveness of the behavioral health system, improve access to care and services, and reduce health disparities for all communities in Monterey County.

EVALCORP utilized a comprehensive mixed-methods approach to ensure that all community members and stakeholders could participate in the assessment process, regardless of their background or role. Community members were engaged through a community survey and a series of focus groups, while stakeholders—defined as providers of behavioral health services and those who connect individuals to these services—participated through a stakeholder survey and focus groups. Additionally, listening sessions were held throughout the county to present the findings to the community and CPPP participants, as well as to gather feedback on both the process and the outcomes of the CPPP.

Community Engagement

Community engagement was achieved through three strategies: a community survey, community focus groups, and community listening sessions. Recognizing the critical role of community engagement in understanding and addressing behavioral health issues, the community survey was deployed through 80 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 507 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 in the county. Focus Group participants were recruited through system partners across Monterey County. A total of ten key populations were identified: 1) Non-English-Speaking Individuals, 2) African American Males, 3) Veterans, 4) LGBTQ+ Community, 5) Individuals Affected by Flooding, 6) Early Childhood Caregivers, 7) South County Residents, 8) Indigenous Communities, 9) Foster Families, and 10) Individuals Affected by Mental Illness. By coordinating with contacts at MCBH system partners, eleven (11) community focus groups were organized to ensure the representation of the above-priority populations. Six (6) focus groups were facilitated in English, four (4) in Spanish, and one (1) in Triqui.

Focus groups were hosted by system partners and conducted in person or virtually, depending on the participants' needs. Four focus groups were facilitated in person, and seven were conducted virtually. Notes were taken at each session. The focus groups lasted 45 to 90 minutes. Demographic data were collected from consenting participants, and each participant received a $40 gift card as a token of appreciation for their time.

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 pressing issues in the County. While Community Members acknowledged the availability of mental health and substance use services, they emphasized that existing services are insufficient to meet the community's needs. Specific service gaps were noted for fentanyl-laced fake prescription pills, schizophrenia, bipolar disorder, and opioid use disorder.

Community Members also identified significant barriers to accessing care. The top barriers included a lack of information about where to get help, limited appointment availability, mental health stigma, the cost of services, and lack of health insurance. Notably, fewer than half of respondents believed individuals with behavioral health issues could receive help within the County, with perceptions varying slightly by type of insurance. Stigma was highlighted as a persistent issue, as many Community Members, despite generally favorable views on seeking mental health support, felt that negative attitudes and beliefs about mental illness continue to prevent access to care.

Regarding communication, social media, email, and newsletters were identified as the preferred methods for receiving information about mental health and substance use services, although preferences varied by generation. To address the identified challenges, Community Members made several recommendations for improving the County's behavioral health care system. These recommendations were organized into three key areas: Workforce Development, Increasing Service Availability, and Enhancing Community Outreach and Education.

The community focus groups provided valuable insights into understanding behavioral health language related to mental health. Participants highlighted a diverse range of perspectives on this language, discussing empowering and supportive terminology, the everyday realities of mental health, and the impact of stigmatizing language.

Participants noted that economic challenges, such as financial stress, poverty, socioeconomic difficulties, and a lack of social support, significantly contributed to poor mental health. Additionally, some discussed negative social influences as factors affecting mental well-being, including bullying, substance use, and gang-related activities. Bullying was a recurring concern, with participants mentioning that schools often did not do enough to address or prevent bullying incidents involving their children.

Furthermore, some participants shared experiences of peer pressure to engage in harmful behaviors, particularly regarding substance use. One participant also raised the issue of "gang violence in some areas" as a factor impacting mental health. It's noteworthy that, although bullying was reported in the FY 2022-2023 focus groups, participants did not mention gang activity as a contributing factor to poor mental health in the previous two fiscal years (FY 2022-23 and FY 2023-2024).

Finally, discussions also included the impact of natural disasters on mental health, echoing sentiments expressed by focus group participants in FY 2023-2024. Survivors of the Pajaro flooding identified natural disasters, such as flooding, as additional contributors to poor mental health.

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 two means: 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 108 responses included in the analyses. Second, EVALCORP collaborated with MCBH to purposefully recruit diverse stakeholders within the community for the focus groups. Seven (7) focus groups were conducted with 60 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 various providers and system partners, highlighting key needs, barriers, and gaps in behavioral health services. Stakeholders identified trauma, anxiety, and chronic stress as the most significant mental health issues. At the same time, alcoholism and prescription drug misuse, particularly opioids, were noted as the primary concerns regarding substance use.

There is a noticeable alignment between these issues and the available services, such as counseling and crisis response; however, most stakeholders feel these services are insufficient to meet current needs.

Barriers to accessing care were often attributed to staffing issues, including shortages and long waitlists. Additionally, there is a knowledge gap in referring clients to services beyond Medi-Cal, indicating a need for improved training in navigating diverse insurance situations and general skepticism about the effectiveness of referrals.

Stakeholders acknowledged MCBH's efforts to improve accessibility and quality while providing a comprehensive approach to care. Recommendations from stakeholders include increasing collaboration, enhancing access to services, and improving staffing and training.

The survey revealed that although MCBH has made progress in delivering essential services, there is a clear demand for expanded training on available resources, better system navigation, and improved coordination to fully address the community's mental health and substance use needs.

In the Stakeholder Focus Groups, 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. 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

A total of 100 community members participated in six (6) listening sessions. Five (5) listening sessions were held in person, and one (1) was virtual. All listening sessions were held in Spanish, with a 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 Aligning with the community survey and focus group results, community members emphasized appointment availability, inconvenient appointment times, long wait lists, distant service locations and transportation challenges, and lack of staff who understand different cultures and are bilingual as barriers to care. Lack of culturally responsive care and language were heavily discussed as barriers to care. Community members noted that standardized mental health tools, rooted in Eurocentric norms, often failed to capture distress in diverse populations, leading to overlooked

concerns. Indigenous communities faced barriers such as a lack of Mixteco- and Triqui-speaking providers and challenges with nonwritten languages in paperwork. Additionally, some Black, Indigenous, and other racialized groups struggled with understanding mental health concepts and clinical terminology, hindering care-seeking. Stigma and religious associations with terms like "depression" and "suicide" further contributed to hesitancy in seeking care.

Stakeholders acknowledged MCBH's efforts to improve accessibility and quality while providing a comprehensive approach to care. Recommendations from stakeholders include increasing collaboration, enhancing access to services, and improving staffing and training.

The survey revealed that although MCBH has made progress in delivering essential services, there is a clear demand for expanded training on available resources, better system navigation, and improved coordination to fully address the community's mental health and substance use needs.

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 posting and distribution of the draft FY25-26 Annual Update in English and Spanish for a minimum 30-day public review and comment period.
2. A Public Hearing with simultaneous Spanish language interpretation to be conducted by the Monterey County Behavioral Health Commission.
3. The adoption of the final FY25-26 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 2024-2025 as follows:

Innovation (INN) Component:

PEI [PEI-12] funds will sustain the WellScreen project for an additional 12 months (July 2025-June 2026). This project transitioned from the Innovation project, Screening to Timely Access [INN-02] which concluded December 2023, and sustained by PEI funds beginning January 2024 for additional 18-months. The 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.

PADs [INN-05]

The PADs Innovation project will conclude June 2025. 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.

PADs Phase II [INN-05] was approved in April 2024 for a four-year term beginning July 2025 (July 2025 thru June 2029). The project will expand services to include On-site training teams for law

enforcement, first responders, crisis teams, courts, and higher education on using the PAD and accessing the web platform. Provide subject matter professionals for training videos, as requested. Identify priority populations to serve within each participating county. Partner with Peer training contractor to provide training support as needed. Continue working with the DOJ to connect the subcontractor web-based platform and the CLETS system for in-the-moment access to the PAD. Provide presentations and participate in conferences or journal articles highlighting the work of the multi-county project. Provide ongoing technical assistance to participating counties. Continued work with legislation aligning PADs language across Probate, Penal, and Welfare and Institution Codes. Provide project transparency through the oversight of the project website. Identify the sustainability of the web-based platform upon completion of the project.

RCFI Project Phase I [INN-07] will conclude June 2025. Phase I of the project includes research and 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.

RCFI Project Phase II [INN-07] will Phase II will begin July 2025 and will include the following: Educate property owners on how to integrate more culturally and linguistically responsive services into their facilities. Provide property owners with training and technical assistance related to operating a small business

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 component. MHSA funds may only be used to pay for those portions of the mental health program/services for which there is no other source of funding 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 and 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, as well as socialization and recreational activities, based upon the individual's needs and goals to obtain successful treatment outcomes. The remaining funds in the CSS component are to be used for General System Development programs that provide a less-intensive level of mental health treatment and supportive services, and often consist of peer supports, family education, wellness centers, and assistance with access to educational, social, vocational rehabilitative and other community services.

Full Service Partnerships

Early Childhood and Family Stability FSP [CSS-01]

The Early Childhood and Family Stability FSP will support programs for children and families that are designed to improve the mental health and well-being of children and youth, improve family functioning, and prevent out-of-home placement of children and youth whose emotional, social, and/or behavioral problems create a substantial risk of placement in publicly funded care, such as foster homes, group homes, correctional institutions, or psychiatric facilities. The goal of these services is to improve the

child's overall functioning within their family, school, peer group and community; reduce risk and incidence of mental health disability; and improve family well-being and functioning. Children and youth who are at acute risk for disruption in home or school placement, or loss of access to extra-curricular activities, will receive a team based, "full service partnership" (FSP) approach that includes a Child & Family Therapist and Family Support Counselor, and 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 in accordance with the FSP model.

Family Reunification Partnership, operated by MCBH, will offer a unique and innovative program model that integrates Children's Behavioral Health (CBH) therapists and Family and Children's Services (FCS/Department of Social Services) social workers into one cohesive program to help families in the reunification process. An intensive, short-term, in-home

Crisis Intervention and Family Education Program will be provided to the same population, when less intensive services are required along the continuum of care. Additional programs will be provided by contracted Partners.

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, and 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 his/her family.

Dual Diagnosis FSP [CSS-02]

The Dual Diagnosis FSP will include programs operated by a contracted service provider to support youth and young adults with co-occurring mental health and substance abuse disorders. This FSP strategy will include both an **Outpatient Program,** 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 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 also reducing symptoms of mental illness.

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.
- 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, as well as preventing out of county and locked placements.

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

For transition age youth, MCBH will work in partnership with public agencies and community partners in providing the Justice-Involved FSP's comprehensive programming to youth involved with MCBH, Juvenile Justice, and/or the Department of Family and Children Services. These FSP programs will include a **Juvenile Mental Health Court Program** in which Probation, Juvenile Court, and Behavioral Health provide supervision and support to youth and their families; and the **Juveniles Who Sexually Offend Response Team** (JSORT) program, a collaborative partnership between Monterey County Probation and MCBH to provide 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 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 who provide regionally based services to address the needs of our community. County **ACCESS clinics** function as entry points into the Behavioral Health system. These clinics are in the Coastal Region (I.e., Marina), Salinas, Soledad, and King City, providing reach in all four regions of the county. The clinics serve children, youth, and adults, and offer walk-in services and appointments to provide early intervention and referral services for mental health and substance use issues. Additional ACCESS clinics provide support specific to medication management and to 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 supports found at a **Wellness Center**, the OMNI Resource Center, 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 programs offering specialized care 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 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/or prenatal exposure to alcohol and other drugs. The primary focus is to identify, assess, refer, and treat infants, children and youth affected by the broad spectrum of developmental, social, emotional, and neurobehavioral disorders 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.

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 2023-24

For CSS Program Data covering the Fiscal Year 2023-24 period, please refer to Appendix II

Community Services and Supports Annual Report FY 2023-2024

For CSS Program Data covering the Fiscal Year 2023-2024 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 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]

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.

During the CPPP, focus group and listening session, participants identified stigma as a prominent barrier. 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 (CHW's) 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. They can help people trust service providers and county agencies by vouching for them."

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 develop capacity to provide MHFA training in all categories relevant to Monterey County and which could include Adult, Youth, Public Safety, 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 in our local CPPP. MCBH will partner with an organization that will provide education and awareness to veterans, their dependents, and survivors on entitled benefits to include mental health services available in the community. Additionally, this program will streamline the process of transitioning service members, veterans and their eligible dependents to healthcare, mental health services, education, employment, and other community-based services. This helps to promote resilience, social connectedness and other protective factors for veterans and their family members which helps to decrease risk for mental health conditions and suicide.

Student Mental Health [PEI-08]

MCBH has a very strong partnership with the Monterey County Office of Education and school districts throughout Monterey County. MCBH staff will provide training, consultation, and support to schools to develop positive school climates, understand and address behavioral health issues in students and implement state mandated district suicide prevention plans. MCBH staff located in the schools 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 emerging needs of the student population that are identified by district administrators and other relevant educational staff. Psychoeducation and training will be provided to educational staff to support trauma informed education practices and wellness for educators.

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 in 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 risk for 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 play groups 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 provided 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 network and decrease stigma through shared experiences. A primary goal will be to increase group participants' knowledge and understanding of how being attuned with their child's cues positively impacts bonding and attachment. Additionally, the groups will incorporate culturally attuned healing practices that support women and families during the perinatal period.

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 wellbeing.

Peer support programs and therapeutic treatment for addressing Maternal Mental Health will be provided by community-based agencies through staff and peers who reflect the racial, ethnic, and cultural groups that make up 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/or 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.

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 to achieve goals noted above of raising awareness, decreasing stigma and building connections so 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.

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 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”).

Prevention & Early Intervention Three-Year Report for Fiscal Years 21-22, 22-23, and 23-24

For PEI Program Data covering the Fiscal Years 2021-22, 2022-23, and 2023-24 period, please refer to Appendix III

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

Residential Care Facility Incubator [INN-04]

On November 1, 2021, the MHSOAC approved the Innovation Plan for the Residential Care Facility Incubator project. This approved Innovation project will support continued research and planning efforts to develop an actionable implementation plan to support culturally and linguistically responsive residential care facilities for severely mentally ill adults enrolled in MCBH services who are homeless or at-risk of homelessness. The total approved budget for this Innovation Plan is $792,130, with a timeline of 2 years to complete all necessary research and planning activities necessary to deliver an implementation plan that will be subject to additional hearing by, and approval for the County's continued use of Innovation funding, through the MHSOAC.

Psychiatric Advance Directives [INN-05]

On June 24, 2021, the MHSOAC approved the Innovation Plan for the Psychiatric Advance Directives Multi-County Collaborative project. This approved Innovation project supports Monterey County in participating in a multi-county collaborative to develop and pilot the use of Psychiatric Advance Directives (PADs). The use of PADs is intended to be a tool for individuals experiencing a mental illness in be afforded self-directed care when they are engaged with medical, emergency response and law enforcement personnel during times of crisis. The total approved budget for Monterey County's participation in this Innovation project is $1,978,237, with a timeline of 4 years for completion.

Rainbow Connections [INN-07]

On May 25, 2023, the MHSOAC approved the Innovation Plan for the Rainbow Connections project. This approved Innovation project aims to 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 the age of 25, and their families. Integral to this interagency collaboration is an adapted version of the evidence-based Positive Behavioral Interventions and Supports (PBIS) model, to create a continuum of

care that may improve the capacity of adults, caregivers, providers and systems responsible for the growth and well-being of LGBTQ youth, specifically by increasing their ability to identify the mental health needs of LGBTQ youth and promote their access to appropriate care. The total approved budget for the Rainbow Connections Innovation Plan is $7,883,562.86, with a timeline of 5 years for completion.

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.

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.

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 FY23-24 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 FY24-25. These transfers will not fully fund these planned projects. Additional funding streams will be required and sought.

FY 2023- 2024 Budget Narrative

This FY 2024-2025 Annual 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.

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: 4/2/2025

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. Actual FY 2023/24 Funding						
1. Actual Unspent Funds from Prior Fiscal Years	0	5,735,577	6,872,530	797,049	5,866,626	0
2. Actual New FY 2023/24 Funding	32,270,665	8,200,895	2,222,340			
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. Actual Available Funding for FY 2023/24	28,126,912	13,936,472	9,094,871	1,797,049	9,010,379	
B. Actual FY 2023/24 MHSA Expenditures	27,701,043	9,252,845	1,432,520	1,788,646	142,603	
C. Estimate FY 2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	425,869	4,683,628	7,662,350	8,403	8,867,776	0
2. Estimated New FY 2024/25 Funding	32,824,086	8,206,022	2,159,479			
3. Transfer in FY 2024/25	(3,479,731)			1,850,000	1,629,731	
4. Access Local Prudent Reserve in FY 2024/25						
5. Estimated Available Funding for FY 2024/25	29,770,224	12,889,649	9,821,830	1,858,403	10,497,507	
D. Estimated FY 2024/25 MHSA Expenditures	24,061,801	5,603,789	2,684,704	1,851,650	2,990,000	
E. Estimate FY 2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	5,708,423	7,285,860	7,137,126	6,753	7,507,507	0
2. Estimated New FY 2025/26 Funding	24,012,984	6,003,246	1,579,802			
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	27,004,573	13,289,106	8,716,927	1,006,753	9,224,341	
F. Estimated FY 2025/26 MHSA Expenditures	17,602,794	5,615,619	2,995,872	999,848	7,475,000	
G. Estimated FY 2025/26 Unspent Fund Balance	9,401,779	7,673,488	5,721,055	6,905	1,749,341	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. Estimated 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. Estimated 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. Estimated Local Prudent Reserve Balance on June 30, 2026	4,795,236

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Monterey Date: 4/2/2025

Community Services and Supports (CSS) Component Worksheet

Fiscal Year 2023/24

		A	B		C	D	E	F
		Actual Total Mental Health Expenditures	Actual CSS Funding	Actual MHSA IGT	Actual Medi-Cal FFP	Actual 1991 Realignment	Actual Behavioral Health Subaccount	Actual Other Funding
FSP Programs								
	Early Childhood and Family Stability FSP (CSS-01)	4,036,050	3,019,834	268,763	723,325	0	0	24,127
	Dual Diagnosis FSP (CSS-02)	659,781	225,351	43,935	367,019	0	0	23,476
	Transition Age Youth FSP (CSS-04)	1,206,666	677,035	80,353	405,776	0	0	43,503
	Adults with Serious Mental Illness FSP (CSS-05)	2,678,214	1,187,853	178,344	1,216,853	0	0	95,164
	Older Adults FSP (CSS-06)	893,830	686,168	59,521	143,945	0	0	4,196
	Justice-Involved FSP (CSS-13)	870,296	644,487	57,954	87,090	0	0	80,766
	Homeless Services and Supports FSP (CSS-14)	1,032,891	524,025	68,781	423,482	0	0	16,604
Non-FSP Programs								
	Access Regional Services (CSS-07)	5,121,812	1,371,160	341,065	2,969,370	0	0	440,217
	Early Childhood Mental Health Services (CSS-08)	1,962,924	1,297,572	130,712	519,217	0	0	15,423
	Supported Services to Adults with Serious Mental Illne	828,506	416,160	55,171	334,523	0	0	22,652
	Dual Diagnosis Services (CSS-11)	2,310,665	1,053,285	153,869	1,037,831	0	0	65,680
	Homeless Outreach & Treatment (CSS-15)	1,501,593	814,482	99,992	546,985	0	0	40,134
	Responsive Crisis Interventions (CSS-16)	4,925,524	2,221,336	327,994	2,209,791	0	0	166,403
	Children's Mental Health Services (CSS-17)	1,433,317	1,287,265	95,446	48,648	0	0	1,958
	Mental Health Services for Adults (CSS-18)	6,517,620	4,482,164	434,013	1,475,427	0	0	126,016
CSS Administration		5,396,953	5,396,953					
CSS MHSA Housing Program Assigned Funds								
Total CSS Program Estimated Expenditures		41,376,642	25,305,131	2,395,912	12,509,281	0	0	1,166,318
FSP Programs as Percent of Total		31.62%						

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 MHSA IGT	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs								
	Early Childhood and Family Stability FSP (CSS-01)	6,054,760	4,530,264	403,191	1,085,110	0	0	36,195
	Dual Diagnosis FSP (CSS-02)	989,783	338,065	65,910	550,591	0	0	35,218
	Transition Age Youth FSP (CSS-04)	1,810,204	1,015,667	120,543	608,733	0	0	65,262
	Adults with Serious Mental Illness FSP (CSS-05)	4,017,775	1,781,981	267,546	1,825,486	0	0	142,762
	Older Adults FSP (CSS-06)	1,340,897	1,029,369	89,291	215,942	0	0	6,294
	Justice-Involved FSP (CSS-13)	1,305,592	966,840	86,940	130,649	0	0	121,163
	Homeless Services and Supports FSP (CSS-14)	1,549,513	786,127	103,183	635,294	0	0	24,908
Non-FSP Programs								
	Access Regional Services (CSS-07)	3,280,105	878,117	218,424	1,901,641	0	0	281,923
	Early Childhood Mental Health Services (CSS-08)	1,257,094	830,990	83,711	332,516	0	0	9,877
	Supported Services to Adults with Serious Mental Illne	530,591	266,517	35,332	214,235	0	0	14,507
	Dual Diagnosis Services (CSS-11)	1,479,794	674,544	98,540	664,646	0	0	42,063
	Homeless Outreach & Treatment (CSS-15)	961,649	521,609	64,037	350,300	0	0	25,703
	Responsive Crisis Interventions (CSS-16)	3,154,399	1,422,586	210,054	1,415,192	0	0	106,568
	Children's Mental Health Services (CSS-17)	917,923	824,389	61,125	31,155	0	0	1,254
	Mental Health Services for Adults (CSS-18)	4,174,007	2,870,463	277,950	944,891	0	0	80,703
CSS Administration		3,138,496	3,138,496					
CSS MHSA Housing Program Assigned Funds								
Total CSS Program Estimated Expenditures		35,962,582	21,876,022	2,185,778	10,906,382	0	0	994,399
FSP Programs as Percent of Total		52.00%						

Community Services and Supports (CSS) Component Worksheet

		Fiscal Year 2025/26						
		A	B		C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated MHSA IGT	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs								
	Early Childhood and Family Stability FSP (CSS-01)	4,429,456	3,314,187	294,961	793,829	0	0	26,479
	Dual Diagnosis FSP (CSS-02)	724,092	247,317	48,218	402,793	0	0	25,764
	Transition Age Youth FSP (CSS-04)	1,324,284	743,027	88,185	445,328	0	0	47,743
	Adults with Serious Mental Illness FSP (CSS-05)	2,939,268	1,303,637	195,728	1,335,464	0	0	104,439
	Older Adults FSP (CSS-06)	980,955	753,051	65,322	157,976	0	0	4,605
	Justice-Involved FSP (CSS-13)	955,127	707,307	63,603	95,579	0	0	88,639
	Homeless Services and Supports FSP (CSS-14)	1,133,571	575,104	75,485	464,760	0	0	18,222
Non-FSP Programs								
	Access Regional Services (CSS-07)	2,399,613	642,400	159,792	1,391,176	0	0	206,245
	Early Childhood Mental Health Services (CSS-08)	919,647	607,924	61,240	243,258	0	0	7,226
	Supported Services to Adults with Serious Mental Illne	388,162	194,975	25,848	156,727	0	0	10,613
	Dual Diagnosis Services (CSS-11)	1,082,567	493,473	72,089	486,233	0	0	30,772
	Homeless Outreach & Treatment (CSS-15)	703,510	381,592	46,847	256,267	0	0	18,803
	Responsive Crisis Interventions (CSS-16)	2,307,651	1,040,715	153,668	1,035,306	0	0	77,961
	Children's Mental Health Services (CSS-17)	671,521	603,095	44,717	22,792	0	0	917
	Mental Health Services for Adults (CSS-18)	3,053,562	2,099,933	203,339	691,250	0	0	59,040
CSS Administration		2,296,017	2,296,017					
CSS MHSA Housing Program Assigned Funds								
Total CSS Program Estimated Expenditures		26,309,001	16,003,753	1,599,041	7,978,738	0	0	727,468
FSP Programs as Percent of Total		52.00%						

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Worksheet

County: Monterey Date: 4/2/2025

Prevention and Early Intervention (PEI) Component

Fiscal Year 2023-24

	A	B		C	D	E	F
	Actual Total Mental Health Expenditures	Actual PEI Funding	Actual MHSA IGT	Actual Medi-Cal FFP	Actual 1991 Realignment	Actual Behavioral Health Subaccount	Actual Other Funding
PEI Programs - Prevention							
Family Support and Education (PEI-02)	1,134,050	1,134,050	0	0	0	0	0
Prevention Services for the Early Identification of MH Symptoms & Disorders Throughout the Lifespan (PEI-12)	871,311	871,311	0	0	0	0	0
Student Mental Health (PEI-08)	666,503	572,081	0	90,269	0	0	4,152
Maternal Mental Health (PEI-15)	1,285,368	1,285,368	0	0	0	0	0
Stigma and Discrimination Reduction (PEI-04)	212,177	212,177	0	0	0	0	0
Suicide Prevention (PEI-06)	500,492	500,492	0	0	0	0	0
			0				
PEI Programs - Early Intervention			0				
Early Intervention Services for Older Adults (PEI-05)	379,307	379,307	0	0	0	0	0
Early Intervention Services for Adolescents, Transition Age & College Age Youth (PEI-13)	283,940	270,296	0	8,464	0	0	5,180
Culturally Specific Early Intervention Services (PEI-14)	1,713,504	1,713,504	0	0	0	0	0
Prevention and Recovery for Early Psychosis (PEI-10)	1,015,845	977,524	0	36,867	0	0	1,454
Prevention and Early Intervention for Substance Use Disorders (PEI-16)	110,747	110,747	0	0	0	0	0
PEI Administration	1,225,987	1,225,987	0	0	0	0	0
PEI Assigned Funds	0	0	0	0	0	0	0
Total PEI Program Estimated Expenditures	9,399,231	9,252,845	0	135,600	0	0	10,787

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

Prevention and Early Intervention (PEI) Component							
	Fiscal Year 2025-26						
	A	B		C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated MHSA IGT	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
Family Support and Education (PEI-02)	734,660	734,660	0	0	0	0	0
Prevention Services for the Early Identification of MH Symptoms & Disorders Throughout the Lifespan (PEI-12)	680,130	680,130	0	0	0	0	0
Student Mental Health (PEI-08)	632,322	432,773	0	175,169	0	0	24,380
Maternal Mental Health (PEI-15)	460,751	460,751	0	0	0	0	0
Stigma and Discrimination Reduction (PEI-04)	319,663	319,663	0	0	0	0	0
Suicide Prevention (PEI-06)	406,856	406,856	0	0	0	0	0
			0				
PEI Programs - Early Intervention			0				
Early Intervention Services for Older Adults (PEI-05)	384,394	384,394	0	0	0	0	0
Early Intervention Services for Adolescents, Transition Age & College Age Youth (PEI-13)	207,747	131,270	0	76,477	0	0	0
Culturally Specific Early Intervention Services (PEI-14)	1,187,385	1,187,385	0	0	0	0	0
Prevention and Recovery for Early Psychosis (PEI-10)	248,934	57,397	0	168,136	0	0	23,401
Prevention and Early Intervention for Substance Use Disorders (PEI-16)	87,866	87,866	0	0	0	0	0
PEI Administration	732,472	732,472	0	0	0	0	0
PEI Assigned Funds	0	0	0	0	0	0	0
Total PEI Program Estimated Expenditures	6,083,182	5,615,619	0	419,782	0	0	47,782

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Monterey Date: 4/2/2025

Innovations (INN) Component Worksheet

Fiscal Year 2023-24

	A	B		C	D	E	F
	Actual Total Mental Health Expenditures	Actual INN Funding	Acutal IGT	Actual Medi-Cal FFP	Actual 1991 Realignment	Actual Behavioral Health Subaccount	Actual Other Funding
INN Programs							
Micro-Innovation Activities for Increasing Latino Engagement (INN-01)	93	93	0	0	0	0	0
Screening to Timely Access (INN-02)	219,313	219,313	0	0	0	0	0
Transportation Coaching by Wellness Navigators (INN-03)	118	118	0	0	0	0	0
Residential Care Facility Incubator (INN-04)	48,794	48,794	0	0	0	0	0
Psychiatric Advance Directives (INN-05)	389,055	389,055	0	0	0	0	0
Center for Mind Body Medicine (INN-06)	0	0	0	0	0	0	0
Rainbow Connections (INN-07)	588,298	588,298	0	0	0	0	0
Eating Disorder (INN-08)	0	0	0	0	0	0	0
INN Administration	186,850	186,850	0	0	0	0	0
Total INN Program Estimated Expenditures	1,432,520	1,432,520	0	0	0	0	0

Innovations (INN) Component Worksheet

Fiscal Year 2024-25

	A	B		C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated MHSA IGT	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	0
Screening to Timely Access (INN-02)	0	0	0	0	0	0	0
Transportation Coaching by Wellness Navigators (INN-03)	0	0	0	0	0	0	0
Residential Care Facility Incubator (INN-04)	69,680	69,680	0	0	0	0	0
Psychiatric Advance Directives (INN-05)	346,557	346,557	0	0	0	0	0
Center for Mind Body Medicine (INN-06)	0	0	0	0	0	0	0
Rainbow Connections (INN-07)	1,518,288	1,518,288	0	0	0	0	0
Eating Disorder (INN-08)	400,000	400,000	0	0	0	0	0
INN Administration	350,179	350,179	0	0	0	0	0
Total INN Program Estimated Expenditures	2,684,704	2,684,704	0	0	0	0	0

Innovations (INN) Component Worksheet

Fiscal Year 2025-26

	A	B		C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated MHSA IGT	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	0
Screening to Timely Access (INN-02)	0	0	0	0	0	0	0
Transportation Coaching by Wellness Navigators (INN-03)	0	0	0	0	0	0	0
Residential Care Facility Incubator (INN-04)	0	0	0	0	0	0	0
Psychiatric Advance Directives (INN-05)	0	0	0	0	0	0	0
Center for Mind Body Medicine (INN-06)	0	0	0	0	0	0	0
Rainbow Connections (INN-07)	1,531,799	1,531,799	0	0	0	0	0
Eating Disorder (INN-08)	0	0	0	0	0	0	0
Psychiatric Advance Directives Phase II (INN-09)	482,457	482,457	0	0	0	0	0
Residential Facility Incubator Implementation Plan (INN-10)	590,850	590,850	0	0	0	0	0
INN Administration	390,766	390,766	0	0	0	0	0
Total INN Program Estimated Expenditures	2,995,872	2,995,872	0	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce Education and Training (WET) Component Worksheet

County: Monterey Date: 4/5/2025

		Fiscal Year 2023-24					
		A	B	C	D	E	F
		Actual Total Mental Health Expenditures	Actual WET Funding	Actual Medi-Cal FFP	Actual 1991 Realignment	Actual Behavioral Health Subaccount	Actual Other Funding
WET Programs							
1.	Pipeline/Career Awareness	196,548	196,548	0	0	0	0
2.	Education and Training	1,357,807	1,357,807	0	0	0	0
3.	Retention	400	400	0	0	0	0
4.	Evaluation and Research	589	589	0	0	0	0
WET Administration		233,302	233,302	0	0	0	0
Total WET Program Estimated Expenditures		1,788,646	1,788,646	0	0	0	0

		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	235,930	235,930	0	0	0	0
2.	Education and Training	1,371,500	1,371,500	0	0	0	0
3.	Retention	2,700	2,700	0	0	0	0
4.	Evaluation and Research	0	0	0	0	0	0
WET Administration		241,520	241,520	0	0	0	0
Total WET Program Estimated Expenditures		1,851,650	1,851,650	0	0	0	0

		Fiscal Year 2025-26					
		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	661,694	661,694	0	0	0	0
3.	Retention	0	0	0	0	0	0
4.	Evaluation and Research	0	0	0	0	0	0
WET Administration		130,415	130,415	0	0	0	0
Total WET Program Estimated Expenditures		999,848	999,848	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Monterey Date: 4/2/2025

	Fiscal Year 2023-24					
	A	B	C	D	E	F
	Actual Total Mental Health Expenditures	Actual CFTN Funding	Actual Medi-Cal FFP	Actual 1991 Realignment	Actual Behavioral Health Subaccount	Actual Other Funding
CFTN Programs - Capital Facilities Projects						
1. Pearl Street Renovations	0	0	0	0	0	0
2. MHRC Renovations	0	0	0	0	0	0
3. BH Integrated Campus	0	0	0	0	0	0
4. Bridge Housing Development	0	0	0	0	0	0
5. New Facility on East Sanborn	124,002	124,002	0	0	0	0
6.	0	0	0	0	0	0
7.	0	0	0	0	0	0
8.	0	0	0	0	0	0
9.	0	0	0	0	0	0
10.	0	0	0	0	0	0
CFTN Administration	18,600	18,600	0	0	0	0
Total CFTN Program Estimated Expenditures	142,603	142,603	0	0	0	0

	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. New Facility on East Sanborn	100,000	100,000	0	0	0	0
3.	0	0	0	0	0	0
4.	0	0	0	0	0	0
5.	0	0	0	0	0	0
6.	0	0	0	0	0	0
7.	0	0	0	0	0	0
8.	0	0	0	0	0	0
9.	0	0	0	0	0	0
10.	0	0	0	0	0	0
CFTN Administration	390,000	390,000	0	0	0	0
Total CFTN Program Estimated Expenditures	2,990,000	2,990,000	0	0	0	0

	Fiscal Year 2025-26					
	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	5,500,000	5,500,000	0	0	0	0
2. Pearl Street Renovations	1,000,000	1,000,000	0	0	0	0
3.	0	0	0	0	0	0
4.	0	0	0	0	0	0
5.	0	0	0	0	0	0
6.	0	0	0	0	0	0
7.	0	0	0	0	0	0
8.	0	0	0	0	0	0
9.	0	0	0	0	0	0
10.	0	0	0	0	0	0
CFTN Administration	975,000	975,000	0	0	0	0

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

Community Program Planning Process Summary of Findings

FY 2024–2025

Prepared by:

EVALCORP
Measuring What Matters℠

Table of Contents

CHAPTER 1:
INTRODUCTION

In November 2004, the Mental Health Services Act (MHSA) passed when a majority of voters approved Proposition 63. The act expanded and transformed the behavioral health system in California by funding behavioral health services through a 1% tax on all personal income over $1 million per year.[1] This funding enables counties to provide vital behavioral health services, focusing on inclusivity and equitable access to care.

To ensure MHSA funds address the diverse needs of all community members, the Mental Health Services Oversight and Accountability Commission (MHSOAC) requires counties receiving these funds to develop a comprehensive Three-Year Program and Expenditure Plan and Annual Updates. These plans are informed through a comprehensive Community Program Planning Process (CPPP), which engages Community Members (individuals who benefit or may benefit from behavioral health services) and Stakeholders (service providers and those who facilitate connection to services) to provide insights and feedback.

This report details findings from across Monterey County Behavioral Health (MCBH)'s CPPP for the Fiscal Year 2024–2025 Annual Update. MCBH contracted EVALCORP, an evaluation firm, to conduct surveys and focus groups with stakeholders to ensure that MCBH's behavioral health services align with the needs of the community and inform program planning. EVALCORP then conducted Listening Sessions with Community Members to get feedback on the findings and gain further insight.

This report presents the findings from data collection efforts for the 2024–2025 Fiscal Year Community Program Planning Process for the Community Survey (Chapter 2), Community Focus Groups (Chapter 3), the Stakeholder Survey (Chapter 4), Stakeholder Focus Groups (Chapter 5), and the Listening Sessions (Chapter 6). An Appendix is included at the end of the report.

[1] Department of Health Care Services, "Mental Health Services Act" |https://www.dhcs.ca.gov/services/MH/Pages/MH_Prop63.aspx

CHAPTER 2:
COMMUNITY SURVEY

Introduction

This chapter details findings from the Community Survey for MCBH's Community Program Planning Process (CPPP) for the Fiscal Year 2024-2025 Annual Update. MCBH contracted EVALCORP, an evaluation firm, to conduct a Community Survey and gather crucial feedback to ensure that MCBH's behavioral health services align with the needs of the community and inform program planning. Alongside additional chapters that summarize findings from the Community Focus Groups (Chapter 3), the Stakeholder Survey (Chapter 4), Stakeholder Focus Groups (Chapter 5), and the Listening Sessions (Chapter 6), this Chapter offers insights from the Survey with Community Members to inform service improvements and strategic priorities for MCBH to meet the diverse needs of Monterey County.

Engagement Strategy

Recognizing the importance of community engagement in addressing behavioral health issues, the Community Health Survey was distributed in English (Appendix A) and Spanish (Appendix B) through approximately 80 channels in collaboration with local agencies and organizations in Monterey County to collect diverse perspectives.

EVALCORP and MCBH collaborated on a coordinated survey distribution effort. EVALCORP initiated the process by requesting partner agencies and organizations share the survey with their clients and other Community Members. To ensure inclusiveness across Monterey County's multifaceted population, EVALCORP monitored survey responses continuously and facilitated targeted online and hardcopy distribution as needed.

After completing data collection, the responses were prepared for analysis. The distribution strategy outlined above successfully yielded 507 community responses, which were included in the analyses.

Key Themes and Findings

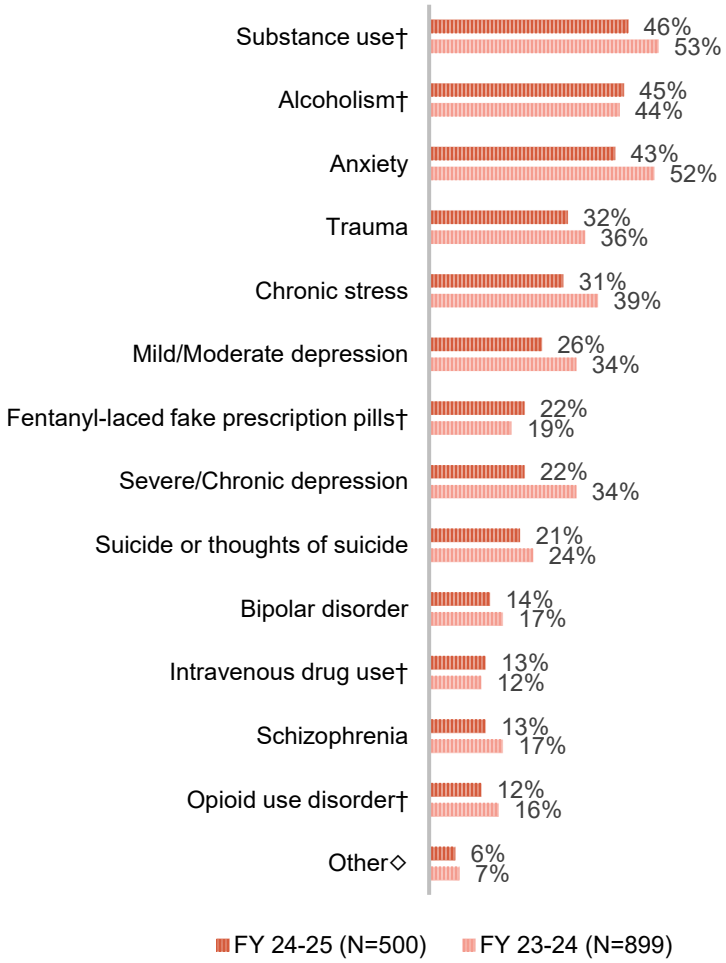
The findings below reflect the community's perspectives on key behavioral health concerns and access to care. Respondents shared their perceptions of significant community issues, service availability, barriers to access, unmet needs, communication preferences, and recommendations for enhancing services. These insights shed light on the community's views of the current state of behavioral health services in Monterey County and highlight areas for improvement. Demographic data was also collected to provide a comprehensive understanding of respondents' identities.

Priority Mental Health and Substance Use Issues

Respondents were asked to identify the most important mental health and substance use issues in their community (see Figure 1).

Overall, substance use and alcoholism were rated as the most important issues to address within Monterey County. Anxiety, chronic stress, and trauma were the highest-rated mental health issues in the community. The percentage of participants identifying any specific issue as important slightly decreased overall compared to last year, except for fentanyl-laced fake prescription pills, alcoholism, and intravenous drug use. Despite downward trends for most issues, the high percentage of community members who continue to identify these issues as important demonstrates the stability of the community's top behavioral health concerns. These results emphasize the ongoing significance of mental health and substance use issues in the County, underscoring the importance of maintaining focus on the identified priority areas.

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



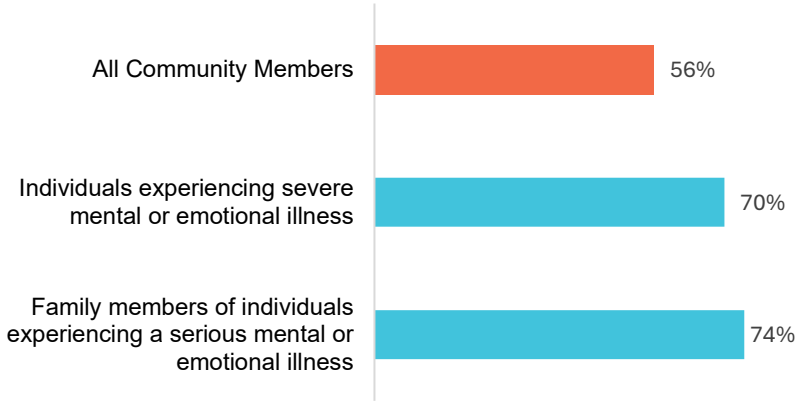
*Percentages exceed 100% because respondents could select more than one issue.
†Substance use issues
◇Other responses for FY 24-25 include Methamphetamine, marijuana, homelessness, co-occurring substance use and mental health issues, post-traumatic stress disorder, and electronic cigarettes.
Other responses for FY 23-24 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.

Gaps in Behavioral Health Services

Community Members were asked a series of questions to understand if and how behavioral health issues are being addressed in Monterey County. Their responses shed light on existing service gaps and areas for improvement.

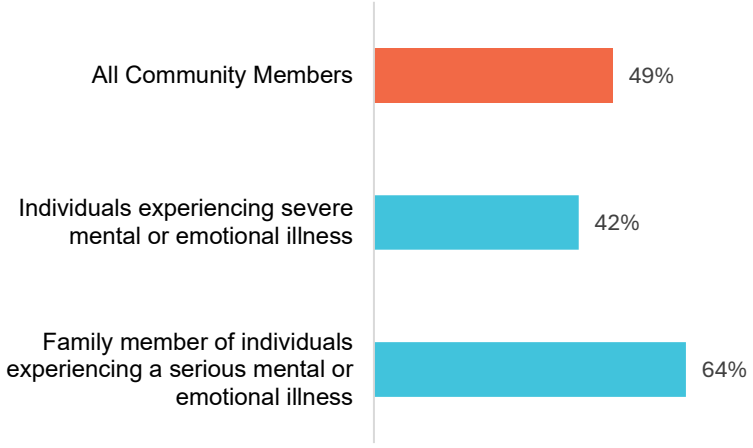
Availability of Services. Survey respondents were asked whether they believed their communities had enough services to address mental health and substance use needs. More than half of Community Members reported that while mental health services were available, they were insufficient to meet community needs. This view was more pronounced among groups likely to use these services. Seventy percent of individuals experiencing severe mental and emotional illness (n=33) and 74% of respondents who identified as family members of such individuals (n=88) viewed services as inadequate (see Figure 2).

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



*N=399 Community Responses. Percentages exceed 100% because respondents could select more than one identity.

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



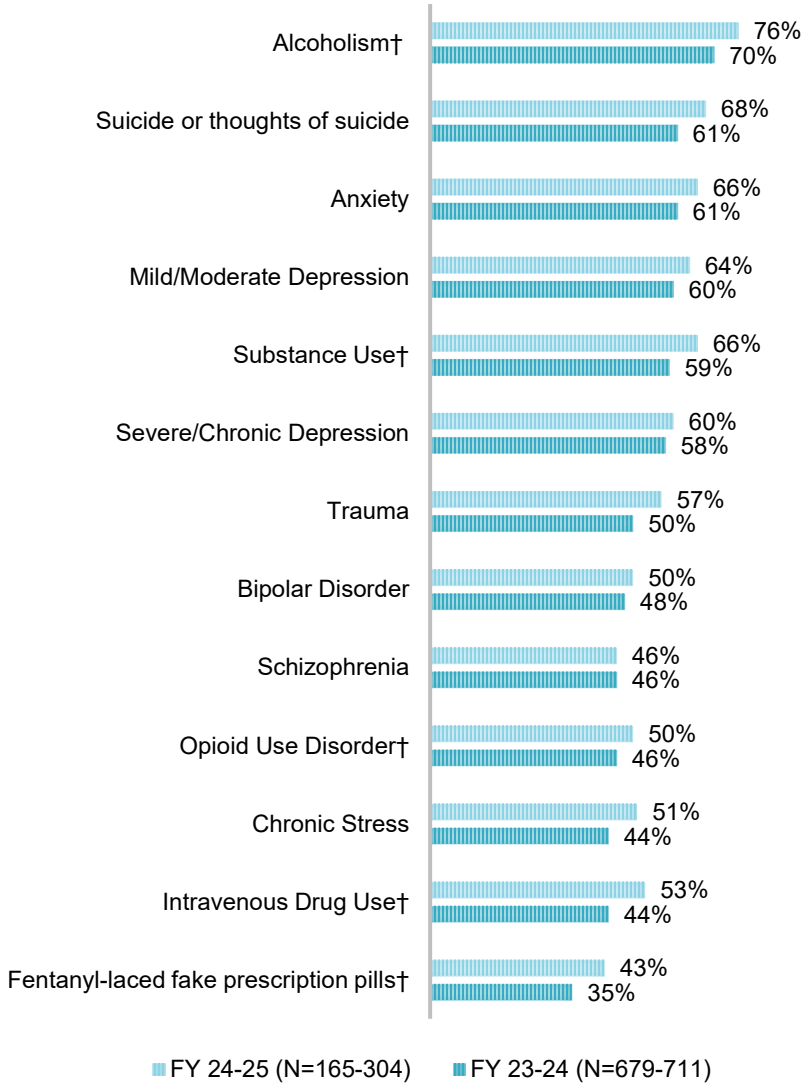
*N=388 Community Responses. Percentages exceed 100% because respondents could select more than one identity.

Views on the availability of substance use services varied. Forty-nine percent of Community Members felt these services were available in the County but not enough to meet the community's needs. Individuals experiencing severe mental and emotional illness (n=14) expressed slightly less concern about service insufficiency. In contrast, family members of these individuals (n=56) reported greater dissatisfaction with the availability of services (Figure 3).

Overall, the findings suggest that Community Members, including frequent service users, are somewhat aware of behavioral health services in Monterey County. However, notable gaps remain, with perceptions of limited support and unmet care needs continuing to impact the community.

To gain a clearer understanding of service gaps, community members rated the availability of various mental health and substance use services in the County as not available, somewhat available, available, or unsure. Figure 4 compares this year's results to last year's, combining "somewhat available" and "available." Responses highlighted Community Members' perceptions of what services are available in the County. Findings show a slight improvement in perceived service availability across all issues. This may reflect MCBH's efforts to improve advertising and raise awareness of services. However, views varied by issue. Alcoholism services were rated as the most available, while services for fentanyl-laced fake prescription pills were seen as the least. These differences highlight the need for issue-specific approaches to improve support.

Figure 4. Availability of Services for Behavioral Health Issues*



*Percentages exceed 100% because respondents could select more than one service category.
†Substance use issues

Community Perspectives on Needed Services. Community Members were asked to identify additional mental health and substance use services needed in Monterey County. Over one-third of responding Community Members (36%) provided write-in responses, which fell into three main themes: Housing and Residential Treatment, Specialized Treatment Services, and Service Accessibility.

*Housing and Residential Treatment***.** Community members highlighted the perceived need for more housing options, particularly residential facilities that provide integrated support services in addition to mental health treatment.

"We are in desperate need of housing for our mentally ill…an environment that has staff, to include medical resources, teachers, counselors, and psychologists to help guide those in desperate need."

Specialized Treatment Services. Respondents shared the observed need for more tailored services in Monterey County to address diverse populations, conditions, and treatment needs. Community members pointed to gaps in resources for youth, families, the unhoused, formerly incarcerated individuals, those with mild mental health issues, and those with co-occurring mental health and substance use conditions.

"We don't have enough programs to provide co-occurring treatment, and existing programs often have waitlists or have specific criteria that don't always support the needs of the community."

Service Accessibility. Across multiple responses, Community Members identified the need for more free or affordable local services, as cost and transportation challenges were frequently cited as barriers to care. They also highlighted the importance of increasing staffing and provider availability to reduce long wait times for appointments. These suggested changes were viewed as especially beneficial for uninsured and underinsured individuals, those facing financial challenges, and residents in rural areas.

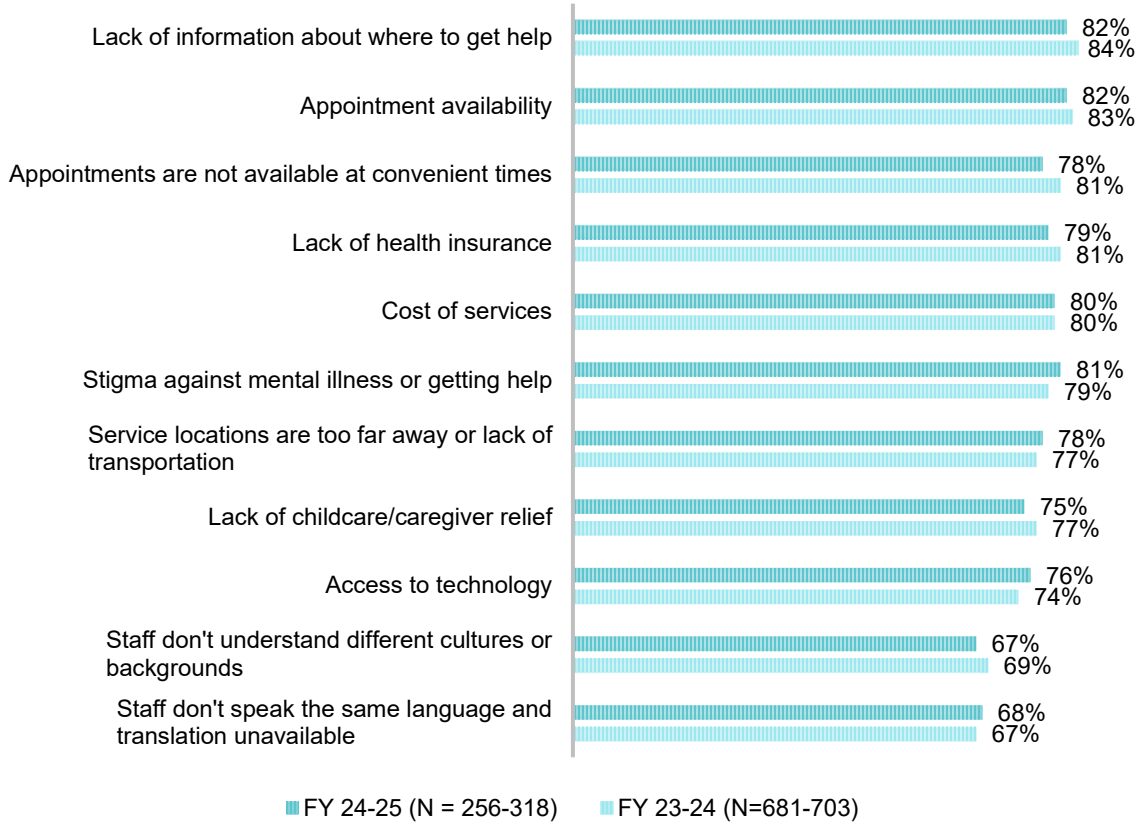
"More providers, less waiting, greater coverage, and outreach."

While most Community Members recognize the availability of services, they view services for various mental health and substance use issues as inadequate to meet the community's needs. Their suggestions for additional services in the County offer potential strategies to address these gaps.

Barriers to Service

To explore access to mental health and substance use services, Community Members were asked about the main barriers they face. Figure 5 shows the top challenges identified this year remain consistent with last year's findings. The most common barriers were a lack of knowledge about where to get help and appointment availability. Over 80% of respondents cited mental health stigma and the cost of services as significant obstacles. Other barriers, not having health insurance, lack of convenient appointment times, transportation or childcare issues, and access to technology, were reported by more than three-fourths of Community Members. These findings highlight widespread challenges to accessing care across the County.

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



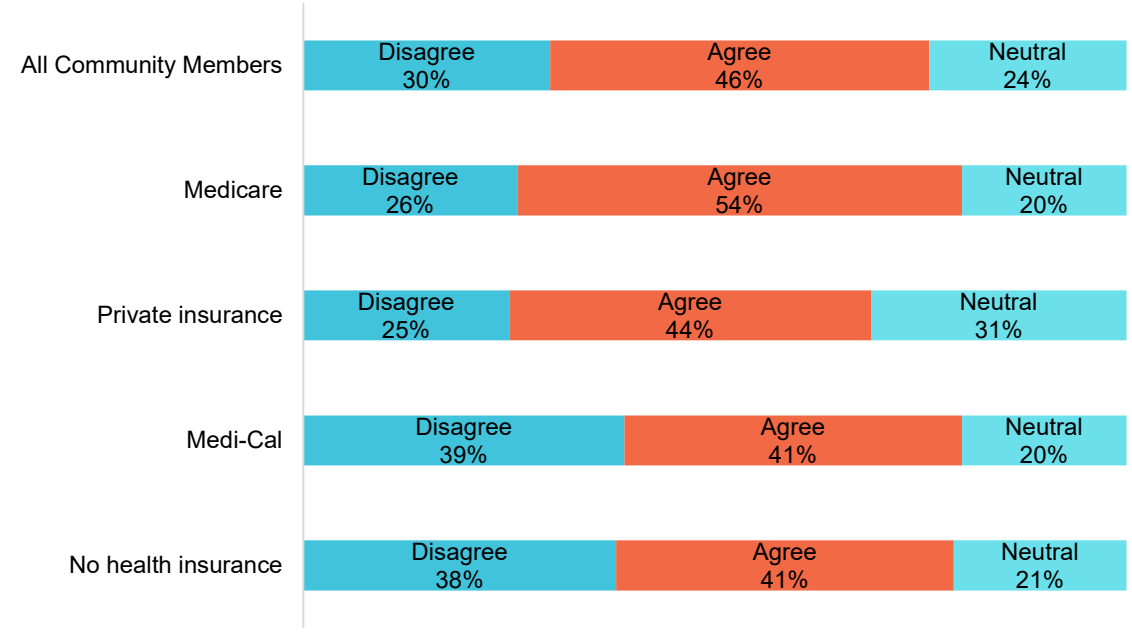
*Percentages exceed 100% because respondents could select more than one barrier.

Lack of awareness about available resources. While Community Members recognized the availability of mental health and substance use services in multiple write-in responses, they stressed the importance of better advertising and expanded community outreach to increase awareness of these resources. These responses provide insight into the disconnect between the high levels of awareness of service availability reported earlier (35%-70%, Figure 4) and a lack of information about where to get help as the greatest barrier to service access.

"Better dissemination of information about the resources available, their locations, and the costs."

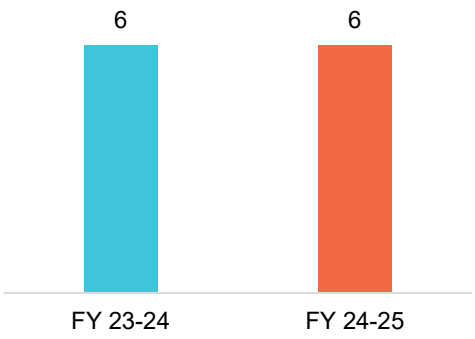
Additional survey questions further explored the lack of information about available services as a significant barrier to accessing care in the County. Respondents were asked if they believed people with mental health and substance use needs could get help in their community. Overall, 46% agreed help was available (n=400) but agreement levels varied by insurance type. Private insurance holders (n=169) showed similar results as the general community while Medicare recipients (n=46) reported higher levels of agreement. Those without insurance (n=29) and Medi-Cal recipients (n=95) were the least likely to agree, highlighting gaps in outreach and education for these populations (Figure 6).

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



Mental Health Stigma. To better understand mental health stigma as a barrier to accessing services in Monterey County, survey respondents were asked to share their opinions about seeking help from a mental health professional using the Mental Help Seeking Attitudes Scale[2] (MHSAS). Responses were categorized as favorable or unfavorable and used to generate an average score of one to seven, where higher scores indicated more favorable attitudes. On average, community members reported highly positive attitudes toward mental health support, consistent with last year's results (Figure 7).

Figure 7. Community Members' Overall Attitude Toward Seeking Mental Health Support* (Average MHSAS Score)



*FY 23-24 N=514, FY 24-25 N=388 Community Responses.

Assessment of the level of agreement with individual items sheds light on stigma related to seeking mental health support. Overall, individual item responses reflect favorable attitudes toward seeking mental health services. However, Figure 8 highlights specific cases where certain priority populations were less likely to express positive sentiment.

[2] 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

Figure 8. Attitudes Toward Seeking Mental Health Support by Identity*

	Useful	Important	Healthy	Effective	Good	Healing	Empowering	Satisfying	Desirable
All Responses (n = 299-342)	85%	87%	69%	77%	88%	85%	78%	77%	81%
Hispanic	85%	87%	58%	77%	89%	86%	75%	79%	84%
Non-Hispanic	89%	90%	94%	80%	87%	87%	89%	75%	82%
Parent/Caretaker of a child under 18	81%	83%	56%	72%	85%	83%	69%	75%	76%
Caretaker of an adult	87%	97%	89%	79%	93%	89%	88%	85%	84%
Individual with SMI	82%	85%	81%	82%	82%	89%	89%	82%	86%
Family of an individual with SMI	88%	94%	85%	81%	93%	86%	78%	77%	84%

*Groups with fewer than 30 individuals are not shown in the table (Veterans N=10; Unhoused N=11; Individual without or family of an individual without immigration status N=18, Individual with SUD N=8)

While most respondents viewed seeking mental health support positively, many Community Members highlighted in their write-in responses that stigma surrounding mental illness remains a significant barrier to accessing services.

"We need stigma-reducing and anti-bias education initiatives pertaining to supporting community mental health needs."

Collectively, these results highlight a range of barriers that limit or prevent service access in Monterey County. Addressing the top challenges requires 1) increasing awareness of available services and 2) actively combating negative attitudes and stigma surrounding mental health support. Partnering with trusted community organizations for outreach and education will be essential to effectively engage and support diverse populations.

Communication Preferences for Receiving Service Information

Respondents shared their preferred ways to receive information about mental health and substance use services, revealing key outreach opportunities (see Figure 9). Social media, email, and newsletters (paper or digital) were the top choices overall. Generational differences likely reflect unique experiences, norms, and values. Generation Z (n=69) and Millennials (n=125) favored social media and email, while Generation X (n=108) and Baby Boomers (n=53) preferred newsletters and online articles. Notably, some similarities emerged with over one-third of individuals in Generation X and Baby Boomers also preferring to receive information via email

and social media. These findings emphasize the need to use diverse communication methods to reach all age groups effectively.

Figure 9. Preferences for Receiving Service Information*

	Email	Newsletters	Phone Calls	Podcasts or online videos	Radio	Social media	Television	Text messages	Websites/ online articles	Other
All Responses (n = 355)	43%	40%	23%	22%	28%	48%	32%	28%	38%	7%
Generation Z *(<29 years)*	43%	30%	17%	20%	26%	64%	32%	28%	33%	-
Millennials *(30-44 years)*	42%	30%	25%	19%	19%	45%	25%	34%	26%	-
Generation X *(45-60 years)*	44%	49%	19%	30%	34%	44%	34%	22%	47%	-
Baby Boomers *(60+ years)*	38%	60%	23%	15%	30%	40%	30%	25%	53%	-

*Highlighted responses indicate the top responses overall and for each generation.

Recommendations

In addition to identifying community challenges, service gaps, and barriers to access, Community Members provided suggestions for enhancing mental health and substance use support in Monterey County. Approximately 50% of Community Members surveyed provided write-in recommendations encompassing three themes: Workforce Development, Increasing Service Availability, and Enhancing Community Outreach and Education.

Workforce Development. Community Members suggested expanding and strengthening the behavioral health workforce by increasing hiring, particularly bilingual staff, providing cultural competence training, and enhancing working conditions (e.g., mental health support and better work-life balance). These efforts aim to address provider shortages, reduce long wait times, and close gaps in care.

"We need more bilingual providers and indigenous-speaking folks who understand culture/language."

Increasing Service Availability. Community Members emphasized the need to expand service availability both geographically and operationally, including the offering of mobile and telehealth services.

"A commitment to meet people where they are instead of the ones who need the services driving an hour to maybe get help – it won't happen."

Enhancing Community Outreach and Education. Respondents recommended public awareness campaigns, culturally tailored messaging, direct community engagement, stigma reduction, and increased resource visibility through partnerships with community organizations, diverse media platforms, and local events.

"There needs to be more awareness in the community regarding educating them [about] what mental health is and what resources [the County] currently have."

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 355 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 44 years, with a range of 13 – 81 years (see Table 1).

Table 1. Age of Surveyed Community Members

Age Category (n = 355)	Percentage
Under 20 years old	4%
20 – 29 years old	15%
30 – 39 years old	23%
40 – 49 years old	21%
50 – 59 years old	21%
60+ years old	17%

Ethnicity and Race. Two-thirds of Community Members identified as Hispanic/Latino (65%) and just over one-fourth of Community Members identified as Caucasian (27%; see Table 2).

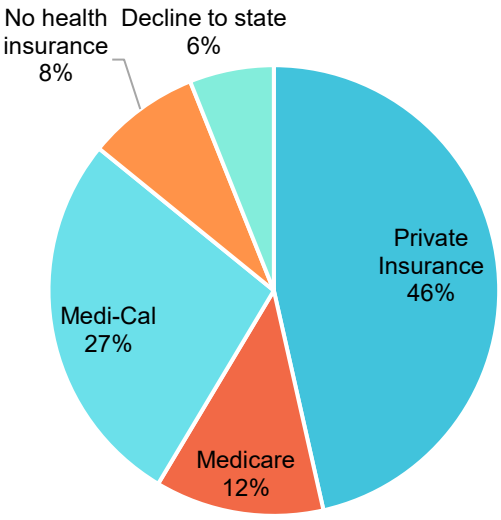
Table 2. Ethnicity and Race of Surveyed Community Members*

Ethnicity and Race (n = 362-376)	Percentage
American Indian or Alaska Native	2%
Asian	2%
Black or African American	2%
Hispanic or Latino	65%
Multiracial	2%
Native Hawaiian or Other Pacific Islander	1%
Non-Hispanic/Latino	27%
White	27%
Another Race/Ethnicity◇	2%
Declined to state	8%

*Community Members could select more than one Race/Ethnicity. Percentages may exceed 100%.
◇Another Race/Ethnicity included Portuguese, Chicano, Armenian, Triqui de San Juan Copala, and Italian.

Health Insurance. Approximately one-third of respondents reported having Medi-Cal insurance (27%; see Figure 10).

Figure 10. Health Insurance Status of Surveyed Community Members



*N=370 Community Responses.

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

Table 3. Gender of Surveyed Community Members*

Gender (n = 371)	Percentage
Female	76%
Genderqueer	1%
I prefer to self-describe◇	1%
Male	19%
Questioning/Unsure of Gender Identity	1%
Transgender	1%
Decline to state	4%

*Percentages exceed 100% due to rounding.
◇Responses to 'I prefer to self-describe' included non-binary trans man.

Sexual Orientation. Approximately three-fourths of surveyed Community Members identified as heterosexual or straight (73%; see Table 4).

Table 4. Sexual Orientation of Surveyed Community Members

Primary Language Spoken at Home (n = 350)	Percentage
Bisexual	5%
Gay or Lesbian	3%
Heterosexual or Straight	73%
I prefer to self-describe◇	1%
Queer	1%
Questioning/Unsure of Sexual Orientation	1%
Decline to state	18%

◇Responses to 'I prefer to self-describe' included 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. Almost half of Community Members spoke Spanish at home sometimes, while just over one-fourth indicated that Spanish was their primary language at home (Table 5).

Table 5. Primary Language of Surveyed Community Members

Primary Language Spoken at Home (n = 379)	Percentage
English	45%
Spanish	26%
Both English and Spanish	19%
Another Language◇	9%
Decline to state	1%

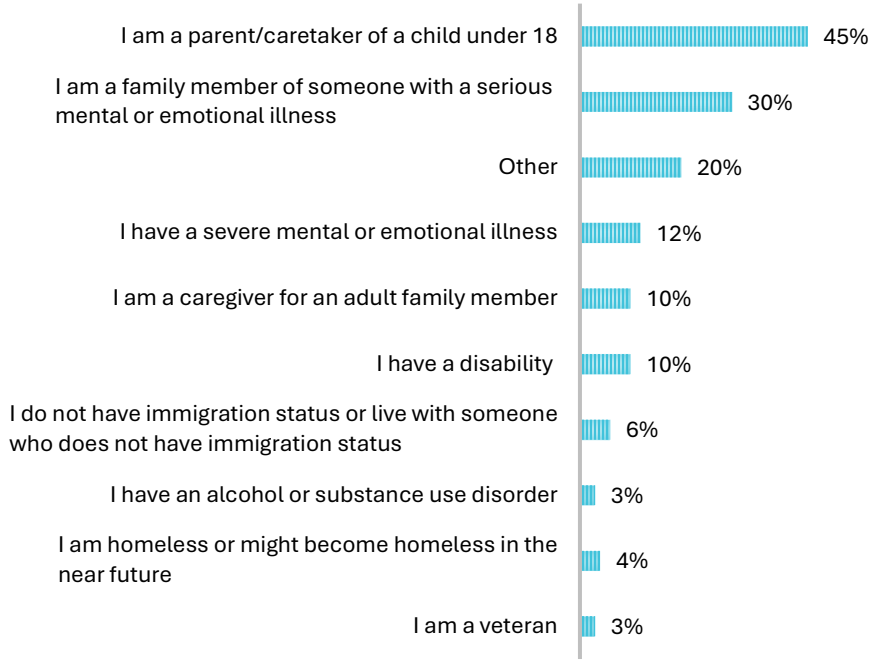
◇Another language included Triqui/Triqui Copala bajo, Mixteco, German, and Chatino.

Personal Identities. To ensure the insights shared through the Community Health Survey were inclusive, respondents were asked about additional personal identities they held. Almost half of respondents (45%) identified as parents or caregivers of a child under 18 years old (see Figure 11).

Summary

A diverse group of Community Members provided valuable insights into the needs, barriers, and gaps in mental health and substance use services in Monterey County. Survey respondents identified substance use, anxiety, and alcoholism as the most pressing issues in the County (see Figure 11). While Community Members acknowledged the availability of mental health and substance use services, they emphasized that existing services are insufficient to meet the community's needs. Specific service gaps were noted for fentanyl-laced fake prescription pills, schizophrenia, bipolar disorder, and opioid use disorder. Additional service needs were categorized into three main themes: Housing and Residential Treatment, Specialized Treatment Services, and Service Accessibility.

Figure 11. Personal Identities of Surveyed Community Members



*N=302 Community Responses. Community Members could select more than one identity. Sum of percentages may exceed 100%.
Other identities included Monterey County employees and law enforcement. Respondents reported the following disabilities, among others: Depression, Anxiety, Attention deficit hyperactivity disorder (ADHD), Post-traumatic stress disorder (PTSD), Schizophrenia, Bipolar Disorder, and physical impairment.

Community Members also identified significant barriers to accessing care. The top barriers included a lack of information about where to get help, limited appointment availability, mental health stigma, the cost of services, and lack of health insurance. Notably, fewer than half of respondents believed individuals with behavioral health issues could receive help within the County, with perceptions varying slightly by type of insurance. Stigma was highlighted as a persistent issue, as many Community Members, despite generally favorable views on seeking mental health support, felt that negative attitudes and beliefs about mental illness continue to prevent access to care.

Regarding communication, social media, email, and newsletters were identified as the preferred methods for receiving information about mental health and substance use services, although preferences varied by generation. To address the identified challenges, Community Members made several recommendations for improving the County's behavioral health care system. These recommendations were organized into three key areas: Workforce Development, Increasing Service Availability, and Enhancing Community Outreach and Education.

Top Community Recommendations

Workforce Development

- Hire additional care providers
- Provide cultural competency training
- Increase access to bilingual providers
- Enhance working conditions for providers

Increasing Service Availability

- Increase services in rural and underserved areas including mobile and telehealth services
- Expand operations to include non-traditional hours (e.g. evenings, weekends)

Enhancing Community Outreach and Education

- Enhance the visibility of behavioral health resources
- Provide education to reduce stigma associated with mental health issues and seeking help
- Increase public awareness campaigns of services with culturally tailored messaging

CHAPTER 3:
COMMUNITY FOCUS GROUPS

Introduction

This chapter details findings from the Community Focus Groups for MCBH's Community Program Planning Process for the Fiscal Year 2024-2025 Annual Update. MCBH contracted EVALCORP, an evaluation firm, to conduct Community Focus Groups and gather crucial feedback to ensure that MCBH's behavioral health services align with the needs of the community and inform program planning. Alongside additional chapters that summarize findings from the Community Survey (Chapter 2), the Stakeholder Survey (Chapter 4), Stakeholder Focus Groups (Chapter 5), and the Listening Sessions (Chapter 6), this Chapter offers insights from Focus Groups with Community Members to inform service improvements and strategic priorities for MCBH to meet the diverse needs of Monterey County.

Engagement Strategy

The community focus groups were organized to gather insights into the current state of behavioral health services in Monterey County, specifically for underserved and underrepresented populations. Participants were recruited through MCBH system partners across the County. A total of ten key populations were identified: 1) Non-English-Speaking Individuals, 2) African American Males, 3) Veterans, 4) LGBTQ+ Community, 5) Individuals Affected by Flooding, 6) Early Childhood Caregivers, 7) South County Residents, 8) Indigenous Communities, 9) Foster Families, and 10) Individuals Affected by Mental Illness. By coordinating with MCBH system partners, 11 community focus groups were conducted to ensure representation from each priority population listed above. Six focus groups were facilitated in English, four in Spanish, and one in Triqui.

Focus groups were hosted by system partners and conducted in person or virtually, depending on the participants' needs. Four focus groups were facilitated in person, and seven were conducted virtually. Notes were taken at each session. The focus groups lasted 45 to 90 minutes. Demographic data were collected from consenting participants, and each participant received a $40 gift card as a token of appreciation for their time.

Analysis and Participant Profile

All qualitative data were cleaned and prepared for analysis, which flowed through two phases. The first phase was a qualitative content analysis of the focus group data for prominent themes. In the second phase, themes were qualitatively synthesized, analyzed, and written up in this summary.

Demographic data were analyzed using descriptive statistics. 87 Community Members participated across the 11 focus groups. A snapshot of participants' demographic and background characteristics is shown below:

Table 6. Race and Ethnicity* (N=65)

Race/Ethnicity	Percentage (%)
American Indian or Alaska Native	3%
Asian	5%
Black or African American	23%
Hispanic or Latino	63%
Native Hawaiian or Pacific Islander	2%
White	17%
Multiracial	6%
Decline to state	2%

*Percentages sum to more than 100% because participants could choose more than one option.

Table 7. Gender Identity* (N=72)

Gender Identity	Percentage (%)
Female	68%
Genderqueer	3%
Male	26%
Questioning	0%
Transgender	3%
Self-Describe	1%
Decline to State	0%

*Percentages sum to more than 100% because participants could choose more than one option.

Table 8. Language Spoken at Home (N=74)

Language	Percentage (%)
English	41%
Spanish	35%
English and Spanish	9%
Triqui	14%
Other	1%

Table 9. Sexual Orientation (N=37)

Sexual Orientation	Percentage (%)
Bisexual	5%
Gay/Lesbian	3%
Heterosexual	57%
Queer	5%
Questioning	3%
Self-Describe	3%
Decline to State	24%

Table 10. Insurance Coverage (N=69)

Coverage	Percentage (%)
Medi-Cal	58%
Medicare	16%
Private	17%
Uninsured	6%
Decline to state	3%

Findings

Focus groups were conducted with Community Members to shed light on the needs, barriers to care, and gaps in behavioral health treatment in Monterey County. The Community Members who participated discussed four main themes. First, participants talked about the language they used to describe mental health. Second, participants discussed what factors they believed contributed to poor mental health. Third, participants described their experiences navigating behavioral health services for people with severe mental illness. Fourth, participants discussed how they coped with severe mental health issues. The following sections share the findings related to each of these four themes.

The Language of Mental Health

Participants were invited to share their perspectives on the language they used to discuss mental health. These findings provide insight into how Community Members themselves talk about mental health. Participants discussed empowering and supportive mental health language, the language of the everyday realities of mental health, and stigmatizing language.

Participants discussed empowering and supportive mental health language, or how they positively frame mental health experiences and resources. In this context, participants used terms like "*happy,*" "*positive,*" "*relaxed,*" and "*well-being*" to describe mental health positively. Additionally, several participants framed mental health as "*resilience*" or the ability to work through challenges. For example, one participant explained, *"I think a lot of mental health is being able to work through when there are complications."*

Others spoke of the connection between mental and physical health, with some describing the need for balance and stability. On this note, a participant described how "*none of us are going to be able to be happy all the time, so we need to be able to develop those skills to cope in healthy ways."* Participants linked a willingness to ask for help to good mental health, as well as the need for support networks and resources. Participants also described practicing emotional regulation. These findings show that participants positively framed mental health as a willingness to manage mental health challenges.

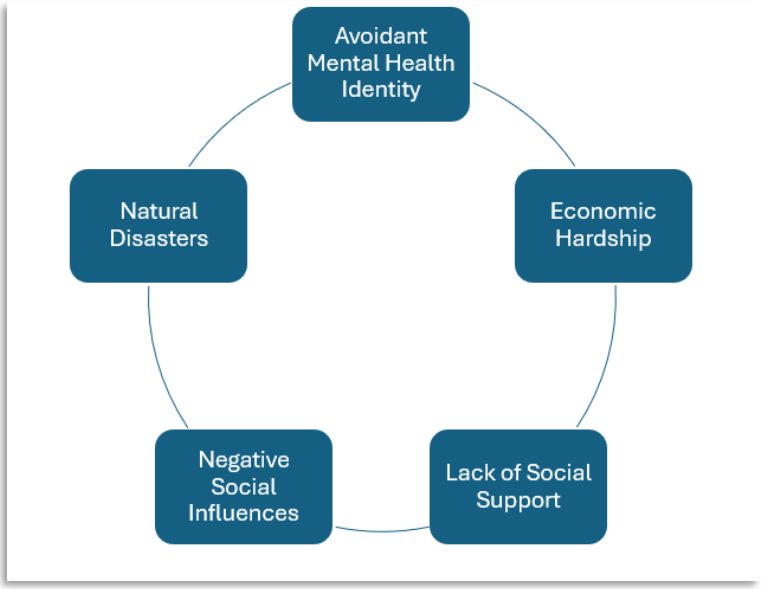
Additionally, participants highlighted the language they used to talk about the everyday realities of mental health, or how individuals experience and discuss mental health in daily life. Participants emphasized that having energy and motivation were key aspects of mental health. As one participant put it, *"Mental health is…successfully finishing your day the way you want to."* Furthermore, participants described mental health as an ever-changing state, with participants using language like "*dynamic*," "*a work in progress*," or "*limited at times*." These findings show the importance of mental health language in the everyday lives of Community Members and how such language acknowledges mental health challenges but is oriented towards overcoming these challenges.

Finally, participants discussed stigmatizing language. These conversations used medical framing and societal stereotypes. For example, many participants associated mental health with clinical diagnoses. As one participant explained, "*Mental Health, the term sounds like a diagnosis the way diabetes is a diagnosis*." This diagnosis was seen by some participants as being assigned to people who were "*crazy*" or "*not strong enough in the mind*" to deal with the challenges or hurdles they encountered. There were also instances in which the language used by participants reflected cultural stigma, including stereotypes such as associating mental health with a lack of control or motivation. These findings show that for some participants, not only was mental illness stigmatized, but mental health diagnoses were stigmatized as well.

Primary Factors Contributing to Poor Mental Health

In addition to discussing mental health language, Community Members also described what they believed to be the primary factors that contribute to poor mental health. Participants discussed an avoidant mental health identity, economic hardship, lack of social support, negative social influences, and natural disasters. For participants, these factors often overlap and reinforce one another (see Figure 12).

Figure 12. Primary Factors that Participants Report Contributing to Poor Mental Health



Some participants described an avoidant mental health identity as a factor that contributed to poor mental health. A major factor for participants was previous experiences with trauma. The trauma described included generational trauma, reported previous negative experiences with caretakers for foster children, abuse, PTSD, and fear related to natural disasters, like flooding. Participants also discussed their difficulty processing challenging emotions and experiences.

In response to these challenges, some described adopting an avoidant mental health identity that resulted in rejecting treatment. One participant explained that "*among my friends [there] is sort of like the romanticization of mental health and not getting help. Like just kind of staying stuck in that pit because that's what they identify with. That's who they think they are."* In other words, participants described how they believed that others adopted their mental health diagnosis as an identity to avoid treatment. Taken together, these findings show that, in some participants' experience, embracing the stigma around mental health contributed to poor mental health by preventing people from seeking help.

Participants also described economic hardship, such as financial stress, poverty, and socioeconomic challenges, as contributing to poor mental health. Financial stress was widely discussed across focus groups. For some participants, financial stress was the source of difficult decisions, such as caring for themselves or providing for their families. Another example is that, according to one participant, the lack of reliable and affordable licensed childcare meant that mothers often had to choose between staying home and struggling to make ends meet or sending their child to unlicensed childcare that was considered potentially unsafe. The affordability of housing was another factor that participants discussed, which for some participants was made worse due to discrimination that they faced in the housing market.

Some participants saw homelessness and "*families living on the street*" as another economic hardship that contributed to poor mental health. Participants often explicitly identified issues related to economic hardship when asked about the "*primary contributing factors to mental illness.*" It is important to note that focus group participants identified some form of financial stress or economic hardship as contributing to poor mental health in past years (FY 2022-2023 and FY 2023-2024), showing the consistency of financial hardship experienced by Community Members.

Participants also identified a lack of social support as contributing to poor mental health. Social support can refer to social relationships, support networks, and/or community. For example, challenging aspects of family life were discussed by participants as contributing to poor mental health. These challenging aspects included feeling discomfort discussing mental health challenges with family and limited support given by family members when facing mental health issues. For instance, some participants noted that their parents stigmatized them for their mental health issues. This challenge was especially acute for foster children, some reportedly living in unstable home environments.

Some participants who were caregivers also reported lacking social support, explaining that they were not educated or prepared for their role as caregivers to a loved one with mental illness. Many of these factors were explicitly identified by participants as negatively affecting their mental health. Like financial hardship, lack of social support also presents consistent challenges, having been identified by focus group participants in FY 2023-2024.

Additionally, some participants discussed negative social influences as a factor that contributed to poor mental health. These included bullying, substance use, and gangs. For example, bullying was a concern that was frequently mentioned. Participants discussed how, in some cases, schools did not do enough to stop or prevent their child(ren) from being bullied. One participant shared that the bullying their child faced was so bad that they needed to threaten legal action to compel their child's school to act.

Furthermore, some participants discussed how they faced negative influences from their peers to engage in harmful behaviors, such as substance use. Finally, one participant identified "*gang violence in some areas*" as a factor that contributed to poor mental health. Beyond a lack of

social support, participants described how these negative social influences contributed to poor mental health. This is noteworthy because while bullying was reported by the focus group participants in the FY 2022-2023, focus group participants did not report gang activity in the past two fiscal years (FY 2022-23 and FY 2023-2024) as a factor that contributed to poor mental health.

Finally, participants discussed natural disasters as contributing to poor mental health. Echoing conversations by focus group participants in FY 2023-2024, focus group participants, including survivors of the Pajaro flooding, again identified natural disasters, like flooding, as factors contributing to poor mental health. However, the findings from this fiscal year emphasize the role of trauma resulting from previous years' natural disasters and the fear of future natural disasters. For example, participants in a focus group with survivors of the flooding in Pajaro reported how children who experienced flooding were fearful and anxious about future flooding. These participants also described experiencing stress related to losing their homes and belongings. Many of these participants also discussed their feelings of powerlessness. The findings show that even natural disasters that occurred years ago still inflict trauma on participants and reportedly contribute to their poor mental health in the present day.

Navigating Services for Severe Mental Health Issues

Participants described the language they use to talk about mental health and their perception of the primary factors that contribute to poor mental health. The results in these two areas provide context for findings on how participants reported navigating services for mental health issues. The findings on how participants navigated services for severe mental illness, which are discussed below, cover barriers to service access and service engagement.

Barriers to Service Access

This section presents findings on barriers to service access. For this analysis, the term "barriers to service access" refers to challenges in accessing treatment for severe mental health issues. The barriers discussed can be remembered by thinking of the five A's (see Figure 13)[3]:

Figure 13. The Five A's of Service Access Barriers

Acceptability

Acceptability refers to factors that participants described as influencing

[3] Penchansky R and Thomas JW. "The Concept of Access: Definition and Relationship to Consumer Satisfaction." *Medical Care*. 1981;19(2):127–40. doi: 10.1097/00005650-198102000-00001

their acceptance of needing services. Across focus groups, several factors impeded acceptance of the need for service. For example, many participants discussed their fear of seeking care. Participants described a general sense of fear, as well as specific fears, including a fear of losing custody of their children if they were discovered to have mental health issues, fear due to immigration status, and fear of legal consequences for substance use issues. One participant described the fear they faced when seeking services for substance abuse: "*I was scared to seek help for [substance use] because I was a minor because I was like, am I going to go to juvie [juvenile detention] or something.*" Another participant described fears of seeking services due to immigration status: "*Some people don't have papers or don't want to give too much information on their family.*"

Another factor that participants described as influencing their acceptance of needing services was the stigma they felt they faced from their community if they sought services. In particular, some participants described how, in some communities, mental health was associated with being "*crazy,*" weak, or using drugs. One participant, for example, explained that there was a "*stigma of mental health as for crazy people or drug abusers*."

Additionally, some participants perceived a "*lack of trusted people to share with.*" Participants explained that, more broadly, they had negative previous service experiences when seeking services, such as staff being unfriendly, rude, or impersonal. One participant described how, in their experience, "*doctors are impatient and act uninterested in the patient and treat them like a number.*" These findings highlight fear, stigma, and negative experiences as factors described by participants as preventing them from accepting their need for services.

Accessibility

Accessibility refers to factors that affect the ease of accessing services or treatment. Some participants described how insurance coverage limited their access to services. One participant explained that "*insurance doesn't always cover the treatment needed.*" Transportation was another factor that hampered participants' service access. Participants described how, in some locations, they perceived that there were no transportation options to areas where most services are located. As one participant put it, "*Salinas is too far to go for services…going to nearby cities in other counties made more sense because they couldn't get all the way to Salinas easily.*" In sum, transportation and limited insurance coverage were factors that participants described as barriers to accessing services.

Accommodation

Accommodation refers to participants' perceptions of how well services are organized to meet the constraints, needs, and preferences of the community. For example, some participants described long wait times for services and treatment appointments. In the focus groups, there were reports of participants waiting from three months to over a year for an appointment. Participants also described what they perceived as limited accommodation of services due to a lack of available providers. For example, participants discussed how they perceived that there were not enough alternate options for mental health services in the case that options like group therapy were not effective for patients. The findings show that participants perceived long wait

times and limited treatment options as factors that negatively impacted how well services accommodated participants.

Availability

Availability refers to the sufficiency of resources to meet the community's demand for services and treatment. Participants described how, in their opinion, there were not enough local mental health and substance use facilities or programs. Participants also described what they saw as a problem of limited availability of some types of services, such as detox and crisis stabilization. For example, one Community Member explained that from their perspective, "*there needs to be more than just going to jail to detox—we need safe detoxing facilities and programs.*"

Participants also discussed what they perceived as a lack of youth services. In particular, some respondents explained how they thought that there was a limited availability of therapists to support minors who were experiencing mental health and substance use issues. One participant described how "*[When] I was ten, [I was] depressed and suicidal…and even then, it was near impossible to get me a therapist because nobody would accept a child my age.*" Finally, some participants explained how they believed that there was a lack of providers available for crisis management and dual diagnoses, such as mental health and substance use. To summarize, participants described their perception of the limited availability of local services, services such as detox programs, services for youth, and services for dual diagnoses.

Awareness

Awareness refers to the level of knowledge the community has about services and treatment. Across focus groups, many participants described being unaware of mental health symptoms, that Medi-Cal provides coverage for mental health services, where to go for services, what service options are available, what the eligibility criteria were for mental health services, and how to connect to MCBH services. These findings show that from participants' perspectives, awareness could be increased in various areas, such as the availability of Medi-Cal coverage and eligibility criteria for services.

Service Engagement

In addition to providing insights into service access barriers, participants made suggestions for how to optimize service engagement. In particular, participants recommended increasing information sharing, expanding community-based services and supports, and optimizing service delivery.

Focus group participants identified what they saw as an opportunity to enhance the dissemination of information about mental health, available services, and navigating the healthcare system. Participants highlighted the importance of sharing this information through trusted channels such as community organizations, churches, school-based educational programs, and community outreach efforts. This is a theme that participants discussed in last year's (FY 2023-2024) community focus groups. For example, one participant described how, from their perspective, when Community Members want information about mental health, "*they go to a trusted friend first, then their 'village' of friends and family, then a doctor.*" Participants

believed these strategies were vital for raising awareness, promoting understanding of mental health and treatment, and reducing stigma.

Additionally, participants emphasized what they saw as the need for more communication regarding how community feedback influences decision-making. As one participant explained, "*To build trust, you need to have meaningful and consistent contact with the community.*" Such transparency was identified as essential for building trust and confidence in the services provided. Below are specific suggestions from participants about the types of topics they wished to see discussed and the specific strategies they wished to see MCBH use.

Topics for Increased Communication	*Strategies for Information Distribution*
1. *Mental Illness Prevention*	1. *Increased Collaboration with Trusted Community Organizations*
2. *Recognizing Symptoms*	2. *Enhanced Advertising*
3. *Treatment Options*	3. *Increased Youth-Focused*
4. *Insurance Eligibility*	4. *Increased Inter-Agency Communication*
5. *Service Availability and Accessibility*	

Furthermore, participants discussed ways in which they wished to see community-based services and supports expanded. Participants emphasized what they believed to be the value of embedding mental health services within trusted community organizations, schools, and local neighborhoods. As one participant explained, "*Having something far is too hard for families to be involved, and you never know when you or a loved one will need that kind of care.*" Another participant discussed the benefits of mental health facilities, such as Mental Health Rehabilitation Centers, being located close to providers in order to help destigmatize such facilities. Moreover, participants suggested offering supports like mobile services and home visits to bridge the gap between individuals and necessary care. Crucially, participants voiced a similar suggestion last fiscal year (FY 2023-2024). For example, one participant suggested that MCBH could "*Make it easier to get to appointments or care providers to come to them because many services are located too far for them to realistically travel by foot or public transportation.*" Participants saw these approaches as critical for promoting service engagement by prioritizing convenience, fostering trust, and aligning with community dynamics.

In one focus group, there was a discussion of how to improve engagement with Mental Health Rehabilitation Centers (MHRCs). While the discussion covered how it would be useful to have MHRCs in more communities to facilitate access, location was not the main concern. Instead, the discussion focused on how the experience was, according to one participant, very isolating. The participant described the experience as being in "*the room alone, it makes you feel crazy. It's just four blank white walls and it makes you feel like you're crazy.*" The solution, according to the participant, was to provide a supportive psychiatric team that would not only give patients access to medication but also mental health services such as therapy. The participant shared, "*I feel like there should be some more compassion and understanding with it, too, because it's isolating, it's scary. Often times these people don't know what to do in those situations. It's just*

scary. And I think it should be put in a frame that's less scary." The participant also shared concerns regarding childcare while someone was in an MHRC. The fear was that the patients would not be able to see their children, which could make their symptoms more acute.

Participants also emphasized what they saw as an opportunity to optimize service delivery. Overall, participants provided suggestions for optimizing comprehensive and accessible service delivery that is tailored to the diverse needs of the community. To provide a holistic care experience, participants described what they saw as the importance of culturally competent and personalized care, follow-up and long-term care, as well as family and peer support. For instance, one participant suggested that MCBH "*Expand culturally relevant and holistic services, including peer support and integration of alternative therapies.*" Another participant suggested making mental health facilities more sensitive to the needs of the transgender community. Additional recommendations included extending hours of operation and increasing staffing to reduce long wait times, which are similar to suggestions voiced by participants last fiscal year (FY 2023-2024).

Finally, participants explained how they valued providers with lived experience in mental health and substance use. For example, one participant explained their need for providers with lived experience: "*I have been improving a lot more with [my provider] because I actually wanted to listen to him more because he was like 'yeah, I've literally…been through these issues, and this is what helped me,' and like, I don't know, it just really helped to have someone actually relate with me.*" Overall, these suggestions to provide holistic care, decrease wait times, enhance provider training, and hire providers with lived experience were ways that participants thought MCBH could optimize service delivery.

Coping with Severe Mental Health Issues

The findings have described the language that participants use to discuss mental health, participants' perceptions of factors contributing to poor mental health, and participants' perceptions of how the community navigates services for severe mental health issues. The last set of findings covers how participants who do not receive mental health services cope with severe mental health issues. These findings discuss participants' descriptions of coping mechanisms, as well as strategies that may provide temporary relief but can cause long-term harm.

Participants identified coping mechanisms, defined as strategies that help people manage stress and difficult emotions. For example, participants discussed the importance of informal support networks that included family, friends, online communities, peers with similar challenges, and support animals. One participant explained that "*peers who also struggled with similar issues have been helpful for me and kind of encouraging each other to get out and do things.*"

Additionally, participants described using cultural healing practices, such as sweat lodges or tea. A participant explained how they "*will sometimes treat the symptoms through curanderos*[4] *or traditional methods of teas.*" These findings show that some participants mobilized informal networks and cultural healing practices as coping mechanisms.

Finally, participants identified strategies that may provide temporary relief but can cause long-term harm. One strategy that participants described was avoidance. Participants discussed how they would cope by ignoring mental health challenges and focusing on other activities. One participant described this as "*distract[ing] yourself from the problem.*" Other participants mentioned substance use and how they would use alcohol, drugs, or other substances to manage emotional distress. According to some participants, substance abuse is often used when care is inaccessible. Finally, some participants discussed isolation and self-harming. The findings reveal that participants used a variety of strategies that may provide temporary relief but can cause long-term harm when care was unavailable. These strategies show the importance of providing care for those in need.

Summary of Findings and Recommendations

A wide range of Community Members shared their valuable perspectives regarding needs, barriers to care, and gaps in behavioral health services in Monterey County. This section summarizes the major findings and then concludes with recommendations for MCBH based on these findings.

Summary

Below is a summary of the major findings.

The Language of Mental Health

- Across different uses of mental health language, the findings show that participants frame mental health in terms of resilience. Many participants described a sort of lose/lose situation in which, regardless of whether or not they sought help for mental illness, they found themselves stigmatized. However, despite these challenges, participants emphasized their resilience in facing the challenges of mental illness.

Primary Factors Contributing to Poor Mental Health

- Economic hardship, bullying, lack of social support, and natural disasters were factors that participants discussed this fiscal year (FY 2024-2025) that were also discussed by participants in FY 2022-2023 and/or FY 2023-2024, and which may merit continued focus.
- Avoidant mental health identity and gang activity were factors that had not been reported in the previous two fiscal years and may merit attention.

[4] A "curandero" is a folk healer who uses traditional medicine or remedies.

Navigating Services for Severe Mental Health Issues

- The findings show that barriers to service access can be thought of as the five A's[3]: acceptability, accessibility, accommodation, availability, and awareness. The findings are discussed below (see Table 11).

Table 11. Findings on the Five A's

Five A's	Findings
Acceptability	Participants highlighted fear, stigma, and negative experiences as factors they perceived prevented acceptance of the need for services.
Accessibility	Participants described transportation and limited insurance coverage as factors they perceived limited access to services.
Accommodation	Participants discussed long wait times and limited treatment options as factors they perceived negatively impacted service accommodation.
Availability	Participants perceived local services, such as detox programs, as well as youth services and dual diagnosis services, as having limited availability.
Awareness	Some participants perceived a lack of awareness in the areas of Medi-Cal coverage and service eligibility criteria.

- Sharing information through trusted sources, providing mobile services, and decreasing wait times were all suggestions for service engagement made by participants this fiscal year (FY 2024-2025) that are similar to suggestions made by participants last fiscal year (FY 2023-2024).
- Enhanced communication regarding the role of community feedback in decision-making, embedding mental health services in trusted organizations, and offering providers with lived experience are all suggestions participants discussed by participants this fiscal year (FY 2024-2025) that were not discussed by participants last fiscal year (FY 2023-2024).
- There was a suggestion to make Mental Health Rehabilitation Centers (MHRC) less isolating by providing patients with a supportive psychiatric team who would provide access to medication as well as therapy. In their current state, being in an MHRC was described as an "*isolating*" and "*scary*" experience.

Coping with Severe Mental Health Issues

- Coping mechanisms that participants described using when not receiving services ranged from mobilizing support from informal networks to cultural healing practices.

- Strategies that may provide temporary relief but can cause long-term harm that participants described using when not receiving services included avoidance, substance use, isolation, and self-harm.

Recommendations

Overarching Recommendation: Leverage Proposition 1 Funding to Address the Needs, Barriers to Care, and Gaps in Behavioral Health Services Identified by Community Members.

Specific Recommendations

Findings show that many participants were resilient in the face of stigma surrounding mental illness and that participants faced stigma against mental illness regardless of whether they sought professional help. MCBH could leverage these findings in education and outreach programs in a two-pronged approach. First, increased efforts could be made to destigmatize not only mental illness, but mental illness diagnoses as well. Second, participants used mental health language that focused on resilience. Education efforts could encourage this language and approach to mental illness.

Findings show that topics for workforce training that are of relevance to participants could include providing support related to economic hardship, bullying, lack of social support, natural disasters, avoidant mental health identity, and gang activity. Outreach and education programs could also be developed that address these topics.

Findings on barriers to service access support the development of outreach programs that focus on education about, and developing skills for, overcoming fear, stigma, and previous negative service experiences while raising awareness of Medi-Cal coverage and service eligibility criteria.

Findings support providing education programs for caregivers regarding how to care for those with mental illness.

Areas of service provision that participants perceived could be addressed were long wait times, as well as increasing availability of detox programs, youth services, and dual diagnosis services.

Mental Health Rehabilitation Centers could be improved by providing patients with a psychiatric support team who could foster trust with patients, provide medication and therapy, and help coordinate childcare issues while patients were in the facility.

A substantial part of Proposition 1 funding is dedicated to providing housing. In combination with Full Service Partnerships (FSPs), housing could potentially help those with SMI who are in economic distress overcome barriers—such as stigma, fear of services, and transportation.

Findings on service engagement suggest the potential to leverage Proposition 1 funding to collaborate and empower outreach and service provision through organizations trusted by Community Members.

Findings on coping with severe mental health issues revealed that when not provided with services, some participants turned to substance use. This supports the expansion of treatment to substance use that will be implemented by Proposition 1. The findings also support developing outreach campaigns that teach techniques for managing mental health issues, so that when Community Members do not have access to services, they have behavioral health skills that they can mobilize.

CHAPTER 4:
STAKEHOLDER SURVEY

Introduction

This chapter details findings from the Stakeholder Survey for MCBH's Community Program Planning Process (CPPP) for the Fiscal Year 2024-2025 Annual Update. MCBH contracted EVALCORP, an evaluation firm, to conduct a Stakeholder Survey and gather crucial feedback to ensure that MCBH's behavioral health services align with the needs of the community and inform program planning. Alongside additional chapters that summarize findings from the Community Survey (Chapter 2), Community Focus Groups (Chapter 3), Stakeholder Focus Groups (Chapter 5), and the Listening Sessions (Chapter 6), this Chapter offers insights from the Survey with Stakeholders to inform service improvements and strategic priorities for MCBH to meet the diverse needs of Monterey County.

Engagement Strategy

Stakeholders involved in directly providing or facilitating access to behavioral health services were invited to participate in a survey from July 1 to August 31, 2024. The survey was available in English (Appendix C) and Spanish (Appendix D). In collaboration with MCBH, EVALCORP employed various outreach strategies to engage a diverse group of participants spanning the full continuum of care. Upon completing data collection, the responses were prepared for analysis, resulting in 108 total responses included in the final dataset.

Key Themes and Findings

The findings below reflect the perspectives of Stakeholders on key behavioral health issues. Participants were asked to provide their views on significant service needs, service availability, barriers to access, strengths of MCBH's continuum of care, and recommendations for improving behavioral health services. Understanding these stakeholder perceptions is crucial for identifying service delivery challenges, highlighting gaps in care, and informing workforce education. The following sections present a detailed analysis of these themes and their implications for MCBH.

Respondent Background

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.

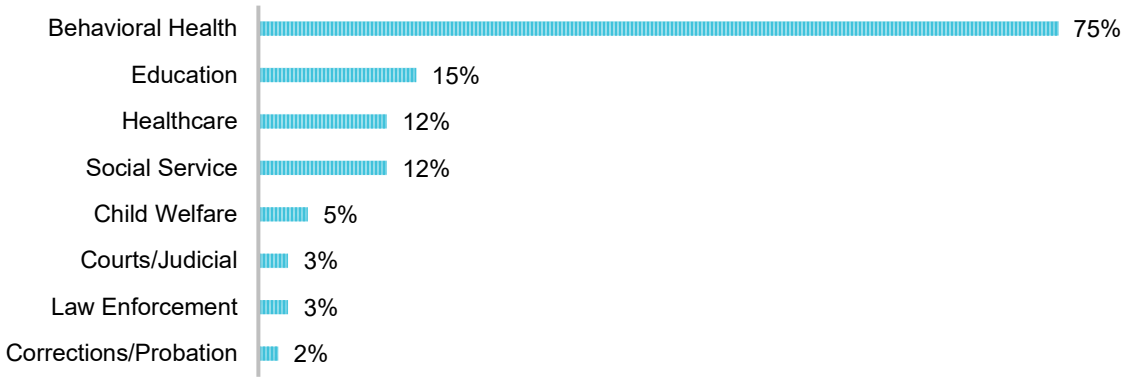
Affiliation with MCBH. Of the 107 respondents to this item, 46% identified as employees of MCBH, while 32% indicated they work at an agency or organization contracted by MCBH. Ten respondents reported working at another Monterey County agency, and 14 indicated no affiliation with Monterey County Behavioral Health. As shown in Table 12, the proportion of MCBH employees decreased compared to last year, while participation from contracting agencies and other County agencies increased, suggesting broader engagement across the County's system of care. The findings in subsequent sections should be interpreted with these shifts in mind.

Table 12. Affiliation with MCBH

Affiliation	FY 23-24 (n=92)	FY 24-25 (n=107)	% change
MCBH Employee	61%	46%	-15%
Contracts with MCBH	28%	32%	+4%
Employee of different County Department	2%	9%	+7%
No affiliation with the County	9%	13%	+4%

Sector. The majority of participants in the stakeholder survey represent the Behavioral Health sector, accounting for 75% of responses, reflecting significant involvement and interest from this field (see Figure 14). Additionally, there is notable representation from the Education sector at 15%, followed by Healthcare and Social Service sectors, each comprising 12% of respondents. A smaller proportion of participants come from Child Welfare (5%), Courts/Judicial (3%), Law Enforcement (3%), and Corrections/Probation (2%), providing a broad yet varied cross-sectoral perspective. This year's Stakeholder Survey saw an increased participation from Behavioral Health, Education, Healthcare, Law Enforcement, and Public Guardian. This diverse range of sectors ensures that the findings capture insights from multiple fields, each with its own unique priorities and challenges.

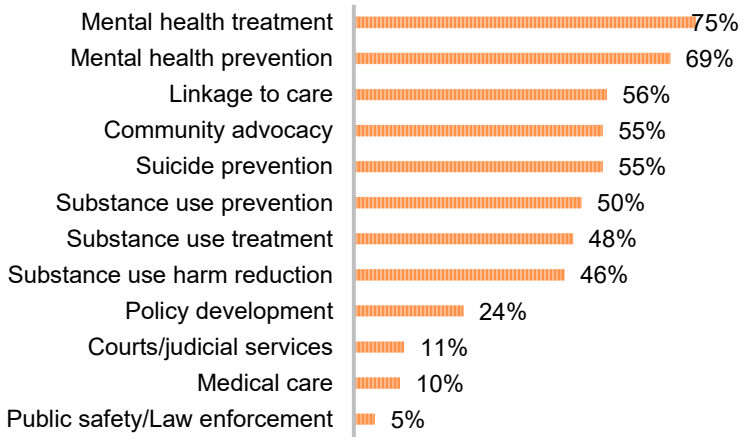
Figure 14. Sector of Professional Engagement of Engaged Stakeholders* (n=108)



* Percentages may add to more than 100% as participants could select more than one option.
Other responses accounted for 10% of the total responses. These included Early Childhood, Veteran Assistance, Community-Based Organizations, Legal Services, Case Management, and Senior Services.

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 15, 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%).

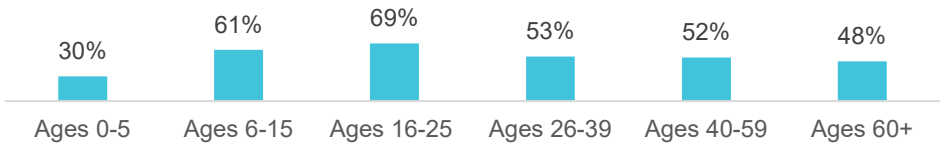
Figure 15. Services Provided by Stakeholders' Agency* (n=108)



* Percentages may add to more than 100% as participants could select more than one option.
15 Respondents selected "Other", accounting for 14% of respondents. These other services included quality improvement, support and advocacy services, counseling services, and educational services.

Time Working in Behavioral Health. When asked how long each participant has been working directly or indirectly with those needing behavioral health services, 26% of participants selected 1-4 years, 22% of participants selected 5-9 years, and more than half of participants, 52%, selected 10 or more years. Of the 108 respondents, more than half of Stakeholders (52%) reported serving these populations for 10 or more years, reflecting a wealth of knowledge and experience informing this needs assessment.

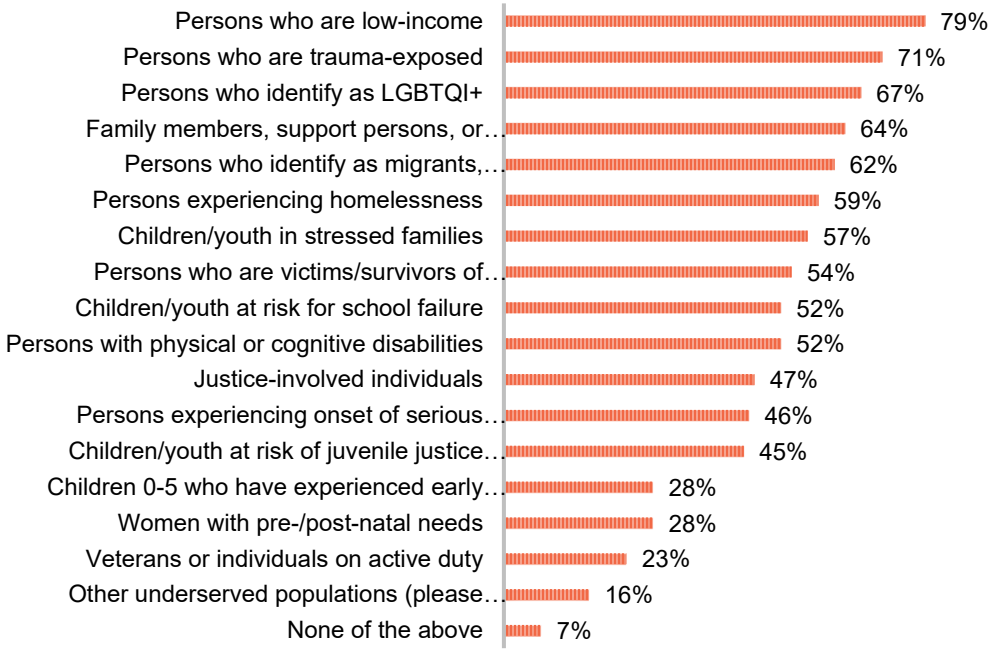
Figure 16. Ages Served* (n=101)



* Percentages may add to more than 100% as participants could select more than one option.

Ages and Populations Served. Stakeholders were asked what age groups and populations they served through their professional engagement. Responses revealed that they served all ages and populations facing diverse needs. See detailed ages and populations in Figures 16 and 17, respectively. Notably, there is a 14% increase in the proportion of survey participants who serve the 60+ population when compared to results from the prior year's Stakeholder Survey.

