Yolo County Mental Health Services Act

2023–2026 Three-Year Program and Expenditure Plan

Draft

Table of Contents

Acronyms & Terms

AA	Adult and Aging Branch
AB2265	California Assembly Bill authorizing the use of MHSA funds for substance use disorder treatment
ACT/AOT	Assertive Community Treatment/Assisted Outpatient Treatment
ADHC	Adult Day Health Centers
ASQ	Ages & Stages Questionnaires
ASQ-3	Ages & Stages Questionnaires Third Generation
ASQ-SE	Ages & Stages Questionnaires Social-Emotional
BBS	Board of Behavioral Sciences
BOS	Board of Supervisors
CalAIM	California Advancing and Innovating Medi-Cal
CARE Act	Community Assistance, Recovery, and Empowerment Act
CBT	Cognitive Behavioral Therapy
CC	Cultural Competency
CCHC	CommuniCare Health Centers
CEWG	Community Engagement Work Group
CFTN	Capital Facilities and Technological Needs
CIT	Crisis Intervention Team
CLAS	National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
COLA	Cost of Living Allowance
CREO	Creando Recursos y Enlaces Paran Oportunidades
CSS	Community Services and Supports
CYF	Child, Youth, and Family Branch
DEA	Drug Enforcement Agency
DEI	Diversity, Equity and Inclusion
DHCS	Department of Health Care Services
ECMH	Early Childhood Mental Health Access and Linkage Program
EDAPT	Early Diagnosis & Preventive Treatment of Psychosis Program
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FB	Facebook
FEP	First-Episode Psychosis
FFP	Federal Financial Participation
FSP	Full-Service Partnership
FTE	Full-Time Employee
FY	Fiscal Year
GPS	Group Peer Support
HFYC	Healthy Families Yolo County
HHSA	Health and Human Services Agency
HIPAA	Health Insurance Portability and Accountability Act
HMG	Help Me Grow
IBHS	Integrated Behavioral Health Services
IG	Instagram
INN	Innovations
IT	Information Technology
K-12	Kindergarten through 12th Grade
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning
LMHB	Local Mental Health Board
M/C	Medi-Cal
M-CHAT	Modified Checklist for Autism in Toddlers
MH	Mental Health
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSSA	Mental Health Student Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
MMH	Maternal Mental Health
MyAvatar	HHSA's electronic health record
N	Number
NAMI	National Alliance on Mental Illness
NVBH	North Valley Behavioral Health
OSHPD	Office of Statewide Health Planning and Development
PEI	Prevention and Early Intervention
PH	Public Health Branch
PHQ9	Patient Health Questionnaire-9
PIP	Pathways to Independence Program
PN	Perinatal
PSH	Permanent Supportive Housing
PTG	Pine Tree Garden
Q1	Quarter 1 (July–September)
Q2	Quarter 2 (October–December)
Q3	Quarter 3 (January–March)
Q4	Quarter 4 (April–June)
QC	Quality Control
QI	Quality Improvement
QPR	Question, Persuade, Refer
RBA	Results-Based Accountability
S&B	Salaries and Benefits
SEEK	Safe Environment for Every Kid
SID	Sensory Integration Disorder
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SUD	Substance Use Disorder
TAY	Transition-Age Youth
ÓRALE	UC Davis Organizations to Reduce, and to Advance, and Lead for Equity Against COVID-19
VOIP	Voice Over Internet Protocol
WCC	Woodland Community College
WET	Workforce, Education and Training
YCN	Yolo Crisis Nursery
YCCD	Yuba Community College District

County Board of Supervisors Adoption Letter

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Certifications

MHSA County Compliance Certification

County/City: Yolo

☑ Three-Year Program and Expenditure Plan
☐ Annual Update

Local Mental Health Director Karleen Jakowski, Mental Health Director (530) 661-2978 Karleen.Jakowski@yolocounty.org	**Program Lead** Brian Vaughn, Public Health Director (530) 666-8771 Brian.Vaughn@yolocounty.org
Local Mental Health Mailing Address: Yolo County Health and Human Services Agency 137 N. Cottonwood St., Suite 2500 Woodland, CA 95695	

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

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

This Three-Year Program and Expenditure Plan or Annual Update, attached hereto, was adopted by the County Board of Supervisors on Month Day, 2023. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached Three-Year Program and Expenditure Plan or AnnualUupdate are true and correct.

Karleen Jakowski, LMFT

_____ _____

Mental Health Director/Designee (PRINT) Signature Date

MHSA County Fiscal Accountability Certification

County/City: Yolo

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

Local Mental Health Director	**County Auditor-Controller/City Financial Officer**
Karleen Jakowski, Mental Health Director (530) 661-2978 Karleen.Jakowski@yolocounty.org	Tom Haynes, Interim CFO (530) 666-8162 Tom.Haynes@yolocounty.org
Local Mental Health Mailing Address: Yolo County Health and Human Services Agency 137 N. Cottonwood St., Suite 2500 Woodland, CA 95695	

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

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

Karleen Jakowski, LMFT

Mental Health Director/Designee (PRINT) _____ Signature _____ Date

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

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is an Annual Revenue and Expenditure Report attached, is true and correct to the best of my knowledge.

Tom Haynes, Interim CFO

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

Background

MHSA Guiding Principles

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

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

2. Cultural Competence.
Incorporating and working into all aspects of policy-making, program design, administration, and service delivery to achieve equal access to services of equal quality; treatment interventions and effective outreach services; proper identification of strategies to reduce and eliminate disparities; an understanding of the diverse belief systems concerning mental illness, health, healing and wellness; the understanding of historical bias, racism, and other forms of discrimination on racial, ethnic, cultural, and linguistic communities, including their mental health; the adoption of contractual services to address the needs and values; and strategies promoting equal opportunities.

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

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

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

6. Integrated Service Experiences for Clients and Their Families.
The client, and when appropriate, the client's family, accesses a full range of services provided by multiple agencies, programs, and funding sources in a comprehensive and coordinated manner.

1 Sources: California Code of Regulations: https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I694558A0D-45311DEB97CF67CD0B99467&originationContext=documenttoc&transitionType=Default&contextData=(sc.Defaul)

About this Report

The Mental Health Services Act (aka Proposition 63) was approved by California voters in 2004 to expand and transform California's behavioral health system to better serve individuals with, and at risk of, serious mental health issues, and their families. The MHSA is funded by a one percent income tax on personal income in excess of $1 million per year.

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

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

This plan is organized into the following sections:

- Context and Overall Summary
- Mental Health Crisis & Navigation
- Community Characteristics
- Systems Capacity Assessment
- Community Engagement Process
- Community-Identified Needs & Solutions
- Three-Year Program Plan
- Budget Plan

The preeminent themes that came from this process are:

- The impacts of the COVID-19 pandemic exacerbated the mental health challenges and needs of the community, with long-lasting effects that are still becoming clear.
- The county and the county's network of providers have experienced substantial workforce challenges, resulting in a shortage of workers to address the mental health needs of the community.
- People can and do get help from Yolo County HHSA to heal, improve, and recover from mental health issues.
- People with co-occurring substance use and mental health issues need better mental health intervention instead of incarceration.
- Co-responder teams have provided effective help with law enforcement/mental health situations and have started handling most mental health holds (5150s). More work is needed to further develop this program.
- Much of what people have asked for is already provided in some form, however, the need exceeds the capacity.
- Access to services is an enduring issue:
  - Not everyone who needs or wants mental health services can get them.
  - Private insurance can prevent people from getting the mental health care they need, especially if their issues are not severe.
  - Many people don't know how to access services.
  - When people try, some have trouble getting a response about how to access services.
- People in Yolo County strongly value prevention, peer support groups, and, in particular, services that prevent youth from developing more serious issues later.
- LGBTQ+ people, especially youth, are at tremendous risk of mental illness, suicide, and homelessness.
- The county prioritizes care for people with the most serious mental illness, but has limited resources to provide more services to individuals who have "mild" to "moderate" mental health issues.
- Latinx, African American, and Native American people are less likely to get the care they need for mental health issues.
- There is universal agreement about the profound seriousness of the needs of people who are experiencing homelessness.

Mental Health Definitions

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

Stages of Mental Health Conditions

STAGE 1
Mild symptoms and warning signs

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

Mild to Moderate

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

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

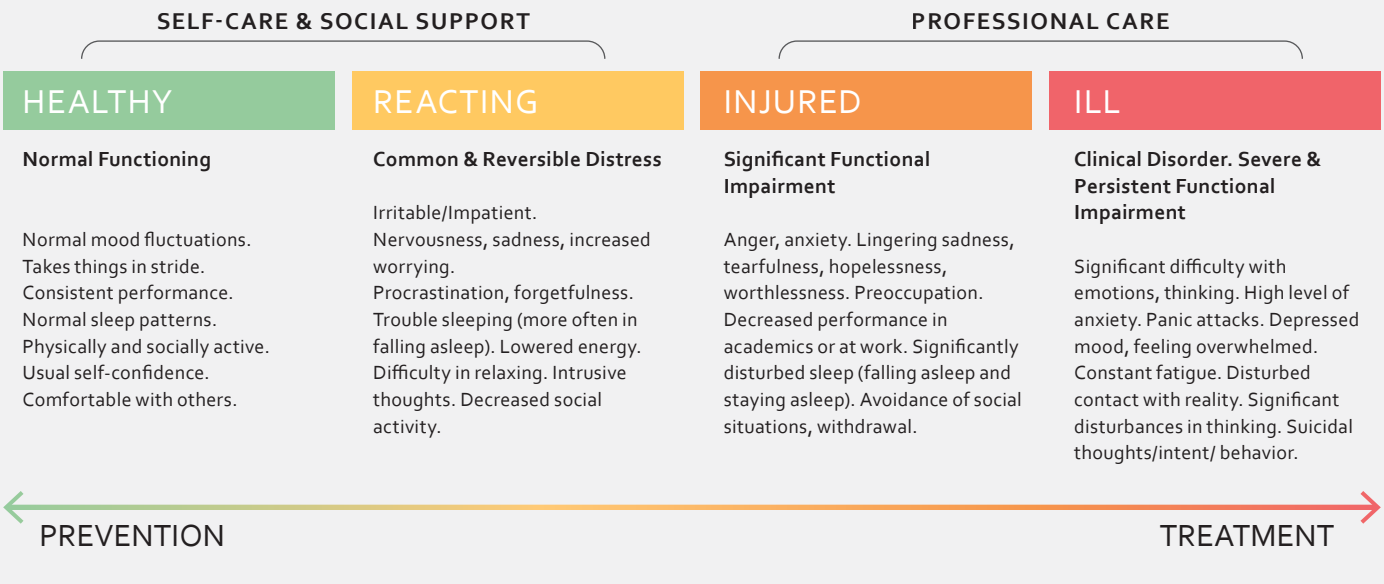
STAGE 4
Symptoms are persistent and severe and have jeopardized one's life

Severe

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

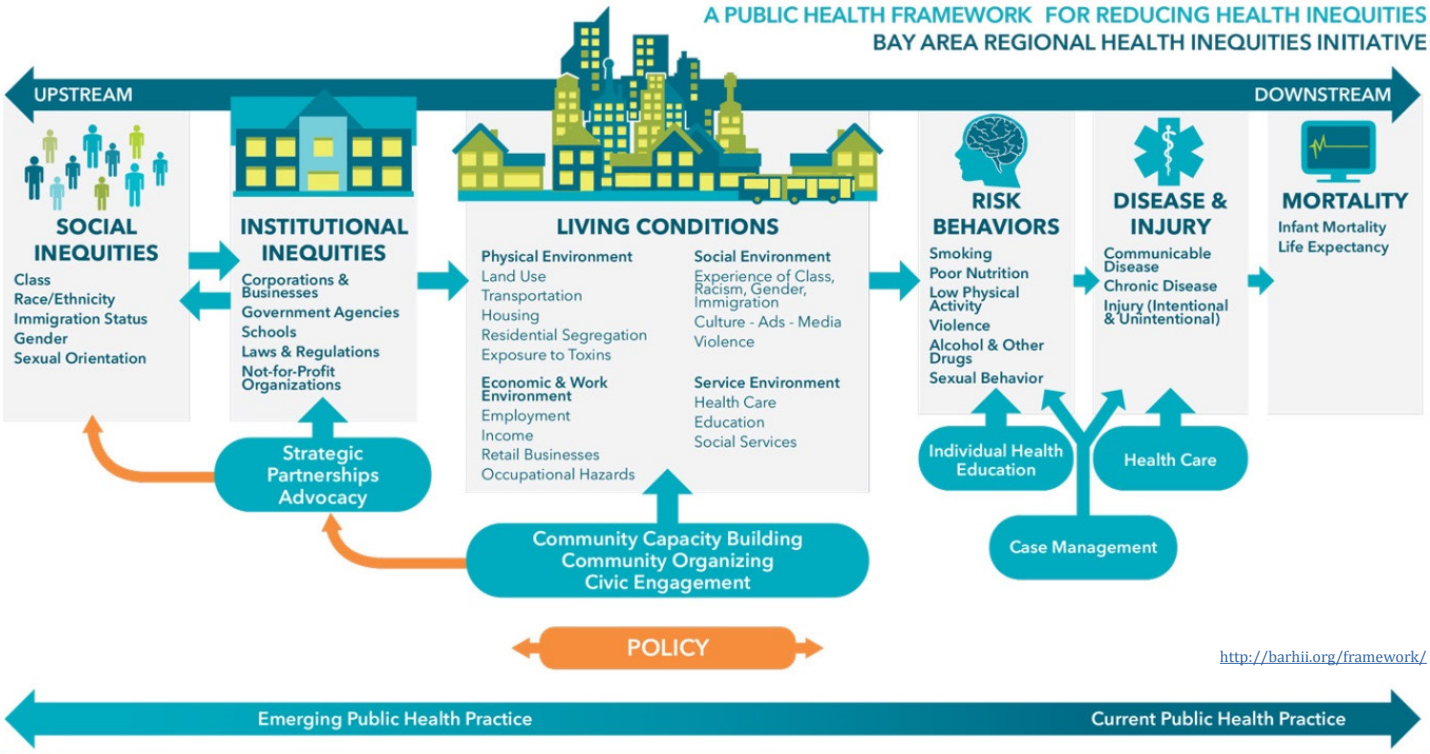
Many people experience depression, but one's ability to function is an important factor that can define the severity of illness.

Mental Health Continuum of Care



Public Health Context for All Health Inequities

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



How California's History Affects Mental Health

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

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

Jails become default psychiatric institutions. Inmates wait a long time for care.

More people with mental illness are living on the street and represent one third of those experiencing homelessness.

Emergency rooms feel the pinch.

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

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

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

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

Executive Summary

Over the past three years, the Yolo County community has demonstrated adaptability, innovation, resilience, and an unwavering commitment to collaboration as we collectively navigated the impacts of the COVID-19 pandemic and public health emergency, natural disasters, and the existing racial and ethnic disparities which were exacerbated by these emergencies.

The pandemic halted some of the vision outlined in the prior MHSA plan, while we shifted to essential work and doing whatever it took to keep our community safe, and many projects were paused or at best, delayed. But if there is one thing that makes Yolo County unique, it is the way we come together to support our community. We have been there for each other; we have taken care of each other- we have truly been in this together.

The past year has been a time of significant transition for Yolo County and for the Health and Human Services Agency. In the broader Behavioral Health landscape, the California Advancing and Innovating Medi-Cal (CalAIM) initiative, a far-reaching, multiyear plan to transform California's Medi-Cal program, implementation began with significant impacts to the local behavioral health delivery system. Several key leadership changes occurred in 2022 with a new Chief Administrative Officer (CAO) joining the county and the appointment of several key HHSA executive leadership positions including a new Health and Human Services Agency Director, Mental Health Director and Child, Youth, and Family Branch Director. These changes and transitions have provided Yolo County with an opportunity to assess our system and infrastructure with a renewed focus on sustainability, improvement, and expansion, as we strive to build a strong foundation for HHSA's Behavioral Health services.

To inform this new three-year plan, Yolo County has facilitated an extensive community engagement process with feedback from hundreds of community members, service providers, and County leaders, in addition to ongoing internal system review and assessment of our progress thus far, while looking ahead to the emerging needs, upcoming state initiatives, and local priorities. Yolo County seeks to address several key strategic priorities over the next several years, which include:

- **Investing in infrastructure, service planning, and fiscal sustainability efforts to expand Yolo County's behavioral health crisis response system** through the implementation of the Crisis Now model which includes a high tech call center with 988 integration, development and implementation of crisis receiving chairs, short-term crisis residential services, expansion of mobile crisis response to 24/7 coverage countywide, and enhancement of Crisis Intervention Team (CIT) training in partnership with local law enforcement agencies.

- **Sustaining critical programming within the current array of services** which has been developed incrementally, starting with the planning efforts at the inception MHSA nearly 20 years ago and continuing to present day. This includes enhancing evaluation efforts, ensuring fiscal sustainability through the effective implementation of CalAIM payment reform and maximizing Medi-Cal revenue, and proactive budgeting and fiscal forecasting amidst future uncertainties related to proposed MHSA reforms.

- **Increasing capacity in Full-Service Partnership (FSP) programs** to expand access to this level of care, particularly for those in the criminal justice system, and as we prepare to implement the Community Assistance, Recovery, and Empowerment (CARE) Act by December 2024. This includes increasing FSP slots and assuming the costs associated with the previously grant funded Mental Health Court expansion, effective October 2023.

- **Expanding access to critical early childhood screening, support, and referral services** through the Early Childhood Access and Linkage program, Help Me Grow, in partnership with First 5 Yolo through increased prevention investments.

- **Advancing cultural competence and diversity, equity, and inclusion efforts.** The intersectionality of sexual orientation, gender identity, race, cultural values, life circumstances, and religious practices presents unique and profound stressors that can, and often do, impact every aspect of individuals' health and wellness—emotionally, psychologically, physically, economically, academically, socially. Yolo County is committed to continued prioritization of and investments in these efforts to identify and dismantle inequities and to ensure inclusive, safe, and trauma-informed care.

As the nation has grappled with "The Great Resignation" that unfolded during the pandemic and a growing behavioral health workforce shortage, Yolo County has experienced similar workforce challenges. Both the county and the county's network of contract providers have experienced fluctuating vacancy rates which have impacted mental health service delivery to the residents of Yolo County. Initial investments in workforce recruitment and retention efforts to stabilize the workforce and to meet the growing need for mental health services have shown early promise and additional Agency-level efforts are both underway and still needed to address hard to fill and retain positions. While the initial three-year plan is focused on sustaining existing levels of mental health services, improving internal infrastructure to support MHSA funded programs, and navigating new implementation requirements, Yolo County is hopeful that there will be an opportunity in the first annual update to this plan to further address workforce challenges.

While we continue to navigate the challenges described above and the changing landscape of Behavioral Health in California, Yolo County HHSA remains committed to supporting our clients, partners, and community while holding firm to the core values of the MHSA: community collaboration; cultural competence; consumer and family-driven services; service integration for consumers and families; prioritization of serving the unserved and underserved; and a focus on the importance of mental wellness, recovery, and resilience.

We are truly grateful for your time and participation in community engagement workgroups, focus groups, and key informant interviews; for sharing your input openly; and for challenging our system to grow and improve. Thank you for your partnership and your investment in the wellness of our community. We are infinitely stronger together.

In partnership,
Karleen Jakowski, LMFT
Mental Health Director

How to Get Help in Yolo County

Resources and services for those experiencing a crisis

Help is available, speak with someone today.

Call or text 988 Suicide and Crisis Lifeline 24/7.
In case of a life-threatening emergency, **call 911**.

Yolo County HHSA

Yolo County Health and Human Services Agency Phone Line
Toll Free: (833) 744-HHSA (4472)

Access & Crisis Lines

24/7 Behavioral Health Access and Crisis Line
Toll Free: (888) 965-6647
TDD: (800) 735-2929
https://www.yolocounty.org/government/general-government-departments/health-human-services/mental-health

Deaf callers will need to call the toll-free number for behavioral health. California Relay Services: 711

ASK — Teen/Runaway Line
Davis: (530) 753-0797
Woodland: (530) 668-8445
West Sacramento: (916) 371-3779

National Alliance on Mental Illness (NAMI), Yolo Message Line
Contact: (530) 756-8181
Suicide Prevention 24/7
988 Suicide & Crisis Lifeline 24/7: Call or Text 988
https://988lifeline.org/talk-to-someone-now/
Veterans text call 988 dial 1 or text 838255
Nacional de Prevención del Suicidio (888) 628-9454

Protective Services

Yolo County Adult Protective Services
Toll Free Adult Abuse Reporting 24/7 Intake Line: (888) 675-1115
Adult Abuse Reporting (24/7 Intake Line): (530) 661-2727

Locations:
25 N. Cottonwood Street
Woodland, CA 95695
https://www.yolocounty.org/government/general-government-departments/health-human-services/adults/adult-protective-services

Yolo County Child Welfare Services
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/
CWS Reporting: (530) 669-2345 CWS Fax: (530) 661-6012

Emergency Child Respite Services

Yolo Crisis Nursery
Contact: (530) 758-6680
Email: info@yolocrisisnursery.org
https://yolocrisisnursery.org

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
https://empoweryolo.org/crisis-support/

Empower Yolo, Dowling Center
175 Walnut Street Woodland CA 95695
Contact: (530) 661-6336
https://empoweryolo.org

Empower Yolo, D-Street House
441 D Street
Davis, CA 95616
Contact: (530) 757-1261
https://empoweryolo.org

Empower Yolo, KL Resource Center
9586 Mill Street
Knights Landing, CA 95465
Contact: (530) 661-5519
https://empoweryolo.org

Empower Yolo, West Sacramento
1025 Triangle Court, Suite 600
West Sacramento, CA 95465
Contact: (916) 873-8824
https://empoweryolo.org

2-1-1 Yolo County
Website: https://www.211sacramento. org/211/2-1-1-yolo-county/

Teen Line
1-310-855-HOPE or
1-800-TLC-TEEN (nationwide toll free) from 6 pm–10 pm PST or
Text "TEEN" to 839863 between 6:00–9:00 p.m. PST
https://www.teenline.org/

The Peer-Run Warm Line
1-855-845-7415
https://www.mentalhealthsf.org/peer-run-warmline/

Yolo County's Children Alliance
https://www.yolokids.org/

Yolo Family Strengthening Network
https://www.yolokids.org/yolo-family-strengthening-network

SAMHSA's Disaster Distress Line
1-800-985-5990 or text TalkWithUs to 66746
https://www.samhsa.gov/find-help/disaster-distress-helpline

Alcoholics Anonymous
https://alcoholicsanonymous.com/aa-meetings/california/

Narcotics Anonymous
https://www.norcalna.org/na_meetings.php

Community Planning Process

Focus groups between November 2022 and March 2023

32 Focus groups

516 Participants

Community Planning Process & Focus Groups

The Community Planning Process consisted of focus group and key informant interviews that aimed to build off the community-based priorities for mental health services that were established in the 2020-2023 plan. Following these focus groups and interviews, Yolo County's HHSA Behavioral Health leadership team met to finalize details of funded programs, based on collaboration with fiscal leadership, to ensure a thorough and comprehensive plan, inclusive of community and stakeholder engagement and HHSA leadership perspectives and priorities.

Focus Groups for Yolo County MHSA with Number of Participants

Nov 21, 2022	Law Enforcement (Police Departments) 4
Dec 6, 2022	Help Me Grow—Early Childhood Mental Health (Parents and Families) 9
Dec 7, 2022	Community Engagement Workgroups 52
Dec 9, 2022	Yolo County School Districts 6
Dec 9, 2022	Help Me Grow- Early Childhood Mental Health (Parents and Families) 7
Dec 13, 2022	North Valley Indian Health 2
Dec 14, 2022	Fourth and Hope (Transitional and Permanent Housing) 14
Dec 14, 2022	Peer Support Group 8
Dec 15, 2022	Yolo County HHSA Substance Use Provider Meeting (DMC-ODS Providers) 26
Dec 15, 2022	Yolo County HHSA Provider Stakeholder Work Group 12
Jan 4, 2023	Yolo County Child, Youth, and Family Branch Staff 67
Jan 5, 2023	Yolo Healthy Aging Alliance Committee 18
Jan 10, 2023	National Alliance on Mental Illness (NAMI) Yolo County 6
Jan 12, 2023	Yolo County Health Council 25
Jan 25, 2023	West Sacramento Community 19
Jan 26, 2023	Davis Community Meals 9
Jan 30, 2023	Latinx Perspectives on Mental Health 5
Jan 30, 2023	Criminal Justice Partners 6
Feb 2, 2023	HHSA Behavioral Health Team 76
Feb 7, 2023	Empower Yolo 29
Feb 10, 2023	Cesar Chavez Community School: Student Participants 10
Feb 13, 2023	Families of Individuals Involved in the Criminal Justice System 6
Feb 15, 2023	Yolo County Maternal Mental Health Advisory Board 18
Feb 15, 2023	Yolo Rainbow Families 10
Feb 17, 2023	Early Childhood Mental Health Professionals Focus Group 8
Feb 17, 2023	Criminal Justice Professionals: Yolo Staff and Contractors 8
Feb 21, 2023	Children's Mental Health Service Providers 17
Feb 24, 2023	People with Lived Experience 10
Feb 24, 2023	Yolo County Veterans Services Office Staff 2
Mar 7, 2023	Woodland Community College: Staff Participants 7
Mar 16, 2023	Emergency Medical Services Partners 10
Mar 29, 2023	Cesar Chavez Community School: Staff Participants 10

Key Informant Interviews

As part of the information gathering process with key stakeholders, all members of the Yolo County Board of Supervisors were invited to participate in an individual one-on-one key informant interview. The list of those who participated is included in the table below, along with when the interview took place. The HHSA Mental Health Director also participated in a key informant interview.

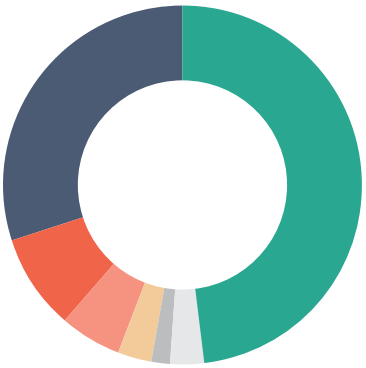
Selected Key Informant Interviews

February 2023	Frerichs, Lucas	Yolo County Supervisor
February 2023	Jakowski, Karleen	Mental Health Director
February 2023	Provenza, Jim	Yolo County Supervisor
December 2022	Saylor, Don	Yolo County Supervisor
January 2023	Villegas, Oscar	Yolo County Supervisor

Participant Demographics

The tables below summarize the demographic data of all participants in the focus groups and community engagement workgroups who chose to share this information.

Participant Race/Ethnicity



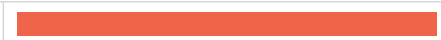
White Non-Hispanic/Latino	**150**	52%
Hispanic or Latino	**93**	32%
African/African American/Black	**27**	9%
Asian	**17**	6%
American Indian or Alaska Native	**10**	3%
Pacific Islander	**5**	2%
Prefer not to answer	**10**	3%

Participant Residence

Woodland	90	32%
Davis	49	18%
West Sacramento	31	11%
Sacramento (Board and Care)	13	5%
Yolo	9	3%
Winters	3	1%
Dunnigan	1	0.4%
Esparto	1	0.4%
Knights Landing	1	0.4%
Homeless	1	0.4%
Out of County	65	23%

There were no participants from Brooks, Clarksburg, Guinda, or Madison.

Participant Affiliation



Community member	86	31%
Mental health service provider	64	23%
City/County employee	62	22%
Mental health client/consumer	39	14%
Educator	36	13%
Family member/Friend of mental health client	27	10%
1st responder	11	4%
Business owner	5	2%
Foster care youth	4	1%
Prefer not to answer	12	4%

Community Needs and Proposed Solutions

Introduction

Over the course of five months, 32 focus groups were conducted with various constituent groups throughout the county.

Disclaimer: All quotes are statements made by participants in the community planning process. The information is reported here as stated and may not reflect factual accuracy, but rather one individual's perception of events.

Groups were mostly held virtually due to ongoing COVID restriction; however, some were held at partner organizations to make the focus group accessible to constituents. These constituents were typically members of special populations such as students and people in permanent and transitional housing. As required by MHSA regulations, these groups represented both service providers and recipients in the following areas: children, youth and families, adults and aging, disability, substance abuse recovery, homelessness, migrant workers, education, schools, higher education, behavioral health providers, foster care, police, first responders, victim services, Latinx, American Indian or Alaska Native, LGBTQ+, emergency medical care, and behavioral health advocacy.

Focus groups included all populations required in the MHSA regulations. In addition, five key informant interviews were held with four Yolo County supervisors and the HHSA Mental Health Director. Data were coded and analyzed to represent the themes that emerged.

Several primary themes emerged as salient across focus groups, including aspects of service provision (access, navigation, integrated services, telehealth, and respite care); prevention (education, support groups, and training); cultural competence (e.g., attending to the special needs of certain groups and reducing stigma); funding; and collaborating to improve community planning and business partnerships. Throughout the focus group and key informant data collection process, suggestions for strategies to address the needs identified in this process emerged. This section details those themes and the proposed solutions.

Keyword Mentions: 2023 Themes

Community Needs and Accessing Services

Connecting to and Maintaining Services
522

Substance Use and Mental Illness
282

COVID-19 and Isolation
250

Prevention, Education, and Outreach

Stigma
212

Education and Outreach
165

Law Enforcement
131

Prevention and Early Intervention
101

Special Populations

Youth
208

Race and Ethnicity
65

Older Adults
45

Pregnant and New Mothers
14

LGBTQ+
10

English as a Second Language
3

Formerly Incarcerated
1

Funding, Workforce, and Capacity Building

Workforce
161

Funding
123

Implementing Initiatives
72

Data Management and Evaluation
34

Keyword Mentions: Issues

Services

Access	242
Housing	188
Transportation	33
Navigation	26
Case Management	15
Telehealth	9
Basic needs	5
Respite	5
Integration	3

Prevention

Education	119
Training	87
Prevention	73
Peer Mentorship	47
Support Groups	16
Social Marketing	0

Special Needs Populations and Cultural Competence

Youth	208
Stigma	205
Homeless	113
Language	62
Aging	56
Latinx	18
Russian	7
Children Aged 0–5	6
LGBTQ+	5
Incarcerated	5
Native American	0

Funding

Religion	5
Predisposing	3

A. Community Needs and Accessing Services

1) Connecting to and Maintaining Services

Needs

> *"We're identifying more and more people with SUD and mental health issues, and resources are incredibly limited to serve all these people flowing into the system."*

> *"It would be nice to have something that's just right here, local, in Yolo County, available for people with early psychosis and a clear path on how to refer."*

> *"We're playing catch up because we don't have adequate services."*

Lack of Services

Participants noted a lack of local rehabilitation and substance use treatment facilities, dedicated mental health hospitals, services for people with serious mental illness, and follow-up services for those who have had a psychiatric hospitalization. This lack of services can lead to re-hospitalization. One participant said, "There's nowhere to go. There's no space that is safe." Another participant explained, "In our community in West Sac [Sacramento], we don't have any services. We don't have a Safe Harbor. We don't have a hospital. We're expected to drive across a causeway or a bypass to get our loved one help unless they want to go in handcuffs."

Fractured Infrastructure

Participants noted substantial difficulty in navigating services because they are often blocked or siloed until individuals reach a certain threshold of severity, such as a relapse or major crisis, leading to increased difficulty in connecting to services and often, law enforcement involvement. Respondents in 11 sessions also reported long waits for services, a lack of consistent services, and a lack of awareness of current services, leading to increased lag time between referral, assignment, and receiving services. One participant explained, "I needed to see a therapist and it took me almost seven months waiting on a wait list. I wasn't necessarily in crisis, but I have a very severe mental health disorder, and sometimes having more immediate access is necessary." Another participant said, "The ROI [release of information form] that we have is four pages. It's really complicated. It's not intuitive. A lot of times, somebody will come in and just be handed this huge stack of paperwork and told to fill it out, and if someone's really symptomatic, they may struggle to do so." Another participant noted that requiring a ROI form annually makes it difficult for family members to be involved in their loved one's treatment planning team.

Another prominent issue was the inability of clients and service providers to meet the requirements of appropriate care due to a lack of facilities and "too many wrong doors." As needs continue to increase, providers need "more of everything" to meet the demand, and some organizations that are meant to treat mild to moderate issues are now seeing clients with "higher acuity" because they've been unable to get services elsewhere. The emergency room, for example, is not only difficult to reach but also one of the "most traumatic places with the highest cost" because it isn't always equipped to address mental health needs.

Challenges with Insurance Coverage

Participants also noted that a lack of insurance or difficulty accessing services through insurance, particularly Medi-Cal, continues to be a problem for residents in Yolo County. One participant, a licensed provider, explained they could see many residents through Anthem, Medi-Cal, MHN, and Aetna, but could not see Medi-Cal clients through Yolo County because of a lack of formal partnership. Respondents also reported that individuals often need to have multiple co-occurring ailments to qualify for some HHSA services, whereas others noted that clinicians they find to be a "good fit" are often out of network or not reimbursable.

Members of county leadership echoed these concerns, indicating that county services are primarily available to the neediest people who are covered by Medi-Cal. Thus, having private insurance can actually inhibit access to services, resulting in private payment

by those who are able to afford it, often leaving many people in a confusing in-between space where it is difficult or impossible to access adequate mental health services. One leader mentioned hearing of residents taking children off their health plans to obtain services for them. In addition, although the Mental Health Services Act (MHSA) opens services to those who do not have serious mental illness, Medi-Cal delivery system changes as a result of California Advancing and Innovating Medi-Cal (CalAIM) has created further confusion.

Food Insecurity
Participants cited food insecurity as a major issue affecting individuals' quality of life. One participant said, "So much of their mental health is already affected by massive amounts of food security. I mean, you have parents who are trying to decide what they're spending their money on in the month and having to decide to spend it on rent instead of feeding their children because they don't have enough for both. And they are terrified of being evicted."

Transportation
Transportation remains an issue, especially for smaller communities. Another respondent expanded: "And a lot of people with the Medi-Cal transportation [benefit] can't navigate it because you have to give five days' notice and, and because of their mental illness, they're not able to schedule things of that nature." Participants also noted that the shelter outside city limits is not connected to a bus line and there is a lack of program-funded vehicles, meaning many workers for contracted partners may end up using their own vehicles and put themselves at risk of liability.

Housing
An incredible need for housing is only increasing and complicated by the "not in my backyard" (NIMBY) movement, wherein community members may hold prejudices against homeless or mentally ill populations. Current housing programs have long wait lists and strict qualifications, especially for those living with severe mental illnesses. As a result, there is still a large need for secure housing facilities, particularly adult residential facilities, board and cares, and medication-administration safe places. One participant noted that housing individuals together who are at different stages of their mental health conditions can lead to "toxic" housing situations and increased recidivism. Other participants discussed the isolation and instability felt when transitioning from long-term homelessness to housing, with one explaining, "I've been homeless for 44 years. I told them the other day I'm not comfortable inside. I've been on the streets for so long, being inside made me uncomfortable. It was a new experience, and I can't understand it." Another participant said, "I just can't sleep. I think I'm going to get kicked out again."

Members of county leadership also spent a good deal of time discussing issues regarding housing. They noted how homelessness can exacerbate mental health issues, as did the pandemic. As unhoused persons have become more visible in the community and there has been an uptick in confrontational behavior, the associations among substance use, mental illness, and crime contribute to stigma. The "not in my backyard" sentiment was brought up as a natural correlate of working to address the homelessness situation, and many neighborhoods throughout the county have reacted negatively to housing support projects. However, one leader felt strongly that if these projects have plenty of lead time, good communication, and strong coordination with the cities and neighborhoods, many concerns can be addressed. One Supervisor emphasized that many elected officials will turn away from the right action due to some small concern instead of doing the work to address the issue, stating "we can do it, but we have to work at it and find ways to do work in interest of the whole and mitigate impact on smaller groups."

Solutions

> *"It should be like your annual physical. You do an annual mental health check in with someone who can see if you might need something more extensive."*

Centralized Resources
One of the most prevalent recommendations was to have a central location for updated resource information (availability, eligibility, etc.) that is disseminated to all service providers and to ensure the county website is relevant, updated, accessible, and direct. Participants specifically recommended listing mental health services on ADRC's 211 core services list, restarting the IHSS newsletter, and increasing information sharing between case workers.

Redesigning Informational Campaigns
Participants in nine sessions noted a need to "normalize the language" by spreading awareness about service accessibility and eligibility through multimedia campaigns (mail, messages, flyers, word of mouth, social events, tabling, etc.) to maximize the ways clients receive information. One participant explained, "What we've encountered in the community is when we call something a certain thing [e.g., mental health], it feels like we're being accusatory. We called it a parenting class, and we got a really low turnout. When we called it teatime or social hour, where community is coming together to talk and process, turnout went up." Respondents also mentioned the need for advertising campaigns for the 988 suicide and crisis line, the county's CommuniCare drop-in Navigation services, weekly seminars at homeless shelters on available resources, and educational videos about prescribed medication, medication adherence, and proper Narcan use.

Addressing Dual Needs

Participants suggested providing more diverse and personalized assessment and counseling services capable of addressing both substance use and mental health needs simultaneously, particularly through increased training for high-intensity services like eating disorders, substance use, and suicidal ideation, as well as personalized case management. This might include increasing rehabilitation services for those with substance use disorders, implementing aftercare programs and services ("alumni programs") to follow up with clients, joining the Recovery Café network and supporting recovery check-ins, and ensuring people discharged from jails or hospitals have strong transition plans and a "secure level of care" with a step-down team approach (similar to Mental Health Court). More specifically, one participant said, "I've always tried to go to one-on-one counseling, but as soon as they want to push medication on me, I get in my head, and I get a case of the screw ups. I don't want to take medication; I just want someone to hear me out."

Intermediate Levels of Care

Participants suggested developing an intermediate level of care before crises escalate to 5150s (involuntary psychiatric holds), having more beds available in hospitals to treat 5150s when they occur, and implementing consistent follow-up services. Participants pointed to a system like that in Contra Costa County, where "ambulances had a central location to transport 5150s" or a board-and-care service for those in need of medication administration. Participants similarly suggested implementing "more meaningful recovery places that aren't jail," like Safe Harbor, especially in areas that have apartments for people struggling with mental illness and housing insecurity. One participant also suggested a mobile counselor team that can provide home health care and drop-in centers with services for people with "low-level issues" to help maintain their progress to prevent escalation to crisis in the future.

Fast-Tracking Services

Another suggestion included making mental health services available right away to people who need them to "reduce barriers to timely treatment so that anyone who needs any treatment could call and have an appointment that same day or the next." More specifically, a participant suggested a "fast track for people to get immediate services when they're struggling," especially if they've already been identified as being at high risk. This might include expanding the full-service partnership (FSP) programs to ensure "after they're assessed, we have somewhere in the community that will treat and house them," and clients won't have to "start over at the bottom and have to work their way back up to FSP." This solution may also look like creating a "bridge" of funding to ensure individuals have access to insurance and services while they're waiting for their new insurance to activate, diversifying the types of insurance accepted, and offering more options rather than being limited to FSP programs.

Increasing Access and Quality

One of the most prominent solutions involved increasing access to and quality of case management services, potentially through programs like Solano County's intake center, Heritage Oaks, group therapy, or comprehensive eating disorder treatment systems. This might also include incorporating more walk-in services, same-day services, "crisis type services," and "wraparound" holistic early intervention into existing programs and services to prevent the escalation of "a full mental health crisis." One participant expanded: "We need a whole system to wrap around these folks to be successful. I would much, much rather spend the resources and make sure people are getting healthy, even if we have to triage it somehow, rather than spreading it so thin that people aren't benefiting really at all."

Addressing Service Gaps and Barriers

Participants' solutions also included making "bureaucratic hurdles as low as possible" to keep people in care. Specific suggestions included building a "pathway" for people to access services that doesn't necessarily involve a social worker, increasing contracts with places like Dignity Health and North Valley to expand access to different types of services and providers, and providing facilities with a "roadmap" showing community members how to obtain resources. One respondent suggested a "central point" where "health navigators" can provide referrals and help clients navigate "these incredibly complex systems."

Transportation

There is a need to focus on individuals lacking access to community-based services, either because they do not have the means to participate in telehealth options or live in rural areas far from services. Participants suggested implementing a trauma-informed mental health cab service that is more reliable and safer than a bus, especially for people with mental health needs who may struggle to acquire transportation through planning. This solution may also include increasing promotion of currently available integrated transportation and medical programs, like Davis's medical van, which first responders noted are important for freeing up emergency vehicles.

Housing

Participants said they would like to see the county assess housing needs to "match a continuum of care for our loved ones with the housing that's available" and promote more affordable housing programs. This may include increasing access to board and cares, skilled nursing facilities, and homeless shelters by moving them closer to where clients live, initiating more tiny home developments, providing more resources for homelessness and basic needs, and having more long-term transitional housing to help stabilize clients during treatment. One participant specifically suggested looking into investing in real estate to build multiunit homes through partnerships with local organizations like North Valley to increase access to board and care.

2) COVID and Isolation

Needs

> *"The pandemic has had a profound impact across the board."*

Service Disruption
Participants explained the pandemic "put the brakes on everything," revealing cracks in "the system that already was deficient," particularly through the curtailment or outright closure of housing and social services (WIC, childcare, etc.) and everyday activities like grocery shopping. Clients not only lost access to in-person services and transportation but were "lost on where to go to access services" in the meantime. According to one participant, "Pre-pandemic, service providers were regularly meeting to talk about individual clients and their case management. During COVID, that went away. The meetings are starting to happen again, but they don't seem to be as coordinated as they were." People experiencing homelessness, people with serious mental illness, and youth were particularly affected, leading to increased rates of depression and anxiety and an overall lack of community trust. One participant explained, "I think everyone, especially kids, really lost faith in all of us as a whole, but then as the pandemic has continued and there's no end in sight and all of those supports are also dropping away, that compounds this feeling of insecurity that people have had."

County leadership noted that although substantive changes to services had been determined by the last 3-year planning process, the pandemic interrupted implementation of those changes and reoriented everyone's focus. In addition to the individual and community effects of isolation, impacts on youth, and distance learning, they discussed the continuing ripple effects being felt in service systems. The pandemic forced new ways of thinking about how to reach and serve the community.

Telehealth Services
As telehealth services increased during the pandemic, demand for such services also increased. According to one participant, "There's just not enough resources in the system to serve all who really need to be served." However, participants also reported difficulty engaging clients without face-to-face interaction, especially clients with limited or no access to the internet or those who are not tech-savvy (e.g., older populations). One participant said, "Pre-COVID, HHSA had their employees out in the field actually making face-to-face contact with clients. That's occurring via telephone and via Zoom now, and it's absolutely not working."

Isolation
Unfortunately, isolation remains an issue for many and has exacerbated already existing mental health issues. According to one participant, "The pandemic and the rise of Zoom has created an isolation gap that Zoom alone cannot bridge." Another said, "People are isolated from an ability to be able to find out what resources are available. There are less of the interactions just within the community where you might happen to hear about something." Other spaces that are vital to community support, like salons or churches, were deemed "nonessential" during the pandemic, and these small businesses are still struggling to survive. Many of these "cultural institutions" allowed people to have "organic social interaction" to improve their confidence and mental health and increase employment prospects for many residents.

Solutions

Multifaceted Supports
Participants said they would like to see more in-person and outdoor opportunities and face-to-face client and provider contact. They also suggested bringing back the weekly phone call check-ins that started during the pandemic (e.g., You'll Help the Aging), endorsing masking in public spaces, and ensuring that telehealth and hybrid options are still available beyond the pandemic through "multilayered offerings," especially for those who may find it difficult to get to an office. However, resources and funding are still needed for community-based services for clients and families who lack access to telehealth options, especially those living in rural areas.

B. Prevention, Education, and Stigma Reduction

1) Prevention and Early Intervention

Needs

> *"The bulk of funding comes in when people meet certain criteria and diagnosis, but there's not much on the preventative side."*

Crisis Support and Wraparound Services

As mentioned in eight listening sessions, there remains an immediate and pressing need for crisis support and wraparound intervention to prevent reinstitutionalization, especially for unhoused individuals with mental illnesses, youth, and those with substance use disorders. Individuals experiencing mental health or housing crises may struggle to take advantage of resources because providers are "dealing with them more in the crisis capacity." One participant explained, "The system is built to wait until you decompensate to the level of being in a serious situation, and that is fundamentally flawed." Members of county leadership echoed the need to intervene early—and have options accessible at every level of intensity—before the need for services becomes extreme. Some felt youth prevention efforts in particular warrant a higher level of investment than has historically been provided.

