Yolo County Mental Health Services Act

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

2020–2023

Three-Year Program & Expenditure Plan

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[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)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

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

Plan 2020–2023

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 Health and Human Services Agency (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

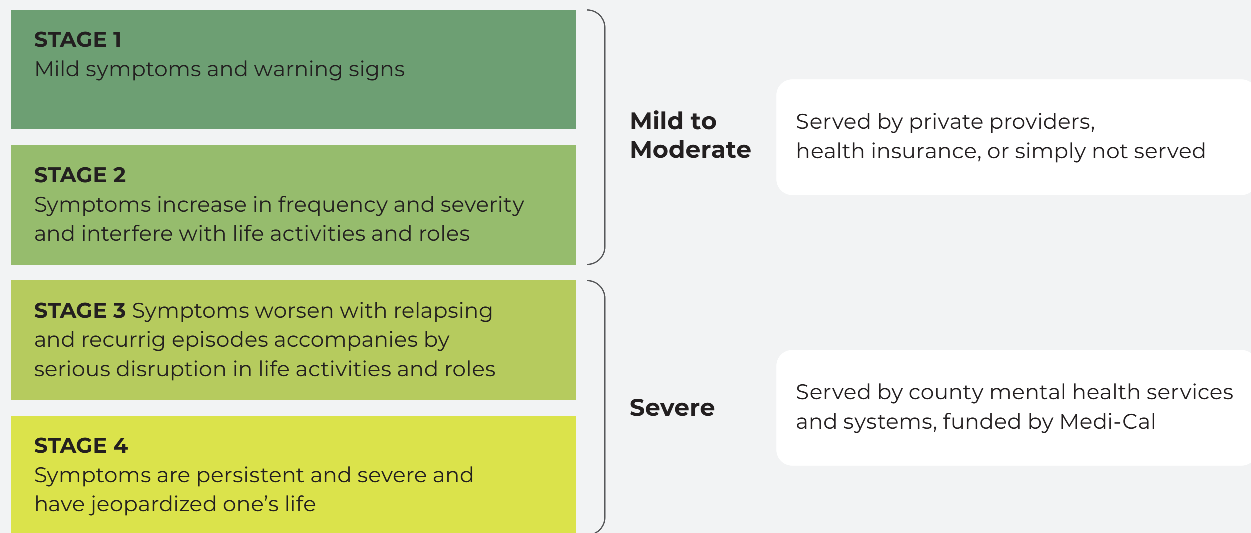
The preeminent themes that came from this process are:

- 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

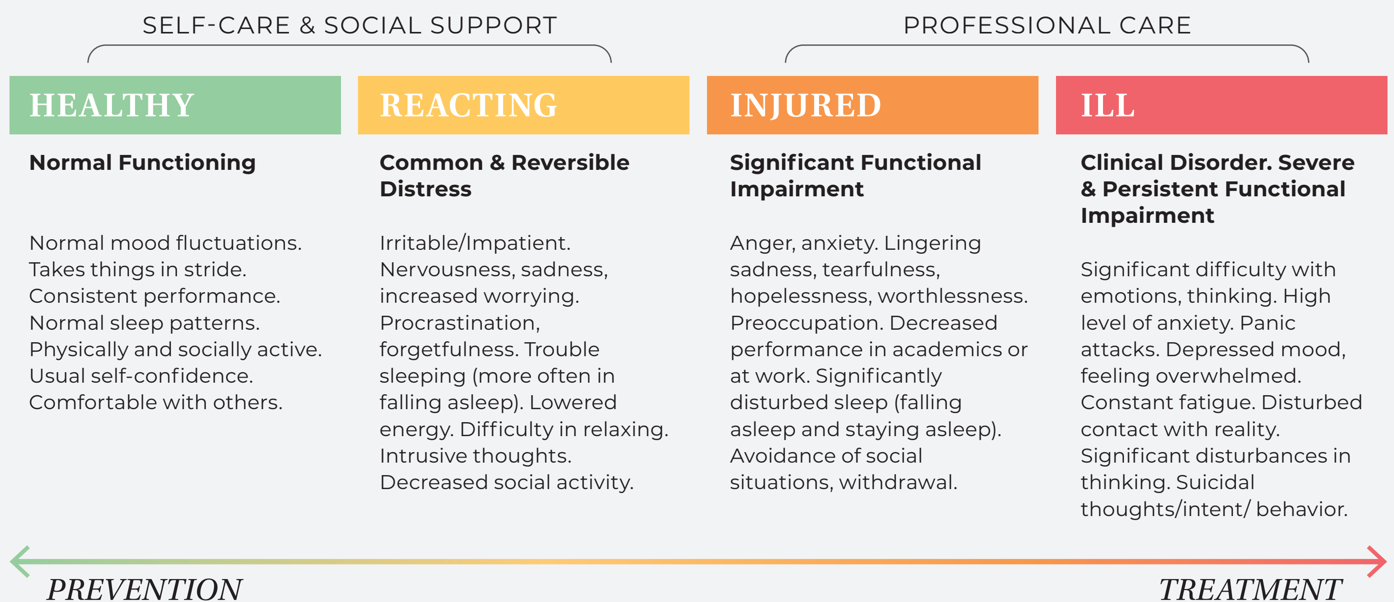
Mental health exists on a spectrum, commonly called “mild to moderate” or “severe.” See Figure 1.

FIGURE 1. STAGES OF MENTAL HEALTH CONDITIONS.



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

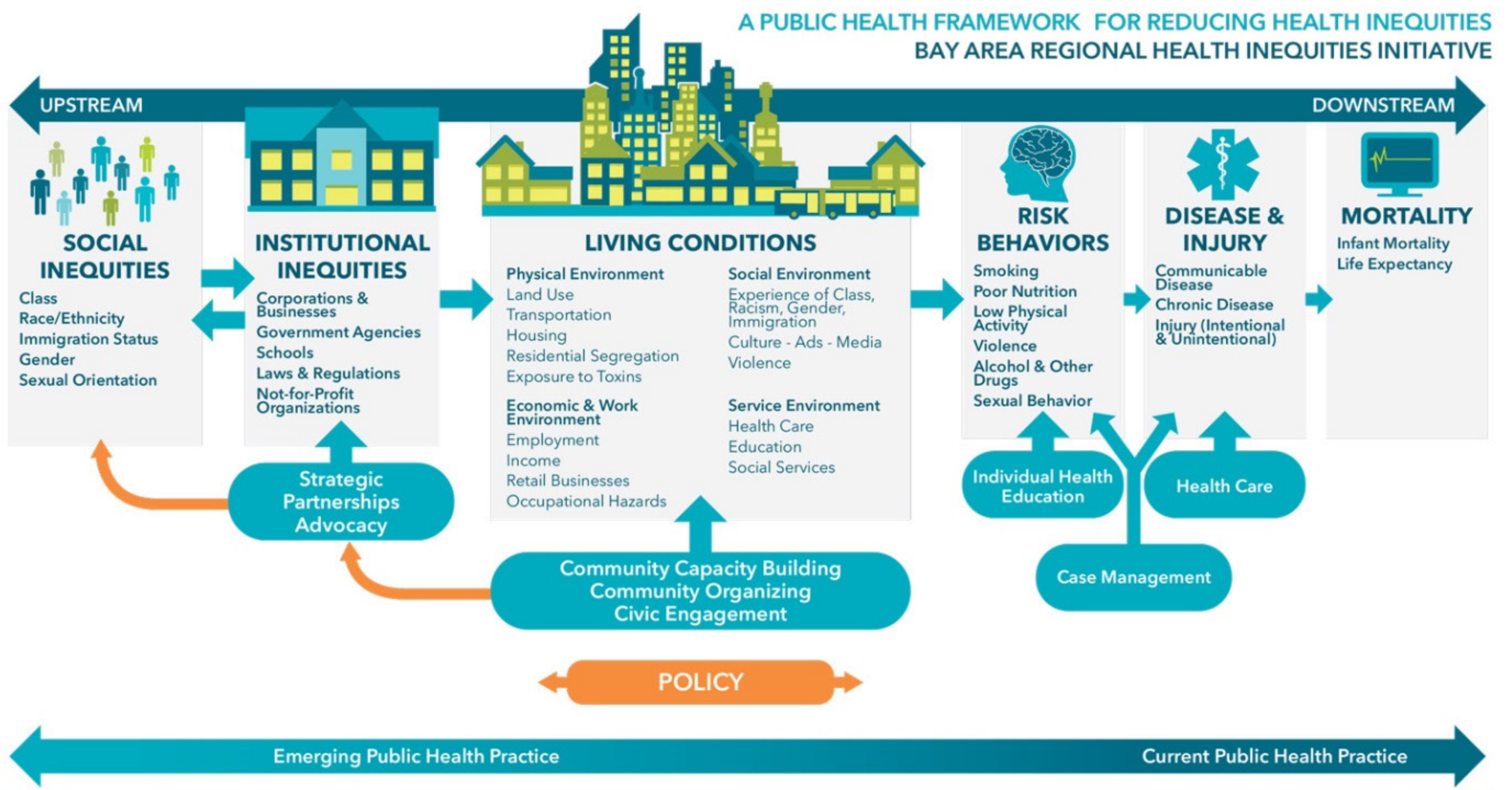
FIGURE 2. MENTAL HEALTH CONTINUUM OF CARE.



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 institutions. 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/break-down-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/

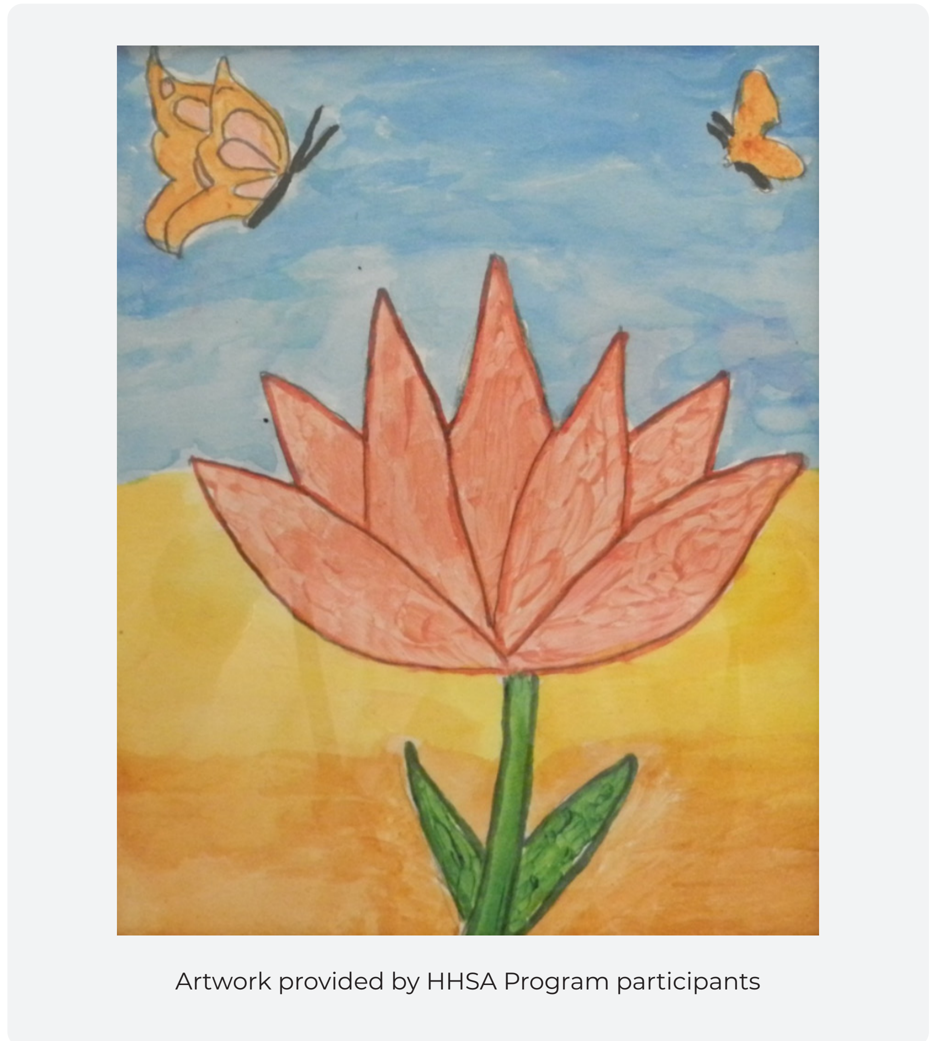
broad-based prevention and community-based services, particularly those that keep people from falling into dire circumstances or having an irreparable setback in their life.

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 intends for all Request For Proposals (RFPs) and subsequent contracts to include Results Based Accountability performance measures to ensure that the programs and services are being evaluated. Additionally, there are investments in the plan to contract with a program evaluator to assist with this work.



Artwork provided by HHSA Program participants

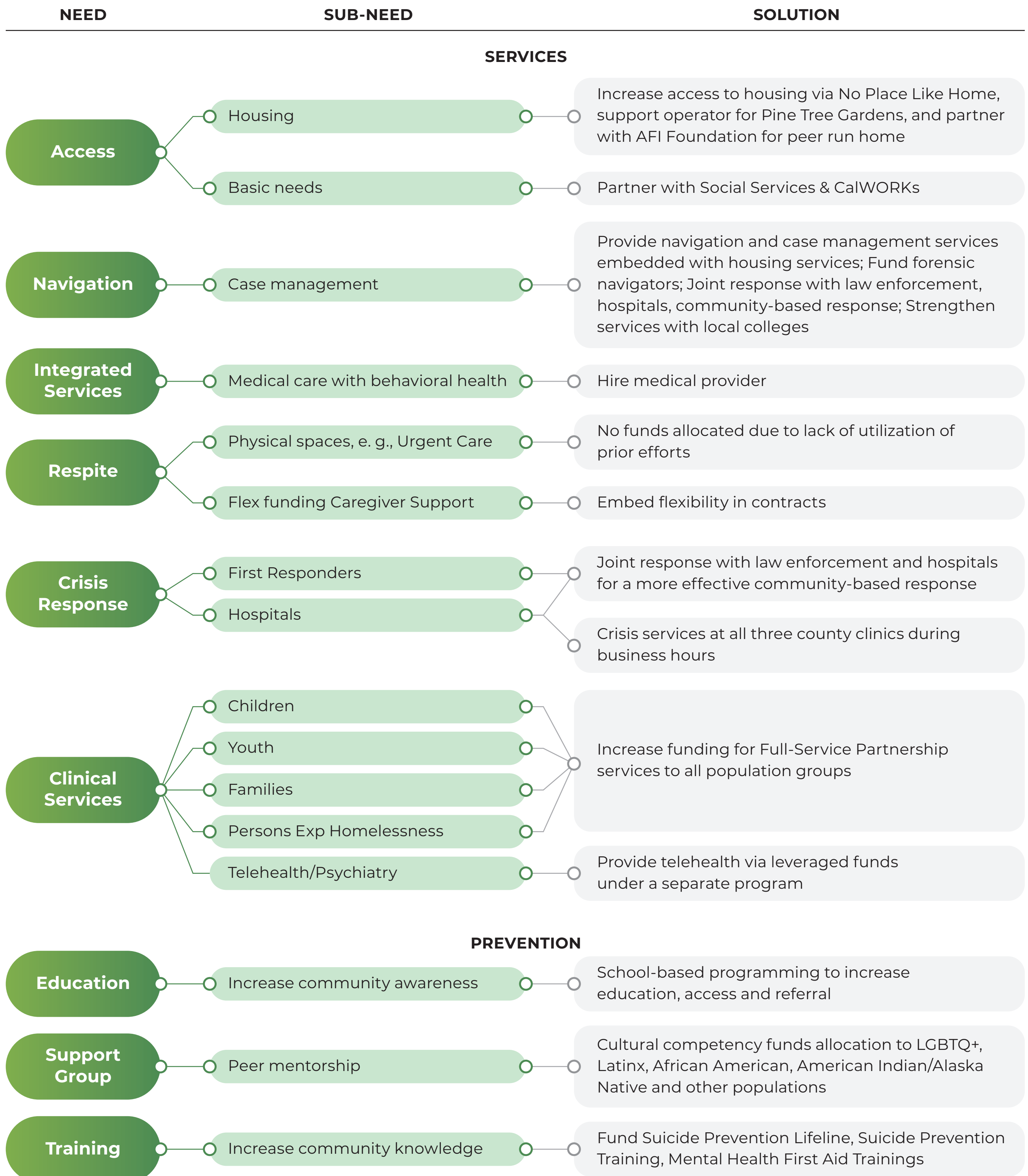
HHSA will include the recommendations from the Yolo County Board & Care Study (April 2019) as part of the evaluation component to capture data and tracking related to adult residential care, consumers, housing and community needs assessment, to support quality improvement processes, and to inform innovative model development to meet the unique needs of Yolo County.

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 Mental Health Services Oversight and Accountability Commission (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 will provide 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.

Overview of Yolo County's Three-Year Plan

Plan 2020–2023



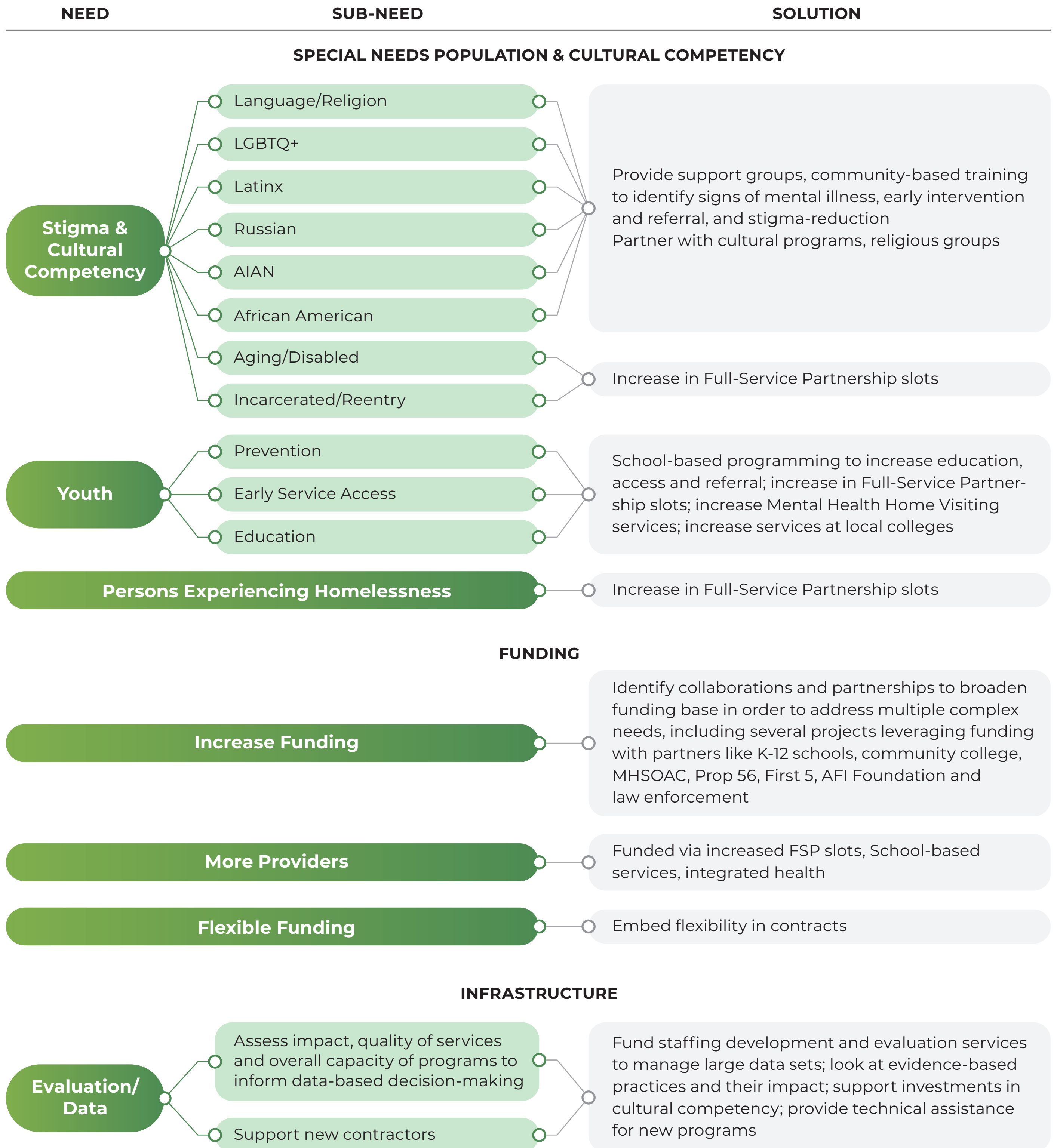
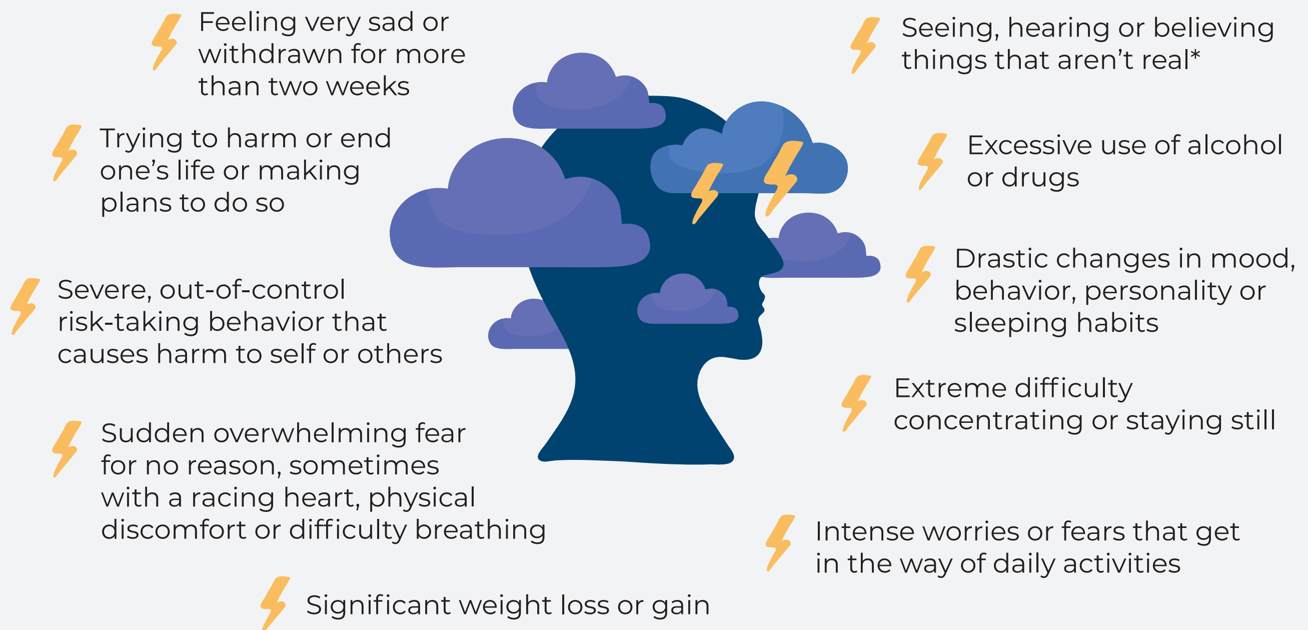

NEED
SUB-NEED
SOLUTION
SPECIAL NEEDS POPULATION & CULTURAL COMPETENCY
Stigma & Cultural Competency
Language/Religion
LGBTQ+
Latinx
Russian
AIAN
African American
Aging/Disabled
Incarcerated/Reentry
Provide support groups, community-based training to identify signs of mental illness, early intervention and referral, and stigma-reduction
Partner with cultural programs, religious groups
Increase in Full-Service Partnership slots
Youth
Prevention
Early Service Access
Education
School-based programming to increase education, access and referral; increase in Full-Service Partnership slots; increase Mental Health Home Visiting services; increase services at local colleges
Persons Experiencing Homelessness
Increase in Full-Service Partnership slots
FUNDING
Increase Funding
Identify collaborations and partnerships to broaden funding base in order to address multiple complex needs, including several projects leveraging funding with partners like K-12 schools, community college, MHSOAC, Prop 56, First 5, AFI Foundation and law enforcement
More Providers
Funded via increased FSP slots, School-based services, integrated health
Flexible Funding
Embed flexibility in contracts
INFRASTRUCTURE
Evaluation/ Data
Assess impact, quality of services and overall capacity of programs to inform data-based decision-making
Support new contractors
Fund staffing development and evaluation services to manage large data sets; look at evidence-based practices and their impact; support investments in cultural competency; provide technical assistance for new programs

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

Plan 2020–2023

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

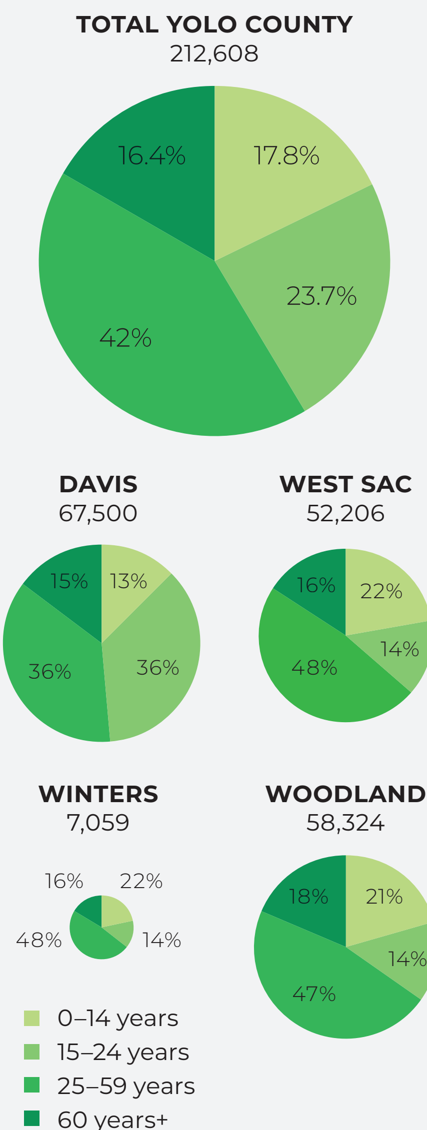
Yolo County is 51% female and 49% male. Countywide, the largest age demographic is 25- to 59-year-olds. Davis has an equal amount of college-age persons and adults younger than 60. West Sacramento, Winters, and Woodland have lower portions of college-age persons compared to adults aged 25–59. West Sacramento, 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.

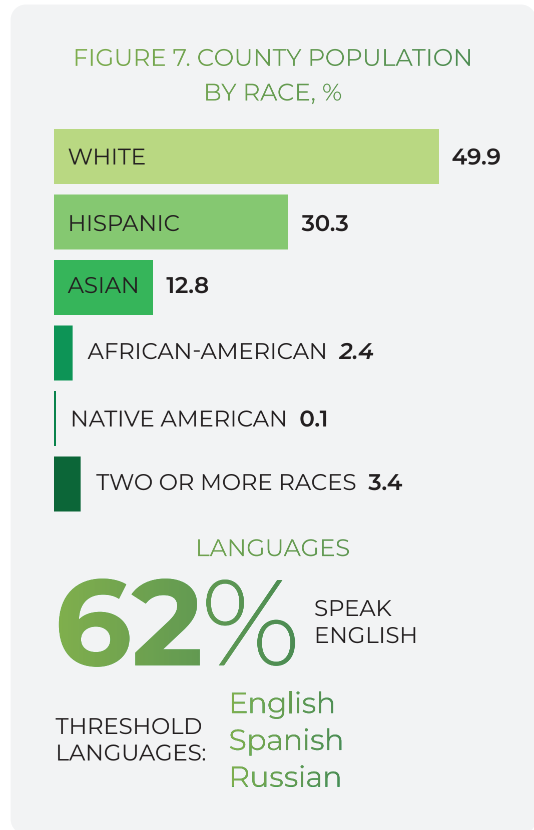
5. U.S. Census Bureau, 2017

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.



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 dimensions 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)

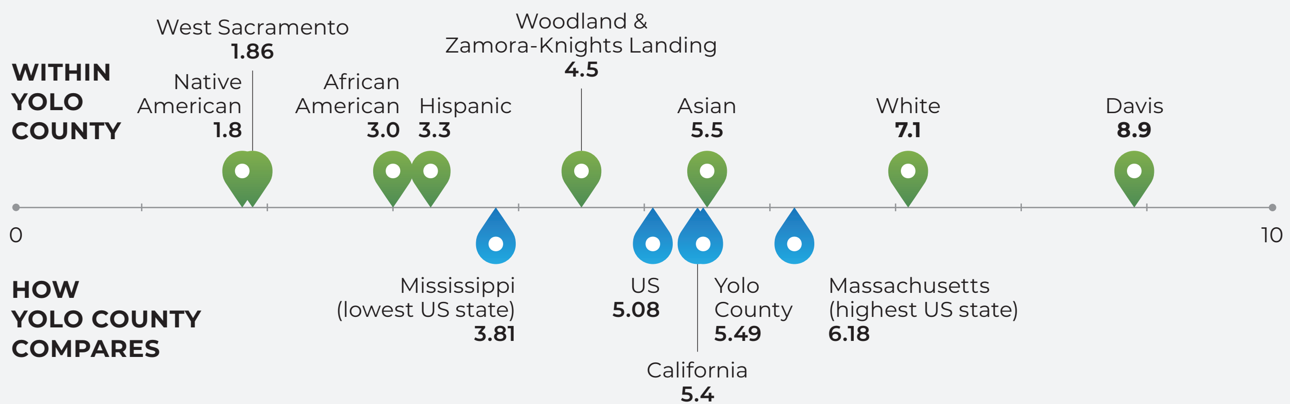
American Human Development Index

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

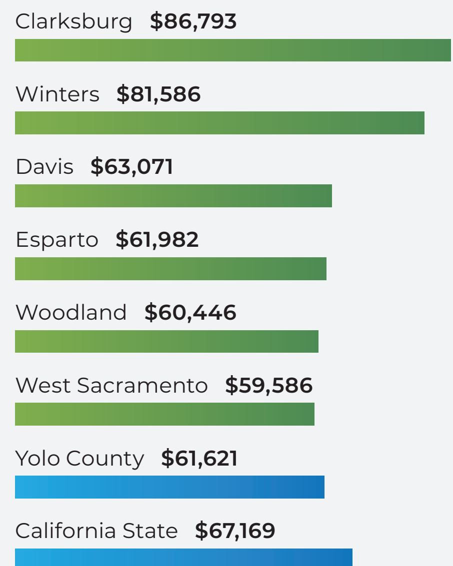
Median Household Income

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).

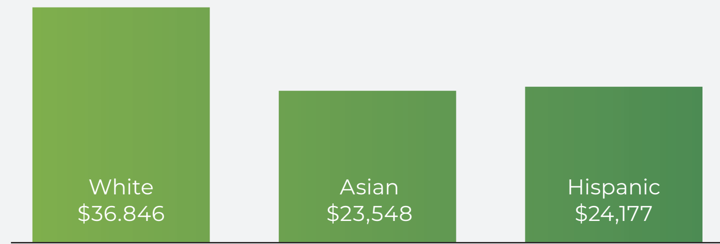
As for those that fall below the county median income, Woodland and West Sacramento's median incomes are $60,446 and $59,586, respectively (Figure 9). This means that these two communities have a great income disparity compared to Winters and Clarksburg. Between Clarksburg and West Sacramento alone,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

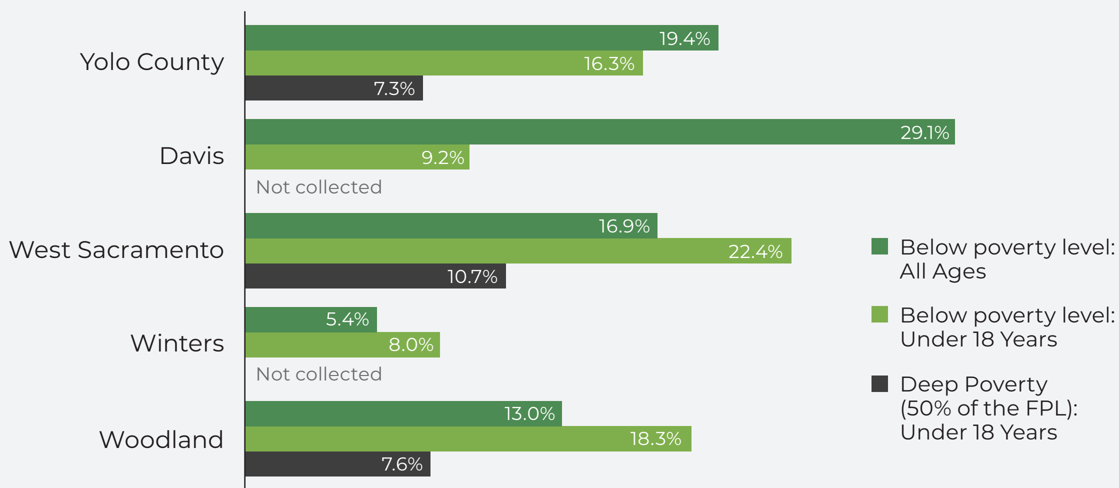
The proportion of people living in poverty varies across Yolo County. In Yolo County, 19.4% of all individuals (adults and children) are living in poverty, compared with 14.6% nationally; 16.3% of children in Yolo County are living in poverty compared with 20.3% nationally (Figure 11).

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's, at 5.4% of overall individuals living in poverty and 8% of children living in poverty. (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 below 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 (See Figure 12).[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 the 3rd Grade Reading Level standards, 65% of Asian and 33% of Latino children.

