Yolo County Mental Health Services Act

Draft

PREPARED BY C.A.R.E. CONSULTING SERVICES

2020–2023

Three-Year Program & Expenditure Plan

Contents

[County Board of Supervisors Adoption Letter]

MHSA County Compliance Certification

County: Yolo

Local Mental Health Director Karen Larsen, Health and Human Services (530) 666-8651 Karen.Larsen@yolocounty.org	**Program Lead** Brian Vaughn, Public Health Director (530) 666-8771 Brian.Vaughn@yolocounty.org
Local Mental Health Mailing Address: Yolo County Health and Human Services Agency 137 N. Cottonwood St., Suite 2500 Woodland, CA 95695	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and non-supplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____,2020.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

_____ _____

Mental Health Director/Designee (PRINT) Signature Date

MHSA County Fiscal Accountability Certification

County/City: _____

☐ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director Name: Telephone Number: E-mail:	**County Auditor-Controller / City Financial Officer** Name: Telephone Number: E-mail:
Local Mental Health Mailing Address:	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/ revenue and expenditure report is true and correct to the best of my knowledge.

_____ _____

Local Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, _____, the County/City has maintained an interest-bearing local Mental health Services (MHS) Fund (WIC 5892(f); and that the County's/City's financial statements are audited annually by an indepepdent auditor and the most recent audit report is dated _____ for the fiscal year ended June 30, _____. I further certify that for the fiscal year ended June 30, _____, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/ City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any othre county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

_____ _____

County Auditor/Controller / City Financial Officer (PRINT) Signature Date

* Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Mental Health Commission Approval Letter

[Letter]

MHSA Guiding Principles

The MHSA principles that guide Yolo County's planning and implementation activities are described briefly here.[1]

1. Community Collaboration

The process by which clients and families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources to fulfill a shared vision and goals.

2. Cultural Competence

Incorporating and working to achieve each of the goals listed below into all aspects of policymaking, program design, administration, and service delivery. Each system and program is assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program, or system is transformed, and new protocols and procedures are developed, as necessary to achieve these goals.

3. Client Driven

The client has the primary decision-making role in identifying his or her needs, preferences, and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for him or her. Client-driven programs and services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes.

4. Family Driven

Families of children and youth with serious emotional disturbance have a primary decision-making role in the care of their own children, including the identification of needs, preferences, and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family-driven programs and services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes.

5. Wellness, Recovery, and Resilience Focused

Planning for services shall be consistent with the philosophy, principles, and practices of the recovery vision for mental health consumers: To promote concepts key to the recovery of individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. To promote consumer-operated services as a way to support recovery. To reflect the cultural, ethnic, and racial diversity of mental health consumers. To plan for each consumer's individual needs.

6. Integrated Service Experiences for clients and their families

The client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs, and funding sources in a comprehensive and coordinated manner.

1. Sources: Thomson Reuters Westlaw California Code of Regulations; FindLaw for Legal Professionals

About This Report

The Mental Health Services Act (aka Proposition 63) was approved by California voters in 2004 to expand and transform the public mental health system. MHSA is funded by a 1% tax on millionaires in the state.

This three-year plan for how Yolo County will use MHSA funds from the State of California was written with input from community members and stakeholders from across the county. The process included consumers, their family and friends, people on the front lines, emergency responders, adults, parents, youth, LGBTQ+ people, diverse racial and cultural communities, and many more.

This plan reflects the deep commitment of Yolo County HHSA leadership to ensuring the meaningful and robust participation of community stakeholders as a whole in designing MHSA programs that are wellness and recovery focused, client and family driven, culturally competent, integrated, and collaborative.

This plan is organized into sections:

- Context and Overall Summary
- Mental Health Crisis & Navigation
- Community Characteristics
- Community Engagement Process
- Community-Identified Needs & Solutions
- Three-Year Program Plan
- Budget Plan
- County MHSA Profile

The preeminent themes that came from this process are:

- People can and do get help from Yolo County HHSA to heal, improve, and recover from mental health issues.
- Much of what people have asked for is already provided in some form.
- Access to services is an enduring issue:
  - Not everyone who needs or wants mental health services can get them.
  - Private insurance can prevent people from getting the mental health care they need, especially if their issues are not severe.
  - Many people don't know how to access services.
  - When people try, many have trouble getting a response about how to access services.
- People in Yolo County strongly value prevention and support groups, particularly work that prevents youth from developing more serious issues later.
- LGBTQ+ people, youth particularly, are at tremendous risk of mental illness, suicide, and homelessness.
- The county prioritizes care for people with the most serious mental illness.
- People in the community generally don't understand the difference between "mild to moderate" and "severe" mental illness.
- People don't understand that county mental health services are generally provided to and designed for the most seriously mentally ill in the community.
- Latinx, African American, and Native American people are less likely to get the care they need for mental health issues.
- There is universal agreement about the profound seriousness of the needs of people who are experiencing homelessness.
- HHSA needs more resources to administer and evaluate the impact of funding.

Mental Health Definitions

Mental health exists on a spectrum, commonly called "mild to moderate" or "severe." See Figure 1.

FIGURE 1. STAGES OF MENTAL HEALTH CONDITIONS.

STAGE 1
Mild symptoms and warning signs

STAGE 2
Symptoms increase in frequency and severity and interfere with life activities and roles

Mild to Moderate

Served by private providers, health insurance, or simply not served

STAGE 3 Symptoms worsen with relapsing and recurrig episodes accompanies by serious disruption in life activities and roles

STAGE 4
Symptoms are persistent and severe and have jeopardized one's life

Severe

Served by county mental health services and systems, funded by Medi-Cal

Many people experience depression, but one's ability to function is an important factor that can define the severity of illness. See Figure 2.

FIGURE 2. MENTAL HEALTH CONTINUUM OF CARE.

SELF-CARE & SOCIAL SUPPORT

PROFESSIONAL CARE

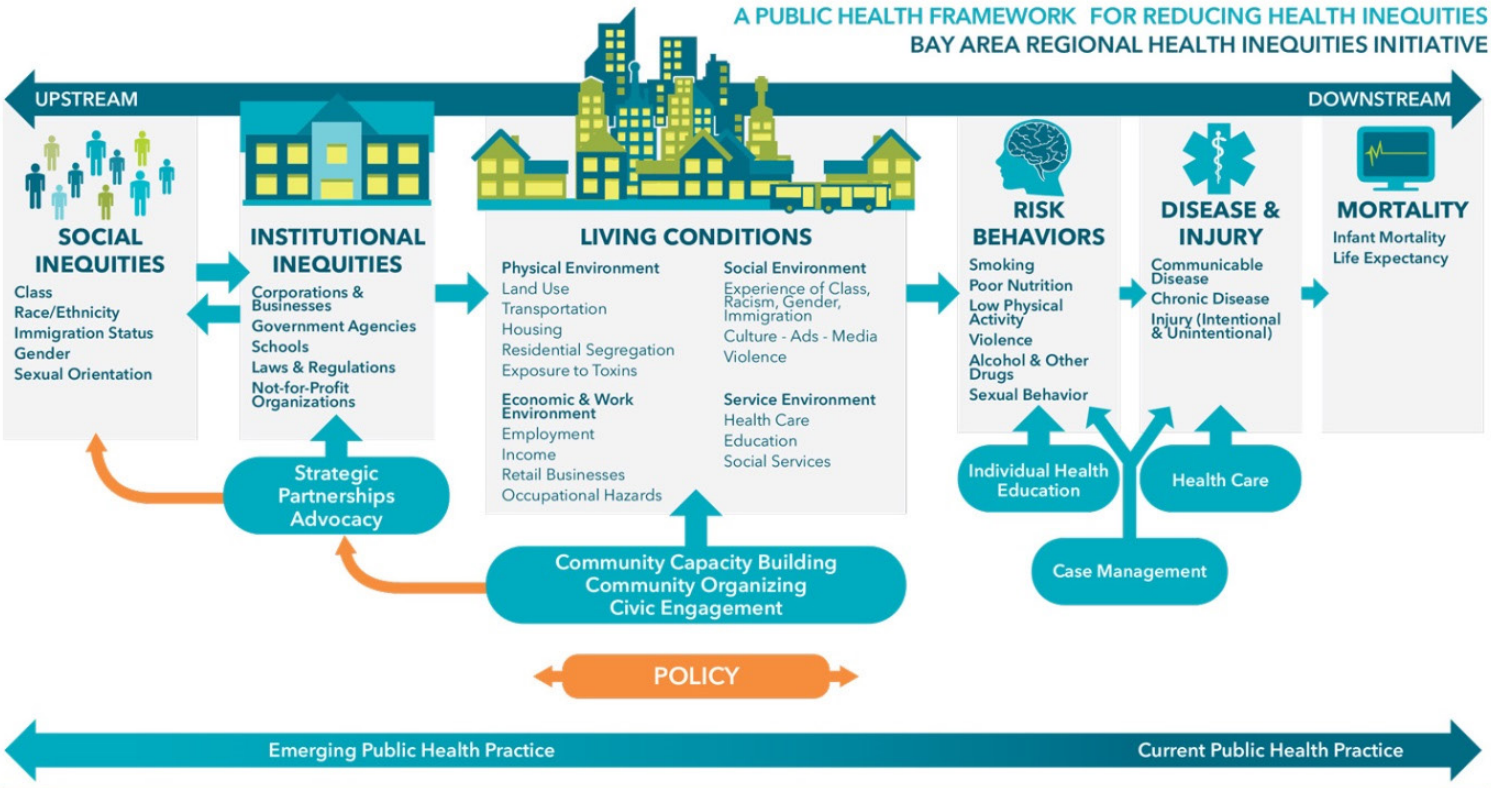
HEALTHY	REACTING	INJURED	ILL
Normal Functioning	**Common & Reversible Distress**	**Significant Functional Impairment**	**Clinical Disorder. Severe & Persistent Functional Impairment**
Normal mood fluctuations. Takes things in stride. Consistent performance. Normal sleep patterns. Physically and socially active. Usual self-confidence. Comfortable with others.	Irritable/Impatient. Nervousness, sadness, increased worrying. Procrastination, forgetfulness. Trouble sleeping (more often in falling asleep). Lowered energy. Difficulty in relaxing. Intrusive thoughts. Decreased social activity.	Anger, anxiety. Lingering sadness, tearfulness, hopelessness, worthlessness. Preoccupation. Decreased performance in academics or at work. Significantly disturbed sleep (falling asleep and staying asleep). Avoidance of social situations, withdrawal.	Significant difficulty with emotions, thinking. High level of anxiety. Panic attacks. Depressed mood, feeling overwhelmed. Constant fatigue. Disturbed contact with reality. Significant disturbances in thinking. Suicidal thoughts/intent/ behavior.

PREVENTION ← → *TREATMENT*

Public Health Context for All Health Inequities

To give context to mental health, it is important to understand that many factors over which individuals have little to no control can have a substantial impact on health. These are shown in Figure 3. Yolo County is embracing this perspective and taking steps to address these social and institutional inequalities and living conditions.

FIGURE 3. A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES FROM THE BAY AREA REGIONAL INEQUITIES INITIATIVE.[2]



2. http://barhii.org/framework/

How California's History Affects Mental Health

The challenges that Yolo County faces to address mental health are not unique within California and are intimately connected to our state's history of managing mental health.

The increasing visibility of mental health issues in the community, schools, hospitals, clinics, jails, and with homelessness is the result of larger policy applications by both the federal and state goverments. Some of the ways we see these issues manifest across the state today:

- Jails become default psychiatric institution. Inmates wait a long time for care.
- More people with mental illness are living on the street and represent one third of those experiencing homelessness.
- Emergency rooms feel the pinch.

These educational, judicial and medical systems are poorly equipped to handle mental health issues yet are being asked to shoulder much of the burden of dealing with the current mental health crisis.

A detailed history can be seen here: https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/

Today, mental health issues are more visible throughout our community and are especially acute in:

- Schools & Colleges
- Clinics & Hospitals
- Jails & Prisons
- Interactions with law enforcement

Executive Summary

Due to the impacts of COVID-19, it is important to note that the current context is more complicated than previously assessed.

Due to the impacts of COVID-19, it is important to note that the current context is more complicated than previously assessed. The information presented here is based on focus groups that happened in fall 2019. Finalization of this plan has happened concurrently with COVID-19. Although the information in this report remains relevant, as does the public health context that frames this report, it is important to note that quick changes in priorities and focus may occur based on the progress of the pandemic and concurrent mental health needs in Yolo County.

There is a cyclic relationship among health outcomes, poverty, life circumstances, race, and sexual or gender orientation that has a strong connection with mental health. Homelessness, incarceration, and reentry challenges can result when early childhood needs are not met and there is high risk of child welfare or foster care involvement, often fueling the larger cycle. The role of mental health issues and substance abuse is significant.

"I see young adults in the justice system that came through 10 years ago as foster children."
– Focus group participant

Involvement in this cycle and the accompanying service systems is not arbitrary. Data shows the clear impact of social and institutional inequities, including systematic racism, on mental health and that the role of these inequities is pervasive and overarching. Early childhood indicators show disproportionate representation of Latinx, African American, and Native American populations among people experiencing homelessness and incarceration. LGBTQ people, particularly youth, are also overrepresented among persons experiencing homelessness. Homeless people have a particularly high rate of co-occurring mental health, substance use, and physical health issues.

Yolo County provides impactful mental health services to people with the most serious mentally illness, for those who are able to access and engage them. It became clear in focus groups that there is a lack of understanding of the scale of mental illness, ranging from mild to moderate to severe, and that overall, the community doesn't necessarily understand the role of functionality in the severity of diagnosis. This illuminated a clear and ongoing need for education about what is mental illness and how to support people who are struggling.

Many focus group participants felt that those who need services are not able to access them due to a broad range of factors, some as simple as lack of response via the Access line. Participants strongly expressed that generally the county should help everyone, even if they are not eligible for Medi-Cal. This included repeated requests for

Serious mental illness can include:

- Severe bipolar disorder, characterized by dramatic swings between mania and depression
- Schizophrenia, which can involve symptoms such as delusions and hallucinations
- Severe major depression, characterized by persistent sadness and disinterest

These illnesses, and others, can impede a person's ability to carry out the normal activities of daily life. Stigma can make it extra difficult for people to talk openly about it.

https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/

broad-based prevention and community-based services, particularly those that keep people from falling into dire circumstances or having an irreparable setback in their life.

There were repeated requests for more services that integrate culture and are welcoming for subpopulations with the most risk: Latinx, African American, Native American, and LGBTQ+. Notably, the needs of the LGBTQ+ population came up in a broad range of groups and subpopulations. Data showed sustained mental health disparities for these groups. Focus group and key informant interviews corroborated this finding. It is clear that the LGBTQ+ subpopulation is highly intersectional with other groups.

Yolo County is committed to working with these groups to increase cultural competence as well as identify and dismantle inequities like systematic racism and oppression that can inhibit all members of our society from living full, safe lives.

Concerns were frequently raised about county capacity to address the range of issues. This includes the capacity of service providers, data systems, financial systems, and evaluation systems. Community participants stated that many of the needs that should be addressed are far outside of the capacity of MHSA and perhaps even HHSA, given limitations in resources. Further capacity concerns arose regarding the importance of ensuring that in addition to funded programs having the necessary capacity, that the types of interventions funded be those with proven efficacy and impact.

This plan engages the MHSA recommended strategy of leveraging resources and developing partnerships in order to meet needs, to a much greater extent than any prior plans. Some examples of this include:

- First 5 to specifically address mental health in the 0–5 age group;
- Partnering with City Law Enforcement to jointly fund Crisis Clinician positions;
- Funding from the MHSOAC to support the second round of the Data Driven Recovery Project;
- Innovation funding put toward Crisis Now TA to assist with optimizing our Crisis Response Continuum;
- Local school districts leveraging Local Control and Accountability Plans and jointly applying for Mental Health Student Services Act grant to increase school based mental health services;
- AFI foundation 50/50 match to purchase home that will be peer run for clients stepping down from Board and Cares and ready to live independently in community.
- Woodland Community College.

Artwork provided by HHSA Program participants

Overview of Yolo County's Three-Year Plan

Plan 2020–2023

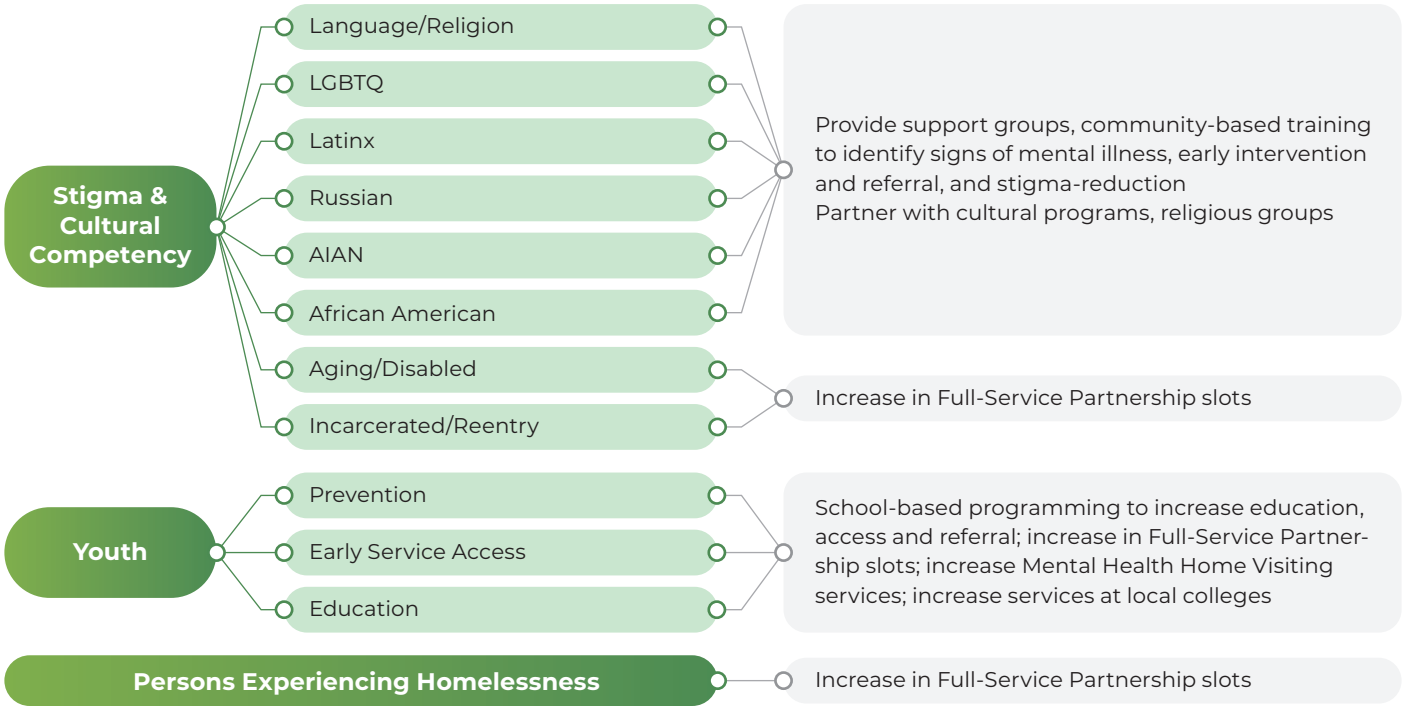
SERVICES

Access	Housing	Increase access to housing via No Place Like Home, support operator for Pine Tree Gardens, and partner with AFI Foundation for peer run home
	Basic needs	Partner with Social Services & CalWORKs
Navigation	Case management	Provide navigation and case management services embedded with housing services; Fund forensic navigators; Joint response with law enforcement, hospitals, community-based response; Strengthen services with local colleges
Integrated Services	Medical care with behavioral health	Hire medical provider
Respite	Physical spaces, e. g., Urgent Care	No funds allocated due to lack of utilization of prior efforts
	Flex funding Caregiver Support	Embed flexibility in contracts
Crisis Response	First Responders	Joint response with law enforcement, hospitals, for a more effective community-based response
	Hospitals	Crisis services at all three county clinics during business hours
Clinical Services	Children	Increase funding for Full-Service Partnership services to all population groups
	Youth	
	Families	
	Persons Exp Homelessness	
	Telehealth/Psychiatry	Provide telehealth via leveraged funds under a separate program

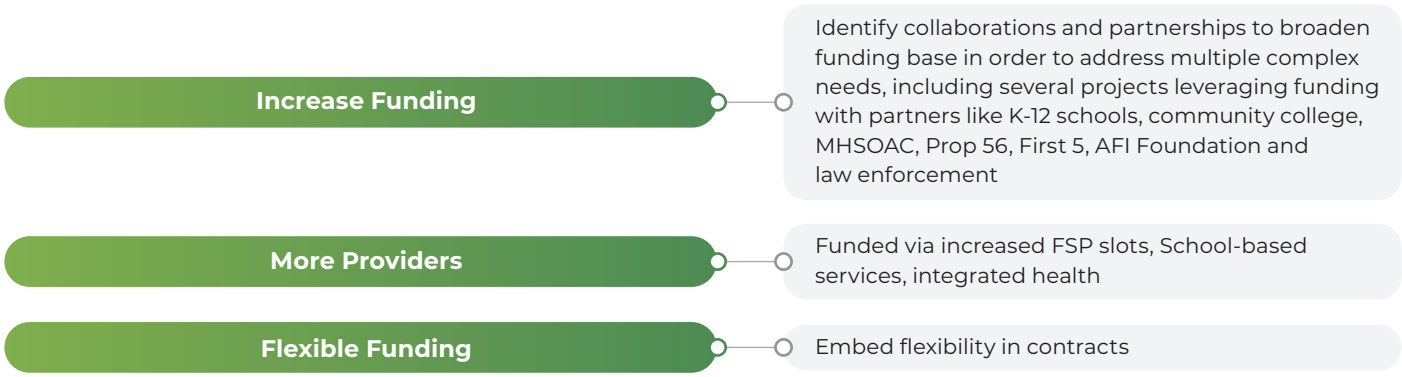
PREVENTION

Education	Increase community awareness	School-based programming to increase education, access and referral
Support Group	Peer mentorship	Funds allocated to special needs populations
Training	Increase community knowledge	Fund Suicide Prevention Lifeline, Suicide Prevention Training, Mental Health First Aid Trainings

SPECIAL NEEDS POPULATION & CULTURAL COMPETENCY



FUNDING



INFRASTRUCTURE

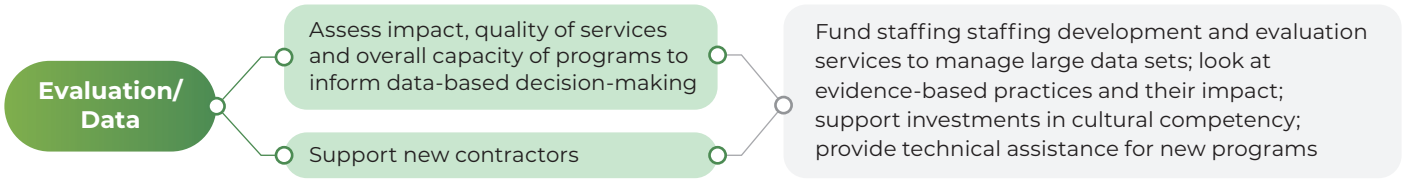
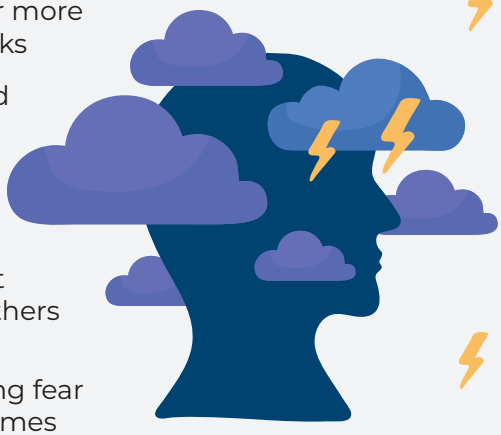


FIGURE 4. WARNING SIGNS OF MENTAL ILLNESS & SUICIDE[3]

Common WARNING SIGNS of Mental Illness

Diagnosing mental illness isn't a straightforward science. We can't test for it the same way we can test blood sugar levels for diabetes. Each condition has its own set of unique symptoms, though symptoms often overlap. Common signs and/or symptoms can include:

- Feeling very sad or withdrawn for more than two weeks
- Trying to harm or end one's life or making plans to do so
- Severe, out-of-control risk-taking behavior that causes harm to self or others
- Sudden overwhelming fear for no reason, sometimes with a racing heart, physical discomfort or difficulty breathing
- Significant weight loss or gain
- Seeing, hearing or believing things that aren't real*
- Excessive use of alcohol or drugs
- Drastic changes in mood, behavior, personality or sleeping habits
- Extreme difficulty concentrating or staying still
- Intense worries or fears that get in the way of daily activities



* Various communities and backgrounds might view this sign differently based on their beliefs and experiences. Some people within these communities and cultures may not interpret hearing voices as unusual.