Figure 17. Populations and Needs Served* (n=102)



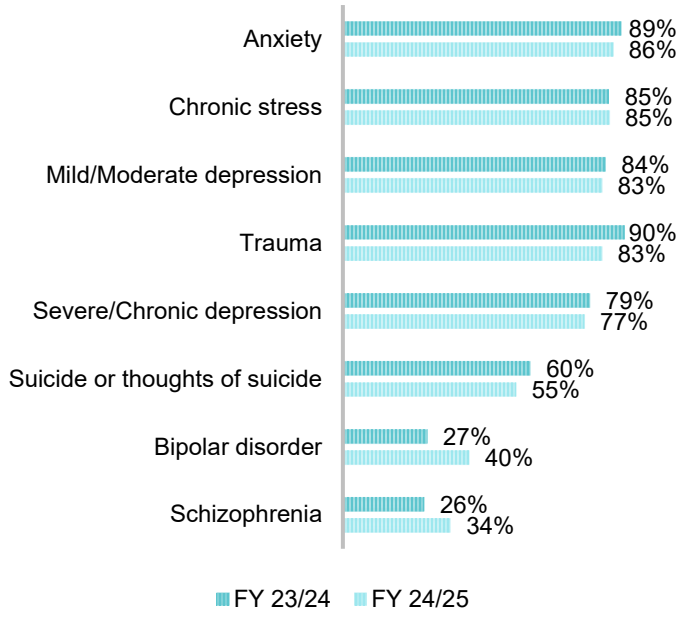
* Percentages may add to more than 100% as participants could select more than one option. 17 Respondents selected "Other", accounting for 16% of Respondents. Other services listed included seniors, South County, Indigenous populations, youth, African Americans, families, and victims of sexual assault and human trafficking.

Area Served. The cities of Monterey County are often grouped into three regions: North County, South County, and the Coastal Region. North and South County cities include various non-English or Spanish-speaking indigenous communities. Regions of Monterey County vary in geographic and population-specific needs. Stakeholders were asked about the areas of the county they serve. Of the 104 respondents surveyed, 61% reported serving the entire County, while 29%, 17%, and 14% of Stakeholders reported that they only served North County, South County, or the Coastal Regions, respectively. Stakeholders were allowed to select more than one area served, so 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.

Mental Health and Substance Use Service Needs

Figure 18. Prevalence of Mental Issues Rated as "A Major Issue"* (n=93-95)



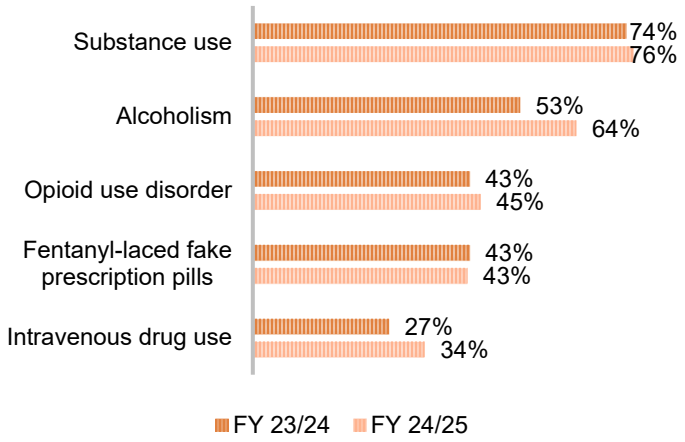
*Respondents were asked to rank each issue listed on a scale from "Not an Issue" to "A Major Issue".
There were no limits on how many issues could be ranked as "A Major Issue".
Other response options included homelessness, community violence, borderline disorder, problems with law enforcement, and sexual trauma.

To better understand the community's behavioral health service needs, Stakeholders 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 access to 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 18, the top mental health issues identified by participants include anxiety, chronic stress, and mild/moderate depression. The percentage of participants who identified trauma as a major issue notably decreased from last year to this year, likely due to the Pajaro Valley flooding that occurred two years ago, which brought greater attention to the trauma experienced from natural disasters. The percentage of respondents indicating that bipolar disorder and schizophrenia are major issues increased in this year's survey. This is likely due to recent efforts to expand programs such as Wellscreen Monterey and Psychiatric Advance Directives (PADs) that lead to greater education and awareness of the experiences and needs of individuals with serious mental health conditions, as well as increased treatment engagement within the County.

Figure 19 shows the percentage of participants who identified specific substance use issues as a major issue. 76% of participants in this year's survey identified substance use as a major issue. Alcoholism was the issue with the next highest percentage, at 64%. This reflects an 11% increase from last year's survey. As with findings for mental health issues in the previous section, these results are likely linked to MCBH's recent emphasis on programs such as Wellscreen Monterey that foster increased awareness of substance use in the community.

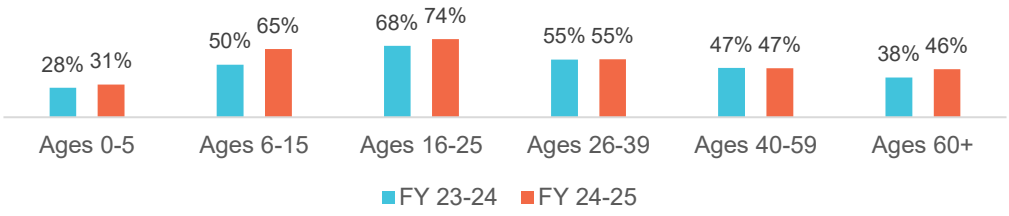
Figure 19. Prevalence of Substance Issues Rated as "A Major Issue"* (n=93-95)



*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".
Other response options included methamphetamine and e-cigarette use among youth.

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. At least half of the respondents identified age groups 6-15, 16-25, and 26-39 as most being in need of additional resources (see Figure 20). Additionally, youth ages 6-15 saw the largest increase from last year's survey to this year's, followed by the 60+ age group.

Figure 20. Age Groups in Most Need of Additional Resources * (n=94)



* Percentages may add to more than 100% as participants could select more than one option.

Connection to Other Services. Stakeholders were asked to identify services with which they could connect their clients. Respondents reported being able to connect their clients to a range of services. Table 13 reveals responses from stakeholder participants last year and this year. Findings show a slight decrease in the ability of respondents to connect individuals to various services. This is likely due to the broader participation of Stakeholders outside of MCBH and

suggests that individuals within system partners, including community-based organizations and other County agencies, may need support with the process of connecting individuals they serve to needed services.

Table 13. Services Stakeholders can Connect Clients to*

Resource	FY 23-24	FY 24-25	% change
Counseling	85%	75%	-7%
Crisis response	74%	65%	-6%
Care related to substance use	73%	62%	-6%
Advocacy on behalf of persons experiencing mental health or substance use issues	64%	61%	-6%
Support groups	63%	53%	-5%
Transportation assistance	51%	42%	-4%
Services for individuals who are homeless/unhoused	48%	44%	-4%
Healthcare	45%	55%	-5%
Short-term shelter	45%	32%	-3%
Translation services	43%	36%	-3%
System navigation assistance	36%	35%	-3%
Financial assistance	30%	42%	-4%
Home visitation services	29%	28%	-3%
Legal services	25%	32%	-3%
Insurance	21%	35%	-3%
Long-term shelter/relocation	21%	28%	-3%
Other mental health services◇	20%	14%	-1%
Spiritual/Faith-based supports	18%	20%	-2%
Reentry support services	12%	28%	-3%
Other substance use services◇	12%	11%	-1%
Hospice care	10%	18%	-2%

N=87

* Percentages may add to more than 100% as participants could select more than one option. Eight respondents indicated that this question did not apply to them as they did not provide direct services to community members. Eleven respondents selected “other” services and listed education, peer support, family support trauma processing, psychotherapy, 5150 evaluation, and outpatient services.

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 in Table 14 show that more than 2/3 of Stakeholder

respondents thought mental health (85%) and substance use (67%) services are available but insufficient to meet the current need.

Together, findings reveal an opportunity to ensure Stakeholders understand behavioral health resources available to the community.

Stakeholder-Identified Barriers to Care

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

Table 14. Availability of Mental Health Services *

Mental Health Services (N=95)	FY 23-24	FY 24-25
Available but insufficient to meet current needs	85%	85%
Available to meet current needs	9%	6%
Not available	4%	2%
I don't know	2%	6%
Substance Use Services (N=95)	**FY 23-24**	**FY 24-25**
Available but insufficient to meet current needs	85%	67%
Available to meet current needs	9%	9%
Not available	4%	7%
I don't know	2%	16%

* Percentages may not add to 100% due to rounding.

System-Wide Barriers. Stakeholders were asked to identify barriers that community members face when trying to access services. To provide an overall view of 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 Table 15, issues regarding staffing, such as staff shortages and long wait lists, were the barriers most frequently identified as “Often a Barrier” by Stakeholders. Of note, Lack of Trust and Language Barriers saw the greatest increases as barriers perceived by participants.[5]

[5] As part of their ongoing commitment to the community, MCBH prioritizes fostering trusting relationships with the community, including Indigenous peoples. It prioritizes respectful communication, cultural competency, community engagement, and active listening to community members. MCBH is actively working to dismantle systemic barriers and challenges, ensuring that Indigenous communities have a voice in decision-making processes. Additionally, it tailors its services to meet the unique needs and cultural practices of these communities. MCBH has also increased their effort to provide educational and outreach materials in both English and Spanish. Findings suggest that those efforts have been noticed and are potentially highlighting other opportunities to address language barriers with other populations, such as the Indigenous communities.

Table 15. Issues Identified as "Often Barriers" to Receiving Services (n=77-79)

Barriers to Care	FY 23-24	FY 24-25	% Change
Not enough staff to meet the needs of the community	70%	81%	11%
Lack of transportation	51%	65%	14%
Long waiting lists	55%	61%	6%
Stigma associated with receiving help	45%	53%	8%
Lack of trust	35%	53%	18%
Language barriers	37%	53%	16%
Residents are unaware of how to access services	42%	52%	10%
Appointment time or hours do not work for their schedule	44%	51%	7%
Inability to take time off work	51%	51%	0%
Residents are unaware of available services	37%	47%	10%
Lack of childcare	34%	44%	10%
Lack of qualified insurance coverage	34%	42%	8%
Lack of technology or skills to use technology	31%	41%	10%
Cost of services	31%	39%	8%
Lack of culturally appropriate services	31%	35%	4%
Service providers do not help residents navigate the system	19%	30%	11%
Service providers are unaware of available services	23%	29%	6%
Lack of a home address	26%	27%	1%
Lack of gender-inclusive services	18%	20%	2%
Services not accommodating to disability	16%	16%	0%

Respondents could also write in other barriers. Write-in responses included the following: VA benefits, not enough education, location of services, staff transitions, and racism. The respondent who reported "racism" did not expand upon this issue.

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 to which services clients can be referred based on the client's condition and insurance status. As shown in Table 16, respondents displayed distinct strengths regarding knowledge of referrals for Medi-Cal. However, respondents were not as confident for clients with other insurance statuses.

Table 16. Knowledge of Referral Process for Severe Mental Health Conditions

"I know how/where to refer persons with **severe mental health conditions** for the services they need."			
Client Population	**FY 23-24**	**FY 24-25**	**% Change**
Persons who have Medi-Cal (N=85)	95%	77%	-18%
Persons who have Medicare (N=85)	52%	53%	+1%
Persons with private insurance (N=85)	51%	46%	-5%
Persons who are uninsured (N=85)	61%	51%	-10%

Respondents displayed similar patterns when asked about knowledge of referrals for persons with mild to moderate mental illness. As shown in Table 17, respondents displayed greater levels of confidence in their knowledge of the referral process for individuals with Medi-Cal. However, respondents were not as confident for clients with other insurance statuses.

Table 17. Knowledge of Referral Process for Mild to Moderate Mental Health Conditions

"I know how/where to refer persons with **mild to moderate mental illness** for the services they need."			
Client Population	**FY 23-24**	**FY 24-25**	**% Change**
Persons who have Medi-Cal (N=85)	89%	81%	-8%
Persons who have Medicare (N=85)	49%	53%	+4%
Persons with private insurance (N=85)	59%	55%	-4%
Persons who are uninsured (N=85)	51%	49%	-2%

An analysis compared MCBH employees' knowledge of referral processes across different insurance types with that of non-MCBH employees. Among MCBH employees, 79%, 48%, 63%, and 33% reported knowing how to refer individuals with severe mental illness who have Medi-Cal, Medicare, private insurance, or no insurance, respectively. Similarly, 89%, 56%, 70%, and 44% of MCBH employees indicated they knew how to refer individuals with mild to moderate mental health needs who have Medi-Cal, Medicare, private insurance, or no insurance to appropriate services, respectively. These findings suggest that MCBH employees are generally more confident referring individuals with Medi-Cal and individuals with private insurance. When compared to non-MCBH employees, there is a notable decrease in perceived knowledge related to referring those with no insurance at all, particularly for those with severe mental illness.

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 needed substance use services. Stakeholders were asked about their knowledge regarding to which services clients can be referred based on their condition and insurance status. As shown in Table 18, respondents displayed distinct strengths regarding knowledge of referrals for Medi-Cal. However, respondents were not as confident for clients with other insurance statuses. Comparatively, 89%, 56%, 70%, and 44% of MCBH employees indicated they know how to refer individuals to substance use services who have Medi-Cal, Medicare, private insurance, or no insurance to appropriate services, respectively.

Table 18. 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	**FY 23-24**	**FY 24-25**	**% Change**
Persons who have Medi-Cal (N=85)	89%	72%	-10%
Persons who have Medicare (N=85)	49%	33%	-7%
Persons with private insurance (N=85)	59%	39%	+2%
Persons who are uninsured (N=85)	51%	45%	+10%

Connecting to Care. Finally, 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”, 16% of the 76 respondents who answered the question agreed with the statement. The percentage of MCBH employee respondents who agreed was slightly higher (22%). Furthermore, when respondents were asked whether they agreed with the statement “I am confident that when I make a referral to substance use services that it will result in treatment”, 15% of the 77 respondents who answered the question agreed with the statement. Of the respondents who identified as MCBH employees, 16% agreed with this statement. These findings present an opportunity for MCBH to examine referral processes and ensure consistent communication across providers throughout the referral process.

Care Management Training. Stakeholders were asked about their training experiences at their organization as well as their openness to complete additional training on providing referrals for behavioral health services. As seen in Tables 19 and 20, fewer than half of respondents indicated that their agency provides training on how to make referrals for individuals with severe mental illness, mild to moderate mental health conditions, or substance use disorders. It is also noteworthy that more than 70% of respondents expressed willingness to attend trainings on how to make referrals for individuals with these health conditions. These results hold steady across those who identified as MCBH employees.

Table 19. Current Training for Referring Individuals* (n=78-79)

My agency provides training on how to make referrals for persons with…	% Agree
Severe Mental Illness	41%
Mild to Moderate Mental Health Conditions	36%
Substance Use Disorders	39%

Table 20. Willingness for Training on Referral Process* (n=78-79)

I would attend a training on how to make referrals for services for persons with…	% Agree
Severe Mental Illness	73%
Mild to Moderate Mental Health Conditions	73%
Substance Use Disorders	71%

Areas of Effectiveness

To understand the strengths within the behavioral health system of care, Stakeholders were asked what they thought was most effective about MCBH's current continuum of care for persons experiencing mental health issues. This question was open-ended, allowing respondents to share their views further in their own words. Themes were identified across responses and detailed below:

Stakeholder Perceptions of Monterey County Behavioral Health Strengths

Quality of Services (8)	Stakeholders recognized MCBH's strong partnerships and diverse service offerings, particularly noting its effective collaboration with community organizations, healthcare providers, and schools. These connections, along with successful rehabilitation programs and preventative services, were seen as contributing to the overall quality of care provided by MCBH.
Caring and Experienced Staff (7)	Stakeholders viewed MCBH staff as dedicated and compassionate, going beyond their basic responsibilities to meet client needs. Staff members were praised for their ability to build trust within the community, often providing bilingual support and taking personal steps to help clients navigate complex systems and access services.
Accessibility of Services (6)	Stakeholders appreciated MCBH's efforts to make services accessible, including offering bilingual staff, extended service hours, and removing

	financial barriers by accepting Medi-Cal. They also valued MCBH's ability to provide outreach to underserved populations and to connect clients with needed services in a timely manner.
Range of Services (6)	MCBH was recognized by Stakeholders for offering a wide variety of services that address both immediate and long-term needs. From LGBTQ+-specific programs to services for individuals dealing with homelessness or substance use, the department is perceived as offering comprehensive support across multiple sectors of the community.
Continuity of Care (6)	Stakeholders emphasized the importance of coordinated care, highlighting the department's ability to ensure smooth transitions between services and providers. Effective communication between various programs, as well as partnerships with external organizations, helps maintain continuity in client care and build trust across service systems.

Stakeholder Recommendations

To solicit recommendations to improve the behavioral health system of care, Stakeholders were asked for recommendations to improve the system of care for individuals needing behavioral health services. This question was also open-ended, and findings bring to light actionable recommendations for improving engagement with services.

Stakeholder Recommendations for Improving Behavioral Health Services

Increase Coordination of Care (16)	Stakeholders expressed the need for stronger coordination between mental health and substance use services, highlighting what respondents perceived to be fragmentation that leaves clients navigating multiple systems without adequate support. Respondents emphasized the importance of establishing a centralized referral process, with better communication across agencies and providers, particularly for clients with co-occurring conditions. Suggestions included creating more structured educational programs for families, improving cultural competence, and increasing access to services through bilingual support. Additionally, respondents called for more training for front-line staff, enhanced collaboration between agencies, and an integrated documentation system to ensure clients receive holistic care without the burden of navigating disjointed systems.
Provide More Education on Available Services and Eligibility (12)	Respondents emphasized what they perceived as a need for clearer and more accessible information on available services and eligibility requirements. Respondents suggested providing updated lists of providers, including providers/services outside the County, along with guidance on wait times, insurance options, and service availability. Simplifying the referral process through user-friendly resources like flowcharts or brochures was recommended to help clients and providers better navigate the system. Stakeholders also expressed the desire for more transparency

	in service criteria and flexibility in eligibility to ensure people receive the care they need without unnecessary delays.
Increase Accessibility of Services (10)	Stakeholders believed that accessibility could be improved by offering services when and where the community needs them most, particularly for underserved populations in rural areas and non-English speakers. Suggestions included more consistent service availability, expanded service hours, and bilingual support to address the language barriers. Additionally, respondents called for better coordination between mental health and substance use services and urged Monterey County to invest in local clinics to reduce the burden of traveling for care. Simplifying the referral process and reducing wait times were also highlighted as key areas for improving the accessibility of services.
Expand Service Offerings (8)	Stakeholders emphasized the need to expand services in areas such as housing for patients, early psychosis treatment for young adults, and additional care teams to meet the growing demand. The need for more coordinated and responsive care, with better communication among providers, was highlighted, as well as the importance of training staff to address critical issues such as perinatal mood disorders and integrating mental health and substance use treatment. Expanding residential treatment options, especially for adolescents and adults, along with more accessible services in high-needs regions, were noted as key areas for growth.
Support Service Staff (5)	Respondents emphasized the importance of supporting staff by reducing unnecessary tasks and focusing on their core responsibilities. Respondents expressed concern about high burnout and turnover due to what they perceived as a lack of proper support and care from leadership. There was a strong recommendation to provide more resources for clinicians, so that they can focus on delivering therapy rather than solely case management, which respondents believed would lead to better treatment outcomes. Additionally, improving communication between providers and offering more training for front-line staff on mental health symptoms, screening, and welcoming clients were highlighted as important to enhancing staff support.

Summary of Findings and Recommendations

The Monterey County Behavioral Health Stakeholder Survey has gathered valuable insights from a diverse group of Stakeholders, 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.

Summary of Findings

Overall Participation and Representation:

- The 2024 Stakeholder Survey saw broad representation from various sectors, including MCBH employees, contracting agencies, and other County agencies.
- Compared to previous years, participation has expanded, reflecting increased engagement from Stakeholders across the system of care.
- Notable sectors include education, healthcare, law enforcement, and child welfare, all of whom provided valuable insights into the unique challenges and priorities faced by different parts of the County's service delivery system.

Mental Health Needs:

- Stakeholders highlighted key mental health issues impacting Monterey County, with anxiety, chronic stress, and mild to moderate depression emerging as the most pressing concerns.
- While there has been a notable decrease in the perception of trauma as a major issue compared to last year, concerns about severe mental health conditions, including bipolar disorder and schizophrenia, have risen.

Substance Use Concerns:

- Substance use continues to be a significant issue, with 76% of participants identifying it as a major concern in Monterey County.
- Alcoholism remains the most frequently mentioned specific substance use problem, with a noticeable increase in concern from last year.
- Additionally, opioid use disorder and the rise of fentanyl-laced fake prescription pills were identified as growing concerns.

Barriers to Care:

- According to respondents, access to behavioral health services is hindered by several barriers.
- Staffing shortages, long wait lists, and transportation issues were the most frequently cited challenges.
- Language barriers, a lack of trust, and limited awareness of how to access services also posed significant obstacles for many community members, according to respondents.

Service Delivery:

- Despite the challenges, respondents identified several strengths within Monterey County's behavioral health system.
- The quality of services provided, particularly through strong partnerships with community organizations and healthcare providers, was consistently praised.
- The accessibility of services, particularly through bilingual support and Medi-Cal acceptance, also received positive feedback.
- Furthermore, MCBH's caring and experienced staff were highlighted for their dedication and ability to build trust with clients, facilitating access to necessary care and services.

Opportunities for Improvement:

- Stakeholders provided actionable recommendations to improve the system of care. A recurring theme was what respondents saw as the need for better coordination between mental health and substance use services, especially for clients with co-occurring conditions.
- There were also calls for increased education on available services and eligibility criteria, with a focus on simplifying referral processes. Expanding services in underserved areas, particularly rural regions and non-English-speaking communities, was seen as a critical step in addressing gaps in service delivery and ensuring equitable access to care.

Training and Workforce Development:

- Workforce development emerged as a key opportunity, with respondents expressing a strong desire for additional training.
- Less than half of the respondents indicated their organizations provide training on how to make referrals for mental health or substance use services. However, over 70% of respondents expressed a willingness to attend such training.

Recommendations

The findings on mental health needs underscore the need to address both acute and chronic mental health disorders as well as broader systemic issues such as stress and anxiety that affect large portions of the community.

The findings on subtance use concerns call for focused interventions targeting both alcohol-related issues and the emerging challenges posed by opioids and synthetic drugs.

Findings on barriers to care suggest an urgent need to expand workforce capacity, improve service accessibility, and enhance communication efforts to address these systemic barriers.

Findings on training and workforce development demonstrate a significant opportunity for MCBH to invest in training programs that enhance the workforce's ability to navigate the referral process and connect clients to the appropriate services.

The findings of this survey underscore the importance of taking action to close existing service gaps and improve access to behavioral health services in Monterey County. By focusing on enhancing coordination between services, expanding workforce capacity, and providing additional training, MCBH can better meet the behavioral health needs of its diverse population. A commitment to continuous quality improvement, resource expansion, and community engagement will ensure MCBH’s system of care remains responsive, equitable, and capable of supporting all residents.

CHAPTER 5:
STAKEHOLDER FOCUS GROUPS

Introduction

This chapter details findings from the Stakeholder Focus Groups for MCBH's Community Program Planning Process (CPPP) for the Fiscal Year 2024-2025 Annual Update. MCBH contracted EVALCORP, an evaluation firm, to conduct Stakeholder Focus Groups and gather crucial feedback to ensure that MCBH's behavioral health services align with the needs of the community and inform program planning. Alongside additional chapters that summarize findings from the Community Survey (Chapter 2), Community Focus Groups (Chapter 3), the Stakeholder Survey (Chapter 4), and the Listening Sessions (Chapter 6), this Chapter offers insights from focus groups with Stakeholders to inform service improvements and strategic priorities for MCBH to meet the diverse needs of Monterey County.

Engagement Strategy

EVALCORP collaborated with MCBH to purposively recruit a diverse set of Stakeholders. The goal of these focus groups was to gather feedback to ensure that MCBH's behavioral health services aligned with the community's needs.

The Stakeholders represented law enforcement and members of organizations that provide mental health services. MCBH staff were involved in the planning process and recruitment of participants. Participants were asked to share insights into unmet needs, resources, barriers, and recommendations. Seven focus groups were conducted over Zoom with a grand total of 60 participants. Additionally, one written response to the focus group protocol was submitted. Finally, demographic forms were collected digitally from participants at the beginning of each focus group.

Below is a discussion of the analysis and a description of the participants. This is followed by findings on Stakeholders' perspectives on behavioral health issues and services in Monterey County. After the findings, the report will provide a summary of the results along with recommendations for MCBH.

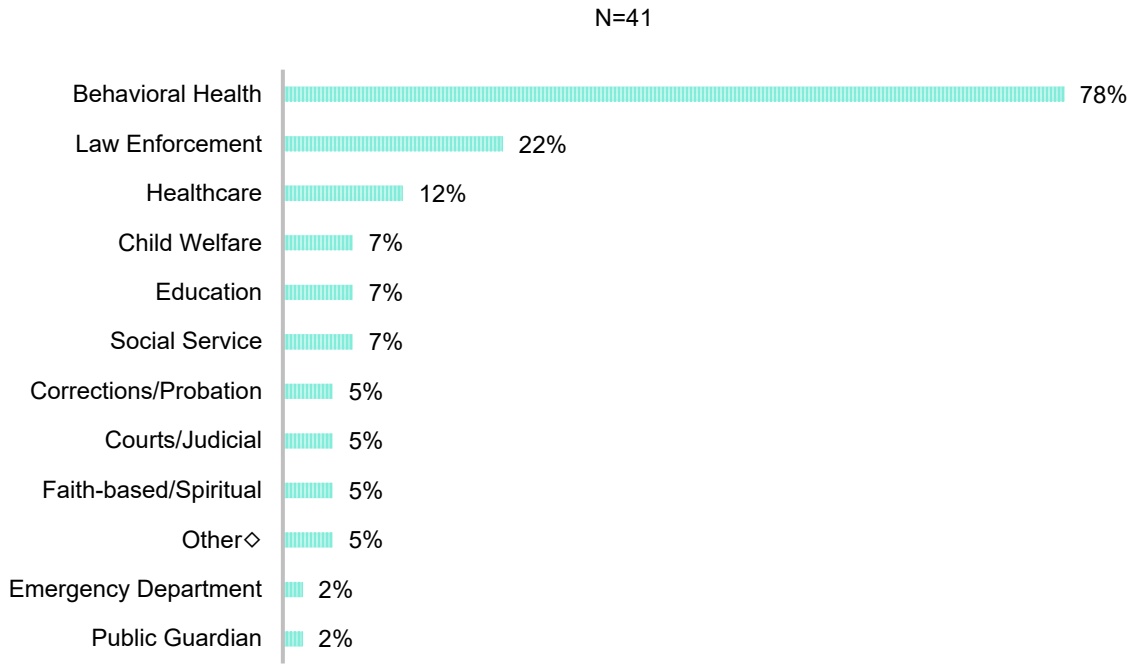
Analysis and Participant Profile

After data collection was completed, the data were cleaned and reviewed. Focus group data were then analyzed with qualitative coding. Additionally, focus group demographic data were analyzed quantitatively.

This report uses data from focus group demographic forms (N=41) to provide tables and a brief summary of Participants' Sector of Occupation (Figure 21) and Affiliation with MCBH (Figure 22).

A majority of participants worked in the behavioral health sector (78%), while almost 1/4 (22%) worked in law enforcement.

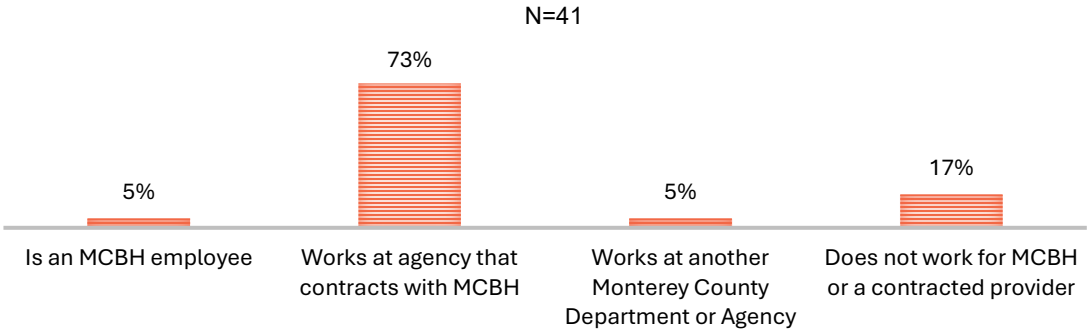
Figure 21. Sector of Professional Engagement of Engaged Stakeholders*



*Stakeholders could select more than one Sector.
◇2 respondents selected "Other", accounting for 5% of Respondents. Additional sectors included Victim Assistance Advocate and Community Organization.

The majority (73%) of participants were MCBH contractors. Additionally, almost 1/5 (17%) of participants did not work for MCBH or a contracted provider. The results from Figure 21 and Figure 22 demonstrate the approach discussed in the engagement strategy, in which participants from MCBH contractors and law enforcement agencies were recruited.

Figure 22. Engaged Stakeholders' Affiliation with Monterey County Behavioral Health



Findings

Focus groups were conducted with Stakeholders to collect feedback aimed at maximizing the effectiveness of behavioral health services and addressing the diverse needs of all community members. Participants provided insights into unmet needs, available resources, barriers to

access, and recommendations for service improvement. The following section presents these findings followed by a summary of results and actionable recommendations.

Unmet Needs

Participants were invited to share their perspectives on the community's unmet behavioral health needs. The findings presented below cover participants' opinions about aspects of the system of care that do not fully address the community's needs. Participants discussed aspects related to community outreach, collaboration, and increased access to MCBH services as perceived gaps in the current continuum of care.

Community Outreach

Participants highlighted what they perceived to be gaps in community outreach as areas needing further attention. This analysis investigates what Stakeholders believed were insufficient elements of MCBH's efforts to increase community awareness of services. Participants described accessibility, advertising, and community education as three types of perceived gaps in community outreach.

Participants were asked how access to behavioral health services could be improved. Participants stressed the need for more accessible outreach, especially for underrepresented populations. One participant described how, from their perspective, underrepresented populations want to see more community outreach from "*trusted messengers.*" Furthermore, both service providers and law enforcement participants described how they wished there was more Spanish-language outreach. Overall, participants conveyed that tailored, culturally appropriate outreach is essential to address the need for equitable access to important behavioral health information.

Additionally, participants discussed how they believed there was not enough advertising to raise awareness about available behavioral health services. One participant described how *"not a lot of people know"* about MCBH and how *"we need people to know that services are available…you can't assume that [parents] will Google mental health."* The participant went on to explain how advertising *"needs to be thrown in their faces…we can't assume they even have the language to Google it."* This echoed the sentiment of many participants who described how they would like to see a more proactive approach taken to advertising and outreach. The takeaway message from Stakeholders on this topic was that they would like to see MCBH more actively advertise its services to raise awareness.

Beyond outreach and advertising, participants discussed education as an unmet need. In particular, participants stressed the need for education regarding awareness of behavioral health issues in schools and strategies for prevention. As one participant succinctly put it, "*the education piece is not there,*" underlining the need for a stronger focus on prevention. Furthermore, a participant in a provider focus group explained "*We have the kids, but we need to have more educational services for them.*" To summarize, participants emphasized what they saw as the need for greater efforts to teach children about mental health and strategies for prevention.

Collaboration

In addition to increased community outreach, participants also expressed their desire for more active collaboration between MCBH and Stakeholders. The analysis of the theme of collaboration focuses on participants' desire to see MCBH increase communication with providers and law enforcement.

Most focus groups expressed a desire to see increased communication between service providers and MCBH. For example, participants in a provider focus group were asked how MCBH can better collaborate with Stakeholders. One participant explained that from their perspective, "*a more collaborative process of communication would be much appreciated*," which would entail more "*consistent communication.*" Participants were also asked about how the interconnected mental health system of care in Monterey County can be improved. A provider focus group participant answered that they wished to see "*increased communication between MCBH and us and other programs.*" Another participant expanded on the theme of increased communication between MCBH and providers by expressing a desire for "*greater communication and collaboration from the county.*" This sentiment was echoed by a participant who explained that "*we just want to make sure that we're all on the same page and [are] able to support the needs of the community.*" These findings show participants' desire for increased communication between MCBH and providers.

Additionally, participants discussed what they saw as the need to increase communication between MCBH and law enforcement. One law enforcement focus group participant described how "*in a perfect world I think [addressing challenges and barriers] would be a collaborative effort*" but acknowledged that "*I know that things get involved with HIPAA and all of these obstacles come up.*" Another law enforcement focus group participant explained how many individuals with substance use issues are arrested but that "*upon release, they just fall off the radar…As soon as they're released here, there's no transfer of information over to the county.*" Taken together, these results show that participants recognized there were complications, but ultimately wished to see efforts to increase communication between law enforcement and MCBH.

Increased Access to Services

In addition to community outreach and collaboration, some participants expressed a desire to see increased access to services for the community. In particular, participants discussed what they saw as the need for cultural representation, culturally sensitive care, and particular services.

Participants discussed their desire for greater cultural representation. For example, participants described what they perceived as the need for increased cultural representation for the African American community. A participant explained that, in their view, "*there are no African American therapists.*" The participant elaborated that "*there are so many young African American males that really need that service from another Black male.*" This quote exemplifies the discussion around the topic of increased cultural representation.

Additionally, a number of participants expressed their desire to see increased culturally sensitive care. For example, one participant explained that many come to Monterey County to work as agricultural laborers. The participant elaborated that the community of agricultural workers was very diverse, as they were from "*not just Mexico, but a lot of other countries.*" The participant then discussed how, from their perspective, clinicians often were not trained to deal with acculturation issues faced by these agricultural workers. Overall, this example typifies the desire among participants to see increased culturally sensitive care.

Finally, participants described various areas where they perceived the community's demand exceeded the availability of services. One participant expressed a desire that "*every county should have an access team*" dedicated to increased capacity. More specifically, participants described what they perceived as the need for increased access to group therapy, the mobile crisis unit, mobile services, preventative services, and telehealth. These findings show that, in the eyes of some participants, MCBH should increase community access to these particular services.

Limited Resources

Finally, participants discussed what they believed were limited community resources. Across provider and law enforcement focus groups, participants described what they perceived as high staff turnover and long appointment wait times. Similarly, participants from both provider and law enforcement focus groups described what they perceived to be a shortage of clinicians, interpretation services, long-term support, service availability, and suicide prevention services. Taken together, these findings reveal the particular resources that participants believe MCBH should increase.

Resources

While participants described the community's unmet needs, they also provided insights into MCBH's resources. Participants discussed provider services and MCBH staff as behavioral health resources.

Provider Services

Participants highlighted the contributions of a number of providers. In alphabetical order, focus group participants highlighted the Center for Community Advocacy, Community Human Services, Hope Housing Project, Interim, Ohana Center, Pajaro Valley Prevention and Student Assistance, Sierra Health + Wellness, Sun Street Centers, The Community Hospital of Monterey Peninsula, The Epicenter, The Village Project, and Veterans Affairs. These findings show specific providers that participants believed were a resource for the community.

MCBH Staff

Additionally, participants identified MCBH staff as a key resource. In particular, participants discussed staff responsiveness and staff friendliness as resources.

Participants discussed MCBH's responsiveness as a resource. A participant in a provider focus group explained that they could easily reach MCBH when a client was "*in crisis.*" The participant then discussed how MCBH staff always responded quickly. The participant mentioned the

responsiveness of county psychiatrists in particular and was very appreciative. There was a similar response from law enforcement participants. In one law enforcement focus group, a participant explained that they worked frequently with MCBH and that MCBH is "*a wonderful resource.*" Another participant explained that "*nobody [from MCBH] has said no, we're not going to help you.*" The participant elaborated that they had "*no complaints, [MCBH is] very supportive to the community, and very receptive when law enforcement calls.*" These findings show that participants across provider and law enforcement focus groups noted and appreciated the responsiveness of MCBH staff.

Another resource that participants discussed was the friendliness of MCBH staff. A participant in a provider focus group explained how "*the people that we've been working with [at MCBH] are really supportive and really nice.*" This was reinforced by a participant from a law enforcement focus group, who explained that "*we appreciate Behavioral Health.*" The participant elaborated that "*the people who work there are absolutely amazing…they're doing a great job.*" It is important to note that participants from across law enforcement and provider focus groups emphasized the friendliness of MCBH staff. This shows the range of participants who had this perception.

Barriers

In addition to the unmet needs and resources, participants also discussed significant barriers that they believed prevented individuals from fully accessing behavioral health services. In particular, participants discussed lack of transportation, substance use disorder, and stigma.

Lack of Transportation

Participants identified a lack of transportation as a barrier to accessing services for some populations. This barrier was highlighted across law enforcement and provider focus groups. One law enforcement participant stated that "*[l]ack of transportation options makes it difficult for individuals to attend appointments.*" Additionally, participants across focus groups described how transportation issues were most acute for South County residents and for the unhoused. Crucially, transportation as a barrier to accessing services was also identified by Stakeholders last Fiscal Year. These findings demonstrate that Stakeholder participants continue to see lack of transportation as a barrier for community members.

Substance Use Disorder

Additionally, some participants saw substance use disorder as a barrier to accessing services. Substance use disorder can be defined as a medical condition characterized by the harmful or hazardous use of psychoactive substances, including drugs and alcohol.

Participants across law enforcement and provider focus groups discussed substance use disorder as a barrier. When a provider focus group was asked about the most common behavioral health-related concerns in the communities they served, one participant said, "*Drug usage is definitely a big one here in this area.*" Law enforcement participants also mentioned substance use disorder as a barrier. Substance use disorder was also identified as a common behavioral health-related concern by law enforcement; when asked, a law enforcement participant mentioned "*addiction.*" Later in the exchange, another participant answered

"*substance abuse*" and explained that some individuals with serious mental illness are "*indulging in drugs or alcohol,*" which exacerbated their symptoms. These findings show that participants across provider and law enforcement focus groups saw substance use disorder as a barrier.

Stigma

Finally, stigma is another barrier that was discussed by participants. In a behavioral health context, stigma can be defined as the negative attitudes, beliefs, and stereotypes that society holds toward individuals with behavioral health conditions.

When asked about the biggest challenges the community faced, one provider focus group participant explained "*I think there's several factors. One of them is stigma.*" The participant elaborated that from their perspective "*a lot of clients are afraid of services. And there's this idea that, like, you have to be crazy in order to like obtain services.*" Another provider focus group participant shared their opinion that stigma was an important barrier in the Spanish-speaking community. The participant explained that in their experience, cultural stigma prevented many people from seeking mental health treatment in Greenfield and South County. The participant elaborated that, from their perspective, many community members did not want to seek mental health treatment because "*that's where crazy people go.*" These findings show that Stakeholders identified stigma as a barrier for both English- and Spanish-speaking community members.

Participant Recommendations

After discussing the barriers that limit access to services, participants offered recommendations on how to overcome these challenges and improve the delivery of behavioral health care. This analysis will focus on specific suggestions offered by participants for improving behavioral health services. Participants discussed their ideas for new MCBH initiatives and suggested specific resources MCBH could provide.

Ideas for New MCBH Initiatives

Participants recommended increasing housing services. Specifically, some participants wanted to see increased housing options offered for unhoused individuals. One participant stated that from their perspective, there was a need to "*prioritize providing stable housing without preconditions, reducing homelessness and improving mental health outcomes.*" The participant elaborated, explaining that "*The Housing Authority's renovation of the Pueblo Del Mar property into transitional housing exemplifies this approach. Stable housing provides a foundation from which individuals can address other issues, such as employment and health care.*" These findings show the importance that some participants placed on providing housing services.

Additionally, some participants described what they saw as the need for a dedicated liaison between Stakeholders and MCBH. This recommendation was made by both provider and law enforcement focus group participants. A provider focus group participant explained that "*We used to have someone that we could call in behavioral health*" but that they no longer had a contact person. The participant then expressed a desire for "*someone that could handle our concerns…I think that that would be a huge area of improvement.*" As a participant in a different

provider focus group put it, "*Somebody also has to provide that direct linkage to care. We need a name and a point of contact.*" This desire for a liaison was also discussed by a law enforcement participant, who explained that from their perspective, it would be helpful to have "*centralized coordination, maybe a liaison.*" The participant explained that "*there should be a consistent person…that kind of oversees the mission for us…to lead that charge.*" These findings show that both service providers and law enforcement focus group participants expressed a desire for an MCBH liaison who could connect providers and law enforcement to services.

Increase Provider Resources

Additionally, some participants described how they wished to see increases in provider resources. These participants recommended increasing provider funding and increasing access to spaces where treatment can be provided.

A number of participants recommended increasing provider funding. As one provider focus group participant explained, "*I would say our main problem is lack of funding. We have so many needs, especially with youth…and just we continue to have a wait list because we don't have the capacity to fill the need of the community.*" A participant reinforced this perspective by stating, "*We get people calling us every day for therapy, but you know, we might have to put them on a waitlist for a period of time because of our capacity due to lack of funding.*" These findings show that some participants thought providers needed increased funding.

Additionally, participants discussed how they believed that some providers needed increased access to spaces where they could provide treatment. One provider focus group participant expressed a desire for their organization to have their own facility, explaining that "*If we had our own facility, we could house all of our programs within one location.*" A participant in another provider focus group echoed this perspective, stating, "*We can do a community outing, but it would be nice to have access to a confidential space.*" A law enforcement participant reinforced this perspective by explaining that "*There are currently no long-term psychiatric facilities in Marina, forcing many individuals to seek help far from their community. This lack of facilities leads to frequent hospitalizations and disruptions in care, which can worsen outcomes for these individuals.*" These findings show that across provider and law enforcement participants, there was a desire to see increased space given to providers in order to facilitate providers' ability to treat those in need.

Recommendations and Summary of Findings

A wide range of participants shared their valuable perspectives regarding behavioral health, including unmet needs, resources, barriers, and participant recommendations. This section provides a summary of findings on each of these four areas and then concludes with recommendations for MCBH based on these findings.

Summary

Below is a summary of the major findings on unmet needs, resources, barriers, and participant recommendations.

Unmet Needs:

- Some participants believed that MCBH could do more in outreach efforts to underrepresented populations and Spanish-speaking communities.
- A number of participants described their desire to see increased behavioral health education for the youth.
- Some participants described what they saw as a need for increased communication between MCBH and service providers, as well as between MCBH and law enforcement.
- A number of participants described how they wished to see increased cultural representation, especially for the African American community.

Resources:

- Participants identified the following organizations (in alphabetical order) as resources to the community: Center for Community Advocacy, Community Human Services, Hope Housing Project, Interim, Ohana Center, Pajaro Valley Prevention and Student Assistance, Sierra Health + Wellness, Sun Street Centers, The Community Hospital of Monterey Peninsula, The Epicenter, The Village Project, and Veterans Affairs.
- MCBH staff were recognized by many participants for their responsiveness in crisis situations and their supportive, friendly approach.

Barriers:

- Some participants believed that transportation, particularly for South County residents and the unhoused, was a barrier.
- A number of participants described how they thought that substance use disorder and the stigma around mental health services, particularly within Spanish-speaking and rural communities, limited access to care.

Provider Recommendations:

- A number of participants recommended increasing housing services for the unhoused.
- Many participants suggested having a dedicated MCBH liaison to improve communication with Stakeholders.
- Some participants recommended increasing provider funding and increasing providers' access to facilities.

Recommendations

Overarching Recommendation: Leverage Proposition 1 Funding to Enact Participant Recommendations

Context: Many participants were Stakeholders who work directly with the community—either as providers or as law enforcement. As such, many participants may have a strong sense of the needs of the community. Their recommendations (increase housing, provide an MCBH liaison,

increase provider funding, and increase provider space for treatment) can be aligned to fulfill Proposition 1 requirements and address the unmet needs and barriers that participants identified.

Specific Recommendations:

Unmet needs concerning community outreach and collaboration can be addressed, in part, by enacting the recommendation to provide MCBH liaisons. MCBH could consider allocating Proposition 1 funding in a way that includes providing MCBH liaisons to providers and law enforcement. These liaisons can help MCBH and Stakeholders work together to navigate the new opportunities presented by Proposition 1. MCBH Stakeholder liaisons will then be perfectly placed to understand the outreach needs of the community by working directly with Stakeholders. These liaisons can also help facilitate increased access to services by working with Stakeholders to understand the access needs of the different parts of the community they support.

A substantial part of Proposition 1 funding is dedicated to providing housing. In combination with FSPs, housing could potentially help those with SMI who are in economic distress overcome barriers—such as transportation, substance use disorder, and stigma.

Increasing resources for providers, such as increasing access to treatment spaces, could be enacted in the process of fulfilling Proposition 1 funding allocation requirements.

CHAPTER 6:
LISTENING SESSION SUMMARY

[this page is intentionally blank - 1]

Participants

[this page is intentionally blank - 2]

[this page is intentionally blank - 3]

[this page is intentionally blank - 4]

[this page is intentionally blank - 5]

[this page is intentionally blank - 6]

APPENDIX A:
COMMUNITY SURVEY – ENGLISH

[this page is intentionally blank - 1]

[this page is intentionally blank - 2]

[this page is intentionally blank - 3]

[this page is intentionally blank - 4]

APPENDIX B:
COMMUNITY SURVEY – SPANISH

[this page is intentionally blank - 1]

[this page is intentionally blank - 2]

[this page is intentionally blank - 3]

[this page is intentionally blank - 4]

[this page is intentionally blank - 5]

APPENDIX C:
STAKEHOLDER SURVEY – ENGLISH

[this page is intentionally blank - 1]

[this page is intentionally blank - 2]

[this page is intentionally blank - 3]

[this page is intentionally blank - 4]

[this page is intentionally blank - 5]

[this page is intentionally blank - 6]

APPENDIX D:
STAKEHOLDER SURVEY – SPANISH

[this page is intentionally blank - 1]

[this page is intentionally blank - 2]

[this page is intentionally blank - 3]

[this page is intentionally blank - 4]

[this page is intentionally blank - 5]

[this page is intentionally blank - 6]

APPENDIX E:
LISTENING SESSION HANDOUT – ENGLISH

[this page is intentionally blank - 1]

[this page is intentionally blank - 2]

APPENDIX F:
LISTENING SESSION HANDOUT – SPANISH

[this page is intentionally blank - 1]

[this page is intentionally blank - 2]

Monterey County Mental Health Services Act
Community Services and Support

ANNUAL REPORT
FY 2023-2024

APPENDIX II

Prepared by
EVALCORP
Measuring What Matters®

MONTEREY COUNTY
BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

TABLE OF CONTENTS

ACKNOWLEDGMENTS

EVALCORP would like to acknowledge the support of numerous individuals whose efforts contributed greatly to the development of this report. First, we would like to thank Monterey County Behavioral Health for their partnership throughout the process. Thank you to Mental Health Services Act (MHSA) Coordinator, Shannon Castro, MHSA Innovations Coordinator, Wesley Schweikhard, and Assistant Bureau Chief, Fabricio Chombo for their leadership and oversight. We would also like to extend our gratitude to Deputy Directors Melanie Rhodes, Marni Sandoval, and Lindsey O'Leary; to the Quality Improvement Team, with special thanks to Quality Improvement Services Manager II, Janet H. Barajas, and Supervising Departmental Information Systems Coordinator, Isaias Betancourt; and to the Finance Team, including Accountant III, Isaura Zamora, for obtaining the information reported here. We greatly appreciate their collaboration and support. Lastly, we would like to thank all the funded providers for their hard work in collecting the data presented throughout this report.

INTRODUCTION

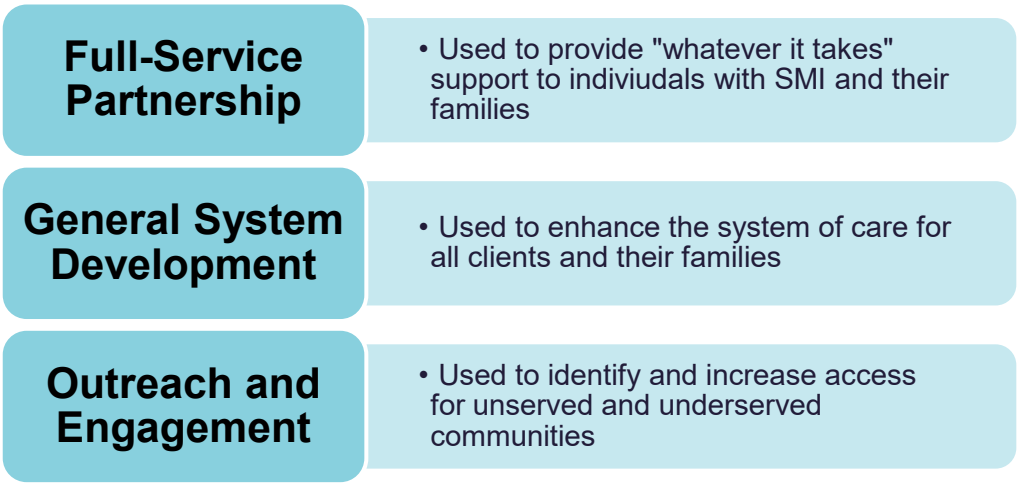
Overview

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-age 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, the 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) 2023–2024, Monterey County funded 43 programs administered by both MCBH and contracted community service providers. This report details those programs, including program descriptions, successes, challenges, goals, and 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 partnership (FSP) services, general system development, and outreach and engagement services.



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**.

REPORT METHODOLOGY

Analytic Approach

MCBH contracted with EVALCORP to develop this report, which summarizes data for CSS programs funded during FY 2023–2024. The evaluation utilized qualitative and quantitative data provided to Monterey County by CSS-funded programs.

Data Sources

Data sources compiled to develop the FY 2023–2024 report include:

1. **Annual Report Form:** CSS programs completed an online survey in which they described program activities, shared program goals, accomplishments, and challenges for the fiscal year, and answered questions about their use of Avatar, the county's electronic health record system.
2. **Avatar:** For a majority of CSS programs, information about service utilization and provision was obtained by pulling data from the county's electronic health record system, Avatar.
3. **Utilization Survey:** For those programs that do not use Avatar, a second online survey was used to record service utilization (e.g., program engagement, discharge information, demographics).

Data Notes

Some considerations to keep in mind while reviewing this report are detailed below.

- **Completeness of data:** Some demographic and other metrics have a lower number of responses than the total number of clients. Generally, when the rate of responses is low for a given metric, data should be interpreted with caution, as they may not be representative all clients.
- **Percentages:** Data may contain total percentages that are slightly lower or exceed 100% due to rounding and/or being able to select more than one response option.
- **Differences in data composition:** Programs may track different information about their clients and the services utilized. Therefore, each program section may differ in its contents.
- **Protection of identifying information:** In programs where there were less than 10 total responses, summarized data were removed to protect individuals' identities.

Report Organization

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

- Program description
- FY 2023–2024 successes and strengths
- Challenges and action plans in FY 2023–2024
- Goals for FY 2024–2025
- Utilization data

CSS-01: EARLY CHILDHOOD AND FAMILY STABILITY FSP

D'Arrigo Outpatient

SENECA FAMILY OF AGENCIES

The D'Arrigo Outpatient program provides outpatient mental health services, medication support, and case management to eligible children, youth and their families who require outpatient services. Crisis services are also provided for infrequent situations where a child/youth is in a foster care home and requires crisis services for stabilization in the home. D'Arrigo services promote the mental health of children whose social and emotional well-being has been negatively impacted by loss and trauma associated with poor family functioning, abuse, neglect, domestic violence, parental incarceration, and parental substance use. The program specializes in serving foster care, adoption care, and adoption preservation and uses 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 for disruption in home or school placement, or loss of community access to extracurricular activities, receive a team-based services approach that includes a child and family therapist and a family support counselor. Adoption preservation is encouraged by integrating a parental course and additional mental health services.

- 150 clients served in FY 23–24
- On average, clients engaged in services for 483 days
- 93 clients discharged in FY 23–24

Successes and Highlights

- Our outpatient services continued to play a crucial role in making mental health services more accessible throughout the county, especially South County.
- We had 175 enrollments for our Salinas, King City and Early Childhood Clinics.
- Our early intervention and prevention services assisted in preventing children and adolescents from seeking higher levels of services (crisis services, psychiatric hospitalization).
- We were fully staffed in both of our clinics with bilingual capacity.
- We were able to hire a 0–5 bilingual clinician which enabled us to provide more services to this population.
- We retained all of our clinic staff throughout the year.

D'Arrigo Outpatient

Challenges and Growth Opportunities

The ongoing request for implementation of multiple screening tools can present significant challenges, which can ultimately impact the ability to focus on client care. It not only diminishes the personal touch of intake sessions but also affects staff morale and client engagement. Additionally, staff members end up spending more time completing paperwork, rather than focusing on the client and families. Continuing requests to complete screening tools appears to move away from the original CalAim goal of documentation reduction. Monterey County Behavioral Health (MCBH) seems to have more screening tool implementation requirements than other counties where outpatient services are being provided. MCBH has seven screening tools, whereas other counties may have four. We have had managers provide training to staff on completing the forms, utilize interns to assist with completing some screening tools, and provide lots of encouragement for our staff in order for them to stay positive.

Service code changes related to payment reform have also been a challenge for our clinics. This has been very confusing and at times frustrating for our staff when trying to complete their documentation on time. To address this, managers have had to provide extra trainings, individual coaching with staff, and incentives.

Goals for the Coming Year

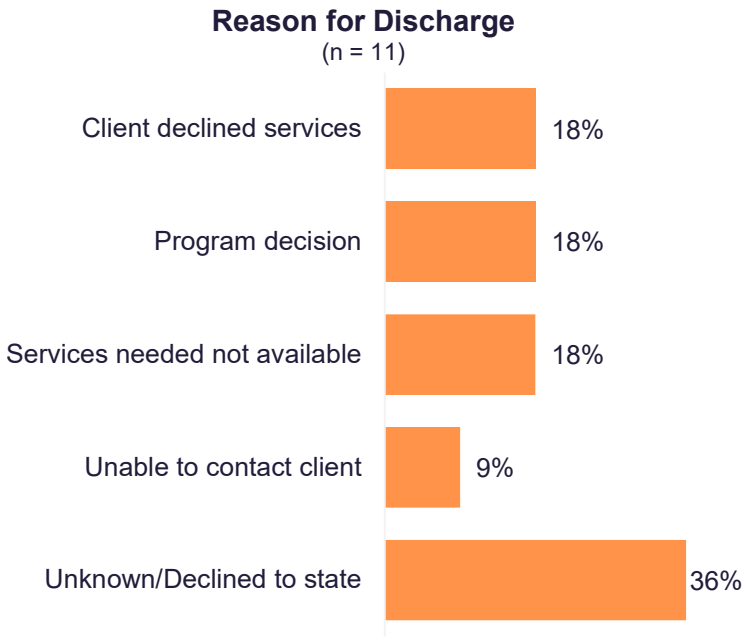
1. Early Childhood Treatment: Provide outpatient mental health services to a minimum of 30 children.
2. Increase family engagement and connection through specialized trainings for clinicians in family therapy.
3. Implement an intern program by partnering with local schools. The goal is to prepare/mentor MSW, MFT and counseling graduate students so that they are prepared to serve our community upon graduating.

D'Arrigo Outpatient

Discharge Information

93 clients were **discharged**.

Of the 82 with goal information, 84% had **achieved some or all their goals**.



Employment and Education

1% of clients were **employed or volunteering** before engaging in services.
(n = 150)

87% of clients enrolled in or completed **school** before engaging in services.
(n = 150)

D'Arrigo Outpatient

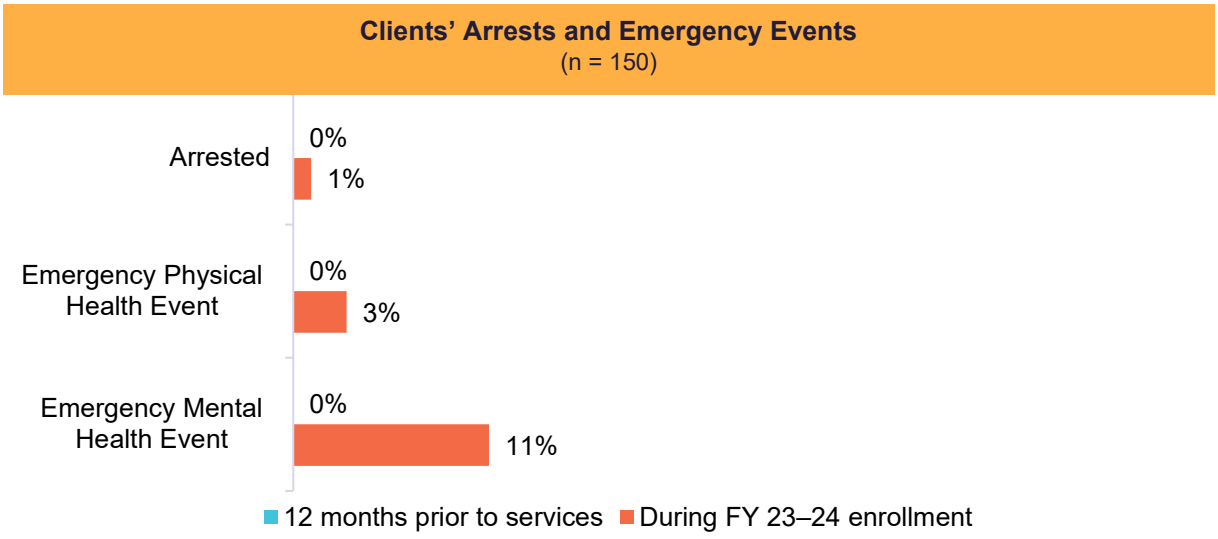
Housing

Housing Type Before Services (n = 150)		Current Housing Type (n = 150)
98%	Independent house or apartment	78%
0%	Friends/family	15%
0%	Shelter or temporary housing	1%
0%	Acute psychiatric facility or hospital	1%
1%	Foster home	0%
1%	Another housing status	0%
0%	Unknown/Declined to state	5%

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

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are compared between 12 months prior to accessing services and FY 23–24.



D'Arrigo Outpatient

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	13%
Black/African American	60%
White	11%
Another Race	17%
Unknown/Declined to State	0%

n = 150

73% Hispanic/Latino
11% Not Hispanic/Latino

n = 150
17% Unknown/Declined to state.

3% of individuals reported having one or more disabilities

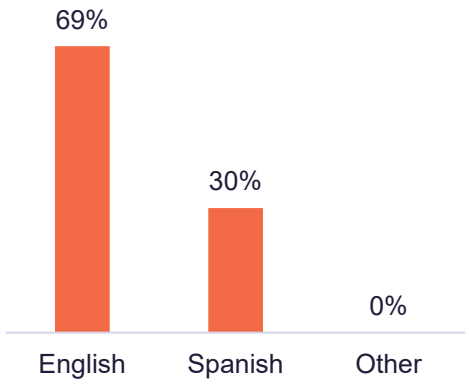
n = 150
0% Unknown/Declined to state.

Disability

No Disability	97%
Hearing	2%
Another Disability	1%
Unknown/Declined to State	0%

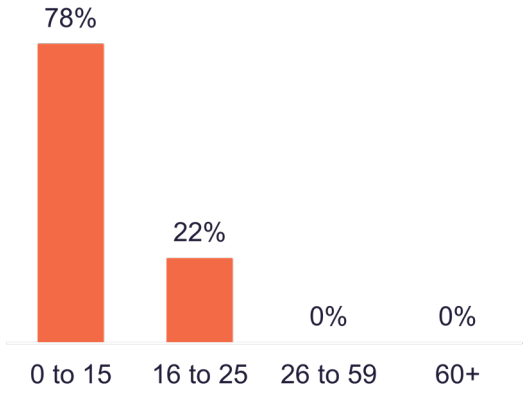
n = 150

Primary Language



n = 150
1% Unknown/Declined to state.

Age



n = 150
0% Unknown/Declined to state.

0% of individuals were veterans

n = 150
0% Unknown/Declined to state.

D'Arrigo Outpatient

Gender Identity

Female	38%
Male	34%
Transgender	2%
Unknown/Declined to State	26%

n = 150

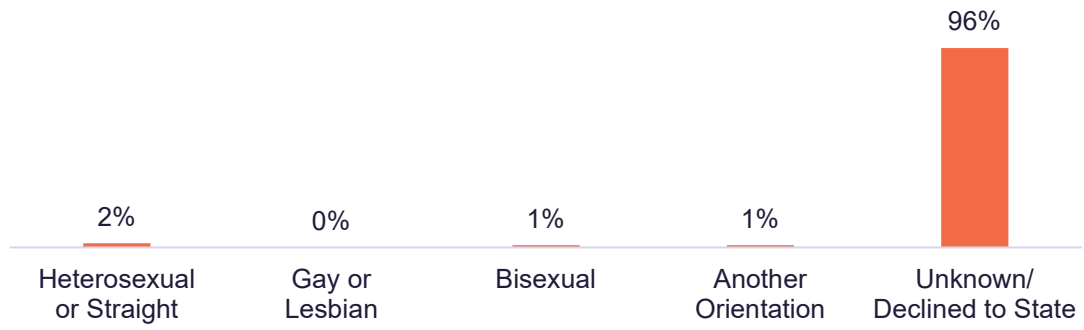
Sex at Birth

Female	53%
Male	46%
Another Sex	1%
Unknown/Declined to State	0%

n = 150

Sexual Orientation

(n = 150)



Family Assessment Support and Treatment (FAST)

COUNTY OF MONTEREY

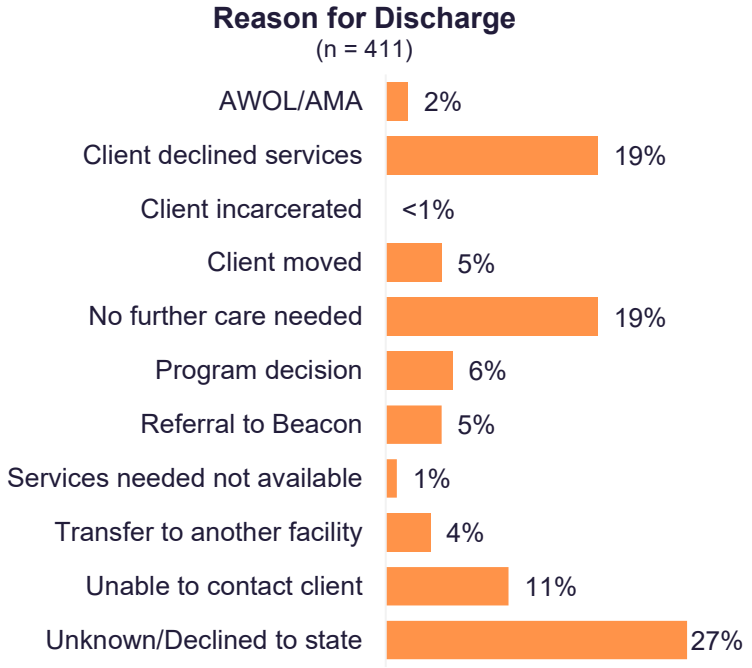
The Family Assessment Support and Treatment (FAST) program team offers mental health treatment and case management services to children and families involved in the Monterey County Dependency Court and Child Welfare system due to severe abuse and neglect. Therapy options include individual therapy, attachment work, group therapy, and family therapy. The FAST program 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.

- 542 clients served in FY 23–24
- On average, clients engaged in services for 244 days
- 450 clients discharged in FY 23–24

Discharge Information

450 clients were **discharged**.

Of the 37 with goal information, 95% had **achieved some or all their goals**.



FAST

Employment and Education

1% of clients were **employed or volunteering** before engaging in services.
(n = 542)

17% of clients enrolled in or completed **school** before engaging in services.
(n = 542)

Housing

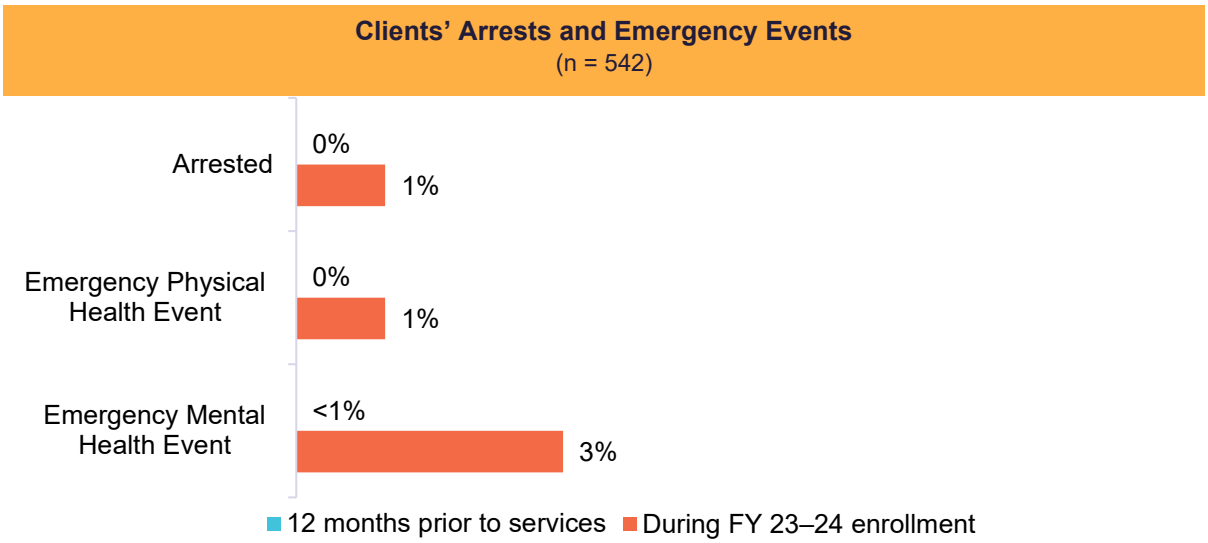
Housing Type Before Services (n = 542)		Current Housing Type (n = 542)
73%	Independent house or apartment	11%
0%	Friends/family	3%
0%	Shelter or temporary housing	2%
5%	Unhoused	1%
0%	Acute medical hospital	<1%
<1%	Acute psychiatric facility or hospital	1%
0%	Assisted living facility	<1%
2%	Residential treatment facility	<1%
13%	Foster home	11%
<1%	Group home	1%
0%	Short-term residential treatment program	1%
<1%	Jail or juvenile detention facility	1%
5%	Another housing status	<1%
2%	Unknown/Declined to state	68%

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

FAST

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are compared between 12 months prior to accessing services and FY 23–24.



FAST

Demographic Data

Race

American Indian/Alaska Native	<1%
Asian	8%
Black/African American	23%
White	13%
Another Race	56%
Unknown/Declined to State	0%

n = 542

31% Hispanic/Latino
13% Not Hispanic/Latino

n = 542
56% Unknown/Declined to state.

11% of individuals reported having one or more disabilities

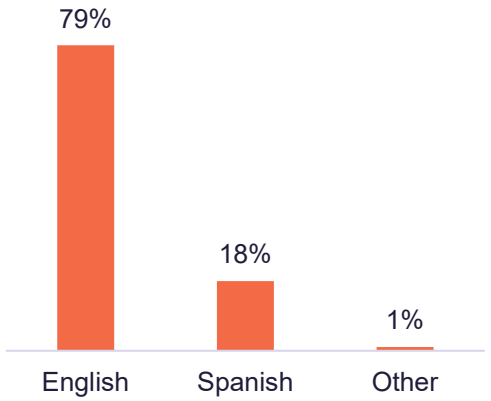
n = 542
0% Unknown/Declined to state.

Disability

No Disability	89%
Visual	<1%
Hearing	0%
Speech	<1%
Mobility	<1%
Mental	8%
Developmental	1%
Another Disability	2%
Unknown/Declined to State	0%

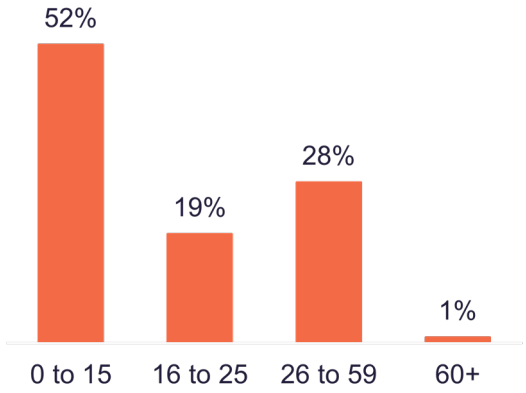
n = 542

Primary Language



n = 542
2% Unknown/Declined to state.

Age



n = 542
0% Unknown/Declined to state.

0% of individuals were veterans

n = 542
20% Unknown/Declined to state.

FAST

Gender Identity

Female	39%
Male	20%
Transgender	<1%
Unknown/Declined to State	41%

n = 542

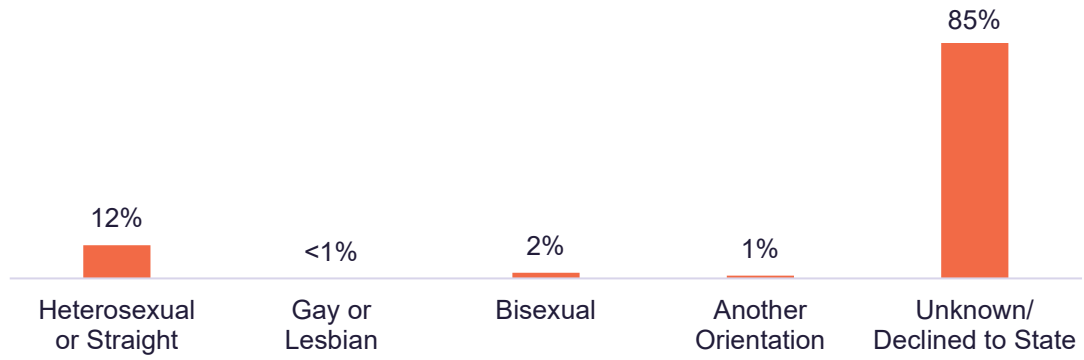
Sex at Birth

Female	59%
Male	38%
Another Sex	0%
Unknown/Declined to State	2%

n = 542

Sexual Orientation

(n = 542)



Family Reunification FSP

COUNTY OF MONTEREY

- 12 clients served in FY 23–24
- On average, clients engaged in services for 387 days
- 5 clients discharged in FY 23–24

Discharge Information

5 clients were **discharged**.

Of the 5 with goal information, 60% had **achieved some or all their goals**.

Reason for Discharge
(n = 2)

Employment and Education

0% of clients were **employed or volunteering** before engaging in services.
(n = 12)

58% of clients enrolled in or completed **school** before engaging in services.
(n = 12)

Family Reunification FSP

Housing

Housing Type Before Services (n = 12)		Current Housing Type (n = 12)
42%	Independent house or apartment	50%
0%	Friends/family	8%
0%	Shelter or temporary housing	8%
8%	Residential treatment facility	0%
33%	Foster home	50%
17%	Another housing status	0%

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

Family Reunification FSP

Demographic Data

Race

Asian	8%
Black/African American	25%
White	17%
Another Race	50%

n = 12

33% Hispanic/Latino
17% Not Hispanic/Latino

n = 12
50% Unknown/Declined to state.

17% of individuals reported having one or more disabilities

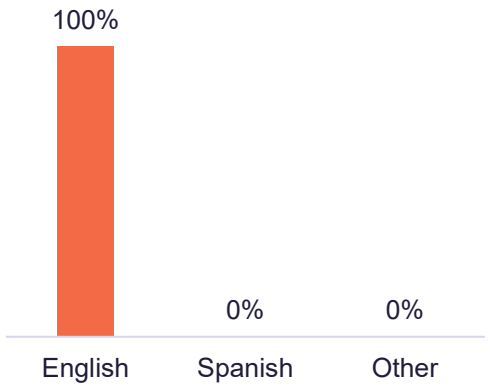
n = 12
0% Unknown/Declined to state.

Disability

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

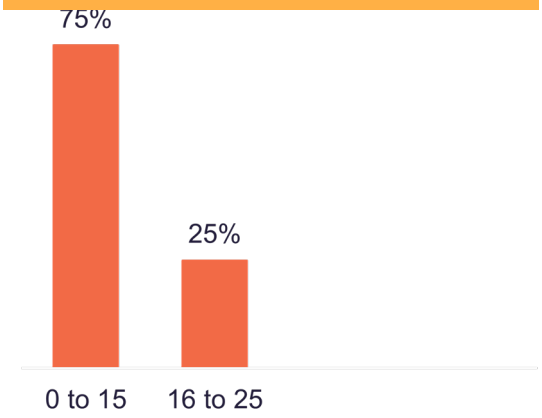
n = 12

Primary Language



n = 12
0% Unknown/Declined to state.

Age



n = 12
0% Unknown/Declined to state.

0% of individuals were veterans

n = 12
0% Unknown/Declined to state.

Family Reunification FSP

Gender Identity

Female	33%
Male	50%
Transgender	8%
Unknown/Declined to State	8%

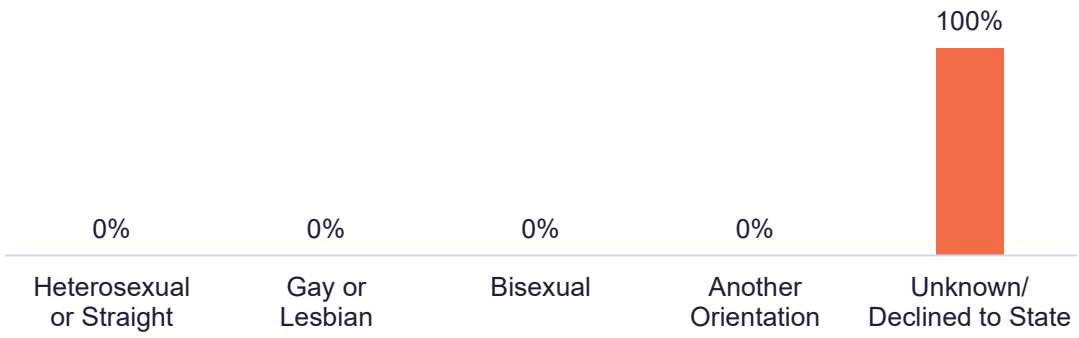
n = 12

Sex at Birth

Female	50%
Male	50%
Another Sex	0%
Unknown/Declined to State	0%

n = 12

Sexual Orientation
(n = 12)



Salinas Home Partners FSP

COUNTY OF MONTEREY

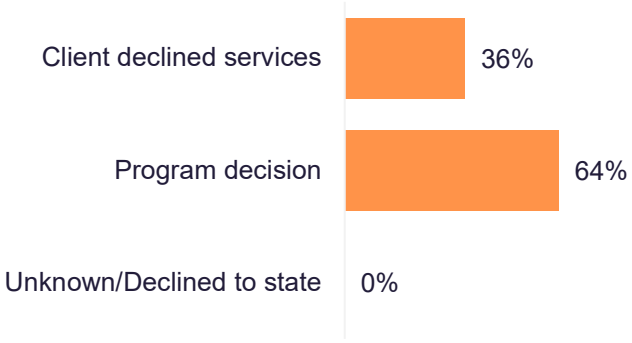
- 16 clients served in FY 23–24
- On average, clients engaged in services for 47 days
- 16 clients discharged in FY 23–24

Discharge Information

16 clients were **discharged**.

Of the 5 with goal information, 80% had **achieved some or all their goals**.

Reason for Discharge
(n = 11)



Salinas Home Partners FSP

Employment and Education

0% of clients were **employed or volunteering** before engaging in services.
(n = 16)

56% of clients enrolled in or completed **school** before engaging in services.
(n = 16)

Housing

Housing Type Before Services (n = 16)	
88%	Independent house or apartment
6%	Residential treatment facility
6%	Another housing status
0%	Unknown/Declined to state

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

Salinas Home Partners FSP

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	19%
Black/African American	25%
White	19%
Another Race	38%
Unknown/Declined to State	0%

n = 16

44% Hispanic/Latino
19% Not Hispanic/Latino

n = 16
38% Unknown/Declined to state.

31% of individuals reported having one or more disabilities

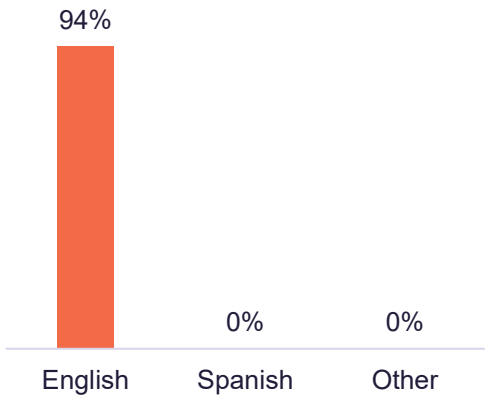
n = 16
0% Unknown/Declined to state.

Disability

No Disability	69%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Mental	25%
Developmental	6%
Another Disability	0%
Unknown/Declined to State	0%

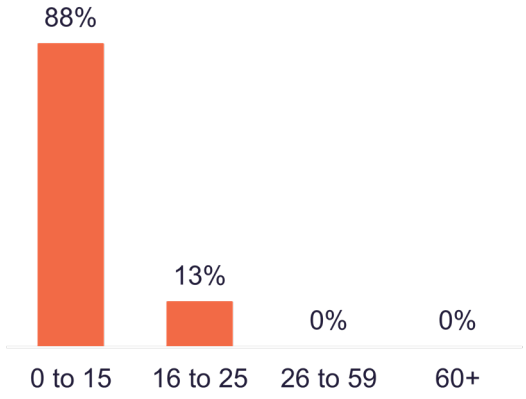
n = 16

Primary Language



n = 16
6% Unknown/Declined to state.

Age



n = 16
0% Unknown/Declined to state.

0% of individuals were veterans

n = 16
0% Unknown/Declined to state.

Salinas Home Partners FSP

Gender Identity

Female	44%
Male	38%
Transgender	0%
Unknown/Declined to State	19%

n = 16

Sex at Birth

Female	56%
Male	44%
Another Sex	0%
Unknown/Declined to State	0%

n = 16

CSS-02: DUAL DIAGNOSIS FSP

Integrated Co-occurring Treatment

DOOR TO HOPE

The Integrated Co-occurring Treatment (ICT) program is designed to meet the challenging needs of youth ages 12–25 years with both substance use and mental health problems. The program provides home and community visits using strength-based and evidence-based practices.

- 44 clients served in FY 23–24
- On average, clients engaged in services for 227 days
- 37 clients discharged in FY 23–24

Successes and Highlights

- The program recruited, hired, and trained therapists. These therapists were hired as trainees and applied for Associate status with the Board of Behavioral Sciences (BBS).
- The program developed and trained peer counselors to support treatment plan objectives for selected youth.
- The program delivered high-quality services to enrolled youth and their families.

Challenges and Growth Opportunities

Therapist recruitment was difficult and took over a year to accomplish. Program staff learned that patience was the key to success in this area. After all COVID restrictions were lifted and applicants were unsuccessful in securing work-from-home employment, the program began to receive more qualified applicants.

Goals for the Coming Year

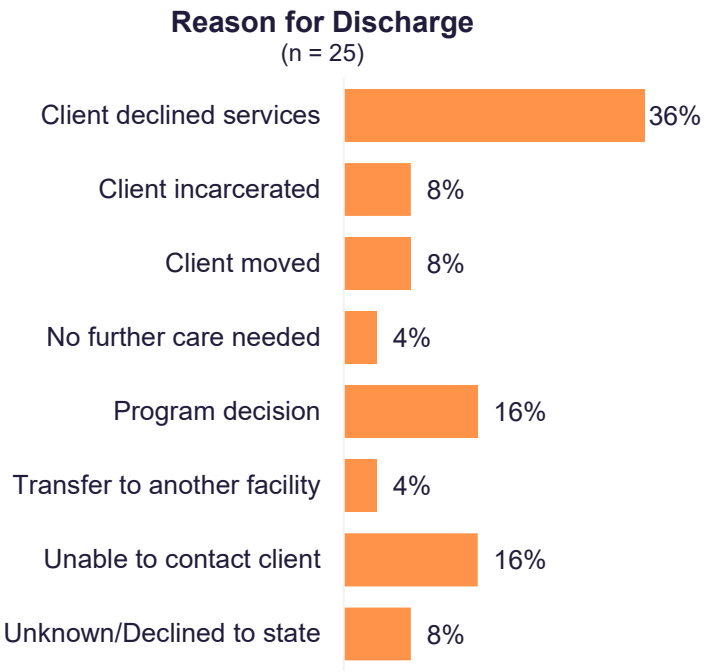
1. Increase productivity.
2. Hire additional therapists.
3. Train therapists in co-occurring treatment and BIPOC and LGBTQIA+ populations.

Integrated Co-occurring Treatment

Discharge Information

37 clients were **discharged**.

Of the 11 with goal information, 27% had **achieved some or all their goals**.



Employment and Education

14% of clients were **employed or volunteering** before engaging in services.
(n = 44)

80% of clients enrolled in or completed **school** before engaging in services.
(n = 44)

Integrated Co-occurring Treatment

Housing

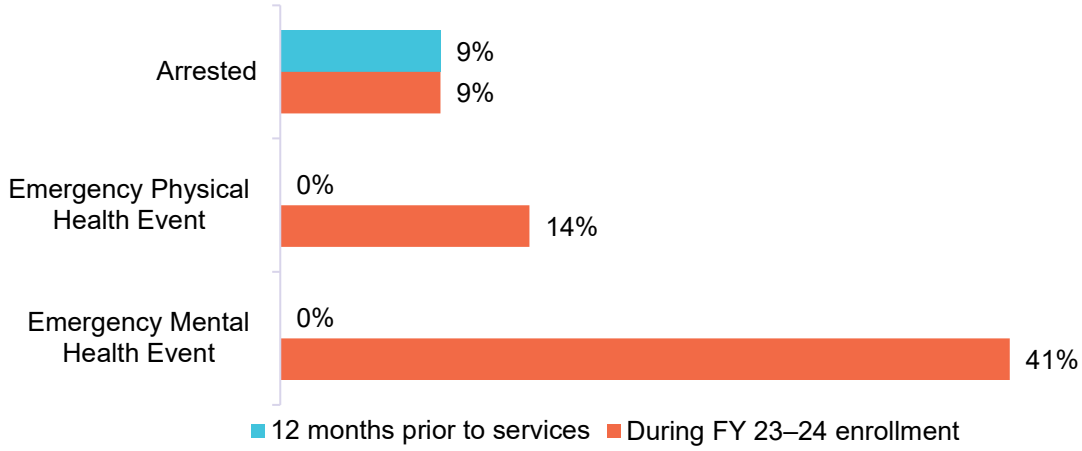
Housing Type Before Services (n = 44)		Current Housing Type (n = 44)
91%	Independent house or apartment	73%
0%	Friends/family	11%
0%	Unhoused	2%
0%	Acute psychiatric facility or hospital	14%
0%	Residential treatment facility	2%
0%	Acute medical hospital	7%
0%	Jail or juvenile detention facility	7%
9%	Another housing status	0%

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

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are compared between 12 months prior to accessing services and FY 23–24.

Clients' Arrests and Emergency Events
(n = 44)



Integrated Co-occurring Treatment

Demographic Data

Race

Asian	14%
Black/African American	55%
White	9%
Another Race	23%

n = 44

68% Hispanic/Latino
9% Not Hispanic/Latino

n = 44
23% Unknown/Declined to state.

18% of individuals reported having one or more disabilities

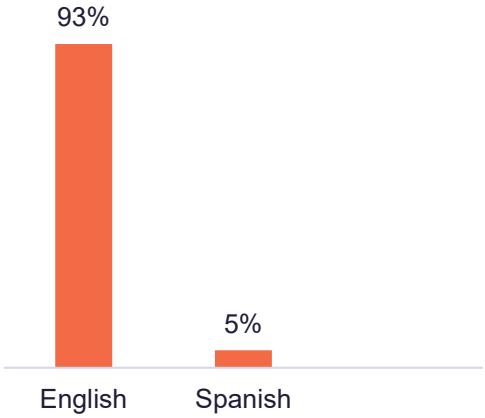
n = 44
0% Unknown/Declined to state.

Disability

No Disability	82%
Visual	2%
Mental	14%
Developmental	2%

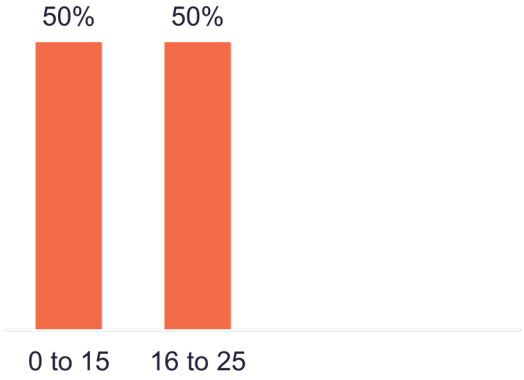
n = 44

Primary Language



n = 44
2% Unknown/Declined to state.

Age



n = 44
0% Unknown/Declined to state.

0% of individuals were veterans

n = 44
0% Unknown/Declined to state.

Integrated Co-occurring Treatment

Gender Identity

Female	55%
Male	30%
Unknown/Declined to State	16%

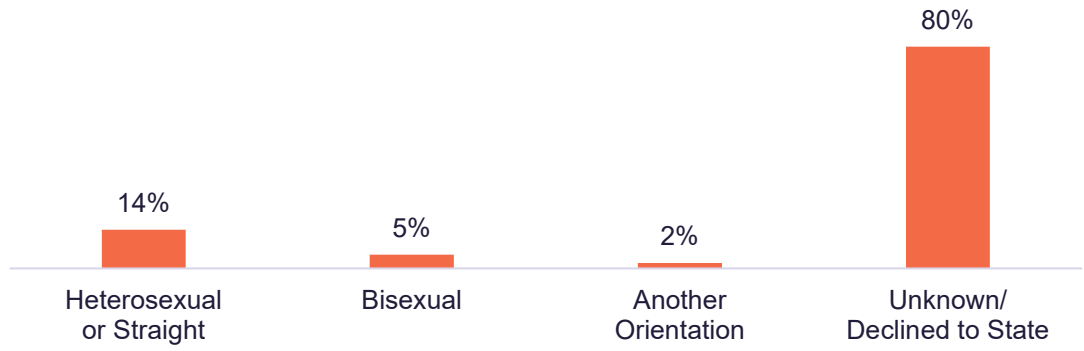
n = 44

Sex at Birth

Female	68%
Male	32%
Unknown/Declined to State	0%

n = 44

Sexual Orientation
(n = 44)



Santa Lucia

DOOR TO HOPE

Santa Lucia Short-term Residential Treatment Program is a six-bed short-term residential treatment program for female youth ages 13–17 years meeting medical necessity for intensive out-of-home services. The program provides individual, group, and collateral therapeutic services to clients and works with families toward reunification and/or transitioning to adulthood.

- 6 clients served in FY 23–24
- On average, clients engaged in services for 202 days
- 6 clients discharged in FY 23–24

Successes and Highlights

- The program developed an enriched staffing pattern to better serve the needs of the difficult youth it serves.
- The program provided re-training and onboarding to all program staff.
- The program utilized Vestige panic buttons for improved safety.

Challenges and Growth Opportunities

A sentinel incident occurred at Santa Lucia which resulted in an injury to a staff member. Unfortunately, this caused the program to close for six months. This period has been a major challenge that the program is working to overcome, with plans to re-open in August of 2024.

Goals for the Coming Year

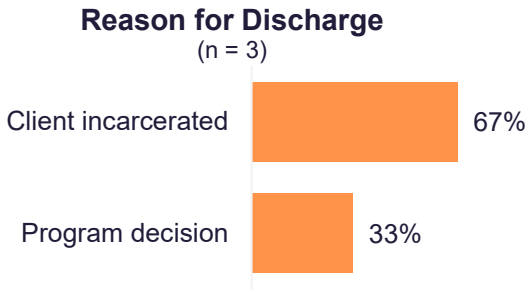
1. Reopen program in August 2024.
2. Achieve CARF re-accreditation.
3. Provide safety and security to youth and staff.

Santa Lucia

Discharge Information

6 clients were **discharged**.

Of the 3 with goal information, 100% had **achieved some or all their goals**.



Employment and Education

0% of clients were **employed or volunteering** before engaging in services.
(n = 6)

100% of clients enrolled in or completed **school** before engaging in services.
(n = 6)

Housing

100% of clients were in group homes before receiving services.
(n = 6)

Santa Lucia

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	17%
Black/African American	50%
White	17%
Another Race	17%
Unknown/Declined to State	0%

n = 6

67% Hispanic/Latino
17% Not Hispanic/Latino

n = 6
17% Unknown/Declined to state.

17% of individuals reported having one or more disabilities

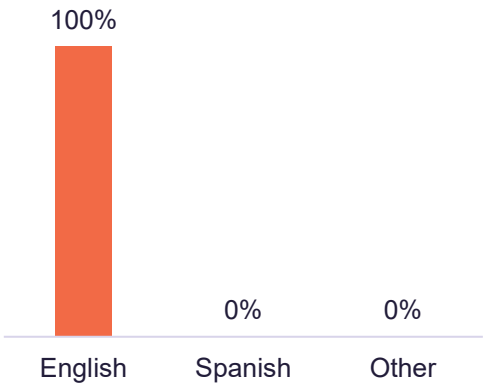
n = 6
0% Unknown/Declined to state.

Disability

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

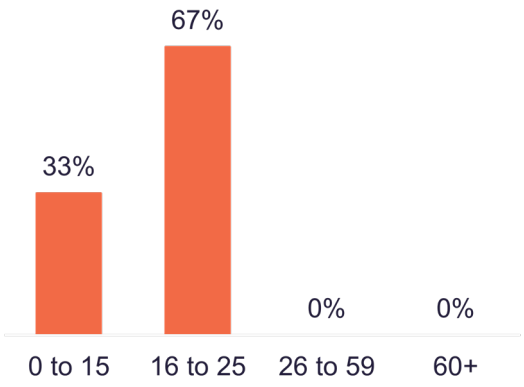
n = 6

Primary Language



n = 6
0% Unknown/Declined to state.

Age



n = 6
0% Unknown/Declined to state.

0% of individuals were veterans

n = 6
0% Unknown/Declined to state.

Santa Lucia

Gender Identity

Female	33%
Male	0%
Transgender	0%
Unknown/Declined to State	67%

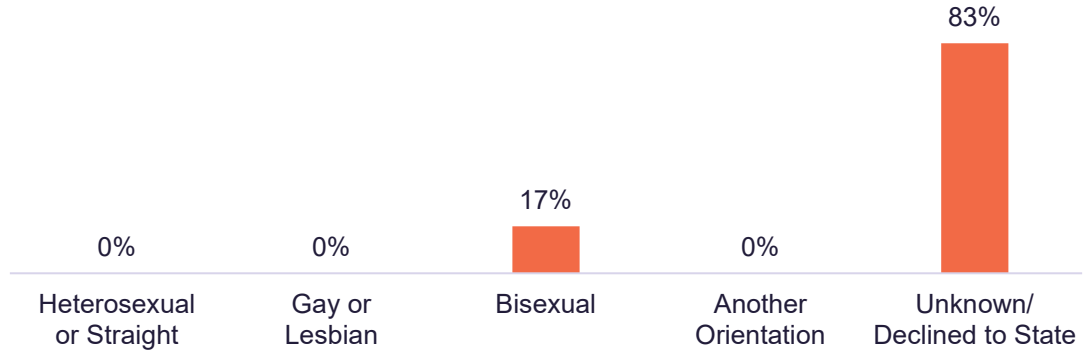
n = 6

Sex at Birth

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

n = 6

Sexual Orientation
(n = 6)



CSS-04: TRANSITION AGE YOUTH FSP

MHSA TIP AVANZA FSP

COUNTY OF MONTEREY

The MHSA TIP Avanza program empowers youth and young adults (ages 16 to 25 years) 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.

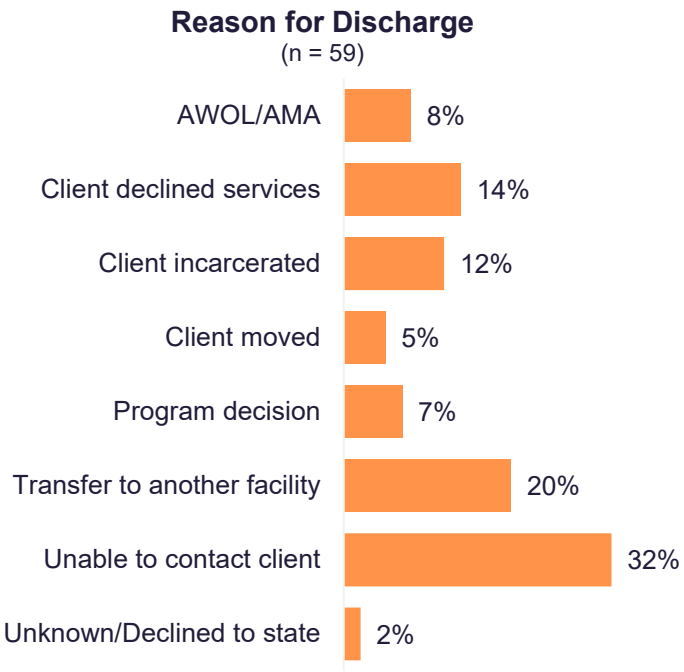
- 211 clients served in FY 23–24
- On average, clients engaged in services for 788 days
- 108 clients discharged in FY 23–24

MHSA TIP AVANZA FSP

Discharge Information

108 clients were **discharged**.

Of the 48 with goal information, 100% had **achieved some or all their goals**.



Employment and Education

7% of clients were **employed or volunteering** before engaging in services.
(n = 211)

82% of clients enrolled in or completed **school** before engaging in services.
(n = 211)

MHSA TIP AVANZA FSP

Housing

Housing Type Before Services (n = 211)		Current Housing Type (n = 211)
90%	Independent house or apartment	56%
0%	Friends/family	7%
0%	Shelter or temporary housing	2%
1%	Unhoused	3%
0%	Acute medical hospital	4%
0%	Acute psychiatric facility or hospital	13%
<1%	Assisted living facility	1%
1%	Residential treatment facility	5%
<1%	Foster home	%
1%	Group home	1%
0%	Short-term residential treatment facility	1%
<1%	Jail or juvenile detention facility	2%
4%	Another housing status	1%
<1%	Unknown/Declined to state	1%

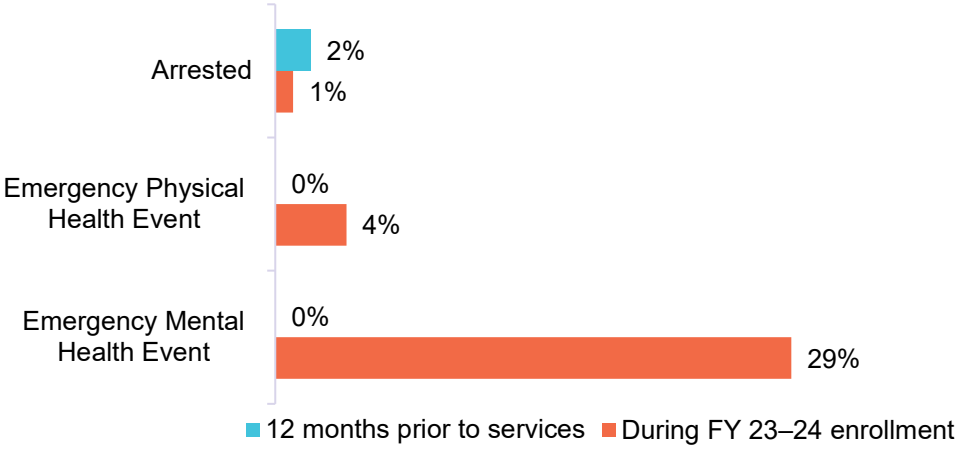
Clients may have more than one housing type. Percentages may exceed 100%.

MHSA TIP AVANZA FSP

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are compared between 12 months prior to accessing services and FY 23–24.

Clients' Arrests and Emergency Events
(n = 211)



MHSA TIP AVANZA FSP

Demographic Data

Race

American Indian/Alaska Native	<1%
Asian	15%
Black/African American	60%
White	15%
Another Race	10%
Unknown/Declined to State	0%

n = 211

75% Hispanic/Latino
15% Not Hispanic/Latino

n = 211
10% Unknown/Declined to state.

68% of individuals reported having one or more disabilities

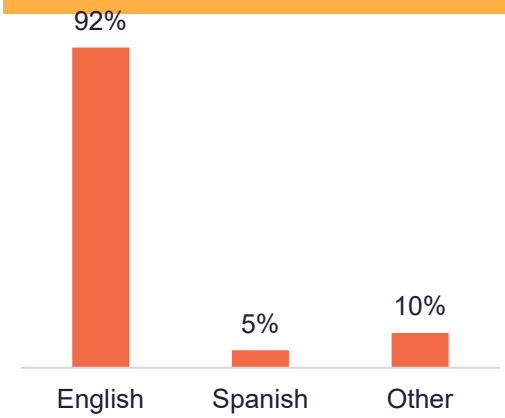
n = 211
0% Unknown/Declined to state.

Disability

No Disability	32%
Visual	1%
Hearing	0%
Speech	1%
Mobility	<1%
Mental	61%
Developmental	2%
Another Disability	1%
Unknown/Declined to State	0%

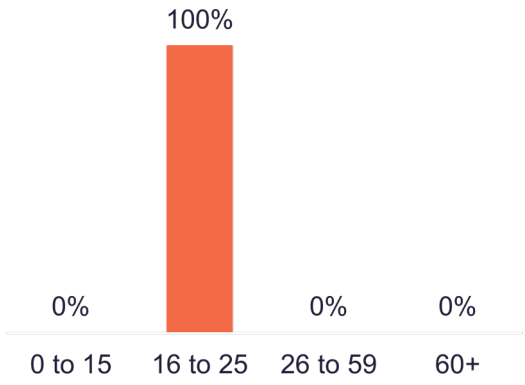
n = 211

Primary Language



n = 211
1% Unknown/Declined to state.

Age



n = 211
0% Unknown/Declined to state.

0 individuals were veterans

n = 211
<1% Unknown/Declined to state.

MHSA TIP AVANZA FSP

Gender Identity

Female	43%
Male	52%
Transgender	1%
Unknown/Declined to State	4%

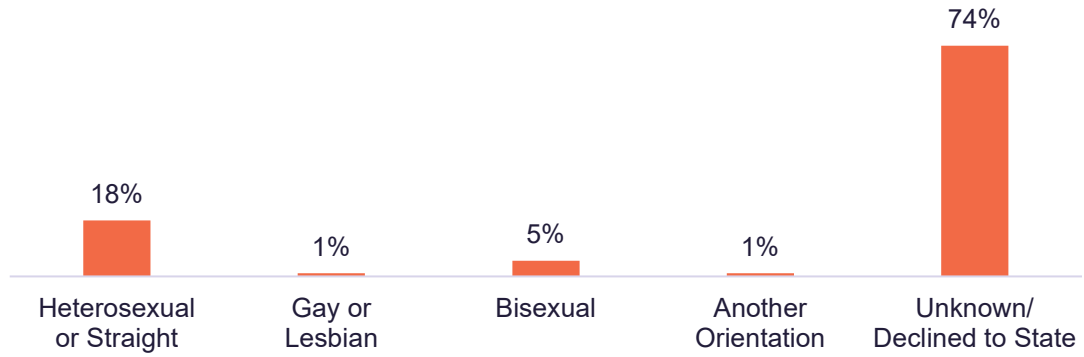
n = 211

Sex at Birth

Female	47%
Male	53%
Another Sex	0%
Unknown/Declined to State	0%

n = 211

Sexual Orientation
(n = 211)



CSS-05: ADULTS WITH SMI FSP

Assertive Community Treatment (ACT)

INTERIM, INC.

The Assertive Community Treatment (ACT) program is a Full-Service Partnership (FSP) that serves up to 100 adults with serious mental illnesses and/or serious functional impairments that meet FSP level of care requirements. ACT is an evidence-based practice that provides wraparound services by a multidisciplinary team that shares caseloads. The ACT team brings community-based mental health services to consumers who are underserved and unable to access or effectively utilize clinic-based treatment to meet their mental health needs. Consumers are referred to the program from Salinas Valley, Monterey Peninsula, and South Monterey County. Those with priority admission include Hispanic/Latino consumers who reside in Salinas Valley and South Monterey County who are frequent users of acute care services, and whose providers have failed to engage in ongoing services in the Adult System of Care (ASOC).

- 104 clients served in FY 23–24
- On average, clients engaged in services for 684 days
- 24 clients discharged in FY 23–24

Successes and Highlights

- The ACT program collaborated closely with Monterey County Behavioral Health to work toward increasing the ACT census to 100 consumers. ACT expanded this fiscal year which allowed the Interim, Inc./ACT program to add a new office in Soledad.
- ACT implemented a daily team communication system that allows the team to stay informed on the most recent consumer updates and provide immediate support.
- ACT had consistent cross-training this fiscal year through which staff gained new skills and knowledge.
- Toward the end of the fiscal year, ACT was able to fill all four new positions that opened with the expansion.
- 86% of consumers served by ACT were not hospitalized throughout the fiscal year.
- 93% of consumers served by ACT were not incarcerated throughout the fiscal year.
- 96% of clients surveyed by ACT expressed satisfaction with the services provided by the team.

Assertive Community Treatment (ACT)

Challenges and Growth Opportunities

ACT experienced challenges in staffing that impacted overall program billing goals and services for our consumers. ACT was also not able to reach the internal goal of admitting 100 consumers into ACT services by the end of the fiscal year. Although ACT met its primary goals, there were increased numbers of hospitalizations and incarcerations this fiscal year, which is an area where ACT can improve by ensuring that consumers are being met with weekly.

For the upcoming fiscal year, ACT will continue to increase training in all areas of ACT fidelity and implement specialties (i.e., housing specialist, benefits specialist, employment and education specialist) for all Counselor II positions to increase wraparound services for consumers and help decrease hospitalizations and incarcerations. ACT will initiate a step-by-step process in screening referrals, documenting engagements and using a checklist to ensure that all steps are completed for each referral. This will resolve the barriers to reaching ACT's desired census.

Goals for the Coming Year

1. 75% of clients served during the FY will eliminate usage of in-patient hospitalization while in the program.
2. 75% of clients served during the FY will not experience incarceration while in the program.

Assertive Community Treatment (ACT)

Discharge Information

24 clients were **discharged**.

Of the 22 with goal information, 91% had **achieved some or all their goals**.

Employment and Education

6% of clients were **employed or volunteering** before engaging in services.
(n = 104)

52% of clients enrolled in or completed **school** before engaging in services.
(n = 104)

Assertive Community Treatment (ACT)

Housing

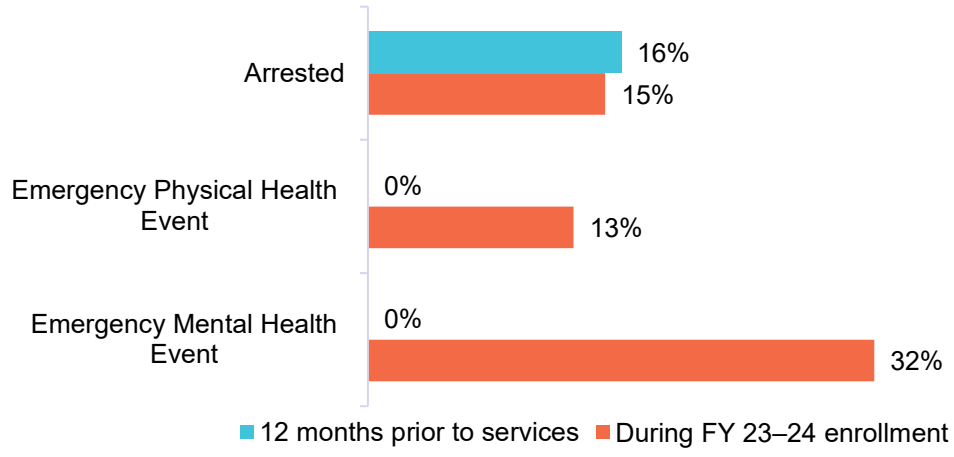
Housing Type Before Services (n = 104)		Current Housing Type (n = 104)
73%	Independent house or apartment	42%
0%	Friends/family	11%
0%	Shelter or temporary housing	5%
11%	Unhoused	13%
0%	Acute medical hospital	11%
2%	Acute psychiatric facility or hospital	16%
1%	Assisted living facility	5%
6%	Residential treatment facility	13%
1%	Foster home	0%
1%	Jail or juvenile detention facility	7%
6%	Another housing status	0%
0%	Unknown/Declined to state	0%

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

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are compared between 12 months prior to accessing services and FY 23–24.

Clients' Arrests and Emergency Events
(n = 104)



Assertive Community Treatment (ACT)

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	23%
Black/African American	75%
White	2%
Another Race	0%
Unknown/Declined to State	0%

n = 104

98% Hispanic/Latino
2% Not Hispanic/Latino

n = 104
0% Unknown/Declined to state.