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

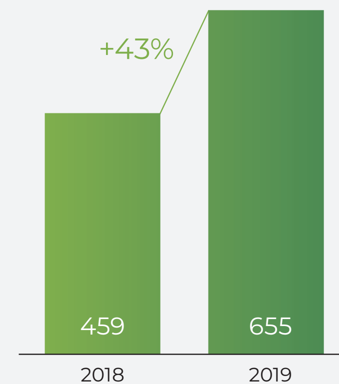


FIGURE 13. EDUCATIONAL ATTAINMENT[10]

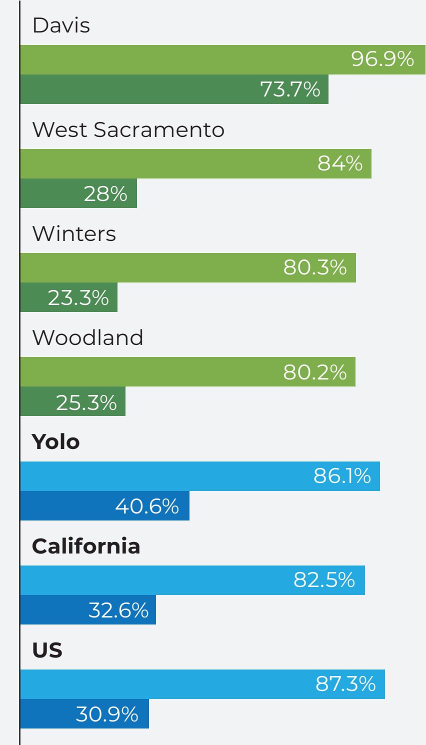


FIGURE 14. YOLO COUNTY HIGH SCHOOL AND BACHELOR'S DEGREE ATTAINMENT BY RACE/ETHNICITY[12]

	3rd Grade Reading—Meets or 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

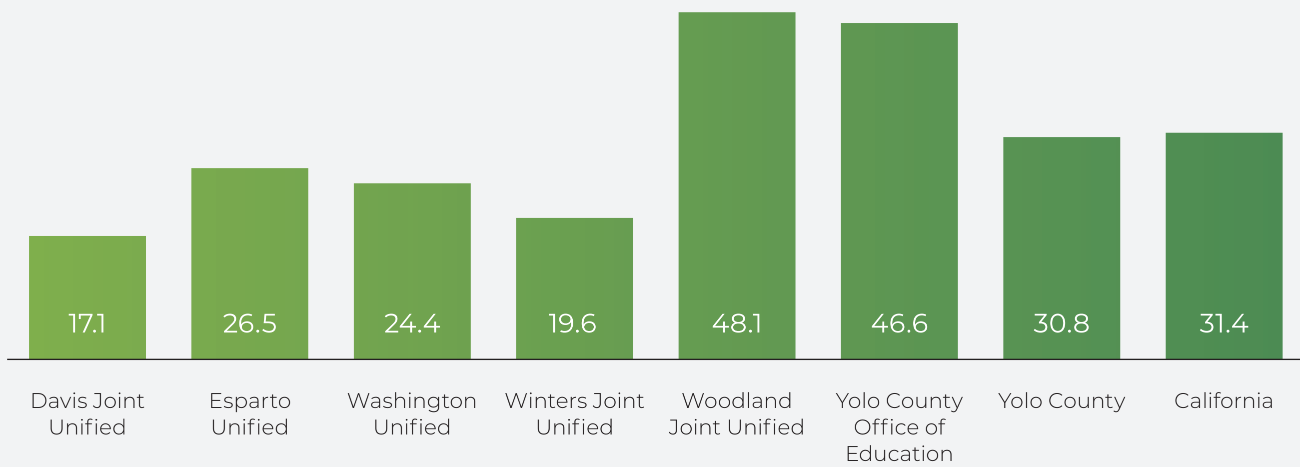
13. Uniform Crime Reporting Statistics

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



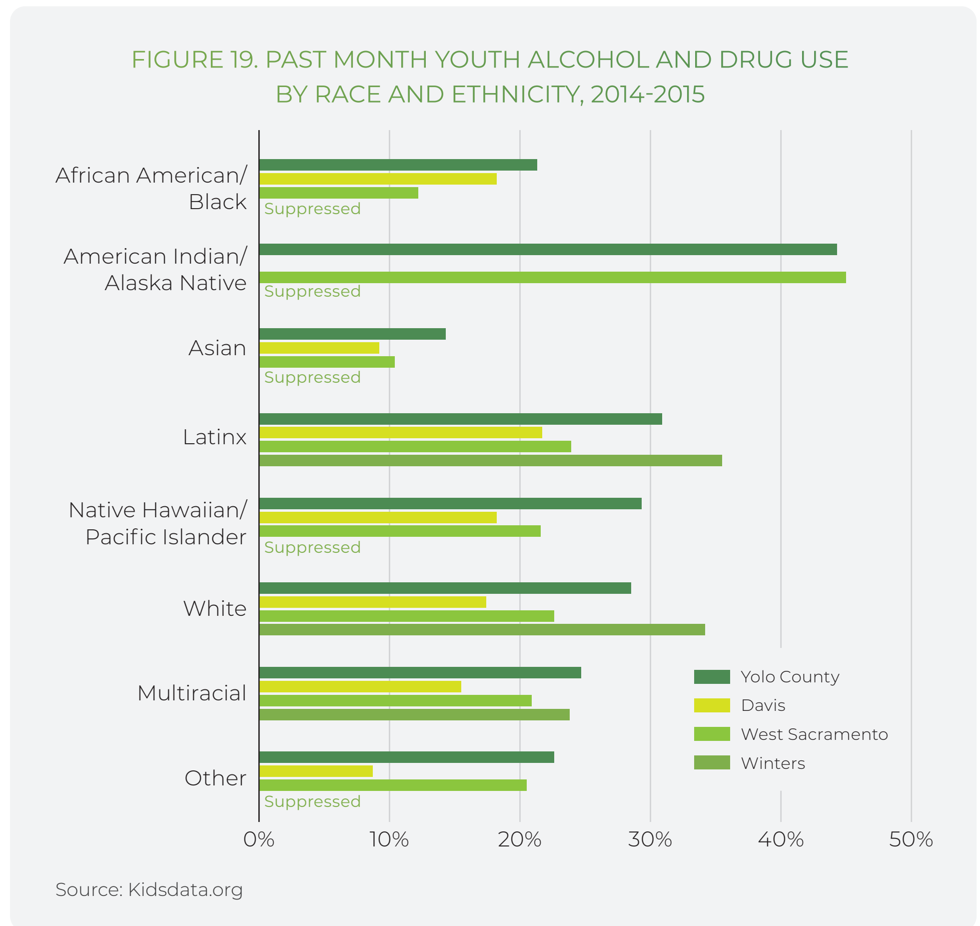
15. Kidsdata.org

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% alcohol and drug use among students 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

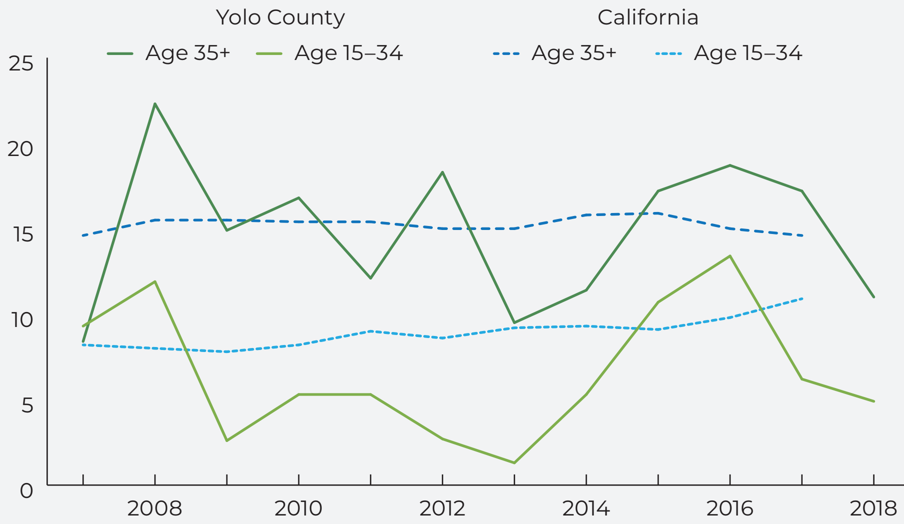


FIGURE 21. SUICIDE COUNTS AND RATES (PER 100,000 PERSONS), YOLO COUNTY VS. CALIFORNIA

	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 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. The CEWG 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 and 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 and 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 were identified to provide insight into the information gathered from the focus group participants. Eight individuals were interviewed. Six work in leadership positions with HHSA and two are Yolo County supervisors (Figure 24).

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

Participant Demographics

The tables below summarize the demographic data of all participants in the focus groups and community engagement workgroups who chose to share this information. Proportion of participants racial/ethnic identification varied in comparison to the county's distribution (see page 23): African American 9.7% versus 2.4%; American Indian/Alaska Native 4% versus 0.1%; Asian 6.9% versus 12.8% Latinx 33% versus 30%; White 57.3% versus 49.9%. Additional information on Yolo County Mental Health Client demographics is included in Appendix 1.

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 COUNTY

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.

"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

Issue	Number of mentions
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.
- **African American:** This population faces unique needs in Yolo County. Their needs are specific and often poorly addressed. Culturally competent and community-based services are needed to properly address the mental health needs of African American people.
- **American Indian/Alaska Native:** Focus groups described that cul-

turally 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 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 experiences of homelessnes 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

Plan 2020–2023

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 organizations (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 a junior intern program to promote interest in mental health careers among young people (like the police do).
- 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 screening for Adverse Childhood Experiences (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 housing 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 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 Figure 30. 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 Individuals	$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	Latinx	$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

FIGURE 31. YOLO COUNTY MHSA OVERALL 3-YEAR PROGRAM PLAN SUMMARY

Program Name	Status	Target Age	Access	Navigation	Integrated Services	Respite	Crisis Response	Clinical Services	Education	Support Group	Training	Stigma & Cultural Competency	Youth	Persons Experiencing Homelessness	Increase Funding	More Providers	Flexible Funding	Evaluation/Data	3-year budget	1-year budget
Community Services & Supports (CSS) Plan																				
Peer- and Family-Led Support Services	C	26–59		●					●	●								●	$300,000	$100,000
Older Adult Outreach Assessment Program	C	60+	●	●				●						●		●	●	●	$3,894,269	$1,251,345
Adult Wellness Services Program	C	26–59	●	●				●						●		●	●	●	$18,205,939	$5,556,979
Community-Based Drop-In Navigation Center	C	16+		●			●	●										●	$2,533,200	$844,400
Tele-Mental Health Services	C	16+						●										●	$2,347,632	$771,538
Mental Health Crisis Service & Crisis Intervention Team Training	N/M	16+	●	●			●		●		●			●	●			●	$5,385,240	$1,505,779
Children's Mental Health Services	C	0–20						●					●	●		●	●	●	$2,142,387	$686,311
Pathways to Independence	C	16–25	●	●				●			●	●	●	●				●	$4,910,466	$1,573,481
Prevention & Early Intervention (PEI) Plan																				
Senior Peer Counseling	C	60+																●	$150,000	$50,000
Latinx Outreach/Mental Health Promotores Program	C	16–59	●	●	●			●				●						●	$885,444	$295,148
Early Childhood Mental Health Access & Linkage Program	C	0–5	●	●				●				●	●		●	●		●	$1,200,000	$400,000
K-12 School Partnerships	N	6–18	●		●				●			●	●		●			●	$3,300,000	$1,100,000
Youth Early Intervention Program	C	6–25						●					●					●	$382,148	$122,421
College Partnerships	N	16–25	●	●	●				●				●		●			●	$450,000	$150,000
Early Signs Training and Assistance	C	16+							●	●	●	●						●	$1,296,014	$425,895
Cultural Competence	N	0+	●						●	●	●	●					●	●	$2,572,221	$675,967
Maternal Mental Health Access Hub	N	0+							●		●							●	$300,000	$100,000
Community Services & Supports/ Prevention & Early Intervention																				
Evaluation	N	0+																●	$600,000	$200,000
Innovation (INN) Plan																				
Integrated Medicine into Behavioral Health	N	16+			●			●								●		●	$1,808,000	$506,000
Crisis Now Learning Collaborative	N	16+					●		●		●							●	$145,000	$145,000
Capital Facilities & Technological (CFT) Plan																				
IT Hardware/Software/Subscription Services	C	NA																●	$2,492,790	$811,374
Peer-Run Housing	N	26–59	●												●			●	$250,000	$250,000
Workforce Education & Training (WET) Plan																				
Mental Health Professional Development	C	16+							●		●	●						●	$167,422	$54,880
Peer Workforce Development Workgroup	C	26+							●	●	●	●						●	$69,111	$23,037
Central Regional WET Partnership	N	16+							●		●				●			●	$85,000	$30,000

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	Provide family- and consumer-led support services and psychoeducation to caregivers and consumers.		
Goal 2	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	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. In response to community feedback, HHSA will add a case manager for non-FSP.

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	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	Provide 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 appointments 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 teleconferencing 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 of 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 0–20) ● 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 Latinx 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 Full Service Partnership (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	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	Expand and augment mental health services to enhance service access, delivery, and recovery.		
Goal 3	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 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 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	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

The Senior Peer Counseling Program 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	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 implementing 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	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 0–5.

Key activities of the ECMH 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	Connect children to the appropriate prevention or mental health treatment service.		
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 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 Program**

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 Latinx 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 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 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 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 and Assistance includes the following training programs:

- Applied Suicide Intervention Strategies Training (ASIST)
- SafeTALK
- Question, Persuade and Refer (QPR) 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: Building Hope
- 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 with 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, 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	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 and 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	Enhance, expand, and implement cultural competence and health equity outreach, engagement, and training throughout the HHSA system in the Yolo community.		
Objective 1	Reduce health disparities and promote health equity through the education of staff and providers in culturally and linguistically appropriate service standards.		
Objective 2	Engage agencies and the community in the advancing of culturally responsive policy and programming in support of the Yolo Cultural Competency Plan.		
Objective 3	Provide targeted, culturally responsive outreach and support to vulnerable populations to reduce stigma and promote service engagement.		
Objective 4	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 (MMH) 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	Improve linkage to services that mitigate and improve the emotional and behavioral health of women preconception, intrapartum and postpartum.		
Goal 2	Increase quality and quantity of evidence based and evidence informed treatments and services for women suffering from or at risk for 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**

Community Services and Supports; Prevention & Early Intervention

Innovation ○ FSP ○ Non-FSP

Program name: **Evaluation**

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

This plan intends for all Request For Proposals (RFPs) and subsequent contracts to include Results Based Accountability (RBA; See Appendix) performance measures to ensure that the programs and services are being evaluated. HHSA will seek an independent evaluator to support development of program performance metrics and with building a system to track and report data. These efforts will create a framework to build from which will provide information to assess outcomes, successes, modifications needed, new approaches, and how meaningful outcomes are ultimately being achieved.

Furthermore, the proposed evaluation shall include support in:

- Building a system to track and report data,
- Development of program deliverable targets and performance metrics,
- Technical assistance to program staff internally and support to community organizations, especially those who are smaller,
- Integrate evaluation metrics based on the Yolo County Board & Care Report recommendations to capture data and tracking related to adult residential care, consumers, housing and community needs assessment, to support quality improvement processes, and to inform innovative model development to meet the unique needs of Yolo County, and
- Future development support on HHSA systems integration within potential Business Intelligence software.

Goal 1	Support creation and development of program performance metrics and systems to track and report data for program evaluation to assess meaningful outcomes.		
Objective 1	RBA development into contracts; technical assistance to support smaller organizations		
Objective 2	Program evaluation components comparable within similar performance functions framework.		
Total Proposed Budget Amount	**$600,000**	**Proposed Budget Amount FY20–21:**	**$200,000**

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 projecting 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	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	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 nonpeer 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 basics of employment and learning to work while using the peer's own story to support clients.
- 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

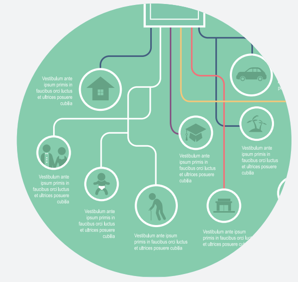
Target Population: ○ Children Aged 0–5 ● Transitional-age Youth Aged 16–25 ● Adult Aged 26–59 ● Older Adult Aged 60+

Program Description

In FY19-20, $40 million was appropriate to fund the California Office of Statewide Health Planning and Development's (OSHPD) 2020–2025 Workforce, Education, and Training (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

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.

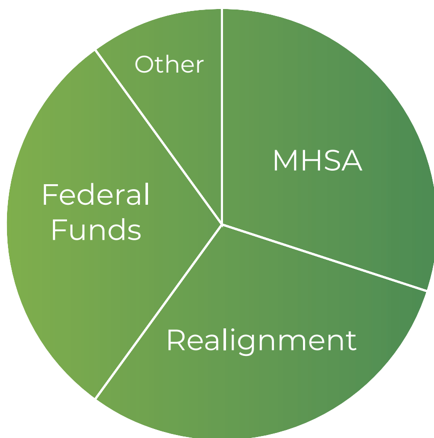
Instructions	County/City Data or Information (If the data/info is not from the 18–19 Update or RER, indicate the data source.)
3. Total number of residents served by MHSA in FY 2018-19 (or FY 2017-18 if this is your most recent data) that were experiencing homelessness at the time of admission or at 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 every-one 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

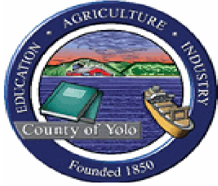
Source: County Annual RBA data.

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

<table>
<tr><th>Instructions</th><th>County/City Data or Information
(If the data/info is not from the 18–19 Update or RER, indicate the data source.)</th></tr>
<tr><td>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.</td><td>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</td></tr>
<tr><td colspan="2">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.</td></tr>
</table>

Appendix 1



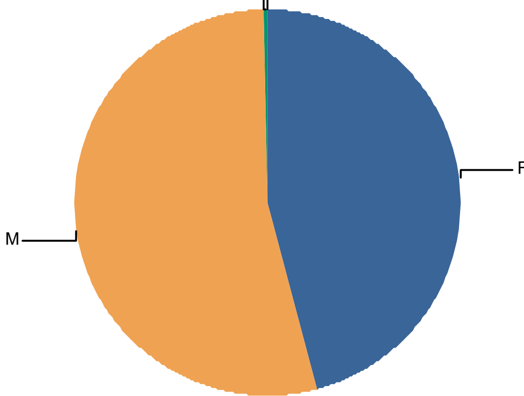
County of Yolo

Health and Human Services Agency

Mental Health Client Demographics

Data displayed is for all clients currently admitted to a Yolo County Mental Health, FSP, GSD outpatient episode as reflected in their demographics

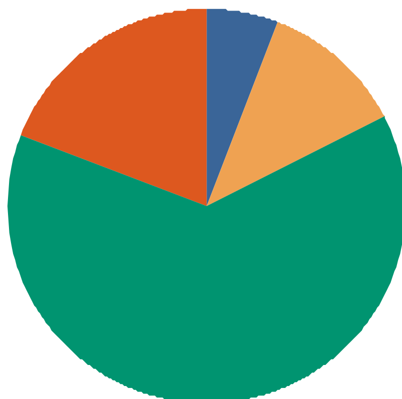
Clients by Gender



F	45.9%
M	53.8%
MTF	0.2%
U	0.1%
Total:	100.0%

	Total
Total	931
F	427
M	501
MTF	2
U	1

Clients by Age

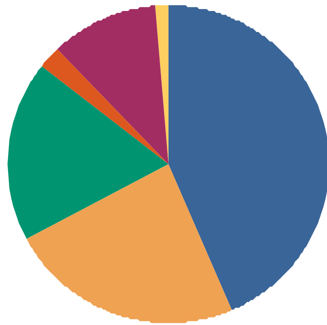


0-15 Children	5.9%
16-25 TAY	11.6%
26-59 Adult	63.3%
60+ Older Adult	19.2%
Total:	100.0%

	Total
Total	931
0-15 Children	55
16-25 TAY	108
26-59 Adult	589
60+ Older Adult	179

This report is intended solely for the use of the authorized party requesting the report and may contain confidential and/or privileged information. Unauthorized review, use, disclosure or distribution of this report is expressly prohibited.

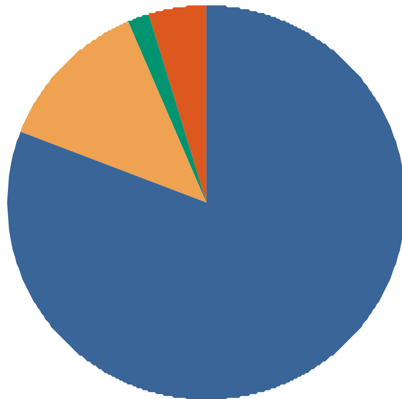
Clients by City of Residence



	Percent
Woodland	43.6%
West Sacramento	23.6%
Davis	18.3%
Winters	2.1%
Other	11.0%
Unknown	1.4%
Total:	100.0%

	Total
Total	931
Woodland	406
West Sacramento	220
Davis	170
Winters	20
Other	102
Unknown	13

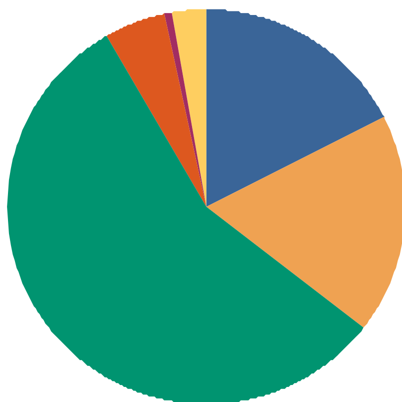
Clients by Primary Language



	Percent
English	80.8%
Other	12.9%
Russian	1.5%
Spanish	4.8%
Total:	100.0%

	Total
Total	931
English	752
Other	120
Russian	14
Spanish	45

Clients by Ethnicity



	Percent
Mexican/Mexican Amer	17.4%
No Entry	18.0%
Not Hispanic	56.3%
Other Hispanic/Latin	4.9%
Puerto Rican	0.4%
Unknown	2.9%
Total:	100.0%

	Total
Total	931
Mexican/Mexican Amer	162
No Entry	168
Not Hispanic	524
Other Hispanic/Latin	46
Puerto Rican	4
Unknown	27

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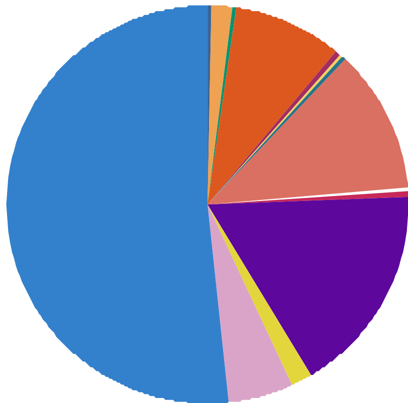
Clients by Race



Race	Percent
Alaskan Native	0.2%
American Indian	1.8%
Asian Native	0.2%
Black/African-Americ	8.8%
Cambodian	0.3%
Chinese	0.2%
Filipino	0.4%
Hispanic	11.7%
Japanese	0.1%
Laotian	0.5%
No Entry	17.1%
Other Asian	1.6%
Other Race	5.2%
White	51.8%
Total:	100.0%

	Total
Total	931
Alaskan Native	2
American Indian	17
Asian Native	2
Black/African-Am	82
Cambodian	3
Chinese	2
Filipino	4
Hispanic	109
Japanese	1
Laotian	5
No Entry	159
Other Asian	15
Other Race	48
White	482

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Appendix 2
Report Back/Public Comment

COUNTY OF YOLO

Health and Human Services Agency

Karen Larsen, LMFT
Director

MAILING ADDRESS
137 N. Cottonwood Street • Woodland, CA 95695
(530) 666-8940 • www.yolocounty.org

July 29th, 2020

To Whom It May Concern-

The Yolo County Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan 2020-2023 30-day public comment period opened on June 19, 2020 and closed Monday July 20, 2020. The plan, along with all written comments received and the responses of the Yolo County Health and Human Services Agency (HHSA) were shared in a public hearing at the Local Mental Health Board meeting on July 27, 2020. Via this community input process, HHSA obtained valuable insight and feedback from all interested parties and the Local Mental Health Board (LMHB). With great care, HHSA has taken all public comments and suggestions into consideration and has revised the MHSA Three- Year Plan for FY 2020-23 to include the following additions and/or edits:

- Added the program plan summary crosswalk to community feedback (p 48);
- Added Evaluation Program Description (p 71); Also referenced in executive summary (p 15);
- Included the recommendations from the Yolo County Board & Care Study (April 2019) referenced in executive summary (p 15); and included in the Evaluation Program Description (p 71); This evaluation plan provides additional funding to support the recommendations within the Board and Care Study.
- Corrected the target population for the Maternal Mental Health to reflect the appropriate ages (p 70);
- Special Needs Population-including African Americans (p 40);
- Participant table-added data on proportion of participants compared to county demographics (p 34); Reference Additional information on Yolo County Mental Health Client Demographics (p 34) is included in the Appendix.
- Added case management for the non-Full Service Partnership (FSP) clients (p 51);
- Worked to streamline readability of the plan with uniform terms, grammatical and spelling corrections; and
- Added public comments received and HHSA responses.

In addition to the revisions above, HHSA is committed to incorporating the other feedback we received into our practices moving forward. Some of these practices include ensuring that our evaluator provides technical assistance and support to providers in the area of performance measures. HHSA will ensure that all requests for proposals and subsequent contracts include clear performance measures and reporting requirements while prioritizing evidence based programming and incorporating fidelity measures for those models, as well as providing regular data/outcome reports to LMHB and Board of Supervisors on MHSA programming.

It is also important to note that the Three- Year Plan is just the beginning of the process and one of many opportunities to provide feedback and make changes. In addition to MHSA Annual Reports, the regularly scheduled Yolo County Community Engagement Work Group (CEWG) meetings provide another opportunity for community input over the term of the plan. HHSA appreciates the engagement of our community and looks forward to implementing the MHSA 2020-23 plan.

With the revisions in place, we asked for the recommendation of the Local Mental Health Board to proceed with the 2020-23 MHSA Three-Year Program and Expenditure Plan.

In Partnership,

Karen Larsen LMFT
Director, Yolo County Health and Human Services Agency

Yolo County MHSA Draft Plan Public Comments

30-Day Public Comment Period: June 19, 2020 – July 20, 2020.

2020–2023

Three-Year Program & Expenditure Plan

Executive Summary

The Yolo County MHSA Three-Year Program and Expenditure Plan 2020-2023 30-day public comment period opened on June 19, 2020 and closed Monday July 20, 2020. The county announced and disseminated the draft plan broadly through community stakeholders, general public, the Community Engagement Work Group, MHSA listservs, service providers, consumers and family members, Board of Supervisors, Local Mental Health Board, county staff, and requested and encouraged partners and community stakeholders to promote the review of the draft plan and participation by posting and sharing with others. Public Notices were also posted in the Davis Enterprise and the Daily Democrat newspapers for several dates. The draft plan was posted to the county's MHSA website, the county Facebook page and could be downloaded electronically, and paper copies were also made available at HHSA department headquarters in Woodland and other sites throughout Yolo County. Any interested party could request a copy of the draft by submitting a written or verbal request to the MHSA program staff.

Attached you will find:

1. A letter from the Yolo County Health and Human Services Agency Director, Karen Larsen, to the Board of Supervisors.
2. Common Public Comment themes and Agency responses.
3. County Summary of the Residents Served by MHSA and Demographic Information
4. All Public Comments and Yolo County Health and Human Services Agency Responses
5. MHSA Budget Overview
6. Results Based Accountability Explanation (Performance Measures)

COUNTY OF YOLO

Health and Human Services Agency

Karen Larsen, LMFT
Director

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(530) 666-8940 • www.yolocounty.org

Chair Sandy and Members of the Board,

This letter comes in response to the letters sent to each of you requesting a delay in the MHSA 3 year plan. The Agency would like to take this opportunity to express our appreciation for these groups. We view them as critical partners in our continuum of care for those struggling with mental illness. We also want to ensure that the Board understands that the MHSA process has not been rushed. In fact, we began community outreach for the MHSA 3-year plan in May of 2019. From August 2019 through March of 2020 we conducted extensive outreach and community engagement. More than 31 focus groups and many individual stakeholder interviews were held, which included more than 500 individuals.

This year the county had a new consultant coordinating and facilitating the community stakeholder process and they dramatically increased the number and breadth of individuals and communities reached. We specifically outreached to underserved and underrepresented communities as an acknowledgement of the work needed in these areas. These groups included North Valley Indian Health, Latinx Perspectives Group, Yolo Rainbow Families as well as members from a variety of faith based organizations, to name a few.

In reference to AB81, the Agency posted our 3-year plan for public comment prior to the passage of this bill. The intent of this bill is to allow counties who did not have the capacity to post their plans in light of COVID, to postpone a new plan for a year, not to extend the process for an already completed plan. Yolo had already completed our plan and therefore is not in that position. We did delay our plan posting from our original goal of March 2020 to June 2020, in light of the COVID pandemic, but strongly oppose delaying the implementation of the plan beyond the August 4th Board meeting.

The 30-day comment period is in statute and closed July 21st The Agency has reviewed all public comments and is providing responses to the Local Mental Health Board (LMHB) on July 23rd in writing as well as via a Public Hearing on July 27th. The LMHB will either support or recommend edits to the Agency's proposed responses and the plan will then come to the Board on August 4th.

It should be noted that further delay of this plan means that the County cannot implement any new initiatives included in the plan. The initiatives outlined in the MHSA plan are critical to serving the community at large and more specifically, the most vulnerable residents of our community including children ages 0-5, school aged children and youth, racial and ethnic minorities, and those struggling with mental illness. Several of these new initiatives have been identified as Board and community priorities and include:

- Police Co-Responder Model
- Cultural Competence/Racial Equity Work
- School Based Mental Health Services

- Expansion of Full Service Partnership Slots
- Partnership with Woodland Community College
- Pine Tree Gardens Operations

Additionally, further delay to accommodate the requests of a few undermines the robust community stakeholder process and is not aligned with MHSA statute and regulations. The Agency appreciates the Board allowing us to move this item from July 21st to August 4th to allow for additional time to respond to comments received during the 30-day comment period.

Thank you for your time and consideration,

Karen Larsen LMFT, Director

Yolo County Health & Human Services Agency

Common Themes of Public Comments and Health and Human Services Agency Responses

Common Themes	Health and Human Services Agency Response
MHSA 3 -year plan process: Request to delay implementation	The MHSA three-year planning process was started in May 2019 with a series of three monthly educational sessions through July 2019, followed by an extensive plan development process beginning in August 2019 and ending in January 2020. During this process over 500+ community residents and stakeholders representing a wide range of geographic and demographic communities participated in providing feedback to the plan. Their interests, priorities, and voice are represented in this plan. As a result, HHSA does not believe further delay in finalizing and implementing the plan is warranted at this time. Furthermore, we believe additional delays beyond what has already happened as a result of COVID, risks undermining the broad community feedback that was received last fall and could jeopardize the timely implementation of new investments around expansion of Full Service Partnership (FSP), the co-responder model with local law enforcement, work around racial equity, and K-12 school-based services at a time when they are in high demand due to the COVID pandemic.
Program Evaulation: Lack of measurable outcomes and objectives	Regarding program evaluation and data, HHSA acknowledges it can do better with evaluating MHSA program outcomes. This is not unique to Yolo county and is a statewide issue, as counties have prioritized service delivery over additional administrative support costs. Nonetheless, HHSA understands the importance of investing in program evaluation and quality improvement, and therefore has already begun implementing Results Based Accountability (RBA) measures for all MHSA contracts and funded programs and will continue to do so with the new plan. The plan does include demographic data on page 94-99, with specific outcomes included for some programming. Pages 7-11 of this response summarize this information. Furthermore, HHSA has set aside funding in the new plan to bring in outside support to help with program evaluation and outcome assessments. HHSA is making edits to the plan to highlight these evaluation activities.
Housing: Permanent Supportive Housing	In regards to allocating additional MHSA funding for housing, the Community Engagement Workgroup (CEWG) was made aware that while it was a highlighted priority for the community, that other funding streams existed to support this priority beyond MHSA. Given the existence of other funding streams available to support housing for those with mental illness, the county has prioritized local MHSA funds to support service delivery. These services include significant investments in staffing to support permanent supportive housing. Furthermore, in 2016, the state passed legislation that carved out a piece of local county MHSA funding (7%) specifically to fund No Place Like Home (NPLH) grants to support permanent supportive housing to mentally ill residents. Over the course of the next three years several developments are planned, adding over 400 units for low/extremely low income individuals in Yolo County. More than half of these units are permanent supportive housing units which have services on site and available to residents. Some units are designated for persons experiencing homelessness but many are not. Some are also more short term in nature. We are prioritizing bringing people back to Yolo who have been placed elsewhere, whether that be an IMD or a Board and Care in another county. MHSA funding is intended to fund a broad array of services, with an emphasis on direct services for FSP clients and prevention for young children. The state and federal government provides other funding streams to support housing for the homeless in addition to local investments by the county and cities. Two recent examples from the state are Project Roomkey and Project House Key. Below is a list of upcoming developments and units. **Name of development, City and Number of Units:** No Place Like Home West Sacramento 85 No Place Like Home Woodland 61 Creekside Davis 90 Paul's Place Davis 18 Mutual Housing Davis 38 CHFFA West Sac 6 CHFFA Woodland 6 AFI Woodland 6-12 Project Homekey West Sacramento 56 Project Homekey Davis 51

Pine Tree Gardens: Funding	The County has invested approximately $200,000 of MHSA dollars over the last two years to repairs of the Pine Tree Gardens Homes. Additionally, the County just ensured the purchase of East House and a long term deed restriction utilizing $1 million of MHSA dollars. Furthermore, the County will be contracting with NVBH to cover the costs of operations for the coming three years which we expect to cost approximately $800,000 MHSA dollars per year for both homes. Additionally, Pine Tree Gardens funding is included across the following: Adult Wellness Services, Pathways to Independence, and Older Adult Outreach and Assessment Programs.
Pacifico: Funding	The County is not pulling funding from Pacifico. The County attempted to invest MHSA dollars in Pacifico but was unsuccessful.
Case Management: Non- FSP clients	The County does provide some case management services for non-FSP clients. Additionally, we work with Beacon to provide ongoing therapy for clients who could benefit and are interested. Additionally, much of what will be provided at the navigation centers includes case management and linkage services.
Cultural Competence	HHSA is committed to cultural competence, cultural humility, and proficiency and strives to embed it in all our work, including MHSA. MHSA will increase attention, 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. We will seek community partners support as HHSA acknowledges we can do better and cannot engage on this one sided. Thank you for informing us of a typo as we work to finalize the draft. HHSA strives to serve the County at all localities and acknowledge the significance of engaging the rural areas as well. This plan includes approximately $3 million in funds over the next 3 years to demonstrate our commitment. All services will be contracted out following an RFP process.
Administration	Administration funding provides for staff time across HHSA to support MHSA components by respective responsibilities (eg. Fiscal administration, Management, and Oversight). All Administration Branch staff are all funded the same, the costs of the Admin branch are allocated across all branches of HHSA. Therefore, the admin branch costs are paid for by the funding sources that pay for the other branches. This includes Federal, State, grants, realignment, MHSA, County General Fund, Intergovernmental Transfers, and fee/permit revenue.
Community Feedback and Program Investments	During this process over 500+ community residents and stakeholders representing a wide range of geographic and demographic communities participated in providing feedback to the plan. Their interests, priorities, and voice are represented in this plan. HHSA is currently updating the plan to provide additional information to better illustrate the connection between the community feedback and program investments.
Fiscal-Prudent Reserve	The County already has policies on cash and reserves, see https://insideyolo2.yolocounty.org/departments/county-administrator/administrative-policies-procedures. The Department of Financial Services (DFS) controls amendments to these policies. During FY19/20 HHSA proposed amending the policy on fund balances and reserves to DFS to include an MHSA reserve in accordance with WIC 5847 and 5892 and DHCS Information Notice 19-037, but then the pandemic hit. During FY20/21 HHSA will make attempts to reestablish these policy revisions as a priority for DFS.