3. Adapted from https://namica.org/resources/mental-illness/mental-health-conditions-warning-signs/

FIGURE 5. RISK FACTORS FOR SUICIDE[4]

4. Adapted from https://www.scyspi.org/risk-factors-and-warning-signs

How to Get Help in Yolo County

Yolo County Crisis Resources

Available resources and services for those experiencing a crisis. In the case of a life-threatening emergency, call 911.

Access & Crisis Lines

24/7 Yolo County Mental Health Services

Toll Free: (888) 965-6647
TDD: (800) 735-2929
Website: https://www.yolocounty.org/health-human-services/mental-health/mental-health-services
Last verified: 02/28/2019

24/7 Sexual Assault & Domestic Violence Line

Contact: (530) 662-1333 or (916) 371-1907
Last verified: 03/22/2019

ASK — Teen/Runaway Line

Davis: (530) 753-0797
Woodland: (530) 668-8445
West Sacramento: (916) 371-3770
Last verified: 02/28/2019

NAMI (National Alliance on Mental Illness), Yolo Message Line

Contact: (530) 756-8181
Last verified: 02/28/2019

Suicide Prevention 24/7

Davis: (530) 756-5000
Woodland: (530) 668-8445
West Sacramento: (916) 372-6565
Last verified: 03/22/2019

Protective Services

Yolo County Adult Protective Services

Toll Free Adult Abuse Reporting: (888) 675-1115
Adult Abuse Reporting: (530) 661-2727
After Hours Emergency: 911
Website: https://www.yolocounty.org/health-human-services/adults/adult-protective-services
Last verified: 02/28/2019

Yolo County Adult Protective Services, Woodland

Location: 137 N. Cottonwood Street
Woodland CA 95695
24/7 Intake Line: (530) 661-2727
Website: https://www.yolocounty.org/health-human-services/adults/adult-protective-services
Last verified: 02/28/2019

Yolo County Adult Protective Services, West Sacramento

Location: 500 A Jefferson Boulevard, Suite 100
West Sacramento, CA 95605
24/7 Intake Line: (530) 661-2727
Website: https://www.yolocounty.org/health-human-services/adults/adult-protective-services
Last verified: 02/28/2019

Yolo County Child Protective Services

Emergency: 911
Online Form: https://www.yolocounty.org/home/showdocument?id=55319
Website: https://www.yolocounty.org/health-human-services/children-youth/child-welfare-services-cws
Last verified: 02/28/2019

Emergency Child Respite Services

Yolo Crisis Nursery
Contact: (530) 758-6680
Email: info@yolocrisisnursery.org
Website: www.yolocrisisnursery.org
Last verified: 02/28/2019

Domestic Violence & Abuse Resources

Empower Yolo
24-Hour Crisis Line: (530) 662-1133
24-Hour Crisis Line: (916) 371-1907
Main Line: (530) 661-6336
Website: http://empoweryolo.org/crisis-support/
Last verified: 02/28/2019

Empower Yolo, Dowling Center
Location: 175 Walnut Street
Woodland CA 95695
Contact: (530) 661-6336
Website: http://empoweryolo.org/
Last verified: 02/28/2019

Empower Yolo, D-Street House
Location: 441 D Street
Davis, CA 95616
Contact: (530) 757-1261
Website: http://empoweryolo.org/
Last verified: 02/28/2019

Empower Yolo, KL Resource Center
Location: 9586 Mill Street
Knights Landing, CA 95465
Contact: (530) 735-1776
Website: http://empoweryolo.org/
Last verified: 02/28/2019

Empower Yolo, West Sacramento
Location: 1025 Triangle Court, Suite 600
West Sacramento, CA 95465
Website: http://empoweryolo.org/
Last verified: 02/28/2019

Community Characteristics

of Yolo County

Introduction

Yolo County is in Northern California and home to 212,605 people, according to recent estimates by the U.S. Census Bureau.

Yolo County is 93% urban and 7% rural. There are four incorporated cities in Yolo County—Davis, West Sacramento, Winters, and Woodland—where most of the population resides. In addition to these cities, there are several unincorporated communities—Brooks, Capay, Conaway, El Macero, Plainfield, Rumsey, and Zamora.

Although a known agricultural area, UC Davis is also in Yolo County and has a population of approximately 35,000. The university creates a dichotomy in the region, bringing academics and students who specialize in medicine, law, and business management to Yolo County. UC Davis has the largest UC enrollment after UCLA and UC Berkeley. The demographics and health outcomes of the county can fluctuate regionally and seasonally with the influx and outflux of UC Davis affiliates.

Age and Sex

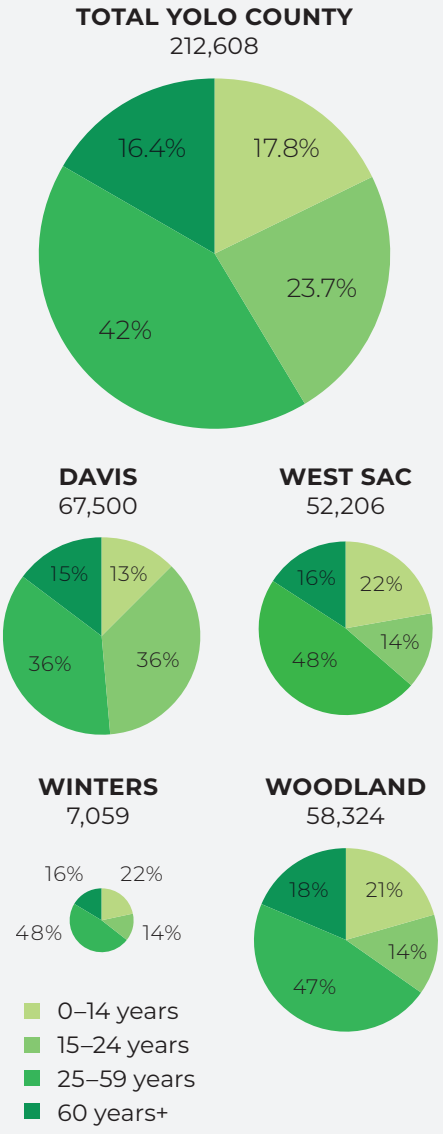
Yolo County is 51% female and 49% male. Countywide, the largest age demographic is 25- to 59-year-olds. Davis has an equal portion of college-age persons and adults younger than 60. West Sacramento, Winters, and Woodland have lower portions of college-age persons compared to adults aged 25–60. West Sacramento, Winters, and Woodland all have a young population wherein people younger than 14 years constitute a greater portion of the population than the 15- to 24-year-old population. Across all cities, persons aged 60 years or older make up 15% to 18% of the population (Figure 6).[5]

Race and Ethnicity and Language

Yolo County is diverse, with White (49.9%), Hispanic (30.3%), and Asian (12.8%) individuals making up most of the population (Figure 7). African Americans are 2.4% of the population, and those who identify with two or more races are 3.4% of the population. American Indians and Alaska Natives, Native Hawaiians, and other groups make up less than 1% of the population each.

5. U.S. Census Bureau, 2017

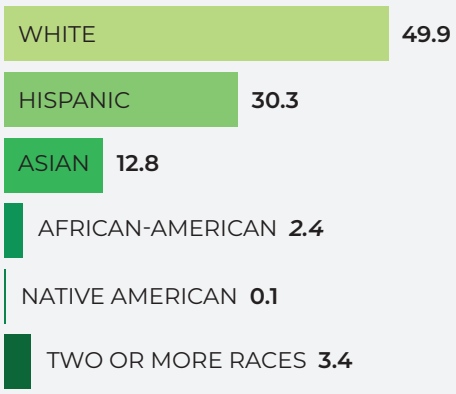
FIGURE 6. COUNTY POPULATION BY AGE



Most of Yolo County residents (62.3%) only speak English; 22.2% speaks Spanish and 7.7% speaks an Asian or Pacific Islander language. The Department of Health Care Services has identified that the threshold languages for Yolo County are English, Spanish, and Russian. A threshold language is described as reflecting a people with a primary language: (a) in a service area with 3,000 people or 5% of the population (whichever is lower) or (b) 1,000 individuals in a ZIP code or 1,500 in two contiguous ZIP codes.

Some populations in Yolo County require special attention due to their complex needs or barriers, which make them a hard-to-reach population. Several were identified in the needs assessment process: people experiencing homelessness, children and youth, adults older than 60, Russian-speaking people, Latinx, Native Americans and Alaska Natives, and LGBTQ+ people. Importantly, a cycle was identified regarding the interrelationship of homelessness and incarceration and its particularly negative and long-term impact on children and youth. The result on child welfare outcomes is noteworthy.

FIGURE 7. COUNTY POPULATION BY RACE, %



LANGUAGES

62% SPEAK ENGLISH

THRESHOLD LANGUAGES: English, Spanish, Russian

Structural Factors and Health Inequities

As noted in the Public Health Framework for Reducing Health Inequities from the Bay Area Regional Health Inequities Initiative (page 12), race/ethnicity is a consistent precursor (or predictor) of socio-economic and health outcomes and ultimately mortality. Throughout the US, including in Yolo County, a person's race and ethnicity directly impacts their life expectancy. This is not an accident. It is due to the sustained and prolonged impact of systemic and structural inequalities like racism, sexism, and other forms of discrimination which is in evidence throughout this report for African American, Latinx, and Native American populations. While the sub-headers within the various sections that follow provide data break-downs by race, this can generally be interpreted as the impact of discrimination and racism.

Health Factors

In addition to a person's individual lifestyle, socioeconomic (income, education, employment) and environmental (community safety, accessible services) factors can influence a person's health outcomes. Sometimes these factors can be so impactful that they supersede an individual's efforts to maintain physical and mental wellness or reach optimum health across the lifespan. In Yolo County, environmental and socioeconomic health disparities seem to exist between regions of the county and between racial and ethnic groups of Yolo County. Two measures that reflect multiple dimension of socioeconomic health factors are life expectancy and the Human Development Index.

Life Expectancy and Disparities

Life expectancy reflects current death rates for a subsection of the population and estimates the number of years a person is expected to live if they were born this year. The overall Yolo County life expectancy is 80.2 years. The life expectancy in Yolo County for Whites is 79.7 years, Hispanics is 78.0 years, African Americans is 73.2 years, Pacific Islanders is 72.6 years, and Native Americans is 70.6 years.[6]

Regionally, those who live in Davis, specifically the Sycamore Lane census tract, have the highest life expectancy at 87.8 years and 88 years. Zamora-Knights Landing and Woodland have life expectancies between 75 years and 79 years. West Sacramento's life expectancy is 69 years.

6. https://www.racecounts.org/county/yolo/ (accessed December 21, 2019)

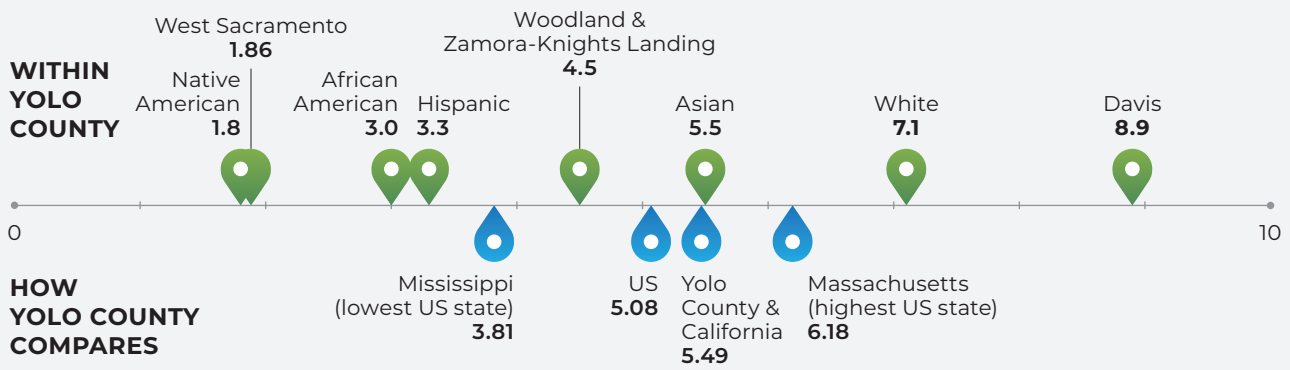
American Human Development Index

The American Human Development Index is a rigorous indicator based on life expectancy, educational attainment, and median income, and features a scale from 0 to 10, with a higher number indicating greater human development. This index is a modification of the Human Development Index, which the United Nations uses to measure whether countries are developed, developing, or underdeveloped.

Notably, the county varies greatly by geography and race. The United States has a score of 5.08 and California has a score of 5.4. The highest scoring state in the country is Massachusetts at 6.18, and the lowest is Mississippi at 3.81.

Yolo County overall scores 5.49, with the White population at 7.1, Asian at 5.5, and Hispanic at 3.3 (Figure 8). By census tract, Davis has a score of 8.9, Woodland and Zamora-Knights Landing score 4.5, and West Sacramento scores 1.86. The latter is extremely low.

FIGURE 8. AMERICAN HUMAN DEVELOPMENT INDEX



Income and Poverty

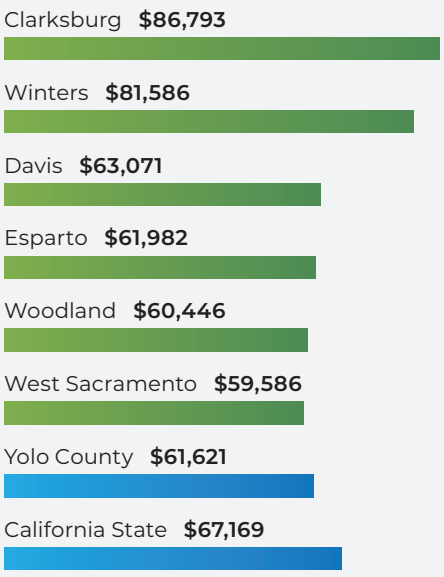
Median Household Income

Household income varies greatly across Yolo County. The median household income in Yolo County is $61,621, which is lower than the California State median household income of $67,169. Both of these income levels are higher than the National average of $57,652 which means as a whole Yolo County is doing well, although there are great disparities across the County.

Beginning with those that meet or exceed the County, Davis' median income level is slightly higher than the County average at $63,071. While Winters and Clarksburg have median incomes far higher than the County. Clarksburg's median household income is $25,172 greater than the County's median income, and Winters' median income is $19,965 greater than the County's median income. Esparto's median income falls very closely to the County's median income at $61,982 (Figure 9).

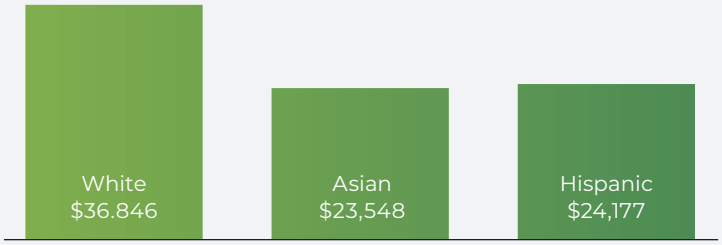
As for those that fall below the county median income, Woodland and West Sacramento's median incomes are $60,446 and $59,586, respectively (Figure 9). This means that these two communities have a great income disparity compared to Winters and Clarksburg. Between Clarksburg and West Sacramento alone, there is a $27,207 median income difference.

FIGURE 9. MEDIAN HOUSEHOLD INCOME



Race and ethnicity: There are racial and ethnic differences between personal median earnings in Yolo County. Among those who identified as White, their median personal earnings were $36,846 per year. Asian individuals earned an average of $23,548 per year, and Hispanic individuals earned $24,177 per year. The difference between White individuals and non-White individuals was about $13,000 per year (Figure 10).

FIGURE 10. PERSONAL MEDIAN EARNINGS IN YOLO COUNTY BY RACE



Poverty

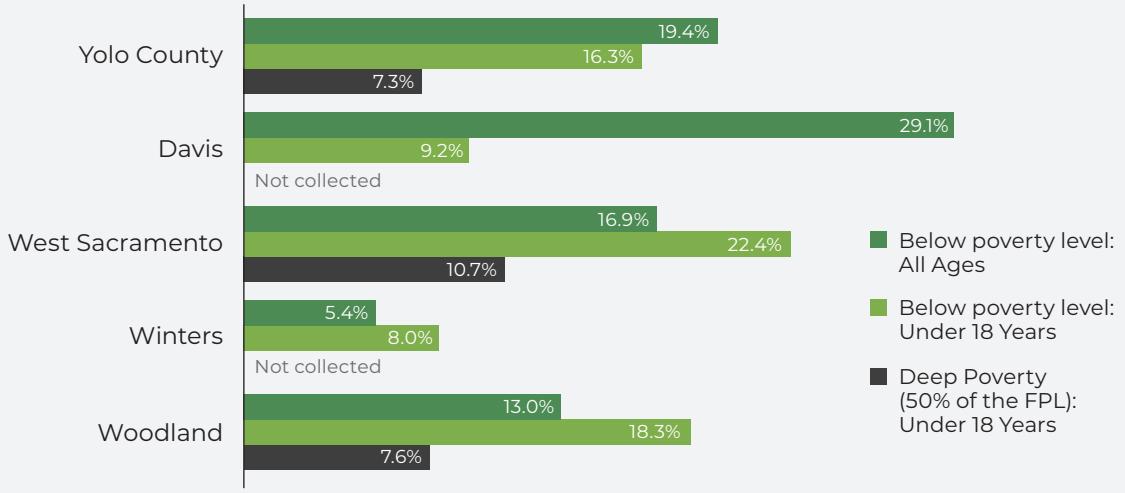
The proportion of people living in poverty varies across Yolo County. In Yolo County, 19.4% of all individuals (adults and children) are living in poverty, compared with 14.6% nationally; 16.3% of children in Yolo County are living in poverty compared with 20.3% nationally (Figure 11).

Those in Winters are faring better than Yolo County overall. Both the overall poverty rate and the children's poverty rate is far less than the county, at 5.4% of overall individuals living in poverty and 8% of children living in poverty. The overall poverty percentage and percentage of children living in poverty in Winters is half to one third of the percentages of Davis and Woodland (Figure 11).

Compared to Yolo County, there is a lesser portion of people living in poverty in West Sacramento (16.9%) and Woodland (13%). However, between a 2% and 6% greater portion of children live in poverty in West Sacramento and Woodland than the county. In Davis, their overall poverty rate was almost 10% greater than the county rate at 29%, but the children's poverty rate was better than the Yolo County rate at 9.2%.

Children living in deep poverty, which is defined as 50% of the federal poverty line, varies across Yolo County. The overall Yolo County percentage was 7.3% from 2013 to 2017. In Woodland, the percentage was 7.6% over the same period. And in West Sacramento, 10.7% of children live in deep poverty.

FIGURE 11. POVERTY IN YOLO COUNTY[7]



7. U.S. Census Bureau and Kidsdata.org

Homelessness

California has seen a dramatic increase in homelessness in the last year, and this is reflected in Yolo County data that showed a point-in-time count of 655 individuals in January 2019, an increase of 42.7% from 2017. Of this population, 86 were children under 18 and another 46 were aged 18–24. Seven percent were veterans. In Yolo County, 21% had posttraumatic stress disorder, 19% had serious mental illness, 27% had a substance use disorder, and 14% had a dual diagnosis.[8]

Race and ethnicity: Most homeless individuals were White (53%), followed by African American (14%), those who identified as multiple races (4%), American Indian or Alaska Native (2%), Asian (2%), and Hawaiian or Pacific Islander (2%). Twenty-two percent of homeless individuals were Latinx. The percentages show a disproportionate relationship to the racial and ethnic demographics in Yolo County, and highlight disparities among the Latinx and African Americans populations in Yolo County. There was a rise in the proportion of homeless people who are African American and White and a reduction in Latinx people.

Gender and sexual identity: A 2015 study found that LGBT youth are overrepresented among homeless populations, often specifically because of their gender or sexual identity, and that these youth experience homelessness for longer periods and have more mental and physical health issues.[9]

Unemployment

According to the Employment Development Department–Labor Market Information Division of the state of California, in October 2019 in California, 3.7% of the population was unemployed. Yolo County's unemployment rate was 4.2%. Davis had the lowest unemployment rate at 2.7%, West Sacramento was at 4%, and Woodland had the highest at 5.3%.

Educational Attainment

In the United States, 87.3% of those aged 25 or older have a high school diploma, compared with 86.1% in Yolo County. In Davis, 96.9% have a high school diploma. That figure in Woodland and Winters is about 80% and in West Sacramento is 84% (Figure 13).

As for college education, 30.9% of the nation has a bachelor's degree or higher, and Yolo County has a higher rate of 40.6%. Davis has a very high percentage with 73.7%; Woodland, Winters, and West Sacramento have lower rates between 17.3% and 12.6% (Figure 13).

Race/Ethnicity: In Yolo County, 100% of Filipino people graduate high school, 96.1% of Asians, 93.8% of people of two or more races, 93.2% of Whites, 83.8% of Blacks, 82.9% of Latinx, and 73.3% of Native Americans (Figure 14).[11]

In Yolo County, there are disparities among racial/ethnic groups beginning early. Among White children, 44% either meet or exceed their 3rd Grade Reading Level standards, 65% of Asian and 33% of Latino children.

FIGURE 12. HOMELESS PERSONS IN YOLO COUNTY, 2018–19

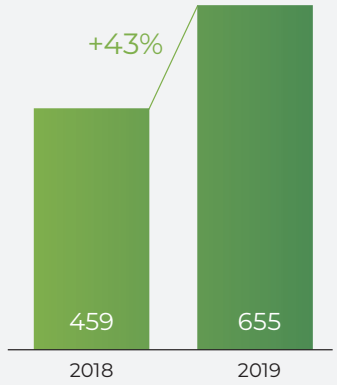


FIGURE 13. EDUCATIONAL ATTAINMENT[10]

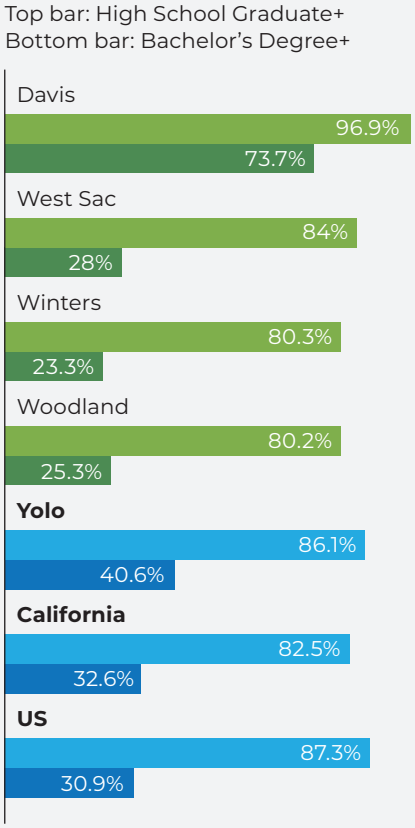


FIGURE 14. YOLO COUNTY HIGH SCHOOL AND BACHELOR'S DEGREE ATTAINMENT BY RACE/ETHNICITY[12]

	3rd Grade Reading —Meets of Exceeds Standards	High School Diploma	Bachelor's Degree
White	44%	95%	49%
Asian	65%	88%	57%
Hispanic	33%	65%	15%

8. Yolo County Homeless Count 2019, https://www.yoloCounty.org/home/showdocument?id=58761

9. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Serving-Our-Youth-June-2015.pdf

10. U.S. Census Bureau Quickfacts

11. https://www.racecounts.org/county/yolo/ (accessed December 23, 2019)

12. CEWG Presentation October 2019

Violence

Property crime arrests were much higher in Woodland, followed by West Sacramento, then Davis.

Violent crime arrests were comparable in both West Sacramento and Woodland, and nearly 4 times the rate of Davis. Domestic violence calls in Yolo County were 5.6 per 1,000, as compared with the state rate of 6.4 per 1,000 (Figure 15).

FIGURE 15. CRIME RATES, 2014[13]

	Davis Police Dept.	West Sac Police Dept.	Woodland Police Dept.	Yolo County Sheriff Dept.
Violent Crimes Total	84	262	298	74
Violent Crime Rate per 100,000 Persons	126.6	522.4	524.1	Unavailable
Property Crime Total	1,455	1,295	1,756	289
Property Crime Rate per 100,000 persons	2,193	2,582	3,089	Unavailable

Children's Health

Noteworthy disparities in child health indicators include:

- 6.3% in foster care in Yolo County versus 5.3% in the state.
- A juvenile felony arrest rate of 9.3% as compared with 5.3% in the state.
- 10.7% of children in deep poverty in West Sacramento as compared to 7.3% overall in Yolo County and 8.5% in California.
- 6.1% of public-school students are homeless in Woodland, compared to 3.3% overall in Yolo and 4.4% in California.
- Hospitalizations for mental health issues for youth aged 5–19 in Yolo County were 6.1 per 1,000, compared to 5 per 1,000 in California.
- In Yolo County, 54.8 per 100,000 youth were hospitalized due to self-inflected injuries, compared to California's 53.1 per 100,000.
- Woodland has a disproportionately high truancy rate at 48.1 per 100 students as compared with Yolo overall at 30.8 and California at 31.4.