80% of individuals reported having one or more disabilities

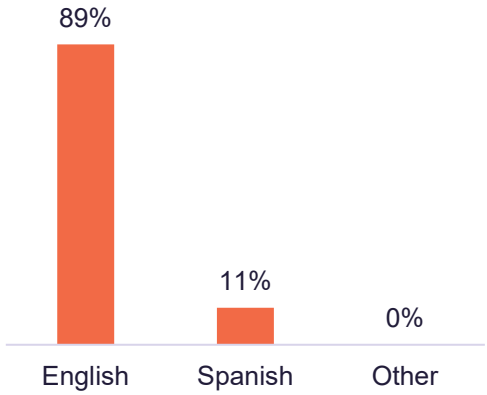
n = 104
0% Unknown/Declined to state.

Disability

No Disability	20%
Visual	1%
Hearing	0%
Speech	0%
Mobility	0%
Mental	79%
Developmental	0%
Another Disability	0%
Unknown/Declined to State	0%

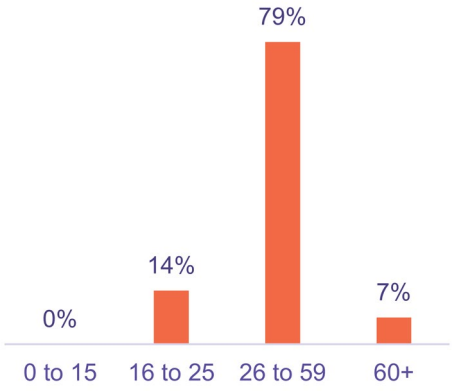
n = 104

Primary Language



n = 104
0% Unknown/Declined to state.

Age



n = 104
0% Unknown/Declined to state.

0% of individuals were veterans

n = 104
0% Unknown/Declined to state.

Assertive Community Treatment (ACT)

Gender Identity

Female	28%
Male	70%
Transgender	1%
Unknown/Declined to State	1%

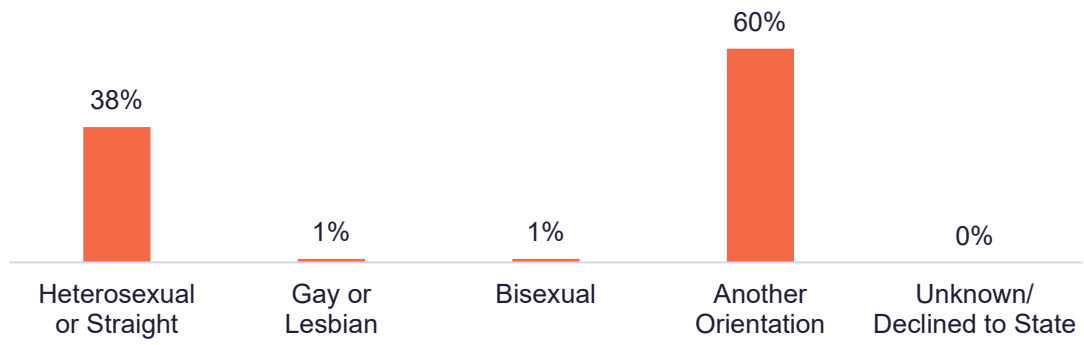
n = 104

Sex at Birth

Female	28%
Male	72%
Another Sex	0%
Unknown/Declined to State	0%

n = 104

Sexual Orientation
(n = 104)



CSS-06: OLDER ADULTS FSP

Drake House FSP

FRONT ST. INC.

Drake House is a Full-Service Partnership (FSP) program that provides residential care and mental health support services to elderly individuals who experience serious and persistent mental illness. Drake House offers on-site groups and one-to-one rehabilitation for its clients.

- 52 clients served in FY 23–24
- On average, clients engaged in services for 2,870 days
- 6 clients discharged in FY 23–24

Successes and Highlights

- With staff assistance, Drake House clients have been able to integrate themselves into the community and have become part of a local congregation.
- Through this congregation, clients have created more interpersonal relationships and enhanced their social support networks.

Challenges and Growth Opportunities

Over the past year, the Drake House program has been able to navigate payment reform requirements and has been able to adjust to billing changes, while still providing high-quality services.

Goals for the Coming Year

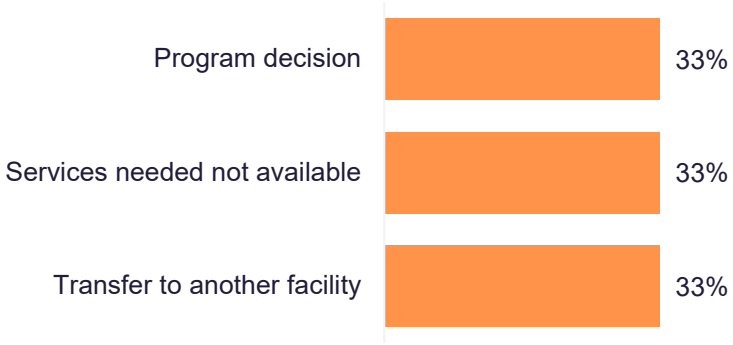
1. Maintain full occupancy.
2. Meet the facility contract goals.
3. Maintain staff retention and enhance trainings.

Drake House FSP

Discharge Information

6 clients were **discharged**.

Reason for Discharge
(n = 6)



Employment and Education

0% of clients were **employed or volunteering** before engaging in services.
(n = 52)

85% of clients enrolled in or completed **school** before engaging in services.
(n = 52)

Drake House FSP

Housing

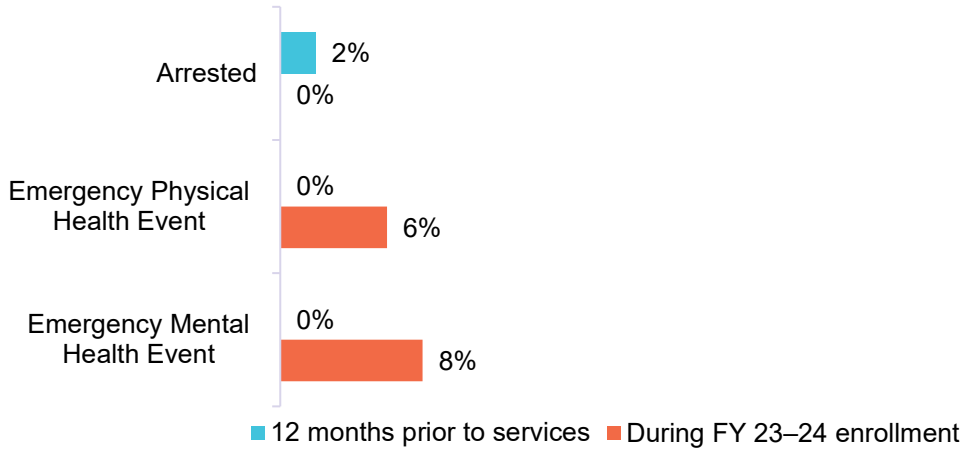
Housing Type Before Services (n = 52)		Current Housing Type (n = 27)
2%	Independent house or apartment	0%
4%	Assisted living facility	48%
0%	Acute psychiatric facility or hospital	7%
35%	Residential treatment facility	37%
60%	Another housing status	0%
0%	Unknown/Declined to state	7%

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

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are compared between 12 months prior to accessing services and FY 23–24.

Clients' Arrests and Emergency Events
(n = 52)



Drake House FSP

Demographic Data

Race

Black/African American	12%
White	77%
Another Race	12%
Unknown/Declined to State	0%

n = 52

12% Hispanic/Latino
77% Not Hispanic/Latino

n = 52
12% Unknown/Declined to state.

85% of individuals reported having one or more disabilities

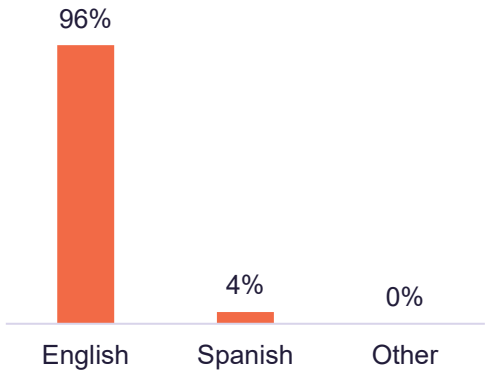
n = 52
0% Unknown/Declined to state.

Disability

No Disability	15%
Mental	83%
Another Disability	2%
Unknown/Declined to State	0%

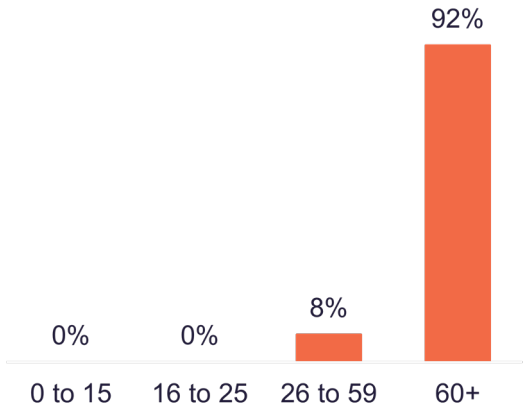
n = 52

Primary Language



n = 52
0% Unknown/Declined to state.

Age



n = 52
0% Unknown/Declined to state.

4% of individuals were veterans

n = 52
33% Unknown/Declined to state.

Drake House FSP

Gender Identity

Female	65%
Male	35%
Transgender	0%
Unknown/Declined to State	0%

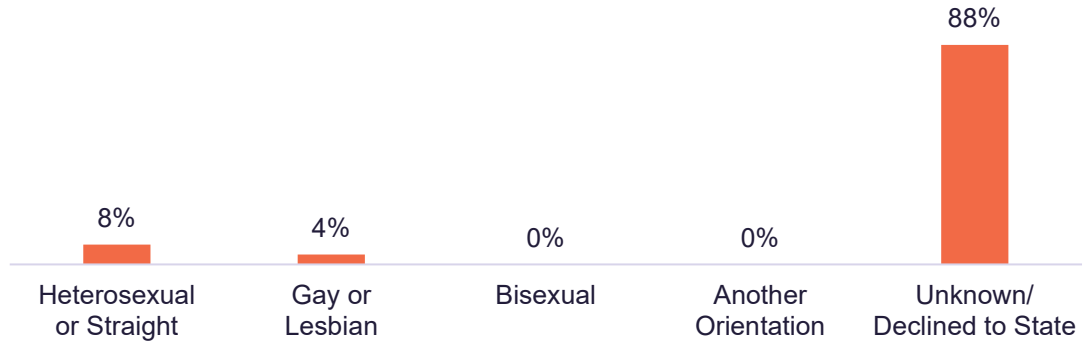
n = 52

Sex at Birth

Female	65%
Male	35%
Another Sex	0%
Unknown/Declined to State	0%

n = 52

Sexual Orientation
(n = 52)



Older Adult FSP

COUNTY OF MONTEREY

Older Adult is a Full-Service Partnership (FSP) program providing services to adults aged 60 years and older. Clients are individuals who have a serious and persistent mental illness with a co-occurring physical and or/substance use disorder and who are risk of losing their community placement due to an ongoing chronic co-existing physical impairment. These adults are at risk of high utilization of unplanned emergency services and institutionalization requiring a higher level of care. They benefit from intensive case management, preventing further deterioration of their conditions and enhancing their capacity to remain in the least restrictive environment. Program services are designed to maximize clients' participation in their recovery and enhance their quality of life in the greater community.

- 6 clients served in FY 23–24
- On average, clients engaged in services for 652 days
- 3 clients discharged in FY 23–24

Successes and Highlights

Through a contract agency, the Older Adult FSP program has been able to provide peer support services utilizing wellness navigators to assist clients with complex medical issues. The wellness navigators assist clients with managing multiple appointments and may sit in on appointments to help clients understand information shared from the provider.

Challenges and Growth Opportunities

The Older Adult FSP program continues to have staffing shortages. This impacts the extent of what the program can do for its clients. With the increase in medical staff, it is hoped that the nurses or medical assistants can help clients understand their medications and assist with the implementation of a medical case coordination model.

Goals for the Coming Year

1. Increase referrals to wellness navigators.
2. Increase referrals for medication reconciliation.
3. Behavioral Health will implement the medical case coordination model.

Older Adult FSP

Discharge Information

3 clients were **discharged**.

100% of discharges
were a **program decision**.

Employment and Education

0% of clients were **employed or volunteering**
before engaging in services.
(n = 6)

50% of clients enrolled in or completed **school**
before engaging in services.
(n = 6)

Older Adult FSP

Housing

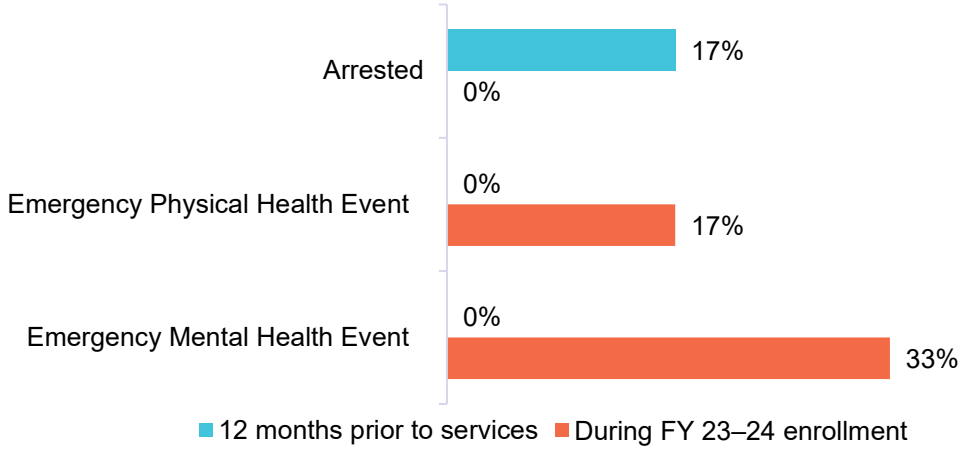
Housing Type Before Services (n = 6)		Current Housing Type (n = 6)
50%	Independent house or apartment	17%
33%	Unhoused	50%
0%	Acute psychiatric facility or hospital	17%
17%	Residential treatment facility	17%
0%	Assisted living facility	17%

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

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are compared between 12 months prior to accessing services and FY 23–24.

Clients' Arrests and Emergency Events
(n = 6)



Older Adult FSP

Demographic Data

Race

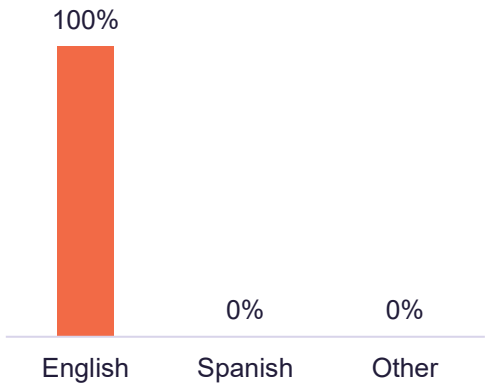
Asian	0%
Black/African American	0%
White	100%
Another Race	0%

n = 6

0% Hispanic/Latino
100% Not Hispanic/Latino

n = 6
0% Unknown/Declined to state.

Primary Language



n = 6
0% Unknown/Declined to state.

67% of individuals reported having one or more disabilities

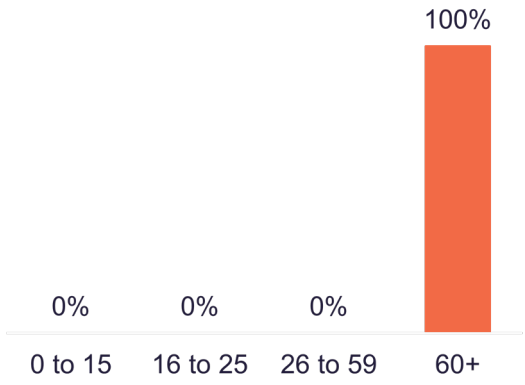
n = 6
0% Unknown/Declined to state.

Disability

No Disability	33%
Mental	50%
Another Disability	17%

n = 6

Age



n = 6
0% Unknown/Declined to state.

0% of individuals were veterans

n = 6
0% Unknown/Declined to state.

Older Adult FSP

Gender Identity

Female	50%
Male	33%
Unknown/Declined to State	17%

n = 6

Sex at Birth

Female	67%
Male	33%
Unknown/Declined to State	0%

n = 6

Sexual Orientation
(n = 6)

CSS-07: ACCESS REGIONAL SERVICES

Access Medication Support Services

COUNTY OF MONTEREY

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).

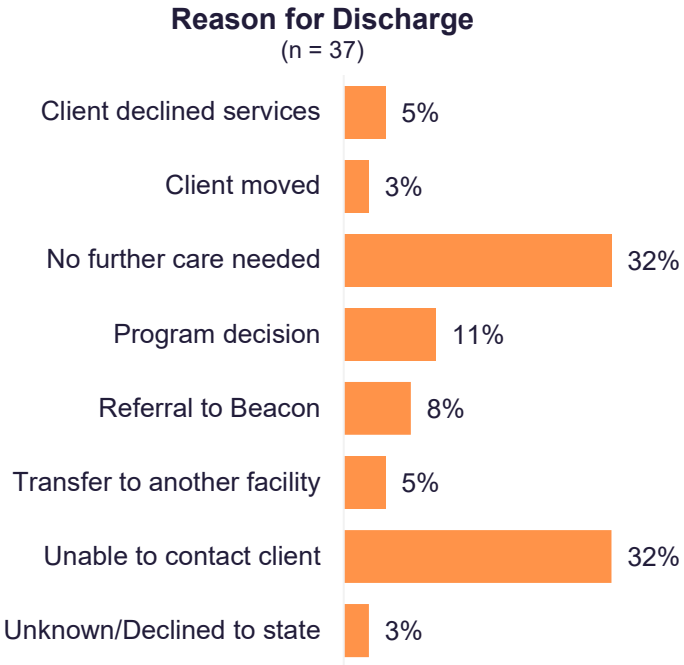
The program's team includes Interim, Inc.-employed or contracted professionals, such as psychiatrists (MDs), psychiatric-mental health nurse practitioners (PMHNPs-BC), registered nurses (RNs), and licensed vocational nurses (LVNs). RN/LVN staff members are integrated into program staffing and supervised 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.

- 42 clients served in FY 23–24
- On average, clients engaged in services for 285 days
- 39 clients discharged in FY 23–24

Discharge Information

39 clients were **discharged**.



Access Medication Support Services

Employment and Education

12% of clients were **employed or volunteering** before engaging in services.
(n = 42)

79% of clients enrolled in or completed **school** before engaging in services.
(n = 42)

Housing

Housing Type Before Services (n = 42)	
86%	Independent house or apartment
12%	Unhoused
0%	Acute psychiatric facility or hospital
0%	Residential treatment facility
0%	Foster home
0%	Group home
0%	Jail or juvenile detention facility
2%	Another housing status
0%	Unknown/Declined to state

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

Access Medication Support Services

Demographic Data

Race

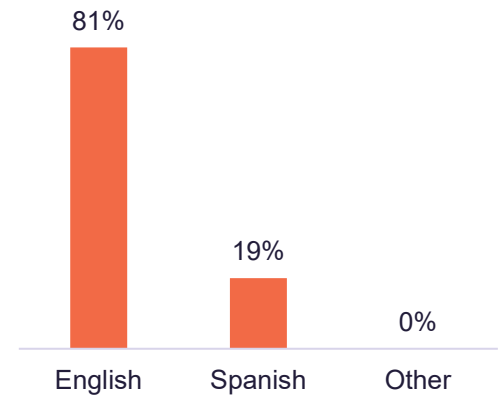
American Indian/Alaska Native	0%
Asian	7%
Black/African American	45%
White	29%
Another Race	19%
Unknown/Declined to State	0%

n = 42

52% Hispanic/Latino
29% Not Hispanic/Latino

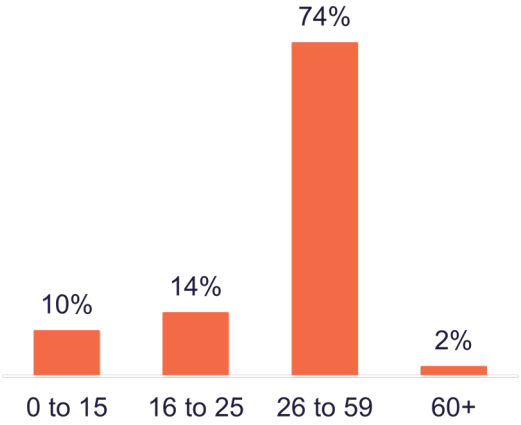
n = 42
19% Unknown/Declined to state.

Primary Language



n = 42
0% Unknown/Declined to state.

Age



n = 42
0% Unknown/Declined to state.

55% of individuals reported having one or more disabilities

n = 42
0% Unknown/Declined to state.

Disability

No Disability	45%
Visual	0%
Hearing	0%
Speech	0%
Mobility	7%
Mental	48%
Developmental	0%
Another Disability	0%
Unknown/Declined to State	0%

n = 42

2% of individuals were veterans

n = 42
2% Unknown/Declined to state.

Access Medication Support Services

Gender Identity

Female	55%
Male	36%
Transgender	5%
Unknown/Declined to State	2%

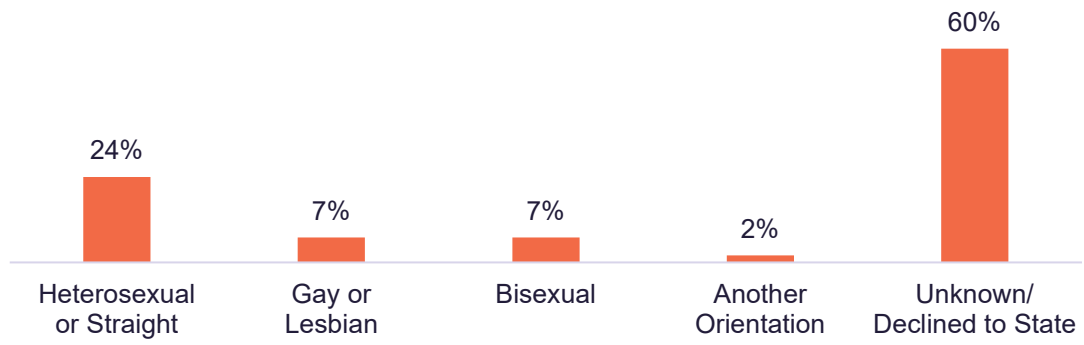
n = 42

Sex at Birth

Female	62%
Male	38%
Another Sex	0%
Unknown/Declined to State	0%

n = 42

Sexual Orientation
(n = 42)



Access to Treatment CalWORKs

COUNTY OF MONTEREY

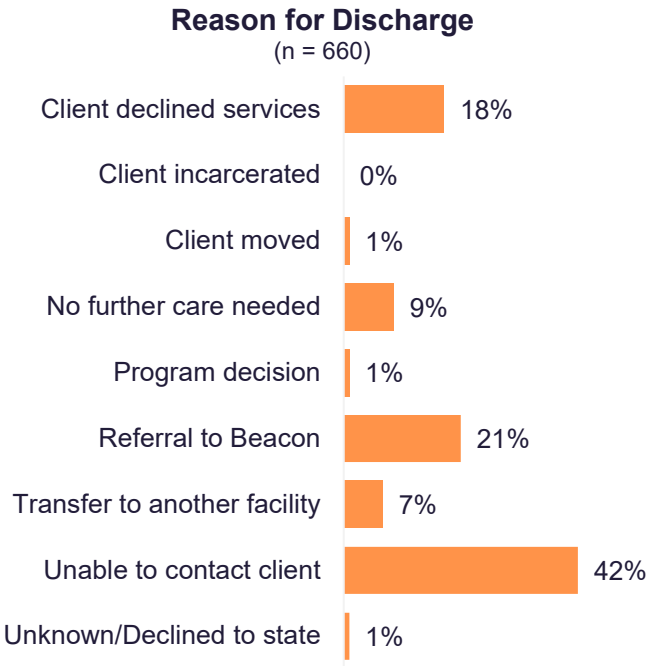
Access to Treatment CalWORKs is a county-staffed program that works with the Department of Social Services (DSS) to act as the mental health provider for clients enrolled in the Welfare-to-Work program. The program offers mental health triage/assessment, therapy, and psychiatry for those who have identified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

- 664 clients served in FY 23–24
- On average, clients engaged in services for 219 days
- 660 clients discharged in FY 23–24

Discharge Information

660 clients were **discharged**.

Of the 15 with goal information, 100% had **achieved some or all their goals**.



Access to Treatment CalWORKs

Employment and Education

13% of clients were **employed or volunteering** before engaging in services.
(n = 664)

80% of clients enrolled in or completed **school** before engaging in services.
(n = 664)

Housing

Housing Type Before Services (n = 664)	
86%	Independent house or apartment
6%	Unhoused
0%	Acute psychiatric facility or hospital
0%	Residential treatment facility
0%	Foster home
0%	Group home
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%.

Access to Treatment CalWORKs

Demographic Data

Race

American Indian/Alaska Native	1%
Asian	14%
Black/African American	53%
White	12%
Another Race	20%
Unknown/Declined to State	0%

n = 664

67% Hispanic/Latino
12% Not Hispanic/Latino

n = 664
20% Unknown/Declined to state.

13% of individuals reported having one or more disabilities

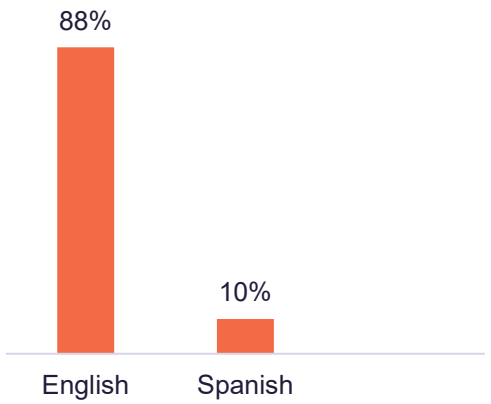
n = 664
XX% Unknown/Declined to state.

Disability

No Disability	87%
Visual	0%
Hearing	0%
Speech	0%
Mobility	1%
Mental	9%
Developmental	0%
Another Disability	3%
Unknown/Declined to State	0%

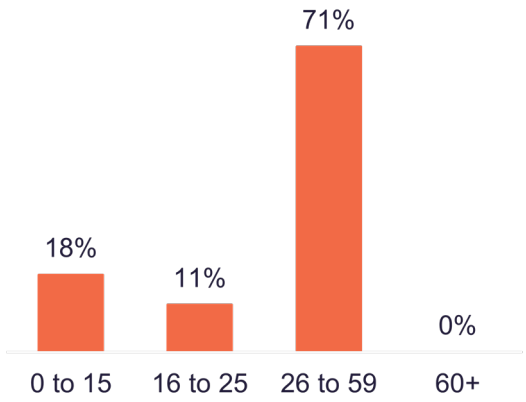
n = 664

Primary Language



n = 664
1% Unknown/Declined to state.

Age



n = 664
0% Unknown/Declined to state.

0% of individuals were veterans

n = 664
1% Unknown/Declined to state.

Access to Treatment CalWORKs

Gender Identity

Female	60%
Male	8%
Another Gender Identity	1%
Unknown/Declined to State	32%

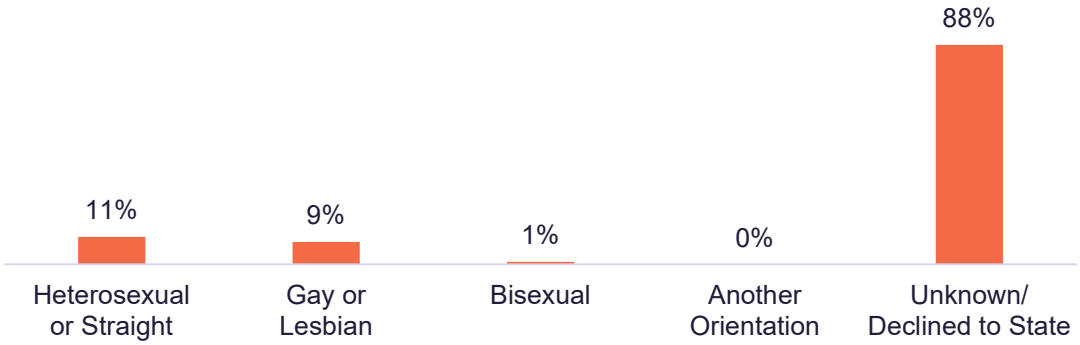
n = 664

Sex at Birth

Female	84%
Male	15%
Unknown/Declined to State	1%

n = 664

Sexual Orientation
(n = 664)



Access to Treatment Coastal Region

COUNTY OF MONTEREY

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.

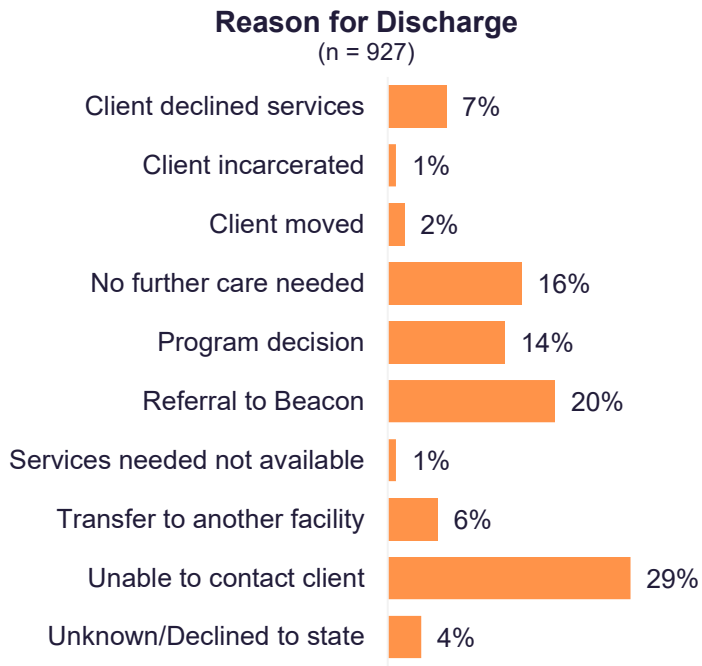
If an individual requires mental health services at a Specialty Mental Health level, then treatment is either provided through this program or the individual is referred to the appropriate team within the MCBH system. Treatment includes group and/or individual therapy, medication support, case management, mental health rehabilitation, and/or collateral treatment.

- 963 clients served in FY 23–24
- On average, clients engaged in services for 113 days
- 948 clients discharged in FY 23–24

Discharge Information

948 clients were **discharged**.

Of the 13 with goal information, 100% had **achieved some or all their goals**.



Access to Treatment Coastal Region

Employment and Education

13% of clients were **employed or volunteering** before engaging in services.
(n = 963)

63% of clients enrolled in or completed **school** before engaging in services.
(n = 963)

Housing

Housing Type Before Services (n = 963)	
77%	Independent house or apartment
10%	Unhoused
<1%	Acute psychiatric facility or hospital
<1%	Assisted living facility
2%	Residential treatment facility
1%	Foster home
0%	Group home
1%	Jail or juvenile detention facility
6%	Another housing status
4%	Unknown/Declined to state

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

Access to Treatment Coastal Region

Demographic Data

Race

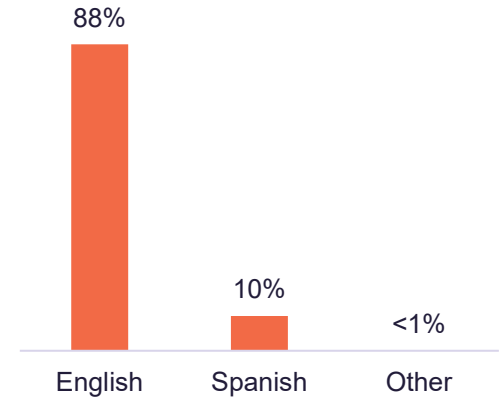
American Indian/Alaska Native	1%
Asian	8%
Black/African American	25%
White	30%
Another Race	36%
Unknown/Declined to State	0%

n = 963

33% Hispanic/Latino
30% Not Hispanic/Latino

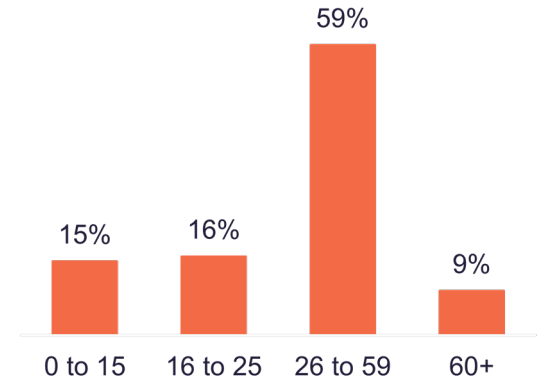
n = 963
37% Unknown/Declined to state.

Primary Language



n = 963
2% Unknown/Declined to state.

Age



n = 963
0% Unknown/Declined to state.

32% of individuals reported having one or more disabilities

n = 963
0% Unknown/Declined to state.

Disability

No Disability	68%
Visual	1%
Hearing	<1%
Speech	1%
Mobility	1%
Mental	21%
Developmental	1%
Another Disability	7%
Unknown/Declined to State	0%

n = 963

1% of individuals were veterans

n = 963
3% Unknown/Declined to state.

Access to Treatment Coastal Region

Gender Identity

Female	32%
Male	30%
Transgender	<1%
Genderqueer	<1%
Unknown/Declined to State	37%

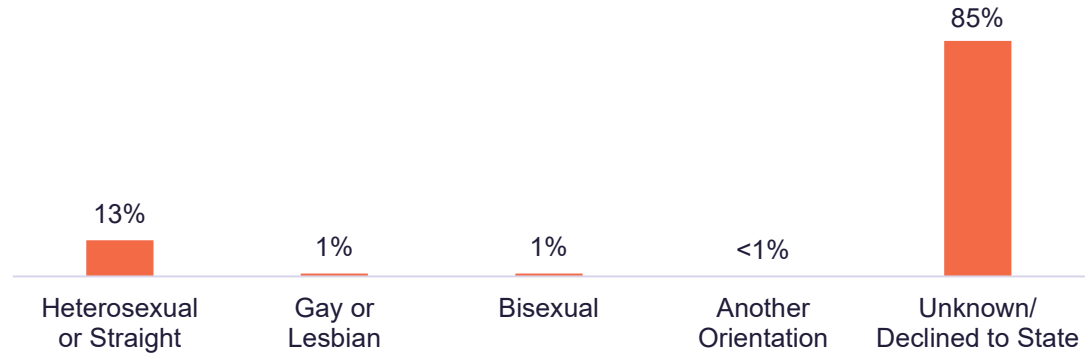
n = 963

Sex at Birth

Female	53%
Male	47%
Another Sex	0%
Unknown/Declined to State	<1%

n = 963

Sexual Orientation
(n = 963)



Access to Treatment King City

COUNTY OF MONTEREY

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

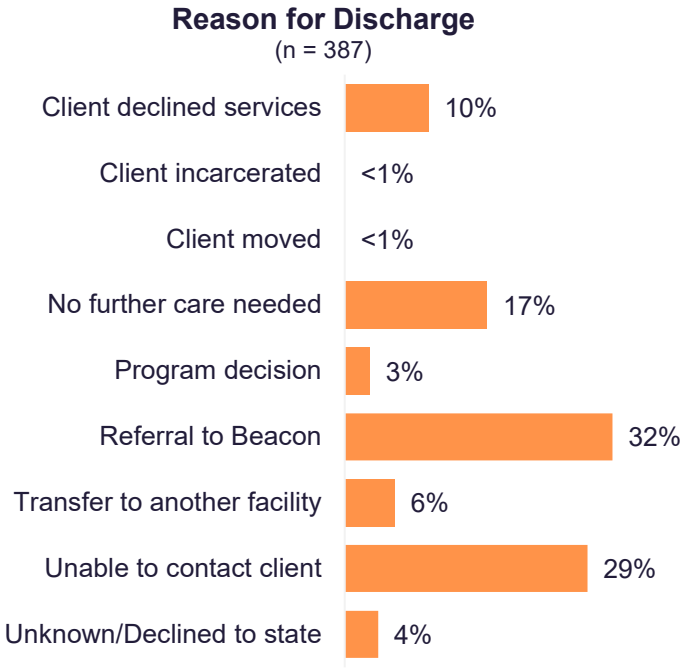
- 425 clients served in FY 23–24
- On average, clients engaged in services for 191 days
- 404 clients discharged in FY 23–24

.

Discharge Information

s404 clients were **discharged**.

Of the 16 with goal information, 87% had **achieved some or all their goals**.



Access to Treatment King City

Employment and Education

6% of clients were **employed or volunteering** before engaging in services.
(n = 425)

46% of clients enrolled in or completed **school** before engaging in services.
(n = 425)

Housing

Housing Type Before Services (n = 425)	
51%	Independent house or apartment
3%	Unhoused
<1%	Residential treatment facility
40%	Another housing status
5%	Unknown/Declined to state

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

Access to Treatment King City

Demographic Data

Race

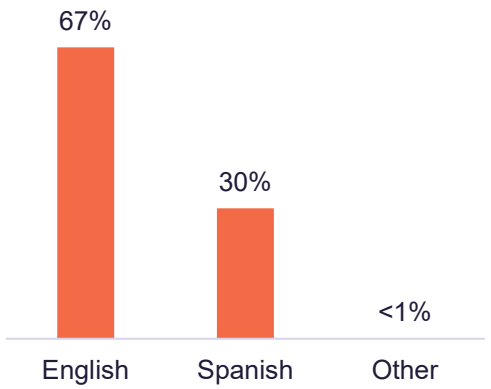
American Indian/Alaska Native	1%
Asian	9%
Black/African American	75%
White	4%
Another Race	11%
Unknown/Declined to State	0%

n = 425

84% Hispanic/Latino
4% Not Hispanic/Latino

n = 425
12% Unknown/Declined to state.

Primary Language

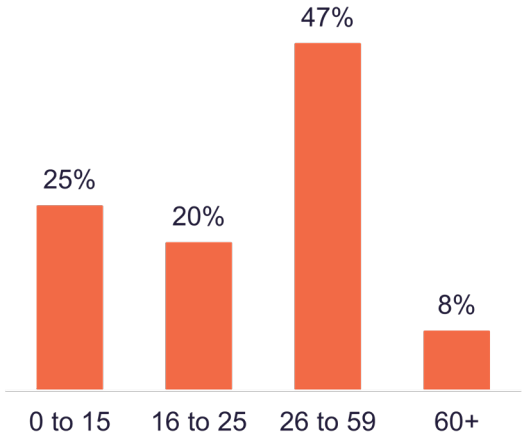


n = 425
2% Unknown/Declined to state.

11% of individuals reported having one or more disabilities

n = 425
0% Unknown/Declined to state.

Age



n = 425
0% Unknown/Declined to state.

Disability

No Disability	89%
Visual	<1%
Hearing	0%
Speech	<1%
Mobility	<1%
Mental	8%
Developmental	1%
Another Disability	1%
Unknown/Declined to State	0%

n = 425

0% of individuals were veterans

n = 425
0% Unknown/Declined to state.

Access to Treatment King City

Gender Identity

Female	40%
Male	23%
Another Gender Identity	<1%
Unknown/Declined to State	37%

n = 425

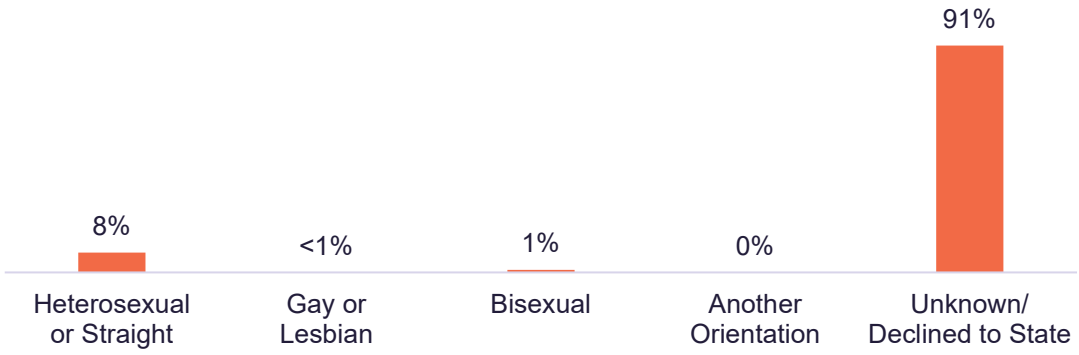
Sex at Birth

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

n = 425

Sexual Orientation

(n = 425)



Access to Treatment Salinas

COUNTY OF MONTEREY

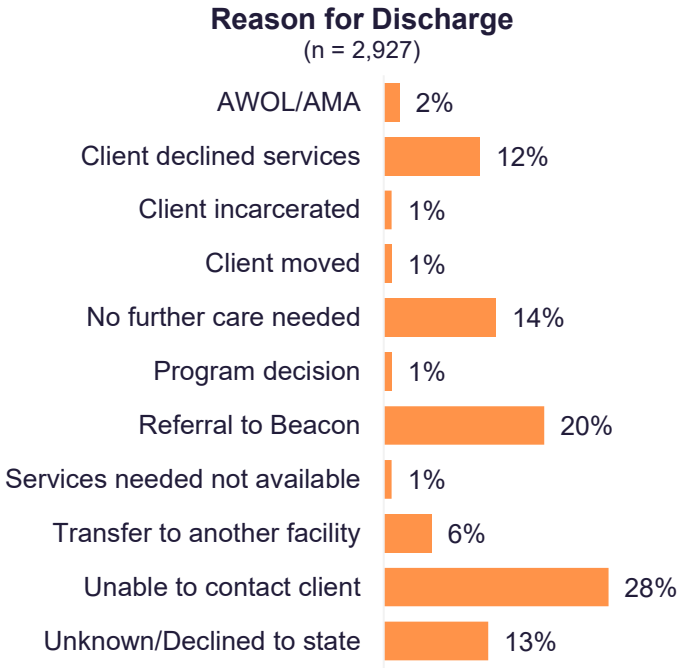
Access to Treatment Salinas is a primary entry point for Medi-Cal-eligible community members seeking mental health services. Community members are screened for level of need and are then either referred to another program for services or receive services from the program directly. The program provides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

- 3,013 clients served in FY 23–24
- On average, clients engaged in services for 85 days
- 2,959 clients discharged in FY 23–24

Discharge Information

2,959 clients were **discharged**.

Of the 31 with goal information, 94% had **achieved some or all their goals**.



Access to Treatment Salinas

Employment and Education

9% of clients were **employed or volunteering** before engaging in services.
(n = 3,013)

38% of clients were enrolled in or completed **school** before engaging in services.
(n = 3,013)

Housing

Housing Type Before Services (n = 3,013)	
42%	Independent house or apartment
5%	Unhoused
<1%	Acute psychiatric facility or hospital
<1%	Assisted living facility
1%	Residential treatment facility
<1%	Foster home
<1%	Group home
1%	Jail or juvenile detention facility
41%	Another housing status
10%	Unknown/Declined to state
<1%	Others

Access to Treatment Salinas

Demographic Data

Race

American Indian/Alaska Native	1%
Asian	8%
Black/African American	26%
White	7%
Another Race	57%
Unknown/Declined to State	0%

n = 3,013

34% Hispanic/Latino
7% Not Hispanic/Latino

n = 3,013
59% Unknown/Declined to state.

14% of individuals reported having one or more disabilities

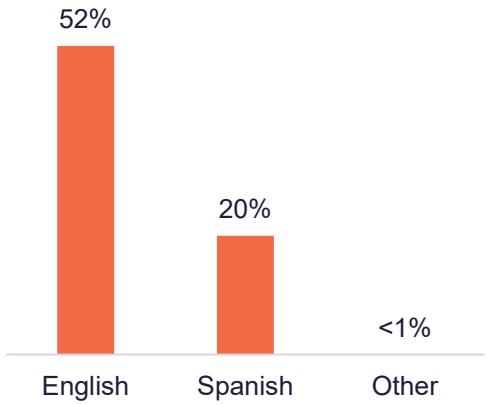
n = 3,013
0% Unknown/Declined to state.

Disability

No Disability	86%
Visual	<1%
Hearing	<1%
Speech	<1%
Mobility	1%
Mental	10%
Developmental	<1%
Another Disability	2%
Unknown/Declined to State	0%

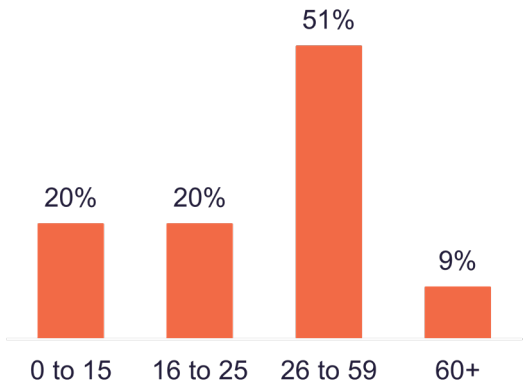
n = 3,013

Primary Language



n = 3,013
28% Unknown/Declined to state.

Age



n = 3,013
0% Unknown/Declined to state.

<1% of individuals were veterans

n = 3,013
15% Unknown/Declined to state.

Access to Treatment Salinas

Gender Identity

Female	30%
Male	25%
Transgender	<1%
Unknown/Declined to State	45%

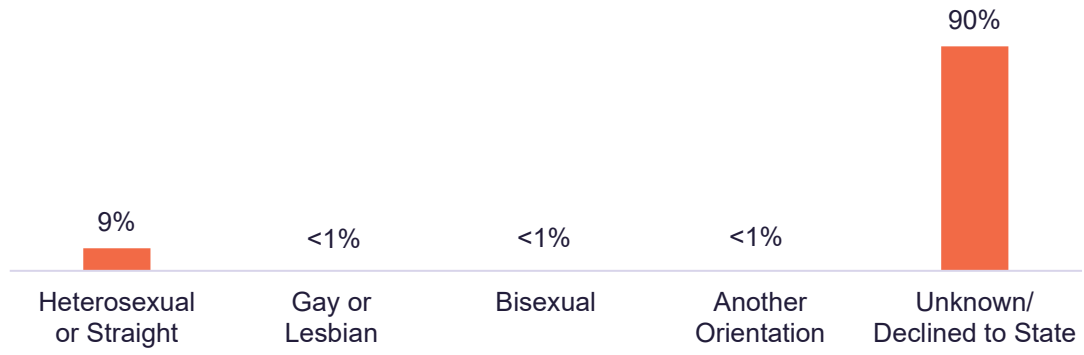
n = 3,013

Sex at Birth

Female	56%
Male	44%
Another Sex	0%
Unknown/Declined to State	0%

n = 3,013

Sexual Orientation
(n = 3,013)



Access to Treatment Soledad

COUNTY OF MONTEREY

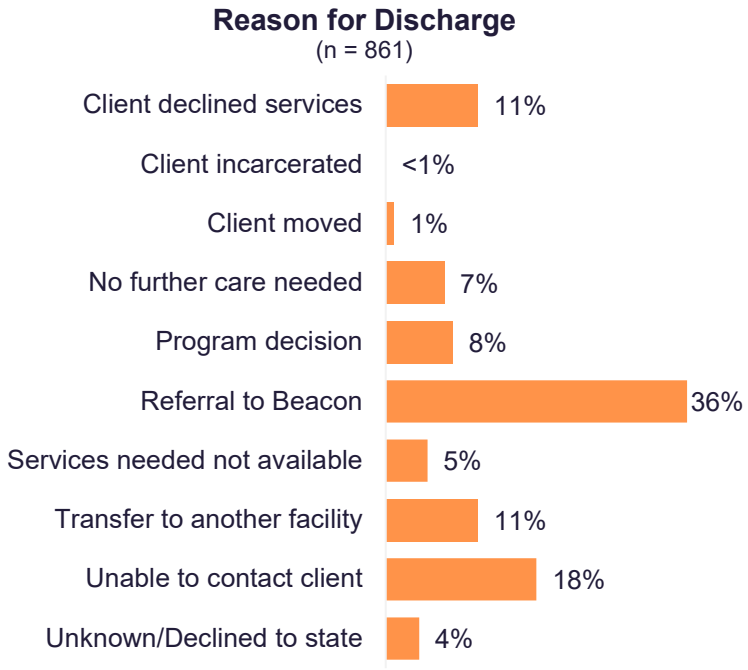
Access to Treatment Soledad provides mental health and substance use triage and assessment for community members. Once a client completes a triage/assessment, a disposition of the client's individual needs is made. Treatment provided to clients includes group and/or individual therapy, medication support, case management, mental health rehabilitation, and/or collateral treatment. 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.

- 928 clients served in FY 23–24
- On average, clients engaged in services for 100 days
- 903 clients discharged in FY 23–24

Discharge Information

903 clients were **discharged**.

Of the 41 with goal information, 93% had **achieved some or all their goals**.



Access to Treatment Soledad

Employment and Education

16% of clients were **employed or volunteering** before engaging in services.
(n = 928)

64% of clients enrolled in or completed **school** before engaging in services.
(n = 928)

Housing

Housing Type Before Services (n = 928)	
96%	Independent house or apartment
2%	Unhoused
<1%	Residential treatment facility
<1%	Foster home
<1%	Group home
<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%.

Access to Treatment Soledad

Demographic Data

Race

American Indian/Alaska Native	1%
Asian	6%
Black/African American	79%
White	5%
Another Race	9%
Unknown/Declined to State	0%

n = 928

85% Hispanic/Latino
5% Not Hispanic/Latino

n = 928
11% Unknown/Declined to state.

13% of individuals reported having one or more disabilities

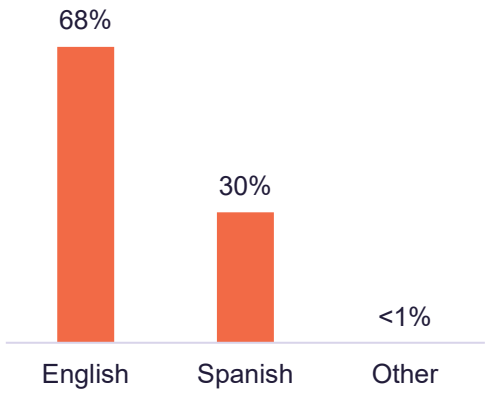
n = 928
0% Unknown/Declined to state.

Disability

No Disability	87%
Visual	1%
Hearing	0%
Speech	<1%
Mobility	<1%
Mental	10%
Developmental	<1%
Another Disability	1%
Unknown/Declined to State	0%

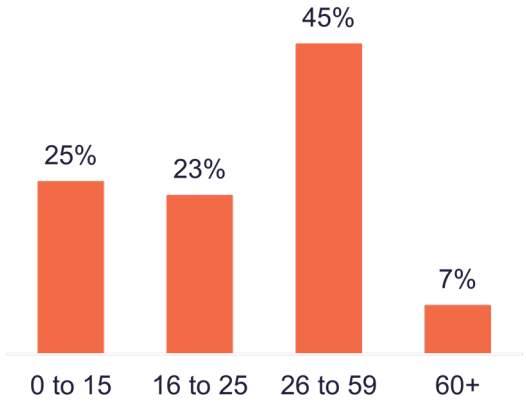
n = 928

Primary Language



n = 928
2% Unknown/Declined to state.

Age



n = 928
0% Unknown/Declined to state.

<1% of individuals were veterans

n = 928
1% Unknown/Declined to state.

Access to Treatment Soledad

Gender Identity

Female	37%
Male	21%
Transgender	0%
Unknown/Declined to State	43%

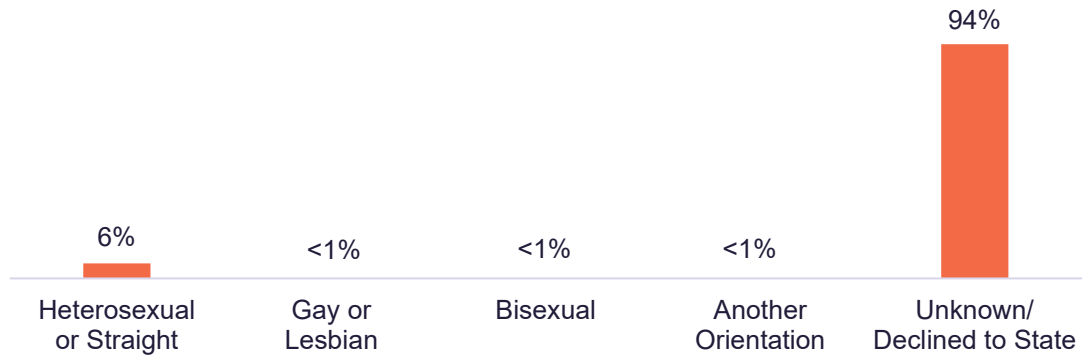
n = 928

Sex at Birth

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

n = 928

Sexual Orientation
(n = 928)



After Hours

CRISIS SUPPORT SERVICES OF ALAMEDA COUNTY

Crisis Support Services of Alameda County provides support to people of all ages to prevent the suicide of those who are actively suicidal and offer hope and caring during times of hopelessness. The program takes overflow from Family Service Agency of the Central Coast (FSACC) and after-hours calls for the 24/7 Access crisis line.

Successes and Highlights

- After Hours built on our pre-existing relationship with Family Service Agency of the Central Coast (FSACC).
- Successfully partnered with FSACC to take on overflow calls for our newly mandated 24/7 mobile crisis
- Average number of calls successfully answered: 76%.

Challenges and Growth Opportunities

This program supported the transition to Family Service Agency of the Central Coast (FSACC). With technical challenges built into the transition plan, we were able to problem-solve with MCBH. When MCBH consistently submitted unsuccessful test calls, within the week they provided training to staff and we responded to MCBH with results/corrections. We maintained communication during major weather events, power issues, and fires.

Goals for the Coming Year

1. Increase number of successful test calls.
2. Increase average number of answered calls to 90%.
3. Continue to maintain 24/7 coverage of the lines.

Family Counseling Salinas

COMMUNITY HUMAN SERVICES

- 262 clients served in FY 23–24
- On average, clients engaged in services for 204 days
- 220 clients discharged in FY 23–24

Successes and Highlights

- Able to offer outpatient services to community members who are unable to access services through other avenues.
- Well-trained and diverse staff employed by Community Human Services (CHS) who have a desire to serve this population.
- Ability to foster longevity with current staff via flexibility in schedules, realistic caseloads, and management support and MCBH collaboratives.

Challenges and Growth Opportunities

Clients' high acuity has been a challenge and has been more so than in previous years. We overcame this challenge by providing additional training opportunities for our staff and with consistent supervision and support from MCBH.

Goals for the Coming Year

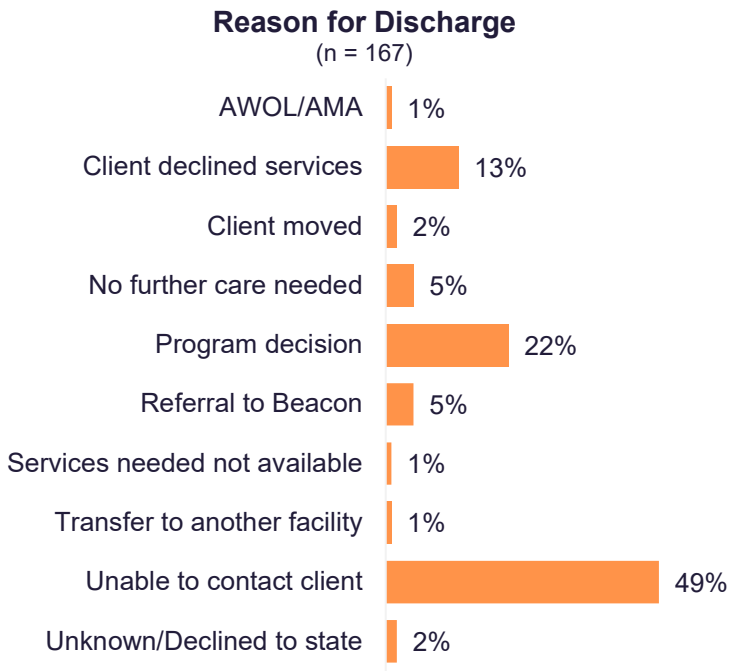
1. Increase days in South County clinics.
2. Provide more evidence-based training for staff.
3. Increase group service participation.

Family Counseling Salinas

Discharge Information

220 clients were **discharged**.

Of the 53 with goal information, 100% had **achieved some or all their goals**.



Employment and Education

22% of clients were **employed or volunteering** before engaging in services.
(n = 262)

77% of clients enrolled in or completed **school** before engaging in services.
(n = 262)

Family Counseling Salinas

Housing

Housing Type Before Services (n = 262)	
86%	Independent house or apartment
2%	Unhoused
1%	Residential treatment facility
8%	Another housing status
2%	Unknown/Declined to state

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

Family Counseling Salinas

Demographic Data

Race

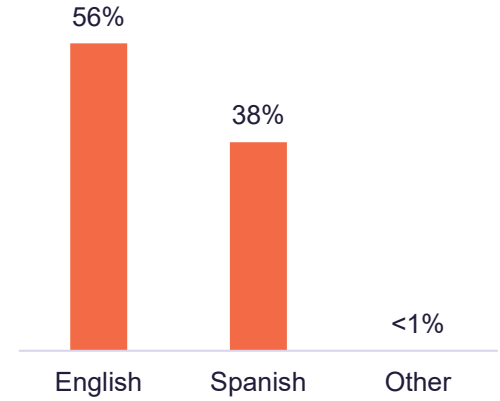
American Indian/Alaska Native	1%
Asian	10%
Black/African American	65%
White	7%
Another Race	17%
Unknown/Declined to State	0%

n = 262

75% Hispanic/Latino
7% Not Hispanic/Latino

n = 262
18% Unknown/Declined to state.

Primary Language



n = 262
5% Unknown/Declined to state.

23% of individuals reported having one or more disabilities

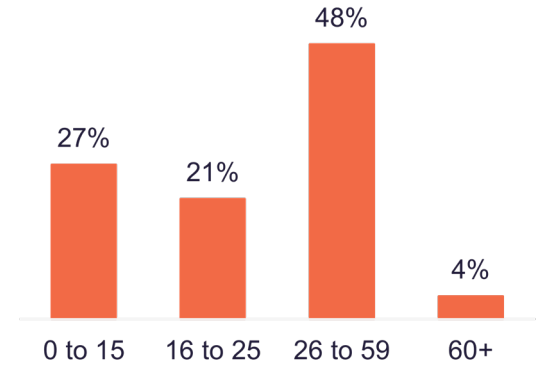
n = 262
0% Unknown/Declined to state.

Disability

No Disability	77%
Visual	<1%
Speech	<1%
Mobility	2%
Mental	17%
Developmental	<1%
Another Disability	2%
Unknown/Declined to State	0%

n = 262

Age



n = 262
0% Unknown/Declined to state.

0% of individuals were veterans

n = 262
1% Unknown/Declined to state.

Family Counseling Salinas

Gender Identity

Female	43%
Male	26%
Transgender	0%
Unknown/Declined to State	31%

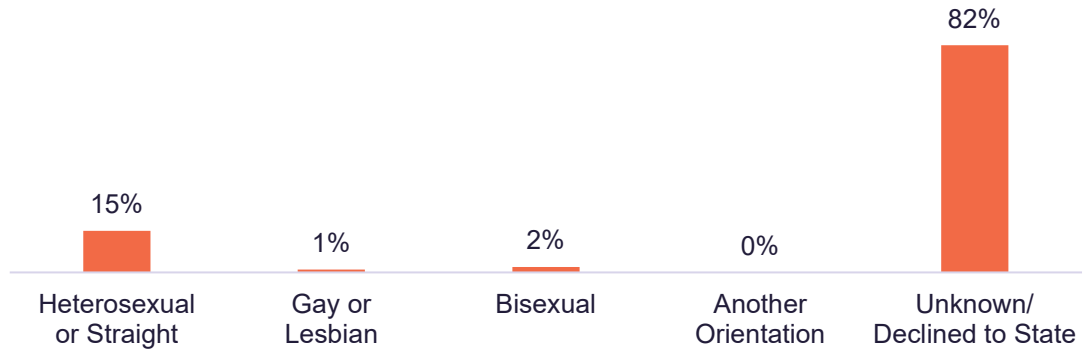
n = 262

Sex at Birth

Female	65%
Male	35%
Another Sex	0%
Unknown/Declined to State	0%

n = 262

Sexual Orientation
(n = 262)



Family Counseling Seaside

COMMUNITY HUMAN SERVICES

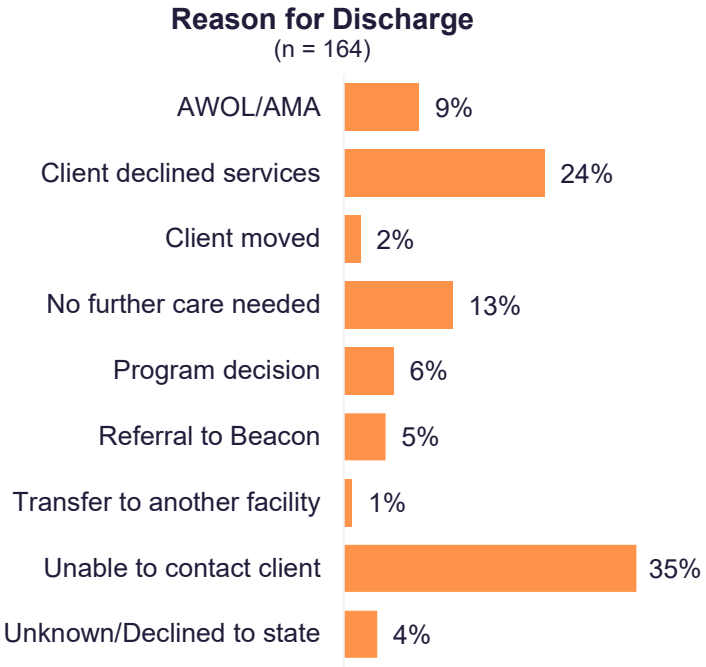
Community Human Services' Family Counseling Seaside provides CalAIM screening, assessment, therapy, case management, linkage/service coordination, and group services, and connections to other resources.

- 224 clients served in FY 23–24
- On average, clients engaged in services for 226 days
- 190 clients discharged in FY 23–24

Discharge Information

190 clients were **discharged**.

Of the 24 with goal information, 96% had **achieved some or all their goals**.



Family Counseling Seaside

Employment and Education

22% of clients were **employed or volunteering** before engaging in services.
(n = 224)

78% of clients enrolled in or completed **school** before engaging in services.
(n = 224)

Housing

Housing Type Before Services (n = 224)	
83%	Independent house or apartment
7%	Unhoused
0%	Acute psychiatric facility or hospital
3%	Residential treatment facility
0%	Foster home
0%	Group home
0%	Jail or juvenile detention facility
6%	Another housing status
2%	Unknown/Declined to state

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

Family Counseling Seaside

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	14%
Black/African American	41%
White	27%
Another Race	18%
Unknown/Declined to State	0%

n = 224

54% Hispanic/Latino
27% Not Hispanic/Latino

n = 224
18% Unknown/Declined to state.

29% of individuals reported having one or more disabilities

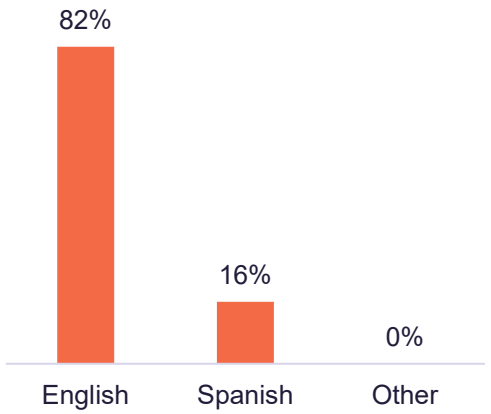
n = 224
0% Unknown/Declined to state.

Disability

No Disability	71%
Hearing	1%
Speech	0%
Mobility	1%
Mental	21%
Developmental	0%
Another Disability	5%
Unknown/Declined to State	0%

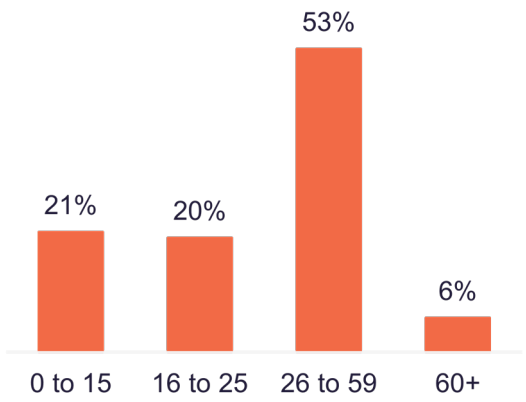
n = 224

Primary Language



n = 224
2% Unknown/Declined to state.

Age



n = 224
0% Unknown/Declined to state.

1% of individuals were veterans

n = 224
11% Unknown/Declined to state.

Family Counseling Seaside

Gender Identity

Female	43%
Male	27%
Transgender	0%
Unknown/Declined to State	28%

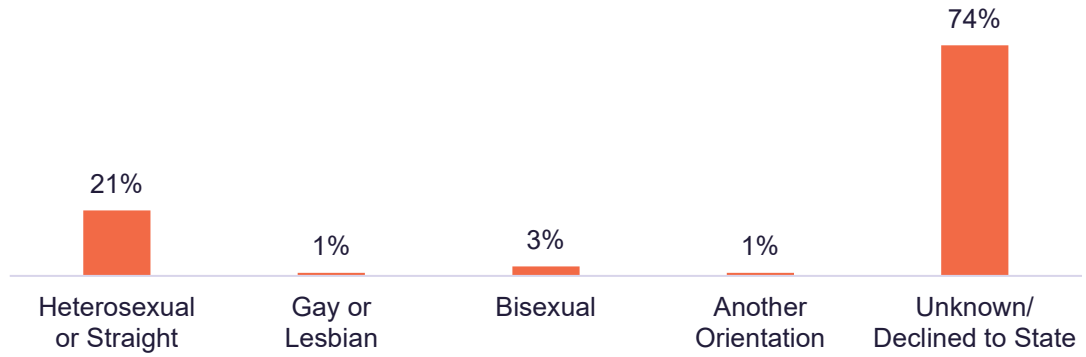
n = 224

Sex at Birth

Female	65%
Male	34%
Another Sex	0%
Unknown/Declined to State	0%

n = 224

Sexual Orientation
(n = 224)



Family Counseling South County

COMMUNITY HUMAN SERVICES

- 24 clients served in FY 23–24
- On average, clients engaged in services for 289 days
- 20 clients discharged in FY 23–24

Successes and Highlights

- Brought services to the South County community to eliminate clients' commute to Salinas.
- Secured a space with MCBH in the South County region.
- Increased our days of service in South County.
- Increased staff who provide services in South County.
- Served a community in need and provided services in clients' primary language(s) by hiring staff who speak multiple languages.

Challenges and Growth Opportunities

Clients have difficulty keeping scheduled appointments due to transportation challenges. This situation was improved in the fiscal year by offering services in our clients' community, and by extending the days on which services are provided in South County.

Goals for the Coming Year

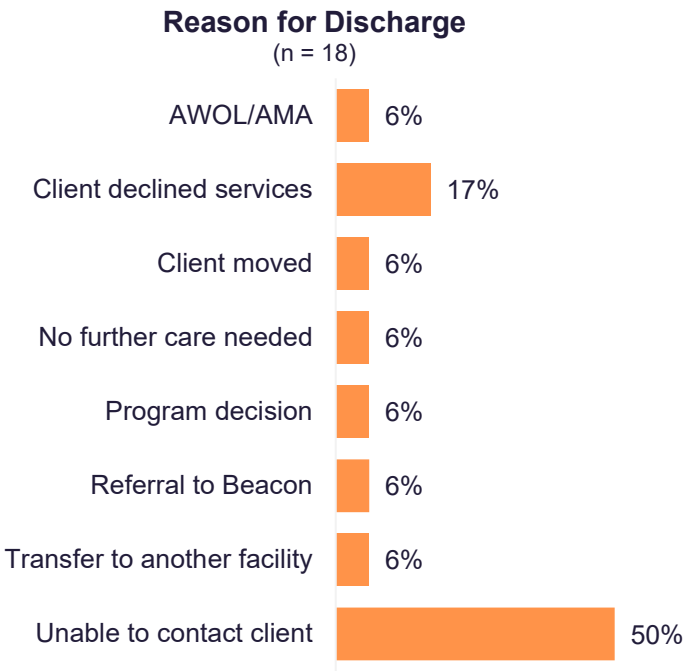
1. Increase the number of days of service delivery in South County.
2. Provide more evidence-based training for staff.
3. Increase group service participation.

Family Counseling South County

Discharge Information

20 clients were **discharged**.

Of the 2 with goal information, 100% had **achieved some or all their goals**.



Housing

Housing Type Before Services (n = 24)	
88%	Independent house or apartment
0%	Unhoused
0%	Acute psychiatric facility or hospital
4%	Residential treatment facility
0%	Foster home
0%	Group home
0%	Jail or juvenile detention facility
8%	Another housing status
0%	Unknown/Declined to state

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

Family Counseling South County

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	8%
Black/African American	83%
White	8%
Another Race	0%
Unknown/Declined to State	0%

n = 24

92% Hispanic/Latino
8% Not Hispanic/Latino

n = 24
0% Unknown/Declined to state.

29% of individuals reported having one or more disabilities

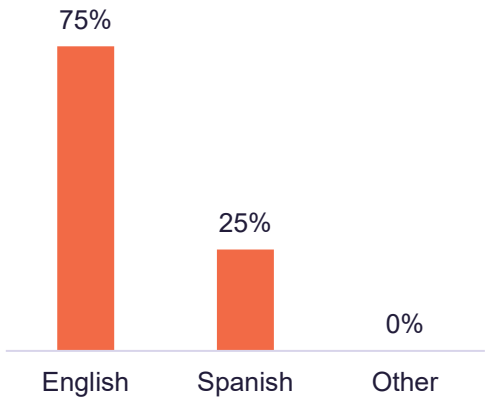
n = 24
0% Unknown/Declined to state.

Disability

No Disability	71%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Mental	25%
Developmental	0%
Another Disability	4%
Unknown/Declined to State	0%

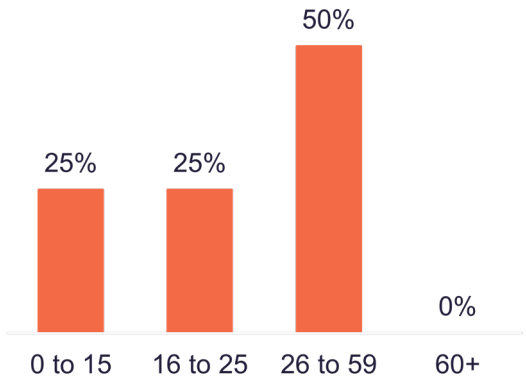
n = 24

Primary Language



n = 24
0% Unknown/Declined to state.

Age



n = 24
0% Unknown/Declined to state.

4% of individuals were veterans

n = 24
0% Unknown/Declined to state.

Family Counseling South County

Gender Identity

Female	50%
Male	33%
Transgender	0%
Unknown/Declined to State	17%

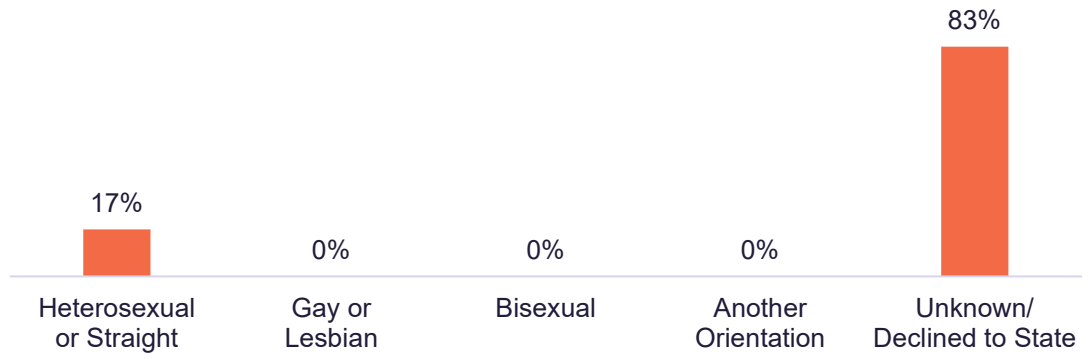
n = 24

Sex at Birth

Female	63%
Male	38%
Another Sex	0%
Unknown/Declined to State	0%

n = 24

Sexual Orientation
(n = 24)



Outpatient Mental Health

COUNTY OF MONTEREY

Community Human Services (CHS) provides outpatient care services to clients with moderate to severe mental illness who are referred to CHS by Monterey County Behavioral Health and to 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.

USC Telehealth

UNIVERSITY OF SOUTHERN CALIFORNIA

University of Southern California provides individual psychotherapy services to MCBH clients with mild to moderate symptomatology. Services are provided via telehealth on clients' personal devices or at an MCBH telesuite.

- 114 clients served in FY 23–24
- On average, clients engaged in services for 444 days
- 3 clients discharged in FY 23–24

Successes and Highlights

- Despite internal challenges, we were able to provide services to MCBH clients.

Challenges and Growth Opportunities

Fiscal year challenges were overcome by maintaining open communication with the MCBH team and being transparent about the challenges encountered. We learned that the strong partnership with MCBH helps our program succeed.

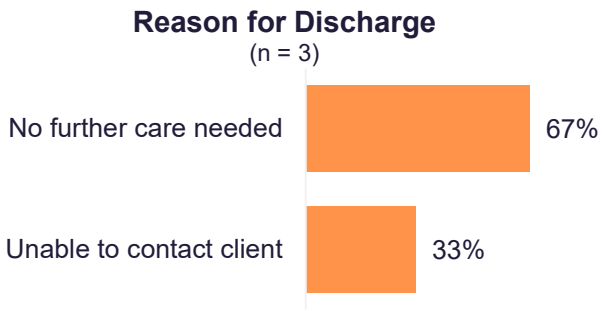
Goals for the Coming Year

1. Increase the number clients served.
2. Close out charts sooner.
3. Improve communication amongst providers and site coordinators.

USC Telehealth

Discharge Information

3 clients were **discharged**.



Employment and Education

16% of clients were **employed or volunteering** before engaging in services.
(n = 114)

46% of clients enrolled in or completed **school** before engaging in services.
(n = 114)

USC Telehealth

Housing

Housing Type Before Services (n = 114)	
67%	Independent house or apartment
1%	Unhoused
23%	Another housing status
10%	Unknown/Declined to state

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

USC Telehealth

Demographic Data

Race

American Indian/Alaska Native	2%
Asian	9%
Black/African American	49%
White	6%
Another Race	34%
Unknown/Declined to State	0%

n = 114

58% Hispanic/Latino
6% Not Hispanic/Latino

n = 114
36% Unknown/Declined to state.

92% of individuals reported having one or more disabilities

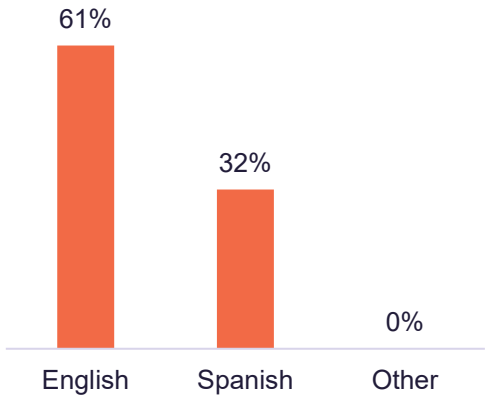
n = 114
0% Unknown/Declined to state.

Disability

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

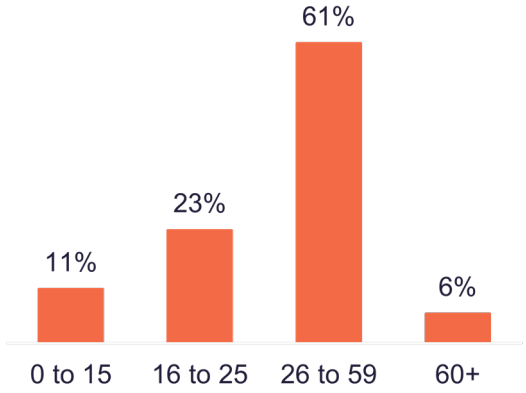
n = 114

Primary Language



n = 114
7% Unknown/Declined to state.

Age



n = 114
0% Unknown/Declined to state.

0% of individuals were veterans

n = 114
0% Unknown/Declined to state.

USC Telehealth

Gender Identity

Female	47%
Male	14%
Transgender	0%
Unknown/Declined to State	39%

n = 114

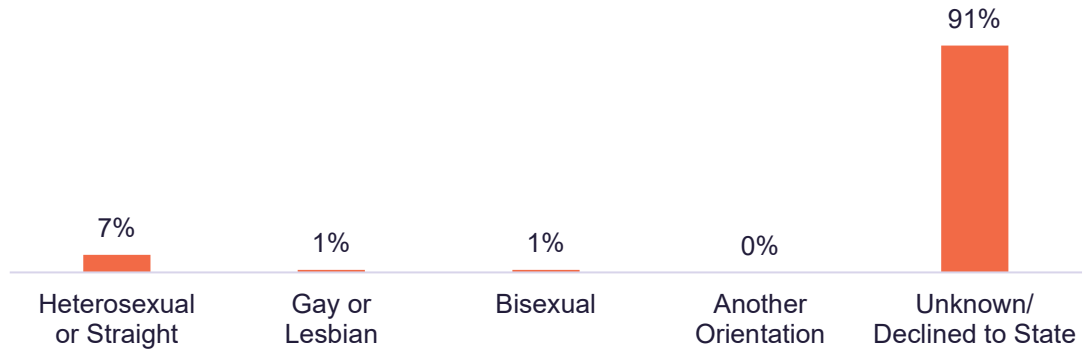
Sex at Birth

Female	73%
Male	26%
Another Sex	0%
Unknown/Declined to State	1%

n = 114

Sexual Orientation

(n = 114)



Wellness Recovery Center (OMNI)

INTERIM, INC.

Through mutual support, self-empowerment, and effective programming, OMNI's mission is to increase the mental health wellness of clients and the community by providing wellness awareness and innovative programs. OMNI is comprised of three components: Peer Counseling, Peer Support, and Supported Education. Clients come together to socialize and interact with others who are going through similar challenges. In Peer Counseling, staff facilitate groups where clients learn communication skills, emotional regulation, and stress reduction. Clients receive individual support sessions to help increase mental health resiliency and improve symptom management as well as social, occupational, educational, and daily functioning. Through the Peer Support component, staff and volunteers facilitate support groups and educational workshops, teach leadership skills, connect clients to resources, provide activities and events, and operate a warmline, increasing structure and improving socialization. Weekly rides are provided to and from residential care facilities, as well as monthly outreach. Supported Education serves adults with mental health challenges who are interested in attending school or a vocational training program. Staff assist clients with registration and managing their school environments, schedules, and coursework effectively. Staff also provide mental health support for client success, campus tours, academic advising and classroom accommodation referrals, and college support groups.

- 110 clients served in FY 23–24
- On average, clients engaged in services for 525 days
- 65 clients discharged in FY 23–24

Successes and Highlights

- OMNI continues to hold numerous events and activities, such as the Mental Health Service Recognition Awards and the agency picnic.
- Staff have planned and hosted many events throughout the year including Star Wars Day, Juneteenth, Harvey Milk Day, ice cream socials, Holi, and many more!
- OMNI averaged almost one event per week in the last six months of the fiscal year.
- Medi-Cal Services: The OMNI program has seen an increase in documentation and clients who want to enroll in Supported Education services. Most of the clients are enrolling in college to obtain higher degrees.
- Collaboration: The OMNI program boasts a strong and cohesive team that works well together and collaborates with other Interim, Inc. programs on events and activities.
- The OMNI team hosts Fun Friday for both OMNI and Choices clients and facilitates groups at Manzanita Houses.
- OMNI provided services to a total of 804 clients throughout the year (Goal: 500).
- 87% of clients surveyed reported satisfaction with the services provided through OMNI (Goal: 85%).
- OMNI assisted 56 clients with pre-enrollment, enrollment, and obtaining educational supportive services during the year (Goal: 20).

Wellness Recovery Center (OMNI)

Challenges and Growth Opportunities

OMNI did not meet its fiscal year goal of 85% of clients participating in individual/group peer counseling reporting maintained or improved mental health recovery. OMNI staff continue to have difficulty obtaining Recovry and Assessment Scale (RAS) from individuals. Going forward, the program coordinator will be responsible for creating a list of clients who have completed surveys. Staff will then follow up daily with clients who have not yet completed the survey. Additionally, the business systems analyst has developed a method to remove inactive clients so that they do not appear on the list of RAS surveys that need to be completed. The OMNI program coordinator and administrative assistant will also compile a list of clients who need to complete a consumer satisfaction survey and will follow up with staff regularly to submit them.

Apart from the program coordinator, there is only one full-time wellness navigator; all other OMNI staff members are part-time. Staff are frequently busy, leading to overtime and dependence on volunteers for assistance. When staff members are out sick, OMNI reduces the pick-up/drop-off service because coverage is needed at the center.

The significant rise in prices had a major impact on OMNI's budget. OMNI's client activities budget was almost exhausted halfway through the fiscal year due to a substantial increase in food expenses.

Pajaro janitorial services has been understaffed. Staff have made calls to numerous applicants, but candidates are not showing up for interviews or calling staff back. One candidate who was offered a position declined because they found another job with more hours and higher pay.

As referrals to Supported Education have increased, additional OMNI staff will receive training on the registration process to better serve the program and clients.

Goals for the Coming Year

1. Provide services to 500 unduplicated clients that will expand knowledge of wellness and recovery.
2. 85% of clients participating in individual/group peer counseling 10 or more times will report maintained or improved mental health recovery.
3. Assist 40 clients with pre-enrollment, enrollment, and obtaining educational supportive services.

Wellness Recovery Center (OMNI)

Discharge Information

65 clients were **discharged**.

Of the 64 with goal information,
97% had **achieved some or all their goals**.

Employment and Education

11% of clients were **employed or volunteering** before engaging in services.
(n = 110)

85% of clients enrolled in or completed **school** before engaging in services.
(n = 110)

Housing

Housing Type Before Services (n = 110)	
69%	Independent house or apartment
9%	Unhoused
1%	Assisted living facility
10%	Residential treatment facility
1%	Group home
1%	Jail or juvenile detention facility
8%	Another housing status
1%	Unknown/Declined to state

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

Wellness Recovery Center (OMNI)

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	9%
Black/African American	38%
White	53%
Another Race	0%
Unknown/Declined to State	0%

n = 110

47% Hispanic/Latino
53% Not Hispanic/Latino

n = 110
0% Unknown/Declined to state.

86% of individuals reported having one or more disabilities

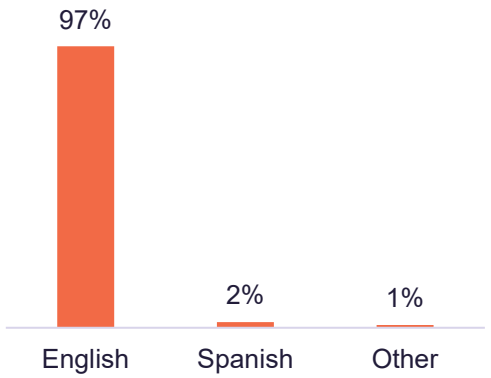
n = 110
0% Unknown/Declined to state.

Disability

No Disability	14%
Visual	1%
Speech	1%
Mobility	1%
Mental	82%
Another Disability	2%
Unknown/Declined to State	0%

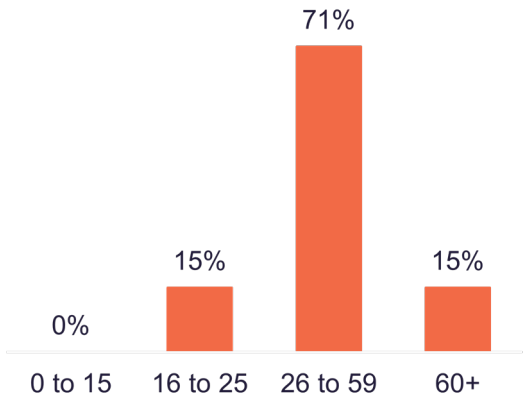
n = 110

Primary Language



n = 110
0% Unknown/Declined to state.

Age



n = 110
0% Unknown/Declined to state.

0% of individuals were veterans

n = 110
33% Unknown/Declined to state.

Wellness Recovery Center (OMNI)

Gender Identity

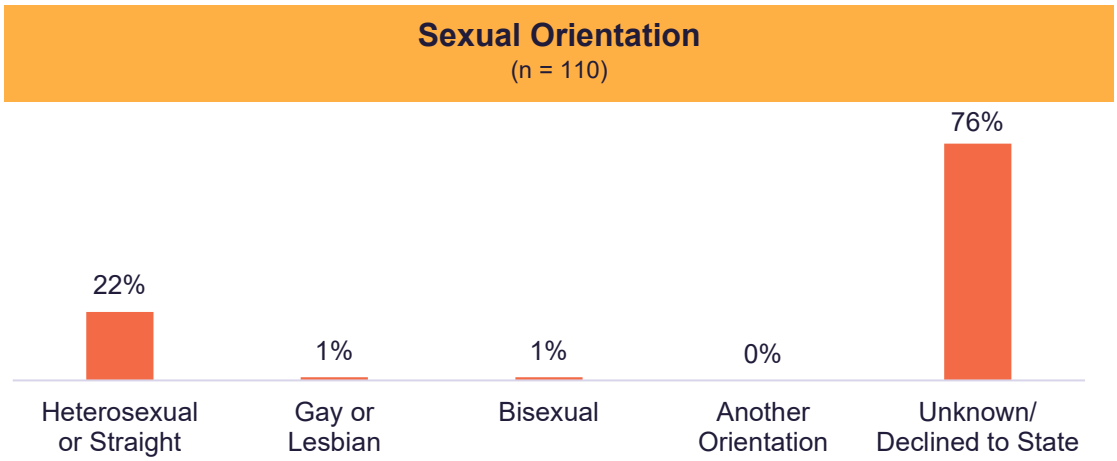
Female	56%
Male	44%
Transgender	0%
Unknown/Declined to State	0%

n = 110

Sex at Birth

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

n = 110



CSS-08: EARLY CHILDHOOD MENTAL HEALTH SERVICES

Monterey County Screening Team for Assessment, Referral, and Treatment (MCSTART)

DOOR TO HOPE

Children ages 0–11 years experiencing trauma, prenatal exposure to alcohol and drugs, and/or domestic violence are assessed and treated at MCSTART for specialty-focused care. MCSTART provides dyadic therapy, attachment therapy, occupational therapy, sensory integration therapy, Parents as Teachers programming, care coordination, and case management.

- 119 clients served in FY 23–24
- On average, clients engaged in services for 273 days
- 92 clients discharged in FY 23–24

Successes and Highlights

- Completed over 150 screenings using the ASQ and ASQ/SE tools.
- Increased the number of young children ages 0–36 months being assessed and treated.
- Provided home visitation services to referrals from county behavioral health and child welfare cases.

Challenges and Growth Opportunities

The MCSTART team, including therapists, rehabilitation specialists, and occupational therapists, meet weekly as a clinical staff and twice a month in an all-inclusive staff meeting to discuss any obstacles/challenges. The program has learned that a team approach works best to help their neediest clients. Additionally, the program administers the CANS at intake and 6-month intervals to monitor progress and complications.

Goals for the Coming Year

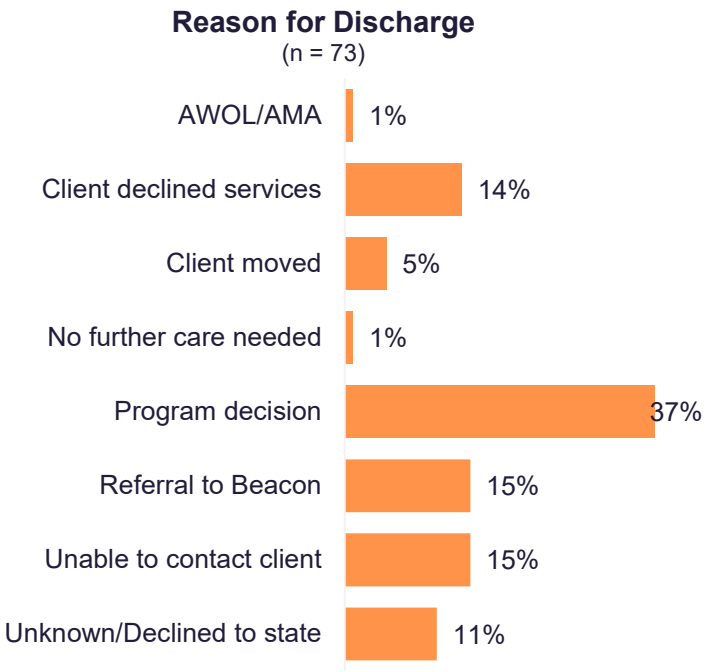
1. Our occupational therapy team will receive reflex integration certification.
2. Occupational therapists will create a home training program based on the reflex integration assessments for each child.
3. Treat 200 young children over the coming year.

MCSTART

Discharge Information

92 clients were **discharged**.

Of the 19 with goal information, 21% had **achieved some or all their goals**.



Employment and Education

61% of clients enrolled in or completed **school** before engaging in services.
(n = 119)

Housing

Housing Type Before Services
(n = 119)

92%	Independent house or apartment
8%	Foster home
1%	Unknown/Declined to state

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

MCSTART

Demographic Data

Race

Asian	10%
Black/African American	50%
White	21%
Another Race	19%

n = 119

60% Hispanic/Latino
21% Not Hispanic/Latino

n = 119
19% Unknown/Declined to state.

15% of individuals reported having one or more disabilities

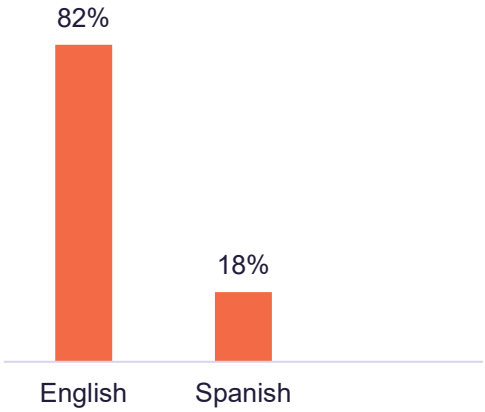
n = 19
0% Unknown/Declined to state.

Disability

No Disability	85%
Speech	3%
Mental	12%
Another Disability	1%

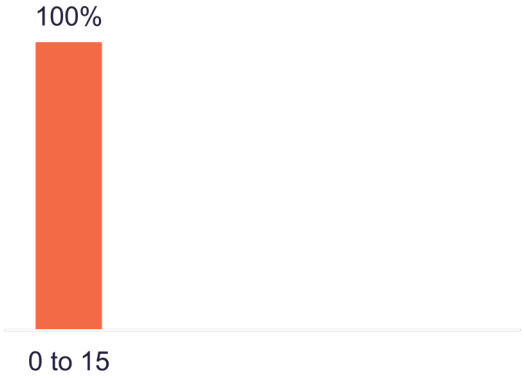
n = 119

Primary Language



n = 119
0% Unknown/Declined to state.

Age



n = 119
0% Unknown/Declined to state.

0% of individuals were veterans

n = 119
0% Unknown/Declined to state.

MCSTART

Gender Identity

Female	17%
Male	33%
Unknown/Declined to State	50%

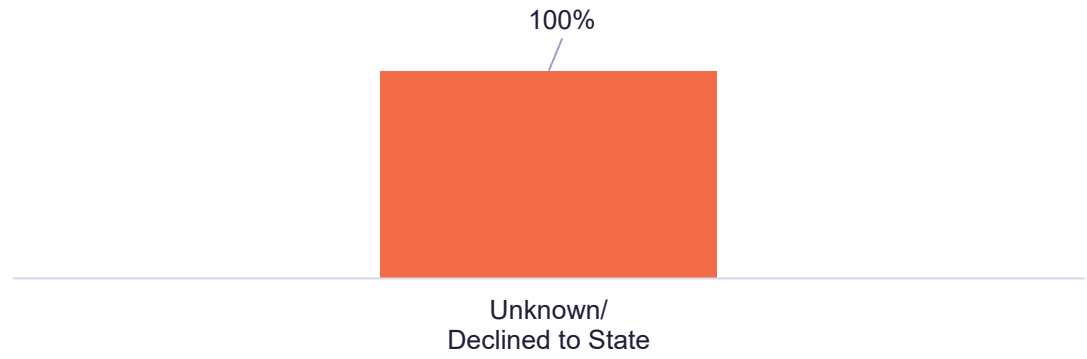
n = 119

Sex at Birth

Female	33%
Male	67%
Unknown/Declined to State	0%

n = 119

Sexual Orientation
(n = 119)



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

Return to Work Benefits Counseling and Housing Assistance

CENTRAL COAST CENTER FOR INDEPENDENT LIVING

Central Coast Center for Independent Living (CCCIL) provides benefits counseling and independent living services to consumers with mental health disabilities. CCCIL supports consumers through individual and system advocacy, assistive technology, traumatic brain injury services (one-on-one services and peer support groups), information and referrals, benefits assistance, independent living skills training, housing assistance, and more. CCCIL also helps consumers with independent living services to assist them in living independently in their community.

- 248 clients served in FY 23–24
- On average, clients engaged in services for 12 days
- 180 clients discharged in FY 23–24

Successes and Highlights

- CCCIL assisted 1,001 consumers agencywide. Of these, 898 were from Monterey County, 92 were from Santa Cruz County, and 21 were from San Benito County.
- Of the 898 consumers from Monterey County, 251 identified living with one or more mental health disability. Among those 251 consumers, 119 were first-time recipients of CCCIL services. Additionally, 25% of those 251 consumers met (or achieved?) an individual goal during this reporting period.
- The organization received calls from 2,072 unique callers totaling over 6,000 contacts from the community. Of those unique callers, 1,549 were from Monterey County.
- CCCIL has continued its goal of assisting consumers with mental health issues to move into permanent housing through the use of different funding sources. One example of how CCCIL is working to leverage funds is through the use of community resources supported by the Central California Alliance For Health. Through this collaboration, consumers were able to access one-time funds to establish basic households, including housing deposits, initial rent, and home goods. The behavioral health contract also assisted with covering staff salaries, benefits, and operating expenses.
- CCCIL's community organizer participated in 103 community events, in-person presentations, and one-on-one meetings to promote our services. Through these efforts, CCCIL reached 4,000 individuals.

Return to Work Benefits Counseling and Housing Assistance

Challenges and Growth Opportunities

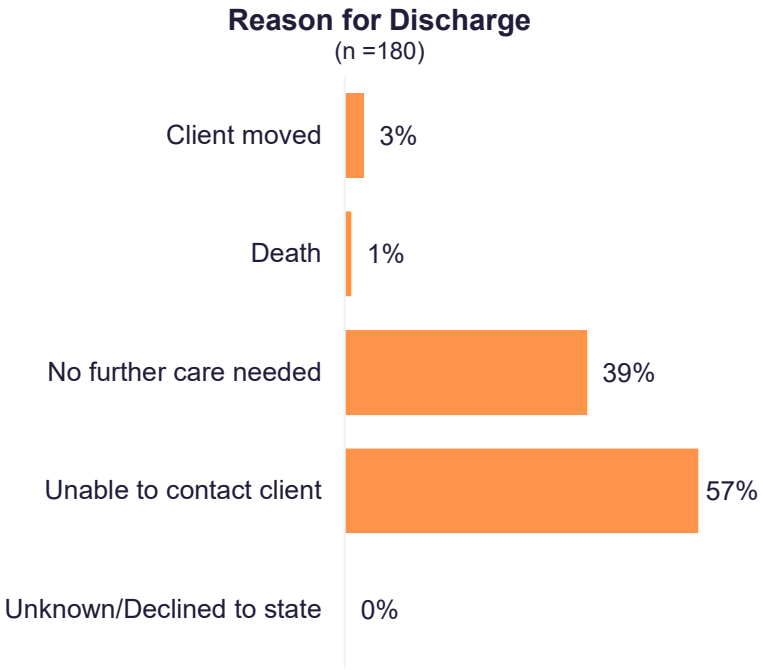
During the last fiscal year, CCCIL had some turnover among its case managers. Nonetheless, CCCIL was able to continue services without interruptions. Another challenge was the lack of affordable and supported housing in the county for consumers with limited income. To overcome this challenge, CCCIL continued its collaboration with the Housing Authority to assist consumers in applying for public housing when it became available.

Return to Work Benefits Counseling and Housing Assistance

Discharge Information

180 clients were **discharged**.

Of the 180 with goal information, 39% had **achieved some or all their goals**.



Education

0% of clients were **employed or volunteering** before enrolling in services.
(n = 248)

34% of clients enrolled in or completed **school** before enrolling in services.
(n = 248)

Return to Work Benefits Counseling and Housing Assistance

Housing

Current Housing Type (n = 248)	
Independent house or apartment	40%
Unhoused	32%
Acute psychiatric facility or hospital	0%
Residential treatment facility	0%
Foster home	0%
Group home	0%
Jail or juvenile detention facility	0%
Another housing status	28%
Unknown/Declined to state	0%

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

Return to Work Benefits Counseling and Housing Assistance

Demographic Data

Race

American Indian/Alaska Native	3%
Asian	1%
Black/African American	7%
Native Hawaiian/Other Pacific Islander	1%
White	77%
Another Race	11%
Unknown/Declined to State	0%

n = 248

45% Hispanic/Latino
55% Not Hispanic/Latino

n = 248
0% Unknown/Declined to state.

100% of individuals reported having one or more disabilities

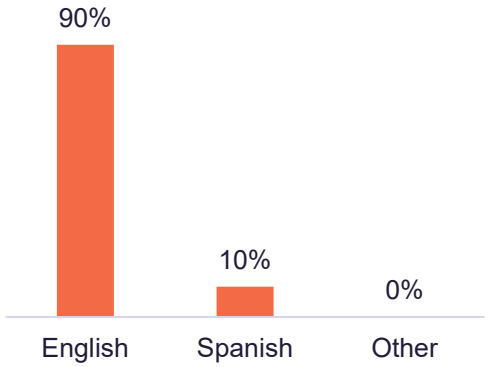
n = 248
0% Unknown/Declined to state.

Disability

No Disability	0%
Visual	2%
Hearing	1%
Speech	0%
Mobility	32%
Mental	44%
Developmental	0%
Another Disability	21%
Unknown/Declined to State	0%

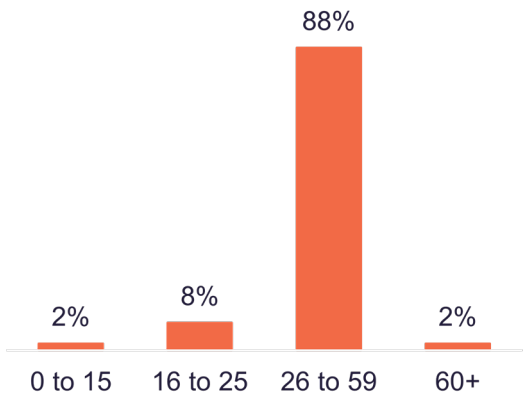
n = 248

Primary Language



n = 248
0% Unknown/Declined to state.

Age



n = 248
0% Unknown/Declined to state.

2% of individuals were veterans

n = 248
0% Unknown/Declined to state.

Return to Work Benefits Counseling and Housing Assistance

Gender Identity

Female	62%
Male	38%
Unknown/Declined to State	0%

n = 248

Sex at Birth

Female	62%
Male	38%
Another Sex	0%
Unknown/Declined to State	0%

n = 248

Wellness Navigation Services

INTERIM, INC.

Wellness Navigation Services is a voluntary peer support program focusing on clients who are working with the Monterey County Behavioral Health Adult System of Care. It consists of the Peer Partners for Health, Primary Care Integration and Transportation Coaching programs, and PADs (Psychiatric Advance Directive, which is funded by the MHSA Innovation component). Wellness Navigation Services supports consumers to decrease the frequency of mental health crises by increasing support in areas including symptom management skills training, education on mental health, connecting clients to community resources, connecting clients to primary care physicians, and teaching clients to navigate transportation systems. The mission of the program is to assist consumers in accessing internal and community resources to maintain wellness.

Peer Partners for Health (PPH): Clients are assisted with creating and utilizing a Wellness Recovery Action Plan (WRAP) to assist with managing mental health symptoms. Staff work to teach and help clients practice medication management skills, including organization of medications and ordering prescription refills.

Primary Care Integration (PCI): Clients are taught and assisted in practicing communication skills to effectively communicate with healthcare providers.

Transportation Coaching Program (TCP): Staff work on assisting clients with learning the public transportation system and engaging clients in developing coping strategies and organizational skills.

- 247 clients served in FY 23–24
- On average, clients engaged in services for 226 days
- 214 clients discharged in FY 23–24

Successes and Highlights

The Wellness Navigation Services team has developed positive working relationships with MCBH staff and has established a good rapport with county teams. Wellness navigators are positioned at MCBH clinics and participate in bi-weekly group supervision (with the navigator, MCBH supervisor, and assistant program director) and weekly team meetings to discuss clients' progress and challenges. All staff have received mobility training through Monterey-Salinas Transit (MST) and can utilize bus transportation at no additional cost. Staff also participate in regular agency and county trainings. Wellness navigators are trained in areas such as Motivational Interviewing, working with the unhoused, verbal de-escalation, suicide awareness, and boundaries, as well as an array of other trainings. Goal achievements are listed below.

- 90% of PPH clients surveyed reported satisfaction with the quality of services (Goal: 80%).
- At least 50% of PPH clients were referred to and obtained services from at least two community resource providers as a result of wellness navigator linkage. (Staff maintain a list of resources and work to link each client to at least two community resources. The assistant program director reviews client resources with staff to ensure that the goal is met.)
- 85% of PCI clients attended at least one PCP appointment (Goal: 75%).

Wellness Navigation Services

Challenges and Growth Opportunities

Wellness Navigation Services had low referrals throughout the year, leading to fewer clients being served than the target goal. Moreover, staff turnover created challenges in maintaining a consistent flow of service. In the fourth quarter, a new combined referral system for PPH, PCI, and TCP was implemented. This new approach resulted in increased referrals for all three programs, and it will be continued in the new fiscal year. Action plan items to support program goals in the new fiscal year are described below.

- PPH, PCI, and TCP services will be merged into one program—Wellness Navigation Services.
- Staff will complete a Recovery Assessment Scale (RAS) at 60 days and the assistant program director will maintain a list of clients needing to complete the assessment.
- The Transportation Needs Assessment Scale will be eliminated. Staff will instead complete the Recovery Assessment Scale at 60 days.

Goals for the Coming Year

1. 75% of clients who have had at least eight contacts with a wellness navigator will report maintained or improved recovery.
2. 50% of clients will be referred to and obtain services from community resource providers as a result of wellness navigator linkage.
3. 75% of clients who are referred specifically for PCP assistance will attend at least one PCP appointment.

Wellness Navigation Services

Discharge Information

214 clients were **discharged**.

Of the 214 with goal information,
80% had **achieved some or all their goals**.

Employment and Education

9% of clients were **employed or volunteering** before engaging in services.
(n = 247)

81% of clients enrolled in or completed **school** before engaging in services.
(n = 247)

Housing

Housing Type Before Services
(n = 247)

70%	Independent house or apartment
10%	Unhoused
2%	Acute psychiatric facility or hospital
7%	Residential treatment facility
0%	Foster home
0%	Group home
0%	Jail or juvenile detention facility
9%	Another housing status
3%	Unknown/Declined to state

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

Wellness Navigation Services

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	14%
Black/African American	40%
White	46%
Another Race	0%
Unknown/Declined to State	0%

n = 247

54% Hispanic/Latino
46% Not Hispanic/Latino

n = 247
<1% Unknown/Declined to state.

75% of individuals reported having one or more disabilities

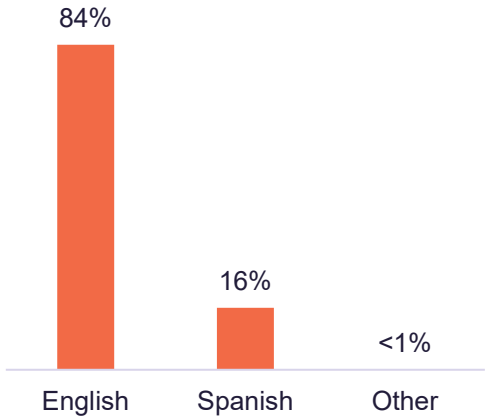
n = 247
0% Unknown/Declined to state.