County SUMMARY of the Residents Served by MHSA and Demographic Information	
Questions:	**County 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/Youth Mental Health First Aid May is Mental Health Month Campaign. Suicide Prevention Line # of Residents: **Estimated 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** Source: 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.

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/risk-of 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 served: 500** **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/risk-of data across all MHSA programs, other than within our Mental Health Court FSP program. Per National studies, approximately 1 in every 37 adults in American are involved in the CJ system.
County/City MHSA FISCAL Information (FY 2018-19)	
Instructions	**County Data or Information** (If the data/info is not from the 18-19 Update or RER, indicate the data source.)

1. 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
County MHSA HOUSING Information	
Instructions	**County 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 MHSA CSS Information	
Instructions	**County 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 MHSA PEI Information	
Instructions	**County 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** 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 yrs: 3,081 15-25 yrs: 1,801 26-59 yrs: 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	**Served under PEI by Race/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

	7. More than one race 8. Number of respondents who declined to answer the question 9. Hispanic or Latino	Other: 2,072 More than one race: 259 Respondents who declined to answer: 102 Source: PEI&INN Demographic Data
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

Preserving sustainable, supported housing for Yolo County family members and friends living with serious mental illness.

July 13, 2020

Gary Sandy
Chair, Yolo County Board of Supervisors
Sent via electronic mail

Nicki King
Chair, Local Mental Health Board
Sent via electronic mail

RE: Request for extension of public process for MHSA three-year program and expenditure plan

Dear Chair Sandy and Chair King:

The Committee is writing to you as local stakeholders invested in the effective expenditure of MHSA funds to best serve members of our community living with mental illness with a request to utilize the flexibility granted in the 2020-21 state budget to extend the public process for development of Yolo County's Mental Health Services Act Three-Year Program and Expenditure Plan ("Three-Year Plan"). The Three-Year Plan allocates $60 million for programs and housing in Yolo County over three years, including a $14 million fund balance. The funding is revenue from a tax on millionaires, passed by voters in 2004 as Proposition 63, specifically for the purpose of helping people living with mental illness.

As you may know, the Governor signed AB 81 in July 2020, a budget trailer bill that includes the following language related to Mental Health Services Act three-year program and expenditure plan:

"This bill would authorize a county that is unable to complete and submit a 3-year plan or annual update for the 2020-21 fiscal year due to the COVID-19 Public Health Emergency to extend the effective timeframe of its currently approved 3-year plan or annual update to include the 2020-21 fiscal year. The bill would require a county to submit a 3-year program and expenditure plan or annual update to the commission and the department by July 1, 2021."

According to Public Health Director Brian Vaughn during a July 10, 2020 call with the Committee, the County normally releases the draft three-year program and expenditure plan in March, but release was understandably delayed until the end of June as a result of the COVID-19 pandemic. The Committee therefore requests changes to the public process to extend the public process,

which currently involves approval by the Local Mental Health Board at the July 20, 2020 meeting and approval by the Board of Supervisors at the August 4, 2020 meeting. The existing process does not make sense given the late release of the plan. Comments from the public are due on July 19th, yet the Local Mental Health Board is scheduled to approve one day later. This process leaves no time for Yolo County staff to make changes to the plan in response to comments. The adopted state budget provides the County with much-needed flexibility to extend the public process to address exactly such a situation caused by COVID-19. The Committee instead recommends the following process:

July 13th: Special Local Mental Health Board meeting to discuss MHSA Three-Year Plan

July 19th: End of 30-day public comment period

July 20th: Special Local Mental Health Board meeting to receive verbal public comments and review written public comments

August 20th: Yolo County staff release updated MHSA Three-Year Plan reflecting changes requested by community and Local Mental Health Board

August 27th: Yolo County staff review changes with Local Mental Health Board and Local Mental Health Board considers approval of Three-Year Plan

September: Board of Supervisors considers approval of Three-Year Plan

As established by WIC § 5848, all submitted comments must be reviewed by the LMHB so they can make recommendations to the County, as applicable, for revisions. The LMHB must approve any recommended revisions by a majority vote at a public hearing. This requirement indicates the need for the draft Three-Year Plan to be on the agenda on at least two separate Local Mental Health Board meetings: one to hear public comments on the draft Three-Year Plan and one to approve any recommended revisions. Giving the Local Mental Health Board the month of August will help ensure the proposed expenditures are closely aligned with community needs, which is a heavy emphasis in the MHSA process.

We understand the County cannot implement new programs proposed in the 2020-2023 Three-Year Plan if it is not approved by the Board of Supervisors, although they are able to continue with existing programs. This is precisely the point of the request to extend the deadline. The community and the Local Mental Health Board need additional information to understand these new proposed expenditures, as well as the proposed use of the $14 million fund balance. The Committee provided a list of 19 initial questions about the proposed Three-Year Plan to Public Health Director Brian Vaughn on July 10, 2020 and expects to have more questions as the Committee develops its comment letter.

The Save Pine Tree Gardens Committee is grateful for the proposal to expend MHSA funds in the Three-Year Plan to help operate the two Pine Tree Gardens houses, but the Three-Year Plan as a

whole does not provide sufficient information for the public to evaluate the proposed expenditure plan for three major reasons:

- **Lack of connection between the focus groups and other stakeholder feedback and the proposed Three-Year Plan**. Starting on page 32, the draft Plan describes the community outreach and education process, in which Save Pine Tree Gardens Committee members participated, including the community engagement workgroup and focus groups. Starting on page 37, the plan describes the needs identified as a result of the focus groups. Starting on page 4, there are proposed solutions from the community, including an exercise described on page 46 that gave the community the ability to prioritize funding. Yet for the goals and objectives for the three-year plan, starting on page 48, there are no connections for each goal and objective back to the community feedback. A glaring omission is the request from the community to allocate funding for housing for the mentally ill, which is also a topic that has come up frequently during conversations between the Yolo County Health and Human Services Agency and the Save Pine Tree Gardens Committee. The County may transfer up to 20 percent of the Community Services and Supports funding to Capital Facilities and Technology every year, but it is not clear whether the Three-Year Plan is transferring the amount needed for housing to these categories.

- **Insufficient information to understand the expenditures.** The Program Plan section, beginning on page 47, provides 1-2-page descriptions of allocations of up to $18 million over three years. These descriptions do not draw connections to community needs or provide information about the success of continuing programs. Additionally, multiple proposed budget amounts listed in the Program Plan section are not represented or are inconsistent with amounts listed in the budget sections, pages 76-93.

- **Lack of measurable outcomes and objectives.** WIC § 5848 states the plan shall include a report on the achievement of performance outcomes for MHSA services. The draft Plan does not include performance outcomes to indicate results of past years' expenditures. The County MHSA Profile, beginning on page 93, serves only as a quantitative summary of MHSA expenditures, and does not measure *impact* of MHSA services. According to Public Health Director Brian Vaughn during the July 10th Zoom meeting, this issue is not unique to Yolo County and his division is allocating resources for both staff and a consultant to develop performance measures in the coming years. This expenditure is not a line item in the plan, however, so it's difficult to evaluate the adequacy of this financial commitment to meet the need.

Given these issues and the flexibility provided by the state budget trailer bill to extend the public process, the Committee respectfully requests the Board of Supervisors and the Local Mental Health Board adopt an updated public process to allow more time for discussion of these important priorities.

Sincerely,

Dorothy Callison
Leslie Carroll
Mavonne Garrity
Phil Garrity
Brian Parker
Petrea Marchand
Marilyn Moyle
Jeni Price
Nancy Temple
Cass Sylvia
Linda Wight
Kathy Williams-Fossdahl
Dian Vorters
Rick Moniz

cc: Members, Yolo County Board of Supervisors
Pat Blacklock, Yolo County Administrator
Karen Larsen, Director, Yolo County Health and Human Services Agency
Brian Vaughn, Yolo County Public Health Director

RESPONSE:
The MHSA three-year planning process was started in May 2019 with a series of three monthly educational sessions through July 2019, followed by an extensive plan development process beginning in August 2019 and ending in January 2020. During this process over 500+ community residents and stakeholders representing a wide range of geographic and demographic communities participated in providing feedback to the plan. Their interests, priorities, and voice are represented in this plan. As a result, HHSA does not believe further delay in finalizing and implementing the plan is warranted at this time.

Furthermore, we believe additional delays beyond what has already happened as a result of COVID, risks undermining the broad community feedback that was received last fall and could jeopardize the timely implementation of new investments around expansion of Full Service Partnership (FSP) and K-12 school-based services at a time when they are in high demand due to the COVID pandemic.

In regards to allocating additional MHSA funding for housing, the Community Engagement Workgroup (CEWG) was made aware that while it was a highlighted priority for the community, that other funding streams existed to support this priority beyond MHSA. Given the existence of other funding streams, the county has prioritized local MHSA funds to support service delivery as intended. These services include significant investments in staffing to support permanent supportive housing. Additionally, in 2016, the state passed legislation that carved out a piece of local county MHSA funding (7%) specifically to fund No Place Like Home (NPLH) grants to support permanent supportive housing to mentally ill residents. There are 41 NPLH units located in West Sacramento and 29 units in Woodland, CA.

Over the course of the next three years several developments are planned, adding over 400 units for low/ extremely low income individuals in Yolo County. More than half of these units are permanent supportive housing units which have services on site and available to residents. Some units are designated for persons experiencing homelessness but many are not. Some are also more short term in nature. We are prioritizing bringing people back to Yolo who have been placed elsewhere, whether that be an IMD or a Board and Care in another county along with the intended Peer-Run Housing Program. Pine Tree Gardens funding is included across the following: Adult Wellness Services, Pathways to Independence, and Older Adult Outreach and Assessment Programs.

Regarding program evaluation and data, HHSA acknowledges it can do better with evaluating MHSA program outcomes. This is not unique to Yolo county and is a statewide issue, as counties have prioritized service delivery over additional administrative support costs. Nonetheless, HHSA understands the importance of investing in program evaluation and quality improvement, and therefore has already begun implementing Results Based Accountability (RBA) measures for all MHSA contracts and funded programs and will continue to do so with the new plan. Furthermore, HHSA has set aside funding in the new plan to bring in outside support to help with program evaluation and outcome assessments. HHSA is making edits to the plan to highlight these evaluation activities. Please see Yolo County MHSA Profile, page 94, for demographics and data on residents served, FSP outcomes, and prevention and early intervention programs.

Lastly, HHSA is currently updating the plan to provide additional information to better illustrate the connection between the community feedback and program investments.

From: Lill Birdsall <lill@namiyolo.org>
Sent: Monday, July 13, 2020 4:26 PM
To: Kim Farina <friends@namiyolo.org>
Subject: Extension of Public Process for MHSA three-year program and expenditure plan

Dear Chair Sandy and Chair King:

I hope this email reaches you in time to peruse it before the LMHB meeting this evening. I have attached a word document as well.

NAMI-Yolo County is very appreciative of the support we have received through MHSA funding to enhance our educational programs, peer and family wellness opportunities, community engagement and advocacy. We are writing to you as local stakeholders requesting the County to utilize the flexibility granted in the 2020-21 state budget to extend the public process for development of Yolo County's Mental Health Services Act three-year program and expenditure plan ("Three-Year Plan").

As you may know, the Governor signed AB 81 in July 2020, a budget trailer bill that includes the following language related to Mental Health Services Act three-year program and expenditure plan:

"This bill would authorize a county that is unable to complete and submit a 3-year plan or annual update for the 2020-21 fiscal year due to the COVID-19 Public Health Emergency to extend the effective timeframe of its currently approved 3-year plan or annual update to include the 2020-21 fiscal year. The bill would require a county to submit a 3-year program and expenditure plan or annual update to the commission and the department by July 1, 2021."

NAMI-Yolo feels that the MHSA community input process this year was successful in increasing participation. However, the current document does not reflect some of the community's highest priorities. Also, the timeline is too short for meaningful discussion and response after the 30-day period is over so that the LMHB and BOS have adequate time to reflect on changes from community input before they have to vote. NAMI-Yolo would like to see a better correlation between the programs funded and the community priorities. Our constituency feels that there is not clear rationale for why some programs were changed or eliminated (CIT, Mental Health Urgent Care, etc.) We would like a better explanation than "They were underutilized or too expensive."

NAMI Yolo County instead recommends the following process:

- **July 19th:** End of 30-day public comment period
- **July 20th:** Special Local Mental Health Board meeting to review public comments
- **July 27th:** Regular Local Mental Health Board meeting at which Board will review written responses from Yolo County staff to Board comments
- **August 20th**: Yolo County staff release updated MHSA Three-Year Plan reflecting changes requested by community and Local Mental Health Board
- **August 27th:** Yolo County staff review changes with Local Mental Health Board and Local Mental Health Board considers approval of Three-Year Plan
- **September:** Board of Supervisors considers approval of Three-Year Plan

We understand the County cannot implement new programs proposed in the 2020-2023 Three-Year Plan if it is not approved by the Board of Supervisors, although they are able to continue with existing programs. This is precisely the point of the request to extend the deadline. The community and the Local Mental Health Board need additional information to understand these new proposed expenditures, as well as the proposed use of the $14 million fund balance.

NAMI Yolo County would like the MHSA three-year program to consider including the following:

- Alternate opportunities during acute episodes besides 911 police response and professional intervention to defuse escalating symptoms to avoid more costly treatment.
- Increased access to supportive housing and case managers.
- Reduced client loads for case managers, allowing targeted supportive services outreach to clients with SMI diagnosis who are NOT currently on FSP.
- Increased use of peer support workers and advocacy for standardization at the state level for their certification.
- Improved cultural competency/race relations dialogs, better outreach to our county to target language populations (Spanish and Russian) and minority mental health consumers and their families, especially in relation to policing and criminal justice involvement.
- No wait time for a psychiatrist upon exit from higher level care.
- EDAPT program that is open to more residents and is not constrained by insurance.
- Crisis-care for children.
- Urgent Care needs to be 24/7 so there is an alternative to calling the police.

Given these issues and the flexibility provided by the state budget trailer bill to extend the public process, the Committee respectfully requests the Board of Supervisors and the Local Mental Health Board adopt an updated public process to allow more time for discussion of these important priorities.

Sincerely,

NAMI Yolo County Board of Directors
Jenifer Price, President
Kim Farina. Vice President
Lill Birdsall, Secretary
Linda Wight, Director
David Segal, Director
Chris Naldoza, Director

cc: Members, Yolo County Board of Supervisors
Karen Larsen, Director, Yolo County HHSA
Pat Blacklock, Yolo County Administrator
Brian Vaughn, Yolo County Public Health Director

RESPONSE:
The MHSA three-year planning process was started in May 2019 with a series of three monthly educational sessions through July 2019, followed by an extensive plan development process beginning in August 2019 and ending in January 2020. During this process over 500+ community residents and stakeholders representing a wide range of geographic and demographic communities participated in providing feedback to the plan. Their interests, priorities, and voice are represented in this plan. As a result, HHSA does not believe further delay in finalizing and implementing the plan is warranted at this time.

Furthermore, we believe additional delays beyond what has already happened as a result of COVID, risks undermining the broad community feedback that was received last fall and could jeopardize the timely implementation of new investments around expansion of Full Service Partnership (FSP) and K-12 school-based services at a time when they are in high demand due to the COVID pandemic.

Regarding program specific recommendations, HHSA will take each of these recommendations into consideration as they assess each of the programs in the new plan.

Fabian Valle

From: Xiaolong Li <xlpsyd@gmail.com>
Sent: Monday, July 13, 2020 8:03 PM
To: MHSA
Subject: Public comment for MHSA plan
Attachments: MHSAPublicCommentFormFY202 page 1.pdf; MHSAPublicCommentFormFY202 page 2.pdf

Here are the full comments/questions but I have attached them through the PDF form as well in 2 pages.

-p. 38 How does new MHSA plan to increase access and reduce waitlists? Would it be feasible to set up a text crisis line in addition to phone lines? How is Beacon access for people trying to access care through Beacon?
-p. 39 In what systems/locations are preventive services being implemented? Would requiring organizers of Picnic day, whole earth festival, farmer's market, any other festivals/large social gatherings to educate the community be feasible/helpful in terms of increasing outreach in large community events?
-p.51 Would walk-in services be provided through telehealth as well due to COVID?
-p.52 Will the budget for any services need to be adapted because of the pandemic and clinicians working from home? I could see it could cut costs because of decreased need for office space/maintenance vs. increased costs of making working from home feasible for clinical/support staff? Would there be an increased telehealth budget to make telehealth possible for other services as well?
-p. 59 Is there a way to make the same promotores program for LGBTQ+, black, indigenous, and asian americans?
-p. 64 Who in the community are being trained for early signs training and assistance programs?
-p. 67 Is non-evaluative cultural humility supervision/consultation available for clinicians? I've found this helpful is increasing my cultural humility more than trainings have. The non-evaluative piece means the supervisor/other members of the consultation group do not have an evaluative role for any of the group's clinicians
-p.71 In the new EMR, is there a way of implementing tracking outcome data and pulling data in batches for future program evaluation research?
-p.75 Is there a way to increase funding of pre/post masters and pre/post doctoral training programs? This could decrease costs, increase access, and improve ability to recruit, train, and retain quality providers for the county.

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RESPONSE:
HHSA has rolled out walk in clinics in all three Yolo County cities open business hours this Fiscal Year to increase both community and existing client access. HHSA has no waitlists for services. Text communication with client is used already by various treatment teams, however text crisis lines often negatively impact low income clients who either lack phones or have to pay/use limited data to send/ receive texts. The County has been exploring with the state, ways to secure mobile devices for certain clients to increased access to treatment and supports during COVID and afterwards. We consistently refer to Beacon and have an open line of communication with them for referrals between HHSA and them. HHSA also intends to increase access with the addition of Nurse Practitioners through Tele-Mental Health Services, modifications in the Mental Health Crisis Service and Crisis Intervention Team, and new prevention and early intervention through the College and K-12 School Partnership to highlight a few areas in the plan.

Early Signs provides training to providers, individuals, and other caregivers who live or work in Yolo County. The MHSA Cultural Competency program intends to expand outreach, linkages, and trainings to diverse groups/populations within Yolo County.

HHSA is in the process of selecting a Business Intelligence software tool which will allow detailed batch reports to utilize for evaluation.

Yolo County is part of a renewed 5-year WET program at the state level in which we will be given funds over the next 5 years for this specific strategy. The Central Regional WET Partnership program will be developed further upon successful regional partnership funding outcome.

Fabian Valle

From: g_bourne@sbcglobal.net
Sent: Thursday, July 16, 2020 4:21 PM
To: MHSA
Cc: 'rick moniz'; 'Rick Heubeck'; 'Petrea Marchand'; 'Sumit Sen'; 'Aquilla Sellew'
Subject: Comments on MHSA and Mental Health Initiatives in Yolo County
Attachments: MentalHealth_LetterofSupport_071620.pdf

Greetings --- please find attached a letter of support for extending the public review and comment period for the MHSA. In addition, we are part of an initiative to help support other aspects of mental health awareness and services in Yolo County and our letter addresses that as well. We look forward to working with Yolo County leaders to expand the understanding of mental health issues and supports in our community – and to get more people engaged on these important issues.

Thank you for considering our request.

Best regards,

Greg Bourne (on behalf of UCC and the coordinating team for mental health week 2020 activities)

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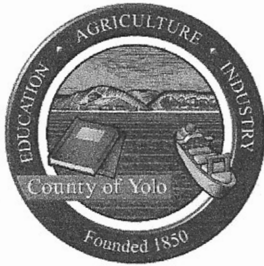

COUNTY OF YOLO

Health and Human Services Agency

Mental Health Services Act (MHSA) 30-Day Public Comment Form

Public Comment Period—Friday June 19, 2020 through Monday July 20, 2020

Document Posted for Public Review and Comment:

MHSA Three-Year Program & Expenditure Plan FY 2020-2023

This document is posted on the Internet at:
http://www.yolocounty.org/mhsa

PERSONAL INFORMATION (optional)

Name: ______________________

Agency/Organization: ______________________

Phone Number: ______________ Email address: ______________

Mailing address: ______________________

What is your role in the Mental Health Community?

_____ Client Consumer

_____ Family Member

_____ Educator

_____ Social Services Provider

_____ Mental Health Services Provider

_____ Law Enforcement/Criminal Justice Officer

_____ Probation Officer

X Other (Specify) Church

Please write your comments below:

If you need more space for your response, please feel free to submit additional pages.

Please see the attached letter directed to the County Board of Supervisors. Thanks for the opportunity to comment on this important issue.

Please return your competed comment form to HHSA/MHSA before 5:00 P.M. on Monday July 20, 2020 in one of two ways:

- Scan and Email this completed form to MHSA@yolocounty.org, Subject: MHSA Plan Draft for FY 2020-2023 Comments
- Mail this form to HHSA/MHSA, Attn: MHSA Coordinator, 25 N. Cottonwood St., Courier #16CH, Woodland, CA 95695.

Dear Yolo County Board of Supervisors:

University Covenant Church (UCC) wishes to commend the County for enhancing its support for mental health services for Yolo County families. Along with other churches and members of the community we have recognized for some time the need to ramp up services and support for those encountering mental illness, and their families.

Beginning with a fundraising event last year supported by Supervisors Saylor and Provenza, members of UCC's Local Missions team has been meeting with representatives of NAMI, the Save Pine Tree Gardens Committee (SPTG) and Supervisor Saylor's office to explore ways the faith community, and community at large, might engage more effectively in support of those encountering mental health issues in Davis and the surrounding area. We are now in the process of forming a Coordinating Team with representatives of various organizations to help develop a series of events this fall to bring more community-wide attention to the mental health needs of families in our community. We plan to work closely with public officials in Yolo County to make these events as successful as possible.

In addition, we wish to add our support for the appeal from the Save Pine Tree Gardens Committee to extend the public review process associated with the development of the MHSA Three-Year Plan. Given the understandable delays, we support extending the public review process, as suggested by SPTG, through August to allow adequate time to address any ideas offered or concerns raised.

Please contact me if you have any questions. We look forward to being part of efforts to enhance mental health services and support for families in Davis and Yolo County.

Rev. Sumit Sen
University Covenant Church
sumit@ucov.com

315 mace blvd :: davis, ca 95618
530.756.3923 :: 530.756.4511 fax
www.ucov.com

RESPONSE: The MHSA three-year planning process was started in May 2019 with a series of three monthly educational sessions through July 2019, followed by an extensive plan development process beginning in August 2019 and ending in January 2020. During this process over 500+ community residents and stakeholders representing a wide range of geographic and demographic communities participated in providing feedback to the plan. Their interests, priorities, and voice are represented in this plan. As a result, HHSA does not believe further delay in finalizing and implementing the plan is warranted at this time.

Furthermore, we believe additional delays beyond what has already happened as a result of COVID, risks undermining the broad community feedback that was received last fall and could jeopardize the timely implementation of new investments around expansion of Full Service Partnership (FSP) and K-12 school-based services at a time when they are in high demand due to the COVID pandemic.

Fabian Valle

From: Linda McCumber <mccumber.peace@gmail.com>
Sent: Saturday, July 18, 2020 3:02 PM
To: MHSA
Subject: MHSA Plan Draft for FY 2020-2023 Comments
Attachments: showdocument.pdf

Please review my comments.

Linda L McCumber
(530) 666-2778 (Home)

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COUNTY OF YOLO

Health and Human Services Agency

Mental Health Services Act (MHSA) 30-Day Public Comment Form

Public Comment Period—Friday June 19, 2020 through Monday July 20, 2020

Document Posted for Public Review and Comment:

MHSA Three-Year Program & Expenditure Plan FY 2020-2023

This document is posted on the Internet at:
http://www.yolocounty.org/mhsa

PERSONAL INFORMATION (optional)

Name: Linda L. McCumber

Agency/Organization:

Phone Number: 530-666-2778 (Home) Email address: mccumber.peace@gmail.com

Mailing address: 159 Glacier Street Woodland, CA 95695

What is your role in the Mental Health Community?

	Client Consumer		Mental Health Services Provider
Parent	Family Member		Law Enforcement/Criminal Justice Officer
	Educator		Probation Officer
	Social Services Provider		Other (Specify)

Please write your comments below:

If you need more space for your response, please feel free to submit additional pages.

As a parent of a love one (my son) that is living with a severe Mental Health Condition, I am very concerned about the lack of Resources Of "Long-Term Housing" In The New MHSA Yolo County's Three-Year Plan Proposal. Noted > " (New) Peer-Run Housing" Purchasing a home so out of county placements of Yolo County Clients can be relocated back into their own County for their living and program resourses > This is excellent and a very good goal and plan!!!
In addition > **Yolo County strongly needs to support with financial resources the current two residental homes in Davis > "Pine Tree Gardens West and Pine Tree Gardens East!!! Currently, they are struggling for financial resources and our Yolo County needs them to remain open and functioning for our Yolo County Residents with Mental Health Issues. Professionals and the Clients have worked so very hard for the "goal" of living in these two programs. They have come too far in their " Wellness Program" to be shut out. Please Help!!!

Please return your competed comment form to HHSA/MHSA before 5:00 P.M. on Monday July 20, 2020 in one of two ways:

- Scan and Email this completed form to MHSA@yolocounty.org, Subject: MHSA Plan Draft for FY 2020-2023 Comments
- Mail this form to HHSA/MHSA, Attn: MHSA Coordinator, 25 N. Cottonwood St., Courier #16CH, Woodland, CA 95695.

RESPONSE:
Given the existences of other funding streams available to support housing for those with mental illness, the county has prioritized local MHSA funds to support service delivery. These services include significant investments in staffing to support permanent supportive housing. Furthermore, in 2016, the state passed legislation that carved out a piece of local county MHSA funding (7%) specifically to fund No Place Like Home (NPLH) grants to support permanent supportive housing to mentally ill residents. There are 41 NPLH units located in West Sacramento and 29 units in Woodland, CA.

Over the course of the next three years several developments are planned, adding over 400 units for low/extremely low income individuals in Yolo County. More than half of these units are permanent supportive housing units which have services on site and available to residents. Some units are designated for persons experiencing homelessness but many are not. Some are also more short term in nature. We are prioritizing bringing people back to Yolo who have been placed elsewhere, whether that be an IMD or a Board and Care in another county along with the intended Peer-Run Housing Program. Pine Tree Gardens funding is included across the following: Adult Wellness Services, Pathways to Independence, and Older Adult Outreach and Assessment Programs.

In response to your comments regarding the Pine Tree Gardens homes, the County has invested a significant amount of resources into these homes including approximately $200,000 in repairs, $1,000,000 to purchase East House, and several hundred thousand dollars per year over the next three years to fund operations.

From:	Jonathan Raven
To:	MHSA
Cc:	Jon Home Email
Subject:	MHSA Plan Draft for FY 2020-2023 Comments
Date:	Sunday, July 19, 2020 9:30:03 AM
Attachments:	MHSA 3 year plan supp comments PDF.pdf MHSA 3 year plan public comment submission.pdf

Please confirm you received the Public Comment Form (below) as well as my supplemental comments (attached and below).

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Thank you.

Supplemental Comments (beyond space allocated on Public Comment Form)

I. THE TIMING OF THE RELASE OF THE DRAFT PLAN DID NOT ALLOW FOR SUFFICIENT TIME FOR A ROBUST REVIEW AND DISCUSSION

RECOMMENDATION: The Chairman of the Board of Supervisors put the vote on the Draft Plan on the agenda of the first meeting in September, a one month delay from the currently scheduled date.

The Draft Plan was released to the public on June 22, 2020. The period for public comments ends on July 21, 2020. Initially the Board of Supervisors (BOS) was going to meet on July 22 to vote – 1 day after public comments ended. At the urging of some LMHB members, in conjunction with a request from HHSA Director Karen Larsen, the vote was moved to August 4. The LMHB is scheduled to meet on July 27. This allows only one week for LMHB members to review the public comments and then only another week after the July 27 LMHB meeting to finalize its review prior to the August 4 BOS meeting.
I realize LMHB members and the public have had many months to provide input to the HHSA MHSA team. But it's impossible to adequately review the Draft Plan when one doesn't yet have the DraftPlan. I also realize we want to start funding programs included in the Draft Plan. The law allows for continuing programs to be funded even if the new Plan isn't yet adopted. About $46 million in the Draft Plan is dedicated to continuing programs. These programs would continue to be funded even if the vote is delayed. For the new programs ($14 million or 23% of the total), the spending would be delayed 1 month. That being said, in year 3 of the plan there will likely be considerably less funding due to reduced tax revenue as a result of COVID-19. The impact of a current year drop in revenue is not applied until 3 years later. One might suggest that the new programs should not be funded until year 2 since it's likely the

Plan will have less revenue in year 3 and these new programs may have to be discontinued. That would not be good.

II. LACK OF PERFORMANCE OUTCOMES AMD AND MEASURABLE RESULTS

RECOMMENDATION: The Draft Plan should be modified to include information for each plan (continuing and new) on achievement and performance outcomes and also set aside funding to have an expert conduct an independent review (on achievement and performance outcomes) of all programs. Additionally, the performance measures should be added to the Plan for continuing programs to see how successful these programs were in the last 3 years.

The Draft Plan does not include any performance outcome measures. The public, BOS and LMHB have never seen these measures for continuing programs during the past 3 years and the Draft Plan doesn't include this information. The Draft Plan also doesn't include how outcomes and performance will be measured in the next 3 years with continuing and new programs.
The MHSA 3-Year Draft Plan can allocate funding to retain an expert to conduct an independent Local Evaluation Plan. Nearly all public grants require the grantee to set aside a sizeable percentage of the grant to do this. This is not required by the MHSA guidelines but it is best practice. I have heard BOS members talk about performance measures numerous times at BOS meetings. This is an ongoing mantra in Yolo County. Why are we not requiring this in this $62 million Plan? To set aside a small percentage of the $62 million would provide us information on the success and achievements of each program and ultimately save money in the long run. We would know what programs shouldn't be funded in the next plan.

Welfare and Institutions code section 5848(c) states, "the plans SHALL include reports on the achievement and performance outcomes...." As stated, this required information has not been reported to the BOS, LMHB and public. And, this is not in the Draft Plan. To illustrate the importance of this, here are a few examples:

1. Adult Wellness is a continuing program funded in the Draft Plan at $18,205,939. The public, BOS or LMHB have not seen measureable results for the past 3 years and there's nothing in the Draft Plan on this topic. We have no way of knowing whether this program was a success or failure in the prior 3 years?
2. The same holds true for the continuing funding Community Based Drop-In Navigation Center at $2,533,200.
3. The same holds true for Tele-Mental Health at $2,347,632.

4. The same holds true for Pathways to Independent Living at $4,910,466.

5. Crisis Intervention Training (CIT) is a new program funded in the Draft Plan at $5,385,240, an increase of over $4 million from the 2017-2020 plan. Yet, the Draft Plan is silent on how this program will measure achievement and program outcomes.

6. Another new program is K-12 School Partnership at $3,300,000 million. Similar to CIT, the Draft Plan is silent on how this program will measure achievement and program outcomes.