FIGURE 16. CHILD HEALTH INDICATORS, YOLO COUNTY

	Yolo	California	Year
Children with two or more adverse experiences	15.2%	16.4%	2016
Reports of child abuse and neglect (per 1,000)	49.3%	55%	1998–2015
Children in foster care	6.3%	5.3%	2018
Teens not in school and not working	3.4%	7.7%	2005–2009 to 2011–2015
Children living in food insecure households	21.7%	22.9%	2011–2014
Medicaid or CHIP coverage	32%	42.4%	2009–2016
Kindergartners with all required immunizations	95.6%	94.8%	2002–2019
Juvenile felony arrest rate	9.3%	5.3%	1998–2015
Infant mortality rate/1,000	4.8	4.3	1996–1998 to 2014–2016
Teen Birth rate/1,000	7.8	15.7	1995–2016
Child/youth death rate/100,000	18	29.4	1996–1998 to 2014–2016
Domestic violence calls for assistance rate/1,000	5.6	6.4	1998–2017
Hospitalizations for mental health issues age 5-19	6.1	5	2016 (rate/1,000)
Hospitalizations due to self-inflicted injuries	54.8	53.1	1993–2014 (rate/100,000)
Children participating in CalWORKs rate/1,000	53.5	90.2	2003–2018
Emotional disturbance reports (number)	188	24,936	2018

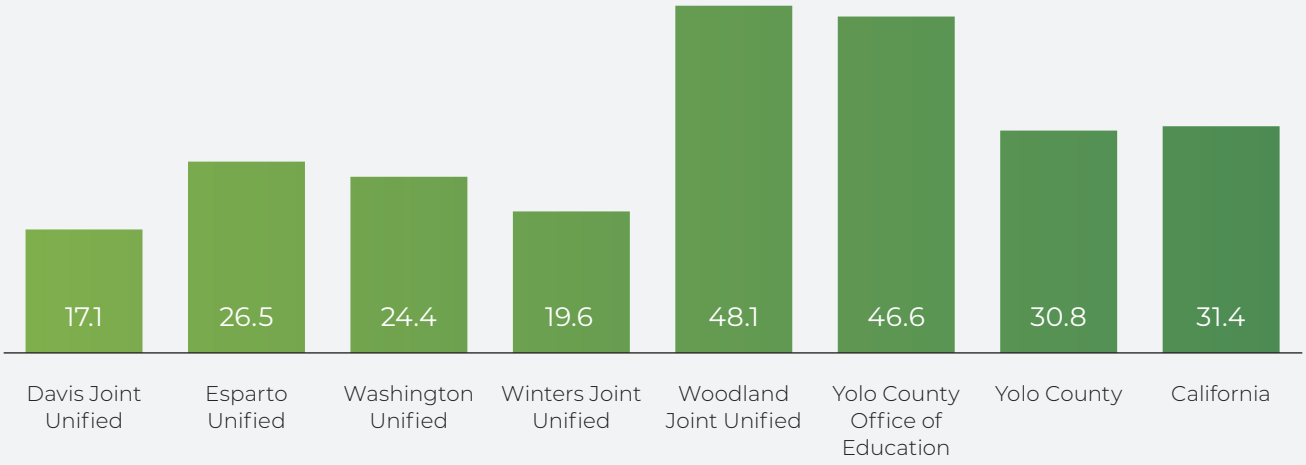
13. Uniform Crime Reporting Statistics

14. https://www.kidsdata.org

FIGURE 17. CHILD HEALTH INDICATORS BY CITY[15]

	Yolo	Davis	West Sac	Winters	Woodland	California	Year
Children with major disabilities	3.7%	2.8%	5.5%		3.4%	3.1%	2011–2015
Special education enrollment	12.9%	12.4%	11.6%		14.4%	12.5%	2018
Children in deep poverty	7.3%	n/a	**10.7%**	n/a	7.6%	8.5%	2013–2017
Homeless public-school students	3.3%	1.1%	2.4%	2.2%	**6.1%**	4.4%	2016
Students suspended from school rate/1,000	6	2.4	4.7	7.2	**9.4**	3.8	2012–2015
Juvenile felony arrests (number)	n/a	19	58	8	n/a	n/a	2015

FIGURE 18. TRUANCY RATES IN 2015



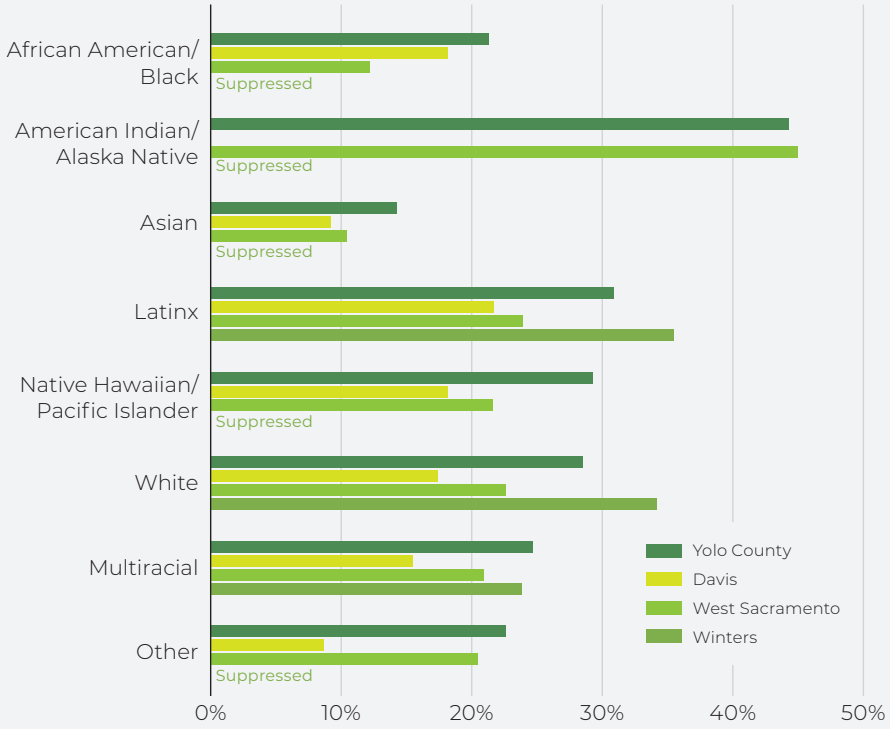
15. Kidsdata.org

Past-Month Alcohol and Drug Use by Ethnicity

Data shows racial disparities as well as regional disparities in alcohol and drug use among students in Yolo County.

American Indians and Alaska Natives have a rate of 45% in West Sacramento. Winters also showed particularly high rates among Latinx students (35.5%) and White students (34.2%). Davis had lower rates of past-month substance use than Yolo County rates across all racial and ethnic groups (Figure 19).

FIGURE 19. PAST MONTH YOUTH ALCOHOL AND DRUG USE BY RACE AND ETHNICITY, 2014-2015



Source: Kidsdata.org

Suicide

Suicide data on adult and youth populations are included in the following tables. Average rates for Yolo appear comparable to state rates.

- For suicidal ideation among ninth graders, the percentage was comparable in Davis, West Sacramento, and Winters, between 14.7 and 14.9%.
- Suicidal ideation among 11th graders showed greater differences among the three high school districts, with Davis at 20.7%, Winters at 15.7%, and West Sacramento at 13.8%.
- Among students who seriously attempted committing suicide in Yolo County, the rate varied by sexual orientation: 37.6% for those who identified as gay, lesbian, or bisexual; 25.7% for those not sure; and 12.3% for straight.

FIGURE 20. SUICIDE RATES PER 100,000 PERSONS, 2007–2018

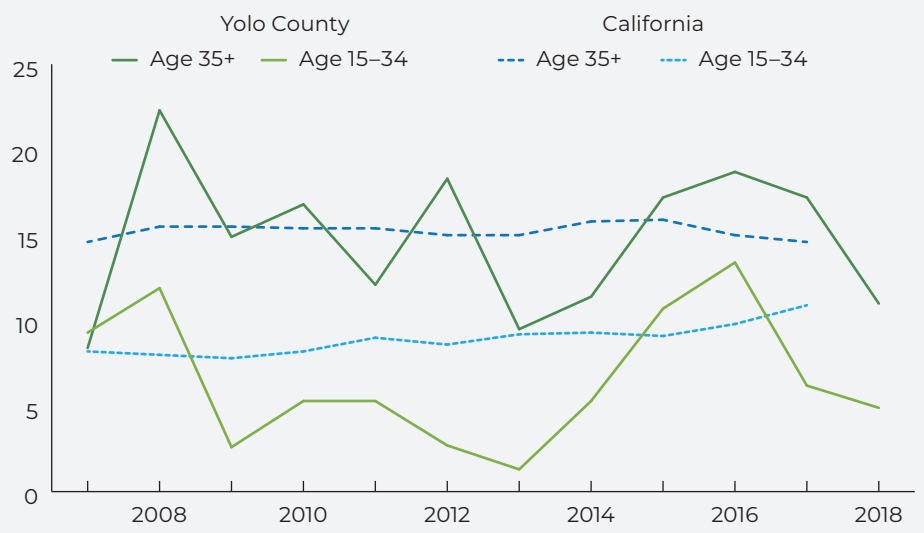


FIGURE 21. SUICIDE COUNTS AND RATES (PER 100,000 PERSONS), YOLO COUNTY VS. CALIFORNIA

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Yolo County												
Count (all ages)	15	29	14	18	15	19	13	21	25	30	22	15
Population Size	194,854	197,589	199,697	200,995	201,071	202,133	205,688	207,312	209,108	211,658	220,171	223,448
Rate per 100,000 Persons												
All Ages	7.7	14.7	7.0	9.0	7.5	9.4	6.3	10.1	12.0	14.2	10.0	6.7
Yolo County Age 15–34	9.3	11.9	2.6	5.3	5.3	2.7	1.3	5.3	10.7	13.4	6.2	4.9
Yolo County Age 35+	8.4	22.3	14.9	16.8	12.1	18.3	9.5	11.4	17.2	18.7	17.2	11.0
California												
Count (all ages)	3,524	3,717	3,743	3,822	3,952	3,857	3,990	4,205	4,214	4,167	4,299	
Rate per 100,000 Persons												
California Age 15–34	8.2	8.0	7.8	8.2	9.0	8.6	9.2	9.3	9.1	9.8	10.9	
California Age 35+	14.6	15.5	15.5	15.4	15.4	15.0	15.0	15.8	15.9	15.0	14.6	

Community and Stakeholder

Engagement Process

Community Outreach and Education Process

Yolo County HHSA conducted three education and outreach sessions to educate the larger community about MHSA.

These education sessions were broadly open to anyone who wanted to attend and were promoted on the HHSA listserv. They focused on the general organization of MHSA services in the county and reviewed what programs and services are currently funded by Yolo County's MHSA. There were 112 unique attendees.

MHSA Education Session 1, 5/2/2019, 22 attendees

- Introduce and explain the MHSA
- Describe the MHSA community planning process and MHSA general standards
- Learn about how you can participate as a stakeholder
- Learn about the Brown Act and how it applies to MHSA

MHSA Education Session, 6/11/2019, 45 attendees

- Describe the Yolo County MHSA distribution of community services and support services, prevention and early intervention, workforce development, and innovation
- Review funded programs, service descriptions, target population, target numbers, and funding allocation by MHSA funding area (Community Services & Supports (CSS), Prevention & Early Intervention (PEI), Workforce Development (WFD), Innovation (INN))

MHSA Education Session, 7/11/2019, 45 attendees

- Review of the prior two education sessions
- Review of data regulations related to MHSA-funded programs
- Snapshot of some Yolo County MHSA-funded program data
- Review next steps in the community planning process

Community Engagement Workgroup

Yolo County HHSA wanted to establish a broad community-oriented body to provide ongoing feedback on mental health services in the county.

To build on momentum generated by the community outreach and education process, the county decided to engage the participants and invite them to be part of an ongoing Community Engagement Workgroup (CEWG). This group has been asked to provide recommendations, help focus HHSA's approach and planning information going into this three-year program plan, and ideally remain an engaged partner as the county moves forward with implementation, review reporting, etc. This body acts as a partner to HHSA in the conduct of its work, supporting the dissemination of information to the community and providing a place for ongoing input and community engagement around HHSA's mental health services.

FIGURE 22. COMMUNITY ENGAGEMENT WORKGROUP MEETINGS AND TOPICS

Date	Topics Discussed	Number of participants
August 29, 2019	▸ Recap MHSA community planning and general standards ▸ Introduce the MHSA CEWG ▸ Share information and hear feedback from the focus groups ▸ Discuss focus group questions ▸ Discuss how engagement can continue ▸ Share next meeting and next steps	56
September 26, 2019	▸ Revisit the purpose of the MHSA CEWG and focus groups ▸ Discuss how feedback from last meeting affected focus group questions ▸ Share plans for future CEWG meeting topics and get feedback ▸ Share plans for the three-year plan and receive feedback ▸ MHSA trivia game ▸ Breakouts: What does this work group need to be equipped with to engage on future meeting topics?	24
October 24, 2019	▸ Provide context for health overall in Yolo County and how it connects to mental health ▸ Share public health data for Yolo County ▸ Share Yolo County and HHSA strategic plans	25
November 18, 2019	▸ Gather input from participants on priorities for funding via an interactive exercise ▸ Share data about focus groups ▸ Share key findings from focus groups ▸ Priorities exercise using key findings data ▸ MHSA regulation recap	20
December 18, 2019	▸ Share priority-setting exercise data ▸ Discuss data findings from priority-setting exercises ▸ Share solutions findings from focus groups ▸ Discussion of solutions findings ▸ Context and transparency: What does all this mean for MHSA planning and decision making?	21
January 30, 2020	▸ Review past CEWG ▸ Share county MHSA priorities for three-year plan, ▸ Introduce outcome measure and results-based accountability framework ▸ Discuss what is most important to participants in upcoming MHSA plan	21

Focus Groups

Between August and November 2019, HHSA conducted 31 focus groups with 446 unique participants.

HHSA decided, wherever possible, to engage community partners through existing organizations to conduct these focus groups. As a team, HHSA reviewed the MHSA regulations and created a list of ideal participants* and partners as part of a larger effort to ensure broad input from all levels of stakeholders throughout the county. Once the ideal list of participant groups was created, HHSA reached out to key community organizations and service partners to set a focus group. When focus groups centered around an organization and its employees, efforts were made to hold the meeting as part of a regularly scheduled meeting. As a result, focus groups varied in length from 45 minutes to 2 hours.

FIGURE 23. FOCUS GROUPS FOR YOLO COUNTY MHSA

Date	Group	Participants
8/27/19	Pilot Group	12
9/6/19	District Attorney – Victims of Crime Unit	12
9/17/19	Yolo Family Strengthening Network	22
9/19/19	HHSA Agency Director Providers Stakeholder Work Group	7
9/24/19	North Valley Indian Health	8
10/1/19	Cesar Chavez Community School: Staff participants	7
10/1/19	Cesar Chavez Community School: Student participants	10
10/3/19	Yolo Healthy Aging Alliance Advocacy Committee (Older Adult)	17
10/4/19	Yolo County Maternal Mental Health Collaborative Monthly Meeting	13
10/7/19	Yolo County Office of Education & School District Staff	21
10/7/19	HHSA Behavioral Health Team	4
10/7/19	Rotary Club of Davis	35
10/9/19	Empower Yolo	34
10/9/19	Washington School District	21
10/9/19	Fourth and Hope	26
10/10/19	National Alliance on Mental Illness	15
10/16/19	Maternal, Child & Adolescent Advisory Board	7
10/17/19	Yolo County Substance Use Provider Meeting-DMC-ODS providers	13
10/17/19	Consumers Beamer Housing	7
10/18/19	Yolo Rainbow Families	10
10/21/19	Peer Support Group	8
10/24/19	Emergency Medical Care Committee	14
11/1/19	Yolo Food Bank	7
11/5/19	Help Me Grow (Professionals)	28
11/5/19	Woodland Community College (Students)	8
11/5/19	Help Me Grow (Parents & Families)	4
11/6/19	Children Youth and Families Staff	50
11/6/19	West Sacramento Police Department	7
11/6/19	Woodland Community College (Staff)	0
11/6/19	Latinx Perspectives on Mental Health	9
11/10/19	Shambhala Meditation Center	10

Key Informant Interviews

Key informant interviews were identified to focus the information gathered from focus group participants. Eight individuals were identified. Six work in leadership positions with HHSA and two are Yolo County supervisors.

FIGURE 24. KEY INFORMANT INTERVIEWS FOR YOLO COUNTY MHSA

10/28/19	Brian Vaughn, Director, Community Health Branch
11/4/19	Karen Larsen, Director, Yolo County HHSA
11/5/19	Sandra Sigrist, Director, Adult and Aging Branch
11/7/19	Jennie Pettet, Director, Child, Youth and Family Branch
11/7/19	Nolan Sullivan, Director, Service Centers Branch
11/8/19	Salvador Torres, Veterans Services Officer
1/6/20	Gary Sandy, Yolo County Supervisor
1/17/20	Oscar Villegas, Yolo County Supervisor

Key Informant Interviews

Key informant interviews were identified to focus the information gathered from focus group participants. Eight individuals were identified. Six work in leadership positions with HHSA and two are Yolo County supervisors.

FIGURE 25. PARTICIPANT RACE

Race (Multiple), N = 524	**Number**	**% of 524 Respondents**
African American or Black	51	9.7
American Indian or Alaska Native	21	4.0
Asian	36	6.9
Pacific Islander or Native Hawaiian	6	1.1
Middle Eastern	7	1.3
Caucasian	300	57.3
Latinx or Hispanic	173	33.0
Total (>100%)	**594**	**113.4**

FIGURE 26. PARTICIPANT RESIDENCE BY COUNTRY

Residence, N = 522	**Number**	**%**
Yolo County	351	67.2%
Outside Yolo County	171	32.8%
Total	**522**	**100.0%**

FIGURE 27. PARTICIPANT RESIDENCE BY CITY WITHIN YOLO COUNTY

Residence, N=522	Number	%
Clarksburg	1	0.2%
Davis	117	22.4%
Dunnigan	2	0.4%
Esparto	8	1.5%
Knights Landing	4	0.8%
West Sacramento	28	5.4%
Winters	13	2.5%
Woodland	170	32.6%
Yolo County unspecified	8	1.5%
Outside Yolo County	171	32.8%
Total	**522**	**100.0%**

FIGURE 28. PARTICIPANT AFFILIATION

Participant Affiliation (Multiple), N = 534	Number	% Overall	% of 534 Respondents
First responder	10	1.2%	1.9%
Business owner	14	1.7%	2.6%
City or county employee	132	15.8%	24.7%
Community agency	22	2.6%	4.1%
Community member	161	19.3%	30.1%
Educator	70	8.4%	13.1%
Family member or friend of mental health client	64	7.7%	12.0%
Intern	4	0.5%	0.7%
Mental health client	71	8.5%	13.3%
Mental health service provider	152	18.2%	28.5%
Other	95	11.4%	17.8%
Prefer not to answer	27	3.2%	5.1%
Student	12	1.4%	2.2%
Total (>100%)	**834**	**100.00%**	**156.18%**

Planning Process

The focus group and key informant interviews were used to develop a set of community-based priorities for mental health services.

This information was then written in a narrative format, the Yolo County MHSA Strategic Planning Brief, and compiled into a single document along with data from a broad range of indicators available through publicly available online data. (The information included in the Planning Brief has been disaggregated and reorganized in this document.)

The brief was then distributed to the executive leadership of HHSA for review and a strategic planning session was held on January 7, 2020, to make funding decisions for the next three-year cycle. This meeting included the Directors of HHSA, Community Health Branch, Adult and Aging Branch, Service Centers Branch, Director of Administration, and Deputy Directors of Child, Youth and Family Branch, Adult and Aging Branch, and Administration, the MHSA Coordinator, and consultants to facilitate the meeting.

The focus of this meeting was on:

- Identifying gaps and needs
- Reviewing program effectiveness
- Prioritizing programs
- Balancing prioritization with identified community needs
- Refining top priorities
- Allocating funding amounts

Yolo County's HHSA executive leadership met to finalize details of programs, based on collaboration with fiscal leadership, to ensure a thorough and comprehensive plan, inclusive of community and stakeholder engagement and HHSA leadership perspectives and priorities.

Community Needs Identified

in Focus Groups & Key Informant Interviews

Introduction

During three months, 30 focus groups were conducted with various constituent groups throughout the county.

Groups were held at partner organizations whenever possible to make it as easy as possible for constituents to participate. Additionally, in the practice of cultural humility, groups were conducted at sites outside of Yolo County offices as much as possible to create safe spaces to engage in conversation about mental health. They were located throughout the county and included a broad range of constituents, including those with a specialized focus. As required by MHSA regulations, these groups represented workers and service recipients in the following areas: child, youth and families, adults and aging, disability, substance abuse recovery, homelessness , migrant workers, education, schools, higher education, behavioral health providers, foster care, police, first responders, victim services, Latinx, American Indian or Alaska Native, LGBTQ, emergency medical care, food bank, and behavioral health advocacy.

They included all populations required in the MHSA regulations. In addition, eight key informant interviews were held with Yolo County supervisors and HHSA executive leadership: HHSA Agency director, Adult & Aging Branch director, Child, Youth & Family Branch director, Service Centers Branch director, Community Health Branch director, and Veterans Services officer. Data were coded and analyzed to represent the themes that emerged. A summary can be seen in Figure 29. Thematic Codes.

> "We are all the face of mental illness."

Several primary themes emerged as salient across focus groups, including aspects of service provision (access, navigation, integrated services, telehealth, and respite care); prevention (education, support groups, and training); cultural competence (e.g., attending to the special needs of certain groups and reducing stigma); funding; and collaborating to improve community planning and business partnerships. More details about these primary thematic findings are found in Figure 29.

FIGURE 29. THEMATIC CODES FROM FOCUS GROUPS AND SIZE OF GROUPS

Services	
Access	102
Transportation	16
Housing	40
Basic needs	11
Navigation	32
Case management	8
Integration	9
Telehealth	5
Respite	5
Prevention	
Prevention	65
Education	44
Social marketing	14
Support groups	40
Peer mentorship	27
Training	44
Special Needs Populations & Cultural Competency	
Stigma	73
Language	20
LGBTQ	43
Latinx	27
Russian	5
Native American	26
Children 0–5	28
Incarcerated	3
Aging	16
Youth	41
Homeless	37
Funding	
Community	
Community	27
Partners	4
Others	
Religion	8
Predisposing	13
Other services	24

A. Services

Five key themes relevant to administration of services were expressed by focus group attendees as key issues and areas where improvements were needed.

1) Access: Respondents described a need to increase access to services, particularly ensuring that the county's Access phone number is answered and messages are returned promptly. Needs for improved customer service and welcoming atmosphere were noted. Stigma was frequently mentioned as a barrier to service access, including fear of service access for undocumented persons and the need for service provision in preferred languages; better access was cited as a need to reduce some aspects of stigma. Participants also described that long waitlists for services were a barrier, and that practical concerns—such as accessibility of hours and childcare support—limited accessibility. Other issues that limit people's ability to access services include transportation, housing, and not being able to meet other basic needs.

- **Transportation:** Lack of transportation was frequently cited as a barrier to accessing services. The geography of the county coupled with few services in remote areas and individual mental health barriers can make accessing services very difficult. There is a need to embed services where people are, including in schools, churches, and housing support centers. There is a need to create better transportation options and infrastructure throughout the county and to be thoughtful about placing services close to transit hubs.
- **Housing:** Participants described the risk of falling into homelessness and struggling to stay housed as significant factors, especially for families and those with mental health issues. In particular, participants described that it is difficult to get housing when you are struggling with mental health issues or other frequent co-occurring disorders, and there is a need for mental health housing, family housing, and increased resources and linkages to housing.
- **Other Basic Needs:** In addition to transportation and housing, focus group participants mentioned the necessity of access to adequate food and having other basic needs met for mental health services to be effective.
- **Predisposing Factors:** Some focus group participants described stress, genetics, racism, ability to cope, affluence, and upstream forces as predisposing factors that need to be addressed in order to improve mental health care.

"It's ridiculous. People come here seeking help and they get turned away 'cause they aren't sick enough or they are told they are faking it."

2) Navigation: Service navigation was mentioned frequently, including the need to assist people in connecting to services even if they are not eligible for free services through the county. Focus group participants cited the "maze" of county services and described needing support in navigating what is available and how and when it can be accessed; participants also described that navigating services is even more difficult when people are in crisis, which is often when they seek services. Other suggestions for improving the ability of users to navigate services included simplifying and improving public information on the website and increasing the knowledgeability of the scope of services among all levels of the county staff, from front desk personnel to mental health service providers.

- **Case Management:** Related to navigation, focus group participants pointed out the myriad ways in

"The services being offered through Yolo are great, it is just getting to them that is the problem."

"The worst time to find mental health services is when you are really in need of mental health services."