Solutions

> *"It'd be nice if we could prevent them from getting to that point or prevent them from having to be incarcerated to have access to these services."*

Building Informal Support Networks

Respondents also recommended creating or supporting informal supports, such as a "warm line," a family resource or wellness center, public restrooms and hygiene spaces for the homeless population, and parenting support groups. These locations or other "third places" could host community events (seasonal, holiday, picnics, etc.) where people feel safe socializing, building peer support groups, and learning about services in a more natural setting. It may also be possible to integrate these services into existing locations, like hair and nail salons and churches. One participant explained, "A lot of individuals go to their religious leaders when they're having issues, so if [the leaders] have good information, then they may be able to point them in the right direction." Several participants pointed to expanding NAMI's peer support services, which have been "invaluable" in providing education, peer, and family support and referrals during mental health crises. Respondents also suggested that service providers be empowered to build more coalitions and informal partnerships with schools and workplaces that would help prevent the "siloing" of services and encourage "more micromovements to connect."

Integrated Services

Participants suggested integrating mental health care outreach and early intervention into existing care systems, schools, and workplaces. This may include facilitating partnerships between medical and mental health services, such as the Continuum of Care and Mental Health Behavioral Coalitions, as well as publicizing services and hosting mental health check-ins at schools, clinics, and hospitals. These relationships would foster resource and information sharing, making educational material and access to services more attainable. Suggested education topics included substance use disorders, mental health and medication, healthy coping skills, and parenting guides and classes.

Members of county leadership also highlighted the benefits of navigation programs, which have increased access and worked well in one city; they suggested exploring how to expand this model into more of the county. They also echoed the listening session participants in terms of the importance of establishing a strong continuum of care and reducing any potential gaps in services to ensure that no one falls out altogether.

2) Stigma

Needs

Many Contributors to Stigma

Many clients struggle to seek support due to expected or perceived stigma and difficulty understanding their condition, which lead to anxiety and avoidance of care. According to one participant, "Families have a hard time seeking help because of the stigma. There are people who sometimes, for fear of what people will say, will not go to a psychologist because 'they will say I am crazy.'" Some individuals may even avoid services altogether for fear of having a record or getting in trouble with the law. There is also a perception that mental health is not treated the same as physical health. One respondent explained, "You can talk all day about your heart condition and your kidneys, but as soon as you start talking about anything neurological, it's just, 'Oh, you must be some really weird person.'"

Some in Yolo County leadership agreed, noting that the challenges residents experience when trying to access services can feed into feelings of stigma. Additionally, growing issues with homelessness contribute to stigma, which in turn contributes to diminished success at reaching people who are struggling. County leadership agreed with themes that arose in listening sessions, including the need for more stigma reduction work among young people, in schools, and with families.

Solutions

> *"I just firmly believe in proactive education, and I think stigmas come from ignorance to a large degree, from people just not understanding exactly what's going on."*

Education and Resources

Participants requested that further programming be mindful of cultural influences related to stigma and reach out to the community to improve education, awareness, and outreach efforts, particularly in early age. Educational efforts should emphasize the concepts of nonlinear recovery and harm reduction efforts.

Additionally, "having as many resources as humanly possible everywhere you go would help destigmatize," according to one participant. This might include celebrating successes of existing employment opportunities for people with mental illnesses, such Cool Beans, and expanding those opportunities. One participant explained, "Those success stories will also make the stigma around mental health less, because now these people who were deemed inefficient or unproductive are actually productive. They just needed help getting stabilized. They needed help getting into certain situations to where they can flourish."

Community-Centered Treatment

Meeting people where they are is an effective form of reducing stigma, whether through incorporating texting services for youth or meeting clients at churches or community events. One respondent described the importance of local peer support workers, stating that many Yolo County residents "didn't even know that they could be a therapist or work in mental health because it's so stigmatized." This might start with a more active presence on social media through a stigma reduction campaign featuring local voices or respected community members, particularly one focusing on historically unrepresented populations. One participant explained their success with this method: "We're making a video right now that just normalizes being in the community; posting them on social media [to show the LGBTQ+ community] in a positive light. It's targeting audiences in a way that will be effective and getting education and normalization out there." Another respondent highlighted NAMI's "In Our Own Voice" program, in which individuals with lived experience give presentations about their mental health challenges, how they worked through them, and how they are living successfully.

Yolo County leadership's comments in this area mirrored these sentiments, with an additional emphasis on the community health angle: considering what a mentally healthy community looks like and what it would take to get there. Solutions included being more creative about outreach strategies, engaging more directly on the ground, and positively promoting mental health, including on social media and at in-person events.

C. Special Populations

Needs

Lack of Diversity in Workforce
A common thread across subpopulations was a call to address diversity issues in the current workforce. There is a need for clinicians who come from the communities and demographic backgrounds of the clients they serve to ensure more culturally competent care. This should function across racial and ethnic groups, LGBTQ+ identities, and language abilities.

Barriers for Marginalized Populations
People from marginalized backgrounds face major barriers when it comes to accessing services and supports. People from similar backgrounds and who are undergoing similar challenges being able to connect with one another also experience difficulties, because "different groups are segregated."

Solutions

Programs Tailored to Underserved Populations
When creating programs to serve the community's mental health needs, decision makers should, "begin constructing, changing, expanding services by addressing minorities and underserved populations first, not as an afterthought."

Trauma-Informed Care
The county can better serve marginalized groups by being trauma informed, meeting people where they are, and understanding each person's specific goals "rather than what we think or project what they need to do."

A More Diverse Workforce
People with lived experience should be involved in making decisions (e.g., on committees determining MHSA funding distribution). Representation matters in these spaces. There should be an increased emphasis on making sure marginalized individuals are included in leadership and decision-making positions. As one participant noted, this recommendation applies to youth as well: "I think there are few opportunities for marginalized kids to get into leadership programs. They're really not well known at all."

Intentional Spaces for Marginalized Community Members to Connect
Improvements should be made to develop "more institutions that are places where marginalized folks can connect with each other." This could involve using more formal networks and cultural centers or contributing funds to improve local malls and other gathering spaces to make them more comfortable places to socialize.

1) Older Adults

Needs

> *"There was a time when there were many older adult mental health programs from the counties. Those are gone."*

Mental Health and Dementia Care
One area with a particular need for more cohesive, holistic care is mental health and dementia services. Currently, mental health issues and dementia are treated as separate, unconnected conditions, rather than being addressed together. One listening session participant shared: "We find that there's a lot of mental health that is tagged dementia, and if dementia is in the picture, then mental health is out."

Dwindling Mental Health Programs
The number of older adult-specific mental health programs is decreasing, alongside cuts to staffing. One community member highlighted this need by sharing: "I have seen a decrease in staffing within mental health that is focused on older adults. There used to be an older adult team that was comprised of an RN [registered nurse] and a social worker. They were out there in the community and at some point, funding dried up and we haven't seen it in a long time." In addition to increasing programs for this population, there needs to be funding to increase staffing of programs and services.

Ongoing Isolation
Isolation is another major issue for older adults in the community that "can lead to further mental health issues." Specific programs, such as congregate meals for seniors, helped meet this need in the past but were discontinued due to the pandemic. As these in-person opportunities become available again, older adults in the community are wary of reengaging, leading to further isolation. Older individuals in the community are requiring "a little more coaxing and a little more time to help them feel like that's a way they want to engage again. It's about more than a virus. There's something else that's kind of getting in their way of engaging in this way again."

Agency–Program Connections
Participants identified the need to utilize existing connections between the county and older adults in the community, through programs such as adult protective services, to provide MHSA interventions and needs assessments.

Web and Telehealth Literacy
Additionally, the challenges that older adults in the community have with technology and web literacy is a factor that, if addressed, would assist in their ability to access and engage in programs and services offered via telehealth.

Solutions

Adult Protective Services as an Intervention Point
One suggested solution was for the county to continue to use adult protective services and MHSA to carry out assessments and interventions for older adults. In the words of one participant, the county has connection to many older adults through programs such as "a friendly visitor," adult protective services, and in-home supportive services. "That would be a way to do assessments and interventions through the Mental Health Services Act."

Increased Quantity, Quality, and Cohesion of Services
Participants recommended increased cohesion of services, with programs that address dementia and mental health issues together, alongside an increase in funding and staffing to supplement older adult services where other providers have been cut. Respondents also promoted increased support to reduce isolation in this population.

Media Advertising for Mental Health Programs
Another suggestion was to prioritize advertising programs and services offered to older people in the community using more traditional media, such as radio and newspaper. This could achieve more reach than solely advertising on the internet or social media, where older community members may be less active. Additionally, helping older adults gain skills with technology could have multiple benefits, including reducing feelings of isolation and stigma.

2) Pregnant Women and New Mothers

Needs

Maternal Mental Health
Depression and maternal mental health remain a challenge in Yolo County. The maternal population presents the need for greater services and promotion of how maintaining good mental health is important for not only for mothers but also their children. Increased services and resources geared toward mothers and pregnant people in the county would be a benefit to this population.

Mental Health and Medication-Assisted Treatment Stigma for Mothers
Pregnant individuals and individuals with young children in Yolo County have unique needs. Stigma associated with receiving medication-assisted treatment as a new mother presents challenges to accessing services. For example, women who receive this treatment who are working with child welfare services toward regaining child custody encounter stigma and would benefit from a greater amount of support while navigating the process. As one participant explained, "What I see sometimes is with our women on methadone and CPS [child protective services], sometimes needing a little bit more support or not getting the stigma of being on medically assisted treatment while they're trying to get their kids back and not viewing it as a program of their choice or a program of preference. I feel like there's some stigma within the county with our pregnant population or new moms."

Solutions

Stigma Reduction Programming
Providing extra support for the pregnant and maternal population of Yolo County would help to meet these needs. Additionally, providing training or services that reduce stigma for individuals involved in systems such as family-centered services, medication-assisted treatment, and child welfare services would benefit the community and assist in meeting its demonstrated needs.

3) Racial and Ethnic Diversity

"If we can't hire, recruit, or retain, that's a problem in and of itself, but how do we ensure that a White provider understands how to, at a minimum, not do harm to a client of color?"

"If you are not someone from a marginalized background, you don't understand how marginalized folks feel when they come here. And, you know, feel this sense of exclusion and a gap of understanding that makes it hard to stay here."

Needs

Diversity Among Clinicians and the Workforce
More racial and ethnic diversity among the clinicians who serve the county is a pressing need in the community. However, there is a concurrent challenge with the hiring and retention of diverse clinicians and adequately training White providers on how to provide culturally aware care that does not risk harming clients of color. This creates a need for more clinicians who hold Latinx, Black, and other minority racial and ethnic identities.

Impacts of Systemic Racism and White Supremacy
Systemic and historic racism continue to have a local impact, resulting in a need to combat White supremacy in the community. Participants shared that a lack of diversity and culturally competent training for clinicians has resulted in practices that involve "pathologizing our kids for what they are, … pathologizing Blackness."

Cultural Stigma
Participants noted that cultural stigma related to perceptions of mental health can keep people from seeking help when needed. This creates a need for more outreach and education about mental health and its importance in a culturally competent manner in marginalized communities.

Fear of Seeking Help Related to Legal Status
A factor that deters people in the community from seeking help for mental health is fear about their legal status. Undocumented community members are hesitant to access mental health services and seek help because of their status.

Solutions

Ethnic Group-Specific Programming
Ethnic group-specific programming has proven success in the community, so increasing the availability of these offerings would allow for a greater portion of the population to access these services. Examples of successful programs that participants felt would benefit from greater funding and increased availability are My Brother's Keeper, a program that connects Black men to mental health services and mentorship, and the Torres group, which offers Latinx-specific programming. Hiring more staff members who "speak the language and are of the culture and look like the people" would fill a gap and meet a major need demonstrated by the community.

Support for Undocumented Community Members
Undocumented community members' needs can be more adequately met with increased support developed for their specific community. Participants suggested that increasing outreach efforts to target the undocumented population and letting them know that about the availability of services that would present no risk to their legal status would improve accessibility and the community's valid fears about filling out paperwork, signing consent forms, and being in systems of care would be assuaged.

Training for Existing Workforce on Cultural Competence
Participants felt that existing staff members should be trained to be culturally competent and approach all clients with kindness, because this would better prepare them to provide high-quality services to all clients. Additionally, funds should be allocated to ensure that clinicians are paid fairly for their work, which will help address current retention and recruitment challenges.

4) LGBTQ+

> *"Queer people are everywhere in every community, and especially young queer kids struggle deeply."*

> *"These poor kids are at sea because they need someone who understands them from a queer cultural aspect, but also understands what it's like to be queer and be in a non-White family."*

Needs

LGBTQ+ Youth-Specific Programs:
Participants referenced research that suggests increased mental health issues and vulnerability among LGBTQ+ youth. One respondent noted, "Queer people are everywhere in every community, and especially young queer kids struggle deeply." Data from the California Healthy Kids Survey show very high rates of suicide and suicidal ideation for youth who identify as queer, questioning, trans, or potentially trans, which suggests a need for greater support and intervention resources focused on suicide prevention.

Programs Designed for Intersectionality
There is a need for mental health programming in the county that is geared toward the LGBTQ+ community. Services for LGBTQ+ clients need to be more capable of handling intersectionality and complex cases. For example, according to one participant, "We do have a lot of kids who are gender expansive and neurodivergent at the same time." Also, systemic White supremacy and anti-trans ideologies make it difficult to meet community needs and best serve the LGBTQ+ population of Yolo County. Relatedly, service providers need to come from queer and non-White communities or understand the experiences of these groups. One participant shared insight about the vulnerability and needs of this population: "If you're Brown and queer, your chances of being thrown out of the house and becoming homeless are profoundly higher than anybody else. To me, they are really the most vulnerable population in our society and in our community." Another participant stated, "I feel like the county doesn't really quite know what to do, so they kind of don't do anything very well."

Family Communication Challenges
LGBTQ+ youth also encounter difficulties communicating with their parents about gender and sexuality, which suggests a need for more education and outreach efforts aimed at bridging that communication gap. With generational gaps, LGBTQ+ youth in the community can have a difficult time finding shared language to talk about gender diversity and sexuality with their parents, causing a disconnection. Communication challenges can be further complicated by cultural and language barriers. Queer youth in the community who are from marginalized racial and ethnic backgrounds expressed a need for additional supports to overcome culture and language gaps when communicating about their gender identity and sexuality with their parents. As one respondent recalled, "I've been meeting with the GSAs [gender and sexuality alliances] at the junior high and high schools, and I cannot tell you how many Asian and Latina kids in those groups are having like this cultural gap between themselves and their parents. In a lot of cases, those parents don't speak English. The kids are living in a completely different world from their parents."

Political Targeting of Queer Youth
The politicizing and hyperscrutiny that LGBTQ+ youth experience creates an additional need for resources and services to address mental health for those living in Yolo County. As one participant said, "If we are talking specifically about LGBTQ+ kids, then we are dealing with a moment where those kids are under a national microscope and are being specifically targeted for political ends. And there's no way to counter that without recognizing that it's happening." Some said they feel the national narrative pathologizes youth who identify as LGBTQ+. One community member explained that "part of that national conversation is framing our kids as mentally ill in one way or another." There is a need for programs and services that are considerate of these factors when providing support to the LGBTQ+ community in Yolo County, especially the young queer population.

Solutions

Programs that Consider Diversity in the LGBTQ+ Community
The queer community has members from all age and demographic groups. Keeping in mind that there is great diversity in the population is important when developing programs and organizing services and outreach efforts.

Workforce Training
Allocating funds to train the workforce to deliver more culturally sensitive care to the LGBTQ+ community should be prioritized.

Parent Education and Support Groups
There is a huge need in the community for parent education groups and support groups for parents of queer youth. These groups could serve as a vital intervention point for remedying communication and cultural gaps LGBTQ+ youth encounter between them and their parents.

Reduction of Stigma Surrounding Mental Health in the LGBTQ+ Community
A proposed solution for youth in the community would involve providing internship opportunities, support groups, or community meetings with time and space dedicated to queer youth speaking with one another and building community to help remove mental health stigma.

5) English as a Second Language

"Language matters to mental health and to proper care. It drives quality and improves our outcomes."

Needs

Language and Cultural Barriers to Receiving Services
Despite being fortunate to have quite a few bilingual staff members, even considering the overall workforce shortage, there is a growing need in Yolo County for more resources and cultural training in Spanish, especially related to trauma and other services for immigrant, undocumented, and refugee families. "There are a lot of doctors or therapists that probably can speak Spanish, but they don't understand the culture. So, it's hard to make a connection."

Inadequate Translation Services
Participants said resources need to be developed to connect Spanish speakers with services such as Medi-Cal and other agencies. As one respondent noted, "There was no interpreter and the family felt very left out of treatment." This suggests a need for education services or other resources for young children in the community who primarily speak Spanish.

English as a Second Language Services Needed
Although many needs surrounding English as a second language services in Yolo County brought up during the listening sessions were specifically for Spanish speakers, participants called for more services tailored to Afghan and Russian community members.

Solutions

Programs for Specific Language and Cultural Populations
Existing programs have achieved great success, such as a leadership workshop for immigrant mothers who speak Spanish put on by Davis Phoenix Coalition. The program teaches self-advocacy skills and how to "speak directly with these institutions to advocate on behalf of their communities." Continuing to fund and develop programs like this example, which are targeted for specific populations and groups, would help community members better advocate for their needs. Programs should also offer services and supports—such as therapy, recreational opportunities, and cultural activities—in languages such as Russian and Spanish.

Expanded Translation Services
Furthermore, translation services should be expanded, and the county should continue providing "translated information into Spanish and get it out through health promoters." Literature and translation services relating to mental health should be prioritized and readily available throughout the county. Cultural services should be offered in conjunction with linguistic and translation services "to enhance treatment." Literacy level should also be taken into consideration when providing language and translation services to clients in Yolo County—matching the language used by interpreters and clinicians to clients' literacy is a vital component of delivering these services.

Free Services for Clients and Better Compensation for Bilingual Clinicians
Participants emphasized that access to interpreters and bilingual clinicians should be funded and come at no cost to clients who require or could benefit from these services. Additionally, bilingual service providers who are currently a part of the workforce should be compensated appropriately for their language skills. In the words of one participant, "Give better pay to bilingual service providers."

6) Youth

Needs

> *"From 5 years old and up, it is more difficult to find services."*

> *"We don't give [youth] tools. We don't teach them emotions and management, and it's critical to integrate it into the school system."*

> *"A lot of people do not know how to help care for their children who are going through something they've never gone through before. It's very scary to them."*

Services for Specific Demographic and Service-Affiliated Groups
Youth in Yolo County face challenges with finding services developed for their age and demographic groups. Participants shared that in some parts of the county, "there's nothing for kids under 5. … So, here we either have to go further away or we just don't go." Other participants said that middle and high school-aged youth were underserved, particularly those who are questioning their sexuality. As one respondent said, "High school and middle school kids need a lot of guidance about sexuality."

Foster youth in the community are also affected by a lack of specifically tailored services and supports. Although foster youth and youth on probation are eligible for certain additional resources, there is a need to expand those resources to all youth who are Medi-Cal beneficiaries in the community.

Eligibility Limits
Young children in the community who "age out" of eligibility criteria (by reaching an age that is no longer covered) are another underserved population in the county. Eligibility criteria need to be broadened, or there should be an increase in services available for children from age 5 to before adolescence because once they age out, members of this population can no longer participate in needed activities.

Early Interventions in Schools
Because "serious mental illness does typically start in childhood," there is a need for more counselors and social workers in schools. Hiring and retaining the in-school workforce is important to meeting the needs of youth in the community. As one participant shared, "I know that [name] is in sixth grade and her elementary school does not actually have a counselor right now. They have the position available, but they weren't able to hire somebody."

Youth-Specific Mental Health Challenges
Young people in the community are suffering more intensely, especially with depression, anxiety, eating disorders, and substance use. Since the pandemic, "mental health concerns with our young people have really kind of exploded over the last couple of years." Part of the impact of the pandemic includes social and emotional delays due to not being able to socialize at school.

Mental Health Struggles Affect Academic Success
Yolo County youths' mental health needs also affect their academic outcomes; in schools, "output" has declined and "educational needs" have increased. The classroom experience is increasingly marked with mental health issues. One educator shared, "we're seeing a high incidence of trauma amongst our youth" and that behavioral outbursts and disciplinary issues are "continuing to build in the classroom." Teachers get frustrated at kids blowing up and being disrespectful, and those kids are labeled as "having issues" when many of them simply need to be taught the words to describe their feelings.

Availability of Treatment for Youth Across the Continuum of Care
The community needs a more "robust continuum of care" for substance use treatment for youth, given current services are generally geared toward adults. Specifically, it is challenging to find "inpatient help" and appropriate services in psychiatric hospitals for youth in the community. There are some community-based services, but they are not the indicated modality for treatment, as compared to other counties that have crisis residential programs for youth and adolescents.

For the few programs that do exist, if and when a young person in the community gains access to mental health services, there is a need for greater support during the intake process. One community member shared that "it could be very anxiety inducing having to admit that these are things that are becoming such an issue in their life." In the words of another respondent, "To really get pediatric patients to where they need to go, it's very time consuming. And the pediatric patient often spends days in our ER [emergency room] while we're trying to organize that. And that would be about the last place I would think that we should have the little kiddos be."

Solutions

Opportunities for Informal, "Low-Stakes" Gatherings
Yolo County should develop low-pressure opportunities for people to come together to build trust in the community and make mental health services "more approachable." Suggestions for activities include art groups, music classes, sports and physical activities, or other fun activities, where mental health services could be lightly introduced and incorporated. This approach has an added benefit of promoting physical, mental, and emotional health simultaneously among youth in the community. Creating wellness centers for youth and families and expanding existing programs such as the Transitional-Age Youth Center and NAMI's Ending the Silence program were other suggestions to better meet youth mental health needs. Creating these opportunities for teens in the community could help meet socioemotional needs caused by reduced social interaction during the pandemic. Offerings should include a "social emotional skills group" and activities tailored to youth who do not necessarily "fall into a severely mentally ill [designation]."

More Mental Health Support and Prevention in Schools
There should be at least one and ideally multiple clinicians and social workers in each school to provide mental health resources and services. In addition, there should be better connections between mental health intervention/prevention resources in schools and programs available in the community. Participants suggested that the county work closely with the Department of Education to increase funding for K-12 and school-based programs, including mental health first aid programming. Further, school and administrative personnel should be required to undergo prevention training to identify mental health problems and potential opioid use issues among youth more expediently.

Normalization of Talking about Mental Health through School Curriculum
Mental health programming in schools should include curriculum that encourages talking opening about mental health and normalizes prioritizing mental health by integrating it into school culture. This curriculum should also include objectives to improve socioemotional health. Education about mental health and terminology should begin in elementary school to give students the language to describe what's happening in their homes or emotional lives. This education would involve teaching all students about mental health, as opposed to only sending certain students to a school counselor.

Youth-Specific Programs and Resources
Additionally, there is a need for increased guidance for anti-bullying and building emotional strength to fight negative influences. Participants emphasized that youth in schools would also benefit from more support for transitioning from online to in-person classes, because some students still struggle with going to school regularly.

Support and Resources for Parents
Parents in the community need increased and varied program offerings to help them support and navigate mental health challenges that their children are experiencing. Some of the examples given included YouTube parent nights, workshops to teach parents how they can advocate for their children, education opportunities on how to navigate complex mental health treatment systems with children, general parenting classes focused on parenting older children and connecting with kids, how to take care of personal mental health and be there for children's mental health, programs with recreational activities for the family, and informative workshops on early signs and prevention measures for youth mental illness. Respondents noted that these services should be offered frequently, including on weekends, and should include childcare. This will make the programs and resources more accessible for parents who work during the week or cannot arrange for outside childcare to attend the activities.

7) Formerly or Currently Incarcerated

Needs

> *"We're not doing a good job of identifying those who are engaging in criminal behavior in our communities, which are creating anything from nuisance to straight up serious crimes, and they keep getting released without mental health treatment."*

Mental Health Interventions Before and After Release
More mental health treatment interventions are needed for incarcerated individuals, particularly those who have been incarcerated for domestic violence, abuse, and other violent acts. As the system currently stands, community members who are incarcerated are being released without being connected to care and mental health treatment. Part of this requires cross-county collaboration, because many incarcerated individuals are not in custody in the county in which they resided and will return to after release. Criminal justice is siloed in each county by residency, making it "pretty much impossible" to connect recently released individuals to services in their county because access points are designed differently. One participant noted that counties outside Yolo have "no interest to engage their residents that are in our jail."

Connection to Additional Services
Community participants identified a need for incarcerated individuals to be connected to other sorts of services and resources that have implications for their mental health when they are released from custody. One member of NAMI shared that some members have family who are being held in jail or encounter additional issues after being released, because they are unable to find housing and treatment plans in the community. Formerly incarcerated individuals also need help accessing their government records, which are usually necessary to secure housing, medical resources, and mental health services. This presents the need for not only better connections between service organizations and incarcerated individuals, but also an increase in the types of resources that are available (e.g., housing), so individuals are not remaining in custody until openings occur.

Clinicians with Lived Experience
More clinicians and providers who have experience being incarcerated and therefore, have experiential knowledge about what incarcerated or formerly incarcerated clients are going through are needed. This may also help build more trusting relationships between service providers and clients.

Solutions

Targeted Services for Abusers, Not Only Victims
Offering more programs to serve community members incarcerated for domestic violence, abuse, and other violent acts to work through traumas and personal backgrounds would support ending cycles of abuse, rather than the current system in which "they're just out there repeating the cycle over and over."

Expanded Mental Health Court and Restorative Justice Programs
Yolo County should prioritize advocating for expanding existing and successful mental health court and restorative justice programs. Focusing on connecting individuals to services as a component of restorative justice is vital, along with planning early in an individual's involvement in the system to ensure they have access to the medication and any other mental health supports they need.

Resources for Subsidized Transportation and Housing
Providing resources such as free transportation and housing stipends to individuals being released from jail in the community would meet major needs and ensure formerly incarcerated community members have more access to the support and resources that would promote mental health. This could include developing and funding services to connect incarcerated individuals with mental illnesses to housing upon release.

Record Access Training
Because some formerly incarcerated individuals do not have the computer literacy skills needed to navigate government websites where their information is stored, training or support for accessing their records would serve this population well.

D. Funding, Workforce, and Capacity Building

1) Funding

"There are some good programs that the county has, but they also lack adequate consistent funding and staffing."

Needs

Listening session participants expressed a general understanding that a single critical factor undergirds most issues in Yolo County: the need for more funding. In the words of one participant: "At every level, we have this huge need, and the supply is so small. And unfortunately, right now, the only way to overcome that is money."

Lack of Central Leadership and Sustainability
A few participants described a need to keep services centralized in county government, instead of distributing them via grants or contracts to external organizations. "I worry that too much of it has been farmed out to other organizations and we have kind of lost some of the county core that they provide." Others mentioned issues with the sustainability of funding, for example, regarding mental health court (which is losing a grant) and other promising programs.

Difficulties Utilizing MHSA Funds
Participants discussed a need for increased transparency regarding where MHSA and other funds are being spent. Interestingly, according to members of county leadership, MHSA has very particular restrictions that can make it difficult to spend its funding. However, several participants stated that it is simply unacceptable to carry such a massive fund balance and that action must be taken to address this issue. They said that any resources that can be deployed, must be deployed.

Solutions

Consistent Funding and Staffing
Participants brought ideas for improving consistency of funding and staffing for important programs, including obtaining noncity funds to create an "effective and staffed" Crisis Now center along with funding an administrative person to help gather reliable data and evidence to make the case for that program, leveraging MHSA funds to supplement Medi-Cal reimbursement of wraparound services, and using "innovation dollars" for potential housing. Additionally, they said that more funds should be allocated to "proactive education" regarding mental health and resources that are available, reducing the differentiation between physical and mental health issues.

Members of county leadership promoted funding "the entire continuum of services," from prevention, investments for ages 0–5 and K-12 populations, and stigma reduction through crisis intervention, co-responder programs, supportive housing, and community health. They suggested building the ideal system and then figuring out where supportive resources will come from. This could take the form of a grants arm to procure and manage funding for programs that can't be funded in traditional ways. They said it is too burdensome at this time to put this responsibility on existing staff members who are already overwhelmed by their typical duties.

Additional Funds
Some said the county should lobby to change MHSA funding to provide more funds for housing, including permanent supportive housing for people with mental health challenges, not only for people experiencing chronic homelessness. Some suggested applying for "triage dollars" to subsidize peer support and augment wages.

Community Input
Some participants promoted obtaining community feedback and consulting with experts regarding how to best utilize funding. "Get to the actual people that you're trying to serve to find out how to spend that money."

Waste Reduction and Advocacy for Better Legislation
Members of county leadership discussed strategies such as cutting funding to programs that are not proving successful and eliminating items from the budget that are perceived as "pet projects." Some also mentioned that the Yolo County Board of Supervisors has experienced state lobbyists on the board; these members could inform (and conduct) action at the state level to correct whatever aspects of the law need to be adjusted to make the funds work more appropriately, noting that this is not only an issue for the Yolo County HHSA, but one that affects many counties.

2) Workforce

"None of the accomplishment of any of these visions or dreams is possible without a really strong workforce in place."

Needs

Labor Shortages

Virtually all listening sessions touched on the challenges with hiring and maintaining an adequate workforce in the behavioral health services field. Common sentiments included: "I think we all are painfully aware of the shortage of clinic mental health clinicians and what a barrier it is just to find a clinician," "What we need most of is more clinicians," "The biggest immediate concern I keep hearing … is the county's inability to hire staff," "We all need more staff," and "It's just very unpredictable, … and it's very stressful knowing how fragile the system is." Although "more open dialogue about mental health," and increased awareness are steps in the right direction, this leads to "higher demand of mental health services and … short workforce to meet the demand." According to one member of county leadership, some units have had vacancy rates as high as 30%. Additionally, workforce costs make up much of many budgets (including MHSA funding); therefore, workforce shortages prevent spending of some portion of those dedicated resources.

Positions seeing the highest shortages include clinicians, social workers, case managers, developmental pediatricians, and psychiatrists.. During and since the pandemic, it's been "really challenging to hire" for these kinds of roles. Both high turnover and a tight job market have contributed to shortages. Some participants expressed concern about an impending severe shortage of case managers as family members currently caring for loved ones with mental and physical illnesses become older and pass away, causing the demand for the services they had been providing to skyrocket. Because the county lacks an estimate of how many people this will affect, the prospect is "a little bit scary."

Difficulties with Recruitment

Many reasons were cited as challenges for recruitment and retention. Low pay stood out as a key contributor, with some participants saying that peer support workers and even clinicians do not receive a livable wage. A major barrier is that salaries outside community-based organizations are "too competitive" and interns in this field "not only get paid less" but also must repay student loans. County leaders noted that because Yolo County workers face pay inequities compared to surrounding counties, it ends up being a place for entry-level workers who move to other counties once they get licensed. Psychiatrists and licensed clinicians are particularly hard to hire and retain.

Barriers to Hiring Locally

Because attracting people to Yolo County is difficult, some participants said it would be beneficial to prioritize hiring in the community. However, they noted local youth are not being prepared educationally to get these kinds of positions in the future. Further, the hiring process poses many obstacles for some: "Our processes are not designed for people of anything but the dominant group to easily navigate." Although local universities could be a source of workers, some noted that it has been "challenging" to collaborate with UC Davis because its programs are more research oriented rather than clinical. Some participants proposed hiring more practitioners with lived experience, perhaps even considering "detaching ourselves from the need to have somebody that is licensed to do the work in the field."

High Levels of Burnout

County leaders noted that burnout is at an all-time high, staff members have experienced both secondary trauma and direct trauma, and recent studies show rates of depression and anxiety in the workforce are higher than that in the community. Other contributors to burnout mentioned during listening sessions included the high level of bureaucratic challenges and compliance requirements that alienate people who are drawn to helping professions. "It's just too hard for our staff. We're already having staff retention problems, and now you're asking them to be insurance experts, computer programmers, and navigating these systems versus just helping them." Further, during the pandemic, some therapists realized they could work from home through private-practice companies that pay higher rates, so they have left community-based work altogether.

Ineffective Workforce

Although few and far between, some participants expressed comments critical of the current clinical workforce. One participant expressed a need for more mental health providers who are "passionate and wanting to have that connection with people." Some residents have expressed feeling that they are talked down to and belittled by service providers, implying a need for more trauma-informed care and culturally competent providers. Others mentioned a gap in "skillset" and problems of "incompetence." One said some practitioners "consider their client a source of amusement" and that "there's nothing more angering [and] aggravating [than] a therapist who will laugh, not with you, but at you."

Solutions

Local Recruitment

Some participants said that despite Yolo County's challenges, it should be possible to recruit a talented, motivated workforce: "There are viable careers here." Many groups discussed the idea of hiring local candidates to aid in recruitment and retention goals. Strategies included finding innovative ways to reach local candidates and initiating a recruitment campaign. Some said organizations should make recruitment and application processes more accessible to the kind of candidates they want, especially targeting residents with lived experience who could be hired as peer advocates and for other roles. Other participants advanced the idea of building "linkages" with local institutions of higher education (two community colleges and one university) to create a pipeline into the local workforce.

Improved Wages and Other Incentives

Some groups promoted "throwing more money" at the problem of workforce shortages—for example, "encouraging recruitment by making sure salaries for those positions are competitive and can entice folks to come to Yolo into those positions." Some specifically named professions like social workers and peer support workers as deserving higher pay. Increased financial incentives would improve recruitment outcomes and reduce the turnover of "valuable staff" in community-based organizations. As one respondent put it: "It is cheaper to keep an employee happy and around than to keep training new employees." Other ideas included repaying student debt for those who stay to serve local communities; creating educational stipends, scholarships, and retention and recruitment incentives to retain newer clinician; and establishing grants with UC Davis psychology or sociology departments for graduate students to provide services to residents.

Participants also discussed the need to ensure agencies' internal reward structures are set up to appreciate staff members for acting in ways that are aligned with the mission and help them feel empowered and valued to reduce turnover of talented workers.

Support for Workers' Mental Health

A few participants encouraged improving mental health services and support for the workforce, especially clinicians and first responders. In the words of one participant, "A very real and difficult component of being a first responder: It takes a huge mental health toll. And because of the type of strong, independent individuals that are drawn to being first responders, it's very difficult sometimes for them to seek help and to get help that feels appropriate to them, because they don't necessarily relate to behavioral health resources the same as a civilian does. … They need someone who understands their special needs." Members of county leadership also discussed the pressing need to revisit how to keep a healthy, engaged workforce more than ever before, because what was once acceptable or expected is no longer working. There is a new emphasis on achieving work–life balance, which was not a priority in the past.

Training

Many participants favored increasing funding for targeted training for certain segments of the workforce. Some mentioned training for paraprofessionals and peer support workers who work with populations with highly acute needs, ensuring they are prepared to handle issues that are currently reserved for licensed clinicians. Others said there should be more training of community mental health workers who could be hired locally and would be "a bridge between the people who really need to hear this information and the county." There should also be more training on HIPAA law to teach clinicians and program staff members that family members have a right to present their information even if the staff cannot give information back. This would help prevent "the HIPAA door slam" and allow better understanding of client needs. Last, participants recommended training first responders to be more trauma informed and aware of social and mental health issues.

Needs Assessment for Workforce Growth

According to some participants, not only does the county need more case managers now, but there should also be a countywide needs assessment to determine how many more will be required in the near future. Currently, many residents rely on family members to provide needed support, and this is not sustainable. Participants emphasized the need to make sure to have enough case workers, because they are critical in de-escalation of crises, providing treatment, navigating services, and guiding the recovery process. Nonclinical services (e.g., support groups) should be increased to meet needs that clinicians do not have capacity to handle.

3) Collaboration with Law Enforcement and Co-Responders

Many respondents felt co-responder teams provided effective help with law enforcement and mental health situations and have started handling most mental health holds (5150s). One participant explained, "Our folks have been so happy to have this resource. They are part of their team. They're not somebody sitting outside looking in, this is part of how we want to operate and how our officers want to operate because they want successful resolutions." The presence of co-responders "influences our [law enforcement] culture" in positive ways, and officers have learned to respond differently, even in the absence of a clinician.

Needs

> *"Instead of getting doctors, you get handcuffs. It's a really brutal system."*

Demand, Availability, and Job Responsibility
Law enforcement and emergency medical responders have seen a "clearly increased need" for mental health care amid a lack of both human and material resources. One participant explained, "Until a decade ago, we weren't expected to be the social workers all the time. [Despite] all of the discussions the last few years about how this is not the job of the police, we are still the frontline responders on this issue. That has not changed." Permanent supportive housing tends to be a "magnet for police calls," even though officers cannot intervene unless someone is actively harming or threatening another. Those who are taken into custody end up staying incarcerated longer or being released without services, perpetuating a cycle of crisis and criminalization.

Fear and Negative Interactions
Respondents described an "extreme fear of calling 911" due to inconsistent police training and uncertainty of outcomes. Some respondents said a fraction of law enforcement officers "mark" and "pick on" homeless individuals. Certain recent local interactions "really rocked the community" and caused increased anger and tension in the community. Furthermore, jails are not equipped to manage mental health crises, and many individuals in need of mental health professionals and hoping for diversion programs end up interacting solely with law enforcement instead, leading to further traumatization.

Poor Coordination
People tend to be unaware of available resources, like the 988 crisis line, or feel they do not work well when utilized. Participants reported poor coordination between police departments and other systems during crises, as well as inconsistent follow-up services and emergency departments that are ill equipped to manage 5150s. One participant explained, "I have a son that has serious mental illness, and he has [been arrested]. He was in a psychosis crisis state and there was really no place to take him, and so law enforcement had to take him to jail, and he was there without treatment services for nearly two months. I had to bail him out to take him physically to the West Sacramento Clinic to get him a psychiatric evaluation … It took four more months for him to get accepted into the Mental Health Court Diversion Program, then it took four more months for them to find his housing. We're doing better, but this is a scary road."

Solutions

> *"When [law enforcement officers] are overtaxed and expected to be the solution to all things, when we fail, there needs to be ownership across these systems."*

Training
Participants requested increased training for law enforcement and other first responders to handle mental health crises, particularly psychosis and schizophrenia, and improved transparency regarding who is trained by the Crisis Intervention Team. Respondents also mentioned an ongoing need for therapeutic training for suicide hotline workers and law enforcement officers with a history of excessive force or violence.

Decriminalization and Expanded Access to Resources
One way to improve public perception of law enforcement encounters is to end the criminalization of mental health issues and expand access to the 988 crisis line, mental health court, the public defender's office, diversion programs, hospitals with crisis care capacity, and the mobile behavioral health crisis team because "people shouldn't have to get arrested to get help for mental health concerns." One participant explained, "I think a lot of a lot of the interactions don't have to be negative. I work in the jail, so I've had

a lot of people tell me, 'I got arrested and now I have access. I'm on somebody's radar. Before I was just like lost on the street.' So, oftentimes having that interaction leads them to resources that they didn't even have access to, to begin with."

Clearer Roles and Responsibilities
Participants asked for a better division of roles and responsibilities among mental health care providers, child welfare services, and law enforcement officers, in part by investing in more co-responders who are available more often (all hours instead of 40 hours a week) to help de-escalate mental health crises and take pressure off the families of those with serious mental illness.

4) Implementing Initiatives

"MHSA is the only legislation in the entire country that actually allows for trying new things."

Needs

Crisis Now
Much discussion time was spent regarding difficulties implementing the Crisis Now program, characterized as "a great concept that we can't achieve." As one person described it: "It brought me to tears to watch mental health responses under that Crisis Now model; the gentleness, the kindness, the respect shown to the individuals compared to handcuffs, chaotic ER scene." Although many had high hopes when it was first initiated several years ago, the Crisis Now project has experienced development challenges which have significantly delayed implementation. Members of county leadership talked about recognizing that there is a high degree of both excitement and misunderstanding about this project in the community.

Outsourcing
One participant said "the HHSA decision to outsource everything has been a disaster. … There's a level of frustration that I just want to put on the table." When HHSA shifted from being a direct provider toward more contract-based services, "systems and processes were not put into place that recognized how service was going to be delivered." Participants also mentioned that there was no opportunity for community input regarding this shift.

Sustainability
According to some, sustainability remains an issue because funds are often one-time offers, not for "repeating and scaffolding program over long terms." As one participant said, "I don't know if there's a way to just focus on the basic services that we seem to have a shortage of, as opposed to trying to come up with something new that ends up not working. And those resources don't seem to be spent well to support the community needs."

Accountability
Other respondents mentioned that the Local Mental Health Board (LMHB) is not doing enough to ensure that the HHSA and Behavioral Health Department are implementing appropriate services or monitoring implementation progress and expenditures. They said community members are seeing the same challenges over time, with no progress since the last plan three years ago. Additionally, participants discussed a lack of clarity regarding the role of the LMHB, the nature of its connection to the Board of Supervisors, and relationship to other county agencies and staff. Questions were also raised about the composition of the LMHB in general and potential conflicts of interest. Some said it is unclear if the LMHB grasps what HHSA staff can reasonably achieve with the current resources available.

Solutions

> *"Make sure that you always have people around the table that are struggling with mental illness. Not just the providers and not just family members, but folks who have gone through it on a daily basis, speaking and representing those who are like them."*

Strategic Planning
Participants had ideas about building a comprehensive strategic plan and including community members in designing and implementing the plan. Strategic planning would be improved by starting with a theory of change for MHSA; collaborating with the Office of Education and individual city staff members; coordinating across services, departments, offices, etc.; and leveraging public and private relationships. Yolo County should also learn from other counties and incorporate best practices. One suggestion was to have a community workgroup or steering committee under the mental health director that includes people with lived experience, stakeholders, community members, and practitioners, a model that has worked well in other counties. As one participant put it: "Community members, us, we need to have an active role in this implementation process, … we need to be embedded in the behavioral health administration somehow, … and we need to have an actual say at the table with some teeth to get this next plan implemented."

Resolve Barriers to Crisis Now
Participants discussed how MHSA funding supported the learning collaborative and development of Crisis Now and that it should be implemented as soon as possible across the county. Many said the delays caused by the pandemic should be resolved now. Although some aspects of the initiative, like building a new physical center, may be "not realistic," other aspects should still be implemented: "We don't need to chase perfect when we can do good." Data collection could be improved to make sure it is "good and accurate and consistent." This would provide the evidence needed to demonstrate effectiveness and worth to higher-level agencies.

Other solutions relating to Crisis Now included initiating a "mobile crisis team" so that police officers would no longer act outside their scope and incorporating Crisis Intervention Training programs. A few participants mentioned increasing the availability of lifeline and crisis services so that they would be operational around the clock to reduce service delays.

Centralization of Leadership
Some participants said that HHSA should play a stronger role in the county. According to one participant, "I would love to see HHSA fully owned mental health here in Yolo County. They are the experts. They should be the ones reaching out and guiding the cities, not the cities asking for additional assistance. … I'd love to see more leadership come out of this new administration in HHSA." But perspectives on this topic varied, with a participant in a different session favoring an increased number of requests for proposals geared toward community-based organizations that are doing great work.

Accountability
There was some discussion that the county should improve accountability regarding disbursement of MHSA funds by hiring a process improvement consultant or establishing an implementation task force.

Expanded Foundation
Members of county leadership emphasized that agency staff members are highly competent, amazing experts who should be trusted to implement initiatives appropriately. They expressed the sentiment that the county is doing a good job of providing services and has made decent investments, though much work remains to be done. The fact that the county is highly collaborative—with teams, departments, agencies, and programs working together—has enabled it to accomplish great results. Its network of nonprofits is strong, very connected to its communities, and includes a network of mental health champions and excellent resources, including CommuniCare, NAMI, Yolo Community Meals, Yolo Community Care Continuum, Pine Tree Gardens, Farmhouse, and various residential settings. All of this provides a strong foundation for growth and improvement.

Innovation
Members of county leadership noted that many in the county clearly embrace innovation, and there have been effective and well-received developments such as a research-driven social media campaign. However, they recognize that innovation can create tension for the staff, so they urged staying cognizant of the need to create stability to counterbalance the changes that come with innovation. Their additional advice to other members of the county staff included taking an honest look at what the county has now; looking at gaps and how to fill them; creating an open, honest platform to bring the best thinking to the table; articulating needs, gaps, and strengths and putting that knowledge on the table at the outset as a rallying point; keeping an eye on the prize and funding the most necessary services; not letting the tail wag the dog; and working closely with NAMI.

5) Data Management and Evaluation

Needs

> *"We need that backend accountability piece."*

Tracking and Accountability
Participants brought up the need for additional tracking and accountability regarding MHSA fund disbursement and impact. As one respondent said, "We need to have some level of confidence that [MHSA-funded program delivery] is being done in a way that we can actually show through the data that what we are doing is working and is having the impact that we're talking about." Others mentioned that someone should be tracking how much money has been spent, how much remains, and "why it's still sitting there."

Similarly, many participants brought up the difficulty of consistent collection of outcomes data. For example, "We all know that this co-responder program works for us as it did the prior iteration, but it went away because data was kept in disparate ways." Others discussed the issue of linking outcomes data and real-life implications with determinations about cost effectiveness and program value. "When a program works well, and then all you get told is it got cut because it wasn't cost effective, that's not a good enough answer. … We need to examine why did it fail? If we really needed it and it was valued, what was the way we could change it and keep it so that it wasn't just chopped?"