7. Also, the new program Integrated Medicine into Behavioral Health at $1,808,000.

III. OTHER COMMENTS AND FEEDBACK (some of these may be geared to the 2024-2028

Plan)

1. Can we include other agencies and individuals, in addition to HHSA staff, in the funding decisions (see p. 36 of the Draft Plan)?

2. Can we include other agencies and individuals, in addition to HHSA staff, in the "Informant Interviews" (See p 37 of Draft Plan)?
3. Can we do a better job of socializing and providing notice to the public of the 30-day comment period for the Draft Plan such as utilizing local newspapers, social media platforms, public service announcements, social media platforms of partner agencies? Maybe some of these things were done and I didn't see it.

4. Only 3.14% of the Draft Plan funds essential and necessary "Services" to those suffering from a serious mental illness, while 34.49 % goes to "Youth" programs. Funding youth programs is important but these percentages seem out of proportion to some degree.

5. It seems very challenging to submit public comments. The directions require one to scan the document as a pdf and email it. Do those with lower socio-economic status have scanners? What about the older population? Will this not create challenges for them? It says you can snail mail comments. Does that mean that if the mail is postmarked on July 20, it will be considered? That, of course means that public comments will not be completed until 3-4 days after July 20 to allow for snail mail.

Thank you for taking the time to review, consider, and hopefully implement these comments and suggestions. Currently, the 3-Year Plan is a "Draft Plan," implying changes and modifications can still be made.

COUNTY OF YOLO

Health and Human Services Agency

Mental Health Services Act (MHSA) 30-Day Public Comment Form

Public Comment Period—Friday June 19, 2020 through Monday July 20, 2020

Document Posted for Public Review and Comment:

MHSA Three-Year Program & Expenditure Plan FY 2020-2023

This document is posted on the Internet at:
http://www.yolocounty.org/mhsa

PERSONAL INFORMATION (optional)

Name: Jonathan Raven

Agency/Organization: ____________________

Phone Number: ____________________ Email address: jonathan.raven@sbcglobal.net

Mailing address: ____________________

What is your role in the Mental Health Community?

_____ Client Consumer
_____ Family Member
_____ Educator
_____ Social Services Provider
_____ Mental Health Services Provider
_____ Law Enforcement/Criminal Justice Officer
_____ Probation Officer
X Other (Specify) multiple roles

Please write your comments below:

If you need more space for your response, please feel free to submit additional pages.

I realize a tremendous amount of time and energy was invested in creating this Draft MHSA 3-year plan. I was particularly impressed with the focus groups (some of which I attended), the program on tele-psychiatry, and the art included in the plan from those with lived experience.

That being said, the Draft Plan calls for the expenditure of over $60 million tax payer dollars so it's critical that those reviewing the Draft Plan have sufficient time to scrutinize it adequately before it becomes the FINAL MHSA 3-year Plan. Additionally, the Draft Plan doesn't include "achievement and performance outcomes," as required by law. Following are some brief comments with constructive feedback. PLEASE SEE ATTACHED PAGES.

Please return your competed comment form to HHSA/MHSA before 5:00 P.M. on Monday July 20, 2020 in one of two ways:

- Scan and Email this completed form to MHSA@yolocounty.org, Subject: MHSA Plan Draft for FY 2020-2023 Comments
- Mail this form to HHSA/MHSA, Attn: MHSA Coordinator, 25 N. Cottonwood St., Courier #16CH, Woodland, CA 95695.

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Thank you for taking the time to review, consider, and hopefully implement these comments and suggestions. Currently, the 3-Year Plan is a “Draft Plan,” implying changes and modifications can still be made.

RESPONSE:
The MHSA three-year planning process was started in May 2019 with a series of three monthly educational sessions through July 2019, followed by an extensive plan development process beginning in August 2019 and ending in January 2020. During this process over 500+ community residents and stakeholders representing a wide range of geographic and demographic communities participated in providing feedback to the plan. Their interests, priorities, and voice are represented in this plan. As a result, HHSA does not believe further delay in finalizing and implementing the plan is warranted at this time.

Furthermore, we believe additional delays beyond what has already happened as a result of COVID, risks undermining the broad community feedback that was received last fall and could jeopardize the timely implementation of new investments around expansion of Full Service Partnership (FSP) and K-12 school-based services at a time when they are in high demand due to the COVID pandemic.

Regarding program evaluation and data, HHSA acknowledges it can do better with evaluating MHSA program outcomes. This is not unique to Yolo county and is a statewide issue, as counties have prioritized service delivery over additional administrative support costs. Nonetheless, HHSA understands the importance of investing in program evaluation and quality improvement, and therefore has already begun implementing Results Based Accountability (RBA) measures for all MHSA contracts and funded programs and will continue to do so with the new plan. Furthermore, HHSA has set aside funding in the new plan to bring in outside support to help with program evaluation and outcome assessments. HHSA is making edits to the plan to highlight these evaluation activities. Please see Yolo County MHSA Profile, page 94, for demographics and data on residents served, FSP outcomes, and prevention and early intervention programs. HHSA regularly reports outcomes to BOS and LMHB regarding several MHSA programs but not all.

The increase in the Mental Health Crisis Service and Crisis Intervention Team Training is an investment for the crisis continuum as a whole. A Co-responder model for all three cities, collaboration with Law Enforcement Agencies, 24/7 access line, Hospital and community crisis response is included here, as is CIT. Costs associated with CIT for the next 3 years, which will now be delivered by existing HHSA staff are budgeted at the same amount of $50,000 but are just not broken out separately from the Crisis Service program like they were in the prior plan, as the training is no longer contracted out.

MHSA can always improve on information dissemination. Furthermore, MHSA requested and encouraged partners and community stakeholders to promote the review of the draft plan and participation by posting and sharing with others and posted the Public Notices in both the Daily Democrat and the Davis Enterprise and by social media. All mailed comments postmarked by July 20th will be included up to the scheduled Public Hearing.

From: Richard Bellows
To: MHSA
Subject: Fwd: Feedback on 2020-2023 Yolo County Mental Services Act 3 Year Program Draft
Date: Sunday, July 19, 2020 11:29:11 AM

Please confirm receipt of this email.

Begin forwarded message:

From: Richard Bellows <bellows_richard_j@sbcglobal.net>
Subject: Feedback on 2020-2023 Yolo County Mental Services Act 3 Year Program Draft
Date: July 18, 2020 at 12:38:41 PM PDT
To: Karen Larsen <Karen.Larsen@YoloCounty.org>, Christina Grandison <Christina.Grandison@yolocounty.org>, "Brian.Vaughn@yolocounty.org" <Brian.Vaughn@YoloCounty.org>

All,

Please forward as appropriate. I could not find who was designated to receive feedback.

Feedback on 2020-2023 Yolo County Mental Services Act 3 Year Program Draft

I have concerns in three areas:

<!--[if !supportLists]-->**1.** <!--[endif]-->**Weak Goal Setting:** Many of the goals are generic! Modern business practice increasingly uses SMART Goals. SMART is an acronym for Specific, Measurable, Achievable, Relevant and Time-based. Organizations have a centuries long history of goal setting on 1 year, 3 year and 5 year schedules. Many goals get repeated year after year after year with little real or measurable progress. There are many admirable goals in this plan but none are SMART. I strongly urge the draft to convert as many goals as possible to the SMART format. There are many online resources.

<!--[if !supportLists]-->**2.** <!--[endif]-->**Clear Definition of What is New:** How many new personnel will be hired or what existing personnel be reassigned. Many of these activities are needed for mental health services across the country. Will HHSA bring in **evidence-based** programs and training to institute change or will the department be **re-inventing the wheel**?

<!--[if !supportLists]-->**3.** <!--[endif]-->**Strange Classifications:** The Mental Health Crisis Service and Crisis intervention Team Training is classified as **new**. The department had been sponsoring CIT training for over a decade. That should be classified as continuing. The Maternal Mental Health Access Hub will be servicing **adults 60+.** How many of the 60+ population in Yolo County suffer from post-partum depression? Is this a real need? **Maybe I was a new mother at**

60+, I might suffer from depression!!!

Pros:

<!--[if !supportLists]-->1. <!--[endif]-->I realize that there are many aspects to this proposal with a large range of activities. Much of the descriptive material is fine.

<!--[if !supportLists]-->2. <!--[endif]-->The range and scope of the community involvement is outstanding as compared to previous years.

Richard Bellows
208 Cypress Drive
Woodland, CA 95695
(530) 668-7981 (h)
(530) 908-0681 (c)

Richard Bellows
208 Cypress Drive
Woodland, CA 95695
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COUNTY OF YOLO

Health and Human Services Agency

Mental Health Services Act (MHSA) 30-Day Public Comment Form

Public Comment Period—Friday June 19, 2020 through Monday July 20, 2020

Document Posted for Public Review and Comment:

MHSA Three-Year Program & Expenditure Plan FY 2020-2023

This document is posted on the Internet at:
http://www.yolocounty.org/mhsa

PERSONAL INFORMATION (optional)

Name: Richard Bellows

Agency/Organization: Local Mental Health Board

Phone Number: 530-668-7981 Email address: bellows_richard_j@sbcglobal.net

Mailing address: 209 Cypress Drive, Woodland, CA 95695

What is your role in the Mental Health Community?

____	Client Consumer	____	Mental Health Services Provider
✓	Family Member	____	Law Enforcement/Criminal Justice Officer
____	Educator	____	Probation Officer
____	Social Services Provider	✓	Other (Specify) LMHB member

Please write your comments below:

If you need more space for your response, please feel free to submit additional pages.

see attachment

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This was my feedback on the MHSA Plan. I sent it to Karen, Christina, Brian Vaughn & Nicki King. Today, someone sent me this form. Please acknowledge its receipt.

Feedback on 2020-2023 Yolo County Mental Health Services Act 3 Year Program Draft

I have concerns in three areas:

1. **Weak Goal Setting:** Many of the goals are generic! Modern business practices increasingly use SMART Goals. SMART is an acronym for Specific, Measurable, Achievable, Relevant and Time-based. Organizations have a centuries long history of goal setting on 1 year, 3 year and 5 year plans. Many goals get repeated year after year after year with little real or measurable progress. There are many admirable goals in this plan but none are SMART. I strongly urge the draft to convert as many goals as possible to the SMART format. There are many online resources for SMART goals..

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Pros:

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2. The range and scope of the community involvement is outstanding as compared to previous years.

Richard Bellows, July 18, 2020

LMHB Member

530-668-7981

RESPONSE:
Regarding program goals, evaluation, and data, HHSA acknowledges it can do better with evaluating MHSA program goals and outcomes. This is not unique to Yolo county and is a statewide issue, as counties have prioritized service delivery over additional administrative support costs. Nonetheless, HHSA understands the importance of investing in program evaluation and quality improvement, and therefore has already begun implementing Results Based Accountability (RBA) measures for all MHSA contracts and funded programs and will continue to do so with the new plan. Furthermore, HHSA has set aside funding in the new plan to bring in outside support to help with program evaluation and outcome assessments. Please see Yolo County MHSA Profile, page 94, for demographics and data on residents served, FSP outcomes, and prevention and early intervention programs.

In terms of identifying new investments, the program descriptions include an indication if the program is new, continuing, a modification, or a combination.

Administration funding provides for staff time across HHSA to support MHSA components by respective responsibilities (eg. Fiscal administration, Management, and Oversight).

The Maternal Mental Health Access Hub intends to provide mental health services and support for all individuals serving in a maternal and/or child caregiver role.

Fabian Valle

From: Nicki King <divabyday@gmail.com>
Sent: Sunday, July 19, 2020 4:58 PM
To: MHSA
Cc: Nicki King
Subject: MHSA Plan Comments
Attachments: unnamed document.pdf

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PERSONAL INFORMATION (optional)

Name: Nicki King

Agency/Organization: LMHB

Phone Number: 530-304-6787 Email address: divabyday@gmail.com

Mailing address: 4318 Vista Way, Davis, CA

What is your role in the Mental Health Community?

_____ Client Consumer
x Family Member
x Educator
_____ Social Services Provider
_____ Mental Health Services Provider
_____ Law Enforcement/Criminal Justice Officer
_____ Probation Officer
_____ Other (Specify)__________________

Please write your comments below:

If you need more space for your response, please feel free to submit additional pages.

The plan as currently constituted has two major omissions:

1. There is no specific evaluation plan for any of the component activities. In fact, ALL of the activities need specific evaluation efforts. Without these, how will the community (or the Department) know if these projects and programs are having the desired effect (e.g., reducing homelessness, reducing re-hospitalization, improving recovery prospects, etc.)? These evaluations should be performed by outside evaluators who begin their activities when the plan begins, so that mid-course corrections are possible.
2. The spending plan is not mapped to the needs identified in the Community Outreach effort. It is recognized that the Plan itself is more of a spending proposal that probably responds to MHSAOAC guidelines, but without a "crosswalk" from the

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RESPONSE:
Regarding program evaluation and data, HHSA acknowledges it can do better with evaluating MHSA program outcomes. This is not unique to Yolo county and is a statewide issue, as counties have prioritized service delivery over additional administrative support costs. Nonetheless, HHSA understands the importance of investing in program evaluation and quality improvement, and therefore has already begun implementing Results Based Accountability (RBA) measures for all MHSA contracts and funded programs and will continue to do so with the new plan. Furthermore, HHSA has set aside funding in the new plan to bring in outside support to help with program evaluation and outcome assessments. HHSA is making edits to the plan to highlight these evaluation activities. Please see Yolo County MHSA Profile, page 94, for demographics and data on residents served, FSP outcomes, and prevention and early intervention programs.

HHSA is currently updating the plan to provide additional information to better illustrate the connection between the community feedback and program investments.

Fabian Valle

From: David Segal <therealprofdave@gmail.com>
Sent: Monday, July 20, 2020 12:02 AM
To: MHSA
Cc: David Segal; Sara Venturini
Subject: MHSA Plan Draft for FY 2020-2023 Comments
Attachments: MHSAPublicCommentFormFY2020_SEGAL.pdf

Dear MHSA review committee,
Please find my completed Public Comment Form attached.
Please let me know if there was any problem opening the document.
Thanks.
- David Segal
1406 Redwood Lane
Davis, CA 95616

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PERSONAL INFORMATION (optional)

Name: David J. Segal

Agency/Organization: Private citizen

Phone Number: ____________ Email address: therealprofdave@gmail.com

Mailing address: 1406 Redwood Lane, Davis, CA 95616

What is your role in the Mental Health Community?

_____ Client Consumer
_X_ Family Member
_____ Educator
_____ Social Services Provider
_____ Mental Health Services Provider
_____ Law Enforcement/Criminal Justice Officer
_____ Probation Officer
_____ Other (Specify)____________

Please write your comments below:

If you need more space for your response, please feel free to submit additional pages.

Please save my brother, Evan Segal. I have just recently learned that the draft 2020-23 MHSA Plan will defund all $3.7M of the Adult Residential Treatment Program (Pacifico). My brother is a tenant in the Pacifico complex in Davis through a program with YCCC. He has had issues with mental health for a long time. When the mental health center in Westchester, NY decided to stop treating him, they put him in a van and dropped him outside a homeless shelter. Thanks to some friends, we helped move him closer to me in Davis, CA. I am the only family he has left. He is kind and respectful. He did not like Pacifico or the people who lived there, but it was the only place he could live. Please, is Yolo County going to throw him out on the street again? He is 56 years old. Where will he go? I am trying to look out for him. I did not know this could happen. Can you tell me what will happen to him and all the others if Pacifico is closed? Please help. I am happy to be contacted.

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RESPONSE: Thank you for your comment. The County is not pulling funding from Pacifico. In fact, the County attempted to invest MHSA dollars in Pacifico but was unsuccessful. HHSA Staff will follow up with you to discuss further.

Fabian Valle

From: Leslie Carroll <lacarrol@yahoo.com>
Sent: Sunday, July 19, 2020 4:30 PM
To: MHSA
Subject: MHSA Plan Draft for FY 2020-2023 Comments
Attachments: 2020-2023 MHSA Comments - Leslie Carroll.pdf

Dear MHSA Coordinator,

Please find attached, my comments regarding the 2020-2023 MHSA Plan Draft.

Thank you for your consideration.

Sincerely,
Leslie Carroll

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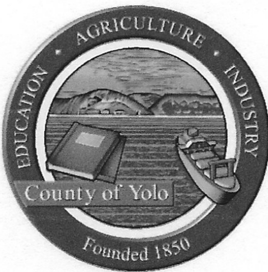

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Document Posted for Public Review and Comment:

MHSA Three-Year Program & Expenditure Plan FY 2020-2023

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PERSONAL INFORMATION (optional)

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What is your role in the Mental Health Community?

___ Client Consumer	___ Mental Health Services Provider
✓ Family Member	___ Law Enforcement/Criminal Justice Officer
___ Educator	___ Probation Officer
___ Social Services Provider	___ Other (Specify)________

Please write your comments below:

If you need more space for your response, please feel free to submit additional pages.

I HAVE A NUMBER OF QUESTIONS ABOUT THE 2020-2023 MENTAL HEALTH SERVICES ACT THREE-YEAR PLAN, ALONG WITH A REQUEST FOR INFORMATION. PLEASE SEE THE FOLLOWING TWO PAGES.

THANK YOU FOR YOUR ATTENTION.

SINCERELY,
Leslie Carroll

Please return your competed comment form to HHSA/MHSA before 5:00 P.M. on Monday July 20, 2020 in one of two ways:

- Scan and Email this completed form to MHSA@yolocounty.org, Subject: MHSA Plan Draft for FY 2020-2023 Comments
- Mail this form to HHSA/MHSA, Attn: MHSA Coordinator, 25 N. Cottonwood St., Courier #16CH, Woodland, CA 95695.

1. The Budget Summary in the PowerPoint 2020-23 Three-Year Program and Expenditure Plan presented by Brian Vaughn projected 2020-2023 expenses at $62,063,175 while the 2020-2023-Year Budget by component shows $55,272,283, a difference of almost $7M. Possible reasons could be administrative costs; prudent reserve contributions but an explanation can't be easily found in the 2020-23 MHSA plan. Please explain the difference. (Ref: Three-Year Plan Summary, 2020-2023 slides 15-18)

MHSA Component	**3 Year Budget 2020-2023**
CSS	$39,719,133
PEI	$10,535,827
INN	$1,953,000
Capital/Tech	$2,742,790
WET	$321,533
Total	$55,272,283

2. Why the big increases for the Adult Wellness ($8.6M), Pathways to Independence (TAY) ($3.2M) and the Older Adult Outreach/ Assessment ($2.1M) programs from the 2017-2020 MHSA 3-Year Plan?

   Adult Wellness Program
   2017-2020: $9,600,000 (2020-2023 MHSA Three Year Plan: pg 49-50
   2020-2023: $18,205,939 (2017-2020 MHSA Three Year Plan: pg 69-71
   TAY (Transitional Age Youth – ages 16-25)
   2017-2020: $1,785,000 (2020-2023 MHSA Three Year Plan: pg 63-65
   2020-2023: $4,910,466 (2017-2020 MHSA Three Year Plan: pg 56-57
   Older Adult Outreach/ Assessment
   2017-2020: $1,785,000 (2020-2023 MHSA Three Year Plan: pg 32-33
   2020-2023: $3,894,269 (2017-2020 MHSA Three Year Plan: pg 47-49

3. Please indicate how much money has been budgeted for the CIT program. . The previous cost for CIT, funded by MHSA was $50K/year for a 3-year cost of $150K. CIT is now part of Crisis Services program and has a budget of $5.38M for the next three years. As a result, it's impossible to understand how much the new CIT program will cost; especially given Yolo County will no longer use the previous contractor but will manage the program itself
   (2020-2023 MHSA Three Year Plan: pg 53-54)
   (2017-2020 MHSA Three Year Plan: pg 83-84)

4. Please give an estimate of how many clients will be served by the various programs as was done in the 2017-2020 MHSA Three-Year Plan.

5. While page 98 of the 2020-2023 plan lists outcomes for FSP clients, there's no indication of the effectiveness of the other continuing programs. Many of these programs have been in place for ten years or longer, more than enough time for a rudimentary evaluation. When can the community expect reporting on program effectiveness?

6. Housing and case management were top priorities for community members yet there are few programs which include these two programs. Why the disconnect between community priorities and the MHSA plan? Housing is essential for all of us but more so for someone living with a psychiatric disorder. The only housing in the plan is for 6 beds in a Peer-run residence.

   Currently case managers are only available for FSP clients, yet there are many others who need these vital services which can mean the difference between recovery/stabilization and relapse. Why can't the MHSA plan include case-management for select non-FSP clients?

7. The Save Pine Tree Gardens Committee has been told $3M has been allocated to the operator/s of Pine Tree Gardens. Another $1M was used to purchase one of the two houses. There's nothing in the 2020-23 MHSA Plan indicating the $3M allocation. Can this funding be included as a line item and iin the program description/s.

   Why were no funds available the last two years to help? How will the $3M be used? To pay North Valley Behavioral to operate Pine Tree Gardens? The current operators of both houses were doing this at no cost to the County.

8. We should be supporting the housing we have. Homestead Cooperative houses twenty-one Yolo County mental health clients. It desperately needs a full-time onsite social worker similar to the staffing at Cesar Chavez. At times the residents are living in a chaotic situation that causes some people to decompensate and need a higher level of care. In one case, a resident committed suicide after not getting the help he needed. There are rumors of people who scream throughout the night, drugs and other problems. An experienced social worker coming in every day could help make a difference for Homestead residents. Please consider funding a social worker position for Homestead by using whatever creative/collaborative means necessary.

RESPONSE:

1. The total projected expenditures in the plan budget = $62,063,175 which includes FY 19/20. See page 78.

2. These were highlighted priority areas in the planning process. The increase in budgeted for the TAY, Adult and OA programs are all due to both increased costs associated with each FSP slot for each of these age groups as well as the Counties plan to grow the number of spots into the next few years with a Forensic ACT team and No Place Like Home developments(also FSP slots). Further, clarification on MHSA regulations has allowed us to attribute more costs to serve FSP clients variety of needs for this plan than in prior years.

3. The increase in the Mental Health Crisis Service and Crisis Intervention Team Training is an investment for the crisis continuum as a whole. A Co-responder model for all three cities, collaboration with Law Enforcement Agencies, 24/7 access line, Hospital and community crisis response is included here, as is CIT. Costs associated with CIT for the next 3 years, which will now be delivered by existing HHSA staff are budgeted at the same amount of $50,000 but are just not broken out separately from the Crisis Service program like they were in the prior plan, as the training is no longer contracted out.

4. HHSA expects to increase services throughout the community in each of these programs in line with what we heard from the community was an unmet need. We anticipate a dramatic increase in FSP, close to doubling, to support the No Place Like Home developments as well as other populations. Increases in this area will also provide additional staff to provide support services for non-FSP clients.

5. HHSA acknowledges it can do better with evaluating MHSA program outcomes. This is not unique to Yolo county and is a statewide issue, as counties have prioritized service delivery over additional administrative support costs. Nonetheless, HHSA understands the importance of investing in program evaluation and quality improvement, and therefore has already begun implementing Results Based Accountability (RBA) measures for all MHSA contracts and funded programs and will continue to do so with the new plan. Furthermore, HHSA has set aside funding in the new plan to bring in outside support to help with program evaluation and outcome assessments. Please see Yolo County MHSA Profile, page 94, for demographics and data on residents served, FSP outcomes, and prevention and early intervention programs. Once the County receives FY19-20 year end data from all providers and internal programs by August 2020, a full outcomes report can be generated.

6. Given the existences of other funding streams available to support housing for those with mental illness, the county has prioritized local MHSA funds to support service delivery. These services include significant investments in staffing to support permanent supportive housing. Furthermore, in 2016, the state passed legislation that carved out a piece of local county MHSA funding (7%) specifically to fund No Place Like Home (NPLH) grants to support permanent supportive housing to mentally ill residents. There are 41 NPLH units located in West Sacramento and 29 units in Woodland,CA. Some units are designated for persons experiencing homelessness but many are not. Some are also more short term in nature. We are prioritizing bringing people back to Yolo who have been placed elsewhere, whether that be an IMD or a Board and Care in another county along with the intended Peer-Run Housing program. FSP programs provide case management services and the County does provide some case management services for non-FSP clients. Much of what will be provided at the navigation centers includes case management and linkage services. HHSA will include increased case management resources for non-FSP clients within the Adult Wellness Services Program. Additionally, we work with Beacon to provide ongoing therapy for clients who could benefit and are interested.

RESPONSE CONTINUED:

7. The County has invested approximately $200,000 of MHSA dollars over the last two years to repairs of the Pine Tree Gardens Homes. Additionally, the County just ensured the purchase of East House and a long term deed restriction utilizing $1 million of MHSA dollars. Furthermore, the County will be contracting with NVBH to cover the costs of operations for the coming three years which we expect to cost approximately$$800,000 MHSA dollars per year for both homes. Pine Tree Gardens funding is included across the following: Adult Wellness Services, Pathways to Independence, and Older Adult Outreach and Assessment Programs.

8. Through the state Mental Health Block Grant, we funded in FY19-20 and will again in FY20-21 a YCCC case manager to provide case management services at Homestead. Outcomes tracking from YCCC for FY19-20 showed these services were offered to all Homestead residents and this data will be shared once all outcome data has been pulled together.

From:	Nancy Temple
To:	MHSA; Karen Larsen; Brian Vaughn
Cc:	Nancy Temple
Subject:	Save PTG MHSA Comments ref Yolo County's draft 2020-2023 Three-Year Program and Expenditure Plan
Date:	Sunday, July 19, 2020 5:53:57 PM
Attachments:	Save PTG MHSA Comments ref Yolo Countys draft 2020-2023 Three-Year Program and Expenditure Plan.msg

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COUNTY OF YOLO

Health and Human Services Agency

Mental Health Services Act (MHSA) 30-Day Public Comment Form

Public Comment Period—Friday June 19, 2020 through Monday July 20, 2020

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Agency/Organization: ____

Phone Number: ____________________Email address: _____________________________

Mailing address: ____

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_____ Family Member

_____ Educator

_____ Social Services Provider

_____ Mental Health Services Provider

_____ Law Enforcement/Criminal Justice Officer

_____ Probation Officer

_____ Other (Specify)_________________

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Preserving sustainable, supported housing for Yolo County family members and friends living with serious mental illness.

To: Karen Larsen, Director, HHSA, Yolo County
Brian Vaughn, Community Health Branch Director, HHSA, Yolo County

From: Save Pine Tree Gardens Committee: Dorothy Callison, Mavonne Garrity, Phil Garrity, Petrea Marchand, Rick Moniz, Marilyn Moyle, Jeni Price, Cass Sylvia, Nancy Temple, Linda Wight, Kathy Williams-Fossdahl, Dian Vorters

RE: Questions and comments on Yolo County's draft 2020-2023 Three-Year Program and Expenditure Plan

Date: July 19, 2020

Thank you for the opportunity to provide comments on the Yolo County Mental Health Services Act 2020-2023 Three-Year Program and Expenditure Plan ("Three-Year Plan"). We greatly appreciate the hard work of you and your staff to engage with the community to develop this Three-Year Plan, especially with the additional stress and responsibilities added by the COVID-19 pandemic. We continue to urge you to postpone adoption of the Three-Year Plan until the September 1, 2020 Board of Supervisors meeting, as allowed by the Governor and the Legislature and requested in our July 13, 2020 letter (Attachment A) to ensure community and Local Mental Health Board questions and concerns are adequately addressed.

The Committee has eleven specific suggestions to change the plan and our Committee members have submitted questions separately. In general, we believe the MHSA Three-Year Plan does not adequately describe the link between the proposed expenditures and extensive and valuable feedback provided by the community, provide sufficient information to understand the rationale for programs and process of fund allocation, and provide performance measures to evaluate the past success of programs. It also does not fund a number of critical mental health services requested by the community.

We understand the time pressure your Department is under to move forward with new programs, but also understand there is significant pressure from the state to potentially use Mental Health Services Act (MHSA) funds for other purposes and/or to reduce the control counties have over expenditures. It is therefore critical that Yolo serve as model for the development of performance-based programs built with community feedback and support.

<u>Overview of Recommendations</u>

The Committee requests the following:

1. **Delay implementation of select new programs for up to one year to establish program descriptions, seek community feedback, and develop performance measures.** A delay of select programs for up to one year will ensure an efficient use of funds, provide a process for evaluating performance to guide program improvements in the future, allow the County time to establish a cash reserve policy for MHSA funds, reserve cash that can be used to fund programs if MHSA revenue declines in future years as a result of the recession, and free up funds for other important needs. The Committee does not recommend delaying the Crisis Services and Crisis Intervention Team or Peer-Run Housing.

2. **Establish a cash reserve policy.** Add an action to the MHSA Three-Year Plan to develop a clear cash reserve policy in the 2020-21 fiscal year, with input from the Local Mental Health Board and approval from the Board of Supervisors, and provide this policy in future Three-Year Plans to demonstrate how Yolo County will ensure three criteria are met: (1) spending MHSA resources so as to avoid reversion of funds while (2) meeting the needs in the County AND (3) maintaining a sufficient cash reserve to ensure that providers can be paid in a timely manner, unanticipated, short-term emergency needs can be met, and significant program cuts are not required at the end of three years.

3. **Set aside additional cash for the reserve.** Although the plan does not specifically provide the 2022-23 fund balance, the Committee calculated it as approximately $1.2 million, or 6% of annual operating expenses. The County should set aside additional funds consistent with the cash reserve policy to avoid cuts to programs if MHSA funds decline as a result of the recession.

4. **Establish measurable objectives and performance measures and include them in the Three-Year Plan.** The Committee recommends the County develop overall goals and measurable objectives for the entire MHSA program, as well as measurable objectives for each program (currently none of the program objectives are measurable), add the results of any existing performance measures to the Three-Year Plan prior to adoption, add a description of the proposed performance measurement process, set a deadline of June 30, 2021 to develop performance measures for the programs that do not have them, and create a line item and a program description in the plan to allocate significant resources to performance measurement and secure feedback from the community.

5. **Fund the housing data recommendations in 2019 Yolo County Board & Care Study.** The Committee recommends including funding in the Three-Year Plan to finance the recommendations related to collection of housing data for adults living with mental illness in the 2019 Yolo County Board & Care Study, which was paid for with MHSA funds. The information collected about housing data should also include a summary of all funding sources used for housing outside of MHSA and housing under construction with those funds.

6. **Fund case management services for non-FSP clients.** The Three-Year Plan states that case management services were one of the five key themes expressed by focus group attendees relevant to administrative services that need improvement. Quality case management services also can address the other four key themes where improvement is needed expressed by focus group attendees that include *Access, Transportation, Housing, Other Basic Needs and Predisposing Factors* (p. 38). The Committee has three specific requests related to improved case management: 1) provide information in Three-Year Plan proposed increase in funding for improved case management for FSP clients and/or provide increased funding; 2) provide improved case management for non-FSP clients, in particular adults with serious mental illness (SMI) who are living at Adult Residential Facilities; c) fund wrap-around services at Adult Residential Facilities.

7. **Fund staff at Supportive Living Services in Yolo County, including Homestead Cooperative, and further develop partnerships with the nonprofits that fund programs at Supportive Living Services.** Homestead Cooperative and similar Supportive Living Services are an important community resource and need additional support and services from MHSA funds. The County should also develop partnerships with Davis Community Meals, Yolo Community Care Continuum, and the Community Housing Opportunities Commission to identify priorities for Supportive Living Services managed by these nonprofits, including providing information generated from these partnerships to the Local Mental Health Board and the Board of Supervisors in every annual report on expenditure of MHSA funds.

8. **Allocate funding to purchase Pine Tree West.** Now that the County owns Pine Tree East, the County should also purchase Pine Tree West to ensure consistent management of the two homes.

9. **Provide more information about the $2 million in administration at HHSA in the Three-Year Plan.** For transparency, the Three-Year Plan should contain information about the number of positions, titles, salaries, MHSA duties, and whether the positions are fully or partially paid for with MHSA funds.

10. **Create a table to link community recommendations to programs.** With the current Three-Year Plan structure, it's impossible to link the community's recommendations to the programs proposed for funding. The Committee recommends creating a table similar to the attached (Attachment B) that demonstrates the link between the community's recommendations and the expenditures, as well as explains why some recommendations were not funded. The Committee has identified at least a dozen community recommendations listed in the Three-Year Plan that the Committee could not match up with a program based on the Three-Year Plan description. Either more information is needed to demonstrate how the community recommendation was addressed or an explanation as to why the recommendation was not funded should be provided for community review.

11. **Add a line item and program description for operation of Pine Tree East and West.** The County should provide a line item and program description for this $2.6 million expenditure, given it's a larger expenditure than some of the other programs that do have line items and program descriptions.

__Justification for Recommendations__

1. **Delay implementation of select new programs for up to one year to establish program descriptions, seek community feedback, and develop performance measures.** A delay of select programs for up to one year will ensure an efficient use of funds, provide a process for evaluating performance to guide program improvements in the future, allow the County time needed to establish a cash reserve policy for MHSA funds, and reserve cash that can be used to fund programs if MHSA revenue declines in future years as a result of the recession. It will also free up funds for other important needs over the next three years recommended by the Local Mental Health Board, including possible expenditures identified in this comment letter. The County is proposing to fund nine new programs for a total of $14 million over three years: Mental Health Crisis Service and Crisis Intervention Team (CIT) Training (3-year budget amount - $5,385,240), K-12 School Partnerships ($3,300,000), College Partnerships ($450,000), Cultural Competence ($2,572,221), Maternal Mental Health Access Hub ($300,000), Integrated Medicine Into Behavioral Health ($1,808,000), Crisis Now Learning Collaborative ($145,000), Peer-Run Housing ($250,000), and Central Regional WET Partnership ($85,000). Rather than fully fund all new programs in Year 1, the Committee suggests selecting appropriate programs and postponing them for up to one year to develop program descriptions, detailed budgets, and associated performance measures, as well as seeking Local Mental Health Board, Board of Supervisors, and community feedback on the structure prior to implementation in Year 2. The Committee does not recommend delaying the Crisis Service and Crisis Intervention Team Training or the Peer-Run Housing.

