Yolo County MHSA **Evaluation Report**

PREPARED BY

c.a.r.e. CONSULTING GROUP

2021–2022

Mental Health Services Act, Evaluation Report

Revised 1/13/2022

Contents

Acronyms

Evaluation Report v.9 Acronym listing*

AA	Adult and Aging Branch
ACT/AOT	Assertive Community Treatment/Assisted Outpatient Treatment
ASQ 3	Ages Stages Questionnaires Third Generation
ASQ SE	Ages Stages Questionnaires Social-Emotional
ASQ	Ages Stages Questionnaires
CBT	Cognitive Behavioral Therapy
CCHC IBH	CommuniCare Integrated Behavioral Health
CCHC PN	CommuniCare Perinatal
CCHC	CommuniCare
CHB	Community Health Branch
CREO	Creando Recursos y Enlaces Paran Oportunidades
CYF	Children, Youth, and Family Branch
FB	Facebook
FEP	First Episode Psychosis
FSP	Full Service Partnership
FTE	Full Time Employee
FY	Fiscal Year
HFYC	Healthy Families Yolo County
HHSA	Health and Human Services Agency
HMG	Help Me Grow
IG	Instagram
K-12	Kindergarten through 12th Grade
M-CHAT	Modified Checklist for Autism in Toddlers
MHP	Mental Health Plan
MHSA	Mental Health Services Act
N	Number
NAMI	National Alliance on Mental Illness
PHQ9	Patient Health Questionnaire-9
Q1	Quarter 1 (July–September)
Q2	Quarter 2 (October–December)
Q3	Quarter 3 (January–March)
Q4	Quarter 4 (April–June)
SEEK	Safe Environment for Every Kid
TAY	Transitional Age Youth
UC Davis ORALE	Organizations to Reduce, and to Advance, and Lead for Equity against COVID-19
YCN	Yolo Crisis Nursery

* (Rev 11-9-21)

Acronyms in the MHSA Response Document

ARP	American Rescue Plan
CLAS standards	The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
CREO	Creando Recursos y Enlaces Paran Oportunidades
ECMHA	Early Childhood Mental Health Access and Linkage Program
FSP	Full Service Partnership
FY	Fiscal Year
HHSA	Health and Human Services Agency
IT	Information Technology
K-12	Kindergarten through 12th Grade
LMHB	Local Mental Health Board
LPS	Lanterman–Petris–Short
MH	Mental Health
MHSA	Mental Health Services Act
PIP	Pathways to Independence Program
PTG	Pine Tree Garden
QC	Quality Control
QI	Quality Improvement
RBA	Results Based Accountability
SID	Sensory Integration Disorder
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SUD	Substance Use Disorder

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Executive Summary

The Mental Health Services Act (a.k.a. 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 document is the Yolo County Mental Health Services Act—Evaluation Report 2021–2022. It provides updated program evaluation data for Year 2020–2021, as part of the larger Yolo County Mental Health Services Act 2020–2023 Three-Year Program & Expenditure Plan. Data from 2019–2020 were included in the Yolo County Mental Health Services Act Annual Update 2021–2022.

This report is organized into sections:

- Executive Summary
- Summary of Program Evaluation Data
- Individual Program Evaluation Reports for 2020–2021

Yolo County HHSA uses Results-Based Accountability as the basis of evaluation to measure the impact of contract-based services provided under MHSA. The intent is to have this framework in place for all MHSA programs in the Three-Year Plan as part of the evaluation program initiatives. These are individualized for each contract and follow a general framework of: (1) How much did we do? (2) How well did we do? (3) Is anyone better off? Data provided throughout this report summarize these individual metrics. They also include some measures for the Full-Service Partnership programs (funded under Community Services and Supports) and demographic information for the Prevention and Early Intervention Programs.

This report includes an analysis of Results-Based Accountability data, where available, as well as demographic information for the Prevention and Early Intervention Programs (FY 2020–2021). HHSA acknowledges the data are incomplete; ongoing progress is being made to strengthen the overall evaluation and reporting on MHSA programs' impact. This report includes data for programs that continued from 2019–2020 forward into 2020–2021 and those that began collecting data in the 2020–2021 fiscal year.

Evaluation work to assess the overall impact, success, and challenges of MHSA funding in Yolo County will continue, as will assessment, planning, and implementation of a stronger and more effective system moving forward. HHSA acknowledges these evaluation efforts are a work in progress and represent one step in a multiphase approach to continuous evaluation of the county MHSA programs focused on accountability and quality improvement, guided by MHSA values and principles, the county strategic plan, HHSA's mission, and the Results-Based Accountability framework.

The data included in this program demonstrate successes and challenges in the MHSA work during the past year:

- The pandemic has clearly had an impact on both demand for services and capacity to provide services.
- The county and its contractors have adapted quickly to frequently changing conditions on the ground, including developing video-based approaches, working around internet connectivity issues, and engaging clients via the telephone, basically doing whatever needs to be done to keep services available.
- Many providers have found it challenging to create strong enough rapport with clients such that referral and service delivery can be provided effectively.
- Despite the broad context of the pandemic and its many demands, providers are committed to adapting and adjusting to ensure information about services continue. Of particular note: Programs have partnered with farmworker vaccination efforts to conduct outreach for mental health services; urgent care services have remained open continuously and safely with no COVID-19 outbreak, providing much needed partnership for first responders.

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.

Yolo County HHSA Directory Line

NEW: Yolo County Health and Human Services Agency Phone Line

Toll Free: (833) 744-HHSA (4472)
The new number provides access to services for callers who do not know how to reach the programs or services directly.

Access & Crisis Lines

24/7 Yolo County Mental Health Services

Toll Free: (888) 965-6647
TDD: (800) 735-2929
Website: https://www.yolocounty.org/government/general-government-departments/health-human-services/mental-health

Last verified: 04/29/2021

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

National Suicide Prevention Lifeline

(800) 273-(TALK) 8255

Nacional de Prevención del Suicidio

(888) 628-9454

Protective Services

Yolo County Adult Protective Services

Toll Free Adult Abuse Reporting: (888) 675-1115
Adult Abuse Reporting (24/7 Intake Line): (530) 661-2727
Locations:
137 N. Cottonwood Street, Woodland, CA 95695
500 A Jefferson Boulevard, Suite 100, West Sacramento, CA 95605
Website: https://www.yolocounty.org/government/general-government-departments/health-human-services/adults/adult-protective-services

Last verified: 04/29/2021

Yolo County Child Welfare Services

Emergency: 911
Online Form: https://www.yolocounty.org/home/showpublisheddocument/55319/636743382093670000
Website: https://www.yolocounty.org/government/general-government-departments/health-human-services/children-youth/child-welfare-services-cws

Last verified: 04/29/2021

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

MHSA Evaluation Report

July 1, 2020–June 30, 2021

PROGRAM EVALUATION SUMMARY TABLE FY2020–2021

Program Name	Yolo HHSA branch**	Target number FY 21/22	Target age	Revised 3-year budget	Page
Community Services & Supports (CSS) Plan					
Children's Mental Health Services*	CYF	90	0–20	$2,108,945	15
Pathways to Independence*	CYF	75	16–25	$5,950,199	18
Adult Wellness Services Program*	AA	200	26–59	$17,534,493	22
Older Adult Outreach Assessment Program*	AA	60	60+	$4,810,961	25
Tele-Mental Health Services*	AA	200	16+	$4,157,433	27
Mental Health Crisis Services & Crisis Intervention Team Training	AA	500	16+	$5,226,235	28
Community Based Drop-In Navigation Center	AA	250	16+	$3,266,142	30
Peer and Family–Led Support Services	AA	500	26–59	$300,000	32
Prevention & Early Intervention (PEI) Plan					
Cultural Competence	CHB	TBD	0+	$2,516,942	36
Early Childhood Mental Health Access & Linkage Program	CYF	9000	0–6	$1,200,000	39
Youth Early Intervention FEP Program	CYF	25	12–25	$582,421	42
Maternal Mental Health Access Hub	CHB	TBD	0–59	$300,000	48
K-12 School Partnerships	CYF	1000	6–26	$3,640,678	56
College Partnerships	CYF	TBD	16–25	$514,133	57
Latinx Outreach/Mental Health Promotores Program	AA	200	16–59	$1,172,172	58
Early Signs Training and Assistance	CHB	450	16+	$1,079,073	64
Senior Peer Counseling	AA	250	60+	$146,800	65
Innovation (INN) Plan					
Crisis Now Learning Collaborative	AA	5000	16+	$1,640,679	70
Workforce, Education, & Training (WET) Plan					
Mental Health Career Pathways	AA	NA	0+	$146,667	73
Mental Health Professional Development	AA	NA	16+	$167,422	74
Central Regional WET Partnership	AA	NA	16+	$130,486	75
Peer Workforce Development Workgroup	AA	NA	26+	$30,265	76

Shaded rows designate evaluation data in process

* Full Service Partnership
** CYF = Children, Youth, and Families Branch
AA = Adult and Aging Branch
CHB = Community Health Branch

Community Services and Supports Data

Evaluation Data 2021–2022

FSP

Evaluation Data for: **Children's Mental Health Services** for FY20/21

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

Administered by: ● Contractor ○ County

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.

Estimated FY21/22 Costs	Estimated Number to be Served FY21/22	Estimated Cost/Person Served
$682,309	**90**	**$7,581**

PROGRAM STAFF: FULL-TIME EMPLOYEES

7 CHILD FSP

We served **110 clients** in 2020–2021

FSP

Evaluation Data for: **Pathways to Independence** for FY20/21

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

Administered by: ● Contractor | ○ County

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.

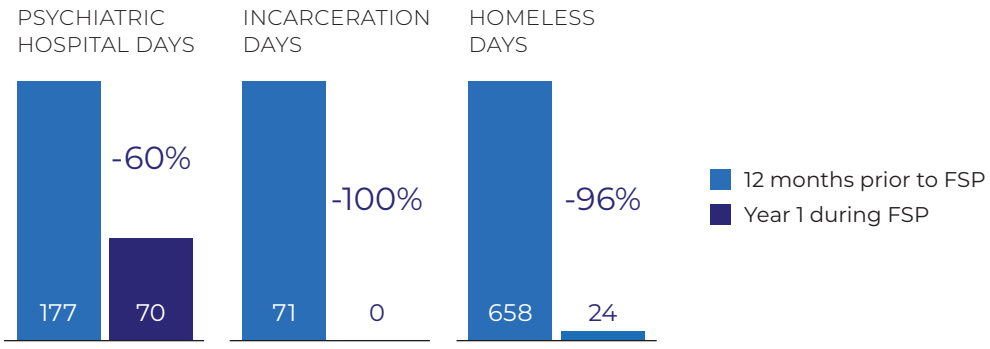
Estimated FY21/22 Costs	Estimated Number to be Served FY21/22	Estimated Cost/Person Served
$2,092,947	**75**	**$27,905**

PROGRAM STAFF: FULL-TIME EMPLOYEES

2 TAY FSP

We served **16 clients** in 2020–2021

TAY PATHWAYS TO INDEPENDENCE OUTCOMES



FSP

Evaluation Data for: **Adult Wellness Services** for FY20/21

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

Administered by: ● Contractor ○ County

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 or at risk of 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.

Estimated FY21/22 Costs	Estimated Number to be Served FY21/22	Estimated Cost/Person Served
$5,961,723	**200**	**$29,809**

PROGRAM STAFF: FULL-TIME EMPLOYEES

6 ADULT FSP

We served **58 clients** in 2020–2021

We served an additional **84 clients** through ACT/AOT FSP in 2020–2021

ADULT FSP OUTCOMES

FSP

Evaluation Data for: **Older Adult Outreach and Assessment Program** for FY20/21

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

Administered by: ● Contractor ○ County

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.

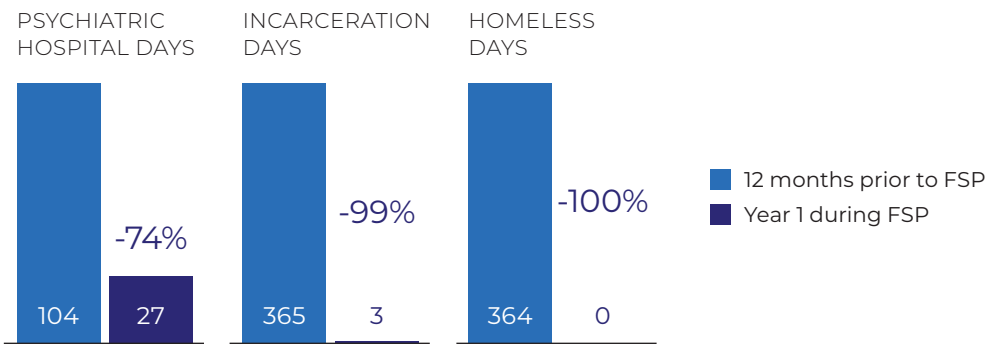
Estimated FY21/22 Costs	Estimated Number to be Served FY21/22	Estimated Cost/Person Served
$1,668,669	**60**	**$27,811**

PROGRAM STAFF: FULL-TIME EMPLOYEES

1.2 OLDER ADULT FSP

We served **11 clients** in 2020–2021

HHSA OLDER ADULT OUTCOMES



FSP

Evaluation Data for: **Tele-Mental Health Services** for FY20/21

Data Status: ● In Process

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

Administered by: ● Contractor ○ 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.

Estimated FY21/22 Costs	Estimated Number to be Served FY21/22	Estimated Cost/Person Served
$1,656,305	**200**	**$8,282**

Evaluation Data for: **Mental Health Crisis Services and Crisis Intervention Team Training** for FY20/21

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

Administered by: ○ Contractor ● County

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 among people with mental illness.
Objective 2	Strengthen the relationship among 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.

Estimated FY21/22 Costs	Estimated Number to be Served FY21/22	Estimated Cost/Person Served
$1,892,082	**500**	**$3,784**

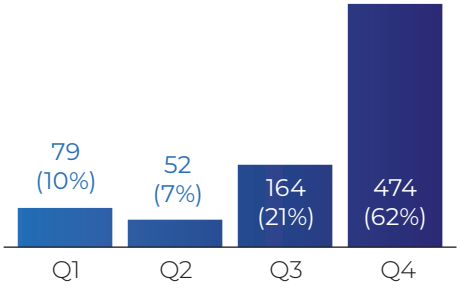
In FY 2020-2021, we spent **9,545 minutes (159 hours)** training, presenting, consulting, and reviewing holds written with law enforcement personnel.

We received **1,982 calls for 911** indicating a behavioral health issue

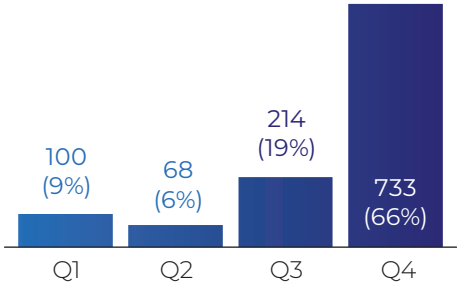
Average clinician response time: **24 minutes**

Average clinician time spent on scene: **67 minutes**

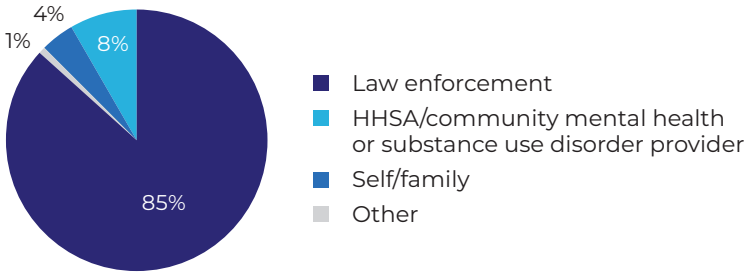
CLIENT SERVED (TOTAL = 769)



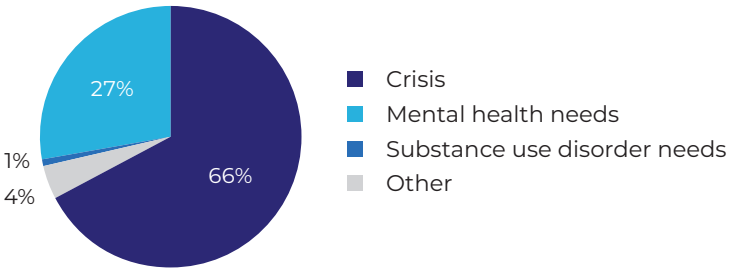
CO-RESPONDER CLINICIAN RESPONSES (TOTAL = 1,115)



SOURCES OF CLIENT REFERRALS



REASONS FOR REFERRALS



79% of clients were NOT placed on an involuntary hold

98% of clients were NOT arrested or taken to jail

46% of clients were linked to an HHSA or community provider mental health or substance use provider

2% of clients were referred to an HHSA or community provider for homeless services

Evaluation Data for: **Community-Based Drop-In Navigation Center** for FY20/21

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

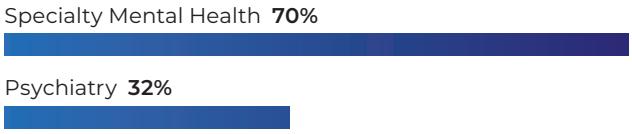
Administered by: ● Contractor | ○ County

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.