Inconsistent Evaluation Standards
Some noted that the real evidence to support program value is more qualitative or abstract in nature: "I didn't agree with how they gathered the documentation to show it failed. There's a lot of ways you can gather statistics. But what was the value of that to me as a family? How do you measure that? We're dealing with some intangibles here." Members of county leadership echoed some of these concerns, adding that MHSA does not provide adequate funding for evaluation. Inconsistency of evaluation standards leads to lack of clarity regarding what is working well versus areas where there are problems.

Solutions

Assessment and Expansion Based on Evidence
Recommendations in this area included having HHSA conduct an internal assessment regarding what activities and services should be brought back "in house" instead of outsourced. Respondents suggested looking at current programing that has demonstrated effectiveness and surveying successful programs to learn what's helping and working and what is not. Then, the county can expand and build on activities that are working and use them as role models for others. Others suggested advocating for policy change regarding mental health and addiction treatment and increased research activities and evidence-based laws. Members of county leadership expressed similar sentiments, emphasizing building a stronger evaluation approach, focusing on evidence-based approaches, and making sure to fund programs that have a known positive impact.

Community Characteristics of Yolo County

Yolo County spans 1,015 square miles and is home to 216,986 people as of the July 2021 estimates by the U.S. Census Bureau.[1] Yolo County has four incorporated cities - Davis, West Sacramento, Winters, and Woodland—and several census designated places and unincorporated communities-Brooks, Clarksburg, Dunnigan, El Macero, Esparto, Guinda, Knights Landing, Madison, Monument Hills, Rumsey, Tancred, University of California-Davis, Yolo, Capay, El Rio Villa, Fremont, Jacobs Corner, Kiesel, Merritt, Mikon, Norton, Plainfield. Riverview, Sugarfield, Valdez, Vin, and Zamora.[2] The Patwin people are native to this region, and they comprise the federally recognized tribes of Cachil DeHe Band of Wintun Indians of the Colusa Indian Community, Kletsel Dehe Wintun Nation, and Yocha Dehe Wintun Nations.[3]

Yolo County has always been an agricultural area. UC Davis, the largest employer in the county, began as a research farm site for UC Berkeley. Currently, UC Davis is number one in the nation for agriculture and veterinary medicine studies. The demographics and health outcomes of the county can fluctuate regionally and seasonally with the influx and outflux of UC Davis affiliates. UC Davis has 38,347 enrolled students this year.

Demographics[4,5]

In Yolo County, 52% of the population is female and 48% is male (Table 1). Age distributions in Yolo County are similar to California, however a greater portion of Yolo County's population are young adults than California's young adult population (15 to 24 years old). Disproportionate to the rest of the county, Davis has more 15- to 24-year-olds (41%) than Yolo County and California. This is likely due to UC Davis enrollment.

Overall, in Yolo County, persons 14 years and younger comprise 17% of the population, 24% are 15 to 24 years, 41% are 25 to 59 years, and 18% are 60 years and older (Table 2). Clarksburg (27%) and Knights Landing's (30%) population skews older, with more people 60 and older.

Table 1. Sex Demographics, 2020 American Community Survey 5-Year Estimates

	Male	Female
Clarksburg	55%	45%
Davis	47%	53%
Esparto	45%	55%
Knights Landing	52%	48%
West Sacramento	49%	51%
Winters	53%	47%
Woodland	50%	50%
Yolo County	**48%**	**52%**
California	**50%**	**50%**

Table 2. Age Demographics, 2020 American Community Survey 5-Year Estimates

	0–14 years	15–24	25–59	≥60
Clarksburg	26%	0%	45%	27%
Davis	11%	41%	33%	16%
Esparto	30%	13%	41%	16%
Knights Landing	20%	9%	40%	30%
West Sacramento	23%	14%	47%	17%
Winters	18%	15%	51%	15%
Woodland	20%	14%	47%	19%
Yolo County	**17%**	**24%**	**41%**	**18%**
California	**19%**	**13%**	**48%**	**20%**

1 U.S. Census Bureau. (2022). Quickfacts: Yolo County, California. Quick Facts. Retrieved November 3, 2022, from https://www.census.gov/quickfacts/fact/table/yolocountycalifornia,US/PST045221
2 Peery, T. (2022, November 9). About Us. UC Davis. Retrieved November 28, 2022, from https://www.ucdavis.edu/about
3 Yolo County. (2022). Tribal Relations. Retrieved December 1, 2022, from https://www.yolocounty.org/government/general-government-departments/county-administrator/county-administrator-divisions/tribal-relations
4 U.S. Census Bureau. (2022). Selected Social Characteristics - Yolo County and County Subdivisions. American Community Survey 2020 5-Year Estimates. Retrieved November 3, 2022, from https://data.census.gov/cedsci/table?g=0400000US06_0500000US06113_0600000US0611390640,0611391500_1600000US0613784,0618100,0622846,0684816,0686034,0686328&tid=ACSDP5Y2020.DP02
5 U.S. Census Bureau. (2022). Demographic and Housing Estimates - Yolo County and County Subdivisions. American Community Survey 2020 5-Year Estimates. Retrieved November 3, 2022, from https://data.census.gov/cedsci/table?g=0400000US06_0500000US06113_0600000US0611390640,0611391500_1600000US0613784,0622846,0684816,0686034,0686328&tid=ACSST5Y2020.S0101

County-wide, the largest groups are White, non-Hispanic/Latino (46%) followed by White, Hispanic/Latino (21%), and Asian (14%). Clarksburg (66%), Davis (51%), and Winters (51%) have greater portions of White, non-Hispanic/Latinos that exceeded Yolo and California's White, non-Hispanic/Latino population (37%). The Black/African American and American Indian/Alaska Native population hovers between 0% to 3% in most Yolo communities, and the Hawaiian/Pacific Islander population is less than 1% in every community (Table 3).

Table 3. Race and Ethnicity, 2020 American Community Survey 5-Year Estimates

	Clarksburg	Davis	Esparto	Knights Landing	West Sacramento	Winters	Woodland	Yolo County	California
White–Not Hispanic or Latino	66%	51%	48%	40%	44%	51%	37%	46%	37%
White–Hispanic or Latino	16%	9%	40%	38%	19%	28%	33%	21%	20%
Black or African American	0%	3%	0%	2%	5%	0%	2%	3%	6%
American Indian and Alaska Native	0%	0%	0%	1%	1%	0%	1%	1%	1%
Asian	2%	25%	2%	1%	12%	0%	8%	14%	15%
Native Hawaiian & Other Pacific Islander	0%	0%	0%	0%	1%	0%	0%	0%	0%
Some other race	0%	3%	4%	7%	7%	9%	8%	6%	14%
Two or more races	16%	8%	6%	12%	12%	11%	11%	10%	8%

Most households in Yolo County speak English only at home (64%) (Table 4). Other languages spoken in Yolo households are Spanish (21%), Other Indo-European languages (7%) which include Russian, and Asian/Pacific Islander languages (8%). The Department of Health Care Services has identified English, Spanish, and Russian as threshold languages in Yolo County. A threshold language is defined as a primary language: (a) in a service area with 3,000 people or 5% of the population (whichever is lower) or (b) 1,000 individuals in a ZIP code or 1,500 in two contiguous ZIP codes.

Knights Landing has the lowest percentage of households speaking only English at home (54%), and Clarksburg has the highest percentage of English only speaking households (100%). In Esparto and Knights Landing, over 40% of households speak Spanish. Davis has the highest percentage of Asian speaking households (15%) in Yolo County.

Table 4. Language Spoken At Home, 2020 American Community Survey 5-Year Estimates

	Clarksburg	Davis	Esparto	Knights Landing	West Sacramento	Winters	Woodland	Yolo County	California
English only	100%	70%	56%	54%	60%	63%	58%	64%	56%
Spanish	0%	8%	42%	45%	21%	37%	34%	21%	28%
Other Indo-European languages (including Russian)	0%	6%	1%	0%	12%	1%	4%	7%	5%
Asian and Pacific Islander languages	0%	15%	2%	1%	6%	0%	4%	8%	10%
Other languages	0%	1%	0%	0%	1%	0%	0%	1%	1%

Following state trends, Yolo County's civilian veteran population rate ranges from 2% to 6%. Esparto (6%) and West Sacramento (6%) have the highest percentage of veterans, and Clarksburg (2%) has the lowest percentage of veterans in their population.

Table 5. Veteran Status, 2020 American Community Survey 5-Year Estimates

	Clarksburg	Davis	Esparto	Knights Landing	West Sacramento	Winters	Woodland	Yolo County	California
Civilian veterans	2%	3%	6%	3%	6%	4%	5%	4%	5%

Structural Factors and Health Inequalities

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

Health Factors[1,2,3,4]

In addition to a person's individual lifestyle, socioeconomic (income, education, employment) and environmental (community safety, accessible services) factors can influence a person's health outcomes. Sometimes these factors can be so impactful that they supersede an individual's efforts to maintain physical and mental wellness or reach optimum health across the lifespan. In Yolo County, environmental and socioeconomic health disparities seem to exist between regions of the county and between racial and ethnic groups of Yolo County. Although most outcomes are comparable to state or national outcomes, some indicators showed that Yolo County is faring better (Table 6).

Yolo County's Racial Disparity in Poverty Score (0.12) showed that that were slightly higher gaps in poverty rates between racial and ethnic groups in Yolo County than poverty disparities by race/ethnic groups in California as a whole (0.10). For this measure, zero indicates no gaps in poverty rates by racial/ethnic groups, and a score of 1 represents great differences in poverty rates by racial/ethnic groups.

When looking at the Segregation Index score, Yolo County had a better score (0.19) than California (0.32) and the United States (0.39). A lower score indicates that a community is more racially and ethnically integrated.

The Gini Index, a smmary measure of income inquality, Score for Yolo County (0.49) was the same as California's score and higher than the United States score (0.44). Unfortunately, a score closer to 0 is more favorable and indicates less income inequality across the population.

Table 6. Disparity Scores, US News and World Report, 2022

	Racial Disparity in Poverty	Segregation Index Score	Gini Index Score
Yolo County	0.12	0.19	0.49
California	0.10	0.32	0.49
United States	0.13	0.39	0.44

In Yolo County, life expectancy at birth varies from 69.5 years to 89.4 years by census tract (Table 7). An average of all census tracts shows a Yolo citizen's life expectancy to be 82.3 years. On average by location, Clarksburg (84.4 years), Davis (86.7 years), Esparto (80.9 years), Woodland (80.1), and Zamora/Knights Landing (82.2 years) have life expectancies that exceed 80 years. The remaining locations, West Sacramento (77.9 years) and Winters (79 years), have life expectancies below 80 years.

If there were equity by location, there would be consistent life expectancies by location and census tract, which we do not see in this region. For example, on average those in West Sacramento have a shorter life expectancy (77.9 years) compared to those living in Davis (84.3 years). Across census tracts with the lowest (69.5 years) and highest (89.4) life expectancies there is a disparity of 19.9 years.

Table 7. Life Expectancy by Census Tract, Yolo County, 2020

Census Tract	Location	Life Expectancy
101.01	West Sacramento	75.6
101.02	West Sacramento	76.2
102.01	West Sacramento	76.3
102.03	West Sacramento	69.5
102.04	West Sacramento	77.7
103.02	West Sacramento	76.1
103.1	West Sacramento	80.2
103.12	West Sacramento	82.5
104.01	Clarksburg	84.4
104.02	West Sacramento	86.8
105.01	Davis	N/A
105.05	Davis	89.4
105.08	Davis	87.7
105.09	Davis	87.2
105.1	Davis	88.6
105.11	Davis	83
105.12	Davis	88.6
105.13	Davis	85.4
106.02	Davis	77.8
106.05	Davis	78.7
106.06	Davis	79.8
106.07	Davis	84.4
106.08	Davis	84.3
107.01	Davis	82.1
107.03	Davis	84.3
107.04	Davis	83.9
108	Woodland	73.4
109.01	Woodland	77.5
109.02	Woodland	74.5
110.01	Woodland	81.6
110.02	Woodland	82.2
111.01	Woodland	78.4
111.02	Woodland	77.8
111.03	Woodland	86.6
112.03	Woodland	87.7
112.04	Woodland	80.2
112.05	Woodland	81.9
112.06	Woodland	79.5
113	Winters	79
114	Zamora/Knights Landing	82.2
115	Esparto	80.9

Life expectancy by race in Yolo varied by group but followed state and national trends (Table 8). In Yolo County, Asian/Pacific Islanders (86.66 years) and Hispanic/Latino (82.65 years) have the longest life expectancy. The White, Non-Hispanic population's life

1 Centers for Disease Control and Prevention. (2020, June 9). NVSS – United States small-area life expectancy estimates project. Centers for Disease Control and Prevention. Retrieved November 6, 2022, from https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html
2 Institute for Health Metrics and Evaluation. (2019). US Health Map. Interactive data visuals. Retrieved November 6, 2022, from https://vizhub.healthdata.org/subnational/usa
3 Lewis, K. (2022, November). A portrait of California 2021–2022 – Measure of America. Measure of America: A Program of the Social Science Research Council. Retrieved November 6, 2022, from https://measureofamerica.org/california2021-22/
4 Yolo County Health and Human Services Agency – Public Health Branch. (2022). Health Equity in Yolo County, Partnership HealthPlan of California, Health Equity Workgroup – June 19, 2022.

expectancy is 80.75 years. The lowest life expectancies were among Black (76.73 years) and American Indian/Alaskan Native (75 years) populations. Across all groups, Yolo County's life expectancy (81.45 years) outpaced United States' life expectancy (79.05 years), but not California's life expectancy (81.53).

Table 8. Life Expectancy at Birth by Race, 2019

	Yolo	California	US
Overall	81.45	81.53	79.05
Black, Non-Hispanic	76.73	75.9	75.32
White, Non-Hispanic	80.75	80.7	78.94
American Indian/Alaskan Native, Non-Hispanic	75	73.57	73.13
Asian or Pacific Islander, Non-Hispanic	86.66	86.05	85.67
Hispanic or Latino	82.65	82.75	82.2

The American Human Development Index (HDI) is a rigorous indicator based on life expectancy, educational attainment, and median income, and features a scale from 0 to 10, with a higher number indicating greater human development. This index is a modification of the Human Development Index, which the United Nations uses to measure whether countries are developed, developing, or underdeveloped. In the 2021-2022 analysis, Yolo County is faring better than the United States (5.33) and California (5.85) with a score of 5.92 (Table 9). Compared to other counties, Marin County has the highest score of 7.99 and Glenn County has the lowest HDI score of 3.44.

Table 9. California HDI Scores By County, 2021-2022

	HDI
United States	5.33
California	5.85
Marin	7.99
Yolo	5.92
Glenn	3.44

Asians (7.16) had the highest HDI score in Yolo County which exceeded Yolo, California, and United States HDI scores. Whites (6.65) also had a high HDI which exceeds county, state, and national HDI scores. Black (3.84) and Latino (4.87) groups had the lowest HDI scores.

Income and Poverty[5,6,7,8,9,10,11]

Income and poverty indicators in Yolo County show that there are regional disparities in income, poverty, educational attainment, homelessness, and violent crimes rate by community and race/ethnic groups within Yolo County (Tables 11-20). Yolo County's unemployment rate has been on the decline, and property crimes rates have also recently declined.

In Yolo County, the median household income was $73,746, which was less than California's median household income ($78,672). Within the county, Knights Landing had the lowest median household income ($57,656) and Clarksburg had the highest household income ($118,222).

Table 11. Median household income, 2020 American Community Survey 5-Year Estimates

	Income
Clarksburg	$118,222
Davis	$73,449
Esparto	$81,181
Knights Landing	$57,656
West Sacramento	$73,979
Winters	$92,538
Woodland	$72,004
Yolo County	**$73,746**
California	**$78,672**

Nineteen percent of Yolo's population is below the poverty level, which is greater than California's population below the poverty level (13%). Davis had the greatest percent population under the poverty level (30%, which is likely due to UC Davis enrollment), and Clarksburg had no population under the poverty level. Knights Landing had a high percentage of children under the age of 18 who were under the poverty level (32%) when compared to county (15%) and state (17%) rates.

5 U.S. News and World Report. (2022). How healthy is Yolo County, California? . Healthiest Communities. Retrieved November 3, 2022, from https://www.usnews.com/news/healthiest-communities/california/yolo-county

6 U.S. Census Bureau. (2022). Selected Economic Characteristics - Yolo County and County Subdivisions. American Community Survey 2020 5-Year Estimates. Retrieved November 3, 2022, from https://data.census.gov/cedsci/table?q=SELECTED%20ECONOMIC%20&g=0400000US06_0500000US06113_0600000US0611390640,0611391500_1600000US0613784,0622846,0684816,0686034,0686328&tid=ACSDP5Y2020.DP03&moe=false

7 U.S. Census Bureau. (2022). Poverty Status in the Past 12 Months. American Community Survey 2020 5-Year Estimates. Retrieved November 16, 2022, from https://data.census.gov/cedsci/table?q=poverty&g=0400000US06_0500000US06113_0600000US0611390640,0611391500_1600000US0613784,0622846,0684816,0686034,0686328&tid=ACSST5Y2020.S1701.

8 Yolo County Homeless and Poverty Action Coalition. (2022). Yolo County Homeless Count 2022. Yolo County. Retrieved November 28, 2022, from https://www.yolocounty.org/home/showpublisheddocument/74617/637991985021070000

9 California Employment Development Department. (2022). Yolo County Labor Force Data. Yolo County Profile. Retrieved November 28, 2022, from https://www.labormarketinfo.edd.ca.gov/geography/yolo-county.html

10 U.S. Census Bureau. (2022). Selected Social Characteristics - Yolo County and County Subdivisions. American Community Survey 2020 5-Year Estimates. Retrieved November 3, 2022, from https://data.census.gov/cedsci/table?g=0400000US06_0500000US06113_0600000US0611390640,0611391500_1600000US0613784,0618100,0622846,0684816,0686034,0686328&tid=ACSDP5Y2020.DP02

11 Office of the Attorney General. (2022, August). Crimes and Clearances (including Arson). State of California Department of Justice. Retrieved November 7, 2022, from https://openjustice.doj.ca.gov/data

Table 12. Percent Below the Poverty Level by Age Group, 2020 American Community Survey 5-Year Estimates

	Overall	Under 18 years	18–64 years	65 years and over
Clarksburg	0%	0%	0%	0%
Davis	30%	9%	38%	5%
Esparto	13%	19%	8%	15%
Knights Landing	16%	32%	14%	4%
West Sacramento	16%	22%	14%	14%
Winters	9%	7%	9%	19%
Woodland	11%	13%	10%	9%
Yolo County	**19%**	**15%**	**22%**	**9%**
California	**13%**	**17%**	**12%**	**10%**

By race, Black/African American (35%), Asian (34%), and American Indian/Alaska Natives (24%) had the greatest percent population under the poverty level in Yolo County. In Davis, the same three groups had the greatest percent population under the poverty level, however these groups had poverty rates that exceeded California rates for the same groups by 2 to 4 times. Clarksburg did not have any groups that were below the poverty level.

Yolo County's homelessness count has increased 15% from 2019 to 2022. At a point-in-time survey administered on February 22, 2022, there were 33.7 individuals experiencing homelessness per 10,000 residents. West Sacramento had the highest rates of homelessness (53.8), and Winters and rural communities had the lowest rates (3.2).

Among those experiencing homelessness, 12% were children under 17 years, 3% were young adults 18 to 24 years, 53% were adults over 24 years, and 32% had unknown ages. A small portion of those experiencing homelessness had post-traumatic stress disorder (14%), serious mental illness (16%), substance use disorder (13%), or had co-occurring mental health and substance use disorders (6%). Three percent were veterans. During this survey, 29% were female, 53% were male, and the remaining had unknown gender identities (17%).

Table 14. Individuals Experiencing Homelessness per 10,000 Residents

	2017	2019	2022
Davis	21.4	27.2	27.9
West Sacramento	32.8	35.6	53.8
Woodland	22.8	39.5	44.4
Winters and Rural Communities	2.3	9.06	3.2
Total County	**21.4**	**29.4**	**33.7**

Table 15. Age Demographics of Those Experiencing Homelessness, February 2022

	%
Children (0–17 years)	12%
Young Adults (18–24 years)	3%
Adults (25+ years)	53%
Unknown Age	32%
Total County	**21.4**

Table 13. Percent Below the Poverty Level by Race, 2020 American Community Survey 5-Year Estimates

	Clarksburg	Davis	Esparto	Knights Landing	West Sacramento	Winters	Woodland	Yolo County	California
Overall	0%	30%	13%	16%	16%	9%	11%	19%	13%
White, including both Hispanic/Latino and not	0%	24%	13%	12%	14%	9%	10%	15%	11%
White, not Hispanic/Latino	0%	20%	6%	8%	11%	9%	8%	13%	9%
Black or African American	-	41%	-	11%	33%	0%	34%	35%	20%
American Indian and Alaska Native	-	51%	-	0%	34%	100%	10%	24%	18%
Asian	0%	46%	0%	0%	16%	0%	14%	34%	10%
Native Hawaiian and Other Pacific Islander	-	2%	-	-	3%	-	0%	2%	12%
Some other race	-	44%	9%	7%	23%	17%	14%	21%	17%
Two or more races	0%	23%	4%	49%	16%	0%	9%	16%	12%

Table 16. Health and Veteran Status of Those Experiencing Homelessness, February 2022

Veterans	3%
Post-Traumatic Stress Disorder	14%
Serious Mental Illness	16%
Substance Use Disorder	13%
Co-occurring MH & SUD	6%

Table 17. Gender Identity of Those Experiencing Homelessness, February 2022

Female	29%
Male	53%
Unknown	17%

The annual average unemployment rate has been declining since 2021. In 2019 the unemployment rate was 4.2%, which increased in 2020 to 7.8%. In 2021, the unemployment rate was 5.8% and the average unemployment rate from January to October 2022 was 3.6%.

Table 18. Annual Average Unemployment Rate, California Employment Development Department, 2019–2022

2019	Annual Averages	4.2%
2020	Annual Averages	7.8%
2021	Annual Averages	5.8%
2022	Average to Date	3.6%

Among the population over 25 years in Yolo County, 18% had a high school diploma or equivalent, 22% had a bachelor's degree, and 21% had a graduate or professional degree. The portion of adults who had a graduate or professional degree was almost double California's portion (13%). Clarksburg (2%), Esparto (4%), and Knights Landing (8%) had lower rates of adults with graduate degrees than state rates. Davis had the greatest rates of adults with graduate or professional degrees (43%) that were more than three times state rates. (See Table 19.)

Violent crimes reported by Yolo law enforcement agencies have increased from 2020 to 2021. There were 27 additional violent crimes in Davis and 50 in Woodland. Property crimes decreased in the same period. Davis, West Sacramento, and Yolo County Sheriff's Department reported 1,010 fewer property crimes in 2021 compared to 2020. There was a decrease of 89 property crimes among the remaining agencies. Woodland had the greatest number of violent crimes, and West Sacramento had the greatest number of property crimes reported by their law enforcement agencies.

Table 20. Crime in Yolo County, State of California Department of Justice, 2020-2021

	Violent Crime		Property Crimes	
Reporting Agency	**2020**	**2021**	**2020**	**2021**
CA Highway Patrol–Yolo	0	0	55	54
Davis	98	125	2,452	1,892
UC Davis	5	10	686	691
Union Pacific RR - Yolo	0	0	2	1
West Sacramento	211	205	1,505	1,377
Winters	16	14	84	88
Woodland	227	277	1,376	1,054
Yolo Co. Sheriff's Department	64	58	266	346
Total	**621**	**689**	**6,426**	**5,503**
Population	216,403	216,986	216,403	216,986
Violent Crime Rate per 100,000	**287.0**	**317.5**	**2,969.5**	**2,536.1**

Table 19. Educational Attainment, 2020 American Community Survey 5-Year Estimates

	Clarksburg	Davis	Esparto	Knights Landing	West Sacramento	Winters	Woodland	Yolo County	California
Less than 9th grade	0%	1%	7%	19%	7%	13%	10%	7%	9%
9th to 12th grade, no diploma	0%	1%	11%	14%	8%	5%	8%	6%	7%
High school graduate (includes equivalency)	26%	7%	22%	23%	21%	21%	25%	18%	20%
Some college, no degree	26%	12%	35%	15%	25%	23%	22%	20%	21%
Associate's degree	27%	5%	5%	7%	10%	13%	8%	7%	8%
Bachelor's degree	19%	32%	16%	15%	19%	12%	17%	22%	22%
Graduate or professional degree	2%	43%	4%	8%	12%	13%	11%	21%	13%

Children's Health[1,2,3]

Children in Yolo County fare better than children statewide across several indicators (Tables 21-29).

Children in Yolo County have a lower mortality rate (18.4. per 1,000) and teen birth rate (8%) than children in California. However, Yolo County had a higher infant mortality rate (5%) than state rates (4%), and a higher rate of youth in foster care (5.7 per 1,000) than California as a whole (5.2 per 1,000).

There were fewer children in Yolo experiencing food insecurity (13%) than children in California, but more experiencing deep poverty (8%). There were also more children with health insurance coverage (98%), and fewer children with Medicaid coverage (30%) or participating in CalWORKS (45.6 per 1,000). Ninety-six percent of kindergarteners in Yolo had all required immunizations, which was the same rate as kindergarteners statewide.

There were fewer teens in Yolo County who were not in school or working (3%), fewer reports of child abuse or neglect (41.1 per 1,000), and fewer juvenile felony arrests (1.8 per 1,000) than California rates respectively. There were also minimally fewer domestic violence calls in Yolo County (5.9) than California (6.1) per 1,000 population.

Yolo had the same rate of hospitalizations for youth due to mental health issues (4.8) and self-inflicted injuries (36.6) as California per 1,000 (see Table 21).

Among fluent-English proficient students in 2021, 62% met or exceeded grade-level standard in English language arts in Yolo County. This is higher than California rates (56%) for the same measure (see Table 22).

Most groups in Yolo County had higher rates of students who were meeting or exceeding grade-level English language arts. However, there were slightly fewer Asian and Multiracial students who were meeting or exceeding English language arts than these groups statewide. American Indian/Alaska Native and Native Hawaiian/Pacific Islander groups have suppressed rates (see Table 23).

Table 21. Yolo County Children's Health, Kidsdata.org, 2014–2020

	Yolo	CA
Infant mortality rate per 1,000 (2014-2016)	4.8%	4.3%
Teen birth rate per 1,000 (2016)	7.8%	15.7%
Child/youth death rate per 100,000 (2015-2017)	18.4	29.8
Households with children (2018)	31.2%	33.4%
Children in deep poverty (2018)	8.2%	7.5%
Children in food insecure households (2019)	12.7%	13.6%
Health insurance coverage ages 0-18 (2018)	98.3%	96.9%
Medicaid or CHIP coverage (2014-2018)	29.9%	40.4%
Children participating in CalWORKS per 1,000 (2020)	45.6	80
Kindergarteners with all required immunizations (2019)	95.6%	95.6%
Teens 16-19 years not in school and not working (2014-2018)	2.8%	6.6%
Reports of child abuse or neglect per 1,000 (2022)	41.1	49.5
Children in foster care per 1,000 (7/1/22)	5.7	5.2
Juvenile felony arrest rate per 1,000 (2020)	1.8	2.7
Domestic violence calls for assistance rate per 1,000 (2020)	5.9	6.1

Table 22. Students Meeting or Exceeding Grade-Level Standard in in English language arts, by English Language Fluency

	Yolo	CA
English Learners	Masked	11%
Fluent-English Proficient and English Only	62%	56%

Table 23. Students Meeting or Exceeding Grade-Level Standard in English Language Arts (CAASPP), by Race/Ethnicity, Kidsdata.org, 2021

	Yolo	CA
African American/Black	40%	34%
American Indian/Alaska Native	Masked	33%
Asian	70%	75%
Filipino	77%	70%
Hispanic/Latino	43%	38%
Native Hawaiian/Pacific Islander	Masked	43%
White	70%	60%
Multiracial	58%	61%

1 Population Reference Bureau. (2020). Yolo County Summary. Kidsdata.org. Retrieved November 28, 2022, from https://www.kidsdata.org/region/340/yolo-county/summary#6/demographics
2 California Department of Education. (2022). Yolo County Report Disaggregated by District . 2020-21 Absenteeism by Reason - Yolo County (CA Dept of Education). Retrieved December 12, 2022, from https://dq.cde.ca.gov/dataquest/DQCensus/AttAbsByRsnLevels.aspx?agglevel=County&cds=57&year=2020-21
3 Child abuse/neglect numbers: California Child Welfare Indicators Project (CCWIP) https://ccwip.berkeley.edu/

Most groups had suppressed rates of students meeting or exceeding grade-level standard mathematics. For Asian and Hispanic/Latino student groups in Yolo County, rates were at or below California rates (see Table 25).

Table 25. Students Meeting or Exceeding Grade-Level Standard in Mathematics (CAASPP), by Race/Ethnicity, Kidsdata.org, 2021

	Yolo	CA
African American/Black	Masked	18%
American Indian/Alaska Native	Masked	19%
Asian	60%	69%
Filipino	Masked	53%
Hispanic/Latino	20%	20%
Native Hawaiian/Pacific Islander	Masked	27%
White	49%	46%
Multiracial	49%	47%

County-wide Yolo students had fewer average days absent (11.5 days) than students statewide (13 days). By district, Yolo County Office of Education, which operates the Cesar Chavez Community School primarily serving justice involved youth, had the highest number of average days absent (40.4 days), and Davis Joint Unified had the lowest number at 7.3 days. Looking at unexcused absences, Yolo County Office of Education had the highest percent of unexcused absences (87%), and Esparto Unified had the lowest (41.2%). Yolo County and each of its districts had out-of-school suspension absences that were at or below state rates (0.1%) (see Table 26).

Most groups had greater rates of past month substance use in Yolo County compared to California; however, rates differed by 1 to 3 percentage points for most groups. African American/Black students in Yolo County had substantially higher rates of past-30-day substance use (29%): this was 16 percentage points greater than rates for the same group at the state-level. American Indian/Alaska Native had rates (4%) substantially below California rates, while White (17%) and Another Group (10%) had past 30-day substance use rates that were the same as state rates.

Table 27. Alcohol/Drug Use in Past Month by Race/Ethnicity, Kidsdata.org, 2017-2019

	Yolo	CA
African American/Black	29%	13%
American Indian/Alaska Native	4%	16%
Asian	8%	7%
Hispanic/Latino	18%	16%
Native Hawaiian/Pacific Islander	21%	16%
White	17%	17%
Multiracial	18%	16%
Another Group	10%	10%

Indicators of mental health showed that Yolo County children have similar mental health outcomes to California children. At every grade level, Yolo County 9th and 11th graders had lower rates of depression-related feelings or suicidal ideation than California students of the same grades. The difference between county and state rates were minimal, with rates differing by an average of 1 percentage point. Following this trend, hospitalizations for mental health issues and self-inflicted injuries were the same or differed minimally as California rates in Yolo County (Tables 28 & 29).

Table 28. Children's Mental Health, Kidsdata.org, 2017-2019

	Depression-Related Feelings		Suicidal Ideation	
Grade 9	32%	33%	14%	16%
Grade 11	36%	37%	15%	16%

Table 29. Children's Hospitalizations, Kidsdata.org, 2014–2020

	Yolo	CA
Hospitalizations for mental health issues ages 5–19 years per 1,000 (2020)	4.8	4.8
Hospitalizations due to self-inflicted injuries per 1,000 (2015)	36.6	36.5

Table 26. District Absenteeism by Reason, 2020–2021

	Eligible Cumulative Enrollment	Count of Students with One or More Absences	Average Days Absent	Excused Absences	Unexcused Absences	Out-of-School Suspension Absences	Incomplete Independent Study Absences
Davis Joint Unified	7,844	4,298	7.3	19.7%	80.3%	0.0%	0.0%
Esparto Unified	946	857	12.3	29.9%	41.2%	0.1%	28.8%
Washington Unified	7,550	4,397	11.7	13.7%	86.0%	0.0%	0.4%
Winters Joint Unified	1,558	1,336	10.3	28.1%	71.9%	0.0%	0.0%
Woodland Joint Unified	9,583	6,674	13.2	15.5%	83.8%	0.1%	0.6%
Yolo County Office of Education	224	215	40.4	12.9%	87.0%	0.0%	0.0%
Yolo County	**27,656**	**17,747**	**11.5**	**17.2%**	**80.9%**	**0.0%**	**1.8%**
Statewide	**5,379,464**	**3,834,664**	**13**	**20.2%**	**75.3%**	**0.1%**	**4.4%**

Mental Health[1,2,3]

From October 5 to October 17, 2022 (Week 50), the Center for Disease Control distributed a household survey to measure impacts of COVID-19. The survey includes questions about symptoms of anxiety, depression, or both in the past 2 weeks by respondents. The Week 50 survey results show that 28% of California respondents had symptoms of anxiety, 20% had symptoms of depression, and 17% had symptoms of both anxiety and depression. By race group, Other race and Black groups had higher rates of each of these symptoms when compared to the aggregate respondent rates (all respondents). White and Asian respondents had lower rates of these symptoms in the past two weeks than all respondents (see Table 30).

Table 30. Symptoms of Anxiety, Depression, or Both in the Past 2 Weeks in California, CDC Pulse Survey, Week 50 (2022)

	Anxiety n=2,255	Depression n=2,246	Both n=2,241
All respondents	28.2%	19.8%	16.6%
Any other race alone or in combination	40.7%	32.7%	27.3%
White, alone	27.3%	18.7%	15.7%
Black, alone	34.4%	23.8%	21.3%
Asian, alone	23.5%	17.1%	13.4%

Deaths by suicide have remained consistent in the past two years. Overall, there were 18 deaths by suicide in 2020 and 2021 respectively which declined from 23 deaths in 2019. By age group, the suicide death rate has been higher among the 35-year-and-older group compared to the under 34-year-old group for the past 4 years (see Table 31).

Table 31. Yolo County Deaths by Suicide, 2018–2019

	2018	2019	2020	2021
Deaths by Suicide (all ages)	15	23	18	18
Population size	220,565	220,723	221,718	225,894
Rate per 100,000 Persons				
All Ages	6.8	10.4	8.1	8.0
Yolo County Age 15–34	4.9	11.1	7.3	8.2
Yolo County Age 35+	11.1	14.1	12.1	11.0

Yolo County HHSA Community Health Branch, 2022

According to SAMHSA's 2021 Uniform Reporting Summary, persons served by the State Mental Health Authority by race varied greatly. Black/African and Asian persons were served at similar rates in California when compared to the United States penetration rates for the same groups. Differing by less than 10 persons per 1,000, Native Hawaiian/Pacific Islander and Multi-Racial groups in California were served less than the same groups nationwide. There was a greater gap between White and American Indian/Alaskan Native person served in California and their counterparts in the United States. In California, penetration rates for these groups fell below Unites States rates by 12.7 (White) and 25.5 (American Indian/Alaskan Native) persons per 1,000 population (see Table 32).

Table 32. Penetration Rate per 1,000 Population: Persons Served by the State Mental Health Authority, FY2021

	California	United States
American Indian/Alaskan Native	8.2	33.7
Asian	4.1	6.0
Black/African American	33.2	32.9
Native Hawaiian/Pacific Islander	21.2	30.3
White	6.3	19.0
Multi-Racial	17.1	24.9

1 Center for Disease Control and Prevention. (2022, October 26). Week 50 Household Pulse Survey: October 5 - October 17. Retrieved November 16, 2022, https://www.census.gov/programs-surveys/household-pulse-survey/data.html.
2 Substance Abuse and Mental Health Services Administration. (2021, December 9). 2021 Uniform Reporting System (URS) Table For California. California 2021 URS Output Tables. https://www.samhsa.gov/data/
3 Yolo County Health and Human Services Agency - Community Health Branch. 2022. California Integrated Vital Records System. Accessed August 15, 2022.

System Capacity Assessment

Yolo County HHSA's capacity to implement mental health programs and services are described here. The county services providers have strengths and limitations that affect their ability to meet the needs of racially and ethnically diverse populations. Most Yolo County residents (63%) only speak English; 22% speaks Spanish, 8% speaks Indo-European, and 7% speaks an Asian or Pacific Islander language.

Bilingual Proficiency[4]

The county's bilingual proficiency (HHSA & network providers) is reflected in its bilingual mental health staff count, as follows:

- Cambodian: 1 staff member
- Cantonese: 1 staff member
- Farsi: 1 staff member
- Hmong: 3 staff members
- Mandarin: 2 staff members
- Russian: 2 staff members
- Spanish: 58 staff members
- Tagalog: 1 staff member
- Punjabi: 1 staff member
- ASL: 1 staff member

Diverse Cultural, Racial, Ethnic, and Linguistic Groups Served by Yolo County

Regarding Medi-Cal population service needs, Yolo County HHSA has a demonstrated need to improve efforts to address disparities across all identified groups. Yolo County has a lower penetration rate compared to other medium-size counties for all populations. A slightly higher rate of service provision for those eligible among the African American population is observed when compared to other medium-size counties, an average of 5.92% to Yolo County's rate of 6.83% (see table below).

Strengths and Limitations

HHSA has made progress to increase the recognition and value of racial, ethnic, and cultural diversity through several efforts beginning in 2020 and ongoing. The county strives to demonstrate equitable practices, policies, and programs across internal departments, among service providers, and throughout the community.

Strengths: The FY 2020–2023 Yolo County MHSA Three-Year Program and Expenditure Plan increased investments in the Cultural Competence Program. A Diversity Equity and Inclusion Coordinator position was established to support this critical work in HHSA and in the community. Activities are underway in HHSA through the Mental Health Career Pathways and Central Regional WET Partnership Programs to strengthen workforce retention and recruit well-trained, diverse, and high-quality staff members in the county's mental health service delivery system. Mental health messaging is currently being developed in partnership with a liaison to the Russian- and Ukrainian-speaking communities to develop culturally and linguistically appropriate messaging to distribute in a multimedia mental health campaign. This transadapted messaging will include tips to combat worry, nervousness (anxiety), sadness, irritability (depression), etc., and how and where to get appropriate services if they need more help. Efforts will also include identifying trusted messengers (cultural brokers) to assist in delivering these messages. This project is part of a larger mental health stigma reduction effort.

Yolo County HHSA has an established contract with Excel Interpreting and Translating to provide linguistically appropriate document translation into relevant languages, as required by Department of Health Care Services and CFR 438 Final Rule.

Limitations: One limitation is the number of Russian-speaking staff members. HHSA has bilingual staff members, but some of them (including Russian speaking) do not provide direct services. Service needs among Russian community members and clients are being addressed by HHSA's bilingual outreach and engagement specialist and contracted community providers. Through collaborative work with community partners, HHSA's Cultural Competence program staff is building inroads for outreach to, and needs assessment, of the Russian-speaking community, along with creating cultural considerations workshops for the staff and community. Additional workshops are being scheduled to educate the staff on the mental health needs, challenges, and strengths of the Asian and Pacific Islander community to address low penetration rates for this population.

4 Yolo MHP NACT [Network Adequacy Certification Tool] Data August 2022.

Medi-Cal Approved Claims Data for Yolo County MHP Calendar Year CY 21[1]

	Yolo						Medium		Statewide	
Program Name	Average Number of Eligible per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
Total										
	60,221	1,940	$17,355,865	3.22%	$8,946		3.67%	$8,601	4.34%	$7,478
Age Group										
0-5	6,323	115	$416,665	1.82%	$3,623		1.08%	$5,014	1.96%	$5,427
6-17	14,215	651	$6,186,809	4.58%	$9,504		4.41%	$8,835	5.93%	$8,668
18-59	31,535	1,023	$9,575,110	3.24%	$9,360		4.05%	$8,632	4.52%	$7,181
60 +	8,150	151	$1,177,281	1.85%	$7,797		2.95%	$8,911	2.83%	$6,176
Gender										
Female	32,328	962	$8,854,934	2.98%	$9,205		3.58%	$8,371	4.22%	$7,139
Male	27,894	978	$8,500,931	3.51%	$8,692		3.77%	$8,850	4.49%	$7,844
Race/Ethnicity										
White	14,121	698	$6,509,354	4.94%	$9,326		5.43%	$9,069	5.96%	$7,599
Hispanic/Latino	24,056	540	$4,230,017	2.24%	$7,833		2.69%	$7,321	3.74%	$6,733
African American	2,547	174	$1,290,779	6.83%	$7,418		5.92%	$8,487	7.64%	$7,786
Asian/Pacific Islander	4,366	50	$424,518	1.15%	$8,490		2.04%	$7,965	2.08%	$7,990
Native American	403	23	$295,917	5.71%	$12,866		5.90%	$9,576	6.33%	$7,891
Other	14,730	455	$4,605,280	3.09%	$10,121		4.17%	$10,336	4.25%	$8,894

1 Behavioral Health Concepts (BHC) External Quality review Organization (EQRO) Report CY21, DHCS Approved Claims and MMEF Data
Disclaimer: The above data reflect only the Medi-Cal clients served by Yolo County Behavioral Health Services.

Yolo County MHSA Three-Year Plan 2023–2026

MHSA Program Plan

Yolo County MHSA Overall 3-Year Program Plan Summary

Program Name	Status	Target Age	Access	Navigation	Integrated Services	Respite	Crisis Response	Clinical Services	Education	Support Group	Training	Stigma & Cultural Competency	Youth	Persons Experiencing Homelessness	Increase Funding	More Providers	Flexible Funding	Evaluation/Data	Formerly or Currently Incarcerated Individuals	1-Year Budget 23/24	3-Year Budget 23/26
Community Services & Supports (CSS) Plan																					
Adult Wellness Services	C	26–59	•	•			•	•					•		•	•	•	•		$8,915,199	$27,812,217
Children's Mental Health Services- FSP	C	0–20						•				•	•				•			$540,000	$1,702,350
Children's Mental Health Services-Non-FSP	C	0–20	•	•				•				•	•				•			$1,303,269	$4,078,367
Co-Occurring Disorder Assessment and Intake-AB2265	C	18+	•	•									•					•		$ 557,470	$1,723,244
Community-Based Drop-In Navigation Center	C	18+	•	•			•	•									•	•		$1,111,928	$3,122,960
Mental Health Crisis Service & Crisis Intervention Team Training	M	16+	•	•			•	•	•		•		•	•	•			•	•	$2,843,659	$10,344,089
Older Adult Outreach Assessment Program	C	60+	•	•			•	•						•		•	•	•	•	$1,620,804	$4,493,268
Pathways to Independence	C	16–25	•	•			•	•			•	•	•	•		•		•		$1,494,984	$4,694,051
Peer- and Family-Led Support Services	C	18–59		•					•	•								•		$170,000	$510,000
Public Guardian Case Managers	C	18+	•	•																$258,300	$790,501
Supportive Housing and Social Service Coordination	C	18+		•						•										$105,000	$331,013
Tele-Mental Health Services	C	18+	•					•										•		$1,925,611	$5,981,373

C – Continuing; M – Modification; P – Pending

Program Name	Status	Target Age	Access	Navigation	Integrated Services	Respite	Crisis Response	Clinical Services	Education	Support Group	Training	Stigma & Cultural Competency	Youth	Persons Experiencing Homelessness	Increase Funding	More Providers	Flexible Funding	Evaluation/Data	Formerly or Currently Incarcerated Individuals	1-Year Budget 23/24	3-Year Budget 23/26
Prevention and Early Intervention (PEI) Plan																					
College Partnership	C	16-25	•	•	•			•	•			•	•		•			•		$315,000	$945,000
Cultural Competence	C	0+	•						•	•	•	•					•	•	•	$708,333	$2,124,999
Early Childhood Mental Health Access & Linkage Program	C	0-5	•	•				•				•	•		•	•		•		$650,000	$1,950,000
Early Signs Training and Assistance	C	16+		•					•	•	•	•						•		$590,334	$1,517,092
K-12 School Partnerships	C	5-18	•		•			•	•			•	•		•			•		$3,507,733	$10,547,615
Latinx Outreach/Mental Health Promotores Program	C	16+	•	•	•			•		•		•	•	•				•		$582,500	$1,782,500
Mobile Hair Professionals to Support Mental Wellness and Connections	C	16+							•											$7,750	$7,750
Senior Peer Support Program	C	60+								•								•		$100,000	$300,000
CSS;PEI:INN:WET																					
Evaluation	C	0+																•			$236,858
Innovation (INN) Plan																					
Crisis Now	P	18+				•	•	•												$5,973,930	$5,973,930
Planning and Stakeholder Input Process for Crisis System Re-Design and Implementation	C	18+								•								•		$344,587	
Workforce Education & Training (WET) Plan																					
Central Regional WET Partnership	C	16+							•		•			•				•		$10,000	
Mental Health Professional Development	C	16+							•		•	•						•		$180,997	$551,823
Capital Facilities & Technological (CFTN) Plan																					
IT Hardware/Software/Subscription Services	C	N/A								•								•		$1,403,304	$4,290,164

Community Services and Supports Programs

Adult Wellness Services

Status: Continued From Prior Year Plan

Target Populations: Adults Aged 26–59

Administered by: Contractor and County

Service Contractors: TLCS, Inc. dba Hope Cooperative; Yolo Community Care Continuum; North Valley Behavioral Health

Estimated FY23/24 Costs	**$8,915,198.51**
Estimated Number to be Served FY23/24	**305**
Estimated Cost/ Person Served	**$26,662**

Program Description

The Adult Wellness Services Program includes the HHSA Wellness Center, the contracted Adult FSP program by Hope Cooperative, and the HHSA Forensics FSP Team that focus on meeting the mental health treatment needs of unserved, underserved, and inappropriately served adults in Yolo County with the highest level of mental health needs. Overall, this program provides outreach and engagement, general systems development, and FSP services for adults with serious mental illness who meet medical necessity for county mental health services. This program serves Yolo County adults aged 26–59 who are unlikely to maintain health or recovery and maximal independence in the absence of ongoing intensive services. FSP programs provide comprehensive and intensive mental health services and employ a "whatever it takes" community-based approach using innovative interventions to help people reach their recovery goals. These services must be available to support clients 24 hours a day, 7 days a week, and target a length of stay of 18 to 24 months, on average, for all clients served. The program includes consumer access to crisis residential facility beds, acute inpatient hospital beds, short-term and supportive housing options, self-help programs, employment support, family involvement, substance abuse treatment, and assistance with criminal court proceedings, thereby offering individual consumers the prospect of wellness and recovery.