2. **Establish a cash reserve policy.** The Committee recommends adding an action to the MHSA Three-Year Plan to develop a clear cash reserve policy in the 2020-21 fiscal year, subject to approval by the Local Mental Health Board and the Board of Supervisors, and provide this policy in future Three-Year Plans to demonstrate how Yolo County will ensure it meets three criteria: (1) spending MHSA resources so as to avoid reversion of funds while (2) meeting the needs in the County AND (3) maintaining a sufficient cash reserve to ensure that providers can be paid in a timely manner, unanticipated, short-term emergency needs can be met, and significant program cuts are not required at the end of three years. The Save PTG recommends this policy because the County is currently proposing to use the majority of its cash reserve for expenditures on the new programs listed above, and have only a 6% cash reserve remaining at the end of 2022-23 (although this information is not directly provided, it can be inferred by the following information on page 76 and page 78):

   a. The total 19-20 project fund balance is $14,810,215 (p. 76)
   b. The plan projects $48,482,454 in revenue between FY 20-21 and FY 22-23 (p. 78)

c. The plan projects $62,063,175 in expenditures between FY 20-21 and FY 22-23 (p. 78)
d. The deficit is therefore $ 13,580,721.00 (calculated by subtracting c from b.
e. The 2022-23 fund balance is therefore $1,229,494 (calculated by subtracting d from a) for annual program expenditures of over $20 million, which is equal to 6%
f. The plan states there is only $514,069 in the prudent reserve (p. 76), but these funds can only be used with state Department of Mental Health approval so are not included in the cash reserve balance calculation

3. **Set aside additional cash for the reserve.** Although the plan does not specifically provide the 2022-23 fund balance, the Committee calculated it as approximately $1.2 million, or 6% of annual operating expenses. The County should set aside additional funds consistent with the cash reserve policy to avoid cuts to programs if MHSA funds decline as a result of the recession. Committee members directly experienced the severe impacts of the cuts to mental health programs funded by the Mental Health Services Act in 2008 and do not want this experience repeated again. The County ramped up hiring staff and contractors for new programs in 2006 (the Mental Health Services Act passed in 2004) and then had to lay people off and cut programs in 2008. County staff without seniority who had worked for two years to build new programs were laid off and County staff with seniority then were transferred to open positions in the Department, but not necessarily in their area of expertise. The result was a significant decline in mental health services.

4. **Establish measurable objectives and performance measures and include them in the Three-Year Plan.** The Committee recommends the County develop overall goals and measurable objectives for the entire MHSA program, as well as measurable objectives (currently none of the objectives are measurable) for each program, add the results of any existing performance measures to the Three-Year Plan prior to adoption, add a description of the proposed performance measurement process, set a deadline of June 30, 2021 to develop performance measures for the programs that do not have them, and create a line item and a program description in the plan to allocate significant resources to performance measurement. (Marin County's 2017-2020 Plan provides a good example of how to succinctly incorporate performance measures into the plan – see Attachment C.) WIC Section 5848 states:

> "the plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California."

The draft Three-Year Plan does not currently include measurable objectives or performance outcomes to indicate results of past years' expenditures. The County MHSA Profile, beginning on page 93, serves only as a quantitative summary of MHSA expenditures, and does not measure impact of MHSA services. According to Public Health Director Brian Vaughn during

a July 10th Zoom meeting with the Committee, this issue is not unique to Yolo County and his division is allocating resources for both staff and a consultant to develop performance measures in the coming years. This expenditure is not a line item in the Three-Year Plan, nor is there a description of the proposed performance measurement process, so it's difficult to evaluate the adequacy of both the proposal and the financial commitment to performance measurement.

5. **Fund the housing data recommendations in the 2019 Yolo County Board & Care Study.** The Committee recommends including funding in the Three-Year Plan to fund the recommendations related to collection of housing data for adults living with mental illness in the 2019 Yolo County Board & Care Study. The County used 2017-2020 MHSA funds to complete the April 2019 Yolo County Board & Care Study, authored by Resource Development Associates, which included the following relevant recommendations:

   - **Improve data collection capacity to track the needs of Yolo County consumers**. Yolo HHSA may want to look for options to capture data on the housing status of behavioral health consumers that is more robust and supports gaining an accurate picture of the magnitude of need in the County for various housing options. Specifically, the County may benefit from data on the number of consumers who are receiving full service partnership services and are homeless or in insecure housing settings; the number of consumers on waitlists for the County's mental health transitional homes; and hospitalization data with the number of high utilizers who subsequently end up on conservatorship following multiple community-based placement efforts (p. 17).

   - **Institute a continuous quality improvement process that uses housing data to assess community needs on a semi-regular basis.** As a component of a more robust data system, we recommend keeping track of the County's efforts to increase the supply of housing and continually reassess the need. This will allow the County to gauge whether new housing options are having a positive impact for their consumers and will provide an ongoing mechanism to reassess the need for new housing options.

   The Committee appreciates the County's response to the Committee's question about using MHSA funding to pay for housing for adults living with mental illness on July 17, 2020, stating "Given the existence of other funding streams available to support housing for those with mental illness, the county has prioritized local MHSA funds to support service delivery." The Committee still requests that the County collect this data, per the recommendations in the Board and Care Study, to better inform decisions about the type of housing needed for adults living with mental illness in Yolo County. The information collected about housing data should also include a summary of all funding sources used for housing outside of MHSA and housing under construction with those funds.

   Please see the example table below which addresses some of the following questions:

- What is the breakdown of slots/beds available for the different levels of housing? How many of each facility/program currently exist in Yolo County?
- How many slots/beds are currently available at each facility/program in Yolo County?
- What are the categories of clients who are eligible for services at each facility/program (e.g. FSP vs. Non-FSP, TAY, Elderly, etc.)?
- What amount and proportion of MHSA funds (direct or indirect) are going to each of the housing facilities?
- How many clients are housed in out-of-county facilities and at what level of housing?
- What information is available to assess whether supply of slots/beds at each level is adequate for the demand?
- Assuming supply is insufficient, to what extent is the MHSA plan addressing the gaps?
- What other funding sources are available for housing and/or currenty in use to address gaps?

					Populations Served						
	Max duration of stay	Facility Name	City	Total number of slots/beds	SMI	non-SMI	FSP	non-FSP	Adults (18-59 yo)	Elderly (>60yo)	Minors (<18yo)
Social Rehabilitiation Programs (AKA Community Residential Treatment Systems)											
Short-term Crisis Residential Programs	3 months	TBD	TBD	TBD	☐	☐	☐	☐	☐	☐	☐
Transitional Residential Treatment Programs	18 months	TBD	TBD	TBD	☐	☐	☐	☐	☐	☐	☐
Mental Health Rehabillitaition Centers (AKA Long-term Residential Programs)	3 years	The Farmhouse	Davis	TBD	☐	☐	☐	☐	☐	☐	☐
Board and Care Homes											
Adult Residential Facilities	Indefinite	Pine Tree Gardens West	Davis	15	☑	☐	☑	☑	☑	☐	☐
		Pine Tree Gardens East	Davis	13	☑	☐	☑	☑	☑	☐	☐
Residential Care Facilities for the Elderly	Indefinite	TBD	TBD	TBD	☑	☐	☐	☐	☐	☑	☐
Supportive Living Services											
Supportive Living Services	Indefinite	Homestead Cooperative	Davis	TBD	☐	☐	☐	☐	☐	☐	☐
	Indefinite	Cesar Chavez Plaza	Davis	TBD	☐	☐	☐	☐	☐	☐	☐

6. **Fund case management services for non-FSP clients.** The Three-Year Plan states that case management services were one of the five key themes expressed by focus group attendees relevant to administrative services that need improvement. Attendees found that case management services are an important tool in helping mental health clients navigate resources available to them (p. 38-39). Quality case management services also can address the other four key themes where improvement is needed expressed by focus group attendees that include *Access, Transportation, Housing, Other Basic Needs and Predisposing Factors* (p. 38). The Committee also contends quality case management that direct clients with serious mental illness (both FSP and non-FSP) to needed resources can save County funds by reducing hospitalizations, police interactions, and homelessness. Additionally, having enough case management and on-

site support to respond quickly to escalating symptoms and reduce the risk of acute episodes in the community is a strong way to address the Yolo County priority of reducing stigma. The Committee has two specific requests related to improved case management:

a. ***Provide information in the Three-Year Plan regarding the proposed increase in funding for improved case management for FSP clients and/or provide increased funding.*** The Committee could not find evidence of increased case management personnel in the plan for FSP clients. HHSA verbally informed the Committee the plan contains increased case management through increased services for FSP clients, but the specific information is lacking in the Three-Year Plan.

b. ***Provide improved case management for non-FSP clients.*** While the Committee supports increased case management for FSP clients, the Committee finds this client category too narrow. There are severely mentally ill clients in the County who are dependent on 24/7 care (and would be at risk for homelessness without that care) that do not fit the County's standard of FSP and these clients lack case management services. (See discussion of the Homestead Cooperative in Recommendation #7.) The Committee notes that until recently, there were no case management services for the non-FSP population The County has recently allowed a hybrid case management service for these individuals for whom case management is allowed for specific discreet services ordered by a County psychiatrist, rather than for the whole individual. These clients are underserved, and the Committee finds this seriously inadequate. We propose that comprehensive case management services be made available to non-FSP clients with SMI, in particular those clients living at Adult Residential Facilities including Pine Tree Gardens (East and West houses). These comprehensive services would be of the kind currently available to FSP clients in which each client is assigned to one case manager for their comprehensive needs. n overwhelming majority of residents at PTG are non-FSP clients, although they are adults with SMI who would be at relatively high risk for hospitalization, incarceration or homelessness if they were not supported in the ARF to ensure the maximum opportunity for stability. As such, the Committee advocates for comprehensive case management services for these clients and/or a revaluation of the process for designating FSP clients that takes into account the risk mitigation achieved by care provided at ARFs.

c. ***Fund previously available wraparound services for clients at ARFs (both FSP and non-FSP).*** The Committee suggests including the development of a public-private partnership with the Save Pine Tree Gardens Committee to restore funding for wrapround services for ARFS in Yolo County, funded in part with MHSA funds. The Williams Family Pine Tree Gardens program success was built around the model of providing independent living skills classes, job coaching, and job opportunities that allowed residents to learn the skills needed for residents to voluntarily move from Pine Tree Gardens to Supportive Living

Services. After the Williams Family transferred Pine Tree Gardens to Turning Point Community Programs, Turning Point let all of these programs lapse. These programs are a critical part of the support needed to help residents achieve their goals to live as independently as possible.

7. Fund staff at Supportive Living Services in Yolo County, including Homestead Cooperative, and further develop partnerships with the nonprofits that fund programs at Supportive Living Services. Homestead Cooperative and similar Supportive Living Services are an important community resource and need additional support and services from MHSA funds The County should also develop partnerships with Davis Community Meals, Yolo Community Care Continuum, and the Community Housing Opportunity Corporation to identify priorities for Supportive Living Services managed by these nonprofits, including providing information generated from these partnerships to the Local Mental Health Board and the Board of Supervisors in every annual report on expenditure of MHSA funds. Defined as "long-term, 24-7 oversight, independent living support services providing assistance in a minimally restrictive setting, no medication administration" on p. 5 of the 2019 Board and Care Study, these Supporting Living Services, such as Cesar Chavez Plaza and Homestead Cooperative, are a critical part of the care continuum for adults living with mental illness. Supportive Living Facilities with full-time social workers (e.g. Cesar Chavez Plaza, which has a full-time and a half-time social worker paid for by Davis Community Meals) provide successful outcomes, while supportive living services without full-time staff (e.g. Homestead Cooperative) are experiencing severe difficulties supporting the adults in residence. Specifically, the program "CSS Adult Wellness Alternatives Non-FSP" should include money for a full-time social worker at Homestead Cooperative. Homestead houses up to 21 Yolo County clients without support. Some of these residents are using drugs, screaming during the middle of the night, isolating themselves, expressing delusions, and otherwise decompensating as a result of not receiving the support they need. One resident died by suicide last year.

8. **Allocate funding to purchase Pine Tree West.** Now the County owns Pine Tree East, the County should also purchase Pine Tree West to ensure consistent management of the two homes. Although the Committee has heard that North Valley Behavioral Health (soon to be operating PTG East and PTG West and interested in the potential purchase of Pine Tree West), the Committee would prefer the County purchase Pine Tree West for two reasons: (1) NVBH has its home office in Yuba City, Sutter County, almost an hour drive from Davis, which makes building repairs a long distance endeavor, whereas Yolo County can more easily keep a concerned eye on the property along with PTG's sister house, PTG East; (2) the April 2019 Yolo County Board And Care Study recommends on page 16 "to de-couple owner and operator" "to contribute to the model successes."

9. **Provide more information about the $2 million in administration at HHSA in the Three-Year Plan.** HHSA answered the Committee's question about the $2 million allocated to administration

over three years as follows, "Administration funding provides for staff time across HHSA to support MHSA components by respective responsibilities (e.g. fiscal administration, management, oversight). For transparency, the Three-Year Plan should contain information about the number of positions, titles, salaries, MHSA duties, and whether the positions are fully or partially paid for with MHSA funds.

10. **Create a table to link community recommendations to programs.** With the current Three-Year Plan structure, it's impossible to link the community's recommendations to the programs proposed for funding. The Committee recommends creating a table similar to the attached (Attachment B) that demonstrates the link between the community's recommendations and the expenditures, as well as explains why some recommendations were not funded. The Committee has identified at least a dozen community recommendations listed in the Three-Year Plan that the Committee could not match up with a program based on the Three-Year Plan description. Either more information is needed to demonstrate how the community recommendation was addressed or an explanation as to why the recommendation was not funded should be provided for community review.

11. **Add a line item and program description for operation of Pine Tree East and West.** The County should provide a line item and program description for this expenditure, given it's a larger expenditure than some of the other programs that do have line items and program descriptions. The County has verbally confirmed to the Committee that the Three-Year Plan includes up to $2.6 million for operation of Pine Tree East and West, but more information is needed.

RESPONSE:

The MHSA three-year planning process was started in May 2019 with a series of three monthly educational sessions through July 2019, followed by an extensive plan development process beginning in August 2019 and ending in January 2020. During this process over 500+ community residents and stakeholders representing a wide range of geographic and demographic communities participated in providing feedback to the plan. Their interests, priorities, and voice are represented in this plan. As a result, HHSA does not believe further delay in finalizing and implementing the plan is warranted at this time.

Furthermore, we believe additional delays beyond what has already happened as a result of COVID, risks undermining the broad community feedback that was received last fall and could jeopardize the timely implementation of new investments around expansion of Full Service Partnership (FSP) and K-12 school-based services at a time when they are in high demand due to the COVID pandemic.

In regards to allocating additional MHSA funding for housing, the Community Engagement Workgroup (CEWG) was made aware that while it was a highlighted priority for the community, that other funding streams existed to support this priority beyond MHSA. Given the existence of other funding streams, the county has prioritized local MHSA funds to support service delivery as intended. These services include significant investments in staffing to support permanent supportive housing. Additionally, in 2016, the state passed legislation that carved out a piece of local county MHSA funding (7%) specifically to fund No Place Like Home (NPLH) grants to support permanent supportive housing to mentally ill residents. There are 41 NPLH units located in West Sacramento and 29 units in Woodland, CA.

Over the course of the next three years several developments are planned, adding over 400 units for low/extremely low income individuals in Yolo County. More than half of these units are permanent supportive housing units which have services on site and available to residents. Some units are designated for persons experiencing homelessness but many are not. Some are also more short term in nature. We are prioritizing bringing people back to Yolo who have been placed elsewhere, whether that be an IMD or a Board and Care in another county along with the intended Peer-Run Housing Program. Pine Tree Gardens funding is included across the following: Adult Wellness Services, Pathways to Independence, and Older Adult Outreach and Assessment Programs. FSP programs provide case management services and the County does provide some case management services for non-FSP clients. Much of what will be provided at the navigation centers includes case management and linkage services. HHSA will include increased case management resources for non-FSP clients within the Adult Wellness Services Program. Additionally, we work with Beacon to provide ongoing therapy for clients who could benefit and are interested.

Through the state Mental Health Block Grant, we funded in FY19-20 and will again in FY20-21 a YCCC case manager to provide case management services at Homestead. Outcomes tracking from YCCC for FY19-20 showed these services were offered to all Homestead residents and this data will be shared once all outcome data has been pulled together.

RESPONSE CONTINUED: Administration funding provides for staff time across HHSA to support MHSA components by respective responsibilities (eg. Fiscal administration, Management, and Oversight).All Administration Branch staff are all funded the same, the costs of the Admin branch are allocated across all branches of HHSA. The Admin branch costs are paid for by the funding sources that pay for the other branches. This includes Federal, State, grants, realignment, MHSA, County General Fund, Intergovernmental Transfers, and fee/permit revenue. The County already has policies on cash and reserves, see https://insideyolo2.yolocounty.org/departments/county-administrator/administrative-policies-procedures. DFS controls amendments to these policies. During FY19/20 HHSA proposed amending the policy on fund balances and reserves to DFS to include an MHSA reserve in accordance with WIC 5847 and 5892 and DHCS Information Notice 19-037, but then the pandemic hit. During FY20/21 HHSA will make attempts to reestablish these policy revisions as a priority for DFS.

Regarding program evaluation and data, HHSA acknowledges it can do better with evaluating MHSA program outcomes. This is not unique to Yolo county and is a statewide issue, as counties have prioritized service delivery over additional administrative support costs. Nonetheless, HHSA understands the importance of investing in program evaluation and quality improvement, and therefore has already begun implementing Results Based Accountability (RBA) measures for all MHSA contracts and funded programs and will continue to do so with the new plan. Furthermore, HHSA has set aside funding in the new plan to bring in outside support to help with program evaluation and outcome assessments. HHSA is making edits to the plan to highlight these evaluation activities. Please see Yolo County MHSA Profile, page 94, for demographics and data on residents served, FSP outcomes, and prevention and early intervention programs.

HHSA is currently updating the plan to provide additional information to better illustrate the connection between the community feedback and program investments.

Preserving sustainable, supported housing for Yolo County family members and friends living with serious mental illness.

July 13, 2020

Gary Sandy
Chair, Yolo County Board of Supervisors
Sent via electronic mail

Nicki King
Chair, Local Mental Health Board
Sent via electronic mail

RE: Request for extension of public process for MHSA three-year program and expenditure plan

Dear Chair Sandy and Chair King:

The Committee is writing to you as local stakeholders invested in the effective expenditure of MHSA funds to best serve members of our community living with mental illness with a request to utilize the flexibility granted in the 2020-21 state budget to extend the public process for development of Yolo County's Mental Health Services Act Three-Year Program and Expenditure Plan ("Three-Year Plan"). The Three-Year Plan allocates $60 million for programs and housing in Yolo County over three years, including a $14 million fund balance. The funding is revenue from a tax on millionaires, passed by voters in 2004 as Proposition 63, specifically for the purpose of helping people living with mental illness.

As you may know, the Governor signed AB 81 in July 2020, a budget trailer bill that includes the following language related to Mental Health Services Act three-year program and expenditure plan:

"This bill would authorize a county that is unable to complete and submit a 3-year plan or annual update for the 2020-21 fiscal year due to the COVID-19 Public Health Emergency to extend the effective timeframe of its currently approved 3-year plan or annual update to include the 2020-21 fiscal year. The bill would require a county to submit a 3-year program and expenditure plan or annual update to the commission and the department by July 1, 2021."

According to Public Health Director Brian Vaughn during a July 10, 2020 call with the Committee, the County normally releases the draft three-year program and expenditure plan in March, but release was understandably delayed until the end of June as a result of the COVID-19 pandemic. The Committee therefore requests changes to the public process to extend the public process,

which currently involves approval by the Local Mental Health Board at the July 20, 2020 meeting and approval by the Board of Supervisors at the August 4, 2020 meeting. The existing process does not make sense given the late release of the plan. Comments from the public are due on July 19th, yet the Local Mental Health Board is scheduled to approve one day later. This process leaves no time for Yolo County staff to make changes to the plan in response to comments. The adopted state budget provides the County with much-needed flexibility to extend the public process to address exactly such a situation caused by COVID-19. The Committee instead recommends the following process:

July 13th: Special Local Mental Health Board meeting to discuss MHSA Three-Year Plan

July 19th: End of 30-day public comment period

July 20th: Special Local Mental Health Board meeting to receive verbal public comments and review written public comments

August 20th: Yolo County staff release updated MHSA Three-Year Plan reflecting changes requested by community and Local Mental Health Board

August 27th: Yolo County staff review changes with Local Mental Health Board and Local Mental Health Board considers approval of Three-Year Plan

September: Board of Supervisors considers approval of Three-Year Plan

As established by WIC § 5848, all submitted comments must be reviewed by the LMHB so they can make recommendations to the County, as applicable, for revisions. The LMHB must approve any recommended revisions by a majority vote at a public hearing. This requirement indicates the need for the draft Three-Year Plan to be on the agenda on at least two separate Local Mental Health Board meetings: one to hear public comments on the draft Three-Year Plan and one to approve any recommended revisions. Giving the Local Mental Health Board the month of August will help ensure the proposed expenditures are closely aligned with community needs, which is a heavy emphasis in the MHSA process.

We understand the County cannot implement new programs proposed in the 2020-2023 Three-Year Plan if it is not approved by the Board of Supervisors, although they are able to continue with existing programs. This is precisely the point of the request to extend the deadline. The community and the Local Mental Health Board need additional information to understand these new proposed expenditures, as well as the proposed use of the $14 million fund balance. The Committee provided a list of 19 initial questions about the proposed Three-Year Plan to Public Health Director Brian Vaughn on July 10, 2020 and expects to have more questions as the Committee develops its comment letter.

The Save Pine Tree Gardens Committee is grateful for the proposal to expend MHSA funds in the Three-Year Plan to help operate the two Pine Tree Gardens houses, but the Three-Year Plan as a

whole does not provide sufficient information for the public to evaluate the proposed expenditure plan for three major reasons:

- **Lack of connection between the focus groups and other stakeholder feedback and the proposed Three-Year Plan**. Starting on page 32, the draft Plan describes the community outreach and education process, in which Save Pine Tree Gardens Committee members participated, including the community engagement workgroup and focus groups. Starting on page 37, the plan describes the needs identified as a result of the focus groups. Starting on page 4, there are proposed solutions from the community, including an exercise described on page 46 that gave the community the ability to prioritize funding. Yet for the goals and objectives for the three-year plan, starting on page 48, there are no connections for each goal and objective back to the community feedback. A glaring omission is the request from the community to allocate funding for housing for the mentally ill, which is also a topic that has come up frequently during conversations between the Yolo County Health and Human Services Agency and the Save Pine Tree Gardens Committee. The County may transfer up to 20 percent of the Community Services and Supports funding to Capital Facilities and Technology every year, but it is not clear whether the Three-Year Plan is transferring the amount needed for housing to these categories.

- **Insufficient information to understand the expenditures.** The Program Plan section, beginning on page 47, provides 1-2-page descriptions of allocations of up to $18 million over three years. These descriptions do not draw connections to community needs or provide information about the success of continuing programs. Additionally, multiple proposed budget amounts listed in the Program Plan section are not represented or are inconsistent with amounts listed in the budget sections, pages 76-93.

- **Lack of measurable outcomes and objectives.** WIC § 5848 states the plan shall include a report on the achievement of performance outcomes for MHSA services. The draft Plan does not include performance outcomes to indicate results of past years' expenditures. The County MHSA Profile, beginning on page 93, serves only as a quantitative summary of MHSA expenditures, and does not measure *impact* of MHSA services. According to Public Health Director Brian Vaughn during the July 10th Zoom meeting, this issue is not unique to Yolo County and his division is allocating resources for both staff and a consultant to develop performance measures in the coming years. This expenditure is not a line item in the plan, however, so it's difficult to evaluate the adequacy of this financial commitment to meet the need.

Given these issues and the flexibility provided by the state budget trailer bill to extend the public process, the Committee respectfully requests the Board of Supervisors and the Local Mental Health Board adopt an updated public process to allow more time for discussion of these important priorities.

Sincerely,

Dorothy Callison
Leslie Carroll
Mavonne Garrity
Phil Garrity
Brian Parker
Petrea Marchand
Marilyn Moyle
Jeni Price
Nancy Temple
Cass Sylvia
Linda Wight
Kathy Williams-Fossdahl
Dian Vorters
Rick Moniz

cc: Members, Yolo County Board of Supervisors
Pat Blacklock, Yolo County Administrator
Karen Larsen, Director, Yolo County Health and Human Services Agency
Brian Vaughn, Yolo County Public Health Director

Community Need				Three-Year Plan Program	Funding Category	New Program?	Descripion of Link to Community Comment
SERVICES							
	ACCESS						
		General					
			County should increase promptness of response to phone calls				
			Improved customer service/welcoming atmosphere				
			Service provision in preferred languages	Cultural Competence	PEI	New	
			Reduce long waitlists				
			Childcare support				
			Accessibility of hours				
		Transportation					
			Embed services where people are				
			Place services close to transit hubs				
			Increase transpotation options				
		Housing					
			Need for mental health housing	Peer-Run Housing	CFTN	New	
			Need for family housing				
			Increased resources and linkages to housing	Adult Wellness Services			
		Other Basic Needs					
			Food				
			Other basic needs				
		Predisposing Factors					
			Stress				
			Genetics				
			Racism				
			Affluence				
			Upstream forces				
	NAVIGATION						
		General					
			Increased connection to services	Early Childhood Mental Health Access and Linkage	PEI	Continuing	
			Improved knowledge of available services	Mental Health Professional Development	WET	Continuing	
			Simplifying and improving information on website	IT Hardware/Software/Subscriptions Services	CFTN	Continuing	
			Increasing County staff 's knowledge of the scope of services	IT Hardware/Software/Subscriptions Services, Mental Health Professional Development	CFTN, WET	Continuing, Continuing	
		Case Management					
			Improved case management services				

	INTEGRATED SERVICES						
		General					
			Need for integrated mental health, substance use and physical health services	Adult Wellness Services, Integrated Medicine into Behavioral Health	CSS, INN	Continuing, New	
			Need for accessibility within integrated services				
			Improved cooperation between departments	IT Hardware/Software/Subscriptions Services	CFTN	Continuing	
			Need for integrated services in schools, justice system, and other areas	K-12 School Partnerships	PEI	New	
	TELEHEALTH/MOBILE HEALTH						
		General					
			Need for distance support services	Tele-Mental Health Services	CSS	Continuing	
	RESPITE						
		General					
			Expanded respite care for people with mental health symptoms				
			Improved respite support for caregivers				
			Need for non-emergency crisis care and space	Community-Based Drop-In Navigation Center	CSS	Continuing	
	CRISIS RESPONSE						
		General					
			Need for crisis response services based in the community	Mental Health Crisis Service and Crisis Intervention Team Training, Crisis Now Learning Collaborative	CSS, INN	New/Modification, New	
	CLINICAL SERVICES						
		General					
			Increased clinical services for children and families	Children's Mental Health Services, Early Childhood Mental Health Access and Linkage Program	CSS, PEI	Continuing	
			Increased clinical services for houseless community members				
			Need for psychiatric services				
PREVENTION							
	EDUCATION						
		General					
			Expanded public education	Peer- and Family-Led Support Services	CSS	Continuing	
			Outreach to promote stigma reduction	Cultural Competence	PEI	New	
			Increase awareness of service availablity				

		Social Marketing/Media Campaigns					
			Need for strengths-based, destigmatizing messages				
	SUPPORT GROUPS						
		General					
			Provide broader basic prevention services				
			Targeted support groups for vulnerable populations	Senior Peer Counseling Program, Cultural Competence, Peer Workforce Development Workgroup	PEI, PEI, WET	Continuing, New, New	
			Targeted support groups for minorities	Cultural Competence	PEI	New	
		Peer Mentorship					
			Need for peer mentorship programs especially with young adults	Peer- and Family-Led Support Services, Community-Based Drop-In Navigation Center	CSS	Continuing	
	TRAINING						
		General					
			Need for community education on mental health symptons	Early Signs Training and Assistance	PEI	Continuing	
			Need for community education on crisis response	Early Signs Training and Assistance	PEI	Continuing	
			Specialized staff training on youth and family care	Early Signs Training and Assistance	PEI	Continuing	
			Specialized staff training on aging adult population care				
			Specialized staff training on disabled populations care				
			Training for first responders on de-escalation techniques	Mental Health Crisis Srevice and Crisis Intervention Team Training	CSS	New/Modification	
SPECIAL NEEDS POPULATION & CULTURAL COMPETENCY							
	STIGMA & CULTURAL COMPETENCY						
		Language					
			Use of language line by mental health staff				
			Increase language competence	Cultural Competence	PEI	New	

PROGRAM CONTINUATION	X	PROGRAM EXPANSION	X	NEW PROGRAM	

YOUTH EMPOWERMENT SERVICES (YES) FULL SERVICE PARTNERSHIP

PROGRAM OVERVIEW

Marin County's Youth Empowerment Services (YES) is a Full Service Partnership program (FSP) serving 40+ seriously high risk youth up to their twenty first birthday.

This program was originally implemented as a Children's System of Care grant in the late nineties. In FY2005-06 the Mental Health Services Act began supporting a major portion of the program which enabled the program to expand and hire Family Partners with lived experience with children who had been in the mental health system and/or the juvenile justice system.

The YES program aims to serve youth who do not have ready access to other mental health resources and are not typically motivated to seek services at more traditional mental health clinics. The YES model is a supportive, strengths based model with the goal of meeting youth and families in their homes and in the community to provide culturally appropriate mental health services with a 'whatever it takes' model, also known as wraparound services.

From beginning of the YES FSP program, notable outcomes include:

- Of youth with poor grades in the 12 months prior to enrollment or since enrollment in the FSP, 53% (n=72) demonstrated improvement in grades, with a 2.79 pre-enrollment average to 3.09 post-enrollment average.
- Of those with school attendance difficulties in the 12 months prior to enrollment or since enrollment in the FSP, 42% (n=166) achieved better attendance in the post FSP enrollment period.
- Of youth having been arrested in the 12 months prior to enrollment or since enrollment in the FSP, arrests following FSP enrollment decreased by 48% (n=52).
- For youth with school suspensions (n=139), rates since enrollment decreased by 93%.

TARGET POPULATION

YES serves youth up to age 21 who present with significant mental health issues that negatively affect their education, family relationships, and psychiatric stability which can often result in substance use. In FY2015-16 there were 43 unduplicated clients and most were under 18 (N=38, 88%) and male (N=25, 58%). Latino youth in particular made up the majority of the YES clients (N=35, 82%) followed by Caucasian/white (N=7, 16%). English was the preferred language for 88% of clients (N=37), while a large proportion of the parents preferred Spanish. Since FY2014-15 the YES Program has broadened the referral base beyond the original juvenile justice system to

include any seriously emotionally disturbed child or youth at risk for high end mental health services regardless of the system that originally served them.

PROGRAM DESCRIPTION

The YES model is a MHSA CSS strengths based model with the goal of meeting youth and families in their homes and in the community, in both the literal and figurative sense. The services incorporate a wraparound philosophy, utilizing a team approach to help families identify their needs and implement ways to address them successfully with on-going collaboration between clinicians, Family Partners and the child and family. Family Partners are parents who have had a child in the mental health or juvenile justice system and are able to engage and support the parent in a unique way because of their life experience, which a professional cannot. These partners provide support and guidance to parents in navigating the various systems and with parenting youth engaged in high-risk behaviors.

The YES program provides culturally appropriate mental health services, intensive case management, and psychiatric care, as well as collaboration with partner agencies (i.e., education, probation, drug court, etc.) to facilitate integrated care and ongoing family support. The FSP model includes the 'whatever it takes' philosophy which includes creative strategizing to maintain stability for clients and their families which may be supported by Flex Funds, to be used, for example, to support stable housing during a short term emergency. Flex Fund decisions are made by the wraparound team and must be in support of the mental health goals of the child and family as described in the Treatment Plan.

Latino youth continue to be over-represented in the juvenile justice system and at County Community School and in our Medi-Cal beneficiary population as a whole. Such clients with high needs are referred from schools or clinics or self-referred by a parent through our Access line. In FY2015-16 only two of the three clinical positions were filled so capacity was reduced. In FY2016-17 YES staffing consists of three (3) bilingual clinicians, one of whom is a Latino male working with students at Marin Community School, an alternative high school. This combination of YES staff provides both linguistic and cultural capability to address the diverse needs of the client population who face many challenges including trauma and environmental stressors. These clients have complex mental health issues on top of poverty, assimilation challenges, and the immigration status of other family members. However, the need for specialty mental health services for these children and youth with complex needs still outpaces the current staff resources.

PROPOSED PROGRAM EXPANSION

Goal: Expand the Youth Empowerment Services (YES) Full Service Partnership Program by 12 slots, from 40 to 52, by hiring an additional LMHP and a supervisor to accommodate the increasing need for intensive services for youth up to age 21 who present with significant mental health issues. Since these youth are not motivated to seek services in traditional mental health clinics a 'whatever it takes' individualized flexible treatment plan is at the heart of the approach for these youth. In addition some of these youth are experiencing first psychotic episodes and require intensive services early on with sufficient support of a full time supervisor in supporting evidenced based treatments for this vulnerable population. Since 82% of the YES youth identified as Hispanic in FY2015-16 it is highly desirable to provide increased cultural and linguistic capability when hiring an additional

LMHP and a supervisor to support these youth most effectively who face many challenges and environmental stressors.