Disability

No Disability	25%
Visual	<1%
Hearing	1%
Speech	<1%
Mobility	3%
Mental	66%
Developmental	1%
Another Disability	3%
Unknown/Declined to State	0%

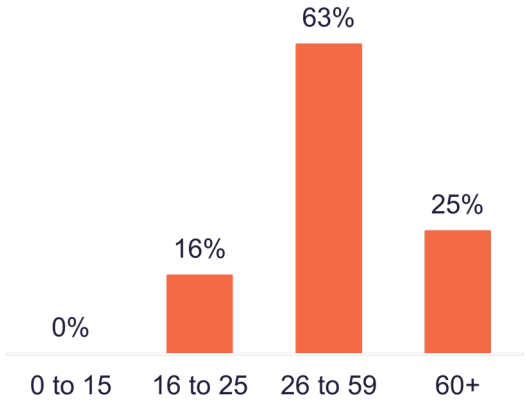
n = 247

Primary Language



n = 247
0% Unknown/Declined to state.

Age



n = 247
0% Unknown/Declined to state.

0% of individuals were veterans

n = 247
0% Unknown/Declined to state.

Wellness Navigation Services

Gender Identity

Female	55%
Male	43%
Transgender	<1%
Unknown/Declined to State	1%

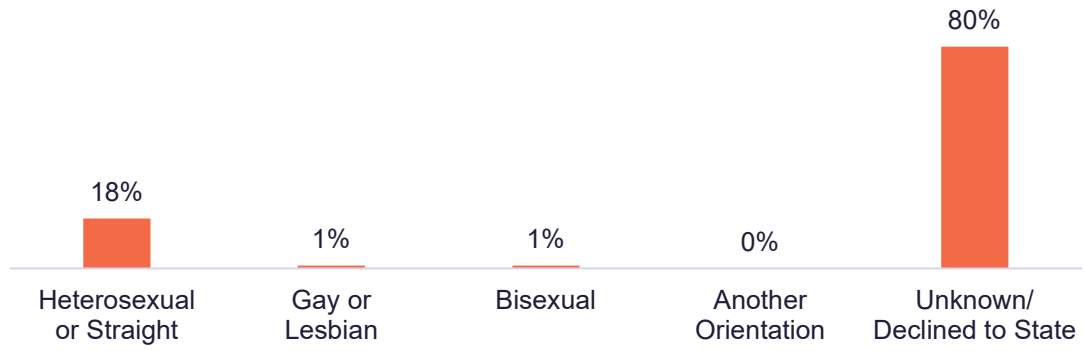
n = 247

Sex at Birth

Female	56%
Male	44%
Another Sex	0%
Unknown/Declined to State	0%

n = 247

Sexual Orientation
(n = 247)



CSS-11: DUAL DIAGNOSIS

Bridge House

INTERIM, INC.

Bridge House is a 14-bed transitional residential treatment program for adults with co-occurring serious mental illnesses and substance use disorders. The program is licensed by the California Department of Social Services, Community Care Licensing (CCL) as a Social Rehabilitation Facility and certified by the Department of Health Care Services (DHCS).

- 59 clients served in FY 23–24
- On average, clients engaged in services for 117 days
- 58 clients discharged in FY 23–24

Successes and Highlights

- 87% of consumers were discharged to a lower level of care.
- 81% of consumers remained abstinent from substances while receiving services.
- 92% of consumers served during the fiscal year eliminated all psychiatric hospitalizations while in the program.
- 88% of consumers appropriately engaged with a primary care physician while receiving services from the program.
- 92% of consumers surveyed reported satisfaction with the quality of services provided.

Challenges and Growth Opportunities

The program faced several significant challenges this past year. The exit of the previous program director in July 2023, followed by another program director change in the third quarter, disrupted operations. This was compounded by understaffing—particularly in overnight positions in the second and third quarters—which put a strain on current staff to cover shifts, negatively impacting the program's operations. The closure of the Bienestar clinic disrupted services to several new and long-term patients. As a result, many struggled to find new primary care physicians, which delayed the completion of intake forms and getting their physical health needs addressed. Additionally, staff experienced challenges in collaborating with other medical professionals in our community to complete the required CCL documentation for client medical care. To address these issues and enhance client care, there is an ongoing need to increase nursing hours. This is necessary to provide quality care and attend to physical health conditions, primarily to support consumers with restricted health care conditions. This would also support the counseling staff, who spend numerous hours helping consumers deal with doctors, medication order updates, pharmacies, and other providers to help meet both consumer and program needs.

Bridge House

Goals for the Coming Year

1. 70% of clients will discharge to a lower level of care.
2. 75% of clients will remain abstinent during their stay at Bridge House.
3. 80% of clients served during the FY will eliminate all psychiatric hospitalizations.

Bridge House

Discharge Information

58 clients were **discharged**.

Of the 58 with goal information, 78% had **achieved some or all their goals**.

Employment and Education

8% of clients were **employed or volunteering** before enrolling in services.
(n = 59)

98% of clients enrolled in or completed **school** before enrolling in services.
(n = 59)

Housing

Housing Type Before Services (n = 59)	
12%	Independent house or apartment
10%	Unhoused
2%	Acute psychiatric facility or hospital
47%	Residential treatment facility
0%	Foster home
0%	Group home
10%	Jail or juvenile detention facility
19%	Another housing status
0%	Unknown/Declined to state

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

Bridge House

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	25%
Black/African American	32%
White	42%
Another Race	0%
Unknown/Declined to State	0%

n = 59

58% Hispanic/Latino
42% Not Hispanic/Latino

n = 59
0% Unknown/Declined to state.

93% of individuals reported having one or more disabilities

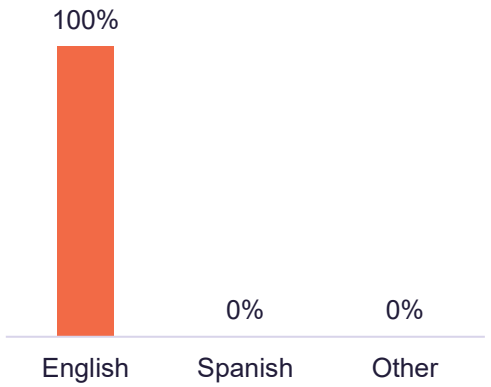
n = 59
0% Unknown/Declined to state.

Disability

No Disability	7%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Mental	93%
Developmental	0%
Another Disability	0%
Unknown/Declined to State	0%

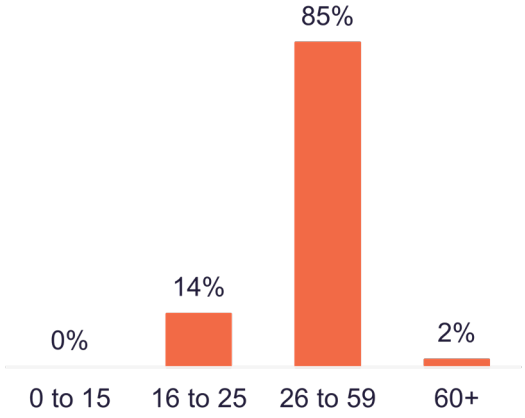
n = 59

Primary Language



n = 59
0% Unknown/Declined to state.

Age



n = 59
0% Unknown/Declined to state.

0% of individuals were veterans

n = 59
0% Unknown/Declined to state.

Bridge House

Gender Identity

Female	34%
Male	66%
Transgender	0%
Unknown/Declined to State	0%

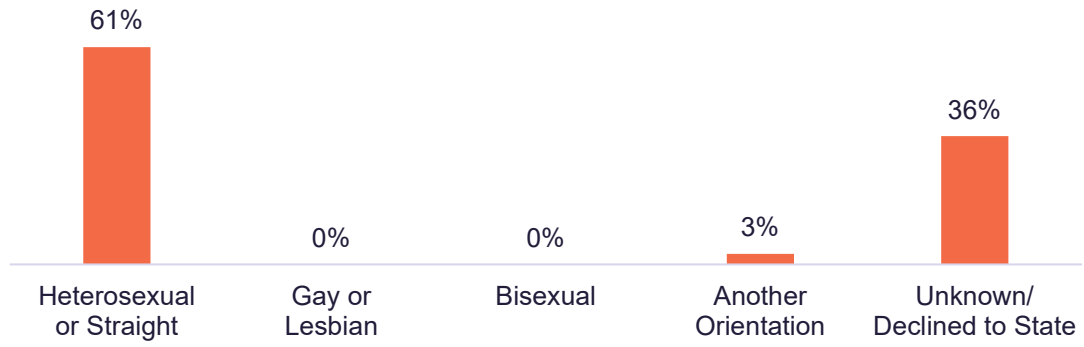
n = 59

Sex at Birth

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

n = 59

Sexual Orientation
(n = 59)



Keep It Real, Harm Reduction Services

INTERIM, INC.

Keep It Real is an outpatient program for adults with co-occurring serious mental illnesses and substance use disorders that receives both CSS and PEI funding. The program provides supportive services including group counseling, individual counseling, and peer support that is trauma-informed and culturally competent for a diverse population. Individuals are taught a variety of methods to achieve abstinence and/or mitigate harm associated with substance use, including how to focus on positive life changes—which will ultimately have positive effects on their relationship to substances. The program's mission is to guide and support individuals while they manage their mental illness, learn to manage their relationship to substances effectively in the community, and reduce the harm caused by substance use. Clients must be 18 years or older, have a serious mental illness, and have a substance use diagnosis causing serious functional impairment. Clients and staff develop collaborative treatment plans to assist clients working towards person-centered goals establish daily and meaningful structure, improve symptom management, increase personal and social functioning, and learn relapse prevention skills. Keep It Real provides transportation to groups and services if needed to support clients' engagement in treatment. In addition, the Keep It Real program conducts safety assessments and planning upon intake and as needed and provides extracurricular activities throughout the month. The program also provides clients with information about other community resources to strengthen social support.

- 117 clients served in FY 23-24
- On average, clients engaged in services for 500 days
- 87 clients discharged in FY 23-24

Successes and Highlights

- The program served 117 unduplicated clients, including 64 new individuals (Goal: 85).
- 94% of clients served were not hospitalized (Goal: 80%).
- 99% of clients were not incarcerated (Goal: 85%).
- 97% of clients surveyed reported satisfaction with the quality of services provided (Goal: 90%).
- Keep It Real outpatient services successfully expanded and increased participation in all groups across the program, including our Salinas, Soledad, and Marina locations.
- The program provided easier access to services by running groups in the newly opened Interim, Inc. office in Soledad. This allowed our team to expand services, including transportation and increasing individual sessions due to its central location in South County.
- The program received CARF (Commission on Accreditation of Rehabilitation Facilities) accreditation as Outpatient Services through May 2026.

Keep It Real, Harm Reduction Services

Challenges and Growth Opportunities

Keep It Real has struggled with client participation in the consumer satisfaction surveys. To get more surveys completed, our team plans to break surveys into smaller sections and work with clients to have them completed in accordance with annual plan schedules.

Another challenge has been consistent attendance of groups on the Peninsula due to transportation issues. To improve Peninsula group attendance, staff facilitating groups in this area will call clients served, offering transportation to and from groups. In addition, staff will provide linkage to alternative transportation services for clients when needed (i.e., Call-the-Car, MST Rides).

To continue building on the South County expansion, Keep It Real will begin facilitating four new groups, for a total of six groups two days a week.

Goals for the Coming Year

1. Program will serve/enroll 150 clients with co-occurring serious mental illness and substance use disorders.
2. 80% of clients served during the FY will eliminate all psychiatric hospitalization while in the program.
3. 85% of clients will not experience incarceration while in the program.

Keep It Real, Harm Reduction Services

Discharge Information

87 clients were **discharged**.

Of the 85 with goal information,
98% had **achieved some or all their goals**.

Employment and Education

10% of clients were **employed or volunteering** before engaging in services.
(n = 117)

92% of clients enrolled in or completed **school** before engaging in services.
(n = 117)

Housing

Housing Type Before Services (n = 117)	
56%	Independent house or apartment
10%	Unhoused
2%	Acute psychiatric facility or hospital
20%	Residential treatment facility
0%	Foster home
0%	Group home
3%	Jail or juvenile detention facility
9%	Another housing status
0%	Unknown/Declined to state

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

Keep It Real, Harm Reduction Services

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	9%
Black/African American	35%
White	56%
Another Race	0%
Unknown/Declined to State	0%

n = 117

44% Hispanic/Latino
56% Not Hispanic/Latino

n = 117
0% Unknown/Declined to state.

91% of individuals reported having one or more disabilities

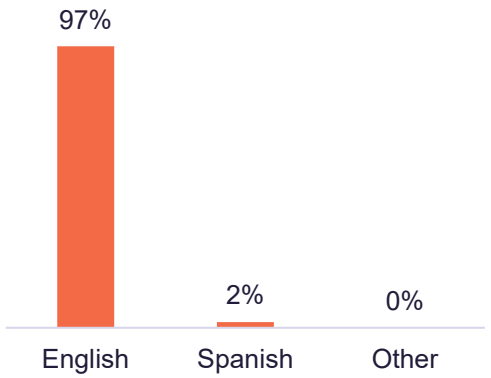
n = 117
0% Unknown/Declined to state.

Disability

No Disability	9%
Visual	0%
Hearing	0%
Speech	0%
Mobility	1%
Mental	89%
Developmental	0%
Another Disability	1%
Unknown/Declined to State	0%

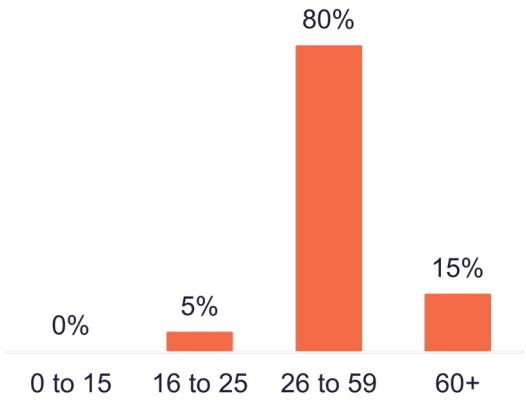
n = 117

Primary Language



n = 117
1% Unknown/Declined to state.

Age



n = 117
0% Unknown/Declined to state.

1% of individuals were veterans

n = 117
0% Unknown/Declined to state.

Keep It Real, Harm Reduction Services

Gender Identity

Female	47%
Male	51%
Transgender	2%
Unknown/Declined to State	0%

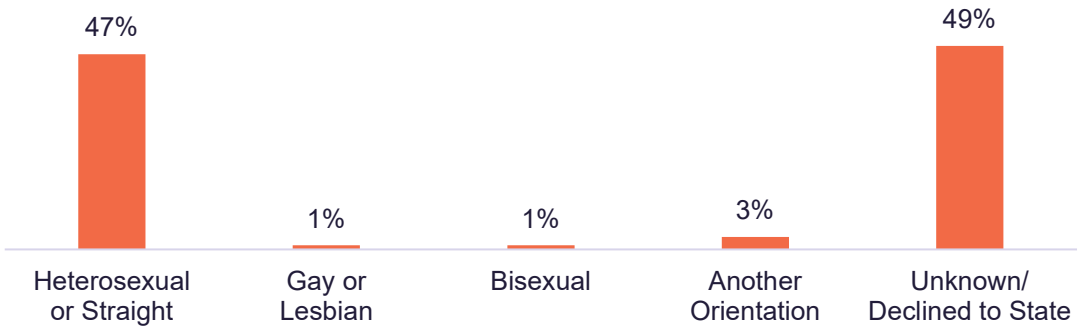
n = 117

Sex at Birth

Female	50%
Male	50%
Another Sex	0%
Unknown/Declined to State	0%

n = 117

Sexual Orientation
(n = 117)



Outreach and Aftercare Services

INTERIM, INC.

Outreach and Aftercare Services (OAS) provides support to people with co-occurring disorders (serious mental illnesses and substance use disorders). Outreach focuses on providing services to underserved adults in the South Monterey County region while Aftercare focuses on serving and providing support to clients exiting the Keep It Real program. OAS operates throughout the county, including South Monterey County, providing group and individual counseling at county-operated Behavioral Health Clinics. The program increases access to services to those not being served by Monterey County Behavioral Health in South Monterey County. Clients learn and practice harm reduction skills, develop and increase abstinence or learn about the safe use of substances, discover how to make positive changes in life, develop and engage in meaningful activities, and successfully integrate into community life. Outreach and Aftercare Services also provides transportation to and from services for clients in remote South County areas. The program makes every effort to provide services to consumers close to their homes who otherwise would struggle with transportation to meet for individual counseling meetings. In addition, Outreach and Aftercare Services offers clients community resources and linkage to other services to help them meet their needs, such as the Food Bank, Housing Authority, shelters, other community treatment facilities, OMNI, AA (Alcoholics Anonymous), and NA (Narcotics Anonymous).

- 193 clients served in FY 23–24
- 49 clients discharged in FY 23–24

Successes and Highlights

- Outreach and Aftercare Services provided services to 193 individuals during the fiscal year, with an original goal of 40 individuals to be served
- 96% of the individuals served by Outreach and Aftercare Services were provided some form of linkage and referral to community resources including co-occurring mental health and substance use disorder treatment options.

Outreach and Aftercare Services

Challenges and Growth Opportunities

Outreach and Aftercare Services fell short of its fiscal year goal of having 75% of clients report improvement in mental health: 62% of clients surveyed reported improvement. This was partially due to a high number of clients served being housed in the Monterey County Jail, where overall services provided do not meet individual needs. During the next fiscal year, Outreach and Aftercare Services will limit the amount of services being provided in the jail system and increase the number of services being provided to other marginalized individuals. This will include those who are homeless/living in shelters, those living in high-risk areas (such as "China Town"/Moongate), or those living in rural areas with a lack of services (South County). To do this, OAS will provide more outreach groups in the community and establish linkages to new resources.

Goals for the Coming Year

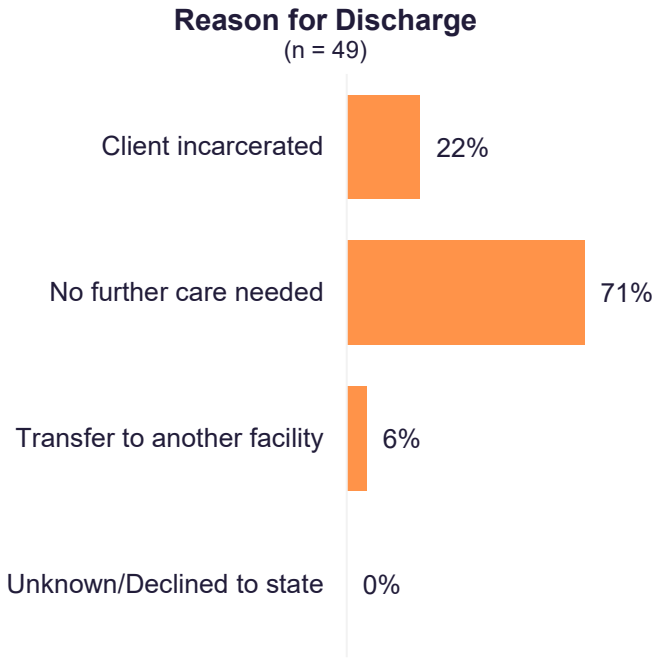
1. Program will serve 70 clients with co-occurring mental illness and substance use disorders who are not receiving services from Monterey County Behavioral Health (exception: South County), are open to MCBH but are homeless or at risk of becoming homeless because of their substance use disorder, or are open to ASOC, but do not want to engage in the dual recovery services offered by Keep It Real.
2. 75% of clients surveyed will improve their mental health recovery.
3. 85% of clients will be referred to and obtain services from community resource providers.

Outreach and Aftercare Services

Discharge Information

49 clients were **discharged**.

Of the 49 with goal information, 62% had **achieved some or all their goals**.



Housing

Housing Type Before Services (n = 193)	
5%	Independent house or apartment
3%	Friends/family
12%	Shelter or temporary housing
4%	Unhoused
4%	Assisted living facility
3%	Residential treatment facility
68%	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%.

Outreach and Aftercare Services

Demographic Data

Race

American Indian/Alaska Native	1%
Asian	4%
Black/African American	5%
Native Hawaiian/Other Pacific Islander	1%
White	32%
Another Race	53%
Unknown/Declined to State	4%

n = 193

42% Hispanic/Latino
58% Not Hispanic/Latino

n = 193
0% Unknown/Declined to state.

100% of individuals reported having one or more disabilities

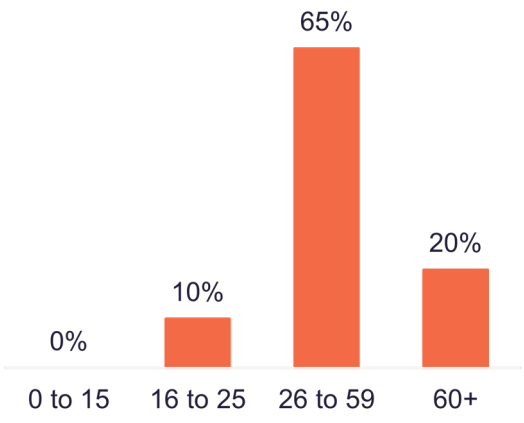
n = 193
0% Unknown/Declined to state.

Disability

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

n = 193

Age



n = 193
5% Unknown/Declined to state.

Outreach and Aftercare Services

Gender Identity

Female	10%
Male	89%
Transgender	1%
Genderqueer	0%
Questioning/Unsure	0%
Another Gender Identity	0%
Unknown/Declined to State	1%

n = 193

Sex at Birth

Female	10%
Male	90%
Another Sex	0%
Unknown/Declined to State	0%

n = 193

Wellness and Recovery Academy

INTERIM, INC.

The Wellness and Recovery Academy is a day rehabilitation program, serving adults 18 years and older diagnosed with serious mental illness and co-occurring substance use disorders. The program is certified by the California Department of Health Care Services. Program services include skills-building groups, group therapy, community meetings, process groups, trauma-informed care, client-centered treatment plan development, harm reduction, community outings, and adjunctive therapies. The program aims to assist adults with developing the recovery skills needed to successfully reintegrate into the community.

- 85 clients served in FY 23–24
- On average, clients engaged in services for 150 days
- 77 clients discharged in FY 23–24

Successes and Highlights

- 87% of clients maintained or improved their mental health (as reported via the Reaching Recovery tool) (Goal: 85%).
- 95% of clients reported satisfaction with the quality of services provided (Goal: 95%).
- The program worked this year to improve communication between Shelter Cove, Bridge House, and the Academy in order to strengthen collaboration and better support the community in maintaining and improving mental health symptoms.
- The Academy achieved CARF (Commission on Accreditation of Rehabilitation Facilities) accreditation as an Intensive Outpatient Services provider. This process has supported the staff and clients in improving consistency with the development of safety plans, treatment plans, and discharge plans and has improved the quality of care.
- Academy staff cross-trained with the Choices program, which supported improvements in the delivery of services for clients and allowed for growth and training for staff.
- The program director has been attending team meetings for various county teams to improve collaboration and increase outpatient referrals for Academy services.

Wellness and Recovery Academy

Challenges and Growth Opportunities

There were challenges in meeting the occupancy (units of service) goals. The Academy relies heavily on Bridge House clients to meet occupancy goals. Client appointments and the needs of Bridge House can at times interfere with client attendance.

As the Academy has grown in census and attendance, space in the group room has been limited, leading to a crowded room and resistance from clients given the limitations of space.

In the next year, the Wellness and Recovery Academy will increase collaboration and communication with Bridge House and Shelter Cove, including meetings held with program directors and Village Meetings. These efforts will support better outcomes for clients in all programs and ensure that staff are aligned on service delivery for quality care. To achieve this, staff will collaborate with clients on incorporating challenges concurrent with their treatment plan when their Bridge House discharge is approaching (a sort of transition plan).

To encourage attendance with outpatient clients (i.e., clients not at Bridge House), the Academy will have an assigned staff (wellness navigator) to call clients daily and invite them to groups. This will support clients with reminders that the Academy is treatment and to consider daily attendance as their appointment. This work started towards the end of the fiscal year. An amendment is to include a call at the end of the day for clients who did not attend.

The program director and/or clinicians will follow up with clients who start to disengage from treatment to obtain feedback (e.g., lack of motivation, lack of progress, treatment goal completion) which will help to improve services and/or reduce disengagement by ensuring that treatment is tailored to client needs.

Goals for the Coming Year

1. 85% of clients will report crisis management and stabilization.
2. 80% of clients surveyed will report satisfaction with the quality of services provided.

Wellness and Recovery Academy

Discharge Information

77 clients were **discharged**.

Of the 77 with goal information,
99% had **achieved some or all their goals**.

Employment and Education

11% of clients were **employed or volunteering** before engaging in services.
(n = 85)

93% of clients enrolled in or completed **school** before engaging in services.
(n = 85)

Housing

Housing Type Before Services (n = 85)	
27%	Independent house or apartment
16%	Unhoused
1%	Acute psychiatric facility or hospital
34%	Residential treatment facility
8%	Jail or juvenile detention facility
13%	Another housing status
0%	Unknown/Declined to state

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

Wellness and Recovery Academy

Demographic Data

Race

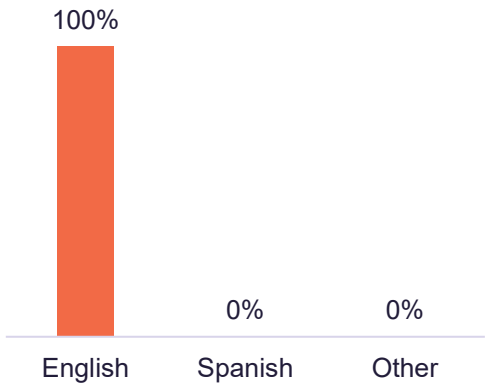
American Indian/Alaska Native	0%
Asian	19%
Black/African American	29%
White	52%
Another Race	0%
Unknown/Declined to State	0%

n = 85

48% Hispanic/Latino
52% Not Hispanic/Latino

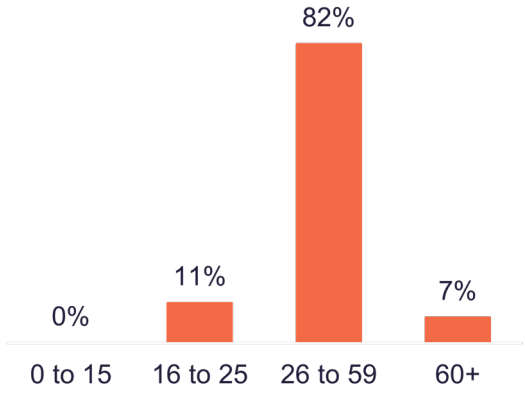
n = 85
0% Unknown/Declined to state.

Primary Language



n = 85
0% Unknown/Declined to state.

Age



n = 85
0% Unknown/Declined to state.

88% of individuals reported having one or more disabilities

n = 85
0% Unknown/Declined to state.

Disability

No Disability	12%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Mental	88%
Developmental	0%
Another Disability	0%
Unknown/Declined to State	0%

n = 85

0% of individuals were veterans

n = 85
0% Unknown/Declined to state.

Wellness and Recovery Academy

Gender Identity

Female	34%
Male	65%
Transgender	0%
Unknown/Declined to State	1%

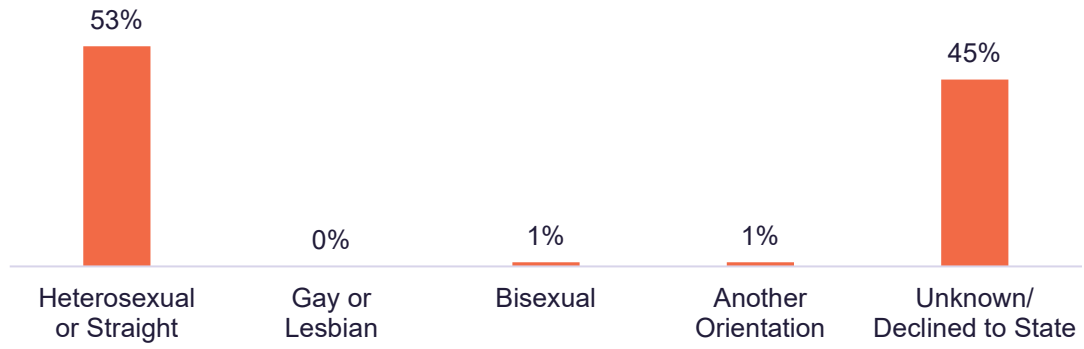
n = 85

Sex at Birth

Female	35%
Male	65%
Another Sex	0%
Unknown/Declined to State	0%

n = 85

Sexual Orientation
(n = 85)



CSS-13: JUSTICE-INVOLVED FSP

Creating New Choices FSP

COUNTY OF MONTEREY

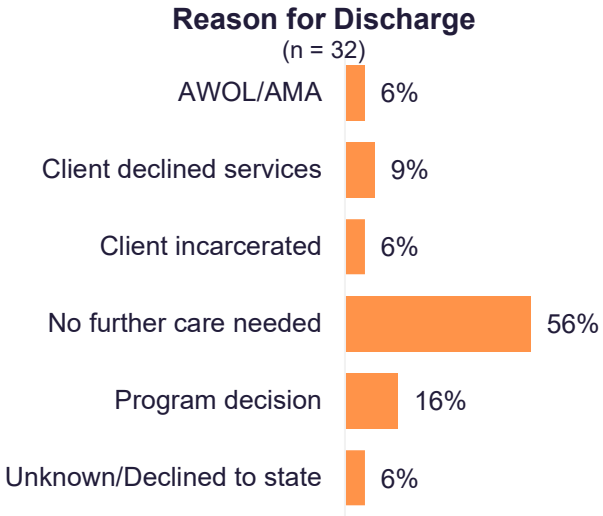
The Creating New Choices (CNC) program is a collaborative court program for justice-involved adults with a serious mental illness (e.g., schizophrenia, schizoaffective disorder, bipolar disorder) and often a co-occurring substance use disorder. CNC is a "whatever it takes" model that engages participants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

- 54 clients served in FY 23–24
- On average, clients engaged in services for 254 days
- 44 clients discharged in FY 23–24

Discharge Information

44 clients were **discharged**.

Of the 11 with goal information, 64% had **achieved some or all their goals**.



Employment and Education

13% of clients were **employed or volunteering** before engaging in services.
(n = 54)

81% of clients enrolled in or completed **school** before engaging in services.
(n = 54)

Creating New Choices FSP

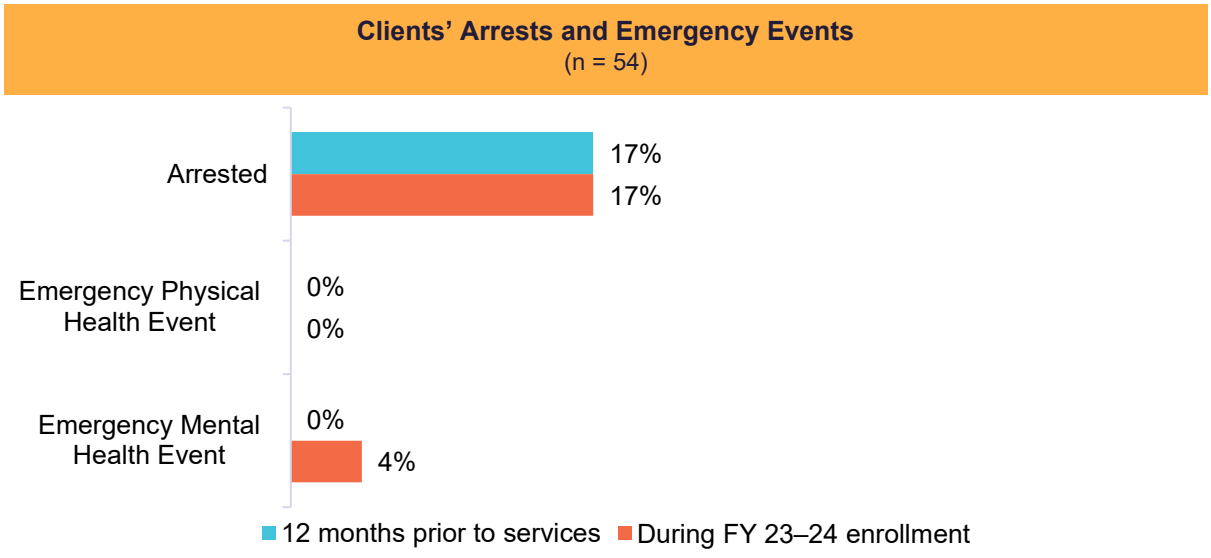
Housing

Housing Type Before Services (n = 54)		Current Housing Type (n = 28)
7%	Independent house or apartment	18%
0%	Friends/family	4%
0%	Shelter or temporary housing	11%
15%	Unhoused	11%
9%	Residential treatment facility	21%
67%	Jail or juvenile detention facility	32%
2%	Another housing status	0%
0%	Unknown/Declined to state	4%

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

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are reported for all clients in Full-Service Partnership programs. These metrics are compared between 12 months prior to accessing services and FY 23–24.



Creating New Choices FSP

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	17%
Black/African American	31%
White	43%
Another Race	9%
Unknown/Declined to State	0%

n = 54

48% Hispanic/Latino
43% Not Hispanic/Latino

n = 54
9% Unknown/Declined to state.

89% of individuals reported having one or more disabilities

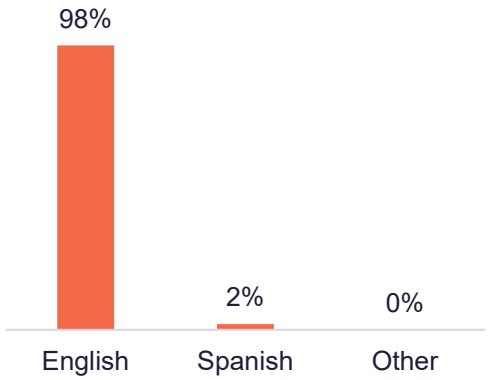
n = 54
0% Unknown/Declined to state.

Disability

No Disability	11%
Mental	89%
Unknown/Declined to State	0%

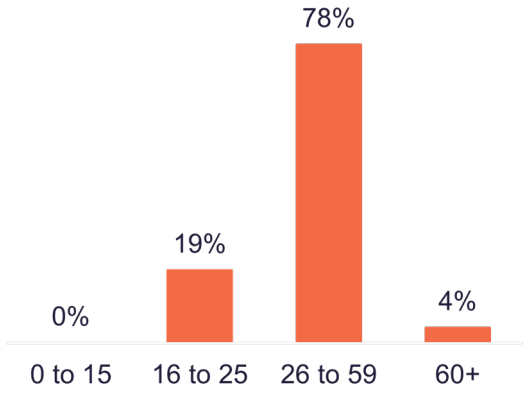
n = 54

Primary Language



n = 54
0% Unknown/Declined to state.

Age



n = 54
0% Unknown/Declined to state.

0% of individuals were veterans

n = 54
31% Unknown/Declined to state.

Creating New Choices FSP

Gender Identity

Female	26%
Male	72%
Transgender	0%
Unknown/Declined to State	2%

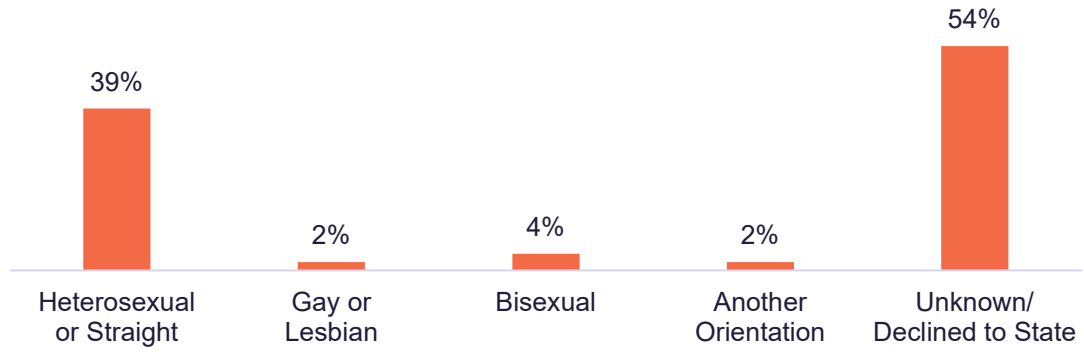
n = 54

Sex at Birth

Female	26%
Male	74%
Another Sex	0%
Unknown/Declined to State	0%

n = 54

Sexual Orientation
(n = 54)



CSS-14: HOMELESS SERVICES AND SUPPORTS FSP

Lupine Gardens FSP

INTERIM, INC.

Lupine Gardens is a permanent 20-unit studio apartment complex that provides a Full-Service Partnership (FSP) level of service to adults with a serious mental health diagnosis, all of whom are homeless or at risk of homelessness. The program is staffed seven days a week from 8:00 a.m. to 7:30 p.m. and offers daily medication support in the morning and evening. Apartment cleaning and laundry services are provided through a fee-for-service agreement. Case managers and case coordinators work with consumers in group and individual settings to provide support with daily living skills (i.e., medication, budgeting, meal planning, hygiene management), referrals, assessments, and symptom management. Program staff also work closely with psychiatrists and doctors to focus on individuals' overall well-being.

- 21 clients served in FY 23–24
- On average, clients engaged in services for 3,162 days
- 2 clients discharged in FY 23–24

Successes and Highlights

- 95% of clients successfully remained housed (Goal: 60%). Lupine Gardens has a sense of community among residents and high participation in services.
- 89% of clients maintained or improved their mental health (Goal: 80%).
- 29% of clients attained employment, or attended school or vocational training (Goal: 20%).
- 100% of clients successfully engaged with a PCP (Goal: 85%).
- 96% of clients reported satisfaction with the quality of services (Goal: 85%).
- 76% of clients eliminated all psychiatric hospitalizations while in the program (Goal: 75%).
- 100% of clients did not experience incarceration while in the program (Goal: 75%).
- Five Lupine clients were enrolled in the local gym and participated in physical activity at least three times per week.
- Student nurses provided education through groups and individual meetings on health conditions such as diabetes to help provide clarity and assist consumers in being proactive with their physical health.

Lupine Gardens FSP

Challenges and Growth Opportunities

Lupine Gardens has seven clients who are over 60 years old. The limited availability of downstairs units has raised concerns about mobility and the safety of going up and down stairs. Staff will collaborate with housing, doctors, and student nurses to provide a safe living environment for our residents who struggle with using stairs.

Increased use of cannabis on and off property impacted the community's sense of safety. Lupine staff will look at creating and facilitating groups that are geared toward wellness and recovery, such as harm reduction and Seeking Safety, to help manage the use of cannabis around the community. In addition, the program will provide education on Narcan and increase the availability of Narcan around the community.

There was a counselor II position vacancy. Lupine staff will review applications for this position and collaborate with hiring managers to attend interview panels to help fill this and any potential staff vacancies.

One consumer faced challenges transitioning from a board and care facility to live independently at Lupine after their conservatorship ended, resulting in increased hospitalizations. Lupine staff will collaborate with the placement team from Monterey County Behavioral Health to ensure smooth transitions from enhanced Board and Cares to Lupine Gardens.

Goals for the Coming Year

1. 60% of clients will remain housed at Lupine or exit to other permanent housing destinations as of the end of the operating year.
2. 80% of clients will maintain or improve their mental health recovery.
3. 85% of clients will appropriately engage with a PCP.

Lupine Gardens FSP

Discharge Information

2 clients were **discharged**.

Of the 2 with goal information,
100% had **achieved some or all their goals**.

Employment and Education

0% of clients were **employed or volunteering** while engaged in services.
(n = 21)

62% of clients enrolled in or completed **school** while engaged in services.
(n = 21)

Lupine Gardens FSP

Housing

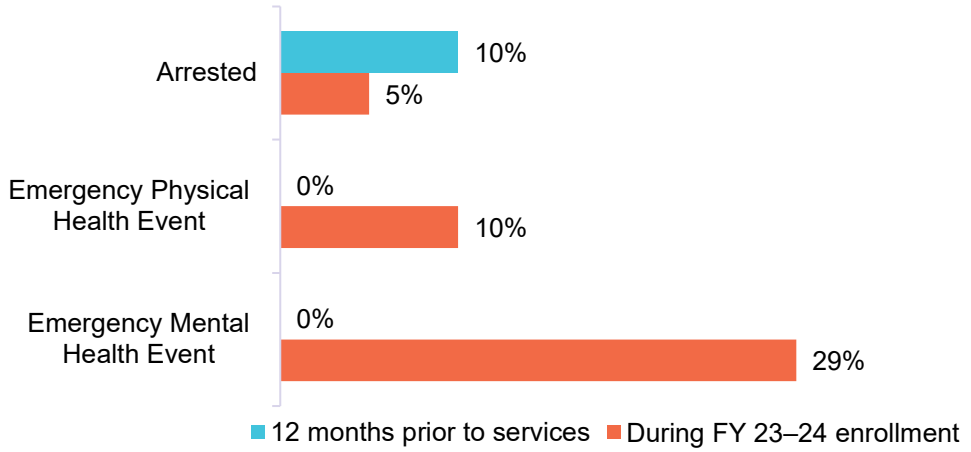
Housing Type Before Services (n = 21)		Current Housing Type (n = 21)
38%	Independent house or apartment	10%
0%	Friends/family	86%
0%	Shelter	5%
0%	Acute psychiatric facility or hospital	5%
0%	Assisted living facility	95%
5%	Residential treatment facility	14%
57%	Another housing status	0%
0%	Unknown/Declined to state	0%

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

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are reported for all clients in Full-Service Partnership programs. These metrics are compared between 12 months prior to accessing services and FY 23–24.

Clients' Arrests and Emergency Events
(n = 21)



Lupine Gardens FSP

Demographic Data

Race

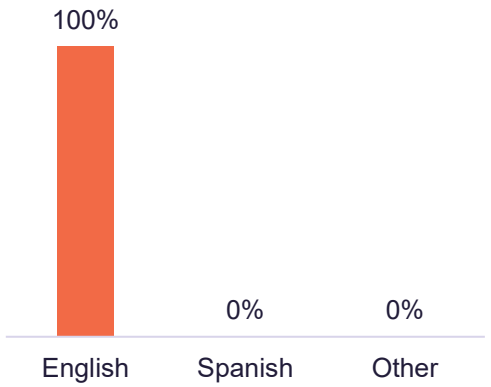
American Indian/Alaska Native	0%
Asian	0%
Black/African American	24%
White	76%
Another Race	0%
Unknown/Declined to State	0%

n = 21

24% Hispanic/Latino
76% Not Hispanic/Latino

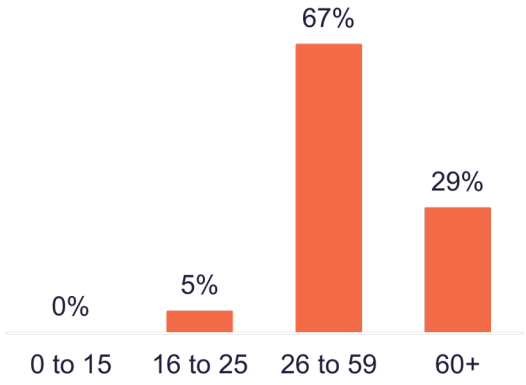
n = 21
0% Unknown/Declined to state.

Primary Language



n = 21
0% Unknown/Declined to state.

Age



n = 21
0% Unknown/Declined to state.

90% of individuals reported having one or more disabilities

n = 21
0% Unknown/Declined to state.

Disability

No Disability	10%
Visual	5%
Hearing	0%
Speech	0%
Mobility	0%
Mental	86%
Developmental	0%
Another Disability	0%
Unknown/Declined to State	0%

n = 21

0% of individuals were veterans

n = 21
5% Unknown/Declined to state.

Lupine Gardens FSP

Gender Identity

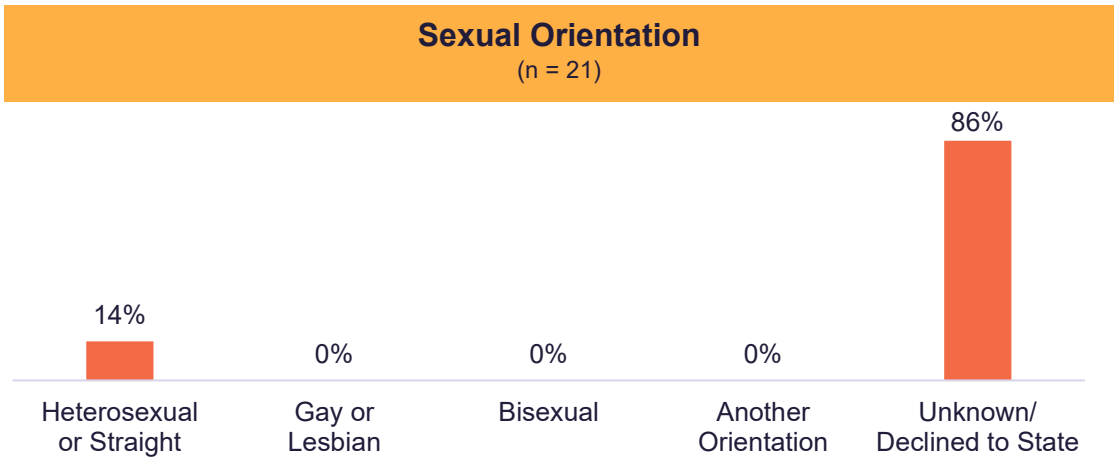
Female	38%
Male	62%
Transgender	0%
Unknown/Declined to State	0%

n = 21

Sex at Birth

Female	38%
Male	62%
Another Sex	0%
Unknown/Declined to State	0%

n = 21



MHSA Homeless FSP (MCHOME)

INTERIM, INC.

MHSA Homeless FSP (MCHOME) has both a Full-Service Partnership (FSP) program and an Outreach program. MCHOME provides intensive case management and mental health services to transition adults with serious mental illness off the streets and into treatment and housing. MCHOME's team consists of counselors, behavioral health clinicians, and peer mentors. MCHOME also manages transitional and permanent housing to house homeless adults immediately exiting homelessness.

- 129 clients served in FY 23–24
- On average, clients engaged in services for 797 days
- 70 clients discharged in FY 23–24

Successes and Highlights

- 87% of consumers maintained or improved their mental health (per Reaching Recovery Assessments) (Goal: 80%).
- Upon discharge from MCHOME, 67% of consumers resided in transitional or permanent housing (Goal: 60%).
- 80% of consumers appropriately engaged with a PCP (Goal: 75%).
- 93% of consumers reported satisfaction with the quality of services provided via the consumer satisfaction survey (Goal: 80%).
- 88% of consumers served during the fiscal year eliminated all psychiatric hospitalizations while in the program (Goal: 67%).
- 94% of consumers served during the fiscal year did not experience incarceration while in the program (Goal: 50%).
- 100% of homeless clients were screened for community resources and appropriate behavioral health services (Goal: 60%).
- 100% of clients reduced re-hospitalizations (Goal: 60%).
- 100% of clients were referred to community support providers and resources such as SEES, OMNI, NA/AA, ACCESS, etc. as part of wellness navigator linkage (Goal: 50 clients).
- Met PCP goal and increased previous year outcomes from 78% to 80%.
- MCHOME reached full staffing for the program including Outreach, Housed FSP, Homeless FSP, and Sun Rose.
- MCHOME continued outreach to homeless clients throughout Monterey County and kept strong relationships with partnering agencies such as Gathering for Women, Salvation Army, Chinatown Navigation Center, Salinas Outreach Response Team (SORT), and Step Up.

MHSA Homeless FSP (MCHOME)

Challenges and Growth Opportunities

MHSA Homeless FSP (MCHOME) had challenges closing clients who had been housed for an extended period of time. Some referrals to MCBH took six months to process which delayed the team in closing them as permanently housed before the end of the fiscal year. Closing clients to scattered site housing also took some time.

MCHOME will work with MCBH and Community Housing scattered site locations to close clients currently housed and no longer needing FSP services in order to transition them to a lower level of care and better meet their treatment needs. This will also support MCHOME with improving its goal of closing 60% of its residents to either transitional or permanent housing upon discharge from the program. In addition, MCHOME will work to build more relationships with motels in the county as access to motels has been challenging.

Goals for the Coming Year

1. 80% of clients will maintain or improve their mental health recovery.
2. Upon discharge from MCHOME, 60% of clients will be residing in transitional and/or permanent housing.
3. 75% of clients will appropriately engage with a PCP.

MHSA Homeless FSP (MCHOME)

Discharge Information

70 clients were **discharged**.

Of the 68 with goal information,
81% had **achieved some or all their goals**.

Employment and Education

7% of clients were **employed or volunteering** before engaging in services.
(n = 129)

87% of clients enrolled in or completed **school** before engaging in services.
(n = 129)

MHSA Homeless FSP (MCHOME)

Housing

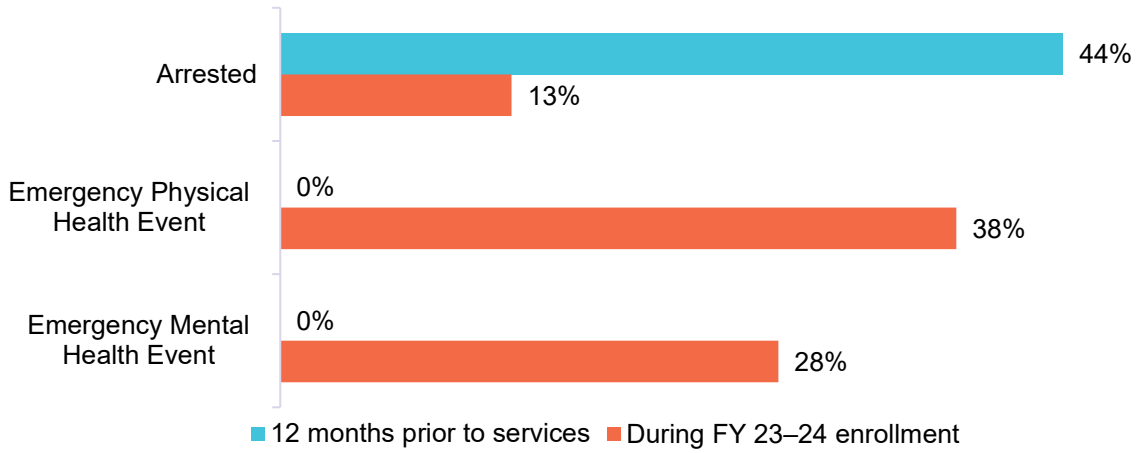
Housing Type Before Services (n = 129)		Current Housing Type (n = 129)
16%	Independent house or apartment	26%
0%	Friends/Family	11%
0%	Shelter or temporary housing	40%
67%	Unhoused	48%
0%	Acute medical hospital	3%
1%	Acute psychiatric facility or hospital	5%
0%	Assisted living facility	5%
10%	Residential treatment facility	13%
0%	Jail or juvenile detention facility	4%
5%	Another housing status	4%
0%	Unknown/Declined to state	1%

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

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are reported for all clients in Full-Service Partnership programs. These metrics are compared between 12 months prior to accessing services and FY 23–24.

Clients' Arrests and Emergency Events
(n = 129)



MHSA Homeless FSP (MCHOME)

Demographic Data

Race

American Indian/Alaska Native	1%
Asian	11%
Black/African American	13%
White	75%
Another Race	0%
Unknown/Declined to State	1%

n = 129

24% Hispanic/Latino
75% Not Hispanic/Latino

n = 129
1% Unknown/Declined to state.

88% of individuals reported having one or more disabilities

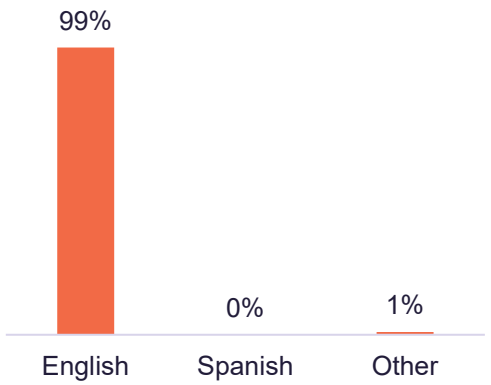
n = 129
0% Unknown/Declined to state.

Disability

No Disability	12%
Visual	2%
Hearing	1%
Speech	0%
Mobility	1%
Mental	83%
Developmental	0%
Another Disability	2%
Unknown/Declined to State	0%

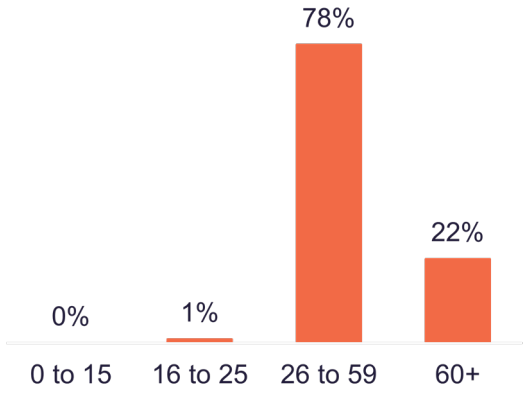
n = 129

Primary Language



n = 129
1% Unknown/Declined to state.

Age



n = 129
0% Unknown/Declined to state.

1% of individuals were veterans

n = 129
2% Unknown/Declined to state.

MHSA Homeless FSP (MCHOME)

Gender Identity

Female	53%
Male	43%
Transgender	1%
Unknown/Declined to State	3%

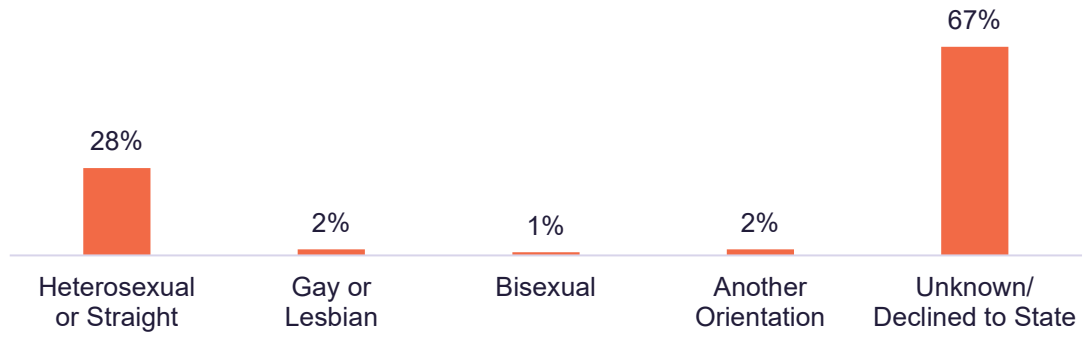
n = 129

Sex at Birth

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

n = 129

Sexual Orientation
(n = 129)



Sandy Shores FSP

INTERIM, INC.

Sandy Shores is a Full-Service Partnership (FSP) program that provides permanent housing and supportive services for 28 adults with serious mental illness. Residents must be homeless immediately prior to moving into Sandy Shores. All vacancies are filled using the CARS (Coordinated Assessment and Referral System) through the Coalition of Homeless Service Providers (CHSP). Each Sandy Shores resident is provided with a case manager and a behavioral health clinician by Interim, Inc. Residents are referred to a psychiatrist with Monterey County Behavioral Health.

- 34 clients served in FY 23–24
- On average, clients engaged in services for 883 days
- 10 clients discharged in FY 23–24

Successes and Highlights

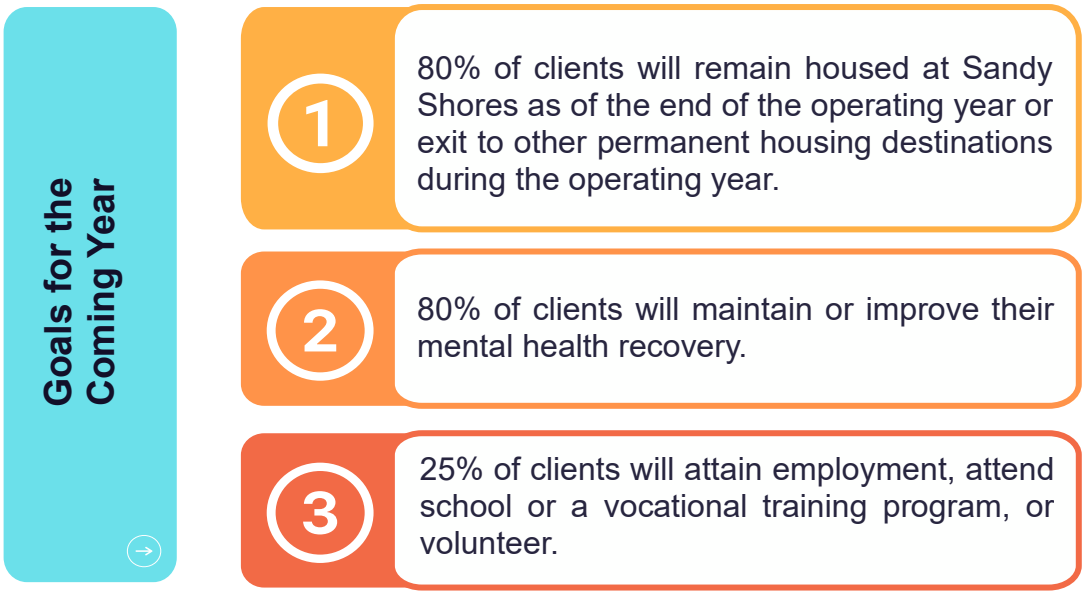
- 91% of people receiving services either maintained their housing at Sandy Shores or moved to other permanent housing (Goal: 80%).
- 87% of people receiving services maintained or improved their mental health (Goal: 80%).
- 30% of people receiving services from Sandy Shores obtained employment, volunteer work, or returned to school (Goal: 25%).
- 91% of people receiving services at Sandy Shores met with their primary care physician (Goal: 85%).
- 93% of people reported satisfaction with the services at Sandy Shores, per the consumer satisfaction survey (Goal: 80%).
- 88% of people receiving services at Sandy Shores eliminated all psychiatric hospitalizations (Goal: 75%).
- 97% of people receiving services at Sandy Shores did not experience incarceration (Goal: 75%).
- Sandy Shores increased the consistency and number of groups offered onsite each week provided by Sandy Shores staff, through peer-led activities, or in collaboration with Keep It Real.
- Sandy Shores increased the number of community activities it led and also collaborated with Shelter Cove and Bridge House to provide residents with numerous community activities throughout the year.

Sandy Shores FSP

Challenges and Growth Opportunities

One case manager resigned during the fiscal year, resulting in a staff shortage for five of 12 months. A counselor from another program partially filled that gap, so at least 1.25 of two counselor positions were filled during that time.

Three people left Sandy Shores to return to homelessness during this fiscal year. Although we are meeting our MCBH contract goals, we want to see a decrease in people returning to homelessness when they leave our program. Sandy Shores will increase collaboration with Interim, Inc.'s Housing Navigation and Retention Services to reduce the number of people who return to homelessness when they are discharged from Sandy Shores. Staff will collaborate with outside agencies (i.e., Meals on Wheels, Project Food Box, Housing Authority, Alliance on Aging) to inform staff and community members of community resources to help alleviate some of the challenges with cost-of-living expenses. Staff will implement a Discharge Planning worksheet to ensure that residents moving out of Sandy Shores are connected to appropriate resources prior to discharge.



Sandy Shores FSP

Discharge Information

10 clients were **discharged**.

Of the 10 with goal information,
60% had **achieved some or all their goals**.

Employment and Education

18% of clients were **employed or volunteering** before engaging in services.
(n = 34)

62% of clients were enrolled in or completed **school** before engaging in services.
(n = 34)

Sandy Shores FSP

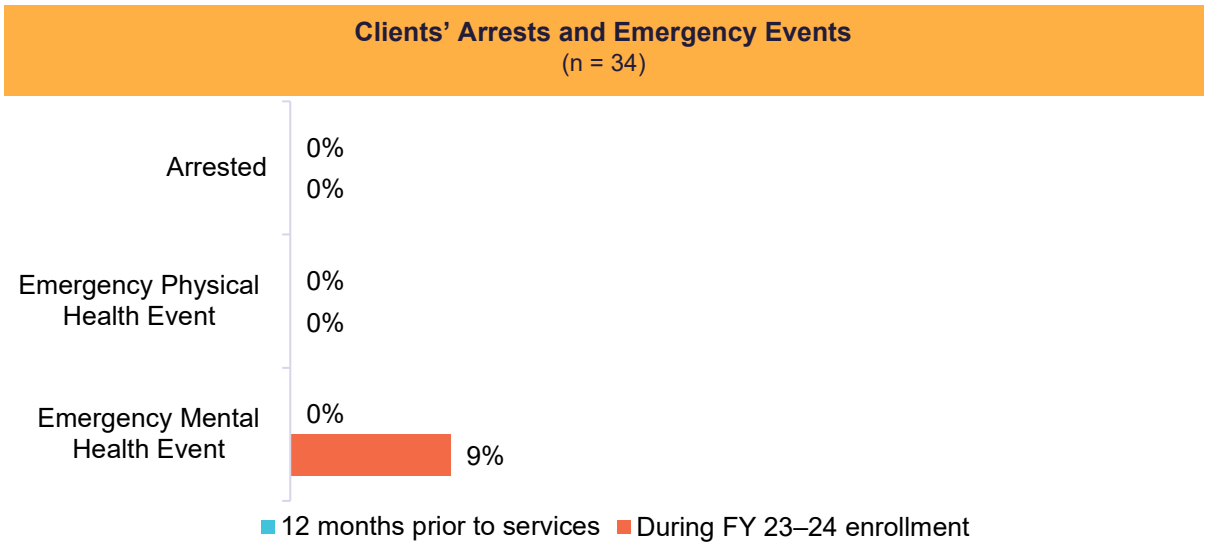
Housing

Housing Type Before Services (n = 34)		Current Housing Type (n = 34)
29%	Independent house or apartment	59%
0%	Friends/family	6%
0%	Shelter or temporary housing	6%
12%	Unhoused	9%
3%	Acute psychiatric facility or hospital	3%
0%	Assisted living facility	6%
38%	Residential treatment facility	12%
18%	Another housing status	0%
0%	Unknown/Declined to state	0%

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

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are reported for all clients in Full-Service Partnership programs. These metrics are compared between 12 months prior to accessing services and FY 23–24.



Sandy Shores FSP

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	9%
Black/African American	21%
White	71%
Another Race	0%
Unknown/Declined to State	0%

n = 34

29% Hispanic/Latino
71% Not Hispanic/Latino

n = 34
0% Unknown/Declined to state.

94% of individuals reported having one or more disabilities

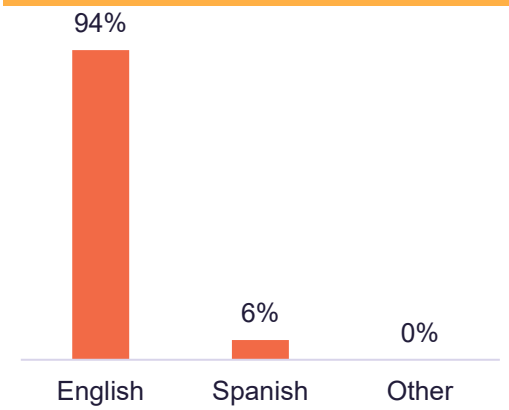
n = 34
0% Unknown/Declined to state.

Disability

No Disability	6%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Mental	94%
Developmental	0%
Another Disability	0%
Unknown/Declined to State	0%

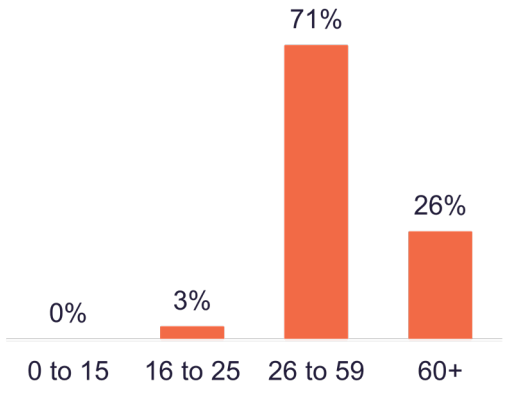
n = 34

Primary Language



n = 34
0% Unknown/Declined to state.

Age



n = 34
0% Unknown/Declined to state.

0% of individuals were veterans

n = 34
0% Unknown/Declined to state.

Sandy Shores FSP

Gender Identity

Female	53%
Male	44%
Transgender	0%
Unknown/Declined to State	3%

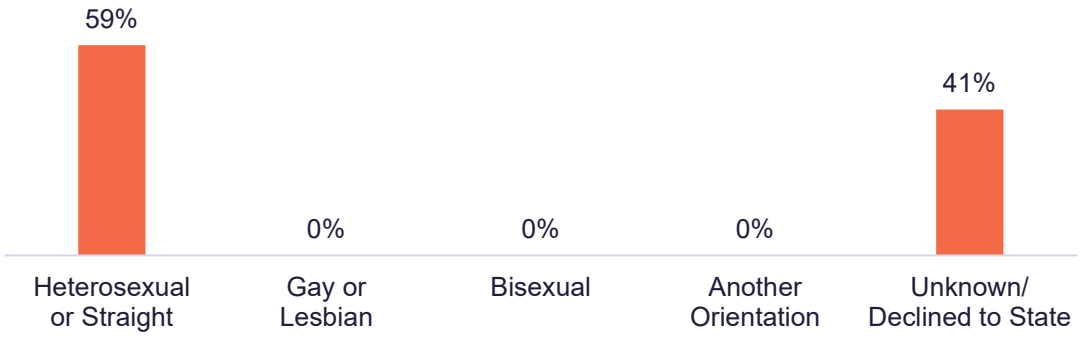
n = 34

Sex at Birth

Female	56%
Male	44%
Another Sex	0%
Unknown/Declined to State	0%

n = 34

Sexual Orientation
(n = 34)



Sunflower Gardens FSP

INTERIM, INC.

Sunflower Gardens is an intensive supportive housing program, which provides a Full-Service Partnership (FSP) level of services to 23 low-income adults with a serious mental health diagnosis, all of whom are homeless or at risk of homelessness. The program offers permanent and transitional housing through 17 housing units (13 permanent studio apartments, two transitional studio apartments, and two permanent four-bedroom shared houses), for a total of 23 beds. The service array includes assessments, evaluation, case coordination, intensive case management provided in the FSP model, assistance in accessing benefits, assistance with symptom management, and assistance with daily living skills to help consumers meet the terms of their lease and live independently in the community.

- 25 clients served in FY 23–24
- On average, clients engaged in services for 1,455 days
- 6 clients discharged in FY 23–24

Successes and Highlights

- 88% of clients remained housed at Sunflower or exited to other permanent housing locations (Goal: 70%). Two consumers moved into a one-bedroom apartment in the community.
- 95% of clients maintained or improved their mental health (Goal: 90%). Sunflower focused on increased consumer engagement in community activities (i.e., holiday and birthday celebrations, weekly cooking groups, monthly tenant meetings, decorating contests, daily morning breakfast) that promoted well-being and community cohesiveness.
- 40% of consumers volunteered, attended school or a vocational training program, and/or attained employment (Goal: 20%).
- 96% of clients appropriately engaged with a primary care provider (PCP) (Goal 85%).
- 96% of clients reported satisfaction with the quality of service provided via the consumer satisfaction survey (Goal: 90%).
- 92% of clients eliminated all psychiatric hospitalizations during the year (Goal: 75%).
- 100% of clients did not experience incarceration while in the program (Goal: 75%).
- Improved retention in the resident manager position.
- Completed construction in the remodeled transitional unit.

Sunflower Gardens FSP

Challenges and Growth Opportunities

One challenge encountered was substance and alcohol use on and off property. There were two consumer deaths due to substance use and/or chronic medical conditions, which caused significant grief and stress for staff and community members. Narcan training was provided to staff and access to Narcan was provided in multiple locations (i.e., laundry room, shared houses, community room, offices) around the property. Sunflower will utilize crisis and safety procedures as described in the manual to support community members, including staff, during emergencies and critical incidents. We will continue to provide refresher Narcan trainings to staff and provide education to consumers.

A second challenge was a decrease in participation in substance use groups due to staff turnover from other programs. To address this, staff will create recovery-based groups (i.e., harm reduction, Seeking Safety) to help consumers manage substance use, and will utilize training offered through Interim, Inc. and Relias e-learning on substance use interventions. We will build connections within the agency and outside agencies (i.e., Door to Hope, Sun Street) to promote recovery groups outside of Sunflower Gardens (SFG).

Goals for the Coming Year

1. 70% of clients will remain housed at SFG as of the end of the operating year or exit to other permanent housing destinations during the operating year.
2. 90% of clients will maintain or improve their mental health recovery.
3. 85% of clients will appropriately engage with a PCP.

Sunflower Gardens FSP

Discharge Information

6 clients were **discharged**.

Of the 4 with goal information, 100% had **achieved some or all their goals**.

Employment and Education

12% of clients were **employed or volunteering** before engaging in services.
(n = 25)

80% of clients enrolled in or completed **school** before engaging in services.
(n = 25)

Sunflower Gardens FSP

Housing

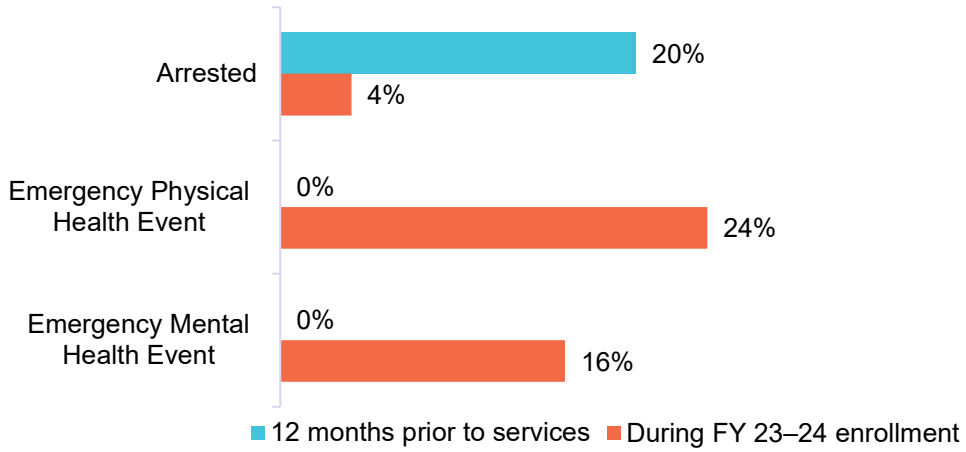
Housing Type Before Services (n = 25)		Current Housing Type (n = 25)
36%	Independent house or apartment	56%
0%	Friends/family	28%
0%	Shelter or temporary housing	20%
20%	Unhoused	32%
0%	Acute medical hospital	8%
0%	Acute psychiatric facility or hospital	16%
4%	Assisted living facility	16%
28%	Residential treatment facility	36%
12%	Another housing status	4%
0%	Unknown/Declined to state	0%

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

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are reported for all clients in Full-Service Partnership programs. These metrics are compared between 12 months prior to accessing services and FY 23–24.

Clients' Arrests and Emergency Events
(n = 25)



Sunflower Gardens FSP

Demographic Data

Race

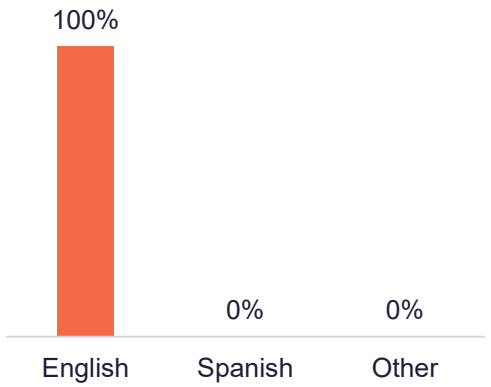
American Indian/Alaska Native	0%
Asian	4%
Black/African American	12%
White	84%
Another Race	0%
Unknown/Declined to State	0%

n = 25

16% Hispanic/Latino
84% Not Hispanic/Latino

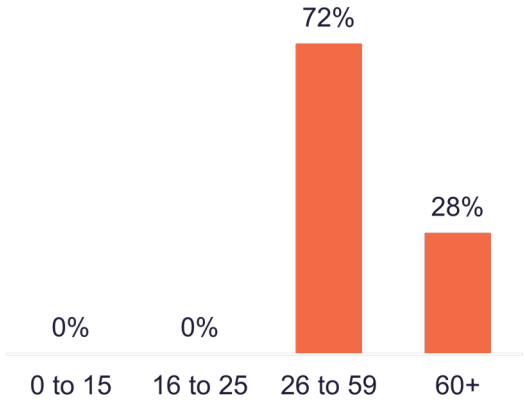
n = 25
0% Unknown/Declined to state.

Primary Language



n = 25
0% Unknown/Declined to state.

Age



n = 25
0% Unknown/Declined to state.

92% of individuals reported having one or more disabilities

n = 25
0% Unknown/Declined to state.

Disability

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

n = 25

0% of individuals were veterans

n = 25
0% Unknown/Declined to state.

Sunflower Gardens FSP

Gender Identity

Female	72%
Male	28%
Transgender	0%
Unknown/Declined to State	0%

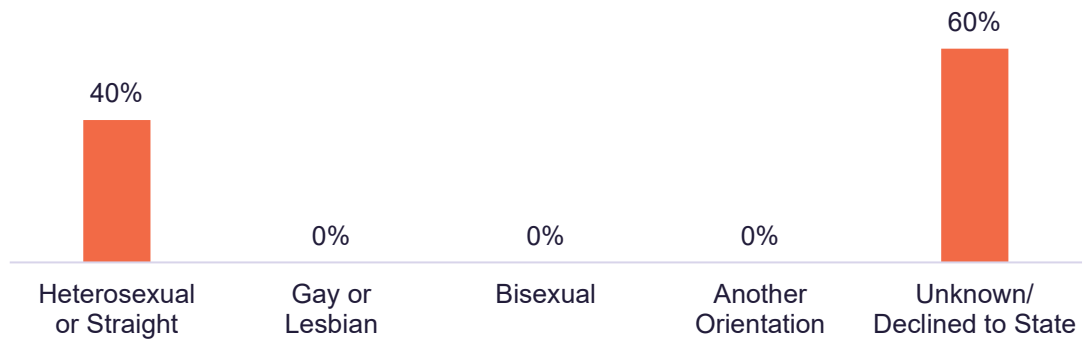
n = 25

Sex at Birth

Female	72%
Male	28%
Another Sex	0%
Unknown/Declined to State	0%

n = 25

Sexual Orientation
(n = 25)



CSS-15: HOMELESS OUTREACH AND TREATMENT

Rockrose Gardens

INTERIM, INC.

Rockrose Gardens is a permanent supportive housing program which provides housing to 20 very low-income individuals with a serious mental health diagnosis. Nine of these individuals are homeless or at risk of homelessness. Staff provide case management, crisis intervention, and mental health services for residents in accordance with state guidelines established under the rehabilitation option, and in accordance with MHSA funding regulations.

- 24 clients served in FY 23–24
- On average, clients engaged in services for 2,155 days
- 4 clients discharged in FY 23–24

Successes and Highlights

- 100% occupancy rate, with 45% of residents being 56 years and older.
- 100% of consumers remained housed or exited to other permanent housing at the end of their opening year in the program. Two consumers moved into non-supportive housing in the community, having completed their Rockrose Gardens treatment goals. Two consumers moved into alternate Interim, Inc. housing, having completed their Rockrose Gardens treatment goals.
- 90% of consumers maintained or improved their mental health recovery.
- 33% of consumers attained employment, attended school or a vocational training program, and/or volunteered.
- 100% of consumers actively engaged in medical services with their primary care physician.
- 90% of consumers reported satisfaction with the quality of services they received.
- Rockrose Gardens employed a certified social worker (CSW) in Q3 for three days a week who has been helping with client support and community building.
- Staff completed Narcan certification and Workplace Violence trainings.
- During Q4, community building began via monthly community meetings, two–three breakfast gatherings (attended by seven to eight clients on average), consistent grocery outing support, consumer connections to food bank resources, and increased visibility and access to available resources.

Rockrose Gardens

Challenges and Growth Opportunities

Rockrose Gardens experienced staffing challenges that impacted the consistency of consumer care. Increased focus was given to staff retention in collaboration with Human Resources and Interim, Inc. leadership. Furthermore, Community Housing will focus on inter-team cooperation and resilience, to ensure coverage and collaboration for consumers.

Staffing shortages and a low sense of Rockrose community may have contributed to minimal community participation for most of the fiscal year. Staff will increase on-site groups and activities to promote a greater sense of community cohesiveness and spirit. Possible groups include Seeking Safety, Healthy Boundaries, and Mind Over Mood. Staff will plan community-building events (BBQs, potlucks, and monthly community meetings) and group opportunities (art groups, walking groups, and breakfast gatherings).

A couple of consumers had very challenging periods of mental health decompensation which significantly impacted the Rockrose community, and impacted the consumers' housing security. Fortunately, their housing has been retained with staff intervention and collaboration with the consumers. Ongoing 1:1 mental health counseling and crisis intervention support will be coupled with case coordinator collaboration for high-acuity consumers, to provide early intervention and reduce the likelihood of adverse housing retention outcomes and overall negative impacts on the community.

Staff will actively work in partnership with case coordinators to identify strategies to engage some of the consumers who have historically been sporadically engaged.

Goals for the Coming Year

1. 90% of clients will remain housed at Rockrose as of the end of the operating year or exit to other permanent housing destinations during the operating year.
2. 80% of clients will maintain or improve their mental health recovery.
3. 30% of clients will attain employment, attend school or a vocational training program, or volunteer.

Rockrose Gardens

Discharge Information

4 clients were **discharged**.

Of the 4 with goal information,
100% had **achieved some or all their goals**.

Employment and Education

25% of clients were **employed or volunteering** before engaging in services.
(n = 24)

96% of clients were enrolled in or completed **school** before engaging in services.
(n = 24)

Rockrose Gardens

Housing

Housing Type Before Services (n = 24)	
79%	Independent house or apartment
4%	Unhoused
8%	Residential treatment facility
8%	Another housing status
0%	Unknown/Declined to state

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

Rockrose Gardens

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	0%
Black/African American	17%
White	83%
Another Race	0%
Unknown/Declined to State	0%

n = 24

17% Hispanic/Latino
83% Not Hispanic/Latino

n = 24
0% Unknown/Declined to state.

92% of individuals reported having one or more disabilities

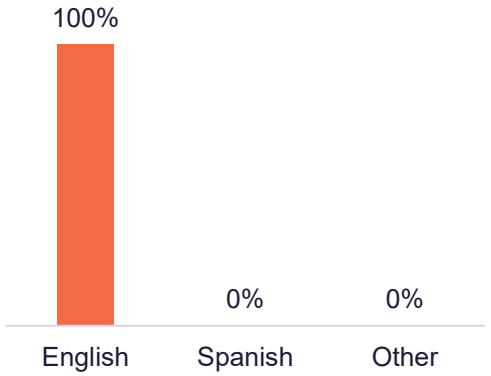
n = 24
0% Unknown/Declined to state.

Disability

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

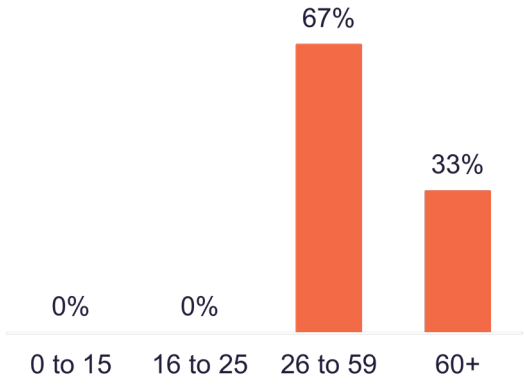
n = 24

Primary Language



n = 24
0% Unknown/Declined to state.

Age



n = 24
0% Unknown/Declined to state.

0% of individuals were veterans

n = 24
4% Unknown/Declined to state.

Rockrose Gardens

Gender Identity

Female	42%
Male	58%
Transgender	0%
Unknown/Declined to State	0%

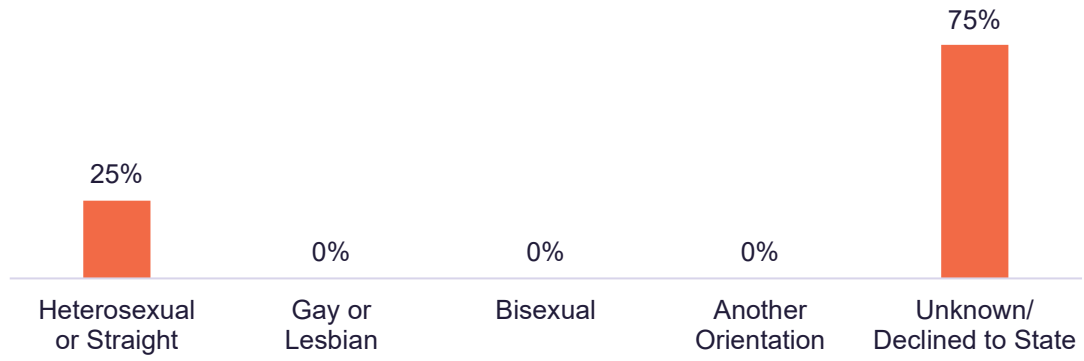
n = 24

Sex at Birth

Female	42%
Male	58%
Another Sex	0%
Unknown/Declined to State	0%

n = 24

Sexual Orientation
(n = 24)



Shelter Cove

INTERIM, INC.

Shelter Cove is a supportive transitional housing program with a two-year lease, providing safe, affordable, and supportive housing for homeless adults with serious psychiatric disabilities. The Shelter Cove program is based on the social rehabilitation principles of the therapeutic community model. Shelter Cove's maximum occupancy is 39 residents. Each Shelter Cove resident is provided with a case manager and a behavioral health clinician by Interim, Inc. All residents at Shelter Cove must be homeless prior to moving into Shelter Cove.

- 61 clients served in FY 23–24
- On average, clients engaged in services for 386 days
- 41 clients discharged in FY 23–24

Successes and Highlights

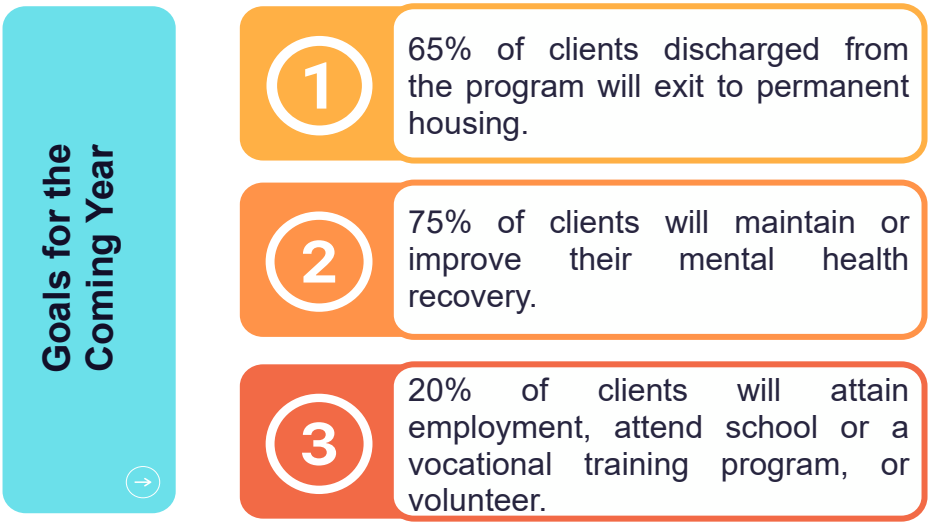
- 75% of people who left Shelter Cove moved into some sort of permanent housing (Goal: 65%).
- 82% of people who received services from Shelter Cove maintained or improved their mental health (Goal: 75%).
- 43% of the people receiving services gained employment or volunteer work or attended school (Goal: 20%).
- 98% of people receiving services at Shelter Cove saw a primary care physician (Goal: 85%).
- 93% of people reported satisfaction with the services they received at Shelter Cove (Goal: 80%).
- Shelter Cove benefited from Interim, Inc.'s Housing Navigation and Retention Program and was able to partner with that program frequently. A housing navigator came to Shelter Cove every Monday morning to facilitate a group on housing resources and preparing for permanent housing.
- Shelter Cove increased community events, collaborating with Sandy Shores and Bridge House to host events.
- Shelter Cove made changes to its medication support process by having staff go to the residents' homes to provide medication support instead of residents having to go to the office.

Shelter Cove

Challenges and Growth Opportunities

During the 2023–24 fiscal year, staff struggled to meet weekly documentation expectations. Several steps were taken to try to improve documentation, including training staff on setting boundaries with clients and better distinguishing between urgent and non-urgent requests, having staff schedule designated documentation time, and providing staff with alternative office spaces to do their documentation. Shelter Cove supervisors will meet with counselors every week to ensure that documentation expectations are met and will work collaboratively with counselors to problem-solve barriers to meeting billing expectations.

Counseling groups were inconsistent throughout the fiscal year. Shelter Cove staff are working to revise the group schedule, utilizing recommendations from residents, to increase the number of groups offered and to provide a variety of mental health groups (i.e., Mind Over Mood, Seeking Safety) and several more leisure groups (i.e., Gardening, Creative Expressions). The Shelter Cove assistant program director will provide staff training on group facilitation. Shelter Cove staff will solicit feedback about groups and recommendations for group topics from Shelter Cove residents quarterly.



Shelter Cove

Discharge Information

41 clients were **discharged**.

Of the 41 with goal information,
76% had **achieved some or all their goals**.

Employment and Education

11% of clients were **employed or volunteering** before engaging in services.
(n = 61)

77% of clients enrolled in or completed **school** before engaging in services.
(n = 61)

Housing

Housing Type Before Services (n = 61)	
21%	Independent house or apartment
18%	Unhoused
56%	Residential treatment facility
5%	Another housing status
0%	Unknown/Declined to state

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

Shelter Cove

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	11%
Black/African American	33%
White	56%
Another Race	0%
Unknown/Declined to State	0%

n = 61

44% Hispanic/Latino
56% Not Hispanic/Latino

n = 61
0% Unknown/Declined to state.

90% of individuals reported having one or more disabilities

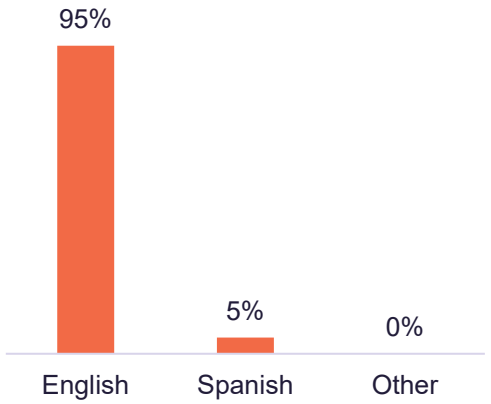
n = 61
0% Unknown/Declined to state.

Disability

No Disability	10%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Mental	90%
Developmental	0%
Another Disability	0%
Unknown/Declined to State	0%

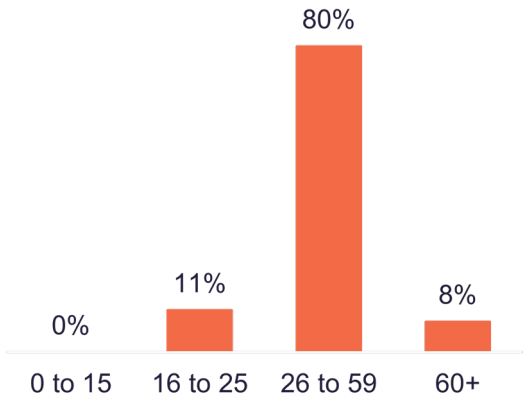
n = 61

Primary Language



n = 61
0% Unknown/Declined to state.

Age



n = 61
0% Unknown/Declined to state.

0% of individuals were veterans

n = 61
0% Unknown/Declined to state.

Shelter Cove

Gender Identity

Female	43%
Male	52%
Transgender	0%
Unknown/Declined to State	5%

n = 61

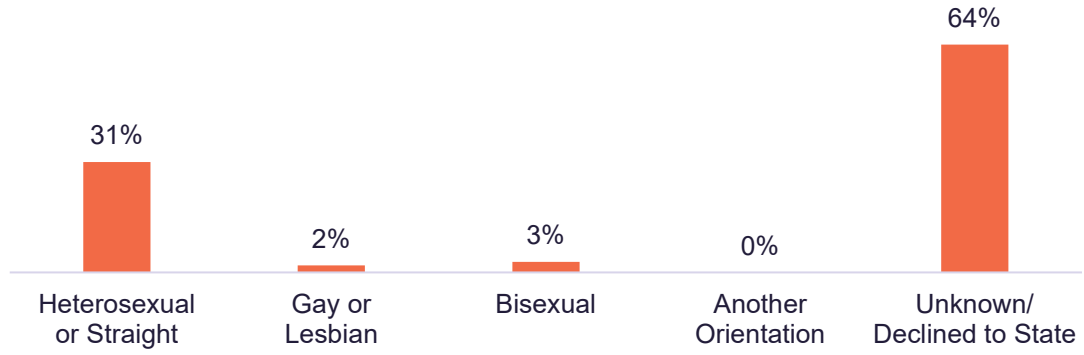
Sex at Birth

Female	44%
Male	56%
Another Sex	0%
Unknown/Declined to State	0%

n = 61

Sexual Orientation

(n = 61)



CSS-16: RESPONSIVE CRISIS INTERVENTIONS

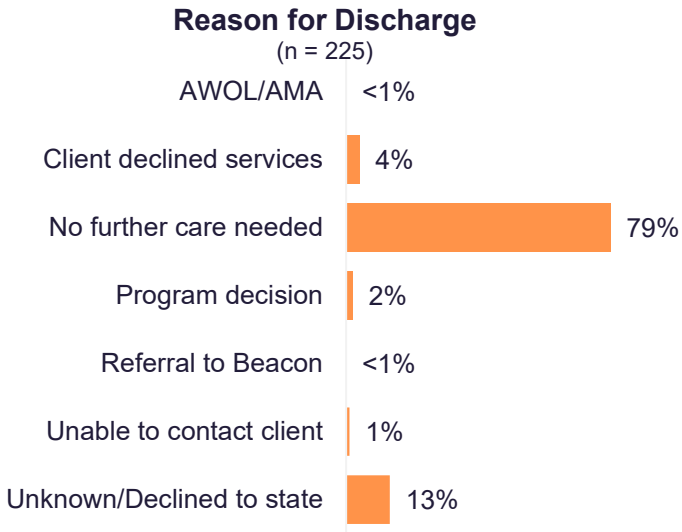
Archer Child Advocacy Center

COUNTY OF MONTEREY

- 226 clients served in FY 23–24
- On average, clients engaged in services for 18 days
- 225 clients discharged in FY 23–24

Discharge Information

225 clients were **discharged**.



Employment and Education

0% of clients were **employed or volunteering** before engaging in services.
(n = 226)

59% of clients enrolled in or completed **school** before engaging in services.
(n = 226)

Archer Child Advocacy Center

Housing

Housing Type Before Services (n = 226)	
91%	Independent house or apartment
1%	Unhoused
0%	Acute psychiatric facility or hospital
1%	Residential treatment facility
1%	Foster home
0%	Group home
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%.

Archer Child Advocacy Center

Demographic Data

Race

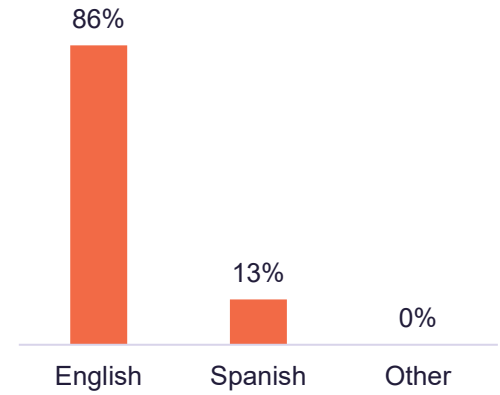
American Indian/Alaska Native	<1%
Asian	10%
Black/African American	43%
White	6%
Another Race	40%
Unknown/Declined to State	0%

n = 226

53% Hispanic/Latino
6% Not Hispanic/Latino

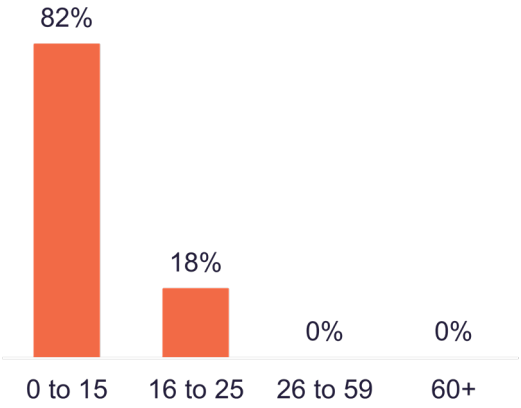
n = 226
41% Unknown/Declined to state.

Primary Language



n = 226
1% Unknown/Declined to state.

Age



n = 226
0% Unknown/Declined to state.

8% of individuals reported having one or more disabilities

n = 226
0% Unknown/Declined to state.

Disability

No Disability	92%
Visual	0%
Hearing	0%
Speech	<1%
Mobility	0%
Mental	5%
Developmental	<1%
Another Disability	2%
Unknown/Declined to State	0%

n = 226

0% of individuals were veterans

n = 215
<1% Unknown/Declined to state.

Archer Child Advocacy Center

Gender Identity

Female	20%
Male	4%
Transgender	<1%
Another Gender Identity	<1%
Unknown/Declined to State	74%

n = 226

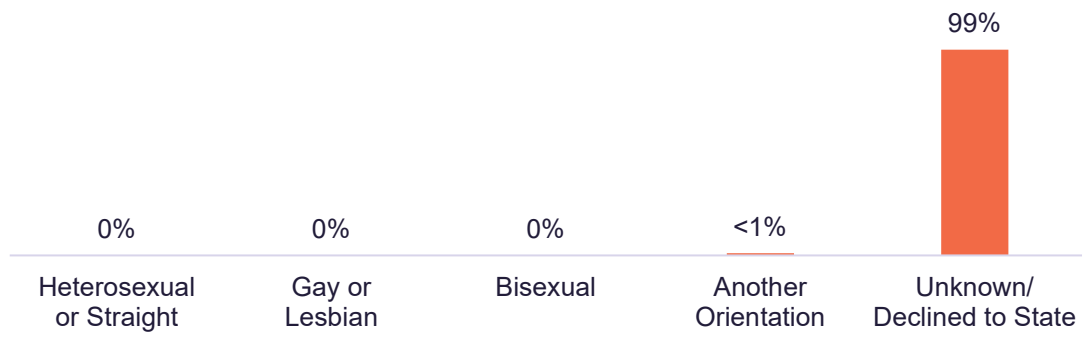
Sex at Birth

Female	85%
Male	15%
Another Sex	0%
Unknown/Declined to State	<1%

n = 226

Sexual Orientation

(n = 226)



Manzanita House Salinas and Monterey

INTERIM, INC.

Manzanita House offers a community-based alternative to inpatient psychiatric care for clients of the Monterey County Behavioral Health system experiencing acute psychological distress. There are two facilities, one in Monterey and one in Salinas. Each facility offers a homelike 24-hour residential treatment program in a community setting where residents take an active role in their recovery. This person-centered approach presumes that individuals receiving mental health services have the ability and desire to change and grow towards self-determination and participation in community activities. Both Manzanita programs are licensed by the California Department of Social Services, Community Care Licensing (CCL) as a Social Rehabilitation Facility and are certified by the Department of Health Care Services as a Short-Term Crisis Program. Both Manzanita facilities are accredited by the nonprofit organization CARF (Commission on Accreditation of Rehabilitation Facilities).

- 210 clients served in FY 23–24
- On average, clients engaged in services for 37 days
- 210 clients discharged in FY 23–24

Successes and Highlights

- Implemented a tracking system to coordinate and streamline the referral process, resulting in Manzanita programs meeting its 85% occupancy goal and averaging 19 clients served per day.
- Provided services to 133 male clients and 77 female clients during the fiscal year.
- 93% of consumers reported crisis management and stabilization (Goal: 70%).
- 78% of consumers were discharged to a lower level of care (Goal: 75%).
- 91% of consumers met or partially met their treatment goals (Goal: 75%).
- 93% of consumers reported satisfaction with the quality of services received (Goal: 80%).
- Strengthened and maintained connections to both Natividad Mental Health Unit staff and Community Hospital of the Monterey Peninsula staff, creating a steady referral flow and streamlined continuum of care.
- Developed a strong working relationship with Monterey County Behavioral Health's Adult Post-Hospitalization team.
- Collaborated with Wellpath and Monterey County Behavioral Health's Placement Team to link incarcerated individuals to Manzanita services upon release to reduce recidivism and promote community integration.
- Participated in the MISTI (Monterey Integrated System Transformation Initiative) by conducting the COMPASS-EZ 2.0 self-assessment tool at both program locations.
- Increased collaboration with Housing Navigation and Retention program, MCHOME, Success Over Stigma, Wellness and Recovery Academy, Choices Day Treatment, and the Bridge House residential program which resulted in residents being connected to continuum of care resources upon discharge.

Manzanita House Salinas and Monterey

Challenges and Growth Opportunities

Staffing vacancies and shortages continued to be a challenge across the Manzanita program sites. The programs experienced vacancies in nursing staff (RN/LVN), behavioral health clinician, counselor II, counselor IB, and counselor IC overnight positions. Staffing constraints resulted in additional coverage being provided by management, counseling, and agency staff to fulfill staffing requirements and regulations. Clients with complex co-occurring conditions presented unique challenges at both Manzanita programs. The closing of Bienestar Clinic impacted clients of Manzanita, as it was one of the more common primary care providers for Manzanita clients.

Goals for the Coming Year

1. 70% of clients will report crisis management and stabilization.
2. 75% of clients will discharge to a lower level of care.
3. 75% of clients will meet or partially meet their treatment plan goals.

Manzanita House Salinas and Monterey

Discharge Information

210 clients were **discharged**.

Of the 210 with goal information,
92% had **achieved some or all their goals**.

Employment and Education

7% of clients were **employed or volunteering** before engaging in services.
(n = 210)

82% of clients enrolled in or completed **school** before engaging in services.
(n = 210)

Housing

Housing Type Before Services (n = 210)	
32%	Independent house or apartment
34%	Unhoused
10%	Acute psychiatric facility or hospital
10%	Residential treatment facility
3%	Jail or juvenile detention facility
11%	Another housing status
<1%	Unknown/Declined to state

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

Manzanita House Salinas and Monterey

Demographic Data

Race

American Indian/Alaska Native	<1%
Asian	12%
Black/African American	32%
White	54%
Another Race	0%
Unknown/Declined to State	0%

n = 210

45% Hispanic/Latino
54% Not Hispanic/Latino

n = 210
1% Unknown/Declined to state.

90% of individuals reported having one or more disabilities

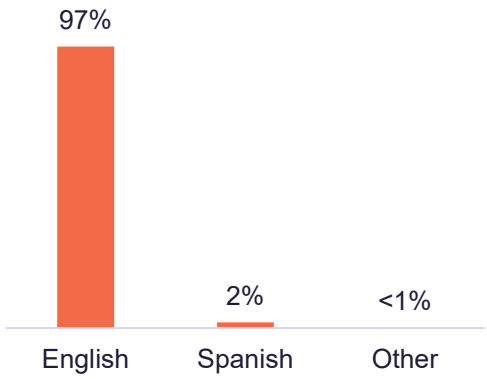
n = 210
0% Unknown/Declined to state.

Disability

No Disability	10%
Visual	0%
Hearing	0%
Speech	0%
Mobility	<1%
Mental	89%
Developmental	0%
Another Disability	<1%
Unknown/Declined to State	0%

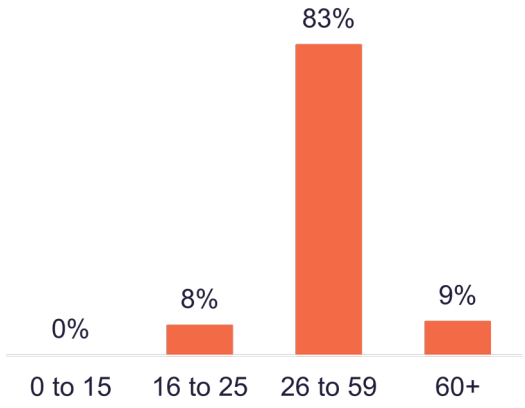
n = 210

Primary Language



n = 210
0% Unknown/Declined to state.

Age



n = 210
0% Unknown/Declined to state.

1% of individuals were veterans

n = 210
<1% Unknown/Declined to state.

Manzanita House Salinas and Monterey

Gender Identity

Female	34%
Male	58%
Transgender	1%
Genderqueer	<1%
Unknown/Declined to State	6%

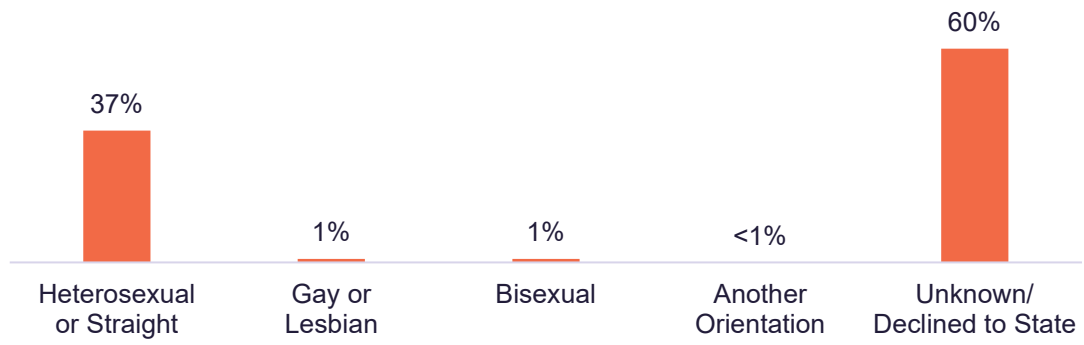
n = 210

Sex at Birth

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

n = 210

Sexual Orientation
(n = 210)



CSS-17: CHILDREN'S MENTAL HEALTH SERVICES

Short-Term Residential Program

PEACOCK ACRES, INC.

Peacock Acres' Short-Term Residential Program provided mental health services, crisis intervention, medication support, targeted case management, and access to other mental health services based on individuals' needs. This program stopped placing new youth in the facility in January 2024 and closed in March 2024.

- 8 clients served in FY 23–24
- On average, clients engaged in services for 592 days
- 0 clients discharged in FY 23–24

Successes and Highlights

- Several youth stepped down into lower levels of care such as transitional housing and resource homes.

Challenges and Growth Opportunities

Due to limited crisis stabilization centers for youth in need of respite or high level of care such as hospitalization, it was decided that it was best to close the program due to limited resources.

Short-Term Residential Program

Employment and Education

0% of clients were **employed or volunteering** before engaging in services.
(n = 8)

100% of clients enrolled in or completed **school** before engaging in services.
(n = 8)

Housing

Housing Type Before Services (n = 8)	
25%	Acute psychiatric facility or hospital
50%	Residential treatment facility
13%	Group home
13%	Another housing status

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

Short-Term Residential Program

Demographic Data

Race

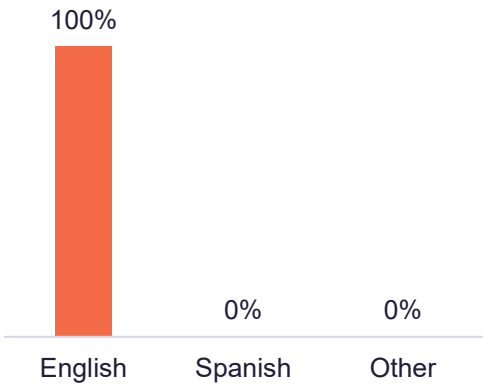
American Indian/Alaska Native	0%
Asian	13%
Black/African American	25%
White	38%
Another Race	25%
Unknown/Declined to State	0%

n = 8

38% Hispanic/Latino
38% Not Hispanic/Latino

n = 8
25% Unknown/Declined to state.

Primary Language



n = 8
0% Unknown/Declined to state.

37% of individuals reported having one or more disabilities

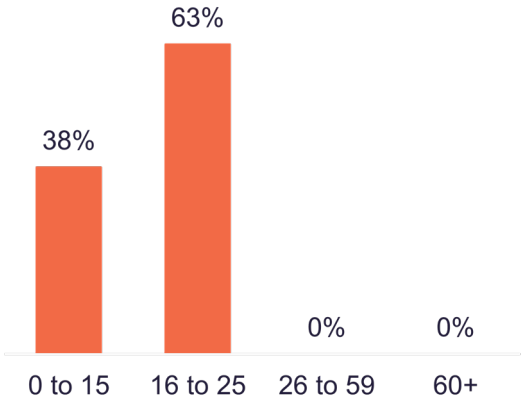
n = 8
0% Unknown/Declined to state.

Disability

No Disability	63%
Mental	25%
Another Disability	13%
Unknown/Declined to State	0%

n = 8

Age



n = 8
0% Unknown/Declined to state.

0% of individuals were veterans

n = 8
0% Unknown/Declined to state.