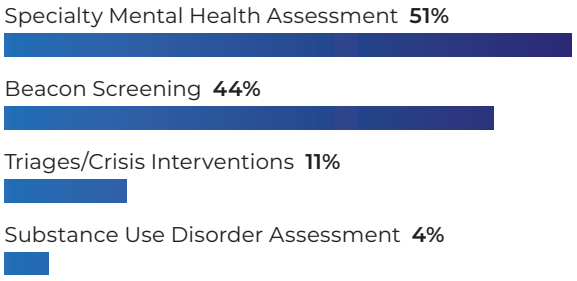
Estimated FY21/22 Costs	Estimated Number to be Served FY21/22	Estimated Cost/Person Served
$1,167,877	**250**	**$4,672**

We served **466 clients** in 2020–2021

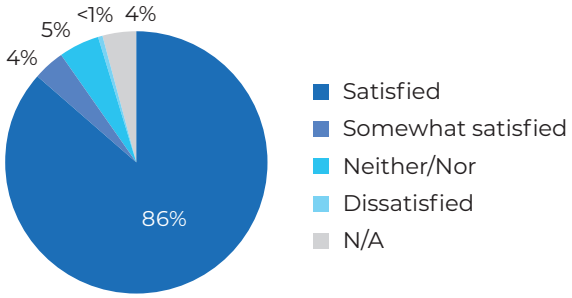
CLIENTS SUCCESSFULLY LINKED WITH PROVIDERS



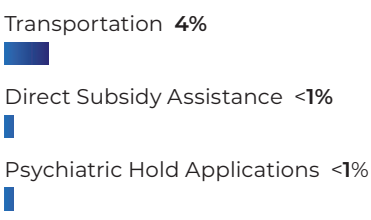
TYPES OF ASSESSMENT GIVEN TO CLIENTS



CLIENT SATISFACTION WITH SERVICES



TYPES OF SERVICES PROVIDED



PROGRAM ACCOMPLISHMENTS

- Adjusting to the changes due to the onset of the Pandemic in 2020 was challenging. Although many agencies closed their doors to the public, navigation services stayed open and provided case management, assessment, and triage services either in person or via phone. Navigation staff also continued to assist law enforcement and HHSA with 5,150 assessments in the community and on-site at the Navigation Center. We saw a continued increase in the number of services provided. While utilizing personal protective equipment and safety measures amid the COVID-19 pandemic, we continued meeting the needs of the community. The first part of 2021 saw lifted restrictions and an increase in foot traffic.
- Navigation staff continued to remain a part of Project Room Key of Yolo County. One of the navigation case managers, Juan Tinoco, spent a majority of his time connecting clients with community resources such as housing, Cal Fresh, medical care, transportation, and mental health care services, etc. Juan and other CommuniCare staff also collaborated with Healthy Davis Together to provide COVID-19 testing and later, vaccinations.
- Navigation Center staff became involved in the Davis Emergency Shelter Project. Two navigation case managers were utilized, one full-time (Dan Walker) and one part-time (Juan Tinoco). They participated in transitioning Project Room Key clients to the emergency shelter apartments in Davis. They also expanded on the services that had been provided in Project Room Key by assisting clients with obtaining housing vouchers, solidifying physical and mental health care services, and linking to any other resources that the clients needed.
- During this time, the Respite Center continued to provide services 6 days per week without a single outbreak of COVID-19 among its clientele. Respite staff remained strict around safety protocols, requiring clients to wear masks and shields as opposed to masks alone. These precautions have resulted in the center being able to remain open and provide services to unhoused clients.
- A consequence of the pandemic was the termination of funding and as a result, navigation services discontinued evening hours and had to eliminate one of the case manager positions.

Evaluation Data for: **Peer- and Family-Led Support Services** for FY20/21

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

Administered by: ● Contractor | ○ County

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.

Estimated FY21/22 Costs	Estimated Number to be Served FY21/22	Estimated Cost/Person Served
$100,000	**500**	**$200**

56 staff and volunteers supported peer- and family-led services in 2020-2021

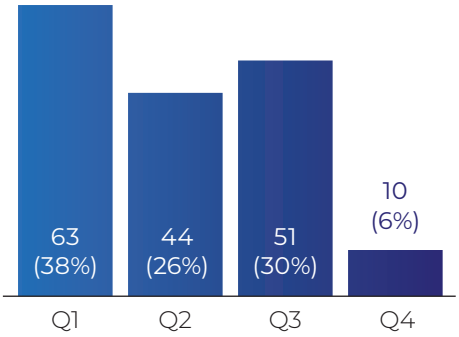
Volunteers dedicated **4,652 hours** this year!

We posted **421 times** to social media (FB and IG)

We held **3 educational presentations and outreach events**

We held **6 annual events**

HELPLINE CALLS RECEIVED AND RESPONDED (TOTAL = 168)

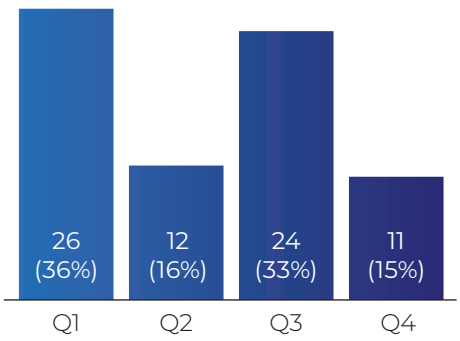


SUPPORT GROUP PARTICIPANTS
Total: 635

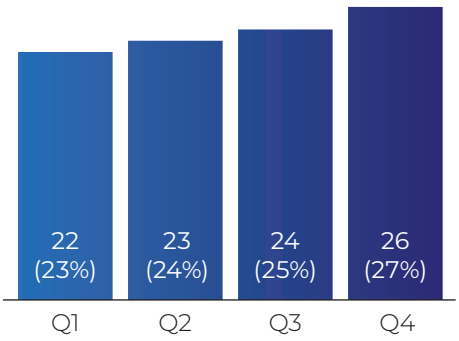
FAMILY SUPPORT GROUPS (N = 324)

CONNECTIONS GROUPS (N = 311)

FAMILY SUPPORT GROUPS (TOTAL = 73)



CONNECTIONS GROUPS HELD (TOTAL = 95)



STIGMA REDUCTION

100% of participants in **Peer to Peer education classes** agreed or strongly agreed that they are better able to manage stress symptoms after attending their session.

100% of participants of **Family Education classes** agreed or strongly agreed that their understanding of mental health symptoms had increased.

INCREASED ACCESS TO MENTAL HEALTH SERVICES

100% of participants in **Peer to Peer education classes** agreed or strongly agreed that their ability to access community resources and services had increased after attending their session.

100% 100% of participants receiving **NAMI supports** agreed or strongly agreed that they had an increased ability to access community resources and services from attending the group.

INCREASED KNOWLEDGE OF MENTAL HEALTH SYMPTOMS

100% of participants in **Peer to Peer education classes** agreed or strongly agreed that their ability to recognize the signs and symptoms of mental illness had increased.

100% of participants of **Family Education classes** agreed or strongly agreed that their knowledge of mental health symptoms had increased.

100% of **community members** agreed or strongly agreed that their knowledge of mental health symptoms had increased after participating in an In Our Own Voice presentation.

INCREASED SUPPORT FOR FAMILY MEMBERS

100% of participants of Family Education classes agreed or strongly agreed that they felt an increase in support after taking the class.

PROGRAM ACCOMPLISHMENTS

- Created a brand new website with double the content. It has more extensive possibilities and a support team. Our "In Crisis" page has been updated and has improved layout. We added a program calendar, Spanish language pages, and updated our local resources pages. In addition to featuring the programs that are part of the grant, it also includes links to on-line classes and support for teens, the BIPOC community, veterans and active-duty military, and frontline professionals.
- We hired a full-time program director on February 9. She has been working to rebuild NAMI Yolo's programs and has conducted outreach in the community, organized trainings, and connected with past NAMI volunteers in an attempt to find teachers, facilitators, and presenters to re-engage with the programs. We also hired a full-time executive director, who began her position on June 1. She has been meeting with county supervisors, learning about NAMI Yolo County programs, and planning the program calendar for the upcoming fiscal year.
- We have used a variety of platforms to recruit volunteers and participants for our programs; Facebook, website, email blasts, and contact with other affiliates. We created interest forms available on our website, allowing those looking for support easier and more streamlined access to NAMI Yolo County.
- Due to COVID-19, much like all other NAMI affiliates, we have seized the opportunity to use Zoom to train our volunteers out of the county. One of our volunteers was trained out of state (NAMI Massachusetts) via Zoom and another was trained out of county (NAMI Sonoma and NAMI Sacramento) via Zoom.
- Nearly 50 individuals participated in a special NAMI Yolo event titled Chalk Walks, which took place in downtown Davis. Individuals were encouraged to draw images and messages of hope. Four elected officials attended (including Assemblymember Aguilar-Curry), as did the Yolo County assistant district attorney. We received 75 photos of messages people created at their homes or places of work in an effort to help bring awareness to the community about mental health conditions and reduce stigma. The chalk drawings remained visible for a week, so countless others also saw the messages of hope.

PROGRAM CHALLENGES

- Class leaders struggled with how to administer surveys while meeting virtually and did not have strong staff support during this period to resolve it. No surveys were collected during trainings and groups.

Prevention and Early Intervention Program Data

Evaluation Data 2021–2022

PREVENTION

Reduce risk of developing a potential serious mental illness and build protective factors. Activities can include universal prevention strategies geared toward populations that may be more at risk of developing a serious mental illness.

Yolo County Programs/Strategies:

- Youth Early Intervention First Episode Psychosis (FEP) Program

EARLY INTERVENTION

Treatment and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence with a goal to lessen the severity and duration of mental illness.

Yolo County Programs/Strategies:

- K-12 School Partnerships
- College Partnerships
- Senior Peer Counseling
- Maternal Mental Health Access Hub
- Cultural Competence

IMPROVE TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS

Track and evaluate access and referrals for services specific to populations identified as underserved.

Yolo County Programs/Strategies:

Yolo County currently does not have any programs or strategies that fall under this category.

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

Activities or strategies to engage, encourage, educate, and train potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

Yolo County Programs/Strategies:

- Early Signs Training and Assistance

ACCESS AND LINKAGE TO TREATMENT

Activities to connect children, adults, and seniors with severe mental illness as early in the onset of these conditions as practicable to medically necessary care and treatment.

Yolo County Programs/Strategies:

Early Childhood Mental Health & Linkage

STIGMA AND DISCRIMINATION REDUCTION

Direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services, which can include training and education, campaigns, and web-based resources.

Yolo County Programs/Strategies:

Latinx Outreach/ Mental Health Promotores Program

SUICIDE PREVENTION

Organized activities that prevent suicide as a consequence of mental illness, which can include trainings and education, campaigns, suicide prevention networks, capacity-building programs, culturally specific approaches, survivor-informed models, screening programs, suicide prevention hotlines, or web-based suicide prevention resources.

Yolo County Programs/Strategies:

Early Signs Training and Assistance

The Yolo County Suicide Prevention Hotline is embedded in the Early Signs Training and Assistance Program

Evaluation Data for: **Cultural Competence** for FY20/21

Data Status: In Process

Target Population: Children Aged 0–5; Transitional-Age Youth Aged 16–25; Adults Aged 26–59; Older Adults Aged 60+

Administered by: Contractor; County

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 advancing 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.

Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$911.732	**To be determined**	**To be determined**

Evaluation Data for: **Early Childhood Mental Health Access and Linkage Program** for FY20/21

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

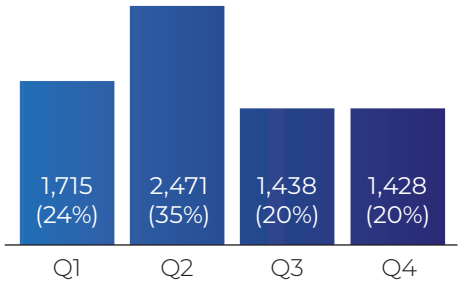
Administered by: ● Contractor ○ County

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.

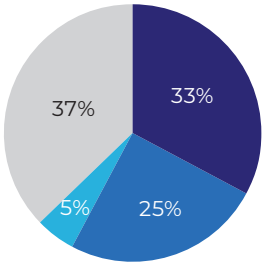
Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$400,000	**9,000**	**$44**

Evaluation Data for **Help Me Grow** for FY20/21

CLIENT CONTACTS (TOTAL = 7,052)



PERSON CONTACTING HELP ME GROW ON BEHALF OF CHILD (TOTAL = 1,229)



- Primary caregivers
- Community agency representatives
- Medical professionals
- Other

154,663 "touches" — combination of direct interactions and potential touches through distributed marketing materials

254 calls to the center

694 unique children were screened with at least one screening tool (ASQ-3, ASQ-SE, M-CHAT, SEEK, PHQ9)

We held **253 developmental playgroups**

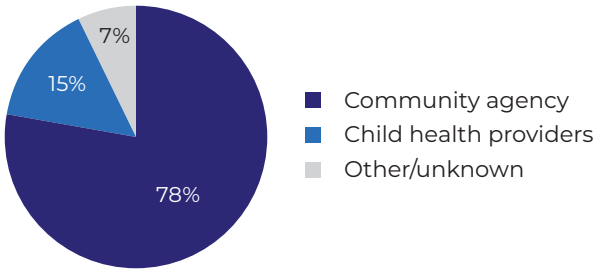
We conducted **1,978 trainings** with **59,031 participants** this year

We completed an additional **174 screens** for returning clients

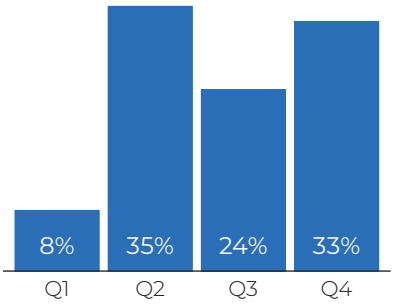
12 medical providers participated in Help Me Grow Yolo County

Average of **5 days** for family or provider to receive screening results

HOW PARENTS/ GUARDIANS HEARD ABOUT HELP ME GROW (TOTAL = 694)



OUTREACH EVENTS (TOTAL = 1,558)



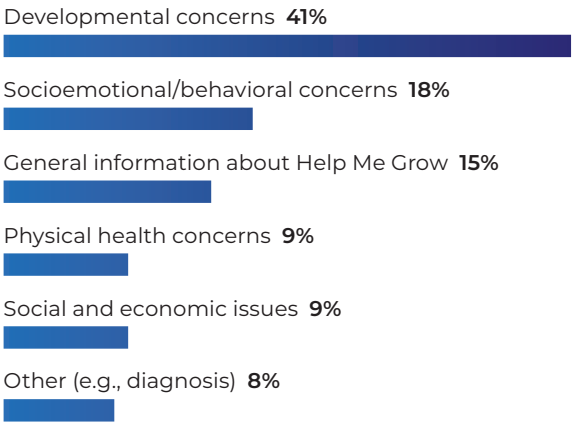
CLIENTS BY TYPE

	Q1	Q2	Q3	Q4	TOTAL
New Clients	28%	23%	22%	28%	1,246
Returning Clients	0%	12%	48%	40%	554
Individual Family Members Served	28%	23%	22%	27%	2,392
Clients Served: Prevention	21%	25%	25%	29%	931
Clients Served: Early Intervention	23%	24%	21%	32%	214

OUTREACH SETTINGS

School	25%
Family Resource Center	8%
Clinic	6%
Residence	2%
Library	2%
Mental/Behavioral Health Care	1%
Support Group	1%
Church	<1%
Substance Use Treatment Location	<1%
Primary Health Care	<1%
Other	56%

ISSUE AT TIME OF REFERRAL



TYPES OF SERVICES CHILD/FAMILY REFERRED TO

Internal resources/support services **63%**

Developmental screening **11%**

Developmental services **9%**

Social and economic support services **9%**

Socioemotional/behavioral services **3%**

Health services **2%**

Other **2%**

TREATMENT/PROGRAM CLIENT WAS REFERRED TO (TOTAL = 215)

ALTA EI **68%**

Family need: parent mental health **13%**

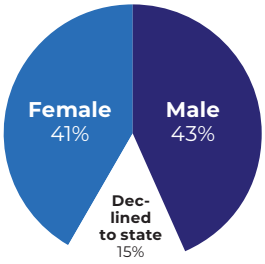
Mental health (child) **9%**

Psychological evaluation (ASD) **9%**

Other (sensory meltdowns module) **<1%**

Other (tantrum mini workshop) **<1%**

CLIENT SNAPSHOT

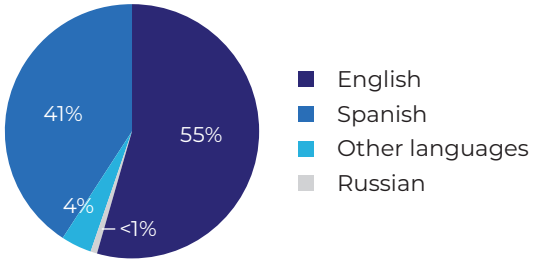


10% Have a disability

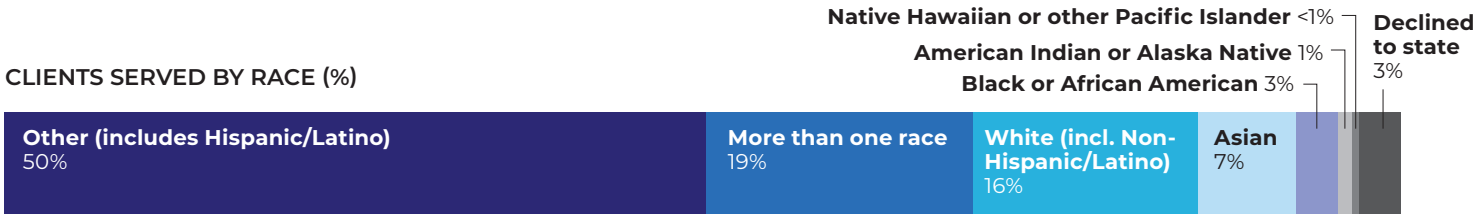
44% Hispanic or Latino

Note: Responses of "Not Recorded" were removed from the analysis.

LANGUAGES CLIENTS SERVED IN



CLIENTS SERVED BY RACE (%)



CLIENTS' CITY OF RESIDENCE	%
Woodland	39%
West Sacramento	25%
Out of County	7%
Davis	7%
Winters	6%
Esparto	5%
Madison	4%
Sacramento [board and care]	4%
Dunnigan	1%
Knights Landing	1%
Brooks, Yolo, Yolo County unincorporated areas, Clarksburg, Guinda, homeless	<1%

IS ANYONE BETTER OFF?