The adult FSP programs have been contracted to HOPE Cooperative. HOPE Cooperative operates two sites: (a) Yolo Inspire in Woodland, whose services include Adult FSP, the TAY FSP program including a TAY drop-in center, MHSA housing, and the Assisted Outpatient Treatment Program (AOT); and (b) Yolo ACT in West Sacramento, where services like Adult FSP, Older Adult FSP, ACT, and MHSA housing programs are provided. This plan includes the addition of 20 FSP slots.

Adult Wellness services also include an HHSA Forensics FSP Team that have clients across the age spectrum, including TAY, adults, and older adults who participate in the Mental Health Court program.

The FSP program uses an outreach and engagement strategy that is relevant to the situational and cultural needs of clients, with engagement "where they are" with respect to their community location, need for clinical and nonclinical services and supports, and stage in the recovery process. This plan includes the assumption of the costs associated with the previously grant funded Mental Health Court program expansion, effective October 2023.

Additional supportive services are delivered in the two Adult wellness centers operated by Yolo County HHSA. The HHSA Wellness Centers, located in the Woodland Clinic and the West Sacramento Clinic, offers rehabilitative activities and services on a drop-in basis for approximately 200 behavioral health consumers each year. In addition to wellness and recovery activities, the Wellness Centers offer skill building groups, computers with internet access, recreational programming and weekly food distribution to supplement groceries for residents experiencing food insecurity. Not only are these a valued place of respite, the Wellness Centers also provide access to case management, psychiatry, and the continuum of services across the county.

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

- Conducting strengths-based integrated assessments that comprehensively examine mental health, social, and physical health needs, focusing on consumer and family member engagement.
- Providing intensive support services and case management to homeless and impoverished adults identified as FSP, including all specialty mental health services as needed.

- Providing AOT to court-mandated consumers unable to accept voluntary treatment or who accept voluntary treatment but need an AOT level of care and who are at continued risk of harm.
- Providing medication management services and nursing support.
- Providing adults with appropriate benefits assistance, including Social Security Disability Insurance, Supplemental Security Income, Medi-Cal, or Medicare applications, and referrals to advocacy services.
- Conducting outreach services to persons who are homeless or at risk of homelessness with persistent and nonthreatening outreach and engagement services.
- Assisting homeless adults and adults without stable housing by locating appropriate, safe, and affordable housing in the community.
- Providing referrals and navigation support for substance abuse treatment services, when needed.
- Providing opportunities for consumers to socialize and create community.
- Providing supportive living services to maintain housing.
- Promoting self-care and healthy nutrition.
- Helping interested adults find employment and volunteer experiences to enhance their integration in the community.
- Promoting prosocial activities, including creative or artistic expression as related to self-care.
- Transporting adult consumers to and from appointments or the wellness centers.
- Operating a 24-hour crisis phone line and referring callers to crisis services and supports.
- Providing resources and information on skills for daily living.
- Providing programs, services, group support, and socialization activities at the wellness centers.
- Providing navigation and linkages to adults in need of resources in the county or community for mental health services through a peer support worker or outreach specialist.
- Referring and linking consumers to other community-based providers for other social services and primary care.
- Delivering mobile services, including assessment and treatment, to reach adults who cannot access Yolo HHSA or other services as a result of barriers to access (rural, transportation difficulties, etc.) or other disabilities.

YCCC Safe Harbor Crisis House provides crisis residential services for SMI adults to reduce psychiatric hospital stays, reduce the risk of homelessness, and serve as a step-down facility for clients transitioning back to the community. Safe Harbor also serves as an alternative to acute inpatient hospitalizations if a client does not meet criteria for an involuntary hold. YCCC's Farmhouse is a residential treatment program for SMI adults requiring intensive support. Their program offers a wide range of therapeutic and rehabilitative services to reduce or avoid long-term hospitalization or institutionalization.

Also included in Adult Wellness Services is dedicated case management services for non-FSP clients in both Pine Tree Gardens (PTG) homes. NVBH's trauma-informed and strengths-based case management services include activities and support that help new PTG clients acclimate to their new homes through frequent connections to support their needs, ensure they get settled, and build a plan around their needs, which may include activities of daily living, financial literacy, how to care for the space and home, scheduling and time management, and medication management. For clients who find they are ready to move on to their next living situation, this position supports them in their successful transition by assisting with housing searches, scheduling tours, move-in documentation, background checks, and connecting with appropriate community supports to ensure the client has connections in the community to help them succeed. Following that transition, the case manager meets with the clients several times after moving out of PTG to support their stability and provide any additional resources needed.

Goals & Objectives

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.

Children's Mental Health Services (FSP)

Status: Continued From Prior Year Plan

Target Population: Children and Youth Aged 0–20

Administered by: Contractor

Service Contractors: Turning Point Community Programs

Estimated FY23/24 Costs	**$540,000**
Estimated Number to be Served FY23/24	**25**
Estimated Cost/ Person Served	**$21,600**

Program Description

The Bridges Full Service Partnership (FSP) program is operated by Turning Point Community Programs and serves children and youth aged 0–20 with severe emotional disturbance who meet medical necessity for specialty mental health services and have unmet or undermet mental health treatment needs. Additionally, the Bridges FSP Program provides services to children who are Latinx or English learners, which are delivered by bilingual–bicultural clinicians. Services are available to children countywide and include outreach to rural areas of the county, where a disproportionate number of Yolo County residents are English learners and experience poverty.

The Bridges FSP program utilizes a client-centered, strengths-based community service model that emphasizes the importance of delivering treatment in settings that best meet the needs of children and families and includes a wide array of services that support recovery, wellness, and resilience to keep children and their families healthy, safe, and successful in their homes, schools, and community. The program assists children in accessing behavioral support services such as assessment; individual, group, and family therapy; medication support services; and case management assistance (which includes but is not limited to assistance with transportation, obtaining housing, fulfilling basic needs, developing social supports, care coordination, and linkages to community resources). The program also utilizes a team approach to ensure that all clients and families served by the program are assigned to a mental health therapist, case manager, and parent partner. All clients and their caregivers have access to a team member known to the family and familiar with the family's needs at all times for crisis support services.

The target population for the program is Yolo County children aged 0–20 who are unserved, underserved, or inappropriately served and who experience barriers to accessing mental health treatment services. This includes children who are seriously emotionally disturbed and experiencing or at risk of experiencing:

- Homelessness or insecure housing
- Foster placement (including children transitioning to less-restrictive environments)
- Involvement with the juvenile justice system or probation
- Substance use or abuse
- Violent behavior (including homicidal ideation)
- Expulsion from school
- Significant self-harm behavior (including suicidal ideation)
- Hospitalization or institutionalization

Key activities of the program are to help children improve their psychosocial well-being, reduce mental health-related hospitalizations, reduce involvement with the juvenile justice system, reduce homelessness, and improve functioning in the family, school, and community by:

- Educating children and their families or other caregivers regarding mental health diagnosis and assessment, medications, services and support planning, treatment modalities, and other information related to mental health services and the needs of children and youth.
- Providing intensive support services to children classified as FSP and their families, including individual and family therapy.
- Providing services to support families of FSP children.
- Developing integrated service plans that identify needs in the areas of mental health, physical health, education, and socialization.
- Providing medication management services and nursing support, if needed.
- Supporting children to achieve academic success.
- Providing community-based services at the child's home, schools, and appropriate community locations.

- Delivering mobile services, including assessment, treatment, and telepsychiatry, to reach children and their families who cannot access mental health services as a result of barriers to access (rural, transportation difficulties, etc.) or other disabilities.
- Providing navigation and linkages to families in need of resources in the community for mental health services through a family partner.
- Operating a 24-hour crisis phone line to provide support to the child or family from a person known to the family and familiar with the family's needs.
- Referring and linking clients to other community-based providers for other needed social services and primary care.
- Providing transportation to and from services.

Goals & Objectives

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 0–20 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.

Children's Mental Health Services (Non-FSP)

Status: Continued From Prior Year Plan

Target Population: Children and Youth Aged 0–20

Administered by: County

Estimated FY23/24 Costs	**$1,303,269**
Estimated Number to be Served FY23/24	**90**
Estimated Cost/ Person Served	**$14,480**

Program Description

The county-operated Children's Mental Health Program provides access, linkage, case management, and individual and family therapy services for children and youth up to age 20. The Children's Mental Health Services Program provides services to children who are Latinx or English learners. These services are provided by bilingual–bicultural clinicians. Services are available to children countywide and provided in the Woodland and West Sacramento offices, community locations, and the child's home when clinically indicated and in best service of the child and family.

The county program utilizes a client-centered, strengths-based model that emphasizes the importance of delivering treatment in settings that best meet the needs of children and families. The Children's Mental Health Program includes an array of services that support recovery, wellness, and resilience to keep children and their families healthy, safe, and successful in their homes, schools, and community. The program assists children in accessing behavioral support services such as assessment; individual, group, and family therapy; medication support services; and case management assistance (which includes but is not limited to assistance with transportation, obtaining housing, fulfilling basic needs, and developing social supports, care coordination, and linkages to community resources). The county clinicians provide evidence-based clinical interventions, including Trauma-Focused Cognitive Behavior Therapy, Child–Parent Psychotherapy, Motivational Interviewing, Eye Movement Desensitization and Reprocessing, and Theraplay.

The county Children's Mental Health Program serves children with the most significant mental health struggles who are not able to have their needs adequately met with a lower level of care. Many of the children served are concurrently involved with child welfare services or the juvenile justice system. The target population for the program is Yolo County children and youth aged 0–20 who are unserved, underserved, or inappropriately served and who experience barriers to accessing mental health treatment services. It serves children who are seriously emotionally disturbed and experiencing or at risk of experiencing:

- Homelessness or insecure housing
- Foster placement (including children transitioning to less-restrictive environments)
- Involvement with the juvenile justice system or probation
- Substance use or abuse
- Violent behavior (including homicidal ideation)
- Expulsion from school
- Significant self-harm behavior (including suicidal ideation)
- Hospitalization or institutionalization

Key activities of the program aim to help children improve their psychosocial well-being, reduce mental health-related hospitalizations, reduce involvement with the juvenile justice system, reduce homelessness, and improve functioning in the family, school, and community by:

- Educating children and their families or other caregivers regarding mental health diagnosis and assessment, medications, services and support planning, treatment modalities, and other information related to mental health services and the needs of children and youth.
- Providing intensive support services to children classified and their families, including individual and family therapy.
- Developing integrated service plans that identify needs in the areas of mental health, physical health, education, and socialization.
- Providing medication management services and nursing support, if needed.

- Supporting children to achieve academic success.
- Providing community-based services at the child's home, school, and appropriate community locations.
- Delivering mobile services, including assessment, treatment, and telepsychiatry, to reach children and their families who cannot access mental health services as a result of barriers to access (rural, transportation difficulties, etc.) or other disabilities.
- Providing navigation and linkages to families in need of resources in the community for mental health services through a family partner.
- Conducting transition and treatment planning for children who have been hospitalized for mental health reasons.
- Referring and linking clients to other community-based providers for other needed social services and primary care.
- Providing trauma-informed services in a location appropriate and accessible to the child and family.

Goals & Objectives

Goal 1: Provide system development and outreach and engagement services to all children and youth 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 and youth aged 0–20 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.

Co-Occurring Disorder Assessment and Intake – AB 2265

Status: Continued From Prior Year Plan

Target Population: Transitional Age Youth 18–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: Contractor and County

Service Contractors: CommuniCare Health Centers

Estimated FY23/24 Costs	**$557,470.26**
Estimated Number to be Served FY23/24	**750**
Estimated Cost/ Person Served	**$743**

Program Description

MHSA funds are used to cover initial clinical assessments completed by the HHSA access team staff and CommuniCare Health Centers staff to determine if an individual has any co-occurring mental health and substance use disorders. This program also covers subsequent referral activities and funds ongoing mental health treatment to people assessed as having co-occurring disorders if their mental health disorder is considered primary, even if their care was not previously eligible for services covered by traditional MHSA funding. If it is determined that a substance use disorder is the primary diagnosis, the individual is referred to substance use treatment and MHSA funding is no longer used for any mental health services.

Assembly Bill 2265 authorizes the assessment and treatment services for adults, older adults, TAY, and children and the provision of innovative programs and prevention and early intervention programs that are provided by counties as part of the MHSA.

Any mental health services provided by HHSA's access team and any ongoing substance use disorder case management services provided by HHSA's internal staff are funded by MHSA via use of AB 2265 program codes. Yolo County has also arranged for CommuniCare Health Centers to provide in-person screening for cooccurring disorders during initial clinical assessments through the Navigation Center, referring those assessed as having co-occurring disorders to the appropriate treatment provider(s). This team is also be funded with MHSA via AB 2265 program codes.

Goals & Objectives

Goal 1: Increase the number of assessments completed for co-occurring disorders.

Goal 2: Increase the number of referrals to appropriate providers for the treatment of individuals with co-occurring disorders.

Objective 1: Provide assessments that address the presence of a co-occurring disorder to any client who requests county services.

Objective 2: Provide appropriate treatment focused on the needs of individuals with co-occurring disorders.

Community-Based Navigation

Status: Continued From Prior Year Plan

Target Population: Transitional Age Youth 18–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: County and Contractor

Service Contractors: CommuniCare Health Centers

Estimated FY23/24 Costs	**$1,111,928.24**
Estimated Number to be Served FY23/24	**400**
Estimated Cost/ Person Served	**$2,780**

Program Description

The Community-Based Drop-In Navigation Center is a community-based location that provides behavioral health and social services to adults (aged 18 or older) who desire mental health support or are at risk of developing a mental health crisis but may not be willing or able to engage in more formalized services. The center provides an array of options for assisting consumers with any level of service engagement, focused on but not exclusive to individuals who were formerly institutionalized or are at risk of incarceration, hospitalization, or homelessness. The center addresses the need to facilitate community integration for adults who are exiting institutional care without formalized community or mental health support and to provide resources for consumers who, although engaged with mental health services, are at risk of developing a crisis and require additional support. Staff members provide a wide range of services, assisting consumers with short-term needs and providing more in-depth services, such as screening, assessment, and linkages to mental health services; activity or psychosocial and educational groups; assistance with housing or public benefit applications; and individualized psychosocial case management utilizing motivational interviewing practices based on the stages of change model.

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

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

Additional Community Navigation services are provided by a small number of HHSA staff, primarily on the Crisis and Hospital Services team, who engage community members or existing clients either in crisis as they discharge from a psychiatric hospital or health facility placement. These HHSA staff also facilitate community integration for adults who are exiting institutional care without formalized community or mental health support and to provide resources for consumers who, although engaged with mental health services, are at risk future crises and require additional support.

Goals & Objectives

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 with identifying and accessing 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.

Mental Health Crisis Services and Crisis Intervention Team (CIT) Training

Status: Continued From Prior Year Plan

Target Population: Transitional Age Youth 16–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: County

Estimated FY23/24 Costs	**$2,843,658.9**
Estimated Number to be Served FY23/24	**2,000**
Estimated Cost/ Person Served	**$1,422**

Program Description

Yolo County's comprehensive mental health crisis services program provides existing Yolo County clients and the larger county community with access to crisis interventions, crisis assessments, urgent and routine service referrals and linkages, and appropriate crisis residential or inpatient psychiatric facility or psychiatric health facility placement, as needed.

Mental health crisis services include walk-in crisis services access, in Davis, West Sacramento, and Woodland during regular business hours. Further, at any day or time, when a Yolo County Medi-Cal beneficiary, indigent individual, or existing Yolo County client is placed on an involuntary psychiatric hold by the local hospital staff, law enforcement, or certified county or provider clinicians, the crisis navigation staff secures placement at the appropriate crisis residential facility, psychiatric health facility, or acute psychiatric inpatient facility.

County crisis clinicians have been embedded with local law enforcement to form a co-responder team to intervene in mental health-related police calls to de-escalate situations that have historically resulted in arrest and assess whether the person should be referred for immediate behavioral health intervention. Currently, six crisis clinicians are embedded with the cites of Davis, Woodland, and West Sacramento and the Yolo County probation and Sheriff's Department. This plan includes the addition of two co-responder clinicians in collaboration with the Davis and West Sacramento Police Departments, for a total of eight co-responder positions. Staff members provide phone and in-person responses to the community, when available, when a family member or loved one reports an individual in crisis. Postcrisis, a staff member follows up with any people known to the county to have recently been in crisis to ensure effective service access and referral linkages. Additionally, a total of five part time Peer Support Worker (PSW) positions have been added to create co-responder teams that include a person with lived experience.

Key activities of Mental Health Crisis Services support outcomes around:

- Reducing unnecessary local emergency room visits and involuntary psychiatric holds of individuals in crisis.
- Reducing crisis reoccurrence and repeat acute inpatient facility placement.
- Reducing unnecessary arrests of individuals in crisis.
- Preventing crisis escalation, which may result in serious injury or consequences to clients, their loved ones, and the community at large.
- Ensuring appropriate mental health service to anyone in need in advance of a crisis.
- Ensuring linkage to city and county homeless program resources for those in need of housing or shelter.

CIT Training

The Yolo County crisis staff delivers CIT training, modeled after a nationally recognized, evidence-based program known as the CIT Memphis Model, which focuses on training law enforcement personnel and other first responders to recognize the signs of mental illness when responding to a person experiencing a mental health crisis. The course curriculum is approved by the local Peace Officers Standards and Training agency, providing materials and 40 hours of training at no cost to the participating law enforcement agency or individual. The course trains participants on the signs and symptoms of mental illness and how to respond appropriately and compassionately to individuals or families in crisis. Further program modifications include the development and county delivery of an annual 8-hour CIT refresher training for all county law enforcement personnel who have previously completed the initial 40-hour curriculum. This refresher course curriculum was developed in concert with local enforcement agencies to ensure it includes relevant and updated topics that further attendees' intervention tools and understanding with diverse populations. This plan

includes the addition of an Outreach Specialist position that will be dedicated to the CIT Training program, expanding HHSA's ability to deliver and track training provided.

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

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

Goals & Objectives

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.

Older Adult Outreach and Assessment Program (FSP)

Status: Continued From Prior Year Plan

Target Population: Older Adults Aged 60+

Administered by: Contractor and County

Service Contractors: TLCS, Inc dba Hope Cooperative; Yolo Community Care Continuum; North Valley Behavioral Health

Estimated FY23/24 Costs	**$1,620,204.36**
Estimated Number to be Served FY23/24	**50**
Estimated Cost/ Person Served	**$32,404**

Program Description

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

Yolo County HHSA has contracted with Hope Cooperative to provide Older Adult FSP services.

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

- Conducting strengths-based integrated assessments that comprehensively examine mental health, social, physical health, and substance abuse trauma, focusing on consumer and family member engagement.
- Providing intensive support services and case management to older adults classified as FSP, including individual and family therapy, medication management, nursing support, and linkages to other services.
- Educating consumers and families or other caregivers regarding mental health diagnosis and assessment, psychotropic medications and their expected benefits and side effects, services and support planning, treatment modalities, and other information related to mental health services and the needs of older adults.
- Assisting with transportation to and from key medical, psychiatric, and benefits-related appointments.
- Promoting positive contact with family members.
- Helping families deal with the mental decline of an older adult.
- Coordinating with the HHSA Adult Protective Services staff.
- Coordinating with the Public Guardian's Office regarding conservatorship of consumers no longer capable of self-care.
- Coordinating with local multidisciplinary alliances to identify and assist older adults in need of mental health treatment.
- Coordinating with assisted-living opportunities to provide a smooth transition, when needed.
- Coordinating with the Senior Peer Support Volunteer Program to match volunteers with older adults to prevent social isolation and promote community living, when desired.
- Assisting with maintaining healthy independent living while avoiding social isolation.
- Helping older adults with serious mental illness locate and maintain safe and affordable housing.
- Providing older adults with appropriate benefits assistance, including Social Security Disability Insurance, Supplemental Security Income, Medi-Cal, or Medicare, and referrals to advocacy services.
- Referring and linking consumers to other community-based providers for other needed social services and primary care.
- Delivering mobile services, including assessment and treatment, to reach older adults who cannot access Yolo HHSA in Woodland or other services as a result of barriers to access (rural, transportation difficulties, etc.) or other disabilities.

Also included in Adult Wellness Services is dedicated case management services for non-FSP clients in both Pine Tree Gardens (PTG) homes. NVBH's trauma-informed and strengths-based case management services include activities and support that help new PTG clients acclimate to their new homes through frequent connections to support their needs, ensure they get settled, and build a plan around their needs, which may include activities of

daily living, financial literacy, how to care for the space and home, scheduling and time management, and medication management. For clients who find they are ready to move on to their next living situation, this position supports them in their successful transition by assisting with housing searches, scheduling tours, move-in documentation, background checks, and connecting with appropriate community supports to ensure the client has connections in the community to help them succeed. Following that transition, the case manager meets with the clients several times after moving out of PTG to support their stability and provide any additional resources needed.

Goals & Objectives

Goal 1: Provide treatment and care that promote wellness, reduce isolation, and extend 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.

Pathways to Independence

Status: Continued From Prior Year Plan

Target Population: Transitional Age Youth 16–25

Administered by: Contractor and County

Service Contractors: TLCS Inc. dba HOPE Cooperative; Yolo Community Care Continuum

Estimated FY23/24 Costs	**$1,494,983.94**
Estimated Number to be Served FY23/24	**75**
Estimated Cost/ Person Served	**$19,933**

Program Description

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

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

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

The FSP program utilizes a team approach that ensures that all youth served by the program are assigned to a mental health therapist, case manager, and peer support worker. All Pathways to Independence clients have access to a team member known to the youth and familiar with the youth's needs at all times for crisis support services. This program is currently provided by a contract with Hope Cooperative. The current capacity for the program is 50 youth. The Pathways to Independence program emphasizes access to case management and psychiatry and a continuum of services across the county that includes professional and peer support provided through the TAY Wellness Center in Woodland.

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

- Educating youth and their families or other caregivers regarding mental health diagnosis and assessment, medications, services and support planning, treatment modalities, and other information related to mental health services and the needs of the youth.
- Providing intensive support services and case management to youth identified as FSP, including individual therapy and other collateral support, when needed.
- Developing integrated service plans that identify needs in the areas of mental health, physical health, education, job training, employment, housing, socialization, and independent living skills.
- Providing seamless linkages between the child, youth, and family mental health system and the adult and aging mental health system, as appropriate.
- Providing medication management services and nursing support, if needed.
- Helping youth enroll in entitlement programs for which they are eligible (to facilitate emancipation), including Social Security Disability Insurance, Supplemental Security Income, and Medi-Cal.
- Assisting youth with obtaining affordable housing in the community (including permanent affordable housing with combined supports for independent living).
- Providing life skills development to promote healthy independent living.
- Assisting youth with developing employment-related readiness skills and seeking employment.
- Supporting youth to graduate high school and pursue college or vocational school.
- Providing referrals and navigation support for substance abuse treatment services, when needed.
- Providing rehabilitative wellness programs, services, group support, and age-appropriate socialization activities.
- Providing services to support families of youth, as appropriate.
- Providing navigation and linkages to youth in need of resources in the county or community for mental health services through a peer navigator or outreach specialist.
- Referring and linking clients to other community-based providers for other needed social services and primary care.
- Delivering mobile services, including assessment, treatment, and telepsychiatry, to reach youth who cannot access services as a result of barriers to access (rural, transportation difficulties, etc.) or other disabilities.
- Transporting youth clients to and from mental health appointments or other program activities.
- Helping youth obtain a driver's license when appropriate.
- Providing a TAY-specific Wellness Center with youth-oriented programming.

Goals & Objectives

Goal 1: Provide FSP, system development, and outreach and engagement services to youth aged 16–25 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.

Peer- and Family-Led Support Services

Status: Continued From Prior Year Plan

Target Populations: Transitional Age Youth 18–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: NAMI Yolo County

Estimated FY23/24 Costs	**$170,000**
Estimated Number to be Served FY23/24	**500**
Estimated Cost/ Person Served	**$340**

Program Description

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

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

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

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

Goals & Objectives

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.

Public Guardian Case Managers

Status: Continued From Prior Year Plan

Target Populations: Transitional Age Youth 16–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: County

Estimated FY23/24 Costs	**$258,300**
Estimated Number to be Served FY23/24	**145**
Estimated Cost/ Person Served	**$1,781**

Program Description

Public guardians are court-appointed conservators for adults who are gravely disabled due to severe mental illness, incapable of accepting or unwilling to accept treatment voluntarily, and cannot provide for their own basic needs, care, or treatment. The Public Guardian program, serving high-risk, gravely disabled adults of all ages, conducts conservatorship investigations to determine if evidence of grave disability is sufficient to petition through the Superior Court for conservatorship and coordinates appropriate services, treatment, food, clothing, shelter, and estate management for conserved individuals.

Public guardians collaborate with other agencies, other county departments, private facilities and practitioners, and individuals to bring necessary and appropriate services to conserved individuals based on their needs to preserve their benefits and assets and coordinate their housing at the level of care needed to support their medical and psychiatric stability. Since 2017, there has been an annual caseload increase of 12%–33% depending on the year. Additionally, with changes in legislation allowing conservatorship referrals to come from custody settings, the complexity of criminal justice involvement with behavioral health needs have made placements and ongoing support more challenging. To support this growing caseload, the Public Guardian program is adding two full-time behavioral health case managers to the Public Guardian team to provide support and case management to Lanterman-Petris- Short Act conservatees with oversight by the conservatorship officers, who are deputized Public Guardian staff members. These additional positions will ensure adequate in-person contact and follow-up that is not possible with the current staffing levels.

Key activities of behavioral health care managers in the Public Guardian program are:

- Conducting regular visits with conservatees to ascertain their needs and review care plans.
- Communicating conservatee needs to deputy Public Guardian staff members and service providers.
- Coordinating with other agencies and community-based partners to provide services to conservatees.
- Assisting with transportation to and from key medical, psychiatric, and benefits-related appointments.
- Researching appropriate housing options for conservatees.
- Gathering records and documents for conservatorship investigations.
- Interviewing services providers, conservatees, and conservatee family members to gather information regarding conservatee history, past benefits, past treatment, and service efforts.
- Contacting service providers to schedule appointments.
- Following up with service providers to gather appropriate information, records, and documents.
- Completing benefits applications and redeterminations.
- Participating in regular check-in meetings with deputy public guardians to review specific conservatee plans, issues, needs, and follow-up.

Goals & Objectives

Goal 1: Coordinate care, treatment, and supports to promote conservatee stability, safety, and appropriate food, clothing, and shelter.

Goal 2: Obtain all appropriate benefits and protect assets of each conservatee.

Objective 1: Ensure each conservatee is receiving the appropriate level of care and all needs for food, clothing, shelter, treatment, and safety are met.

Objective 2: Provide comprehensive estate management, protecting conservatee assets and guaranteeing all benefits and income for which each conservatee is eligible are received.

Supportive Housing and Social Services Coordination

Status: Continued From Prior Year Plan

Target Populations: Transitional Age Youth 18–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: Contractor

Service Contractors: Yolo County Continuum of Care

Estimated FY23/24 Costs	**$105,000**
Estimated Number to be Served FY23/24	**30**
Estimated Cost/ Person Served	**$3,500**

Program Description

Individuals with severe mental illness, living independently in various housing settings, are often more successful when they have access to coordinated and supportive services in these settings. The presence of dedicated supportive housing or social service coordinator at both Pacifico and Homestead permanent supportive housing (PSH) programs in Davis and additional PSH units throughout the county ensure residents have on-site access to the necessary supports and services to remain successfully housed and avoid homelessness.

The coordinator provides PSH residents with:

- Case management
- Group counseling
- Initial and ongoing needs assessments
- Monthly individual check-ins
- Referrals to community resources
- Linkages to substance use disorder intervention services
- Coordination of access to various county, state, and federal eligibility programs
- Crisis intervention
- Assistance with activities of daily living

Goals & Objectives

Goal 1: Ensure PSH residents remain successfully housed.

Goal 2: Support PSH residents in achieving and maintaining behavioral health and wellness.

Objective 1: Provide PSH residents with on-site access to social service supports, community resources, and referrals to address preexisting and emerging needs.

Objective 2: Provide PSH residents with on-site access to routine and urgent behavioral health supports.

Tele-Mental Health Services

Status: Continued From Prior Year Plan

Target Populations: Transitional Age Youth 18–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: Contractor and County

Service Contractors: Locum Tenens

Estimated FY23/24 Costs	**$1,925,611.23**
Estimated Number to be Served FY23/24	**1,000**
Estimated Cost/ Person Served	**$1,926**

Program Description

Yolo County mental health clinics currently use telepsychiatry to expand consumer access to a prescriber. Telepsychiatry appointments are supported by an in-clinic medical assistant and nursing staff. County prescribers use the tele-mental health software to assists clients' medication needs. When tele-mental health software is already in use, clients and prescribers have access to HIPAA-compliant Zoom channels for services.

The Tele-Mental Health Services program supports outcomes around reducing barriers to providing psychiatric services to individuals throughout the county. Both the telepsychiatry and nurse practitioner services provided by telehealth expand the reach of the county's psychiatric and therapeutic services to various communities and enhance access to both psychiatric appointments and other clinical services in Yolo County. Previously purchased tablets, paid for by MHSA funding in FY 22/23, will be distributed to the most in-need clients (e.g., those without transportation, who live in rural areas of the county, and who have limiting physical disabilities) to support increased tele-mental health services use.

Goals & Objectives

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 prescriber telehealth consultations.

Objective 2: Continue current use of telepsychiatry for existing Yolo County clients.

Prevention and Early Intervention Programs

Prevention

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

Yolo County Programs/Strategies: College Partnership Program, Cultural Competence

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 Partnership Program, Senior Peer Support Program

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 older adults 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 Access & 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, Mobile Hair Professionals to Support Mental Wellness and Connections

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: Cultural Competence, Early Signs Training and Assistance

College Partnership Program

Status: Continued From Prior Year Plan

Program Type: Prevention & Early Intervention Program

Target Populations: Transitional Age Youth 16–25

Administered by: Contractor

Service Contractors: CommuniCare Health Centers

Estimated FY23/24 Costs	**$315,000**
Estimated Number to be Served FY23/24	**175**
Estimated Cost/ Person Served	**$1,800**

Program Description

The College Partnership Program is a collaboration between Yuba Community College District and HHSA to provide engagement, access, linkage, and direct services to college students who are at risk of or currently experiencing mental health problems with the goal of promoting recovery, resilience, and connection to mental health services for those in need. CommuniCare Health Centers is contracted to provide these services on three community college campuses in the Yuba Community College District. The program promotes health and well-being for college students through the provision of physical and behavioral health services. This program continues to build on the successes of the college-based wellness center program and offers a robust campus-based behavioral health program, providing a broad array of engagement, prevention, early intervention, and physical and behavioral health intervention services. The College Partnership Program braids MHSA and Medi-Cal funding with funds from the Yuba Community College District to expand the array of mental health services and supports available on college campuses.

This partnership aims to increase access to mental health services in locations that are easily accessible to college-age students. The program provides more fully integrated mental health services into the college system by offering site-based services that include wellness center activities and services, screening, assessment, and physical and behavioral health services. Additionally, the program meets the unique cultural needs of colleges by providing culturally relevant services to Spanish-speaking students. Education and learning opportunities are available for students and staff members to increase knowledge of healthy living habits and college-based services available to them. Key activities of the College Partnership Program support outcomes around improving mental health wellness, social connectivity, and service utilization by:

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

Goals & Objectives

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.

Cultural Competence

Status: Continued From Prior Year Plan

Program Type: Prevention and Suicide Prevention Program

Target Populations: Children Aged 0–5, Transitional Youth Aged 16–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: Contractor and County

Service Contractors: TBD

Estimated FY23/24 Costs	**$708,333**
Estimated Number to be Served FY23/24	**N/A**
Estimated Cost/ Person Served	**N/A**

Program Description

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

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

Additionally, cultural competence extends its focus to address the significant and disproportionate involvement of African Americans in both the child welfare and criminal justice systems in Yolo County to improve the mental health and well-being of the Black community, identified as a special population in the MHSA plan and the most impacted population according to both child welfare and criminal justice data.

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

- Diversity, equity, and inclusion coordinator and staffing support
- Cultural competence and equity outreach engagement and trainings
- Culturally responsive service delivery
- Cultural support groups
- Stigma reduction and outreach to specific populations
- Additional funding for expansion of scopes and incentives into contracts to support outreach and service delivery to vulnerable populations
- Culturally responsive resilience support
- Targeted marketing efforts to vulnerable populations
- Support for the Yolo Cultural Competence plan
- Cultural competence committee with workgroups to address areas of emphasis
- An internal workgroup addressing staff mental health and the relationship between the staff and leadership

Goals & Objectives

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 the 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 Competence Plan.

Objective 3: Reduce stigma, promote service engagement, and provide targeted, culturally responsive outreach and support to vulnerable populations.

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.

Goal 2: Engage and support the staff by identifying systemic inequities and developing racial and health equity programming that is trauma informed in the implementation.

Objective 1: Increase retention and recruitment of a diverse workforce that reflects the community it serves by building on diversity, equity, inclusion, and belonging principles and practices.

Objective 2: Increase the staff's mental health, well-being, and resilience to encourage and maintain culturally responsive service delivery.

Objective 3: Address systemic inequities that ultimately affect culturally and linguistically appropriate service delivery.

Goal 3: Create a formal framework and template for cultural competence and diversity, equity, and inclusion activities, programming, and communications networks.

Objective 1: Develop a comprehensive 3-year Cultural Competence Plan for HHSA and educate staff members and providers in appropriately reporting program activities to inform the plan.

Objective 2: Establish an internal agency and external public-facing communications network to support collective impact efforts through ongoing community, interdepartmental, and cross-sector collaboration, partnership, and communications.

Early Childhood Mental Health Access and Linkage Program

Status: Continued From Prior Year Plan

Program Type: Access and Linkage to Treatment Program

Target Populations: Children Aged 0–5

Administered by: Contractor

Service Contractors: First 5 Yolo

Estimated FY23/24 Costs	**$650,000**
Estimated Number to be Served FY23/24	**6,200**
Estimated Cost/ Person Served	**$105**

Program Description

The Early Childhood Mental Health (ECMH) Access and Linkage Program provides universal screenings to parents/caregivers and their children aged 0–5. The intent of the program is to identify young children who are either at risk of or beginning to develop mental health problems that are likely to affect their healthy development. Based on the screening, the ECMH Access and Linkage program connects children and their families to prevention or early intervention services to address mental health problems affecting healthy development. The county contracts with First 5 Yolo to provide these screenings and referrals to services.

The program provides screening, identification, and referral services for children aged 0–5 in the community setting to provide prompt identification and intervention for potential issues and timely access to and coordination of services to address existing issues at an appropriate service intensity. Children are linked to the most suitable service, regardless of funding source or service setting (e.g., county; early and periodic screening, diagnosis, and treatment; or school).

The purpose of this program is to address the needs identified during the community program planning process for a simplified method of assessment and referral of children to the services that they need. Community stakeholders identified that due to the multitude of programs available and different admission criteria, children and youth were not always linked appropriately. This program seeks to bridge this gap by placing a referral and access specialist in community settings to serve children aged 0–5.

First 5 Yolo subcontracts with CommuniCare Heath Centers to provide in-home therapy for caregivers. The In-Home Therapy for Caregivers program strives to remove barriers to accessing caregiver mental health services by providing therapy services in their home. The program serves primary caregivers who have been identified by First 5 Yolo's Help Me Grow developmental screening or through First 5 Yolo's Heathy Families America home visiting program. This program aims to identify those who are not being served by existing systems and connect them to family-centered, culturally and linguistically sensitive mental health services in their home. The goal is to empower parents to create the nurturing environments and relationships that help break the cycle of adversity in young children.

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

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

Goals & Objectives

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.

Early Signs Training and Assistance

Status: Continued From Prior Year Plan

Program Type: Suicide Prevention Program
Outreach for Increasing Recognition of Early Signs of Mental Illness

Target Populations: Transitional Youth Aged 16–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: Contractor and County

Service Contractors: TBD

Estimated FY23/24 Costs	**$590,334**
Estimated Number to be Served FY23/24	**500**
Estimated Cost/ Person Served	**$1,180**

Program Description

Early Signs Training and Assistance focuses on mental illness stigma reduction and community education to intervene earlier in mental health crises. Early Signs provides training to providers, individuals, and other caregivers who live or work in Yolo County. The purpose of these training programs is to educate public and nonmental health staff members to respond to or prevent a mental health crisis in the community; support people living with mental illness or substance abuse; and reduce the stigma associated with mental illness. This program also provides for community outreach and engagement work at various events throughout Yolo community (I.e., food banks, resource fairs, immigrant and refugee-targeted activities, farmer's markets), in which the public is provided County and community resource information, as well as literature to address stigma reduction.

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

Early Signs Training and Assistance includes the following training programs:

- Question, Persuade, Refer (QPR) Suicide Prevention Training
- Adult Mental Health First Aid Certification
- Youth Mental Health First Aid Certification
- Suicide Prevention in the Workplace Training
- Parenting Children Experiencing Trauma Parent/RFA Training
- Group Peer Support Facilitator Training.

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

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

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

- MHFA Higher Education offered to university and community college audiences. This module offers additional materials, statistics, and exercises relevant to student and staff populations.
- MHFA Public Safety provides probation, corrections, and law enforcement personnel with additional materials, safety considerations, and exercises relevant to this audience and their families.
- MHFA for caregivers of older adults with later-life issues.

All trainings offer discussion of cultural considerations and messaging regarding differences in help-seeking and help-needing behaviors across diverse cultures.

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

3. Working Minds: Suicide Prevention in the Workplace Training
Created by the Helen and Arthur E. Johnson Depression Center at the University of Colorado, Suicide Prevention in the Workplace Training is a 2-hour training designed to educate about and create awareness of suicide prevention; create a forum for dialogue and critical thinking about workplace mental health challenges; promote help seeking and help giving in the workplace; and reduce stress-related absenteeism. The target audience is those who work in high-skill and high-stakes careers, e.g., first responders, social workers, and others. It is delivered to providers, fire and emergency medical services, and law enforcement personnel. The training also provides education on agency and business postintervention strategies for stabilizing the mental health of a workforce in the immediate aftermath of a suicide (www.coloradodepressioncenter.org/vitalcog).

4. Parenting Children Experiencing Trauma
This evidence-based resource family caregiver and parent workshop was created by the National Child Traumatic Stress Network in partnership with the Substance Abuse and Mental Health Services Administration and the U.S. Department of Health and Human Services. The curriculum is delivered in eight sessions on topics including the following:

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

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

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

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

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

Goals & Objectives

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.

K-12 School Partnerships Program

Status: Continued From Prior Year Plan

Program Type: Early Intervention Program

Target Populations: Children and Transitional Youth Aged 5–18

Administered by: County

Service Contractors: CommuniCare Health Centers; Victor Community Support Services; Rural Innovations in Social Economics, Inc.

Estimated FY23/24 Costs	**$3,507,733**
Estimated Number to be Served FY23/24	**6,000**
Estimated Cost/ Person Served	**$585**

Program Description

The K-12 School Partnerships Program is a collaboration among the five county school districts, the Office of Education, and community-based organizations to provide access to mental health professionals at schools throughout the county. The mental health staff provides services including universal screening, assessment, referral, and treatment for children and youth aged 6–18. The K-12 School Partnerships Program expands on a prior, more limitedservice array that only provided access, linkage and strengths-based mentoring services to students. The current program helps identify children and youth who need mental health services to provide access, linkage, and direct services and support to students and the school system. The K-12 School Partnerships Program provides evidence-based, culturally responsive services and offers promising practices in outreach and engagement for at-risk children and youth that build their resilience and help mitigate and support their mental health experiences. The K-12 School Partnerships Program braids MHSA funding with the Mental Health Student Services Act (MHSSA) grant funding and Medi-Cal billing for eligible beneficiaries.

The program utilizes the interconnected systems framework, which focuses on the whole child, incorporating academic, behavioral, and socioemotional development. The services provided through the K-12 School Partnerships Program align with the school districts' use of the multitiered systems of support model. This model features three tiers of services. Tier I services are available to all students and include campuswide or districtwide interventions and trainings meant to benefit the entire student and staff population. Tier II services are more targeted and include small groups and targeted interventions that are for students with identified needs. Tier III is intensive individualized intervention, including individual therapy and rapid linkage to long-term or intensive care. The partnership uses an integrated approach to blend resources, training, systems, data, and practices to improve outcomes for all children and youth. It emphasizes prevention, early identification, and intervention that address the social, emotional, and behavioral needs of students. Family and community partner involvement is critical to this framework.

Key activities of the K-12 School Partnerships Program include preventing the development of mental health challenges among school-aged children and improving linkages to mental health services, mental health wellness, school engagement, and personal, social, and community stability. The program supports children and youth to increase their social, emotional, and coping skills, including anger management, distress tolerance, self-esteem, relationship building, and cognitive life skills, in the following ways:

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

Goals & Objectives

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.

Latinx Outreach/Mental Health Promotores Program

Status: Continued From Prior Year Plan

Program Type: Stigma and Discrimination Reduction Program

Target Populations: Transitional Age Youth 16–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: Contractor

Service Contractors: CommuniCare Health Centers; Rural Innovations in Social Economics, Inc.

Estimated FY23/24 Costs	**$582,500**
Estimated Number to be Served FY23/24	**200**
Estimated Cost/ Person Served	**$2,913**

Program Description

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

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

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

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

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

Both CommuniCare & RISE received additional funding in FY22/23 to help meet the increased demand and ensure the Latinx community gets these vital supports.

Goals & Objectives

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.

Mobile Hair Professionals to Support Mental Wellness and Connections

Status: Continued From Prior Year Plan

Program Type: PEI Stigma and Discrimination Reduction Program

Target Populations: Transitional Age Youth 16–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: Contractor

Service Contractors:

Estimated FY23/24 Costs	**$7,750**
Estimated Number to be Served FY23/24	**300**
Estimated Cost/ Person Served	**$26**

Program Description

COVID-19 disproportionately affected people living with a mental illness, a substance use disorder, or both, especially people of color, which highlights that health equity is still not a reality in many communities in Yolo County. The mental wellness effects of living with a mental illness, such as low-self-esteem, anger management issues, relationship struggles, difficulty balancing work and life, anxiety about death, and stress of competition, have all increased dramatically due to the pandemic and especially among those living with serious mental illness and serious emotional disturbance.

The Giveback program improves the mental wellness of members of the Yolo County community by providing free haircuts and connections to social services for adults living with mental illness and other disabilities in Yolo County by working with nonprofit partners. With a budget of $7,750, this talented team of mobile hair care professionals give free haircuts for 6 hours every 21 days for 1 year to residents living at numerous housing locations serving people with serious mental illness throughout Yolo County. Giveback also hosts five mental wellness giveback events across Yolo County, at which free haircuts, showers, vaccinations, HIV and hepatitis C testing, clothes, food, toys, hygiene products, and information regarding mental health and social services in coordination with the county and nonprofit partners The project also helps an important segment of the community—both hair care professionals, who often are a source of advise, counseling, and friendship for their clients, and individuals who receive haircuts or participate in the mental wellness giveback events. Giveback provides hair care professionals with an incredible opportunity to earn additional income while helping people in need by providing guaranteed appointments on specific days and improving the mental wellness of those who need it most through free haircuts and genuine conversation. In addition, the Giveback mental wellness giveback events connects people living with mental illness to goods and services and provide an opportunity for meaningful social interaction.

The interactions helps both hair care professionals and the people served increase their confidence, decrease anxiety, foster community, and simply enjoy social interactions during and after the unpredictable, economically unstable, and protracted pandemic.

Goals & Objectives

Goal 1: Improve the self-esteem, anger management abilities, relationship struggles, work-life balance, and confidence of people living with a serious mental illness in various housing settings throughout the county through haircuts, shared connection, and support.

Objective 1: Provide on-demand haircuts to support every 21 days with a different nonprofit housing partner throughout Yolo County, serving the MHSA target population of TAY, adults, and older adults.