"In an ideal world if someone wanted help, they would get it."

which improved case management services can help persons to navigate the system and deal with other barriers to service access, including housing support, transportation, and financial services.

3) Integrated Services: Focus group participants described a significant need for integrated and colocated mental health, substance use, and physical health services as a way to better serve persons dealing with co-occurring disorders. Participants cited the need for these integrated services to be more readily available and for the providers of these services to be able to work in teams and communicate across service types. Participants suggested other ways to improve integrated services would be to embed them in other organizations, including schools, victim services, the justice system, and children's museums.

4) Telehealth/Mobile Health: Telehealth and mobile health interventions were also frequently cited by focus group participants as a way to improve services. Participants emphasized the need to invest in service models that can support the needs of people who are geographically isolated due to the size and rural nature of Yolo County; older adults who may be isolated due to age and mobility issues; and individuals who are struggling with stigma due to their culture, mental health status, sexual orientation, or gender identity.

5) Respite: In the context of services, focus group participants described the need for improved and expanded respite care for both people experiencing mental health disorder symptoms and caregivers. In particular, it was stressed that individuals with mental health challenges need some place to seek help when in a crisis that does not automatically result in emergency response teams (something aside from 911, 5150, or emergency room care) where they could have a safe space to be. Participants also recognized the need to provide respite support to caregivers to help reduce stress and avoid burnout.

6) Crisis Response: Given the frequency of issues arising in community-based settings, with first responders, in hospitals and clinics, and in schools, it is natural that the groups and key informant interviews emphasized the need for crisis response services based in the community. It is particularly important for first responders and hospitals to have support with mental health crisis in the field.

7) Clinical Services: Overall, there was a strong voice for the need for more clinical services for the entire *community*, including children, youth, families, and those experiencing homelessness. Some emphasized that these services align with supportive housing options that are nearing completion. In this category, the need for telehealth and psychiatric services also came up.

B. Prevention

Three primary themes were described by participants related to necessary improvements in prevention.

1) Education: Focus group participants mentioned the need for expanded public education and outreach to promote stigma reduction around mental health disorders and increase awareness of service availability.

- *Social Marketing/Media Campaigns:* The need for strengths-based, destigmatizing messaging was repeatedly cited as necessary to reduce the idea that "mental illness equals crazy" and strengthen the idea that "it is just as important as caring for your physical health" that "we all face challenges and it's okay to ask for help." Participants also recommended using prominent local citizens as the face of the campaign.

2)Support Groups: The sentiment came up repeatedly that there is a need to provide much broader basic prevention services in the community. Participants described that people need places to go to connect *before* there is a crisis. This includes practical support, peer support, peer mentorship, family support, and support groups targeted to groups with particular stigma or vulnerability, including aging adults, LGBTQ persons, Native American or American Indian populations, and youth. Focus group participants acknowledged that the need and

"Sometimes it doesn't even look like anything, it could look like they are doing fine but in reality, they are going through it."
– Youth

execution of these supports may be different in different communities; as such, efforts may be most effective if they are community-based and rooted in on-the-ground knowledge.

- *Peer Mentorship:* Regarding support groups and broader prevention services, the power of the role of peers came through strongly from focus group participants. Community members frequently cited the importance of having individuals who have gone through difficult times and are now in a healthy space trained and available to support others who are struggling. The need to train young people in the world of mental health was cited as essential to reducing stigma, improving help-seeking behavior, and potentially preventing problems before they reach a crisis level.

3) Training: Two primary aspects of training were described by participants: (a) there is a high need for people of all ages and cultures to learn about and understand general signs of mental health and how to respond when someone is in crisis, including suicide; and (b) specialized training for staff is needed on how to work with youth or family populations, aging adult populations, and those with disabilities. A particular need to train first responders, including in de-escalation techniques, was cited.

"That person's a human being and they need help. We got to be more about humans. I am shocked at how much discrimination goes on today."

C. Special Needs Population & Cultural Competency

Focus group participants frequently mentioned limitations to service provision and access for underserved and historically underrepresented groups, and several population groups were frequently mentioned as needing additional focus and education to reduce stigma.

1) Stigma & Cultural Competency: The prevalence of stigma was the overarching theme in the realm of special needs populations and cultural competence cited by focus group participants. Both community members and providers noted the necessity of improving cultural competence and designing culture-specific programs to help combat the negative consequences of stigma. Several specific groups were frequently described by participants as being important targets for education, specialized programs, and improved cultural competence.

- **Language:** Language competence was mentioned frequently, with participants expressing that all mental health staff should use the language line at a minimum.
- **Religions/Spirituality:** There is an expressed need for understanding of spirituality and belief systems and for services to link with religious institutions.
- **LGBTQ+ Persons:** LGBTQ+ persons were cited as a large youth population that can be relatively unsupported by parents, especially because many LGBTQ+ youth have revealed their sexual or gender identity at school but not at home. This population's high rates of mental health issues and very limited availability for prevention support were also mentioned, particularly the fact that transgender youth frequently have co-occurring disorders (autism spectrum, physical disabilities) that may complicate their ability to access appropriate services. It was also mentioned that older transgender people may be afraid to leave their homes for fear of not passing as their identified gender and may need telehealth or other mobile services to receive effective assistance.
- **Latinx:** Focus groups discussed strong taboos around discussing mental health struggles, particularly for men, in the Latinx community; strong, culturally based programs to address these taboos may be helpful in reducing stigma.
- **Russian:** It was mentioned that it's difficult for the Russian community to engage around mental health discussions, and there is limited staffing available in Russian. People in this community often turn to the church for support first, so reaching out to the religious community may improve service access.
- **American Indian/Alaska Native:** Focus groups described that culturally specific values for American Indian and Alaska Native persons are often not reflected in mainstream mental health services and that this population already struggles

with a tremendous impact from the lack of culturally based services and historical trauma that must be addressed for services to best assist this population.

- **Children Ages 0–5:** Children aged 5 or younger are a high-risk population when it comes to poverty, housing, violence, and mental health issues. Focus groups discussed that this period can be an excellent point of intervention in terms of supporting family unification, education, and long-term impact of mental health and other services. The need for programs to reduce child abuse and address childhood trauma was cited, as was the need to integrate education and services into primary school, including support for moms and dads. Focus groups expressed a general sentiment to start when people are young as the best way to keep them out of the system later and as the only way to "break the cycle."
- **Incarcerated/Reentry:** People reentering the community from jail often do not have good support to help them land on their feet and reintegrate into society. Focus groups emphasized that necessary services for these folks include mental health, physical health, and housing support.
- **Aging/Adult/Persons with Disabilities:** Older adults and those with disabilities can be particularly isolated and there are not enough services and supports for them, as described by focus participants. In particular, dementia is not considered a mental health issue, so they cannot access necessary supportive services. Participants also mentioned that transportation can be an issue for older adults who can no longer drive themselves.

"Gang violence, anger issues in the community, lot of people screamin' at each other, issues in your community, a whole lot of death, a whole lot of moms crying... can all lead to a traumatizing environment."
– Youth

2) Youth: In general, youth described feeling helpless to do anything but see and live with the challenges of their families, poverty, community violence, interpersonal violence, and racism. They discussed needing support with their mental health and identifying pathways that will keep them out of jail and housed. Youth were mentioned frequently as a special needs population with unique prevention and early intervention service needs.

"I'm a child and I can't move out of it."
– Youth

- **Prevention:** Participants mentioned a need for greater prevention with young people at early ages, including mental health stigma reduction, mental health awareness, antibullying and antiviolence education in elementary school, and greater access to extracurricular activities for middle and high school youth. Participants also described needing to address childhood trauma experiences among young people. Other services mentioned by participants as important for healing includes arts programs, grief therapy, sports, food and nutrition, and modeling good behaviors.
- **Early Service Access:** Focus groups described a strong need for school therapists to be available to youth and their families and a need for greater case management, housing, and general resource support for struggling families.
- **Education:** The school system was frequently identified as an optimal place for intervention regarding prevention for youth. Needs cited included the importance of educating teachers about mental health issues, developing peer mentors, and teaching mindfulness in schools.

"You are a product of your environment... your environment is why you have those issues."
– Youth

3) Persons Experiencing Homelessness: The growing population of persons experiencing homelessness was frequently cited as a statewide crisis. Focus groups mentioned that homelessness experiences often include co-occurring mental health disorders, physical health and disability issues, criminal justice involvement, and substance use issues, in addition to a lack of housing. These multiple co-occurring issues complicate treatment and require multipronged, coordinated efforts to most effectively help this population. It is also important to leverage existing and ongoing work, including No Place Like Home, to achieve maximum impact.

D. Funding

Focus group participants described three primary areas featuring issues with funding.

1) Need for Increased Funding: Focus groups agreed that the work that is needed simply cannot be done with the amount of money currently allocated. The county needs to be creative about leveraging resources and bringing in more funding.

2) Providers: Focus group participants mentioned that therapists, case managers, and peer support staff need to be paid more and given other monetary benefits, such as retention bonuses. Increased funding for additional providers is also necessary, because participants felt that there are simply not enough of them.

3) Flexible Funding: There is a need to identify flexible resources for mental health care, so that individuals can be supported beyond therapeutic needs with practical needs (such as those discussed above) that can have a tangible impact on mental health outcomes.

E. Infrastructure

1) Improve capacity to assess impact, quality of services, and program capacity: Internal limitations with the county's capacity became clear during this process. To improve the overall effectiveness of programming, make data-driven decisions, and understand impact, it is essential to have good-quality data and the capacity to analyze data.

2) Support new contractors: To support cultural and racial subpopulations, it is important to collaborate with community-based organizations that have possibly not previously received or managed county contracts. These organizations may require technical assistance to succeed.

Proposed Solutions

from Community Focus Groups

Throughout the focus group and key informant data collection process, suggestions for strategies to address the needs identified in this process emerged.

A. Basic Needs

- Provide intensive case management support for homeless people; meet them where they are.
- Improve support for housing needs.
- Embed services where people are already: schools, churches, housing, and associations.
- Create viable transportation options, like Via in West Sacramento, throughout the county.
- Provide healthy food.

"Help my mom."

– Youth

B. Children, Youth & Families

- Case management, housing support, and general resource support for families.
- Start younger, with populations aged 5 or younger, in primary school, and by supporting mothers and fathers.
- Targeted resources and support for maternal mental health and mothers.
- Targeted resources and supports for fathers.
- Provide stronger navigation support to youth in foster care.
- Education on mental health awareness and antibullying in elementary school (e.g., Upstander Carnival).
- Education on mental health awareness and accessing care in junior high.
- Provide mental health care to youth aged 12 or older regardless of payer source, insurance, or severity, because they have capacity for self-consent but may have financial limitations regarding parental support.
- Extracurricular activities for middle and high school youth.
- More school therapists.
- Educate teachers on mental health issues.
- Mindfulness education in schools.

"We are backfilling because that early education piece is super important. We have kids now who aren't in early ed, who are in a slow, steady, subtle crisis, that we need to help now."

– Teacher

C. Services Access

- Find solutions to provide care or support to those throughout the mental health spectrum, with specific supports to those in the mild-to-moderate space.
- Make all HHSA community-facing spaces more welcoming.
- Answer the Access phone and return calls promptly.
- Improve, streamline, and make the website user friendly.
- Provide more patient navigators.

- More case management support to help access a full range of services and address needs, including housing support.
- Colocate mental health, substance use, and physical health services, embed them at school and in victim services.
- Recognize the role of physical health in mental health.
- Provide care regardless of payer source.

"I don't think I could have gotten through 10 years without this place."
– Wellness Center Consumer

D. Community-Based Services

- Provide mobile unit with integrated services, including shower.
- Provide mobile unit with telepsychiatry.
- Provide mobile mental health crisis response.
- Provide mental health first responders.
- Provide field-based mental health services (with a baseline of providing it on-site to people in need at social services).
- Provide community-based intake for mental health services in schools, satellite clinics, and the community.
- Provide services in the community where people are (school, church, housing facilities, children's museums).
- Train police on de-escalation.

E. Physical Spaces

- Provide a safe space that isn't 911, emergency rooms, or 5150 at all hours.
- Provide parental respite services and after-hours family services, with education and coaching.
- Provide a weekend wellness center.
- Provide 24-hour urgent care.
- Provide substance use treatment and detox facilities.
- Provide a co-occurring residential substance abuse and mental health treatment program.

F. Prevention

- Basic prevention groups in the community.
- More support groups to build social connectedness, for all populations but emphasis on older adults and parents who can be particularly isolated.
- Training on signs of mental health throughout the community provided through partnership with community orgs (housing, schools, religious).
- Create a peer-to-peer mental health corps that can run community support groups and provide regular trainings and support (e.g., Grandmother's Bench).
- Social marketing campaign to include messages like: "Mental illness does not equal crazy," "It is just as important as caring for your physical health," and "We all face challenges and it's OK to ask for help."
- Stigma-reduction campaign with targeted messages, particularly for Latinx and Russian populations.

"Have them hire more peer support workers, it helps not only the community, it helps the individual feel part of the community. I know it helps me with my mental illness, helps me feel better about myself. It helps me get more money so I'm not barely making it."

G. Cultural and Linguistic Competence

- All mental health staff should use the language line, at a minimum.
- Greater access to providers with Spanish and Russian language skills.
- Targeted resources needed: Native American, Latinx, Russian, African American, LGBTQ, children aged 0–5, youth, adults, those with disabilities, aging adults, incarcerated or reentering populations, and people experiencing homelessness.
- Culturally competent programs and service delivery.
- Hire a workforce that reflects the service population in terms of race, culture, and gender and sexual identity.
- Provide more training on trauma-informed care for service providers.

H. Funding & Capacity Building

- The county needs to be creative about leveraging resources and bringing in more money.
- Therapists, case managers, and peer support staff need to be paid more and get retention bonuses. There are simply not enough of them.
- Create junior intern program to promote interest in mental health careers among young people (like police).
- Identify flexible resources for care itself, so that individuals can be supported with practical needs that can have a tangible impact on mental health outcomes.
- Leverage resources from the newly proposed payment for ACES.
- HHSA cannot address all identified needs with MHSA resources. Partnerships must be built to bring in more resources.
- Assessment of the literature to determine effective evidence-based approaches needs to be completed to ensure that the county is using resources most effectively.

I. Partnerships, Capacity and Upstream Factors

- Plan new developments so that they support health and community.
- Collaborate with local businesses and employers to implement mental health, family-friendly, and environmental policies.
- The county should build partnerships with cities to address mental health issues.
- The county should build the infrastructure to collect meaningful data and a staffing infrastructure to execute quality programs.
- The county should invest more in prevention activities, especially those related to social and environmental factors.

"Pour it into our youth, because they are going to impact their families."

Artwork provided by HHSA Program participants

Community and Stakeholder Input on Funding Priorities

A. CEWG Priorities

The CEWG met in November and provided input on funding priorities based on categories listed in the table below. This information is being provided to the executive leadership in preparation for input into decisions regarding determining HHSA's priorities for allocating MHSA dollars in alignment with regulations and their expectation of community engagement and input regarding these determinations.

The categories for participants to vote were selected based on themes that emerged from the focus groups and key informant interviews. Each participant in the meeting received $6 million in faux money to allocate among envelopes for each of the categories. The group allocated more than 30% to youth in the areas of early intervention, education, and prevention; 15% to housing and homelessness; and about 5% each for incarceration and reentry, children aged 0–5, Latinx populations, and case management.

In December, CEWG participants provided feedback on the proposed solutions list and advised that the mental health needs in the county far outweigh the capacity and resources available. New approaches and partnerships must be built to make progress and identify additional resources (see Figure 30). The CEWG further advised on the importance of understanding the most effective approaches for addressing the identified needs. The county must assess the literature and use evidence-based practices with demonstrated impact.

FIGURE 30: COMMUNITY ENGAGEMENT WORKGROUP PRIORITY FUNDING EXERCISE

Major Need Category	Need Subcategory	$ Allocated	Overall %
Youth	Early Intervention	$12,700,000	12.41%
	Education	$12,000,000	11.72%
	Prevention	$10,600,000	10.36%
Homeless/Housing	Homeless	$8,700,000	8.50%
	Housing	$7,550,000	7.38%
Special Needs Populations	Incarcerated/Re-entry	$6,100,000	5.96%
	0–5	$5,850,000	5.72%
Services	Case Management	$4,950,000	4.84%
Special Needs Populations	Latin X	$4,650,000	4.54%
Prevention	Peer Mentorship	$3,700,000	3.62%
	Training	$3,500,000	3.42%
Services	Access	$3,250,000	3.18%
Funding	Flex Funding	$3,000,000	2.93%
	Providers	$2,700,000	2.64%
Services	Respite	$2,000,000	1.95%
Special Needs Populations	LGBTQ	$1,650,000	1.61%
Services	Navigation	$1,500,000	1.47%
Prevention	Support Groups	$1,250,000	1.22%
Special Needs Populations	Aging/Adult/Disability	$1,250,000	1.22%
Services	Telehealth/Mobile Health	$1,000,000	1.07%
Special Needs Populations	Cultural Competence	$850,000	0.83%
	Native American	$700,000	0.68%
Services	Integrated Services	$650,000	0.64%
Partners	Community Planning	$600,000	0.59%
Transportation	Options	$500,000	0.49%
	Embed Services	$500,000	0.49%
Special Needs Populations	Russian	$450,000	0.44%
Prevention	Social Media	$50,000	0.05%
Partners	Business	$50,000	0.05%

Yolo County MHSA Three-Year Program Plan

2020–2023

Community Services and Supports Plan

Community Services and Supports (AA) ○ FSP ● Non-FSP

Program name: **Peer- and Family-Led Support Services**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ○ Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ○ Older Adult Aged 60+

Program Description

Peer- and Family-Led Support Services are psychoeducation groups and other support groups targeting peers and families. The services help consumers: (1) understand the signs and symptoms of mental health and resources, (2) develop ways to support and advocate for an individual or loved one to access needed services, and (3) receive support to cope with the impact of mental health for an individual or in the family. Services are exclusively led by peers and family members and are provided outside of HHSA clinics and throughout the community, as appropriate, to best serve consumers and families.

This family member component of this program features evidence-based psychoeducational curriculum that covers the knowledge and skills that family members need to know about mental illnesses and how best to support their loved one in their recovery. The peer component of the program features an evidence-based psychoeducational curriculum that includes information about medications and related issues; evidence-based treatments that promote recovery and prevention; strategies for avoiding crisis or relapse; improving understanding of lived experience; problem solving; listening and communication techniques; coping with worry, stress, and emotional flooding; supporting your caregiver; and making connections to local services and advocacy initiatives.

Key activities of Peer- and Family-Led Support Services will support outcomes around improved mental health wellness, family stability, and psychoeducation by:

- Providing a safe, collaborative space for consumers and family members to share experiences.
- Providing accurate, up-to-date information about mental illnesses and evidence-based treatments.
- Providing an environment conducive to self-disclosure and the dismissal of judgement, for both self and others.
- Providing services where they are appropriate and needed, including but not limited to community centers, wellness centers, libraries, adult-education locations, inpatient hospitals, and board-and-care facilities.
- Facilitating groups in a supportive way that models appropriate prosocial behavior.
- Providing one-on-one support when appropriate.
- Making referrals to other services as appropriate.

Goal 1	The Peer and Family Led Support Services program aims to provide family- and consumer-led support services and psychoeducation to caregivers and consumers.		
Goal 2	To expand and augment mental health services to enhance service access, delivery and recovery.		
Objective 1	Provide community-building activities for consumers and their families.		
Objective 2	Develop a knowledge base for consumers and their families.		
Objective 3	Develop self-advocacy skills for family members and peers.		
Total Proposed Budget Amount	**$300,000**	**Proposed Budget Amount FY20–21:**	**$100,000**

Community Services and Supports (AA) ● FSP ● Non-FSP

Program name: **Older Adult Outreach and Assessment Program**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ○ Transitional-age Youth Aged 16–25 ○ Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

The Older Adult Outreach and Assessment Program provides a blend of full-service partnership, general system development, outreach and engagement services, and necessary assessments for seniors with mental health issues who are at risk of losing their independence or facing institutionalization. This program serves Yolo County older adults aged 60 years or older who may also have underlying medical or co-occurring substance abuse problems or be experiencing the onset of mental illness. This program includes case management, psychiatric services, and a continuum of services across the county. Additionally, the program coordinates services with the Older Adult Senior Peer Counselor Volunteers PEI Program.

Key activities of the Older Adult Outreach and Assessment program will support outcomes around improved mental health wellness, personal social and community stability, and connection to other services for older adults by:

- Conducting strengths-based integrated assessments that comprehensively examine mental health, social, physical health and substance abuse trauma, focusing on consumer and family member engagement.
- Providing intensive support services and case management to older adults classified as full-service partners, including individual and family therapy, medication management, nursing support, and linkages to other services.
- Educating consumers and families or other caregivers regarding mental health diagnosis and assessment, psychotropic medications and their expected benefits and side effects, services and supports planning, treatment modalities, and other information related to mental health services and the needs of older adults.
- Assisting with transportation to and from key medical, psychiatric, and benefits-related appointments.
- Promoting positive contact with family members.
- Assisting families to deal with mental decline of an older adult.
- Coordinating with HHSA Adult Protective Services staff.
- Coordinating with the Public Guardian's Office regarding conservatorship of consumers no longer capable of self-care.
- Coordinating with local multidisciplinary alliances to identify and assist older adults in need of mental health treatment.
- Coordinating with assisted-living opportunities to provide a smooth transition, when needed.
- Coordinating with the Senior Peer Counselor Volunteer Program to match volunteers with seniors to prevent social isolation and promote community living, when desired.
- Assisting with maintaining healthy independent living while avoiding social isolation.
- Assisting older adults with serious mental illness to locate and maintain safe and affordable housing.

- Providing older adults with appropriate benefits assistance, including Social Security Disability Insurance, Supplemental Security Income, Medi-Cal, or Medicare, and referrals to advocacy services.
- Referring and linking consumers to other community-based providers for other needed social services and primary care.
- Delivering mobile services, including assessment and treatment to reach older adults who cannot access Yolo HHSA in Woodland or other services as a result of barriers to access (rural, transportation difficulties, etc.) or other disabilities.

Goal 1	The program aims to provide treatment and care that promotes wellness, reduces isolation, and extends the individual's ability to live as independently as possible.		
Objective 1	Support older adults and their families through the aging process to develop and maintain a circle of support, thereby reducing isolation.		
Objective 2	Promote the early identification of mental health needs in older adults to prevent suicide, isolation, and loss of independence and address co-occurring medical and substance use needs.		
Objective 3	Coordinate an interdisciplinary approach to treatment that collaborates with the relevant agencies that support older adults.		
Total Proposed Budget Amount	**$3,894,269**	**Proposed Budget Amount FY20–21:**	**$1,251,345**

Community Services and Supports (AA) ● FSP ● Non-FSP

Program name: **Adult Wellness Services Program**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ○ Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ○ Older Adult Aged 60+

Program Description

The Adult Wellness Services Program focuses on meeting the mental health treatment needs of unserved, underserved, and inappropriately served adults in Yolo County with the highest level of mental health needs. Overall, the program provides outreach and engagement, general systems development, and full-service partnership (FSP) services for adults with serious mental illness who meet medical necessity for county mental health services. This program serves Yolo County adults aged 26–59 who are unlikely to maintain health or recovery and maximal independence in the absence of ongoing intensive services.

The program includes consumer access to crisis residential facility beds, acute inpatient hospital beds, short-term and supportive housing options, self-help programs, employment support, family involvement, substance abuse treatment, and assistance with criminal court proceedings, thereby offering individual consumers the prospect of wellness and recovery. Many of these services are delivered in the two adult wellness centers, where consumers can gather and access an array of consumer-driven services and social and recreational programming. These wellness centers also provide access to case management, psychiatry, and the continuum of services across the county.

The adult FSP program includes a generalized intensive services program and two specialized intensive services programs: Assertive Community Treatment (ACT) and Assisted Outpatient Treatment (AOT). ACT serves FSP consumers at the highest level of need with strong fidelity to the evidence-based ACT model, whereas AOT, also referred to as Laura's Law, serves court-mandated consumers who are unable to

accept voluntary treatment and are at continued risk of harm.