Mental Health Practitioner: A clinician experienced in providing direct mental health services in a clinic or program with youth of color who are often marginalized and in need of a supportive, intensive, trauma focused model of treatment, especially those experiencing a first psychotic episode. This is a very challenging population and depending on their age and development require a clinician who understands the unique challenges in successfully engaging them.

Mental Health Unit Supervisor: An experienced clinician who has had experience in providing direct services to youth at risk and is able to plan, oversee, review and evaluate the YES Program and YES staff on a full time basis (currently there is only a part time supervisor). This supervisor would serve as a resource and consultant on daily activities as well as provide long term planning for the program, including outcome measures, in collaboration with the other Children's Mental Health supervisors and the Division Director.

EXPECTED OUTCOMES

In FY2015-16, the YES program served 43 clients with only 2 of the 3 clinical staff positions filled as noted above. Services provided to the 43 youth included assessment, case management and individual/family therapy, as well as family partner support and medication services. YES services helped prevent several youth from becoming homeless and also supported many clients to avoid psychiatric hospitalization. Because many YES clients present with significant emotional/behavioral challenges, at times resulting in psychiatric hospitalization, YES clinicians are available to provide intensive support during crises, as well as aid in discharge planning from the hospital.

To support our larger objective of decreasing barriers to service, most of the YES services were provided in schools and in clients' homes rather than in an outpatient office setting. Services were also provided at alternative sites like Marin Community School (a school for students at risk of academic failure) as well as in the community as appropriate.

The YES program also supports our outreach efforts to reach unserved and underserved communities. 82% of YES clients identify as Hispanic, with 12% (N=5) reported as primarily Spanish speaking. The YES program also serves clients who are newcomers or who immigrated to the US within the past few years. These clients often experience educational disruption, trauma, separation and significant loss, all the while having to navigate a new culture. In many cases, YES clients are bilingual, but family based services to parents often require a bilingual clinician in order to engage parents successfully.

Three areas of focus during FY2015-16 included identifying early psychosis, substance use and trauma for YES clients. Specific issues of trauma such as exposure to domestic violence, the experience of immigration trauma, and sexual abuse were salient issues in the YES client population. In FY2015-16 the YES staff began using the Child Adolescent Needs and Strengths tool (CANS) to assess and monitor specific areas of concern that should be the focus of clinical intervention. In FY2016-17, the CANS ratings for these factors will be monitored at regular intervals to assess individual progress and overall effectiveness of the program in addressing these needs.

PROGRAM CHALLENGES

In FY2015-16, The YES program remained understaffed for much of the year, at times with only one staff other times with two staff.

In FY2016-17, with a full complement of staff the YES program will serve at least 40 unduplicated clients and track the most frequent actionable items on the CANS to align training needs of staff with the clinical needs of the client. Staff has been trained in a software program that can show client progress, clinical areas of focus and the effectiveness of treatment. Staff has required and will continue to require ongoing support and consultation so as to effectively use this tool for the benefit of the client and program.

Currently, the YES Program has only a part time supervisor so the ability to monitor the quality and effectiveness of the program and provide timely consultation to staff in utilizing the CANS as effectively as possible in determining level of care and treatment planning and overall effectiveness of the program is challenging.

PROGRAM CONTINUATION	X	PROGRAM EXPANSION	X	NEW PROGRAM	

TRANSITIONAL AGE YOUTH (TAY) FULL SERVICE PARTNERSHIP

PROGRAM OVERVIEW

Marin County's Transition Age Youth (TAY) Program, provided by Sunny Hills Services is a full service partnership (FSP) for young people (16-25) with serious emotional disturbance or emerging mental illness. The TAY program provides independent living skills workshops, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services. There is also a well-attended Partial program for youth who can take advantage of the group activities and ongoing social support. This Partial Program may be used as a step down for FSP participants on their way to a more independent path as well as outreach to youth who are just realizing the importance of connection and support in dealing with emerging mental illness.

TARGET POPULATION

The priority population is transitional age youth, 16-25 years of age, with serious emotional disturbances/serious mental illness which is newly emerging or for those who are aging out of the children's system, child welfare and/or juvenile justice system. Priority is also given to TAY who are experiencing first-episode psychosis and need access to developmentally appropriate mental health services. Research has shown there are significant benefits from early intervention with this high risk population. There is increased awareness that young people experiencing first episode psychosis symptoms should be engaged early and provided with a collaborative, recovery oriented approach through a multidisciplinary team Coordinated Specialty Care model. Untreated psychosis has been associated with increased risk for delayed or missed developmental milestones resulting in higher rates of unemployment, homelessness, reduced quality of life and a higher risk for suicide. First episode psychosis has become an area of focus across the mental health system of which TAY is an important partner.

Full Service Partnership Client Demographics FY2015-16

Age Group	# served	% of served
0-15 years old		
16-25 years old	28	100%
26-59 years old		
60+ years old		
TOTAL	**28**	**100%**
Race/Ethnicity		
White	13	
African American	3	
Asian	2	
Pacific Islander		
Native		
Hispanic	10	
Multi		
Other/Unknown		

Primary Language		
Spanish	2	
Vietnamese	1	
Cantonese		
Mandarin		
Russian		
Farsi		
Arabic		
English	25	
Other		

PROGRAM DESCRIPTION

The TAY Program is a Full Service Partnership (FSP) providing young people (16-25 yr. old) with 'whatever it takes' to move them toward their potential for self-sufficiency and appropriate independence, with their natural supports in place from their family, friends and community. Initial outreach and engagement is essential for this age cohort who is naturally striving toward independence and face more obstacles due to their mental illness than the average youth. Independent living skills, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services are available through the TAY Program which strives to be strengths based, evidence based and client centered. A multi-disciplinary team provides assessment, individualized treatment plans and linkages to needed supports and services, as well as, coordinated individual and group therapy and psychiatric services for TAY participants.

This goal of the program is to provide treatment, skills-building and a level of self-sufficiency needed to manage their illness and accomplish their goals, thus avoiding high end services, incarceration and homelessness. In addition, partial services, such as drop-in hours and activities, are available to TAY FSP as well as those not yet a full service partner who are given the opportunity to explore how a program such as TAY could support them.

Partial services are provided on a drop-in basis to full and partial clients. These services include an Anxiety Management Group, cooking groups, no cost physical activities such as hikes led by staff and job support and coaching. These activities provide a forum for healthy self-expression, an opportunity for participants to expand their cultural horizons, and a place to for them to practice

their social skills. A regular Family Support Group for families of TAY with mental health illness and substance use, whether or not their child is enrolled in the TAY programs is provided by a TAY staff in both Spanish and English. The monthly TAY calendar of activities is available in English and Spanish.

EXPECTED OUTCOMES

In FY2015-16, there were 28 unduplicated FSP clients in the TAY Program. Currently 14 of the FSP's receive psychiatric medication support directly through the TAY Program and 25% receive individual therapy (N=7). Approximately 70% attended independent living skills activities.

Outcomes	Goal
Number of clients served: • FSP • Partial/drop-in	 24 60
FSP clients engaged in work, vocational training or school.	55%
FSP clients engaged in activities designed to improve independent living skills.	60%
FSP clients screened for substance use.	100%
Clients identified as having substance use issues that receive substance use services.	50%

Only three clients were identified as having substantial risk for alcohol and drugs which is 11% and two of the three or 66% accepted substance use services but the number is so small that the percentage is meaningless. However, one of the two clients worked with an AA sponsor outside of TAY and the other collaboratively developed a plan with their individual case manager. It is believed that many denied use and/or under reported, specifically the use of marijuana/medical marijuana which was frequently explored in drop in activities and groups utilizing Motivational Interviewing (MI) techniques. The challenge, through MI and Seeking Safety groups, will be to increase awareness of the impact alcohol and drug use has on their lives and wellbeing and to support these youth through the stages of change as appropriate.

PERFORMANCE GOALS

- The TAY program will maintain 95% capacity (19 clients) or higher of FSP clients by active outreach and engagement, in collaboration with the BHRS TAY liaison.
- The program will have served at least 45 unduplicated clients in the drop in center with active outreach and engagement by TAY Program staff. at least 60% of FSP will have participated in at least one drop in activity.
- 70% of Full Service TAY members will have engaged in either work, vocational training or school.
- 50% of FSP will have attended two or more activities designed to improve their independent living skills.
- Ongoing assessment and interventions related to clients' needs/issues with substance use and safety. 100% of FSP clients will receive alcohol and drug screening. Clients identified

with possible substance use issues will receive further assessment, and when indicated, intervention and treatment services.

- Maintain full occupancy (two FSP) 80% of the time.

PROPOSED EXPANSION

The recent trend of referrals of 17 and 19-year olds immediately following a First Psychotic Episode (FEP), require an extraordinary amount of coordination and delivery of services. In order to provide the core functions of a Coordinated Care Model in collaboration with the county FEP Project a (0.5 FTE) Clinical Case Manager would need to be added. This increased staffing resource would also allow an increase of four FSP slots in the TAY Program. The TAY Program is often at capacity and therefore the proposed expansion of four new slots would increase capacity to 24 FSPs, to better meet client need pending approval of the MHSA Three Year Plan.

PROGRAM CONTINUATION [X] PROGRAM EXPANSION [ ] NEW PROGRAM [ ]

SUPPORT AND TREATMENT AFTER RELEASE (STAR) PROGRAM
FULL SERVICE PARTNERSHIP

PROGRAM OVERVIEW

The Marin County Support and Treatment After Release (STAR) Program has been an MHSA-funded Full Service Partnership serving adults with serious mental illness who are at risk of incarceration or re-incarceration since 2006. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce incarceration, and reduce hospitalization.

The STAR Program was originally implemented in 2002 through a competitive Mentally Ill Offender Crime Reduction Grant (MIOCRG) awarded by the California Board of Corrections. A collaborative effort that included the Sheriff's Department, Probation Department, Marin County Superior Court, San Rafael Police Department, Department of Health and Human Services-Division of Community Mental Health Services (CMHS), and Community Action Marin's Peer Mental Health Program, the program implemented an improved system for providing strengths-based modified assertive community treatment and support for adult mentally ill offenders with the goal of reducing their recidivism and improving their ability to function within the community. The STAR Program's unique combination of law enforcement's community policing, problem-solving approach, the county's clinical treatment delivery methods, and multi-disciplinary outreach and collaboration clearly demonstrated that Marin was able to effectively serve individuals who have been previously thought to be beyond help.

The initial grant that supported the program ended in June 2004. In March 2004, the Marin Community Foundation approved a grant to support continuation of the STAR Program for an additional 12 months. Key stakeholders and community partners fully supported the conversion of the STAR Program into a new full service partnership to continue serving the MIOCRG target population. During FY2005-06, the County Board of Supervisors provided bridge funding to continue the STAR Program until MHSA funding became available. This plus additional funding commitments from key partners in the program made it possible to build upon the initial success of the STAR Program to further the development of a comprehensive system of care for Marin's mentally ill offenders that consists of three critical components: 1) In-custody screening and assessment, individualized treatment and comprehensive discharge planning; 2) post-release intensive community-based treatment and services to support functioning and reduce recidivism, and 3) a mental health court – the STAR Court – to maximize collaboration between the mental health and criminal justice systems and ensure continuity of care for mental health court participants.

The re-design of the program incorporated the valuable experiences and lessons learned from the MIOCRG-funded services and in 2006, the STAR Program was approved as a new full service partnership providing culturally competent intensive, integrated services to 40 mentally ill offenders. Operating in conjunction with Marin's mental health court – the STAR Court – the program was

designed to provide comprehensive assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports.

A substantial percentage of program participants present with co-occurring substance use disorders, increasing the risk for suicide, aggressive behavior, homelessness, incarceration, hospitalization and serious physical health problems. Studies have documented the effectiveness of an integrated approach to individuals with co-occurring psychiatric and substance use disorders, in which the mental illness and substance use disorder are treated by the same clinician or team. In 2011 the program added a part-time substance use specialist who provides assessments and consultation to the team, as well as facilitates a weekly treatment group for program participants with co-occurring substance abuse disorders. This position is expected to provide integrated substance use services to 15-20 program participants annually.

Originally all program enrollees were required to agree to participate in STAR Court. This presented an obstacle to enrollment for some individuals who would clearly benefit from the program's services. In 2011 the program expanded to serve and additional 15 clients without the requirement of participation in STAR Court. Hopefully removing the court requirement will also allow the STAR Program to engage and enroll a more diverse participant population.

In 2012 the program added Independent Living Skills (ILS) training for targeted STAR clients. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. ILS training is expected to be provided to 4-5 program participants annually.

Beginning in 2011, the program began providing CIT Training, a 32-hour training program for police officers to enable them to more effectively and safely identify and respond to crisis situations and mental health emergencies. Through MHSA CSS funds this training is provided to 25-30 sworn officers annually.

TARGET POPULATION

The target population of the STAR Program is adults, transition-age young adults, and older adults with serious mental illness, ages 18 and older, who are currently involved with the criminal justice system and are at risk of re-offending and re-incarceration. Priority is given to individuals who are currently unserved by the mental health system or are so inappropriately served that they end up being incarcerated, often for committing "survival crimes" or other nonviolent offenses related to their mental illness. These individuals may or may not have a co-occurring substance use disorder and/or other serious health condition.

PROGRAM DESCRIPTION

The STAR Program is a Full Service Partnership providing culturally competent intensive, integrated services to 60 mentally ill offenders. As stated above, the goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce incarceration, and reduce hospitalization.

Operating in conjunction with Marin's Jail Mental Health Team and the STAR Court (mental health court), a multi-disciplinary, multi-agency assertive community treatment team comprised of professional and peer specialist staff provides comprehensive assessment, individualized client-

centered service planning, crisis management, therapy services, peer counseling and support, psychoeducation, employment services and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained. The team's mental health nurse practitioner furnishes psychiatric medication to program participants under the supervision of the team psychiatrist. The team's mental health nurse practitioner also provides participants with medical case management, health screening/promotion and disease prevention services, and coordinates linkage to community-based physical health care services. The program also has a volunteer family member who brings the voice and perspective of families to the program and is available to provide outreach to family members of STAR Program participants.

EXPECTED OUTCOMES

Listed in the table below, the expected outcomes for the STAR Program are based on the goals of the program and remain unchanged The data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the STAR Program staff on a daily basis. Program staff will continue to explore methods for measuring self-sufficiency and recovery that will permit the program to evaluate its success in these key areas.

Outcomes	GOAL
Decrease in homelessness	75%
Decrease in arrests	75%
Decrease in incarceration	80%
Decrease in hospitalization	40%

PROPOSED CHANGES

This plan proposes an increase in administrative staffing. In recent years Behavioral Health and Recovery Services has expanded dramatically, and current resources are inadequate to provide prompt and reliable customer service and leads to inefficiencies in staffing patterns.

Additional support staffing would also allow for increased accuracy and consistency of data collection, and is expected to have a measureable impact on data quality and timeliness of reporting.

PROGRAM CONTINUATION	X	PROGRAM EXPANSION		NEW PROGRAM	

HELPING OLDER PEOPLE EXCEL (HOPE) FULL SERVICE PARTNERSHIP

PROGRAM OVERVIEW

The HOPE Program has been an MHSA-funded Full Service Partnership serving older adults with serious mental illness who are at risk of homelessness, hospitalization or institutionalization since 2007. The program is designed to provide community-based outreach, comprehensive geropsychiatric assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports by a multi-disciplinary, multi-agency team. The over-arching vision of the HOPE Program is "*Aging with dignity, self-sufficiency and in the life style of choice*". The goals of the program are to promote recovery and self-sufficiency, maintain independent functioning, reduce isolation and avoid institutionalization.

Prior to implementation of MHSA, Marin County did not operate a comprehensive integrated system of care for older adults with serious mental illness. Due to limited resources and service capacity, the existing Older Adult Services County mental health program had been unable to provide much more than assessment and peer support services. Of all the age groups served by Marin's public mental health services, older adults had received the least services and had the lowest penetration rates, despite the fact that they constituted the fastest growing age cohort in Marin.

Key stakeholders and community partners had consistently agreed that Marin needed to more comprehensively address the needs of older adults who have serious mental illness, and they strongly supported the creation of a new full service partnership as a critical step toward an integrated system of care for this population. In 2006, Marin's HOPE Program was approved as a new MHSA-funded full service partnership providing culturally competent, intensive, integrated services to 40 priority population at-risk older adults. Older adults were identified to be Marin's fastest growing population and comprise 24% of the total population. By 2014, demand for HOPE Program services had exceeded its capacity, and MHSA funding was used to add a full-time Spanish speaking clinician to the assertive community treatment team. This enabled the program to enroll an additional 15 individuals, bringing the capacity of the Full Service Partnership to 50.

In 2014 the program was also expanded to provide increased outreach to at-risk Hispanic/Latino older adults by increasing the hours of the Spanish-speaking mental health clinician supporting and supervising the Amigos Consejeros a su Alcance (ACASA) component of the Senior Peer Counseling Program. These additional hours are used to outreach into the community to increase awareness of the mental health needs of Hispanic/Latino older adults and their families, and the services that ACASA and the HOPE Program offer. ACASA is expected to identify and engage with 5 new monolingual community liaisons annually. It is also anticipated that the addition of Spanish-speaking capacity to the Full Service Partnership will facilitate the identification, engagement, and enrollment of at-risk Hispanic/Latino older adults who have serious mental illness and have been unserved or underserved by the Older Adult System of Care.

Also in 2014, the program was also expanded to provide Independent Living Skills (ILS) training for targeted HOPE clients. These services facilitate independence and recovery by providing training in

specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. ILS training is expected to be provided to 4-5 program participants annually.

TARGET POPULATION

The target population of the HOPE Program is older adults with serious mental illness, ages 60 and older, who are currently unserved by the mental health system, who have experienced or are experiencing a reduction in their personal or community functioning and, as a result, are at risk of hospitalization, institutionalization or homelessness. These older adults may or may not have a co-occurring substance abuse disorder and/or other serious health condition. Transition age older adults, ages 55-59, may be included when appropriate.

PROGRAM DESCRIPTION

The Hope Program is a full service partnership that provides culturally competent intensive, integrated services to 50 priority population at-risk older adults. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. As stated above, the goals of the program are to promote recovery and self-sufficiency, maintain independent functioning, reduce isolation and avoid institutionalization.

The HOPE Program's multi-disciplinary assertive community treatment team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psychoeducation, assistance with money management, and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained.

The team's mental health nurse practitioner furnishes psychiatric medication to program participants under the supervision of the team psychiatrist. The team's mental health nurse practitioner also provides participants with medical case management, health screening/promotion and disease prevention services, and coordinates linkage to community-based physical health care services.

Because of the stigma associated with mental health issues for older adults in general, mental health issues often reach crisis proportions and require emergency medical and psychiatric care before they seek help. Outreach services are critical for engaging these individuals before they experience such crises. Marin's highly successful Senior Peer Counseling Program, staffed by older adult volunteers and the County mental health staff who support and supervise that program, has been integrated into the team and provides outreach, engagement, and support services. In addition, the Senior Peer Counseling Program provides "step-down" services to individuals ready to graduate from intensive services.

EXPECTED OUTCOMES

Listed in the table below, the expected outcomes for the HOPE Program are based on the goals of the program and remain unchanged. The data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the HOPE Program staff on a daily basis. Program staff will continue to explore age-appropriate methods for measuring self-sufficiency and isolation that will permit the program to evaluate its success in these key areas.

Outcomes	GOAL
Decrease in homelessness	75%
Decrease in hospitalization	50%

PROGRAM CONTINUATION	X	PROGRAM EXPANSION		NEW PROGRAM	

ODYSSEY PROGRAM (HOMELESS) FULL SERVICE PARTNERSHIP

PROGRAM OVERVIEW

The Odyssey Program has been an MHSA-funded Full Service Partnership serving adults with serious mental illness who are homeless or at-risk of homelessness since 2008. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

Following the loss of AB2034 funding for Marin's Homeless Assistance Program which had been in operation since 2001, key stakeholders and community partners fully supported the creation of a new Full Service Partnership, the Odyssey Program, to continue serving the AB2034 target population. Over the course of its existence, Marin's AB2034 program demonstrated significant success in assisting adults with serious mental illness who were homeless to obtain and maintain housing, despite the County's very challenging housing environment, and to avoid incarceration and hospitalization. The design of the new program incorporated the valuable experiences and lessons learned from the AB2034-funded services and in 2007, the Odyssey Program was approved as a new MSHA-funded CSS Full Service Partnership providing culturally competent intensive, integrated services to 60 priority population adults who were homeless or at-risk of homelessness. The Odyssey Program was designed to provide comprehensive assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports by a multi-disciplinary, multi-agency team.

A substantial percentage of program participants present with co-occurring substance use disorders, increasing the risk for suicide, aggressive behavior, homelessness, incarceration, hospitalization and serious physical health problems. Studies have documented the effectiveness of an integrated approach to individuals with co-occurring psychiatric and substance use disorders, in which the mental illness and substance use disorder are treated by the same clinician or team. In 2011 the program added a part-time substance use specialist who provides assessments and consultation to the team, as well as facilitates a weekly treatment group for program participants with co-occurring substance abuse disorders. This position is expected to provide integrated substance use services to 15-20 program participants annually.

In 2012 the program added Independent Living Skills (ILS) training for targeted ODYSSEY clients. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. ILS training is expected to be provided to 4-5 program participants annually.

Beginning in 2011 MHSA funds were used to fund emergency housing in a 2-bedroom apartment for program participants who are homeless to provide a safe place for residents to live while seeking permanent housing. While in the emergency housing, program participants are able to save money for security and rent deposits and can work closely with program staff to develop budgeting and

living skills needed for a successful transition to independent living. Emergency housing serves 5-10 program participants annually.

In 2014 Odyssey implemented a "Step-Down" component, staffed by a Social Service Worker with lived experience and a Peer Specialist and targeting individuals already enrolled in the program who no longer need assertive community treatment services, but continue to require more support and service than is available through natural support systems. This program did not achieve the intended outcomes. Since implementation, the team has been challenged by needing to provide frequent transfers between this component and the assertive community treatment component of the team. Marin proposes to re-structure both components by integrating the two services in support of participants being able to access services at different intensities, depending on their needs, without the need to transfer between two separate FSP components.

TARGET POPULATION

The target population of the Odyssey Program is adults, transition age young adults and older adults with serious mental illness, ages 18 and older, who are homeless or at-risk of homelessness due to their mental health challenges. Priority is given to individuals who are unserved by the mental health system or are so underserved that they end up homeless or at risk of becoming homeless. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

PROGRAM DESCRIPTION

The Odyssey Program is a Full Service Partnership that provides culturally competent intensive, integrated services to 80 priority population at-risk adults. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. As stated above, the goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

A multi-disciplinary, multi-agency assertive community treatment team comprised of professional, para-professional and peer specialist staff provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, medication support, psychoeducation, employment services, independent living skills training, assistance with money management, and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained.

The team's mental health nurse practitioner furnishes psychiatric medication to program participants under the supervision of the team psychiatrist. The team's mental health nurse practitioner also provides participants with medical case management, health screening/promotion and disease prevention services, and coordinates linkage to community-based physical health care services.

The program's part-time employment specialist provides situational assessments, job development and job placement services for program participants, and coordinates services with other vocational rehabilitation providers in the county. Where appropriate, participants are assisted to enroll in the

Department of Rehabilitation to leverage funding for additional vocational services, including job coaching.

EXPECTED OUTCOMES

Listed in the table below, the expected outcomes for the Odyssey Program are based on the goals of the program and remain unchanged The data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the Odyssey Program staff on a daily basis. Program staff will continue to explore methods for measuring self-sufficiency and recovery that will permit the program to evaluate its success in these key areas.

Outcomes	GOAL
Decrease in homelessness	80%
Decrease in arrests	50%
Decrease in incarceration	60%
Decrease in hospitalization	40%

PROPOSED CHANGES

This plan proposes an increase in administrative staffing. In recent years Behavioral Health and Recovery Services has expanded dramatically, and current resources are inadequate to provide prompt and reliable customer service and leads to inefficiencies in staffing patterns. Additional support staffing would also allow for increased accuracy and consistency of data collection, and is expected to have a measureable impact on data quality and timeliness of reporting.

PROGRAM CONTINUATION ☐ **PROGRAM EXPANSION** ☐ **NEW PROGRAM** ☒ X

INTEGRATED MULTI-SERVICE PARTNERSHIP ASSERTIVE COMMUNITY TREATMENT (IMPACT) FULL SERVICE PARTNERSHIP

PROGRAM OVERVIEW

In recent years, the Marin County Adult System of Care has struggled with an increasing number of individuals with serious mental illness who are in need of more intensive services than those offered by either of the integrated clinics. This plan proposes the addition of a Full Service Partnership specifically targeting those who do not necessarily fall into the one of the target populations of the current Full Service Partnerships: homeless (Odyssey), Older Adults (HOPE), or involved with the criminal justice system (STAR). The goals of the Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT) Full Service Partnership will be to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

PROGRAM DESCRIPTION

The IMPACT FSP will provide culturally competent intensive, integrated services to thirty (30) priority population at-risk adults. The program will be strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. As stated above, the goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

Following the Assertive Community Treatment model, a diverse multi-disciplinary team will be developed to provide comprehensive "wrap-around" services for individuals in need of the highest level of outpatient services. Staffing will be comprised of mental health clinicians, Peer Specialists, Family Partners, para-professionals, psychiatry and Nurse Practitioners. Services will include comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, medication support, psycho-education, employment services, independent living skills training, assistance with money management, and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and will be provided on a case-by-case basis. The team will have a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained.

TARGET POPULATION

The target population of the proposed program is adults, transition age young adults and older adults with serious mental illness, ages 18 and older, which are un-served by the mental health system or are so underserved that they are unable to stabilize in the community without additional

support. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

EXPECTED OUTCOMES

Listed in the table below, the expected outcomes are based on the goals of the program. We expect to serve up to forty (40) 18+ year old adults. The data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the program staff on a daily basis. Program staff will explore methods for measuring self-sufficiency and recovery that will permit the program to evaluate its success in these key areas.

Outcomes	Goal
Decrease in homelessness	25%
Decrease in arrests	50%
Decrease in incarceration	60%
Decrease in hospitalization	40%

RESPONSE:

The MHSA three-year planning process was started in May 2019 with a series of three monthly educational sessions through July 2019, followed by an extensive plan development process beginning in August 2019 and ending in January 2020. During this process over 500+ community residents and stakeholders representing a wide range of geographic and demographic communities participated in providing feedback to the plan. Their interests, priorities, and voice are represented in this plan. As a result, HHSA does not believe further delay in finalizing and implementing the plan is warranted at this time.

Furthermore, we believe additional delays beyond what has already happened as a result of COVID, risks undermining the broad community feedback that was received last fall and could jeopardize the timely implementation of new investments around expansion of Full Service Partnership (FSP) and K-12 school-based services at a time when they are in high demand due to the COVID pandemic.

In regards to allocating additional MHSA funding for housing, the Community Engagement Workgroup (CEWG) was made aware that while it was a highlighted priority for the community, that other funding streams existed to support this priority beyond MHSA. Given the existence of other funding streams, the county has prioritized local MHSA funds to support service delivery as intended. These services include significant investments in staffing to support permanent supportive housing. Additionally, in 2016, the state passed legislation that carved out a piece of local county MHSA funding (7%) specifically to fund No Place Like Home grants to support permanent supportive housing to mentally ill residents. There are 41 NPLH units located in West Sacramento and 29 units in Woodland, CA.

Over the course of the next three years several developments are planned, adding over 400 units for low/ extremely low income individuals in Yolo County. More than half of these units are permanent supportive housing units which have services on site and available to residents. Some units are designated for persons experiencing homelessness but many are not. Some are also more short term in nature. We are prioritizing bringing people back to Yolo who have been placed elsewhere, whether that be an IMD or a Board and Care in another county along with the intended Peer-Run Housing Program. Pine Tree Gardens funding is included across the following: Adult Wellness Services, Pathways to Independence, and Older Adult Outreach and Assessment Programs.

Regarding program evaluation and data, HHSA acknowledges it can do better with evaluating MHSA program outcomes. This is not unique to Yolo county and is a statewide issue, as counties have prioritized service delivery over additional administrative support costs. Nonetheless, HHSA understands the importance of investing in program evaluation and quality improvement, and therefore has already begun implementing Results Based Accountability (RBA) measures for all MHSA contracts and funded programs and will continue to do so with the new plan. Furthermore, HHSA has set aside funding in the new plan to bring in outside support to help with program evaluation and outcome assessments. HHSA is making edits to the plan to highlight these evaluation activities. Please see Yolo County MHSA Profile, page 94, for demographics and data on residents served, FSP outcomes, and prevention and early intervention programs.

Lastly, HHSA is currently updating the plan to provide additional information to better illustrate the connection between the community feedback and program investments.

Fabian Valle

From: Antonia Tsobanoudis <antonia.tsobanoudis@gmail.com>
Sent: Monday, July 20, 2020 1:42 PM
To: MHSA
Cc: Don Saylor
Subject: My Comments of the Draft MHSA 3-yr Plan
Attachments: MHSAPublicCommentFY2020_AT.pdf; AT Comments MHSA 2020-2023.xlsx

To Whom It May Concern,

Please find attached my 6-page comments in PDF form on the draft MHSA 3-yr Plan. I recognize I have been heavy on the writing edits and while I am not trying to tell anyone how to write the report, there are just some professional, or in my case technical, writing techniques that I have been trained to catch. So, being that it is a draft I thought it the best time to mention these distractions I had in reading the Report. I did give up steam around page 54, so there are many edits I did not mention after that.

I tried to organize my comments with my more general ones at the top of Page 2, but there exist some substance comments in with the writing edits ordered by page number of the Report.

Thank you for your time,
Antonia

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COUNTY OF YOLO

Health and Human Services Agency

Mental Health Services Act (MHSA) 30-Day Public Comment Form

Public Comment Period—Friday June 19, 2020 through Monday July 20, 2020

Document Posted for Public Review and Comment:

MHSA Three-Year Program & Expenditure Plan FY 2020-2023

This document is posted on the Internet at:
http://www.yolocounty.org/mhsa

PERSONAL INFORMATION (optional)

Name: Antonia Tsobanoudis

Agency/Organization: self

Phone Number: (530) 219-2021 Email address: antonia.tsobanoudis@gmail.com

Mailing address: 1220 Olive Drive, Apt. #115, Davis, CA 95616

What is your role in the Mental Health Community?

X Client Consumer	___ Mental Health Services Provider
X Family Member	___ Law Enforcement/Criminal Justice Officer
___ Educator	___ Probation Officer
___ Social Services Provider	X Other (Specify) MH volunteer, speaker

Please write your comments below:

If you need more space for your response, please feel free to submit additional pages.

As part of the Local Mental Health Board, I have been in a unique position to more closely follow the development of the MHSA 3-year Plan by being informed of and participating in Stakeholder WorkGroups, and seeing the detailed presentations made to the LMHB by Staff regarding MHSA over the last two and a half years.

I am impressed by the Report I am reviewing. It is easy to read (except for Figure 29) and is beautifully presented. Overall, I find it very comprehensive and superb in detailing how the selection process was achieved, though I have made some comments asking for more information like on budget and homelessness. The following attached pages detail my comments and include minor edits, and I recognize that some of them may be more appropriate to address than others.

Thank you for your time addressing my detailed review.

ease return your competed comment form to HHSA/MHSA before 5:00 P.M. on Monday July 20, 2020 in one of two ways:

- Scan and Email this completed form to MHSA@yolocounty.org, Subject: MHSA Plan Draft for FY 2020-2023 Comments
- Mail this form to HHSA/MHSA, Attn: MHSA Coordinator, 25 N. Cottonwood St., Courier #16CH, Woodland, CA 95695.

Page	Original	Suggestion/Comment
GEN	The budget is difficult to track from FY 19-20 and the previous 3-yr plan.	Include comparitve budget and program participation values for CONTINUING and MODIFIED programs so that any major changes can be tracked and better understood.
GEN	Homelessness	What are the other funding streams for homelessness? e.g. what, how, who are HHSA collaborators especially wrt subtantial sums? How much?
GEN	the use of the term "consumer" or "client" throughout	should consumer be replaced with client or patient in various places used throughout the report? I want to discuss here patient vs client vs consumer? If I receive physical therapy, I am that PT's patient. If I receive psychotherapy or even case management, I am a consumer? I like "consumer" much less than "client," or "mental health client." I'd prefer to be called a patient, but realize that could denote active treatment (from a doctor or other professional) or hopsitalization -- oh wait, all these programs described herein *are* active treatments and when I see my PCP I am their patient, either an inpatient or outpatient. Recommend to either stick to one "client" or "consumer" throughout the Report, or just switch now to patient, inpatient vs outpaitient if necessary for clarity, which is what I prefer as a patient in various stages of a fluid lifelong recovery.
GEN	Performance Measures	In 2015, I was involved in a press conference at the Steinberg Institute trying to dispell myths about Prop63 funding. There has to be some mechanisms in place by now to show the effectiveness of these programs. How come the Report does not give a few more details?
11	Figure 1, Stage 3 "…and recurrig episodes accompanies by"	Correct spelling errors. Change to "and recurring episodes accompanied by"
15	Right-most column, top bullet	Is AFI a foundation? So a partner to HHSA? Now I see page 16 explains a little further under housing. First mention of many, maybe a good place to introduce the full name of AFI.
17	Stigma & Cultural Competency	Consider using a period to separate the two thoughts in the right-most light grey bubble
17	Flexible Funding - Embed flexibility in contracts	Good, especially to respond to increased MH response due COVID concerns and decrease in 22-23 budget due to COVID
17	bottom right bubble, "Fund staffing…"	Remove one of the "staffing staffing" listed. Or use another verb or adjective since "staffing development" could be a term. Or add "for" so that "Fund staff(ing) for staffing development…"
22	First paragraph, last sentence	missing the later-referenced CDP (Census-designated Places) of Dunnigan, Esparto, and Knights Landing.
22	First paragraph, last sentence	Remove Conoway Ranch -- not listed as unincorporated or CDP in most references that I've researched; it is ag and wildlife reserves.
37	NUMBERS in Figure 29 are unclear.	Can split up table in two?, or add simply "(count)" to the end of the title to denote that the numbers represent how many times those issues were raised.