Children who were successfully connected to at least one service or pending a start date due to a "concern" referral

Parents or caregivers who reported increased knowledge of appropriate activities to facilitate their child's development

Children who had an improved score on screening after receiving internal resources or referrals (e.g., developmental handouts)

PROGRAM ACCOMPLISHMENTS

- Help Me Grow Yolo County organized a drive-through event where families received community resource information, books, diapers, wipes, jackets, developmentally appropriate activities, dental care supplies, and personal protective equipment. We created web pages to support parents in their use of the activity kits and partnered with the Yolo County Libraries to provide family literacy info via video on these pages to reach families that are struggling with literacy in English or Spanish.
- Help Me Grow Yolo County started work on grants to collaborate in a countywide, multiagency effort to integrate and utilize screenings administered by medical providers to identify any adverse childhood experiences and provide support and intervention needed to mitigate their long-term effects. The program's role will be to serve as the centralized referral point for all children with needs identified during screenings and to work with UniteUs to create a smooth referral pathway. This opened communication between Help Me Grow Yolo, CommuniCare, Winters Healthcare, and Sutter Health.
- Help Me Grow Yolo began offering Ready4K, a texting program that provides age-specific developmental information and activities for parents.
- Our partnership with the Migrant Education Program and the E-Center Migrant Head Start Program has provided additional support for migrant families. The children attending their program and their younger siblings are referred for ongoing support.
- Increased collaboration with Child Welfare Services has provided additional opportunities for Help Me Grow Yolo County referrals when a child is reunited with their biological family to provide additional ongoing support.
- A Help Me Grow Yolo staff member was interviewed with La Ranchera radio station, where she discussed the importance of developmental screenings and all the services Help Me Grow Yolo offers. In addition, a radio ad about Help Me Grow Yolo was aired from 5/4/21–5/16/21; each time it aired, it reached approximately 40,000 listeners.

PROGRAM CHALLENGES

- Similar to previous quarters during the pandemic, Help Me Grow has continued outreach safely, connecting with providers and community–based organizations virtually. However, this creates its own challenge in that forming a new connection via email is not ideal or possible, and may be unsuccessful.
- Although Help Me Grow Yolo has been able to reach families in Yolo County in new ways (new outreach locations, events held virtually and in person, etc.), families are needing and asking for basic needs to be met or not being able to prioritize developmental screenings at this time. Also, when they do complete a screening, their needs are more complex because the services they are looking for are not available due to the pandemic.
- The pandemic kept some school districts from maintaining their referral timelines. This has left a gap in services for school-age children identified by Help Me Grow Yolo as having delays. Not only is it unfortunate that these children are missing out on important services but also requires the Help Me Grow Yolo team to spend much more time on tracking these referrals and providing the families activities to help the children stay engaged while they wait for services to begin.
- Mental health has become a bigger need. Families with private insurance have a harder time navigating this system because Help Me Grow Yolo doesn't have a toll-free number that we can give them like with Medi-Cal recipients. Mental health services for the whole family has become a big need.

Evaluation Data for **Maternal Mental Health Services** for FY20/21

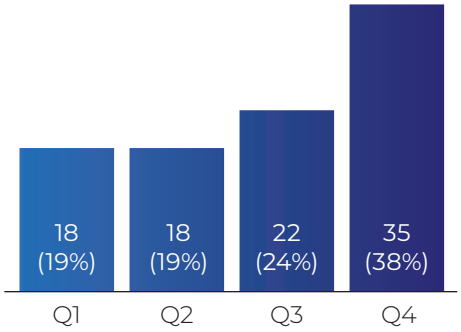
12 CLIENTS WHO RECEIVED IN-HOME COGNITIVE BEHAVIORAL THERAPY

72 SESSIONS PROVIDED

12 clients were referred in 2020–2021

50% received in-home assessments

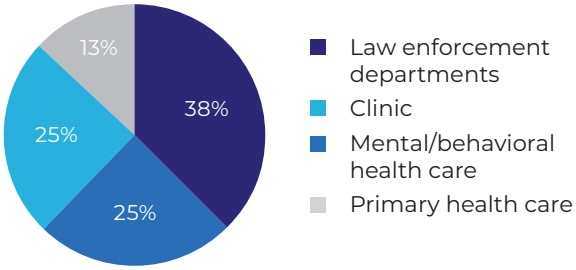
CLIENT CONTACTS (TOTAL = 93)



CLIENTS BY TYPE	Q1	Q2	Q3	Q4	TOTAL
New Clients	33%	17%	33%	17%	6
Returning Clients	100%	0%	0%	0%	4
Clients Served: Early Intervention	60%	10%	20%	10%	10

75% CLIENTS ELIGIBLE FOR IN-HOME CBT

OUTREACH SETTING



We held **8 outreach events** with **82 total participants** this year

CLIENT OUTCOMES

Clients showing improvements in function, skill development, PM, and strengths — **100%**

Clients showing improvement on pre/post Patient Health Questionnaire, PHQ-9, and self-report of functioning — **100%**

Clients completing PM CBT or graduating — **25%**

CLIENT SNAPSHOT

100% Female

80% Ages 26–59

20% Ages 16–25

10% Have a disability

10% Bisexual

CLIENTS SERVED BY RACE

1. Includes Hispanic/Latino. 2. Includes Non-Hispanic/Latino.
Note: Responses of "Not Recorded" were removed from the analysis.

70% of clients were Hispanic or Latino

50% of clients requested communications in Spanish

CLIENTS' CITY OF RESIDENCE	%
Woodland	70%
Clarksburg	10%
Davis	10%
West Sacramento	10%

PROGRAM ACCOMPLISHMENTS

- Clinician engaged in coordinating care with referring partners as needed including (CCHC IBH, CCHC Creo Program, HMG, HFYC, and the County ACCESS team). The program manager met with the Help Me Grow team to review program eligibility and benefits.
- As soon as the expanded and broadened program criteria are approved by the county, we are planning to meet with all referring parties (HMG, HFYC, County ACCESS, CCHC IBH team, CCHC CREO, CCHC PN, YCN) again to give them the updates and generate more referrals.
- We are training the new Spanish-speaking clinician, who is already taking clients. We will be implementing the use of the feedback-informed treatment model to elicit client feedback and track client progress.
- Clinicians will now be able to match the treatment modality to the client diagnosis and presenting problem, resulting in a better clinical fit for some clients.

PROGRAM CHALLENGES

The quality of the referrals were low and did not result in any ongoing engagement. We were planning for staff turnover, because our Spanish-speaking clinician is going on maternity leave in July 2021.

Evaluation Data for: **Youth Early Intervention First Episode Psychosis (FEP) Program** for FY20/21

Data Status: ● In Process

Target Population: ○ Children Aged 0–5 ● Transitional-Age Youth Aged 12–25 ○ Adults Aged 26–59 ○ Older Adults Aged 60+

Administered by: ● Contractor ○ County

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.

Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$230,000	**25**	**$9,200**

Evaluation Data for: **Maternal Mental Health Access Hub** for FY20/21

Data Status: ● In Process

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

Administered by: To be determined

Goal 1	Improve linkage to services that mitigate and improve the emotional and behavioral health of women preconception, intrapartum, and postpartum.
Goal 2	Increase the quality and quantity of evidence-based and evidence-informed treatments and services for women suffering from or at risk of 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 maternal mental health disorders.

Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$100,000	**To be determined**	**To be determined**

Evaluation Data for: **K-12 School Partnerships Program** for FY20/21

Target Population: ● Children and Transitional-Age Youth Aged 6–18 ○ Adults Aged 26–59 ○ Older Adults sAged 60+

Administered by: ● Contractor ○ County

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.

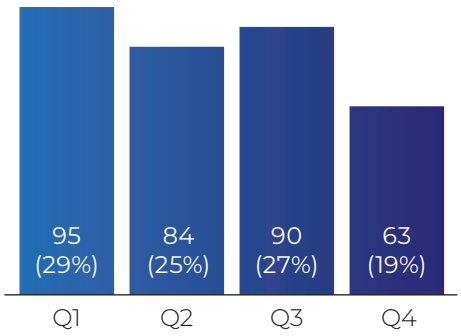
Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$1,120,339	**1,000**	**$1,120**

Evaluation Data for **Rural School-Based Access and Linkage Program** for FY20/21

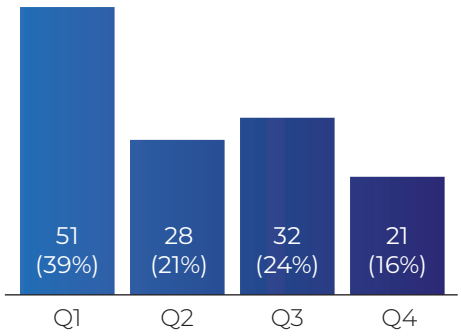
2 TOTAL FTEs (ALL BILINGUAL)

We served **132 clients** in 2020–2021

CLIENT CONTACTS (TOTAL = 332)



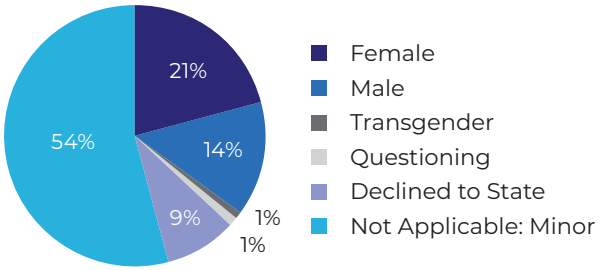
PARTICIPANTS SERVED (TOTAL = 132)



CLIENTS BY TYPE	Q1	Q2	Q3	Q4	TOTAL
New Clients	39%	21%	24%	16%	132
Returning Clients	0%	0%	0%	0%	0

100% of children needing mental health triage received the service within **48 hours** of referral from school districts or family referral

CLIENT SNAPSHOT

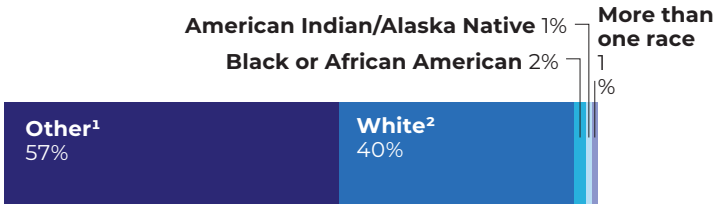


Note: Responses of "Not Recorded" were removed from the analysis.

14% Have a Disability

2% Questioning Sexual Orientation

CLIENTS SERVED BY RACE (%)



1. Includes Hispanic/Latino. 2. Includes Non-Hispanic/Latino.
Note: Responses of "Not Recorded" were removed from the analysis.

78% of clients were Hispanic or Latino

5% of clients requested written communication in Spanish

5% of clients requested spoken communication in Spanish

CLIENTS' CITY OF RESIDENCE	%
Winters	42
Esparto	36
Madison	7
Yolo County Unincorporated Areas	7
Knights Landing	4
Woodland	3
Davis	2

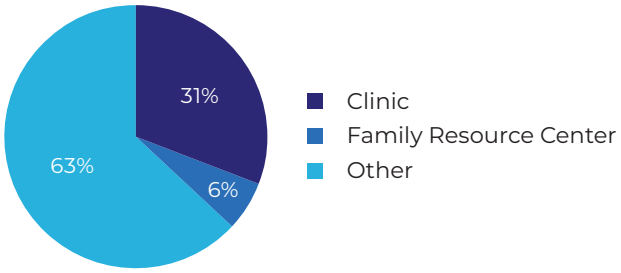
CLIENTS SERVED BY DISABILITY TYPE (18 CLIENTS TOTAL)	%
Communication Domain: Difficulty seeing	6
Communication Domain: Other	11
Mental Domain: Not including mental illness (including but not limited to learning disabilities, developmental disabilities, or dementia)	61
Chronic Health Conditions: Including but not limited to chronic pain	6
Other Disability	17
Total	**100**

OUTREACH EVENTS AND PARTICIPANTS

CLIENTS BY TYPE	Q1	Q2	Q3	Q4	TOTAL
Events	19%	31%	19%	31%	16
Participants	11%	48%	15%	26%	174

We held **16 events** in 2020–2021

OUTREACH SETTINGS



PROGRAM ACCOMPLISHMENTS

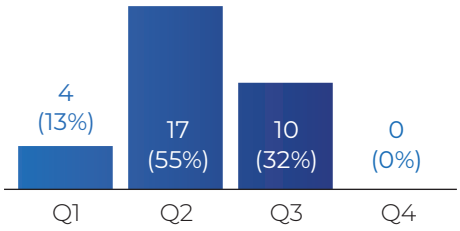
- 100% of youth referred were connected and received at least one mental health service for Q4.
- 100% of those children and family received services in their preferred language.
- In Q4, 100% of family members reported improvement in child or youth family circumstances after 30 days.
- 91% reported improvement in overall mental health symptoms after 90 days of receiving mental health services.

PROGRAM CHALLENGES

The primary challenge we encountered was related to **broadband Internet access**. Many community members had no or low-quality internet service, which caused many clients to miss sessions. We began to implement sessions over the phone during these barriers, so clients could still have accessible mental health services. There has been a great deal of stress caused by the uncertainty of these times.

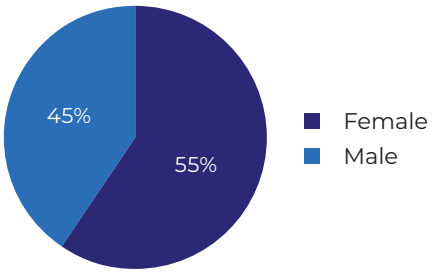
Evaluation Data for **Urban School-Based Access and Linkage Program** for FY20/21

CLIENT CONTACTS (TOTAL = 31)



We served
31 clients in 2020–2021

CLIENT SNAPSHOT



OUTREACH SETTINGS

100% other

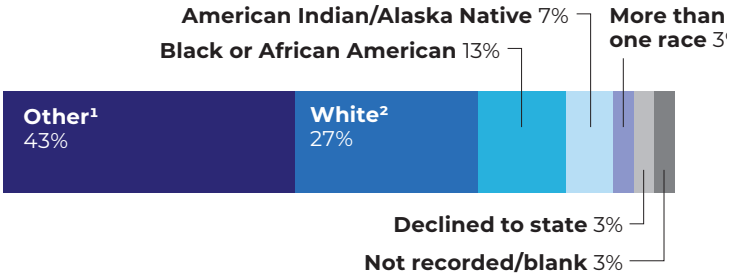
We attended **4 outreach events** in 2020–2021

CLIENTS BY TYPE	Q1	Q2	Q3	Q4	TOTAL
New Clients	13%	55%	32%	0%	31
Returning Clients	0%	0%	0%	0%	0

Schools are returning to in-person teaching. We expect to see an increase in the number of referrals we receive when school restarts in the fall.

CLIENTS' CITY OF RESIDENCE	%
Woodland	65
West Sacramento	26
Out of County	6
Declined to State	3

CLIENTS SERVED BY RACE (%)



1. Includes Hispanic/Latino. 2. Includes Non-Hispanic/Latino.

48% of clients were Hispanic or Latino

6% of clients requested written communication in Spanish

6% of clients requested spoken communication in Spanish

PROGRAM ACCOMPLISHMENTS

- 54% of children, youth, and family members were referred to a mental health provider.
- 100% of routine mental health triage services were provided within 7 calendar days of request for service.
- Staff continued to consult and assist school partners to ensure referrals were completed accurately and follow-up occurred in a timely manner.

PROGRAM CHALLENGES

A major barrier for this program in this quarter was the COVID-19 pandemic's continued closure of the schools and early completion of the school year, which resulted in a lack of referrals.

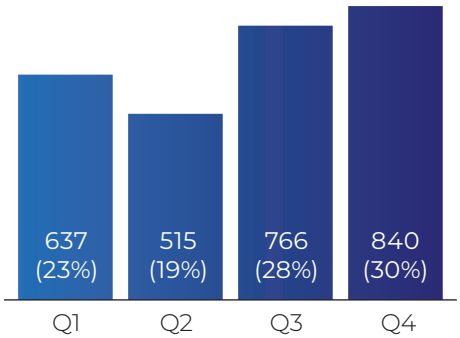
Evaluation Data for **Rural School-Based Strengths and Mentoring Program** for FY20/21

2.5 TOTAL FTEs (ALL BILINGUAL)

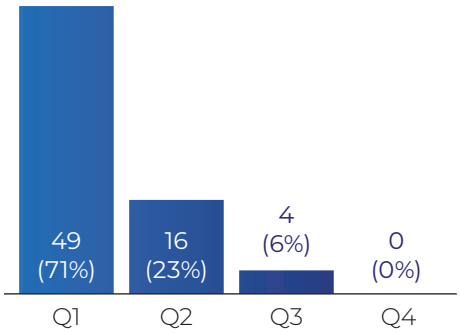
We served **69 clients** in 2020–2021

No volunteer hours of service data

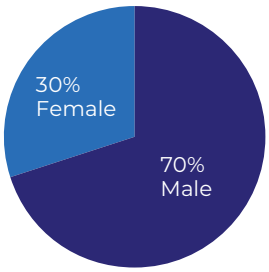
CLIENT CONTACTS (TOTAL = 2,758)



PARTICIPANTS SERVED (TOTAL = 69)



CLIENT SNAPSHOT



6% have a disability

87% of youth participants demonstrated an overall improvement in well-being on the Youth Asset Survey in Quarter 4.

CLIENTS SERVED BY RACE (%)

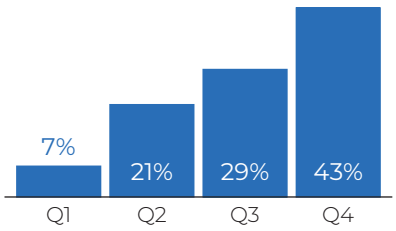
1. Includes Hispanic/Latino. 2. Includes Non-Hispanic/Latino.