Key activities of the Adult Wellness Services Program will support outcomes around improved mental health wellness, personal social and community stability, and connection to other services by:

- Conducting strengths-based integrated assessments that comprehensively examine mental health, social, physical health and substance abuse trauma, focusing on consumer and family member engagement.
- Providing intensive support services and case management to homeless and impoverished adults identified as FSP, including individual therapy and collateral support where needed.
- Providing ACT for consumers at the highest level of need who have experienced repeated hospitalizations or have a history of placement in an Institute for Mental Disease.
- Providing AOT to court-mandated consumers unable to accept voluntary treatment and who are at continued risk of harm.
- Providing medication management services and nursing support.
- Providing adults with appropriate benefits assistance, including Social Security Disability Insurance, Supplemental Security Income, Medi-Cal, or Medicare applications, and referrals to advocacy services.
- Conducting outreach services to persons who are homeless or at risk of homelessness with persistent and nonthreatening outreach and engagement services.
- Assisting homeless adults and adults without stable housing by locating appropriate, safe, and affordable housing in the community.
- Providing referrals and navigation support for substance abuse treatment services, when needed.
- Providing opportunities for consumers to socialize and learn alongside consumers from neighboring counties.
- Providing supportive living services to maintain housing.
- Promoting self-care and healthy nutrition.
- Providing transportation to and from services.
- Assisting interested adults to find employment and volunteer experiences to enhance their integration in the community.
- Promoting prosocial activities, including creative or artistic expression as related to self-care.
- Transporting adult consumers to and from appointments or the wellness centers.
- Operating a 24-hour crisis phone line and referring callers to crisis services and supports.
- Providing resources and information on skills for daily living.
- Providing programs, services, group support, and socialization activities at the wellness centers.
- Providing navigation and linkages to adults in need of resources in the county or community for mental health services through a peer support worker or outreach specialist.
- Referring and linking consumers to other community-based providers for other social services and primary care.
- Delivering mobile services, including assessment and treatment, to reach adults who cannot access Yolo HHSA or other services as a result of barriers to access (rural, transportation difficulties, etc.) or other disabilities.

Goal 1	The Adult Wellness Services program aims to meet the mental health treatment needs of unserved, underserved, and inappropriately served adults in Yolo County with serious mental illness who may be experiencing homelessness or be at risk for homelessness, have criminal justice system involvement, have a co-occurring substance abuse disorder, or have a history of frequent use of hospital and emergency rooms.		
Goal 2	Expand and augment mental health services to enhance service access, delivery, and recovery.		
Objective 1	Provide treatment and care that promote wellness, recovery, and independent living.		
Objective 2	Reduce the impact of living with serious mental illness (e.g., homelessness, incarceration, isolation).		
Objective 3	Promote the development of life skills and opportunities for meaningful daily activities.		
Total Proposed Budget Amount	**$18,205,939**	**Proposed Budget Amount FY20–21:**	**$5,556,979**

Community Services and Supports (AA) ○ FSP ● Non-FSP

Program name: **Community-Based Drop-In Navigation Center**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

A Community-Based Drop-In Navigation Center is a community-based location that provides behavioral health and social services to adults (aged 18 or older) who desire mental health support or are at risk of developing a mental health crisis but may not be willing or able to engage in more formalized services. The center provides an array of options for assisting consumers with any level of service engagement, focused on but not exclusive to individuals who were formerly institutionalized or are at risk of incarceration, hospitalization, or homelessness. The center addresses the need to facilitate community integration for adults who are exiting institutional care without formalized community or mental health support and to provide resources for consumers who, although engaged with mental health services, are at risk of developing a crisis and require additional support.

Staff provide a wide range of services, assisting consumers with short-term needs and more in-depth services, such as assessment and linkage to mental health services, activity or psychosocial and educational groups, assistance with housing or public benefit applications, and individualized psychosocial case management utilizing motivational interviewing practices based on the stages of change model.

Key activities of the Community-Based Drop-In Navigation Center will support outcomes around overall wellness, mental health stability, housing access and stability, and connection to other services by:

- Ensuring a seamless system of mental health engagement, assessment, treatment, and navigation, especially for individuals who may not otherwise receive treatment through Yolo County's Wellness Services program.
- Conducting strengths-based, consumer-driven, motivational interviews to support consumers to meet their personal goals and maintain strong mental health.
- Providing support services and stages of change-based case management, including service linkages when desired and appropriate.
- Collaborating with clients to secure benefits for which the person may be eligible including Social Security Income or other financial and income assistance programs, Medi-Cal, and Medicare.
- Addressing the gap in housing awareness and accessibility by providing coordination of housing openings in Yolo County for consumers, improving access to the identified available openings, and increasing retention of housing once obtained.
- Providing referrals and navigation support for substance abuse treatment services, when needed.
- Providing opportunities for consumers to socialize.
- Promoting prosocial activities, including creative or artistic expression as related to self-care.
- Promoting self-care and healthy nutrition.
- Assisting adults to find employment and volunteer experiences to enhance their integration in the community.
- Transporting adult consumers to and from initial appointments associated with their psychosocial rehabilitation.
- Providing crisis services and supports.
- Providing resources and information on skills for daily living.
- Providing programs, services, group support, and socialization activities at the center.
- Referring and linking consumers to other community-based providers for general services, social services, and primary care.

Goal 1	The Community-Based Drop-In Navigation Center provides support to consumers who may not yet be ready to engage in more intensive, clinic-based mental health services, with the goal of preventing mental health crises and connecting consumers to services when and if they desire them.		
Goal 2	Expand and augment mental health services to enhance service access, delivery and recovery.		
Objective 1	Provide supportive, flexible, consumer-driven services to all consumers at their preferred level of engagement.		
Objective 2	Assist consumers at risk of developing a mental health crisis to identify and access the supports they need to maintain their mental health.		
Objective 3	Reduce the impact of living with mental health challenges through the provision of basic needs.		
Objective 4	Increase access to and service connectedness of adults experiencing mental health problems.		
Total Proposed Budget Amount	**$2,533,200**	**Proposed Budget Amount FY20–21:**	**$844,400**

Community Services and Supports (AA) ● FSP ● Non-FSP

Program name: **Tele-Mental Health Services**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

Yolo County mental health clinics currently use telepsychiatry to expand adult consumer access to a physician prescriber. Telepsychiatry appointment are supported by an in-clinic medical assistant and nursing staff. Because our telepsychiatrist is known to be warm and personable, his clients usually rate treatment as equal to in-person visits.

In addition to telepsychiatry, Yolo County will begin to provide adult community members in crisis who seek HHSA support with access to a psychiatric nurse practitioner via telehealth means. Although this provider will be housed on-site in one HHSA clinic, individuals in crisis at the other two county mental health walk-in clinics will have access to these staff members via secure tele-conferencing means. Psychiatric nurse practitioners can provide medication evaluations, bridging medications (between existing psychiatric medication appointments with a routine provider), crisis evaluations, and prescriptions for psychiatric medication.

Key activities of the Tele-Mental Health Services program will support outcomes around reducing barriers to providing psychiatric services to individuals throughout the county, especially when in crisis. Both the telepsychiatry and nurse practitioner services provided by telehealth will expand the reach of the county's psychiatric and therapeutic services to various communities and enhance access to both psychiatric appointments and other clinical services in Yolo County.

Goal 1	Enhance access to psychiatric appointments for current clients in Yolo County.		
Goal 2	Provide access to a psychiatric medication provider to community members in crisis throughout Yolo County.		
Objective 1	Secure and implement the necessary technology for two county clinics to provide psychiatric nurse practitioner telehealth consultations.		
Objective 2	Continue current use of telepsychiatry for existing Yolo County clients.		
Total Proposed Budget Amount	**$2,347,632**	**Proposed Budget Amount FY20–21:**	**$ 771,538**

Community Services and Supports (AA) ○ FSP ● Non-FSP

Program name: Mental Health Crisis Service and Crisis Intervention Team (CIT) Training

Status: ● New ○ Continuing ● Modification

Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

Mental Health Crisis Services

Yolo County will implement a comprehensive mental health crisis service program that will provide existing Yolo County clients and the larger County community with access to crisis interventions, crisis assessments, urgent and routine service referrals and linkage, and appropriate crisis residential and/or inpatient psychiatric facility/psychiatric health facility placement, as needed.

Mental Health Crisis services will include walk-in crisis service access, including urgent psychiatric medication evaluations, in Davis, West Sacramento, and Woodland during regular business hours. Further, at any day or time 24/7, when a Yolo County Medi-Cal beneficiary or indigent individual, and/or an existing Yolo County client is placed on an involuntary psychiatric hold by local hospital staff, law enforcement, or certified County or Provider clinician, Crisis Navigation staff will secure placement at the appropriate crisis residential facility, psychiatric health facility, or acute psychiatric inpatient facility.

Additionally, working with existing City Homeless Coordinators, County crisis staff will provide phone and possibly, field response to support local law enforcement officers who encounter community members in crisis. In at least one city in the County, as a pilot program, a County clinician will be embedded with local law enforcement to form a Co-Responder team, to intervene on mental health-related police calls to de-escalate situations that have historically resulted in arrest and to assess whether the person should be referred for immediate behavioral health intervention. Staff will also provide phone and in-person response to the community, when available, when a family member/loved one reports an individual in crisis. Post-crisis, a staff member will follow-up with any persons know to the County to have recently been in crisis to ensure effective service access and referral linkage.

Key activities of the Mental Health Crisis Services will support outcomes around

- reducing unnecessary local emergency room visits and/or psychiatric involuntary holds pf individuals in crisis,
- reducing crisis reoccurrence and/or repeat acute inpatient facility placement,
- reducing unnecessary arrests of individuals in crisis,
- preventing crisis escalation which may resulting in serious injury/consequences to clients, their loved ones, and the community at large, and
- ensuring appropriate mental health service to anyone in need in advance of a crisis.

Crisis Intervention Team (CIT) Training

Yolo County will take over the delivery of the prior CIT training, modeled after a nationally recognized, evidence-based program known as the CIT Memphis Model, which focuses on training law enforcement personnel and other first responders to recognize the signs of mental illness when responding to a person experiencing a mental health crisis. The course curriculum will be approved by the local Peace Officers Standards and Training agency, providing materials and 32 hours of training at no cost to the participating law enforcement agency or individual. The course trains participants on the signs and symptoms of mental illness and how to respond appropriately and compassionately to individuals or families in crisis. Further program modifications include the development and county delivery of an annual 8-hour CIT refresher training for all county law enforcement personnel who have previously completed the initial 32-hour certification. This refresher course curriculum will be developed in concert with local enforcement agencies to ensure it includes relevant and updated topics that further attendees' intervention tools and understanding with diverse populations.

Key activities of the CIT trainings will support outcomes around improved recognition of mental health needs in the community by law enforcement professionals and by providing them with intervention tools to intervene appropriately by:

- Helping law enforcement personnel and first responders recognize the signs of mental illness when responding to mental health calls.
- Helping law enforcement and first responders to work with persons in crisis and noncrisis situations to receive the necessary intervention to promote wellness, recovery, and resilience.
- Training law enforcement personnel and first responders to have adequate understanding of the needs of culturally diverse populations.
- Raising awareness of the community needs among law enforcement and first responders.

Goal 1	De-escalate clients and community members in crisis by providing appropriate mental health interventions and support.		
Goal 2	Implement a community-oriented and evidence-based policing model for responding to psychiatric emergencies.		
Objective 1	Reduce the number of arrests and incarcerations for people with mental illness.		
Objective 2	Strengthen the relationship between law enforcement, consumers, and their families and the public mental health system.		
Objective 3	Reduce the trauma associated with law enforcement intervention and hospital stays during psychiatric emergencies.		
Total Proposed Budget Amount	**$5,385,240**	**Proposed Budget Amount FY20–21:**	**$ 1,505,779**

Community Services and Supports (CYF 0-5) ● FSP ● Non-FSP

Program name: **Children's Mental Health Services**

Status: ○ New ● Continuing ○ Modification

Target Population: ● Children Aged 0–20 ○ Transitional-age Youth Aged 16–25 ○ Adult Aged 26–59 ○ Older Adult Aged 60+

Program Description

The Children's Mental Health Services Program provides a comprehensive blend of outreach and engagement, systems development, and full-service partnership (FSP) services for children and youth with severe emotional disturbance who meet medical necessity for county mental health services.

This program specifically provides case management and individual and family services to Yolo County children and youth up to age 20 with unmet or undermet mental health treatment needs. Additionally, the Children's Mental Health Services Program provides services to children who are Latino or English learners, which are delivered by bilingual–bicultural clinicians. Services are available to children countywide and include specific outreach into rural portions of the county, where a disproportionate number of Yolo County residents are English learners and experience poverty.

The children's FSP program provides outreach and engagement, systems development, and FSP services for children and youth aged 0–15 with severe emotional disturbance who meet medical necessity for specialty mental health services. The children's FSP program utilizes a client-centered, strengths-based, community service model that emphasizes the importance of delivering treatment in settings that best meet the needs of children and families and includes a wide array of services that support recovery, wellness, and resilience to keep children and their families healthy, safe, and successful in their homes, schools, and community.

The FSP program assists children in accessing behavioral support services such as assessment; individual, group, and family therapy; medication support services; and case management assistance (which includes but is not limited to assistance with transportation, obtaining housing, fulfilling basic needs, developing social supports, care coordination, and linkage to community resources). The children's FSP program also utilizes a team approach that ensures that all clients and families served by the program are assigned to a mental health therapist, case manager, and parent partner. All children's FSP clients and their caregivers have access to a team member known to the family and familiar with the family's needs at all times for crisis support services.

The target population for the children's FSP program are Yolo County children aged 0–15 who are unserved, underserved, or inappropriately served and who experience barriers to accessing mental health treatment services. This includes children who are seriously emotionally disturbed and experiencing or at risk of experiencing:

- Homelessness or insecure housing
- Foster placement (including children transitioning to less-restrictive environments)
- Involvement with the criminal justice system or probation
- Substance use or abuse

- Violent behavior (including homicidal ideation)
- Expulsion from school
- Significant self-harm behavior (including suicidal ideation)
- Hospitalization or institutionalization

This program is currently provided by Yolo County HHSA through a contract with Turning Point Community Programs. The current capacity of the program is 25 children.

Key activities of the children's FSP program will support children to improve their psychosocial well-being, reduce mental health-related hospitalizations, reduce involvement with the criminal justice system, reduce homelessness, and improve functioning in the family, school, and community by:

- Educating children and their families or other caregivers regarding mental health diagnosis and assessment, medications, services and support planning, treatment modalities, and other information related to mental health services and the needs of children and youth.
- Providing intensive support services to children classified as FSP and their families, including individual and family therapy.
- Providing services to support families of FSP children.
- Developing integrated service plans that identify needs in the areas of mental health, physical health, education, and socialization.
- Providing medication management services and nursing support, if needed.
- Supporting children to achieve academic success.
- Providing community-based services at the child's home, schools, and appropriate community locations.
- Delivering mobile services, including assessment, treatment, and telepsychiatry, to reach children and their families who cannot access mental health services as a result of barriers to access (rural, transportation difficulties, etc.) or other disabilities.
- Providing navigation and linkages to families in need of resources in the community for mental health services through a family partner.
- Operating a 24-hour crisis phone line to provide support to the child or family from a person known to the family and familiar with the family's needs.
- Referring and linking clients to other community-based providers for other needed social services and primary care.
- Providing transportation to and from services.

Goal 1	Children's Mental Health Services aims to provide FSP, system development, and outreach and engagement services to all children up to age 20 in Yolo County who are experiencing serious emotional difficulties.		
Goal 2	To expand and augment mental health services to enhance service access, delivery, and recovery.		
Goal 3	Children's FSP program aims to provide high-quality, community-based mental health services to Yolo County children aged 0–15 who are experiencing serious emotional disturbances.		
Objective 1	Increase the level of participation and involvement of ethnically diverse families in all aspects of the public mental health system.		
Objective 2	Reduce ethnic and cultural disparities in accessibility, availability and appropriateness of mental health services to more adequately reflect mental health prevalence estimates.		
Objective 3	Increase the array of community supports for children and youth diagnosed with serious emotional disturbance and their families.		
Objective 4	Improve success in school and at home, and reduce institutionalization and out-of-home placements.		
Total Proposed Budget Amount	**$2,142,387**	**Proposed Budget Amount FY20–21:**	**$686,311**

Community Services & Supports (TAY 16–25) ● FSP ● Non-FSP

Program name: **Pathways to Independence**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ○ Adult Aged 26–59 ○ Older Adult Aged 60+

Program Description

The Pathways to Independence Program provides outreach and engagement, systems development, and full-service partnership (FSP) services for youth aged 16–25 who meet medical necessity for county mental health services. The Pathways to Independence Program assists youth with access to behavioral support services including assessment; individual, group, and family therapy; medication support services; and case management assistance (which includes but is not limited to assistance with: transportation, obtaining housing, fulfilling basic needs, developing social supports, care coordination, and linkage to community resources). This program is provided by Yolo County HHSA. The program utilizes a client-centered, strengths-based, community service model that emphasizes the importance of delivering treatment in settings that best meet the needs of transitional-age youth and includes a wide array of services that support recovery, wellness, and resilience to assist youth with remaining safe, living independently, and making a successful transition to self-supportive adulthood. The program seeks to fully implement the transition to independence process (TIP) model in all phases of treatment. The TIP model establishes a practice framework that assists youth in setting and achieving their own short-term and long-term goals across relevant transition domains, such as: employment and career, educational opportunities, living situation, personal effectiveness and well-being, and community-life functioning.

The target population for the Pathways to Independence FSP Program are Yolo County youth aged 16–25 who are unserved, underserved, or inappropriately served and who experience barriers to accessing mental health treatment services. This includes youth who are seriously emotionally disturbed or who have a severe and persistent mental illness and who are experiencing or at risk of experiencing:

- Homelessness or insecure housing
- Emancipation from the child welfare or juvenile justice system
- Involvement with the criminal justice system or probation
- Substance use or abuse
- Self-injurious or high-risk behavior
- First onset of serious mental illness
- Hospitalization or institutionalization

The FSP program utilizes a team approach that ensures that all youth served by the program are assigned to a mental health therapist, case manager, and a peer support worker. All Pathways to Independence clients have access to a team member known to the youth and familiar with the youth's needs at all times for crisis support services. This program is currently provided by Yolo County HHSA through an internal team of therapists, case managers, and peer support workers. The current capacity of the program is 25 youth.

The Pathways to Independence program will continue to addresses the needs identified through this year and prior year's needs assessment, which emphasize access to case management and psychiatry and a continuum of services across the county that include professional and peer support provided through transitional-age youth wellness centers in Davis, Woodland, and West Sacramento. As part of the process, stakeholders also identified a need for increased support for young people who are entering the mental health system and need help navigating the service system.

Key activities of the Pathways to Independence Program will support youth to improve their psychosocial well-being, reduce mental-health related hospitalizations, reduce involvement with the criminal justice system, reduce homelessness, improve community, and support a transition to self-supportive adulthood by:

- Educating youth and their families or other caregivers regarding mental health diagnosis and assessment, medications, services and support planning, treatment modalities, and other information related to mental health services and the needs of the youth.
- Providing intensive support services and case management to youth identified as FSP, including individual therapy and other collateral support, when needed.
- Developing integrated service plans that identify needs in the areas of mental health, physical health, education, job training, employment, housing, socialization, and independent living skills.
- Providing seamless linkages between the child, youth, and family mental health system and the adult

and aging mental health system, as appropriate.

- Providing medication management services and nursing support, if needed.
- Assisting youth to enroll in entitlement programs for which they are eligible (to facilitate emancipation) including Social Security Disability Insurance, Supplemental Security Income, and Medi-Cal.
- Assisting youth with obtaining affordable housing in the community (including permanent affordable housing with combined supports for independent living).
- Providing life skills development to promote healthy independent living.
- Assisting youth with developing employment-related readiness skills and with seeking employment.
- Empowering youth to participate in efforts to reduce stigma associated with mental illness while developing confidence and public-speaking skills through the TAY Speakers Bureau.
- Supporting youth to graduate high school and pursue college or vocational school.
- Providing referrals and navigation support for substance abuse treatment services, when needed.
- Providing rehabilitative wellness programs, services, group support, and age-appropriate socialization activities.
- Providing services to support families of youth, as appropriate.
- Provide navigation and linkages to youth in need of resources in the county or community for mental health services through a peer navigator or outreach specialist.
- Referring and linking clients to other community-based providers for other needed social services and primary care.
- Delivering mobile services, including assessment, treatment, and telepsychiatry, to reach youth who cannot access services as a result of barriers to access (rural, transportation difficulties, etc.) or other disabilities.
- Transporting youth clients to and from mental health appointments or other program activities.
- Assisting youth to obtain a driver's license when appropriate.

Goal 1	Pathways to Independence aims to provide FSP, system development, and outreach and engagement services to youth aged 16–24 in Yolo County who are experiencing serious mental illness while transitioning to adulthood.		
Goal 2	Expand and augment mental health services to enhance service access, delivery, and recovery.		
Objective 1	Reduce ethnic and cultural disparities in accessibility, availability, and appropriateness of mental health services and more adequately reflect mental health prevalence estimates.		
Objective 2	Address existing mental health challenges promptly with assessment and referral to the most effective services.		
Objective 3	Support successful transition from the foster care and juvenile justice systems.		
Total Proposed Budget Amount	**$4,910,466**	**Proposed Budget Amount FY20–21:**	**$1,573,481**

Prevention and Early Intervention Program Plan

Prevention and Early Intervention (AA) ○ FSP ● Non-FSP

Program name: **Senior Peer Counseling Program**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ○ Transitional-age Youth Aged 16–25 ○ Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

Senior Peer Counseling mobilizes volunteers from the community to provide free, supportive counseling and visiting services for adults aged 60 or older in Yolo County who are troubled by loneliness, depression, loss of spouse, illness, or other concerns of aging. Services are voluntary, consumer directed, and strengths based. By providing psychosocial supports and identifying possible signs and symptoms of mental illness early on and with ongoing assistance, senior peer counselors assist older adults to live independently in the community for as long as reasonably possible.

Senior Peer Counseling volunteers coordinate with existing HHSA older adult service programs to provide opportunities for earlier intervention to avoid crises for older adults and create more opportunities for their support through companionship and counseling. Volunteers and staff members employ wellness and recovery principles, addressing both immediate and long-term needs of program members and delivering services in a timely manner with sensitivity to the cultural needs of those served.

Key activities for the Senior Peer Counseling program will support outcomes of improved service access and connection for older adults and prolonged healthy and safe independent living by:

- Recruiting, screening, and coordinating all peer counselor volunteers.
- Training peer counselors in mental health resources, signs of mental illness, and how to work with older adults experiencing mental illness.
- Visiting older adults in the home or in the community to provide companionship and social support.
- Coordinating with the Friendship Line, a warmline and hotline that is operated out of the San Francisco Institute on Aging.
- Referring and linking consumers to other community-based providers for other needed social services and primary care.

Goal 1	The Senior Peer Counseling program aims to support older adults to live independently in the community for as long as reasonably possible while ensuring their mental and physical well-being.		
Objective 1	Recruit, train, and support volunteers to provide peer counseling services.		
Objective 2	Support independent living and reduce social isolation for seniors.		
Objective 3	Promote the early identification of mental health symptoms in older adults.		
Total Proposed Budget Amount	**$150,000**	**Proposed Budget Amount FY20–21:**	**$50,000**

Prevention and Early Intervention (AA) ○ FSP ● Non-FSP

Program name: **Latinx Outreach/Mental Health Promotores Program**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ○ Older Adult Aged 60+

Program Description

The Latinx Outreach/Mental Health Promotores program provides culturally responsive services to Yolo County Latinx residents (aged 18 or older) with health issues, mental health illnesses, or substance use issues. The program serves the entire Latinx community and seeks to develop relationships between providers and consumers, including their supports, families, and community.

This program addresses several needs, including:

- Integrating behavioral health services (to decrease costs to the county and providers for uninsured individuals).
- Reducing mental health hospitalizations for patients receiving services.
- Increasing the quality of life and independence for individuals with health, mental health, and substance use issues.
- Expanding participatory input on program activities.
- Reducing stigma in the Latinx community with a resulting increase in service penetration rates in that community.

By utilizing promotores (a Latinx community member who receives training to provide basic health and mental health education in the community), information can be disseminated to the community in culturally appropriate ways. Promotores focus on addressing the engagement challenges that arise due to stigma related to mental illness, the transient nature of seasonal harvest workers, long working hours for the population, and geographical barriers (e.g., rural or isolated settings) that make traveling to and from behavioral health service locations difficult. To ensure accessibility, the program's outreach strategy follows a "meet individuals where they are" approach that includes a mobile component. Promotores can visits local farms and worksites to provide information and resources to the target population. Additionally, the program offers extended hours beyond traditional work hours each month, including events during the weekend.

Key activities of Latinx Outreach/Mental Health Promotores will support outcomes around improved mental health wellness, personal, social, and community stability, and connection to other services by:

- Providing culturally competent and evidence-based practices training for staff.
- Providing counseling services in accessible locations at convenient times.
- Providing culturally competent services in English and Spanish.
- Using evidence-based practices and implemented quality-assurance practices.
- Increasing access to primary care mental health and substance abuse treatment services for Latinx residents of Yolo County, including weekly outreach activities and whole-person health screenings.
- Connecting Latinx residents to entitlement supports as needed.
- Providing screening, assessment, short-term solution-focused therapy, and access to psychiatric support for medication assistance to address mental health concerns.
- Reducing stigma and behavioral health underutilization in Latinx communities.