37	Figure 29. Funding	Funding was not an issue raised? But it is listed under the descriptive paragraph starting with "Several Primary Themes emerged..."? If not an issued raised by stakehodlers, then add an appropraite note under the Heading "Funding" or make up a subheading like "lack of funding" and put a zero after the periods.
37	Figure 29. Community and Others Headers	Community and Others should be more left indented to match the other primary themes that emerged as salient
37	Figure 29. Title, part "SIZE OF GROUPS"	It's starting to become clearer to me now, maybe noone else will put as much thought into it… instead of "SIZE OF GROUPS" in Title, you may be showing the "AMOUNT of PARTICIPANTS" or "AMOUNT OF CODE INCEDENCES IN GROUPS"? I'm just very confused by the figure. Maybe it is a count of the people who identified with or represented/brought-up these thematic codes, taking me back up to my previous comment regarding the numbers being unclear. At first, I thought they were page references and then I thought they may show the count of thematic codes referenced in the groups. If they show the amount of incidences a topic was raised as important, why not have them ranked in order of highest riased topics within the headers identified?
38	Through p 39, under "A. Services," "Five key themes...."	There are 7 themes numbered across the two pages under "Services". Change Five to Seven. Especially not to confuse them with the several primary thematic codes (services, prevention, special needs, funding, and community as outlined in Figure 29)?
38	through p 39, under 1) Access, 2) Navigation, 3) Integrated Services, 4) Telehealth/Mobile Health, 5) Respite, 6) Crisis Response, and 7) Clinical Services	these numbered themes do not match the thematic codes under Services from Figure 29. Some do, no order. Could be on purpose, a little distracting for me after how much time I put into Figure 29, maybe not a big deal.
39	At end of 3) Integrated Services	what are children's museums? Do we have any in Yolo? Maybe meant to read "children's schools?"
39	At the end of 6) Crisis Response… "mental health crisis in the field."	change "crisis" to plural: "crises."
40	under 3) Training	I have personally found, on numerous occasions, the first responders (especially PD) should listen to MH workers if their patient needs more help than is available through the worker, ie offering respite care, voluntary stays at Safe Harbor (Res Crisis House), or acute treatment at a behvioral health hospital. If the clinician cannot place a 5150 hold but recommends it--sees their patient as sick gravely disabled, the officer should communicate with said clinician to place the hold especially if the patient is involuntary to treatment.
40	at end of bullet -> Language under 1) Stigma and…	add a qualifier: "...language line, or interpretation service, at a" or capitalize Language Line if that's its name
41	Sentence spanning bottom middle to top right of p 41 "Other services…includes"	change to "include"

42	under D. Funding 3) Flexible Funding "….(such as those discussed above) …"	please elaborate, unclear - Section or page number reference maybe?
42	E. Infrastructure	not introduced at all in beginning of section page 37 … as Figure 29 points out, a header labeled "Community" may be called and renamed to "Infrastructure"
42	E. Infrastructure middle of 2) Support new contractors: "… have possibly not previously …"	Rephrase sentence, hard to read the split "have not"
43	under A. Basic Needs "...homeless people..."	Replace with "people experiencing homelessness"
43	under A. Basic Needs "Improve support for housing needs. "	Add "Provide support to prevent homelessness." OR "Prevent homelessness."
43	through p 44, under B. Children, Youth, & Families, C. Top left on p 44, F. Prevention some, and G, many under H. Funding & Capacity Bldg	Some (~20) bullets missing a leading verb… Should we clarify more with an appropriate verb like most other bullets on pages? And not always ujust "Provide"
44	under C. Services Access " > Recognize the role of physical health in mental health."	add "and proper nutrition" so that it reads "Recognize the role of physical health and proper nutrition in mental health."
44	first bullet under D. Community-Based Services "> Provide mobile unit with integrated services, including shower."	Add for whom the shower is for? "Provide mobile unit with integrated services, including shower, for those experiencing homelessness." Or maybe it is for anyone in crisis or experiencing trauma and doesn't need a qualifier?
44	Under D. Community-Based Services, 2nd bullet from the last	Again, I don't understand such a specific term as "children's museums." Must either be a psych term or a common reference, unknown to me, for places like the Exploratorium, skate parks, and other such resources where children may frequent outside of school. If that is the case, how about providing MH support at child development centers and daycares throughout the County as well?
44	Under F. Prevention, 2nd to last bullet, "> Social marketing campaign to include messages like: "Mental illness does not equal crazy," "It is just as important as caring..."	I do not like even putting the two ideas together negatively as in when reading "Mental illness does not equal crazy." Can we put something more ambiguous and to the effect of "-> Social marketing campaign with distinct slogans fighting MH stigma" or "-> Social marketing campaign including hiring of a third-party advertiser for professional marketing strategies and branding of HHSA, Mental Health." ? Or see, next bullet and remove entirely~
44	"-> Stigma-reduction campaign with targeted messages, particularly for Latinx and Russian populations."	Add LGBTQ+ to populations listed: "-> Stigma-reduction campaign with targeted messages, particularly for Latinx, Russian, and LGBTQ+ populations."
44	Under G. Cultural and Linguistic Competence "-> All mental health staff should use the language line, at a minimum."	Change to a verb and for what is actually wanted here: Train mental health staff on how to use the language line for interpretation help.
44	In the second bullet, under H. Funding & Capacity Building	County psychiatrists also need retention bonuses, we have too high a turnover of Psychiatrists.

44	Third bullet from the bottom right of page "-> Leverage resources from the newly proposed payment for ACES."	ACEs are not a program but an acronym that stands for Adverse Childhood ExperienceS… maybe comment should read " Leverage resources from the newly proposed *program* for ACEs."
45	3rd - 5th bullets "-> The County…"	These are not the first time I read "the county" (which should be capitalized), but since most of the report is what Yolo County's HHSA should or will be doing, I suggest removing all references like this to "the county" and format with appropriate verbs like the rest of the bullets. Or, be specific and say HHSA. "The County" to me usually means the Board of Supervisors and County staff, conversely it could also mean ***us*** --the group of people receiving services, not necessarily HHSA, or County Mental Health which used to be called Alchohol, Drug, and Mental Health but now we refert o it all under Health and Human Services Agency.
46	The CEWG	
47	middle column, end of large paragraph, "…; supporting your caregiver; and making connections; …"	Remove "your" and make caregiver plural to read "supporting caregivers;"
50	"…an Institute for Mental Disease"	Probably shouldn't be capitalized since there are more than one (implied) and it seems like a type of care, not a name.
52	Under Program Description, "Because our psychiatrist…"	Should first person be used here? It is a nicely personable sentence. The next paragraph refers to HHSA support--who else would "our" be of, keep consistent. Recommend changin sentence to read "Because the telepsychiatrist for HHSA is known…."
53	First sentence paragraph under Mental Health Crisis Services	What is the difference between "inpatient psychiatric facility/psychiatric health facility placement?" inpatient vs outpatient? Maybe rephrase this portion of the sentence, paragraph, or both if it must stay in one sentence.
53	Two-sentence second paragraph under Mental Health Crisis Services	recommend not using and/or throughout entire Report. Further, for this sentence many designations are redundant or nessitate another sentence: "Further, at any day or time, 24 hours a day seven days a week, when an indigent individual in Yolo County 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. An indigent individual could be an existing Yolo County 'mental health) client, any Yolo County Medi-Cal beficiary, or others who are in Yolo County and are in need."

53	"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.	Remove "possibly" in all reformatting of this sentence or find another way to say the possibility isn't sure in each city. Recommend "Additionally, working with existing City Homeless Coordinators, County crisis staff will provide phone and *sometimes* field response to support local law enforcement officers who encounter community members in crisis. At the time of the writing this Report, at least one city wide pilot program exists in the County that will have an HHSA County clinician embedded with local law enforcement..."
53	"...mental health-related..."	remove the hyphen
53	"...when a family member/loved one reports…" and other instances throughout, but especially on page 53	Consider never using a "/" in professional writing. Change to "...when a family member or loved one reports…" for example…. See below.. Many "/" in this report can be written as "or". Many "and/or" in this report can be written as "option1, option2, or both."
53	First bullet of page "-> reducing unnecessary local emergency room visits and/or psychiatric involuntary holds pf individuals in crisis, "	Recommend "-> Reducing unnecessary local emergency room visits, psychiatric involuntary holds of individuals in crisis, or both," Change "pf" to "of"
53	Middle of page, bullet "-> preventing crisis escalation which may resulting in serious injury/consequences to clients, their loved ones, and the community at large, and	Change "resulting" to "result" and remove "/". Recommend "-> preventing crisis escalation which may result in serious injury or other consequences to clients, their loved ones, and the community at large, and "
54	Objective 2 "Strengthen the relationship between law enforcement, consumers, and their families and the public mental health system."	Consider "Strengthen the relationship between the public mental health system and law enforcement, mental health patients(or I can live with "clients" or "MH clients" here), and their families."
54	2nd paragraph under Program Descritpion	Consider not using "This" as well as removing an "and": Maybe, "The Program specifically provides case management with other individual and family services to Yolo County children and youth up to age 20 with unmet or undermet mental health treatment needs."
72	The AFI Foundation	This is really cool!
75	The Central Regional WET Partnership	Also, very cool… I think there should be adequate incentives to retain good MH Professionals, and for contractors.

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%

		From Reading Section PP 47-75							
Subtotals	Community Services and Supports Plan (AA)					20-23	20-21	Extrapolate	Surplus?
$39,719,133	~ AA	Peer- and Family-Led Support Services	non-FSP	Continuing	adults	$300,000	$100,000	$8,333.33	0
	~ AA	Older Adult Outreach and Assessment Program	Both	Continuing	Older	$3,894,269	$1,251,345	$3,754,035	$140,234
	~ AA	Adult Wellness Services Program	Both	Continuing	adults	$18,205,939	$5,556,979	$16,670,937	**$1,535,002**
	~ AA	Community-Based Drop-In Navigation Center	non-FSP	Continuing	All A	$2,533,200	$844,400	$2,533,200	$0
	~ AA	Tele-Mental Health Services	Both	Continuing	All A	$2,347,632	$771,538	$2,314,614	$33,018
	~ AA	Mental Health Crisis Service and Crisis Intervention	non-FSP	NEW + MOD	All A	$5,385,240	$1,505,779	$4,517,337	**$867,903**
	~CYF 0-5	Children's Mental Health Services	Both	Continuing	0-5	$2,142,387	$686,311	$2,058,933	$83,454
	~TAY 16-25	Pathways to Independence	Both	Continuing	TAY	$4,910,466	$1,573,481	$4,720,443	$190,023
$10,535,827	Prevention and Early Interve	Senior Peer Counseling Program	non-FSP	Continuing	Older	$150,000	$50,000	$150,000	$0
	~ AA	LatinX Outreach/Mental Health Promotores Prograr	non-FSP	Continuing	TAY + Adults	$885,444	$295,148	$885,444	$0
	~CYF 0-5	Early Childhood Mental Health Access and Linkage F	under 25	Continuing	0-5	$1,200,000	$400,000	$1,200,000	$0
	~CYF	K-12 School Partnerships	under 25	NEW	C6-18	$3,300,000	$1,100,000	$3,300,000	$0
	~TAY	Youth Early Intervention Program	under 25	Continuing	TAY	$382,148	$122,421	$367,263	$14,885
	~TAY	College Partnerships	under 25	NEW	TAY	$450,000	$150,000	$450,000	$0
	~CHB	Early Signs Training and Assistance	non-FSP	Continuing	All A	$1,296,014	$425,895	$1,277,685	$18,329
	~CHB	Cultural Competence	non-FSP	NEW	ALL PATIENT	$2,572,221	$675,967	$2,027,901	**$544,320**
	~	Maternal Mental Health Access Hub	non-FSP	NEW	ALL PATIENT	$300,000	$100,000	$300,000	$0
$1,953,000	Innovation Plans	Integrated Medicine into Behavioral Health		NEW	ALL A	$1,808,000	$506,000	$1,518,000	$290,000
	~	Crisis Now Learning Collaborative		NEW	ALL A	$145,000	$145,000	n/a	$0
$2,742,790	Capital Facilities and Techno	IT Hardware/Software/Subscriptions Services	non-FSP	Continuing	n/a	$2,492,790	$811,374	$2,434,122	$58,668
	~	Peer-Run Housing	non-FSP	NEW	adults	$250,000	$250,000	n/a	$0
$321,533	Workforce, Education, and T	Mental Health Professional Development	non-FSP	Continuing	ALL A	$167,422	$54,880	$164,640	$2,782
	~ AA	Peer Workforce Development Workgroup	non-FSP	Continuing	Older + Adul	$69,111	$23,037	$69,111	$0
	~	Central Regional WET Partnership	non-FSP	NEW	ALL A	$85,000	$30,000	***$90,000***	***-$5,000***
$55,272,283	TOTAL								

RESPONSE:
Thank you for your suggested edits related to grammar and formatting of the plan. MHSA strives to improve the readability of the plan. In 20166, the state passed legislation that carved out a piece of local county MHSA funding (7%) specifically to fund No Place Like Home (NPLH) grants to support permanent supportive housing to mentally ill residents. There are 41 NPLH units located in West Sacramento and 29 units in Woodland, CA. Regarding program evaluation and data, HHSA acknowledges it can do better with evaluating MHSA program outcomes. This is not unique to Yolo county and is a statewide issue, as counties have prioritized service delivery over additional administrative support costs. Nonetheless, HHSA understands the importance of investing in program evaluation and quality improvement, and therefore has already begun implementing Results Based Accountability (RBA) measures for all MHSA contracts and funded programs and will continue to do so with the new plan. Furthermore, HHSA has set aside funding in the new plan to bring in outside support to help with program evaluation and outcome assessments. HHSA is making edits to the plan to highlight these evaluation activities. Please see Yolo County MHSA Profile, page 94, for demographics and data on residents served, FSP outcomes, and prevention and early intervention programs.

AFI is a foundation that HHSA is seeking to partner with under Innovation. Childrens museums are institutions that provide exhibits and programs to stimulate informal learning experiences for children. Mental health support for children are currently funded through community partners at the local level. Proposed solutions, included in the plan, were community generated and included with the terminology as provided.

Fabian Valle

From: Esmeralda Mandujano <emandujano@ucdavis.edu>
Sent: Monday, July 20, 2020 4:58 PM
To: MHSA
Subject: MHSA Plan Draft for FY 2020-2023_Feedback
Attachments: MHSAPublicCommentFormFY202.pdf

Good afternoon,

Please see attached comments. Also, would it be possible to know who runs this program "Latinx Outreach/Mental Health Promotores Program?" I work with a coalition of promotores in the county and it would be ideal to collaborate with this program.

Best,

Esmeralda

[THIS EMAIL ORIGINATED FROM OUTSIDE YOLO COUNTY. PLEASE USE CAUTION AND VALIDATE THE AUTHENTICITY OF THE EMAIL PRIOR TO CLICKING ANY LINKS OR PROVIDING ANY INFORMATION. IF YOU ARE UNSURE, PLEASE CONTACT THE HELPDESK (x5000) FOR ASSISTANCE]

COUNTY OF YOLO

Health and Human Services Agency

Mental Health Services Act (MHSA) 30-Day Public Comment Form

Public Comment Period—Friday June 19, 2020 through Monday July 20, 2020

Document Posted for Public Review and Comment:

MHSA Three-Year Program & Expenditure Plan FY 2020-2023

This document is posted on the Internet at:
http://www.yolocounty.org/mhsa

PERSONAL INFORMATION (optional)

Name: Esmeralda Mandujano

Agency/Organization: Puentes de Yolo

Phone Number: 530-867-7531 Email address: emandujano@ucdavis.edu

Mailing address: ____________________

What is your role in the Mental Health Community?

_____ Client Consumer	_____ Mental Health Services Provider
X Family Member	_____ Law Enforcement/Criminal Justice Officer
X Educator	_____ Probation Officer
_____ Social Services Provider	_____ Other (Specify)__________

Please write your comments below:

If you need more space for your response, please feel free to submit additional pages.

Page 9/67: Cultural Competence has some pitfalls, such as falling into stereotypes.
The community could benefit from exploring Cultural Humility.
Page 19: Spelling for 'relationship problems'
Poverty or economic challenges and living in a rural area are also important risk factors for this community.

Please return your competed comment form to HHSA/MHSA before 5.00 P.M. on Monday July 20, 2020 in one of two ways:

- Scan and Email this completed form to MHSA@yolocounty.org, Subject: MHSA Plan Draft for FY 2020-2023 Comments
- Mail this form to HHSA/MHSA, Attn: MHSA Coordinator, 25 N. Cottonwood St., Courier #16CH, Woodland, CA 95695

RESPONSE:

HHSA is committed to cultural competence, cultural humility, and proficiency and strives to embed it in all our work, including MHSA. MHSA will increase attention, 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. We will seek community partners support as HHSA acknowledges we can do better and cannot engage on this one sided. Thank you for informing us of a typo as we work to finalize the draft. HHSA strives to serve the County at all localities and acknowledge the significance of engaging the rural areas as well. This plan includes $2.6 million in funds over the next 3 years to demonstrate our commitment. All services will be contracted out following an RFP process.

Fabian Valle

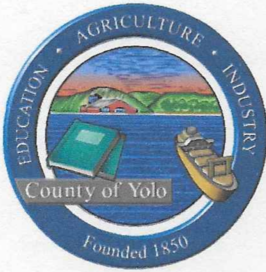
From: Linda Wight <l.wight@sbcglobal.net>
Sent: Monday, July 20, 2020 2:32 PM
To: MHSA
Subject: Fwd: MHSA Plan Draft for FY 2020-2023 Comments
Attachments: HPSCAN-20200720210202126.pdf

Sent from my iPad

Begin forwarded message:

> **From:** Linda Wight <linda@namiyolo.org>
> **Date:** July 20, 2020 at 2:19:58 PM PDT
> **To:** l.wight@sbcglobal.net
> **Subject: MHSA Plan Draft for FY 2020-2023 Comments**
>
> Attached please find our comments related to the MHSA Plan Draft.
> Thank you.
> Linda Wight

[THIS EMAIL ORIGINATED FROM OUTSIDE YOLO COUNTY. PLEASE USE CAUTION AND VALIDATE THE AUTHENTICITY OF THE EMAIL PRIOR TO CLICKING ANY LINKS OR PROVIDING ANY INFORMATION. IF YOU ARE UNSURE, PLEASE CONTACT THE HELPDESK (x5000) FOR ASSISTANCE]



COUNTY OF YOLO

Health and Human Services Agency

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http://www.yolocounty.org/mhsa

PERSONAL INFORMATION (optional)

Name: Linda Wight, Jeni Price, Kim Farina, David Segal

Agency/Organization: NAMI Yolo County

Phone Number: (408)578-3576 Email address: linda@namiyolo.org

Mailing address: 1960 Witham Dr. Woodland, CA 95776

What is your role in the Mental Health Community?

_____ Client Consumer
X Family Member
_____ Educator
_____ Social Services Provider
_____ Mental Health Services Provider
_____ Law Enforcement/Criminal Justice Officer
_____ Probation Officer
_____ Other (Specify)________________

Please write your comments below:
If you need more space for your response, please feel free to submit additional pages.

Please see attached document.

Thank you!

Please return your competed comment form to HHSA/MHSA before 5:00 P.M. on Monday July 20, 2020 in one of two ways:

- Scan and Email this completed form to MHSA@yolocounty.org, Subject: MHSA Plan Draft for FY 2020-2023 Comments
- Mail this form to HHSA/MHSA, Attn: MHSA Coordinator, 25 N. Cottonwood St., Courier #16CH, Woodland, CA 95695.

To: **Karen Larsen, Director, HHSA, Yolo County**
Brian Vaughn, Community Health Branch Director, HHSA, Yolo County
From: **Jeni Price, Kim Farina, David Segal, Linda Wight**
RE: **Questions and comments on Yolo County's draft 2020-2023 Three-Year MHSA Program and Expenditure Plan**
Date: **July 20, 2020**

Thank you for the opportunity to provide comments on the Yolo County Mental Health Services Act proposal. We are sure this is a very intense time at Health and Human Services, so the overview of our request to the MHSA proposal team is as follows:

- Identify and serve as many county mental health clients as possible with "whatever it takes" FSP services.
- Efficiently track SMI clients who are not on FSP to sustain wellness and prevent the need for more costly services (i.e. ER visits, IMD and/or Out of County Placement, Conservatorship, Criminal Justice involvement, etc).
- Sustain every supportive housing unit and expand supportive services to currently existing residences as needed to improve community acceptance and avoid decompensation and create a cohesive coalition of housing partners throughout the county.
- Maintain our two remaining Adult Residential Facilities (Both Pine Tree Gardens homes) with the same operating structure so that they can remain "sister properties" with similar administration and services.

Should you have enough time to read the substantiation for our concerns, please continue below.
Thank you,
Jenifer Price (President), Kim Farina (Vice-President)
David Segal, Linda Wight (Directors and Advocacy Co-chairs)
NAMI Yolo County

This year, it was outstanding to see how much the MHSA community input process and educational outreach was expanded. As a result, it is predictable that there is more involvement during the 30 day public review of the proposal and we view that as a positive outcome. Thank you for listening and responding to the request for an adjusted ratification timeline and for taking time out during this critical global health crisis to answer questions. It is most sincerely appreciated. After so much hard work, allowing the Local Mental Health Board time to reflect on public comment and HHSA responses is a key component to sending a document to the Board of Supervisors that represents the most important community mental health issues and clarifies the plan to show how these needs will be addressed and evaluated over the next three years. It was wonderful to see program participant artwork and focus group quotations included in the narrative.

While participating in the MHSA process over the previous two three-year funding cycles, supportive housing and case management have always surfaced as high priorities by the participants. While the emphasis of CSS funding in particular is rightly directed towards the clients with highest needs (51%), we have seen a population of SMI adults who are currently NOT receiving Full Service Partnership (FSP) support whose needs are not being adequately tracked by the County (the other 49%). Since FSP clients can draw down additional funding, it would seem productive to identify as many FSP clients as we possibly can. In addition, we need to redouble our efforts to sustain those who fall outside those parameters. There currently is not data to suggest how many hours family members, community volunteers and/or Adult Residential Facility operators devote to this population for activities that FSP clients receive like doing welfare checks, patient advocacy, de-escalating acute episodes 24/7, providing transportation to Dr/lab appointments, managing medication, including residents in community activities, and knowing the clients well enough to detect the first signs of escalating symptoms. It is important for the County to value these unpaid efforts because they represent a dramatic cost savings in the continuum of care and it's a service that won't be there forever. When a caregiver/family member can no longer provide this undocumented service, we can't allow the county to be taken off-guard and left ill-prepared. We urge you to do a better job of recognizing the needs of these SMI clients and show greater appreciation for the extraordinary efforts that go on unseen every day. We hear about those efforts on a regular basis when we respond to NAMI helpline callers or listen to the anguish in the voices of NAMI Family Support Group participants as they struggle with the dilemma of solving problems in silence on their own or enduring the pain of watching their loved ones struggle and decline far enough to qualify for a higher level of care. This "Fail First" strategy of support is counterproductive.

Stable and supportive housing is critical for this underserved group and early detection of decompensation is mandatory. We are pleased to see a proposal for peer-run housing, but if we want to have any impact on NIMBYISM and STIGMA so that supportive housing opportunities can be expanded in the future, we can't continue to let individuals deteriorate to the point of being "a danger to themselves or others" in the community. That standard of care is simply unacceptable. Pacifico should have taught us this very painful lesson. Waiting for a crisis to initiate care geometrically increases the chances of a negative outcome (jail/morgue instead of access to medical intervention). When you factor in cultural reticence for initiating a police encounter for a loved one, it's no wonder that it might take longer than one three year cycle to accomplish a systemic change and conclude that a program has had a positive impact. We will definitely need for families to see some positive outcomes from any new proposal before they are comfortable using it. That should be taken into account as a mitigating factor when evaluating program successes.

Although we participated in many MHSA sessions, we still do not have an adequate understanding of why the change is being made in CIT training and how the new social worker response will be sustained this time. We hope we will have improved statistical analysis. NAMI has a strong history of CIT involvement all the way back to 1988 in Memphis and we would like to ensure that we have a place in discussions about changes in policing policy and/or First

Responder training. Having access to after-hours urgent care is also still a high priority. We have been on the cutting edge with some new programs in Yolo County, CIP, Urgent Care, and a Navigation Center in particular, and yet we need to improve our roll out and community awareness campaign to change the mindset in the community that it is still too scary to call 9-1-1 for mental health support because one thing we know for sure is that the response team will be bringing a lethal weapon to the encounter. Even better, we need to look at alternate options besides 9-1-1 to access appropriate medical treatment.

In the Board and Care Study completed by Research Development Associates, several recommendations were made that are yet to be implemented. Supportive housing is a high priority from the community input process and a strong predictor of mental health stability. While we are most appreciative of the Ad Hoc Committee that was formed to explore ways to Save Pine Tree Gardens, the decision to purchase Pine Tree East was rushed and hectic. We felt short-changed because sustaining the homes and their successful programs with fidelity to the founders was one of the main reasons for forming the Save Pine Tree Gardens Committee, and the advocacy for better local/state/federal funding and fund-raising campaign had only just begun to make an impact. Most of all, the guiding principles of the MHSA to be a community collaboration that was client and family driven was largely ignored in this transaction. In the frantic effort to meet the funding deadline, the last consideration was what effect this plan would have on the residents, their families and the current operators. While we appreciate that $1 million didn't have to be sent back to the state, we need a better system for avoiding these funding crises in the future.

It is not our intention with these inquiries to create barriers to the implementation of new programs, but to help generate a more cohesive and transparent document that reflects the work that took place in the focus groups, community outreach and education process and community engagement workgroup meetings. Allowing a more reasonable timeframe for Health and Human Services to respond to this input and the Local Mental Health Board to reflect and suggest changes based on this input will result in strengthening the final document so that it will earn the support of the Board of Supervisors. We are very grateful for the care and attention that Mental Health issues have received from the Board during this unprecedented year of increased stress for our communities.

NAMI Yolo County appreciates our continued support from MHSA funding to provide education and services to families and peers and expand culturally responsive training and advocacy. We have seen some dramatic successes in our county's diversion programs and as a result, the Forensic Team has been awarded additional funding to expand their programs which should be celebrated. In addition, it is time to look at why this model is working well and investigate ways to incorporate some of these strategies into other care level teams for smoother transitions or ideally early response and prevention. As always, NAMI Yolo County is committed to do whatever it takes, not just for FSP levels of care, but for all people living with mental health challenges and their families and friends.

Response:

The MHSA three-year planning process was started in May 2019 with a series of three monthly educational sessions through July 2019, followed by an extensive plan development process beginning in August 2019 and ending in January 2020. During this process over 500+ community residents and stakeholders representing a wide range of geographic and demographic communities participated in providing feedback to the plan. Their interests, priorities, and voice are represented in this plan. As a result, HHSA does not believe further delay in finalizing and implementing the plan is warranted at this time. Furthermore, we believe additional delays beyond what has already happened as a result of COVID, risks undermining the broad community feedback that was received last fall and could jeopardize the timely implementation of new investments around expansion of Full Service Partnership (FSP) and K-12 school-based services at a time when they are in high demand due to the COVID pandemic.

Regarding program specific recommendations, HHSA will take each of these recommendations into consideration as they assess each of the programs in the new plan.

In regards to allocating additional MHSA funding for supportive housing, the Community Engagement Workgroup (CEWG) was made aware that while it was a highlighted priority for the community, that other funding streams existed to support this priority beyond MHSA. Given the existence of other funding streams, the county has prioritized local MHSA funds to support service delivery as intended. These services include significant investments in staffing to support permanent supportive housing. Additionally, in 2016, the state passed legislation that carved out a piece of local county MHSA funding (7%) specifically to fund No Place Like Home (NPLH) grants to support permanent supportive housing to mentally ill residents. There are 41 NPLH units located in West Sacramento and 29 units in Woodland, CA. Over the course of the next three years several developments are planned, adding over 400 units for low/extremely low income individuals in Yolo County. More than half of these units are permanent supportive housing units which have services on site and available to residents. Some units are designated for persons experiencing homelessness but many are not. Some are also more short term in nature. We are prioritizing bringing people back to Yolo who have been placed elsewhere, whether that be an IMD or a Board and Care in another county along with the intended Peer-Run Housing Program.

The County has invested approximately $200,000 of MHSA dollars over the last two years to repairs of the Pine Tree Gardens Homes. Additionally, as referenced, the County just ensured the purchase of East House and a long term deed restriction utilizing $1 million of MHSA dollars. Furthermore, the County will be contracting with NVBH to cover the costs of operations for the coming three years which we expect to cost approximately $800,000 MHSA dollars per year for both homes. Lastly, HHSA is currently updating the plan to provide additional information to better illustrate the connection between the community feedback and program investments.

MHSA Budget Overview

	19/20	20/21	21/22	22/23
MHSA Revenue	12,064,027.00	13,245,716.00	12,548,762.00	10,624,859.00
Administration	510,619.00	653,529.00	678,470.00	704,409.00
Salaries & Benefits	5,266,208.00	7,442,081.00	7,730,699.00	8,030,863.00
Contracts	6,398,783.00	9,916,184.00	10,712,822.00	11,129,970.00

Contribution/(Use) of Fund balance					
FY1920	**FY2021**	**FY2122**	**FY2223**	**4-year total**	**3-year total**
$ 348,926	$ (2,801,040)	$ (4,463,085)	$ (6,999,612)	$ (13,914,810)	$ (14,263,737)
small contribution to fund balance in 19/20					

HHSA Positions Partially or fully funded by MHSA

Position Title	# of Positions
Psychiatrist	5
Behavioral Health Case Manager	25
Clinical Psychiatrist	1
Clinician	21
Deputy Branch Director	1
HHSA Program Coordinator	2
Medical Assistant	1
HHSA Manager	1
Extra Help- Consultant	3
Mental Health Peer Support Worker	23
Nurse Practitioner	1
Outreach Specialist	4
Staff Nurse	4
Supervising Staff Nurse	1
Supervising Clinician	8
Psychiatric Health Specialist	1

102 HHSA positions are either all, or partially funded by MHSA

Approximately 5.6% of total MHSA revenue received is used for MHSA Administration (average of FY19/20-FY22/23)

What is Results Based Accountability (RBA)?

	Quantity	Quality
Effort	**PM 1** **How much did we do?** # Staff Functions & Percentages Personnel Costs & Contract Totals Grant/Benefit Totals # of Customers	**PM 2** **How well did we do it?** Efficiencies Workload ratios Waiting Time/Waiting Lists Timelines Satisfaction
Effect	**#**	**%**

PM 3

Is anyone better off?

Change in…

Skills/Knowledge

Attitude/Opinion

Behavior/Circumstance

Select a Program

Determine the Purpose

- Why is this important?
- What outcome do you hope to achieve?

Verify Connection to:

- County Strategic Goals
- Department Goals
- Program Goals
- Employee Goals

Craft Performance Measures

1. How much did we do?

Quantity x Effort

- Output
- # of Staff
- # of Customers

2. How well did we do it?

Quality x Effort

- Efficiencies
- Workload ratios
- Wait times
- Timelines
- Satisfaction

*3. Is anyone better off?

Quantity x Quality x Effect

- Change in
  - Skills/knowledge
  - Attitude/opinion,
  - Behavior/circumstance

MHSA Programs Outcome Goals: Child Youth & Family Branch

- ***Primary (EPSDT)/Intensive Services (Wrap)/FSP/Bridges Outcome Measures for Outside Vendors:***

Program Measures (PM1's) measure: How Much did we do? This is typically a number quantifying volume

1.1 Number of FTE's
1.2 Number of open and authorized clients
1.3 Number of Intakes
1.4 Number of discharges
1.5 Number of discharges to a lower level of care
1.6 Number of Referrals received
1.7 Number of children meeting ICC or IHBS criteria
1.8 Number of children served who are non-English speakers

Program Measures 2 (PM2's) measures: How Well Did We Do?

2.1 Percent of clients who received an intake assessment within 14 days of referral

2.2 Percent of clients assessed with Child and Adolescent Needs and Strengths (CANS)

2.3 Percent of clients with completed authorization packet within 60 days of admit

2.4 Percent of authorization requests completed within 30 days of renewal

2.5 Percent of open clients with submitted 6 months progress report

2.6 Number of clients per clinician

2.7 Number of days to successful discharge (quarterly average)

2.8 Percent of discharge disposition submitted within 14 days of discharge

2.9 Percent of ICC and IHBS eligible clients with facilitated CFT every 90 days

2.10 Percent of clients who successfully met treatment plan goals

2.11 Percent of clients who received 1st clinical appointment within 7 days post psychiatric hospitalization

2.12 Percent of clients who received 1st psychiatric follow up within 30 days post psychiatric hospitalization

2.13 Number of provider changes per client

Program Measures 3 (PM3's) measures: Is Anyone Better Off?