Short-Term Residential Program

Gender Identity

Female	13%
Male	38%
Transgender	0%
Unknown/Declined to State	50%

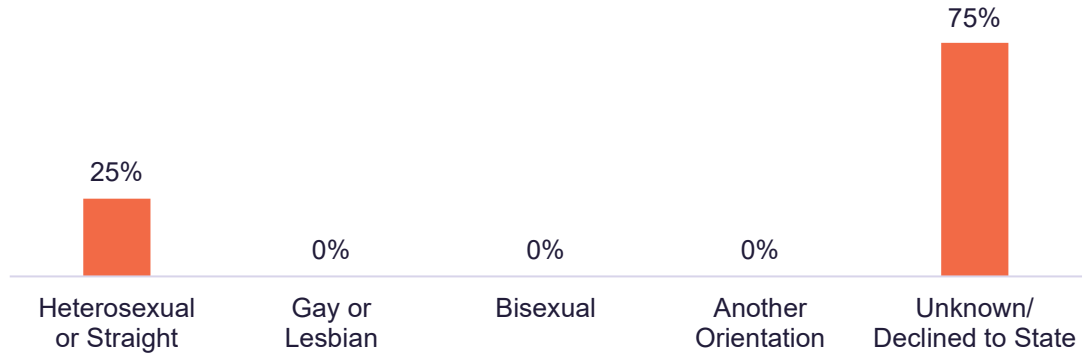
n = 8

Sex at Birth

Female	13%
Male	88%
Another Sex	0%
Unknown/Declined to State	0%

n = 8

Sexual Orientation
(n = 8)



CSS-18: MENTAL HEALTH SERVICES FOR ADULTS

Community Housing

INTERIM, INC.

Community Housing is a permanent supportive housing program that provides 100 affordable housing placements for low-income independent adults with serious and persistent, long-term psychiatric disabilities. These placements are provided as individual apartments and/or shared housing units located in Salinas, Marina, and Monterey. Interim, Inc. provides case coordination, case management, crisis intervention, and mental health treatment services for residents in all the supported housing programs in accordance with state guidelines established under the rehabilitation option. Consumers utilize a variety of resources within Monterey County Behavioral Health.

- 112 clients served in FY 23–24
- On average, clients engaged in services for 3,443 days
- 18 clients discharged in FY 23–24

Successes and Highlights

- Collaboration with the Housing Authority helped the program fill vacancies, manage waiting lists, and provide clarity to residents that the program services were not linked to tenant services.
- Increased collaboration with housing navigators helped consumers attain Section 8 vouchers and explore additional low-cost housing options.
- 90% of consumers maintained or improved their mental health recovery (Goal: 90%).
- 98% of clients appropriately engaged with a primary care provider (Goal: 85%).
- 93% of consumers reported satisfaction with the quality of services (a 2% increase from last year).
- Opportunities for socialization to combat loneliness (e.g., OMNI center, adult day rehabilitation center, local gyms, volunteer work, school, employment, SEES) are available through Interim, Inc. sites.

Challenges and Growth Opportunities

Staff turnover impacted consistency and rapport building. Consumers voiced hesitation with meeting new staff due to fear of staff leaving. Although collaborating with housing navigators helped provide opportunities for low-income housing, income limitations continue to be a barrier with moving to more independent settings. The increased cost of food and living expenses create challenges with managing funds and focusing on healthier food options. The action plan for the coming year will focus on cross-training staff to support other properties. The program will cross-train counselors and supportive staff to fill vacancies and build rapport with consumers outside their assigned properties. Staff will collaborate with outside agencies (i.e., Meals on Wheels, Project Food Box, Housing Authority, Alliance on Aging) to inform staff and community members of community resources aimed at helping alleviate some of the challenges associated with cost-of-living expenses. The program will continue to connect consumers to opportunities for socialization to combat loneliness (e.g., OMNI center, adult day rehabilitation center, local gyms, volunteer work, school, employment, SEES).

Community Housing

Goals for the Coming Year

1. 90% of clients will maintain or improve their mental health recovery.
2. 85% of clients will appropriately engage with a PCP.
3. 80% of clients surveyed will report satisfaction with the quality of services provided.

Community Housing

Discharge Information

18 clients were **discharged**.

Of the 17 with goal information, 89% had **achieved some or all their goals**.

Employment and Education

12% of clients were **employed or volunteering** before engaging in services.
(n = 112)

97% of clients enrolled in or completed **school** before engaging in services.
(n = 112)

Housing

Housing Type Before Services (n = 112)	
68%	Independent house or apartment
4%	Unhoused
2%	Assisted living facility
13%	Residential treatment facility
3%	Group home
12%	Another housing status
0%	Unknown/Declined to state

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

Community Housing

Demographic Data

Race

American Indian/Alaska Native	0%
Asian	3%
Black/African American	22%
White	75%
Another Race	0%
Unknown/Declined to State	0%

n = 112

25% Hispanic/Latino
75% Not Hispanic/Latino

n = 112
0% Unknown/Declined to state.

91% of individuals reported having one or more disabilities

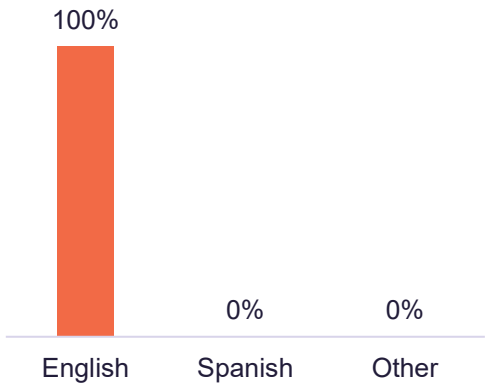
n = 112
0% Unknown/Declined to state.

Disability

No Disability	9%
Visual	4%
Hearing	0%
Speech	0%
Mobility	0%
Mental	87%
Developmental	%
Another Disability	1%
Unknown/Declined to State	0%

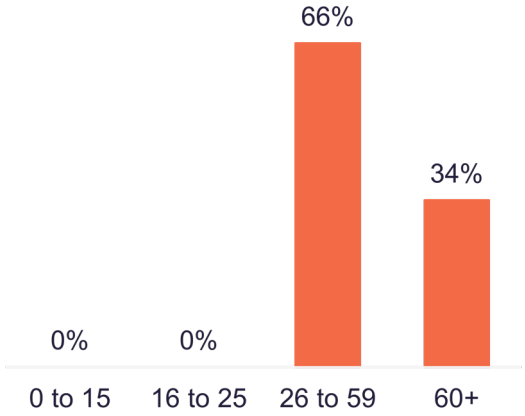
n = 112

Primary Language



n = 112
0% Unknown/Declined to state.

Age



n = 112
0% Unknown/Declined to state.

0% of individuals were veterans

n = 112
15% Unknown/Declined to state.

Community Housing

Gender Identity

Female	42%
Male	58%
Transgender	0%
Unknown/Declined to State	0%

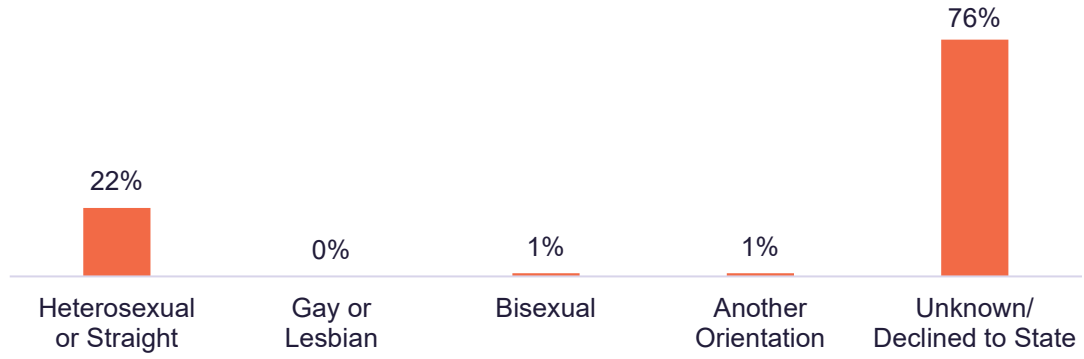
n = 112

Sex at Birth

Female	42%
Male	58%
Another Sex	0%
Unknown/Declined to State	0%

n = 112

Sexual Orientation
(n = 112)



Sun Rose FSP

INTERIM, INC.

Sun Rose FSP houses eight transitional clients with serious mental illness and nine permanent clients with serious mental illness. Intensive case management, psychiatry, and mental health services are provided to Sun Rose clients. Sun Rose receives all referrals from the Coalition of Homeless Services Providers (CHSP) through the CARS survey.

- 17 clients served in FY 23–24
- On average, clients engaged in services for 289 days
- 3 clients discharged in FY 23–24

Successes and Highlights

- Sun Rose FSP opened in September of 2023.
- Served 17 residents between permanent supportive housing and transitional housing within the last fiscal year.
- Implemented groups and provided house meetings and activities to build community.
- Provided an array of groups Monday through Friday to consumers.
- Developed events for consumers to socialize with one another and build community.

Challenges and Growth Opportunities

Sun Rose had challenges with staff vacancies earlier in the year. Additionally, Sun Rose, which requires all clients to be referred via a dual system of MCBH and the Coalition of Homeless Services Providers' CARS, had challenges meeting full occupancy. Full occupancy was only accomplished once this past year for a one-week period of time.

Goal for the Coming Year

1. Provide housing for 17 individuals in Sun Rose.

Sun Rose FSP

Discharge Information

3 clients were **discharged**.

Of the 3 with goal information,
33% had **achieved some or all their goals**.

Employment and Education

0% of clients were **employed or volunteering** while engaged in services.
(n = 17)

12% of clients completed **school** while engaged in services.
(n = 17)

Sun Rose FSP

Housing

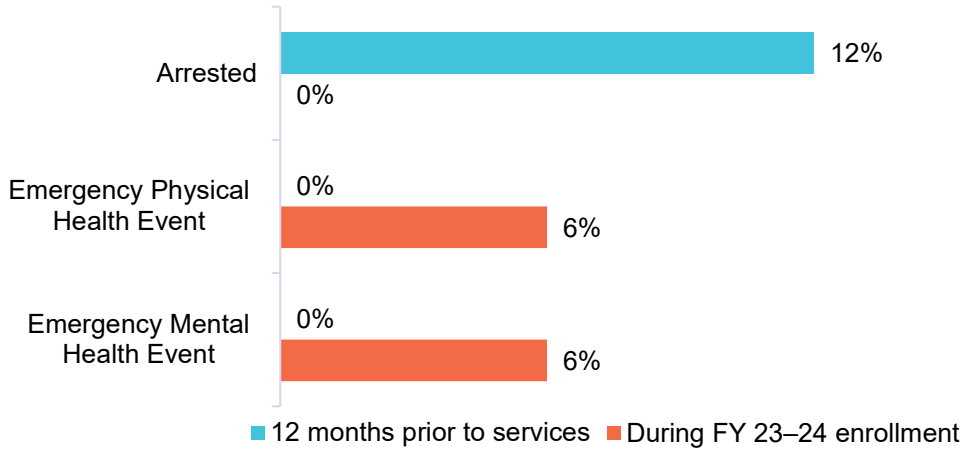
Housing Type Before Services (n = 17)		Current Housing Type (n = 17)
76%	Independent house or apartment	6%
0%	Friends/family	6%
0%	Shelter or temporary housing	6%
6%	Unhoused	6%
0%	Acute psychiatric facility or hospital	6%
6%	Residential treatment facility	6%
12%	Another housing status	0%
0%	Unknown/Declined to state	65%

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

Arrests and Emergency Events

Arrests, physical health emergency events, and mental health emergency events are compared between 12 months prior to accessing services and FY 23–24.

Clients' Arrests and Emergency Events
(n = 17)



Sun Rose FSP

Demographic Data

Race

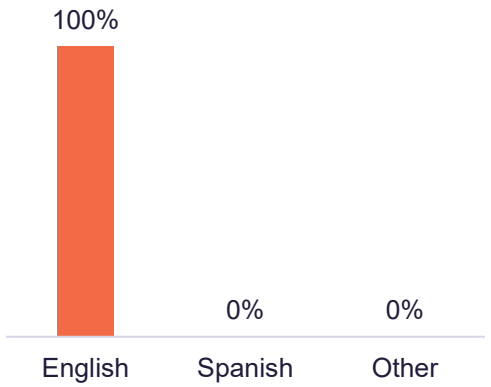
American Indian/Alaska Native	0%
Asian	29%
Black/African American	18%
White	53%
Another Race	0%
Unknown/Declined to State	0%

n = 17

47% Hispanic/Latino
53% Not Hispanic/Latino

n = 17
0% Unknown/Declined to state.

Primary Language

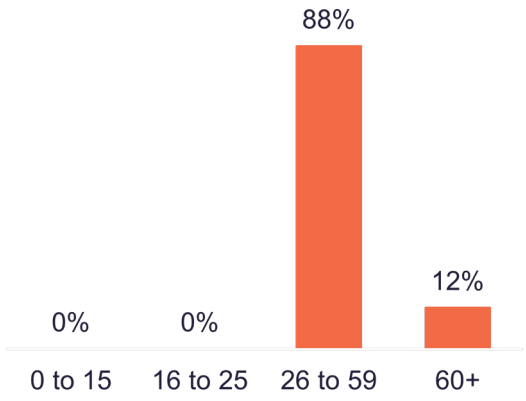


n = 17
0% Unknown/Declined to state.

94% of individuals reported having one or more disabilities

n = 17
0% Unknown/Declined to state.

Age



n = 17
0% Unknown/Declined to state.

Disability

No Disability	6%
Visual	0%
Hearing	0%
Speech	0%
Mobility	0%
Mental	88%
Developmental	0%
Another Disability	6%
Unknown/Declined to State	0%

n = 17

0% of individuals were veterans

n = 17
0% Unknown/Declined to state.

Sun Rose FSP

Gender Identity

Female	35%
Male	65%
Transgender	0%
Unknown/Declined to State	0%

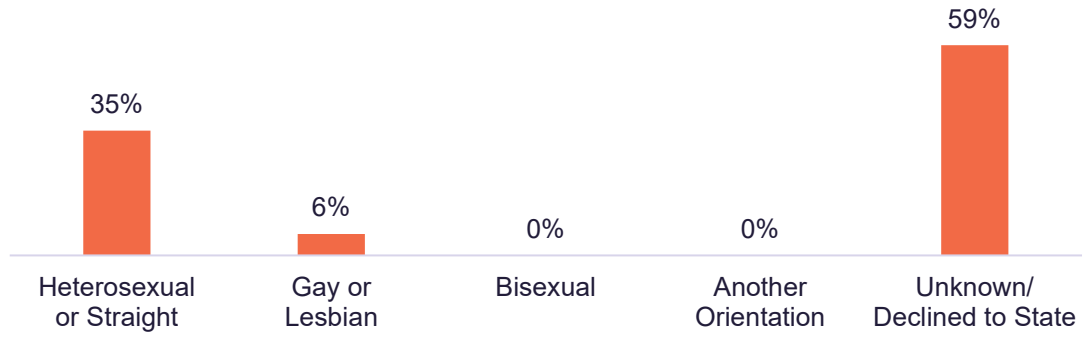
n = 17

Sex at Birth

Female	35%
Male	65%
Another Sex	0%
Unknown/Declined to State	0%

n = 17

Sexual Orientation
(n = 17)



CSS: WORKFORCE EDUCATION AND TRAINING

Workforce Education and Training

INTERIM, INC.

The Workforce Education and Training (WET) program, funded under the California Mental Health Services Act, supports consumers and family members who work in the public mental health system or are interested in working in this area. WET provides support to consumers employed in the mental health workforce, enabling them to influence the care system. This program also promotes recovery and fosters a more collaborative community. WET provides outreach, recruitment, and employment support services, including job analysis, training, and job coaching for individuals with mental health conditions and their family members. WET aims to encourage a diverse and stable mental health workforce. The program offers groups and training to promote cultural competency, wellness and recovery principles, healthy boundaries, social rehabilitation, and communication skills. WET services are available to consumers and family members, to integrate them into the workplace effectively. Referrals to benefits counseling and support with reporting income to Social Security are also provided.

- 71 clients served in FY 23–24

Successes and Highlights

- The WET team is fully staffed with bilingual employees who have strong working relationships with clients and their supervisors. The team holds regular meetings for custodial staff, community support workers, wellness navigators, and the landscaping crew.
- Served 71 consumers and family members and opened services for 11 new consumers.
- Provided a total of 24 support groups and trainings.
- Twelve peer staff members obtained their peer certification. Other staff are continuing to enroll in peer certification courses.
- Supervisors received training materials on working with peer staff and were provided with supervision support on various occasions.

Workforce Education and Training

Challenges and Growth Opportunities

The WET team had difficulty reaching out to external agencies throughout the year. Staff will collaborate to deliver presentations to community organizations, such as NAMI and Community Human Services, Door to Hope, and Monterey County Behavioral health, to outreach more clients in the community. Through this effort, they will develop a networking list of contacts. They will also distribute flyers and brochures to these external agencies and will invite them to attend supervisor trainings throughout the year.

Staff will develop a training schedule for peer staff and will partner with other agencies to assist with trainings. They will work to schedule supervisor trainings for MCBH, Interim, Inc. staff, and outside agencies on working with and supervising peers.

Goals for the Coming Year

1. Serve 45 (unduplicated) clients or family members employed in the public mental health system, including wellness navigators.
2. Provide three vocational support groups per month.
3. Provide 12 trainings on skill development.

Employment

100% of clients were **employed or volunteering** while enrolled in the program.
(n = 71)

Workforce Education and Training

Demographic Data

Race

American Indian/Alaska Native	6%
Asian	4%
Black/African American	11%
Native Hawaiian/Other Pacific Islander	0%
White	24%
Another Race	55%
Unknown/Declined to State	0%

n = 71

Primary Language

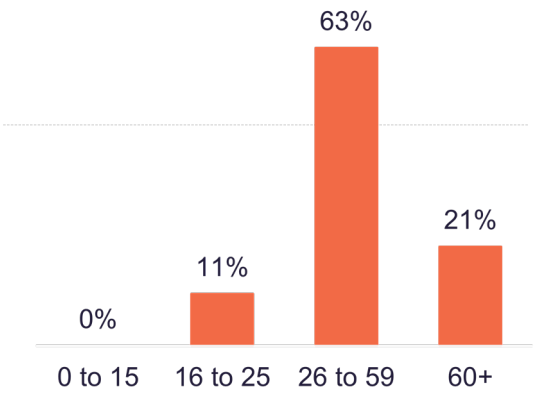
100% English

n = 71
0% Unknown/Declined to state.

41% Hispanic/Latino
59% Not Hispanic/Latino

n = 71
0% Unknown/Declined to state.

Age



n = 71
4% Unknown/Declined to state.

100% of individuals reported having one or more disabilities

n = 71
0% Unknown/Declined to state.

Disability

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

n = 71

APPENDIX A. LIST OF CSS-FUNDED PROGRAMS

CSS-01: Early Childhood and Family Stability FSP

- D'Arrigo Outpatient
- Family Assessment Support and Treatment (FAST)
- Family Reunification FSP
- Salinas Home Partners FSP

CSS-02: Dual Diagnosis FSP

- Integrated Co-occurring Treatment
- Santa Lucia

CSS-04: Transition Age Youth FSP

- MHSA TIP AVANZA FSP

CSS-05: Adults with SMI FSP

- Assertive Community Treatment (ACT)

CSS-06: Older Adults FSP

- Drake House FSP
- Older Adult FSP

CSS-07: Access Regional Services

- Access Medication Support Services
- Access to Treatment CalWORKs
- Access to Treatment Coastal Region
- Access to Treatment King City
- Access to Treatment Salinas
- Access to Treatment Soledad
- After Hours
- Family Counseling Salinas
- Family Counseling Seaside
- Family Counseling South County
- Outpatient Mental Health
- USC Telehealth
- Wellness Recovery Center (OMNI)

CSS-08: Early Childhood Mental Health Services

- Monterey County Screening Team for Assessment, Referral, and Treatment (MCSTART)

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

- Return to Work Benefits Counseling and Housing Assistance
- Wellness Navigation Services

CSS-11: Dual Diagnosis

- Bridge House
- Keep it Real, Harm Reduction Services
- Outreach and Aftercare Services
- Wellness and Recovery Academy

CSS-13: Justice-Involved FSP

- Creating New Choices FSP

CSS-14: Homeless Services and Supports FSP

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

CSS-15 Homeless Outreach and Treatment

- Rockrose Gardens
- Shelter Cove

CSS-16: Responsive Crisis Interventions

- Archer Child Advocacy Center
- Manzanita House Salinas & Monterey

CSS-17: Children's Mental Health Services

- Short-Term Residential Program

CSS-18: Mental Health Services for Adults

- Community Housing
- Sun Rose FSP

CSS: Workforce Education and Training

- Workforce Education and Training (WET)

Monterey County Mental Health Services Act

Prevention & Early Intervention Three-Year Report

Fiscal Years 21-22, 22-23, & 23-24

Prepared by
EVALCORP
Measuring What Matters®

MONTEREY COUNTY
BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

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; Bureau Chief, Jon Drake; Mental Health Services Act (MHSA) Coordinator, Shannon Castro; and MHSA Innovation Coordinator, Wesley Schweikhard. 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.

Table of Contents

Introduction

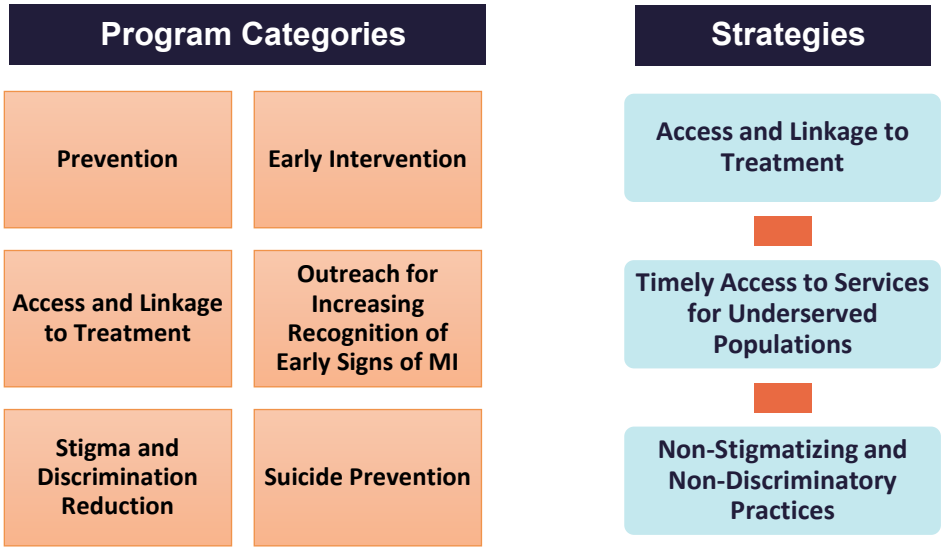
Overview

The Mental Health Services Act (MHSA) was passed by California voters in 2004 through Proposition 63, which designated funding to improve mental health service systems throughout the state. MHSA has several 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 county's culturally and regionally diverse communities' mental health prevention and early intervention needs. In fiscal year (FY) 23–24, MCBH funded 36 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 is 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 that were given to providers in FY 23–24 for online collection of process and outcomes data. This online system enabled a streamlined and consistent process for collecting important data that supports an understanding of PEI programs' reach to Monterey community members and the impact of the programs on their lives.

Report Methodology

Analytic Approach

MCBH contracted with EVALCORP Research & Consulting to develop this report, which summarizes data for PEI programs funded during fiscal years 2021–2022, 2022–2023, and 2023–2024. 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 three-year 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.

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 Programs
	Outreach for Increasing Recognition of Early Signs of Mental Illness Programs
Suicide Prevention	Suicide Prevention Programs
Stigma and Discrimination Reduction	Stigma and Discrimination Reduction 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 referrals made to MHSA-funded services by type, such as referrals to mental/behavioral health treatment and 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 2023–2024, MCBH continued to implement an enhanced data collection and evaluation infrastructure, which allowed for more robust PEI program data to be provided in this comprehensive three-year report. 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.

- **Overall individuals served**: Providers report the total number of individuals served. This information is located in the Program Highlights subsection of each program section. The number of individuals served is often higher than the number of demographic and outcome forms received, as some individuals decline the opportunity to complete these forms.

- **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 as the number of completed demographic forms within each program section and underestimates the total number of individuals each program has reached. To reduce burdens for program participants who were in emotional distress, there were instances where programs did not collect demographic data. Additionally, 211, a United Way Monterey County program, 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 collect 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 surveys with fewer than 10 total responses. In these instances, the section with low submissions has been removed from that particular program section.

Report Organization

This report presents PEI data by program category. Report sections are organized by five core PEI categories: Prevention; Early Intervention; Access and Linkage to Treatment; Suicide Prevention; and Stigma and Discrimination Reduction. (Outreach for Increasing Recognition of Early Signs of Mental Illness was not included as a sixth separate report section, as no programs funded in fiscal year 2023–2024 fell under this PEI program category.)

The following information has been aggregated for each program category over the past three years, where available:

- Program Highlights and Activities (which include the overall number of individuals engaged in all programmatic activities)
- Program Outcomes
    - Program Cultural Competency and Satisfaction
    - Participant Feedback
- Service Referrals

- Demographic Data
- Program Successes and Learnings

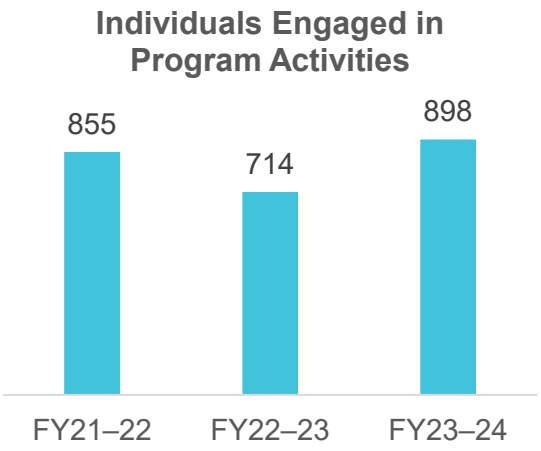
Independent program sections spanning the last three fiscal years are available for programs that received PEI funding in FY 23–24, and those that had sufficient data to report. Any programs that are not represented by an independent section are included in the complete list of PEI programs provided in **Appendix A**.

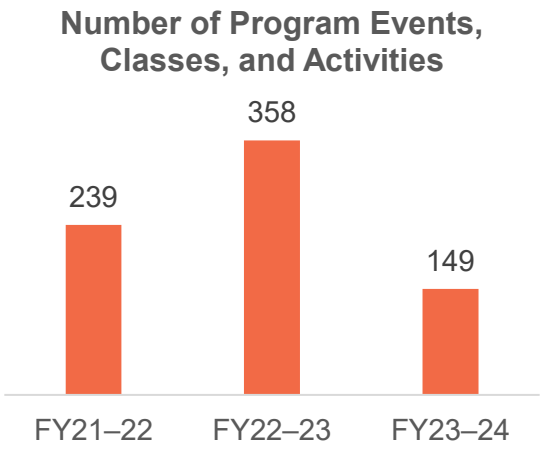
PREVENTION

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 strategically employs Health Promoters (Promotores de Salud) to empower the Latino/a/e community with vital knowledge about mental health issues while effectively diminishing the stigma attached to seeking help. This transformative program provides essential leadership development and skills training, equipping individuals to become influential community health advocates. With their strength and dedication, these advocates are instrumental in sharing critical health-related information and connecting those in need to necessary services. Moreover, the Promotores de Salud enhance access to a variety of programs and mental health care, ensuring that everyone in the community can seek and receive support.

Program Highlights



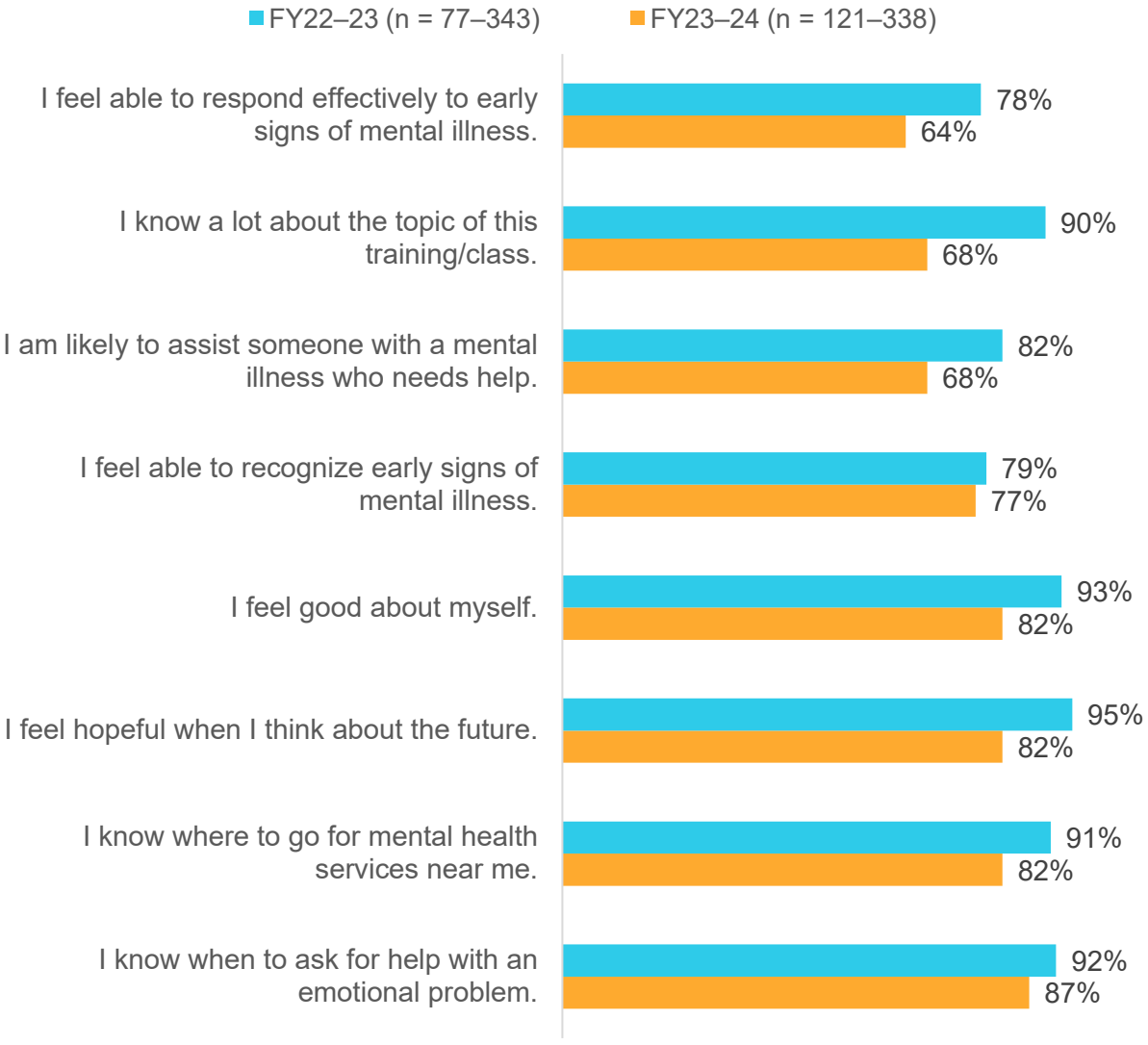


Culturally Specific Prevention and Early Intervention Through Outreach and Engagement

Program Outcomes, Satisfaction, and Feedback

Center for Community Advocacy (CCA) tracks program outcomes by asking participants questions to self-assess their overall well-being, satisfaction with life, and psychological health after the program. Where available, survey results for the past three fiscal years are presented in the charts below.

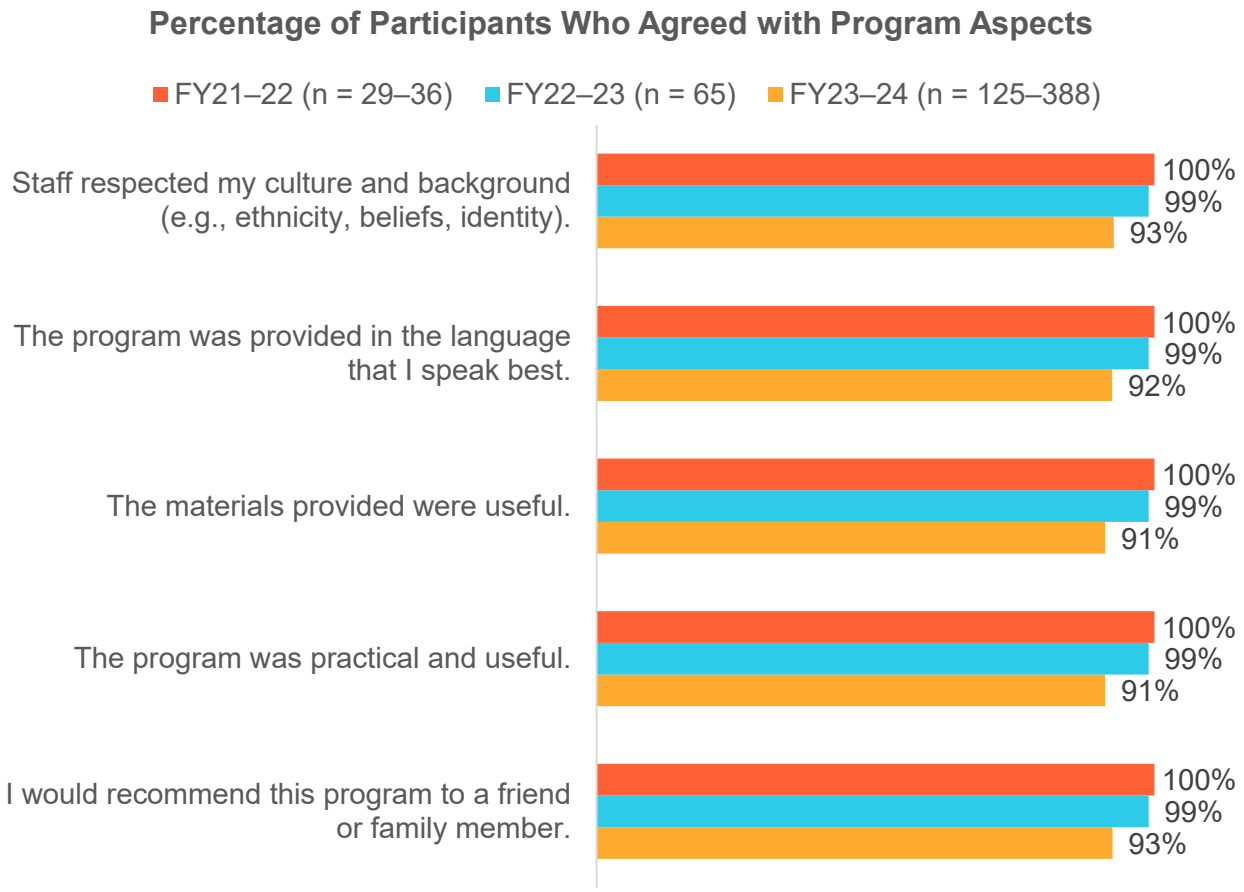
Percentage of Participants Reporting Knowledge, Awareness, and Well-being After the Program



¤ Data not available for FY 21–22.

Culturally Specific Prevention and Early Intervention Through Outreach and Engagement

Program Outcomes, Satisfaction, and Feedback



Culturally Specific Prevention and Early Intervention Through Outreach and Engagement

Program Outcomes, Satisfaction, and Feedback

Participants were also asked to give additional feedback through two open-ended questions. Their comments were categorized by theme, and the most common responses from the past three years are summarized below.

What was most useful or helpful about this program?

- FY 21–22: Learning about healthy relationships and how to identify abuse
- FY 22–23: Information about mental health disorders
- FY 23–24: Mental health awareness and coping strategies

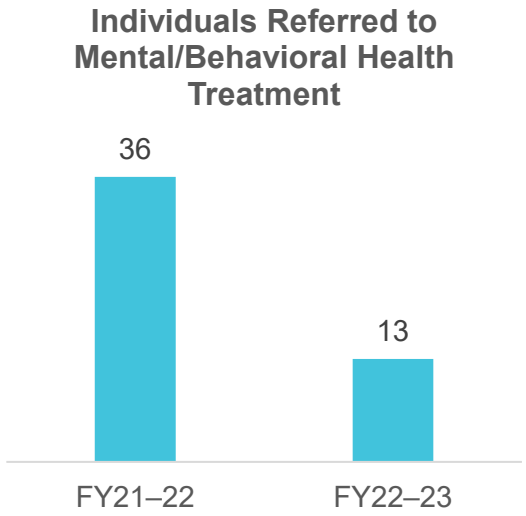
What are your recommendations for improvement?

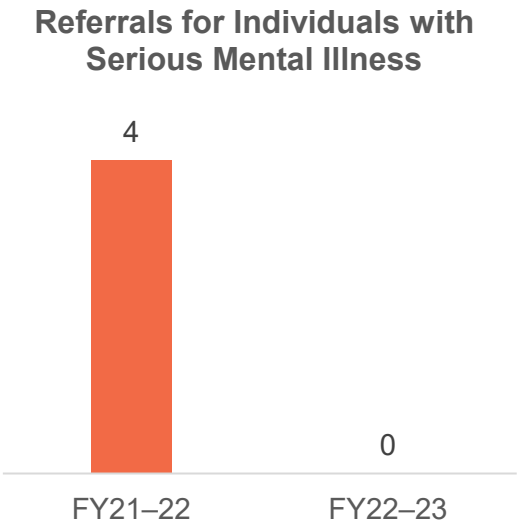
- FY 21–22: General positive feedback (e.g., “Everything’s fine”)
- FY 22–23: More time and more sessions
- FY 23–24: Extended duration and continuity

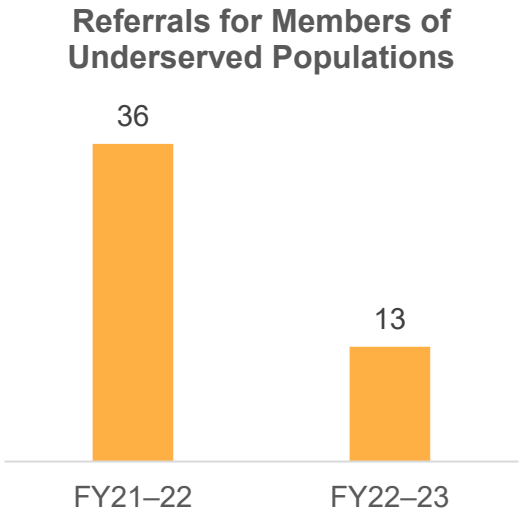
Culturally Specific Prevention and Early Intervention Through Outreach and Engagement

Referrals

Program referrals encompass referrals to mental and behavioral health treatment. The figures below summarize the total number of program participants referred to these services over two previous fiscal years, including those with serious mental illnesses and those from underserved populations.







No referrals were made in FY 23–24.

Culturally Specific Prevention and Early Intervention Through Outreach and Engagement

Demographic Data

CCA collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 204**	**n = 219**	**n = 246**
American Indian/Alaska Native	0%	0%	0%
Asian	0%	0%	0%
Black/African American	0%	0%	0%
Hispanic/Latino/a/e	100%	98%	96%
Native Hawaiian/Other Pacific Islander	0%	0%	0%
White	0%	0%	0%
More Than One Race	0%	0%	1%
Other	0%	2%	4%
Decline to State	--	0%	1%
Ethnicity*	**n = --¤**	**n = 100**	**n = 104**
Hispanic/Latino/a/e			
Caribbean	--	1%	0%
Central American	--	2%	3%
Mexican/Mex. Am./Chicano	--	93%	90%
Puerto Rican	--	0%	0%
South American	--	0%	0%
Other Hispanic/Latino/a/e	--	4%	8%
Declined to State	--	0%	0%
Primary Language*	**n = 205**	**n = 221**	**n = 240**
English	3%	2%	1%
Spanish	84%	70%	82%
English and Spanish	13%	14%	14%
Other	0%	14%	3%
Age Groups	**n = 208**	**n = 216**	**n = 246**
0 to 15 years	2%	1%	1%
16–25 years	12%	7%	6%
26–59 years	77%	80%	81%
60+ years	9%	12%	12%
Declined to State	--	1%	0%
Gender Identity	**n = --¤**	**n = 96**	**n = 106**
Female	--	84%	82%
Genderqueer	--	0%	0%
Male	--	14%	17%
Nonbinary	--	0%	0%

	FY 21–22	FY 22–23	FY 23–24
Questioning or Unsure	--	0%	0%
Transgender	--	0%	1%
Another Gender Identity	--	0%	0%
Declined to State	--	2%	0%
Sex Assigned at Birth	**n = --¤**	**n = 116**	**n = 111**
Female	--	69%	83%
Male	--	10%	17%
Another Sex Assigned	--	0%	0%
Declined to State	--	2%	--
Sexual Orientation	**n = --¤**	**n = 82**	**n = 61**
Bisexual	--	0%	3%
Gay or Lesbian	--	0%	0%
Heterosexual or Straight	--	100%	82%
Pansexual	--	0%	0%
Queer	--	0%	0%
Questioning or Unsure	--	0%	0%
Another Sexual Orientation	--	0%	0%
Declined to State	--	--	15%
Disability*	**n = --¤**	**n = 102**	**n = 109**
Mental Domain	--	26%	0%
Seeing	--	5%	2%
Hearing	--	3%	0%
Other Communication	--	1%	2%
Physical	--	4%	2%
Chronic Health Condition	--	6%	3%
Another Disability	--	0%	0%
Declined to State	--	1%	--
Veteran	**n = --¤**	**n = --¤**	**n = 111**
Yes	--	--	0%
No	--	--	100%
Declined to State	--	--	--

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

¤ Category not available for that fiscal year.

-- Data not available.

Intervention Through Outreach and Engagement

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** During the COVID-19 pandemic, CCA offered a safe platform for the Monterey County community to have conversations about mental health through Zoom.
- **FY 22–23:** The program excelled in direct community engagement, resource distribution, and shifting care responsibility to providers.
- **FY 23–24:** Counselor accessibility was increased, a strong support network was provided, and robust outreach efforts were made.

Achievements

- **FY 21–22:** Community increased openness to discussing mental health and problems.
- **FY 22–23:** Gained 52 new participants.
- **FY 23–24:** Organizers were warmly welcomed in rural areas, ensuring that communities felt supported and had access to resources.

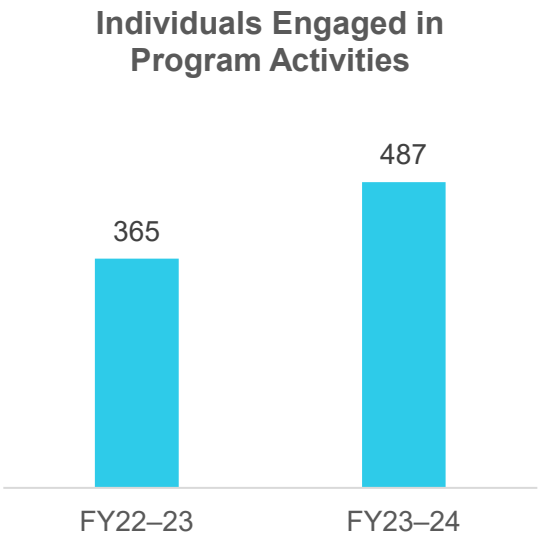
Challenges

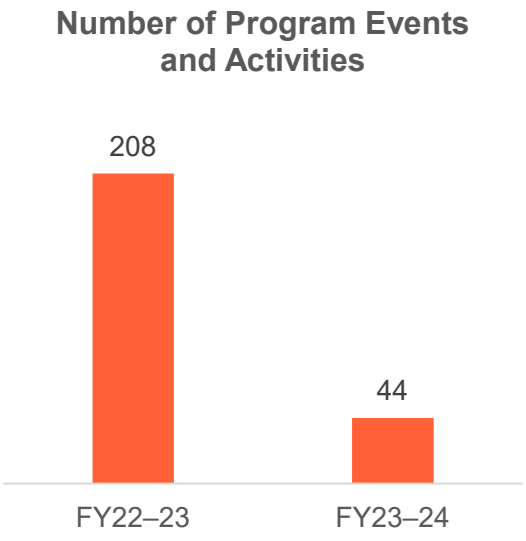
- **FY 23–24:** CCA found it challenging to find a good space to hold support groups that would make the community comfortable enough to attend and participate.

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 such disorders in Greenfield, Soledad, and King City, putting 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."

Program Highlights





Maternal Mental Health Peer Navigation Program

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 in Spanish and 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.

The results highlighted below reflect qualitative data captured during conversations about knowledge and attitudes regarding mental health and associated resources. Responses from the past two fiscal years are summarized. This ensures that the selected responses reflect the broader community's experiences while respecting the diversity of individual perspectives.

What does mental health mean to you?

Throughout the program, there was a clear improvement in participants' understanding of mental health.

In FY 22–23, the percentage of participants who initially expressed uncertainty about the meaning of mental health decreased from 34% (n = 44) to 21% (n = 39) by the end of the program. Participants began defining mental health as *platicar de lo que siento* (talking about what I feel) and *tu estado de ánimo, cómo te sientes* (your mood, how you feel).

In FY 23–24, this uncertainty dropped from 13% before the program to 0% afterward (n = 32), with participants describing mental health as *como me siento en todos los sentidos* (how I feel in every sense). These findings indicate that the program effectively enhanced participants' awareness and understanding of mental health, contributing to a more informed community.

Maternal Mental Health Peer Navigation Program

Program Outcomes, Satisfaction, and Feedback

A text analysis explored participants' emotions associated with talking about their feelings. Prior to the program, over the past two fiscal years, the dominant emotions were *pena* (embarrassment), *vergüenza* (shame), and *tristeza* (sadness). In contrast, after the program, participants expressed more positive emotions, such as *no me da pena* (unashamed), *mejor* (better), and *aprendiendo* (learning). This shift in emotional responses highlights the program's success in fostering a more open and positive attitude toward discussing emotions among participants. The two word clouds below summarize these findings, with participants' feelings translated into English for clarity.

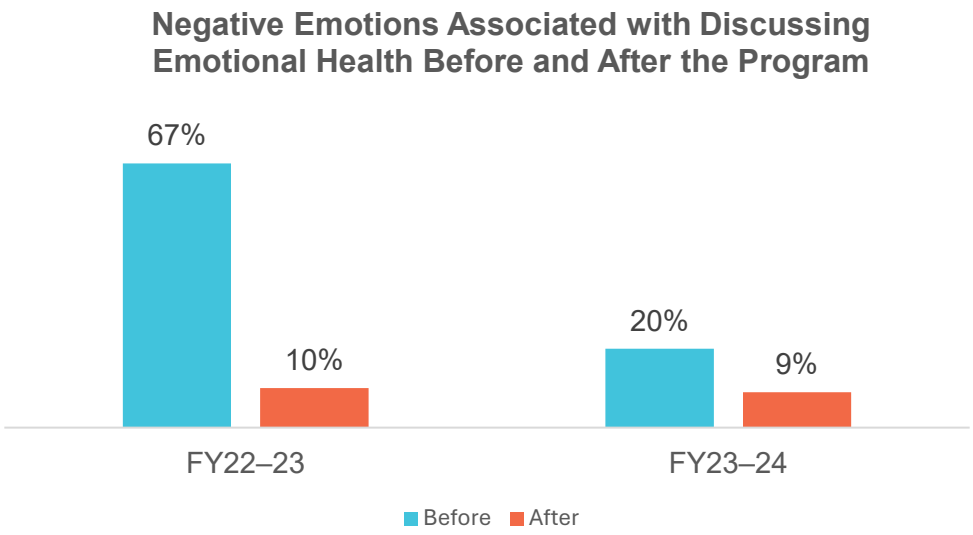
Pre-Survey: How Participants Feel When Talking About Their Emotions (FY 22–23 and FY 23–24)

Post-Survey: How Participants Feel When Talking About Their Emotions (FY 22–23 and FY 23–24)

Maternal Mental Health Peer Navigation Program

Program Outcomes, Satisfaction, and Feedback

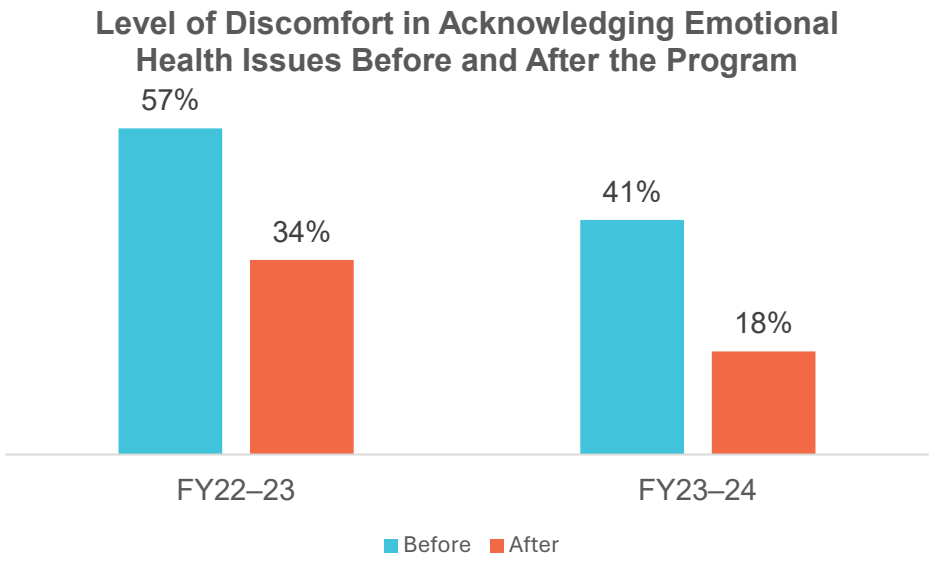
The CBDIO Maternal Mental Health Peer Navigation program has positively influenced participants' comfort levels when discussing their emotional health. In FY 22–23, 67% of participants initially expressed experiencing negative emotions when talking about their emotional health. By the end of the program, this number decreased to 10%, reflecting an improvement in how participants felt. Similarly, in FY 23–24, the percentage of participants reporting negative emotions before the program was 20%, which decreased to 9% after program completion. These findings are shown in the chart below and indicate that the program has cultivated a supportive and understanding environment, helping participants feel more comfortable and empowered when discussing their emotions.



Participants were additionally asked about their level of discomfort in acknowledging health issues before and after the program. In FY 22–23, 57% of participants reported feeling uncomfortable discussing their emotional health concerns before the program. This figure decreased to 34% after the program, indicating a positive shift in their comfort levels. In FY 23–24, before the program, 41% of participants expressed discomfort when discussing emotional health issues, which further declined to 18% afterward. These findings suggest that the program effectively fostered a supportive environment, encouraging participants to address their health concerns more confidently.

Maternal Mental Health Peer Navigation Program

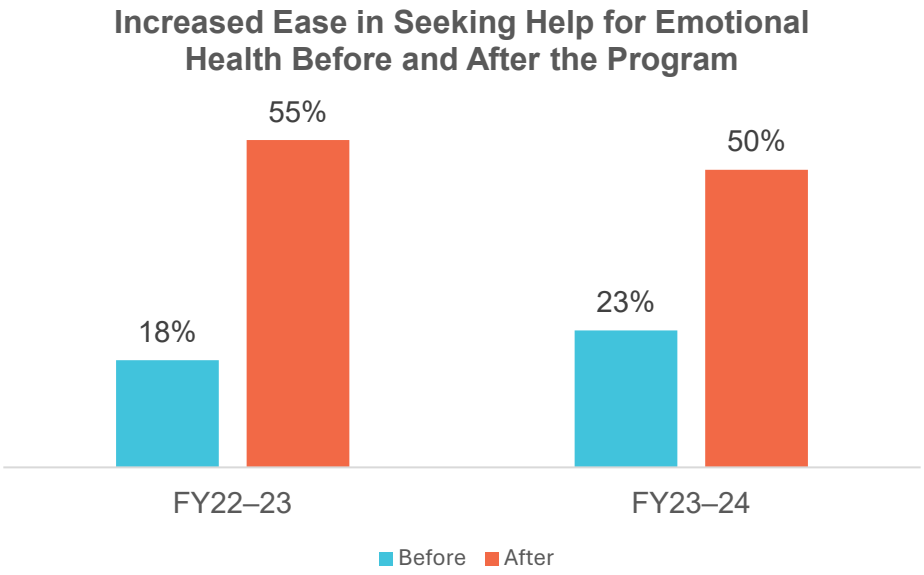
Program Outcomes, Satisfaction, and Feedback



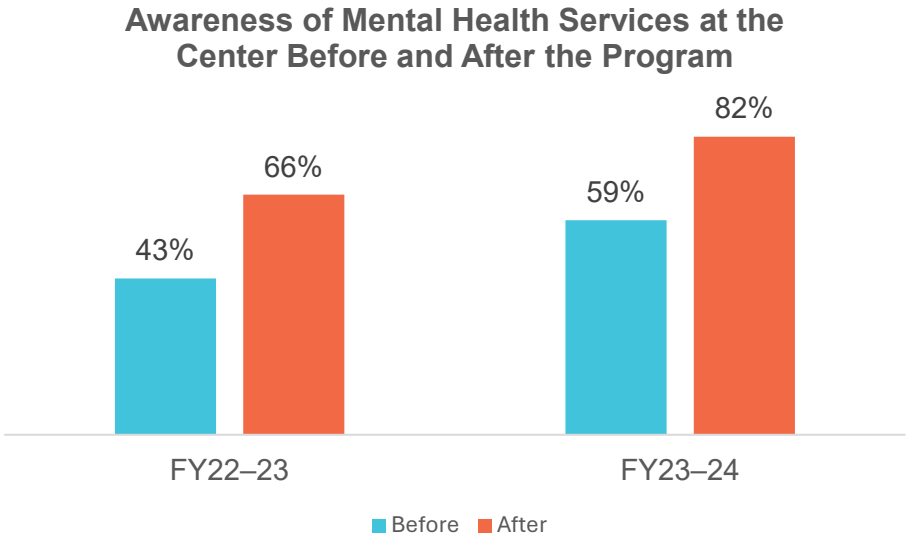
The program has also enhanced participants' ease in asking for help with their emotional health. In FY 22–23, only 18% of participants initially reported that it was easy for them to seek help. After completing the program, this number increased to 55%, reflecting a growing comfort in reaching out for support. Likewise, in FY 23–24, the percentage of participants who felt it was easy to ask for help rose from 23% before the program to 50% afterward. These results, summarized in the chart below, suggest that the program has created a more welcoming and supportive atmosphere, empowering participants to feel more confident in seeking help for their emotional well-being.

Maternal Mental Health Peer Navigation Program

Program Outcomes, Satisfaction, and Feedback



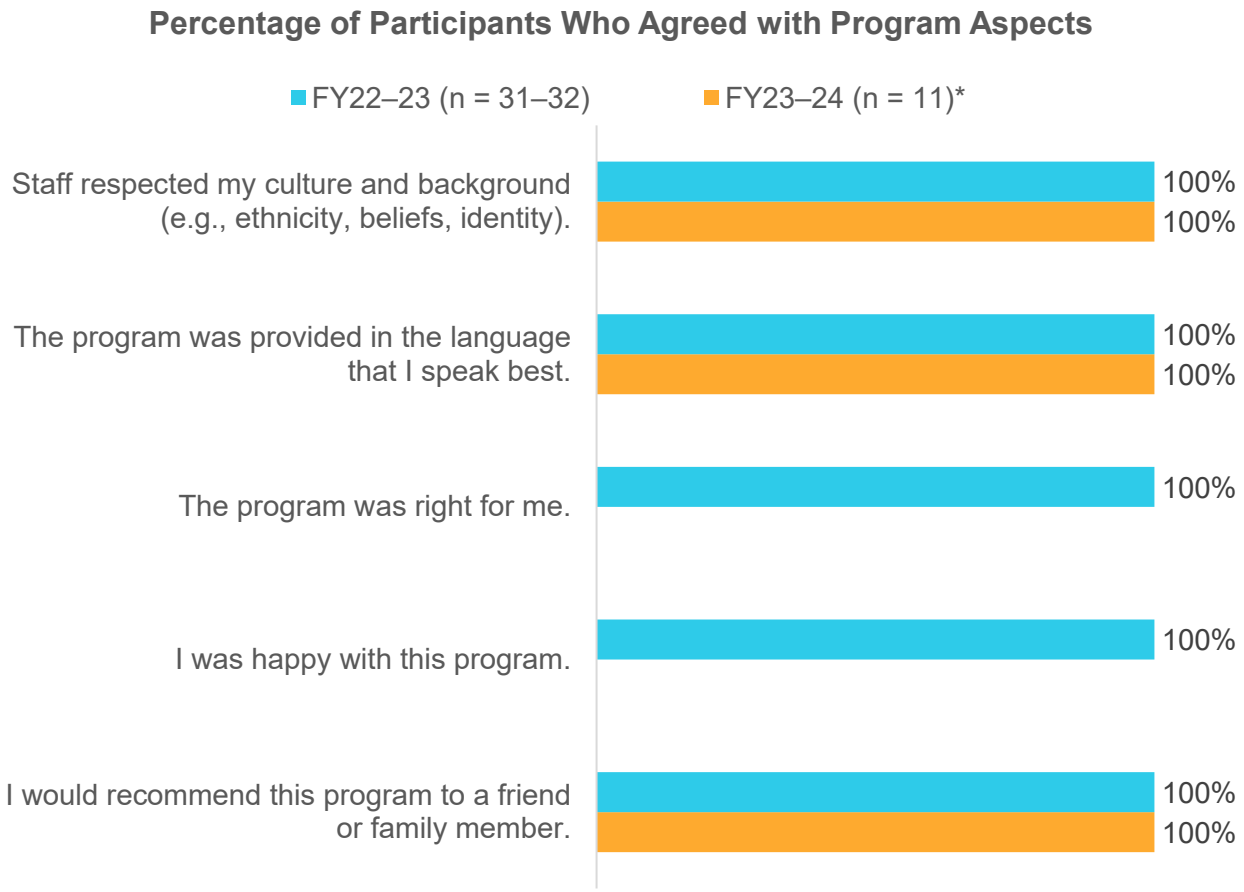
The program has contributed to increasing participants' awareness of the mental health services available at the center. In FY 22–23, 43% of participants initially knew about the services offered. By the end of the program, this awareness increased to 66%. In FY 23–24 this trend continued, and the percentage of participants aware of these services rose from 59% before the program to 82% afterward. These findings indicate that the program has enhanced participants' knowledge of available resources, ensuring that Indigenous women are better informed about the mental health supports accessible to them.



Maternal Mental Health Peer Navigation Program

Program Outcomes, Satisfaction, and Feedback

Over the past two fiscal years, 100% of participants agreed that CBDIO's staff respected their culture and background, provided services in the languages they were most comfortable with, tailored the program to meet their needs, and delivered a positive experience. Additionally, all participants indicated that they would recommend the program to family or friends. These unanimous endorsements reflect the program's commitment to cultural sensitivity and responsiveness, highlighting its effectiveness in meeting the community's needs.



*Data was not collected for two of the questions in FY 23–24.

Maternal Mental Health Peer Navigation Program

Referrals

In FY 22–23, 14 referrals were made to mental and behavioral health treatment services. However, in FY 23–24, there were no referrals. This was related to past challenges, where services were not available in Indigenous languages or Spanish and did not incorporate culturally competent or trauma-informed approaches. Some clients faced uncomfortable or stigmatizing situations, which may have deterred them from seeking support. To address these barriers, the CBDIO team actively worked to identify providers for the upcoming fiscal year who can meet their clients' needs in a culturally and linguistically appropriate manner, creating a more positive and inclusive experience.

Maternal Mental Health Peer Navigation Program

Demographic Data

CBDIO collects unduplicated demographic data from the individuals they serve.

	FY 22–23	FY 23–24
Race*	**n = 55**	**n = 93**
American Indian/Alaska Native	2%	0%
Asian	0%	0%
Black/African American	0%	0%
Hispanic/Latino/a/e	73%	94%
Native Hawaiian/Other Pacific Islander	0%	0%
White	0%	0%
More Than One Race	--	6%
Other	2%	0%
Declined to State	2%	0%
Ethnicity*	**n = 54**	**n = 94**
Hispanic/Latino/a/e		
Caribbean	0%	0%
Central American	2%	0%
Mexican/Mex. Am./Chicano	48%	51%
Mixteco	22%	27%
Puerto Rican	0%	0%
South American	0%	0%
Triqui	44%	48%
Zapoteco	20%	3%
Primary Language*	**n = 55**	**n = 87**
English	14%	0%
Spanish	23%	100%
English and Spanish	18%	0%
Mixteco	--	38%
Triqui	--	55%
Zapoteco	--	7%
Other	0%	0%

* Percentages may exceed 100% because participants could choose more than one response option.
-- Data not available.

Maternal Mental Health Peer Navigation Program

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below summarizes the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** The program created a safe and supportive environment, providing vital education on maternal mental health, and effectively adapting content to the community's languages.
- **FY 23–24:** The program adjusted its curriculum by incorporating more accessible activities such as drawing and acting out scenes to help mothers better understand the themes discussed.

Achievements

- **FY 22–23:** Successfully engaged mothers from the Triqui and Mixteco communities and facilitated valuable transformations in their understanding and management of mental health issues.
- **FY 23–24:** Ten or more mothers consistently attended Mixteco *platicas*, with about 20 attending Triqui *platicas*.

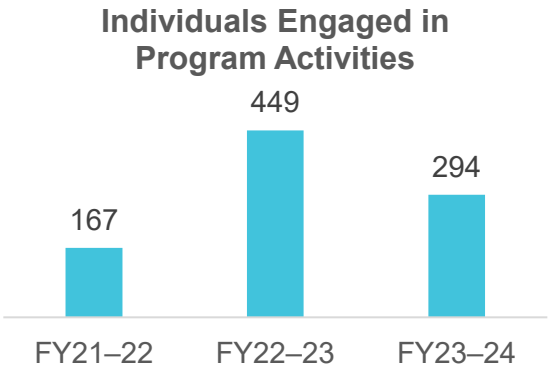
Challenges

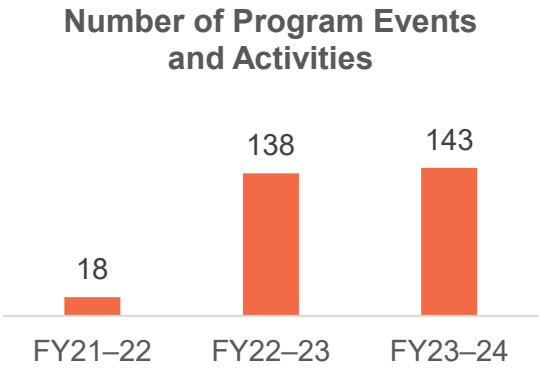
- **FY 23–24:** A recent challenge the program addressed was the influence of traditional gender roles among some fathers. When reaching out to mothers, CBDIO emphasized the importance of confidentiality and assured them that it provides a safe and supportive environment.

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

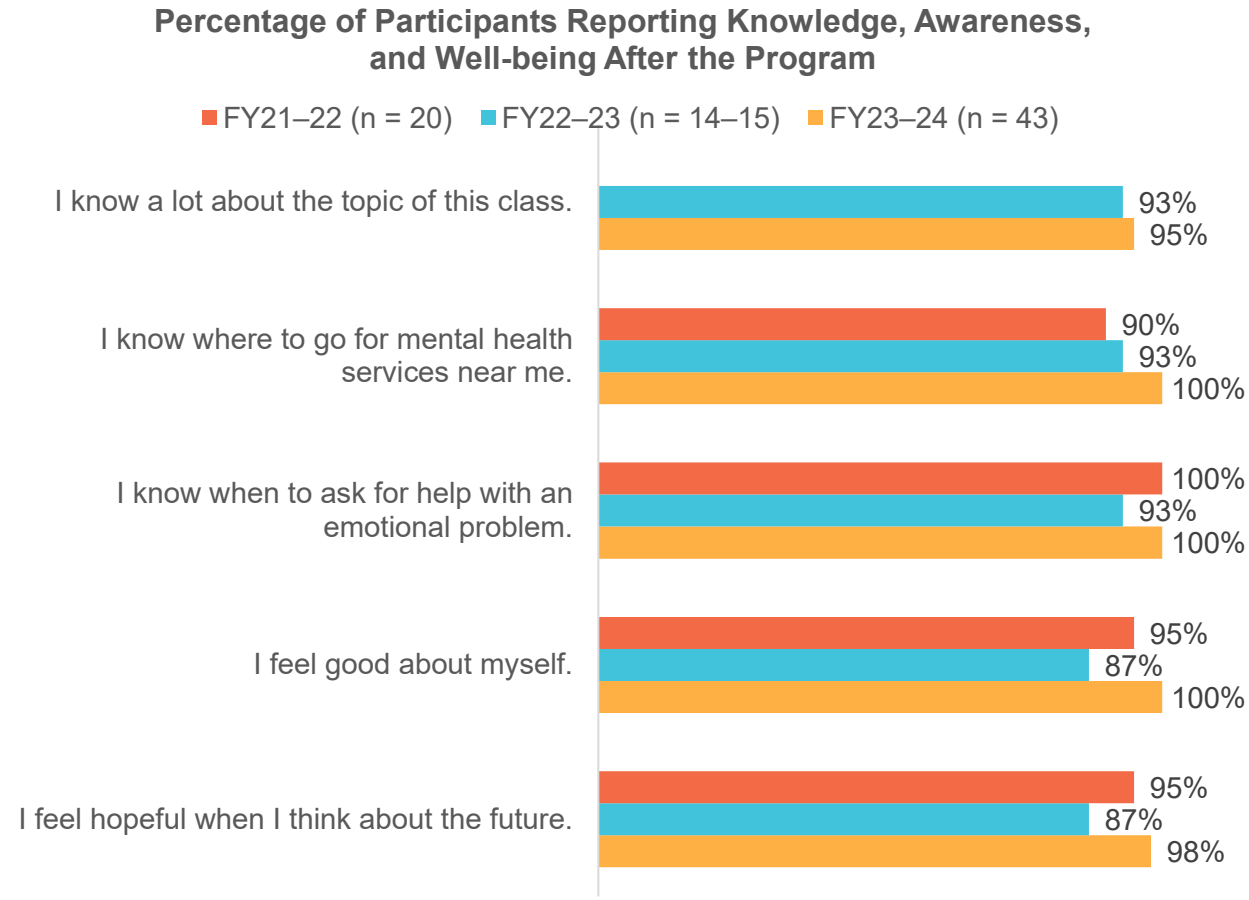




Parent Education Program

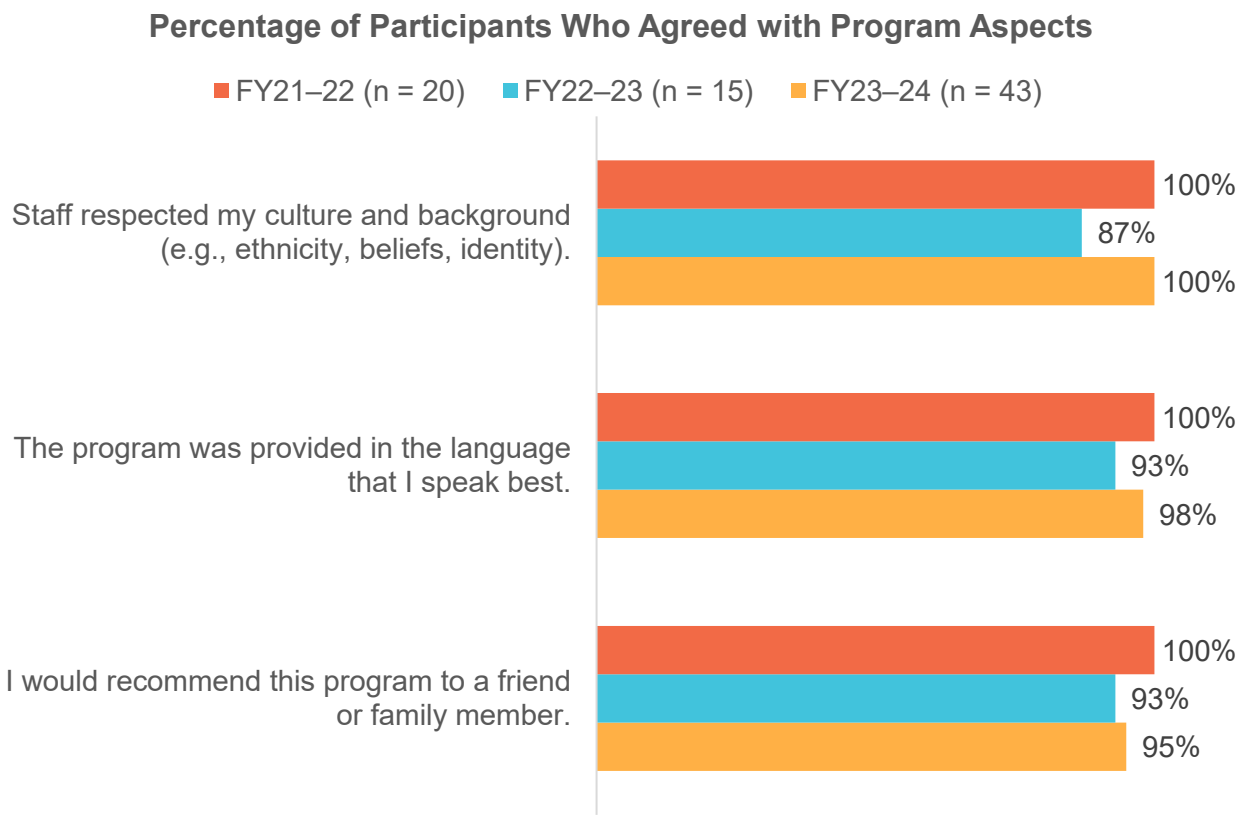
Program Outcomes, Satisfaction, and Feedback

The Parent Education Program tracks program outcomes by asking participants to self-assess their knowledge and satisfaction after receiving program services. Survey results for the past three fiscal years are presented in the charts below.



Parent Education Program

Program Outcomes, Satisfaction, and Feedback



Participants who received services from the Parent Education Program were asked to give additional feedback through two open-ended questions. Their comments were categorized by theme, and the most common responses from the past three years are summarized below.

What was most useful or helpful about this program?

- FY 21–22: Having support and understanding
- FY 22–23: Learning how to understand, help, and care for children
- FY 23–24: Improved parenting skills and communication

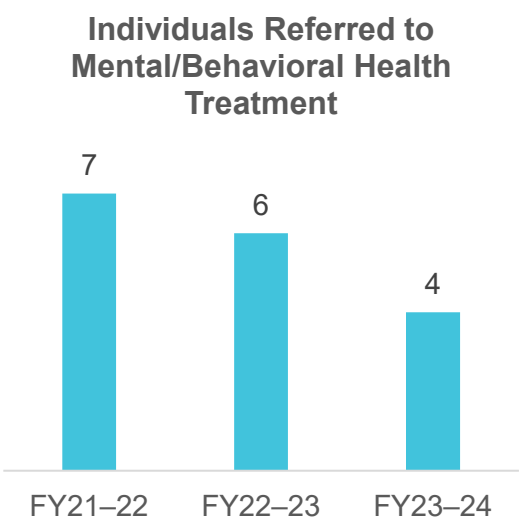
What are your recommendations for improvement?

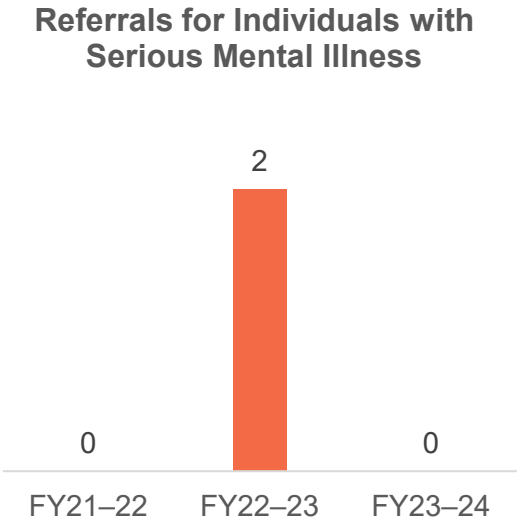
- FY 21–22: In-person sessions
- FY 22–23: Additional classes/services
- FY 23–24: High satisfaction, with no changes needed

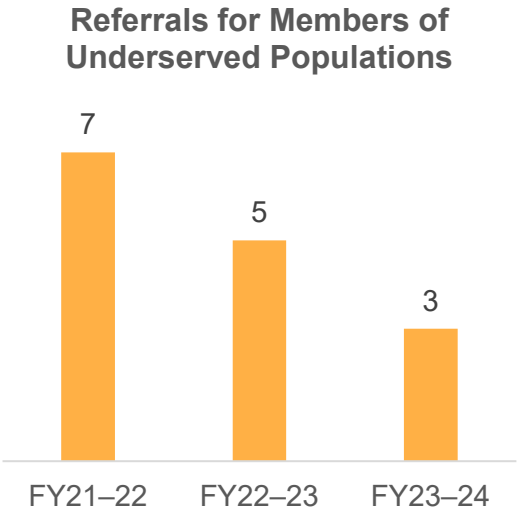
Parent Education Program

Referrals

Program referrals encompass referrals to mental and behavioral health treatment. The figures below summarize the total number of program participants referred to these services over the past three fiscal years, including those with serious mental illnesses and those from underserved populations.







Parent Education Program

Demographic Data

The Parent Education Program collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 274**	**n = 132**	**n = 138**
American Indian/Alaska Native	3%	2%	2%
Asian	1%	1%	0%
Black/African American	3%	3%	7%
Hispanic/Latino/a/e	74%	71%	66%
Native Hawaiian/Other Pacific Islander	0%	1%	1%
White	16%	22%	19%
Other	4%	0%	1%
More Than One Race	--	--	0%
Declined to State	--	2%	4%
Ethnicity*	**n = 236**	**n = 134**	**n = 129**
Hispanic/Latino/a/e			
Caribbean	0%	0%	0%
Central American	2%	3%	4%
Mexican/Mex. Am./Chicano	76%	40%	64%
Puerto Rican	0%	0%	1%
South American	0%	1%	0%
Other Hispanic/Latino/a/e	9%	35%	6%
Non-Hispanic/Non-Latino/a/e			
African	1%	0%	5%
Asian Indian/South Asian	0%	1%	2%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	0%	1%	2%
European	1%	2%	5%
Filipino	0%	1%	1%
Japanese	1%	1%	2%
Korean	0%	0%	0%
Middle Eastern	0%	1%	0%
Vietnamese	--	--	--
Other Non-Hispanic/Non-Latino/a/e	10%	16%	5%
Declined to State	--	4%	9%
Primary Language*	**n = 276**	**n = 139**	**n = 136**
English	47%	71%	50%
Spanish	38%	20%	32%
English and Spanish	18%	7%	16%
Other	0%	1%	0%

	FY 21–22	FY 22–23	FY 23–24
Declined to State	--	0%	2%
Age Groups	**n = 284**	**n = 136**	**n = 108**
0 to 15 years	0%	0%	0%
16–25 years	12%	16%	12%
26–59 years	87%	84%	87%
60+ years	1%	0%	1%
Declined to State	--	2%	--
Gender Identity	**n = 276**	**n = 136**	**n = 267**
Female	56%	51%	29%
Genderqueer	0%	0%	0%
Male	44%	48%	19%
Nonbinary	0%	0%	0%
Questioning or Unsure	0%	1%	0%
Transgender	0%	0%	0%
Another Gender Identity	0%	0%	0%
Declined to State	--	0%	51%
Sex Assigned at Birth	**n = 286**	**n = 139**	**n = 136**
Female	56%	51%	58%
Male	44%	48%	40%
Another Sex Assigned	0%	0%	0%
Declined to State	--	0%	1%
Sexual Orientation	**n = 250**	**n = 127**	**n = 121**
Bisexual	2%	2%	2%
Gay or Lesbian	0%	1%	1%
Heterosexual or Straight	94%	88%	86%
Pansexual	1%	1%	1%
Queer	1%	0%	0%
Questioning or Unsure	0%	0%	2%
Another Sexual Orientation	2%	8%	7%
Declined to State	--	--	1%
Disability*	**n = 87**	**n = 133**	**n = 105**
Mental Domain	92%	35%	74%
Seeing	5%	6%	26%
Hearing	0%	1%	11%
Other Communication	7%	2%	19%
Physical	1%	0%	7%
Chronic Health Condition	2%	0%	4%
Another Disability	0%	4%	4%
Declined to State	--	2%	4%
Veteran	**n = 280**	**n = 136**	**n = 135**
Yes	2%	1%	5%
No	98%	99%	94%
Declined to State	--	2%	1%

* Percentages may exceed 100% because participants could choose more than one response option.
-- Data not available.

Parent Education Program

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Participants who were enrolled in the Nurturing Parenting Program gained skills, tools, knowledge, and guidance.
- **FY 22–23:** The program provided a safe and welcoming space for community members to openly discuss their parenting concerns.
- **FY 23–24:** Participants reported happier relationships with their children, benefiting the community.

Achievements

- **FY 21–22:** Helped participants parent their children in a healthier and empathetic environment.
- **FY 22–23:** The organization successfully hosted its 6th Annual Parent University, attracting over 300 attendees.
- **FY 23–24:** Served 294 parents and caregivers, positively impacting 294 households.

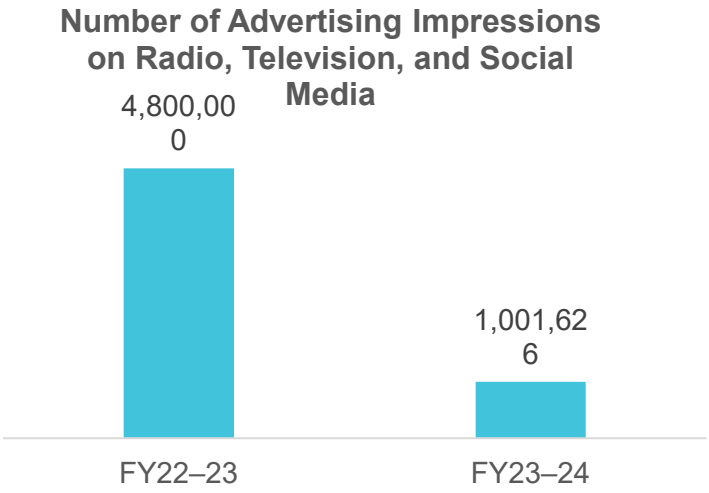
Challenges

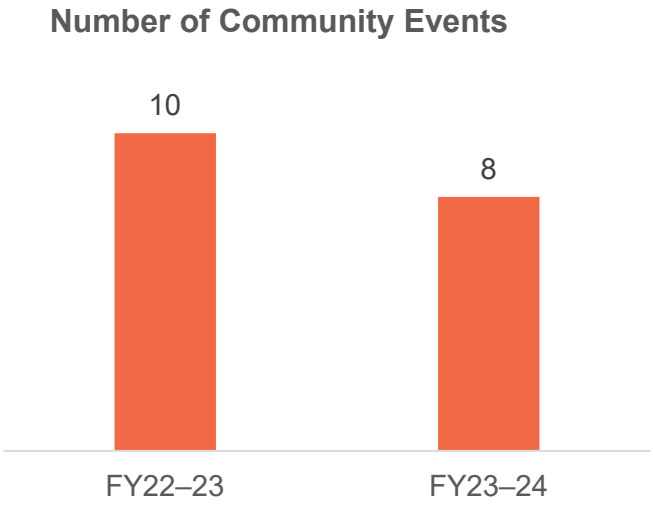
- **FY 23–24:** One enduring challenge is the shortage of staff. The program continues to work diligently to get the positions filled.

Culturally Specific Outreach and Engagement
COMMUNITY HUMAN SERVICES (CHS)

Community Human Services (CHS) Culturally Specific Outreach and Engagement, in partnership with Your Social Marketer (YSM), which entails the development and execution of a plan of culturally specific, bilingual outreach and community education strategies. These include social marketing campaigns, narrow casting, community presentations, outreach events and other promotional activities to engage historically underserved populations in identified priority geographic regions in mental health services to support their general health and well-being. Priority populations include Latino/a/e, Black/African American, and LGBTQ individuals in Gonzales, Castroville, and Seaside.

Program Highlights





Culturally Specific Outreach and Engagement

Outreach and Engagement

Culturally Specific Outreach and Engagement

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** 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.
- **FY 23–24:** Engaged at least 4–6 community events per quarter, targeting the Spanish-speaking population and community events.

Achievements

- **FY 22–23:** Multi-agency materials with the wellness4us and bienestarparati brands were developed and distributed in narrow casting, promoting the mental health services of several participating providers to the target populations.
- **FY 23–24:** Continued farmworker outreach efforts by attending lunch events every other week with locations spread throughout the county. Each lunch event had between 30–45 attendees.

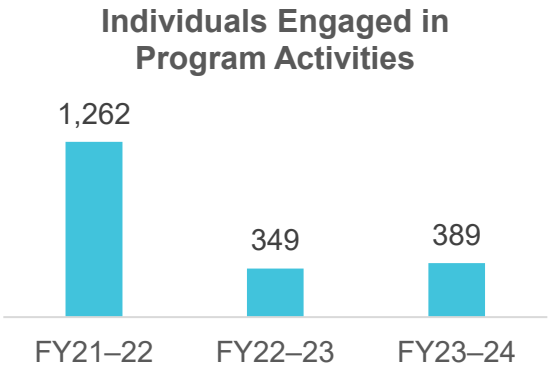
Challenges

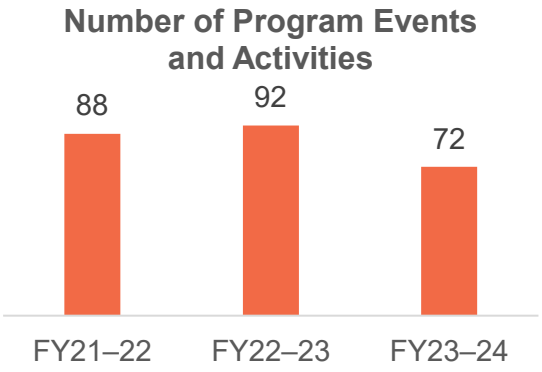
- **FY 23–24:** Not reported

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

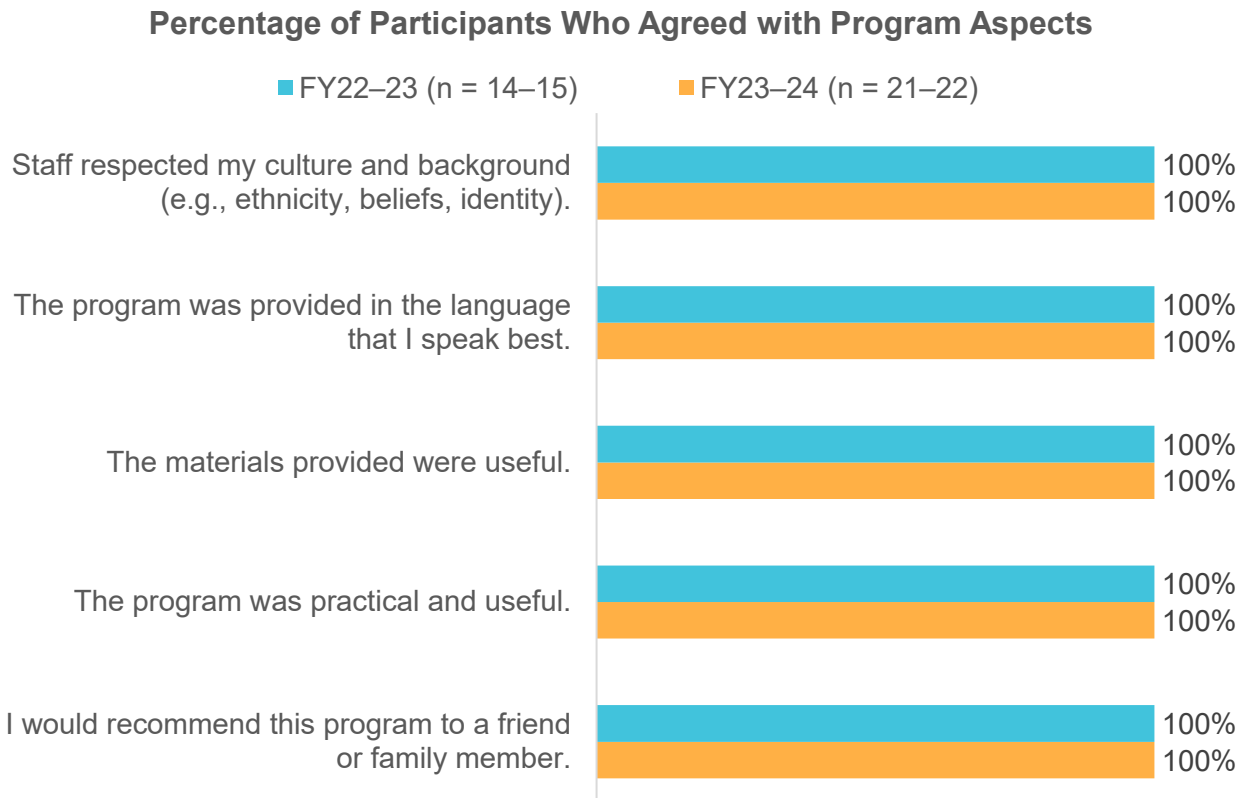




The Epicenter

Program Outcomes, Satisfaction, and Feedback

The Epicenter tracks program outcomes by asking participants to self-assess their satisfaction after receiving program services. Survey results for the past two fiscal years are presented in the chart below.



Note: This survey was not used in FY 21–22.

The Epicenter

Program Outcomes, Satisfaction, and Feedback

Participants who received services from The Epicenter were asked to give additional feedback through two open-ended questions. Their comments were categorized by theme, and the most common responses from the past two years are summarized below.

What was most useful or helpful about this program?

- FY 22–23: Learning about the influence of social media
- FY 23–24: Learning about gender identity and inclusivity

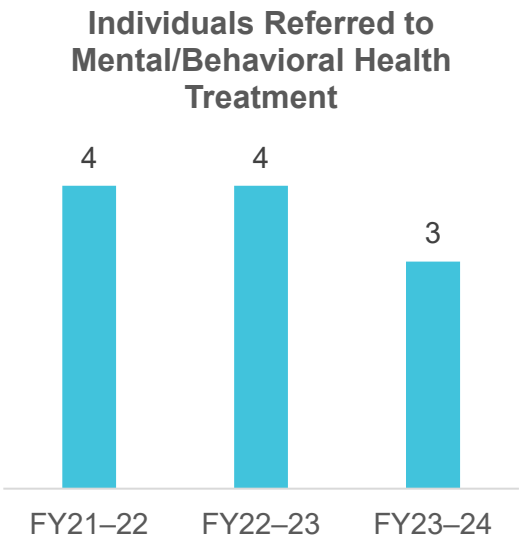
What are your recommendations for improvement?

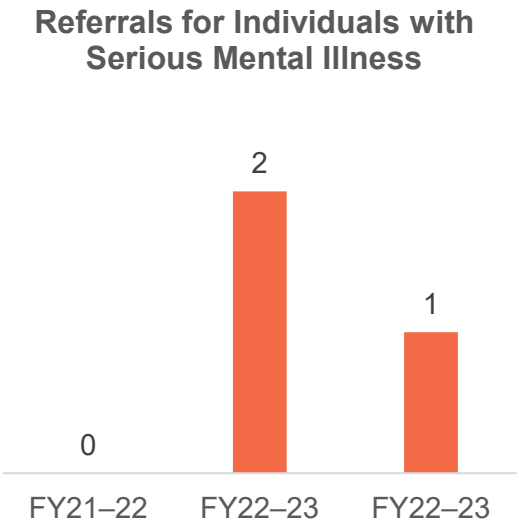
- FY 22–23: More resources to handle the technological aspects of the class
- FY 23–24: High satisfaction, with no major changes needed

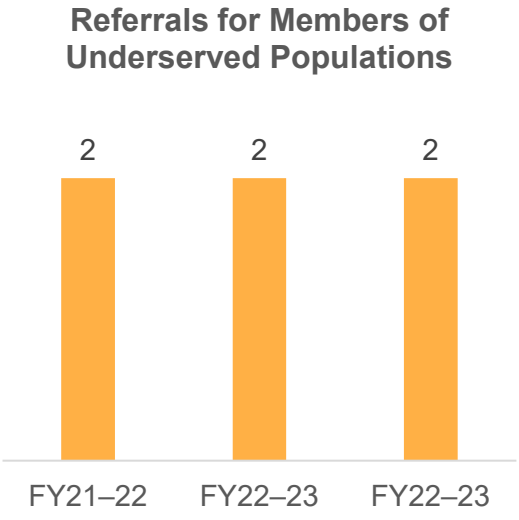
The Epicenter

Referrals

Program referrals encompass referrals to mental and behavioral health treatment. The figures below summarize the total number of program participants referred to these services over the past three fiscal years, including those with serious mental illnesses and those from underserved populations.







The Epicenter

Demographic Data

The Epicenter collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 125**	**n = 55**	**n = 51**
American Indian/Alaska Native	7%	2%	0%
Asian	4%	2%	4%
Black/African American	4%	4%	10%
Hispanic/Latino/a/e	68%	76%	73%
Native Hawaiian/Other Pacific Islander	0%	0%	0%
White	28%	16%	20%
Other	2%	0%	0%
More Than One Race	--	--	4%
Declined to State	3%	0%	0%
Ethnicity*	**n = 37**	**n = 40**	**n = 39**
Hispanic/Latino/a/e			
Caribbean	5%	0%	0%
Central American	0%	0%	3%
Mexican/Mex. Am./Chicano	63%	73%	37%
Puerto Rican	0%	0%	0%
South American	0%	8%	5%
Other Hispanic/Latino/a/e	0%	13%	13%
Non-Hispanic/Non-Latino/a/e			
African	5%	0%	10%
Asian Indian/South Asian	0%	0%	0%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	3%	3%	0%
European	22%	5%	3%
Filipino	5%	3%	0%
Japanese	3%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	0%	0%
Vietnamese	0%	0%	0%
Other Non-Hispanic/Non-Latino/a/e	3%	0%	0%
More Than One Ethnicity	0%	0%	5%
Declined to State	--	0%	0%
Age Groups	**n = 127**	**n = 53**	**n = 49**
0 to 15 years	2%	21%	22%
16–25 years	43%	60%	65%

	FY 21–22	FY 22–23	FY 23–24
26–59 years	47%	19%	10%
60+ years	8%	0%	2%
Primary Language*	**n = 126**	**n = 55**	**n = 51**
English	63%	53%	49%
Spanish	13%	7%	25%
English and Spanish	29%	38%	25%
Other	2%	2%	0%
Gender Identity*	**n = 40**	**n = 43**	**n = 45**
Female	50%	51%	49%
Genderqueer	10%	2%	0%
Male	28%	26%	33%
Nonbinary	18%	14%	4%
Questioning or Unsure	3%	2%	2%
Transgender	18%	5%	4%
Another Gender Identity	0%	2%	7%
Declined to State	--	2%	--
Sexual Orientation*	**n = 40**	**n = 43**	**n = 40**
Bisexual	18%	14%	15%
Gay or Lesbian	8%	16%	8%
Heterosexual or Straight	43%	35%	58%
Pansexual	18%	9%	13%
Queer	13%	9%	5%
Another Sexual Orientation	3%	5%	3%
Sex Assigned at Birth	**n = 40**	**n = 43**	**n = 42**
Female	68%	72%	69%
Male	32%	26%	31%
Another Sex Assigned	0%	0%	0%
Declined to State	--	2%	0%
Disability*	**n = 21**	**n = 43**	**n = 10**
Mental Domain	100%	63%	10%
Seeing	14%	0%	30%
Hearing	5%	2%	10%
Other Communication	0%	0%	0%
Physical	10%	2%	0%
Chronic Health Condition	10%	2%	30%
Another Disability	10%	2%	20%
Veteran	**n = 40**	**n = 43**	**n = 43**
Yes	0%	0%	0%
No	100%	100%	98%
Declined to State	--	--	2%

* Percentages may exceed 100% because participants could choose more than one response option.
-- Data not available.

The Epicenter

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Our queer/trans youth collective built a network for our youth leaders to continue developing leadership and life skills.
- **FY 22–23:** A culture of support was created between program staff, youth staff, and drop-in youth participants.
- **FY 23–24:** Our team of peer supporters were able to use their lived experience to help youth their age navigate similar experiences.

Achievements

- **FY 21–22:** Invited to provide LGBTQ+ sensitivity trainings for staff and faculty of Salinas City Elementary School District schools.
- **FY 22–23:** Hosted several community health events centered on topics such as mental health strategies and services, MPox awareness, and HIV/AIDS awareness and risk reduction.
- **FY 23–24:** Members of QTYC were interviewed by KAZU for a story on "Trans Day of Visibility," lending credibility to our agency being a place to learn and participate in the LGBTQ+ community.

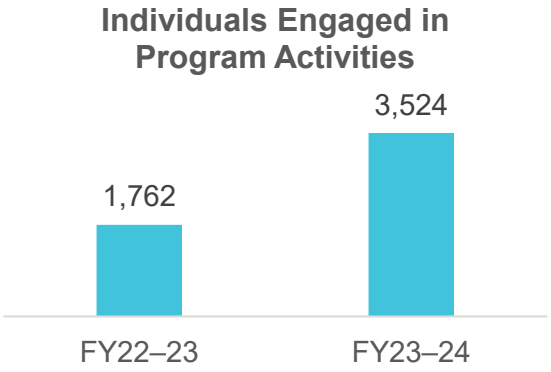
Challenges

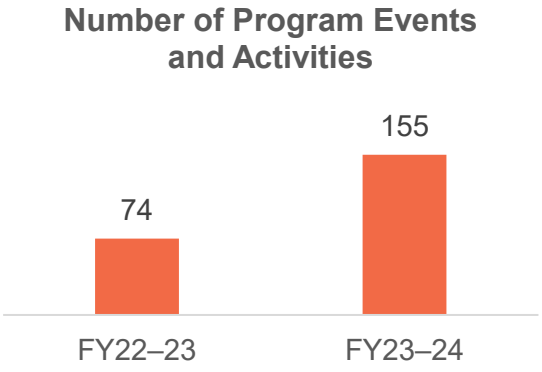
- **FY 23–24:** There has been an increase in community requests for our outreach and services. With our moderately small team, we have had to be resourceful with our staff's time and our resources in order to ensure our agency has a presence in all of the community events we have been invited to. We have been happy to come across this challenge as we are striving to increase awareness of our agency's services and resources here in Monterey County.

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.

Program Highlights





Bullying Prevention Program

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** Coordinated "Pink Shirt Day" to raise anti-bullying awareness.
- **FY 23–24:** Over 700 students participated in Pink Shirt Day in schools and at a community event.

Achievements

- **FY 22–23:** Established strong partnerships with administration and staff at assigned school sites throughout the school year.
- **FY 23–24:** Bilingual coaches increased the speed and efficiency of communication between our team and those we support.

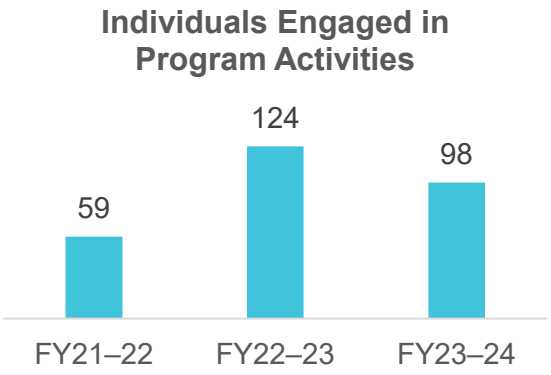
Challenges

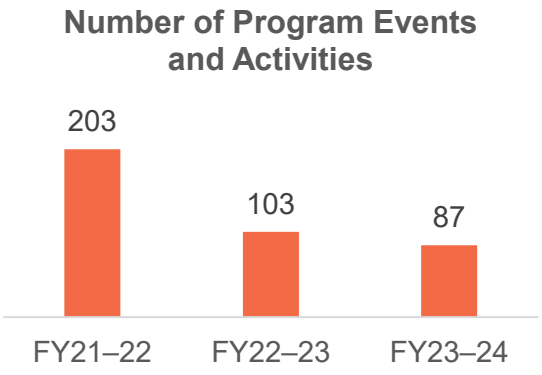
- **FY 23–24:** Our program is new to all four schools we are working with this year which presents challenges of overcoming stigma about reporting unacceptable behaviors and creating a positive school culture.

Teen Success, Inc.
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





Teen Success, Inc.

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Peer group sessions were an essential program component since they allowed program participants to gather support from one another while strengthening their parenting and self-care skills.
- **FY 22–23:** Engaged in community outreach.
- **FY 23–24:** Education for teen parents provided.

Achievements

- **FY 21–22:** Advocates facilitated peer group sessions, fostering participation and positive outcomes like reduced isolation and a supportive, safe space for improving parenting and self-care.
- **FY 22–23:** Prioritized professional development to support members on their educational journeys.
- **FY 23–24:** Implemented Wellness Checks and Self-Sufficiency scales which helped us better support our members.

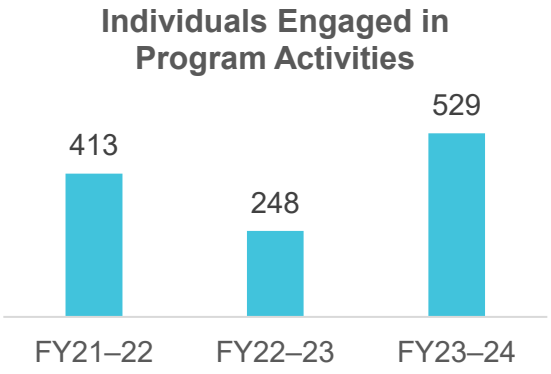
Challenges

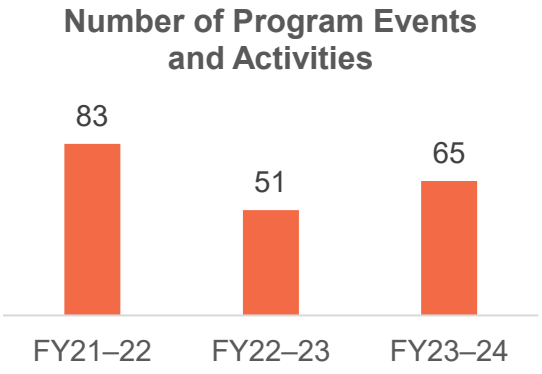
- **FY 23–24:** Have had difficulty connecting members to services due to limited access to transportation. We are working with the county to find solutions.

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 Latino/a/e 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. The primary goal of the program is to increase participants' knowledge and understanding of how being attuned with 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

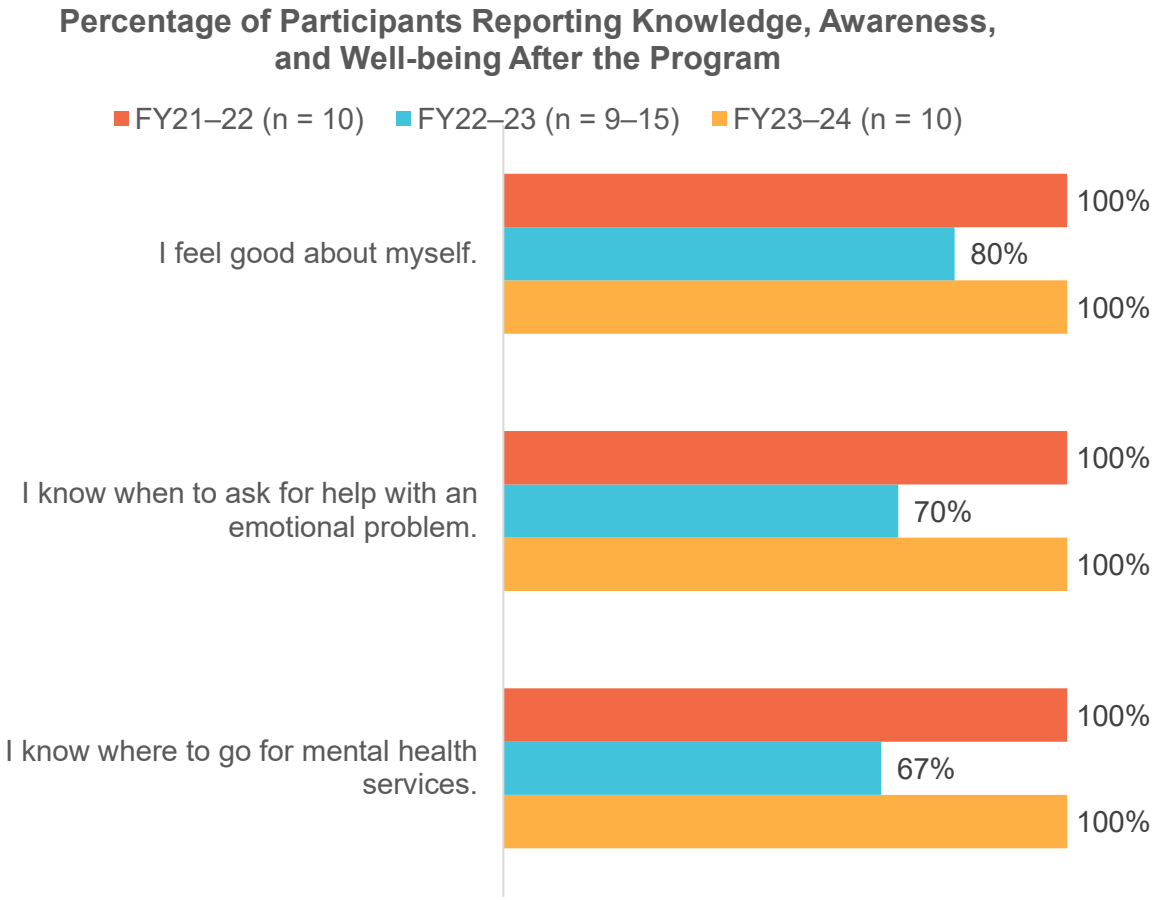




Maternal Mental Health (MMH)

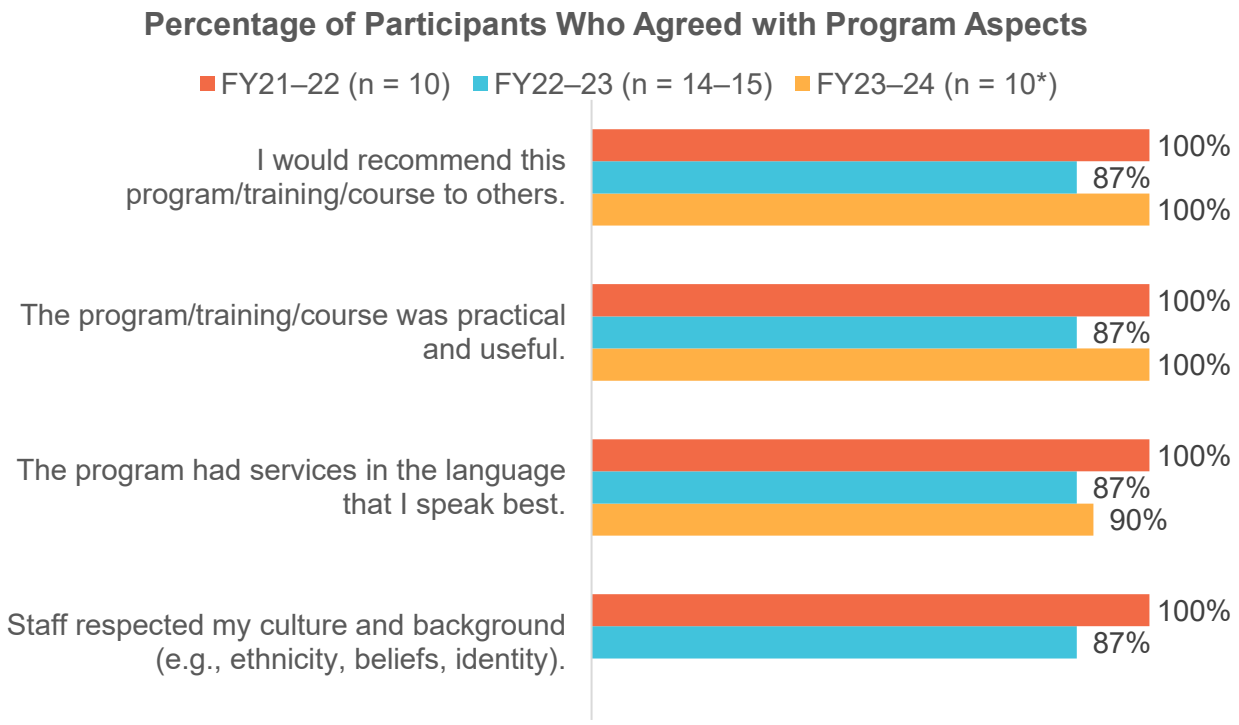
Program Outcomes, Satisfaction, and Feedback

Maternal Mental Health tracks program outcomes by asking participants to self-assess their knowledge and satisfaction after receiving program services. Survey results for the past three years are presented in the charts below. Only survey items available across all three fiscal years are reported on in this section.