Objective 2: Organize and host five mental wellness giveback events throughout Yolo County, connecting clients with their community, organizations, and partners.

Senior Peer Support Program

Status: Continued From Prior Year Plan

Program Type: Early Intervention Program

Target Populations: Older Adults Aged 60+

Administered by: Contractor

Service Contractors: YoloCARES

Estimated FY23/24 Costs	**$100,000**
Estimated Number to be Served FY23/24	**50**
Estimated Cost/ Person Served	**$2,000**

Program Description

The Senior Peer Support Program mobilizes volunteers from the community to provide free, supportive counseling and visiting services for adults aged 60 or older in Yolo County who are troubled by loneliness, depression, loss of spouse, illness, or other concerns of aging. Services are voluntary, consumer directed, and strengths based. By providing psychosocial supports and identifying possible signs and symptoms of mental illness early and with ongoing assistance, senior peer counselors help older adults live independently in the community for as long as reasonably possible. Senior Peer Support volunteers coordinate with existing HHSA and community-based older adult services to provide opportunities for earlier intervention to avoid crises for older adults and create more opportunities for support through companionship and counseling. Volunteers and staff members employ wellness and recovery principles, addressing both immediate and long-term needs of program members and delivering services in a timely manner with sensitivity to the cultural needs of those served.

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

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

Goals & Objectives

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 older adults.

Objective 3: Promote the early identification of mental health symptoms in older adults.

Innovation Plan

Crisis Now

Status: Continued From Prior Year Plan or Update

Target Populations: Transitional Age Youth 18–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: Contractor and County

Service Contractors: TBD

Estimated FY23/24 Costs	**$5,973,930**
Estimated Number to be Served FY23/24	**5,000**
Estimated Cost/ Person Served	**$1,195**

Program Description

Based on lessons learned from previous programs and the assistance of experts sponsored by the Mental Health Services Oversight and Accountability Commission, the Crisis Now model is recommended as a highly effective methodology to meet the needs of individuals in mental health crisis who may otherwise end up in the emergency room, at risk of suicide, or involved in the criminal justice system. There is a growing consensus that providing crisis services when a person is "out of control" or "a danger to self or others" is insufficient. The goal of the Crisis Now model is to provide wide-ranging crisis care that prevents individuals aged 18 or older from falling through the cracks between mental health episodes. These cracks occur because of interminable delays for services deemed essential based on professional assessments and are often attributable to two critical gaps: the absence of real-time coordination of outgoing services and linked, flexible services specific to crisis response. Because of these gaps in care, individuals often exit emergency departments against medical advice or are released from police custody and disappear until the next crisis occurs.

A broader conceptualization of crisis response must include crisis prevention, early intervention, and postcrisis services and support. As a result, the Crisis Now model focuses on the following three elements:

- High-tech crisis call centers that coordinate all aspects of an immediate crisis response.
- Mobile crisis outreach teams that work in the community with those at risk to reduce the need for uniformed officers to provide behavioral health triage in the community (currently provided by HHSA through the MHSA partially funded Co-Responder Program).
- Facility-based crisis centers (i.e., crisis receiving or sobering centers) that divert those experiencing a behavioral health crisis from emergency departments and provide crisis specific interventions in safe and secure environments.

MHSA Innovation funding will be used to partially fund HHSA's crisis receiving center. An updated approach to the development and implementation of the Crisis Now continuum project is included in the appendix. Key activities of the Crisis Now model include:

- Using evidence-based safe care practices such as trauma-informed care and zero suicide.
- Engaging individuals at risk in a discussion about thoughts of suicide and experiences of psychic pain.
- Exploring individuals' strengths and resources while building hope for recovery, empowering them to work toward securing their safety.
- Offering law enforcement (and other first responders) a more appropriate alternative to address crises than local emergency rooms.
- Employing a multidisciplinary approach to crisis resolution.
- Providing a safe environment for care and recovery from behavioral health crises.
- The full Crisis Now Innovation Proposal is included with this report as part of the public comment period. Thereafter, this proposal will be submitted to the Mental Health Services Oversight & Accountability Commission for approval.

Goals & Objectives

Goal 1: Improve how HHSA meets the needs of individuals in behavioral health crisis who may otherwise end up in the emergency room, at risk of suicide, or involved in the criminal justice system.

Goal 2: Provide integrated care resulting in linkage to follow-up services that may prevent crisis recurrence.

Objective 1: Prevent or ameliorate a behavioral health crisis or reduce acute symptoms of mental illness by providing 24-hour observation and supervision for people who do not require inpatient services.

O**bjective 2:** Provide community-based interventions to support individuals in crisis wherever they are, including home, school, or any other community location.

Objective 3: Provide a "no wrong door" mechanism for those in crisis to receive immediate behavioral health services.

Planning and Stakeholder Input Process for Crisis System Re-Design and Implementation

Status: Continued From Prior Year Plan

Target Populations: Transitional Age Youth 18–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: Contractor and County

Service Contractors: RI International; Other contractors TBD

Estimated FY23/24 Costs	**$344,586.61**
Estimated Number to be Served FY23/24	**N/A**
Estimated Cost/ Person Served	**N/A**

Program Description

HHSA is utilizing a portion of this funding to support the development of a revised approach to crisis response throughout the county for all residents aged 18 or older, including Medi-Cal beneficiaries and those without insurance, using Crisis Now core principles. Utilizing tools gained and lessons learned from the Crisis Now Academy, the staff will engage with local partners including the local health system providers, MHSA Community Engagement Workgroup, Local Mental Health Board, city leadership, UC Davis, local law enforcement agencies, consumers and family members, and other relevant county agencies. A system redesign as large as Crisis Now takes a significant amount of time to review best practices, utilize proven tools to calculate local need, and engage partners for feedback and redesign considerations to ensure the Yolo County Crisis Now model not only fits the community but also meets the needs identified by the community.

Further building on the Crisis Now Academy learnings and incorporating feedback from the planning and stakeholder input process, HHSA intends to use most of this funding for the upcoming preparatory work necessary to take the community planning process to the next phase, which will ultimately result in the redesign coming to fruition. Further, this plan includes the addition of technical assistance from RI International, the developer of the Crisis Now model to assist with program development and implementation efforts. The following are expected uses of this additional funding during this preparatory implementation process, all of which have been informed in some way by the robust community planning process conducted to date:

- Site location, redesign, engagement, and renovation preparation
- Architect and engineer support for location needs
- Preparatory renovation work to create a suicide-safe Crisis Now program
- Training of staff members, internal and external, on Crisis Now programming needs, expectations, outcomes, policies, and procedures
- Policy, procedure, and practice development required to connect high-tech call center with 988 and local dispatch
- Request for proposal development, review, and contracting execution
- Purchasing and securing of required equipment, including suicide-safe furniture
- Staff members required to support these efforts
- Technical assistance for crisis system re-design and implementation efforts

Goals & Objectives

Goal 1: Build an effective adult crisis system in Yolo County utilizing the lessons learned from the Crisis Now Academy through planning, stakeholder engagement, redesign development, and preparatory work necessary to implement the Crisis Now model in Yolo County.

Objective 1: Engage stakeholders in the community planning process.

Objective 2: Create a crisis system design for Yolo County incorporating all four components of the Crisis Now model.

Objective 3: Complete preparatory work necessary to launch Crisis Now in Yolo County.

Workforce, Education, and Training Programs

Central Regional WET Partnership

Status: Continued From Prior Year Plan

Target Populations: Children and Transitional Age Youth 6–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: Contractor and County

Service Contractors: Regional Partnership Memorandum of Understanding with California Mental Health Services Authority

Estimated FY23/24 Costs	**$10,000**
Estimated Number to be Served FY23/24	**25**
Estimated Cost/ Person Served	**$400**

Program Description

In FY 19/20, $40 million was appropriated to fund the California Department of Healthcare Access and Information or HCIA's (formerly the California Office of Statewide Health Planning and Development) 2020–2025 Workforce, Education, and Training (WET) 5-year plan. . Yolo County is a part of the Central Regional Partnership, along with 18 other counties, which has access to a total grant amount of $6,463,031 during the 5-year period. Yolo County has already awarded qualifying staff with $25,000 loan forgiveness grants and is now looking toward using remaining funds for staff recruitment and retention and potential graduate intern stipends. A small amount of additional match funds may be required from Yolo County should HCAI may additional WET monies available to the Central region.

Goals & Objectives

Goal 1: Provide funding opportunities to attract and retain well-trained, diverse, and high-quality staff members in the county's mental health service delivery system.

Objective 1: Offer educational loan repayment assistance to professional staff members.

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 students to support professional internships in the county system.

Mental Health Professional Development

Status: Continued From Prior Year Plan

Target Populations: Children and Transitional Age Youth 6–25, Adults Aged 26–59, Older Adults Aged 60+

Administered by: County

Estimated FY23/24 Costs	**$180,997**
Estimated Number to be Served FY23/24	**N/A**
Estimated Cost/ Person Served	**N/A**

Program Description

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

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

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

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

In an increasingly competitive work environment, retaining qualified professionals is critical to the support and infrastructure of a robust mental health plan. Many clinical staff members often have significant experience providing clinical services to clients, but they may be unlicensed and need supervision to ensure that they are adequately equipped to handle the needs of the population they serve and meet the requirements of the California Board of Behavioral Sciences (BBS) for licensure. Without the training and support needed for this clinical supervision, staff members can experience greater rates of burnout and leave the workforce or seek other employment opportunities that provide the training and support needed, ultimately affecting client care.

Through a pending agreement with CalMHSA, Yolo County will secure assistance with staff professional development initiatives until 2027, including:

A. Remote BBS pre-licensure supervision

B. Access to the statewide Peer Support Specialist certification training and exam materials (which includes training for HHSA staff to become supervisors of such Certified Peer Special staff)

C. Additional staff training resources via CalMHSA Learning Management Software platform.

Capital Facilities and Technological Plan

IT Hardware/Software/Subscriptions Services

Status: Continued From Prior Year Plan

Administered by: Contractors

Service Contractors: Netsmart, SacValley Med Share

Estimated FY23/24 Costs	**$1,403,304.10**
Estimated Number to be Served FY23/24	**1,000**
Estimated Cost/ Person Served	**$1,403**

Program Description

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

- Updating hardware and software
- Implementing upgrades to the Netsmart MyAvatar Information System
- Joining local health information exchange and integrating it into MyAvatar
- Integrating MyAvatar with a future business intelligence platform
- Ensuring better strategic planning project management using SmartSheets
- Implementing new Current Procedural Terminology (CPT) service codes and billing code adoption to ensure HHSA fiscal stability
- Becoming compliant with federal and state interoperability expectations

Yolo County HHSA is also in the process of joining a local Health Information Exchange (HIE) via SacValley Med Share in order to meet the data exchange expectations put forth by DHCS CalAIM. This HIE platform will allow for the protected, real time, exchange of client information between HHSA, our County Managed Care Plans, local hospitals and other health providers who serve our clients. Further, this plan includes increased access to Relias, a learning management platform providing on-line training and continuing education.

Goals & Objectives

Goal 1: Implement and support data infrastructure for quality measurement and improvement of programs and improve the necessary technology for service delivery in Yolo County.

Objective 1: Increase efficiencies in reporting, billing, retrieving, and storing personal health information.

Objective 2: Implement a consistent, dependable clinic safety tool.

Objective 3: Improve staff and client communication technologies.

Cross-Area Work Plan

IT Hardware/Software/Subscriptions Services

Status: Continued From Prior Year Plan or Update

Administered by: County and Contractor

Service Contractor: TBD

Estimated FY23/24 Costs	**$236,858**
Estimated Number to be Served FY23/24	**N/A**
Estimated Cost/ Person Served	**N/A**

Program Description

This plan intends to develop measures not only for contracts greater than $1 million, but for all requests for proposals and contracts. To do this, Yolo County will utilize results-based accountability (see Evaluation) performance measures and outcomes, which include SMART goals, and align with evidence-based practices wherever possible. HHSA will seek an independent evaluator to support development of program performance metrics and a system to track and report data. These efforts will create a framework that will provide information to assess outcomes, successes, modifications needed, new approaches, and how meaningful outcomes are ultimately being achieved.

Furthermore, the proposed evaluation will include support with:

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

Evaluation work to assess overall impact, success, and challenges of the 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.

Goals & Objectives

Goal 1: Support creation and development of program performance metrics and systems to track and report data for program evaluation to assess meaningful outcomes.

Objective 1: Embed results-based accountability development into contracts and provide technical assistance to support smaller organizations.

Objective 2: Ensure program evaluation components are comparable in similar performance functions framework.

FY 2023/24 through FY 2025/26 Mental Health Services Act Three-Year Plan

Funding Summary

Yolo County 05/31/2023

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2023/24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years*	13,121,513	3,310,847	2,520,123	422,488	1,089,337	
2. Estimated New FY 2023/24 Funding**	20,019,813	5,010,860	1,318,676			
3. Transfer in FY 2023/24[a/]	(1,728,325)			207,053	1,521,272	0
4. Access Local Prudent Reserve in FY 2023/24	0	0				0
5. Estimated Available Funding for FY 2023/24	31,413,000	8,321,707	3,838,799	629,541	2,610,609	
B. Estimated FY 2023/24 MHSA Expenditures	17,185,734	5,079,014	791,250	207,053	1,521,272	
C. Estimated FY 2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	14,227,267	3,242,693	3,047,549	422,488	1,089,337	
2. Estimated New FY 2024/25 Funding**	13,356,682	3,361,402	883,511			
3. Transfer in FY 2024/25[a/]	(1,740,339)			200,610	1,539,730	0
4. Access Local Prudent Reserve in FY 2024/25	0	0				0
5. Estimated Available Funding for FY 2024/25	25,843,610	6,604,095	3,931,060	623,097	2,629,067	
D. Estimated FY 2024/25 MHSA Expenditures	17,911,781	4,940,244	950,571	200,610	1,539,730	
E. Estimated FY 2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	7,931,829	1,663,851	2,980,489	422,488	1,089,337	
2. Estimated New FY 2025/26 Funding**	13,174,703	3,312,601	869,975			
3. Transfer in FY 2025/26[a/]	(1,795,464)			201,872	1,593,592	0
4. Access Local Prudent Reserve in FY 2025/26	0	0				0
5. Estimated Available Funding for FY 2025/26	19,311,068	4,976,452	3,850,464	624,360	2,682,928	
F. Estimated FY 2025/26 MHSA Expenditures	18,947,578	4,957,274	1,671,384	201,872	1,593,592	
G. Estimated FY 2025/26 Unspent Fund Balance	363,490	19,178	2,179,080	422,488	1,089,337	

H. Estimated Local Prudent Reserve Balance*	
1. Estimated Local Prudent Reserve Balance on June 30, 2023	2,224,069
2. Contributions to the Local Prudent Reserve in FY 2023/24	0
3. Distributions from the Local Prudent Reserve in FY 2023/24	0
4. Access Local Prudent Reserve in FY 2024/25	2,224,069
5. Contributions to the Local Prudent Reserve in FY 2024/25	0
6. Distributions from the Local Prudent Reserve in FY 2024/25	0
7. Estimated Local Prudent Reserve Balance on June 30, 2025	2,224,069
8. Contributions to the Local Prudent Reserve in FY 2025/26	0
9. Distributions from the Local Prudent Reserve in FY 2025/26	0
10. Estimated Local Prudent Reserve Balance on June 30, 2026	2,224,069

* Based on Reversion Tables issued 3/16/23 and projected FY2223 spending as of 04/19/23

** Estimated New Funding includes projected interest earned

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve.
The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

*** Pursuant to SB192, W&I section 5892(b)(2), and DHCS Information Notice 19-017, each county must calculate an amount to establish its prudent reserve that does not
exceed 33 percent of the average amount allocated to the CSS component in the preceding five years. The county shall reassess the maximum amount of this reserve
every five years and certify the reassessmet as part of the three-year program and expenditure plan.

Community Services and Supports (CSS) Funding FY 23/24

Yolo County 05/31/2023

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Adult Wellness Services	8,915,199	5,589,014	3,011,185	315,000		
2. Children's Mental Health Services	540,000	161,500	378,500			
3. Pathways to Independence	1,494,984	607,678	887,306			
4. Older Adult Outreach and Assessment Program	1,620,804	704,835	915,970			
5. Tele-Mental Health Services Mental Health Crisis Services and Crisis Intervention Team	89,646	53,210	36,436			
6. (CIT) Training	102,756	100,765	1,991			
Non-FSP Programs						
1. Adult Wellness Services	1,511,674	1,436,532	75,142			
2. Children's Mental Health Services	1,303,269	973,296	311,308			18,665
3. Pathways to Independence	260,353	212,897	47,456			
4. Older Adult Outreach and Assessment Program	156,260	156,260				
5. Tele-Mental Health Services	1,835,965	1,598,927	237,039			
6. Community-Based Drop-In Navigation Center	1,111,928	703,044	408,884			
7. Peer- and Family-Led Support Services	170,000	170,000				
8. Mental Health Crisis Services and Crisis Intervention Team (CIT) Training	2,740,903	1,952,229	203,674	225,000		360,000
9. Public Guardian Case Managers	258,300	258,300				
10. Supportive Housing and Social Services Coordination	105,000	105,000				
11. Co-Occurring Disorder Assessment and Intake – AB2265	557,470	380,898	176,572			
CSS Annual Planning (CPP)	253,886	253,886				
CSS Evaluation	157,589	157,589				
CSS Administration	1,519,865	1,409,874	1,409,874			
CSS Expenses Incurred by a JPA	200,000	200,000				
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Component Estimated Expenditures	24,905,853	17,185,734	6,801,453	540,000	0	378,665
FSP Programs as Percent of Total	**51.2%**					

Community Services and Supports (CSS) Funding FY 24/25

Yolo County 05/31/2023

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Adult Wellness Services	9,265,595	5,879,187	3,071,408	315,000		
2. Children's Mental Health Services	567,000	180,930	386,070			
3. Pathways to Independence	1,563,552	658,500	905,052			
4. Older Adult Outreach and Assessment Program	1,401,231	466,942	934,289			
5. Tele-Mental Health Services Mental Health Crisis Services and Crisis Intervention Team	94,260	57,096	37,165			
6. (CIT) Training	150,671	148,641	2,030			
Non-FSP Programs						
1. Adult Wellness Services	1,581,144	1,504,499	76,645			
2. Children's Mental Health Services	1,353,358	1,016,785	317,534			19,039
3. Pathways to Independence	272,955	272,955	272,955			
4. Older Adult Outreach and Assessment Program	4,852	4,852				
5. Tele-Mental Health Services	1,866,541	1,624,762	241,779			
6. Community-Based Drop-In Navigation Center	980,967	563,905	417,062			
7. Peer- and Family-Led Support Services	170,000	170,000				
8. Mental Health Crisis Services and Crisis Intervention Team (CIT) Training	3,528,023	2,531,875	207,748	428,400		360,000
9. Public Guardian Case Managers	263,466	263,466				
10. Supportive Housing and Social Services Coordination	110,250	110,250				
11. Co-Occurring Disorder Assessment and Intake – AB2265	568,523	388,420	180,103			
CSS Annual Planning (CPP)	256,316	256,316				
CSS Evaluation	160,805	160,805				
CSS Administration	1,612,192	1,500,001	112,191			
CSS Expenses Incurred by a JPA	200,000	200,000				
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Component Estimated Expenditures	25,971,702	17,911,781	6,937,483	743,400	0	379,039
FSP Programs as Percent of Total	**50.2%**					

Community Services and Supports (CSS) Funding FY 25/26

Yolo County 05/31/2023

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Adult Wellness Services	9,631,424	6,183,587	3,132,836	315,000		
2. Children's Mental Health Services	595,350	201,559	393,791			
3. Pathways to Independence	1,635,515	712,362	923,153			
4. Older Adult Outreach and Assessment Program	1,471,232	518,257	952,975			
5. Tele-Mental Health Services Mental Health Crisis Services and Crisis Intervention Team	99,023	61,115	37,908			
6. (CIT) Training	153,474	151,403	2,071			
Non-FSP Programs						
1. Adult Wellness Services	1,652,853	1,574,676	78,178			
2. Children's Mental Health Services	1,421,742	1,078,437	323,885			19,419
3. Pathways to Independence	285,963	236,589	49,374			
4. Older Adult Outreach and Assessment Program	5,082	5,082				
5. Tele-Mental Health Services	1,995,878	1,749,263	246,615			
6. Community-Based Drop-In Navigation Center	1,030,065	604,662	425,403			
7. Peer- and Family-Led Support Services	170,000	170,000				
8. Mental Health Crisis Services and Crisis Intervention Team (CIT) Training	3,668,262	2,667,960	211,903	428,400		360,000
9. Public Guardian Case Managers	268,735	268,735				
10. Supportive Housing and Social Services Coordination	115,763	115,763				
11. Co-Occurring Disorder Assessment and Intake – AB2265	597,250	413,545	183,706			
CSS Annual Planning (CPP)	276,229	276,229				
CSS Evaluation	163,862	163,862				
CSS Administration	1,708,929	1,594,494	114,435			
CSS Expenses Incurred by a JPA	200,000	200,000				
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Component Estimated Expenditures	27,146,630	18,947,578	7,076,232	743,400	0	379,419
FSP Programs as Percent of Total	**50.0%**					

Prevention and Early Intervention (PEI) Funding FY 23/24

Yolo County 05/31/2023

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Access and Linkage Programs						
1. Early Childhood Mental Health Access and Linkage Program	650,000	650,000				
Early Intervention Programs						
2. Senior Peer Support Program	100,000	100,000				
3. College Partnership	315,000	315,000				90,000
4. K-12 School Partnerships Program	3,507,733	1,685,125	804,522			1,018,086
Prevention Programs						
5. Cultural Competence	708,333	708,333				
Stigma and Discrimination Reduction Programs						
6. Early Signs Training and Assistance	590,335	590,335				
Early Intervention Programs						
7. Latinx Outreach/Mental Health Promotores Program	582,500	582,500				
8. Mobile Hair Professionals to Support Mental Wellness and Connections	7,750	7,750				
PEI Annual Planning (CPP)	71,406	71,406				
PEI Evaluation	44,322	44,322				
PEI Administration	427,467	414,242	13,224			
PEI Assigned Funds	0	0				
Total PEI Component Estimated Expenditures	7,004,846	5,079,014	817,746	0	0	1,108,086

Prevention and Early Intervention (PEI) Funding FY 24/25

Yolo County 05/31/2023

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Access and Linkage Programs						
1. Early Childhood Mental Health Access and Linkage Program	650,000	650,000				
Early Intervention Programs						
2. Senior Peer Support Program	100,000	100,000				
3. College Partnership	315,000	225,000				90,000
4. K-12 School Partnerships Program	3,515,786	1,677,087	820,612			1,018,086
Prevention Programs						
5. Cultural Competence	708,333	708,333				
Stigma and Discrimination Reduction Programs						
6. Early Signs Training and Assistance	455,551	455,551				
Early Intervention Programs						
7. Latinx Outreach/Mental Health Promotores Program	600,000	600,000				
PEI Annual Planning (CPP)	67,923	67,923				
PEI Evaluation	42,613	42,613				
PEI Administration	427,227	413,738	13,489			
PEI Assigned Funds	0	0				
Total PEI Component Estimated Expenditures	6,882,432	4,940,244	834,101	0	0	1,108,086

Prevention and Early Intervention (PEI) Funding FY25/26

Yolo County 05/31/2023

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Access and Linkage Programs						
1. Early Childhood Mental Health Access and Linkage Program	650,000	650,000				
Early Intervention Programs						
2. Senior Peer Support Program	100,000	100,000				
3. College Partnership	315,000	225,000				90,000
4. K-12 School Partnerships Program	3,524,097	1,668,987	837,025			1,018,086
Prevention Programs						
5. Cultural Competence	708,333	708,333				
Stigma and Discrimination Reduction Programs						
6. Early Signs Training and Assistance	471,207	471,207				
Early Intervention Programs						
7. Latinx Outreach/Mental Health Promotores Program	600,000	600,000				
PEI Annual Planning (CPP)	70,375	70,375				
PEI Evaluation	41,747	41,747				
PEI Administration	435,383	421,625	13,759			
PEI Assigned Funds	0	0				
Total PEI Component Estimated Expenditures	6,916,143	4,957,274	850,783	0	0	1,108,086

Innovations (INN) Funding

Yolo County 05/31/2023

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Planning and Stakeholder Input Process for Crisis System Re-Design and Implementation	344,587	344,587				
2. Crisis Now: Receiving Center	3,155,866	152,400				3,003,466
INN Annual Planning (CPP)	38,683	38,683				
INN Evaluation	24,011	24,011				
INN Administration	231,570	231,570				
Total INN Component Estimated Expenditures	3,794,716	791,250	0	0	0	3,003,466

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Crisis Now: Receiving Center	3,374,550	664,550				2,710,000
INN Annual Planning (CPP)	36,126	36,126				
INN Evaluation	22,665	22,665				
INN Administration	227,230	227,230				
Total INN Component Estimated Expenditures	3,660,571	950,571	0	0	0	2,710,000

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Crisis Now: Receiving Center	3,113,702	1,403,702				1,710,000
INN Annual Planning (CPP)	34,407	34,407				
INN Evaluation	20,411	24,011				
INN Administration	212,864	212,864				
Total INN Component Estimated Expenditures	3,381,384	1,671,384	0	0	0	1,710,000

Workforce, Education and Training (WET) Funding

Yolo County 05/31/2023

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Workforce Staffing Support Programs						
1. Central Regional WET Partnership	10,000	10,000				
Training and Technical Assistance Programs						
2. Mental Health Professional Development	180,997	180,997				
WET Annual Planning (CPP)	2,111	2,111				
WET Evaluation	1,310	1,310				
WET Administration	12,635	12,635				
Total WET Component Estimated Expenditures	207,053	207,053	0	0	0	0

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Training and Technical Assistance Programs						
1. Mental Health Professional Development	184,935	184,935				
WET Annual Planning (CPP)	1,980	1,980				
WET Evaluation	1,242	1,242				
WET Administration	12,453	12,453				
Total WET Component Estimated Expenditures	200,610	200,610	0	0	0	0

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Training and Technical Assistance Programs						
1. Mental Health Professional Development	185,891	185,891				
WET Annual Planning (CPP)	2,054	2,054				
WET Evaluation	1,219	1,219				
WET Administration	12,708	12,708				
Total WET Component Estimated Expenditures	201,872	201,872	0	0	0	0

Capital Facilities/Technological Needs (CFTN) Funding

Yolo County 05/31/2023

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Technological Needs Projects						
1. IT Hardware/Software/Subscription Services	1,403,304	1,403,304				
CFTN Annual Planning (CPP)	15,508	15,508				
CFTN Evaluation	9,626	9,626				
CFTN Administration	92,835	92,835				
Total CFTN Component Estimated Expenditures	1,521,272	1,521,272	0	0	0	0

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Technological Needs Projects						
1. IT Hardware/Software/Subscription Services	1,419,422	1,419,422				
CFTN Annual Planning (CPP)	15,196	15,196				
CFTN Evaluation	9,533	9,533				
CFTN Administration	95,579	95,579				
Total CFTN Component Estimated Expenditures	1,539,730	1,539,730	0	0	0	0

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Technological Needs Projects						
1. IT Hardware/Software/Subscription Services	1,467,437	1,467,437				
CFTN Annual Planning (CPP)	16,215	16,215				
CFTN Evaluation	9,619	9,619				
CFTN Administration	100,319	100,319				
Total CFTN Component Estimated Expenditures	1,593,592	1,593,592	0	0	0	0

FY 2022/23 Prudent Reserve Calculation

Yolo County 05/31/2023

	MHSA Allocation
A. Distributions from Mental Health Services Fund (MHSF)	
1. FY 2017/18	10,880,652.61
2. FY 2018/19	10,680,186.64
3. FY 2019/20*	9,962,277.29
4. FY 2020/21*	15,179,712.66
5. FY 2021/22	17,376,005.29
6. Sum of distributions	64,078,834.49
B. Amount allocated to CSS (Sum multiplied by 76%)	48,699,914.21
C. Reallocated CSS funds not included above (FY2019/20)	1,073.93
D. Average amount allocated to CSS (B+C divided by 5)	9,740,197.63
E. Prudent Reserve maximum (D multiplied by 33%)	**3,214,265.22**

F. Estimated Local Prudent Reserve Balance**	
1. Estimated Local Prudent Reserve Balance on June 30, 2023	2,224,069.00
2. Contributions to the Local Prudent Reserve in FY 2023/24	0.00
3. Distributions from the Local Prudent Reserve in FY 2023/24	0.00
4. Access Local Prudent Reserve in FY 2024/25	2,224,069.00
5. Contributions to the Local Prudent Reserve in FY 2024/25	0.00
6. Distributions from the Local Prudent Reserve in FY 2024/25	0.00
7. Estimated Local Prudent Reserve Balance on June 30, 2025	2,224,069.00
8. Contributions to the Local Prudent Reserve in FY 2025/26	0.00
9. Distributions from the Local Prudent Reserve in FY 2025/26	0.00
10. Estimated Local Prudent Reserve Balance on June 30, 2026	2,224,069.00

* Distribution amounts from MHSF do not include "Reallocated" funds. They are added in step C.

** Pursuant to SB192, W&I section 5892(b)(2), and DHCS Information Notice 19-017, each county must calculate an amount to establish its prudent reserve that does not exceed 33 percent of the average amount allocated to the CSS component in the preceding five years. The county shall reassess the maximum amount of this reserve every five years and certify the reassessmet as part of the three-year program and expenditure plan.

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: Yolo

Fiscal Year: FY2022-23

Local Behavioral Health Director

Name: Karleen Jakowski, LMFT

Telephone: (530) 661-2978

Email: Karleen.Jakowski@yolocounty.org

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Karleen Jakowski, LMFT

Local Behavioral Health Director
(PRINT NAME)

Signature

Date

[1] Welfare and Institutions Code section 5892 (b)(2)

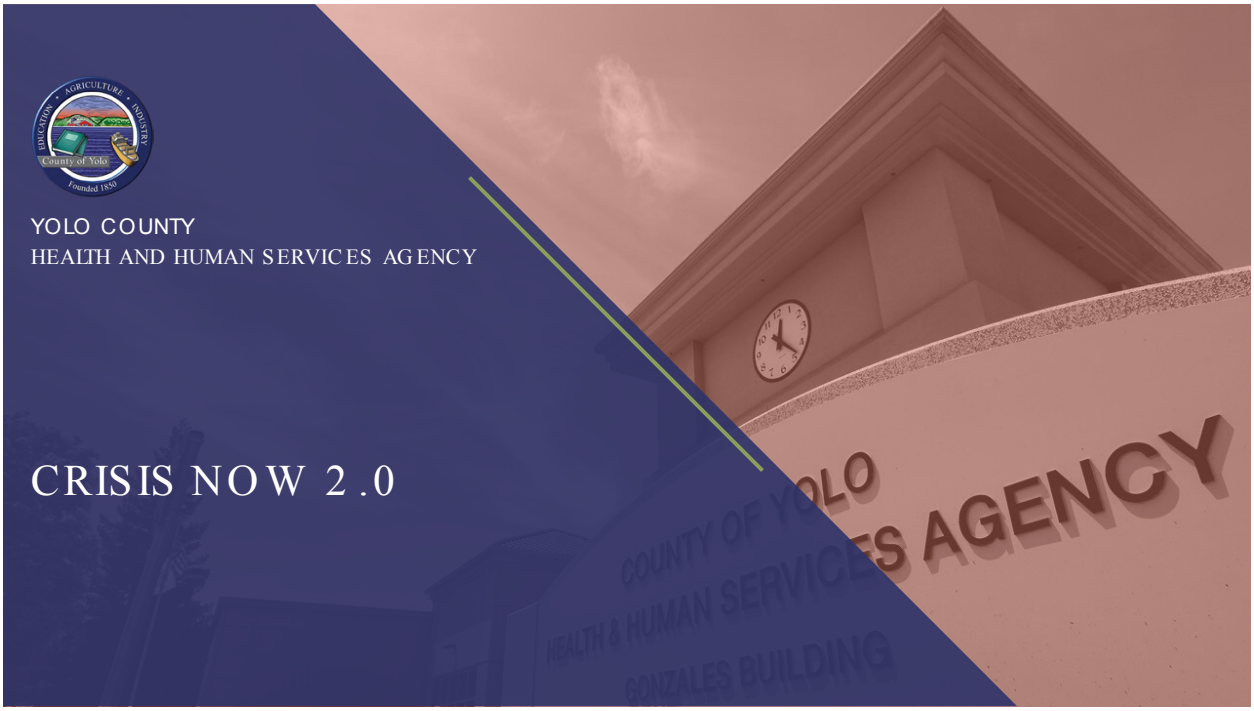
DHCS 1819 (Revised 11/2022)

Appendix 1:

Community Feedback & County Response

Appendix 2:

Crisis Now



AGENDA

- Background
- What is Crisis Now?
  - Components of Crisis Now
- Initial Timeline
- Challenges
- Proposed Timeline
- Deltas

BACKGROUND

- HHSA participated in a 10-month (Sept 2020-July 2021) Crisis Now learning collaborative sponsored by the Mental Health Services Oversight and Accountability Commission (MHSOAC).
- The nationally recognized Crisis Now Model was identified as a solution to several gaps in the Yolo crisis care continuum.
- In an effort to maintain full fidelity to the Crisis Now model, HHSA proposed a project plan that included a facility renovation, an estimated budget, and an ambitious timeline.
- HHSA staff have attempted to implement the proposed plan, but have determined that it's not financially feasible to follow the initial project proposal and timeline.
- The following slides include a new timeline that includes a phased approach to building the Crisis Now model.

WHAT IS CRISIS NOW?

- Access/ Crisis Call Center (24/ 7)
- Co-Responder vs Crisis Responder (24/ 7)
- Receiving Center/ Sobering Center and Short-Term Crisis Residential (24/ 7)

CHALLENGES

Facility: The previously identified site for the Receiving Chairs and Short Term beds proved to be cost prohibitive after initial site plans were created. Staff also encountered significant issues with Call Center Infrastructure.

Budget: Stable long term funding was not identified to support all components of the Crisis Now model in development and operation.

Timeline: The previously proposed timeline assumed stable funding sources, a satisfactory location, and qualified and interested contracted providers to launch the services.

PREVIOUSLY PROPOSED TIMELINE

May 2021- September 2021	October 2021- March 2022	July 2022 - September 2022	Future of Crisis Response
Release RFP for 24/7 Access Line	Locate/ Renovate Site for Receiving/ Sobering Center and Short-Term Crisis Residential	RFP / Contract for Crisis Provider	Moving from Co-Responder to Clinician/ Peer

Phase 1: Planning	Phase 2: High-Tech Call Center	Phase 3: Short-Term Crisis Beds	Phase 4: Crisis Receiving Chairs	Phase 5: System Evaluation
Spring-Fall 2023	Winter 2023	Fall/ Winter 2023	Spring/ Fall 2024	2025/26

UPDATED TIMELINE

	Crisis Now Program Component	Crisis Now 2.0 Projected Cost & Timeline	Delta
1	System Planning	Cost: up to $10,000 in consulting fees + Staff time Timeline: FY22/23-23/24 ↑	HHSA will consult with RI International for Technical Assistance in building out a phased approach, budget, and implementation strategies.
2	High Tech Call Center: 24/7 Access and Crisis Line + Telehealth services	Cost: TBD Timeline: RFP in development ↓	The original proposal intended to create a standalone 24/7 call center that would be constructed by the county, on county property. The revised plan proposes to consolidate services: 1) 24/7 Access and Crisis, 2) 988/Local suicide prevention hotline, and 3) Crisis Now Mobile Dispatch all into one service. This would be contracted out to a local call center provider.
3	Mobile Crisis	Cost: $1.4 mil/FY Timeline: N/A =	Projected costs and primary functions of current co-responder teams will not change. There may be an expansion to include after-hours coverage aligned with a mobile crisis Medi-Cal benefit implementation later this year.
4	Short Term Beds	Cost: $1.3 mil/FY Timeline: Fall/Winter 2023 ↓	16 beds were suggested in the original proposal. HHSA will start with a smaller number of beds (~6) and intends to contract out beds with a local provider in lieu of the original plan to build a county bed facility. This would increase transportation costs but significantly decrease construction and ongoing facility costs.
5	Receiving Chairs	Cost: $3.4 mil/FY Timeline: Spring/Fall 2024 ↓	Reduction of chairs from 10-12 to 6-8. Chairs will not be co-located with short term beds.
6	System Evaluation	Cost: ~$15,000 Timeline: FY25/26 ↑	System evaluation was not built into the original budget. HHSA recommends including a small budget for 3rd party evaluation after the 3-year pilot is complete.

County of Yolo
www.yolocounty.org

To: The Chair and Members of the Board of Supervisors

Time Set # 30.

Board of Supervisors

Meeting Date:	05/23/2023
Brief Title:	Crisis Now Update
From:	Nolan Sullivan, Director, Health and Human Services Agency
Staff Contact:	Nolan Sullivan, Director, Health and Human Services Agency, x3826
Supervisorial District Impact:	Countywide

Subject

Receive informational update regarding the Yolo County Health and Human Services Agency's development and implementation of the Crisis Now continuum. (No general fund impact) (Sullivan) (Est. Time: 20 minutes)

Recommended Action

Receive informational update regarding the Yolo County Health and Human Services Agency's development and implementation of the Crisis Now continuum, including an updated approach to the project and a timeline for next steps.

Strategic Plan Goal(s)

Thriving Residents

Safe Communities

Reason for Recommended Action/Background

Yolo County, in partnership with local jurisdictions, law enforcement and healthcare systems have worked collaboratively over the last several years towards achieving a Crisis Now system in Yolo County to address the behavioral health crisis continuum of care. The Crisis Now model has three (3) main components (someone to call, someone to come, and somewhere to go) which are detailed below. The Crisis Now model is intended to create a countywide crisis system that works for all involved and serves anyone in need, and therefore this project focuses on Medi-Cal, Medicare, Private insurance, and the Uninsured population.
Crisis Now Components:

1. 24/7 Crisis and Access line: receiving all Crisis and Access calls in Yolo County regardless of insurance type, providing crisis linkage/dispatch, and brief screening and transfer to appropriate services.
2. Mobile Crisis Teams: clinician and peer teams in place to dispatch throughout Yolo for mobile response.
3. Crisis Receiving Center(s): includes two levels of care - the first is a 24/7 drop-off or walk-in behavioral health receiving center that would serve anyone in need of crisis support whether it is substance use or mental health related. The receiving “chairs” can serve clients for up to 23 hours for evaluation, support, and stabilization. The second level of care would be short-term acute beds where clients would remain for an average of four (4) days and these beds would be available to support those not stabilizing in the first 23 hours and needing to be transitioned for more support.

This critical project has experienced several challenges during the development phase. The HHSA Crisis Now team will provide the Board of Supervisors and subsequently the Local Mental Health Board and other stakeholders an update that will unveil a reimagined approach to implementing the essential components of the Crisis Now model - someone to call, someone to come, and somewhere to go. This will involve a shift to a phased approach to the full Crisis Now implementation. Additionally, HHSA is working with RI International, the developers of the Crisis Now model, for technical assistance during this process. This phased approach is expected to offer additional opportunities for collaboration and may provide funding stability should the planned 3-year pilot prove valuable to the community.

Collaborations (including Board advisory groups and external partner agencies)

Yolo County Health and Human Services Agency
Local Law Enforcement Jurisdictions
Local Healthcare Systems (Dignity, Sutter, UC Davis)
Yolo County Local Mental Health Board (LMHB)
Community Corrections Partnership and Related Partner Agencies (District Attorney, LEAs, Probation, Public Defender)
RI International

Fiscal Impact

No Fiscal Impact

	Fiscal Impact (Expenditure)
Total cost of recommended action:	$

Amount budgeted for expenditure:	$
Additional expenditure authority needed:	$
On-going commitment (annual cost):	$

Source of Funds for this Expenditure

$0

Attachments

Att. A. Presentation

Form Review

Inbox	Reviewed By	Date
Nolan Sullivan	Nolan Sullivan	04/10/2023 03:57 PM
Shapree Butler	Shapree Butler	04/24/2023 12:58 PM
Form Started By: Tracey Dickinson		Started On: 07/14/2022 01:53 PM
Final Approval Date: 05/09/2023		

Appendix 3:

Performance Outcomes

Yolo County

Performance Outcomes FY 21-22

(Results Based Accountability data)

(July 1, 2021, to June 30, 2022)

ADULT WELLNESS PROGRAM

Program: Adult Wellness Program					
Provider: TLCS, Inc dba Hope Cooperative; Telecare Corporation					
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**	**Full Year**
Number of FTEs onsite at permanent supportive housing locations	2 FTEs provided along with additional staff to support these 2 FTEs				
Number of beneficiaries served during reporting period	105	138	72	160	160 clients by the end of FY
Number of newly enrolled beneficiaries during the reporting period	60	34	18	9	
Total service hours broken out by: Medication Support; Case Management/Rehab; Individual & Group Therapy; Crisis Intervention	1,631	2,756	1,575	2,522	8,484 total hours of service
Beneficiary Demographics broken out by: Age; Gender; Race, Ethnicity; and Primary and Secondary Diagnosis	Demographics report provided as separate attachment.				
Percentage of no-shows for prescribing staff (psychiatrists and nurse practitioners)	8%	8%	14%	13%	Average 11%
Percentage of no-shows for non-prescribing staff (clinicians, case managers and nurses)	8%	8%	4%	9%	Average 7%
Percentage of beneficiaries that voluntarily discontinued FSP services (program total)	0%	1%	0%	0%	Average 0%
Percentage of beneficiaries referred for FSP assessment accepted into the FSP program	99%	100%	84%	100%	Average 96%
Percentage of beneficiaries seen for post hospital follow-up within 7 calendar days of discharge	100%	100%	100%	97%	Average 99%
Percentage of beneficiaries who are contacted within 4 hours of hospital or jail notification for discharge	98%	98%	97%	97%	Average 98%
Percentage of beneficiaries reporting satisfaction with FSP services	Satisfaction surveys results were not available				
Percentage of referred beneficiaries contacted within 2 calendar days from HHSA referral	85%	100%	100%	100%	Average 96%
Number of days beneficiaries experienced homelessness while enrolled compared to prior 12-month period (Total)	Number of days beneficiaries experienced homelessness went down to 625 days during FY 21-22 as compared to 4,535 days of homelessness in prior 12-month period				
Number of days beneficiaries experienced incarceration while enrolled compared to prior 12-month period (program total)	Data was not available in DCR outcomes report				

Program: Adult Wellness Program					
Provider: TLCS, Inc dba Hope Cooperative; Telecare Corporation					
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**	**Full Year**
Number of days beneficiaries experienced psychiatric hospitalization while enrolled compared to prior 12-month period (program total)	Number of days beneficiaries experienced psychiatric hospitalization went down to 335 days during FY 21-22 as compared to 1,135 days during prior 12-month period				
Number of days beneficiaries employed while enrolled compared to prior 12-month period (program total)	Data was not available in DCR outcomes report				
Number of days beneficiaries enrolled in school while enrolled compared to prior 12-month period (program total)	N/A				
Number of beneficiaries who have met goals and stepped down to a lower level of care	Data not available as program just started during FY 21/22				
Percentage of beneficiaries who have met goals and stepped down to a lower level of care	Data not available as program just started during FY 21/22				

Subprogram: Wellness Centers					
Provider: Yolo County Health & Human Services Agency					
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
Total FTE	6 FTEs during FY				
Number of unduplicated participants at the Wellness Centers quarterly	106	129	163	233	631
Number of visits to the Wellness Centers (including duplicated participants) quarterly	810	579	334	422	2,145
Number of groups offered quarterly	77	145	279	285	786
Number of unduplicated group participants quarterly	59	73	90	184	406
Number of participants across all groups (including duplicated participants) quarterly	432	410	279	146	1,267
Number of food bags distributed quarterly	841	333	180	319	1,673
Number of outings quarterly	Wellness Center suspended outings due to COVID-19 restrictions.				
Number of participants in outings quarterly	Wellness Center suspended participant outings due to COVID-19 restrictions.				
Percentage of participants who reported they felt respected	88%	88%	100%	94%	Average 93%
On average, 93% of participants reported they felt respected.					
Percentage of participants who reported their needs were met	75%	88%	100%	81%	Average 86%
On average, 86% of participants reported their needs were met.					
% Of weekly groups attended	100%	94%	88%	100%	Average 96%

Subprogram: Wellness Centers					
Provider: Yolo County Health & Human Services Agency					
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
On average, 96% of participants attended weekly groups.					
Number of participants who reported they felt more connected or made at least one friend	7	7	17	15	46
Percentage of participants who reported they felt more connected or made at least one friend	88%	77%	94%	100%	Average 90%
Number of participants who reported they felt less isolated	8	7	16	15	46
Percentage of participants who reported they felt less isolated Note:	100%	77%	94%	94%	Average 91%
Number of participants who reported they felt comfortable at the center	0	8	9	15	32
Percentage of participants who reported they felt comfortable at the center	0%	80%	90%	94%	Average 66%
Number of participants who were able to identify at least one way to support wellness and recovery	8	9	16	16	49
Percentage of participants who were able to identify at least one way to support wellness and recovery	100%	100%	94%	100%	Average 99%

CHILDREN'S MENTAL HEALTH SERVICES

Program: Access & Crisis				
Provider: Yolo County Health & Human Services Agency				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Number of unduplicated clients served	191	274	229	195
Number of client contacts from Yolo County HHSA access line	67	78	87	90
Number of client contacts from psychiatric hospitals	42	49	48	33
Number of client contacts from school-based access & linkages program	2	3	3	1
Number of client contacts from Yolo County HHSA child welfare services	59	76	54	42
Number of client contacts from external child welfare services (presumptive transfers)	14	8	9	8
Percentage of clients who were offered a mental health assessment within 10 business days or 14 calendar days of service request	ND*	ND	ND	ND
Percentage of clients seen for first mental health service post hospital discharge within 7 calendar days	ND	ND	ND	ND
Number of clients that were linked to mental health services	ND	ND	ND	ND
Percentage of clients that were linked to mental health services	ND	ND	ND	ND
Number of clients who received a crisis assessment who do not have a repeated crisis assessment within 30 calendar days	ND	ND	ND	ND
Percentage of clients who received a crisis assessment who do not have a repeated crisis assessment within 30 calendar days	ND	ND	ND	ND
Number of clients who were psychiatrically hospitalized who do not have a repeated hospitalization within 6 months	37	74	N/A	N/A

Program: Access & Crisis				
Provider: Yolo County Health & Human Services Agency				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Percentage of clients who were psychiatrically hospitalized who do not have a repeated hospitalization within 6 months	78%	82%	N/A	N/A

*ND: No data to report.