67% of clients were Hispanic or Latino

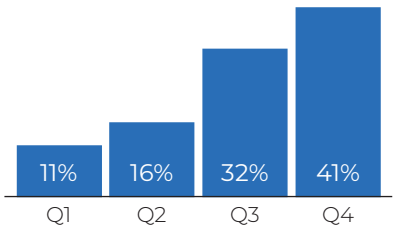
0% of clients requested communications in Spanish

CLIENTS' CITY OF RESIDENCE	%
Winters	52%
Esparto	45%
Woodland	3%

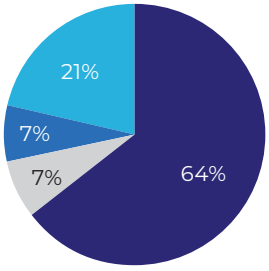
EVENTS (TOTAL = 14)



PARTICIPANTS (TOTAL = 513)



OUTREACH SETTINGS



- Family Resource Center
- Clinic
- Church
- Faith-Based Organization

We held **15 outreach events** in 2020–2021

PROGRAM ACCOMPLISHMENTS

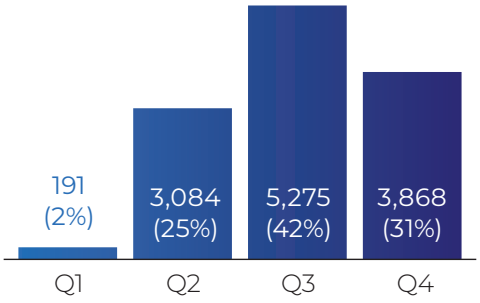
- 100% of staff received the Why Try and Strengths Finder evidence-based training.
- 80% of youth participants demonstrated improvement on the Global Self-Worth Assessment.
- In Q1, 4 participants were referred to RISE Community Center to receive additional services and received services within 7 days of referral.

PROGRAM CHALLENGES

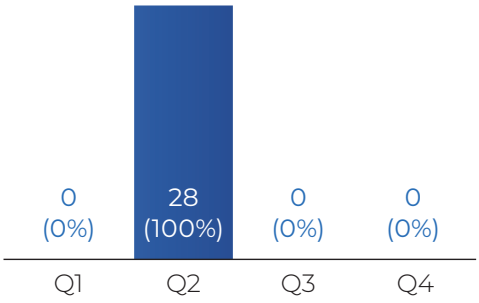
The overall fear of the COVID-19 virus and the new variants are still barriers for our communities. Families are fearful to return to consistent programming. Our team provided year-round in-person services to youth in the rural communities. However, it was a challenge to provide consistent progressive services and programs because attendance was sporadic.

Evaluation Data for **Urban School-Based Mentorship and Strengths Building Program** for FY20/21

CLIENT CONTACTS (TOTAL = 12,418)



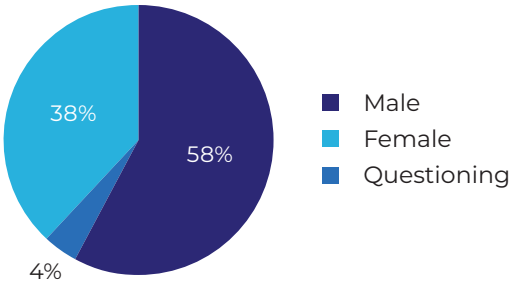
PARTICIPANTS SERVED (TOTAL = 28)



We served **28 clients** in 2020–2021

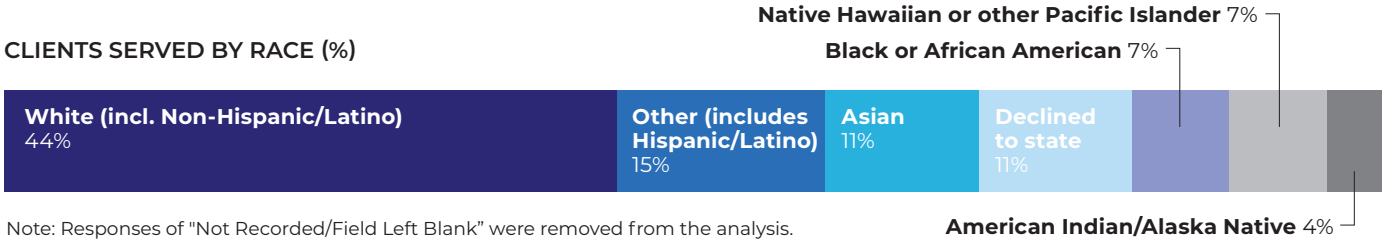
96% of respondents reported improved personal skills, improved school or family circumstances, or feeling better overall

CLIENT SNAPSHOT



We did **2 outreach events** in 2020–2021

CLIENTS SERVED BY RACE (%)



Note: Responses of "Not Recorded/Field Left Blank" were removed from the analysis.

18% of clients were Hispanic or Latino

12% of clients had a disability

CLIENTS' CITY OF RESIDENCE	%
West Sacramento	59
Davis	41

Responses of "Not Recorded/Field left blank" were removed from the analysis.

PROGRAM ACCOMPLISHMENTS

- 91% of children, youth, and families engaged in this program said it was efficacious.
- We provided full classroom strengths-building services during the virtual school day for multiple schools, as well as many large group presentations for secondary-level students who were previously difficult to access due to low attendance.
- Virtual after-school groups continued through the school year and were replaced by a full summer groups schedule advertised to the community before the school year closed.

PROGRAM CHALLENGES

- A major barrier for this program was the COVID-19 pandemic's closure of the schools, as well as some schools experiencing transitions toward a hybrid method, which resulted in our inability to provide our usual in-person groups and presentations.
- As we continue providing virtual services during and after school, a key challenge has been unusually low student attendance due to the virtual environment.
- Additionally, the school year completed mid-quarter, which further limited the ability to receive referrals.

Evaluation Data for: **College Partnerships** for FY20/21

Data Status: ● In Process

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

Administered by: ● Contractor ○ County

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.

Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$172,924	**To be determined**	**To be determined**

Evaluation Data for: **Latinx Outreach/Mental Health Promotores Program** for FY20/21

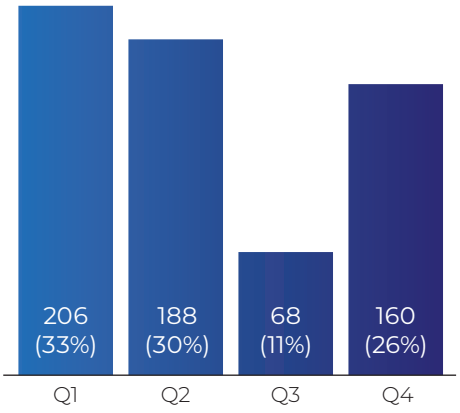
Target Population: ○ Children Aged 0–5 | ● Transitional-Age Youth Aged 16–25 | ● Adults Aged 26–59 | ○ Older Adults Aged 60+

Administered by: ● Contractor | ○ County

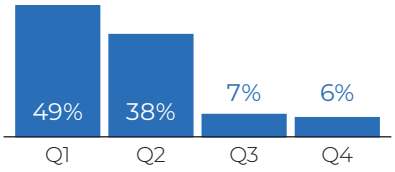
Goal 1	Provide comprehensive health services, including physical and behavioral health, to the Latinx community.
Goal 2	Expand and augment mental health services to enhance service access, delivery, and recovery.
Objective 1	Utilize culturally responsive approaches to engaging the Latinx population.
Objective 2	Increase engagement with Latino men.
Objective 3	Improve health and behavioral health outcomes for the Latinx population.

Estimated FY21/22 Costs	Estimated Number to Be Served	Estimated Cost/Person Served
$438,512	**200**	**$2,193**

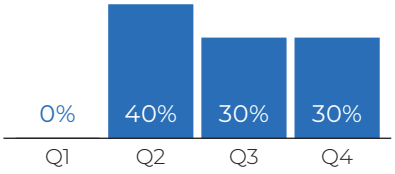
CLIENT CONTACTS (TOTAL = 622)



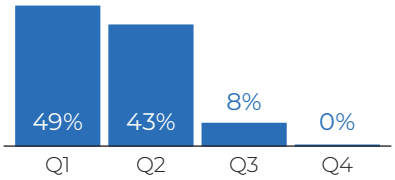
NEW CLIENTS (TOTAL = 84)



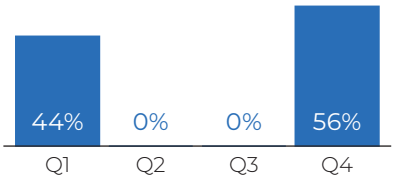
RETURNING CLIENTS (TOTAL = 93)



CLIENTS SERVED: PREVENTION (TOTAL=75)



CLIENTS SERVED: EARLY INTERVENTION (TOTAL=9)



We served **84 clients** in 2020–2021

9 clients were referred for services

100% followed through on referral and engaged in treatment

100% of participants were referred and received services within 7 days

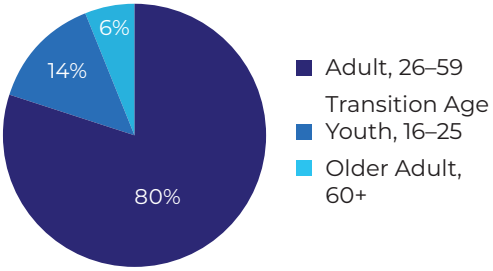
100% of participants reported being satisfied with the services provided and that their cultural background, beliefs, and language were respected

CLIENT SNAPSHOT

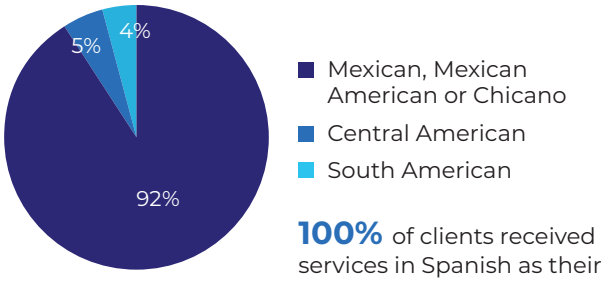
100%
Male

4%
Have a disability

CLIENTS SERVED BY AGE



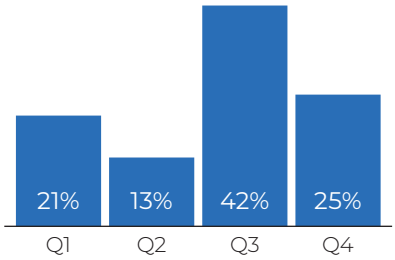
CLIENTS SERVED BY ETHNICITY



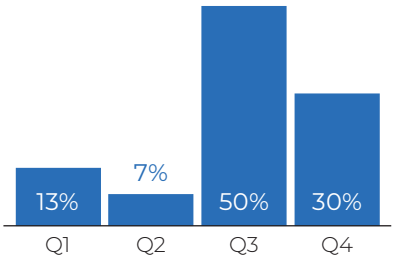
100% of clients received services in Spanish as their preferred language

CLIENTS' CITY OF RESIDENCE	%
Esparto	60
Winters	13
Madison	11
Dunnigan	8
Brooks	5
Guinda	4

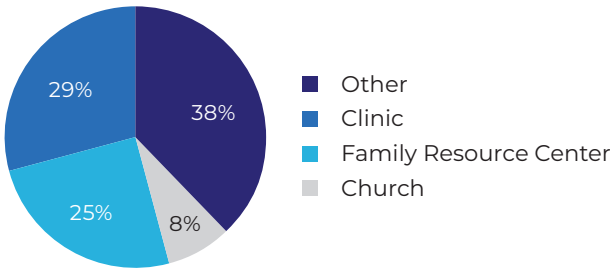
EVENTS (TOTAL = 24)



PARTICIPANTS (TOTAL = 904)



OUTREACH SETTINGS



PROGRAM ACCOMPLISHMENTS

- Our team continued to provide on-site farm outreach to Latino male heads of household. The key success for this program is that through our outreach efforts, we received five mental health self referrals from local farmworkers. It took time to establish a relationship and build trust with these individuals. As a result, they felt comfortable enough asking for help, and we were able to connect them immediately to a mental health clinician to provide services.
- Our team partnered with the UC Davis ORALE program that provides weekly COVID-19 rapid testing. This program specifically targets Latino farmworkers throughout Yolo County. We also partnered the Yolo County vaccine clinics conducted at the farms. Our team provided information about our mental health services offered at RISE.

PROGRAM CHALLENGES

Although we are providing boots on the ground with in-person outreach to local farmworkers, it is a challenge to navigate through the COVID-19 pandemic. Local farms have been amazing at allowing our team access to their workers; however, the times that we are invited are limited, and farmworkers are extremely busy during the spring and summer months. Our team did not get a lot of quality in-person, one-to-one time with farmworkers.

Evaluation Data for: **Early Signs Training and Assistance** for FY20/21

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

Administered by: ● Contractor | ○ County

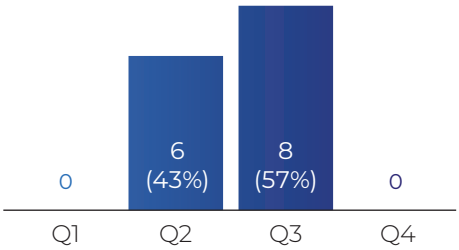
Goal 1	Expand the reach of the mental health system through the training of individuals who have the knowledge and skills to respond to or prevent a mental health crisis in the community.
Objective 1	Expand the reach of mental health and suicide prevention services.
Objective 2	Reduce the risk of suicide 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.

Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$321,826	**450**	**$715**

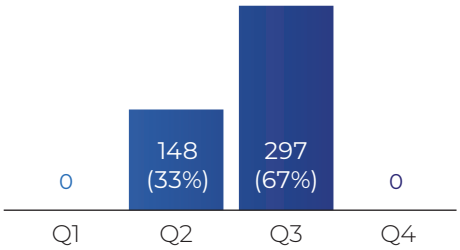
During FY20/21, all trainings and presentations were presented using the Zoom platform. Due to the virtual format, demographic data and evaluation measures could not be collected. The data below reflect information available for Q2 and Q3 (data were not available for Q1 and Q4).

2 TOTAL FTE

TRAININGS OFFERED (TOTAL = 14)



TRAININGS PARTICIPANTS (TOTAL = 445)



PRESENTATIONS	QUARTER	ATTENDEES
Mental Health and Self Care (2)	Q2	24
Supporting African American Families and Their Mental Health	Q2	45
The Nature of Trauma and Resilience	Q2	48
Preserving Your Mental Health During COVID	Q2	23
Group facilitation training in support of Black staff and student groups	Q2	8
Trauma and Resilience (7)	Q3	150
QPR Suicide Prevention	Q3	147
Total		**445**

Note: Presentation data were only available for Q2 and Q3

Evaluation Data for: **Senior Peer Counseling Program** for FY20/21

Target Population: ● Started ○ Pending ○ Canceled ○ New 21/22 ● COVID Delayed

Administered by: ○ Children Aged 0–5 ○ Transitional-Age Youth Aged 16–25 ○ Adults Aged 26–59 ● Older Adult Aged 60+

● Contractor ○ County

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.

Estimated FY21/22 Costs	Estimated Number to be Served FY21/22	Estimated Cost/Person Served
$48,400	**250**	**$194**

1 TOTAL FTE

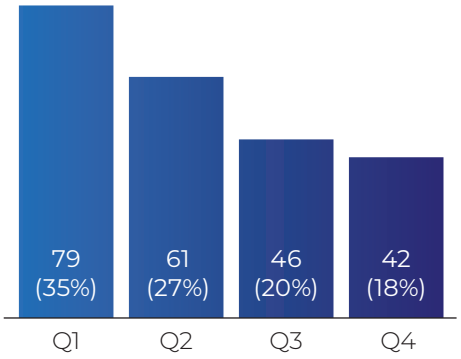
14 SENIOR PEER COUNSELORS

2 SENIOR PEER COUNSELOR VOLUNTEERS RECRUITED

2 FAMILY MEMBERS RECEIVING SUPPORT FROM VOLUNTEERS

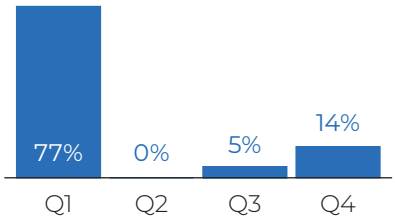
228.7 VOLUNTEER HOURS OF SERVICE PROVIDED

CLIENT CONTACTS (TOTAL = 228)

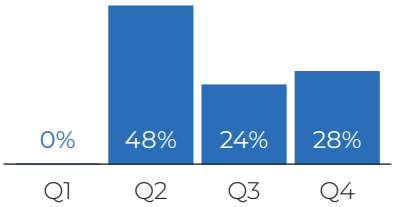


We served **47 clients** in 2020–2021

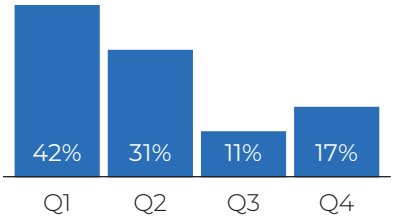
NEW CLIENTS (TOTAL = 22)



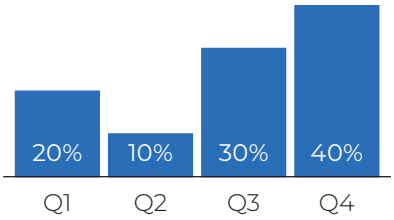
RETURNING CLIENTS (TOTAL = 25)



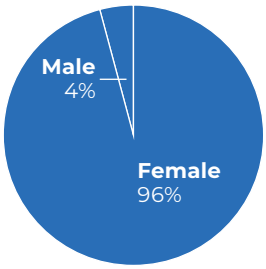
CLIENTS SERVED: PREVENTION (TOTAL = 36)



CLIENTS SERVED: EARLY INTERVENTION (TOTAL = 10)



CLIENT SNAPSHOT



29% Have a Disability

4% Bisexual

CLIENTS SERVED BY DISABILITY TYPE

50% Communication Domain: Difficulty hearing, seeing, or having speech understood

33% Physical Mobility Domain

17% Chronic Health Condition: including but not limited to chronic pain

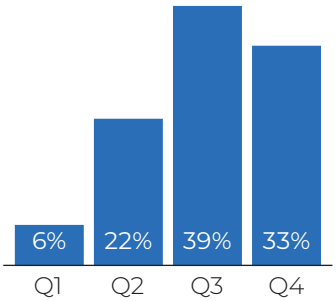
17% Other Disability

CLIENTS SERVED BY RACE (%)

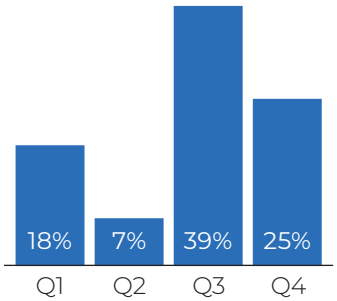
We held **18 events** in 2020–2021

CLIENTS' CITY OF RESIDENCE	%
Woodland	72%
Davis	20%
Yolo County Unincorporated Areas	6%
Knights Landing	2%

EVENTS (TOTAL = 18)



PARTICIPANTS (TOTAL = 28)



PROGRAM ACCOMPLISHMENTS

- The new program manager created a strong rapport with past clients and volunteers to understand the program inside and out. They were able to assess weaknesses in the program and set goals each quarter to address them.
- The program manager created a new brochure for the program to engage in outreach to increase census. During this year, the program manager made connections to multiple Yolo County communities and organizations with information about the program. The program manager also did presentations for communities to increase awareness of the program and draw more clients and volunteers
- The referral process was revamped, new guidelines were implemented, new partnerships were created, status updates were offered for clients and volunteers, client and volunteer intake packet standards were upgraded to Yolo Hospice Standards, and new procedures were implemented for documenting hours and visits.
- Clients started "graduating from the program" this year, and a survey was created to measure the success of the program.
- We added home visits to the intake process to help determine if an individual is a client or volunteer appropriate.