Goal 1	The Latinx Outreach/Mental Health Promotores Program aims to provide comprehensive health services, including physical and behavioral health, to the Latinx community.		
Goal 2	Expand and augment mental health services to enhance service access, delivery, and recovery.		
Objective 1	Utilize culturally responsive approaches to engaging the Latinx population.		
Objective 2	Increase engagement with Latino men.		
Objective 3	Improve health and behavioral health outcomes for the Latinx population.		
Total Proposed Budget Amount	**$885,444**	**Proposed Budget Amount FY20–21:**	**$295,148**

Prevention and Early Intervention (CYF 0-5) ○ Over 25 ● Under 25

Program name: **Early Childhood Mental Health Access and Linkage Program**

Status: ○ New ● Continuing ○ Modification

Target Population: ● Children Aged 0–5 ○ Transitional-age Youth Aged 16–25 ○ Adult Aged 26–59 ○ Older Adult Aged 60+

Program Description

The Early Childhood Mental Health (ECMH) Access and Linkage Program provides universal screenings to parents and their children aged 0–5 to identify young children who are either at risk of or beginning to develop mental health problems that are likely to affect their healthy development. The ECMH Access and Linkage program then connects children and their families to services that would either prevent or provide early intervention to address mental health problems affecting healthy development.

The ECMH Access and Linkage program provides screening, identification, and referral services for children aged 0–5 in the community setting to: provide prompt identification and intervention for potential issues and provide timely access to and coordination of services to address existing issues at appropriate service intensity. Children will be linked to the most suitable service, regardless of funding source or service setting (e.g., county, ESPDT, or school).

The purpose of this program is to address the needs identified during the community program planning process for a simplified method of assessment and referral of children to the services that they need. Community stakeholders identified that due to the multitude of programs available and different admission criteria for each, children and youth were not always linked appropriately. This program seeks to bridge this gap by placing a referral and access specialist in community settings to serve children aged 05.

Key activities of the ECMH Program Access and Linkage program will support outcomes around preventing the development of mental health challenges in children and improved linkages to mental health services by:

- Providing assessment and referrals for children aged 0–5 and their families in community settings.
- Addressing service access challenges when they are identified.
- Maintaining an up-to-date list of available programs and services across funding sources.
- Maintaining relationships with available programs and services to smoothly facilitate linkages.
- Performing outreach to community to raise awareness of the program's purpose and services.

Goal 1	The Early Childhood Mental Health Program Access and Linkage program aims to connect children to the appropriate prevention or mental health treatment service.		
Goal 2	To expand and augment mental health services to enhance service access, delivery and recovery.		
Objective 1	Prevent the development of mental health challenges through early identification.		
Objective 2	Address existing mental health challenges promptly with assessment and referral to the most effective service.		
Objective 3	Strengthen access to community services for children and their families.		
Total Proposed Budget Amount	**$1,200,000**	**Proposed Budget Amount FY20–21:**	**$400,000**

Prevention and Early Intervention (CYF) ○ Over 25 ● Under 25

Program name: **K-12 School Partnerships**

Status: ● New ○ Continuing ○ Modification

Target Population: ● Children and Transitional-age Youth Aged 6–18 ○ Adult Aged 26–59 ○ Older Adult Aged 60+

Program Description

The K-12 School Partnerships program collaborates with school districts and community-based organizations to embed clinical staff members at schools throughout the county to provide a wide array of services including universal screening, assessment, referral, and treatment for children and youth aged 6–18. Similar to the Early Childhood Mental Health Access and Linkage program, the K-12 School Partnerships program helps identify children and youth who need mental health services and expand the current service model to provide direct services and supports to students and the school system. The K-12 School Partnerships program provide evidence-based, culturally responsive services and offer promising practices in outreach and engagement for at-risk children and youth that build their resilience and help mitigate and support their mental health experiences.

This new school-based program builds on two previous iterations of school-based MHSA programs to respond to stakeholder feedback regarding the need to expand access to mental health services on school campuses throughout the county. The focus of the newly designed K-12 School Partnerships program will leverage MHSA and EPSDT funds and local control (LCAP/LCFF) funds from school districts to expand the array of mental health services and supports available on school campuses. The vision of these district-specific partnerships is to increase access to mental health services in locations that are easily accessible to students and families.

The program expands the current, and more limited, array of services and supports available to students to more fully integrate mental health services into the school systems by utilizing an integrated systems model and multi-tiered systems of support. The goal of this integrated approach is to blend resources, training, systems, data, and practices to improve outcomes for all children and youth. There is an emphasis on prevention, early identification, and intervention of the social, emotional, and behavior needs of students. Family and community partner involvement is critical to this framework.

The K-12 School Partnerships program provides comprehensive and universal screening, identification, and referral services for children and youth aged 6–18 in school-based settings to: (a) provide prompt identification and intervention for potential issues; (b) provide timely access to and coordination of services to address existing issues at appropriate service intensity; and (c) utilize evidence-based practices and data-driven decision making focused on ensuring positive outcomes for all children, youth, and their families. Children, youth, and their families are linked to the most suitable service, regardless of funding source or service setting (e.g., county, ESPDT, or school). Services are culturally responsive and embedded in schools in each district and will provide community-, district-, and school-specific services to meet the unique needs of children, youth, and their families.

The purpose of this program is to address the needs identified during the community planning process for an expanded array of mental health services and supports for children and youth on school campuses throughout the county. This program greatly expands the reach of mental health services outside of the typical service delivery setting and provides interventions that are likely to reduce the stigma associated with receiving mental health services. This program also intends to target services in both urban and rural areas of the county and in the Latino community. Stakeholders identified that although services are currently available on school campuses, they are limited and the overall needs outweigh capacity.

Key activities of the K-12 School Partnerships program will support outcomes around preventing the development of mental health challenges in children of all ages, improved linkages to mental health services, improved mental health wellness, school engagement, and personal, social, and community stability by:

- Supporting children and youth to increase their social, emotional, and coping skills, including anger management, distress tolerance, self-esteem, relationship building, and cognitive life skills.
- Supporting school staff, parents, and caregivers to learn trauma-informed and strength-based skills to support children and youth.
- Providing comprehensive screening and assessment for children aged 6–18 and their families in school settings.

- Providing direct services and supports to children and youth aged 6–18 on school campuses and referral to higher levels of care as needed.
- Addressing service access challenges when they are identified.
- Providing training and consultation to school staff to build capacity in schools to identify and support students with mental health needs.
- Maintaining an up-to-date list of available programs and services across funding sources.
- Maintaining relationships with available programs and services to smoothly facilitate linkages.
- Performing outreach to schools, staff, and the community to raise awareness of the program's purpose and services.

Goal 1	Increase access to a continuum of mental health services in locations that are easily accessible to students and their families.		
Goal 2	Expand and augment mental health services to enhance service access, delivery, and recovery.		
Objective 1	Prevent the development of mental health challenges through early identification.		
Objective 2	Address existing mental health challenges promptly with assessment, referral to the most effective service, and short-term treatment.		
Objective 3	Increase capacity to support wellness on school campuses by expanding access to mental health services and supports for children, youth, and their families.		
Total Proposed Budget Amount	**$3,300,000**	**Proposed Budget Amount FY20–21:**	**$1,100,000**

Prevention and Early Intervention (TAY 16–25) ○ Over 25 ● Under 25

Program name: **Youth Early Intervention Program**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ○ Adult Aged 26–59 ○ Older Adult Aged 60+

Program Description

Serious mental health problems (i.e., schizophrenia, bipolar disorder, major depression) are most likely to present in late adolescence or early adulthood. PEI regulations require that counties develop an early intervention program for youth who are beginning to show signs or symptoms of a serious mental illness. UC Davis and the Early Diagnosis and Preventive Treatment of Psychosis Illness (EDAPT) Clinic have developed a program for youth experiencing a first episode of psychosis and have committed to serving Yolo County residents who meet their eligibility criteria; this program is not MHSA funded.

For youth who do not meet eligibility criteria for the EDAPT Clinic, the Youth Early Intervention program is focused primarily on youth developing mood disorders (i.e., bipolar and major depressive disorders). This program includes clinical and other supportive services at home-, clinic-, and community-based settings and provides evidence-based interventions to address emerging symptoms and support the youth to stay on track developmentally.

Services address and promote recovery and related outcomes for a mental illness early in emergence and include services and support to parents and other natural supports.

Key activities of the Youth Early Intervention program will support outcomes around interrupting or mitigating early signs of mental illness by:

- Providing age-appropriate mental health services in the community, clinic, and home.
- Providing clinical interventions to mitigate early onset of mental health issues.
- Promoting prosocial activities, including creative or artistic expression as related to self-care.

Goal 1	Provide early intervention services for youth who are beginning to develop a mood or anxiety-related serious mental illness.		
Goal 2	To expand and augment mental health services to enhance service access, delivery, and recovery.		
Objective 1	Support young adults to stay on track developmentally and emotionally.		
Objective 2	Mitigate the negative impacts that may result from an untreated mental illness.		
Total Proposed Budget Amount	**$382,148**	**Proposed Budget Amount FY20–21:**	**$122,421**

Prevention and Early Intervention (TAY 16–25) ○ Over 25 ● Under 25

Program name: **College Partnerships**

Status: ● New ○ Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ○ Adult Aged 26–59 ○ Older Adult Aged 60+

Program Description

The College Partnerships program aims to collaborate with local colleges and community-based organizations to provide engagement, access, and linkage services for college students who are either at risk of, beginning to, or currently experiencing mental health problems with the goal of promoting recovery, resilience, and connection to mental health services for those in need. Additionally, the program intends to promote health and well-being for college students through the provision of physical and behavioral health services. This new program builds on the successes of the college-based wellness center program developed in the previous three-year plan and expands to a more robust college-based behavioral health program, providing a broad array of engagement, prevention, early intervention, and both physical and behavioral health intervention services. The focus of the newly designed College Partnerships program will leverage MHSA and Medi-Cal funds and funds from local colleges to expand the array of mental health services and supports available on college campuses.

The vision of these partnerships is to increase access to mental health services in locations that are easily accessible to college-age students. The program will expand the current, and more limited, array of services and supports available to students to more fully integrate mental health services into the college system by offering a full range of site-based services to include: wellness center activities and services, screening, assessment, and physical and behavioral health services. Additionally, the program will meet the unique cultural needs of the college by providing culturally relevant services to Spanish-speaking students. Education and learning opportunities will be available for students and staff to increase knowledge of healthy-living habits and the college-based services available to them.

Key activities of the College Partnerships program will support outcomes around improving mental health wellness, social connectivity, and service utilization by:

- Providing engagement and physical and behavioral health screenings.
- Providing behavioral health assessments, referrals, and short-term treatment.
- Providing recovery-based activities.
- Providing opportunities for consumers to socialize and learn alongside peers.
- Promoting prosocial activities, including creative or artistic expression as related to self-care.
- Providing resources and information on skills for coping mechanisms.
- Providing education and information about mental health and available services.
- Providing mental health first-aid training for faculty and staff.
- Offering educational opportunities for students and staff including health and wellness fairs, behavioral wellness classes, workshops, trainings, and flex presentations.
- Participating in ongoing collaborative implementation and program coordination with the school site.

Goal 1	Connect students to appropriate prevention or mental health treatment services in college settings.		
Goal 2	Expand and augment behavioral health services to enhance service access, delivery, and well-being for college students.		
Objective 1	Prevent the development of mental health challenges through early identification, resources, and support.		
Objective 2	Address existing mental health challenges promptly with assessment, referral, and short-term treatment.		
Objective 3	Increase capacity to support student wellness on school campuses.		
Total Proposed Budget Amount	**$450,000**	**Proposed Budget Amount FY20–21:**	**$150,000**

In addition to the direct service PEI programs described in the systems of care, Yolo HHSA has planned the following programs to support outreach for increasing recognition of early signs of mental illness and access and linkage to treatment, described below.

Prevention and Early Intervention (CHB) ○ FSP ● Non-FSP

Program name: **Early Signs Training and Assistance**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

Early Signs Training and Assistance focuses on mental illness stigma reduction and community education to intervene earlier in mental health crisis. Early Signs provides training to providers, individuals, and other caregivers who live or work in Yolo County. The purpose of these training programs is to educate public and nonmental health staff to respond to or prevent a mental health crisis in the community; support people living with mental illness or substance abuse; and reduce the stigma associated with mental illness.

This program addresses the need to enhance supports available to individuals before, during, and after a crisis; promote the provision of trauma-informed service delivery by nonmental health staff through education on mental health and suicide prevention; and increase resilience in the Yolo County community.

Early Signs Training includes the following training programs:

- Applied Suicide Intervention Strategies Training (ASIST)
- SafeTALK
- QPR-Question, Persuade and Refer Suicide Prevention Training
- Adult Mental Health First Aid certification
- Youth Mental Health First Aid certification
- Suicide Prevention in the Workplace Training
- Educate, Equip, and Support Parent Training
- Parenting Children Experiencing Trauma Parent/RFA Training
- Group Peer Support Facilitator Training

1. Applied Suicide Intervention Strategies Training (ASIST)

ASIST is a national suicide prevention training program for caregivers of individuals who are at risk of committing suicide. During a 2-day training, caregivers learn how to recognize and intervene to prevent the immediate risk of suicide (www.livingworks.net/programs/asist).

2. SafeTALK

SafeTALK is a 3-hour training that prepares anyone older than 15 to identify people with thoughts of suicide and connect them to suicide first-aid resources. SafeTALK curriculum emphasizes three main skills:

a. How to move beyond common

tendencies to miss, dismiss, or avoid suicide.

b. How to identify people who have thoughts of suicide.

c. Apply the TALK steps: Tell, Ask, Listen, and KeepSafe.

These steps prepare someone to connect a person with thoughts of suicide to first-aid and intervention caregivers (www.livingworks.net/programs/safetalk).

3. QPR

QPR (Question, Persuade, Refer) is a 90-minute training designed to teach three simple steps anyone can learn to help save a life from suicide. QPR provides innovative, practical, and proven suicide prevention training that reduces suicidal behaviors by training individuals to serve as gatekeepers—those in a position to recognize a crisis and the warning signs that someone may be contemplating suicide. Yolo County's MHSA Team will train anyone to be a gatekeeper—parents, friends, neighbors, teachers, ministers, doctors, nurses, office workers, caseworkers, firefighters—anyone who may be strategically positioned to recognize and refer someone at risk of suicide (https://www.qprinstitute.com/about-qpr).

4. Mental Health First Aid and Youth Mental Health First Aid Certifications

Both Mental Health First Aid and Youth Mental Health First Aid are 8-hour courses designed to teach individuals in the community how to help someone who is developing a mental health problem or experiencing a mental health crisis. Trainees are taught about the signs and symptoms of mental illness, including anxiety, depression, psychosis, and substance use. Youth Mental Health First Aid is especially designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, providers, and other individuals how to help adolescents and transition-age youth (12–24) experiencing mental health or substance use problems or in mental health crisis situations. The training covers health challenges for youth, offers information on adolescent development, and includes a five-step action plan to help young people in both crisis and noncrisis situations.

In addition to the basic MHFA training curriculum, the following modules are provided:

- MHFA Higher Education offered to university and community college audiences. This module offers additional materials, statistics, and exercises relevant to student and staff populations.
- MHFA Public Safety provides probation, corrections, and law enforcement with additional materials, safety considerations, and exercises relevant to this audience and their families.
- MHFA for caregivers of older adults and later-life issues.
- All trainings offer discussion of cultural considerations and messaging regarding differences in help-seeking and help-needing behaviors across diverse cultures.

Information for both courses can be found at www.mentalhealthfirstaid.org.

5. Working Minds: Suicide Prevention in the Workplace training

Created by the Helen and Arthur E. Johnson Depression Center at the University of Colorado, Suicide Prevention in the Workplace training is a 3-hour training designed to educate and create awareness of suicide prevention; create a forum for dialogue and critical thinking about workplace mental health challenges; promote help seeking and help giving in the workplace; and reduce stress-related absenteeism. The target audience is those who work in high-skill and high-stakes careers, e.g., first responders, social workers, and others. It is delivered to providers, agency, fire and emergency medical services; and law enforcement personnel. The training also gives education on agency and business postintervention strategies for stabilizing the mental health of a workforce in the immediate aftermath of a suicide (https://www.coloradodepressioncenter.org/workingminds/).

6. Educate, Equip, and Support: Building Hope

Educate, Equip, and Support: Building Hope is an award-winning 30-hour course completed in 10 weekly sessions designed to educate parents and caregivers raising children and youth identified as having serious emotional disturbances. Parents and caregivers learn about several types of emotional problems and how these issues manifest differently in children and youth. Parents also learn techniques to manage the stress, grief, and depression associated with parenting children with special needs. In 10 weeks, parents and caregivers learn about mental illnesses, develop new coping skills and parenting techniques, and form bonds with parents in similar circumstances; as a byproduct of their success in learning more about mental illness, stigma is reduced.

7. Parenting Children Experiencing Trauma

This evidence-based resource family caregiver and parent workshop was created by the National Child Traumatic Stress Network in partnership with SAMHSA and the U. S. Department of Health and Human Services. The curriculum is delivered in eight sessions.

- Resource parents learn the essentials of trauma-informed parenting, how trauma affects children's development, and the effects of trauma on children of various ages
- The importance of safety and creating safe spaces
- New approaches for changing negative or destructive behaviors and reactions
- Helping children maintain positive connection and make meaning of their traumatic pasts
- How to avoid compassion fatigue, burnout, and vicarious trauma

This workshop is delivered in partnership with Children's Mental Health, Child Welfare, Yolo Foster Kinship program; Yolo County Office of Education (https://www.nctsn.org/resources/training/training-curricula).

8. Group Peer Support (GPS) and GPS Facilitator training

GPS is a replicable group support model used for diverse populations including maternal mental health, parent, racial equity, and recovery support groups. GPS integrates evidence-based modalities: mindfulness-based stress reduction, cognitive behavioral therapy, and motivational interviewing in group settings. This model addresses the intersection of race, class, culture, and gender identity on individuals' lived experience. GPS can also be used to train others in this modality (https://grouppeersupport.org/).

Key activities of Early Signs Training and Assistance will support outcomes around improved mental health education and early identification skills by:

- Training community and family members to recognize the signs of persons in need of mental health support.
- Training community and family members to recognize the signs of persons who are at risk of suicide or developing a mental illness.
- Promoting wellness, recovery, and resilience.
- Training and working with families and caregivers to develop plans and strategies that are tailored to their family member's need.
- Training participants to address the specific needs of certain populations, including youth.
- Offering support and trauma-informed facilitation of groups and presentations to organizations about mental health, suicidality, resilience-building strategies, and self-care.
- Offering trainings in multiple languages to ensure accessibility for all interested persons.
- Offering trainings to an intentionally diverse group of community members, family members, and partners to ensure that persons are trained across populations to meet the needs of those in crisis and noncrisis situations.
- Offering expanded suicide hotline services to community members.

Goal 1	Early Signs Training and Assistance aims to expand the reach of the mental health system through the training of individuals who have the knowledge and skills to respond to or prevent a mental health crisis in the community.		
Objective 1	Expand the reach of mental health and suicide prevention services.		
Objective 2	Reduce the risk of suicide through prevention and intervention trainings.		
Objective 3	Promote the early identification of mental illness and signs and symptoms of suicidal behavior.		
Objective 4	Advance the wellness, recovery, and resilience of the community through the creation and offering of supportive spaces and trauma-informed group facilitation for diverse audiences.		
Total Proposed Budget Amount	**$1,296,014**	**Proposed Budget Amount FY20–21:**	**$425,895**

Prevention and Early Intervention (CHB) ○ FSP ● Non-FSP

Program name: **Cultural Competence**

Status: ● New ○ Continuing ○ Modification

Target Population: ● Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

Yolo County HHSA remains committed to cultural competence, humility, and proficiency and strives to embed it in all our work, including MHSA. We achieve this by increasing attention, activities, outreach, and training to incorporate the recognition and value of racial, ethnic, cultural, and linguistic diversity in the county mental health system while also seeking to address broader health disparities and the roots of their existence.

For this new plan, we intend to increase our MHSA investments in cultural competence to ensure we are reaching and serving all communities in our county. Cultural competence programming provides consistent workforce education in culturally and linguistically appropriate service delivery and the impact of social determinants of health and health disparities. Community outreach and engagement focus on promoting inclusion and building resilience in our most vulnerable and marginalized communities while offering opportunities to appreciate, connect, and assess the needs of diverse populations. The programming also includes the implementation of a creative multimedia campaign to reduce stigma, provide mental health education to diverse populations, and promote access and engagement. Targeted messaging are designed to reach all communities but with an emphasis on monolingual Russian- and Spanish-speaking community members.

All programming is designed to reduce disparities in populations and promote behavioral health equity. Demographic data and evaluation are collected to assess program efficacy and provide ongoing community needs assessment.

The program provides:

- Cultural competence and equity outreach engagement and trainings
- Culturally responsive service delivery
- Cultural support groups
- Stigma reduction, outreach to specific populations
- Additional funding for expansion of scopes and incentives into contracts to support outreach and service delivery to vulnerable populations
- Culturally responsive resilience support
- Targeted marketing efforts to vulnerable populations
- Addition of cultural competence outreach specialist
- Support the Yolo Cultural Competency Plan

Goal 1	To enhance, expand, and implement cultural competence and health equity outreach, engagement, and training throughout the HHSA system in the Yolo community.		
Objective 1	To reduce health disparities and promote health equity through the education of staff and providers in culturally and linguistically appropriate service standards.		
Objective 2	To engage agencies and the community in the advancing of culturally responsive policy and programming in support of the Yolo Cultural Competency Plan.		
Objective 3	To provide targeted, culturally responsive outreach and support to vulnerable populations to reduce stigma and promote service engagement.		
Objective 4	To increase understanding of the intersectionality of race, class, and culture to increase community resilience and health equity by offering supportive settings and facilitated discussion.		
Total Proposed Budget Amount	**$2,572,221**	**Proposed Budget Amount FY20–21:**	**$675,967**

Prevention and Early Intervention ○ FSP ● Non-FSP

Program name: **Maternal Mental Health Access Hub**

Status: ● New ○ Continuing ○ Modification

Target Population: ● Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

Maternal depression is a widespread public health concern that negatively impacts health outcomes for maternal/infant dyads and women preconception, interconception and throughout the maternal life course.

The program shall create a Maternal Mental Health Access Hub housed in the Community Health Branch of the Yolo County HHSA. The hub shall be modelled after the MCPAP for Moms program utilizing tools and trainings from the Lifeline4Moms program. Both these programs are national models that leverage partnerships between healthcare systems and local State and/or county public health or mental health departments.

A proposed full time clinician shall:

Provide Clinical Consultation:

- Yolo County HHSA Funded home visitation programs/staff working with high risk maternal/infant dyads enrolled in home visitation to improve mental health assessments and linkage to Medi-Cal services.
- Yolo County HHSA Behavioral Health programs and clinicians responding to perinatal mental health emergencies and/or hospital discharge planning to assure linkage to behavioral services (i.e. perinatal psychiatric consult service)

Facilitate the Yolo County MMH Collaborative to increase community engagement for the purposes of increasing resources and educating agencies and provider serving maternal/infant dyads.

Coordinate the Yolo County HHSA –May is MMH and MH Awareness month activities including the Travelling Blue Dot Campaign to increase provider engagement and awareness in the identification and prevention of maternal mental health disorders.

Develop a county wide hub within Yolo County HHSA to serve as a holding space for trainings, resources, innovations, and data for healthcare providers, behavioral health clinicians and community based agency staff.

Goal 1	To improve linkage to services that mitigate and improve the emotional and behavioral health of women preconception, intrapartum and postpartum.		
Goal 2	To increase quality and quantity of evidence based and evidence informed treatments and services for women suffering from or at risk for maternal mental health disorders.		
Objective 1	Provide clinical consult to identify appropriate and timely interventions and treatments for women referred to the Yolo County HHSA Maternal Mental Health Hub.		
Objective 2	Develop a Yolo County HHSA Maternal Mental Health Access Hub for the purposes of increasing provider capacity to prevent, mitigate and treat women for maternal mental health disorders.		
Total Proposed Budget Amount	**$300,000**	**Proposed Budget Amount FY20–21:**	**$100,000**

Innovation Plan

These are proposed INN programs and budgets pending MHSOAC Approval.

Innovation

Program name: **Integrated Medicine into Behavioral Health**

Status: ● New ○ Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

Yolo County's Integrated Medicine into Behavioral Health Innovation project will pilot the integration of physical health care in the County's existing West Sacramento specialty mental health clinic. Primary care providers from a community partner will be embedded in the HHSA clinic so that, using culturally and linguistically appropriate interventions in primary care, substance use disorder treatment, and serious mental illness (SMI) treatment, existing HHSA clients will receive coordinated comprehensive care. Such coordinated care efforts (e.g. psychiatric consultation, team-care approach, health screenings, enhanced linkages to community and/or behavioral health providers) have resulted in significant improvements in health outcomes for SMI clients.