Maternal Mental Health (MMH)

Program Outcomes, Satisfaction, and Feedback



* Items with fewer than 10 responses were not analyzed.

Participants who received services from Maternal Mental Health Pop-Up and Play events were asked to give additional feedback through two open-ended questions. Their comments were categorized by theme, and the most common responses from the past two years are summarized below.

What was most useful or helpful about this program?

- FY 22–23: The social skills their children learn
- FY 23–24: Child development and social interaction

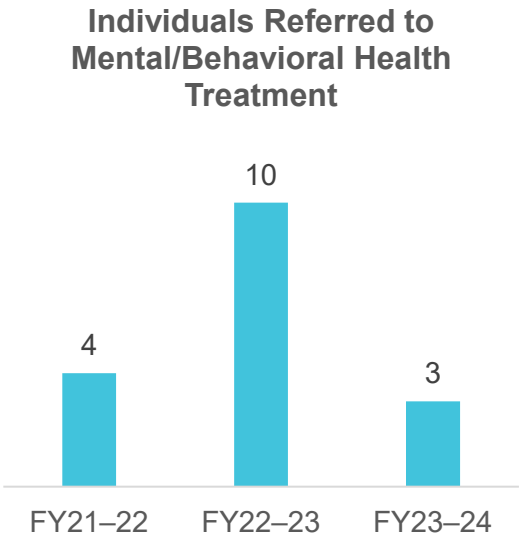
What are your recommendations for improvement?

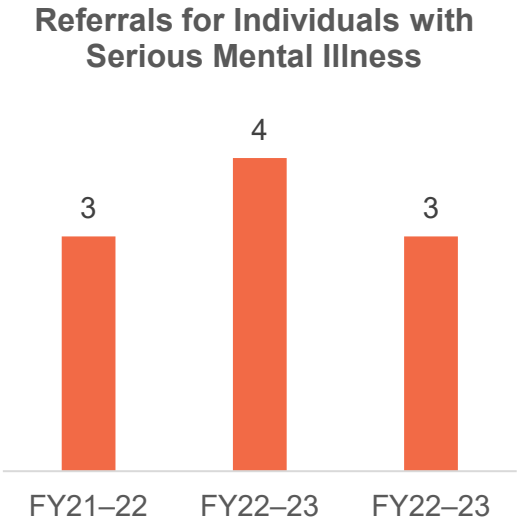
- FY 22–23: Promote services more widely
- FY 23–24: More opportunities for interaction and socialization

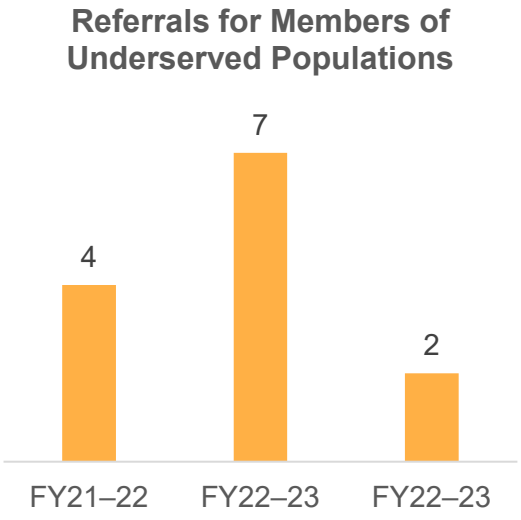
Maternal Mental Health (MMH)

Referrals

Maternal Mental Health makes referrals to mental health treatment and services for program participants. The figures below summarize the total number of program participants referred to these services over the past three fiscal years, including those with serious mental illnesses and those from underserved populations.







Maternal Mental Health (MMH)

Demographic Data

Maternal Mental Health collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 15**	**n = 13**	**n = 10**
American Indian/Alaska Native	0%	0%	0%
Asian	0%	0%	0%
Black/African American	0%	0%	0%
Hispanic/Latino/a/e	87%	100%	80%
Native Hawaiian/Other Pacific Islander	0%	0%	0%
White	13%	0%	0%
More Than One Race	0%	0%	0%
Other	0%	0%	20%
Age Groups	**n = 15**	**n = 12**	**n = 11**
0 to 15 years	13%	33%	18%
16–25 years	13%	0%	9%
26–59 years	74%	67%	73%
60+ years	0%	0%	0%
Declined to State	--	2%	--
Primary Language*	**n = 15**	**n = 14**	**n = 16**
English	20%	7%	9%
Spanish	67%	79%	73%
English and Spanish	20%	14%	0%
Other	--	--	18%

* Percentages may exceed 100% because participants could choose more than one response option.
-- Data not available.

Maternal Mental Health (MMH)

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Mothers felt safe expressing worries about their children's development.
- **FY 22–23:** Pop-Up and Play groups supported mothers' mental health and reduced stigma.
- **FY 23–24:** High client satisfaction led participants to share and invite friends and family members to participate in the Pop-Up and Play group.

Achievements

- **FY 21–22:** Not reported
- **FY 22–23:** The team organized an event for participants to share birth stories and discuss pregnancy challenges, and also promoted mental health resources at the Birth and Baby Fair.
- **FY 23–24:** Continued to have a close collaborative relationship with WIC. They continued to support and refer families to the Pop-Up and Play group. This also provided opportunities to reach directly to mothers in the perinatal period.

Challenges

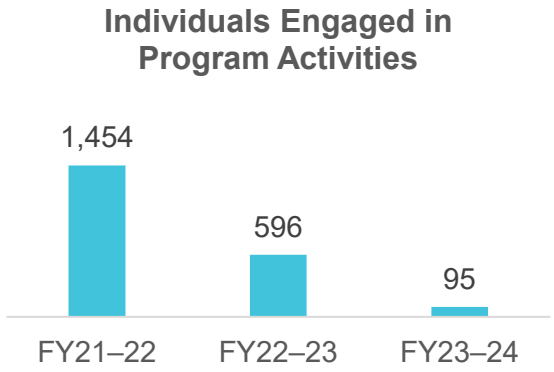
- **FY 23–24:** Playgroup attendance has continued to be a challenge this quarter in both Pop-Up and Play Alisal Integrated Health Center (AIHC) and Structured Dyadic Playgroup in King City. One potential reason is due to the change of location from WIC to AIHC.

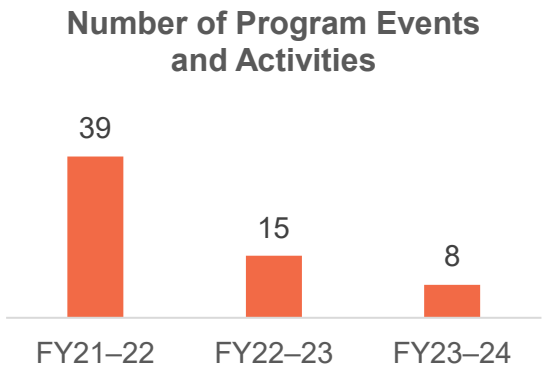
Proyecto Contigo and School-Based Counseling PAJARO VALLEY PREVENTION AND STUDENT ASSISTANCE

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. Through the Promotora's engagement efforts, the Promotora also provides linkages to youth- and family-specific community resources and services.

Program Highlights





Proyecto Contigo and School-Based Counseling

Demographic Data

Proyecto Contigo and School-Based Counseling collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 79**	**n = 65**	**n = 495**
American Indian/Alaska Native	0%	0%	0%
Asian	0%	0%	0%
Black/African American	0%	0%	0%
Hispanic/Latino/a/e	100%	100%	91%
Native Hawaiian/Other Pacific Islander	0%	0%	0%
White	0%	0%	0%
More Than One Race	0%	0%	0%
Other	0%	0%	9%
Declined to State	--	--	0%
Age Groups	**n = 81**	**n = 65**	**n = 503**
0 to 15 years	0%	0%	20%
16–25 years	24%	6%	13%
26–59 years	75%	80%	62%
60+ years	1%	14%	5%
Declined to State	--	3%	--
Primary Language*	**n = 81**	**n = 62**	**n = 429**
English	0%	0%	4%
Spanish	95%	97%	85%
English and Spanish	4%	3%	15%
Other	52%	0%	0%
Declined to State	--	--	--
Gender Identity	**n = 71**	**n = 18**	**n = --**
Female	54%	94%	--
Genderqueer	0%	0%	--
Male	46%	6%	--
Nonbinary	0%	0%	--
Questioning or Unsure	0%	0%	--
Transgender	0%	0%	--
Another Gender Identity	0%	0%	--
Declined to State	--	--	--
Sex Assigned at Birth	**n = 130**	**n = 18**	**n = 54**
Female	55%	94%	54%
Male	45%	6%	46%
Another Sex Assigned	0%	0%	0%

	FY 21–22	FY 22–23	FY 23–24
Declined to State	--	--	--

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

-- Data not available.

Proyecto Contigo and School-Based Counseling

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Built relationships with the community-based partners.
- **FY 22–23:** Remained adaptable and flexible to meet the needs of the community.
- **FY 23–24:** Program staff developed activities and events based on the feedback and needs of the community being served, making community members feel heard and enjoy participating in program activities.

Achievements

- **FY 21–22:** Not reported
- **FY 22–23:** Reached more participants through presentations, and adapted materials to be relevant to immediate crises faced by community members.
- **FY 23–24:** Program staff developed an activity (Padres Con Poder) based on feedback from parents who wanted to create change and support by bringing awareness to other community members around issues of mental health, resources, and programming available to support families.

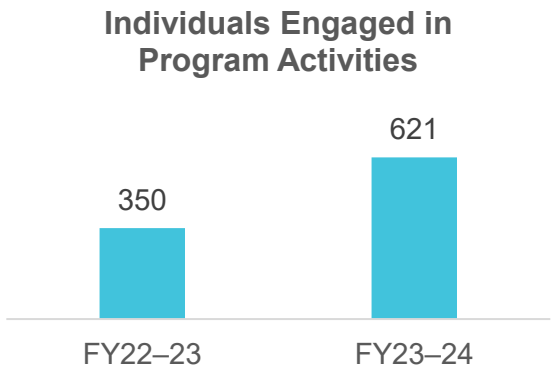
Challenges

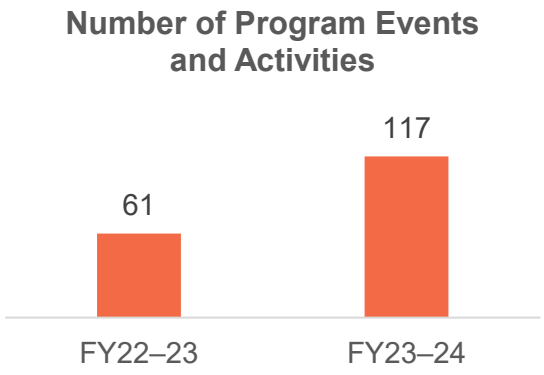
- **FY 23–24:** Finding ways to engage new community members who have not participated in any program workshops or events.

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

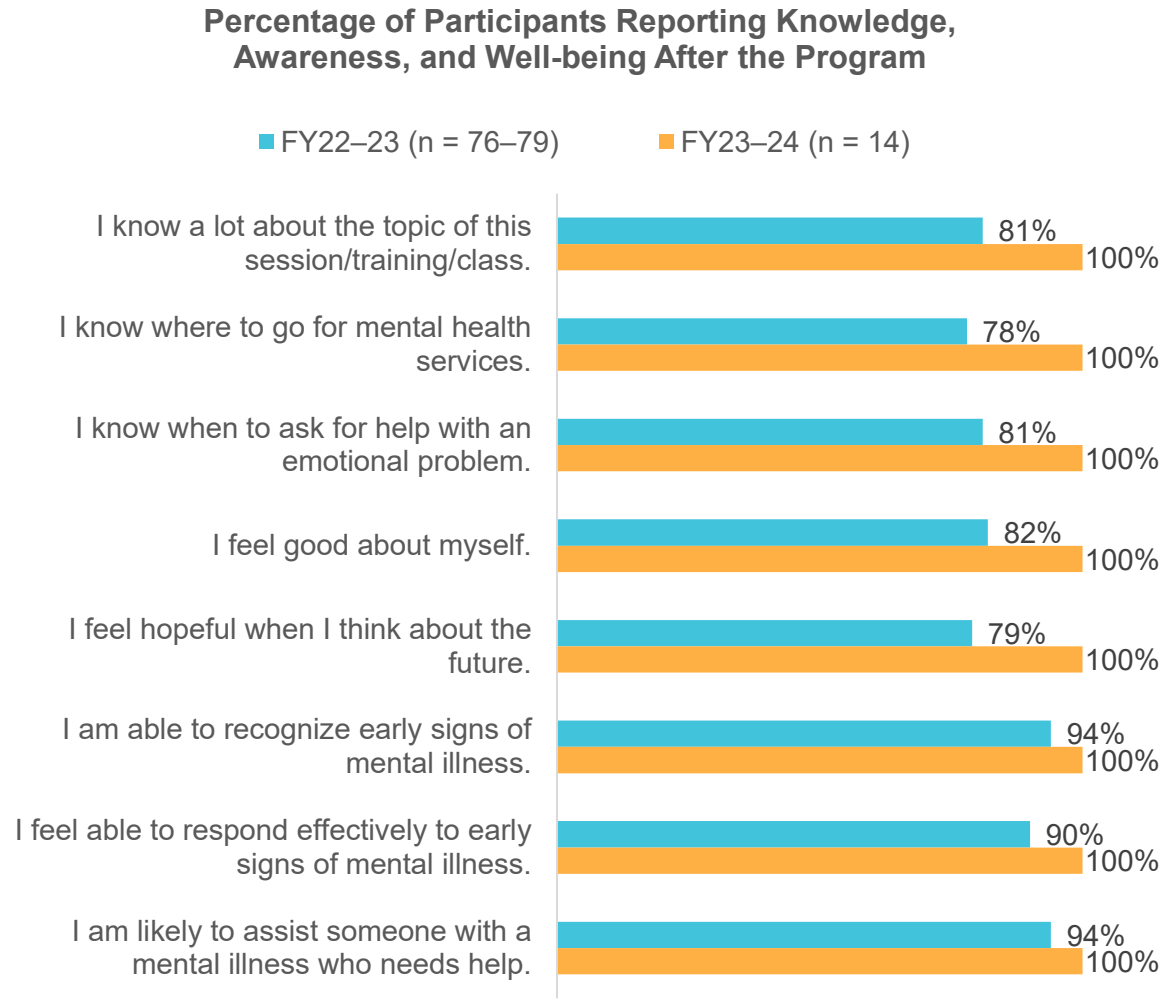




Maternal Mental Health Peer Navigation Program

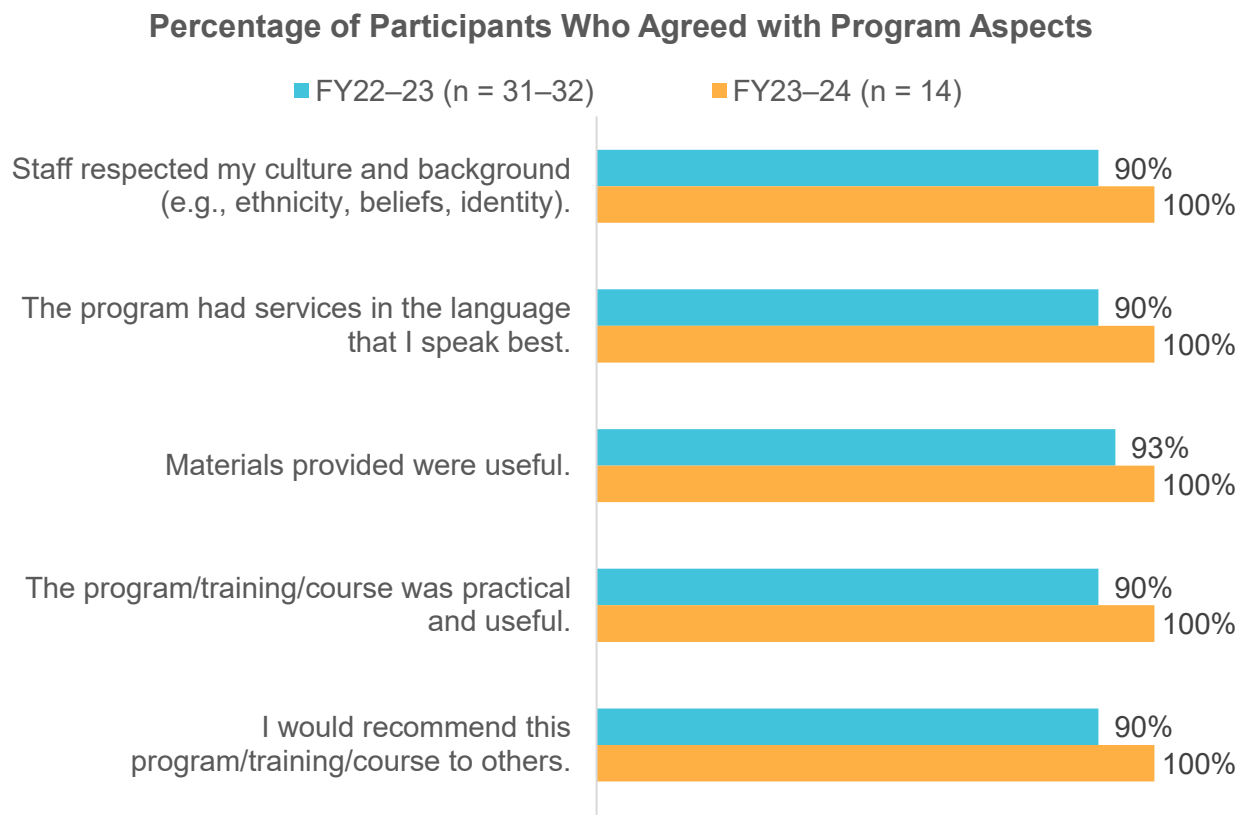
Program Outcomes, Satisfaction, and Feedback

Maternal Mental Health Peer Navigation Program tracks program outcomes by asking participants to self-assess their knowledge and satisfaction after receiving program services. Survey results for the past two fiscal years are presented in the charts below.



Maternal Mental Health Peer Navigation Program

Program Outcomes, Satisfaction, and Feedback



Participants who received services from Maternal Mental Health Peer Navigation Program were asked for their recommendations for improving the program.

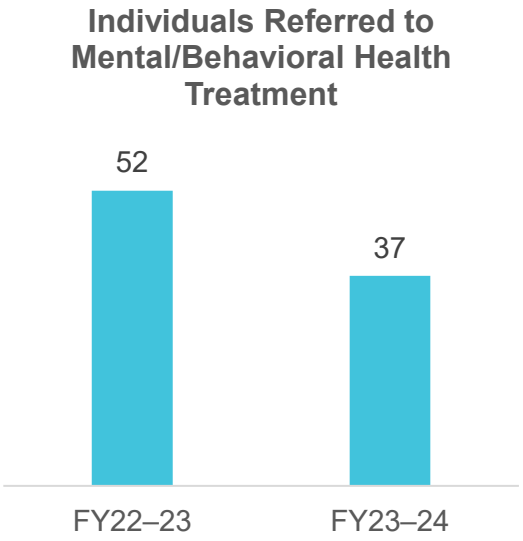
What are your recommendations for improvement?

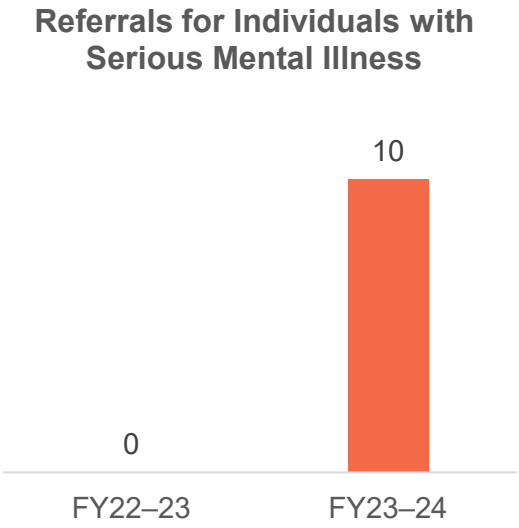
- FY 22–23: Greater frequency/duration/locations
- FY 23–24: More detailed information on program offerings

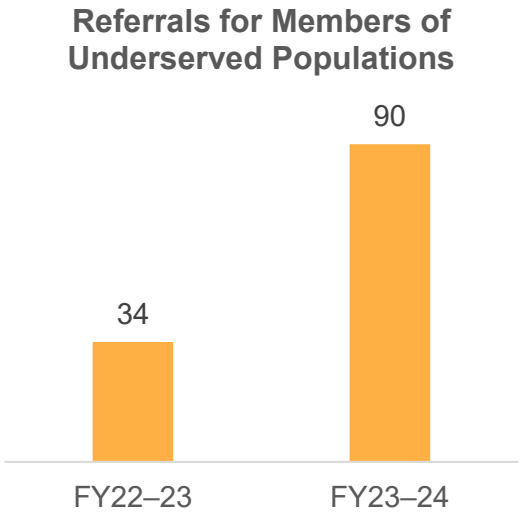
Maternal Mental Health Peer Navigation Program

Referrals

Maternal Mental Health Peer Navigation Program makes referrals to mental health treatment and services for program participants. The figures below summarize the total number of program participants referred to these services over the past two fiscal years, including those with serious mental illnesses and those from underserved populations.







Maternal Mental Health Peer Navigation Program

Demographic Data

Maternal Mental Health Peer Navigation Program collects unduplicated demographic data from the individuals they serve.

	FY 22–23	FY 23–24
Race*	**n = 103**	**n = 43**
American Indian/Alaska Native	0%	0%
Asian	5%	0%
Black/African American	6%	0%
Hispanic/Latino/a/e	56%	63%
Native Hawaiian/Other Pacific Islander	1%	0%
White	34%	37%
More Than One Race	--	2%
Other	3%	0%
Declined to State	1%	2%
Ethnicity*	**n = 81**	**n = 27**
Hispanic/Latino/a/e		
Caribbean	0%	0%
Central American	0%	4%
Mexican/Mex. Am./Chicano	60%	68%
Puerto Rican	1%	0%
South American	3%	0%
Other Hispanic/Latino/a/e	8%	11%
Non-Hispanic/Non-Latino/a/e		
African	0%	0%
Asian Indian/South Asian	1%	0%
Cambodian	0%	0%
Chinese	0%	0%
Eastern European	1%	4%
European	18%	4%
Filipino	1%	0%
Japanese	0%	0%
Korean	0%	0%
Middle Eastern	3%	0%
Vietnamese	1%	0%
Other Non-Hispanic/Non-Latino/a/e	7%	0%
More Than One Ethnicity	0%	4%
Declined to State	7%	14%
Age Groups	**n = 100**	**n = 38**

	FY 22–23	FY 23–24
0 to 15 years	3%	5%
16–25 years	18%	29%
26–59 years	76%	61%
60+ years	3%	5%
Declined to State	2%	
Primary Language*	**n = 103**	**n = 43**
English	53%	65%
Spanish	2%	19%
English and Spanish	25%	16%
Other	25%	0%
Declined to State	1%	--
Gender Identity	**n = 86**	**n = 29**
Female	87%	100%
Genderqueer	0%	0%
Male	11%	0%
Nonbinary	1%	0%
Questioning or Unsure	0%	0%
Transgender	0%	0%
Another Gender Identity	0%	0%
Declined to State	2%	0%
Sexual Orientation	**n = 82**	**n = 24**
Bisexual	1%	0%
Gay or Lesbian	1%	0%
Heterosexual or Straight	76%	96%
Pansexual	1%	0%
Queer	2%	0%
Questioning or Unsure	1%	0%
Another Sexual Orientation	0%	0%
Declined to State	--	4%
Sex Assigned at Birth	**n = 86**	**n = 29**
Female	85%	100%
Male	10%	0%
Another Sex Assigned	0%	0%
Declined to State	2%	0%
Disability*	**n = 86**	**n = 29**
Mental Domain	41%	25%
Seeing	2%	50%
Hearing	0%	0%
Other Communication	0%	0%
Physical	0%	0%
Chronic Health Condition	3%	25%
Another Disability	1%	0%

	FY 22–23	FY 23–24
Veteran	**n = 87**	**n = 28**
Yes	2%	4%
No	98%	96%
Declined to State	2%	0%

* Percentages may exceed 100% because participants could choose more than one response option.
-- Data not available

Maternal Mental Health Peer Navigation Program

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** Secured spaces and partnered with various organizations to offer Spanish-language Maternal Mental Health program services.
- **FY 23–24:** New program coordinator attended nearly 20 outreach events and reached close to 1,000 community members.

Achievements

- **FY 22–23:** Partnerships led to requests for Maternal Mental Health program presentations, expansion to new locations, and increased awareness of our services.
- **FY 23–24:** A surge in outreach efforts also led to a rise in warmline calls, indicating heightened community engagement and awareness of available services.

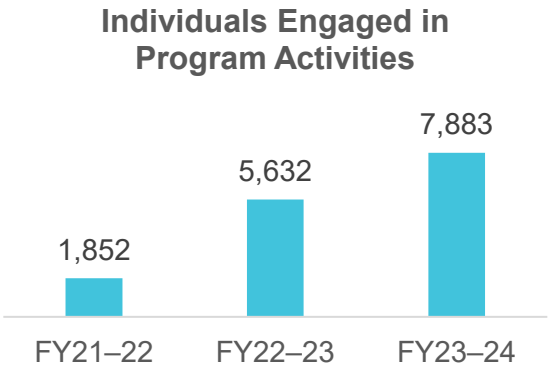
Challenges

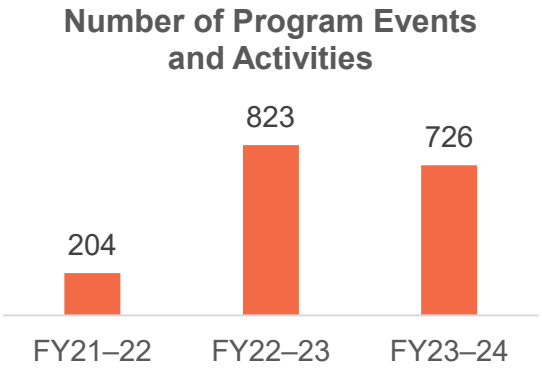
- **FY 23–24:** Consistent participation in Family Circles continues to be a challenge.

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

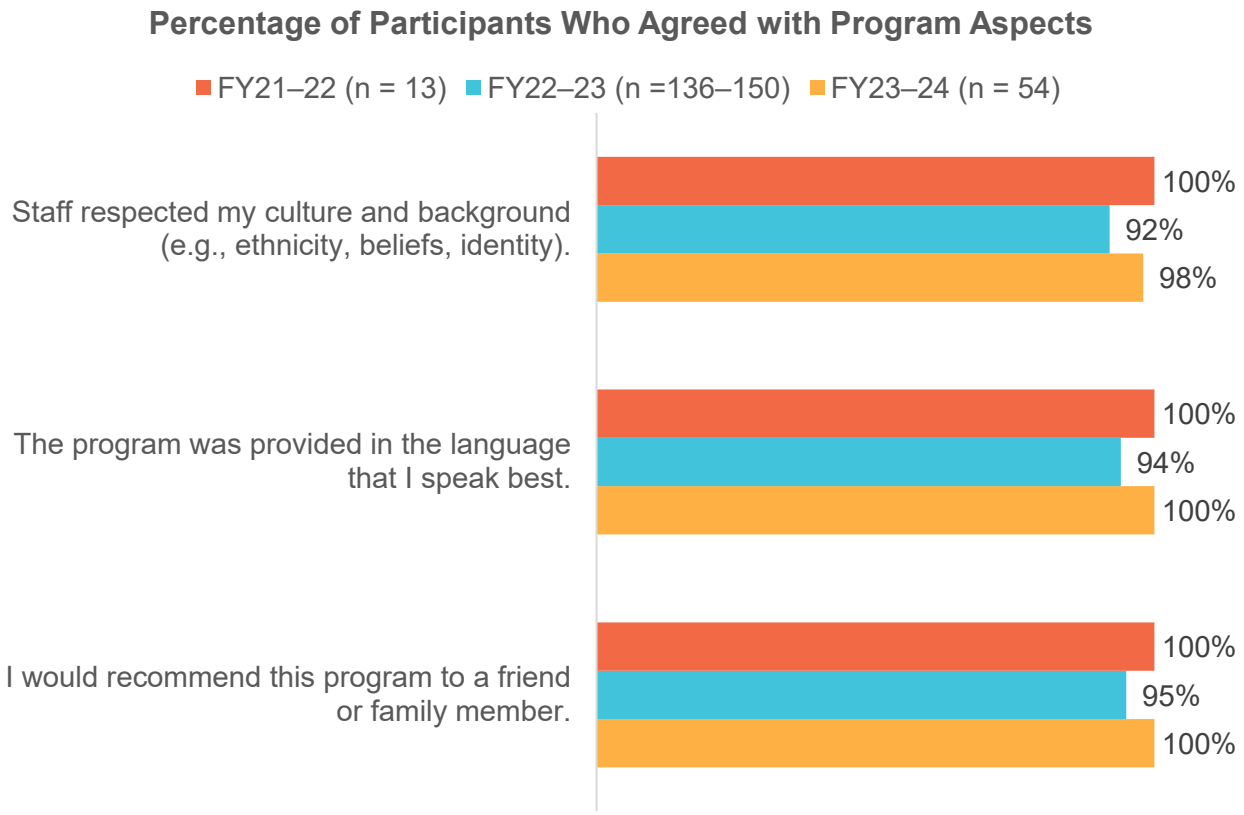




Culturally Relevant Parenting Classes

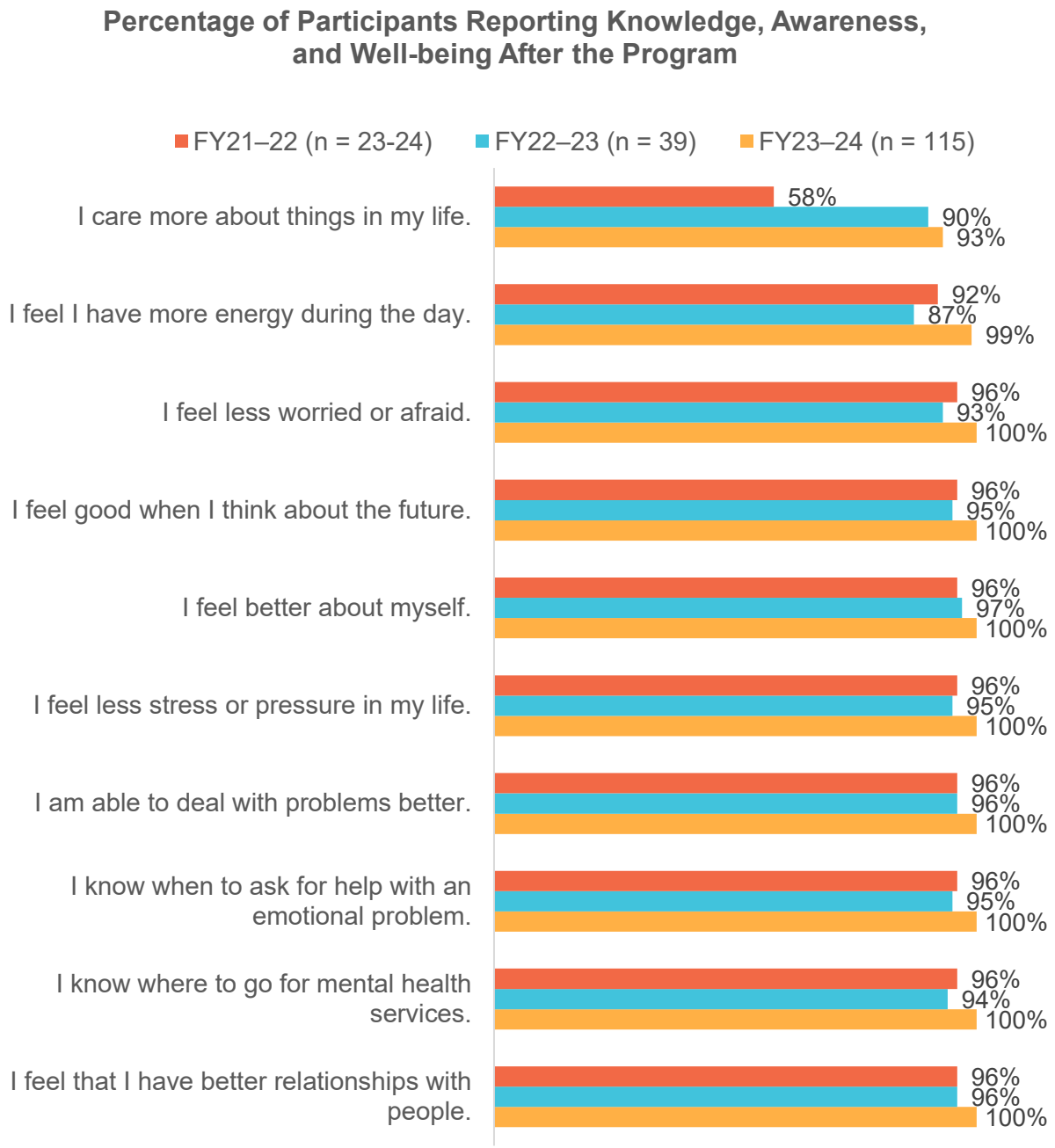
Program Outcomes, Satisfaction, and Feedback

Partners for Peace tracks program outcomes by asking participants to self-assess their knowledge and satisfaction after receiving program services. Survey results for the past three fiscal years are presented in the charts below.



Culturally Relevant Parenting Classes

Program Outcomes, Satisfaction, and Feedback



Culturally Relevant Parenting Classes

Demographic Data

Partners for Peace collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 85**	**n = 796**	**n = 1,102**
American Indian/Alaska Native	4%	1%	<1%
Asian	4%	1%	1%
Black/African American	2%	2%	1%
Hispanic/Latino/a/e	88%	69%	82%
Native Hawaiian/Other Pacific Islander	2%	0%	<1%
White	6%	12%	8%
More Than One Race	0%	3%	1%
Other	1%	1%	1%
Declined to State	--	11%	5%
Ethnicity*	**n = 80**	**n = 796**	**n = 1,102**
Hispanic/Latino/a/e			
Caribbean	0%	--	<1%
Central American	1%	2%	1%
Mexican/Mex. Am./Chicano	91%	60%	76%
Puerto Rican	0%	0%	1%
Other Hispanic/Latino/a/e	1%	10%	6%
Non-Hispanic/Non-Latino/a/e			
African	0%	1%	<1%
Asian Indian/South Asian	0%	0%	0%
Cambodian	--	--	--
Chinese	3%	0%	<1%
Eastern European	0%	0%	1%
European	1%	3%	2%
Filipino	0%	1%	1%
Japanese	--	0%	--
Korean	--	0%	--
Middle Eastern	0%	0%	<1%
Vietnamese	--	--	--
Other Non-Hispanic/Non-Latino/a/e	6%	3%	2%
More Than One Ethnicity	0%	4%	2%
Declined to State	--	14%	7%
Age Groups	**n = 83**	**n = 767**	**n = --¤**
0 to 15 years	6%	8%	--
16–25 years	7%	14%	--

	FY 21–22	FY 22–23	FY 23–24
26–59 years	83%	76%	--
60+ years	4%	2%	--
Primary Language*	**n = 87**	**n = 769**	**n = 1,102**
English	25%	38%	50%
Spanish	61%	45%	35%
English and Spanish	11%	9%	11%
Other	3%	2%	2%
Declined to State	--	5%	1%
Gender Identity	**n = 89**	**n = --¤**	**n = 1,102**
Female	69%	--	61%
Genderqueer	0%	--	0%
Male	31%	--	36%
Nonbinary	0%	--	<1%
Questioning or Unsure	0%	--	<1%
Transgender	0%	--	<1%
Another Gender Identity	0%	--	0%
Declined to State	--	--	2%
Sexual Orientation	**n = 48**	**n = 769**	**n = 1,102**
Bisexual	0%	1%	15%
Gay or Lesbian	0%	0%	1%
Heterosexual or Straight	100%	66%	83%
Pansexual	0%	--	0%
Queer	0%	0%	<1%
Questioning or Unsure	0%	--	<1%
Another Sexual Orientation	0%	1%	<1%
Declined to State	--	32%	0%
Sex Assigned at Birth	**n = 87**	**n = 769**	**n = 1,102**
Female	84%	68%	61%
Male	16%	24%	37%
Another Sex Assigned	0%	0%	0%
Declined to State	--	7%	2%
Disability*	**n = 5¬**	**n = 70**	**n = 24**
Mental Domain	--	19%	100%
Seeing	--	0%	--
Hearing	--	0%	--
Other Communication	--	0%	--
Physical	--	0%	--
Chronic Health Condition	--	0%	--
Another Disability	--	1%	--
Declined to State	--	8%	--
Veteran	**n = 88**	**n = 769**	**n = 1,102**
Yes	0%	1%	1%

	FY 21–22	FY 22–23	FY 23–24
No	100%	99%	99%
Declined to State	--	6%	--

* Percentages may exceed 100% because participants could choose more than one response option.
▪ Category not available for that fiscal year.
¬ Demographics with fewer than 10 responses are not reported.
-- Data not available.

Culturally Relevant Parenting Classes

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Parents and caregivers reported increased communication and bonding with their youth.
- **FY 22–23:** Parents reported increased youth adherence to family rules, increased family activities, improved school attendance, and enhanced youth-parent communication.
- **FY 23–24:** A recruitment campaign for new coaches yielded a great response, bolstering the organization's capacity.

Achievements

- **FY 21–22:** First post-pandemic in-person classes offered.
- **FY 22–23:** Despite challenges (atmospheric rivers, power outages, class cancellations, etc.) 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.
- **FY 23–24:** The graduation rate for participants completing 8 out of 10 classes reached 78%, while full-time staff retention over the past 15 months was at 100%, indicating program effectiveness and staff satisfaction.

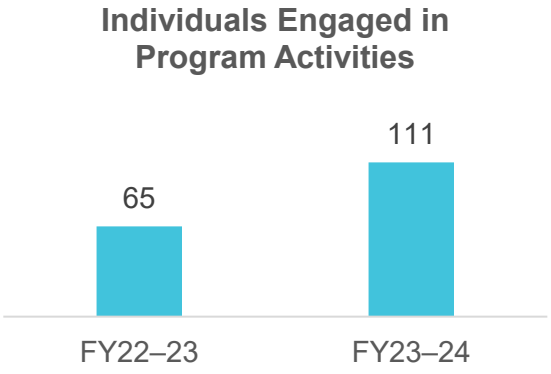
Challenges

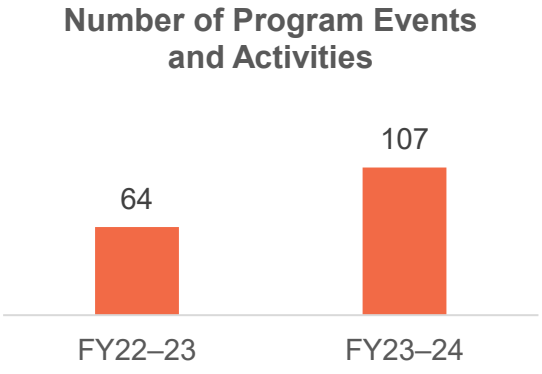
- **FY 23–24:** Date changes of classes cause extra work. Anytime a class in a class series is cancelled it leads to extra staff work to retain participants.

Maternal, Child and Adolescent Health Home Visiting Program
PUBLIC HEALTH BUREAU

The Maternal, Child and Adolescent Health (MCAH) Home Visiting 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





Maternal, Child and Adolescent Health Home Visiting Program

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** The program worked to increase presence in the community to generate more referrals.
- **FY 23–24:** Public Health Nurses were made available to refer clients with severe depression and anxiety (identified through PHQ9/GAD7 screening tools) to Monterey County Behavioral Health for specialized mental health services.

Achievements

- **FY 22–23:** Presented at WIC pregnancy classes to introduce the program to potential clients.
- **FY 23–24:** Hiring two additional Public Health Nurses (PHNs) into the MHSA program ensured full staffing, enhancing program capacity and service delivery.

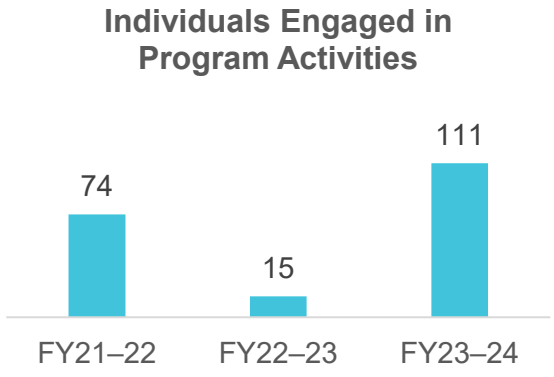
Challenges

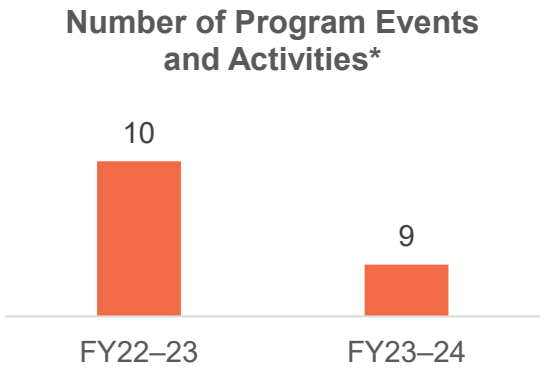
- **FY 23–24:** We experienced a loss of institutional knowledge through an employee's retirement that would have benefited new Public Health Nurses during their onboarding and training process.

Senior Companion Program
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 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





* *Number of activities for FY 21–22 not available.*

Senior Companion Program

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Companions maintained contact via phone or video calls through the pandemic to support their clients' mental health.
- **FY 22–23:** Companions started visiting clients in person after COVID restrictions were lifted.
- **FY 23–24:** The AmeriCorps Seniors Senior Companion Program allowed our Companions to visit their clients in person, and provide transportation to senior clients to shop, get medicine or see a doctor, or even go to the park to get out of the house.

Achievements

- **FY 21–22:** Not reported
- **FY 22–23:** Older adults were actively engaged with the program's outreach materials.
- **FY 23–24:** AmeriCorps was hard hit after COVID-19. Since then, wepartnered with Del Mar Resource Center, and some senior volunteers were placed.

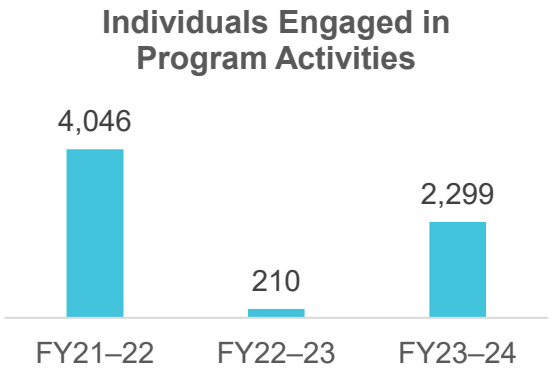
Challenges

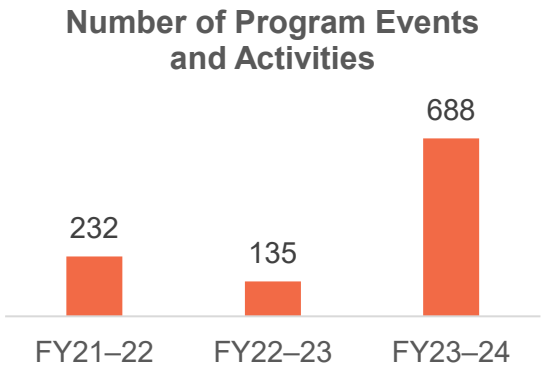
- **FY 23–24:** After the COVID-19 pandemic, we went through many transitions in the agency (from a change in a director, to a change in the Program Coordinator position, to a change in the Program Specialist position). This delayed placement of the Senior Companions, and ultimately impacted a growing partnership created with MCBH.

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

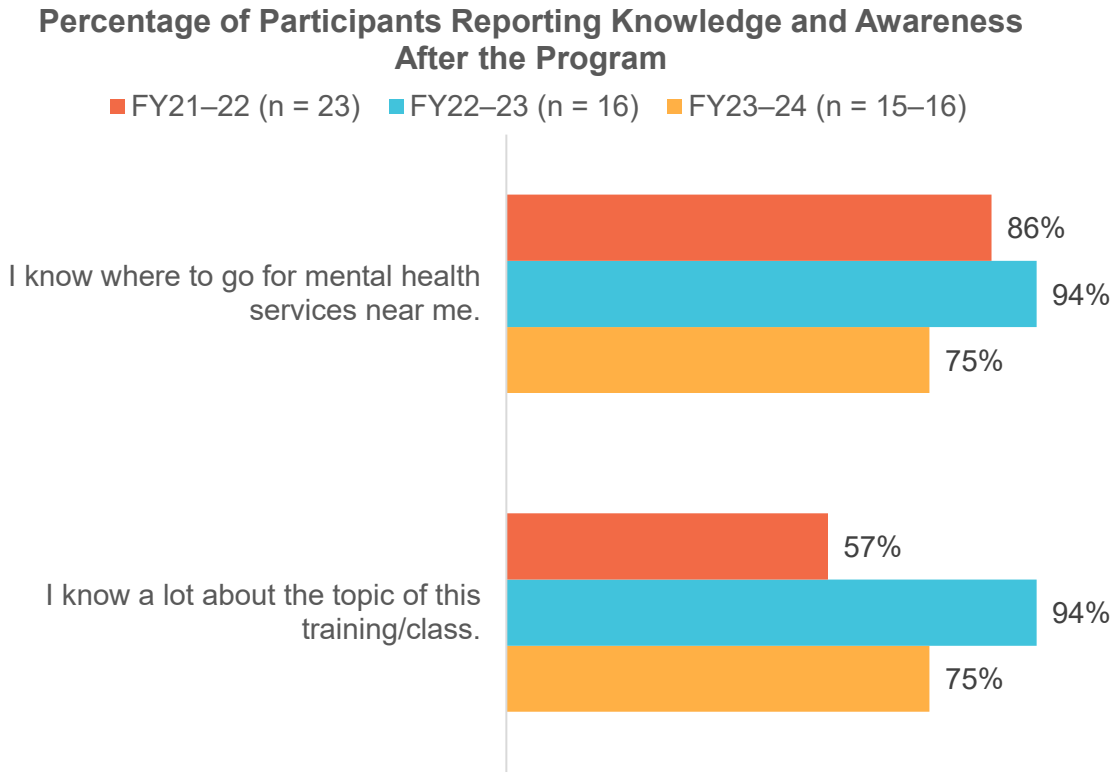




Services to Education

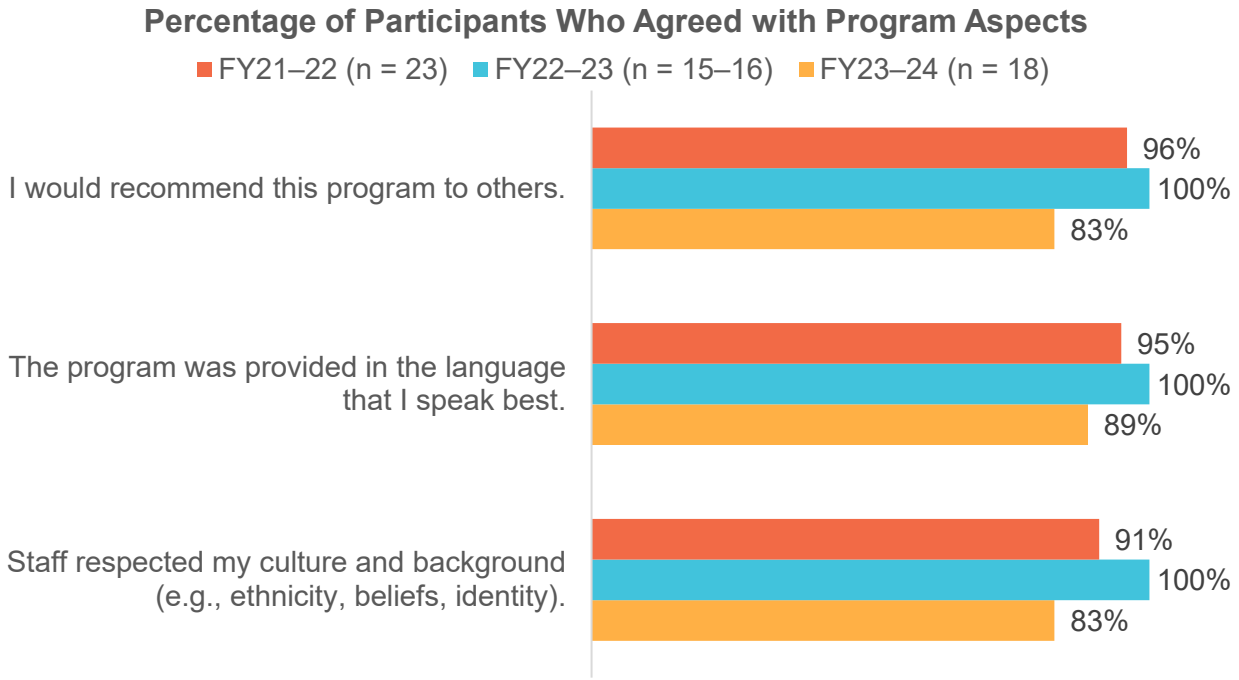
Program Outcomes, Satisfaction, and Feedback

Services to Education tracks program outcomes by asking participants to self-assess their knowledge and satisfaction after receiving program services. Survey results for the past three fiscal years are presented in the charts below.



Services to Education

Program Outcomes, Satisfaction, and Feedback



Participants who received Services to Education services were asked to give additional feedback through two open-ended questions. Their comments were categorized by theme, and the most common responses from the past three years are summarized below.

What was most useful or helpful about this program?

- FY 21–22: Information and resources provided
- FY 22–23: Learning about tools that support my mental health
- FY 23–24: Understanding mental health services and resources

What are your recommendations for improvement?

- FY 21–22: More detailed explanations/discussion of topics
- FY 22–23: Have a more interesting, engaging, or interactive presentation
- FY 23–24: Desire for practical tools and resources

Services to Education

Demographic Data

Services to Education collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 29**	**n = 73**	**n = 9¬**
American Indian/Alaska Native	7%	0%	--
Asian	0%	4%	--
Black/African American	0%	0%	--
Hispanic/Latino/a/e	72%	82%	--
Native Hawaiian/Other Pacific Islander	0%	0%	--
White	24%	18%	--
More Than One Race	0%	0%	--
Other	0%	0%	--
Declined to State	--	0%	--
Ethnicity*	**n = 14**	**n = 73**	**n = 9¬**
Hispanic/Latino/a/e			
Caribbean	0%	0%	--
Central American	0%	0%	--
Mexican/Mex. Am./Chicano	93%	95%	--
Puerto Rican	0%	0%	--
South American	0%	0%	--
Other Hispanic/Latino/a/e	7%	5%	--
Non-Hispanic/Non-Latino/a/e			
African	0%	0%	--
Asian Indian/South Asian	0%	0%	--
Cambodian	0%	0%	--
Chinese	0%	0%	--
Eastern European	0%	0%	--
European	0%	0%	--
Filipino	0%	0%	--
Japanese	0%	0%	--
Korean	0%	0%	--
Middle Eastern	0%	0%	--
Vietnamese	0%	0%	--
Other Non-Hispanic/Non-Latino/a/e	0%	5%	--
More Than One Ethnicity	0%	0%	--
Declined to State	--	10%	--
Age Groups	**n = 28**	**n = 71**	**n = 9¬**
0 to 15 years	50%	0%	--

	FY 21–22	FY 22–23	FY 23–24
16–25 years	4%	4%	--
26–59 years	42%	92%	--
60+ years	4%	4%	--
Declined to State	--	3%	--
Primary Language*	**n = 20**	**n = 73**	**n = 9¬**
English	0%	53%	--
Spanish	80%	2%	--
English and Spanish	10%	25%	--
Other	10%	25%	--
Declined to State	--	3%	--

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

¬ Demographics with fewer than 10 responses are not reported.

-- Data not available.

Services to Education

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Partnerships with schools enabled a high number of PEI activities.
- **FY 22–23:** Was a collaborative partner with schools and other community agencies.
- **FY 23–24:** Our program was able to adapt to the community's evolving needs. Whether it required adjusting strategies based on feedback or addressing emerging issues, the program remained flexible and agile.

Achievements

- **FY 21–22:** Not reported
- **FY 22–23:** Built capacity across family, school, and community settings.
- **FY 23–24:** Monterey County Behavioral Health Bureau rolled out an innovative project (Rainbow Connections Project) aimed at delivering a comprehensive range of LGBTQ+-affirming services and support for youth and their caregivers in Monterey County.

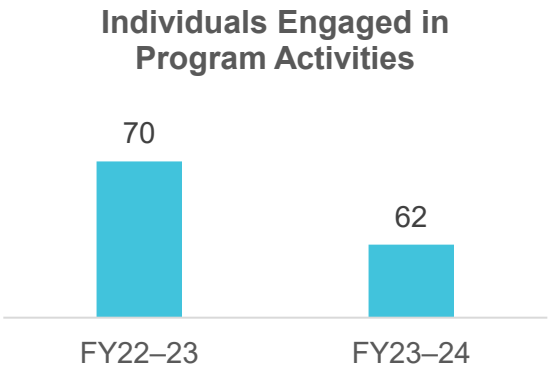
Challenges

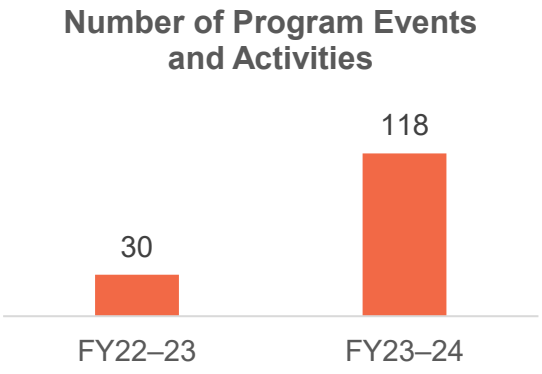
- **FY 23–24:** Staffing challenges to support the demand for services at the schools in the county continues to be a struggle. Supportive colleagues, prioritization of high-risk cases, and partnership and collaboration with school partners continues to support staffing deficits in the meantime. Program leadership works tirelessly to ensure that staff's needs and concerns are heard and addressed to maintain morale and prevent burnout.

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. As part of this mission, After School Academy is offers services that are focused on the specific needs of students/youth

Program Highlights





After School Academy

Demographic Data

The After School Academy collects unduplicated demographic data from the individuals they serve.

	FY 22–23	FY 23–24
Race*	**n = 29**	**n = 78**
American Indian/Alaska Native	0%	3%
Asian	17%	8%
Black/African American	93%	85%
Hispanic/Latino/a/e	28%	15%
Native Hawaiian/Other Pacific Islander	7%	0%
White	14%	6%
More Than One Race	--	21%
Other	3%	1%
Declined to State	0%	5%
Ethnicity*	**n = 29**	**n = 72**
Hispanic/Latino/a/e		
Caribbean	3%	0%
Central American	3%	0%
Mexican/Mex. Am./Chicano	21%	3%
Puerto Rican	7%	0%
South American	0%	0%
Other Hispanic/Latino/a/e	0%	3%
Non-Hispanic/Non-Latino/a/e		
African	76%	88%
Asian Indian/South Asian	3%	8%
Cambodian	0%	0%
Chinese	0%	0%
Eastern European	0%	0%
European	0%	0%
Filipino	0%	3%
Japanese	21%	7%
Korean	3%	0%
Middle Eastern	0%	0%
Vietnamese	0%	0%
More Than One Ethnicity	--	15%
Other Non-Hispanic/Non-Latino/a/e	0%	0%
Declined to State	0%	3%
Age Groups	**n = 30**	**n = 78**

	FY 22–23	FY 23–24
0 to 15 years	100%	95%
16–25 years	0%	5%
26–59 years	0%	0%
60+ years	0%	0%
Primary Language*	**n = 30**	**n = 78**
English	93%	100%
Spanish	7%	0%
English and Spanish	0%	0%
Other	0%	0%
Sex Assigned at Birth	**n = 30**	**n = 46**
Female	50%	52%
Male	50%	46%
Another Sex Assigned	0%	0%
Declined to State	--	2%
Disability*	**n = 30**	**n = 20**
Mental Domain	30%	100%
Seeing	0%	0%
Hearing	0%	0%
Other Communication	0%	0%
Physical	0%	0%
Chronic Health Condition	0%	0%
Another Disability	0%	0%

* Percentages may exceed 100% because participants could choose more than one response option.
-- Data not available.

After School Academy

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** Engaged community members.
- **FY 23–24:** Broadened client base and made new connections with community members previously unaware of our agency's services.

Achievements

- **FY 22–23:** Collaborated with a variety of outside organizations and businesses.
- **FY 23–24:** External collaborations were established with the Naval Post Graduate School and the Monterey Bay Aquarium on the development of a new program that will expose our communities to diverse career opportunities with relatable role models and future opportunities for career shadowing.

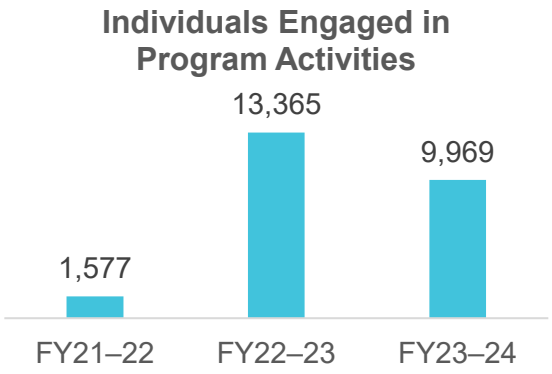
Challenges

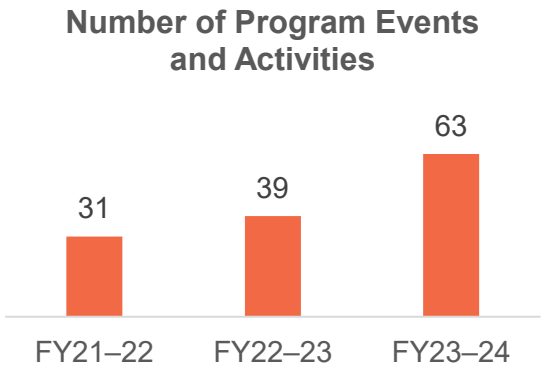
- **FY 23–24:** As a result of our increased outreach efforts, we've witnessed an expansion in our client base, prompting the need to onboard more skilled therapists.

Outreach and Engagement 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. Outreach and engagement services are a central focus of PEI services to these communities for The Village Project, Inc

Program Highlights





Outreach and Engagement Services

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–23:** Staff are well known by the community.
- **FY 22–23:** Engaged community members and cultivated new partnerships.
- **FY 23–24:** Through outreach and engagement efforts, we welcomed new clients through our mental health education series.

Achievements

- **FY 21–22:** Became a highly trusted agency in the community.
- **FY 22–23:** Collaborated with a variety of outside organizations and businesses.
- **FY 23–24:** External collaborations made with the Naval Post Graduate School and the Monterey Bay Aquarium.

Challenges

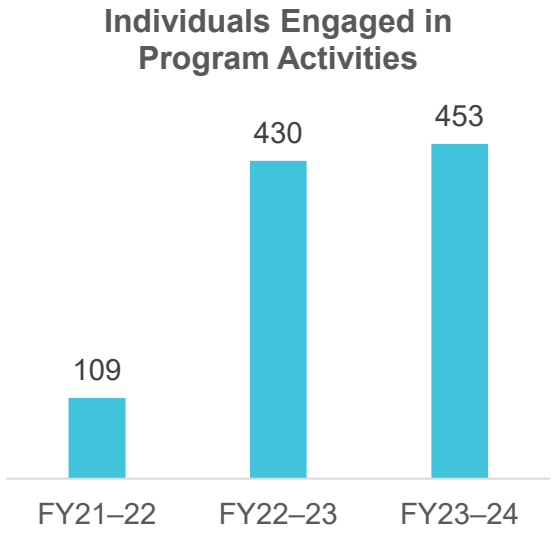
- **FY 23–24:** We frequently receive inquiries from individuals residing in Santa Cruz or Santa Cruz County about our services and whether we cater to their area.

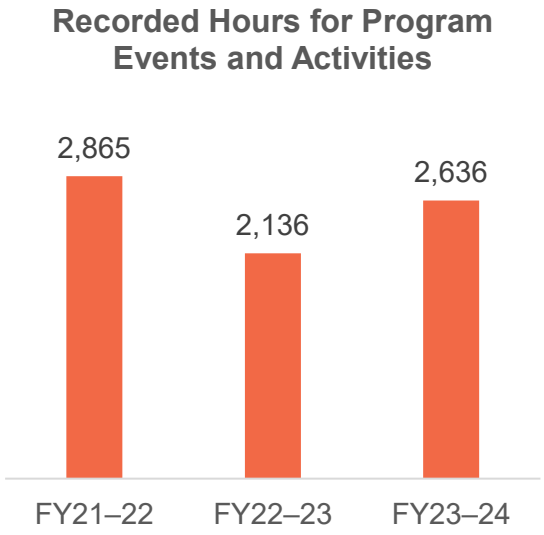
EARLY INTERVENTION

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 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/a/e elders residing in Salinas and Salinas Valley and is a natural complement to Alliance on Aging's Senior Peer Counseling Program.

Program Highlights

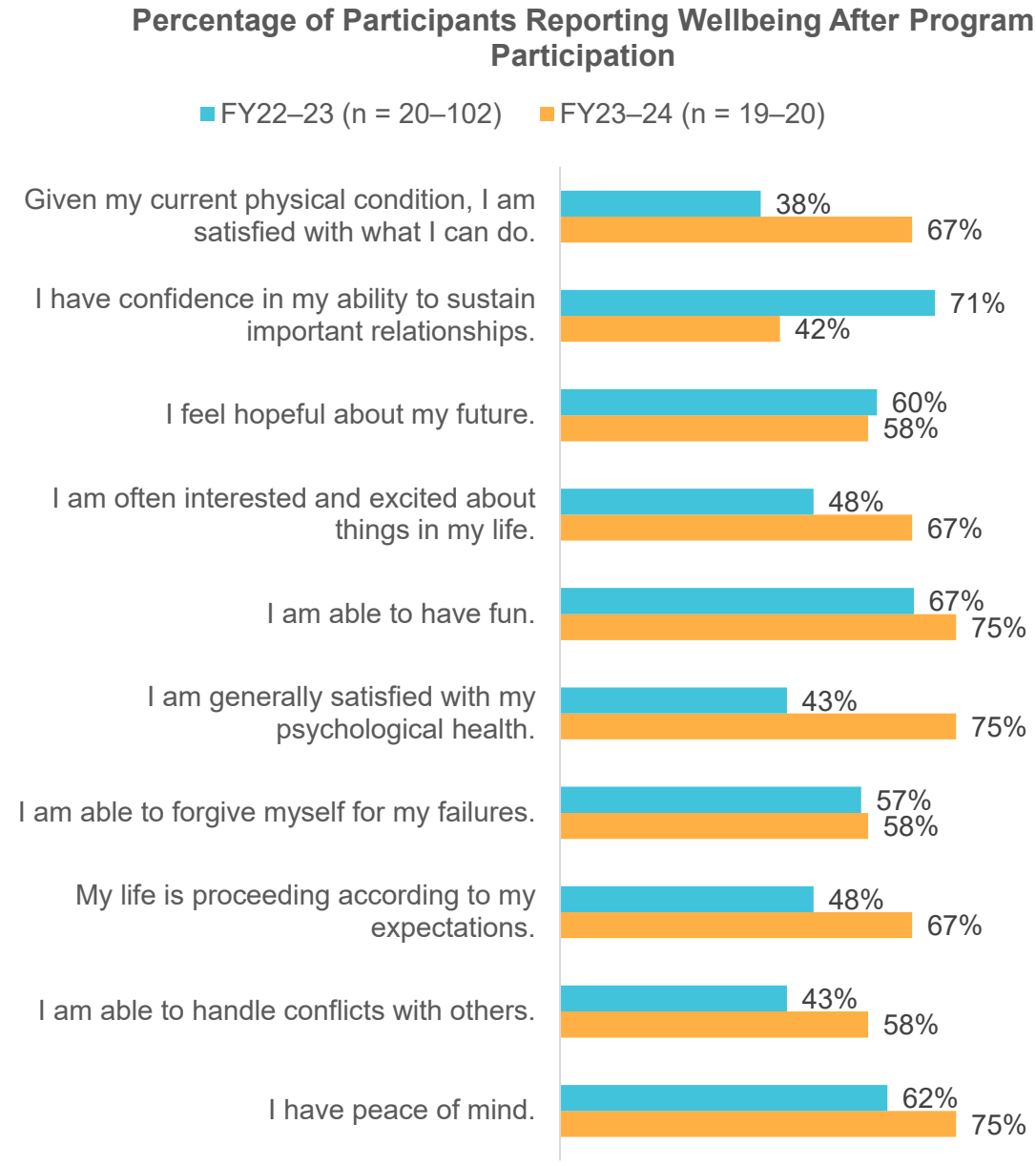




Senior Peer Counseling and Fortaleciendo el Bienestar

Program Outcomes, Satisfaction, and Feedback

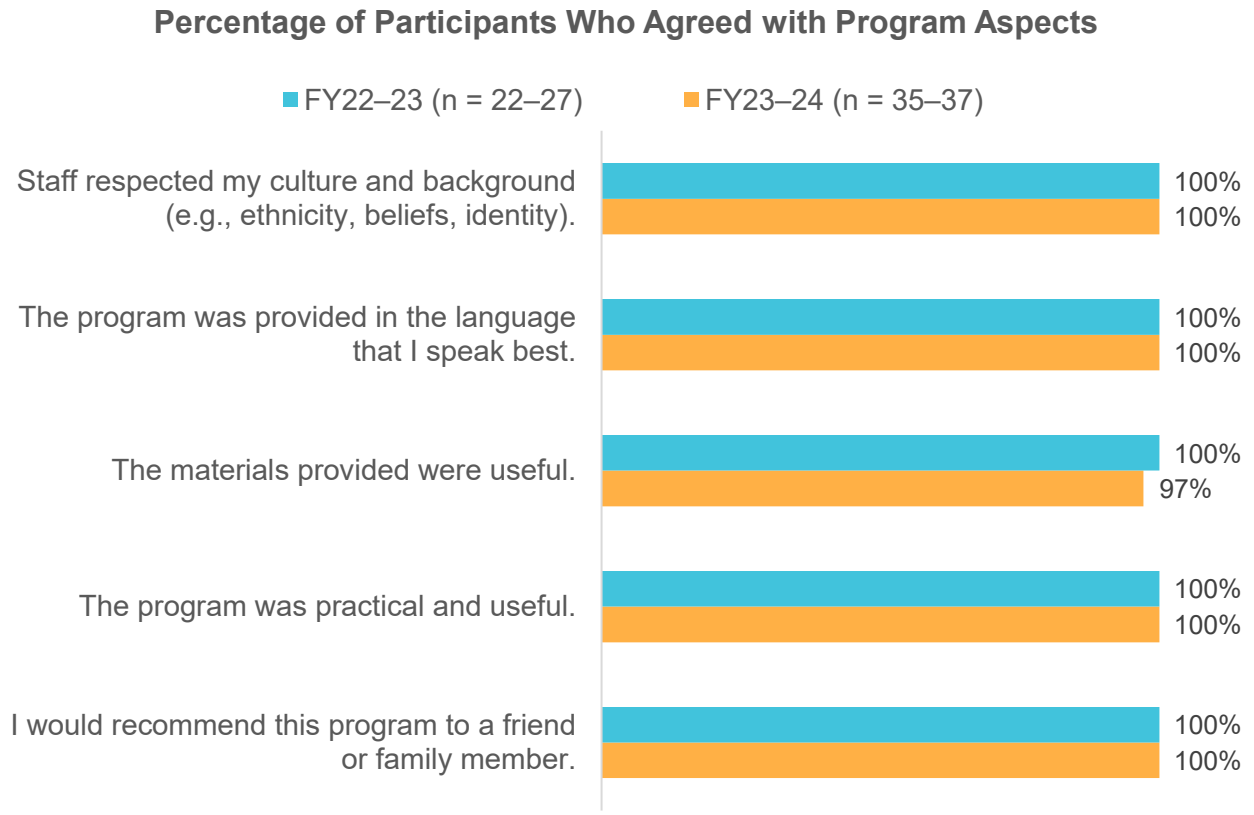
The Alliance on Aging tracks program outcomes by asking participants questions to self-assess their overall well-being, satisfaction with life, psychological health, and program satisfaction after the program. Survey results for the past two fiscal years are presented in the charts below.



*FY 21–22 outcomes data not reported due to low outcomes data submissions.

Senior Peer Counseling and Fortaleciendo el Bienestar

Program Outcomes, Satisfaction, and Feedback



*FY 21–22 outcomes data not reported due to low outcomes data submissions.

Senior Peer Counseling and Fortaleciendo el Bienestar

Demographic Data

Alliance on Aging collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 166**	**n = 171**	**n = 574**
American Indian/Alaska Native	0%	0%	1%
Asian	1%	0%	1%
Black/African American	2%	1%	2%
Hispanic/Latino/a/e	27%	49%	45%
Native Hawaiian/Other Pacific Islander	0%	0%	0%
White	70%	50%	52%
More Than One Race	0%	0%	1%
Other	0%	1%	0%
Declined to State	--	1%	1%
Ethnicity*	**n = 166**	**n = 171**	**n = 532**
Hispanic/Latino/a/e			
Caribbean	0%	0%	0%
Central American	0%	1%	0%
Mexican/Mex. Am./Chicano	27%	48%	42%
Puerto Rican	0%	0%	0%
South American	0%	1%	0%
Other Hispanic/Latino/a/e	0%	0%	0%
Non-Hispanic/Non-Latino/a/e			
African	2%	0%	1%
Asian Indian/South Asian	0%	0%	1%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	2%	1%	0%
European	68%	50%	54%
Filipino	0%	0%	0%
Japanese	0%	0%	0%
Korean	1%	0%	0%
Middle Eastern	0%	0%	0%
Vietnamese	0%	0%	0%
Other Non-Hispanic/Non-Latino/a/e	0%	0%	0%
Declined to State	--	2%	1%
Primary Language*	**n = 166**	**n = 172**	**n = 575**
English	80%	53%	59%
Spanish	16%	40%	36%
English and Spanish	7%	6%	5%

	FY 21–22	FY 22–23	FY 23–24
Declined to State	--	--	--
Age Groups	**n = 166**	**n = 170**	**n = 575**
0 to 15 years	0%	0%	<1%
16–25 years	0%	0%	<1%
26–59 years	0%	6%	4%
60+ years	100%	94%	95%
Declined to State	--	1%	0%
Gender Identity	**n = 166**	**n = 172**	**n = 534**
Female	73%	71%	71%
Genderqueer	0%	0%	0%
Male	27%	29%	29%
Nonbinary	0%	0%	0%
Questioning or Unsure	0%	0%	0%
Transgender	0%	0%	0%
Another Gender Identity	0%	0%	0%
Declined to State	--	0%	--
Sex Assigned at Birth	**n = 166**	**n = 172**	**n = 539**
Female	72%	72%	73%
Male	28%	28%	27%
Another Sex Assigned	0%	0%	0%
Declined to State	--	0%	--
Sexual Orientation	**n = 157**	**n = 168**	**n = 455**
Bisexual	0%	0%	0%
Gay or Lesbian	0%	1%	1%
Heterosexual or Straight	100%	96%	98%
Pansexual	0%	0%	0%
Queer	0%	0%	0%
Questioning or Unsure	0%	0%	0%
Another Sexual Orientation	0%	0%	0%
Declined to State	--	4%	1%
Disability*	**n = 86**	**n = 172**	**n = 539**
Mental Domain	14%	9%	4%
Seeing	14%	13%	8%
Hearing	21%	4%	2%
Other Communication	2%	1%	0%
Physical	59%	26%	22%
Chronic Health Condition	43%	31%	26%
Another Disability	10%	1%	1%
Declined to State	--	--	--
Veteran	**n = 166**	**n = 171**	**n = 537**
Yes	1%	3%	2%
No	99%	97%	98%

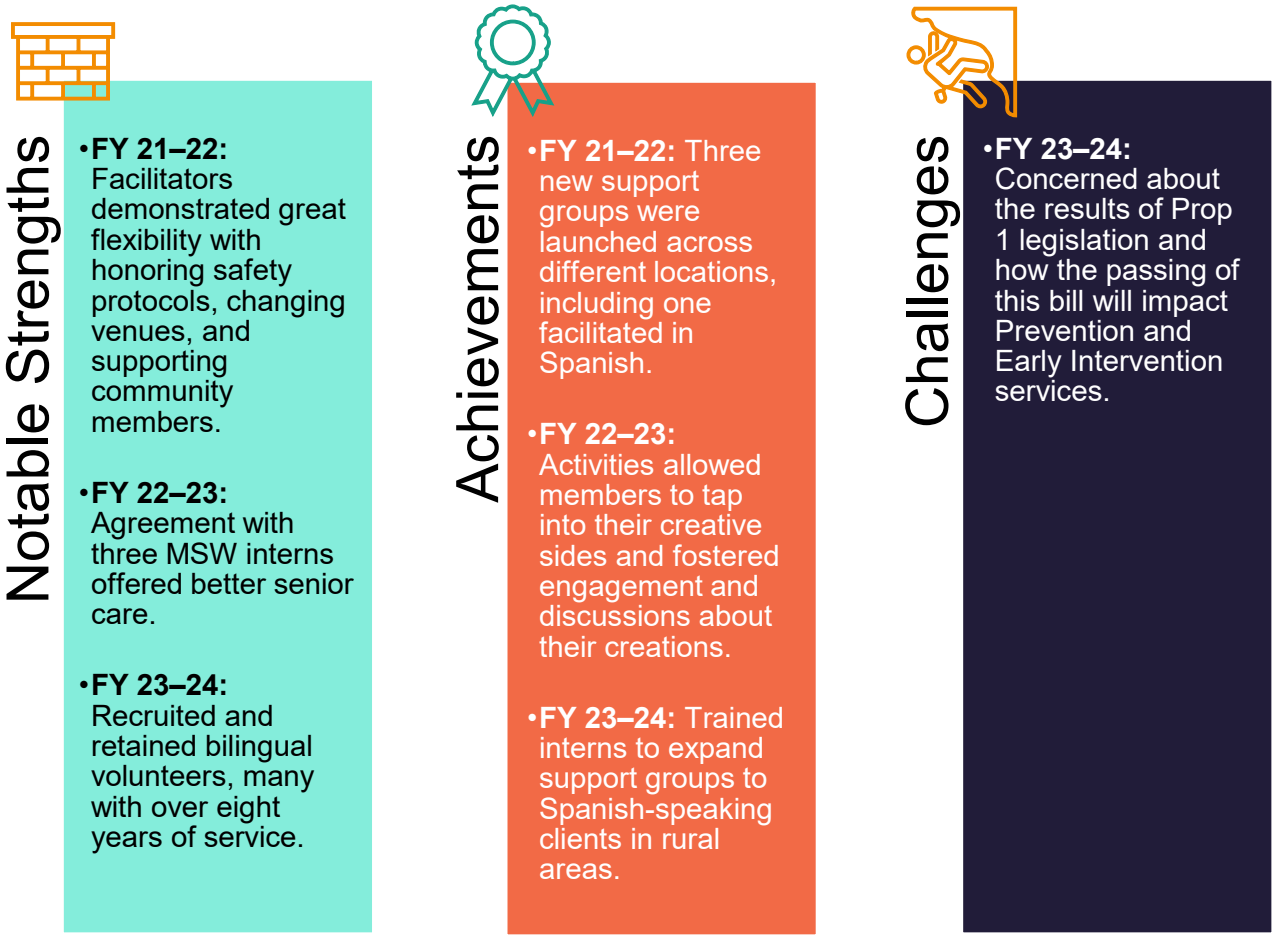
* Percentages may exceed 100% because participants could choose more than one response option.

-- Data not available.

Senior Peer Counseling and Fortaleciendo el Bienestar

Successes and Learning

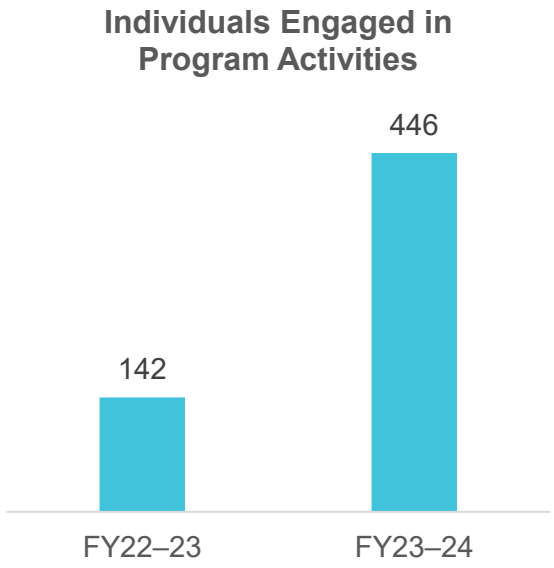
Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

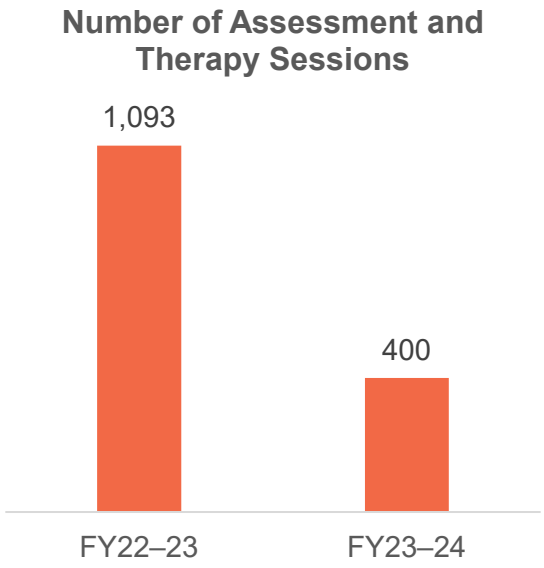


Culturally Specific Short-term Therapeutic Services (CSSTS)
COMMUNITY HUMAN SERVICES (CHS)

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





Culturally Specific Short-term Therapeutic Services (CSSTS)

Demographic Data

CHS collects unduplicated demographic data from the individuals they serve.

	FY 22–23	FY 23–24
Race*	**n = 88**	**n = 53**
American Indian/Alaska Native	0%	0%
Asian	0%	0%
Black/African American	0%	0%
Hispanic/Latino/a/e	97%	92%
Native Hawaiian/Other Pacific Islander	0%	0%
White	6%	8%
Other	1%	0%
Declined to State	0%	0%
Ethnicity*	**n = 79**	**n = 53**
Hispanic/Latino/a/e		
Caribbean	0%	0%
Central American	3%	0%
Mexican/Mex. Am./Chicano	91%	89%
Puerto Rican	0%	0%
South American	0%	2%
Other Hispanic/Latino/a/e	5%	0%
Non-Hispanic/Non-Latino/a/e		
African	0%	0%
Asian Indian/South Asian	0%	0%
Cambodian	0%	0%
Chinese	0%	0%
Eastern European	0%	0%
European	1%	6%
Filipino	0%	0%
Japanese	0%	0%
Korean	0%	0%
Middle Eastern	0%	0%
Vietnamese	0%	0%
More Than One Ethnicity	0%	0%
Other Non-Hispanic/Non-Latino/a/e	0%	0%
Declined to State	3%	4%
Primary Language*	**n = 90**	**n = 52**
English	19%	15%
Spanish	79%	77%

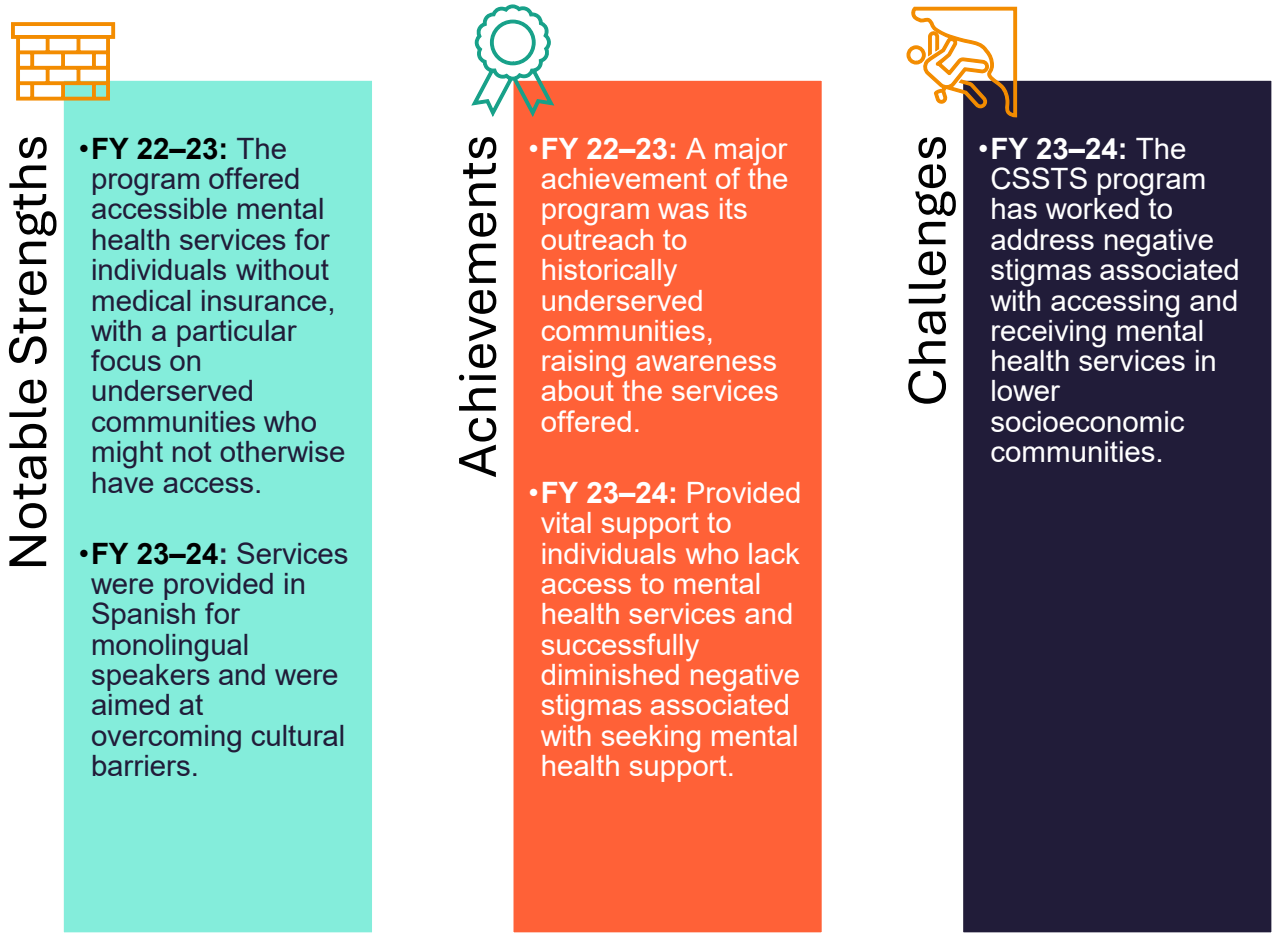
	FY 22–23	FY 23–24
English and Spanish	2%	8%
Age Groups	**n = 93**	**n = 53**
0 to 15 years	2%	0%
16–25 years	8%	6%
26–59 years	89%	92%
60+ years	1%	2%
Gender Identity	**n = 92**	**n = 53**
Female	71%	62%
Genderqueer	0%	4%
Male	28%	34%
Nonbinary	0%	0%
Questioning or Unsure	0%	0%
Transgender	1%	0%
Another Gender Identity	0%	0%
Sex Assigned at Birth	**n = 93**	**n = 53**
Female	70%	60%
Male	30%	40%
Another Sex Assigned	0%	0%
Sexual Orientation	**n = 93**	**n = 53**
Bisexual	2%	2%
Gay or Lesbian	0%	2%
Heterosexual or Straight	78%	91%
Pansexual	0%	0%
Queer	0%	2%
Questioning or Unsure	0%	0%
Another Sexual Orientation	4%	2%
Declined to State	4%	2%
Disability*	**n = 90**	**n = 53**
Mental Domain	43%	97%
Seeing	0%	0%
Hearing	0%	0%
Other Communication	0%	0%
Physical	0%	0%
Chronic Health Condition	0%	0%
Another Disability	1%	0%
Declined to State	3%	0%

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

Culturally Specific Short-term Therapeutic Services (CSSTS)

Successes and Learning

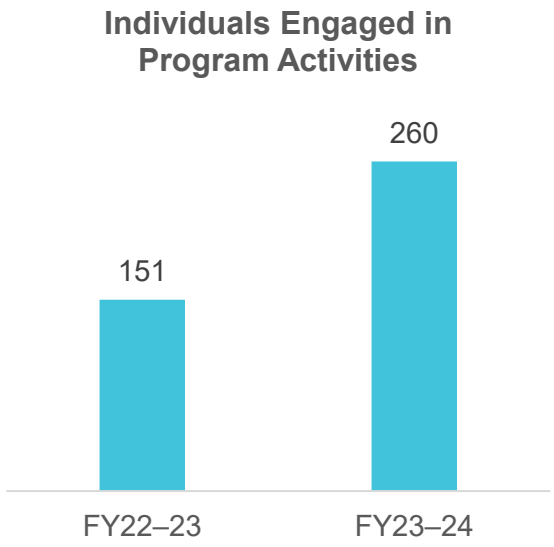
Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

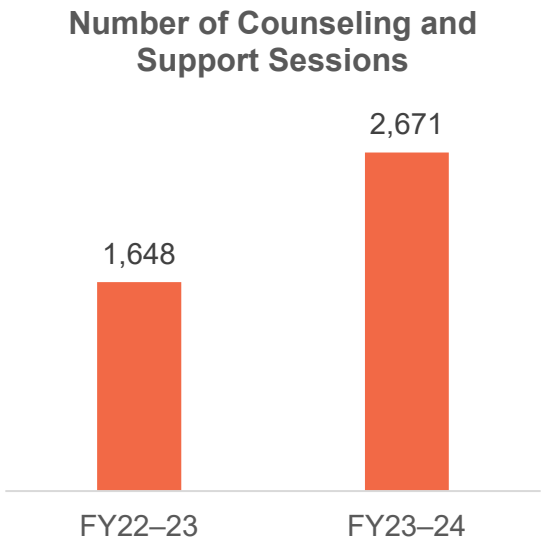


Drug and Alcohol Intervention Services for Youth (DAISY)
COMMUNITY HUMAN SERVICES (CHS)

Community Human Services' (CHS's) Drug and Alcohol Intervention Services for Youth (DAISY) program provides bilingual drug intervention and education services to substance-using youth, primarily in grades 7–12 or ages 13–18. Through individual and group counseling and interactive journaling, the program 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

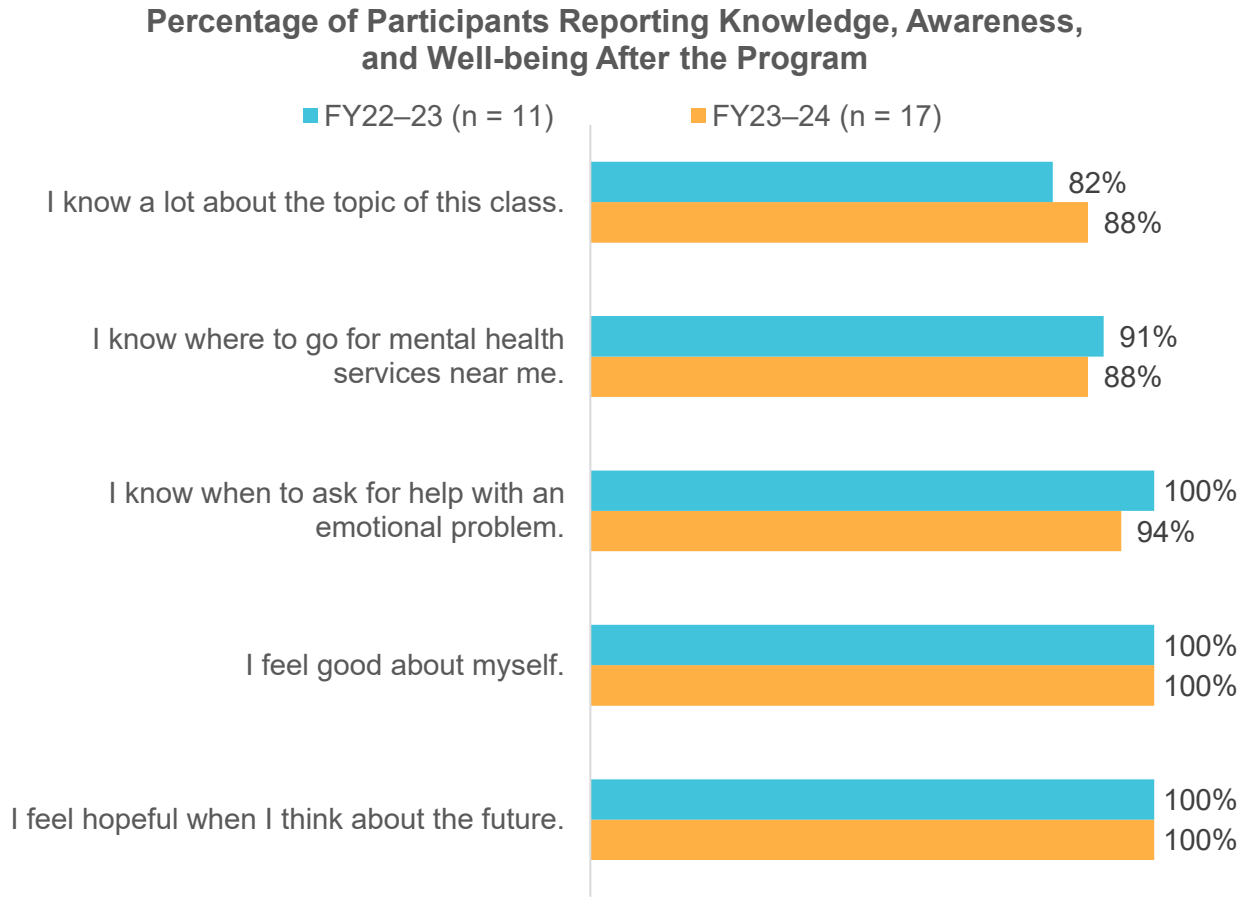




Drug and Alcohol Intervention Services for Youth (DAISY)

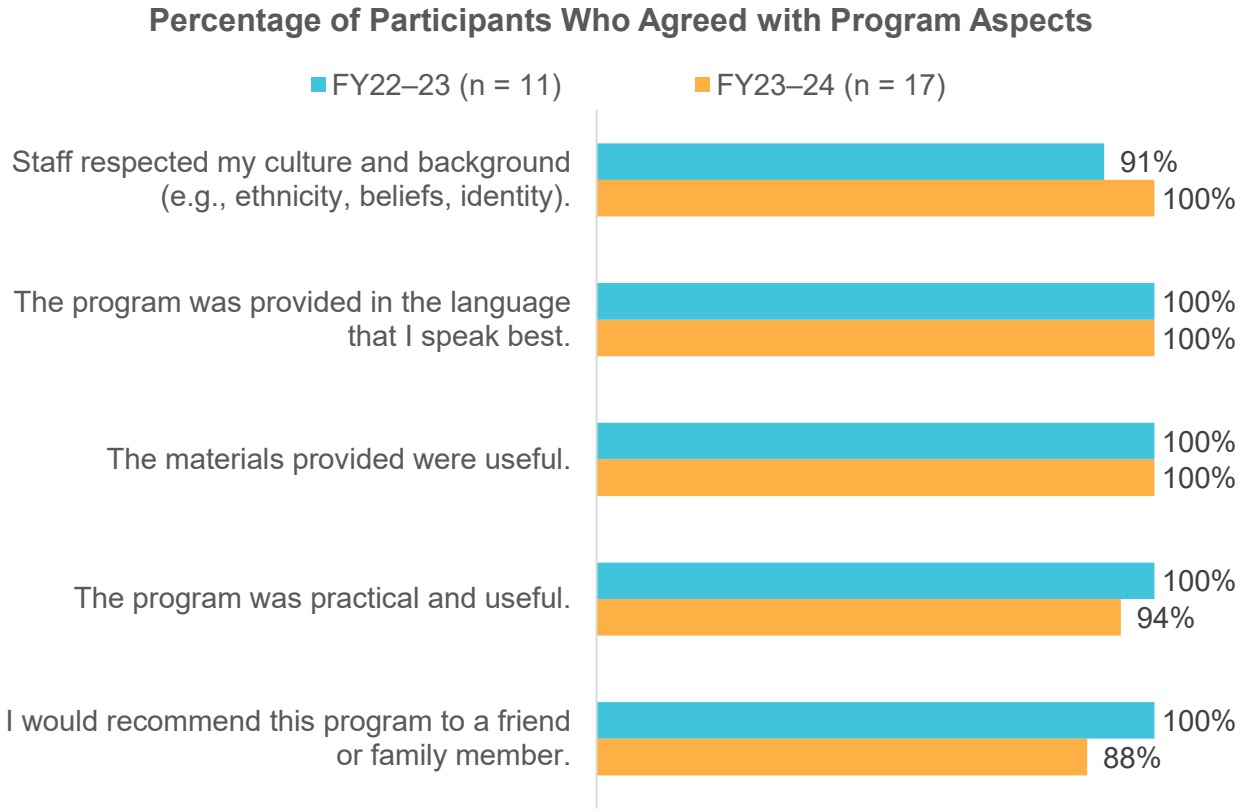
Program Outcomes, Satisfaction, and Feedback

DAISY tracks program outcomes by asking participants to self-assess their knowledge and satisfaction after receiving program services. Survey results for the past two fiscal years are presented in the charts below.



Drug and Alcohol Intervention Services for Youth (DAISY)

Program Outcomes, Satisfaction, and Feedback



Drug and Alcohol Intervention Services for Youth (DAISY)

Program Outcomes, Satisfaction, and Feedback

Participants who received services from DAISY were asked to give additional feedback through two open-ended questions. Their comments were categorized by theme, and the most frequent responses from the past two years are summarized below.

What was most useful or helpful about this program?

- FY 22–23: Improved symptoms/behaviors
- FY 23–24: Self-reflection and personal growth

What are your recommendations for improvement?

- FY 22–23: Additional activities
- FY 23–24: High program satisfaction, with no need for change

Drug and Alcohol Intervention Services for Youth (DAISY)

Demographic Data

DAISY collects unduplicated demographic data from the individuals they serve.

	FY 22–23	FY 23–24
Race*	**n = 55**	**n = 199**
American Indian/Alaska Native	2%	1%
Asian	0%	0%
Black/African American	0%	1%
Hispanic/Latino/a/e	98%	96%
Native Hawaiian/Other Pacific Islander	2%	1%
White	2%	3%
More Than One Race	--	2%
Other	0%	0%
Declined to State	0%	0%
Ethnicity*	**n = 52**	**n = 193**
Hispanic/Latino/a/e		
Caribbean	0%	0%
Central American	6%	2%
Mexican/Mex. Am./Chicano	92%	94%
Puerto Rican	0%	1%
South American	0%	0%
Other Hispanic/Latino/a/e	0%	1%
Non-Hispanic/Non-Latino/a/e		
African	0%	1%
Asian Indian/South Asian	0%	1%
Cambodian	0%	0%
Chinese	0%	0%
Eastern European	0%	0%
European	0%	1%
Filipino	2%	1%
Japanese	0%	0%
Korean	0%	0%
Middle Eastern	0%	0%
Vietnamese	0%	--
Other Non-Hispanic/Non-Latino/a/e	0%	1%
Declined to State	0%	0%
Primary Language*	**n = 56**	**n = 201**
English	21%	31%
Spanish	18%	17%
English and Spanish	59%	51%

	FY 22–23	FY 23–24
Other	2%	1%
Age Groups	**n = 56**	**n = 201**
0 to 15 years	41%	50%
16–25 years	48%	50%
26–59 years	11%	0%
60+ years	0%	0%
Gender Identity	**n = 50**	**n = 200[+]**
Female	22%	31%
Genderqueer	0%	0%
Male	78%	70%
Nonbinary	0%	0%
Questioning or Unsure	0%	0%
Transgender	0%	0%
Another Gender Identity	0%	0%
Sex Assigned at Birth	**n = 56**	**n = 201**
Female	29%	30%
Male	71%	70%
Another Sex Assigned	0%	0%
Sexual Orientation	**n = 47**	**n = 198**
Bisexual	2%	2%
Gay or Lesbian	0%	1%
Heterosexual or Straight	98%	96%
Pansexual	0%	0%
Queer	0%	0%
Another Sexual Orientation	0%	0%
Declined to State	0%	1%
Disability	**n = --[¤]**	**n = 201**
Yes	--	9%
No	--	90%
Declined to State	--	1%

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

[¤] Category not available for that fiscal year.

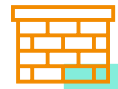
[+] Percentages may exceed 100% due to rounding.

-- Data not available.

Drug and Alcohol Intervention Services for Youth (DAISY)

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.



Notable Strengths

- **FY 22–23:** The program offered a non-judgmental, evidence-based curriculum, creating a supportive and effective environment for clients.
- **FY 23–24:** Three bilingual counselors enhanced accessibility, Zoom sessions were available, and bus passes were provided for those with transportation issues.

Achievements

- **FY 22–23:** Flexible scheduling through Zoom sessions, dual curriculums tailored to individual assessment results, and a parent support group all contributed to client successes, an increase in graduation rates, and program curriculum completion.
- **FY 23–24:** Increased referrals for Substance Abuse and YATV (Anger Management) programs.

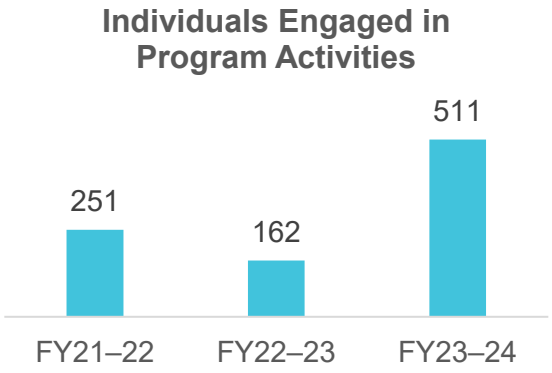
Challenges

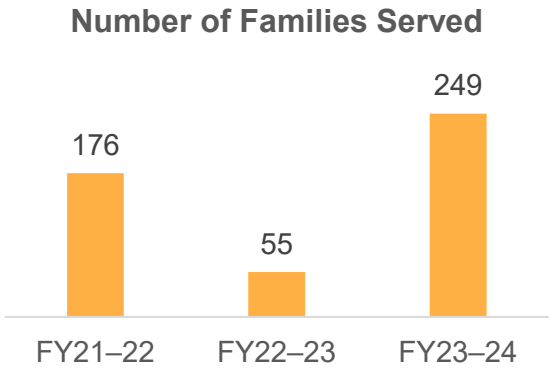
- **FY 23–24:** The program has had a slight decline in client attendance due to transportation challenges, which counselors overcame by offering Zoom sessions and bus passes.

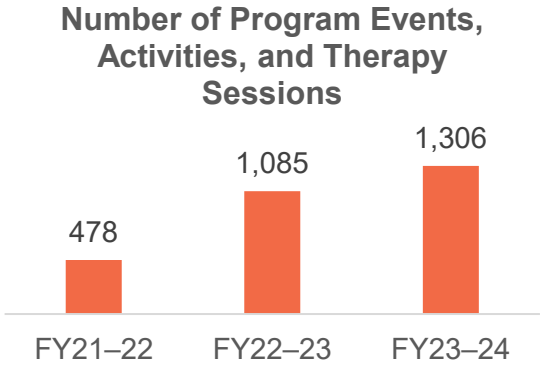
(re)MIND®
FELTON INSTITUTE

(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



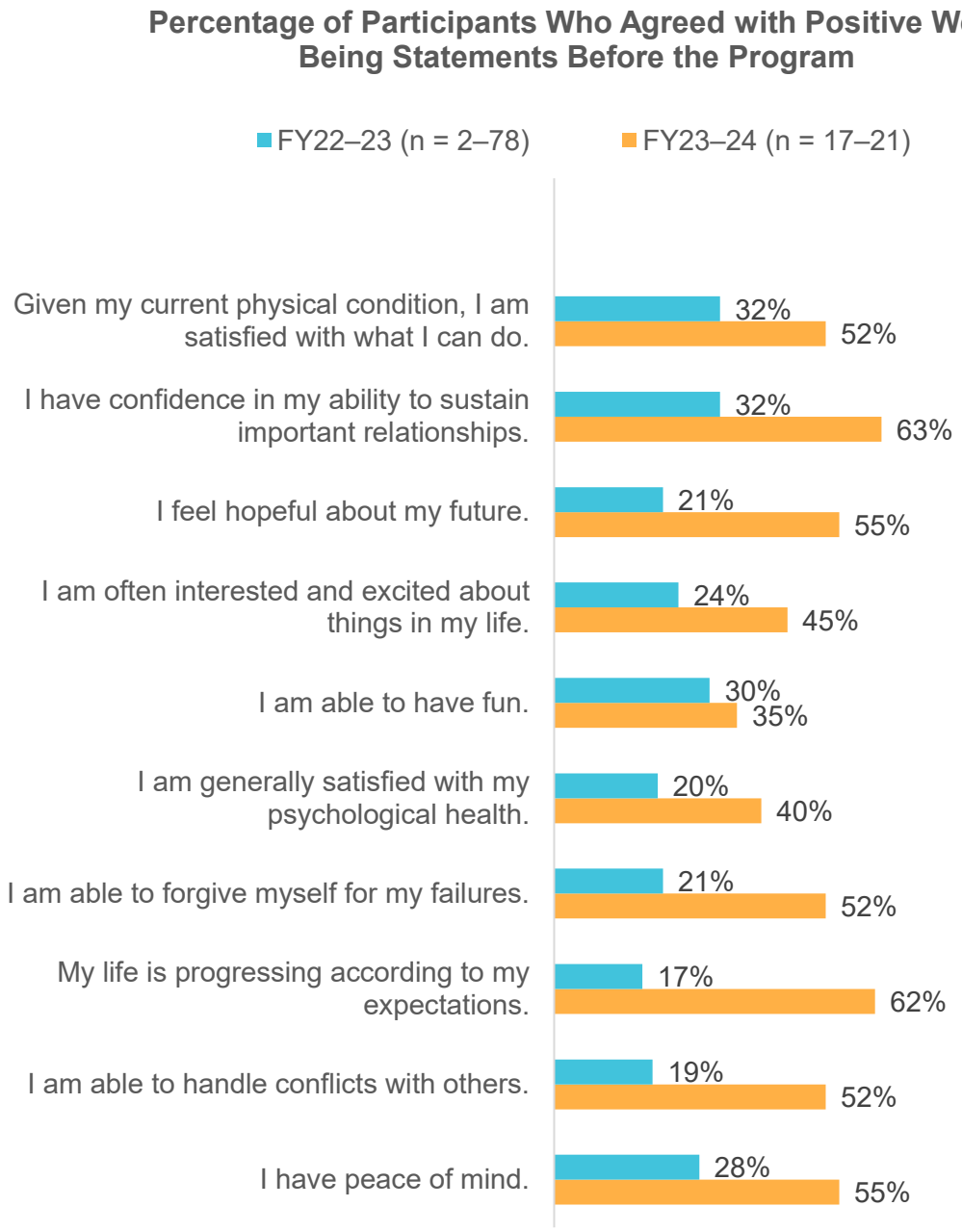




(re)MIND®

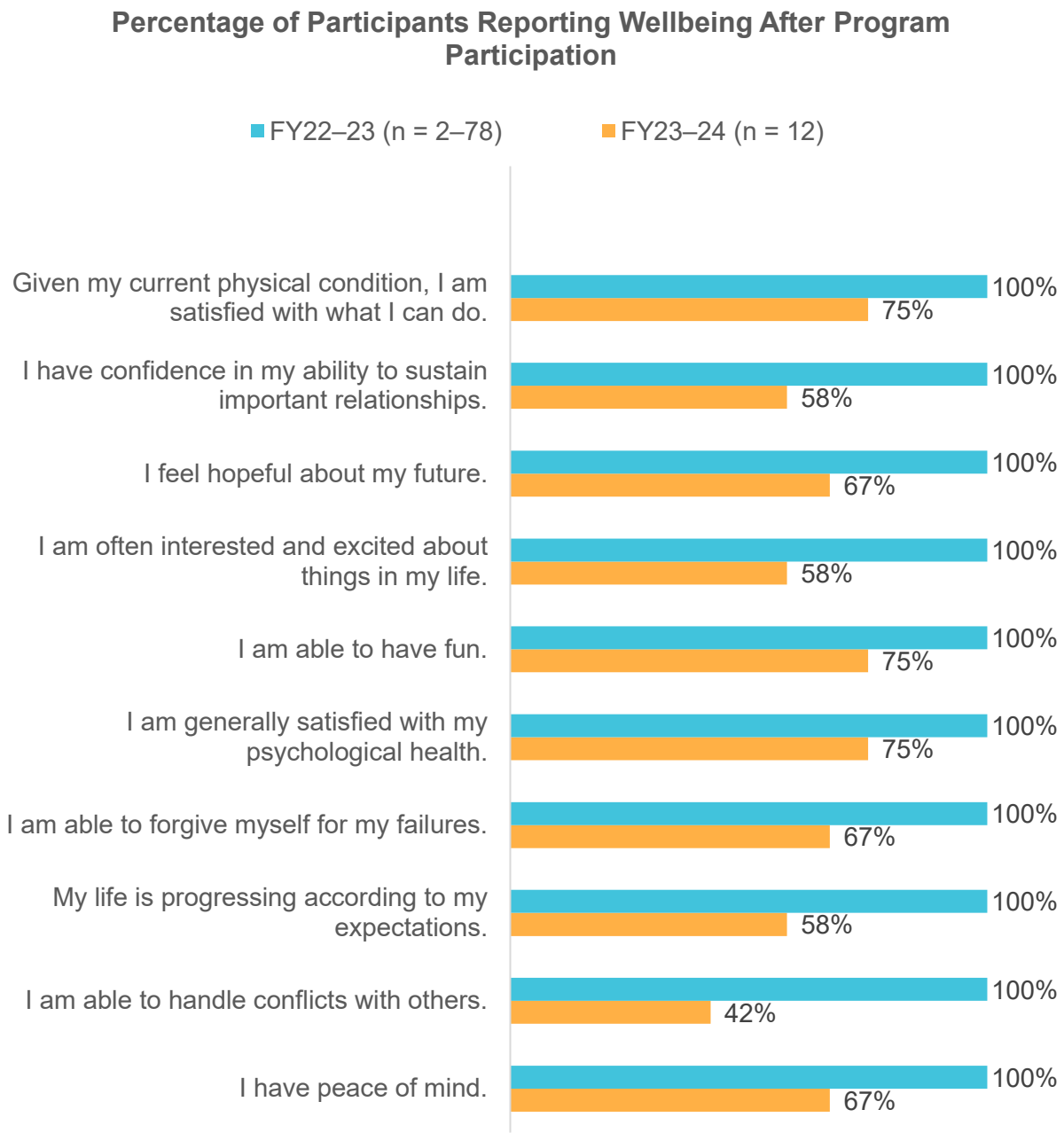
Program Outcomes, Satisfaction, and Feedback

(re)MIND® tracks program outcomes by asking participants to self-assess well-being before and after receiving program services. Survey results for the past two fiscal years are presented in the charts below.