Subprogram: Training & Outreach		
Provider: Yolo County Health & Human Services Agency		
Performance Measure	**H1 (Q1/Q2)**	**H2 (Q3/Q4)***
Number of caregivers trained	11	
Number of community partners trained	0	
Number of school personnel trained	0	
Number of community events attended or hosted	1	
Percentage of participants who reported they found training content to be useful and relevant	100%	
Percentage of participants who reported they would recommend the training to a colleague, friend, and family member	N/A**	
Number of participants who reported they could better identify mental health symptoms as a result of the training	N/A	
Percentage of participants who reported they could better identify mental health symptoms as a result of the training	N/A	
Number of participants who reported they better knew how to access mental health services as a result of the training	N/A	
Percentage of participants who reported they better knew how to access mental health services as a result of the training	N/A	
Number of participants who reported they increased their capacity to respond appropriately to children with mental health symptoms as a result of the training	11	
Percentage of participants who reported they increased their capacity to respond appropriately to children with mental health symptoms as a result of the training	100%	

*Note: H2 data are not reported because no training or outreach was documented or logged during the second half of the year
** In H1 a survey had not been developed to gather this information from participants.

Subprogram: Treatment				
Provider: Yolo County Health & Human Services Agency				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Total FTE	7	7	6	6
Number of open clients	35	44	50	43
Number of intakes	12	15	18	14
Number of unplanned discharges	6	3	6	0
Number of successful discharges	5	4	5	4
Number of closed referrals	9	4	11	12
Number of referrals received	14	18	22	18
Number of children eligible for IHBS criteria	1	11	10	7
Number of children served who are non-English speakers	1	1	2	1
Number of families served who are non-English speakers	8	8	8	6

Subprogram: Treatment				
Provider: Yolo County Health & Human Services Agency				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Percentage of clients who received an intake assessment with 10 business days of service request	100%	95%	98%	89%
On average, 96% clients received an intake assessment with 10 business days of service request				
Percentage of clients assessed with Child and Adolescent Needs and Strengths (CANS) within 30 days	100%	100%	100%	100%
On average, 100% clients were assessed with Child and Adolescent Needs and Strengths (CANS) within 30 days				
Percentage of clients assessed with CANS at discharge	100%	100%	100%	100%
On average, 100% of clients were assessed with CANS at discharge				
Percentage of open clients assessed with 6-month CANS	100%	100%	100%	100%
On average, 100% of open clients were assessed with 6-month CANS				
Number of days to successful discharge	483	688	673	366
On average, 553 was the number of days to successful discharge				
Percentage of Intensive Care Coordination (ICC) and intensive Home-Based Services (IBHS) eligible clients with facilitated Child and Family Team (CFT) every 90 days	89%	92%	85%	100%
On average, 92% of ICC and IBHS eligible clients were facilitated CFT every 90 days				
Percentage of clients who successfully met treatment plan goals	65%	84%	100%	100%
On average, 87% of clients successfully met treatment plan goals				
Percentage of clients who received 1st clinical appointment within 7 business days post psychiatric hospitalization	ND	ND	ND	ND
Percentage of clients who received 1st psychiatric follow up within 15 business days post psychiatric hospitalization	ND	ND	ND	ND
Number of clients with decrease in number of items needing action on Child Behavioral/Emotional Needs section of CANS from intake to discharge	3	5	5	4
Percentage of clients with decrease in number of items needing action on Child Behavioral/Emotional Needs section of CANS from intake to discharge	83%	84%	100%	100%
Number of clients with decrease in number of items needing action on Life Domain Functioning section of CANS from intake to discharge	3	5	4	4
Percentage of clients with decrease in number of items needing action on Life Domain Functioning section of CANS from intake to discharge	100%	100%	100%	100%
Number of clients with decrease in number of items needing action on Caregiver Resources and Needs section of CANS from intake to discharge	2	3	2	1

Subprogram: Treatment				
Provider: Yolo County Health & Human Services Agency				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Percentage of clients with decrease in number of items needing action on Caregiver Resources and Needs section of CANS from intake to discharge	100%	100%	67%	25%
Number of clients with decrease in number of items needing action on Risk Behaviors section of CANS from intake to discharge	2	4	1	2
Percentage of clients with decrease in number of items needing action on Risk Behaviors section of CANS from intake to discharge	75%	100%	50%	50%
Number of clients who remained in their home or maintained foster home placement	15	11	41	247
Percentage of clients who remained in their home or maintained foster home placement	98%	81%	91%	97%

CHILDREN'S MENTAL HEALTH SERVICES- FSP

Program: Children's Mental Health Services - FSP				
Provider: Turning Point Community Programs				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Total FTE	7	6	6	6
Number of open and authorized clients	29	31	33	31
Number of intakes	10	9	8	5
Number of unplanned discharges	5	2	4	9
Number of successful discharges	6	5	0	7
Number of referrals received	12	11	12	7
Number of children meeting ICC or IHBS criteria	22	22	13	17
Number of children served who are non-English speakers	6	1	3	3
Percentage of clients who received an intake assessment within 10 days of referral	90%	67%	75%	60%
On average, 73% of clients received an intake assessment within 10 days of referral				
Percentage of clients who successfully met treatment plan goals	100%	83%	0%	88%
% of clients assessed with Child and Adolescent Needs and Strengths (CANS) within 30 days	67%	86%	100%	25%
% of discharged clients with a CANS completed at discharge	50%	71%	0%	75%
% of clients assessed with a 6-month CANS	80%	71%	30%	50%
Percentage of clients who received 1st clinical appointment within 7 days post psychiatric hospitalization	N/A	N/A	100%	N/A
On average, 100% clients received 1st clinical appointment within 7 days post psychiatric hospitalization. No clients were hospitalized in Q1, 2 or 4.				

Program: Children's Mental Health Services - FSP				
Provider: Turning Point Community Programs				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Percentage of clients who received 1st psychiatric follow up within 30 days post psychiatric hospitalization	N/A	N/A	N/A	N/A
There were no hospitalizations in Q1, 2 or 4. For the client who was hospitalized in Q3 there was no psychiatric/medication needs requiring follow up post hospitalization.				
Number of days to successful discharge (quarterly average)	567	455	0	292
Percentage of ICC and IHBS eligible clients with facilitated CFT every 90 days	71%	90%	90%	82%
On average, 83% of ICC and IHBS eligible clients were facilitated CFT every 90 days				
Number of clients with decrease in number of items needing action on Child Behavioral/Emotional Need section of CANS from intake to discharge	2	5	0	7
Percentage of clients with decrease in number of items needing action on Child Behavioral/Emotional Need section of CANS from intake to discharge	100%	100%	N/A	100%
Number of clients with decrease in Number of items needing action on Life Domain Functioning section of CANS from intake to discharge	1	2	N/A	7
Percentage of clients with decrease in number of items needing action on Life Domain Functioning section of CANS from intake to discharge	50%	100%	N/A	100%
Number of clients with decrease in Number of items needing action on Caregiver Resources and Needs section of CANS from intake to discharge	N/A	N/A	N/A	4
Percentage of clients with decrease in Number of items needing action on Caregiver Resources and Needs section of CANS from intake to discharge	N/A	N/A	N/A	100%
Number of clients who remained in their home (without jail or psychiatric hospital admits) or maintained foster home placement	29	27	26	27
Percentage of clients who remained in their home (without jail or psychiatric hospital admits) or maintained foster home placement	100%	100%	96%	96%

CO-OCCURRING DISORDER ASSESSMENT AND INTAKE-AB2265

Program: Co-Occurring Disorder Assessment and Intake -AB2265	
Provider: Yolo County Health and Human Services Agency, CommuniCare Health Centers	
Performance Measure	**Full Year**
Co-occurring assessments completed	225
Number of assessments resulting in a client with ONLY an SUD diagnosis identified	26
Percentage of assessments resulting in a client with ONLY an SUD diagnosis identified	10%

COMMUNITY-BASED NAVIGATION CENTER

Program: Community-Based Navigation Center		
Provider: CommuniCare Health Centers		
Performance Measure	**H1 (July 1, 2021-December 31, 2021)**	**H2 (January 1, 2022-June 30, 2022)**
Number of unduplicated clients who visited Navigation Center	235	134+
Note: H1 – Due to Covid-19, services were mostly provided by phone. However, not all calls made to Navigation Center are tracked. H2 (January to June 2022) – 134 clients had contact for a service. This does not include phone and in-person contacts that didn't result in a service.		
Number of unduplicated Beacon Triage Screenings completed	186	104
Note: H1 - 26 were triage/MH walk ins and 160 were assessments. H2 - 58 were as a part of a specialty mental health services (SMHS) assessment. 46 were with triage clients who did not go on to complete an assessment.		
Number of unduplicated SMHS assessments completed	101	75
Note: H1-160 appts scheduled, 101 completed. 76 completed/sent to UMC for SMHS; 160 unique appts scheduled; 25 completed or were referred to mild or moderate services. H2 – 118 assessments were scheduled. 30 did not attend, and 13 had contact but declined assessment.		
Number of unduplicated substances use disorder assessments completed	4	8
Number of unduplicated clients provided with transportation	41	8
Note: H1-30 received van transportation; 11 received car transportation. H2-Many of these clients received multiple transportation services. Type of transportation was only provided in H1		
Number of unduplicated clients provided with peer support assistance	This information was not collected during H1	9
Number of unduplicated clients provided with direct subsidy assistance	0	5+

Note: H2 – Five clients received direct individual subsidy. Food and beverages were offered to all clients at the Navigation Center.		
Number of psychiatric hold applications completed	1	1
Note: H2 – One 5150 hold application was completed. Three clients did not meet 5150 criteria but voluntarily presented to the emergency department.		
Number of Triages/Crisis Interventions completed	39	0
Percentage of clients who report they are satisfied with Navigation Center services	87% (Unduplicated clients who reported “satisfied” & “somewhat satisfied”)	80% (Unduplicated clients who reported “satisfied” or “somewhat satisfied”)
Number of unduplicated clients who successfully link with a SMHS assessment appointment	76	75
Note: H1 - 76 of 160 were linked to SMHS appointment; 51 of 76 were referred to county psychiatry and successfully linked; 19 completed or were referred to mild or moderate services; six declined assessment services. H2 – 118 SMHS assessments were scheduled. 75 completed, 30 did not attend, and 13 declined assessments.		
Percentage of unduplicated clients successfully linked with an SMHS assessment appointment	48%	64%
Note: H1 – 48% linked with SMHS appointment; 63% of 76 were referred to county psychiatry and successfully linked; 25% completed, were referred to mild or moderate service. 8% declined assessment services.		
Number of unduplicated clients who successfully link with a SMHS psychiatric appointment	51	39
Note: H2 – 52 clients were scheduled for SMHS psychiatry. 10 did not attend, and three were scheduled outside the date range of this report.		
Percentage of unduplicated clients who successfully link with a SMHS psychiatric appointment.	67%	75%

Program: MH Crisis Services – Co-Responder Program				
Provider: Yolo County Health & Human Services Agency				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Number of unduplicated clients served.	306	337	334	302
Number of Co-Responder clinician responses.	450	524	595	449
Number of clients referred by Law Enforcement Agency	183	154	167	164
Percentage of clients referred by Law Enforcement Agency	41%	29%	28%	37%
Number of clients referred by Family/Self	131	197	254	185
Percentage of clients referred by Family/Self	29%	38%	43%	41%
Number of clients referred by HHSA/community MH or SUD provider	24	36	48	50
Percentage of clients referred by HHSA/community MH or SUD provider	5%	7%	8%	11%
Number of clients referred by Other	100	129	128	50
Percentage of clients referred by Other	22%	25%	22%	11%
Number of clients referred for Crisis needs	268	277	294	230
Percentage of clients referred for Crisis needs	60%	53%	49%	51%
Number of clients referred for Mental Health needs	116	141	172	130
Percentage of clients referred for Mental Health needs	26%	27%	29%	29%
Number of clients referred for Crisis Substance Use Disorder needs	12	29	45	43
Percentage of clients referred for Crisis Substance Use Disorder needs	3%	6%	8%	10%
Number of clients referred for other needs	52	72	86	46
Percentage of clients referred for other needs	11%	14%	15%	10%
Number of minutes spent providing training or presentations/consulting/reviewing holds written with law enforcement personnel. Note: This data was not collected in Q4.	7,376	3,142	2,354	N/A
Average clinician response time (from request notification to initial in-person contact with client) in minutes	17	24	39	24
Average clinician time spent on scene (in minutes)	46	43	44	46
Average law enforcement officer wait time for clinician response (in minutes) Note: This data was not collected in Q3 or Q4.	9	10	N/A	N/A
Percentage of law enforcement personnel who reported satisfaction with Co-Responder Project services Note: This data was not collected in Q3 or Q4.	92%	92%	N/A	N/A
Number of clients served who were not placed on an involuntary hold	397	447	539	419
Percentage of clients served who were not placed on an involuntary hold	88%	85%	91%	93%

Number of clients served who were not arrested/taken to jail	436	511	588	443
Percentage of clients served who were not arrested /taken to jail	97%	98%	99%	99%
Number of client served who were linked to an HHSA/community provider mental health and/or substance use provider	71	134	173	59
Percentage of client served who were linked to an HHSA/community provider mental health and/or substance use provider	42%	30%	29%	25%
Number of clients referred to an HHSA/community provider for homeless services	22	43	77	25
Percentage of clients referred to an HHSA/community provider for homeless services	14%	10%	13%	15%

ACCESS & CRISIS

Subprogram: Access & Crisis					
Provider: Yolo County Health & Human Services Agency					
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
Number of involuntary holds written Note: This data was not collected in Q3 and Q4.	47	58	N/A	N/A	105
Number of unduplicated clients receiving a crisis service	283	287	328	315	1,213
Number of total crisis services provided	406	380	464	457	427
Number of individuals with a crisis contact who do not have a repeat crisis contact within 30 calendar days	1,481 Note: This data was only tracked for the entire FY				
Percentage of individuals with a crisis contact who do not have a repeat crisis contact within 30 calendar days	87% Note: This data was only tracked for the entire FY				

OLDER ADULT OUTREACH AND ASSESSMENT PROGRAM (FSP)

Program: Older Adult Outreach and Assessment Program (FSP)				
Provider: TLCS, Inc dba Hope Cooperative				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Number of FTEs onsite at permanent supportive housing locations	2 FTEs onsite at both permanent supportive housing sites			
Number of beneficiaries served during reporting period	16	17	18	19
Number of newly enrolled beneficiaries during the reporting period	16	1	2	1

Total service hours broken out by: Medication Support; Case Management/Rehab; Individual & Group Therapy; Crisis Intervention	432	608	574	398
Beneficiary Demographics broken out by: Age; Gender; Race, Ethnicity; and Primary and Secondary Diagnosis	Demographics data was provided as separate attachments			
Number of Senior Peer Counseling referrals were made	0	0	2	0
Percentage of no-shows for prescribing staff (psychiatrists and nurse practitioners)	1%	10%	7%	0%
Percentage of no-shows for non-prescribing staff (clinicians, case managers and nurses)	0%	5%	2%	0%
Percentage of beneficiaries that voluntarily discontinued FSP services (program total)	0%	0%	0%	0%
Percentage of beneficiaries referred for FSP assessment accepted into the FSP program	100%	100%	50%	100%
Percentage of beneficiaries seen for post hospital follow-up within 7 calendar days of discharge	100%	100%	100%	100%
Percentage of beneficiaries who are contacted within 4 hours of hospital or jail notification for discharge	100%	100%	100%	100%
Percentage of beneficiaries reporting satisfaction with FSP services	Satisfaction surveys results were not available from the provider.			
Percentage of referred beneficiaries contacted within 2 calendar days from HHSA referral	100%	100%	100%	100%
Number of days beneficiaries experienced homelessness while enrolled compared to prior 12-month period (program total)	0 (None of the older adult beneficiaries experienced homelessness while enrolled in the program).			
Number of days beneficiaries experienced incarceration while enrolled compared to prior 12-month period (program total)	0 (None of the older adult beneficiaries experienced incarceration while enrolled in the program).			
Number of days beneficiaries experienced psychiatric hospitalization while enrolled compared to prior 12-month period (program total)	0 (None of the older adult beneficiaries experienced psychiatric hospitalization while enrolled in the program).			
Number of days beneficiaries employed while enrolled compared to prior 12-month period (program total)	0 (None of the older adult beneficiaries was employed while enrolled in the program).			
Number of days beneficiaries enrolled in school while enrolled compared to prior 12-month period (program total)	0 (None of the beneficiaries were enrolled in school while enrolled in the program)			

Number of beneficiaries who have met goals and stepped down to a lower level of care	4
Percentage of beneficiaries who have met goals and stepped down to a lower level of care	13%

PATHWAYS TO INDEPENDENCE

Program: Pathways to Independence (FSP)				
Provider: Telecare Corporation				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Number of FTEs onsite at permanent supportive housing locations	2 FTEs onsite during FY			
Number of beneficiaries served during reporting period	15	17	19	19
Number of newly enrolled beneficiaries during the reporting period	12	1	2	2
Total service hours broken out by: Medication Support; Case Management/Rehab; Individual & Group Therapy; Crisis Intervention	212	346	138	335
Beneficiary Demographics broken out by: Age; Gender; Race, Ethnicity; and Primary and Secondary Diagnosis	Demographic reports were provided as separate attachment			
Number of EDAPT referrals made	0	0	0	0
Percentage of no-shows for prescribing staff (psychiatrists and nurse practitioners)	3%	5%	5%	15%
Percentage of no-shows for non-prescribing staff (clinicians, case managers and nurses)	0%	10%	10%	14%
Percentage of beneficiaries that voluntarily discontinued FSP services (program total)	0%	0%	0%	0%
Percentage of beneficiaries referred for FSP assessment accepted into the FSP program	100%	100%	100%	100%
Percentage of beneficiaries seen for post hospital follow-up within 7 calendar days of discharge	100%	100%	100%	100%

Program: Pathways to Independence (FSP)				
Provider: Telecare Corporation				
Percentage of beneficiaries who are contacted within 4 hours of hospital or jail notification for discharge	95%	95%	98%	100%
On average, 97% of beneficiaries were contacted within 4 hours of hospital or jail notification for discharge				
Percentage of beneficiaries reporting satisfaction with FSP services	Satisfaction survey results were not available from the provider.			
Percentage of referred beneficiaries contacted within 2 calendar days from HHSA referral	70%	70%	100%	N/A
On average, 80% of referred beneficiaries were contacted within 2 calendar days from HHSA referral				
Number of days beneficiaries experienced homelessness while enrolled compared to prior 12-month period (program total)	Data was not available for # of days. However, only one beneficiary experienced homelessness while enrolled compared to 5 Partners during prior 12-month period.			
Number of days beneficiaries experienced incarceration while enrolled compared to prior 12-month period (program total)	Data was not available for # of Days. However, 2 beneficiaries experienced incarceration while enrolled in the program			
Number of days beneficiaries experienced psychiatric hospitalization while enrolled compared to prior 12-month period (program total)	0 (None of the beneficiary experienced psychiatric hospitalization while enrolled in the program)			
Number of days beneficiaries employed while enrolled compared to prior 12-month period (program total)	Data was not available for # of days employed. However, 2 beneficiaries got employed while enrolled in the program.			
Number of days beneficiaries enrolled in school while enrolled compared to prior 12-month period (program total)	Data was not available. However, 98% of the beneficiaries (43/44) were enrolled in school while enrolled in the program			
Number of beneficiaries who have met goals and stepped down to a lower level of care	Data was not available			

Program: Pathways to Independence (FSP)	
Provider: Telecare Corporation	
Percentage of beneficiaries who have met goals and stepped down to a lower level of care	Data was not available

PEER- AND FAMILY-LED SUPPORT SERVICES

Program: Peer-And Family-Led Support Services				
Provider: NAMI Yolo County				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Number of NAMI staff hours Note: No hours were provided in Q2 as there was no active volunteers due to the pandemic.	430	N/A	412	563
Number of NAMI volunteer hours Note: No hours were provided in Q2; only a note that there were 42 volunteers. Q1 and Q3 have more hours because the executive director position was vacant, and the Volunteer Board was putting in a significant number of hours. By Q4, most of those duties shifted to paid staff. Additionally, there were no events in Q4, which usually results in a higher number of volunteer hours.	4,400	N/A	1,006	300
Number of NAMI Peer to Peer educational classes offered	1	0	1	0
Number of NAMI Basics educational classes offered	1	0	0	0
Number of NAMI Family to Family educational classes offered	1	0	1	0
Number of NAMI Familia to Familia educational classes offered	0	0	0	0
Number of NAMI Family Support Group sessions offered	8	4	6	4
Number of NAMI Connection sessions offered	24	27	27	31
Number of Basics support group sessions offered	2	6	6	4
Number of Family support group in Spanish sessions offered	0	10	10	12
Number of Young Adults Connection support group sessions offered	0	0	6	6
Number of NAMI First Wednesday Gathering community educational presentations provided	1	1	1	3
Number of NAMI Salud Mental 101 community educational presentations provided	0	1	0	0
Number of NAMI Mental Health 101 community education presentations provided	0	1	0	0
Number of NAMI In Our Own Voice community education presentations provided	0	0	0	0

Number of NAMI Faith Net community education presentations provided	0	0	0	1
Number of NAMI Ending the Silence community education presentations provided	0	0	0	1
Number of unduplicated NAMI Educational class participants	24	0	20	0
Number of unduplicated NAMI Support Group session participants	27	70	58	60
Number of unduplicated NAMI Community Educational presentation attendees	43	50	47	133
Number of volunteers recruited and/or trained in the quarter	9	2	0	0
Percentage of Support Group or Educational class participants that reported increased ability to manage stress.	90%	91%	86%	85%
Percentage of Support Group or Educational class participants that reported increased ability to recognize the signs and symptoms of mental illness.	90%	87%	67%	62%
Percentage of Support Group or Educational class participants that reported increased access to community resources.	71%	63%	62%	54%
Percentage of Support Group or Educational class participants that reported increased support as a result of group involvement.	92%	81%	90%	100%
Percentage of Community Education Presentations that reported increased understanding of mental illness and associated stigma.	50%	not measured this quarter	70%	85%
Percentage of Community Education Presentations that reported increased ability to recognize the signs and symptoms of mental illness.	50%	76%	not measured this quarter	85%
Percentage of Community Education Presentations that reported increased access to community resources.	100%	87%	90%	not measured this quarter

Percentage of First Wednesday Gathering attendees reported having increased access to community resources	no First Wed Gatherings this quarter due to COVID	96%
Percentage of First Wednesday Gathering attendees reported having an increased ability to recognize the signs and symptoms of mental illness	no First Wed Gatherings this quarter due to COVID	71%
Percentage of First Wednesday Gathering attendees reported having an increased understanding of mental illness and associated stigma	no First Wed Gatherings this quarter due to COVID	79%

SENIOR PEER SUPPORT PROGRAM (FORMERLY SENIOR PEER COUNSELING)

Program: Senior Peer Support Program				
Provider: Yolo CARES				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Total FTE	1	2	2	1
Senior Peer Counselors	5	6	5	5
Total # of older adults served by YH/CWC	8	8	8	5
Total # of Family members receiving support from volunteers	0	0	0	0
Total # of Senior Peer Counselor volunteers recruited	0	1	0	4
Total # of older adults referred to services	1	1	1	2
# of volunteer hours of service rendered to older adults and their families	65.75 hours	35.08 hours	33.16 hours	29 hours
# of volunteer hours spent in training for service	6	5	3	12
# & % of older adults who reported improvement in their overall mental wellness as a result of contact with Senior Peer Counselor Program Volunteer	3 (37.5%)	6 (75%)	3 (75%)	5 (100%)
# & % of older adults who reported an ability to maintain level of self-care/independence as a result of contact with Senior Peer Counselor volunteers	0 (0%)	6 (75%)	3 (75%)	5 (100%)
# & % of 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	1 (12.5%)	6 (75%)	3 (75%)	5 (100%)

IBHS FOR LATINO COMMUNITY AND FAMILIES

Program: IBHS - Creando Recursos y Enlaces Paran Oportunidades (CREO)
Provider: CommuniCare Health Centers

Performance Measure	Q1	Q2	Q3	Q4
Total # of participants served	102	113	104	109
Total # of participants identifies as male heads of household	28	6	12	8
Total # of participants who received services in Spanish as their preferred language	102	113	104	109
Total # of FTE Promotores actively involved in the program	1	1	1	1
Total # of unduplicated participants who received a whole person health screening	29	28	37	29
Total # of outreach events (minimum one per week)	28	48	43	35
Average # of participants at outreach events	45	65	37	52
Total # of group counseling “platicas”	12	11	13	13
Average # of participants at group counseling	18	20	18	17
Total # of advisory panel meeting that included representatives from the target population and community-based agencies	0 due to COVID	0 due to COVID	0 due to COVID	0 due to COVID
# and % of participants who reported satisfaction with services.	33 (100%)	28 (100%)	37 (100%)	29 (100%)
Total # of participants referred to Services	61	50	52	44
# & % Of new participants who completed a referral and engaged in treatment	61 (100%)	50 (100%)	52 (100%)	44 (100%)
Average interval between the referral and participants in treatment	25 days	25 days	25 days	25 days
% of program staff trained in using evidence informed and evidence-based practices	100%	100%	100%	100%
# of new participants with reduced stigmatizing attitudes, knowledge and/ or behavior related to mental illness and seeking mental health services	26	25	30	29
Reduced % and # of mental health hospitalization and average length of stay	0 hospitalizations			
% and # of participants who reported increased knowledge of services (e.g., they learned new skills to help them in their mental wellness, how to define health/mental health needs, access culturally sensitive health/ mental health services	21 (75%)	93(82%)	88 (85%)	94 (86%)

RISE LATINO FARMWORKER OUTREACH PROGRAM

Program: IBHS- Promotores				
Provider: RISE, Inc				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Total # of participants served	47	90	54	41
Total # of participants identifies as male heads of household	39	50	10	18
Total # of participants who received services in Spanish as their preferred language	47	59	15	41
Total # of FTE Promotores actively involved in the program	.5	.5	.5	.5
Total # of Yolo County farm outreach events (minimum one per week)	4	12	8	10
Average # of participants at farm outreach events	50	40	25	8
Total # of Latino Male Farmworker conferences	0	0	0	0
Total # of participants at each Latino Male Farmworker Conference	0	0	0	0
Total # of Drop-in opportunities	10	17	8	11
Average # of participants at Drop-in events	3	6	5	3
# and % of participants who reported satisfaction with services.	28 (100%)	17 (100%)	9 (100%)	14 (100%)
Total # of participants referred to Services	13	59	15	14
# & % Of new participants who completed a referral and engaged in treatment	13 (100%)	59 (100%)	15 (100%)	14 (100%)
Average interval between the referral and participants in treatment	7 days	7 days	5 days	5 days
# of new participants with reduced stigmatizing attitudes, knowledge and/ or behavior related to mental illness and seeking mental health services	0	0	0	0
% and # of participants who reported increased knowledge of services (e.g., they learned new skills to help them in their mental wellness, how to define health/mental health needs, access culturally sensitive health/ mental health services	0	0	0	0

TELE-MENTAL HEALTH SERVICES

Program: Tele-mental Health Services												
Provider: Yolo County Health & Human Services Agency												
	Jan	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
All Telehealth*	425	452	488	381	422	522	414	477	485	458	358	363
Percentage of total HHSA services delivered by Telehealth	9.6%	10.9%	10.0%	9.1%	9.6%	12.0%	9.8%	10.0%	10.3%	9.9%	10.3%	12.1%
Unduplicated Clients Served	316	234	260	223	266	293	274	291	307	287	246	227

*Total number of telehealth service hours in Calendar Year 2022.

COLLEGE PARTNERSHIP PROGRAM

Program: College Partnership				
Provider: CommuniCare Health Centers				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Behavioral Health Services				
Number of students served	14	42	51	30
Number of students referred through the Early Alert Interface	0	6	6	1
Number of referrals made to County-based supports and programs	3	9	10	46
Number of students receiving services during peak hours (8:30 a.m. to 4:30 p.m.)	14	37	47	25
Number of students receiving services during after-hours (4:30 p.m. to 7:00 p.m.)	2	5	4	5
Physical Health Services				
Number of students served	7	14	6	8
Number of students receiving services during peak hours (8:30 a.m. to 4:30 p.m.)	7	14	6	8
Social Services				
Number of students served	0	55	43	3
Number of tabling events held	0	0	0	1
Number of health fairs held	0	3	1	0
Number of Flu Shot Clinics held	0	2	0	0
Number of education and learning events held for staff	2	4	2	0
Number of education and learning events held for students	0	5	15	1
Number of students that received services in their primary language of Spanish	0	0	7	4
Number & percentage of students who self-report that they received an initial appointment timely	1/1 (100%)	3/3 (100%)	4/4 (100%)	No responses received during this quarter.
Number & percentage of students satisfied with access to and services provided based on results of the Student Satisfaction Survey	1/1 (100%)	3/3 (100%)	4/4 (100%)	No responses received during this quarter.

Program: College Partnership				
Provider: CommuniCare Health Centers				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Percentage of students seen at the Woodland campus	93%	83%	86%	73%
Percentage of students seen at the Colusa County campus	7%	7%	7%	17%
Percentage of students seen at Lake County campus	0	10%	7%	7%
Number & percentage of students that self-report improved access to behavioral/physical/social services on campus	1/1 (100%)	3/3 (100%)	4/4 (100%)	No responses received during this quarter.
Number & percentage of students that received routine care	7	14	6	8/8 (100%)
Number & percentage of students that self -report improved access to training and education opportunities	1/1 (100%)	3/3 (100%)	4/4 (100%)	No responses received during this quarter
Number & percentage of faculty/staff that self -report improved access to training and education opportunities	6/6 (100%)	9/10 (90%)	No responses received during this quarter.	No responses received during this quarter.
Number & percentage of students that self -report increased knowledge of healthy living habits	1/1 (100%)	3/3 (100%)	4/4 (100%)	No responses received during this quarter.
Number & percentage of faculty/staff that self -report increased knowledge of healthy living habits	6/6 (100%)	8/10 (80%)	No responses received during this quarter.	No responses received during this quarter.

EARLY CHILDHOOD MENTAL HEALTH ACCESS & LINKAGE PROGRAM

Program: Help Me Grow		
Provider: First 5 Yolo		
Performance Measure	**1st 6 months**	**Annual Total**
Total number of FTE Staff	6.15	Missing
Number of “touches” - combination of direct interactions and potential touches (estimate of distributed marketing materials that found audience)	75,316	112,036
Number of trainings conducted for agencies/programs (outreach)	626	1,107
Number trained on HMG Yolo services (parents, providers, community agencies)	47,814	50,539
Number of unique children screened with at least one screening tool (ASQ-3, ASQ-SE, M-CHAT, SEEK, PHQ9)	326	888
Number of re-screens/non-unique screens completed on returning clients with at least one screening tool (YTD)	132	155
Number of medical providers who referred a child to HMG Yolo (unique number of medical homes/offices)	6	6
Number of Developmental Playgroups	167	167

Program: Help Me Grow		
Provider: First 5 Yolo		
Performance Measure	**1st 6 months**	**Annual Total**
Report of who initially contacted HMG on behalf of the child - Primary Caregiver	178	523
Report of who initially contacted HMG on behalf of the child - Medical Professional	61	95
Report of who initially contacted HMG on behalf of the child - Community Agency Representative	211	566
Report of who initially contacted HMG on behalf of the child - Other	429	721
Number of clients entered through the Central Access Point (primary point of contact between HMG and children, families, and providers including electronic intake system or call center)	97	226
Percentage of children/families who received internal resources	56%	59%
Percentage of children families who received referrals for: Developmental Services	9%	9%
Percentage of children/families who received referrals for: Health Services	2%	2%
Percentage of children/families who received referrals for: Social-Emotional/Behavioral Services	5%	3%
Percentage of children/families who received referrals for: Social and Economic Support Services	12%	13%
Percentage child/family receiving a referral out for: Developmental Screening	12%	12%
Percentage child/family receiving a referral out for: Other	4%	2%
Percentage of issues/concerns identified at time of intake that prompted the HMG Interaction: Developmental Concerns	44%	44%
Percentage of issues/concerns identified at time of intake that prompted the HMG Interaction: Physical Health Concerns	13%	12%
Percentage of issues/concerns identified at time of intake that prompted the HMG Interaction: Socio-Emotional/Behavioral Concerns	19%	19%
Percentage of issues/concerns identified at time of intake that prompted the HMG Interaction: Social and Economic Issues	7%	5%
Percentage of issues/concerns identified at time of intake that prompted the HMG Interaction: General Information about HMG	14%	17%
Percentage of issues/concerns identified at time of intake that prompted the HMG Interaction: Other	3%	3%
Number of unique families served	736	
Number of children screened whose entry point was: Community Agency	242	704
Percentage of children screened whose entry point was: Community Agency	74%	Missing
Number of children screened whose entry point was: Child Health Providers	63	125
Percentage of children screened whose entry point was: Child Health Providers	19%	Missing
Number of children screened whose entry point: Other/Unknown	21	59
Percentage of children screened whose entry point: Other/Unknown	6%	Missing
Average number of days it takes a family/provider to receive result after completing a screen (days)	3	4
Length of time between screening completion and first attempt by staff to deliver results to a family/provider (days)	3	3
Number and percentage of children who were screened this Fiscal Year and who scored in the “monitor” range across one or more categories/developmental domains and who were subsequently re-screened within the same fiscal year	29%	29%
Number and percentage of Caregivers/Providers who indicated that they were satisfied with the tools, information, skill-building, and supports provided to support optimal family growth	99%	99%

Program: Help Me Grow		
Provider: First 5 Yolo		
Performance Measure	**1st 6 months**	**Annual Total**
Number and percentage of children successfully connected to at least one service or pending a start date due to a "concern" referral	100%	100%
Number and percentage of children who were screened in the current Fiscal Year, scored in the "monitor" range across one or more categories, and who were re-screened within the same Fiscal Year and had an improved score in at least one of those same categories after receiving internal resources/referrals	84%	84%
Number and percentage of parent/caregivers who report increased knowledge of appropriate activities to facilitate their child's developmental	99%	99%
Number and percentage of services/program gaps identified	0%	0%
Number and percentage of barriers identified	5%	6%

Program: Help Me Grow		
Provider: First 5 Yolo		
Performance Measure	**Semi-Annual**	**Annual Totals**
Unique children were screened with at least one screening tool (ASQ-3, ASQ-SE) to check on their developmental, behavioral, physical, and social wellbeing and connect them to additional support as needed in a timely manner.	561	888
Percentage of children screened who had at least 1 monitor		44%
Percentage of children screened had at least one concern in areas of their development.		38%
Number of unique caregivers received in home therapy		19
Number of developmental playgroups were offered to the community.	88	167
Percentage caregivers/Provider survey respondents indicated they were satisfied with the tools, information, skill-building, and supports provided to support optimal family growth.	98%	99%
Percentage of children who completed their recommended follow-up screen, showed improved scores after receiving internal resources/referrals (i.e., developmental handouts and activities).	67%	84%
Percentage of parents/caregiver survey respondents reported increased knowledge of appropriate activities to facilitate their child's development after participating in developmental playgroups or parent support groups through HMG.	99%	99%
Percentage of clients who engaged in cognitive behavioral therapy showed reduced depression scores and improved functioning based on standardized depression screening tools and feedback surveys.	100%	100%

K-12 SCHOOL PARTNERSHIPS

Program: K-12 School Partnership Services in the Davis Catchment Area				
Provider: CommuniCare Health Centers				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Staff		Chief BH Officer = .0250, Manager = .25 FTE, Supervisor=.40 FTE, Case Manager=1 FTE, Clinician = 1.5FTE, Administrative Assistant=.5 FTE	Chief BH Officer = .0250, Manager = .25 FTE, Supervisor=.40 FTE, Case Manager=1 FTE, Clinician = 3 FTE, Administrative Assistant=.5 FTE	Chief BH Officer = .0250, Manager = .25 FTE, Supervisor=.40 FTE, Case Manager=1 FTE, Clinician = 3 FTE, Administrative Assistant=.5 FTE
Number of unduplicated participants served		Program Participants	Program Participants	Program Participants
		0	24	64
Number of Tier I services (unduplicated)		0	1	1
Number of Tier I services provided (duplicated)		0	1	2
Number of Tier II services (unduplicated)		0	1	15
Number of Tier II services provided (duplicated)		0	1	75
Number of Tier III services (unduplicated)		0	24	64
Number of Tier III services provided (duplicated)		0	105	332
		Timeliness	**Timeliness**	**Timeliness**
Average interval (days) between referral and completion of screening		N/A	14	14
On average, participants received a screening within 14 days of their referral.				
Percentage of participants who receive an assessment within 10 business days of screening		N/A	68%	44%
On average, 56% of participants received an assessment within 10 business days of screening.				
		Referral/Linkage	**Referral/Linkage**	**Referral/Linkage**
Number of participants (with private health insurance) referred to services through their insurance plan		N/A	7	11
Percentage of participants (with private health insurance) referred to services through their insurance plan		N/A	25%	39%

Program: K-12 School Partnership Services in the Davis Catchment Area				
Provider: CommuniCare Health Centers				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Number of participants in treatment services utilizing Medi-Cal billing (managed care)		N/A	3	8
Percentage of participants in treatment services utilizing Medi-Cal billing (managed care)		N/A	13%	13%
Number of participants in treatment services utilizing Medi-Cal billing (SMHS)		N/A	2	5
Number and percentage of participants in treatment services utilizing Medi-Cal billing (SMHS)		N/A	8%	8%
Average number of sessions per participant in therapeutic services		Service Delivery	Service Delivery	Service Delivery
		N/A	4	5
On average, participants in therapeutic services had 4.5 sessions.				
		Participant Satisfaction	**Participant Satisfaction**	**Participant Satisfaction**
Number of participants (including parent/guardians) who reported satisfaction with services		N/A	N/A – data provided in Quarter 4	20
Percentage of participants (including parent/guardians) who reported satisfaction with services		N/A	N/A – data provided in Quarter 4	100%
Number of clients with a decrease in number of items needing action on Child Behavior/Emotional Need section of CANS from intake to discharge		N/A	N/A – 1 client discharged due to disengagement and had no change on this measure	5 of 8 ((4 of 4 [100%] clients who completed the program decreased score)
Percentage of clients with a decrease in number of items needing action on Child Behavior/Emotional Need section of CANS from intake to discharge		N/A	N/A – 1 client discharged due to disengagement and had no change on this measure	63% (4 of 4 [100%] clients who completed the program decreased score)
Number of clients with a decrease in number of items needing action on Life Domain Functioning section of CANS from intake to discharge		N/A	N/A – 1 client discharged due to disengagement and had no change on this measure	4 of 5 (2 of 2 [100%] clients who completed program decreased score)

Program: K-12 School Partnership Services in the Davis Catchment Area				
Provider: CommuniCare Health Centers				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Percentage of clients with a decrease in number of items needing action on Life Domain Functioning section of CANS from intake to discharge		N/A	N/A – 1 client discharged due to disengagement and had no change on this measure	80% (2 of 2 [100%] clients who completed program decreased score)

Program: K-12 School Partnership Services in the Woodland Catchment Area				
Provider: CommuniCare Health Centers				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Staff		Chief BH Officer = .05, Manager = .25 FTE, Supervisor=.60 FTE, Case Manager=1 FTE, Clinician = 1.8 FTE, Administrative Assistant=.6 FTE	Chief BH Officer = .05, Manager = .25 FTE, Supervisor=.60 FTE, Case Manager=1 FTE, Clinician = 2.55 FTE, Administrative Assistant=.6 FTE	Chief BH Officer = .05, Manager = .25 FTE, Supervisor=.60 FTE, Case Manager=1 FTE, Clinician = 2.55 FTE, Administrative Assistant=.6 FTE
Number of unduplicated participants served		Program Participants	Program Participants	Program Participants
		3	39	50
Number of Tier I services (unduplicated)		0	1	1
Number of Tier I services provided (duplicated)		0	6	3
Number of Tier II services (unduplicated		0	51	6
Number of Tier II services provided (duplicated)		0	73	14
Number of Tier III services (unduplicated)		3	39	48
Number of Tier III services provided (duplicated)		5	230	334
		Timeliness	**Timeliness**	**Timeliness**
Average interval (days) between referral and completion of screening		24	18	16
Percentage of participants who received an assessment within 10 business days of screening		100% (3 of 3)	90% (20 of 22)	83% (5 of 6), the 6th client disengaged between screening appt. and assessment, resulting in delay for assessment to occur within 10 business days.
		Referral/Linkage	**Referral/Linkage**	**Referral/Linkage**

Program: K-12 School Partnership Services in the Woodland Catchment Area				
Provider: CommuniCare Health Centers				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Number of participants (with private health insurance) referred to services through their insurance plan		0	3	4
Percentage of participants (with private health insurance) referred to services through their insurance plan		0%	7%	8%
Number of participants in treatment services utilizing Medi-Cal billing (managed care)		2	5	5
Percentage of participants in treatment services utilizing Medi-Cal billing (managed care)		67%	13%	10%
Number of participants in treatment services utilizing Medi-Cal billing (SMHS)		0	13	14
Percentage of participants in treatment services utilizing Medi-Cal billing (SMHS)		0%	33%	28%
Average number of sessions per participant in therapeutic services		Service Delivery	Service Delivery	Service Delivery
		1.7	6	7
		Participant Satisfaction	**Participant Satisfaction**	**Participant Satisfaction**
Number of participants (including parent/guardians) who reported satisfaction with services		N/A – data reported in Q4	N/A – data provided in Quarter 4	13
Percentage of participants (including parent/guardians) who reported satisfaction with services		N/A – data reported in Q4	N/A – data provided in Quarter 4	100%

Program: K-12 School Partnerships Services Rural Catchment Area				
Provider: RISE, Inc				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Staff		Total FTEs by Classification (Manager, Supervisor, Clinician, Case Manager, Administrative Support)	Total FTEs by Classification (Manager, Supervisor, Clinician, Case Manager, Administrative Support)	Total FTEs by Classification (Manager, Supervisor, Clinician, Case Manager, Administrative Support)
		.05 FTE Manager - .10 Supervisor – 2.0 Clinician – 1.0 Case Manager – 1.0 Linkage/Outreach	.05 FTE Manager - .10 Supervisor – 2.0 Clinician – 1.0 Case Manager – 1.0 Linkage/Outreach	.05 FTE Manager - .10 Supervisor – 2.0 Clinician – 1.0 Case Manager – 1.0 Linkage/Outreach
		Total 4.15 FTE to support the program.	Total 4.15 FTE to support the program.	Total 4.15 FTE to support the program.
Program Participants				
Number of unduplicated participants served		(All Students includes mentoring)	64	55
Number of Tier I services (unduplicated)		(All Students including mentoring)	67	55
Number of Tier I services provided (duplicated)		(Individual counseling and/or Group counseling)	153	55
Number of Tier II services (unduplicated)		(Beacon Partnership referrals — Yolo County Referrals)	1	(Beacon Partnership referrals — Yolo County Referrals)
Number of Tier II services provided (duplicated)		missing	67 — 30 small groups or 67 (total participants referred to treatment)	(N/A)
		Timeliness	**Timeliness**	**Timeliness**
Average interval (days) between referral and completion of screening		(Typically, the time of referral and completion is within 3-5 days)	(Typically, the time of referral and completion is within 3-5 days)	(Typically, the time of referral and completion is within 3-5 days)
Percentage of participants (with private health insurance) referred to services through their insurance plan			100%	
Average number of sessions per participant in therapeutic services			14	744

Program: K-12 School Partnerships Services Rural Catchment Area				
Provider: RISE, Inc				
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**
Number of participants (including parent/guardians) who reported satisfaction with services			Participant Satisfaction — Data gathered, collected, and reported in Quarter 4.	14 surveys were reported throughout the fourth quarter. Students and parents were provided with satisfaction surveys (28 total) all ratings from good to excellent. 16 excellent and 12 good satisfaction surveys were collected.