Goal 1	Improve the use of evidence-based medical and behavioral health integration practices within a specialty mental health provider clinic.		
Goal 2	Improve physical and behavioral health outcomes for clients, care delivery efficiency, and client experience.		
Objective 1	Promote the early identification of physical health conditions in clients with severe mental illness.		
Objective 2	Facilitate linkage to appropriate specialty health care providers for clients with severe mental illness, when necessary.		
Objective 3	Improve physical health medication and other prescribed medical intervention adherence among clients with severe mental illness.		
Total Proposed Budget Amount	**$1,808,000**	**Proposed Budget Amount FY20–21:**	**$506,000**

Innovation

Program name: **Crisis Now Learning Collaborative**

Status: ● New ○ Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

Yolo County intends to take part in MHSOAC's proposed multi-county collaborative to use the *Crisis Now* model to develop a systematic approach to meeting urgent mental health needs in their communities. The overarching goal of the collaborative would be to evolve cost-effective crisis services that offer real-time access to care in lieu of justice system or emergency department involvement. The collaborative will address these issues by deploying a replicable framework that has demonstrated success in multiple communities throughout the nation. The framework includes quantifying community needs, defining opportunities to evolve care based on those needs, and project the potential community impact and cost of implementing new models of care. The collaborative also will incorporate expertise in Medicaid and managed care systems to identify long-term funding and coding solutions that reduce the financial burden of care experienced by local communities. By the close of the collaborative, county participants will have created an actionable strategic plan designed to move from their current crisis system into a system with high fidelity to the Crisis Now model.

Goal 1	Ensure Yolo County's crisis services match up with community need, community access to crisis care is enhanced, and overall cost savings are realized.		
Objective 1	Assess overall County crisis service needs.		
Objective 2	Understand current crisis service access points as well as gaps.		
Objective 3	Enhance crisis service cost tracking mechanisms across providers.		
Total Proposed Budget Amount	**$145,000**	**Proposed Budget Amount FY20–21:**	**$145,000**

Capital Facilities and Technological Plan

Capital Facilities and Technology Needs (AA) ○ FSP ● Non-FSP

Program name: **IT Hardware/Software/Subscriptions Services**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ○ Transitional-age Youth Aged 16–25 ○ Adult Aged 26–59 ○ Older Adult Aged 60+

Program Description

Yolo County HHSA is working to expand access to Netsmart's MyAvatar (the behavioral health system's electronic medical record [EMR] system) for all contracted providers; convert its hybrid charting to a full EMR; implement electronic health information exchange; strengthen its analytic and reporting process to improve the quality and delivery of behavioral health services; and convert to electronic claims submission for all providers. These goals will be achieved through:

- Updating hardware and software.
- Implementing upgrades to the Netsmart MyAvatar Information System.
- Implementing either "Little Green Button" software on all computers or another panic button solution.
- Expanding tele-mental health service provision.
- Integrating MyAvatar with a future business intelligence platform.
- Ensuring better strategic planning project management using SmartSheets.
- Ensuring better communication and collaboration as a result of the Office 365 implementation.
- Improving client communication as a result of a VOIP phone system implementation.

Goal 1	Implement and support data infrastructure for quality measurement and improvement of programs and improve the necessary technology for service delivery in Yolo County.		
Objective 1	Increase efficiencies in reporting, billing, retrieving, and storing personal health information.		
Objective 2	Implement a consistent, dependable clinic safety tool.		
Objective 3	Improve staff and client communication technologies.		
Total Proposed Budget Amount	**$2,492,790**	**Proposed Budget Amount FY20–21:**	**$811,374**

Capital Facilities and Technology Needs ○ FSP ● Non-FSP

Program name: **Peer-Run Housing**

Status: ● New ○ Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ○ Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ○ Older Adult Aged 60+

Program Description

The AFI Foundation is a non-profit, formed in 2016, to fund projects for people who are severely disabled and/or disadvantaged with mental illness. Funding for projects goes to other non-profits who provide services and is intended to supplement their work. The Foundation's particular interests include funding the purchase of permanent sustainable housing for individuals with severe mental illness.

Through Turning Point Community Programs, AFI Foundation will match Yolo County funds for the purchase of a home in Yolo County to house six county residents in a peer-run home who receive their mental health services through Yolo County HHSA.

Goal 1	To increase permanent housing options within Yolo County for residents with severe mental illness.		
Objective 1	Reduce the number of Yolo County mental health clients residing out of county.		
Objective 2	Support Yolo County mental health clients in transitioning to a greater level of independence.		
Total Proposed Budget Amount	**$250,000**	**Proposed Budget Amount FY20–21:**	**$250,000**

Workforce Education and Training Plan

Workforce, Education, and Training (AA) ○ FSP ● Non-FSP

Program name: **Mental Health Professional Development**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

The Mental Health Professional Development program is intended to provide training and capacity building for internal and external mental health providers. The program will provide:

- Clinical training in identified evidence-based and promising practices.
- Online professional development courses using HHSA's E-Learning platform.
- A strength-based approach to leadership and team development using Gallup's StrengthsFinder.
- Training and technical assistance to promote cultural competence throughout the behavioral health system and with identified experts.
- Training for all providers to screen for and identify perinatal mental health issues for pregnant and new mothers.
- Resources to ensure the mental health system of care develops a trauma-informed approach across all staff and programs.

To ensure that staff, providers, consumers, family members, and the community have the most recent and comprehensive guides and resources available, Yolo HHSA will also dedicate resources to updating HHSA's website, county crisis cards, and other brochures.

Mental Health Professional Development will support the outcome of increased formal training and skill building for HHSA staff in all roles and at all levels to respond to both ongoing and community-identified needs in the workforce.

Goal 1	The Mental Health Professional Development program aims to ensure a competent and trained workforce in alignment with MHSA values that is versed in relevant evidence-based practices.		
Objective 1	Ensure clinical staff are trained in relevant evidence-based practices.		
Objective 2	Provide support to front-office staff to provide supportive and welcoming experiences.		
Objective 3	Ensure a culturally competent and informed workforce.		
Total Proposed Budget Amount	**$167,422**	**Proposed Budget Amount FY20–21:**	**$54,880**

Workforce, Education, and Training (AA) ○ FSP ● Non-FSP

Program name: **Peer Workforce Development Workgroup**

Status: ○ New ● Continuing ○ Modification

Target Population: ○ Children Aged 0–5 ○ Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

HHSA's Peer Workforce Development Workgroup is designed to provide persons with lived experience the opportunity to learn basic occupational skills and reenter the workforce. The focus of the program is to assist peer employees with balancing work and the various challenges a job presents with ongoing, necessary self-care and wellness strategies to address any ongoing symptoms of mental illness. Ultimately, the goal of the program is to assist a peer staff member in deciding if working in the mental health field is a good choice for them or if seeking work in an unrelated field is a better fit. Should a peer staff member want to pursue a career in the mental health or human services field, options for non-peer positions in county employment or in the community will be explored.

Support for peer staff occurs through:

- Daily task supervision by their direct supervisor, addressing the basic of employment and learning to work while using the peer's own story to support clients, and
- Monthly clinical social worker-facilitated process groups, designed to provide a safe place for peer staff to process how sharing their story feels and how a work–life balance is best managed.

During these monthly process groups, peer staff have elected to address:

- Group facilitation strategies
- Conflict resolution
- De-escalation techniques
- Compassion and empathy development
- Self-care strategies
- Strategies to best serve clients from diverse groups (e.g., age, residence status, ethnicity, culture)
- Employment searching; marketing oneself
- Ethics and legal issues in mental health
- Maintaining good boundaries
- Specific job skill development
- Available community services

The Peer Workforce Development Committee will support the outcomes of increasing peer workforce visibility, skill development, and role clarity while simultaneously decreasing stigma and inherent bias in the nonpeer workforce.

Goal 1	The Peer Workforce Development Workgroup aims to create a program that will ensure that peers are provided with the evidence-based skill building, professional development opportunities, training, and internal HHSA support they require to provide effective services to consumers, reduce stigma, and expand their own foundation of marketable skills.		
Objective 1	Strengthen the onboarding, training, and supervision available to peer support staff.		
Objective 2	Consider evidence-based practices in the peer support model.		
Objective 3	Increase inclusion of peer workforce across the agency.		
Total Proposed Budget Amount	**$69,111**	**Proposed Budget Amount FY20–21:**	**$23,037**

Workforce, Education, and Training ○ FSP ● Non-FSP

Program name: **Central Regional WET Partnership**

Status: ● New ○ Continuing ○ Modification

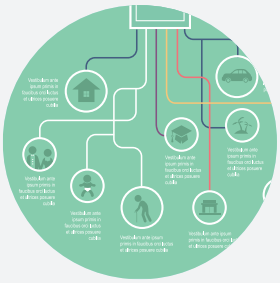
Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

In FY19-20, $40 million was appropriate to fund the California Office of Statewide Health Planning and Development's (OSHPD) 2020-2025 WET five-year plan. Counties have been invited to apply for WET funding grants by way of their Regional Partnerships in five key areas as long as each participating Partnership provides a 33% local match. Yolo County is a part of the Central Regional Partnership, along with 19 other Counties, which have access to a total OSHPD grant amount of $6,463,031 over the five-year period.

Goal 1	Provide funding opportunities to attract and retain well-trained, diverse, and high quality staff within the County's Mental Health Service delivery system.		
Objective 1	Offer educational loan repayment assistance to professional staff.		
Objective 2	Develop and enhance employment efforts for hard-to-find and hard-to-retain positions.		
Objective 3	Offer stipends to clinical Master and Doctoral graduate students to support professional internships within the County system.		
Total Proposed Budget Amount	**$85,000**	**Proposed Budget Amount FY20–21:**	**$30,000**

MHSA Three-Year Expenditure Plan



2020–2023

The documents enclosed in the following section are submitted in compliance with the Mental Health Services Oversight and Accountability Commission's FY 19-20 through FY 20-23 MHSA Three-Year Program and Expenditure Plan Submittals (www.mhsoac.ca.gov) instructions for documenting the expenditure of the proposed MHSA programs.

Overall Budget FY 2019–2023

Fiscal Year Summaries	CSS	PEI	INN	WET	CFTN	Prudent Reserve	TOTAL
Balance of FY1718 revenue	984,482	1,536,900	568,165	124,766	311,357	514,069	4,039,739
Balance of FY1819 revenue	9,211,716	3,626,631	1,095,380	3,030	10,462	514,069	14,461,288
Revertable end FY1920, if unspent	984,482	1,536,900	555,709	0	0	0	3,077,091
FY1920 Revenue							
Estimated MHSA Allocation	9,009,662	2,252,416	592,741	0	0	N/A	11,854,819
Estimated Interest	138,176	54,399	16,431	45	157	N/A	209,208
Total Projected Revenue	**9,147,838**	**2,306,815**	**609,172**	**45**	**157**	**0**	**12,064,027**
FY1920 Expenditures							
Budgeted Salaries and Benefits	4,218,764	459,841	536,432	51,171	0	N/A	5,266,208
Budgeted Contracts	3,756,671	1,544,258	369,689	335,530	392,636	N/A	6,398,783
Budgeted Operating/Other	697,770	76,535	91,674	67,107	1,234,673	N/A	2,167,759
Proposed Transfers	1,988,341			(371,650)	(1,616,691)	0	
Estimated Medi-Cal/Other	(2,117,343)	(306)	0	0		N/A	(2,117,649)
Projected MHSA Funded Expenditures	**8,544,203**	**2,080,327**	**997,794**	**82,158**	**10,619**	**0**	**11,715,101**
Fund Balance FY1920 revenue	9,815,351	3,853,119	706,758	(79,082)	0	514,069	14,810,215
Estimated to revert, end FY1920	0	0	0	0	0		0
Revertable end FY2021, if unspent	667,513	1,546,304	110,042	0	0		2,323,859

Fiscal Year Summaries	CSS	PEI	INN	WET	CFTN	Prudent Reserve	TOTAL
FY2021 Revenue							
Projected MHSA Allocation	9,903,768	2,475,942	651,564	0	0	N/A	13,031,274
Estimated Interest	147,230	57,797	10,601	(1,186)	0	N/A	214,442
Total Projected Revenue	**10,050,999**	**2,533,739**	**662,165**	**(1,186)**	**0**	**0**	**13,245,716**
FY2021 Expenditures							
Salaries and Benefits	6,485,523	714,933	193,715	47,910	0	N/A	7,442,081
Contracts	5,747,537	2,522,935	684,386	3,442	677,884	N/A	9,636,184
Operating/Other	1,184,844	168,376	35,233	66,949	133,490	N/A	1,588,891
Proposed Transfers	1,559,942			(198,568)	(811,374)	(550,000)	
Estimated Medi-Cal	(2,888,176)	(12,224)	0	0	0	N/A	(2,900,400)
Projected MHSA Funded Expenditures	**12,089,670**	**3,394,020**	**913,334**	**(80,268)**	**0**	**(550,000)**	**15,766,756**
Fund Balance FY2021 revenue	7,776,679	2,992,838	455,589	0	0	1,064,069	12,289,175
Estimated to revert, end FY2021	0	0	0	0	0		0
Revertable end FY2122, if unspent	0	459,099	0	0	0		459,099
FY2122 Revenue							
Projected MHSA Allocation	9,408,580	2,352,145	618,986	0	0	N/A	12,379,710
Estimated Interest	116,650	44,893	6,834	0	0	N/A	168,377
Total Projected Revenue	**9,525,230**	**2,397,038**	**625,819**	**0**	**0**	**0**	**12,548,087**
FY2122 Expenditures							
Salaries and Benefits	6,741,590	738,484	201,464	49,162	0	N/A	7,730,699
Contracts	6,537,387	2,771,246	680,875	3,080	690,234	N/A	10,682,822
Operating/Other	1,238,844	173,160	36,642	68,089	133,490	N/A	1,650,225
Proposed Transfers	944,055			(120,331)	(823,724)	0	
Estimated Medi-Cal	(3,069,626)	(12,273)	0	0	0	N/A	(3,081,899)
Projected MHSA Funded Expenditures	**12,392,250**	**3,670,616**	**918,981**	**0**	**0**	**0**	**16,981,847**
Fund Balance FY2122 revenue	4,909,659	1,719,259	162,428	0	0	1,064,069	7,855,416
Estimated to revert, end FY2122	0	0	0	0	0		0
Revertable end FY2223, if unspent	0	0	0	0	0		0

Fiscal Year Summaries	CSS	PEI	INN	WET	CFTN	Prudent Reserve	TOTAL
FY2223 Revenue							
Projected MHSA Allocation	7,997,293	1,999,323	526,138	0	0	N/A	10,522,754
Estimated Interest	73,645	25,789	2,436	0	0	N/A	101,870
Total Projected Revenue	**8,070,938**	**2,025,112**	**528,574**	**0**	**0**	**0**	**10,624,624**
FY2223 Expenditures							
Salaries and Benefits	7,007,899	762,976	209,523	50,464	0	N/A	8,030,863
Contracts	6,931,405	2,769,473	677,190	2,700	724,202	N/A	11,104,970
Operating/Other	1,287,395	178,135	38,108	69,275	133,490	N/A	1,706,403
Proposed Transfers	980,132			(122,440)	(857,692)	0	
Estimated Medi-Cal	(3,239,486)	(3,278)	0	0	0	N/A	(3,242,765)
Projected MHSA Funded Expenditures	**12,967,345**	**3,707,306**	**924,820**	**0**	**0**	**0**	**17,599,471**
Fund Balance FY2223 revenue	13,252	37,065	(233,818)	0	0	1,064,069	880,568
Estimated to revert, end FY2223	0	0	0	0	0		0
Revertable end FY2224, if unspent	**0**	**0**	**0**	**0**	**0**		**0**
Totals							
Total Projected Revenue FY1920–2223	**36,795,004**	**9,262,704**	**2,425,730**	**(1,141)**	**157**	**0**	**48,482,454**
Total Projected Expend. FY1920–2223	**45,993,468**	**12,852,270**	**3,754,929**	**1,890**	**10,619**	**(550,000)**	**62,063,175**
Total Projected Reversion FY1920–2223	0	0	0	0	0	0	0

Community Services and Supports Budget FY 2020–2021

CSS Component Summary	FY 2021 Proposed					
Program Name (Expenditures)	**M/C**	**FSP**	**Staff & Benefits**	**Contracts**	**Operating Costs**	**Total**
CSS Children's Mental Health FSP	Y	Y	–	500,000	–	500,000
CSS Children's Mental Health Non-FSP	Y		159,240	–	27,071	186,311
CSS Pathways to Independence for TAY FSP	Y	Y	602,901	192,215	109,434	904,550
CSS Pathways to Independence for TAY Non-FSP	Y		517,547	34,728	116,657	668,931
CSS Adult Wellness Alternatives FSP	Y	Y	1,463,163	2,393,292	262,101	4,118,556
CSS Adult Wellness Alternatives Non-FSP	Y		879,268	397,111	162,043	1,438,423
CSS Older Adult Outreach and Assessment FSP	Y	Y	439,710	227,649	75,876	743,236
CSS Older Adult Outreach and Assessment Non-FSP	Y		214,987	256,575	36,548	508,110
CSS Mobile Tele-Mental Health FSP	Y	Y	41,152	250,000	6,996	298,148
CSS Mobile Tele-Mental Health Non-FSP	Y		187,742	250,000	35,648	473,390
CSS Community-Based Drop-in Navigation Centers	Y	Y	148,505	844,400	25,246	1,018,150
CSS Peer and Family Member Led Support Services			–	100,000	–	100,000
CSS MH Crisis & Crisis Intervention Training (CIT)		Y	1,180,153	125,000	200,626	1,505,779
MHSA Comm Plan & Eval – CSS			302,815	153,481	58,146	514,442
MHSA Administration – CSS			348,341	23,085	68,453	439,878
CSS Total	FSP%:	67.7%	6,485,523	5,747,537	1,184,844	**13,417,904**
			48.3%	42.8%	8.8%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						*667,513*
CSS Revenue						
MHSA Allocation						9,903,768
MHSA Interest Earned (on fund balance)						147,230
Medi-Cal Reimbursement						2,888,176
Total Revenue Earned per Fiscal Year						12,939,174
Transfer to Prudent Reserve (current 514,069)						(225,000)
Transfer to WET					(228,568)	(228,568)
Transfer to CFTN					(1,061,374)	(1,061,374)
Available Revenue					**(1,906,401)**	**11,424,232**
*Available Prior Year Revenue (Fund Balance)						9,815,351
*Maximum Revenue Available:						21,239,583
Ending Fund balance: Surplus or (Deficit)						**7,821,679**

Community Services and Supports Budget FY 2021–2022

CSS Component Summary	FY 2122 Proposed					
Program Name (Expenditures)	**M/C**	**FSP**	**Staff & Benefits**	**Contracts**	**Operating Costs**	**Total**
CSS Children's Mental Health FSP	Y	Y	-	520,000	-	520,000
CSS Children's Mental Health Non-FSP	Y		165,609	-	28,154	193,763
CSS Pathways to Independence for TAY FSP	Y	Y	627,017	199,904	113,811	940,732
CSS Pathways to Independence for TAY Non-FSP	Y		538,249	36,117	120,891	695,256
CSS Adult Wellness Alternatives FSP	Y	Y	1,521,689	2,788,934	280,194	4,590,817
CSS Adult Wellness Alternatives Non-FSP	Y		914,439	411,442	168,525	1,494,406
CSS Older Adult Outreach and Assessment FSP	Y	Y	453,944	236,755	78,341	769,041
CSS Older Adult Outreach and Assessment Non-FSP	Y		223,586	266,838	38,010	528,434
CSS Mobile Tele-Mental Health FSP	Y	Y	42,798	250,000	7,276	300,074
CSS Mobile Tele-Mental Health Non-FSP	Y		195,252	250,000	37,074	482,326
CSS Community-Based Drop-in Navigation Centers	Y	Y	154,445	844,400	26,256	1,025,100
CSS Peer and Family Member Led Support Services			-	100,000	-	100,000
CSS MH Crisis & Crisis Intervention Training (CIT)		Y	1,227,359	475,000	208,651	1,911,010
MHSA Comm Plan & Eval – CSS			314,927	134,913	60,472	510,312
MHSA Administration – CSS			362,275	23,085	71,191	456,550
CSS Total	FSP%:	69.3%	6,741,590	6,537,387	1,238,844	**14,517,821**
			46.4%	45.0%	8.5%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						–
CSS Revenue						
MHSA Allocation						9,408,580
MHSA Interest Earned (on fund balance)						117,325
Medi-Cal Reimbursement						3,069,626
Total Revenue Earned per Fiscal Year						12,595,531
Transfer to Prudent Reserve (current 514,069)						–
Transfer to WET					(150,331)	(150,331)
Transfer to CFTN					(823,724)	(823,724)
Available Revenue					**(2,121,686)**	**11,621,476**
*Available Prior Year Revenue (Fund Balance)						7,821,679
*Maximum Revenue Available:						19,443,155
Ending Fund balance: Surplus or (Deficit)						**4,925,334**

Community Services and Supports Budget FY 2022–2023

CSS Component Summary	FY 2223 Proposed					
Program Name (Expenditures)	**M/C**	**FSP**	**Staff & Benefits**	**Contracts**	**Operating Costs**	**Total**
CSS Children's Mental Health FSP	Y	Y	–	540,800	–	540,800
CSS Children's Mental Health Non-FSP	Y		172,234	–	29,280	201,513
CSS Pathways to Independence for TAY FSP	Y	Y	652,098	207,900	118,364	978,362
CSS Pathways to Independence for TAY Non-FSP	Y		559,778	37,561	125,295	722,635
CSS Adult Wellness Alternatives FSP	Y	Y	1,582,557	3,137,151	291,402	5,011,110
CSS Adult Wellness Alternatives Non-FSP	Y		951,017	426,345	175,266	1,552,628
CSS Older Adult Outreach and Assessment FSP	Y	Y	468,748	246,226	80,904	795,878
CSS Older Adult Outreach and Assessment Non-FSP	Y		232,530	277,512	39,530	549,571
CSS Mobile Tele-Mental Health FSP	Y	Y	44,510	250,000	7,567	302,077
CSS Mobile Tele-Mental Health Non-FSP	Y		203,062	250,000	38,557	491,619
CSS Community-Based Drop-in Navigation Centers	Y	Y	160,622	844,400	27,306	1,032,328
CSS Peer and Family Member Led Support Services			–	100,000	–	100,000
CSS MH Crisis & Crisis Intervention Training (CIT)		Y	1,276,454	475,000	216,997	1,968,451
MHSA Comm Plan & Eval – CSS			327,524	115,425	62,891	505,840
MHSA Administration – CSS			376,766	23,085	74,038	473,889
CSS Total	FSP%:	69.8%	7,007,899	6,931,405	1,287,395	**15,226,700**
			46.0%	45.5%	8.5%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						–
CSS Revenue						
MHSA Allocation						7,997,293
MHSA Interest Earned (on fund balance)						73,880
Medi-Cal Reimbursement						3,239,486
Total Revenue Earned per Fiscal Year						11,310,659
Transfer to Prudent Reserve (current 514,069)						–
Transfer to WET					(147,440)	(147,440)
Transfer to CFTN					(857,692)	(857,692)
Available Revenue					**(2,295,145)**	**10,305,527**
*Available Prior Year Revenue (Fund Balance)						4,925,334
*Maximum Revenue Available:						15,230,862
Ending Fund balance: Surplus or (Deficit)						**4,162**

Prevention and Early Intervention Budget FY2020–2021

PEI Component Summary	FY 2021 Proposed					
Program Name	**M/C**	**<26**	**S&B**	**Contracts**	**Optg**	**Total**
PEI Early Childhood MH Access & Linkage		100%	-	400,000	-	400,000
PEI Senior Peer Counseling			-	50,000	-	50,000
PEI Youth Early Intervention Program	Y	85%	104,633	-	17,788	122,421
PEI Early Signs Training and Assistance		41%	239,555	111,725	74,616	425,895
PEI Latinx Outreach/MH Promotores		10%	-	295,148	-	295,148
PEI Home Visiting Expansion			-	100,000	-	100,000
PEI Cultural Compentency		20%	311,511	300,000	64,457	675,967
PEI College Partnerships		80%	-	150,000	-	150,000
PEI K-12 School	Y	100%	-	1,100,000	-	1,100,000
MHSA Comm Plan & Eval – PEI			27,546	13,962	5,289	46,798
MHSA Administration – PEI			31,688	2,100	6,227	40,015
PEI Total	<26%:	60.6%	714,933	2,522,935	168,376	**3,406,244**
			21.0%	74.1%	4.9%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						*1,546,304*
PEI Revenue						
MHSA Allocation						2,475,942
MHSA Interest Earned (on fund balance)						57,797
Medi-Cal Reimbursement						12,224
Total Revenue Earned per Fiscal Year						2,545,963
Funds Due to Revert						–
Available Revenue						**2,545,963**
*Available Prior Year Revenue (Fund Balance)						3,853,119
*Maximum Revenue Available:						6,399,082
Ending Fund balance: Surplus or (Deficit)						**2,992,838**