(re)MIND®

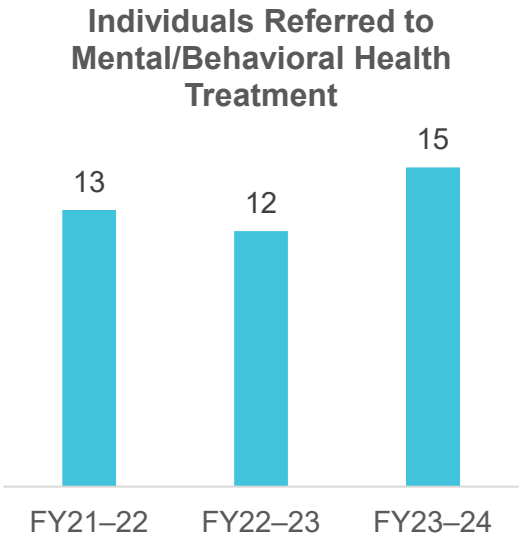
Program Outcomes, Satisfaction, and Feedback

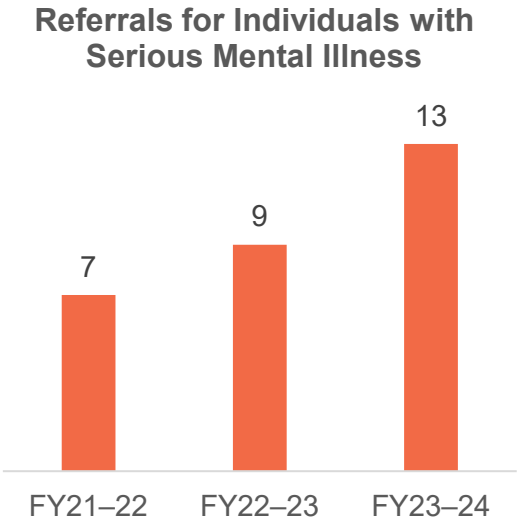


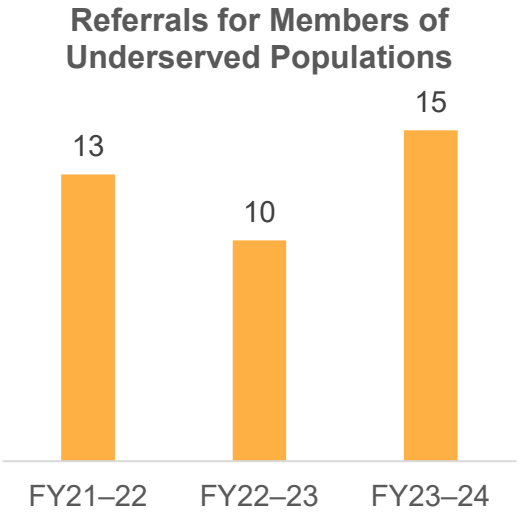
(re)MIND®

Referrals

Program referrals encompass referrals to mental and behavioral health treatment. The figures below summarize the total number of program participants referred to these services over the past three fiscal years, including those with serious mental illnesses and those from underserved populations.







(re)MIND®

Demographic Data

(re)MIND® collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 59**	**n = 50**	**n = 132**
Black/African American	0%	0%	1%
Hispanic/Latino/a/e	72%	62%	39%
White	14%	14%	7%
Other	14%	24%	53%
Declined to State	--	--	--
Age Groups	**n = 59**	**n = 50**	**n = 132**
0 to 15 years	10%	14%	14%
16–25 years	80%	78%	73%
26–59 years	10%	8%	13%
60+ years	0%	0%	0%
Declined to State	--	--	--
Gender Identity	**n = 59**	**n = 50**	**n = 132**
Female	31%	38%	31%
Genderqueer	0%	--	--
Male	68%	62%	69%
Nonbinary	0%	--	--
Questioning or Unsure	0%	--	--
Transgender	0%	--	--
Another Gender Identity	1%	--	--
Declined to State	--	--	--

* Percentages may exceed 100% because participants could choose more than one response option.
-- Data not available for these items.

(re)MIND®

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Empowered clients to have a voice and make decisions in their own care.
- **FY 22–23:** The division's network of providers committed to the specialty of early psychosis.
- **FY 23–24:** Teams were very responsive and coordinated during crises.

Achievements

- **FY 21–22:** Increased support and coordination of care across multiple systems and providers.
- **FY 22–23:** Started a Family Support Group, which provided crucial psychoeducation, information, and resources to participants' main support persons.
- **FY 23–24:** Filled two essential bilingual roles which increased capacity and coordination of care.

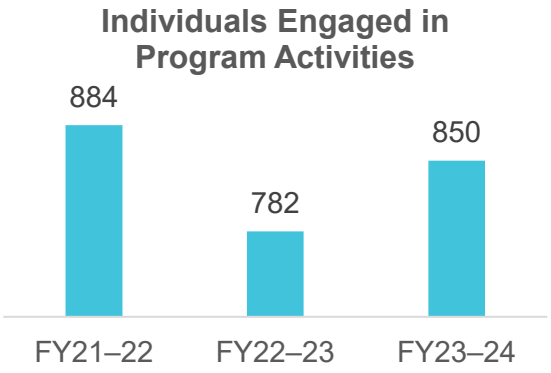
Challenges

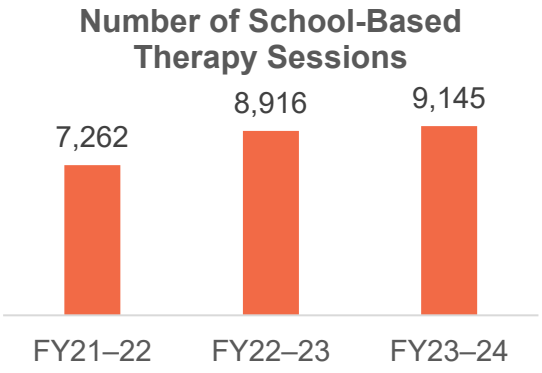
- **FY 23–24:** Was notified that program's funding was terminated. Staff prioritized client care and minimized any service disruption due to transitions to new providers.

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





Sticks & Stones® School-Based Counseling

Demographic Data

The Sticks & Stones® school-based counseling program collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 485**	**n = 419**	**n = 34**
American Indian/Alaska Native	1%	0%	0%
Asian	2%	1%	0%
Black/African American	2%	3%	3%
Hispanic/Latino/a/e	90%	88%	91%
Native Hawaiian/Other Pacific Islander	1%	2%	0%
White	9%	13%	6%
Other	2%	1%	0%
Declined to State	--	--	--
Ethnicity*	**n = 454**	**n = 369**	**n = 33**
Hispanic/Latino/a/e			
Caribbean	0%	0%	0%
Central American	3%	2%	0%
Mexican/Mex. Am./Chicano	87%	91%	97%
Puerto Rican	0%	1%	0%
South American	1%	1%	0%
Other Hispanic/Latino/a/e	6%	4%	0%
Non-Hispanic/Non-Latino/a/e			
African	1%	0%	0%
Asian Indian/South Asian	0%	0%	0%
Cambodian	0%	0%	0%
Chinese	1%	0%	0%
Eastern European	0%	1%	0%
European	1%	3%	0%
Filipino	1%	1%	0%
Japanese	0%	1%	0%
Korean	0%	0%	0%
Middle Eastern	0%	0%	0%
Vietnamese	0%	0%	0%
Other Non-Hispanic/Non-Latino/a/e	3%	2%	0%
More Than One Ethnicity	0%	--	0%
Declined to State	--	--	3%
Age Groups	**n = 501**	**n = 439**	**n = 36**
0 to 15 years	95%	97%	81%
16–25 years	5%	2%	17%
26–59 years	0%	<1%	3%
60+ years	0%	0%	0%
Declined to State	--	1%	--

	FY 21–22	FY 22–23	FY 23–24
Primary Language*	**n = 495**	**n = 392**	**n = 32**
English	42%	39%	16%
Spanish	37%	29%	34%
English and Spanish	28%	32%	50%
Other	1%	--	0%
Gender Identity	**n = 68**	**n = 59**	**n = 10**
Female	59%	44%	100%
Genderqueer	2%	0%	0%
Male	38%	54%	0%
Nonbinary	0%	0%	0%
Questioning or Unsure	0%	2%	0%
Transgender	2%	0%	0%
Another Gender Identity	0%	0%	0%
Sexual Orientation*	**n = 47**	**n = 47**	**n = 10**
Bisexual	13%	4%	10%
Gay or Lesbian	0%	0%	10%
Heterosexual or Straight	81%	79%	50%
Pansexual	4%	2%	0%
Queer	0%	0%	0%
Questioning or Unsure	2%	6%	0%
Another Sexual Orientation	0%	0%	50%
Declined to State	--	9%	30%
Sex Assigned at Birth	**n = 500**	**n = 410**	**n = 32**
Female	51%	41%	53%
Male	49%	51%	47%
Another Sex Assigned	0%	0%	0%
Declined to State	--	--	--
Disability*	**n = 112**	**n = 366**	**n = 8¬**
Mental Domain	71%	13%	--
Seeing	16%	1%	--
Hearing	20%	1%	--
Other Communication	4%	0%	--
Physical	0%	0%	--
Chronic Health Condition	0%	0%	--
Another Disability	4%	1%	--
Declined to State	--	1%	--
Veteran	**n = 71**	**n = --¤**	**n = 11**
Yes	0%	--	0%
No	100%	--	100%

* Percentages may exceed 100% because participants could choose more than one response option.
¬ Demographics with fewer than 10 responses are not reported.
¤ Category not available for that fiscal year.
-- Data not available.

Sticks & Stones® School-Based Counseling

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** The program was able to get more consent forms signed and have effective parent conversations and positive outreach.
- **FY 22–23:** The program was well known and accepted in the community.
- **FY 23–24:** Thanks to our program's history of maintaining strong relationships, more and more districts have now been reaching out to partner with us.

Achievements

- **FY 21–22:** Doubled the number of sessions provided to schools by increasing signed consent forms, enhancing parent outreach, and conducting staff refresher trainings on referrals.
- **FY 22–23:** Served most of the students that were referred to the program.
- **FY 23–24:** Increased partnerships to 15 school districts with 48 school sites.

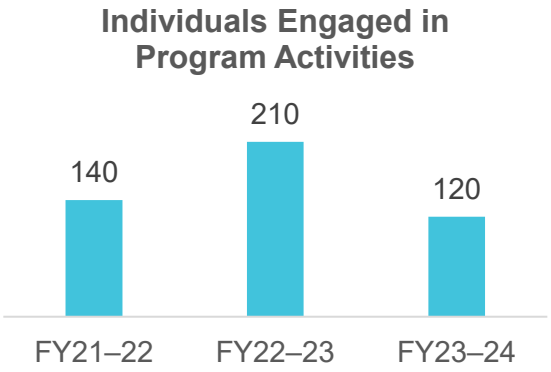
Challenges

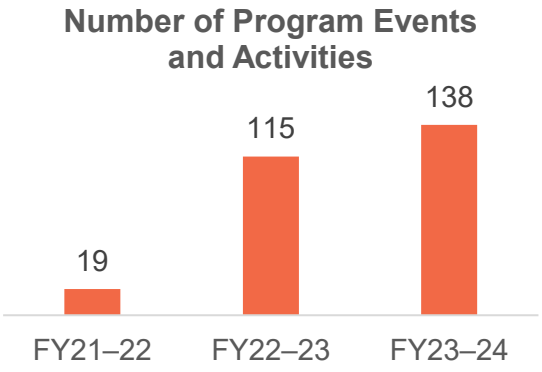
- **FY 23–24:** As we grow, there is an increased need for attention to various parts of our program as well as an increase in the number of invitations for us to be present at various community events.

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

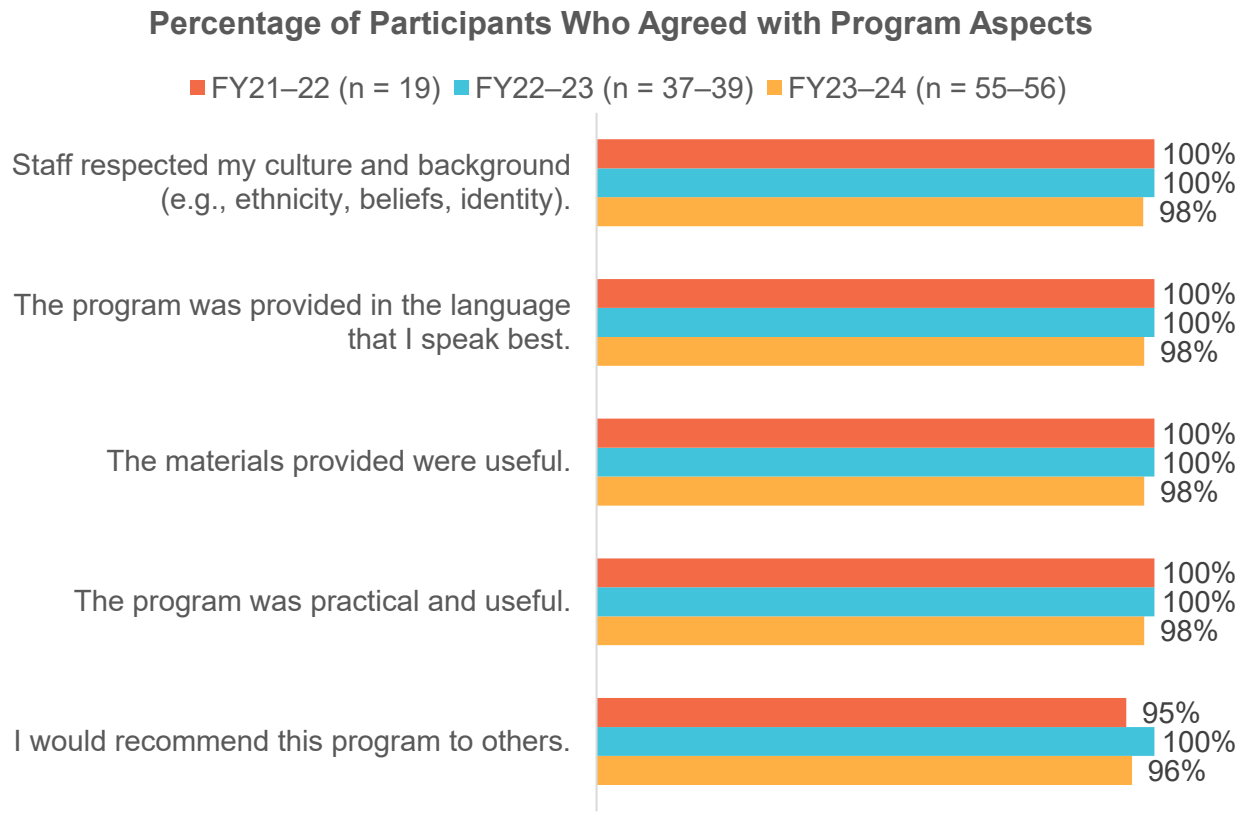




Silver Star Resource Center

Program Outcomes, Satisfaction, and Feedback

Silver Star Resource Center tracks program outcomes by asking participants to self-assess their satisfaction after receiving program services. Survey results for the past three fiscal years are presented in the chart below.



Silver Star Resource Center

Program Outcomes, Satisfaction, and Feedback

Participants who received services from Silver Star Resource Center were asked to give additional feedback through two open-ended questions. Their comments were categorized by theme, and the most common responses from the past three years are summarized below.

What was most useful or helpful about this program?

- FY 21–22: Having someone to talk to
- FY 22–23: Connection with others and the opportunity to share experiences
- FY 23–24: Emotional support and non-judgmental listening

What are your recommendations for improvement?

- FY 21–22: No recommendations
- FY 22–23: Hearing from more diverse perspectives
- FY 23–24: High satisfaction with the program as it is

Silver Star Resource Center

Demographic Data

Silver Star Resource Center collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 184**	**n = 119**	**n = 100**
American Indian/Alaska Native	0%	0%	0%
Asian	1%	0%	0%
Black/African American	1%	2%	0%
Hispanic/Latino/a/e	40%	34%	31%
Native Hawaiian/Other Pacific Islander	0%	0%	0%
White	2%	1%	0%
More Than One Race	0%	0%	0%
Other	56%	64%	69%
Declined to State	--	--	--
Age Groups	**n = 184**	**n = 119**	**n = 100**
0 to 15 years	61%	62%	54%
16–25 years	39%	38%	46%
26–59 years	0%	0%	0%
60+ years	0%	0%	0%
Declined to State	--	--	--

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

-- Data not available.

Silver Star Resource Center

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Minimum waitlist was maintained for those seeking services.
- **FY 22–23:** Offered extensive engagement efforts for new referrals.
- **FY 23–24:** Coordinated SUD support through another Children's Behavioral Health team that will be doing a family training for SUD services.

Achievements

- **FY 21–22:** Not reported
- **FY 22–23:** Most clients set an intake within 5–7 days.
- **FY 23–24:** Had consistent staffing. Although the number of referrals was more than what the assigned staff could carry themselves, having consistent and high performing staff was key to getting better data, more successful client engagement, and faster turnaround times between referral and intake appointments.

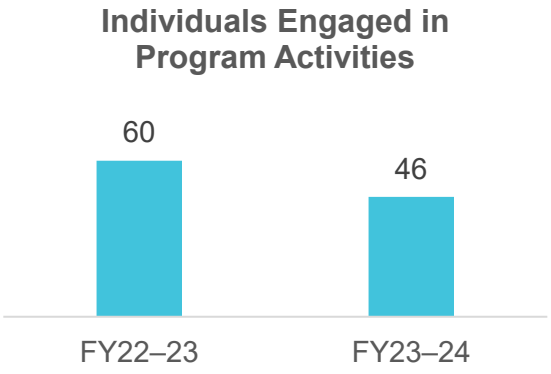
Challenges

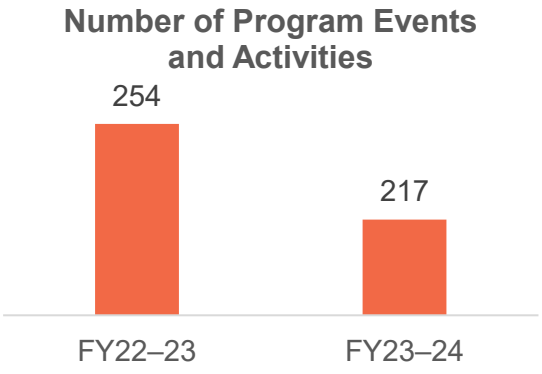
- **FY 23–24:** Silver Star Resource Center began to struggle with getting referrals for youth who are not interested in engaging in treatment services at the start of Quarter 3.

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





Outpatient Mental Health Services

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** Engaged community members.
- **FY 23–24:** Our outreach and engagement efforts, as well as our mental health education series, resulted in welcoming new clients to our services. These efforts not only broadened our client base but also enabled us to forge connections with community members previously unaware of our agency's services.

Achievements

- **FY 22–23:** Conducted interviews that were nationally aired.
- **FY 23–24:** The addition of a full-time bilingual therapist to our team significantly expanded our ability to serve the Spanish-speaking community—a demographic we've been eager to reconnect with and serve.

Challenges

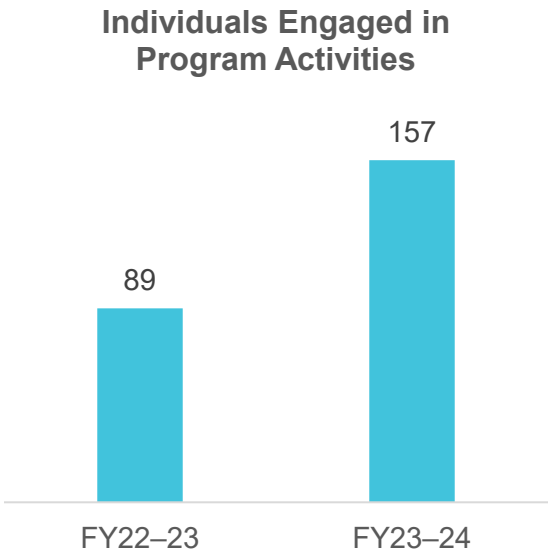
- **FY 23–24:** As a result of our increased outreach efforts, we've witnessed an expansion in our client base, prompting the need to onboard more skilled therapists.

ACCESS AND LINKAGE TO TREATMENT

Street Outreach Program
COMMUNITY HUMAN SERVICES (CHS)

Community Human Services (CHS) offers street outreach services to youth and young adults ages 18–24 throughout Monterey County (particularly Salinas Valley and Monterey Peninsula). The Street Outreach Program provides bilingual street-based outreach services to youth experiencing homelessness, including runaway youth. This program addresses immediate crises, providing survival aid like food and water, and facilitating access to behavioral health services. Linkages to vital resources and services are also made to improve the mental health of homeless youth.

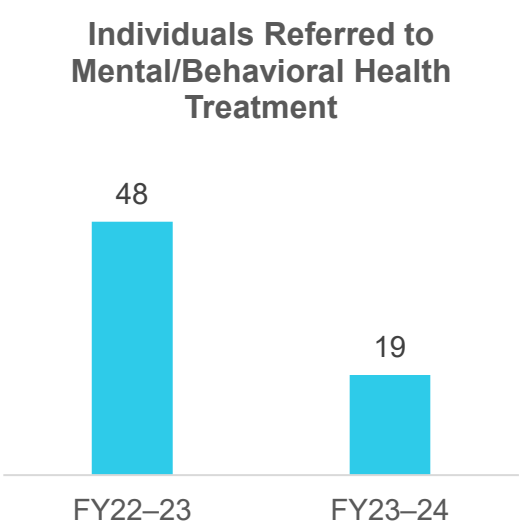
Program Highlights

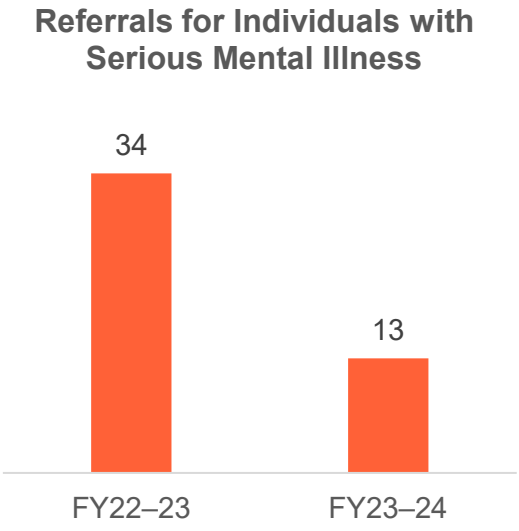


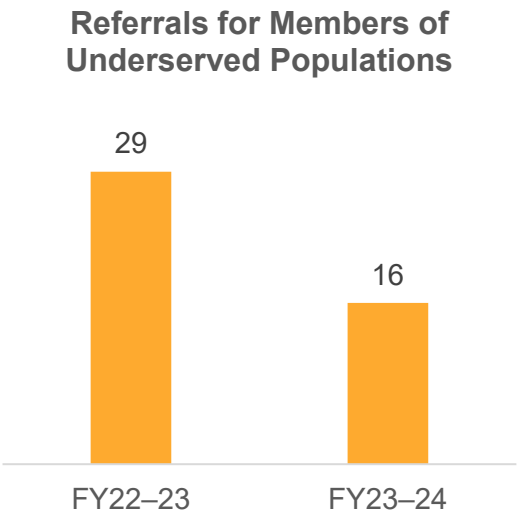
Street Outreach Program

Referrals

Program referrals encompass referrals to mental and behavioral health treatment. The figures below summarize the total number of program participants referred to these services over the past two fiscal years, including those with serious mental illnesses and those from underserved populations.







Street Outreach Program

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** The program excelled in achieving successful housing outcomes for clients through the continued advocacy efforts of street outreach counselors.
- **FY 23–24:** Staff effectively utilized access to language services to make sure that non-English-speaking clients were connected to services they needed.

Achievements

- **FY 22–23:** Notable accomplishments included housing clients through subsidized and non-subsidized housing into a variety of housing options that included transitional housing, emergency shelters, and permanent housing.
- **FY 23–24:** Notable accomplishments included successfully supporting clients in their educational endeavors, which resulted in clients' graduation from high school, vocational training programs, and community colleges.

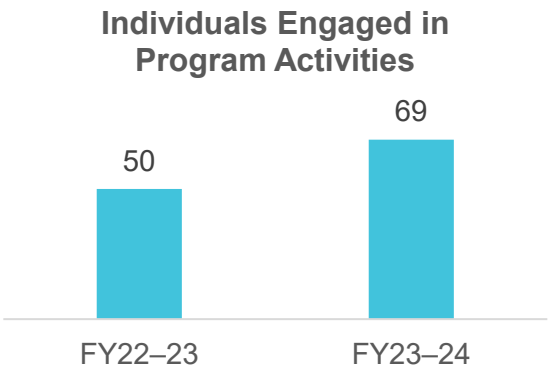
Challenges

- **FY 23–24:** The unexpected sweeps of encampments was a notable challenge.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.

Keep It Real Community Outreach & Navigation 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 Monterey County Behavioral Health, 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.

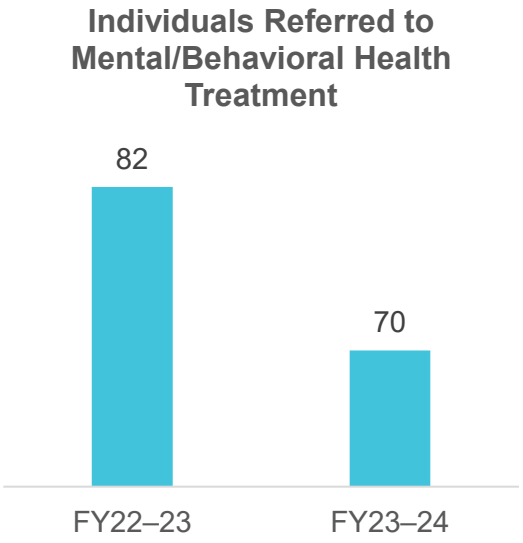
Program Highlights

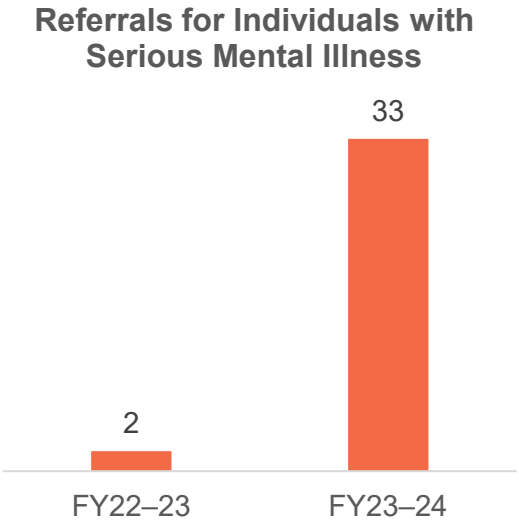


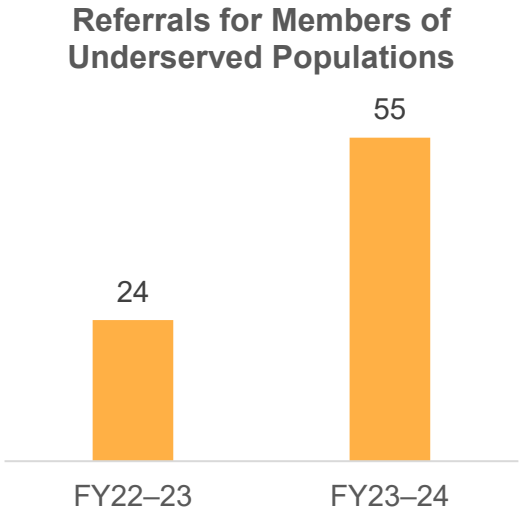
Keep It Real Community Outreach & Navigation

Referrals

Program referrals encompass referrals to mental and behavioral health treatment. The figures below summarize the total number of program participants referred to these services over the past two fiscal years, including those with serious mental illnesses and those from underserved populations.







Keep It Real Community Outreach & Navigation

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** The program increased clients' confidence through outreach.
- **FY 23–24:** Our bilingual staff enabled us to reach more clients in underserved demographic groups and regions.

Achievements

- **FY 22–23:** Improved linkages with additional community resources to be provided to clients.
- **FY 23–24:** Connections with The Epicenter and low-income housing units increased our ability to provide referral services to these target populations.

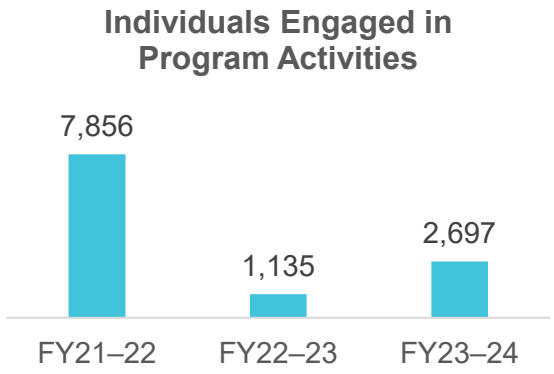
Challenges

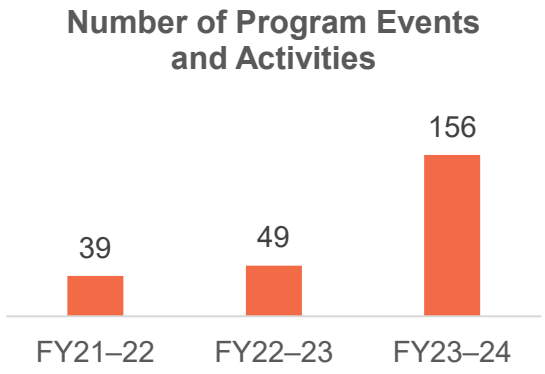
- **FY 23–24:** Staff changes resulted in fewer referrals than usual.

Veterans Reintegration Transition Program MONTEREY COUNTY MILITARY & VETERANS AFFAIRS OFFICE (MVAO)

The Veterans Reintegration Transition Program provides education and awareness to veterans, transitioning service members, 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 state and/or federal 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





Veterans Reintegration Transition Program

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Claims filed on behalf of veterans resulted in both retroactive and monthly payments.
- **FY 22–23:** Collaborations with county agencies, DVA, and elected officials were established to improve access, funding, and availability of veterans benefits and services.
- **FY 23–24:** Collaborations with county agencies, DVA, and elected officials were continued to improve access, funding, and availability of veterans benefits and services.

Achievements

- **FY 21–22:** Not reported
- **FY 22–23:** Responded to 7,898 telephone/email inquiries and made 4,238 in-person or remote appointments to serve 3,040 unique veterans. Earned over $14.1M in disability payments.
- **FY 23–24:** Responded to 6,271 telephone/email inquiries and made 4,336 in-person or remote appointments to serve 2,991 unque veterans. Earned over $19.7M in disability payments.

Challenges

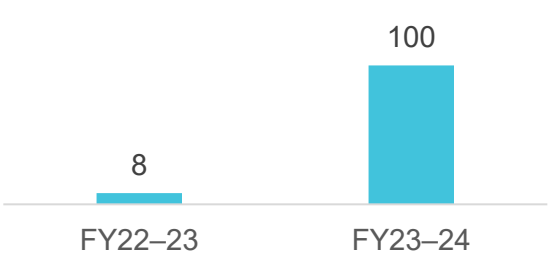
- **FY 23–24:** Staffing shortages continued. Staff have stepped up to fill multiple roles and responsibilities, of which serving veterans is foremost. MVAO is now staffed at five of six Veteran Service Representatives, though recent hires needed training before being able to carry full client loads.

Family Partners Program
SENECA CENTER

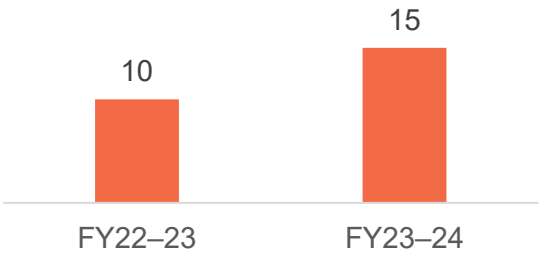
The Family Partners program provides peer support to family members of clients receiving mental health services. Family partners work individually with family members to engage them in the process of mental health services and assist them in achieving their individual/family goals. They can also support 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 perform a wide range of activities to function as members 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

Individuals Engaged in Program Activities



Number of Program Events and Activities



Family Partners Program

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** Ensured comprehensive and consistent care.
- **FY 23–24:** Coordinated and collaborated in care planning efforts with other child-serving agencies and institutions involved in delivering services to the child and family, to ensure comprehensive and consistent care.

Achievements

- **FY 22–23:** Hired two bilingual family partners.
- **FY 23–24:** Maintained employment of two bilingual family partners who received their Peer Certification through CalMHSA.

Challenges

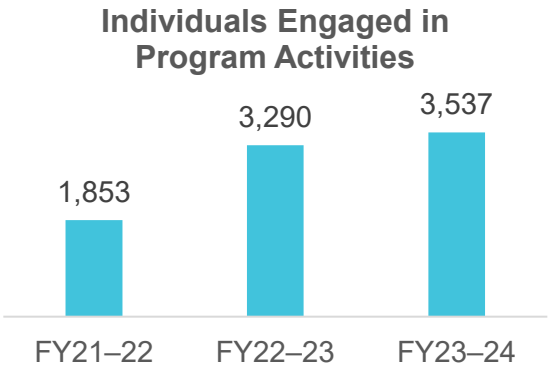
- **FY 23–24:** The pace at which referrals are coming in is a challenge. Leadership is being proactive and setting up meetings with collaborative partners to discuss the referral stream and is planning to host refresher trainings with county partners, and open up referrals to other teams by the end of the calendar year.

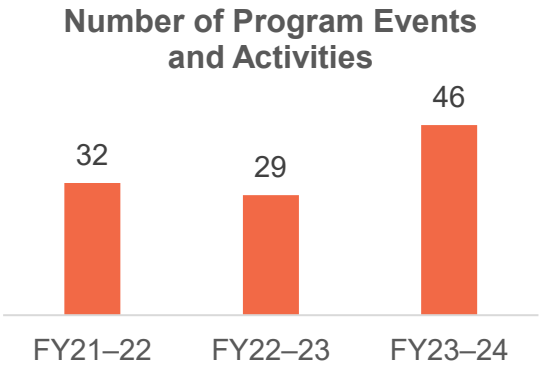
211
UNITED WAY MONTEREY COUNTY

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 utilized by 211 that allows case managers, other front-line workers, and residents in need of services to identify resources and enroll 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 that are committed to working together to more effectively connect residents to care.

Program Highlights

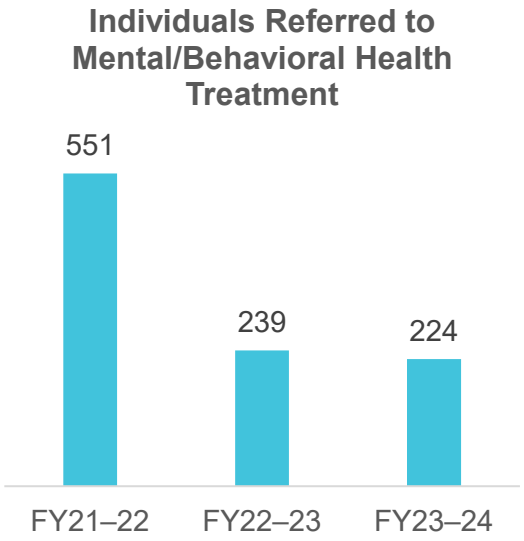




211

Referrals

Program referrals encompass referrals to mental and behavioral health treatment. The figure below summarizes the total number of program participants referred to these services over the past three fiscal years.



211

Demographic Data

211 collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 12,996**	**n = 8,643**	**n = 7,810**
American Indian/Alaska Native	1%	1%	1%
Asian	2%	2%	1%
Black/African American	3%	5%	4%
Hispanic/Latino/a/e	78%	77%	67%
Native Hawaiian/Other Pacific Islander	1%	1%	1%
White	33%	36%	33%
Other	60%	55%	43%
Declined to State	--	--	5%
Age Groups	**n = 14,439**	**n = 8,587**	**n = 7,527**
0 to 15 years	7%	3%	3%
16–25 years	6%	7%	7%
26–59 years	68%	70%	71%
60+ years	19%	20%	19%
Primary Language*	**n = 14,868**	**n = 8,578**	**n = 7,721**
English	47%	50%	46%
Spanish	51%	48%	44%
Indigenous	1%	2%	--
Mixteco	9	--	1%
Triqui	--	--	0%
Other	1%	1%	1%
Declined to State	--	--	3%
Was Not Asked	--	--	5%
Sex Assigned at Birth	**n = 19,288**	**n = 10,309**	**n = 9,331**
Female	73%	72%	70%
Male	27%	28%	28%
Another Sex Assigned	0%	0%	0%
Unknown	--	--	2%
Disability	**n = 12,933**	**n = 8,483**	**n = 7,579**
Yes	22%	28%	26%
No	78%	72%	62%
Declined to State	--	--	4%
Was Not Asked	--	--	8%
Veteran	**n = 13,370**	**n = 8,516**	**n = 7,699**
Yes	2%	2%	2%

	FY 21–22	FY 22–23	FY 23–24
No	98%	98%	87%
Declined to State	--	--	4%
Was Not Asked	--	--	7%

* Percentages may exceed 100% because participants could choose more than one response option.
-- Data not available.

211

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Provided consistent services, connecting Monterey County residents to a variety of services and resources.
- **FY 22–23:** Increased capacity to support and grow the Hope and Help Network.
- **FY 23–24:** Maintained core connection services while also providing support to the Access and Functional Needs community during power outages resulting from winter storms.

Achievements

- **FY 21–22:** Smart Referral and Active Referral Networks, which are critical to 211's success, continued to grow.
- **FY 22–23:** Expanded participation in groups and with partners who served residents in relation to mental health, substance use disorder, and social determinants of health.
- **FY 23–24:** Services available in the 211 database were able to meet the needs of 91% of individuals seeking mental health and substance use care.

Challenges

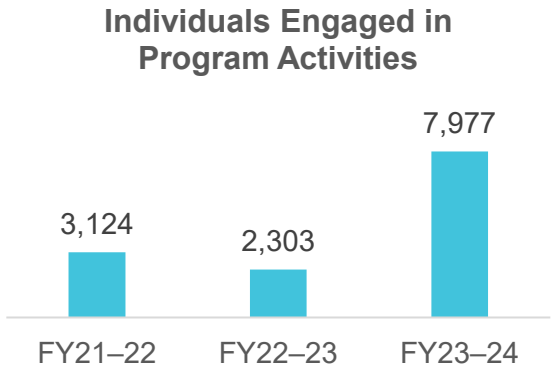
- **FY 23–24:** There was low attendance in bimonthly Hope and Help Network meetings. In response, the Network was polled about meetings times and other feedback on how to grow the Network. A new meeting time was established and other feedback will be incorporated into future meetings and initiatives.

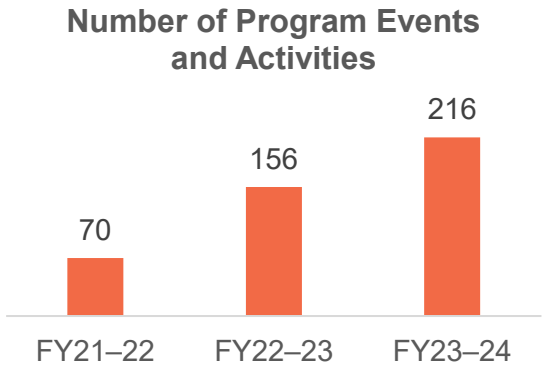
SUICIDE PREVENTION

Suicide Prevention Service
FAMILY SERVICE AGENCY OF THE CENTRAL COAST

Suicide Prevention Service is a program of Family Service Agency of the Central Coast. The primary mission is to identify high-risk individuals, families, and groups and provide them with safe alternatives to suicidal behavior. The program's integrated method of service delivery includes a 24/7/365 free 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

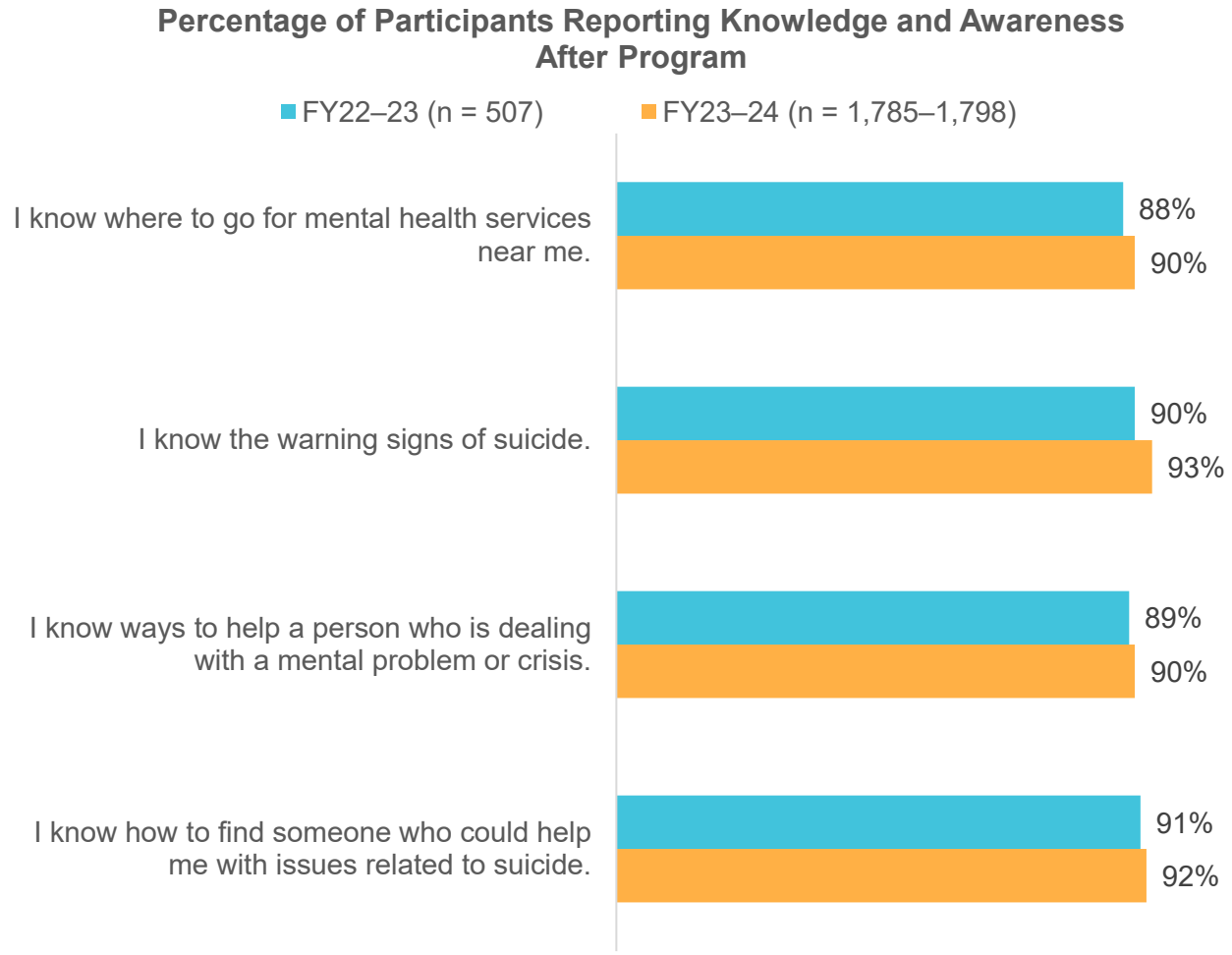




Suicide Prevention Service

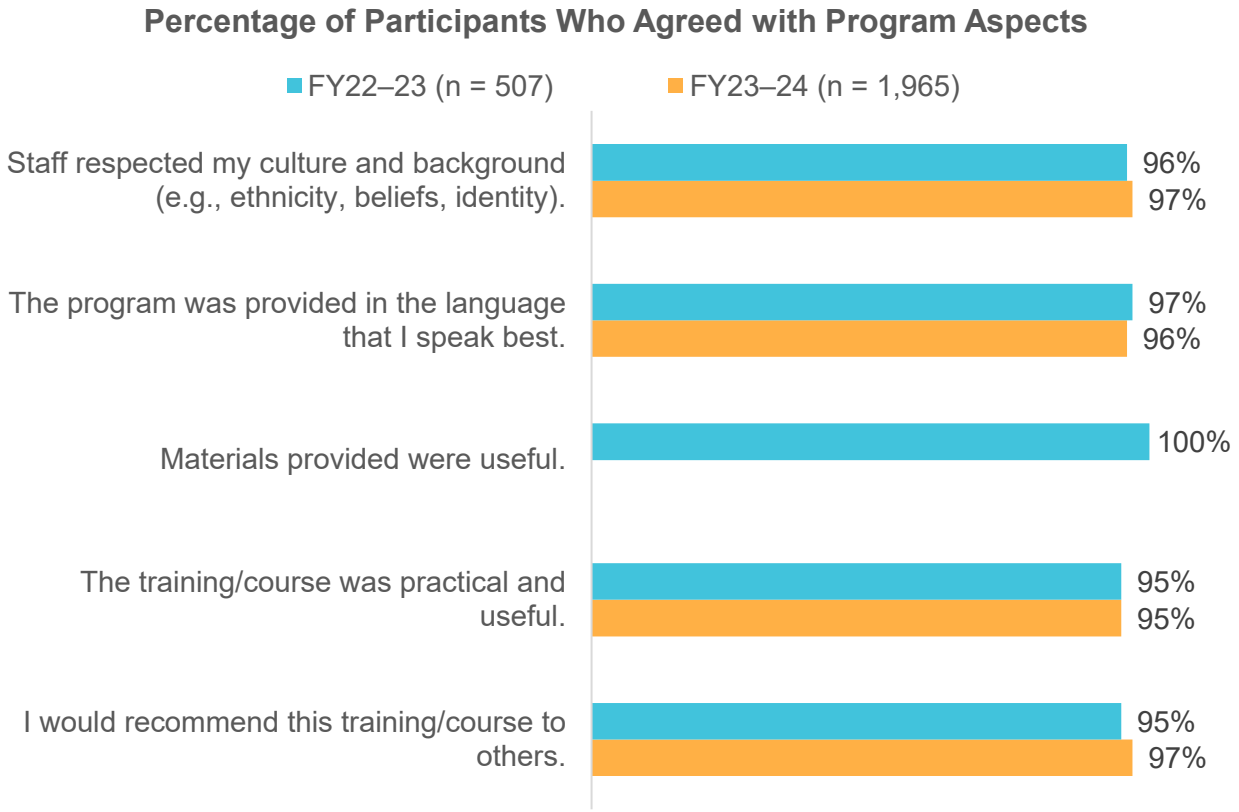
Program Outcomes, Satisfaction, and Feedback

Suicide Prevention Service tracks program outcomes by asking participants to self-assess their knowledge and satisfaction after receiving program services. Survey results for the past two fiscal years are presented in the charts below.



Suicide Prevention Service

Program Outcomes, Satisfaction, and Feedback



Participants who received services from Suicide Prevention Service were asked to give additional feedback through two open-ended questions. Their comments were categorized by theme, and the most common responses from the past two years are summarized below.

What was most useful or helpful about this program?

- FY 22–23: Learning how to help people
- FY 23–24: Increased awareness of resources and hotline services

What are your recommendations for improvement?

- FY 22–23: More resources and information (e.g., on warning signs)
- FY 23–24: More interactive and hands-on activities

Suicide Prevention Service

Demographic Data

Suicide Prevention Service collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 484**	**n = 1,033**	**n = 2,013**
American Indian/Alaska Native	4%	2%	1%
Asian	10%	5%	4%
Black/African American	4%	3%	3%
Hispanic/Latino/a/e	57%	69%	70%
Native Hawaiian/Other Pacific Islander	2%	1%	1%
White	37%	18%	14%
More Than One Race	0%	7%	10%
Other	7%	1%	2%
Declined to State	--	6%	3%
Primary Language*	**n = 488**	**n = 1,023**	**n = 2,025**
English	63%	43%	40%
Spanish	13%	23%	21%
English and Spanish	27%	31%	35%
Other	2%	1%	2%
Declined to State	--	3%	1%
Age Groups	**n = 479**	**n = 950**	**n = 1,958**
0 to 15 years	81%	69%	72%
16–25 years	13%	28%	23%
26–59 years	5%	2%	5%
60+ years	1%	1%	0%
Declined to State	--	7%	--

* Percentages may exceed 100% because participants could choose more than one response option.
-- Data not available.

Suicide Prevention Service

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** The program developed a new group facilitator training for clients, volunteers, and staff who were potentially interested in becoming support group facilitators.
- **FY 22–23:** The program restructured and was able to handle increased call volume.
- **FY 23–24:** Staff planned a significant project aimed at spreading awareness during May Mental Health Month by setting up booths in schools at lunchtime.

Achievements

- **FY 21–22:** The American Association of Suicidology re-accredited SPS (for 5 years), validating that work met nationally recognized standards.
- **FY 22–23:** Responded to requests for media interviews (English and Spanish), with outlets including KSBW, KION, Telemundo, Unison, Santa Cruz Sentinel and Santa Cruz Local online newspaper.
- **FY 23–24:** Developed a Safety Plan form for the public, which was distributed during trainings and presentations to reduce suicidal ideation.

Challenges

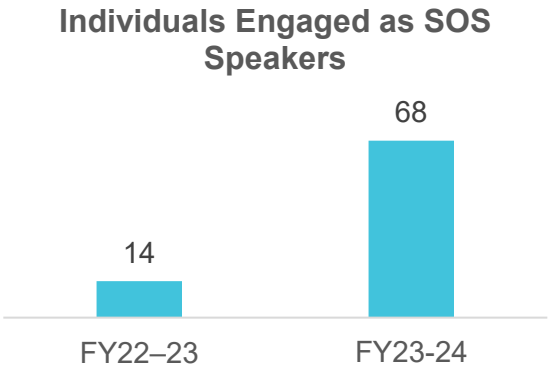
- **FY 23–24:** As we increase our reach, the number of providers we collaborate with has increased, stretching our capacity and resources.

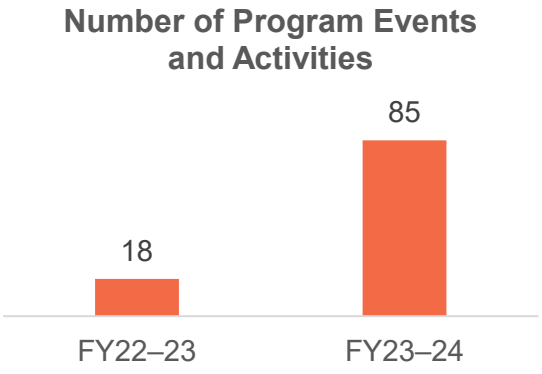
STIGMA AND DISCRIMINATION REDUCTION

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

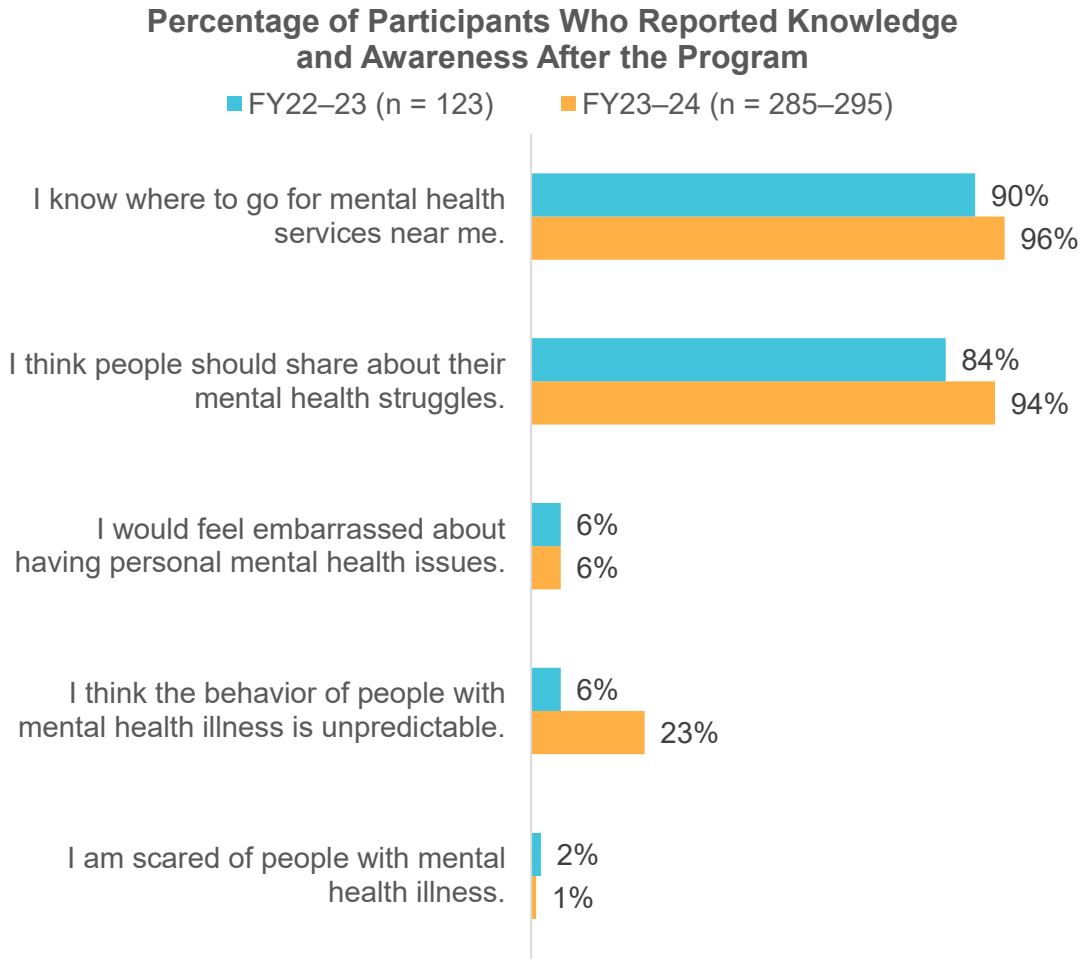




Success Over Stigma (SOS)

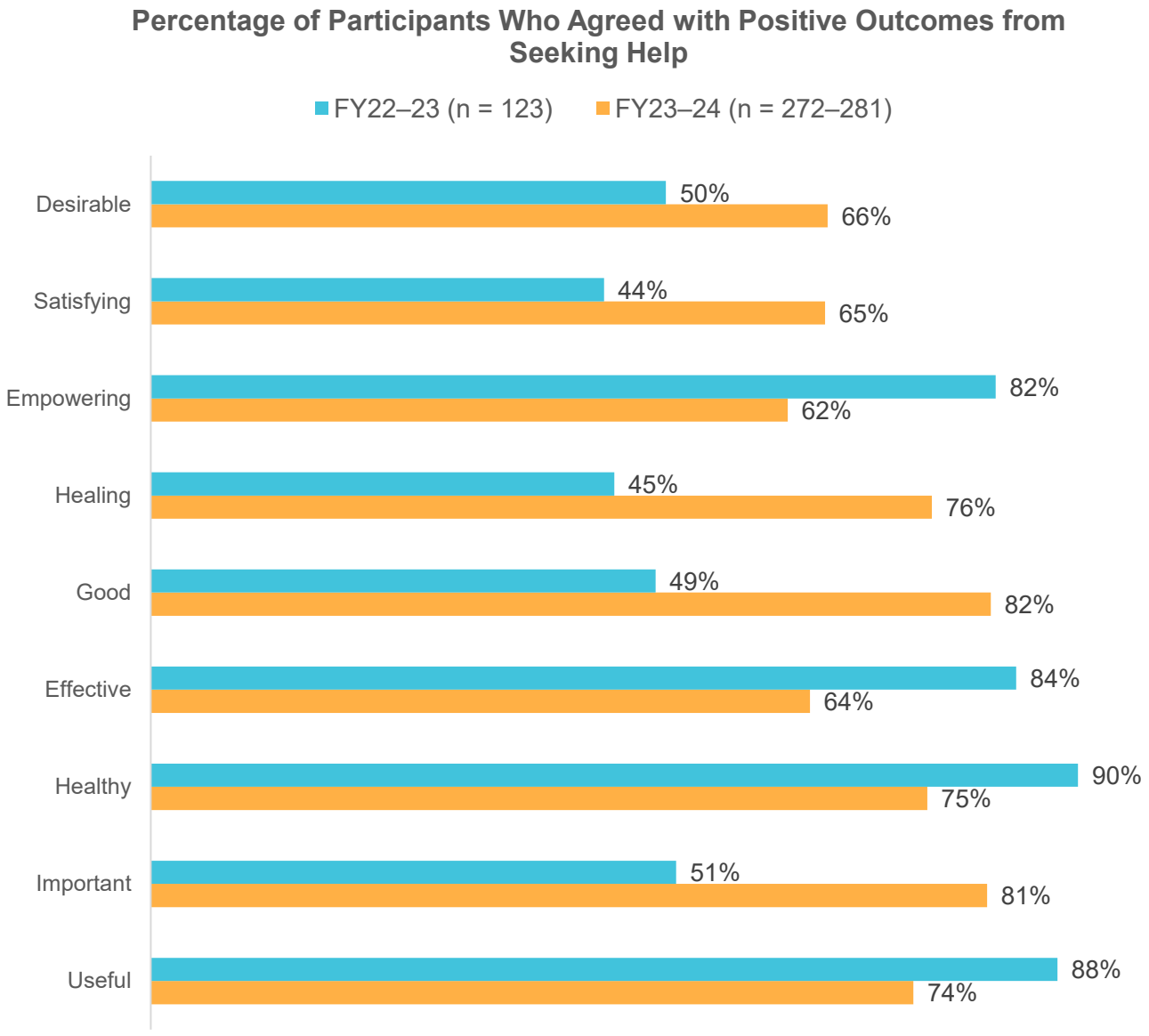
Program Outcomes, Satisfaction, and Feedback

Interim's Success Over Stigma program tracks program outcomes by asking participants to self-assess knowledge, satisfaction, and well-being after receiving program services. Survey results for the past two fiscal years are presented in the charts below.



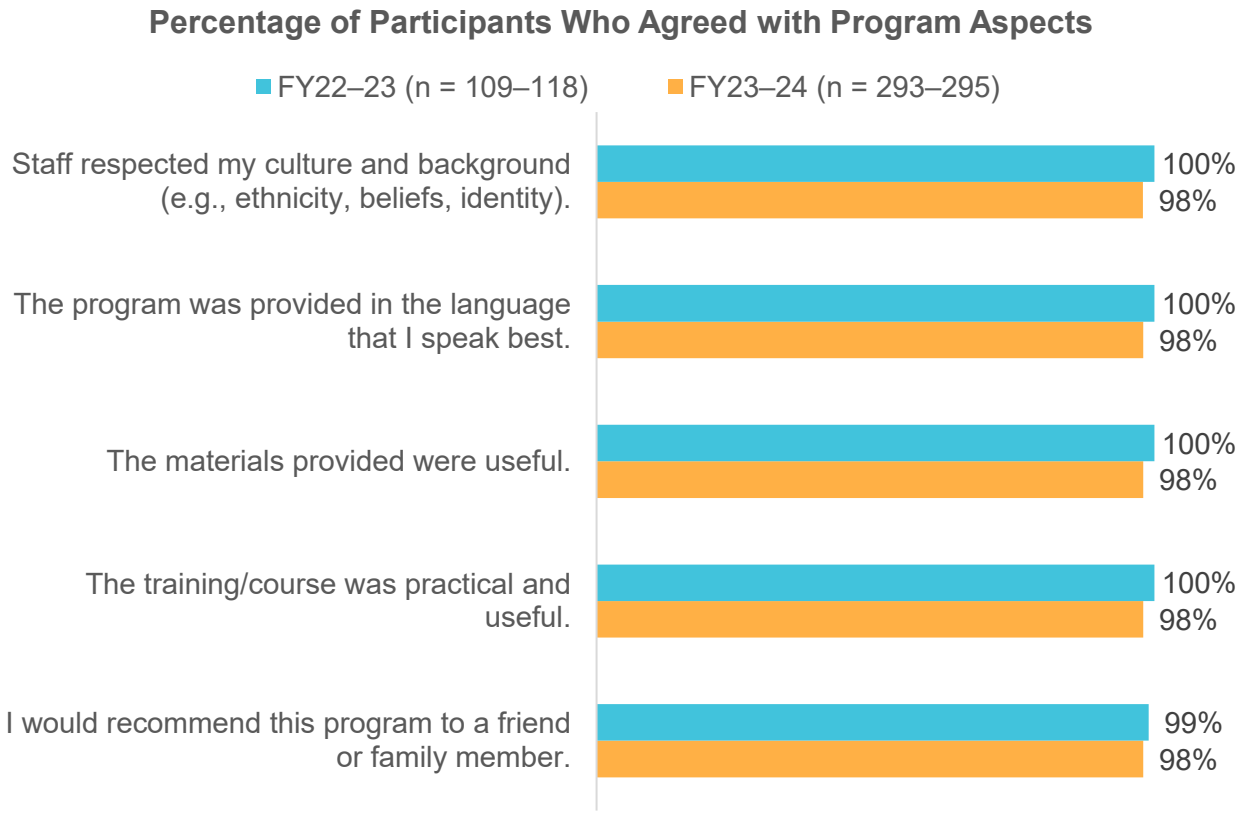
Success Over Stigma (SOS)

Program Outcomes, Satisfaction, and Feedback



Success Over Stigma (SOS)

Program Outcomes, Satisfaction, and Feedback



Participants who received services from Success Over Stigma were asked to give additional feedback through two open-ended questions. Their comments were categorized by theme, and the most common responses from the past two years are summarized below.

What was most useful or helpful about this program?

- FY 22–23: Hearing people's stories
- FY 23–24: Power of personal stories and shared experience

What are your recommendations for improvement?

- FY 22–23: Knowing help is available
- FY 23–24: More time and expanded discussion

Success Over Stigma (SOS)

Demographic Data

Success Over Stigma collects unduplicated demographic data from the individuals they serve.

	FY 22–23	FY 23–24
Race*	**n = 456**	**n = 551**
American Indian/Alaska Native	3%	2%
Asian	5%	5%
Black/African American	4%	3%
Hispanic/Latino/a/e	43%	53%
Native Hawaiian/Other Pacific Islander	4%	2%
White	31%	23%
More Than One Race	7%	8%
Other	8%	8%
Declined to State	--	15%
Ethnicity*	**n = 38**	**n = --¤**
Hispanic/Latino/a/e		
Caribbean	0%	--
Central American	0%	--
Mexican/Mex. Am./Chicano	71%	--
Puerto Rican	0%	--
South American	0%	--
Other Hispanic/Latino/a/e	0%	--
Non-Hispanic/Non-Latino/a/e		
African	0%	--
Asian Indian/South Asian	0%	--
Cambodian	0%	--
Chinese	0%	--
Eastern European	0%	--
European	13%	--
Filipino	8%	--
Japanese	0%	--
Korean	0%	--
Middle Eastern	5%	--
Vietnamese	0%	--
Other Non-Hispanic/Non-Latino/a/e	5%	--
More Than One Ethnicity	0%	--
Declined to State	0%	--
Age Groups	**n = 414**	**n = 351⁺**
0 to 15 years	0%	22%
16–25 years	36%	40%
26–59 years	57%	32%
60+ years	7%	7%

	FY 22–23	FY 23–24
Declined to State	10%	0%
Primary Language*	**n = 456**	**n = 549**
English	58%	49%
Spanish	7%	10%
English and Spanish	21%	25%
Other	2%	1%
Declined to State	13%	15%
Gender Identity	**n = 40**	**n = --¤**
Female	85%	--
Genderqueer	0%	--
Male	15%	--
Nonbinary	0%	--
Questioning or Unsure	0%	--
Transgender	3%	--
Another Gender Identity	0%	--
Declined to State	--	--
Sex Assigned at Birth	**n = 40**	**n = --¤**
Female	88%	--
Male	13%	--
Another Sex Assigned	0%	--
Declined to State	--	--
Sexual Orientation	**n = 40**	**n = --¤**
Bisexual	8%	--
Gay or Lesbian	5%	--
Heterosexual or Straight	83%	--
Pansexual	0%	--
Queer	5%	--
Questioning or Unsure	0%	--
Another Sexual Orientation	0%	--
Declined to State	0%	--
Disability*	**n = 40**	**n = --¤**
Mental Domain	58%	--
Seeing	3%	--
Hearing	0%	--
Other Communication	0%	--
Physical	5%	--
Chronic Health Condition	8%	--
Another Disability	0%	--
Declined to State	--	--

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

¤ Category not available for that fiscal year.

+ Percentages may exceed 100% due to rounding.

-- Data not available.

Success Over Stigma (SOS)

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** The program had a strong speaker training curriculum.
- **FY 23–24:** The program recruited three new speakers who can share their impactful stories of mental health recovery.

Achievements

- **FY 22–23:** Started a monthly advocacy group.
- **FY 23–24:** Participated in the annual Gonzales High School Mental Health Resource Fair, which brought opportunities for SOS presentations in South County.

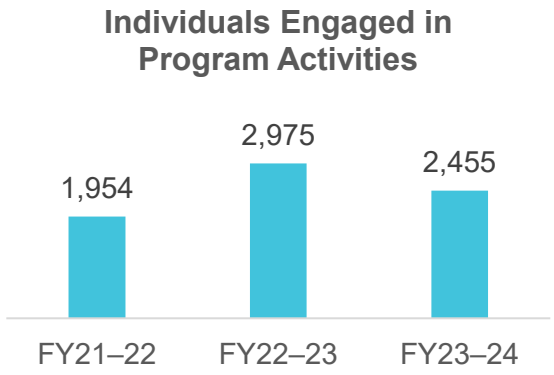
Challenges

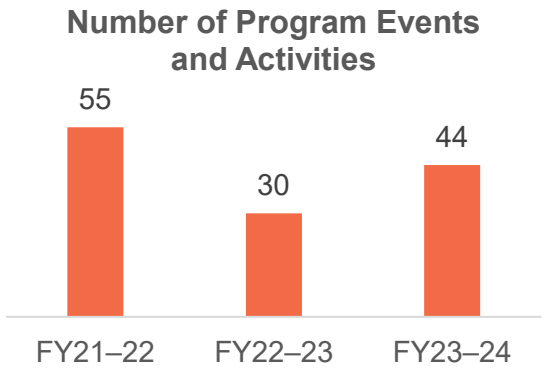
- **FY 23–24:** We have an ongoing need for bilingual speakers and TAY speakers.

Family Self-Help Support and Advocacy: NAMI Signature Programs
NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) MONTEREY COUNTY

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

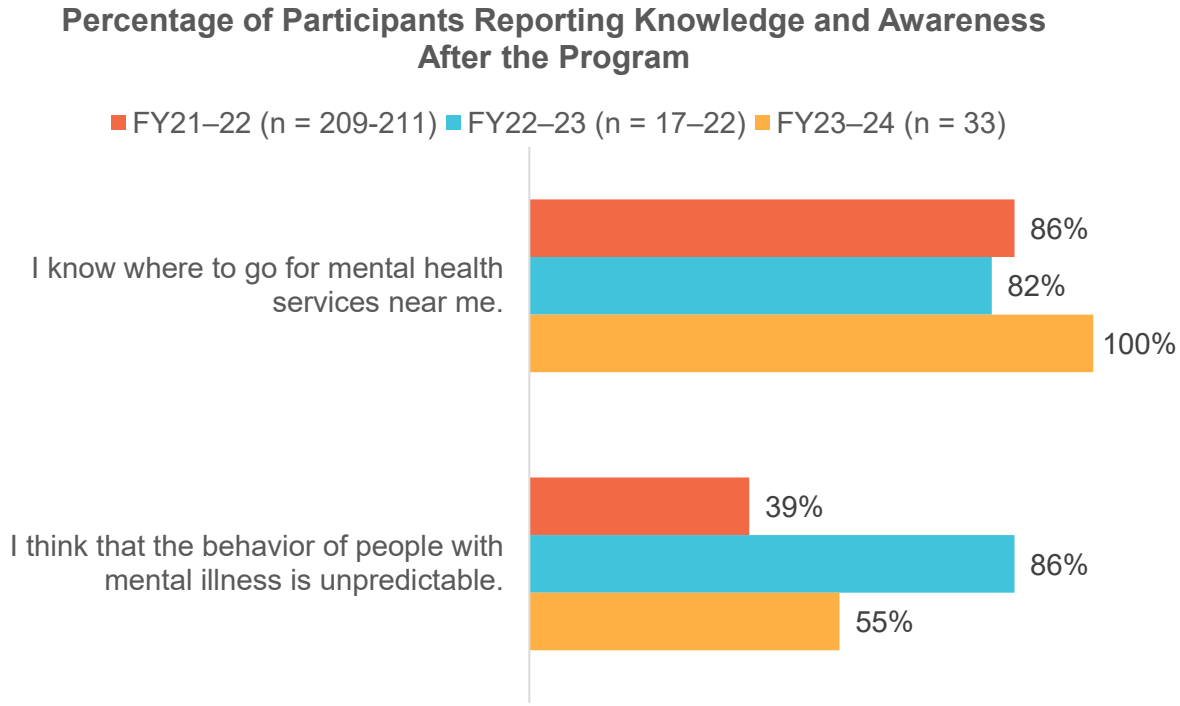




Family Self-Help Support and Advocacy: NAMI Signature Programs

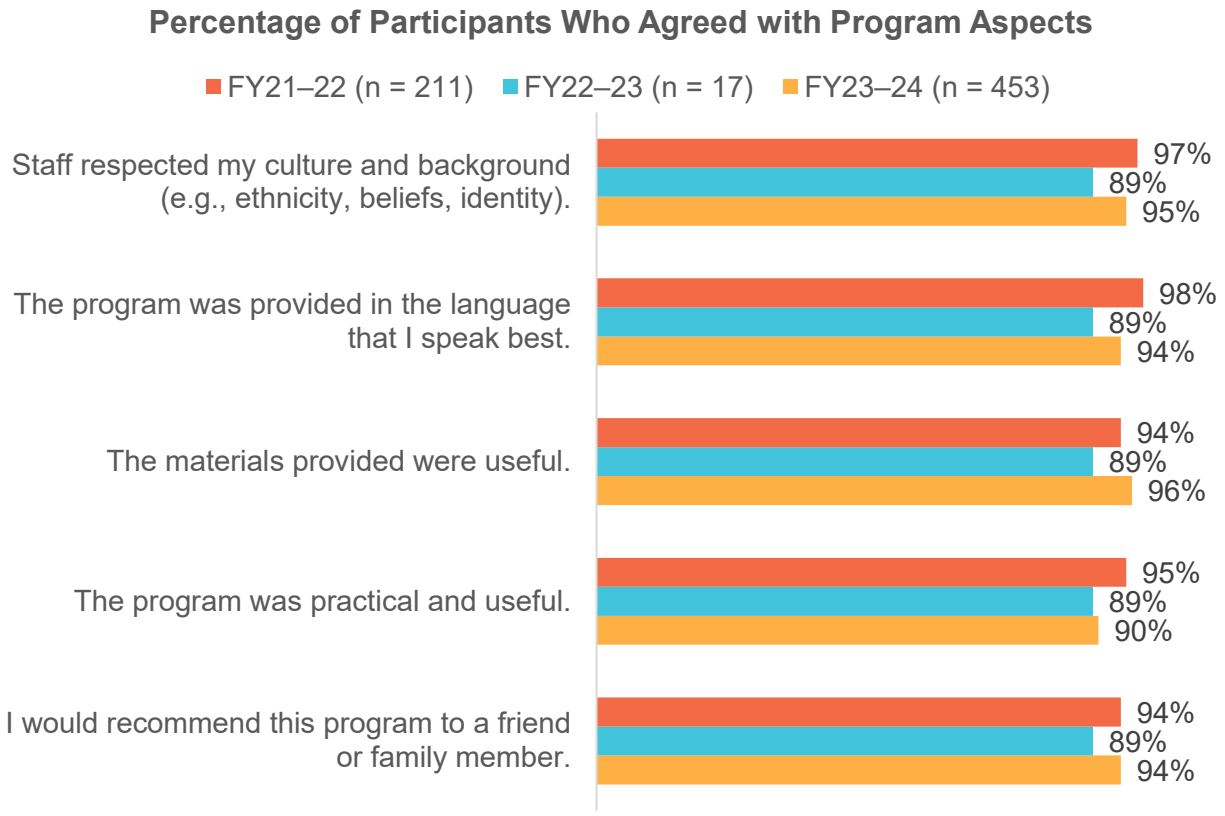
Program Outcomes, Satisfaction, and Feedback

Family Self-Help Support and Advocacy tracks signature program outcomes by asking participants to self-assess their knowledge and satisfaction after receiving program services. Survey results for the past three fiscal years are presented in the charts below. Only survey items available across all three years are reported on in this section.



Family Self-Help Support and Advocacy: NAMI Signature Programs

Program Outcomes, Satisfaction, and Feedback



Participants who received signature program services from Family Self-Help Support and Advocacy were asked to give additional feedback through two open-ended questions. Their comments were categorized by theme, and the most common responses from the past three years are summarized below.

What was most useful or helpful about this program?

- FY 21–22: Knowing where to go for help
- FY 22–23: The support group and feeling more connected to others
- FY 23–24: Personal stories and lived experiences

What are your recommendations for improvement?

- FY 21–22: Additional/more in-depth topics
- FY 22–23: Offered on different days and times
- FY 23–24: More time and longer presentations

Family Self-Help Support and Advocacy: NAMI Signature Programs

Demographic Data

Family Self-Help Support and Advocacy collects unduplicated demographic data from the individuals they serve.

	FY 21–22	FY 22–23	FY 23–24
Race*	**n = 1,189**	**n = 130**	**n = 32**
American Indian/Alaska Native	3%	2%	0%
Asian	5%	8%	0%
Black/African American	18%	2%	6%
Hispanic/Latino/a/e	64%	3%	56%
Native Hawaiian/Other Pacific Islander	3%	36%	0%
White	17%	55%	44%
More Than One Race	0%	0%	9%
Other	3%	2%	3%
Declined to State	--	2%	19%
Ethnicity*	**n = 102**	**n = 95**	**n = 9**
Hispanic/Latino/a/e			
Caribbean	3%	1%	--
Central American	6%	1%	--
Mexican/Mex. Am./Chicano	53%	41%	--
Puerto Rican	3%	1%	--
South American	9%	0%	--
Other Hispanic/Latino/a/e	0%	0%	--
Non-Hispanic/Non-Latino/a/e			
African	1%	0%	--
Asian Indian/South Asian	0%	2%	--
Cambodian	0%	0%	--
Chinese	0%	2%	--
Eastern European	3%	7%	--
European	25%	38%	--
Filipino	3%	7%	--
Japanese	3%	22%	--
Korean	0%	0%	--
Middle Eastern	0%	0%	--
Vietnamese	0%	1%	--
Other Non-Hispanic/Non-Latino/a/e	15%	5%	--
More Than One Ethnicity	0%	2%	--
Declined to State	--	8%	--

	FY 21–22	FY 22–23	FY 23–24
Age Groups	**n = 1,184**	**n = 116**	**n = 32**
0 to 15 years	71%	16%	0%
16–25 years	13%	21%	13%
26–59 years	14%	37%	81%
60+ years	2%	27%	6%
Declined to State	--	1%	--
Primary Language*	**n = 1,191**	**n = 129**	**n = 40**
English	39%	72%	68%
Spanish	24%	6%	3%
English and Spanish	35%	17%	20%
Other	3%	2%	0%
Declined to State	--	2%	10%
Gender Identity	**n = 111**	**n = 108**	**n = 10**
Female	68%	60%	40%
Genderqueer	0%	0%	0%
Male	32%	36%	40%
Nonbinary	0%	2%	0%
Questioning or Unsure	0%	0%	0%
Transgender	0%	0%	0%
Another Gender Identity	0%	0%	0%
Declined to State	--	2%	20%
Sexual Orientation	**n = 98**	**n = 108**	**n = 9¬**
Bisexual	12%	3%	--
Gay or Lesbian	1%	2%	--
Heterosexual or Straight	75%	82%	--
Pansexual	6%	2%	--
Queer	0%	0%	--
Questioning or Unsure	0%	1%	--
Another Sexual Orientation	6%	1%	--
Declined to State	--	1%	11%
Sex Assigned at Birth	**n = 111**	**n = --¤**	**n = 10**
Female	74%	--	40%
Male	26%	--	40%
Another Sex Assigned	0%	--	0%
Declined to State	--	--	20%
Disability*	**n = 72**	**n = 107**	**n = 10**
Mental Domain	93%	44%	60%
Seeing	11%	1%	0%
Hearing	1%	3%	30%
Other Communication	0%	1%	0%
Physical	13%	6%	10%
Chronic Health Condition	17%	8%	0%

	FY 21–22	FY 22–23	FY 23–24
Another Disability	4%	2%	10%
Declined to State	--	7%	0%
Veteran	**n = 1,092**	**n = 103**	**n = 10**
Yes	0%	35%	20%
No	100%	65%	80%
Declined to State	--	4%	0%

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

¤ Category not available for that fiscal year.

¬ Demographics with fewer than 10 responses are not reported.

-- Data not available.

Family Self-Help Support and Advocacy: NAMI Signature Programs

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past three fiscal years. Notably, each year, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 21–22:** Provided evidence-based programs that support people with mental illness and their family members.
- **FY 22–23:** Established NAMI on high school campus clubs with the Salinas Union High School District.
- **FY 23–24:** NAMI programming gave opportunities for people to actively explore the realities of mental illness and tools to live well, while staying in relationships with loved ones.

Achievements

- **FY 21–22:** Created and maintained networks.
- **FY 22–23:** Facilitated over 25 support groups for family members, friends, and peers with lived experience.
- **FY 23–24:** Demand for our peer support groups was high, so we began work to develop more peer groups.

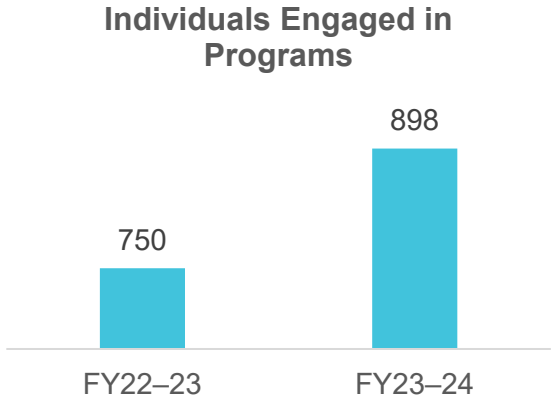
Challenges

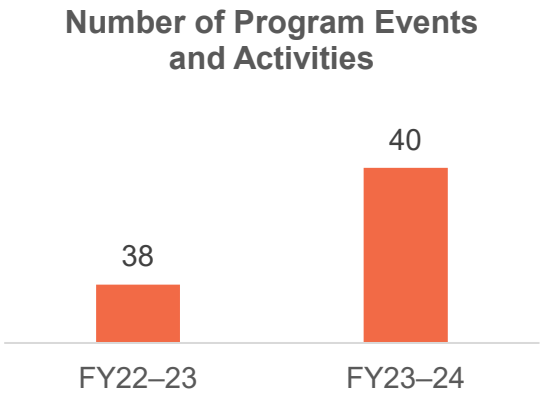
- **FY 23–24:** NAMI Monterey County had some staffing hiccups in the first and second quarters of this fiscal year. Because we are such a small organization, the impact to programs was significant and, as a result, much of our programming paused in order for us to regroup and hire new staff.

Family Self-Help Support and Advocacy: Youth Leadership and Empowerment
NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) MONTEREY COUNTY

National Alliance on Mental Illness (NAMI) Monterey County 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 facilitates youth leadership and empowerment regarding mental health in Monterey County. NAMI 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 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 to develop and serve on a Youth Empowerment Council.

Program Highlights

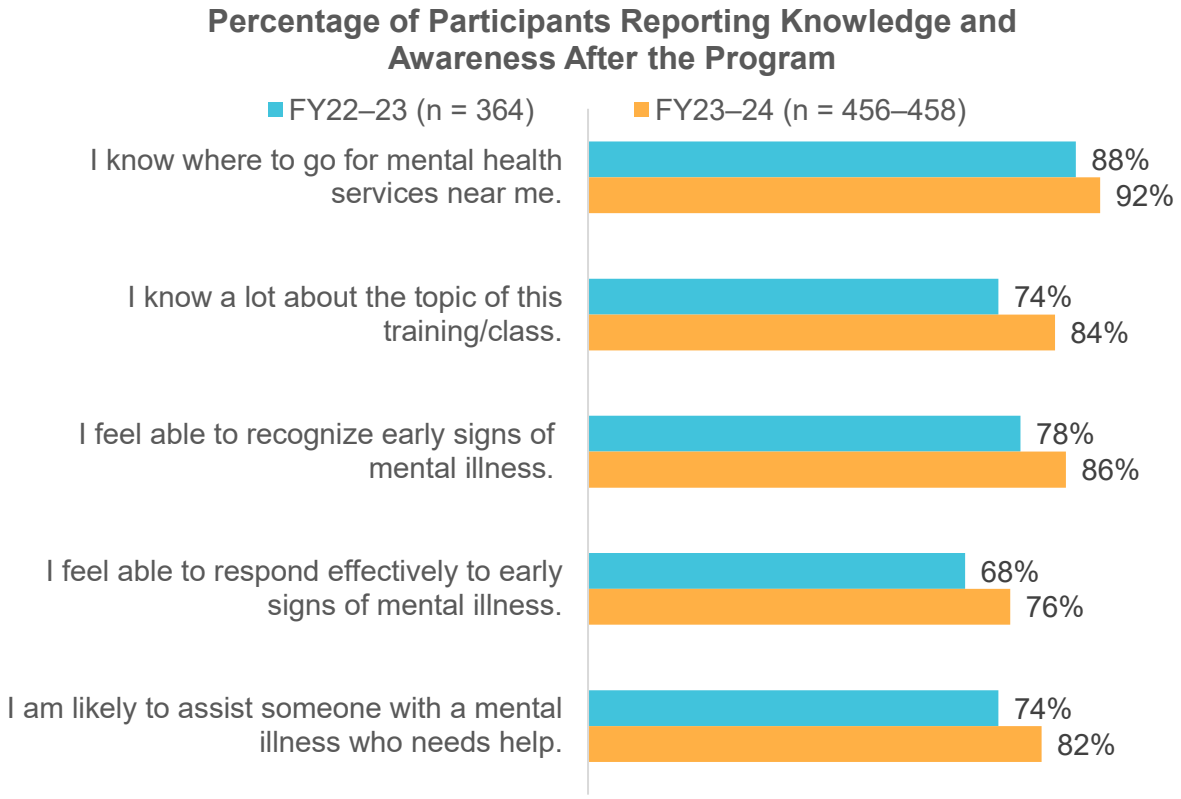




Family Self-Help Support and Advocacy: Youth Leadership and Empowerment

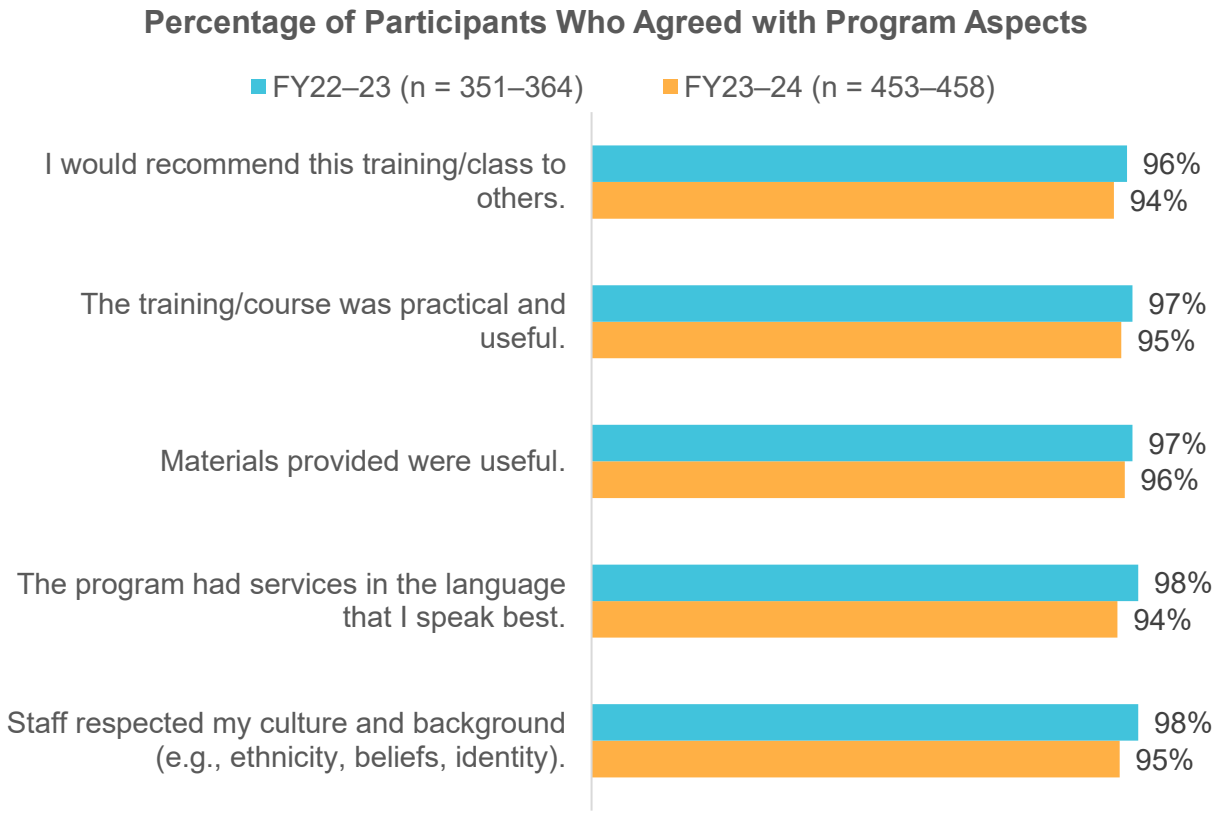
Program Outcomes, Satisfaction, and Feedback

Family Self-Help Support and Advocacy: Youth Leadership and Empowerment tracks program outcomes by asking participants to self-assess their knowledge and satisfaction after receiving program services. Survey results for the past two fiscal years are presented in the charts below.



Family Self-Help Support and Advocacy: Youth Leadership and Empowerment

Program Outcomes, Satisfaction, and Feedback



Family Self-Help Support and Advocacy: Youth Leadership and Empowerment

Program Outcomes, Satisfaction, and Feedback

Participants who received services from Family Self-Help Support and Advocacy: Youth Leadership and Empowerment were asked to give additional feedback through two open-ended questions. Their comments were categorized by theme, and the most common responses from the past two years are summarized below.

What was most useful or helpful about this program?

- FY 22–23: Feeling more educated
- FY 23–24: Recognizing early signs of mental illness and understanding symptoms

What are your recommendations for improvement?

- FY 22–23: More information to assist self or others with mental illness
- FY 23–24: More interactive and engaging activities

Family Self-Help Support and Advocacy: Youth Leadership and Empowerment

Demographic Data

Family Self-Help Support and Advocacy: Youth Leadership and Empowerment collects unduplicated demographic data from the individuals they serve.

	FY 22–23	FY 23–24
Race*	**n = 668**	**n = 327**
American Indian/Alaska Native	2%	0%
Asian	5%	9%
Black/African American	2%	2%
Hispanic/Latino/a/e	80%	72%
Native Hawaiian/Other Pacific Islander	1%	1%
White	12%	24%
More Than One Race	0%	6%
Other	0%	3%
Declined to State	5%	6%
Age Groups	**n = 581**	**n = 326**
0 to 15 years	93%	53%
16–25 years	7%	37%
26–59 years	1%	9%
60+ years	0%	1%
Declined to State	12%	--
Primary Language*	**n = 668**	**n = 363**
English	31%	43%
Spanish	21%	22%
English and Spanish	41%	29%
Other	2%	1%
Declined to State	5%	5%

* Percentages may exceed 100% because participants could choose more than one response option.
-- Data not available.

Family Self-Help Support and Advocacy: Youth Leadership and Empowerment

Successes and Learning

Program staff were asked each year to highlight notable strengths, successes, and challenges encountered. The chart below provides a summary of the key strengths and achievements reported by program staff across the past two fiscal years. Notably, program staff actively addressed and overcame previous years' challenges, so only challenges specific to fiscal year 2023–2024 are included in the chart.

Notable Strengths

- **FY 22–23:** The program enhanced youth outreach through collaborations with local schools.
- **FY 23–24:** The most common thing that we hear from our participants (and is also demonstrated in the peer-reviewed literature) about our programming is that it supports people to not feel alone.
- Our NAMI On Campus Club at Rancho San Juan High School grew in both numbers and capacity, and established a "Wellness Wednesdays" program.

Achievements

- **FY 22–23:** Our youth outreach coordinator built relationships with youth-serving organizations and prepared for the youth summit.
- **FY 23–24:** NAMI hosted a youth summit and then pivoted youth outreach efforts into building the "Youth Empowerment Success Squad (YESS)."

Challenges

- **FY 23–24:** The Youth Summit took signficant staff effort and, after reviewing its outcomes with community partners, it was determined to pivot our efforts to the YESS group and growing NAMI On Campus clubs.
- Demand for NAMI presence within schools has expanded beyond our capacity.
- Parents and schools frequently request programming and presentations to educate and support parents and caregivers.

APPENDICES

Preface to Appendices

Appendix A is a list of programs receiving Prevention and Early Intervention funding at any time during fiscal years 21–22, 22–23, and 23–24. The programs are listed by PEI category as categorized for FY 23–24. Program status for each fiscal year is indicated in the columns to the right of the program name: a red X indicates that the program was inactive in that fiscal year, and a green check mark indicates that the program was active in that particular fiscal year. Programs active for more than one fiscal year can switch categories. For programs where this has occurred, the category that the program fell into is noted in the cell for that fiscal year.

Appendix B shows the number of individuals engaged by each program in each fiscal year. The number of individuals served for each fiscal year is indicated in the columns to the right of the program name. Programs active for more than one fiscal year can switch categories. For programs where this has occurred, the category that the program fell into is noted in the cell for that fiscal year. Only programs included in this three-year report appear in this appendix.

Appendix C shows the number of activities hosted by each program in each fiscal year. The number of activities hosted for each fiscal year is indicated in the columns to the right of the program name. Programs active for more than one fiscal year can switch categories. For

programs where this has occurred, the category that the program fell into is noted in the cell for that fiscal year. Only programs included in this three-year report appear in this appendix.

Appendix D shows the number of individuals referred to other services by each program in each fiscal year. The number of individuals referred to other services for each fiscal year is indicated in the columns to the right of the program name. Programs active for more than one fiscal year can switch categories. For programs where this has occurred, the category that the program fell into is noted in the cell for that fiscal year. Only programs noted as making referrals in this three-year report appear in this appendix.

Appendix E shows aggregate participant outcomes data by survey type. Questions from each survey type are presented in the rows. The percentage of individuals agreeing with each statement is shown in the columns. The range of the number of respondents who answered questions on a particular survey in a given fiscal year is noted at the top of the column under the fiscal year.

Appendix F shows aggregate PEI participant demographics across all programs and primary program categories. These aggregate values include all programs, including those with fewer than 10 respondents and programs whose demographic data was not presented because there were less than 2 years of data available. The 211 program from United Way is excluded from these aggregate values due to the high number of clients that connect to the program; inclusion of their service numbers prohibits the ability to see the reach of the smaller programs serving Monterey County residents. Demographic categories (e.g., race, ethnicity, age) and response options are shown in the rows. Demographic responses were collected by an MCBH PEI demographic form (adult, parent, or presentation version) or from Avatar.

APPENDIX A

PEI PROGRAMS BY CATEGORY

PROGRAM	YEARS ACTIVE		
	FY 21–22	FY 22–23	FY 23–24
PREVENTION			
Culturally Specific Prevention and Early Intervention Through Outreach and Engagement *(Center for Community Advocacy [CCA])*	Outreach	✓	✓
Maternal Mental Health Peer Navigation Program *(Centro Binacional para el Desarrollo Indígena Oaxaqueño [CBDIO])*	✗	✓	✓
Parent Education Program *(Community Human Services [CHS])*	✓	✓	✓
Culturally Specific Outreach and Engagement *(Community Human Services [CHS])*	✗	✓	✓
The Epicenter	✓	✓	✓
Bullying Prevention *(Harmony At Home)*	✗	✓	✓
Teen Success, Inc. *(Harmony At Home)*	✗	✓	✓
Maternal Mental Health (MMH) *(Monterey County Behavioral Health [MCBH])*	✓	✓	✓
Proyecto Contigo and School-Based Counseling *(Pajaro Valley Prevention and Student Assistance)*	Early Intervention	✓	✓
Maternal Mental Health Peer Navigation Program *(Parenting Connections of Monterey County)*	✗	✓	✓
Culturally Relevant Parenting Classes *(Partners for Peace)*	✓	✓	✓
Maternal, Child and Adolescent Health Home Visiting Program *(Public Health Bureau)*	✗	Early Intervention	✓

PROGRAM	YEARS ACTIVE		
	FY 21–22	FY 22–23	FY 23–24
Senior Companion Program *(Seniors Council of Santa Cruz and San Benito Counties)*	✓	✓	✓
Services to Education *(Monterey County Behavioral Health [MCBH])*	Early Intervention	Early Intervention	✓
After School Academy *(The Village Project, Inc.)*	✗	✓	✓
Outreach and Engagement Services *(The Village Project, Inc.)*	Outreach[α]	✓	✓
EARLY INTERVENTION			
Senior Peer Counseling and Fortaleciendo el Bienestar *(Alliance on Aging)*	Prevention	Prevention	✓
Culturally Specific Short-term Therapeutic Services (CSSTS) *(Community Human Services [CHS])*	✗	✓	✓
Drug and Alcohol Intervention Services for Youth (DAISY) *(Community Human Services [CHS])*	✗	✓	✓
(re)MIND® *(Felton Institute)*	✓	✓	✓
Sticks & Stones® School-Based Counseling *(Harmony At Home)*	✓	✓	✓
Family Support Groups[#] *(Monterey County Behavioral Health [MCBH], Adult System of Care [ASOC])*	✓	✓	✓
Silver Star Resource Center *(Monterey County Behavioral Health [MCBH])*	✓	✓	✓

PROGRAM	YEARS ACTIVE		
	FY 21–22	FY 22–23	FY 23–24
Outpatient Mental Health Services *(The Village Project, Inc.)*	✗	✓	✓
ACCESS AND LINKAGE TO TREATMENT			
Street Outreach Program *(Community Human Services [CHS])*	✗	✓	✓
Community Health Workers* *(Community Foundation for Monterey County)*	✗	✗	✓
WellScreen Monterey* *(Credible Minds)*	✗	✗	✓
Keep It Real Community Outreach & Navigation *(Interim)*	✗	✓	✓
Veterans Reintegration Transition Program *(Monterey County Military & Veterans Affairs Office [MVAO])*	✓	✓	✓
Family Partners Program *(Seneca Center)*	✗	✓	✓
211 *(United Way Monterey County)*	✓	✓	✓
SUICIDE PREVENTION			
Monterey County Helping One another to Prevent and Eliminate Suicide (MC HOPES)# *(Applied Crisis Training and Consulting, Inc.)*	✗	✓	✓
Suicide Prevention Service *(Family Service Agency of the Central Coast)*	✓	✓	✓
STIGMA AND DISCRIMINATION REDUCTION			
Success Over Stigma (SOS) *(Interim)*	✗	✓	✓

PROGRAM	YEARS ACTIVE		
	FY 21–22	FY 22–23	FY 23–24
Family Self-Help Support and Advocacy: NAMI Signature Programs *(National Alliance on Mental Illness [NAMI] Monterey County)*	✓	✓	✓
Family Self-Help Support and Advocacy: Youth Leadership and Empowerment *(National Alliance on Mental Illness [NAMI] Monterey County)*	✗	Outreach	✓
OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS			
Community Presentations and Outreach *(Monterey County Behavioral Health [MCBH])*	✓	✓	✗

*WellScreen Monterey and Community Health Workers only received 6 months of PEI funding during the covered period of time. Due to the short duration, data for these programs are not presented in this report.
#Family Support Groups and MC HOPES had insufficient data for FY 23–24. Due to the lack of information for the covered period of time in the last fiscal year, this report does not present data for these programs.
αIn FY 21-22 this program was called the African American Community Partnership.

Note: *Depending on changes in program offerings, a program may switch to another PEI category from one year to the next. If a program was active in a particular fiscal year under a different category, that category is denoted in the cell for that particular fiscal year in the above table.*

APPENDIX B

NUMBER OF INDIVIDUALS ENGAGED BY EACH PROGRAM

PROGRAM	FISCAL YEAR		
	21–22	22–23	23–24
PREVENTION			
Senior Peer Counseling and Fortaleciendo el Bienestar *(Alliance on Aging)*	109	430	Early Intervention
Culturally Specific Prevention and Early Intervention Through Outreach and Engagement *(Center for Community Advocacy [CCA])*	Outreach	714	898
Maternal Mental Health Peer Navigation Program *(Centro Binacional para el Desarrollo Indígena Oaxaqueño [CBDIO])*	n/a	365	487
Parent Education Program *(Community Human Services [CHS])*	167	449	294
Culturally Specific Outreach and Engagement *(Community Human Services [CHS])*	n/a	~	~
The Epicenter	1,262	349	389
Bullying Prevention *(Harmony At Home)*	n/a	1,762	3,524
Teen Success, Inc. *(Harmony At Home)*	59	124	98
Maternal Mental Health (MMH) *(Monterey County Behavioral Health [MCBH])*	413	248	529
Proyecto Contigo and School-Based Counseling *(Pajaro Valley Prevention and Student Assistance)*	Early Intervention	596	95
Maternal Mental Health Peer Navigation Program *(Parenting Connections of Monterey County)*	n/a	350	621
Culturally Relevant Parenting Classes *(Partners for Peace)*	1,852	5,632	7,883

PROGRAM	FISCAL YEAR		
	21–22	22–23	23–24
Maternal, Child and Adolescent Health Home Visiting Program *(Public Health Bureau)*	n/a	Early Intervention	111
Senior Companion Program *(Seniors Council of Santa Cruz and San Benito Counties)*	74	15	111
Services to Education *(Monterey County Behavioral Health [MCBH])*	Early Intervention	Early Intervention	2,299
After School Academy *(The Village Project, Inc.)*	n/a	70	62
Outreach and Engagement Services *(The Village Project, Inc.)*	Outreach	13,365	9,969
Subtotal	3,936	24,469	27,370
EARLY INTERVENTION			
Senior Peer Counseling and Fortaleciendo el Bienestar *(Alliance on Aging)*	Prevention	Prevention	453
Culturally Specific Short-term Therapeutic Services (CSSTS) *(Community Human Services [CHS])*	n/a	142	446
Drug and Alcohol Intervention Services for Youth (DAISY) *(Community Human Services [CHS])*	n/a	151	260
(re)MIND® *(Felton Institute)*	251	162	511
Sticks & Stones® School-Based Counseling *(Harmony At Home)*	884	782	850
Services to Education *(Monterey County Behavioral Health [MCBH])*	4,046	210	Prevention

PROGRAM	FISCAL YEAR		
	21–22	22–23	23–24
Silver Star Resource Center *(Monterey County Behavioral Health [MCBH])*	140	210	120
Proyecto Contigo and School-Based Counseling *(Pajaro Valley Prevention and Student Assistance)*	1,454	Prevention	Prevention
Maternal, Child and Adolescent Health Home Visiting Program *(Public Health Bureau)*	n/a	65	Prevention
Outpatient Mental Health Services *(The Village Project, Inc.)*	n/a	60	46
Subtotal	6,775	1,782	2,686
ACCESS AND LINKAGE TO TREATMENT			
Street Outreach Program *(Community Human Services [CHS])*	n/a	89	157
Keep It Real Community Outreach & Navigation *(Interim)*	n/a	50	69
Veterans Reintegration Transition Program *(Monterey County Military & Veterans Affairs Office [MVAO])*	7,856	1,135	2,697
Family Partners Program *(Seneca Center)*	n/a	8	100
211 *(United Way Monterey County)*	1,853	3,290	3,537
Subtotal	9,709	4,572	6,560
SUICIDE PREVENTION			
Suicide Prevention Service *(Family Service Agency of the Central Coast)*	3,124	2,303	7,977
Subtotal	3,124	2,303	7,977
STIGMA AND DISCRIMINATION REDUCTION			

PROGRAM	FISCAL YEAR		
	21–22	22–23	23–24
Success Over Stigma (SOS) *(Interim)*	n/a	14	68
Family Self-Help Support and Advocacy: NAMI Signature Programs *(National Alliance on Mental Illness [NAMI] Monterey County)*	1,954	2,975	2,455
Family Self-Help Support and Advocacy: Youth Leadership and Empowerment *(National Alliance on Mental Illness [NAMI] Monterey County)*	n/a	Outreach	898
Subtotal	1,954	2,989	3,421
OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS			
Culturally Specific Prevention and Early Intervention Through Outreach and Engagement *(Center for Community Advocacy [CCA])*	855	Prevention	Prevention
Family Self-Help Support and Advocacy: Youth Leadership and Empowerment *(National Alliance on Mental Illness [NAMI] Monterey County)*	n/a	750	Stigma Reduction
Outreach and Engagement Services *(The Village Project, Inc.)*	1,577	Prevention	Prevention
Subtotal	2,432	750	n/a
OVERALL NUMBER OF INDIVIDUALS SERVED			
TOTAL	**27,930**	**36,865**	**48,014**

n/a: program not active during that fiscal year
~: Culturally Specific Outreach and Engagement metrics are for Number of Advertising Impressions on Radio, Television, and Social Media (not for number of individuals directly engaged). Number of impressions was 4.8M For FY 22–23 and 1.01M for FY 23–24.