Program: K-12 School Partnerships – West Sacramento Catchment Area					
Provider: Victor Community Support Services					
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
Staff FTE Classification					
Manager/Supervisor		1	1	1	1
Clinicians (Direct Service Staff)		2	3	3	3
Office Support:		2	2	3	3
Number of unduplicated participants served		524	474	1175	1736
Number of unduplicated participants served in Tier I		498	381	1002	1527
Number of unduplicated participants served in Tier II		26	83	145	179
Number of unduplicated participants served in Tier III		0	15	25	30
Number of services provided		47	251	536	834
Number of services provided in Tier I		35	48	108	191
Number of services provided in Tier II		12	85	104	201
Number of services provided in Tier III		0	118	324	442
Percentage of referrals who received an intake assessment within 14 days of referral		N/A	68%	64%	67%
Average calendar days between referral and assessment completion		N/A	14.6	13.1	14.1
Percentage of participants who received an assessment within 14 days of referral		N/A	68%	64%	67%
Percentage of participants (with health insurance) successfully linked to services with private health insurance		N/A	N/A	N/A	N/A
Number of participants in treatment services utilizing Medi-Cal billing		N/A	15	19	25
Average number of sessions per participant in therapeutic services		N/A	4	29	16
Percentage of participants who reported satisfaction with services		N/A	100%	100%	100%
Number and percentage of students with improved attendance		N/A	N/A	4 of 5	4 of 5
Number of clients with decrease in actionable items on CANS' Life Functioning domain;		N/A	N/A	4 of 5	4 of 5

URBAN & RURAL SCHOOL-BASED ACCESS & LINKAGE AND STRENGTHS BASED MENTORING

This program preceded the K-12 School Partnerships Program and ended in Q2 when the K12 program began operations.

Program: RISE School-Based Mentoring	
Provider: RISE, Inc	
Performance Measure	**Q1**
Staff	Number of staff FTEs providing Mentorship and Strengths Programs Services including breakdown of program staff who are bilingual. 2.5 FTE All Bilingual Staff
Total number of unduplicated participants served	66 new participants

Program: RISE School-Based Mentoring	
Provider: RISE, Inc	
Performance Measure	**Q1**
Total number of participants identified as at risk of a mental illness (Prevention)	66
Total number of participants who received services in their preferred language	66/66 100%
Program Activities: Total number of services provided in each service category (After-school mentoring programs)	264 service units provided (includes all enrolled youth)
Percentage of participants who completed a referral and engaged in treatment.	100% received the resources and services they needed.
Percentage of program staff trained in using evidence informed and evidence -based practices	100% of staff received Why Try and Strengths Finder Evidence-Based Trainings.
Percentage of participants who reported satisfaction with services	100%
Number of participants who reported satisfaction with services	48

Program: Victor Access and Linkage Program					
Provider: Victor Community Support Services					
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
Number receiving Universal Outreach/Engagement services specifically for the Access and Linkage Program	0	0	0	0	0
Number of services provided, including direct MH triage and referral, risk assessment, brief intervention and linkage services	0	0	0	0	0
Number of children, youth, and family members (CYF) referred to a MH service provider.	0	0	0	0	0
Rate of children, youth, and family members (CYF) referred to a MH service provider.	N/A%	N/A%	N/A%	N/A%	N/A%
Number of routine mental health triage services provided within seven (7) calendar days of request for service.	0	0	0	0	0
Rate of routine mental health triage services provided within seven (7) calendar days of request for service.	N/A%	N/A%	N/A%	N/A%	N/A%
Number of urgent mental health triage services provided within forty-eight (48) hours of request for service.	0	0	0	0	0
Rate of urgent mental health triage services provided within forty-eight (48) hours of request for service.	N/A	N/A	N/A	N/A	N/A
Number of Access and Linkage Services provided in the child, youth or family member's preferred language.	0	0	0	0	0
	N/A%	N/A%	N/A%	N/A%	N/A%

Program: Victor Access and Linkage Program					
Provider: Victor Community Support Services					
Performance Measure	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
Number of referred CYF who received at least one mental health service from the referred provider.	N/A	N/A	N/A	N/A	N/A
Rate of referred CYF who received at least one mental health service from the referred provider.					
Of the children/youth who participated in recommended services, how many reported improvement in overall mental health symptoms	N/A	N/A	N/A	N/A	N/A
Of the family members who participated in recommended services, how many reported improvement in child/youth's family circumstance.	N/A	N/A	N/A	N/A	N/A

Program: Victor School-Based Mentorship and Strengths-Building Program					
Provider: Victor Community Support Services					
Outreach and Engagement Services	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
Number receiving any service	2085	1563	0	0	3004
Mentorship Program (Selective)	Q1	Q2	Q3	Q4	FY
Number receiving any service	2085	1563	0	0	3004
(Most widely used EBP program for children under 12)					
Q1 & Q2: Second Step					
	Q1	Q2	Q3	Q4	FY
Number receiving any service	2085	1563	N/A	N/A	3004
Number receiving this particular service	344	1209	N/A	N/A	1553
Percentage of CYF receiving Outreach/Engagement services engaged in services provided by this program	16%	77%	N/A	N/A	52%
How did those CYF engaged in this program or service rate the efficacy of the program?					
Percent that answered yes to a yes/no question of satisfaction.	87%	80%	N/A	N/A	81%
Of those CYF engaged this service, how many reported improved personal skills, improved school or family circumstances, or feeling better overall?	298 of 344	963 of 1209	N/A	N/A	1261 of 1553
(Most widely used EBP program for children aged 12-18)					
Q1: Suicide Prevention	Q1	Q2	Q3	Q4	FY

Program: Victor School-Based Mentorship and Strengths-Building Program					
Provider: Victor Community Support Services					
Outreach and Engagement Services	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
Q2: Emotion Management					
Number receiving any service	2085	1563	N/A	N/A	3004
Number receiving this particular service	678	183	N/A	N/A	861
Percentage of CYF receiving Outreach/Engagement services engaged in services provided by this program	33%	12%	N/A	N/A	29%
How did those CYF engaged in this program or service rate the efficacy of the program? *Percent that answered yes to a yes/no question of satisfaction.*	83%	83%	N/A	N/A	83%
Of those CYF engaged this service, how many reported improved personal skills, improved school or family circumstances, or feeling better overall?	563 of 678	153 of 183	N/A	N/A	716 of 861

Appendix 4:

Annual PEI Report FY 2021–22

Yolo County

Annual Prevention and Early Intervention Report FY 21-22

(July 1, 2021 to June 30, 2022)

Program: College Partnership					
Provider: CommuniCare Health Centers					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Clients Served					
Total Client Contacts	73	274	437	154	938
New Clients: Not seen previously in this Fiscal Year)	14	28	13	20	75
Returning Clients: Returning from previous Quarter in same Fiscal Year	0	14	38	10	62
Clients Served: Early Intervention	14	42	51	30	137
Clients Served By Age					
Transitional Age Youth (16-25)	11	25	29	19	84
Adults (26-59)	3	17	22	11	53
Client Race					
American Indian or Alaska Native	1	1	1	0	3
Asian	0	2	2	1	5
Black or African American	0	2	3	0	5
Native Hawaiian or other Pacific Islander	0	1	1	0	2
White (includes Non Hispanic/Latino)	4	21	26	16	67
Other (Includes Hispanic/Latino)	4	4	0	5	13
More than one race	1	2	3	1	7
Declined to State	0	9	16	0	25
Race not recorded /Field left blank	4	0	0	7	11
Client Ethnicity					
Hispanic or Latino					
Declined to State	3	12	24	13	52
Not recorded/Field left Blank	6	4	11	5	26
Non-Hispanic or Non-Latino					
African	0	2	2	0	4
Asian Indian/South Asian	0	2	2	1	5
Other	0	9	10	3	22
More than one ethnicity	0	2	2	1	5
Not recorded/Field left Blank	5	0	0	7	12
Clients Served By Language Requested for Written Communication					
English	14	42	50	26	132
Spanish	0	0	1	4	5
Clients Served by Language Requested for Spoken Communication					
English	14	42	44	26	126

Spanish	0	0	7	4	11
Clients Served By Sexual Orientation					
Gay or Lesbian	3	3	4	3	13
Heterosexual or Straight	4	23	29	13	69
Bisexual	3	5	5	3	16
Questioning or unsure of sexual orientation	0	1	1	1	3
Another Sexual Orientation	1	0	1	3	5
Declined to State	1	1	3	3	8
Not recorded/Field left Blank	2	9	8	4	23
Clients Served With Physical Or Mental Impairment (Disability) Not a Result of Severe Mental Illness					
Yes, Disability Indicated	2	3	4	2	11
Mental Domain: Not including mental illness (including but not limited to learning disabilities, developmental disabilities, or dementia)	1	1	0	0	2
Chronic Health Condition: including but not limited to chronic pain	1	2	0	0	3
Other Disability:	0	0	0	2	2
No, Not disabled	8	28	35	22	93
Not recorded/Field left Blank	4	11	12	6	33
Clients Served By Sex Assigned at Birth					
Males	5	11	17	12	45
Females	9	31	34	17	91
Not recorded/Field left Blank	0	0	0	1	1
Clients Served By Gender Current Gender Identity					
Male	5	11	17	12	45
Female	8	30	33	16	87
Transgender	1	1	1	1	4
Another Gender Identity	0	0	0	1	1
Clients Served by Veterans Status					
Yes, Veteran	0	0	1	1	2
No, Not Veteran	10	31	38	23	102
Not recorded/Field left Blank	4	11	12	6	33
Clients Served By City of Residence					
Davis	3	5	6	1	15
Esparto	0	1	1	0	2
Knights Landing	0	4	4	3	11
West Sacramento	0	0	1	0	1
Woodland	8	21	27	16	72
Yolo	0	0	1	1	2
Out of County	3	11	0	9	23
Clients Served By City of Residence					

Note: Homeless people are counted as part of the homeless community and not the locality where they are homeless.	0	1	0	0	1
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer	14	42	51	30	137
Outreach					
Number of outreach Events Held/Attended	0	7	19	2	28
Outreach Participant Demographics					
Total Outreach Participants	0	62	86	3	151
Outreach Setting					
School	0	7	19	2	28
Number of Individuals Referred to Treatment					
Total Participants Referred	8	23	24	87	142
Total SMI Participants Referred	0	0	0	1	1
Kind of Treatment to which participants were referred					
Behavioral/Mental Health	3	9	9	21	42
Treatment/Program Client was Referred To					
Psychiatry	0	3	0	3	6
Insurance Linkage	0	3	0	3	6
Crisis Nursery	0	1	0	2	3
Dental	1	1	0	1	3
Empower Yolo	1	7	1	8	17
Other community	1	0	8	34	43
Medical Services	0	4	5	16	25
CalWORKs	0	0	1	1	2
Housing	1	1	0	1	3
Treatment Follow Through					
Participants who followed through on referral and engaged in treatment	14	28	13	20	75
Average Interval between the referral and participation in treatment /referred service					
Less than 1 month	14	28	13	20	75

What were the program's key successes in the previous quarter?
Q1- Implementing Drop-in consultations for students, faculty and staff. Gradual increase in student participation for individual counseling services. Q2- Big increase in students served with mental health services. More outreach events and greater attendance at outreach events. Q3- Consistency with number of students served with mental health services. More outreach events and greater attendance at outreach events. Q4- Consistency with number of students served with mental health services.

What were some challenges or barriers this program encountered from the previous quarter?
Q1- Low participation during summer months for services. By September student participation had increased. Q2- Low participation during winter break for students. Q3- Balancing mental health service needs with outreach and presentation requests within contract capacity. Q4- Scheduling of outreach events. Keeping engagement with students over the summer.

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?
Q1, Q2, Q3- Disability Services and Programs for Students at Woodland Community College Q4- CARE Program

What are the key activities you expect this program to achieve in the following quarter?
Q1, Q2, Q3, Q4- More prevention focused services. Wellness Wednesdays and Mindful Mondays, continue class presentations on various topics, partner with Career Center and Dream Center.

Are the program's services and activities to change in the following quarter? If so, how?
No

Program: Cultural Competence
Provider: Yolo County Health & Human Services Agency
Prior to 2021, Cultural Competence trainings were confined to Behavioral Health staff, and other than attendance, little evaluation data was collected, and no demographic data. In the fall of 2021, we began to offer CC/DEIB trainings, expanding the offerings to all HHSA staff, contracted providers, and interested stakeholders. We experienced challenges collecting data in virtual settings, although the number of attendees clearly demonstrated a marked increase in participation. In late 2022, we began to take attendance in virtual trainings, and in 2023 began collecting demographic data. We anticipate that a virtual platform will continue accommodating increased participation and will develop an evaluation form to gauge training adequacy and performance measures. The above is also true for The Nature of Trauma and Resilience trainings (PEI) during 2021-2022.
Program Accomplishments
• HHSA engaged in various virtual activities to demonstrate the ongoing commitment to community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities. • The CC Coordinator, Tessa Smith, was reclassed as Diversity, Equity, and Inclusion Coordinator. This expanded cultural competence efforts to include the HHSA Strategic Plan objective of identifying systemic inequities and developing racial equity programming. • The CC plan was completed and submitted to the state for reporting compliance under the HHSA Mental Health Plan contract. • Made CC/DEIB an agency-wide initiative, taking a holistic approach to individuals and families addressing both physical and mental health needs. • Increased CLAS delivery, adherence, and accountability with the expansion of CC/DEIB training to all HHSA staff, providers, and interested stakeholders. • Increased cross-sector and inter-departmental collaboration with exponential growth in CC Committee participation.
Program Challenges
In FY 21-22 Cultural Competence activities were impacted by both the pandemic and unprecedented staffing shortages. Our staff experienced COVID reassignments, personal loss, illness, and trauma. Our capacity as an agency to engage and implement new programming was understandably compromised. With a majority of activities taking place online, CC unit did not incur travel, space rentals, printing costs, etc., due to the virtual nature of our engagement during this time. Plans to present an in-person CC/DEIB conference and other agency and community-wide events were necessarily suspended. Site monitoring was also halted during the pandemic. Additionally, a traffic jam was experienced by our fiscal and procurement staff, as many new RFP requests hit our system simultaneously as we anticipated exiting pandemic crisis mode and a return to a new normal. Contract requests have been delayed. The CC program is awaiting additional staff to increase outreach and expand diversity and inclusion activities.

Program: Early Childhood Mental Health Access & Linkage					
Provider: CommuniCare Maternal Mental Health - In-Home Therapy 4 Caregivers					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Clients Served					
Total Client Contacts	16	31	60	54	161
New Clients: Not seen previously in this Fiscal Year)	5	3	5	1	14
Clients Served: Early Intervention	5	3	5	1	14
Clients Served By Age					
Transitional Age Youth (16–25)	0	0	1	0	1
Adults (26–59)	5	3	4	1	13
Client Race					
Asian	0	0	1	0	1
White (includes Non Hispanic/Latino)	0	1	0	0	1
Other (Includes Hispanic/Latino)	5	1	4	1	11
More than one race	0	1	0	0	1
Client Ethnicity					
Hispanic or Latino	5	1	1	1	8
Mexican/Mexican-American/Chicano	5	1	1	1	8
Non-Hispanic or Non-Latino					
European	0	0	1	0	1
Middle Eastern	0	1	0	0	1
More than one ethnicity	0	1	1	0	2
Clients Served By Language Requested for Written Communication					
English	0	3	1	1	5
Spanish	5	0	4	0	9
Clients Served by Language Requested for Spoken Communication					
English	0	3	1	1	5
Spanish	5	0	4	0	9
Clients Served By Sexual Orientation					
Heterosexual or Straight	5	2	5	1	13
Another Sexual Orientation	0	1	0	0	1
Clients Served With Physical Or Mental Impairment (Disability) Not a Result of Severe Mental Illness					
Yes, Disability Indicated	2	1	0	0	3
Communication Domain: Difficulty Seeing	1	0	0	0	1
Mental Domain: Not including mental illness (including but not limited to learning disabilities, developmental disabilities, or dementia)	1	0	0	0	1
No, Not disabled	3	0	5	0	8
Not recorded/Field left Blank	0	1	0	0	1
Clients Served By Sex Assigned at Birth					
Females	5	3	5	1	14
Clients Served By Gender Current Gender Identity					
Female	5	3	5	1	14
Clients Served by Veterans Status					
No, Not Veteran	5	3	5	1	14
Clients Served By City of Residence					

Clarksburg	1	0	0	0	1
Davis	0	1	1	0	2
West Sacramento	1	0	0	0	1
Woodland	3	2	3	0	8
Yolo	0	0	0	1	1
Yolo County Unincorporated areas	0	0	1	0	1
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer	5	3	5	1	14
MHSA Required Performance Measures: Outreach Tracking					
Outreach					
Number of outreach Events Held/Attended	5	3	4	3	15
Outreach Participant Demographics					
Total Outreach Participants	40	23	18	25	106
Outreach Setting					
Family Resource Center	10	0	3	0	13
Law Enforcement Departments	10	10	5	10	35
Mental/Behavioral Health Care	10	5	5	0	20
Primary Health Care	10	8	5	15	38
Number of Individuals Referred to Treatment					
Total Participants Referred	2	0	0	1	3
Kind of Treatment to which participants were referred					
Behavioral/Mental Health	2	0	0	1	3
Treatment Follow Through					
Participants who followed through on referral and engaged in treatment	2	0	0	0	2
Participants who did not engage in treatment to which they were referred.	0	0	0	1	1
Average Duration of Untreated Mental Illness					
Less than 1 month	2	0	0	1	3
More than 12 Months	0	0	1	0	1
Unable to determine	0	3	4	0	7
Average Interval between the referral and participation in treatment /referred service					
Less than 1 month	2	1	0	0	3
2-3 Months	0	2	5	1	8

What were the program's key successes in the previous quarter?
Q1- The key successes were related to project scope expansion and greater flexibility to better match the mental health needs of clients. In Q1 we received approval to expand services in the following ways: 1) Offer treatment to any primary caregiver of a child ages 0-5 - previously, the focus was on mothers of children 0-2 2) provide a range of evidence based interventions to address the presenting mental health challenges of the clients - previously the program focused on CBT based interventions only 3) A range of evidenced based assessment tools can be used to track client progress including PHQ-9, GAD-7 , Edinburgh and PCL-5 - previously only the PHQ-9 was recognized. Q2- The biggest success was the continued increase of referrals. In Q1 we received approval to expand services in the following ways. 1) Offer treatment to any primary caregiver of a child ages 0-5 - previous the focus was on mothers of children 0-2 2) provide a range of evidence based interventions to based address the presenting mental health challenges of the clients - previous the program focused on CBT based interventions 3) A range of evidenced based assessment tools can be used to track client progress including PHQ-9, GAD-7 , Edinburgh and PCL-5 - previously only the PHQ-9 was recognized.

Q3- In Q3 we had several successes. We on-boarded and trained a MSW intern to help address demand in the face of staffing shortages. The intern was able to take two cases. We also had a previous staff member return from maternity leave and take one case, until she had to leave again due to family issues. Increasing staff from two to four helped us increase the number of clients seen and the number of visits from 33 to 60.

Q4- 1)Treatment effectiveness was demonstrated by decreases in PHQ-9 (Patient Health Questionnaire), GAD-7 (Generalized Anxiety Disorder Screener) and increased rates on the client ORS(Outcome Reporting Scale) indicating improved overall well being.

What were some challenges or barriers this program encountered from the previous quarter?

Q1- In Q4 of last fiscal year - we again experienced some staffing challenges with the IHT4C program. The Spanish-speaking clinician went out on maternity leave which was expected. While we had a new staff member identified before this clinician left, there was a small delay in engaging new clients as the new staff person was engaging in training. Our English-speaking clinician went on medical leave unexpectedly for 5 weeks resulting in significant delays in engaging new referrals. Additionally, with the expansion of the program scope we have experienced an increase in the number of referrals, but a decrease in the quality of referrals. Upon follow up with the referred clients, it was determined for at least 5 of the new referrals that either they were already engaged in therapy services elsewhere, or that another provider would be a better fit. For example, two clients with existing CWS cases were referred and were subsequently referred to the Strengthening Protective Factors team for care.

Q2- Insufficient staffing continues to be the greatest challenge for the program. By Q2, the new Spanish speaking clinician was on boarded and engaged with clients. The English speaking clinician ending returned from medical leave and resumed services, but these two clinicians could not meet the demand. Roll over funds were approved to hire a new clinician at .175 FTE and a candidate was identified but by the time she was onboarded management needed her to fill another opening that had been vacant due to medical leave and followed by resignation. Efforts at hiring clinicians were met with small numbers of applicants who were not qualified for the posted positions and with new programs for mental health being funded there was increased competition for the few applicants who were qualified. Additionally, with the expansion of the program scope we have continued experiencing an increase in the number of referrals, but a decrease in the "quality of referrals" with several new referrals already engaged in therapy services elsewhere.

Q3- Insufficient staffing levels continue to be the greatest challenge for the program. While three additional clients were served due to onboarding an intern and a previous staff returning and taking one case, the additional .175 FTE funded by roll over funds was not filled. Efforts at hiring clinicians were met with small numbers of applicants who were not qualified for the posted positions. While significant effort has been made with HR related to recruitment and retention efforts, the IHT4C program remains understaffed resulting in a significant wait list and clients waiting up to 3 months for services. When possible and based on client interest, staff have worked with clients to identify alternative services to address emergency mental health needs.

Q4- 1) Insufficient staffing levels continue to be the greatest challenge for the program and lack of staff meant that referred clients were either referred out to other services or they were on a wait list receiving periodical screenings. We recently onboarded a new clinician who will take several cases soon and we are recruiting one more Spanish speaking clinician to take cases. 3) With increased eligibility criteria, referring partners are making more referrals when they identify any mental health needs, but are not screening effectively for current engagement in mental health treatment or willingness to engage in treatment.

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?

Q1- We continue to partner with Help Me Grow in identifying potential referrals to the program. The MMH - In Home Therapy for Caregivers Manager met with the Help Me Grow team twice to discuss the new referral criteria, answer questions and attempt to fine tune the quality of the referrals sent. Additionally, both Help Me Grow and IHTMC programs committed to using the Unite Us platform to send referrals.

Q2-We continue to partner with Help Me Grow in identifying potential referrals to the program. While we did not meet with the Help Me Grow team this quarter, we did have contact with staff members regarding referrals. The manager overseeing the program gave two presentations to new employees in primary care, dental and behavioral health departments of CommuniCare Health Centers. Additionally, referral information was shared with Child Welfare representatives at a meeting in October.

Q3- We continue to partner with Help Me Grow in identifying potential referrals to the program, communicate about wait times and follow through with cross referrals.

Q4- Staffing illness got in the way of our quarterly meeting with Help Me Grow in FQ4 21/22. As we head into FQ1 of 22/23 our next presentation and discussion are scheduled and confirmed for August.

What are the key activities you expect this program to achieve in the following quarter?

Q1, Q2- We are looking to grow the staff after being awarded 7 additional hours per week to meet increased referral demand. We will continue to engage in outreach efforts in Q2 to ensure all community partners are aware of the program expansion and which clients would be a good fit for the program. We will continue to provide training for the staff to improve the effective use of evidenced based therapeutic interventions.

Q3- Our hope is that we will identify, hire and on-board staff to meet demand and eliminate the program wait list. Following that we will resume outreach efforts to ensure all families with children 0-5 who have unaddressed mental health challenges are connected to services. We will continue to provide training for the staff to improve the effective use of evidenced based therapeutic interventions.

Q4- 1) Improve staff recruitment efforts to identify and hire qualified, motivated, and engaging clinicians to working in the IHT4C program. 2) Explore resuming use of Beacon/Partnership funding to ensure existing budget constraints are not a barrier to engaging all referred and eligible families. 3) Increase engagement of clients in conversations about barriers to treatment and family stability and then utilize already budgeted direct to client funds, team consultation, and community resource referrals to address barriers and improve stability, thus improving client outcomes. 4) Invest in continuing education related to Feedback Informed Treatment model with goal of improving outcomes for clients in therapy process. 5) Train Help Me Grow team to screen clients for current therapy engagement and interest prior to submitting referrals. Review existing referral and intake forms/workflows with the team and make adjustments if needed.

Are the program's services and activities to change in the following quarter? If so, how?

Q1, Q2- We are planning to hire and add more clinician time to this program (from someone who already provides services to this program part-time), to address the increase in referrals coming in with the new eligibility criteria.

Q3- We are not planning in significant changes to the services provided, other than improving our ability to meet demand.

Q4- First 5Yolo and direct service partner CommuniCare BH Health, are not planning any significant changes to the services provided, other than improving our ability to meet demand through hiring and exploring the leveraging of Beacon funding again.

Program: Early Childhood Mental Health Access & Linkage					
Provider: First 5 Yolo: Help Me Grow Yolo County					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Clients Served					
Total Client Contacts	2580	1161	522	1743	6006
New Clients: Not seen previously in this Fiscal Year	537	504	228	274	1543
Returning Clients: Returning from previous Quarter in same Fiscal Year	0	73	294	163	530
Individual Family Members Served	905	969	438	240	2552
Clients Served: Prevention	465	447	129	242	1283
Clients Served: Early Intervention	72	57	99	32	260
Clients Served By Age					
Children 0-15	503	460	197	243	1403
Not recorded /Field left blank	34	44	31	31	140
Client Race					
American Indian or Alaska Native	6	1	1	0	8
Asian	21	19	5	10	55
Black or African American	7	8	3	3	21
Native Hawaiian or other Pacific Islander	0	1	0	0	1
White (includes Non Hispanic/Latino)	43	46	18	25	132
Other (Includes Hispanic/Latino)	140	148	75	97	460
More than one race	65	60	24	29	178
Declined to State	8	33	3	3	47
Race not recorded /Field left blank	247	188	99	107	641
Client Ethnicity					
Hispanic or Latino	174	168	83	36	461
Central American	1	0	4	2	7
Mexican/Mexican-American/Chicano	46	58	37	30	171
Puerto Rico	1	0	0	0	1
South American	1	0	1	0	2
Other	32	24	2	4	62
Not recorded/Field left Blank	93	86	39	0	218
Non-Hispanic or Non-Latino	278	336	145	238	997
African	3	8	0	3	14
Asian Indian/South Asian	3	9	3	5	20
Chinese	4	3	0	1	8

Eastern European	1	4	0	1	6
European	14	1	3	5	23
Filipino	2	0	0	0	2
Korean	0	1	0	0	1
Middle Eastern	1	0	0	0	1
Vietnamese	1	1	0	0	2
Other	16	0	9	0	25
More than one ethnicity	28	35	15	16	94
Declined to state ethnicity	43	33	3	3	82
Not recorded/Field left Blank	247	188	112	204	751
Clients Served By Language Requested for Written Communication					
English	317	241	114	125	797
Spanish	132	133	48	84	397
Russian	1	0	0	1	2
Other (Not a county threshold language)	14	6	5	3	28
Declined to State	1	20	1	0	22
Not recorded/Field left Blank	72	104	60	61	297
Clients Served by Language Requested for Spoken Communication					
English	319	231	114	128	792
Spanish	128	138	49	85	400
Russian	1	1	0	3	5
Other (Not a county threshold language)	16	12	6	2	36
Declined to State	1	20	1	0	22
Not recorded/Field left Blank	72	102	58	56	288
Clients Served With Physical Or Mental Impairment (Disability) Not a Result of Severe Mental Illness					
Yes, Disability Indicated	33	45	25	23	126
Communication Domain: Difficulty Seeing	1	1	0	0	2
Communication Domain: Difficulty hearing or having speech understood	11	13	9	10	43
Mental Domain: Not including mental illness (including but not limited to learning disabilities, developmental disabilities, or dementia)	7	12	5	4	28
Physical Mobility Domain: Physical or mobility issue	0	0	0	3	3
Chronic Health Condition: including but not limited to chronic pain	10	8	6	2	26
Other Disability:	4	11	5	6	26
No, Not disabled	307	307	125	183	922
Declined to State	2	23	0	1	26

Not recorded/Field left Blank	195	129	78	67	469
Clients Served By Sex Assigned at Birth					
Males	183	230	98	118	629
Females	205	180	82	108	575
Declined to State	42	35	26	38	141
Not recorded/Field left Blank	107	59	22	10	198
Clients Served By City of Residence					
Brooks	3	0	0	0	3
Clarksburg	0	3	0	1	4
Davis	40	26	22	35	123
Dunnigan	0	3	2	1	6
Esparto	7	11	9	9	36
Guinda	0	0	1	0	1
Knights Landing	0	1	1	8	10
Madison	0	6	0	15	21
Sacramento (board and care)	0	0	0	9	9
West Sacramento	78	124	31	26	259
Winters	50	17	7	5	79
Woodland	141	186	82	85	494
Yolo	0	0	1	1	2
Yolo County Unincorporated areas	3	4	5	1	13
Out of County	54	19	7	21	101
Not recorded/Field left Blank	161	104	60	57	382
MHSA Required Performance Measures: Outreach Tracking					
Outreach					
Number of outreach Events Held/Attended	187	201	274	122	784
Outreach Participant Demographics					
Total Outreach Participants	1166	836	1146	1378	4526
Outreach Setting					
Church	2	3	0	0	5
Clinic	24	29	10	2	65
Faith-Based Organization	0	0	3	0	3
Family Resource Center	5	2	20	2	29
Library	1	2	2	0	5
Mental/Behavioral Health Care	7	2	9	1	19

Other	97	105	155	106	463
Primary Health Care	0	0	27	2	29
Recreation Center	0	0	2	0	2
School	46	58	46	7	157
Shelter	1	0	0	2	3
Support Group	4	0	0	0	4
Number of Individuals Referred to Treatment					
Total Participants Referred	62	57	35	32	186
Kind of Treatment to which participants were referred					
Behavioral/Mental Health	62	57	35	32	186
Treatment/Program Client was Referred To					
Alta Regional Center	39	40	22	27	128
Mental Health	12	9	2	1	24
Psychological Evaluation	11	8	11	4	34
Treatment Follow Through					
Participants for which referral engagement data is not available	62	57	35	32	186
Average Duration of Untreated Mental Illness					
Unable to determine	62	57	35	32	186
Average Interval between the referral and participation in treatment /referred service					
Participation in Treatment not Recorded	62	57	35	32	186

What were the program's key successes in the previous quarter?
Q1- Help Me Grow Yolo County has been working on grants to collaborate in a county wide, multi-agency effort to integrate and utilize ACEs screenings administered by medical providers to identify any adverse experiences and provide support and intervention needed to mitigate their long-term effects. HMG'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. The previously organized committee addressing racial disparities in service provision is currently participating in a rate study to determine an appropriate service code rate for seeing historically underserved Early Intervention clients outside of typical work hours. Our partnership with the Migrant Education Program has provided additional support for migrant families in Woodland, Davis, Esparto, and Madison. The children attending their program and their younger siblings are referred upon enrollment for ongoing support. Our partnership with the E-Center Migrant Head Start Program has provided additional support for migrant families in Woodland. The children attending their program will be screened and referred again at the end of the program for ongoing support. Help Me Grow Yolo also started planning a screening night event with the E-Center program, where other agencies like CommuniCare will be present to offer dental screenings for children. Increased collaboration with Child Welfare Services has provided additional opportunities for Help Me Grow Yolo referrals when a child is reunited with their biological family to provide additional ongoing support. We began receiving referrals for Child Welfare Services "maintenance" families, providing child development support during a very vulnerable time. Help Me Grow Yolo started offering developmental playgroups in-person again. We began accepting unborn clients whose mothers are working with another program or who had an older sibling in the yesyolo system.

Help Me Grow Yolo worked with the Yolo Food Bank to help distribute food boxes that were not picked up during their Kids Farmers Market hours and distributed to Help Me Grow Yolo families.
Help Me Grow Yolo staff started using the Unite Us platform to send referrals to the In-Home Therapy for Caregivers program. Using the platform helps us easily track families who were referred and improves communication with staff from the In-Home Therapy for Caregivers program.

Help Me Grow Yolo also participated in the National Night Out outreach event located in one of Esparto and Woodland's low income neighborhoods. We provided activity kits, resources and information on connecting with Help Me Grow Yolo.

Help Me Grow Yolo provided virtual parent training for the Woodland Joint Unified School District's State Preschool Program families in both English and Spanish. In these trainings, we were able to address the areas of development that are on the Ages & Stages Questionnaires, why they are completing the developmental screening with the school, and answered questions parents had about their child. These parent trainings were offered multiple times throughout the week to accommodate any working families' schedules. Additionally, a staff training was provided on how to use the results of the developmental screenings for lesson planning and parent education at their sites.

Help Me Grow Yolo County staff completed their certificates in Mental Health First Aid.
Q3- Help Me Grow Yolo County has been working on grants to collaborate in a county wide, multi-agency effort to integrate and utilize ACEs screenings administered by medical providers to identify any adverse experiences and provide support and intervention needed to mitigate their long-term effects. HMGY's role was 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. We are currently the top Yolo County referral agency in Unite Us. Partially due to HMGY receiving more referrals and screenings from certain pediatricians at CommuniCare which is something that we hadn't seen in previous quarters.
We worked with other agencies involved in the grant to create a set of informational videos to inform patients about ACEs.

Our partnership with the Migrant Education Program has provided additional support for migrant families in Woodland, Davis, Esparto, and Madison. The children attending their program and their younger siblings are referred upon enrollment for ongoing support.

Help Me Grow Yolo was able to provide developmental playgroups in-person (except a month during a variant spike).

Help Me Grow Yolo participated in the Caesar Chavez Community Day. We provided books, resources and information on connecting with Help Me Grow Yolo.

Started monthly rotations with Sutter Health Family Practice residents at Help Me Grow Yolo site to give them an opportunity to better understand the Centralized Access Point.

Distributed 100s of COVID test kits and other PPE to families and child care providers.

Most HMGY staff at CTC have begun training to be Resilience Champions.

Had a no-cost referral path to psychological assessments; allowing our clients to skip long wait lists with insurance and the Regional Centers.

HMGY staff attended Alta's focus groups where we were able to share barriers that our families are facing and hear from other agencies barriers they have encountered.

We continue to screen and re-screen children from the YMCA of the East Bay in Woodland and Woodland Joint Unified State Preschool.

HMGY continues to collaborate with agencies to provide screenings to families.

HMGY presented and began attending the Yolo County Childcare Planning Council meetings once a month to listen and offer feedback that may be helpful in planning for programs beneficial for the First 5 populations.

Word of mouth about HMGY became a way of connecting to programs that may not have known about us before. Programs like Woodland Haven and MILE preschools have reached out wanting more information about our program and how we can support their programs after conversations with people from the public.

Q4- Some Help Me Grow Yolo staff at CTC completed training to be Resilience Champions.

HGMY staff attended Alta's focus groups to share barriers that families are facing and hear from other agencies barriers they have encountered.

Partnered with United Way and YMCA Woodland to screen children participating in the Kindercamp program.

Help Me Grow Yolo continues to collaborate with agencies to provide screenings to families. HMG partnered with the UCD MIND Institute's LEND volunteers to develop plain language infographics to strengthen parental knowledge about milestones and development, promote HMG and help parents know when to ask for professional help in a child's first year. These have been well received by the local community and helped more than double the usual social media impact on the MIND's facebook page. The plan is to expand these into other languages beyond Spanish and English when other LEND Trainees with the language and clinical skills are identified.

As large in-person events remain infrequent; Help Me Grow Yolo provides monthly in-person Family Fun Events to educate caregivers on child development.
List of tools needed to complete screenings is now provided to foster families before they start screening so they can be prepared to observe skills for unfamiliar children.

Help Me Grow Yolo started receiving referrals for Welcome Baby families.

Help Me Grow Yolo offered Zoom presentations for Family Hui participants which helped them gain more knowledge of child development.

Help Me Grow Yolo staff was invited to a TV presentation at a local station in Woodland to talk about services offered and how it helps children and families.

As First 5 Yolo continues to offer diapers to families in need, Help Me Grow Yolo staff continues distributing these essential items.

What were some challenges or barriers this program encountered from the previous quarter?

Q1- Before the pandemic, many families learned about Help Me Grow Yolo through their friends or other people who they interacted with.
Similar to previous quarters during the pandemic, Help Me Grow Yolo 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.
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 staying on 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 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 the Medi-Cal recipients.
Mental health services for the whole family has become a big need.
As we have moved toward reopening, workplace procedures have been changed as needed.

Q3- Help Me Grow Yolo staff spent on average more time working with clients, affecting the amount of time that could be spent on outreach to bring in new clients, resulting in fewer clients served than usual.

Help Me Grow Yolo has continued outreach safely, connecting with providers and community based organizations virtually but adding in-person events when possible.

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 and the Regional Center from staying on their referral timelines. While assessments have resumed, this left a gap in services for 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 while they wait for services to begin.

Mental health has been a bigger need. Families need assistance navigating the eligibility criteria of this impacted sector. There is a triage system in place for MediCal recipients but the systems for private insurance companies is currently unknown. Even with a triage system in place, if there are a lot of people in crisis, those not in crisis do not get served (are waitlisted and the wait can be over a year).

Documentation was much more time consuming this quarter than in those previous.
Using the Unite Us platform for initiating referrals is time consuming (more than doubles our documentation time). Also, Help Me Grow Yolo's client management system went down and when it returned it was quite broken, resulting in nearly a week of not being able to document work in the system. Once the major issues were corrected smaller (but still time consuming) bugs continued for a couple of weeks. Any documentation had to be tracked separately and entered at a later time. This also stopped the way other agencies like Healthy Families Yolo County, Road 2 Resilience submitted screenings. We asked them to complete screenings on paper and HMGY staff would be responsible for entering them into our system. This was more time consuming for HMGY staff and for other agencies completing screenings or sending referrals to HMGY. For parents, they were unable to start a screening by finding their children's profiles in the system, creating a duplicate profile or stopping them from starting a screening.

Because developmental playgroups are still held indoors, the number of families served is limited. In addition, feedback that parents would like to see these playgroups being offered outdoors so children don't have to wear a facemask has been received. Even when it's indoors, some families would like for participants to be maskless.

Q4- Given the increasingly intensive needs of clients, Help Me Grow Yolo staff continue to require more time to directly serve clients, affecting the amount of time that could be spent on outreach to bring in new clients, resulting in fewer clients served than usual.

Help Me Grow Yolo has continued outreach safely, connecting with providers and community based organizations virtually attending in-person events when scheduled. As people began to congregate again but not into large groups, Help Me Grow Yolo returned to offering monthly, in-person Family Fun Events, to focus on development.

While it is easier to get screenings completed than at the start of the pandemic, needs remain complex because services are still impacted.

The pandemic kept some school districts and the Regional Center from staying on their referral timelines. While assessments have resumed, this left a gap in services for 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 while they wait for services to begin. In order to better manage workflow, Help Me Grow Yolo had to adjust follow-up timelines and, in some cases, how follow-up and connection are defined.

Partnership's (Yolo's Medi-Cal provider) website was compromised by ransomware and was down for over a month. During that time, medical referrals for Partnership recipients could not be made by doctors; this created a bottleneck in our referral and follow-up process.

Mental health has been a bigger need. Families need assistance navigating the eligibility criteria of this impacted sector. There is a triage system in place for MediCal recipients but it is unclear for private insurance companies. But even with a triage system in place, if there are a lot of people in crisis, those not in crisis do not get served (are waitlisted with waits over a year). Children waiting for a psychological evaluation are being told, incorrectly, that they cannot access services without a diagnosis.

To meet the communities changing needs, some new programs (i.e Welcome Baby) and platforms (i.e. United Us) have started to be integrated into Help Me Grow's workflow. These additions have resulted in the need to alter and add to Help Me Grow's current systems which has resulted in additional documentation and processing time.

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?

Q1-4- HMG partnered with 77 agencies to promote and/or deliver the program.

- A Better Way
- Academy 4 Kids
- aces aware
- Adventure Time Preschool
- All About Children daycare
- Alphabet Soup Childcare
- Alta California Regional Center (ACRC)
- Alyce Norman
- Ana Luisa
- Angelina Ramirez Daycare
- Breastfeeding Coalition
- Bridges of the Mind
- Bright Beginnings
- Busy Little hands
- Capital Pediatrics West Sacramento
- CapitolCROWD
- Carmen Campos
- Center for Living Health
- Child Welfare Services (CWS)
- Children's Home Society (CHS)
- Children's Mental Health Team (Yolo County Health and Human Serv
- Children's Therapy Center (CTC)
- Children's Therapy Center's Yolo Baby
- Claudia Martinez
- CommuniCare's In Home Therapy for Caregivers
- CommuniCare Primary Care
- CommuniCare's R2R
- CommuniCare's Creating Links to Resources and Opportunities (CRE
- creative kids
- Davis Arts Center
- Davis Community Church Nursery School DCCNS
- Davis Joint Unified School District
- Davis Joint Unified State Preschool
- Davis Migrant Center CDC
- Davis Parent Nursery School
- Davis Waldorf
- Delta Dental
- Hive Academy (previously Little Busy Bees)
- Home Run (previously Quality Counts)
- IDreammac
- Iglesia Jesus Salva
- Itsy Bitsy Preschool
- James Marshall Parent Nursery School
- Jazmin Burns
- Joanne's daycare
- Kaiser Permanente Medical Group
- Korematsu State Preschool DJUSD
- La Rue Park (Campus Childcare Inc.)
- Lanai Court Montessori
- Madison Migrant Center CDC
- Maternal Child Adolescent Health HHSA
- McCormick Center for Early Childhood Leadership
- MILE Preschool
- MIND Institute Air-B Mind the Gap
- Montessori Country Day (Campus Child Care Inc.)
- Montessori Country Day II (Campus Child Care Inc.)
- NAMI yolo
- Natomas Unified SD
- North Bay Regional Center EI Intake
- Nurturing Parenting Program
- Partnership Health Plan of California
- Programa de Educacion Migrante (Migrant Education Program)
- Puspa's Home Daycare
- Ready4K
- Resilient Yolo
- RISE
- River Charter Schools Lighthouse
- Riverbank Elementary
- Russell Park CDC (Campus Childcare Inc.)
- Sacramento County Office of Education (SCOE)
- SELPA Yolo County
- Shores of Hope
- St. John's Preschool
- St. Luke's Preschool

- Dignity Health Bronze Star (Common Spirit)
- Dignity Health Gibson (Common Spirit)
- Dignity Healthcare Davis office
- Dingle Elementary
- Discovery Preschool
- Dulce Daycare
- E-Center Migrant Head Start
- Esparto Joint Unified School District
- Eva's Day Care
- Family Hui
- First 5 Colusa
- First 5 Sacramento
- First 5 Yolo
- Garden of Edynn Childcare
- Hanna Interpreting Services
- Hansen Family Health
- Healthy Families Yolo County HFYC previously Step by Step/Paso a
- Help Me Grow National
- Help Me Grow Sacramento County
- Help Me Grow Solano County
- Helping Hands Childcare
- Hens and chicks early learning
- St. Paul's Lutheran Preschool
- Stanford Sierra Youth & Families (was previously Stanford Youth
- State Council on Developmental Disabilities (SCDD)
- Sutter Davis Family Practice
- Sutter Davis Pediatrics
- Tina Prasad
- Turning Point
- TVFURSTAR
- Twin Rivers Unified School District
- UC Davis Early Childhood Lab
- UC Davis MIND Institute
- UCD Communication Interns
- Unite Us
- United Way Woodland Kindercamp
- Valley Oak State Preschool DJUSD
- Warmline FRC
- Wash Mill
- Washington unified school district (WUSD)
- Washington Unified: Preschool Evaluations/Special Ed
- Welcome Baby

What are the key activities you expect this program to achieve in the following quarter?

Q1- Help Me Grow Yolo County will continue to modify the services provided to support families appropriately through reopening after the COVID-19 pandemic. This includes:
-Meet families where they are at. Outreach in places that no other organizations are going except the Yolo Food Bank.
-New outreach to Yolo County businesses to offer support for their staff that are parents.
-Integrate Help Me Grow Yolo's work with UniteUs registry.
-Serve as centralized community access point for referrals from medical providers after concerning ACEs screenings
-Partner with Yolo County Office of Education to support developmental screening and monitoring for children enrolled in Head Start programs.
- Keep offering Developmental Playgroups in-person where a number of families and children with different needs are taking advantage of them.

Q3- Help Me Grow Yolo County will continue to modify the services provided to support families appropriately through reopening after the COVID-19 pandemic. This includes:
-Meet families where they are at
-Attending community events
-New outreach to Yolo County businesses to offer support for their staff that are parents.
-Increase referring programs in UniteUs registry.
-Serve as centralized community access point for referrals from medical providers after concerning ACEs screenings
-Partner with Yolo County Office of Education to support developmental screening and monitoring for children enrolled in Head Start programs.
- Keep offering Developmental Playgroups in-person where a number of families and children with different needs are taking advantage of them.