3.1 Number of clients with decrease in number of items needing action on Child Behavioral/Emotional Need section of CANS from intake to discharge

3.1a Percent of clients with decrease in number of items needing action on Child Behavioral/Emotional Need section of CANS from intake to discharge

3.2 Number of clients with decrease in number of items needing action on Life Domain Functioning section of CANS from intake to discharge

3.2a Percent of clients with decrease in number of items needing action of Life Domain Functioning sections of CANS from intake to discharge

3.3 Number of clients with decrease in number of items needing action on Caregiver Resources and Needs section of CANS from intake to discharge

3.3a Percent of clients with decrease in number of items needing action on Caregiver Resources and Needs section of CANS from intake to discharge

3.4 Number of clients who remained in their home (without jail or psychiatric hospital admits) or maintained foster home placement

3.4a Percent of clients who remained in their home (without jail or psychiatric hospital admits) or maintained foster home placement

- ***Primary (EPSDT) Outcome Measures for CYF Internal Team***

Program Measures 1 (PM1'S): How Much did we do?

1.1 Number of FTE's
1.2 Number of open clients
1.3 # of intakes
1.4 Number of unplanned discharges
1.5 Number of successful discharges
1.6 Number of closed out referrals
1.7 Number of Referrals received
1.8 Number of children meeting IHBS Criteria
1.9 Number of children served who are non-English speakers
1.10 Number of Families served who are non-English speakers

Program Measures 2 (PM2's) measures: How Well Did We Do?

2.1 Percent of clients who received an intake assessment within 10 days of referral

2.2 Percent of clients assessed with Child and Adolescent Needs and Strengths (CANS) within 30 days

2.3 Percent of clients assessed with CANS at discharge

2.4 Percent of clients assessed with 6-monhts CANS

2.5 Number of days to successful discharge (quarterly average) (not for closed out referrals) (successful discharge is defined as met treatment goals and/or no longer meets medical necessity for SMHS)

2.6 Percent of ICC and IHBS eligible clients with facilitated CFT every 90 days

2.7 Percent of clients who successfully met treatment plan goals

2.8 Percent of clients who received 1st clinical appointment within 7 days post psychiatric hospitalization

2.9 Percent of clients who received 1st psychiatric follow up within 15 days post psychiatric hospitalization

Program Measures 3 (PM3's) measures: Is Anyone Better Off?

3.1 Number of clients with decrease in number of items needing action on Child Behavioral/Emotional Need section of CANS from intake to discharge

3.1a Percent of clients with decrease in number of items needing action on Child Behavioral/Emotional Need section of CANS from intake to discharge

3.2 Number of clients with decrease in number of items needing action on Life Domain Functioning section of CANS from intake to discharge

3.2a Percent of clients with decrease in number of items needing action of Life Domain Functioning sections of CANS from intake to discharge

3.3 Number of clients with decrease in number of items needing action on Caregiver Resources and Needs section of CANS from intake to discharge

3.3a Percent of clients with decrease in number of items needing action on Caregiver Resources and Needs section of CANS from intake to discharge

3.4 Number of clients with decrease in number of items needing action on Risk Behaviors section of CANS from intake to discharge

3.4a Percent of clients with decrease in number of items needing action on Risk Behaviors section of CANS from intake to discharge

3.5 Number of clients who remained in their home (without jail or psychiatric hospital admits) or maintained foster home placement

3.5a Percent of clients who remained in their home (without jail or psychiatric hospital admits) or maintained foster home placement

- ***TBS Outcome Measures:***

Program Measures (PM1's) measure: How Much did we do? This is typically a number quantifying volume

1.1 Number of FTE's
1.2 Number of open and authorized clients
1.3 Number of Intakes
1.4 Number of discharges
1.5 Number of discharges to a lower level of care
1.6 Number of Referrals received
1.7 Number of children served who are non-English speakers

Program Measures 2 (PM2's) measures: How Well Did We Do?

2.1 Percent of clients who received a functional behavior assessment within 10 days of referral

2.2 Percent of clients with completed authorization packet within 30 days of admit

2.3 Percent of authorization requests completed within 15 days of renewal

2.4 Number of clients per specialist

2.5 Number of days to successful discharge (quarterly average)

2.6 Percent of discharge dispositions submitted within 14 days of discharge date

2.7 Percent of clients who successfully met treatment plan goals

2.8 Number of provider changes per client

2.9 Percent of children/youth and caregivers with completed TOM-T at intake and discharge

Program Measures 3 (PM3's) measures: Is Anyone Better Off?

3.1 Number of children/youth who are able to utilize pro-social replacement behaviors by time of discharge

3.1a Percent of children/youth who are able to utilize pro-social replacement behaviors by time of discharge

3.2 Number of caregivers with increase in necessary skills to be able to intervene consistently with a target behavior by time of discharge

3.2a Percent of caregivers with increase in necessary skills to be able to intervene consistently with a target behavior by time of discharge

3.3 Number of clients who remained and maintained their home placement (without jail or psychiatric hospital admits, without out of home foster or group home placement)

3.3a Percent of clients who remained and maintained their home placement (without jail or psychiatric hospital admits, without out of home foster or group home placement)

- ***VCSS Urban School-Based Mental Health Access and Linkage Outcomes***

1.1 Number receiving Universal Outreach/Engagement services specifically for the Access and Linkage Program

1.2 Number of services provided, including direct MH triage and referral, risk assessment, brief intervention, and linkage services

1.3 Number and rate of children, youth, and family members (CYF) referred to a MH service provider.

2.1 Number and rate of routine mental health triage services provided within 7 calendar days of request for service.

2.2 Number and rate of urgent mental health triage services provided within 48 hours of request for service

2.3 Number of Access and Linkage Services provided in the child, youth or family members preferred language

3.1 Number and rate of referred CYF who received at least one mental health service from the referred provider

3.2 Of the children/youth who participated in recommended services, how many reported improvement in overall mental health symptoms

3.3 Of the family members who participated in recommended services, how many reported improvement in child/youth's family circumstance

- ## Urban School-Based Mentorship and Strengths-Building Program (USBMSBP) Outcome Measures

- Outreach and Engagement Services (Universal)

1.1 Number receiving any service from the USBMSBP
1.2 Number receiving this particular service
2.1 Percentage of CYF receiving Outreach/Engagement services engaged in services provided by this program?
2.2 What percentage of engaged CYF requested additional services (beyond initial participation)?
2.3 How did those CYF engaged in this program or service rate the efficacy of the program? (*Percent that answered yes to a yes/no question of satisfaction)*
3.1 Of those CYF engaged this service, how many reported improved personal skills, improved school or family circumstances, or feeling better overall?

-Mentorship Program (Selective)

1.1 Number receiving any service from the USBMSBP
1.2 Number receiving this particular service
2.1 Percentage of CYF receiving Outreach/Engagement services engaged in services provided by this program?
2.2 What percentage of engaged CYF requested additional services (beyond initial participation)?
2.3 What percentage of engaged CYF requested additional services (beyond initial participation)?
3.1 Of those CYF engaged this service, how many reported improved personal skills, improved school or family circumstances, or feeling better overall?

-(the most widely used EBP program for children under 12)

Q1: Real Colors
Q2: Second Step

1.1 Number receiving any service from the USBMSBP
1.2 Number receiving this particular service

2.1 Percentage of CYF receiving Outreach/Engagement services engaged in services provided by this program?

2.2 What percentage of engaged CYF requested additional services (beyond initial participation)?

2.3 How did those CYF engaged in this program or service rate the efficacy of the program? (*Percent that answered yes to a yes/no question of satisfaction)*

3.1 Of those CYF engaged this service, how many reported improved personal skills, improved school or family circumstances, or feeling better overall?

-(the most widely used EBP program for children aged 12-18)

Q1: Suicide Prevention
Q2: Anxiety and Depression

1.1 Number receiving any service from the USBMSBP
1.2 Number receiving this particular service
2.1 Percentage of CYF receiving Outreach/Engagement services engaged in services provided by this program?
2.2 What percentage of engaged CYF requested additional services (beyond initial participation)?
2.3 How did those CYF engaged in this program or service rate the efficacy of the program? (*Percent that answered yes to a yes/no question of satisfaction*)

3.1 Of those CYF engaged this service, how many reported improved personal skills, improved school or family circumstances, or feeling better overall?

- ## PEI Early Intervention—RISE Rural School-Based Mentorship and Strengths-Building Program Outcome Measures:

Program	Agency	Contact
Program Purpose	**PEI Early Intervention – RISE Rural School-Based Mentorship and Strengths-Building Program:** Increase mental, emotional, and relational well-being and resiliency among rural Yolo County youth.	
Program Information	The Rural School-Based Mentorship and Strengths-Building Program provides evidence-based, culturally responsive services and offer promising practices in outreach and engagement for at-risk children and youth in multiple settings, to build their resiliency and help to mitigate and/or support their mental health experiences.	
PM1: How much did we do?		
Staff	Total FTEs by Classification, including breakdown of program staff who are bilingual	
1.1 1.2	**Program Participants**: Total # of participants served • Total # of unduplicated participants served o Total # of participants identified as at risk of a mental illness (Prevention) [1] o Total # of participants identified with early onset of a mental illness (Early Intervention) [1] o Total # of individual family members served[1] • Total # of participants who received services in their preferred non-English language **Program Activities**: Total # of services provided in each service category • After-school mentoring programs • School-day programs • Support to parents and caregivers, as applicable	
PM2: How well did we do it?		
2.1	**Referral/Linkage**[2] Total # of participants referred to: • Primary Care services • Mental Health and / or Substance Use Disorder services • Other support services (e.g., health benefits enrollment, food resources, housing support)	

2.2	Total # of participants referred to any service. **Treatment Engagement**[2]: % and # of participants who completed a referral and engaged in treatment. Engagement is defined as participating at least once in the Program to which they were referred, including: • Primary Care services • Mental Health and / or Substance Use Disorder services • Other support services (e.g., health benefits enrollment, food resources, housing support)
2.3	**Timeliness**[2]: Average interval (in days) between the referral and participation in treatment. Participation is defined as participating at least once in the treatment to which referred.
2.4	**Duration of Untreated Mental Illness (DUMI)** [2]: Average DUMI across participants. DUMI is defined as, for persons who are referred to treatment and who have not previously received treatment, the time between the self-reported and/or parent-or-family-reported onset of symptoms of mental illness and entry into treatment. Entry into treatment is defined as participating at least once in treatment to which the person was referred.
2.5	**Staff Training**: % of program staff trained in using evidence informed and evidence based practices[3]
2.6	**Satisfaction**[4]: % and # of participants who reported satisfaction with services (e.g., services were provided at a convenient time and location; program staff treated me with respect, made me feel welcomed, respected my cultural background / beliefs, spoke to me in a language that I understood)
PM3: Is anyone better off?	
3.1	**Well-Being**[1.1]: • % and # of participants enrolled in the after-school Mentoring/Strengths Programs who demonstrate an improvement in well-being on the Youth Asset Survey. • % and # of participants enrolled in the Social Emotional Learning and Well Being Programs who demonstrate an improvement in well-being on the Global Self Worth Assessment.
3.2	**Resiliency**[1.1]: • % and # of participants enrolled in the Gallup Strengths Finder 2.0 programs who demonstrate an increase in resiliency in on the Resiliency Scale. • % and # of participants who demonstrate an improvement in overall wellbeing based on results from the Why Try pre/post assessments.

[1] PEI Regulation reporting requirement specific to Early Intervention Programs (Sections 3710, 3560.010(b)(1))

[1.1] PEI Regulation reporting requirement specific to Early Intervention Programs (Sections 3710, 3750(a), 3750(c)). These are indicators that are applicable to the Program and are intended to reduce negative outcomes as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness.

[2] PEI Regulation Strategy that shall be included in specified PEI Programs (Sections 3735, 3560.010(b))

[3] Practices may include, but are not limited to: Why Try? Curriculum; NCTI Curricula (Life Skills; Real Colors; Anger Management; Drug/Alcohol Abuse); Strengths Finder 2.0

[4] Examples from the California Consumer Perception Survey, Youth versions available in Spanish (and other languages) at: https://www.cibhs.org/consumer-perception-surveys

The PEI Regulations have additional data reporting requirements depending on different program classifications. Not all metrics are incorporated into this form but can be accessed in the Regulation document here: http://mhsoac.ca.gov/document/2016-03/pei-regulations

Early Childhood Mental Health Access & Linkage: Help Me Grow Outcome Measures:

Help Me Grow Yolo	First 5 Yolo	Gina Daleiden, Executive Director
Program Purpose	To provide universal mental health screening to parents and their children ages 0-5 years to identify young children who are either at risk of or beginning to develop mental health problems that are likely to impact their healthy development. In addition, this program will connect children and their families to services that would either prevent or intervene early to address mental health problems impacting healthy development.	
Program Information	Help Me Grow Yolo (HMG) expands and enhances identification and intervention services to young children facing mental health challenges and further the effectiveness and sustainability of First 5 Yolo programs, which assist the community to raise children who are health and ready to learn. HMG allows for prevention and early identification of developmental concerns to allow young children 0-5 years of age access to the treatment they need and deserve, mitigating for more advanced issues later in life. HMG provides for this early childhood mental health system approach to prevention and early intervention, creating access and linkage in a multitude of settings from family to school to medical and other service providers.	
PM1: How much did we do?		
Customers Units of Service	Demographic data reported: # of beneficiaries served, by gender, age of child at time of initial entry, race/ethnicity of child, culture if known, or disability (e.g. hearing impaired, seeing impaired, wheel-chair bound) # of trainings conducted for agencies/programs (outreach) # of trained individuals on the HMG Yolo services (parents, providers, community agencies) Report of who contacted HMG Yolo on behalf of the child # of calls to the Call Center Services to which child/family referrals were made (# and % of each) Presenting issues (# and % of each) # of screenings completed based on screening tools (ASQ-3, ASQ-SE, M-CHAT, SEEK) # of medical providers participating in HMG Yolo	
PM2: How well did we do it?		

2.1	# and % of how each child screened heard about/entered HMG Yolo (compare to marketing plan)
2.2	Wait time for delivery of results after screenings
2.3	# and % of subsequent screenings that are performed for children who fall into the “monitoring” category
2.4	# and % indicated on the Caregiver/Provider Satisfaction Survey as satisfied with the tools, information, skills, and supports provided to properly support optimal family growth
PM3: Is anyone better off?	
3.1	# and % of children successfully connected to at least one service or pending a start date due to a “concern” referral
3.2	# and % of children rescreened with an improved score after referrals were made due to a “monitor” result
3.3	# and % of service/program gaps identified
3.4	# and % of barriers identified

Yolo County MHSA Documentation and Information Resources

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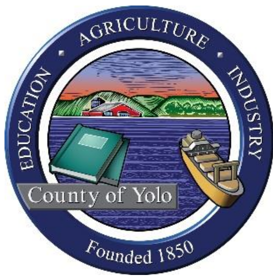
Updated:06/19/2020

New and Noteworthy

- NEW The Draft MHSA Three-Year Program and Expenditure Plan FY2020-2023 has been posted as of June 19, 2020. This draft is available for public comment through July 20, 2020 at 5:30 p.m. at which time a Public Hearing will be held. Submit comments by completing a public comment form: English | Spanish | Russian.

- The MHSA 19-20 Annual Update has been posted as of 5.2.2019. The Draft Update is available for public comment through our public comment forms. A public hearing is scheduled for June 3, 2019 at 5pm at 137 N. Cottonwood Blvd, Woodland, CA. 95695.
- The 2017-2018 Plan Update: Plan to spend reverted funds subject to AB 114 was approved by the Yolo County Board of Supervisors, Tuesday, June 5, 2018



COUNTY OF YOLO

Health and Human Services Agency

MENTAL HEALTH SERVICES ACT (MHSA):
NOTICE OF 30-DAY PUBLIC COMMENT PERIOD and NOTICE OF PUBLIC HEARING

MHSA Three-Year Program & Expenditure Plan FY 2020-2023

To all interested stakeholders, Yolo County Health and Human Services Agency (HHSA), in accordance with the Mental Health Services Act (MHSA), is publishing this **Notice of 30-Day Public Comment Period and Notice of Public Hearing** regarding the above-entitled document.

I. **THE PUBLIC REVIEW AND COMMENT PERIOD begins Friday, June 19, 2020 and ends at 5:00 p.m. on Monday, July 20, 2020.** Interested persons may provide written comments during this public comment period. Written comments and/or questions should be addressed to HHSA, Attn: MHSA Coordinator, 25 N. Cottonwood Street, Courier #16CH, Woodland, CA 95695. Please use the Public comment form provided for the MHSA Plan FY 2020-2023.

II. **A PUBLIC HEARING will be held by the Yolo County Local Mental Health Board on Monday, July 27, 2020, at 5:30 PM,** by teleconference**.** Call information will be published in advance of the meeting and listed on the Local Mental Health Board event listing found here for the purpose of receiving further public comment on the MHSA Plan for FY 2020-2023 pursuant to the Governor's Executive Order N-29-20 (March 17, 2020), available at the following link.

III. **To review the MHSA Draft Plan for FY 2020-2023**, or other MHSA documents via Internet, follow this link to the Yolo County website: http://www.yolocounty.org/mhsa.

IV. **Printed copies** of the MHSA Plan Draft for FY 2020-2023, are available. To obtain copies by mail, or to request an accommodation or translation of the document into other languages or formats, call HHSA's MHSA Office at (530) 666-8536 or email mhsa@yolocounty.org by Friday July 3, 2020.

CONDADO DE YOLO

Agencia de Salud y Servicios Humanos

LEY DE SERVICIOS DE SALUD MENTAL (MHSA):
AVISO DE PERÍODO DE COMENTARIOS DEL PÚBLICO POR 30 DÍAS y AVISO DE AUDIENCIA PÚBLICA

Programa de tres años y plan de gastos de la MHSA para el año fiscal 2020-2023

A todos los participantes interesados: La Agencia de Salud y Servicios Humanos (Health and Human Services Agency, HHSA) del Condado de Yolo, de conformidad con la Ley de Servicios de Salud Mental (Mental Health Services Act, MHSA), publica este **aviso de período de comentarios del público por 30 días y aviso de audiencia pública** con respecto al documento mencionado arriba.

I. **EL PERÍODO DE REVISIÓN Y COMENTARIOS DEL PÚBLICO comienza viernes 19 de junio de 2020 hasta el lunes 20 de julio de 2020 a las 5:00 p.m.** Las personas interesadas pueden presentar comentarios escritos durante este período de comentarios del público. Las preguntas o comentarios escritos se deben enviar por correo a HHSA, Attn: MHSA Coordinator, 25 N. Cottonwood Street, Courier #16CH, Woodland, CA 95695. Use el formulario de comentarios del público destinado al Plan de la MHSA para el año fiscal 2020-2023.

II. **La junta local de salud mental del Condado de Yolo hará UNA AUDIENCIA PÚBLICA el lunes 27 de julio de 2020 a las 5:30 p.m.,** mediante videoconferencia, con el objetivo de recibir más comentarios del público sobre el Plan de la MHSA para el año fiscal 2020-2023, en virtud de la orden ejecutiva del gobernador N-29-20 (17 de marzo de 2020), a la que puede acceder mediante este enlace.

III. **Para revisar el Proyecto de Plan de la MHSA para el año fiscal 2020-2023**, u otros documentos de la MHSA en internet, haga clic en este enlace y visite el sitio web del Condado de Yolo: http://www.yolocounty.org/mhsa.

IV. **Hay copias impresas** del Proyecto de Plan de la MHSA para el año fiscal 2020-2023. Para obtener copias por correo postal, o para solicitar una adaptación o traducción del documento en otros idiomas o formatos, llame a la oficina de la MHSA de la HHSA al (530) 666-8536 o envíe un correo electrónico a mhsa@yolocounty.org, antes del viernes 3 de julio de 2020.

Округ Йоло (County of Yolo)

Агентство здравоохранения и социальных служб

ЗАКОН ОБ УСЛУГАХ В ОБЛАСТИ ПСИХИЧЕСКОГО ЗДОРОВЬЯ (MENTAL HEALTH SERVICES ACT, MHSA):
СООБЩЕНИЕ О 30-ДНЕВНОМ ПЕРИОДЕ ДЛЯ ОТКЛИКОВ ОБЩЕСТВЕННОСТИ и СООБЩЕНИЕ ОБ ОБЩЕСТВЕННЫХ СЛУШАНИЯХ

Программа MHSA на три года и план расходов на финансовый год 2020-2023

Для всех заинтересованных сторон, Агентство здравоохранения и социальных услуг в округе Йоло (HHSA) в соответствии с Законом об услугах в области психического здоровья (Mental Health Services Act, MHSA), публикуют это **Сообщение о 30-дневном периоде для откликов общественности и Сообщение об общественных слушаниях** в связи с выше указанным документом.

I. **ПЕРИОД ОБЩЕСТВЕННОГО ОЗНАКОМЛЕНИЯ И ОТКЛИКОВ начинается в Пятница, 19 июня, 2020 г. и заканчивается в 5:00 p.m. в Понедельника, 20 июля, 2020 г.** На протяжении этого периода для откликов общественности заинтересованные лица могут подавать отклики в письменном виде. Письменные отклики и/или вопросы следует направлять по адресу HHSA, Attn: MHSA Coordinator, 25 N. Cottonwood Street, Courier #16CH, Woodland, CA 95695. Пожалуйста, используйте форму для общественных откликов, предоставленную для MHSA Plan FY 2020-2023.

II. **ОБЩЕСТВЕННЫЕ СЛУШАНИЯ будут проводиться Локальным комитетом по вопросам психического здоровья в округе Йоло в понедельник,27 июля, 2020 года, в 5:30 PM,** при помощи телеконференции**,** с целью получения дополнительных откликов общественности на MHSA Plan for FY 2020-2023 в соответствии с Исполнительным Указом Губернатора (Governor's Executive Order N-29-20 (март 17, 2020 г.), с которым можно ознакомиться по следующей ссылке.

III. **Для ознакомления с документом MHSA Draft Plan for FY 2020-2023**, или другими документами MHSA в Интернете, перейдите по этой ссылке на вебсайт округа Йоло: http://www.yolocounty.org/mhsa.

IV. Доступны **печатные копии документа** MHSA Plan Draft for FY 2020-2023. Чтобы получить копии почтой или запросить помощь в пояснении документа или перевод документа на другие языки или форматы, позвоните в офис HHSA’s MHSA Office по номеру (530) 666-8536 или email mhsa@yolocounty.org в пятницу, 3 июля 2020 г.

THE DAVIS enterprise

PROOF OF PUBLICATION
(2015.5 C.C.P.)

Proof of Publication
PUBLIC NOTICE
#895

Yolo County Health & Human Services Community Health Branch
Attn: Fabian Valle
137 N. Cottonwood Street
Woodland, CA 95695

STATE OF CALIFORNIA
County of Yolo

I am a citizen of the United States and a resident of the County aforesaid; I'm over the age of eighteen years, and not a party to or interested in the above-entitled matter. I am principal clerk of the printer at the Davis Enterprise, 315 G Street, a newspaper of general circulation, printed and published Monday, Wednesday, and Friday, in the City of Davis, County of Yolo, and which newspaper has been adjudged a newspaper of general circulation by the Superior Court to the County of Yolo, State of California, under the date of July 14, 1952, Case Number 12680; that the notice, of which the annexed is a printed copy (set in type no smaller than non-pareil), has been published in each regular and entire issue of said newspaper and not in any supplement thereof on the following dates, to-wit:

July 1, 10, 19

All in the year **2020.**
I certify (or declare) under penalty of perjury that the foregoing is true and correct.

Dated at Davis, California, this **21st day** of **July, 2020**

Shawn Collins

PUBLIC NOTICE

Notice is hereby given: the 30-Day Public Review and Comment Period pertaining to the draft Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan FYs 2020-2023 began June 19, 2020; the draft plan and comment forms are posted on the MHSA page of the Yolo County Website at www.yolocounty.org/mhsa. The draft MHSA Three-Year Program and Expenditure Plan is available for public comment and review until 5:00 PM on 07/20/2020; all interested stakeholders are encouraged to submit comments. Submission instructions are included in the comment forms. A public hearing will be held by the Yolo County Local Mental Health Board on Monday, July 27, 2020, at 5:30 PM, by teleconference. Call information will be published in advance of the meeting and listed on the Local Mental Health Board event listing page. After final revisions the MHSA Three-Year Program and Expenditure Plan will be presented to the Yolo County Board of Supervisors on 08/4/2020. Questions? Email MHSA@yolocounty.org or call 530-661-2745.
7/1, 7/10, 7/19 895

From:	Brittany Peterson
To:	Fabian Valle
Subject:	FB posts for your records
Date:	Thursday, July 23, 2020 4:25:18 PM
Attachments:	image001.png image002.png

Yolo County Health & Human Services Agency

July 8 at 12:30 PM ·

The draft Yolo County Mental Health Services Act (MHSA) Three-Year Program & Expenditure Plan FY 2020-2023 has been posted to the MHSA page of the Yolo County website, at www.yolocounty.org/mhsa

This draft MHSA document will remain posted for Public Review and Comment until 5:00 p.m. on Monday, July 20, 2020.

YOLOCOUNTY.ORG

Mental Health Services Act | Yolo County

In November 2004, California voters passed Proposition 63, the Me...

336
People Reached

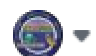
10
Engagements

Boost Unavailable

2

1 Share

Like Comment Share



Comment as Yolo County Health & Huma...

Yolo County Health & Human Services Agency

June 25 at 12:29 PM ·

The draft Yolo County Mental Health Services Act (MHSA) Three-Year Program & Expenditure Plan FY 2020-2023 has been posted to the MHSA page of the Yolo County website, at www.yolocounty.org/mhsa

This draft MHSA document will remain posted for Public Review and Comment until 5:00 p.m. on Monday, July 20, 2020.

YOLOCOUNTY.ORG

Mental Health Services Act | Yolo County

In November 2004, California voters passed Proposition 63, the Me...

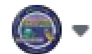
184
People Reached

2
Engagements

Boost Unavailable

2

Like Comment Share



Comment as Yolo County Health & Huma...

Brittany Peterson
HHSA Analyst
530-419-9607

Yolo County Local Mental Health Board Website Public Posting

Local Mental Health Board | Yolo

Not secure | yolocounty.org/health-human-services/boards-committees/local-mental-health-board/-toggle-all

- 2020-23 MHSA Plan - Public Comments and Agency Responses

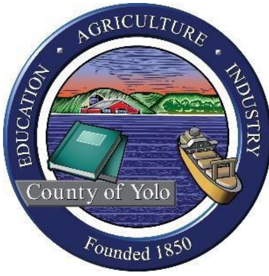
Meetings

Meeting agendas, minutes, and other related materials are attached to the calendar events listed below. Click on the meeting date to download meeting materials for review.

(All Categories) (All Departments)

Today | Next 7 days | Next 30 days | All Upcoming | All Past | All

EVENT	DATE/TIME	AGENDA	MINUTES
Local Mental Health Board	12/07/2020 6:00 PM - 8:00 PM	Not Included	Not Included
Local Mental Health Board	10/26/2020 6:00 PM - 8:00 PM	Not Included	Not Included
Local Mental Health Board	09/28/2020 6:00 PM - 8:00 PM	Not Included	Not Included
Local Mental Health Board	08/31/2020 6:00 PM - 8:00 PM	Not Included	Not Included
Local Mental Health Board Special Meeting	07/27/2020 6:00 PM - 8:00 PM	2020_07_27_LMHB Agenda_Final Final County PTG Sustainability Plan 2020 7.14.20 MHSA. Public Comments received FY2023 Draft Plan (Rev 7.24.20)	Not Included
Local Mental Health Board Special Meeting	07/13/2020 6:00 PM - 7:30 PM	2020_07_13_LMHB Agenda_Draft 700-demographic summary mh clients 062920	Not Included
Local Mental Health Board	06/29/2020 6:00 PM - 8:00 PM	2020_06_29_LMHB Agenda_Final LMHB Agenda Packet _06292020 Mental Health Directors Report_06292020 MHSA Plan LMHB 6.29.2020	2020-05-18_20 LMHB Minutes_Draft
Local Mental Health Board	05/18/2020 6:00 PM - 8:00 PM	2020_05_18_LMHB Agenda_Draft Local Mental Health Board Agenda Packet 05_18_20	2020-04-27 LMHB Minutes_Draft



COUNTY OF YOLO

Health and Human Services Agency

Karen Larsen, LMFT
Director

137 N. Cottonwood Street • Woodland, CA 95695
(530) 666-8940 • www.yolocounty.org

Nicki King
Chair

Jonathan Raven
Vice-Chair

Xiaolong Li
Secretary

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(Oscar Villegas)
Aleecia Gutierrez
Maria Simas
Rachel Warren

District 2
(Don Saylor)
Serena Durand
Nicki King
Antonia Tsobanoudis

District 3
(Gary Sandy)
Richard Bellows
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(Jim Provenza)
Carol Christensen
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(Duane Chamberlain)
Brad Anderson
Xiaolong Li

Board of Supervisors Liaison
Don Saylor

Alternate
Jim Provenza

Local Mental Health Board

Special Meeting: Monday, July 27th, 2020, 6:00 PM–8:00 PM

Join Zoom Meeting
https://us02web.zoom.us/j/82483355378?pwd=bWluUnY4clVBc0dWVzB1YU1KbUkxZz09
Meeting ID: 824 8335 5378
Password: bv2KyL
Dial: 1 408 638 0968

CALL TO ORDER--6:00 PM – 6:05 PM

1. Public Comment
2. Approval of Agenda

TIME SET AGENDA---6:05 PM – 6:40 PM

3. Mental Health Services Act (MHSA) Plans 2020-2023-Response to Public Comment

SPECIAL MEETING---6:40 PM – 7:50PM

4. Mental Health Services Act (MHSA) Plans 2020-2023-Review
   (Action: Public Hearing and Board Recommendations)
5. Wrap Up/Next Steps- Karen Larsen
6. PTG Sustainability Plan Review

PLANNING AND ADJOURNMENT--- 7:50 PM – 8:00 PM

7. Future Meeting Planning and Adjournment-Nicki King
   a. Propose August Recess

Next Meeting Date and Location
Regular Meeting Scheduled: August 31, 2020-ZOOM

If requested, this agenda can be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the American with Disabilities Act of 1990 and the Federal Rules and regulations adopted implementation thereof. Persons seeking an alternative format should contact the Local Mental Health Board Staff Support Liaison at the Yolo County Health and Human Services Agency, LMHB@yolocounty.org or 137 N. Cottonwood Street, Woodland, CA 95695 or 530-666-8516. In addition, a person with a disability who requires a modification or accommodation, including auxiliary aids of services, in order to participate in a public meeting should contact the Staff Support Liaison as soon as possible and preferably at least twenty-four hours prior to the meeting.

CONTINUED ON REVERSE

I certify that the foregoing was posted on the bulletin board at 625 Court Street, Woodland CA 95695 on or before Thursday, July 23rd, 2020.

Christina Grandison
Local Mental Health Board Administrative Support Liaison
Yolo County Health and Human Services

Yolo Performance Model
5-Step Performance Measurement Walkthrough

Below is a 5-step walkthrough of Yolo Performance, the County's outcome-focused performance measurement system based on the results based accountability model.

Measures are created in three categories (PM1, PM 2, PM3) using the Results Based Accountability format:

Step 1: Select a significant program

Step 2: Determine the purpose of the program

Determine the purpose of your program through the creation of a program purpose statement. The purpose statement should be succinct and outcome focused. It should also:

- In many cases, answer the question: Why is this important?
- Identify the outcome you hope to achieve
- Begin with a descriptive action word; avoid using "provide"
- Focus on the end result, not the means by which we get there

Example: Purpose Statement for Employment Center

Correct: Increase employment and maximize wages for unemployed Yolo County Residents (ends)

Incorrect: Provide job counseling (means)

Step 3: Develop the PM3 outcome measure

This measure examines if there has been any kind of positive change for clients after participation in a program or activity. Use the purpose statement previously created to identify the PM3 measure, essentially, the outcome you hope to achieve.

These measures can be reported as both # (quantity) and % (quality).

To determine if people are better off as a result of your program, you can measure:

- Impact/effectiveness of program
- Change in: Skills/Knowledge, Attitude/Opinion or Behavior/Circumstances

Purpose	PM3 Better off Measure
Prevent foster care placement for children at risk of removal and reduce time in care for children who enter foster care.	# and % of children at risk of removal who entered foster care # of days children are in foster care

Step 4: Identify the PM1 quantity measures

The PM 1 quantity measures examine “How much did we do?” and is usually expressed as a #. These measures describe basic program functions of inputs (# of staff, $ personnel costs, etc.) and outputs (# of units provided, # customers served, etc.).

Step 5: Identify the PM2 quality measures

The PM 2 measures look at the quality of our effort as either a #, % or both. Essentially, during the process of providing the service, this measure seeks to answer: “How well did we do?”

PM2 measures commonly look at efficiency (unit costs, administrative overhead rates), workload ratios (caseloads per worker), wait times, timeliness (callbacks, follow-up of referrals, application processing), and satisfaction (asking clients their satisfaction with the process).

Next Steps:

- Once the measures have been developed a “Program Information” section may be utilized to provide any background or clarification information regarding the program.

For further information can be obtained from your department representative of the Yolo Performance Work Group or by contacting:

Carolyn West
County Administrator’s Office
Senior Management Analyst
Phone: (530)406-5775
Email: Carolyn.west@yolocounty.org

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