PROGRAM CHALLENGES

Senior Peer Counseling has suffered throughout the pandemic from attrition of both clients and volunteers. Lack of ability to facilitate in-person meetups between clients and volunteers due to pandemic safety requirements has made it difficult to maintain volunteer and client engagement. Numbers have steadily dropped, prompting program leads to refocus on a dual strategy of increased program outreach and intensified internal support of current clients and volunteers. Though the challenges we've face have created short-term program attrition, we believe they have also allowed us an opportunity to refocus the program's energy and structure in a more effective way going forward.

Innovation Data

Evaluation Data 2021–2022

Evaluation Data for: **Crisis Now Learning Collaborative** for FY20/21

Data Status: ● In Process

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

Administered by: ● Contractor ○ County

Goal 1	Ensure Yolo County's crisis services match 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 and gaps.
Objective 3	Enhance crisis service cost-tracking mechanisms across providers.

Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$700,989	**5,000**	**$140**

Workforce, Education, and Training Data

Evaluation Data 2021–2022

Evaluation Data for: **Mental Health Career Pathways** for FY20/21

Data Status: ● In Process

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

Administered by: ● Contractor ○ County

Goal 1	Ensure well-developed clinical skills among unlicensed clinicians.
Objective 1	Provide clients of all ages with current and appropriate clinical interventions.
Objective 2	Retain licensed clinicians, post-successful licensure, as a result of the MHP's provision of supervised clinical hours to secure license.

Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$69,369	**Not applicable**	**Not applicable**

Evaluation Data for: **Mental Health Professional Development** for FY20/21

Data Status: ● In Process

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

Administered by: ○ Contractor ● County

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 members 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.

Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$55,795	**Not applicable**	**Not applicable**

Evaluation Data for: **Central Regional WET Partnership** for FY20/21

Data Status: ● In Process

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

Administered by: ○ Contractor ● County

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's and doctoral graduate students to support professional internships in the county system.

Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$52,188	**Not applicable**	**Not applicable**

Evaluation Data for: **Peer Workforce Development Workgroup** for FY20/21

Data Status: ● In Process

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

Administered by: ○ Contractor ● County

Goal 1	Provide peers 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 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.

Estimated FY21/22 Costs	Estimated Number to Be Served FY21/22	Estimated Cost/Person Served
$3,614	**Not applicable**	**Not applicable**

Appendices

Appendix I
Performance Measures

Peer and Family Led Support Services

PM1: How much did we do?	
Staff	NAMI volunteers and peer and family led workers
Customers Units of Service	# of Peer to Peer educational classes offered # of Family classes offered # of participants who received NAMI supports
PM2: How well did we do it?	
2.1	# of attendees for Peer to Peer educational classes
2.2	# of attendees for Family educational classes
2.3	# of attendees for In our Own Voice presentations
2.4	# of participants served by NAMI supports
PM3: Is anyone better off?	
Stigma Reduction	
3.1	% of participants of Peer to Peer educational classes that reported an increase in management of stress symptoms
3.2	% of participants of Family educational classes that reported an increased understanding of mental health symptoms
3.3	% of community members reporting an increase in understanding mental health symptoms and how to recognize after participating in a In Our Own Voice presentation
Increased Knowledge of Mental Health Symptoms	
3.4	% of participants of Peer to Peer education classes reporting an increase in the ability to recognize the signs and symptoms of mental illness
3.5	% of participants of Family education classes reporting an increase in knowledge of mental health symptoms
3.6	% of community members reporting an increase in knowledge of mental health symptoms after participating in an In Our Own Voice presentation
Increased Access to Mental Health Services	
3.7	% of participants of Peer to Peer educational classes reporting an increased ability to access community resources/services
3.8	% of participants receiving NAMI supports who report an increased ability to access community resources/services
Increased Support for Family Members	
3.9	% of participants of Family education classes reporting increased support

Older Adult Outreach Assessment: Adult Wellness Alternative

PM1: How much did we do?	
1.1	# of FTEs onsite at permanent supportive housing locations
1.2	# of beneficiaries served during reporting period
1.3	# of newly enrolled beneficiaries during the reporting period
1.4	Total service hours broken out by: Medication Support: Case Management/Rehab; Individual & Group Therapy; Crisis Intervention
1.5	Beneficiary Demographics broken out by: Age, Gender, Race, Ethnicity, and Primary and Secondary Diagnosis
1.6	# of Senior Peer Counseling referrals made
PM2: How well did we do it?	
2.1	% of no-shows for prescribing staff (psychiatrists and nurse practitioners)
2.2	% of no-shows for non-prescribing staff (clinicians, case managers and nurses)
2.3	% of beneficiaries that voluntarily discontinued FSP services (program total)
2.4	% of beneficiaries referred for FSP assessment accepted into the FSP program
2.5	% of beneficiaries seen for post hospital follow-up within 7 calendar days of discharge
2.6	% of beneficiaries who are contacted within 4 hours of hospital or jail notification for discharge
2.7	% of beneficiaries reporting satisfaction with FSP services
2.8	% of referred beneficiaries contacted within 2 calendar days from HHSA referral
PM3: Is anyone better off?	
3.1	# of days beneficiaries experienced homelessness while enrolled compared to prior 12-month period (program total); # of days beneficiaries experienced homelessness while enrolled compared to prior 12-month period (average)
3.2	# of days beneficiaries experienced incarceration while enrolled compared to prior 12-month period (program total); # of days beneficiaries experienced incarceration while enrolled compared to prior 12-month period (average)
3.3	# of days beneficiaries experienced psychiatric hospitalization while enrolled compared to prior 12-month period (program total); # of days beneficiaries experienced psychiatric hospitalizations while enrolled compared to prior 12-month period (average)
3.4	# of days beneficiaries employed while enrolled compared to prior 12-month period (program total); # of days beneficiaries employed while enrolled compared to prior 12-month period (average)
3.5	# of days beneficiaries enrolled in school while enrolled compared to prior 12-month period (program total); # of days beneficiaries enrolled in school while enrolled compared to prior 12-month period (average)
3.6	# of beneficiaries who have met goals and stepped down to a lower level of care; % of beneficiaries who have met goals and stepped down to a lower level of care

Adult Wellness Services: Mental Health Promotion, Wellness Centers

PM1: How much did we do?	
1.1	Total FTEs Behavioral Health Specialists, Program Coordinator, Peer Support Workers
1.2	# of unduplicated participants at the Wellness Centers quarterly
1.3	# of visits to the Wellness Centers (including duplicated participants) quarterly
1.4	# of groups offered quarterly
1.5	# of unduplicated group participants quarterly
1.6	# of participants across all groups (including duplicated participants) quarterly
1.7	# of food bags distributed quarterly
1.8	# of outings quarterly
1.9	# of participants in outings quarterly
1.10	# of special events hosted by Wellness Centers quarterly
1.11	# of participants in special events quarterly
PM2: How well did we do it?	
2.1	% of participants who reported they felt respected
2.2	% of participants who reported their needs were met
2.3	% of weekly groups attended
PM3: Is anyone better off?	
3.1	# of participants who reported they felt more connected or made at least one friend % of participants who reported they felt more connected or made at least one friend # of participants who reported they felt less isolated
3.2	% of participants who reported they felt less isolated
3.3	# of participants who reported they felt comfortable at the center % of participants who reported they felt comfortable at the center
3.4	# of participants who were able to identify at least one way to support wellness and recovery % of participants who were able to identify at least one way to support wellness and recovery

Adult Wellness Services: Adult Outpatient Mental Health, Adult Wellness Alternative

PM1: How much did we do?	
1.1	# of FTEs onsite at permanent supportive housing locations
1.2	# of beneficiaries served during reporting period
1.3	# of newly enrolled beneficiaries during the reporting period
1.4	Total service hours broken out by: Medication Support: Case Management/Rehab; Individual & Group Therapy; Crisis Intervention
1.5	Beneficiary Demographics broken out by: Age, Gender, Race, Ethnicity, and Primary and Secondary Diagnosis
PM2: How well did we do it?	
2.1	% of no-shows for prescribing staff (psychiatrists and nurse practitioners)
2.2	% of no-shows for non-prescribing staff (clinicians, case managers and nurses)
2.3	% of beneficiaries that voluntarily discontinued FSP services (program total)
2.4	% of beneficiaries referred for FSP assessment accepted into the FSP program
2.5	% of beneficiaries seen for post hospital follow-up within 7 calendar days of discharge
2.6	% of beneficiaries who are contacted within 4 hours of hospital or jail notification for discharge
2.7	% of beneficiaries reporting satisfaction with FSP services
2.8	% of referred beneficiaries contacted within 2 calendar days from HHSA referral
PM3: Is anyone better off?	
3.1	# of days beneficiaries experienced homelessness while enrolled compared to prior 12-month period (program total); # of days beneficiaries experienced homelessness while enrolled compared to prior 12-month period (average)
3.2	# of days beneficiaries experienced incarceration while enrolled compared to prior 12-month period (program total); # of days beneficiaries experienced incarceration while enrolled compared to prior 12-month period (average)
3.3	# of days beneficiaries experienced psychiatric hospitalization while enrolled compared to prior 12-month period (program total); # of days beneficiaries experienced psychiatric hospitalizations while enrolled compared to prior 12-month period (average)
3.4	# of days beneficiaries employed while enrolled compared to prior 12-month period (program total); # of days beneficiaries employed while enrolled compared to prior 12-month period (average)
3.5	# of days beneficiaries enrolled in school while enrolled compared to prior 12-month period (program total); # of days beneficiaries enrolled in school while enrolled compared to prior 12-month period (average)
3.6	# of beneficiaries who have met goals and stepped down to a lower level of care; % of beneficiaries who have met goals and stepped down to a lower level of care

Adult Wellness Services: Turning Point ACT/AOT

PM1: How much did we do?	
1.1	Total FTEs
1.2	# of Clients
PM2: How well did we do it?	
2.1	% of no-shows for prescribing staff (psychiatrists and nurse practitioners)
2.2	% of non-prescribing staff (clinicians, case managers, and nurses)
PM3: Is anyone better off?	
3.1	# of days clients experienced homeless (program total) # of days of homelessness per client (average)
3.2	# of days clients experienced incarceration (program total) # of days incarceration per client (average)
3.3	# of days clients experienced psychiatric hospitalization (program total) # of days psychiatric hospitalization per client (average)
3.4	# of clients with a psychiatric inpatient admission % of clients with a psychiatric inpatient admission
3.5	# of hospital discharges that result in readmission within 7 days % of hospital discharges that result in readmission within 7 days
3.6	# of hospital discharges that result in hospital readmission within 30 days % of hospital discharges that result in hospital readmission within 30 days

Community-Based Drop-In Navigation Center

PM1: How much did we do?	
1.1	# unduplicated clients who receive services at the Navigation Center
1.2	# unduplicated Beacon Screenings completed
1.3	# unduplicated Specialty Mental Health assessment completed
1.4	# unduplicated substance use disorder assessments completed
1.5	# unduplicated clients provided with transportation
1.6	# unduplicated clients provided with peer support assistance
1.7	# unduplicated clients provided with direct subsidy assistance
1.8	# psychiatric hold applications completed
1.9	# of drop-offs received by Davis Police Department
1.10	# of in-field triage request completed
PM2: How well did we do it?	
2.1	% of clients who report they are satisfied with services received at the Navigation Center
PM3: Is anyone better off?	
3.1	# and % of unduplicated clients who successfully link with a Specialty Mental Health Services appointment.
3.2	# and % of unduplicated clients who successfully link with a Specialty Mental Health Services Psychiatry appointment.
3.3	# and % of unduplicated clients who were provided warm hand-offs to mild to moderate mental health services.
3.4	# and % unduplicated clients who were provided warm hand-offs to substance use services.

Mental Health Crisis Services & Crisis Intervention Team Training: Co-Responder

PM1: How much did we do?	
1.1	Total # of unduplicated clients served.
1.2	Total # of Co-Responder Clinician responses.
1.3	# and % of clients referred by each referral source (Law Enforcement Agency, Family/Self, HHSA/ community MH or SUD provider, Other).
1.4	# and % of clients referred for each of Crisis, Mental Health needs, Substance Use Disorder needs, or Other.
1.5	Total # of minutes spent training/consulting/reviewing holds written with Law Enforcement personnel
1.6	Total # of 911 calls indicating a behavioral health issue
PM2: How well did we do it?	
2.1	Average Clinician response time (from request notification to initial in-person contact with client, in minutes).
2.2	Average Clinician time spent on scene (in minutes).
2.3	Average law enforcement officer wait time for Clinician response (in minutes).
2.4	Law enforcement personnel satisfaction with Co-Responder services.
PM3: Is anyone better off?	
3.1	# and % of clients served who were NOT placed on an involuntary hold .
3.2	# and % of clients served who were NOT arrested/taken to jail.
3.3	# and % of client served who were linked to an HHSA/community provider mental health and/or substance use provider.
3.4	# and % of clients referred to an HHSA/community provider for homeless services.

Children's Mental Health Services: Turning Point Community Programs

PM1: How much did we do?	
Staff 1.1	Total FTE's: Manager/Supervisor Clinicians Office Support
1.2	# of open and authorized clients
1.3	# of intakes
1.4	# of discharges
1.5	# of discharges to a lower level of care
1.6	# of referrals received
1.7	# of children meeting ICC or IHBS criteria
1.8	# of children served who are non-English speakers
PM2: How well did we do it?	
2.1	% of clients who received an intake assessment within 14 days of referral
2.2	% of clients assessed with Child and Adolescent Needs and Strengths (CANS)
2.3	% of clients with completed authorization packet within 60 days of admit
2.4	% of authorization requests completed within 30 days of renewal
2.5	% of open clients with submitted 6 months progress report
2.6	# of clients per clinician
2.7	# of days to successful discharge (quarterly average)
2.8	% of discharge dispositions submitted within 14 days of discharge date
2.9	% of ICC and IHBS eligible clients with facilitated CFT every 90 days
2.10	% of clients who successfully met treatment plan goals
2.11	% of clients who received 1st clinical appointment within 7 days post psychiatric hospitalization
2.12	% of clients who received 1st psychiatric follow up within 30 days post psychiatric hospitalization
2.13	# of provider changes per client
PM3: Is anyone better off?	
3.1	# of clients with decrease in # of items needing action on Child Behavioral/Emotional Need section of CANS from intake to discharge; % of clients with decrease in # of items needing action on Child Behavioral/Emotional Need section of CANS from intake to discharge
3.2	#of clients with decrease in# of items needing action on Life Domain Functioning section of CANS from intake to discharge % of clients with decrease in# of items needing action on Life Domain Functioning section of CANS from intake to discharge
3.3	# of clients with decrease in# of items needing action on Caregiver Resources and Needs section of CANS from intake to discharge % of clients with decrease in# of items needing action on Caregiver Resources and Needs section of CANS from intake to discharge
3.4	# of clients who remained in their home (without jail or psychiatric hospital admits) or maintained foster home placement % of clients who remained in their home (without jail or psychiatric hospital admits) or maintained foster home placement

Pathways to Independence: Outpatient Mental Health

PM1: How much did we do?	
1.1	# of FTEs onsite at permanent supportive housing locations
1.2	# of beneficiaries served during reporting period
1.3	# of newly enrolled beneficiaries during the reporting period
1.4	Total service hours broken out by: Medication Support; Case Management/Rehab; Individual & Group Therapy; Crisis Intervention
1.5	Beneficiary Demographics broken out by: Age; Gender; Race, Ethnicity; and Primary and Secondary Diagnosis
1.6	# of EDAPT referrals made
PM2: How well did we do it?	
2.1	% of no-shows for prescribing staff (psychiatrists and nurse practitioners)
2.2	% of no-shows for non-prescribing staff (clinicians, case managers and nurses)
2.3	% of beneficiaries that voluntarily discontinued FSP services (program total)
2.4	% of beneficiaries referred for FSP assessment accepted into the FSP program
2.5	% of beneficiaries seen for post hospital follow-up within 7 calendar days of discharge
2.6	% of beneficiaries who are contacted within 4 hours of hospital or jail notification for discharge
2.7	% of beneficiaries reporting satisfaction with FSP services
2.8	% of referred beneficiaries contacted within 2 calendar days from HHSA referral
PM3: Is anyone better off?	
3.1	# of days beneficiaries experienced homelessness while enrolled compared to prior 12-month period (program total)
3.2	# of days beneficiaries experienced incarceration while enrolled compared to prior 12-month period (program total); # of days beneficiaries experienced incarceration while enrolled compared to prior 12-month period (average)
3.3	# of days beneficiaries experienced psychiatric hospitalization while enrolled compared to prior 12-month period (program total) # of days beneficiaries experienced psychiatric hospitalization while enrolled compared to prior 12-month period (average)
3.4	# of days beneficiaries employed while enrolled compared to prior 12-month period (program total) # of days beneficiaries employed while enrolled compared to prior 12-month period (average)
3.5	# of days beneficiaries enrolled in school while enrolled compared to prior 12-month period (program total) # of days beneficiaries enrolled in school while enrolled compared to prior 12-month period (average)
3.6	# of beneficiaries who have met goals and stepped down to a lower level of care % of beneficiaries who have met goals and stepped down to a lower level of care