Note: *Depending on changes in program offerings, a program may switch to another PEI category from one year to the next. If a program was active in a particular fiscal year under a different category, that category is denoted in the above table.*

APPENDIX C

NUMBER OF PROGRAM ACTIVITIES HOSTED BY EACH PROGRAM

PROGRAM	FISCAL YEAR		
	21–22	22–23	23–24
PREVENTION			
Senior Peer Counseling and Fortaleciendo el Bienestar *(Alliance on Aging)*	2,865	2,136	Early Intervention
Culturally Specific Prevention and Early Intervention Through Outreach and Engagement *(Center for Community Advocacy [CCA])*	Outreach	358	149
Maternal Mental Health Peer Navigation Program *(Centro Binacional para el Desarrollo Indígena Oaxaqueño [CBDIO])*	n/a	208	44
Parent Education Program *(Community Human Services [CHS])*	18	138	143
Culturally Specific Outreach and Engagement *(Community Human Services [CHS])*	n/a	10	8
The Epicenter	88	92	72
Bullying Prevention *(Harmony At Home)*	n/a	74	155
Teen Success, Inc. *(Harmony At Home)*	203	103	87
Maternal Mental Health (MMH) *(Monterey County Behavioral Health [MCBH])*	83	51	65
Proyecto Contigo and School-Based Counseling *(Pajaro Valley Prevention and Student Assistance)*	Early Intervention	15	8
Maternal Mental Health Peer Navigation Program *(Parenting Connections of Monterey County)*	n/a	61	117
Culturally Relevant Parenting Classes *(Partners for Peace)*	204	823	726

PROGRAM	FISCAL YEAR		
	21–22	22–23	23–24
Maternal, Child and Adolescent Health Home Visiting Program *(Public Health Bureau)*	n/a	Early Intervention	107
Senior Companion Program *(Seniors Council of Santa Cruz and San Benito Counties)*	--	10	9
Services to Education *(Monterey County Behavioral Health [MCBH])*	Early Intervention	Early Intervention	688
After School Academy *(The Village Project, Inc.)*	n/a	30	118
Outreach and Engagement Services *(The Village Project, Inc.)*	Outreach	39	63
Subtotal	3,461	4,148	2,559
EARLY INTERVENTION			
Senior Peer Counseling and Fortaleciendo el Bienestar *(Alliance on Aging)*	Prevention	Prevention	2,636
Culturally Specific Short-term Therapeutic Services (CSSTS) *(Community Human Services [CHS])*	n/a	1,093	400
Drug and Alcohol Intervention Services for Youth (DAISY) *(Community Human Services [CHS])*	n/a	1,648	2,671
(re)MIND® *(Felton Institute)*	478	1,085	1,306
Sticks & Stones® School-Based Counseling *(Harmony At Home)*	7,262	8,916	9,145
Services to Education *(Monterey County Behavioral Health [MCBH])*	232	135	Prevention

PROGRAM	FISCAL YEAR		
	21–22	22–23	23–24
Silver Star Resource Center *(Monterey County Behavioral Health [MCBH])*	19	115	138
Proyecto Contigo and School-Based Counseling *(Pajaro Valley Prevention and Student Assistance)*	39	Prevention	Prevention
Maternal, Child and Adolescent Health Home Visiting Program *(Public Health Bureau)*	n/a	64	Prevention
Outpatient Mental Health Services *(The Village Project, Inc.)*	n/a	254	217
Subtotal	8,030	13,310	16,513
ACCESS AND LINKAGE TO TREATMENT			
Street Outreach Program *(Community Human Services [CHS])*	n/a	~	~
Keep It Real Community Outreach & Navigation *(Interim)*	~	~	~
Veterans Reintegration Transition Program *(Monterey County Military & Veterans Affairs Office [MVAO])*	39	49	156
Family Partners Program *(Seneca Center)*	n/a	10	15
211 *(United Way Monterey County)*	32	29	46
Subtotal	71	88	217
SUICIDE PREVENTION			
Suicide Prevention Service *(Family Service Agency of the Central Coast)*	70	156	216
Subtotal	70	156	216

PROGRAM	FISCAL YEAR		
	21–22	22–23	23–24
STIGMA AND DISCRIMINATION REDUCTION			
Success Over Stigma (SOS) *(Interim)*	n/a	18	85
Family Self-Help Support and Advocacy: NAMI Signature Programs *(National Alliance on Mental Illness [NAMI] Monterey County)*	55	30	44
Family Self-Help Support and Advocacy: Youth Leadership and Empowerment *(National Alliance on Mental Illness [NAMI] Monterey County)*	n/a	Outreach	40
Subtotal	55	48	169
OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS			
Culturally Specific Prevention and Early Intervention Through Outreach and Engagement *(Center for Community Advocacy [CCA])*	239	Prevention	Prevention
Family Self-Help Support and Advocacy: Youth Leadership and Empowerment *(National Alliance on Mental Illness [NAMI] Monterey County)*	n/a	38	Stigma Reduction
Outreach and Engagement Services *(The Village Project, Inc.)*	31	Prevention	Prevention
Subtotal	270	38	n/a
OVERALL NUMBER OF PROGRAM ACTIVITIES HOSTED			
TOTAL	**11,957**	**17,788**	**19,674**

n/a: program not active during that fiscal year
--: program was active, but data was not available for that fiscal year
~: number of program activities not recorded

Note: *Depending on changes in program offerings, a program may switch to another PEI category from one year to the next. If a program was active in a particular fiscal year under a different category, that category is denoted in the above table.*

APPENDIX D

NUMBER OF INDIVIDUALS REFERRED TO SERVICES BY EACH PROGRAM

PROGRAM	FISCAL YEAR		
	21–22	22–23	23–24
PREVENTION			
Culturally Specific Prevention and Early Intervention Through Outreach and Engagement *(Center for Community Advocacy [CCA])*	36	13	0
Parent Education Program *(Community Human Services [CHS])*	7	6	4
The Epicenter	4	4	3
Maternal Mental Health (MMH) *(Monterey County Behavioral Health [MCBH])*	4	10	3
Maternal Mental Health Peer Navigation Program *(Parenting Connections of Monterey County)*	n/a	52	37
Subtotal	51	85	47
EARLY INTERVENTION			
(re)MIND® *(Felton Institute)*	13	12	15
Subtotal	13	12	15
ACCESS AND LINKAGE TO TREATMENT			
Street Outreach Program *(Community Human Services [CHS])*	n/a	48	19
Keep It Real Community Outreach & Navigation *(Interim)*	n/a	82	70
211 *(United Way Monterey County)*	551	239	224
Subtotal	551	369	313
OVERALL NUMBER OF PROGRAM ACTIVITIES COMPLETED			
TOTAL	**615**	**466**	**375**

n/a: program not active during that fiscal year.

APPENDIX E

SUMMARY OF OUTCOMES ACROSS SURVEY TYPE

PREVENTION AND EARLY INTERVENTION PROGRAM SURVEY

Percentage of respondents who selected "agree" or "strongly agree" after receiving services	FISCAL YEAR		
	21–22 (n = 53–88)	**22–23** (n = 632–656)	**23–24** (n = 505–512)
I know a lot about the topic of this session/training/class.	--	87%	85%
I know where to go for mental health services.	94%	88%	86%
I know when to ask for help with an emotional problem.	99%	88%	88%
I feel better/good about myself.	96%	88%	83%
I feel good/hopeful when I think about the future.	96%	86%	84%

--Data not available.

PREVENTION AND EARLY INTERVENTION MULTI-SESSION POST SURVEY

Percentage of respondents who indicated higher level of health (4+ on a 6-point scale)	FISCAL YEAR		
	21–22 (n/a)	**22–23** (n = 51–644)	**23–24** (n = 65–69)
Given my current physical condition, I am satisfied with what I can do.	--	73%	71%
I have confidence in my ability to sustain important relationships.	--	74%	66%
I feel hopeful about my future.	--	70%	72%
I am often interested and excited about things in my life.	--	78%	59%
I am able to have fun.	--	74%	62%
I am generally satisfied with my psychological health.	--	74%	55%
I am able to forgive myself for my failures.	--	69%	48%
My life is progressing according to my expectations.	--	68%	59%
I am able to handle conflicts with others.	--	75%	60%
I have peace of mind.	--	75%	66%

--Data not available.

STIGMA AND DISCRIMINATION REDUCTION SURVEY

Percentage of respondents who selected "yes" after receiving services	FISCAL YEAR		
	21–22 (n = 235–241)	**22–23** (n = 213–221)	**23–24** (n = 318–328)
I know where to go for mental health services near me.	87%	87%	96%
I think people should share about their mental health struggles.	--	87%	94%
I would feel embarrassed about having personal mental health issues.	--	19%	7%
I think that the behavior of people with mental illness is unpredictable.	43%	28%	26%
I am scared of people with mental illness.	53%	17%	2%

If I had a mental health problem, seeking help would be…	FISCAL YEAR		
	21–22 (n/a)	**22–23** (n = 161–179)	**23–24** (n = 298–308)
Useful	--	88%	88%
Important	--	51%	93%
Healthy	--	90%	88%
Effective	--	84%	86%
Good	--	49%	97%
Healing	--	45%	96%
Empowering	--	82%	86%
Satisfying	--	44%	92%
Desirable	--	50%	90%

--Data not available.

SUICIDE PREVENTION SURVEY

Percentage of respondents who selected "yes" after receiving services	FISCAL YEAR		
	21–22 (n/a)	**22–23** (n = 493–497)	**23–24** (n = 1,785–1,798)
I know where to go for mental health services.	--	88%	90%
I know the warning signs of suicide.	--	90%	93%
I know the ways to help a person who is dealing with a mental problem or crisis.	--	89%	90%
I know how to find someone who could help me with issues related to suicide.	--	91%	92%

--Data not available.

OUTREACH SURVEY

Percentage of respondents who selected “yes” after receiving services	FISCAL YEAR		
	21–22 (n/a)	22–23 (n = 516–528)	23–24 (n = 594–628)
I know where to go for mental health services.	--	90%	91%
I know a lot about the topic of this training/class.	--	76%	76%
I am able to recognize early signs of mental illness.	--	82%	84%
I feel able to respond effectively to early signs of mental illness.	--	74%	74%
I am likely to assist someone with a mental illness who needs help.	--	79%	79%

--Data not available.

PEI PROGRAM SATISFACTION

Percentage of respondents who selected "agree" or "strongly agree" after receiving services	FISCAL YEAR		
	21–22 (n = 293–383)	**22–23** (n = 1,460–1,964)	**23–24** (n = 1,549–3,504)
Staff respected my culture and background (e.g., ethnicity, beliefs, identity).	98%	97%	96%
The program had services in the language that I speak best.	98%	97%	96%
Materials provided were useful.	96%	98%	96%
This training/course was practical and useful.	96%	97%	95%
I would recommend this training/class to others.	96%	97%	95%

--Data not available.

APPENDIX F

SUMMARY OF DEMOGRAPHICS FOR ALL INDIVIDUALS SERVED

DEMOGRAPHICS	FISCAL YEAR		
	21–22	22–23	23–24
Race*	**n = 3,089**	**n = 4,618**	**n = 6,280**
American Indian/Alaska Native	78	58	51
Asian	134	147	163
Black/African American	261	148	136
Hispanic/Latino/a/e	2,055	2,929	4,276
Native Hawaiian/Other Pacific Islander	52	55	46
White	633	870	968
More Than One Race	251	164	143
Other	97	83	140
Declined to answer/skipped	96	164	238
Ethnicity*	**n = 1,055**	**n = 1,453**	**n = 2,396**
Hispanic/Latino/a/e	829	1,100	1,726
Caribbean	7	6	39
Central American	26	22	25
Mexican/Mex. Am./Chicano	749	935	1,485
Puerto Rican	4	6	10
South American	13	13	10
Other Hispanic/Latino/a/e	51	118	157
Non-Hispanic/Non-Latino/a/e	249	288	570
African	15	24	21
Asian Indian/South Asian	1	5	5
Cambodian	0	0	1
Chinese	4	3	3
Eastern European	10	15	12
European	154	157	315
Filipino	11	17	13
Japanese	8	13	3

DEMOGRAPHICS	FISCAL YEAR		
	21–22	22–23	23–24
Korean	2	2	2
Middle Eastern	0	5	5
Vietnamese	1	3	0
Other Non-Hispanic/Non-Latino/a/e	55	44	26
More Than One Ethnicity	43	26	61
Declined to answer/skipped	0	39	103
Age Groups	**n = 3,089**	**n = 3,880**	**n = 4,568**
0 to 15 years	1,636	1,759	1,931
16–25 years	347	631	1,052
26–59 years	797	1,028	933
60+ years	233	231	640
Declined to answer/skipped	76	231	12
Primary Language*	**n = 3,089**	**n = 4,175**	**n = 6,028**
English	1,316	1,754	2,185
Spanish	940	1,146	1,977
English and Spanish	783	1,070	1,362
Other	121	79	100
Declined to answer/skipped	90	126	176
Gender Identity	**n = 784**	**n = 1,044**	**n = 2,115**
Female	492	671	1,303
Male	270	346	780
Genderqueer	5	1	0
Nonbinary	7	9	4
Transgender	8	4	5
Questioning or Unsure	1	2	1
Another Gender Identity	1	2	3
Declined to answer/skipped	0	9	15

DEMOGRAPHICS	FISCAL YEAR		
	21–22	22–23	23–24
Sexual Orientation	**n = 789**	**n = 1,239**	**n = 2,046**
Bisexual	31	21	28
Gay or Lesbian	5	14	15
Heterosexual or Straight	587	1,103	1,805
Pansexual	17	12	5
Queer	7	8	5
Questioning or Unsure	3	7	4
Another Sexual Orientation	10	16	3
Declined to answer/skipped	129	58	181
Sex Assigned at Birth	**n = 1,164**	**n = 1,641**	**n = 2,150**
Female	701	976	1,333
Male	454	656	792
Another Sex Assigned	0	0	0
Declined to answer/skipped	9	9	25
Disability	**n = 1,165**	**n = 1,400**	**n = 2,099**
Yes	232	328	367
No	876	1,046	1,689
Declined to answer/skipped	57	26	43
Type of Disability*	**n = 390**	**n = 649**	**n = 715**
Chronic Health Condition	58	86	162
Difficulty Seeing	44	46	68
Difficulty Hearing or Having Speech Understood	45	26	23
Other Communication Difficulty	12	9	5
Mental Domain Disability	270	398	296
Physical Disability	70	67	138
Another Disability	19	17	23
Veteran	**n = 832**	**n = 1,066**	**n = 1,977**

DEMOGRAPHICS	FISCAL YEAR		
	21–22	22–23	23–24
Yes	33	47	29
No	788	1,010	1,938
Declined to answer/skipped	11	9	10

* Sums may exceed the total n for the category because participants could choose more than one response option.

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

PSYCHIATRIC ADVANCE DIRECTIVES MULTI-COUNTY COLLABORATIVE INNOVATIONS REPORT

FY 2023-2024

Prepared by:

EVALCORP
Measuring What Matters℠

Contents

Introduction

This is the third 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 (additional entities have since joined the project). This report pertains to activities that took place during FY 2023-2024.

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 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, 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, law enforcement, 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:

- 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

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 page 9 of the FY 2022-2023 report for additional information.

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

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***

Project Updates

The following is an overview of activities completed during the first half of the fiscal year (July-December 2023). While the intended reporting period spans FY 2023-2024, the scope of information available at the time of writing was limited to the 2023 calendar year[2]. Updates or activities from 2024 will be incorporated into the final report. See Appendix A for additional information regarding this decision.

Described below are activities relative to the PAD technology platform, legislative efforts, integration of the PADs platform, and meetings and communication.

PAD Technology Platform

In FY 2022-2023 a county workgroup was formed to develop the Terms of Services language. Monterey County participants include the core project team, County Counsel, Compliance Officer, and a Patient Services Representative. Meetings continued in FY 2023-2024.

Legislation

A time-limited workgroup was created that included support from the Painted Brain peer-run services, California Hospital Association, State Psychiatric Association representatives, NAMI California, MHSOAC, California Behavioral Health Directors, and Patient Rights and Lanterman Petris Short act knowledgeable attorneys. The group identified that a legislative champion would be needed to move this initiative forward. The workgroup will align PADs language with that of the Probate and Welfare and Institution codes to create a streamlined PADs statute, one that recognizes a PAD as a document of self-determination and autonomy.

Integration

The project sought to integrate the PADs platform into the California Law Enforcement Telecommunication System (CLETS), which would allow crisis teams, first responders, and dispatch in-the-moment access to a PAD when dispatched to a call for service. In pursuit of this, discussions were also held with law enforcement and the Executive Officer Council on Criminal Justice and Behavioral Health California Department of Corrections and Rehabilitation.

Meetings and Communication

Throughout the project and FY 2023-2024, meetings continued to occur frequently and at multiple levels. This included monthly workgroups with community-centered stakeholder groups, monthly county meetings, monthly subcontractor meetings, bimonthly workgroup meetings, and meetings with stakeholders, and one-on-one calls between subcontractors and counties.

Throughout the project, bi-annual convenings of the participating counties and subcontractors have allowed for in-person discussions, planning, and sharing learnings. In FY 2023-2024, two in-person convenings were held—Orange County hosted in September and Shasta County hosted in April. Both convenings are showcased on the project website, www.padsCA.org.

[2] Multi-County PADs Innovation Project Annual Report, *Kiran Sahota, Concepts Forward Consulting*. https://cdn.prod.website-files.com/63066e4efb10ef3cedec132e/6605ac991c459b43ddcead91_PADs%20CY%202023Annual%20Report%20_ks_F.v2%5B95%5D.pdf

Evaluation

RAND and the Burton Blatt Institute are the multi-site evaluators for the PADs project. Monterey County continued working with Evalcorp to support county-specific evaluation needs. Evaluation activities for FY 2023-2024 are described next.

RAND

In FY 2022-2023 RAND developed and finalized an evaluation protocol and workflow for the Peer Specialists' training that uses 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 is 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 focus group.

The mini-survey (Level 1) was developed with input from Painted Brain and the California Association of Mental Health Peer-Run Organizations (CAMPHRO). It was launched in the Spring 2024. RAND received 37 complete responses, 80% of which were from Specialists who will be facilitating PADs directly. Findings from the surveys collected will be presented in the final report.

Level 2 is still in the planning phase—RAND is working with Painted Brain and CAMHPRO to finalize the focus group protocol and survey questions. RAND plans to contact the Peer Specialists who selected at the end of the mini-survey to participate in an additional survey or feedback discussion about PADs in FY 2024-2025.

Burton Blatt Institute (BBI)

BBI is focused on the evaluation of the PADs web-based platform. They are 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 2023-2024, BBI:

- Observed PADs project on-site, semi-annual, all-county, county-specific subcontractor, and workgroup meetings (in-person and virtually)
- Continued conducting a series of semi-structured interviews with county staff and community partners to gather perceptions on the web platform

Initial findings from the BBI evaluation are described below:

Individual Level:

Observation: Peer representation in the development of the platform has been mainly comprised of Peer Specialists and not all counties are represented by peers.

Challenge: Platform content has been informed by a limited number of peers who may not represent the diversity of experiences and opinions of peers across all counties where the platform will be implemented.

Services Level:

Observation: Law enforcement, hospital and caregiver participation in workgroups has decreased and not all counties have these agencies represented.

Challenge: Development of the platform has been informed by a limited number of these community stakeholders among only a few counties.

Systems Level:

Observation: The mental health policy, funding and legislative environment is rapidly changing and there may be an opportunity to integrate the PADs platform as an essential feature of Prop 1 (Care Courts).

Challenge: Counties' capacity to continue their present services and sustain PADs progress may be affected by policy, funding and legislative challenges.

Monterey County

Preparation for the county-specific evaluation efforts continued in FY 2023-2024, as PADs were to begin implementation with MCBH clients in August 2024. The county had originally planned to include a field in the electronic health record system, Avatar, to signify that a client had completed a PAD. However, in collaboration with Interim, Inc., an alternative tool was developed to track individuals who were offered and/or completed a PAD. This approach simplified the process and will allow the county to link clients that completed PADs with demographic and other information collected in Avatar. Metrics regarding individuals who were offered and/or completed a PAD will be included in the final report.

Appendix A.

CONCEPTS FORWARD CONSULTING

January 23, 2025

Subject: Mental Health Services Act Innovations: Multi-County Psychiatric Advance Directives (PADs) Project, 2024 Annual Update.

Dear County PADs liaison,

This letter is to inform you that the 2024 annual project repoting will now be incorporated into the final Phase One project evaluation report. The consolidated report is scheduled to be submitted for county review by the end of April 2025 and will be discussed during the upcoming May 2025 convening at Tri-City Mental Health Authority.

This arrangement makes most sense as the subcontractors would be required to provide their final Phase One documentation a mere four months after the annual update. By combining both requirements, the subcontractors can focus on a comprehensive project report.

Concept Forward Consulting will ensure the final Phase One project evaluation report is submitted to the Behavioral Health Services Oversight and Accountability Commission (BHSOAC, formerly MHSOAC) at the conclusion of Phase One.

Should you have any questions or require further clarification, please feel free to reach out to me. Thank you for your continued support and collaboration on this important initiative.
Sincerely,

Kiran Sahota, MA
President & CEO
805-409-0988
www.conceptsforward.com

Rainbow Connections

Annual Innovations Project Report

Monterey County
Mental Health Services Act

FY 23-24

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos
Forward Together

Acknowledgments

Monterey County Behavioral Health (MCBH) is deeply grateful to the many individuals, partner agencies and supporters who have made the Rainbow Connections project possible. Their commitment to the mental health and wellbeing of LGBTQ+ youth has helped us to realize this vision so that our LGBTQ+ youth have access to quality, affirming care and environments of inclusion and belonging across home, school and community settings.

First and foremost, we would like to thank the LGBTQ+ youth whose beauty, courage and resilience inspire this work. Their voices and stories are at the heart of this project.

We are also grateful for our incredible MCBH team of staff and administrators, whose unwavering dedication and expertise have been instrumental in bringing Rainbow Connections to life. With a shared focus on improving the quality of care and increasing access of mental health services to vulnerable and underserved populations, each team member has contributed to the success of this project.

We also extend our appreciation to the Rainbow Connections collaborative partner agencies, Harmony at Home, The Epicenter, Partners 4 Peace, Monterey County Office of Education and EvalCorp. Their wholehearted commitment to public service is reflected the time, heart, and energy devoted to creating and evaluating a such a comprehensive project model. Their partnership remains invaluable as we work together to align our collective forces and resources to support LGBTQ+ youth and the adults who care for them.

Finally, we express our sincere gratitude to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for approving the Mental Health Services Act (MHSA) funding that has enabled us to secure the essential resources to implement the Rainbow Connections project. This significant investment allows us to expand this vital work across Monterey county and beyond, making a meaningful difference in the lives of LGBTQ+ youth and ensuring they have the love, care, and support they need to thrive.

Table of Contents

Introduction

LGBTQ+ children and youth often encounter challenges related to acceptance and inclusion, which can affect their mental health and well-being. Research indicates that LGBTQ+ individuals are at a higher risk of experiencing bullying, discrimination, and social isolation, particularly in settings where support systems may be limited or underdeveloped. These factors contribute to disparities in mental health outcomes, including higher rates of anxiety, depression, and suicidal ideation. In light of these challenges, targeted initiatives that foster inclusive and affirming environments are crucial for addressing the needs of LGBTQ+ children and youth.

Program Overview

Rainbow Connections is an MHSA Innovations Project proposed by Monterey County Behavioral Health and funded by MHSOAC, with a budget of $7.8 million. Its mission is to interconnect youth-serving systems with community-based organizations, to improve school climate and to cultivate environments of belonging for LGBTQ+ youth across home, school, and community settings. The program serves LGBTQ+ youth aged 24 and under, and their families. Implementation began in October 2023, focusing on three key strategies:

- capacity building in family and community environments,
- capacity building in school environments, and
- integration of the Monterey County Child and Adolescent System of Care (CSOC).

Key activities include training for families, community members, students, and school personnel, hiring specialized support staff, and creating an Integrated Care Team to provide specialized care for LGBTQ+ youth and families. This comprehensive approach aims to enhance support systems across multiple settings to foster safer and more inclusive communities for LGBTQ+ youth.

The Rainbow Connections Program is designed with several key learning goals to ensure its effectiveness and impact. The first goal is to **build capacity** by increasing the ability of parents/caregivers school personnel, mental and physical healthcare providers and adult community members to identify and affirmatively respond to the mental health needs of LGBTQ+ youth through targeted training and initiatives. The second goal is to **enhance collaboration** by increasing interagency and community cooperation to effectively refer LGBTQ+ youth and their families to affirming care, supported by a online referral resources. Finally, the program aims to **improve service quality and increase accessibility** by providing affirming, culturally responsive services through a collaborative framework applied across the primary domains where these youth live, learn, and grow. Together, these goals aim to foster a more inclusive and supportive environment for LGBTQ+ children and youth in Monterey County, empowering them through opportunities for authentic self-expression, leadership development, and meaningful input to inform and shape Rainbow Connections offerings.

---

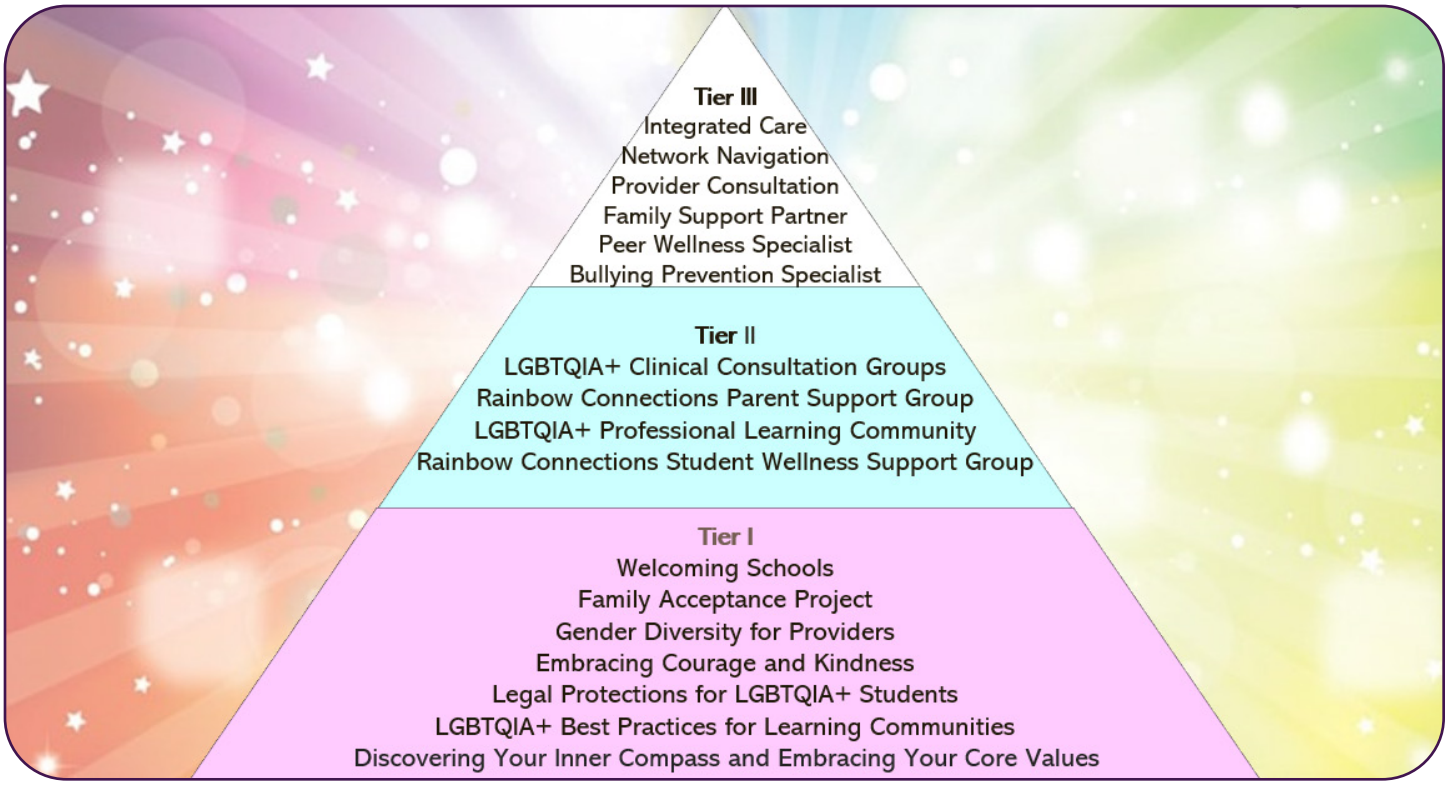
[1] Trevor Project. (2019). National Survey on LGBTQ Mental Health. The Trevor Project. https://www.thetrevorproject.org/survey-2019/?section=Suicidality-Mental-Health

[2] Johns, M. M., Poteat, V. P., Horn, S. S., & Kosciw, J. (2019). Strengthening Our Schools to Promote Resilience and Health Among LGBTQ Youth: Emerging Evidence and Research Priorities from The State of LGBTQ Youth Health and Wellbeing Symposium. LGBT health, 6(4), 146–155. https://doi.org/10.1089/lgbt.2018.0109

[3] Gorse, M. (2022). Risk and protective factors to LGBTQ+ youth suicide: A review of the literature. Child and Adolescent Social Work Journal, 39(1), 17-28. https://doi.org/10.1007/s10560-020-00710-3

Framework

Rainbow Connections is a public health model designed to create conditions for LGBTQ+ youth to access affirming services and supports and to experience belonging across home, school, and community settings. Drawing inspiration from Bronfenbrenner's Social-Ecological Systems Model, the program recognizes that interactions within multiple environments shape a young person's identity development. By focusing on the microsystem (home, school, peer relationships), mesosystem (connections between these environments), and exosystem (community services and broader social networks), the program ensures that LGBTQ+ youth are supported in every facet of their lives, fostering resilience and belonging at each level. The following figure illustrates the three tiers of services and supports available to everyone across all settings, demonstrating the program's comprehensive and inclusive approach.



Collaborative Partners

Rainbow Connections collaborates with key partners to leverage diverse expertise and resources, ensuring a comprehensive approach to supporting LGBTQ+ youth and their families:

Capacity-Building Partners

The Family Acceptance Project® (FAP) plays a pivotal role in supporting Rainbow Connections by focusing on training and capacity building for the Rainbow Connections Family Support team. This training equips staff with strategies and intervention models that help diverse families, foster families, and caregivers reduce the risks faced by LGBTQ+ youth and promote their well-being. Additionally, FAP collaborates with Partners for Peace to enhance existing family support curriculums and develop new content that better serves the needs of LGBTQ+ youth and their families.

FAP also provides a series of virtual trainings designed for family members, community leaders, and professionals responsible for the care of LGBTQ+ youth, ensuring they have the tools and knowledge needed to provide affirming, culturally responsive support. As part of this partnership, FAP produces and supplies educational materials to Rainbow Connections partners, helping them meet the learning objectives of the Rainbow Connections Innovation Plan.

Beyond these activities, FAP offers ongoing support and consultation by participating in regular and ad-hoc meetings with County staff and project partners. In these meetings, FAP provides guidance, discusses progress, and addresses any challenges in the implementation process. Given the innovative and time-sensitive nature of the program, FAP may also engage in additional projects as needed to ensure the effective and efficient execution of Rainbow Connections' goals.

Welcoming Schools is an inclusive and comprehensive educational program designed to create supportive and respectful environments for all students, regardless of their sexual orientation or gender identity. Developed by the Human Rights Campaign Foundation, the curriculum fosters understanding and acceptance of LGBTQ+ individuals and families in K-8 schools. Its partnership with Rainbow Connections seeks to enhance capacity-building efforts among educators. The program provides essential training on best practices to foster inclusivity and belonging, enabling staff to effectively seek teachable moments and respond to questions about LGBTQ+ topics.

A key focus is on preventing bias-based bullying, particularly concerning transgender and non-binary students. Participants gain insight into establishing safe spaces and familiarizing themselves with policies and practices that affirm these students' identities.

The concept of intersectionality is integral to the Welcoming Schools approach, as educators explore how intersecting identities—such as race, ethnicity, gender, disability, and LGBTQ+ status—impact student experiences. Through its collaboration with Rainbow Connections, Welcoming Schools proactively fosters allyship and addresses biased behavior, empowering educators to create safe and supportive environments for all students.

Service Delivery Partners

Partners for Peace is dedicated to promoting non-violence and building healthy communities. Through this partnership, Rainbow Connections enhances its ability to serve LGBTQ+ youth and their families by leveraging the organization's Family Support Partner (FSP). The FSP specifically supports parents and caregivers of LGBTQ+ youth by applying research-based evidence from The Family Acceptance Project©, which encourages positive behaviors that strengthen family relationships.

The FSP provides individual peer support to help parents and caregivers of diverse children decrease family rejection and increase support for their LGBTQ+ child within their cultural and religious contexts. The FSP also assists parents and caregivers in obtaining appropriate services and care, addressing institutional barriers, addressing bullying, and learning to advocate for their child's needs. Additionally, the program conducts support groups for parents and caregivers in both English and Spanish and offers access to the Rainbow Connections LGBTQ+ Affirming Continuum of Care.

Harmony at Home promotes healthy relationships and supportive environments for families and youth. Its key role in the Rainbow Connections ecosystem is to provide a Rainbow Connections Bullying Prevention (BP) Coach who delivers essential training and resources in collaboration with Rainbow Connections project partners to school staff through the Welcoming Schools Program.

The Rainbow Connections BP Coach offers support at designated school sites through on-the-spot interventions, classroom meetings, de-escalation strategies, and teacher coaching sessions. They serve as an expert resource on bullying prevention and harassment related to LGBTQ+ students. Additionally, the Rainbow Connections BP Coach provides consultation and one-on-one support for school staff, providers, and parents/caregivers to advocate effectively for LGBTQ+ students who are targets of bullying and harassment due to their identities.

Furthermore, Harmony at Home helps create, coordinate, and facilitate Student-Led Assemblies driven by LGBTQ+ students to educate the entire student body and foster a culture of acceptance, inclusion and support.

The Epicenter is devoted to supporting LGBTQ+ youth and promoting wellness within the community. In partnership with Rainbow Connections, they welcome a Rainbow Connections Wellness Outreach and Engagement Coordinator to facilitate various initiatives. This role involves providing LGBTQ+ Best Practices and Mental Health and Wellness training in local schools.

Additionally, the Rainbow Connections Wellness Outreach and Engagement Coordinator will assist in developing the Gender and Sexuality Alliance (GSA) and Be Yourself Clubs by offering training and technical assistance as well as ongoing guidance as safe spaces are created on school campuses across Monterey County. The Epicenter's Queer Trans Youth Collective (QTYC) will play a crucial role in leading the Rainbow Connections Youth Empowerment Council, which will be open to all LGBTQ+ middle and high school students in the Tri-County area. This collaborative effort is designed to gather input and feedback on Rainbow Connections programming, ensuring it aligns with the needs of LGBTQ+ youth.

Moreover, the Rainbow Connections Wellness Outreach and Engagement Coordinator will provide learning communities with access to information about the LGBTQ+ Affirming Continuum of Care, promote Rainbow Connections program offerings through outreach at schools and community events, and distribute resource materials to support the mental health and wellness of LGBTQ+ students.

Milestones

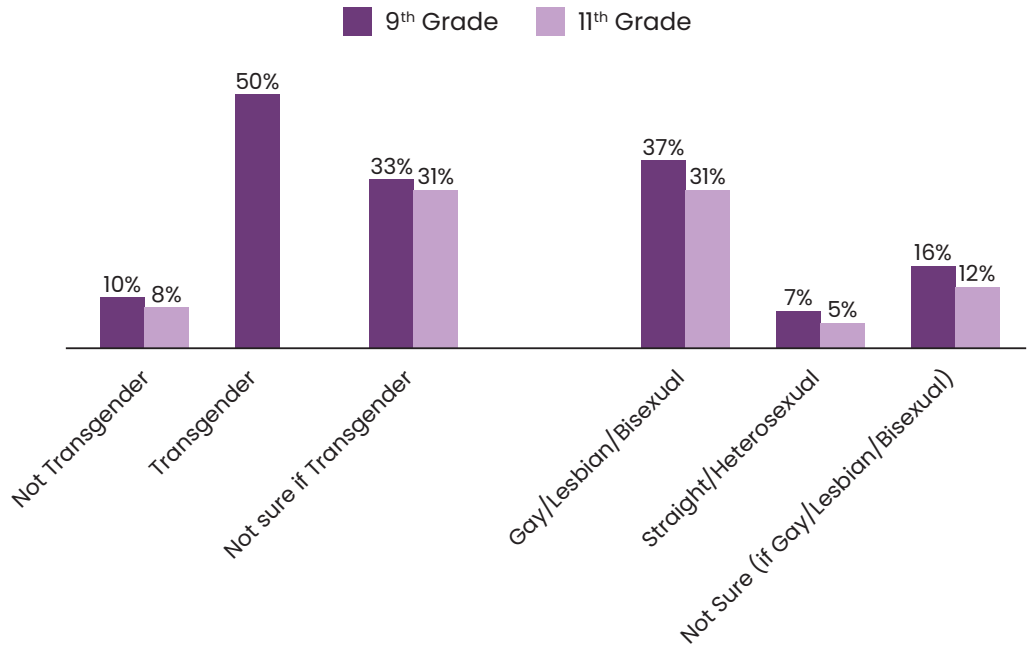
The following table outlines key milestones in the launch and implementation of the Rainbow Connections Innovation Project, highlighting important events from project approval to the first outreach and training initiatives during FY 2023-2024.

Date	Milestones	Event
May 2023		Innovation Project Approved
August 25, 2023		Collaborative Partner Kickoff
September 1, 2023		Family Acceptance Project contract begins
	Project Launch	
October 2023		Innovation Project Begins (first $ spent)
October 10, 2023		Partners For Peace (amendment) begins
October 17, 2023		The Epicenter contract (amendment) begins
November 1, 2023		RC Logo contest begins
November 30, 2023		RC Logo submission deadline
	Implementation	
February 2, 2024		First outreach event/campaign (The Epicenter)
March 18, 2023		First referral (from The Epicenter)
May 22, 2024		First training (from FAP)

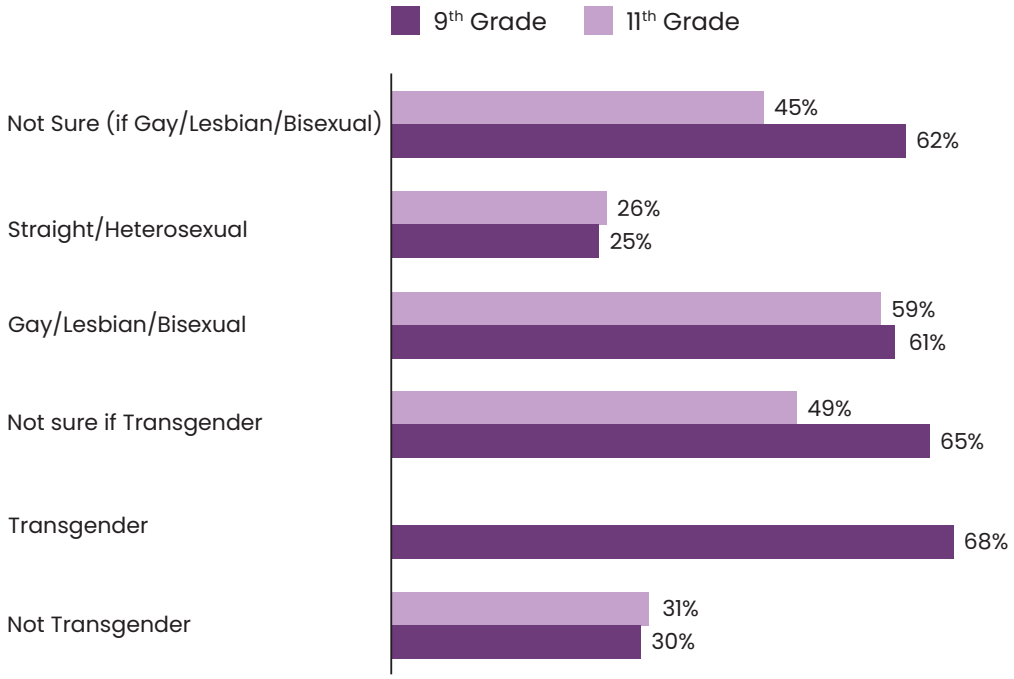
County-Level Insights on LGBTQ+ Youth

As mentioned above, LGBTQ+ youth face distinct mental health challenges stemming from bullying, harassment, discrimination, and social isolation. The following charts present baseline population-level data on social and emotional health indicators for Monterey County, providing additional local context for the program's intervention.

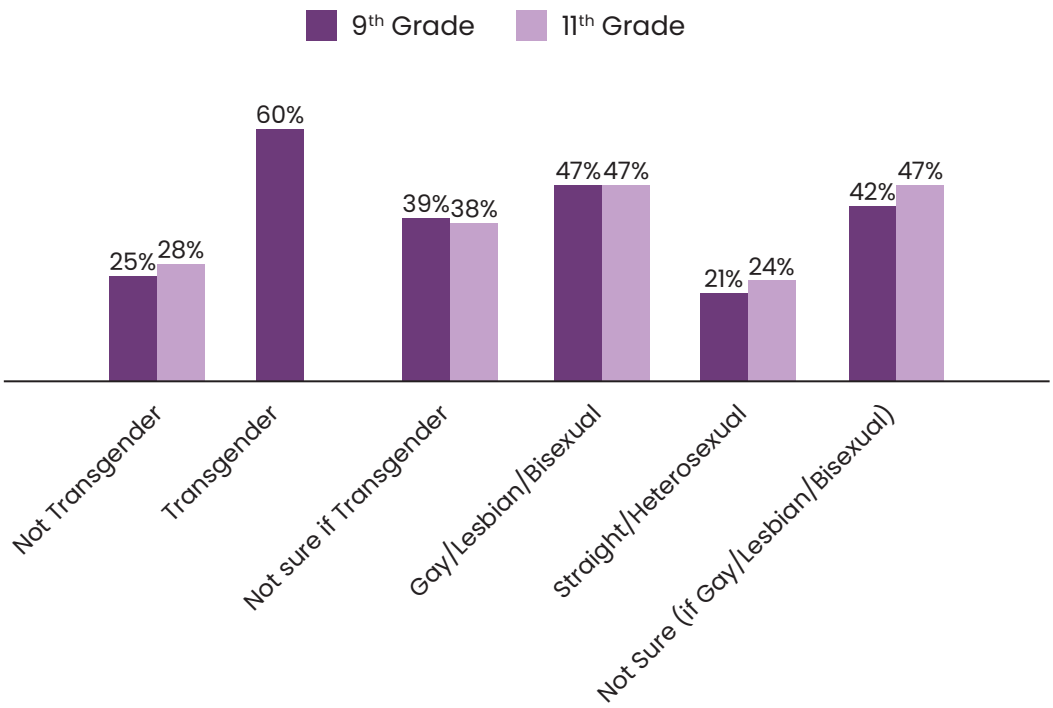
Percentage of Monterey Students Who Considered Suicide in the Past 12 Months



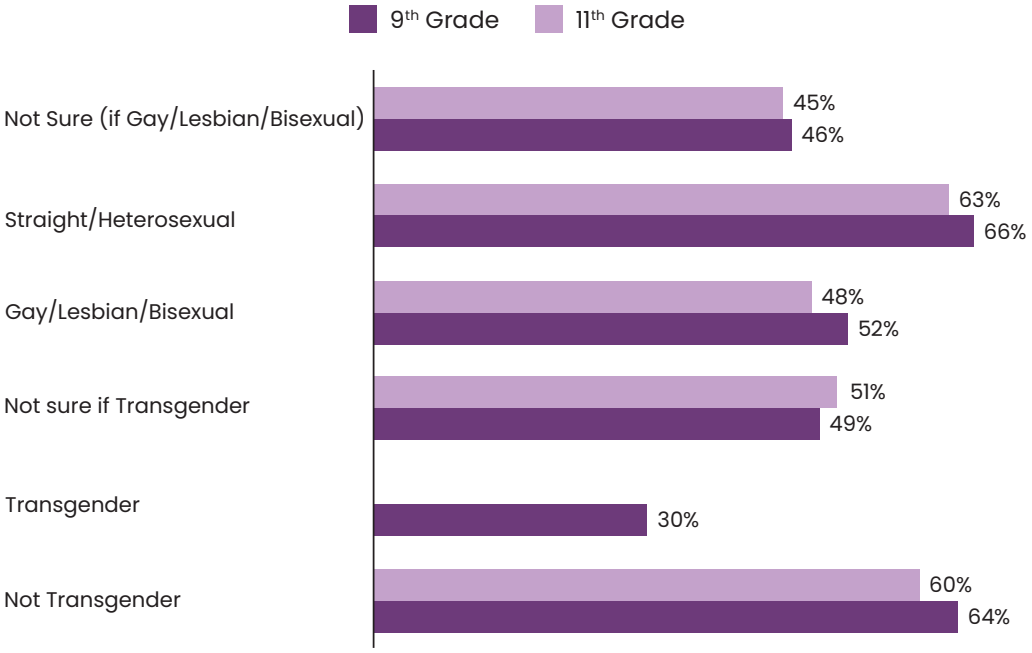
Percentage of Monterey Students Who Experienced Chronic Sadness/Hopelessness in the Past 12 Months



Percentage of Monterey Students Who Experienced Social Emotional Distress in the Past 12 Months



Percentage of Monterey Students Reporting Life Satisfaction in the Past 12 Months



Evaluation Approach and Methodology

Evaluation Objectives

Monterey County Behavioral Health partnered up with EVALCORP to conduct a system-level evaluation, focusing on the effectiveness of Rainbow Connection's LGBTQ+ Network of Affirming Care by assessing three key areas:

- building capacity,
- enhancing collaboration, and
- improving the quality and accessibility of services for LGBTQ youth.

This evaluation aims to provide valuable insights to inform strategies for enhancing Rainbow Connections' efforts to create a more inclusive and welcoming environments and effectively meet the diverse needs of LGBTQ youth and their families.

Overview of Data Sources, Tools and Indicators

Three primary data sources were used to evaluate the Rainbow Connections program to address the project learning goals listed above: an activity tracking log, a partner survey, and a post-training survey. These tools are provided below, followed by additional details about their purpose and implementation.

Data Source/Tool	Type of Indicators	Corresponding Project Learning Goal(s)
Activity Tracking Log	Process	1, 3
Partner Survey	Process and Outcome	2
Post Training Survey	Outcome	1

Activity Tracking Log

The Activity Tracking Log is a spreadsheet with four tabs: Trainings, Referrals, Other Services, and Outreach Events & Campaigns. This spreadsheet is intended for use by Rainbow Connections partners to track activities that are conducted and the number of individuals reached on an ongoing basis. Each partner/provider can track their activities in a separate log, which can then be merged and aggregated quarterly or annually for reporting. Five tracking logs will be used: one for each of the four partner organizations and one for the Rainbow Connections ICT.

Post-Training Survey

The post-training survey is intended to be completed by trainees at the end of each training session provided through Rainbow Connections. This survey allows parents/caregivers, community members, etc., to provide direct feedback on their experience of the training and provides a way to document the utility and effectiveness of the training and curriculum provided across the Rainbow Connections program. A few variations on the post-training survey will be implemented, depending on the training content and intended audience.

Partner Survey

The partner survey is intended for Rainbow Connections providers to compete roughly annually. It allows providers to give feedback on the processes and impact of the Rainbow Connections activities they are involved with from their perspective. The results from this survey can be used to modify the program's implementation and assess the effectiveness of the system-wide strategies for increasing capacity for and quality of service provision for LGBTQ+ youth and their families. The first partner survey will be completed in Spring 2025.

Evaluation Insights and Results

Capacity Building

Trainings

To advance their capacity-building goals, Rainbow Connections partnered with the Family Acceptance Project® (FAP) to deliver a comprehensive series of trainings designed to empower providers, educators, and other stakeholders with the critical knowledge and strategies necessary to promote family acceptance and mitigate health risks for LGBTQ+ children and youth. During the fiscal year 2023-2024, FAP conducted two 8-hour training sessions via Zoom, engaging a total of 148 participants.

The primary goals of the training were to enhance participants' understanding of the impact of family dynamics on the well-being of LGBTQ+ children and youth, particularly focusing on the detrimental effects of family rejection and the protective benefits of family acceptance. The training emphasized key objectives, including the ability to articulate the relationship between family acceptance, trauma, and health risks and to recognize specific family behaviors that either exacerbate or mitigate these risks. Participants were introduced to evidence-based strategies developed from FAP research, enabling them to better support diverse families in creating nurturing environments for their LGBTQ+ children and youth.

An online survey link was distributed to participants before and after the training sessions to evaluate the effectiveness of the training and gather insights into participants' backgrounds and understanding of the material covered. A total of 97 responses were collected from both trainings, and the findings below highlight how well the training met its objectives and its overall effects on participants' knowledge and readiness to address the challenges faced by LGBTQ+ children, youth, and their families.

Baseline Knowledge

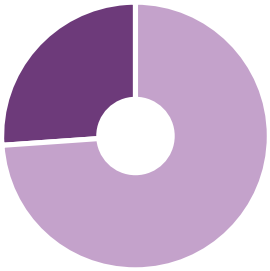
Respondents were asked about their prior training experience, revealing that 58% had previously participated in training sessions focused on supporting family members of LGBTQ+ children and youth, while 42% had not. Before this training, 74% of respondents reported having received information about health risks specific to LGBTQ+ children and youth, indicating a level of awareness regarding these issues. The chart below illustrates these findings.

Prior Training Experience in Supporting Family Members of LGBTQ+ Children and Youth

(N=97) No Yes

Prior Awareness of Health Risks for LGBTQ+ Children and Youth

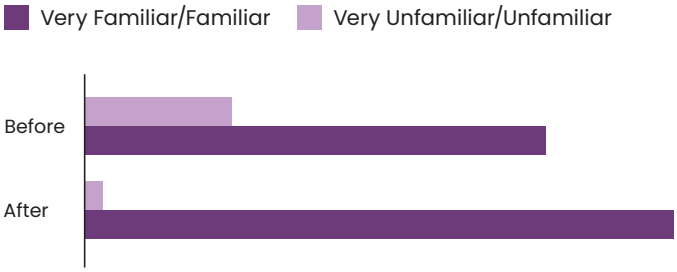
(N=97) No Yes



Outcomes and Satisfaction

Respondents were asked to indicate their familiarity with the role of family support in reducing health risks and promoting well-being for LGBTQ+ children and youth both before and after the training. Before the training, 76% reported being very familiar or familiar with this role, while 24% indicated they were either very unfamiliar or unfamiliar. Following the training, familiarity increased to 97%. The chart below illustrates these changes.

Changes in Familiarity with Family Support's Role in LGBTQ+ Children and Youth Well-Being: Before and After Training



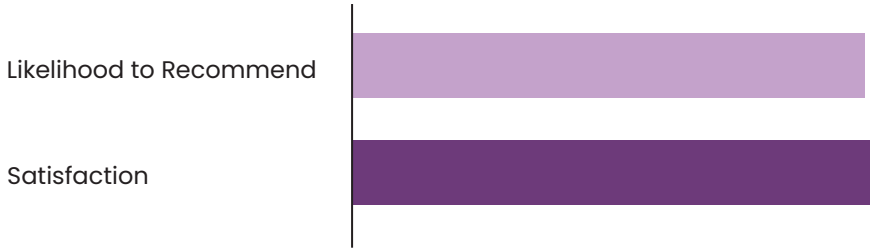
97% { Feel very familiar/familiar with health risks of LGBTQ+ children and youth

94% { Feel very/somewhat confident in explaining the role of family rejection and acceptance on health risks and well-being for LGBTQ+ children and youth

The chart below shows that overall, participants expressed high satisfaction with the training sessions, as 96% reported feeling very satisfied or satisfied, while 97% indicated they would likely or very likely recommend the training to others.

Respondents Satisfaction and Likelihood to Recommend Training

(N=97)



Feedback

Respondents were asked three open-ended questions to gather insights on their key takeaways from the training session, suggestions for improvements, and commitments to enhance their interactions with diverse families of LGBTQ+ children and youth. The detailed findings are outlined below, with a summary in the following figure:

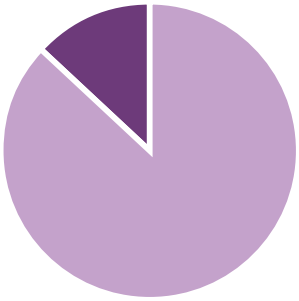
Respondents found various aspects of the training helpful, with videos and visual resources frequently highlighted as impactful. These resources helped illustrate theoretical concepts through real-life examples, fostering emotional engagement and discussions. Group discussions and active participation were also valued, as they encouraged sharing diverse perspectives and deepened understanding. Testimonies and real-life examples of LGBTQ+ families were cited as emotionally powerful and informative, humanizing the challenges faced by these families. Additionally, many resonated with the distinction between values and beliefs and the importance of aligning actions with core values. Finally, respondents appreciated the resources and materials provided, particularly those available in different languages and cultural contexts, which were seen as useful both during and after the training.

Respondents provided several suggestions for improving the training session. A common theme was the desire for in-person or hybrid training options, as many felt face-to-face interaction would enhance engagement and connection. While the virtual format was appreciated, some believed that in-person training would feel more dynamic and personal. Additionally, respondents requested more interactive and engaging activities, such as frequent group work, increased individual participation, and more breakout sessions, to maintain focus during longer training formats. Another suggestion was to split the all-day session into shorter sessions over multiple days to prevent fatigue and improve information retention. Some respondents also noted that the training could benefit from greater cultural diversity in its content, specifically with case studies and examples that reflect the experiences of historically marginalized groups, including immigrant communities and youth from lower socioeconomic backgrounds.

Several key themes emerged regarding changes respondents plan to implement in their interactions with diverse families of LGBTQ+ youth. Many expressed a commitment to focusing on specific accepting and rejecting behaviors, aiming to highlight the impact of these behaviors on LGBTQ+ youth's well-being during family interactions. Psychoeducation emerged as another important area, with respondents intending to use visual aids, such as FAP Healthy Futures posters and informational pamphlets, to provide families with concrete resources for supporting their children. Leading with empathy and meeting families where they are emotionally was also emphasized, as respondents recognized the need to help families navigate their feelings without judgment. Improved communication strategies, such as active listening and asking open-ended questions, were also highlighted as essential tools for fostering more open and supportive dialogues. Finally, respondents plan to use values-based interventions, helping families align their actions with core values like love and care, even when their beliefs might differ.

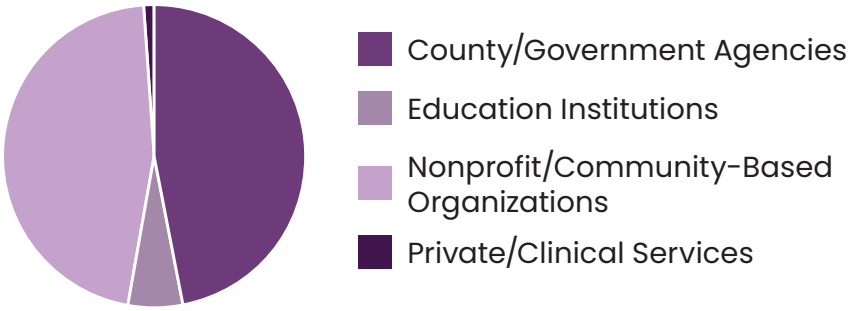
Do you provide services for families in your professional role?

(N=97) No Yes



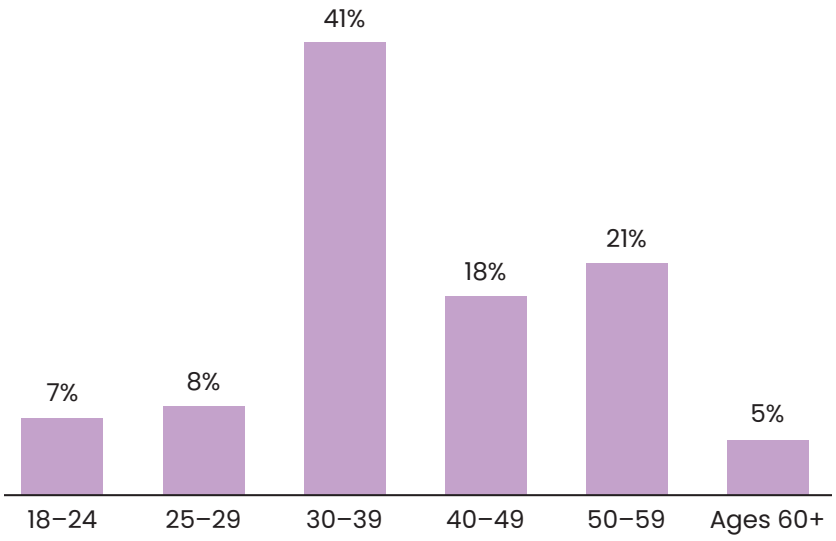
Sectors Represented by Training Participants

(N=114)



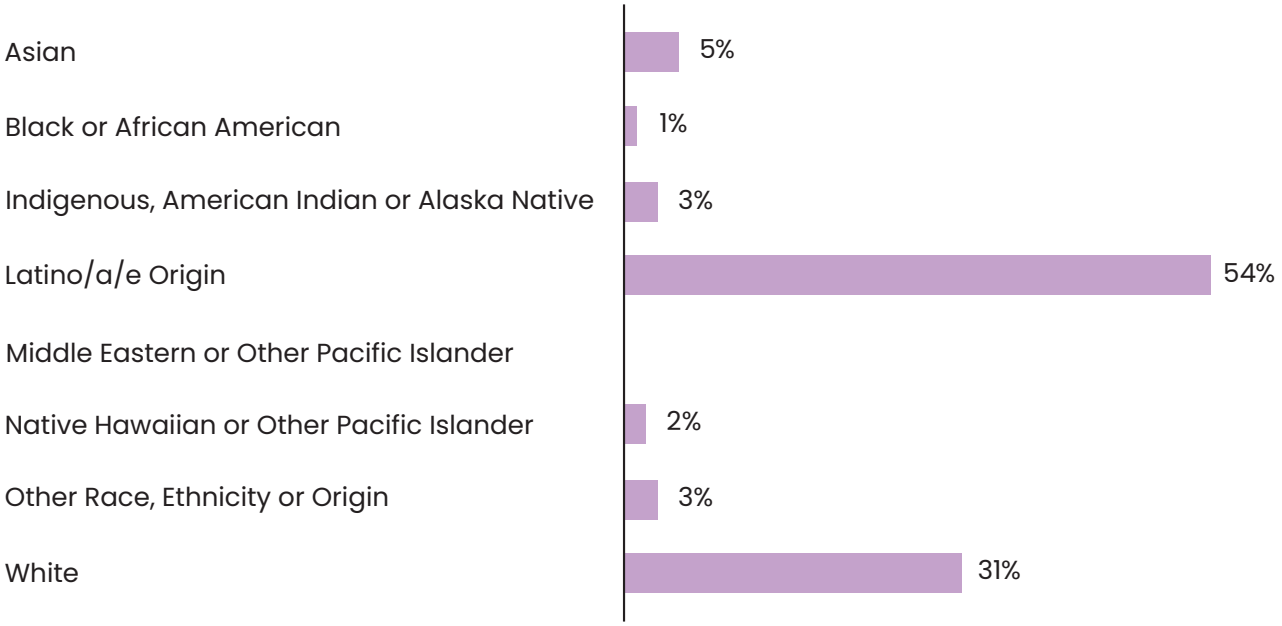
Age Group

(N=97)



Race/Ethnicity

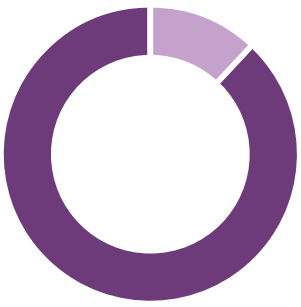
(N=97)



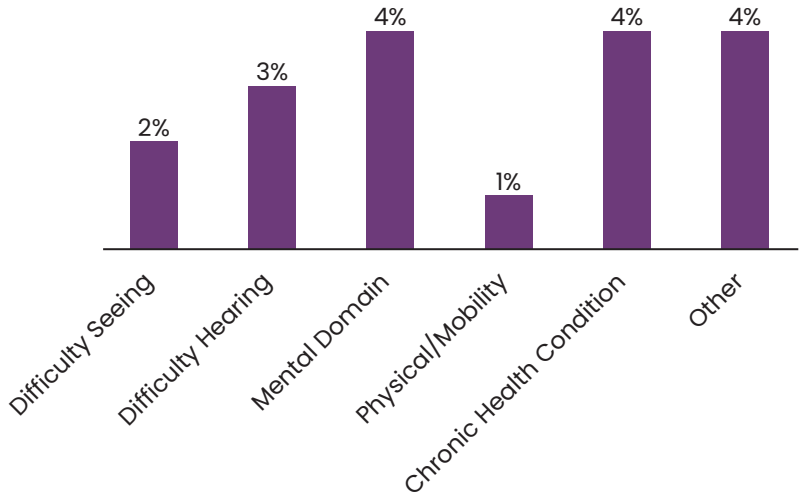
4 respondents chose the option "prefer not to answer."

Disability Status: Yes or No

(N=97) No Yes



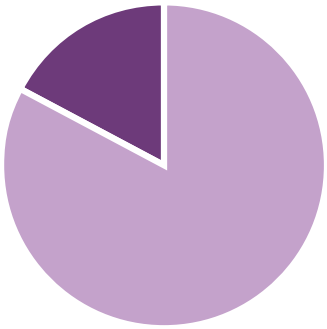
2 respondents chose the option "prefer not to answer."



Only 1% of respondents identified as veterans.

Sex Assigned at Birth

(N=97) Male Female

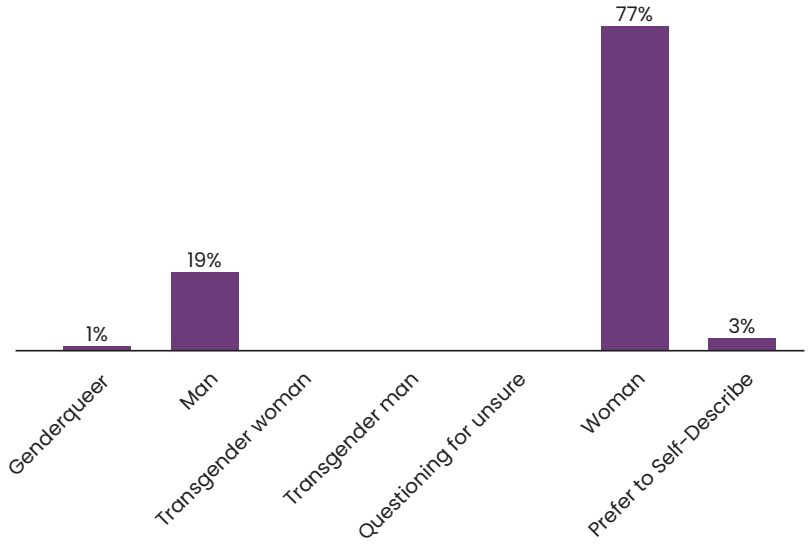


4 respondents chose the option "prefer not to answer."

The "Prefer to Self-Describe" category included identities such as gender fluid and non-binary.

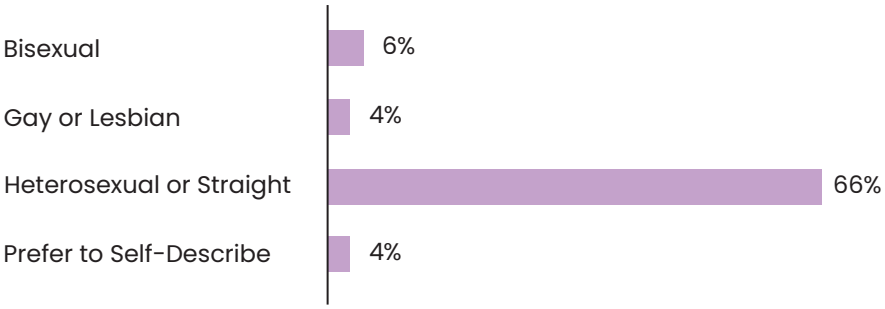
Gender Identity

(N=97)



Sexual Orientation

(N=97)



10 respondents chose the option "prefer not to answer."

The "Prefer to Self-Describe" category included orientations such as pansexual and asexual.

Evaluation Insights and Results

Interagency and Community Collaboration

Connections

Connections are defined here as referrals within and between core Rainbow Connections partners, illustrating collaborative efforts to support diverse families and youth. The table below highlights cross-organizational collaboration, showcasing how these partnerships provide comprehensive support.

Initiating Connection	Receiving Connection			
	The Epicenter	Partners for Peace/ Family Acceptance Project	Harmony at Hom	RC Integrated Care Team
The Epicenter	1 parent 2 students/youth*	5 Parents	2 Parents	1 student/youth
Partners For Peace	-	3 parents*	-	-
ICT/MCBH	-	2 parents	-	-

*Confirmed linkage

Referrals

Referrals are categorized as "outgoing" and tracked when a client is directed to an external service or organization outside the Rainbow Connections network. The table below summarizes the referrals made during FY 23-24.

Referring Organization	Number of Referrals	Type of Referral/Support
Partners For Peace	1 parent	Adult Education for GED
The Epicenter	2 parents	Diversity Center of Santa Cruz
	2 parents	Transmasculine Support Group & Proud Parents Support Group

Access and Quality of Supportive Services

Outreach Activities

The table below summarizes the outreach and engagement activities conducted by The Epicenter and Partners for Peace. The total number of activities undertaken by The Epicenter and Partners for Peace is 54. The total attendance across all events was 2,109, and a total of 1,041 materials were distributed.

Activity Type	The Epicenter	Parents for Peace	Total
Digital Campaigns	21	-	**21**
In-Person Events	23	10	**33**
Attendance	444	1.665	**2.109**
Materials Distributed	246	795	**1.041**

The Epicenter and Partners for Peace organized key events and initiatives to demonstrate their community engagement efforts to help launch the Rainbow Connections project. The Epicenter supported facilitating campaigns such as the Rainbow Connection Logo Challenge, the "Thriving Not Surviving" initiative, a presentation to the School Climate and Transformational Leadership Team, and an Everett Alvarez High School Be Yourself Club session. Partners for Peace focused on large-scale community outreach in supporting with organizing the LGBTQIA+ Student Wellness Expo, participating in the Monterey County Jail Resource Fair, and contributing to the Frank Paul Elementary Dia del Niño celebration.

Receiving Connection	
The Epicenter	**Parents For Peace**
RC Logo Challenge	LGBTQIA+ Student Wellness Expo
Thriving Not Surviving	Monterey County Jail Resource Fair
Introduction to School Climate - Transformational Leadership Team	Frank Paul Elementary Dia del Nino
Everett Alvarez High School Workshop	

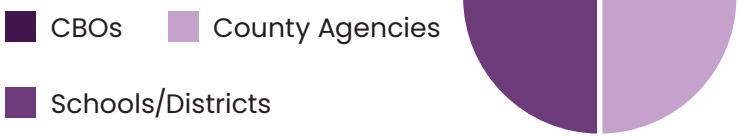
[4] Organizations represented at the Expo included: Alisal Union School District, Blue Zones Project, Central California Alliance for Health, Monterey County Behavioral Health, Monterey County Office of Education, Monterey Peninsula Pride, Monterey Peninsula Unified School District, Ohana Center for Child and Adolescent Behavioral Health, Pacific Grove Unified School District, Restorative Justice Partners Inc, Safe Schools Project, Salinas Family YMCA, Salinas Regional Sports Authority, Salinas Union High School District, Salinas Valley Pride Celebrations, San Mateo County Office of Education, Santa Cruz County Office of Education, Seneca Family of Agencies, Silver Star Resource Center, Soledad Unified School District, Suicide Prevention Service, and The Epicenter.

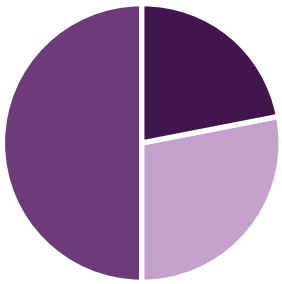
Rainbow Connections Community Access Points

Rainbow Connections' Community Access Points (CAPs) are individuals, organizations, or locations that actively bridge the program or its initiatives with the broader community. They play a key role in supporting engagement, outreach, and resource access by intentionally promoting initiatives, sharing information, and encouraging community involvement. CAPs also facilitate connections by creating pathways for individuals to access services, programs, or key resources. As such, Rainbow Connection's CAPs provide sustained support through ongoing, formal, or semi-formal roles, serving as trusted messengers, allies, or referral points to advance program goals.

Community Access Points by Type

(N=18)





Community Access Points by Type		
Schools and Districts	**Clinics and County Agencies**	**Community-Based Organizations**
CSU Monterey Bay	Alisal Integrated Health Center	Door to Hope
Everett Alvarez High School	Monterey County Behavioral Health FAST Team	Diversity Center of Santa Cruz
Frank Paul Elementary	Monterey County Jail	Monterey Peninsula Pride
Main Street Middle School	Monterey County Office of Education	Northridge Mall
Mount Toro High School	Ohana Monarch (Behavioral Health)	
North Salinas High School		
Salinas High School		
Salinas Union High School District		
Santa Rita Union School District		
Soledad Unified School District		

Conclusions and Recommendations

The collaboration between Rainbow Connections and the Family Acceptance Project (FAP) has established a strong foundation for building the capacity of providers, educators, community-based organizations, and other youth-serving agencies in Monterey to support LGBTQ+ youth and their families in an impactful way. The training sessions conducted during the fiscal year 2023-2024 enhanced participants' understanding of family acceptance's vital role in promoting the well-being of LGBTQ+ youth. The increase in familiarity with family support mechanisms—from 76% to 97%—demonstrates the effectiveness of the training in equipping participants with evidence-based strategies to foster nurturing family environments. These insights highlight the importance of ongoing education and training in addressing the challenges faced by LGBTQ+ youth.

Survey respondents expressed a desire for enhancements in the training delivery format. Many indicated a preference for in-person or hybrid training options, which could increase engagement and connection that virtual formats may not fully capture. Additionally, respondents suggested incorporating more interactive activities to deepen learning and maintain focus. To address these needs, future training sessions could benefit from adopting shorter, more frequent workshops and expanding the materials to include examples that reflect the experiences of additional historically marginalized groups. This approach will enrich the content and make it more relevant for participants interacting and working with diverse youth populations.

The Rainbow Connections project has just launched and is building its foundational pillars. The project's first year focuses on creating the infrastructure, processes and procedures, establishing contracts with providers and securing staffing. As the project develops, establishing ongoing evaluation and feedback mechanisms will be crucial for Rainbow Connections' collaborative partners to continuously assess their interventions' impact and make adjustments as needed. These mechanisms will facilitate adaptive learning, ensuring that the program can effectively respond to the needs of participants and the community it serves.

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

Residential Care Facility Incubator Innovations Report

FY 2023-2024

Prepared by:

EVALCORP

Measuring What Matters℠

Contents

Introduction

This is the Third 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 from July 1, 2023, to June 30, 2024 (FY 2023-2024).

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 goal of the RCFI project is to 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 engages both existing facility operators and new property owners 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 culturally and linguistically responsive 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 (1) insufficient beds for adults with SMI, and (2) a lack of culturally and linguistically responsive residential care services.

Leading up to the approval of the RCFI project, at least three residential care facilities in Monterey County had closed. The closures resulted in a loss of over 50 beds for adults experiencing SMI. Common barriers to opening and maintaining adult residential care facilities include insufficient finances, lack of community buy-in, and costs related to hiring and retaining staff.

Challenges in opening and maintaining adult residential care facilities impact patient outcomes. 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.

Additionally, 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.

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 aims to 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 facilities. 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, which focuses on researching the challenges facing residential care facility operators and 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.
5. Identify what materials and technical assistance will be required to support implementation in Phase II.

Resources

The RCFI project received support from the following personnel during FY 2023-2024:

Job Title	Responsibilities
Assistant Bureau Chief	Provided guidance and technical assistance on service coordination and other matters as needed.
Deputy Director of Behavioral Health	Monitored and approved vendor deliverables and provided technical assistance on service coordination and other matters as needed.
Management Analyst III	Functioned as MHSA Coordinator to provide/support project management, evaluation, and reporting activities.

Job Title	Responsibilities
Management Analyst II	Functioned as Innovation Coordinator to provide/support project management, service coordination, communications and outreach, vendor procurement, evaluation, and reporting activities.
Management Analyst II	Functioned as Bridge Housing Grant Manager and assisted in program planning.
Behavioral Health Services Manager II	Provided oversight of the Adult System of Care, which includes population of focus for this project, and assisted in program planning and coordination.
Chronic Disease Prevention Coordinator	Served as the Ethnic Services Manager and ran the Cultural Competency meetings which were leveraged for project planning purposes. Acted as the subject matter expert on maintaining cultural competency with the diverse communities in Monterey County.
Consultant(s)	Provided subject matter expertise in residential care facility certification and management, supportive housing services, cultural and linguistic competency, marketing, and communications. Conducted research toward designing 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 occurs over a period of 2 years:

1. *3-6 Months*: Acquire the necessary consultant(s) and/or vendor(s) through a Request for Proposal (RFP) process.
2. *12-18 Months*: Consultant(s) and/or vendor(s) 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:
    a. 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
    b. 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
    c. Identifying and recruiting interested property owners

d. 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	*$386,156*
Direct Costs	$171,921	$171,921	*$343,842*
Indirect Costs	$31,066	$31,066	*$62,132*
Total	*$396,065*	*$396,065*	*$792,130*

Project Updates and Changes in FY 2023-24

Planned Activities

Planned activities for FY 2023-2024 included creating a Community Engagement Plan, conducting a Landscape Analysis, conducting Community Engagement and Research to Develop Culturally and Linguistically Responsive Strategies, and preparing a Findings Report incorporating findings from all activities. Specific planned activities for the Landscape Analysis and Community Engagement and Research to Develop Culturally and Linguistically Responsive Strategies are listed below.

1. **Landscape Analysis:** interviews with RCF operators, an inventory of available housing resources, site visits, and a "Residential Care Facilities Guidance Manual."
2. **Community Engagement and Research to Develop Culturally and Linguistically Responsive Strategies:** focus groups with community members with lived experience and interviews with subject matter experts.

Project Updates and Adjustments

Completed Activities

Planned activities completed in FY 2023-2024 included engaging with RCF operators, site visits to facilities, interviews with subject matter experts, and the first of five focus groups with the priority population (adults experiencing severe mental health conditions).

Adjustments to Planned Activities

As data collection with RCF operators began, it became clear that adjustments in approach would be needed. These adjustments included 1) exchanging the planned interviews with RCF operators to a survey format, 2) replacing the "Residential Care Facilities Guidance Manual" with the "Economic Analysis of Residential Care Facility Expansion Strategies for Monterey County," and 3) shifting the timeline of community engagement activities with individuals with lived experience.

RCF Interviews and Survey

Engaging RCF operators in the interview process proved challenging, with operators having limited time to dedicate to such activities due to their high workload. To allow RCF operators more flexibility in engaging with this process, a survey was created and sent to 108 operators. Only 10 operators completed the survey. Efforts were made to contact operators by phone to complete the survey verbally.

However, operators were hesitant to formally engage in the process due to concerns that information could be used to penalize them.

Residential Care Facilities Guidance Manual

As a result of the hardships uncovered during the interview and survey process, Housing Tools proposed to replace the "Residential Care Facilities Guidance Manual" with the "Economic Analysis of Residential Care Facility Expansion Strategies for Monterey County." This shift of focus was responsive to the interview and survey findings. It aimed to provide information that would be most helpful for Monterey County Behavioral Health, based on the obtained findings. The shift also aligns with the above-stated activity, "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."[1] Rather than focusing on increasing cultural competence capacity, the new report provided an economic breakdown of the cost of maintaining existing RCFs or building new RCFs. Monterey County Behavioral Health approved the proposed change of focus. The economic assessment was delivered to Monterey County Behavioral Health on February 1, 2024.

Focus Groups

Community engagement with individuals with lived experience was planned for FY 2023-2024. This timeline was shifted, with one focus group occurring in FY 23-24 and the remaining four focus groups occurring in FY 2024-2025.

Findings Report

As result of shifted timelines for 2023-2024 activities, delivery of the Findings Report was also shifted. The Findings Report will be developed and delivered to MCBH once all related activities have been completed.

Evaluation Data

RCFI Phase I is focused on front-end processes leading toward implementing a new, innovative, culturally and linguistically responsive approach in RCFs. As such, the evaluation focuses on whether and how the completed activities address the Learning Goals listed above.[2]

The conducted activities and project adjustments maintained steady progress toward several of the Learning Goals outlined for RCFI Phase I, including identifying barriers that prevent residential care facilities from being developed and remaining sustainable, determining 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, and outlining the support needed to ensure residential care facilities are financially sustainable for property owners.

Landscape Analysis

RCF Operator Survey

Outreach to 108 RCF operators was completed. Ten operators completed the survey. Facility demographics of surveyed operators were as follows:

Average length of operation	22.8 years
Number of facilities occupied at full capacity	3 of 10

[1] See bullet 2.b. in the Timeline section.
[2] See the Learning Goals section.

Through the survey, operators reported the following challenges related to the successful and sustainable operation of their facilities:

1. Issues with staff retention
2. Low reimbursement rates and delayed payment for clients who receive Supplemental Security Income (SSI)
3. Inflationary pressures from staff wages, insurance, supplies, food, rent, utilities, and repairs
4. Lack of financial assistance for major repairs and maintenance

These challenges shared by operators through their survey responses speak to two of the Learning Goals:

Learning Goal	Related Finding
Ascertain barriers that prevent residential care facilities from being developed and remaining sustainable (Learning Goal #2)	Challenges related to staff retention, low reimbursement rates, and inflationary pressures can impact the sustainability of existing RCFs and dissuade current property owners from developing new RCFs.
Outline the support needed to ensure residential care facilities are financially sustainable for property owners (Learning Goal #4)	Understanding the challenges faced by operators can help develop the supports needed to ensure RCFs are financially sustainable. Addressing the lack of financial assistance for major repairs and maintenance can help support the sustainability of RCFs. Additionally, understanding the challenges described for Learning Goal #1 can provide guidance on the support property owners need to reach financial sustainability.

Site Visits

Two site visits, with accompanying interviews, were conducted. The sites were selected to better understand the range of challenges and successes experienced by operators of small and large facilities. Facility demographics were as follows:

	RCF #1: **Small with Low Resources**	**RCF #2:** **Large with High Resources**
Location	Salinas	Greenfield
Operation	Family-owned & operated	Corporate-owned & operated
Number of beds	Not listed	250 beds across 3 facilities

Interviews with the operators revealed differences in available support across the two facilities, shared in the table below.

RCF #1: Small with Low Resources	RCF #2: Large with High Resources
Patch Funding Rate: $15–$17 per resident per day[3] **Challenges Experienced:** • High insurance costs • Backlog of client debt to the facility due to overdue rent payments • Understaffed • In need of substantial rehabilitation	**Patch Funding Rate:** $120–$150 per resident per day **Successes Experienced:** • Offers a wide array of programs and services • Resident participation in decision-making process • Accepted residents have lower care needs and rarely admit residents who are currently unsheltered

The challenges faced by RCF #1 and the successes experienced by RCF #2 address multiple Learning Goals:

Learning Goal	Related Finding
Describe the attributes of and specific needs for culturally and linguistically responsive residential care facilities that serve the SMI population (Learning Goal #1)	Understanding what contributes to the success of RCF #2 can speak to the attributes of RCFs that can dedicate resources to becoming culturally and linguistically responsive. These successes also touch on practices that can more seamlessly support these efforts, such as already having processes in place that allow residents to participate in the decision-making process.
Ascertain barriers that prevent residential care facilities from being developed and remaining sustainable (Learning Goal #2)	The challenges experienced by RCF #1 directly speak to this Learning Goal and align with the challenges identified through the RCF Operator Survey.

[3] During the fiscal year 2023-2024, Housing Tools, the contractor for the RCFI project, and the MCBH Preservation Grant Team identified several findings. One key finding was that the patch rate was below the market average, which is approximately $50 per day per client. Following a thorough review, MCBH staff concluded that these findings reflected a common challenge faced by RCF operators throughout the state. In response, MCBH has increased the patch rate for local RCFs to align with market rates. These adjustments have contributed to improved client care and assisted with the daily operational expenses of the facilities.

Learning Goal	Related Finding
Outline the support needed to ensure residential care facilities are financially sustainable for property owners (Learning Goal #4)	The ability to see the range of challenges and successes RCFs with differing resources experience can help identify the support property owners require to experience financial sustainability. With respect to challenges, exploring ways to address the challenges faced by RCF #1 can contribute to outlining the supports required. Whereas understanding the successes experienced by RCF #2 can allow for potential replication in other RCFs that support financial sustainability.

Economic Analysis of Residential Care Facility Expansion Strategies for Monterey County

In carrying out the Landscape Analysis and Community Engagement activities, Housing Tools discovered that operators need systemic operational and financial sustainability assistance to create and maintain culturally and linguistically responsive services and facilities. The Economic Analysis of RCF Expansion Strategies aimed to understand the need for RCF bed expansion for the priority population and compare the costs and benefits of different strategies. The explored strategies included:

1. Conversion of Small Hotels or Multifamily Properties
2. Conversion of Large Homes
3. Development on Vacant Land
4. Increasing Utilization of Existing RCFs

Though the primary purpose of the Economic Analysis was to understand the need for RCF bed expansion and related costs for implementing such expansion, the work included in the analysis addressed multiple Learning Goals, including:

Learning Goal	Related Finding
Ascertain barriers that prevent residential care facilities from being developed and remaining sustainable (Learning Goal #2)	The costs of opening and/or rehabilitating properties for use as RCFs provided to the County also highlights the financial barriers that current and potential operators face.
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 (Learning Goal #3)	Understanding the long-term operating costs of RCFs can assist the County in determining what financial supports and other incentives existing property owners might need to successfully turn their property into an RCF.

Outline the support needed to ensure residential care facilities are financially sustainable for property owners (Learning Goal #4)	The challenges shared above for Learning Goals #2 and #3 can inform the development of supports needed to ensure RCFs are financially sustainable for property owners.

Community Engagement and Research to Develop Culturally and Linguistically Responsive Strategies

Focus Group

The first of five focus groups was conducted in FY 2023-2024. The protocol was geared toward understanding how to support the development of RCFs that are 1) financially sustainable and 2) offer quality services and residential settings that contribute to health equity and healing. Once all activities are complete, focus group findings will be aligned with the Learning Goals and included in the RCFI Phase I Final Report.

Approximately 40 RCF residents, their family members, and staff from local social services and mental health agencies who support them participated in this first focus group. Topics explored included:

1. Safety and Security
2. Reporting and Communication
3. Quality of Care and Support
4. Living Conditions
5. Food and Nutrition
6. Community and Social Engagement
7. Shared Space Rules and Policies
8. Transportation and Accessibility

Subject Matter Expert Interviews

Interviews were also conducted with Subject Matter Experts employed at Monterey County Behavioral Health. The Subject Matter Experts included a Program Manager for the Adult System of Care, Case Managers who work directly with clients, and the Health Department's Equity Coordinator. The interviews focused on:

1. The referral and acceptance process
2. The challenges faced in serving clients effectively
3. The common grievances received from clients, family, or staff
4. Cultural and linguistic considerations

Through focusing on the above topics, the Subject Matter Expert Interviews were able to address multiple Learning Goals:

Learning Goal	Related Finding
Describe the attributes of and specific needs for culturally and linguistically responsive residential	The Subject Matter Experts staffed at MCBH were able to identify several current practices that can

care facilities that serve the SMI population (Learning Goal #1)	speak to attributes and needs surrounding culturally and linguistically responsive RCFs: • Facilities that can accommodate monolingual clients • Cultural competence training • Positive reviews about facilities that serve diverse foods, not only standard American fare The interviews also identified areas that can be enhanced: • Greater translation services, especially for the Mexican Indigenous population that speak non-Spanish languages • Beds for undocumented individuals • Integration of cultural practices for facilities to feel more welcoming and to help reduce stigma
Ascertain barriers that prevent residential care facilities from being developed and remaining sustainable (Learning Goal #2)	Several barriers to remaining sustainable were identified, including: • Lack of official and standardized policies and related training procedures for how to refer clients to RCFs • Inability to fill beds due to high costs – many clients cannot afford the cost of an RCF • Issues related to sanitation, such as pest infestation (e.g., lice, bedbugs) • Inappropriate behavior by staff
Outline the support needed to ensure residential care facilities are financially sustainable for property owners (Learning Goal #4)	Two of the biggest financial hurdles are the inability to receive payments on time and finding clients who can afford services. Understanding that these are critical barriers faced by operators can help provide direction on what kind of support will be more likely to ensure that RCFs are financially sustainable for property owners.

30-Day Public Comment Period

In accordance with MHSA regulations and procedures, the draft version of this FY2025-2026 Annual Update document was available for public input and review for the required minimum 30-days.

Announcement of the 30-Day Public Comment Period was made via the Monterey County Health Department website, mass email distribution, 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 9, 2025, and ended at 5:00 p.m. on June 9**,** 2025. No written public comments were received during the 30-Day review period. Monterey County residents were encouraged to submit their comments using the following two methods:

email: MHSAPublicComment@co.monterey.ca.us; OR

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

In addition to the 30-Day Public Comment Period, the Behavioral Health Commission conducted a Public Hearing to receive and public comments on the FY2023-2024 MHSA Annual Update. **This Hearing was conducted at 5:30 p.m. on _May 29, 2025_, at Seaside City Hall, 440 Harcourt Avenue, Seaside 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 FY2025-2026 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.

Appendix VI

Monterey County Behavioral Health Commission
Public Hearing to Approve

DRAFT
Mental Health Service Act (MHSA)
FY 2025-26 Annual Update and Expenditure Plan

MONTEREY COUNTY BEHAVIORAL HEALTH COMMISSION

MAY 29, 2024

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

Monterey County's MHSA Team

Fabricio Chombo, Assistant Bureau Chief (WOC)

Shannon Castro, MHSA Coordinator

Nicholas (Nick) Cronkhite, Finance Manager II (WOC)

Isaura Zamora, Accountant III

Wesley Schweikhard, Innovation Coordinator

and

EVALCORP

Introduction

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

- California passed the Mental Health and Services Act (MHSA) in **2004**, which designated funding to improve mental health service systems throughout the state.
- MHSA programs comprise nearly one-third of the Bureau's total annual expenditures.
- The MHSA requires a Three-Year Program & Expenditure Plans and subsequent Annual Updates for the second & third years.
- Monterey County's currently approved Three-Year Plan covers the fiscal years of 2023/24, 2024/25, and 2025/26.
- This third and final **Annual Update** for the Three-Year Plan and covers the fiscal year period beginning July 1, 2025, through June 30, 2026.
  - BH Commissioner's Received:
    - **Annual Update FY 2025-2026**
    - **Community Program Planning Process**
    - **Annual Evaluation Reports for MHSA Components, CSS, PEI Three-Year Report, Innovation**
    - **Expenditure report**

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

Annual Community Program, Planning Process (CPPP)

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

July 2024 - April 2025

Outreach
Stakeholder
&
Community Member
(English/Spanish)

Surveys
Stakeholders
&
Community Members

80 distinct distribution channels
507 community responses
95 stakeholder responses

Stakeholder Focus Groups

11 Focus Groups
60 Participants
Law Enforcement and member organizations that provide mental health services

Community Focus Groups

11 Focus Groups

87 Participants

Focus Groups Community Members
10 populations:
1) **No-English-Speaking Individuals**
2) **African American Males**
3) **Veterans, 4) LGBTQ+**
5) **Individuals affected by the 2023 floods**
6) **Early childhood caregivers**
7) **South County Community Members**
8) **Indigenous community**
9) **Foster Families**
10) **Individual Affected by Mental Illness**

Listening Sessions

6 Listening Session
110 Participants

30-Day Public Review Period

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

Posting and Announcement for public review on May 8, 2025

→

Public Comment will close on June 9, 2025**, at 5 pm**

→

Public Announcements via: County of Monterey **website, and mass e-mail to community partners and stakeholders.**

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 25-26 Annual Plan for approval during the May 29th Meeting.

Public Comments

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

	Intentionally left blank **Pending the close of the Public Comment Period.**

Prevention & Early Intervention (PEI)

No Significant Changes to the Three-Year Plan

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

- 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

Summary of Findings and Implications Prevention and Early Intervention Programs Three-Year Evaluation Report

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

MCBH supports PEI programs that address the mental health prevention and early intervention needs of the county's culturally and regionally diverse communities.

MCBH contracted with EVALCORP Research & Consulting to evaluate **36** MHSA funded programs FY 23–24.

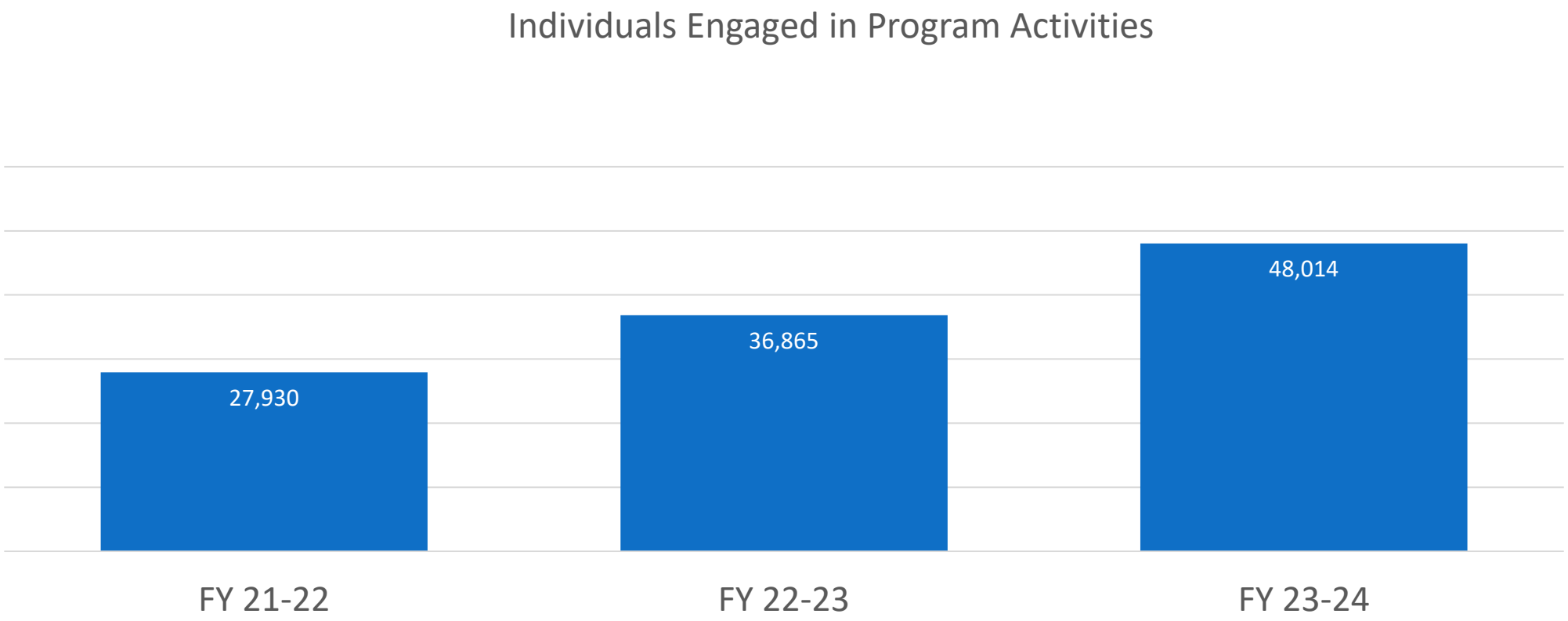
PEI Program Categories

- **Prevention** — (16 programs)
- **Early Intervention** — (8 programs)
- **Access and Linkage to Treatment** — (7 programs)
- **Stigma and Discrimination Reduction** — (3 program)
- **Suicide Prevention** — (2 programs)

*"Outreach for Increasing Recognition of Early Signs of MI" did not have any programs under the category for FY 23-24

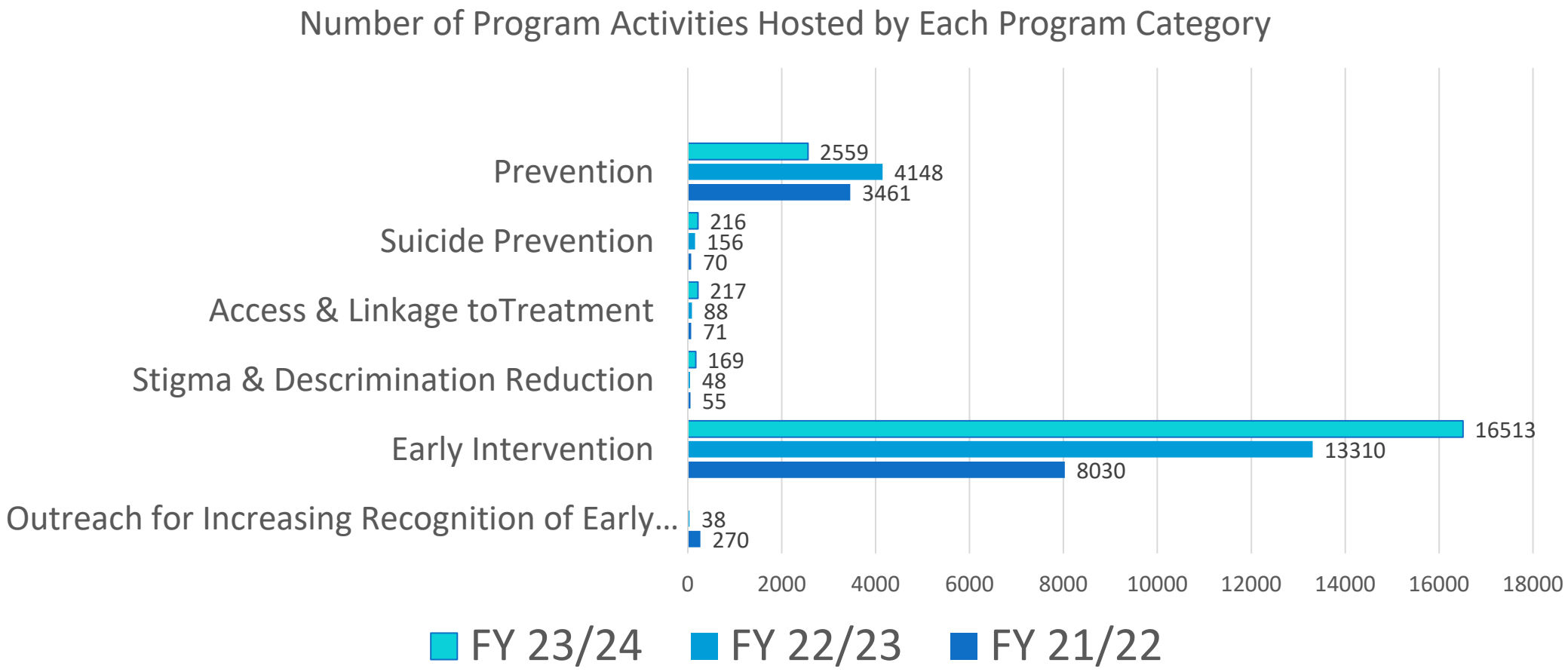
MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

PEI - Program Reach

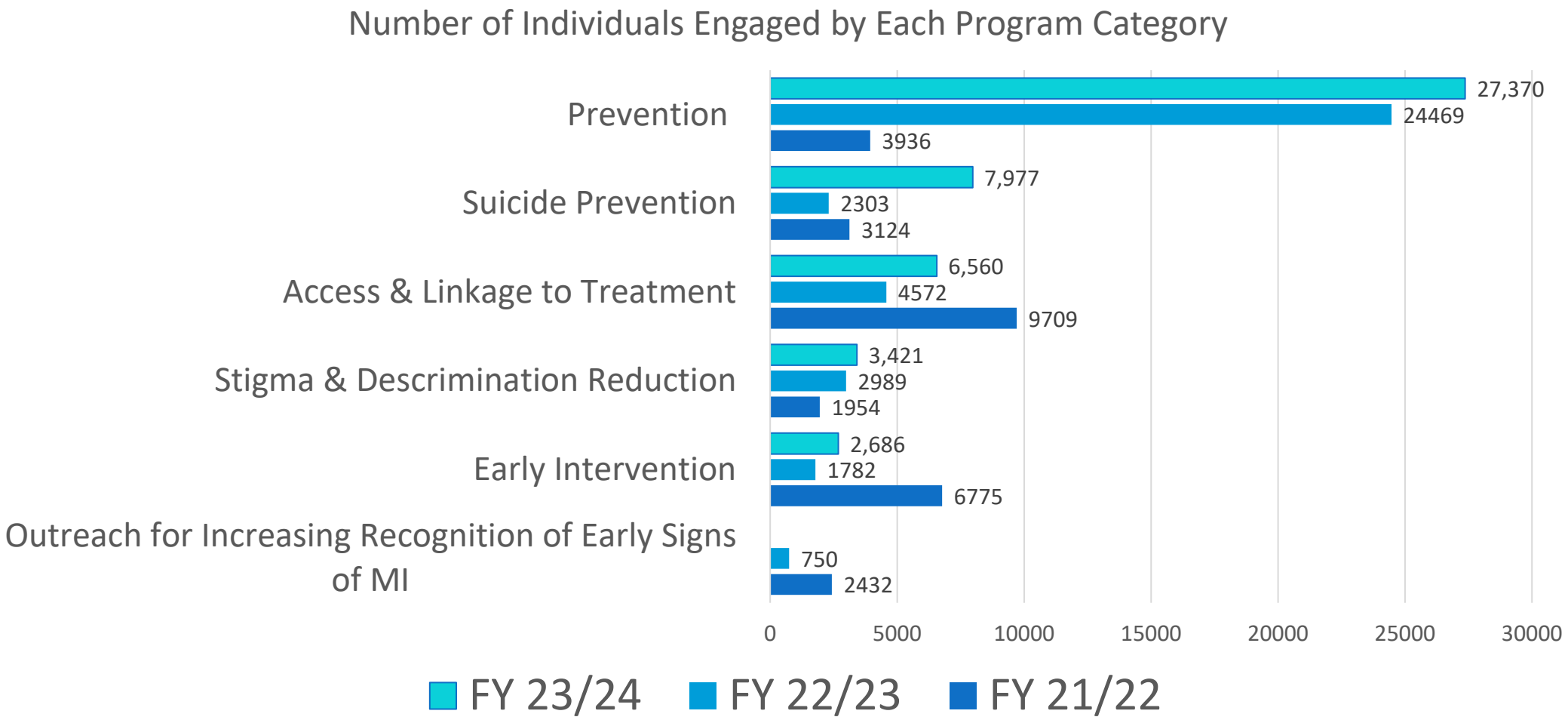


MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

PEI - Program Activities by Category



PEI - Program Reach by Category



MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

PEI Recommendations

Deepen Focus on Access & Linkage Outcomes

Expand Provider and Community Education

Refine Data Collection for Equity Monitoring

PEI Summary

Over the past three fiscal years, PEI-funded programs in Monterey County have demonstrated meaningful growth and sustained impact. Key findings include:

- **Steady increase in program reach**, with over 30,000 services delivered in FY 23/24 alone.
- **Substantial growth in Access and Linkage services**, indicating improved pathways to treatment.
- **Consistently high client satisfaction and positive outcomes**, especially in knowledge of mental health resources and hope for the future.
- **Equitable demographic reach**, with services delivered across diverse age, race/ethnicity, and gender groups.

To build on this momentum, recommendations include focusing on **refining referral and outcome tracking**, expanding **provider and community education**, increasing **support group offerings**, and enhancing **data collection to inform equity-focused planning**.

MHSA Component Overview

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

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
- In addition to the Annual Update MCBH is must provide a Three-Year PEI report.

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

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

Community Services & Supports (CSS)

No significant Changes to the Three-Year Plan

- 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.

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

Innovation (INN)

No changes to the Three-Year Plan

- 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.

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

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.

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

Questions?

Agenda Item No. 5

Monterey County Behavioral Health Commission (BHC)
Draft Action Meeting Minutes

Jeff Wardwell, Chairperson
Derrick Elder, Chairperson-Elect

Thursday, May 29, 2025 5:30 PM Seaside City Hall
440 Harcourt Ave, Seaside, CA

Quorum Met: ☒ Yes ☐ No *Excused Absence

District	Commissioner	Commissioner	Commissioner
1 – *Alejo*	☐ Albert Lomeli	☒ Jeff Wardwell	* Carissa Purnell
2 – *Church*	☒ Alma McHoney	* Terri Larson	☒ Jennie Clayton
3 – *Lopez*	☒ Mark Lopez	☐ *VACANT*	☒ Claudia Gomez
4 – *Askew*	☒ Derrick Elder	☐ *VACANT*	☒ Renie Rondon Jackson
5 – *Daniels*	☐ *VACANT*	☒ Linda Fosler	* Jean-Jacques Murphy
Law Enforcement	☐ *VACANT*		
BOS Member	☒ Wendy Askew, District 4	☐ **Alt**: Luis Alejo, District 1	

Staff:	Melanie Rhodes, Fabricio Chombo, Kevin Serrano, Lindsey O'Leary, Nick Cronkhite, Wesley Schweikhard, Susana Careaga, Jessica Ramirez, Isaura Zamora
Guests:	Sara Cervantes Weber (Spanish Interpreter), Gabriel Mejia (Spanish Interpreter), Audrey Riggin, Sonja Koehler, Christopher Mclarty, Relindis Diaz, Charles Carman, Alex Ycaza Herrera, Ramona McCabe, Francine Rodd, Casey Day, Maria Rondon

1. CALL TO ORDER

Meeting was called to order by Chairperson Wardwell at 5:37 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

Chief Casey Day, Chief of Pacific Grove Police – introduced himself as someone interested in joining the Behavioral Health Commission.

Jenny Sanchez, Admissions Manager for Psynergy Programs – introduced herself and shared information about Psynergy Programs. Psynergy Programs is a residential board and care for people 18 years of age and older and currently has a contract with Monterey County Behavioral Health. Psynergy Programs also offers tours to those who are interested in learning more; they currently have facilities in Greenfield, Morgan Hill, and Sacramento.

5. APPROVAL OF MEETING MINUTES OF APRIL 24, 2025

Motion to approve by Comm. Elder; Seconded by Supv. Askew — *Approved*

Aye: Wardwell, McHoney, Lopez, Gomez, Elder, Rondon-Jackson, Askew
Nay: None
Abstain: Clayton, Fosler

Public comment was opened and closed.

6. MOTION TO CORRECT AGENDA ITEM #9 TO AGENDA ITEM #7

Motion to correct agenda item #9 to agenda item #7 by Supv. Askew; Seconded by Comm. Fosler — *Approved*

Aye: Wardwell, Purnell, McHoney, Larson, Lopez, Gomez, Elder, Rondon-Jackson, Askew
Nay: None
Abstain: None

Public comment was opened and closed.

7. AMEND 2025 MEETING CALENDAR LOCATIONS

Motion to approve by Supv. Askew; Seconded by Comm. Fosler — *Approved*

Aye: Wardwell, Purnell, McHoney, Larson, Lopez, Gomez, Elder, Rondon-Jackson, Askew
Nay: None
Abstain: None

Public comment was opened and closed.

8. INFORMATION: PRESENTATION OF THE COUNTY RESOLUTION FOR MATERNAL MENTAL HEALTH TO MATERNAL MENTAL HEALTH TASK FORCE DOULA COMMITTEE AND BRIGHT BEGINNINGS — *Attached in Agenda Packet*

Presentation of the County Resolution for Maternal Mental Health to Maternal Mental Health Task Force Doula Committee and Bright Beginnings, presented by Supervisor Askew.

Public comment was opened and received.

9. PUBLIC HEARING AND APPROVAL OF THE DRAFT FY 2025-26 MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL UPDATE AND EXPENDITURE PLAN

Public hearing held on the Draft FY 2025-26 MHSA Annual Update and Expenditure Plan, presented and led by Shannon Castro, MHSA Coordinator.

Motion to approve by Comm. Elder; Seconded by Comm. Clayton — *Approved*

Aye: Wardwell, Purnell, McHoney, Larson, Lopez, Gomez, Elder, Rondon-Jackson, Askew
Nay: None
Abstain: None

Public comment was opened and received.

10. REPORT: MEMBER OF THE BOARD OF SUPERVISORS

Supervisor Askew provided her report. Public comment was opened and closed.

11. REPORT: BEHAVIORAL HEALTH BUREAU CHIEF — *Attached in Agenda Packet*

Public comment was opened and received.

12. REPORT FROM COMMISSIONERS — *Verbal Reports*

The Commissioners provided their reports. Public comment was opened and closed.

13. ADJOURN

The meeting was adjourned at 7:44 PM.