Prevention and Early Intervention Budget FY2021–2022

PEI Component Summary	FY 2122 Proposed					
Program Name	**M/C**	**<26**	**S&B**	**Contracts**	**Optg**	**Total**
PEI Early Childhood MH Access & Linkage		100%	-	400,000	-	400,000
PEI Senior Peer Counseling			-	50,000	-	50,000
PEI Youth Early Intervention Program	Y	85%	108,818	-	18,499	127,317
PEI Early Signs Training and Assistance		41%	244,090	111,725	76,109	431,924
PEI Latinx Outreach/MH Promotores		10%	-	295,148	-	295,148
PEI Home Visiting Expansion			-	100,000	-	100,000
PEI Cultural Compentency		20%	323,971	550,000	66,575	940,546
PEI College Partnerships		80%	-	150,000	-	150,000
PEI K-12 School	Y	100%	-	1,100,000	-	1,100,000
MHSA Comm Plan & Eval – PEI			28,648	12,273	5,501	46,422
MHSA Administration – PEI			32,955	2,100	6,476	41,532
PEI Total	<26%:	57.6%	738,484	2,771,246	173,160	**3,682,889**
			20.1%	75.2%	4.7%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						*459,099*
PEI Revenue						
MHSA Allocation						2,352,145
MHSA Interest Earned (on fund balance)						44,893
Medi-Cal Reimbursement						12,273
Total Revenue Earned per Fiscal Year						2,409,311
Funds Due to Revert						–
Available Revenue						**2,409,311**
*Available Prior Year Revenue (Fund Balance)						2,992,838
*Maximum Revenue Available:						5,402,149
Ending Fund balance: Surplus or (Deficit)						**1,719,259**

Prevention and Early Intervention Budget FY2022–2023

PEI Component Summary	FY 2223 Proposed					
Program Name	**M/C**	**<26**	**S&B**	**Contracts**	**Optg**	**Total**
PEI Early Childhood MH Access & Linkage		100%	–	400,000	–	400,000
PEI Senior Peer Counseling			–	50,000	–	50,000
PEI Youth Early Intervention Program	Y	85%	113,171	–	19,239	132,410
PEI Early Signs Training and Assistance		41%	248,808	111,725	77,662	438,194
PEI Latinx Outreach/MH Promotores		10%	–	295,148	–	295,148
PEI Home Visiting Expansion			–	100,000	–	100,000
PEI Cultural Compentency		20%	336,930	550,000	68,778	955,708
PEI College Partnerships		80%	–	150,000	–	150,000
PEI K-12 School	Y	100%	–	1,100,000	–	1,100,000
MHSA Comm Plan & Eval – PEI			29,794	10,500	5,721	46,015
MHSA Administration – PEI			34,274	2,100	6,735	43,109
PEI Total	<26%:	57.5%	762,976	2,769,473	178,135	**3,710,584**
			20.6%	74.6%	4.8%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						–
PEI Revenue						
MHSA Allocation						1,999,323
MHSA Interest Earned (on fund balance)						25,789
Medi-Cal Reimbursement						3,278
Total Revenue Earned per Fiscal Year						2,028,390
Funds Due to Revert						–
Available Revenue						**2,028,390**
*Available Prior Year Revenue (Fund Balance)						1,719,259
*Maximum Revenue Available:						3,747,650
Ending Fund balance: Surplus or (Deficit)						**37,065**

Innovation Budget FY2020–2021

INN Component Summary	**FY 2021 Proposed**					
Program Name	**M/C**	**N/A**	**S&B**	**Contracts**	**Optg**	**Total**
INN Integrated Medicine			-	506,000	-	506,000
MHSA Comm Plan & Eval – INN			57,257	29,021	10,994	97,273
MHSA Administration – INN			136,458	4,365	24,238	165,061
MH First Responder			-	-	-	-
Crisis Now			-	145,000		145,000
INN Total		0	193,715	684,386	35,233	**913,334**
			21.2%	74.9%	3.9%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						*110,042*
INN Revenue						
MHSA Allocation						651,564
MHSA Interest Earned (on fund balance)						10,601
Medi-Cal Reimbursement						–
Total Revenue Earned per Fiscal Year						662,165
Funds Due to Revert						–
Available Revenue						**662,165**
*Available Prior Year Revenue (Fund Balance)						706,758
*Maximum Revenue Available:						1,368,923
Ending Fund balance: Surplus or (Deficit)						**455,589**

Innovation Budget FY2021–2022

INN Component Summary	FY 2122 Proposed					
Program Name	**M/C**	**N/A**	**S&B**	**Contracts**	**Optg**	**Total**
INN Integrated Medicine			–	651,000	–	651,000
MHSA Comm Plan & Eval – INN			59,548	25,510	11,434	96,492
MHSA Administration – INN			141,916	4,365	25,208	171,489
MH First Responder			-	-	-	-
Crisis Now						-
INN Total		0	201,464	680,875	36,642	**918,981**
			21.9%	74.1%	4.0%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						–
INN Revenue						
MHSA Allocation						618,986
MHSA Interest Earned (on fund balance)						6,834
Medi-Cal Reimbursement						–
Total Revenue Earned per Fiscal Year						625,819
Funds Due to Revert						–
Available Revenue						**625,819**
*Available Prior Year Revenue (Fund Balance)						455,589
*Maximum Revenue Available:						1,081,408
Ending Fund balance: Surplus or (Deficit)						**162,428**

Innovation Budget FY2022–2023

INN Component Summary	FY 2223 Proposed					
Program Name	**M/C**	**N/A**	**S&B**	**Contracts**	**Optg**	**Total**
INN Integrated Medicine			–	651,000	–	651,000
MHSA Comm Plan & Eval – INN			61,930	21,825	11,892	95,646
MHSA Administration – INN			147,593	4,365	26,216	178,174
MH First Responder			-	-	-	-
Crisis Now						-
INN Total		0	209,523	677,190	38,108	**924,820**
			22.7%	73.2%	4.1%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						–
INN Revenue						
MHSA Allocation						526,138
MHSA Interest Earned (on fund balance)						2,436
Medi-Cal Reimbursement						–
Total Revenue Earned per Fiscal Year						528,574
Funds Due to Revert						–
Available Revenue						**528,574**
*Available Prior Year Revenue (Fund Balance)						162,428
*Maximum Revenue Available:						691,002
Ending Fund balance: Surplus or (Deficit)						**(233,818)**

Workforce Education and Training Budget FY2020–2021

WET Component Summary	FY 2021 Proposed					
Program Name	**M/C**	**N/A**	**S&B**	**Contracts**	**Optg**	**Total**
WET Coordinator			18,615	–	3,165	21,780
WET Professional Development			–	–	54,880	54,880
WET Peer Workforce			16,601	–	6,436	23,037
MHSA Comm Plan & Eval – WET			5,903	2,992	1,133	10,028
MHSA Administration – WET			6,790	450	1,334	8,575
Central Regional Partnership Grants			-	30,000	-	30,000
WET Total		0	47,910	33,442	66,949	**148,300**
			32.3%	22.6%	45.1%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						–
WET Revenue						
MHSA Allocation						–
MHSA Interest Earned (on fund balance)						(1,186)
Medi-Cal Reimbursement						–
Total Revenue Earned per Fiscal Year						(1,186)
Transfer from CSS						228,568
Funds Due to Revert						-
Available Revenue						**227,382**
*Available Prior Year Revenue (Fund Balance)						(79,082)
*Maximum Revenue Available:						148,300
Ending Fund balance: Surplus or (Deficit)						**0**

Workforce Education and Training Budget FY2021–2022

WET Component Summary	FY 2122 Proposed					
Program Name	**M/C**	**N/A**	**S&B**	**Contracts**	**Optg**	**Total**
WET Coordinator			19,360	–	3,291	22,651
WET Professional Development			–	–	55,795	55,795
WET Peer Workforce			16,601	–	6,436	23,037
MHSA Comm Plan & Eval – WET			6,139	2,630	1,179	9,948
MHSA Administration – WET			7,062	450	1,388	8,900
Central Regional Partnership Grants			-	30,000	-	30,000
WET Total		0	49,162	33,080	68,089	**150,331**
			32.7%	22.0%	45.3%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						–
WET Revenue						
MHSA Allocation						–
MHSA Interest Earned (on fund balance)						–
Medi-Cal Reimbursement						–
Total Revenue Earned per Fiscal Year						–
Transfer from CSS						150,331
Funds Due to Revert						-
Available Revenue						**150,331**
*Available Prior Year Revenue (Fund Balance)						-
*Maximum Revenue Available:						150,331
Ending Fund balance: Surplus or (Deficit)						**0**

Workforce Education and Training Budget FY2022–2023

WET Component Summary	FY 2223 Proposed					
Program Name	**M/C**	**N/A**	**S&B**	**Contracts**	**Optg**	**Total**
WET Coordinator			20,134	-	3,423	23,557
WET Professional Development			-	-	56,747	56,747
WET Peer Workforce			16,601	-	6,436	23,037
MHSA Comm Plan & Eval – WET			6,384	2,250	1,226	9,860
MHSA Administration – WET			7,344	450	1,443	9,238
Central Regional Partnership Grants			-	25,000	-	25,000
WET Total			50,464	27,700	69,275	**147,440**
			34.2%	18.8%	47.0%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						–
WET Revenue						
MHSA Allocation						–
MHSA Interest Earned (on fund balance)						–
Medi-Cal Reimbursement						–
Total Revenue Earned per Fiscal Year						–
Transfer from CSS						147,440
Funds Due to Revert						-
Available Revenue						**147,440**
*Available Prior Year Revenue (Fund Balance)						-
*Maximum Revenue Available:						147,440
Ending Fund balance: Surplus or (Deficit)						**0**

Capital Facilities and Technological Needs Budget FY2020–2021

CFTN Component Summary	FY 2021 Proposed					
Program Name	**M/C**	**N/A**	**S&B**	**Contracts**	**Optg**	**Total**
CFTN Adult Residential - NA			-	-	-	-
CFTN Information Technology			-	677,884	133,490	811,374
CFTN Peer Run Housing (AFI Match)			-	250,000	-	250,000
CFTN Total		–	-	927,884	133,490	**1,061,374**
			0.0%	87.4%	12.6%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						–
CFTN Revenue						
MHSA Allocation						–
MHSA Interest Earned (on fund balance)						0
Medi-Cal Reimbursement						–
Total Revenue Earned per Fiscal Year						0
Transfer from CSS						1,061,374
Funds Due to Revert						-
Available Revenue						**1,061,374**
*Available Prior Year Revenue (Fund Balance)						0
*Maximum Revenue Available:						1,061,374
Ending Fund balance: Surplus or (Deficit)						**0**

Capital Facilities and Technological Needs Budget FY2021–2022

CFTN Component Summary	FY 2022 Proposed					
Program Name	**M/C**	**N/A**	**S&B**	**Contracts**	**Optg**	**Total**
CFTN Adult Residential – NA			-	-	-	-
CFTN Information Technology			-	690,234	133,490	823,724
CFTN Peer Run Housing (AFI Match)			-	-	-	-
CFTN Total		–	–	690,234	133,490	**823,724**
			0.0%	83.8%	16.2%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						–
CFTN Revenue						
MHSA Allocation						–
MHSA Interest Earned (on fund balance)						0
Medi-Cal Reimbursement						–
Total Revenue Earned per Fiscal Year						0
Transfer from CSS						823,724
Funds Due to Revert						–
Available Revenue						**823,724**
*Available Prior Year Revenue (Fund Balance)						0
*Maximum Revenue Available:						823,724
Ending Fund balance: Surplus or (Deficit)						**0**

Capital Facilities and Technological Needs Budget FY2022–2023

CFTN Component Summary	FY 2023 Proposed					
Program Name	**M/C**	**N/A**	**S&B**	**Contracts**	**Optg**	**Total**
CFTN Adult Residential – NA			-	-	-	-
CFTN Information Technology			-	724,202	133,490	857,692
CFTN Peer Run Housing (AFI Match)			-	-	-	-
CFTN Total		–	–	724,202	133,490	**857,692**
			0.0%	84.4%	15.6%	100.0%
**Minimum required to be spent to avoid prior year reversion:*						–
CFTN Revenue						
MHSA Allocation						–
MHSA Interest Earned (on fund balance)						0
Medi-Cal Reimbursement						–
Total Revenue Earned per Fiscal Year						0
Transfer from CSS						857,692
Funds Due to Revert						–
Available Revenue						**857,692**
*Available Prior Year Revenue (Fund Balance)						0
*Maximum Revenue Available:						857,692
Ending Fund balance: Surplus or (Deficit)						**0**

County MHSA Profile

Plan 2020–2023

Yolo County provides input to the County Behavioral Health Directors Association (CBHDA) to share its MHSA county profile with state policymakers including the legislature, administration, and key stakeholders. The profiles are intended to increase the understanding among decision makers of the importance of MHSA to the county behavioral health system and those we serve. Data shared with CBHDA is included here to provide context regarding the work of Yolo County MHSA services.

County/City Summary of the Residents Served by MHSA

Instructions	**County/City Data or Information** (If the data/info is not from the 18–19 Update or RER, indicate the data source.)
1. Did you implement MHSA program(s) in FY 2018–19 (or FY 2017–18 if this is your most recent data) that broadly target county/city residents such as **public education campaigns**? (e.g. suicide prevention and stigma reduction education) Please list all the programs and estimate the number of residents impacted by these programs.	▸ Early Signs Training and Assistance ▸ Mental Health First Aid and Youth Mental Health First Aid ▸ May is Mental Health Month Campaign ▸ Suicide Prevention Line **Residents served: 7,274**
2. Total number of **county residents** served by MHSA in FY 2018–19 (or FY 2017–18 if this is your most recent data). Include residents receiving direct services under any MHSA component (CSS, PEI, INN, etc.), including those for whom you collect unique identifier information.Exclude outreach and marketing activities. (These activities can be included above in 1.)	**Residents served: 23,979** Sources: HHSA Annual Fiscal Charge Report; DCR, Annual program RBA Reports, Wellness Center sign-in sheets, Avatar Annual MH Service Report, Program Management, Turning Point Annual Outcomes Report, PEI&INN Demographic Data
2a. Total number of **children** (ages 0–15) served by MHSA in FY 2018–19 (or FY 2017–18 if this is your most recent data).	**Children served: 3,476** Sources: DCR, Turning Point Annual Outcomes Report, PEI&INN Demographic Data
2b. Total number of **transition age youth** (16–25) served by MHSA in FY 2018–19 (or FY 2017–18 if this is your most recent data).	**TAY served: 3,921** Sources: DCR, Wellness Center sign-in sheets. Turning Point Annual Outcomes Report, PEI&INN Demographic Data.

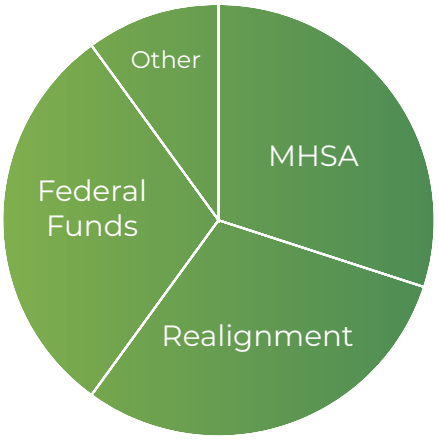
Instructions	County/City Data or Information (If the data/info is not from the 18–19 Update or RER, indicate the data source.)
3. Total number of residents served by MHSA in FY 2018-19 (or FY 2017-18 if this is your most recent data) that were experiencing homelessness at the time of admission or at risk of becoming homeless. Include residents served under any MHSA component. Many definitions for "at risk of homelessness" exist. If your county has a definition used in MHSA, please report this information using the county definition. The following is a definition from the No Place Like Home Program that can be used: "At risk of homelessness" includes, but is not limited to, persons who are at high risk of long-term or intermittent homelessness, including persons with mental illness exiting institutionalized settings, including, but not limited to, jail and mental health facilities, who were homeless prior to admission, transition age youth experiencing homelessness or with significant barriers to housing stability, and others, as defined in program guidelines.	**Those experiencing homelessness served: 204** **Those at risk of homelessness served: approximately 13,000** Source: DCR, Annual Program RBA Report. Source: Turning Point Annual Outcomes Report, PEI&INN Demographic Data. NOTE: In FY18-19, Yolo County was not consistently tracking homelessness and risk data across all MHSA programs. Per national studies, 50%–70% of Americans are one paycheck away from homelessness; clients receiving MHSA-funded services are likely to be in even less stable housing situations.
4. Total number of residents served by MHSA in FY 2018-19 (or FY 2017-18 if this is your most recent data) that are justice-involved or at risk of becoming justice-involved. Include residents served under any MHSA component. If you do not typically collect this information, please use any accurate count you are able to provide such as focusing on those that are justice-involved and enrolled in your Full Service Partnership programs. As with "at risk of homelessness", "at risk of justice-involvement" has many definitions and these two "at-risk" populations often overlap. Please use a county definition that is already in use. Otherwise, the following factors that contribute to an individual's risk of justice involvement can be used. The following list are only a few factors and we do not intend to imply that individuals with the following factors will become justice- involved, but according to research, these factors contribute or create risk of justice involvement. – Prior justice involvement – Poverty, limited educational and employment opportunities – Child physical abuse and parental neglect – Living with someone involved in illegal activity and Association with deviant peers	**Justice-involved individuals served: 500** **Individuals at risk of justice involvement served: approximately 7,200** Sources: DCR, Avatar Annual MH Services Report, Annual Program RBA Report. Source: Turning Point Annual Outcomes Report. NOTE: In FY18-19, Yolo County was not consistently tracking justice involvement or risk data across all MHSA programs, other than in our mental health court FSP program. Per national studies, approximately 1 in every 37 adults in American are involved in the criminal justice system.

County/City MHSA Fiscal Information (FY 2018–2019)

Instructions	County/City Data or Information (If the data/info is not from the 18–19 Update or RER, indicate the data source.)
1. CBHDA will include the amount of MHSA funds allocated to your county/city from the State Controller Report for FY 2018-19	State Controller's Office FY 2018-19 Report
2. In FY 2018-19, how much **federal matching funding** was secured using MHSA as the non-federal share for Medi-Cal. Include federal matching funds secured from all MHSA components.	Amount of federal funding: $2,156,582.61 Source: FY18-19 MHSA RER
3. In FY 2018-19, what was your county's/city's total budget for public behavioral health system? Include all revenue from local, state and federal sources.	Total County Behavioral Health Budget: $49,343,542.00 Source: FY18-19 Behavioral Health (Mental Health, SUD & MHSA) budgets
2b. Total number of **transition age youth** (16–25) served by MHSA in FY 2018–19 (or FY 2017–18 if this is your most recent data).	**TAY served: 3,921** Sources: DCR, Wellness Center sign-in sheets. Turning Point Annual Outcomes Report, PEI&INN Demographic Data.

For FY 2018-19, CBHDA will calculate the percent of your county's/city's total public behavioral health system budget represented by MHSA funding. (CBHDA will divide 1. by 3. to secure the %.)

For FY 2018-19, CBHDA will calculate the percent of your county's/city's total public behavioral health system budget represented by MHSA funding and the federal funding leveraged by MHSA funding. (CBHDA will divide 1. + 2. by 3. to secure the %.)



Pie Chart on Public Behavioral Health System

CBHDA will create a pie chart to visually represent the largest funding sources that make up your county's behavioral health system, including MHSA.

Realignment funding will be derived from the State Controller's Office data on FY 18-19 by adding the county/city allocation from the Behavioral Health Subaccount; the Health and Welfare Realignment from Sales Tax Collections; the Mental Health Sales Tax Base; and the Mental Health VLF Base. MHSA will come from the Mental Health Services Fund Report from State Controller's Office FY 2018-19 Report

County/City MHSA Housing Information

Instructions	County/City Data or Information (If the data/info is not from the 18–19 Update or RER, indicate the data source.)
1. The total number of **housing units** secured through MHSA funding since the inception of MHSA, including rental units.	**Total MHSA Housing units: 42** Source: TPCP Master Leases, West Beamer Place, Helen Thompson Homes
2. The total number of **housing units** secured in FY 18-19 (or FY 2017-18 if this is your most recent data) through MHSA, including rental units.	**Added FY18-19 MHSA Housing Units: 20** Source: West Beamer Place
3. The total number of housing units expected from No Place Like Home Program. (A program funded through MHSA.)	**Total expected: 71**

County/City MHSA CSS Information

Instructions	County/City Data or Information (If the data/info is not from the 18–19 Update or RER, indicate the data source.)
1. The number of **unduplicated clients** receiving a direct mental health service through CSS in FY 2018–19 (or FY 2017–18 if this is your most recent data), including those for whom you collected unique identifier information.	**CSS served: 3,175** Sources: HHSA Annual Fiscal Charge Report, Annual program RBA Reports, Wellness Center sign-in sheets, Avatar Annual MH Service Report, Turning Point Outcomes Annual Report.
2. The number of **unduplicated FSP clients** served in FY 2018-19 (or FY 2017-18 if this is your most recent data). Please include everyone served at any time in the FSP in the most recent 12- month timeframe where data exists.	**FSP clients served: 241** Source: DCR, Turning Point Outcomes Annual Report.
3. Attach a separate document with a brief description (2-3 paragraphs) of a **particularly innovative or effective CSS program.**	

Instruction: For FY 2018–19 (or FY 2017–18 if this is your most recent data), complete the following table with information from your FSP Program(s). We understand that some of the county systems may not capture this information in a format that is easily reportable. Please briefly indicate any caveats to data accuracy that you believe it is important for us to know. We understand some counties may be unable to report some or all of this data.

Outcomes of the FSP Program, FY 2018–19 (or FY 2017–18)

FSP Program	Percentage by Clients	Percentage by Days
Reduction in Homelessness		
Transitional Age Youth (TAY)	40% reduction	9% increase
Adult	56% reduction	56% reduction
Older Adult	0	56% reduction
Reduction in Justice Involvement		
TAY	83% reduction	100% reduction
Adult	30% reduction	65% reduction
Older Adult	0	0
Reductions in Psychiatric Hospitalization		
Child	75% reduction	50% reduction
TAY	18% reduction	<1% increase
Adult	50% reduction	80% reduction
Older Adult	72% reduction	68% reduction

Source: County Annual RBA data.

County/City MHSA PEI Information

Instructions	County/City Data or Information (If the data/info is not from the 18–19 Update or RER, indicate the data source.)
Small Counties may need to report prevention data (1) and early onset data (2) information together. Please indicate this. 1. The number of **unduplicated clients** at risk of a mental illness (Prevention) served under PEI in FY 2018-19 (or FY 2017-18 if this is your most recent data).	**Served under PEI: 14,201** PEI&INN Demographic Data (new clients not seen previously in FY).
2. The number of unduplicated clients with **early onset** of a mental illness (Early Intervention) served under PEI in FY 2018-19 (or FY 2017-18 if this is your most recent data).	*Yolo MHSA Demographic form did not indicate to report prevention and early intervention unduplicated counts.
3. Demographic Profile of **PEI clients – Age Group** FY 2018-19 (or FY 2017-18 if this is your most recent data). The number of PEI clients in the following age groups: – 0–15 children/youth – 15–25 transition age youth – 26–59 adults – 60+ older adults	**Served under PEI by age group:** 0-15 years: 3,081 15-25 years: 1,801 26-59 years: 4,990 60+ yrs: 672 Source: PEI&INN Demographic Data
4. Demographic Profile PEI clients – Race/Ethnicity Group FY 2018-19 (or FY 2017-18 if this is your most recent data). The number of PEI clients from the following race/ethnic groups: 1. American Indian or Alaska Native 2. Asian 3. Black or African American 4. Native Hawaiian or other Pacific Islander 5. White 6. Other 7. More than one race 8. Number of respondents who declined to answer the question 9. Hispanic or Latino	**Served under PEI by race and ethnicity group:** American Indian or Alaska Native: 153 Asian: 760 Black or African American: 665 Native Hawaiian or other Pacific Islander: 29 White: 1,900 Hispanic or Latino: 1,730 Other: 2,072 More than one race: 259 Respondents who declined to answer: 102 Source: PEI&INN Demographic Data

Instructions	County/City Data or Information (If the data/info is not from the 18–19 Update or RER, indicate the data source.)
5. Demographic Profile of **PEI clients – Sexual Orientation** FY 2018–19 (or FY 2017–18 if this is your most recent data). The number of PEI clients with the following sexual orientation: 1. Gay or Lesbian 2. Heterosexual or Straight 3. Bisexual 4. Questioning or unsure of sexual orientation 5. Queer 6. Another sexual orientation 7. Number of respondents who declined to answer the question Leave the information blank, if you do not have clients that identified themselves in any of the above population groups.	**Served under PEI by Sexual Orientation:** Gay or Lesbian: 88 Heterosexual or Straight: 2,231 Bisexual: 63 Questioning or unsure of sexual orientation: 37 Queer: 19 Another sexual orientation: 48 Respondents who declined to answer: 240 Source: PEI&INN Demographic Data
6. In a separate document, please list the most notable PEI outcomes for FY 2018-19 (or FY 2017-18 if this is your most recent data) (e.g.: % reduction in post trauma stress symptoms or anxiety; % reduction in disruptive behavior or severe behavioral conduct; measurable reduction in stigma within particularly vulnerable communities; % reduction in suicide risk) Please do not take more than half a page for this information. Please NOTE: Due to a change in the way outcome data was collection in late FY17-18/early 18-19, Yolo County currently does not have any comparable data between the two FY to provide such information. Yolo County will have this outcome data available when we compare FY18-19 and FY19-20 outcomes in the near future.	


C.A.R.E.
Community Advocacy Research
and Evaluation Consulting Group
Putting Community First