Senior Peer Counseling: Yolo Hospice

PM1: How much did we do?	
Staff 1.1	Total FTEs: Senior Peer Counselors; Program Director
1.2	# of older adults served by YH/CWC
1.3	# of family members receiving support from volunteers
1.4	# of Senior Peer Counselor volunteers recruited
PM2: How well did we do it?	
2.1	# of older adults referred to services
2.2	# of volunteer hours of service rendered to older adults and their families
2.3	# of volunteer hours spent in training for services
PM3: Is anyone better off?	
3.1	# and % of older adults who reported improvement in their overall mental wellness as a result of contact with Senior Peer Counselor Program volunteers.
3.2	# and % of older adults who reported an ability to maintain level of self-care/independence as a result of contact with Senior Peer Counselor Program volunteers.
3.3	# and % above average Likert Scores provided by older adults engaged in this program/or their family members on the efficacy of the Senior Peer Counseling program

Latinx Outreach/Mental Health Promotores Program: CREO IBHS

PM1: How much did we do?	
1.1	Total FTEs by Classification, including breakdown of program staff who are bilingual and bicultural
1.2	Program Participants: Total # of participants served ▸ Total # of unduplicated participants served ▸ Total # of participants identified as male heads of household ▸ Total # of participants who received services in Spanish as their preferred language
1.3	Program Activities: ▸ Total # of FTE Promotores actively involved in the program ▸ Total # of unduplicated participants who received a whole-person health screening ▸ % of participants screened for a history of trauma ▸ Total # of outreach events (minimum weekly) ▸ Average # of participants at outreach events ▸ Total # of group counseling "platicas" (minimum bi-weekly) ▸ Average # of participants at group counseling "platicas" ▸ Total # of advisory panel meetings that included representatives from the target population and community-based agencies
PM2: How well did we do it?	
2.1	Satisfaction: % 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, respected my cultural background/beliefs, spoke to me in a language that I understood)
2.2	Referral/Linkage: 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) Total # of participants referred to any service
2.3	Treatment Engagement: % and # of participants who completed a referral and engagement 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)
2.4	Timeliness: Average interval (in days) between the referral and participation in treatment. Participation is defined as participating at least once in treatment to which referred.
2.5	Duration of Untreated Mental Illness (DUMI): 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.
2.6	Staff Training: % of program staff trained in using evidence informed and evidence-based practices

PM3: Is anyone better off?	
3.1	Stigma: % and # of participants with reduced stigmatizing attitudes, knowledge, and/or behavior related to mental illness and seeking mental health services
3.2	Hospitalizations: Reduced % and # of mental health hospitalizations and average length of stay.
3.3	Quality of Life: ▸ % and # of participants with improved functional outcomes (e.g., enrollment in entitlement benefits, employment status, housing status, health insurance coverage, food security) ▸ % and # of participants with improved mental, physical, and/or emotional well-being outcomes.

Latinx Outreach/Mental Health Promotores Program: Promotores Integrated Behavioral Health Services for Latino Community Program

PM1: How much did we do?	
Staff	# of staff providing resource and referral services
Customers Units of Service	# of residents requesting referrals
PM2: How well did we do it?	
2.1	# and % of referral requests where staff was unable to refer to a program
2.2	# and % of clients that report feeling welcomed
2.3	# and % of clients families or individuals reporting that they are satisfied with the service they received
PM3: Is anyone better off?	
3.1	# and % of clients who connected to their referral service within 2, 7, 14, 30 days of receiving referral information (days are depending on the services needed)
3.2	# and % of clients who reported they are continuing with care after it was obtained
3.3	# and % of clients who reported it is easier to manage their personal situations after receiving referral information

Latinx Outreach/Mental Health Promotores Program: RISE Latino Farmworker Outreach Program

PM1: How much did we do?	
Staff	Total FTEs by Classification, including breakdown of program staff who are bilingual and bicultural
Customers Units of Service	**Program Participants:** Total # of participants served ▸ Total # of unduplicated participants served ▸ Total # of participants identified as male heads of household ▸ Total # of participants who received services in Spanish as their preferred language **Program Activities:** ▸ Total # of FTE Promotores actively involved in the program ▸ Total # of Yolo County farm outreach events (minimum one farm per week) – Average # of participants at farm outreach events ▸ Total # of Latino Male Farmworker Conferences (minimum two per year) – Total # of participants at each Latino Male Farmworker Conference ▸ Total # of Drop-In Opportunities (minimum two per month; one Saturday and one weekday evening) – Average # of participants at Drop-In events
PM2: How well did we do it?	
2.1	**Satisfaction[1]:** % and # of participants who reported satisfaction with services (e.g., services were provided at a convenient time and location; program staff made me feel welcomed, connected me to resources in a timely manner, treated me with respect, respected my cultural background / beliefs, spoke to me using language that I understood) **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 benefit enrollment, food resources, housing support) Total # of participants referred to any service. **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.
PM3: Is anyone better off?	
3.1	**Stigma[3]:** % and # of participants with reduced stigmatizing attitudes, knowledge, and/or behavior related to mental illness and seeking mental health services. **Knowledge:** % and # of participants who reported increased knowledge about resources (e.g., they learned new skills to help them in their mental wellness, how to better address health / mental health needs, access culturally sensitive health / mental health resources) **Access:** 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 benefit enrollment, food resources, housing support) **Access:** Referral Outcome: % and # of participants who, at follow-up, reported improved outcomes a result of RISE's referral.

Early Childhood Mental Health Access & Linkage: Help Me Grow Yolo & Maternal Mental Health

PM1: How much did we do?	
Staff 1.1	Total FTEs: Manager Supervisor; Clinicians; Office Support
1.2	# 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)
1.3	# of trainings conducted for agencies/programs (outreach)
1.4	# of trained individuals on the HMG Yolo services (parents, providers, community agencies)
1.5	Report of who contacted HMG Yolo on behalf of the child # of calls to the Call Center
1.6	Services to which child/family referrals were made (# and % of each)
1.7	# Presenting issues (# and % of each)
1.8	# of screenings completed based on screening tools (ASQ-3, ASQ-SE, M-CHAT, SEEK)
1.9	# of medical providers participating in HMG Yolo PM1s regarding Maternal Mental Health Services
1.10	# of staff FTE's working in the program
1.11	# of referrals for assessment received
1.12	# of sessions provided (total)
1.13	# of clients who received in-home cognitive behavioral therapy
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 PM2s regarding Maternal Mental Health Services
2.5	# and % of clients completing Cognitive Behavioral Therapy/Graduating and/or successfully meetings goals of treatment
2.6	# and % of referred clients receiving in-home assessment
2.7	# and % of clients for which successful referrals were made
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 PM3s regarding Maternal Mental Health Services
3.5	# and % of clients showing improvement on pre/post Patience Health Questionnaire
3.6	# and % of clients showing improvements in function, skill development and strengths

K-12 School Partnerships Services

PM1: How much did we do?	
Staff	Total FTEs by Classification (Manager, Supervisor, Clinician, Case Manager, Administrative Support)
1.1	**Program Participants:** # of unduplicated participants served
1.2	# of Tier I services (unduplicated)
1.3	# of Tier I services provided (duplicated)
1.4	# of Tier II services (unduplicated)
1.5	# of Tier II services provided (duplicated)
1.6	# of Tier III services (unduplicated)
1.7	# of Tier III services provided (duplicated)
PM2: How well did we do it?	
2.1	**Timeliness:** Average interval (days) between referral and completion of screening
2.2	% of participants who receive an assessment within 10 business days of screening
2.3	**Referral/Linkage** # and % of participants (with private health insurance) referred to services through their insurance plan # and % of participants (with private health insurance) successfully linked to services through their insurance plan
2.4	# and % of participants in treatment services utilizing Medi-Cal billing (managed care)
2.5	# and % of participants in treatment services utilizing Medi-Cal billing (SMHS)
2.6	**Service Delivery:** Average # of sessions per participant in therapeutic services
2.7	**Participant Satisfaction:** # and % of participants (including parent/guardians) who reported satisfaction with services (as calculated from responses to satisfaction surveys)
PM3: Is anyone better off?	
3.1	# and % of clients with a decrease in # of items needing action on Child Behavior/Emotional Need section of CANS from intake to discharge.
3.2	# and % of clients with a decrease in # of items needing action on Life Domain Functioning section of CANS from intake to discharge.
3.3	# and % of students with improved attendance (as calculated by % of attendance days quarter of referral vs. % of attendance days in quarter of discharge).
3.4	# and % of students with decreased instances/frequency of school-based behavioral interventions (as calculated by % of days with behavioral interventions in quarter of referral vs. % of days with behavioral interventions in quarter of discharge).

College Partnerships: College Campus Based Physical Healthcare, Behavioral Healthcare, and Related Social Services

PM1: How much did we do?	
1.1	**Behavioral Health Services**
1.1A	# of students served
1.1B	# of students referred through the Early Alert Interface
1.1C	# of referrals made to County-based supports and programs
1.1D	# of students receiving services during peak hours (8:30am to 4:30pm)
1.1E	# of students receiving services during after-hours (4:30pm to 7:00pm)
1.2	**Physical Health Services**
1.2A	# of students served
1.2B	# of students referred through the Early Alert Interface
1.2C	# of referrals made to County-based supports and programs
1.2D	# of students receiving services during the peak hours (8:30am to 4:30pm)
1.2E	# of students receiving services during after-hours (4:30pm to 7:00pm)
1.3	**Social Services**
1.3A	# of students served
1.3B	# of referrals made to County-based supports and programs
1.3C	# of tabling events held
1.3D	# of health fairs held
1.3E	# of Flu Shot clinics held
1.3F	# of STI Testing Clinics held
1.3G	# of education and learning events held for staff
1.3H	# of education and learning events held for students
1.4	# of students that received services in their primary language of Spanish
1.5	# of students that received services in their primary language of Russian
PM2: How well did we do it?	
2.1	# and % of students who self-report that they received an initial appointment timely
2.2	# and % of students satisfied with access to and services provided based on results of the Student Satisfaction Survey
2.3	% of students seen at the Woodland campus
2.4	% of students seen at the Colusa County campus
2.5	% of students seen at Lake County campus

PM3: Is anyone better off?	
3.1	# and % of students that self-report improved access to behavioral/physical/social services on campus
3.2	# and % of students that received routine care
3.3	# and % of students that self-report improved access to training and education opportunities
3.4	# and % of faculty/staff that self-report improved access to training and education opportunities
3.5	# and % of students that self-report increased knowledge of healthy living habits
3.6	# and % of faculty/staff that self-reported increased knowledge of healthy living habits

Early Signs Training and Assistance

PM1: How much did we do?	
1.1	Total FTE
1.2	# of training participants
1.3	# of trainings offered
1.4	# of trainings offered in Davis
1.5	# of trainings offered in West Sacramento
1.6	# of trainings offered in Winters
1.7	# of trainings offered in Woodland
PM2: How well did we do it?	
2.1	% of Youth and Adult Mental Health First Aid training participants reporting during the course evaluation that the course goals and objectives were achieved
2.2	% of safeTALK training participants who indicated in the course evaluation that they intend to tell others that they would benefit from safeTALK trainings
2.3	% of Question Persuade Refer (QPR) training participants who indicated in the course evaluation they would recommend QPR training to others
PM3: Is anyone better off?	
3.1	# of Mental health First Aid (Youth & Adult) training participants who report they felt more confident in reaching out to a young person who may be dealing with a mental health challenge % of Mental Health First Aid (Youth & Adult) participants who report they felt more confident in reaching out to a young person who may be dealing with a mental health challenge
3.2	# of Question Persuade Refer (QPR) training participants who report an increase in knowledge about how to ask someone about suicide % of Question Persuade Refer (QPR) training participants who report an increase in knowledge about how to ask someone about suicide
3.3	# of safeTALK training participants who report they felt prepared to talk to someone about their thoughts of suicide % of safeTALK training participants who report they felt prepared to talk to someone about their thoughts of suicide
3.4	# of Educate, Equip, and Support: Building Hope participants who expressed a high score (Score of 7 or higher) on the evaluation of the training topics on session evaluations % of Educate, Equip, and Support: Building Hope participants who expressed a high score (Score of 7 or higher) on the evaluation of the training topics on session evaluations

Appendix II
Program Contract List

Program Name	Contractor	Contractor Name
Community Services & Supports (CSS) Plan		
Peer and Family Led Support Services	Y	NAMI Yolo County
Older Adult Outreach Assessment Program	Y	TLCS, Inc dba Hope Cooperative
Adult Wellness Services Program	Y	Telecare Corp & TLCS, Inc dba Hope Cooperative
Communty Based Drop-In Navigation Center	Y	CommuniCare
Tele-Mental Health Services	Y	HHSA Program; Locum Tenens
Mental Health Crisis Services & Crisis Intervention Team Training	N	HHSA Program
Children's Mental Health Services	Y	HHSA Program; Turning Point Community Programs
Pathways to Independence	Y	Telecare Corp
Prevention & Early Intervention (PEI) Plan		
Senior Peer Counseling	Y	Yolo Hospice
Latinx Outreach/Mental Health Promotores Program	Y	RISE, Inc; CommuniCare
Early Childhood Mental Health Access & Linkage Program	Y	First 5
K-12 School Partnerships	Y	CommuniCare; RISE, Inc., Victor Community Support Services
Youth Early Intervention FEP Program	Y	NA
College Partnerships	Y	CommuniCare
Early Signs Training and Assistance	Y	HHSA Program; CalMHSA
Cultural Competence	Y & N	HHSA Program; Contractor(s) TBD
Maternal Mental Health Access Hub	TBD	TBD
CSS; PEI; INN; WET		
Evaluation	Y	Community Advocacy Research and Evaluation Consulting Group (C.A.R.E.)
Innovation (INN) Plan		
Integrated Medicine into Behavioral Health	NA	NA
Crisis Now Learning Collaborative	Y	HHSA Program; MHSOAC
Workforce, Education, & Training (WET) Plan		
Mental Health Professional Development	N	HHSA Program
Peer Workforce Development Workgroup	N	HHSA Program
Central Regional WET Partnership	N	Regional Partnership MOU with CalMHSA
Mental Health Career Pathways	Y	Individual Provider

Appendix III
Community Feedback

Submitted by Antonia Tsobanoudis

The electronic file name implies it is an Evaluation of the Year 20-21, which I think it is, but the title on the document title page says 21-22. Either make it a Fall 2021 Evaluation of FY 20/21, or Evaluation of FY 20/21 by changing the report name. Is this some kind of County nomenclature I haven't noticed before?

I don't see any contractor's names in it -- it would help me, in Board meetings especially, to know who did what, for how much, and possibly *why* they needed more or less than the original contract.

Project descriptions, goals and data, synopsis of contract execution, should all be submitted by the contractors to almost plug and play. Maybe a simple one-page form can be filled out as part of their payment quarterly or yearly, so they track what you want to put in the MHSA reports? I know there are the LOCUS, RDA, and other evaluatory important field specific surveys and goals, but I just mean having an overarching view of a Contract/Project tracking would be nice. Like easily seeing k vs actual,

Page 10: could it please add three columns for Estimated 21-22, Contracted for 20-21, and Actual for 20-21 since that's the year we're evaluating? Maybe take out the "target numbers" served" to put in another table? (i think the columns can be added in portrait view, as is, if some program names wrap text and other columns like HHSA BRanch narrow/) This is a critical and first step to better integrating the separate financial report, which could still be an addendum, in the same report and referenced.

page 10 -- thank you for highlighting which programs are still in process.

Also, I see an importance in adding another table ,same format as on page 10, highlighting the Target Number SERVED 21/22, Actual Numbers Served 20/21, and proposed increase in 3-year budget (just actual change in this table). This clearly spells out one reason to increase budgets so that in hindsight, MHSA funds will be more protected in any future critical review that could happen. It happens.

Again, in overall format of program reviews (which are great by the way! easy on the eyes, good job!) adding more evaluation of previous year in the bubble table so that there is an additional row showing, Estimated/Contracted costs for 20/21, squeeze in an ACTUAL 20/21 Costs, then actual Numbers served 20/21, and Actual Cost/person served 20/21? Again, bring in more financials info into the actual Eval Report

p 11 -- the number of estimated children under 5 to be served is going down to 90 from 110. Are the costs for this program going up, sorry it's hard (time consuming) for me not to have a stand alone document and play sleuth? Why are the numbers served going down? especially in the aftermath of covid? I hear covid produced more babies!

p 12 -- how is this program addressing high schoolers? Is there any collaboration with the school districts (list in objectives)? How or why are the numbers served jumping from 15 up to estimated 75? Why ONLY 2 FT staff for a $2.1 million project?--Ah, it's County staff, not contracted staff, listed right?

p 13 -- It is not clear that the previously contracted out FSP and the COunty's FSP are now under one contract, this change having happend in 20/21. Big change!

p 13 -- Is 200 estimated enough? That's estimating an increase of 52 adults... with PTG, potential increase in housing from ARP funds, should this increase estimated number increase and funding increase here more? I guess PTG, Paul's Place, are under other contract's? I'm not sure of that because actual contractors aren't mentioned in this report or any MHSA report -- i'd have to go digging in posted contracts.

p 13 -- I'd like to see last year's "bubble table numbers" here to compare and make it an easier read and evaluation, please.

p 13 -- in working my FSP case workers, new Telecare and old TPCP, supported housing in Yolo needs an increase! Where can the cost of many 6-bed or less (easier licensure) Board and Care go? Or another 15-bed PTG3? Where can semi-supported Room and Boards go?? Especially long-term Room and Board's for people with SUD!??? Then that homeless days will surely drop to less than half.

Submitted by Nick Birtcil

I'd still love more information about spending down that $17m

To: Local Mental Health Board Members
Karen Larsen, Director, Yolo County Health and Human Services Agency

From: Nicki King, Chair, Local Mental Health Board
Jonathan Raven, Vice Chair, Local Mental Health Board

Date: October 18, 2021

RE: Opportunities to Improve 2021-22 Yolo County MHSA Evaluation Report

This memo proposes opportunities to improve the clarity and effectiveness of the Yolo County MHSA Evaluation Report. We recommend the Yolo County Health and Human Services Agency (HHSA) implement the recommendations in the memo for the 2021-22 Yolo County MHSA Evaluation Report and release a second draft to the Local Mental Health Board to assist with the community's effort to evaluate new projects and advise the Agency on funding for existing programs. In an effort to streamline the comment process, we coordinated with NAMI Yolo County leadership to draft these recommendations. The NAMI Yolo County Board of Directors will consider support for these recommendations at their October 28th meeting and also submitted separate questions regarding the Evaluation Report to HHSA.

Opportunities to Improve 2021-22 Yolo County MHSA Evaluation Report

The 2021-22 Yolo County MHSA Evaluation Report is an excellent tool to communicate the benefits of MHSA expenditures to the community and the Yolo County Board of Supervisors. While not required by the MHSA, it provides information essential to evaluate whether existing programs are benefiting people living with serious mental illness, including intervention and prevention. We agree with the Health and Human Services Agency characterization in the executive summary of the Evaluation Report that the performance evaluation process is incomplete.[1] Much more work is needed to determine whether the 22 programs allocated a total of $18.9 million in 2020-21 ($12.9 million was spent) accomplished their intended goals. We believe the report could turn into a model for other counties, as well as a roadmap to needed adjustments and changes in our own delivery of service if the County continues to improve data collection for each program and the recommendations suggested in this report are implemented.

Overview of Report Omissions

While the Evaluation Report provides some useful information to guide conversations about program efficacy, additional information is needed. Of the 22 programs described in the report,

[1]. We wanted to recognize the honesty of HHSA in introducing the report with the following sentence on page 6 of the Executive Summary, "HHSA acknowledges the data is incomplete; ongoing progress is being made to strengthen the overall evaluation and reporting on MHSA programs impact…HHSA acknowledges these evaluation efforts are a work in progress represent one step in a multiphase approach to continuous evaluation of the county MHSA programs focused on accountability and quality improvement.."

none of the programs list the performance measures for the three Results-Based Accountability questions:

1) How much of our original goals did we accomplish? ~~did we do?~~
2) How well did we do it?
3) Is anyone better off? If so, who, and are there any equity implications for this assessment of outcomes?

We recognize HHSA is in the process of updating its contracting processes to ensure all contractors and internal divisions provide this information but wanted to document the need to provide the information in case this information is available to include in the report. See Attachment A for NAMI Yolo County's example of the type of information listed for these questions in a contract and which is available to include in the report. In addition, no baseline information is provided about the services the County or contractor expected to provide to compare to the services the County or contractor actually provided. For 15 of the 22 programs (68%) no or limited data is provided in the Evaluation Report, as shown below. We recognize that many of these programs are delayed by COVID-19, but the Evaluation Report does not provide information as to why no data is provided for these programs.

Limited Data

- Children's Mental Health Services
- Pathways to Independence
- Adult Wellness Services
- Older Adult Outreach and Assessment Program

No Data

- Tele-Mental Health Services
- Cultural Competence
- Youth Early Intervention First Episode Psychosis Program
- Maternal Mental Health Access Hub
- K-12 School Partnerships Program
- College Partnerships
- Crisis Now Learning Collaborative
- Mental Health Career Pathways
- Mental Health Professional Development
- Central Regional WET Partnership
- Peer Workforce Development Workgroup
- Race and Ethnicity data (should be collected where possible, and explanations of why such data could not be collected for each program should be provided

In some cases, no data is reported but the MHSA Finance Update shows expenses in the 2020-21 fiscal year. Tele-Mental Health Services (non-FSP) spent $265,640 in 2020-21, for example. For the programs that do have data, the Health and Human Services Agency does not appear to present information about services that were not provided but are listed in the contract as a

deliverable. NAMI Yolo County, for example, did not provide any peer-to-peer education classes in 2020-21, but that information is not included in the evaluation report of peer-and family-led services on page 20. For some important programs, such as the $800,000/year in funding provided to support services at Pine Tree Gardens East and West, two adult residential facilities for 28 adults living with a serious mental illness, there is no mention of the program in the Evaluation Report.

Opportunities for Improvements

The Health and Human Services Agency could implement the following improvements to create a model evaluation report for use by the community, HHSA staff, the Local Mental Health Board, and the Board of Supervisors.

1. **Describe whether HHSA staff members, a contractor, or both are providing the services and identify how many staff in each category and the approximate number of total hours.** The description of the program in the report does not describe whether the Health and Human Services Agency delivered the program, a contractor delivered the program, or both. In the case of Peer and Family-Led Support Services on page 20, for example, NAMI Yolo County provides 100% of the services for this program and all data represents NAMI Yolo County's work.
2. **Provide the name of the contractor (if applicable), the amount of the contract, the amount spent, and the cost/individual served.** HHSA provided this information in a separate document entitled MHSA Finance Update, which requires the reader to flip back and forth between the Evaluation Report and the Finance Update. HHSA should include this information in the Evaluation Report to make it easy for stakeholders to understand the status of expenditures under the program. NAMI Yolo County, for example, signed a contract for $100,000 last year to provide Peer and Family-Led Support Services last year, but spent less than $70,000 of the contract. The potential cost/individual served is provided as an estimate for 2021-22, but no information from 2020-21 is provided in the report although the Health and Human Services Agency has this data.
3. **Provide an overview of the program in the evaluation report, including the program's connection to eligible MHSA activities, and deliverables for the fiscal year.** For each program, HHSA should provide information about the program to complement the goals and objectives, as well as provide information tying the program to eligible MHSA activities. Without this information, it's impossible to measure the program's performance against HHSA's expectation for the program in that fiscal year. We also need to know how many of those performance goals were even partially met during FY21? We think there are things we could be learning about the appropriateness of our objectives and how long it will take to reach them.
4. NAMI Yolo County suggested including deliverables in their 2021-22 HHSA contract and is willing to provide such information as an example. Each program should develop deliverables at the start of the fiscal year and report on progress as part of the Results-Based Accountability process at the end of the fiscal year.
5. **Provide the Results-Based Accountability measures included in the contract and or/developed for staff at the Health and Human Services Agency in the evaluation**

report, as well as the relevant associated data. For NAMI Yolo County, for example, this information is provided in Attachment A and would provide an overview of what NAMI Yolo County did and did not accomplish during the fiscal year.

6. **Add explanations for programs with no or limited data.** For each of the programs for which there is limited or no data, the Evaluation Report could explain why and efforts underway to move the programs forward and expend money allocated to that program in the three-year plan. The County may also recommend reallocating some of these funds to another program or a new program.
7. **Include information about important expenditures that are part of a larger program.** The Evaluation Report should describe major expenditures like the operation of Pine Tree Garden East and West and collect data to measure performance consistent with the contracts. The contract between North Valley Behavioral Health (the operator of the Pine Tree Gardens homes) and Yolo County contains RBAs, for example

ATTACHMENT A: NAMI YOLO COUNTY EXAMPLE

(Shared by Petrea Marchand, President of Nami-Yolo)

NAMI Yolo County contracted with the Health and Human Services Agency for $100,000 to provide peer- and family-led support services. NAMI Yolo County's 2020-21 contract has the following Results-Based Accountability performance measures:

PM1: How much did we do?

Staff – NAMI volunteers and peer and family led workers

Customers - # of Peer-to-Peer educational classes offered, # of Family classes offered, # of participants who received NAMI support

PM2: How well did we do it?

2.1. # of attendees for Peer to Peer educational classes

2.2. # of attendees for Family educational classes

2.3. # of attendees for In Our Own Voice presentations

2.4. # of participants served by NAMI supports

PM3: Is anyone better off?

Stigma Reduction

3.1 % of participants of Peer-to-Peer education classes that report an increase in the management of stress symptoms

3.2. % of participants of Family Educational classes that reported an increased understanding of mental health symptoms

3.3 % of community members reporting an increase in understanding mental health symptoms and how to recognize after participating in an In Our Own Voice presentation

Increased Knowledge of Mental Health Symptoms

3.4 % of participants of Peer-to-Peer education classes reporting an increase in the ability to recognize the signs and symptoms of mental illness

3.5 % of participants of Family education classes reporting an increase in knowledge of mental health symptoms

3.6 % of community members reporting an increase in knowledge of mental health symptoms after participating in an In Our Own Voice presentation

Increase Access to Mental Health Services

3.7 % of participants of Peer to Peer educational classes reporting an increased ability to access community resources/services

3.8 % of participants receiving NAMI supports who report an increased ability to access community resources/services

Increase Support for Family Members

3.9 % of participants of Family education classes reporting increased support

NAMI Yolo County
National Alliance on Mental Illness

Date: October 20, 2021

To: Local Mental Health Board Members
Karen Larsen, Director, Yolo County Health and Human Services Agency

From: Petrea Marchand, President, NAMI Yolo County
Anya McCann, Vice President, NAMI Yolo County
Stacie Frerichs, Treasurer, NAMI Yolo County

RE: Proposed Process to Consider New Projects for Mental Health Services Act Funding

This memo proposes a process for the community to recommend new projects for Mental Health Services Act (MHSA) funding for inclusion in the 2022-23 Annual Expenditure Plan, due to the Yolo County Board of Supervisors in June 2022. The NAMI Yolo County Board of Directors will consider support for this process at their October 28th meeting.

Proposed Process to Consider New Projects

We recommend the Yolo County Health and Human Services Agency (HHSA) adopt the following process for soliciting new projects for allocation of available MHSA funding, which we understand could total as much as $20 million over the next two fiscal years (2021-22 and 2022-23). We understand the current process involves providing proposed projects at the October 21, 2021 Community Engagement Working Group, which does not provide stakeholders enough time to develop robust projects for consideration.

1. **Utilize a project description and budget template.** NAMI Yolo County proposes the attached sample project description and budget template for consideration (Attachment B and C). The project description should provide information about responsible party, site control, costs, and other information necessary to determine whether a proposal is viable.

2. **Assist stakeholders with securing the date necessary to complete the project description and budget template.** Some proposals will require data from the HHSA to complete. We suggest working with project proponents to provide that data and further develop the project.

3. **Provide stakeholders with sufficient time to develop proposals.** At the September Community Engagement Workgroup, HHSA staff suggested stakeholders should provide project proposals within one month. Stakeholders need more time to secure the data and conduct the research needed for develop proposals. We suggest the following timeline, but are obviously open to other alternatives that provide stakeholders with sufficient time to develop projects:

    - **November 15, 2021:** Deadline for draft proposals
    - **December 15, 2021:** Deadline for HHSA to work with stakeholders to provide data needed for project proposals (schedule meetings between 11/15 and 12/15)
    - **January 15, 2022:** Final proposals due to HHSA
    - **January 2022:** HHSA provides all proposals submitted to Community Engagement Workgroup and Local Mental Health Board and requests comments
    - **February 2022:** HHSA proposes criteria for ranking projects and allocating funding and seeks feedback on these criteria from Community Engagement Workgroup and Local Mental Health Board.
    - **March 2022:** HHSA provides draft recommendations for priority projects recommended for funding to Community Engagement Workgroup and Local Mental Health Board
    - **May-June 2022:** HHSA prepares annual report and presents recommendations to Board of Supervisors for allocation of funds to MHSA programs for 2022-23

NAMI Yolo County
National Alliance on Mental Illness

NAMI Yolo County Executive Committee Questions on
Yolo County MHSA Evaluation Report
October 20, 2021

1. Why doesn't the Evaluation Report include the Results-Based Accountability metrics from each contract and for each Health and Human Services Agency program?
2. Why doesn't the Evaluation Report include information about the work or contract deliverables, as well as information about work contractors or the County did not accomplish in a given year (e.g. because of COVID-19 or other reasons)? This information helps with program evaluation.
3. On page 18 for Community-Based Drop-In Navigation Center, why were only 30% of clients successfully linked with psychiatry? Why only 70% to specialty mental health? What can be done to improve these percentages?
4. On the Community-Based Drop-In Navigation Center summary (p. 19), the accomplishments mention helping people experiencing homelessness to move to more permanent housing and access services but does not mention that these people are living with a mental illness per the MHSA requirements. Was this program focused on helping adults living with serious mental illness?
5. On page 28 for the Early Childhood Mental Health Access and Linkage Program, is it possible to provide improved descriptions of the work this program is doing related to prevention, defined as "reduce risk of developing a potential Serious Mental Illness and build protective factors (p. 22)" and "treatment and interventions, including relapse prevention, to address and promise recovery and related functional outcomes for a mental illness early its emergence…(p. 22)"[1]? The accomplishments section does not clearly link the purpose of the funding with the program work.
6. On page 30, what is PM BT and why did only 25% of the clients graduate?
7. On page 34 for the Rural School-Based Access and Linkage Program, why doesn't the report state the cost per person served like other programs? It appears from the HHSA expenditure report that this program cost $135,400 and served 132 people for a cost of $1,025/person.
8. On page 35 for the Rural School-Based Access and Linkage Program, one of the challenges is insufficient broadband internet access. Has HHSA considered requesting American Rescue Plan funding to address this issue, since broadband access in disadvantaged communities in an eligible expense of these funds?
9. On page 36 for the Urban School-Based Access and Linkage Program, why doesn't the report state the cost per person served like other programs? This program cost $247,128 and served 31 people in 2020-21 for a total of $7,971/person served. How

[1] On page 29, one of the program challenges is "Mental health has become a bigger need. Families with private insurance have a harder time navigating the system because Help Me Grow doesn't have a toll free number that we can give them like with Medi-Cal recipients, Mental health services for the whole family has become a big need." If the focus of this program is early intervention to address mental health issues, why is this listed as a challenge?

many people does the program expect to serve in 2021-22 and how is the program planning to improve their performance?

10. Same question as Question 9 for Rural School-Based Strengths and Mentoring Program and Urban School-Based Strengths and Mentoring Program.
11. On page 41 for the Latinx Outreach/Mental Health Promotores Program, why does it provide the estimated cost/person served for 2021-22 and not for 2020-21? The program served 84 clients in 2020-21 at a cost of $263,458 or $3,136/person served. The program is slated to receive $438,512 in 2021-22. What is the justification for this increase in funding?
12. For the Tele-Mental Health non-FSP program, which reported no data for 2020-21, why is the amount budgeted increasing from $73,390 to $1.38 million? What did the program accomplish for the $265,000 spent in 2020-21?

MHSA Evaluation Report Questions/Feedback/Suggestions
Jonathan Raven
LMHB Vice-Chair
October 11, 2021

1. One critical piece of information if the $20 million fund balance. As most people will not read the full report (e.g., most BOS members), it would be helpful to include this in the Executive Summary. You can separate into the 3 categories. Include how much is already encumbered (i.e., unspent) as well as new money (increase in tax revenue). Also include a sentence or two about the process to apply for the available funding.
2. Please include in each program report who the contractor is.
3. Have you given direction to each program about how to report the Outcome Measures using RBA? In reports from HHSA, Probation, the Sheriff, outcome measures are specifically separated into the 3 RBA questions with responses for each of them. It would be helpful to have this consistency in all program reports.
4. Most of the reports have an "Estimated Number to be served in FY 21/22" and a total served in FY 20/21. It would be helpful to see the estimated number of clients served for FY 20/21 to see if they met their goal (of course this year, COVID will have an impact on that).
5. Why is there no RBA analyses for Tele Mental Health Services (p. 15)? The data provided does not answer the latter 2 RBA questions.
6. Computer-Based Drop in Nav (p. 18) does a great job of listing accomplishments.
7. Peer and family led support (p. 20) does an outstanding job of providing information.
8. Why is there no data for Cultural Competence (p. 24)?
9. Early Childhood (p. 25) program provided an outstanding report.
10. Same with Maternal Mental Health (p. 30).
11. Why is there such limited information on Youth Early Intervention (p. 32)?
12. What is "In Process" mean for Maternal Mental Health (p. 33)?
13. K-12 School Partnership report is great (p. 34)!
14. What is the status of College Partnerships (p. 40)?
15. Latinx Outreach is great (p. 41)!
16. Senior Peer is great (p. 44)!
17. Are we unable to get any results or Innovation Data (I realize it's data)?
18. Under Yolo MHC, it would be great to see the allocation of MHSA $ to this program. Most of the program is not covered by MHSA $.
19. Yolo Assertive Community Treatment is actually formatted by RBA with the questions and responses. Can all program be formatted that way?

Local Mental Health Board Responses to Feedback

[1] Submitted by Antonia Tsobanoudis

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Again, in overall format of program reviews (which are great by the way! easy on the eyes, good
job!) adding more evaluation of previous year in the bubble table so that there is an additional row showing, Estimated/Contracted costs for 20/21, squeeze in an ACTUAL 20/21 Costs, then actual Numbers served 20/21, and Actual Cost/person served 20/21? Again, bring in more financials info into the actual Eval Report

Response: Thank you for your feedback and recommendations. HHSA will take each of these recommendations into consideration for next year fiscal year's Annual Update and Evaluation report. Some of the additional data requested is already included in the regular Annual Update to which the evaluation report is attached. For example, every program within the Annual Update HHSA included whether they are administered by the County, a Contractor or both. The intent moving forward will be to name the contracted entity(ies) to increase transparency.

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p 11 -- the number of estimated children under 5 to be served is going down to 90 from 110. Are
the costs for this program going up, sorry it's hard (time consuming) for me not to have a stand alone document and play sleuth? Why are the numbers served going down? especially in the aftermath of covid? I hear covid produced more babies!

Response: The "Estimated Number to Be Served in FY21-22" is an estimate by program staff of how many clients that program is likely to serve in the fiscal year considering funding, staffing, previous years clients, etc. This estimate does not limit the number of clients that the program may serve, as is the case here, where the program exceeded that estimate in the previous fiscal year when it served 110 clients.

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p 12 -- how is this program addressing high schoolers? Is there any collaboration with the school-
districts (list in objectives)? How or why are the numbers served jumping from 15 up to estimated 75? Why ONLY 2 FT staff for a $2.1 million project?--Ah, it's County staff, not contracted staff, listed right?

Response: This is a good example of an MHSA program that needs additional evaluation data review and refinement in the coming months and highlights some of the complexities of MHSA programs as they are categorized by the state. For example, Pathways to Independence Program (PIP) serves transitional age youth (TAY) with FSP services, but also provides non-FSP services as well. The county also utilizes more than one contractor to provide this service and these contractors provide additional services outside of TAY FSP. The section referenced here is an attempt to pull-out specific TAY FSP data; however, the funding amount listed is for all PIP services, including non-FSP services. How to better capture and report data for this program is a priority for the evaluation team in the coming months.

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p 13 -- It is not clear that the previously contracted out FSP and the COunty's FSP are now under one contract, this change having happend in 20/21. Big change!

p 13 -- Is 200 estimated enough? That's estimating an increase of 52 adults... with PTG, potential
increase in housing from ARP funds, should this increase estimated number increase and funding increase here more? I guess PTG, Paul's Place, are under other contract's? I'm not sure of that because actual contractors aren't mentioned in this report or any MHSA report -- i'd have
to go digging in posted contracts.

> **Response: We believe that the 200 contracted-out slots are enough based on historical/current client need; 50 are for TAY, 100 are for adult, and 50 are for older adults. This does not include the 15 FSP slots for MH Court clients. These slots do include any PTG clients who need FSP level services and any LPS conserved clients placed in the community. We have the flexibility to increase our 200 slots should we find the need arises.**

p 13 -- I'd like to see last year's "bubble table numbers" here to compare and make it an easier read and evaluation, please.

p 13 -- in working my FSP case workers, new Telecare and old TPCP, supported housing in Yolo needs an increase! Where can the cost of many 6-bed or less (easier licensure) Board and Care go? Or another 15-bed PTG3? Where can semi-supported Room and Boards go?? Especially long-term Room and Board's for people with SUD!??? Then that homeless days will surely drop to less than half.

[2] Submitted by Nick Birtcil

I'd still love more information about spending down that $17m

Response: **MHSA held a Community Engagement Work Group meeting on Oct 21, 2021 to garner additional community feedback on funding prioritization based on the MHSA 3 Year Community Planning Process. This information will be conveyed to the Yolo County Local Mental Health Board (LMHB) on October 25, 2021 for feedback. Upon review of community and LMHB feedback, HHSA will draft a proposed spending plan for the MHSA surplus dollars.**

Additionally, HHSA behavioral health leadership have identified ongoing gaps in our existing programming where additional investments could improve access to care and outcomes. These priorities align with the existing MHSA 3-year plan and are as follows:

- **K12**
- **Children's FSP**
- **Juvenile Justice Services**
- **Crisis Now and Evaluation**
- **Suicide Prevention**
- **Public Media Campaign**
- **Behavioral Health Supports for High Risk (Forensics, Public Guardian, Housing)**
- **Board & Care Operations Support**
- **Board & Care Treatment Services**
- **Expanding existing contracts (CREO, Senior Peer Counseling etc)**
- **Infrastructure supports (fiscal, IT, Analysts, etc)**
- **Increased Peer Workforce**

[3] Local Mental Health Board

REPONSE: Thank you for your feedback and recommendations. HHSA will take each of these into consideration as we assess each of the MHSA programs, descriptive content, outcome measurements, as well as financials, and structure reporting. The evaluation program process, in conjunction with HHSA, will work to improve data reporting and streamline comparable data sets for analysis. In addition, the intent moving forward will be to name the contracted entity to increase transparency.

Regarding program evaluation and data, HHSA acknowledges COVID response activities delayed the Evaluation Program process as Yolo County Health and Human Services Agency (HHSA) holds an essential and central role in addressing the COVID-19 pandemic, which has included the reassignment of significant numbers of staff members to critical COVID emergency response activities.

Despite the challenges of COVID-19 and unexpected changes, Yolo County HHSA has been able to accomplish a great deal regarding implementation and has established significant infrastructure in the past year, acknowledging that we can do better with evaluating MHSA program outcomes. The Yolo HHSA staff have risen to the challenge of the day and shown incredible commitment and work effort in the face of this crisis.

A preliminary first action was to provide an analysis of RBA data, as well as demographic information for the Prevention and Early Intervention Programs (FY 2019–2020) from the prior Yolo MHSA Three-Year Plan which was analyzed and included in the Annual Update. HHSA acknowledges the data was incomplete, however, efforts were made for an initial evaluation of MHSA programs that continued forward into the 2020–2021 fiscal year. Subsequently, an updated MHSA Evaluation Report FY 20-21 was provided to the LMHB to continue to provide evaluation and assessment data as the evaluation process continues.

Evaluation work to assess the overall impact, success, and challenges of the MHSA funding within Yolo County will continue as well as assessment, planning and implementation of a stronger and more effective system moving forward. HHSA acknowledges these evaluation efforts are a work in progress and represent one step in a multiphase approach to continuous evaluation of the county MHSA programs focused on accountability and quality improvement, guided by MHSA values and principles, the county strategic plan, HHSA's mission, and the Results-Based Accountability framework.

The timeline below reiterates the evaluation planning process and we look forward to providing additional updates and context at the October LMHB meeting.

Yolo MHSA Evaluation Timeline		2021										2022												2023	
Activity	Due Date	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-Mar	Apr-Jun
Prepare evaluation reports with FY19/20 RBA data for Annual Update	4/30/21																								
Analyze quality of existing data for 2017-2020 and 2020 onward	6/30/21																								
Develop matrix of RBA metrics for all MHSA programs	6/30/21																								
Review logic model approach as basis for metric development	7/31/21																								
Quality review of RBA metrics and overall program inventory	8/31/21																								
Prepare evaluation report with FY20/21 RBA data for Evaluation Report	10/27/21																								
Integrate feedback from LMHB into timeline	11/30/21																								
Branch Focus Groups to assess feasibility of cross-program metrics	11/30/21																								
Review Q1 RBA data with each Branch as part of ongoing QC/QI process	11/30/21																								
Conduct 'Success Story' key informant interviews	1/31/22																								
Determine next steps for cross-program metrics	1/31/22																								
Review Q2 RBA data with each Branch as part of ongoing QC/QI process	2/28/22																								
Review and test possible cross-program metrics	4/30/22																								
Analyze and write-up 'Success Story' data	5/30/22																								
Review Q3 RBA data with each Branch as part of ongoing QC/QI process	5/30/22																								
Establish cross-program metrics, by program (if feasible)	6/30/22																								
Present 'Success Story' data	6/30/22																								
Review and adjust timeline and approach for final year	7/31/22																								
Review Q4 RBA data with each Branch as part of ongoing QC/QI process	8/31/22																								
Gather comprehensive RBA data for FY21/22	8/31/22																								
Analyze and report on FY21/22 RBA data	10/31/22																								
Present FY21/22 Evaluation Data to LMHB	11/15/22																								
Provide technical assistance on data reporting to HHSA and contractors	6/30/23																								

[4] NAMI Questions:

1. Why doesn't the Evaluation Report include the Results-Based Accountability metrics from each contract and for each Health and Human Services Agency program?

Response: For this first iteration of the evaluation report, we attempted to report out on all the MHSA funded programs with existing RBA data. The choice to present it in its current format was a stylistic choice meant to make the report accessible to a broader audience who may not be familiar with the RBA framework. Based on this feedback, we will revisit the pros and cons of how the data was presented and determine the best way forward for future reports.

2. Why doesn't the Evaluation Report include information about the work or contract deliverables, as well as information about work contractors or the County did not accomplish in a given year (e.g. because of COVID-19 or other reasons)? This information helps with program evaluation.

Response: Program updates were included as part of the Annual Update FY 21-22 which provided context for activities, challenges, delays, and successes. WWW.YOLOCOUNTY.ORG/MHSA

3. On page 18 for Community-Based Drop-In Navigation Center, why were only 30% of clients successfully linked with psychiatry? Why only 70% to specialty mental health? What can be done to improve these percentages?

Response: The goal of navigation services is to link clients with the appropriate level of care. Our goal is not to enroll 100% of clients into specialty mental health. Many clients are more appropriate for mild to moderate mental health services or need linkage to substance use disorder treatment, housing supports or other resources. Clinical staff at the Navigation Center are an access/screening point for MH and SUD services needs for anyone in the community. Staff there use existing County MH and SUD Access screening tools to navigate clients to the most appropriate provider based on the indicated level of care needed. This 70% data point shows that of all those persons who presented at the Navigation center for MH services, 70% were screened as needing County SMHS. The remaining 30% were linked to community MH providers for mild-to-moderate MH services. Regarding the 30% linkage to psychiatry data point, after screened persons are linked to the County for SMHS, they undergo a full clinical evaluation. In some instances, the result of the clinical evaluation is that the client does not in fact need/qualify for ongoing SMHS (and thus they are referred to community MH provider). This means they are never served by a psychiatric provider. In other instances, while the client is accepted for County SMHS, they either refuse psychiatric services (which we respect their decision), they fail to show for any

scheduled psychiatric service appointments, or they never follow up with the County for any ongoing SMHS services (despite our best efforts to engage them) post-assessment.

4. On the Community-Based Drop-In Navigation Center summary (p. 19), the accomplishments mention helping people experiencing homelessness to move to more permanent housing and access services but does not mention that these people are living with a mental illness per the MHSA requirements. Was this program focused on helping adults living with serious mental illness?

Response: Yes, Navigation staff also provide ongoing services to community members living with SMI (unlike their separate duty of screening anyone in community for ongoing SMHS and/or SID services).

5. On page 28 for the Early Childhood Mental Health Access and Linkage Program, is it possible to provide improved descriptions of the work this program is doing related to prevention, defined as "reduce risk of developing a potential Serious Mental Illness and build protective factors (p. 22)" and "treatment and interventions, including relapse prevention, to address and promise recovery and related functional outcomes for a mental illness early its emergence…(p. 22)"1? The accomplishments section does not clearly link the purpose of the funding with the program work.

Response: The description for the Early Childhood Mental Health Access and Linkage Program starts on page 25. The information on Page 22 describes "Prevention and Early Intervention" programs and identifies which programs are assigned to "prevention," "early intervention," "improved access," etc. The first quoted text from this question is for the "prevention" definition and the second is for the "early intervention" definition, but the ECMHA program is not listed for either. The ECMHA program is listed on page 23 under "access and linkage to treatment," ("Activities to connect children, adults, and seniors with severe mental illness as early in the onset of these conditions as practicable to medically necessary care and treatment"), and although the program accomplishments on page 28 don't correspond with that specific purpose, there is ample evidence on pages 25-27 that speak to the results of the program connecting children to services.

6. On page 30, what is PM BT and why did only 25% of the clients graduate?

Response: We have contacted the contractor to solicit additional information regarding this question. Staff will report back at a future date.

7. On page 34 for the Rural School-Based Access and Linkage Program, why doesn't the report state the cost per person served like other programs? It appears from the HHSA expenditure report that this program cost $135,400 and served 132 people for a cost of $1,025/person.

Response: This program technically ended with the prior MHSA plan. Because there were significant, unavoidable delays with getting the new and expanded approach to school based mental health, outlined in the new MHSA plan (K-12 School Partnerships), the Rural and Urban Access and Linkage and Strengths Based Mentoring programs were extended to ensure there was no gap in services while we are getting the K-12 School Partnerships projects implemented. This program is being replaced with the K-12 School Partnerships projects in November as described above.

8. On page 35 for the Rural School-Based Access and Linkage Program, one of the challenges is insufficient broadband internet access. Has HHSA considered requesting American Rescue Plan funding to address this issue, since broadband access in disadvantaged communities in an eligible expense of these funds?

Response: There is significant discussion at a county-level regarding broadband access as well as a pending ARP request regarding broadband needs in rural areas of the county.

9. On page 36 for the Urban School-Based Access and Linkage Program, why doesn't the report state the cost per person served like other programs? This program cost $247,128 and served 31 people in 2020-21 for a total of $7,971/person served. How many people does the program expect to serve in 2021-22 and how is the program planning to improve their performance?

Response: This program technically ended with the prior MHSA plan. Because there were significant, unavoidable delays with getting the new and expanded approach to school based mental health, outlined in the new MHSA plan (K-12 School Partnerships), the Rural and Urban Access and Linkage and Strengths Based Mentoring programs were extended to ensure there was no gap in services while we are getting the K-12 School Partnerships projects implemented. For additional context, this program is dependent on referrals from the partnered school systems that were, for one reason or another, not choosing to use this resource. This program is being replaced with the K-12 School Partnerships projects in November as described above.

Footnote Question: 1 On page 29, one of the program challenges is "Mental health has become a bigger need. Families with private insurance have a harder time navigating the system because Help Me Grow doesn't have a toll free number that we can give them like with Medi-Cal recipients, Mental health services for the whole family has become a big need." If the focus of this program is early intervention to address mental health issues, why is this listed as a challenge?

Response: This is again regarding the Early Childhood Mental Health Access and Linkage Program. The focus of the program is access and linkage, not early intervention. The challenge is that families with private insurance have a very difficult time navigating their networks for care and do not receive adequate support in the same manner that Medi-Cal clients do.

10. Same question as Question 9 for Rural School-Based Strengths and Mentoring Program and Urban School-Based Strengths and Mentoring Program.

Response: Same as above re: this program being continued while the K-12 School Partnerships Projects are getting up and running. For additional context, we do not have the expenditure report data, but would note that these programs had 2,758 and 12,418 client contacts, but only reported serving 150 and 28 clients, respectively. We can't make sense of that discrepancy and would need more time to explore this, if needed. Again, this program is being replaced with the K-12 School Partnerships projects in November as described above.

11. On page 41 for the Latinx Outreach/Mental Health Promotores Program, why does it provide the estimated cost/person served for 2021-22 and not for 2020-21? The program served 84 clients in 2020-21 at a cost of $263,458 or $3,136/person served. The program is slated to receive $438,512 in 2021-22. What is the justification for this increase in funding?

Response: Increased funding for FY21-22 of this contract is slated to support the addition of needed personnel within this CommuniCare program, as the vendor demonstrated staffing levels in FY20-21 lead to service access delays and an unnecessary waitlist for clients.

12. For the Tele-Mental Health non-FSP program, which reported no data for 2020-21, why is the amount budgeted increasing from $73,390 to $1.38 million? What did the program accomplish for the $265,000 spent in 2020-21?

Response: In FY20-21 this program allowed us to serve more clients effectively through telehealth means during the ongoing pandemic (as in person appointments were not provided). The budget has gone up as the County is investing in more staff and equipment to offer clients ongoing telehealth services in specific instances as many clients have expressed a desire to continue to receive services in this way even once in-person services at clinics resume. These interventions reduce appointment no-show rates, address some client transportation barriers, and allow us to retain qualified clinicians and prescribers.

[5] MHSA Evaluation Report Questions/Feedback/Suggestions

Jonathan Raven
LMHB Vice-Chair
October 11, 2021

1. One critical piece of information if the $20 million fund balance. As most people will not read the full report (e.g., most BOS members), it would be helpful to include this in the Executive Summary. You can separate into the 3 categories. Include how much is already encumbered (i.e., unspent) as well as new money (increase in tax revenue). Also include a sentence or two about the process to apply for the available funding.

2. Please include in each program report who the contractor is.

> **Response: For every program within the Annual Update, HHSA included whether they are administered by the County, a Contractor, or both. The intent moving forward will be to name the contracted entity to increase transparency.**

3. Have you given direction to each program about how to report the Outcome Measures using RBA? In reports from HHSA, Probation, the Sheriff, outcome measures are specifically separated into the 3 RBA questions with responses for each of them. It would be helpful to have this consistency in all program reports.

> **Response: HHSA staff inform and educate contractors on the RBA process, when applicable, to provide technical assistance. The evaluation program process, in conjunction with HHSA, will work to improve data reporting and streamline comparable data sets for analysis. Our intent is to make the report as accessible as possible to the public, regardless of whether they are familiar with the RBA framework or not. We will continue to revisit our data presentation format to see how we can improve our reporting of this data.**

4. Most of the reports have an "Estimated Number to be served in FY 21/22" and a total served in FY 20/21. It would be helpful to see the estimated number of clients served for FY 20/21 to see if they met their goal (of course this year, COVID will have an impact on that).

5. Why is there no RBA analyses for Tele Mental Health Services (p. 15)? The data provided does not answer the latter 2 RBA questions.

> **Response: This is an internally delivered HHSA program and an RBA has not yet been developed.**

6. Computer-Based Drop in Nav (p. 18) does a great job of listing accomplishments.

7. Peer and family led support (p. 20) does an outstanding job of providing information.

8. Why is there no data for Cultural Competence (p. 24)?

Response: The Cultural Competence Program is undergoing a planning phase in conjunction with the Cultural Competence Plan, which is aligned with CLAS standards. This program is in development as a dedicated Cultural Competence Coordinator was recently established. Data metrics will be established as part of the evaluation program process.

9. Early Childhood (p. 25) program provided an outstanding report.

10. Same with Maternal Mental Health (p. 30).

11. Why is there such limited information on Youth Early Intervention (p. 32)?

Response: Additional program data is being collected regarding this program and will be included in the revised version of the evaluations report that will be provided to the LMHB at their next meeting in December.

12. What is “In Process” mean for Maternal Mental Health (p. 33)?

Response: This program was delayed due to the departure of the Director of Public Health Nursing and the resulting ongoing position vacancy and limited nursing staff resources. These staff members were redirected to support county emergency response efforts to the COVID-19 pandemic and continue to be assigned to these duties. It remains in process pending staff.

13. K-12 School Partnership report is great (p. 34)!

14. What is the status of College Partnerships (p. 40)?

Response: The program is operational and we are awaiting the first quarterly report which is expected at the end of the month.

15. Latinx Outreach is great (p. 41)!
16. Senior Peer is great (p. 44)!

17. Are we unable to get any results or Innovation Data (I realize it’s data)?

Response: There is no Innovation Data to share. Last year's Innovation was solely participation in the Crisis Now Learning Collaborative.

18. Under Yolo MHC, it would be great to see the allocation of MHSA $ to this program. Most of the program is not covered by MHSA $.

Response: Noted. We do allocate MHSA funding for 15 FSP slots to this program. HHSA MHC staff are MHSA funded.

19. Yolo Assertive Community Treatment is actually formatted by RBA with the questions and responses. Can all program be formatted that way?

Response: We are undertaking systems improvements to report out utilizing the RBA format.

c.a.r.e.
CONSULTING GROUP