Q4- Help Me Grow Yolo will continue to modify the services provided to support families appropriately through reopening after the COVID-19 pandemic. This includes:
-Using a trauma informed care approach Help Me Grow Yolo staff will continue to try to meet the needs of the families
-Attending community events
-New outreach to Yolo County businesses to offer support for their staff that are parents.
-Increase referring programs in Unite Us registry.
-Serve as centralized community access point for referrals from medical providers after concerning ACEs screenings
-Partner with Yolo County Office of Education to support developmental screening and monitoring for children enrolled in Head Start programs.
- Keep offering Developmental Playgroups in-person where a number of families and children with different needs are taking advantage of them.
- Screen all children at the Migrant E-Center and continue this partnership for the following years
- Start-of-school-year screening at the State Preschools in Yolo County.
- Finish screening all children at the Madison and Davis Migrant Centers
- Monthly screening events called Family Fun Events where screening and education happens for families.

Are the program's services and activities to change in the following quarter? If so, how?

Q1- Accepting screening scores with incoming provider referrals to prevent duplication of services and ensure families are receiving more coordinated care.

Help Me Grow Yolo County will continue our services and activities supporting families, healthcare providers, child care and development providers, and community based organizations by connecting families to resources and increasing their knowledge and understanding of child development.

Q3- Accepting screening scores with incoming provider referrals.

Our work with the ACEs Aware grant has ended; we will move toward maintaining the relationships forged during the grant work.

Will (re)start offering monthly screening events; HMGY started the collaborative process with the Yolo County Library to begin in-person screening events again starting in the 4th quarter of 21/22.

The time period for Fellows working off scholarship hours in Mental Health has ended; this will reduce referral pathways… for example, we will lose our shortcut to psychological evaluations meaning many families will have to wait until their child is nearly three years of age to get evaluated/diagnosed.

Help Me Grow Yolo County will continue our services and activities supporting families, healthcare providers, child care and development providers, and community based organizations by connecting families to resources and increasing their knowledge and understanding of child development.

Q4- Help Me Grow Yolo will continue providing services and activities supporting families, healthcare providers, child care and development providers, and community based organizations by connecting families to resources and increasing their knowledge and understanding of child development. In the coming fiscal year, HMG will focus on systems change and may make adjustments to align to HMG national's newest family and community outreach requirements. This will result in fewer but more strategic community outreach and engagement events. These events will be designed to help meaningfully connect with families and providers and work with them to identify their needs to learn more about how HMG works and identify ways to promote a more nurturing environment for all children in Yolo county collectively.

Program: Early Signs Training & Assistance					
Provider: Yolo County Health & Human Services Agency					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Total Client Contacts	34	0	0	0	34
Client Contacts by Quarter	100%	0%	0%	0%	100%

Program Accomplishments:

To meet the needs of the community, a 4-hour mental health training was developed titled "The Nature of Trauma and Resilience." This training was provided to a broad range of communities and adapted as needed for each group. Yolo County also increased funding to support the suicide prevention hotline for additional community access due to pandemic needs.

Program Challenges:

Due to COVID-19, in-person training was not possible and one training was implemented virtually. This program experienced staffing shortages related to the national trend (i.e., Great Resignation) which directly affected the work. A new outreach specialist was hired in May 2022 who began training in the prevention and early intervention curricula and the program resumed weekly community offerings.

In FY 22-23 new staff have successfully attained trainer certification in QPR, Mental Health First Aid (Adult & Youth) and trained 252 individuals under the Early Signs Training and Assistance Program. Trainings were cut short due to staff Disaster Service Worker reassignment in April 2023 which effectively ended trainings for the FY. Trainings will resume in July 2023.The program will also recruit an additional staff to expand community outreach and engagement activities in FY 23-24.

Subprogram: Yolo County North Valley Suicide Prevention Hotline Report		
Provider: California Mental Health Services Authority (CalMHSA)		
	July 2021-December 2021	January 2022-June 2022
Total Yolo County calls	1004	1407
Incoming calls	538	976
Follow-ups placed (outgoing calls)	466	431
Moderate or higher lethality calls	66	186
Active rescues	6	40
Imminently lethal callers de-escalated	3	5
Callers requiring follow-up	95	122
Referrals made to Yolo County Behavioral Health	9	7
Caller Concerns		
Mental health	34%	40%
Social issues	20%	21%
Basic needs	19%	16%
Health care/Physical health	14%	13%
Abuse/Violence	7%	7%
Sexual orientation	3%	2%
COVID-19	2%	1%
Gender Identity	0.55%	0.36%

Homicidal Ideation	1%	0.18%
Other Issue		0.09%
Suicidal Content		
Past attempt/Ideation	38%	38%
Suicide desire	32%	38%
Suicidal intent	28%	18%
Imminently lethal caller	2%	6%
Gender		
Female	56%	60%
Male	38%	14%
Unknown	6%	24%
Other Gender Identity	0.40%	
Decline to state/Unable to tell	0.30%	
Transgender	0.10%	2%
Age Range		
5 to 14 years	1%	0.50%
15 to 24 years	15%	10%
25-34 years	28%	39%
35-44 years	8%	7%
45-54 years	9%	4%
55-64 years	17%	3%
65-74 years	14%	13%
75-84 years	2%	0.36%
Unknown	6%	24%
Race		
White	36%	22%
Hispanic/Latino	9%	2%
African American/Black	2%	1%
Asian American	1%	2%
Mixed		24%
Unknown	51%	49%
Native American/Alaskan Native	1%	
City		
Davis	45%	49%
Woodland	29%	17%
West Sacramento	7%	7%
Winters	4%	1%
Guinda	0.20%	0.07%
Knights Landing	0.20%	0.21%

Unknown	14%	26%
Esparto	1%	0.14%
Clarksburg	0.10%	0.14%

K-12 School Partnerships Program

The K-12 School Partnerships Program contracted services started 11/15/2021. Most providers were onboarding staff and training during Q2 and did not have data to report until Q3. The partial data for these programs is due to the programs not being operational for the entire fiscal year.

Program: K-12 School Partnerships Program: Davis Catchment Area					
Provider: CommuniCare Health Centers					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Clients Served					
Total Client Contacts			106	395	501
New Clients: Not seen previously in this Fiscal Year)			24	21	45
Returning Clients: Returning from previous Quarter in same Fiscal Year			0	43	43
Clients Served: Early Intervention			24	64	88
Clients Served By Age					
Children (0-15)			10	39	49
Transitional Age Youth (16-25)			14	25	39
Client Race					
Asian			1	3	4
Black or African American			1	2	3
White (includes non-Hispanic or Latino)			7	9	16
More than one race			2	3	5
Decline to state			13	33	46
Race not recorded or field left blank			0	14	14
Client Ethnicity					
Non-Hispanic or non-Latino					
Other			5	7	12
Decline to state			13	31	44
Not recorded or field left blank			0	15	15
Other			6	11	17
Clients Served by Language Requested for Written Communication					
English			24	64	88
Clients Served by Language Requested for Spoken Communication					
English			19	19	38
Spanish			3	8	11

Other (Not a county threshold language)			2	2	4
*Clients Served By Sexual Orientation					
Heterosexual or Straight			4	5	9
Bisexual			2	3	5
Questioning or unsure of sexual orientation			1	1	2
Another Sexual Orientation			6	6	12
Declined to State			11	3	14
Not recorded/Field left Blank			0	49	49
Clients Served With Physical Or Mental Impairment (Disability) Not a Result of Severe Mental Illness					
No, Not disabled			2	3	5
Clients Served By Sex Assigned at Birth					
Males			8	16	24
Females			16	34	50
Not recorded/Field left Blank			0	14	14
Clients Served By Gender Current Gender Identity					
Male			8	15	23
Female			15	32	47
Transgender			1	1	2
Another Gender Identity			0	2	2
Declined to State			0	1	1
Not recorded/Field left Blank			0	13	13
Clients Served By City of Residence					
Davis			19	55	74
Woodland			5	7	12
Out of County			0	2	2
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer			24	64	88
MHSA Required Performance Measures: Outreach Tracking					
Outreach					
Number of outreach Events Held/Attended			3	1	4
Outreach Participant Demographics					
Total Outreach Participants			75	150	225
Outreach Setting					
School			75	150	225
MHSA Required Performance Measures: MHSA Referral Tracking					
Number of Individuals Referred to Treatment					
Total Participants Referred			15	33	48
Kind of Treatment to which participants were referred					
Behavioral/Mental Health			5	10	15

Treatment/Program Client was Referred To					
Other Community			10	0	10
Group counseling			0	13	13
Psychiatry			0	1	1

What were the program's key successes in the previous quarter?
Q3 & Q4- Increase in referrals and services to students.

What were some challenges or barriers this program encountered from the previous quarter?
Q3 & Q4- Clinicians reached capacity and wait list had to be started.

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?
Q3 & Q4- No. By design this is a partnership with HHSA and Davis Joint Unified School District, so partnering with those two agencies is inherent in the program.

What are the key activities you expect this program to achieve in the following quarter?
Q3 & Q4- Hiring more clinicians, embedding clinicians in schools.

Are the program's services and activities to change in the following quarter? If so, how?
Q3 & 4- Increase staff and services.

Program: K-12 School Partnerships Program: Woodland Catchment Area					
Provider: CommuniCare Health Centers					
Clients Served	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Total Client Contacts			236	340	576
New Clients: Not seen previously in this Fiscal Year)			40	10	50
Returning Clients: Returning from previous Quarter in same Fiscal Year			0	40	40
Clients Served: Early Intervention			40	50	90
Clients Served By Age					
Children (0-1)			34	39	73
Transitional Age Youth (16-25)			6	11	17
Client Race					
American Indian or Alaska Native			0	1	1
Asian			0	2	2
Black or African American			1	0	1
White (includes Non Hispanic/Latino)			21	23	44
Other (Includes Hispanic/Latino)			0	0	0
More than one race			3	3	6
Declined to State			15	20	35
Race not recorded /Field left blank			0	1	1

Client Ethnicity					
Hispanic or Latino					
Other			19	25	44
Declined to State			6	10	16
Not recorded/Field left Blank			0	1	1
Non-Hispanic or Non-Latino					
Other			12	12	24
More than one ethnicity			1	1	2
Declined to state ethnicity			2	1	3
Clients Served By Language Requested for Written Communication					
English			40	50	90
Clients Served by Language Requested for Spoken Communication					
English			34	37	71
Spanish			6	13	19
Clients Served By Sexual Orientation					
Gay or Lesbian			1	2	3
Heterosexual or Straight			17	22	39
Bisexual			2	3	5
Questioning or unsure of sexual orientation			5	5	10
Another Sexual Orientation			1	1	2
Declined to State			3	3	6
Not Applicable			11	14	25
Clients Served With Physical Or Mental Impairment (Disability) Not a Result of Severe Mental Illness					
Yes, Disability Indicated			1	1	2
No, Not disabled			15	15	30
Not recorded/Field left Blank			24	34	58
Clients Served By Sex Assigned at Birth					
Males			21	23	44
Females			19	26	45
Not recorded/Field left Blank			0	1	1
Clients Served By Gender Current Gender Identity					
Male			23	28	51
Female			13	17	30
Another Gender Identity			1	1	2
Declined to State			3	3	6
Not recorded/Field left Blank			0	1	1
Clients Served By City of Residence					
Davis			2	2	4
Esparto			0	1	1
Woodland			37	46	83
Yolo			1	1	2
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer			40	50	90
MHSA Required Performance Measures: MHSA Referral Tracking					

Number of Individuals Referred to Treatment					
Total Participants Referred			8	1	9
Kind of Treatment to which participants were referred					
Behavioral/Mental Health			8	1	9
Other Community			1	2	3

What were the program's key successes in the previous quarter?
Q3 & Q4- Increase in referrals and services to students.

What were some challenges or barriers this program encountered from the previous quarter?
Q3 & Q4- Clinicians reached capacity quickly.
Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?
Q3 & Q4- No. By design this is a partnership between HHSA and WJUSD so partnering with those agencies is inherent in the design.

What are the key activities you expect this program to achieve in the following quarter?
Q3 & Q4- Hiring more clinicians.

Are the program's services and activities to change in the following quarter? If so, how?
Q3 & Q4- Increase staff and expand services.

Program: K-12 School Partnerships Program: Rural Catchment Area					
Provider: Rural Innovations in Social Economics Inc. (RISE)					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Clients Served					
Total Client Contacts		125	153	129	407
New Clients: Not seen previously in this Fiscal Year)		50	67	55	172
Clients Served By Age					
Children (0–15)		48	59	51	158
Transitional Age Youth (16–25)		2	8	4	14
Client Race					
American Indian or Alaska Native		0	3	0	3
Asian		0	1	0	1
Black or African American		0	4	2	6
Native Hawaiian or other Pacific Islander		0	0	0	0
White (includes non-Hispanic or Latino)		19	32	11	62
Other (includes Hispanic or Latino)		21	27	37	85
More than one race		2	0	1	3

Decline to state		1	0	0	1
Not recorded or field left blank		7	0	4	11
Client Ethnicity					
Hispanic or Latino					
Mexican/Mexican-American/Chicano		29	31	39	99
Non-Hispanic or Non-Latino					
African		2	4	2	8
European		8	26	3	37
Filipino		0	1	0	1
Other		3	0	5	8
More than one ethnicity		1	3	1	5
Declined to state ethnicity		1	0	0	1
Not recorded/Field left Blank		6	2	5	13
Clients Served By Language Requested for Written Communication					
English		47	63	53	163
Spanish		3	4	2	9
Clients Served by Language Requested for Spoken Communication					
English		47	63	53	163
Spanish		3	4	2	9
Clients Served By Sexual Orientation					
Gay or Lesbian		1	0	0	1
Heterosexual or Straight		9	21	10	40
Bisexual		0	2	0	2
Questioning or unsure of sexual orientation		0	2	0	2
Queer		0	0	1	1
Declined to State		3	4	9	16
Not Applicable: Minor exempt from answering this question		37	37	35	109
Not recorded/Field left Blank		0	1	0	1
Clients Served With Physical Or Mental Impairment (Disability) Not a Result of Severe Mental Illness					
Yes, Disability Indicated		6	2	1	9
Communication Domain: Difficulty hearing or having speech understood		0	0	1	1
Mental Domain: Not including mental illness (including but not limited to learning disabilities, developmental disabilities, or dementia)		5	2	0	7
Other Disability:		1	0	0	1
No, Not disabled		40	43	38	121
Declined to State		4	22	16	42
Not recorded/Field left Blank		4	0	0	0
Clients Served By Sex Assigned at Birth					

Males		25	41	25	91
Females		25	26	28	79
Not recorded/Field left Blank		0	0	2	2
Clients Served By Gender Current Gender Identity					
Male		9	17	16	42
Female		14	14	20	48
Questioning or unsure of gender identity		0	1	0	1
Not Applicable		26	24	18	68
Declined to State		1	11	1	13
Clients Served by Veterans Status					
No, Not Veteran		13	34	20	67
Declined to State		0	0	1	1
Not Applicable		37	32	32	101
Not recorded/Field left Blank		0	1	2	3
Clients Served By City of Residence					
Esparto		14	37	6	57
Guinda		0	3	0	3
Knights Landing		0	1	0	1
Madison		0	2	1	3
Winters		34	23	48	105
Woodland		1	0	0	1
Yolo County Unincorporated areas		1	1	0	2
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer		26	25	3	54
Family Member of Mental Health Client/Consumer		3	5	0	8
Not Applicable		21	31	24	76
Prefer Not to Answer		0	6	28	34
MHSA Required Performance Measures: Outreach Tracking					
Outreach					
Number of outreach Events Held/Attended		11	15	9	35
Outreach Participant Demographics					
Total Outreach Participants		197	264	189	650
Outreach Setting					
Family Resource Center		0	1	0	1
Other		11	14	9	34
MHSA Required Performance Measures: MHSA Referral Tracking					
Number of Individuals Referred to Treatment					
Total Participants Referred		50	67	55	172
Kind of Treatment to which participants were referred					

Behavioral/Mental Health		38	37	15	90
Treatment/Program Client was Referred To					
Essential Groups/Skills for Students		12	30	40	82
Treatment Follow Through					
Participants who followed through on referral and engaged in treatment		45	61	54	160
Participants who did not engage in treatment to which they were referred		5	6	1	12
Average Duration of Untreated Mental Illness					
Less than 1 month		1	0	0	1
4–5 months		1	0	0	1
6–7 months		0	3	0	3
8–9 months		0	1	0	1
More than 12 months		0	0	0	0
Unable to determine		5	10	3	18
Not applicable		43	53	52	148
Average Interval between Referral and Participation in Treatment or Referred Service					
Less than 1 month		45	61	54	160
Treatment not completed: Referral Closed		5	6	1	12

What were the program's key successes in the previous quarter?

Q2- As one of the only bilingual and bicultural Mental Health providers in rural Yolo County, Rise continues to provide mental health services to rural clients that would otherwise find accessing services difficult. We continue to give immediate access and referral's to students and their families for mental health services. Our goal is to provide behavioral health services that expand the current and more limited array of services and supports available to students.

One of the key successes to this previous quarter was having 125 client contacts, which is a significant number of client contacts while slightly less than the first quarters numbers it was still a significant considering this reporting period which included the holidays and the constantly challenging COVID conditions.

Another success was that we had 50 new clients in the last quarter which is a significant number of new clients only slightly less than our first quarter, Again, a success especially while dealing with school closures due to the holidays and the consistent challenging COVID conditions.

When looking at clients served by age we are consistently serving our targeted population. When we look at our clients by race and ethnicity we continue to offer services to a substantial number of diverse clients, especially to the Latino community. We are also serving students with disabilities meaning that we are able to successfully engage students with disabilities and meet their needs
Another programming success is the increased number of students seen in our Winters programming, This can be attributed to our group work and is a sign that knowledge about our programs in Winters is increasing, that students ability to access our programming is increasing and that we are able to enhance our programming through groups to meet more students needs through prevention, early identification, and intervention of the social, emotional, and behavioral needs of students.

Another success is the number of outreach events we were able to hold or attend, increased substantially from 1 in the previous reporting quarter to 11 during this current reporting quarter. This enabled us to increase our outreach participants from 4 to 197 which is another example of our program success and ability to inform and engage the public about our services. In the last reporting period we were able to attend more meetings in Yolo County and had more opportunities to collaborate with our partner agencies.

REFERRAL TRACKING

This reporting period we had a substantial number of referrals. While our numbers are slightly down to 50 from 56 in our previous reporting period the total participants referred are similar to the last reporting period. This can be seen as a success during the challenges that COVID presents and the holiday period when school was out. . One unique success is the service of clients through our essential groups category which grew substantially as the previous reporting periods did not have any clients served.

Another great success in service provided was that the average interval period between the referral and participation in treatment or service was less than month for all qualifying referrals.

Q3- Our key success were increasing total client contacts and new clients, increasing Transition age Youth 16-25, increasing the Diversity of clients served, increasing clients in the rural areas, increasing outreach events and participants, Increasing essential groups/skills for students participants, and increasing total participants referred. As RISE continues its culturally competent outreach activities, increases group activities and as COVID restrictions are lifting, RISE is seeing more participation in diversity, by rural geography, and in total clients served.

Q4- Able to serve students from many rural towns including Esparto, Madison, Winters, Guinda and Knights Landing. All our referrals took less than a month between referral and participation in services. Doing surveys for parents and students receiving counseling services.

What were some challenges or barriers this program encountered from the previous quarter?

Q2- Despite some challenges RISE has continued to provide behavioral health services that expand the current and more limited array of services and supports available to students.

Some of the challenges this program encountered had to do with the COVID conditions and people not seeking services because they did not want to expose themselves unnecessarily to others and risk of COVID.

This reporting period also had substantial school closure due to the holidays which shortened our time for service delivery. We also had a clinician leave in our Winters program but we were able to quickly replace her and orient the new hire to continue services.

RISE remains dedicated to identifying and addressing any challenges which arise as we continue to meet the behavioral health needs of students and families in our rural communities.

Q3- There were no challenges. As we near the end of the school year we may see our numbers change.

Q4- Continued challenges with outreach to Spanish speakers. Although many served are bilingual and choose English as their language, there is continued need to outreach to Spanish speakers. Our outreach will continue to battle the negative stereotypes of counseling in all communities but especially in the Latino community. Generally, in the 4th quarter we didn't get as many referrals as schools focus is on the end of the school year.

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?

Q2- We partner internally in RISE to help produce intake, direct services, quality linkages and program reports. We also partner with the Esparto Unified School District and the Winters Joint Unified School District and the Sci Tech Charter School. Other partners include, Empower Yolo, Winters Health Foundation, and Resilient Yolo . All of partnerships insure that we are providing comprehensive services that enable us to prevent, apply universal screening, referral, identify early intervention and treatment for our students and families.

Q3- Yes, we partnered with the organizations as in the last report which included: RISE (intake, direct services, quality linkages, and program reports), Esparto Unified School District, Winters Unified School District, and the Knights Landing Charter School SCI Tech, Empower Yolo, Winters Health Foundation, and Resilient Yolo. We added one new partner and that was Sierra Health.

Q4- Partnered with Esparto and Winters school districts. Also with Sci-Tech Elementary in Knights Landing. And Yolo county HHSA.

What are the key activities you expect this program to achieve in the following quarter?
Q2- RISE expects to continue and see an increase of group work in the next quarter. Expand and continue to develop social /emotional support groups. We also expect to continue serving a substantial diverse group of clients and continue to grow our outreach opportunities as we continue to integrate mental health services into our school districts. Q3- We expect to transition into summer programming as the school year ends. Q4- Continue doing outreach to increase the number of students served.

Are the program's services and activities to change in the following quarter? If so, how?
Q2- Our services are not expected to substantially change other than to continue the development of group work and groups for our students. Q3- Q4 - No changes anticipated.

K-12 School Partnerships Program: West Sacramento Catchment Area					
Provider: Victor Community Support Services (VCSS)					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Clients Served					
Total Client Contacts	n/a	1,499	1,793	3169	6,461
New Clients: Not seen previously in this Fiscal Year)	n/a	524	469	908	1,901
Returning Clients: Returning from previous Quarter in same Fiscal Year	n/a	n/a	5	267	272
Individual Family Members Served	n/a	n/a	15	28	30
Clients Served: Prevention	n/a	498	376	1002	1527
Clients Served: Early Intervention	n/a	26	83	145	179
Clients Served: TIER III	n/a	n/a	15	28	30
Clients Served By Age					
Children (0--15)		26	81	78	185
Transitional Age Youth (16–25)			12	12	24
Client Race					
American Indian or Alaska Native			1		1
Asian			7	2	9
Black or African American			14	12	26
Native Hawaiian or other Pacific Islander			3	2	5
White (includes non-Hispanic or Latino)			36	31	67
Other (Includes Hispanic or Latino)			15	27	42
More than one			3	2	5
Decline to state			9		9
Race not recorded or field left blank		26	5	14	45
Client Ethnicity					

Hispanic or Latino					
Central American			1		1
Mexican, Mexican American, or Chicano			12	18	30
Not recorded or field left blank			3	13	16
Non-Hispanic or Non-Latino					
African				14	14
Asian Indian or South Asian			2	2	4
Eastern European			2	22	24
European				9	9
Filipino			2		2
Japanese			1		1
Middle Eastern			2		2
Other			2	2	4
More than one			3	2	5
Not recorded or field left blank		26	63	8	97
Clients Served by Language Requested for Written Communication					
English		26	66	74	166
Russian				6	6
Other (not a county threshold language)				2	2
Not recorded /Field left Blank			27	8	35
Clients Served by Language Requested for Spoken Communication					
English		26	66	74	166
Russian				6	6
Other (Not a county threshold language)				2	2
Not recorded/Field left Blank			27	8	35
*Clients Served By Sexual Orientation					
Gay or Lesbian				4	4
Heterosexual or Straight			16	17	33
Bisexual			2	16	18
Questioning or unsure of sexual orientation			1	0	1
Queer				2	2
Another Sexual Orientation				4	4
Declined to State			15		15
Not Applicable		26	59	47	132
Clients Served With Physical Or Mental Impairment (Disability) Not a Result of Severe Mental Illness					
Yes, Disability Indicated			4	10	14
Communication Domain: Difficulty Seeing			1	2	3
Mental Domain: Not including mental illness (including but not limited to learning disabilities, developmental disabilities, or dementia)			4	2	6

Physical Mobility Domain: Physical or mobility issue			1	2	3
Chronic Health Condition: including but not limited to chronic pain			2		2
Other Disability:				2	2
No, Not disabled			8	20	28
Declined to State			57		57
Not recorded/Field left Blank		26	24	60	110
Clients Served By Sex Assigned at Birth					
Males		14	42	24	80
Females		12	51	10	73
Not recorded/Field left Blank				56	56
Clients Served By Gender-Current Gender Identity					
Male			5	19	24
Female			5	33	38
Transgender			1	4	5
Another Gender Identity			2	3	5
Not Applicable: Minor exempt from answering this question		26	80	28	134
Declined to State				3	3
Clients Served By City of Residence					
West Sacramento		26	27	38	91
Not recorded/Field left Blank			66	52	118
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer			3	2	5
Family Member of Mental Health Client/Consumer			2	4	6
Not Applicable		26	3	2	31
Prefer Not to Answer			85	82	167
MHSA Required Performance Measures: Outreach Tracking					
Outreach					
Number of outreach Events Held/Attended		5	23	2	30
Outreach Participant Demographics					
Total Outreach Participants		0	42	14	56
Outreach Setting					
Other		5	18	2	25
School			5		5

What were the program's key successes in the previous quarter?
Q3- This quarter began as school resumed after Winter Break. We continued providing full classroom series, such as Second Step and small groups, including Personal Power. We continued scheduling and providing large school-wide preventative presentations upon request. This quarter, social workers began utilizing are Tier III referral process and we were able to begin providing mental health services to WUSD students.

Q4- This quarter closed out the school district's school year. We continued providing full classroom series, such as Second Step and small groups, including Personal Power through until the school year closed. We also provided large school-wide preventative presentations upon request. This quarter, social workers continued utilizing our now established referral process to refer students to receive Tier III support through the summer.

What were some challenges or barriers this program encountered from the previous quarter?

Q3- Now that we are again able to serve schools in person we experienced far fewer barriers to providing Tier I and Tier II services to the district. The process for referring students to receive Tier III services was still new to district partners and managing the transition into the new program was an obstacle. Social workers were not utilizing this process at the beginning of the quarter but gradually began to do so as the quarter progressed.

Q4- This quarter we provided as much clarity as possible about the referral process for the school social workers. We continue to receive some incomplete referrals, as well as referrals that clients/families are not aware of (which often results in families declining services immediately due to lack of need/interest.)

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?

Q3- In this quarter, we continued to partner with the Yolo County Youth and Family Services Network and the Yolo/Yuba/Sutter/Colusa County SEL Community of Practice. We worked closely with Yolo County Office of Education, Yolo County K12 Partnership providers and school districts to maintain up to date information and seek support for implementing the new contract. WUSD school staff and administration continue to partner with us to advertise our available services and get them scheduled in a timely manner to meet student needs.

Q4- In this quarter, we continued to partner with the Yolo County Youth and Family Services Network and the Yolo/Yuba/Sutter/Colusa County SEL Community of Practice. We worked closely with Yolo County Office of Education, Yolo County K12 Partnership providers and school districts to maintain up to date information and seek support for implementing the contract. WUSD school staff and administration continue to partner with us to advertise our available services and get them scheduled in a timely manner to meet student needs.

What are the key activities you expect this program to achieve in the following quarter?

Q3- In Q3 of FY2022, we intend to further increase our school and community collaboration in order to schedule as many services as we can. We intend to continue clarifying the referral process for all who will use it in order to encourage utilization of this process.
In our ongoing groups, the PEI staff will be addressing the needs that have been identified by participants and school staff, such as: Helping the students manage their anxiety through mindfulness exercises, providing the students with coping skills/strategies to handle their emotions, and how to manage grief.

Q4- Our team has grown, thus we expect our capacity to provide Tier I, Tier II and Tier III services to increase. We will partner with WUSD staff who are running in person summer school programs to provide as many services as possible throughout the summer. We will also offer virtual groups as an option for families. Internally we will address any steps of the referral process that need adjusting and take note of any information we need to pass along to school staff to begin the school year.

Are the program's services and activities to change in the following quarter? If so, how?

Q3- The K-12 program's services and activities are not expected to change in the next quarter, beyond an expected increase in the number of services as the program is implemented.

Q4- The K-12 program's services tend to slow during the summer months, but we have a variety of both in person and virtual services scheduled such that they will not decrease drastically.

Urban & Rural School Based Access/Linkage & Strengths Based Mentoring (program prior to K12)

The contracts for the Urban and Rural School Based services ended 11/14/2021 when the K-12 School Partnerships Program began. Only 2 quarters (partial) of data are available for this program due to the program sunsetting during this fiscal year.

Program: Urban School Based Access & Linkage and Strengths Based Mentoring					
Provider: Victor Community Support Services					
Access & Linkage Data					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Clients Served					
Total client Contacts	0	0	n/a	n/a	0
New Clients: Not seen previously in this Fiscal Year)	0	0	n/a	n/a	0
Returning Clients: Returning from previous Quarter in same Fiscal Year	n/a	n/a	n/a	n/a	0
Individual Family Members Served	0	0	n/a	n/a	0
Clients Served: Prevention	0	0	n/a	n/a	0
Clients Served: Early Intervention	0	0	n/a	n/a	0

Program: Urban School Based Access & Linkage and Strengths Based Mentoring					
Provider: Victor Community Support Services (VCSS)					
Strengths Based Mentoring Data					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Clients Served					
Total Client Contacts	4,824	3,531			8,355
New Clients: Not seen previously in this Fiscal Year)	2,085	919			3,004
Returning Clients: Returning from previous Quarter in same Fiscal Year	n/a	644			644
Clients Served: Prevention	2072	1540			2976
Clients Served: Early Intervention	13	23			28
Clients Served By Age					
Children (0-15)	13	15			28
Client Race					
Black or African American		2			2
White (includes Non-Hispanic/Latino)	4	8			12
Other (Includes Hispanic/Latino)	3	3			6
More than one race	5	0			5
Race not recorded /Field left blank	1	2			3

Client Ethnicity					
Hispanic or Latino					
Mexican/Mexican-American/Chicano	3	3			6
Non-Hispanic or Non-Latino					
African		1			1
Eastern European		1			1
European		1			1
Declined to state ethnicity	5				5
Not recorded/Field left Blank	5	9			14
Clients Served By Language Requested for Written Communication					
English	12	15			27
“Other (Not a county threshold language) “	1				1
Clients Served by Language Requested for Spoken Communication					
English	10	15			25
Other (Not a county threshold language)	2	0			2
Not recorded /Field left Blank	1	0			1
Clients Served By Sexual Orientation					
Heterosexual or Straight	9	3			12
Bisexual	1	0			1
Questioning or unsure of sexual orientation		2			2
Another Sexual Orientation	1	0			1
Declined to State	2	0			2
Not Applicable		10			10
Clients Served With Physical Or Mental Impairment (Disability) Not a Result of Severe Mental Illness					
Yes, Disability Indicated	1	1			2
Communication Domain: Difficulty Seeing	1				1
Chronic Health Condition: including but not limited to chronic pain		1			1
No, Not disabled	11	5			16
Declined to State	1	0			1
Not recorded/Field left Blank		9			9
Clients Served By Sex Assigned at Birth					
Males	13	12			25
Females		3			3
Clients Served By Gender Current Gender Identity					
Male		6			6
Female	11				11
Another Gender Identity	1				1
Not Applicable: Minor exempt from answering this question		9			9

Declined to State	1				1
Clients Served By City of Residence					
West Sacramento	11	14			25
Not recorded/Field left Blank	2	1			3
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer	1	3			4
Family Member of Mental Health Client/Consumer	1	0			1
Not Applicable	9	2			11
Prefer Not to Answer	1	10			11

What were the program's key successes in the previous quarter?
Q1- In response to safety measures due to COVID, we consistently provided a full schedule of virtual summer services to students through the end of the summer. As school contacts returned to work we began scheduling a variety of in-person services for students in school including full classroom series' such as Second Step and small groups, including Personal Power. We also continue to offer virtual services as a safe alternative. We began scheduling and providing large school-wide preventative presentations including Suicide Prevention both in person and virtually. Q2- As schools returned, we provided a variety of in-person services for students in school including full classroom series' such as Second Step, and small groups including Personal Power. We also continue to offer virtual services as a safe alternative. We provided large school-wide preventative presentations including Suicide Prevention both in person and virtually upon request.

What were some challenges or barriers this program encountered from the previous quarter?
Q1- Now that we are again able to serve schools in person we experience far fewer barriers this quarter. We are still providing most assembly style presentations virtually as schools avoid gathering larger groups of students, but our virtual services continue to be held to our standard of excellence. Q2- Now that we are again able to serve schools in person we experience far fewer barriers this quarter. Staffing changes affected our capacity for scheduling as many services as we have in previous quarters, as well as transitioning school staff toward the implementation of the new contract starting mid-November which will condense the strengths/mentoring portion of our contract.

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?
Q1- In this quarter, we continued to partner with the Yolo County Youth and Family Services Network and utilize a local online parenting resource-sharing groups to advertise our virtual services. We continue working closely with school staff and administration to advertise our available services and get them scheduled in a timely manner to meet student needs. Q2- In this quarter, we continued to partner with the Yolo County Youth and Family Services Network and utilize a local online parenting resource-sharing groups to advertise our virtual services. We continue working closely with school staff and administration to advertise our available services and begin preparing for the closing of this contract in Mid-November.
What are the key activities you expect this program to achieve in the following quarter?
Q1- In Q2 of FY2022, we intend to further increase our school and community collaboration in order to schedule as many services as we can. In our ongoing groups, the PEI staff will be addressing the needs that have been identified by participants and school staff, such as: Helping the students manage their anxiety through mindfulness exercises, providing the students with coping skills/strategies to handle their emotions, and how to manage grief. Q2- This program ended in mid-November, as the new K-12 program started and provided these services thereafter.

Are the program's services and activities to change in the following quarter? If so, how?
Q1- We will remain adaptable to provide services either virtually or in person depending on school safety practices and student needs. We will continue to work with school staff, parents, and students to adapt services in order to effectively respond to identified needs. Q2- This program ended in mid-November, as the new K-12 program started and provided these services thereafter.

Program: Rural School Based Access & Linkage and Strengths Based Mentoring					
Provider: Rural Innovations in Social Economics Inc (RISE)					
Strengths Based Mentoring					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Clients Served					
Total Client Contacts	264				
New Clients: Not seen previously in this Fiscal Year)	66				
Clients Served: Prevention	66				
Clients Served By Age					
Children (0–15)	60				
Transitional Age Youth (16–25)	6				
Client Race					
Asian	4				
Black or African American	6				
White (includes Non-Hispanic/Latino)	20				
Other (Includes Hispanic/Latino)	36				
Client Ethnicity					
Hispanic or Latino					
Central American	4				
Mexican/Mexican-American/Chicano	32				
Non-Hispanic or Latino					
Not recorded/Field left Blank	30				
Clients Served By Language Requested for Written Communication					
English	66				
Clients Served by Language Requested for Spoken Communication					
English	66				
Clients Served By Sexual Orientation					
Gay or Lesbian	6				
Heterosexual or Straight	20				
Not Applicable	40				
Clients Served By Sex Assigned at Birth					

Males	41				
Females	25				
Clients Served By Gender Current Gender Identity					
Male	41				
Female	25				
Clients Served By City of Residence					
Esparto	40				
Winters	26				
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer	66				
MHSA Required Performance Measures: Outreach Tracking					
Outreach					
Number of outreach Events Held/Attended	6				
Outreach Participant Demographics					
Total Outreach Participants	210				
Outreach Setting					
Clinic	2				
Family Resource Center	2				
School	2				

What were the program's key successes in the previous quarter?
Q1- Our community was thankful to Yolo County for extending the Strengths Program until the new MHSA Contracts become effective. The key success was the smooth transition of youth services into the new school year. Our team was able to continue providing prevention and early intervention direct services to students throughout the summer months and carried into the new school year.

What were some challenges or barriers this program encountered from the previous quarter?
Q1- Our RISE team experienced some recent turnover in staffing. We have been fortunate to retain our key staff throughout the previous three years. Most recently, a few key staff members moved out of state which caused some challenges across all programs and services. We are quickly recruiting new staff members and looking at our hiring practices to ensure that we can retain quality professionals to serve our rural residents.

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?
Q1- Our key partners has been the school districts. We continued to partner in order to keep direct services functioning throughout the summer and into the new school year. Our long term relationship with the Winters and Esparto School District provides access to children and families during the school day which is critical to the overall success of our programs.
What are the key activities you expect this program to achieve in the following quarter?
Q1- The current programs are ending and will transition to the new contracts in November. Our team is working with school staff to make the necessary changes to some of the programs and services offered. We will be transitioning to the new contract.
Are the program's services and activities to change in the following quarter? If so, how?
Q1- The existing programs will end November 14th. We are incredibly thankful to Yolo County for extending our existing contracts so that there were no gaps in services. The new program begins November 15th which reflects the updated Mental Health Services Plan, program, and services.

Program: Rural School Based Access & Linkage and Strengths Based Mentoring					
Provider: Rural Innovations in Social Economics Inc (RISE)					
Access & Linkage					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Clients Served					
Total Client Contacts	162				
New Clients: Not seen previously in this Fiscal Year)	56				
Clients Served: Prevention	0				
Clients Served By Age					
Children (0–15)	48				
Transitional Age Youth (16–25)	8				
Client Race					
Asian	0				
Black or African American	1				
White (includes Non-Hispanic/Latino)	20				
Other (Includes Hispanic/Latino)	29				
Client Ethnicity					
Hispanic or Latino					
Mexican/Mexican-American/Chicano	34				
Non-Hispanic or Latino					
Clients Served By Language Requested for Written Communication					
English	54				
Spanish	2				
Clients Served by Language Requested for Spoken Communication					
English	54				
Spanish	2				
Clients Served By Sexual Orientation					
Gay or Lesbian	0				
Heterosexual or Straight	16				
Questioning/Unsure	2				
Declined to State	7				
Clients Served By Sex Assigned at Birth					
Males	29				
Females	27				
Clients Served By Gender Current Gender Identity					
Male	5				
Female	15				
N/A	27				

Clients Served By City of Residence					
Esparto	23				
Winters	21				
Madison	2				
Woodland	5				
Dunnigan	1				
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer	35				
Family Member of MH Client/Consumer	5				
MHSA Required Performance Measures: Outreach Tracking					
Outreach					
Number of outreach Events Held/Attended	1				
Outreach Participant Demographics					
Total Outreach Participants	4				
Outreach Setting					
Other	1				

What were the program's key successes in the previous quarter?
Q1- RISE Inc.'s first-quarter success has provided accessible mental health services to all children, youth, and adults. Although the Covid-19 pandemic affected many community members and many organizations closed, RISE Inc. remains open and modified our resource centers for all safety. We changed our in-person services to telehealth regarding our mental health services when schools began distance learning sessions. Now that schools are in person, we provide mental health services to Esparto, Winters, and Knights Landing schools. We want to create a safe environment for students, school staff, and community members to offer mental health services with no restrictions at all.

What were some challenges or barriers this program encountered from the previous quarter?
Q1- Thus far, our first quarter hasn't had any challenges or barriers that have affected our services. Now that Yolo County lifted all Covid-19 restrictions and students return to school for in-person lessons, our Mental Health services are now in-person instead of telehealth. We had clients having difficulty adjusting to telehealth sessions in previous quarters due to poor internet connections or lack of response. Moving forward, we've had a significant reaction to returning to in-person sessions.

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?
Q1- N/A
What are the key activities you expect this program to achieve in the following quarter?
Q1- RISE Inc. expects to continue to provide accessible Mental Health Services, and our program has no set schedule to change any activities within the second quarter. RISE Inc's Mental Health Program promotes behavioral and mental health wellness and currently partners with the public schools of Esparto and Winters and Sci-Tech Academy in Knights Landing. Our goal is to identify children and youth who need mental health counseling services, provide linkages.

Are the program's services and activities to change in the following quarter? If so, how?
Q1- The program services are not expected to change in the upcoming quarter. We will continue to offer Mental Health services to students, staff, and community members throughout the Capay Valley, Winters, Knights Landing, and Clarksburg.

Program: Latinx Outreach/Mental Health Promotores Program					
Provider: CommuniCare Health Centers-Creando Recursos y Enlaces Paran Oportunidades(CREO)					
Performance Measure	Q1	Q2	Q3	Q4	Full Year
Clients Served					
Total Client Contacts	717	723	525	647	2,612
New Clients: Not seen previously in this Fiscal Year)	33	28	37	29	127
Returning Clients: Returning from previous Quarter in same Fiscal Year	70	85	67	80	302
Individual Family Members Served					
Clients Served: Prevention	8	7	8	5	28
Clients Served: Early Intervention	23	21	29	24	97
Clients Served By Age					
Children (0-15)	0	0	0	0	0
Transitional Age Youth (16-25)	0	1	1	1	3
Adult (26–59)	31	26	32	27	116
Older Adult (60+)	2	1	4	1	8
Declined to State	0	0	0	0	0
Not recorded /Field left blank	0	0	0	0	0
Client Race					
American Indian or Alaska Native	0	0	1	0	1
Asian	0	0	0	0	0
Black or African American	0	0	0	0	0
Native Hawaiian or other Pacific Islander	0	0	0	0	0
White (includes Non Hispanic/Latino)	0	0	0	0	0
Other (Includes Hispanic/Latino)	26	23	28	22	99
More than one race	0	0	1	2	3
Declined to State	7	4	7	5	23
Race not recorded /Field left blank	0	1	0	0	1
Client Ethnicity					
Hispanic or Latino					
Caribbean	0	0	0	0	0
Central American	2	2	3	3	11
Mexican/Mexican-American/Chicano	24	24	30	25	103
Puerto Rico	0	0	0	0	0
South American	6	1	4	1	12
Other	0	0	0	0	0
Declined to State	1	0	0	0	1
Not recorded/Field left Blank	0	1	0	0	1
Non-Hispanic or Non-Latino					
African	0	0	0	0	0

Asian Indian/South Asian	0	0	0	0	0
Cambodian	0	0	0	0	0
Chinese	0	0	0	0	0
Eastern European	0	0	0	0	0
European	0	0	0	0	0
Filipino	0	0	0	0	0
Japanese	0	0	0	0	0
Korean	0	0	0	0	0
Middle Eastern	0	0	0	0	0
Vietnamese	0	0	0	0	0
Other	0	0	0	0	0
More than one ethnicity	0	0	0	0	0
Declined to state ethnicity	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
Clients Served By Language Requested for Written Communication					
English	0	0	0		
Spanish	33	28	37		
Russian	0	0	0		
"Other (Not a county threshold language) "	0	0	0		
Declined to State	0	0	0		
Not recorded/Field left Blank	0	0	0		
Clients Served by Language Requested for Spoken Communication					
English	0	0	0	0	0
Spanish	33	28	37	29	127
Russian	0	0	0	0	0
Other (Not a county threshold language)	0	0	0	0	0
Declined to State	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
*Clients Served By Sexual Orientation					
Gay or Lesbian	0	0	0	0	0
Heterosexual or Straight	21	21	16	7	65
Bisexual	0	0	0	0	0
Questioning or unsure of sexual orientation	0	0	0	0	0
Queer	0	0	0	0	0
Another Sexual Orientation	0	0	0	0	0
Declined to State	1	7	0	0	8
Not Applicable: Minor exempt from answering this question	0	0	0	0	0
Not recorded/Field left Blank	11	0	21	22	54
Clients Served With Physical Or Mental Impairment (Disability) Not a Result of Severe Mental Illness					

Yes, Disability Indicated	2	2	3	0	7
Communication Domain: Difficulty Seeing	0	0	0	0	0
Communication Domain: Difficulty hearing or having speech understood	0	1	0	0	1
Communication Domain: Other	0	0	0	0	0
Mental Domain: Not including mental illness (including but not limited to learning disabilities, developmental disabilities, or dementia)	0	0	0	0	0
Physical Mobility Domain: Physical or mobility issue	0	1	1	0	2
Chronic Health Condition: including but not limited to chronic pain	2	0	2	0	4
Other Disability:	0	0	0	0	0
No, Not disabled	31	26	34	29	120
Declined to State	0	0	0		
Not recorded/Field left Blank	0	0	0		
Clients Served By Sex Assigned at Birth					
Males	9	6	12	8	35
Females	24	22	25	21	92
Declined to State	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
Clients Served By Gender Current Gender Identity					
Male	9	6	12	8	35
Female	24	22	23	21	90
Transgender	0	0	2	0	2
Genderqueer	0	0	0	0	0
Questioning or unsure of gender identity	0	0	0	0	0
Another Gender Identity	0	0	0	0	0
Not Applicable: Minor exempt from answering this question	0	0	0	0	0
Declined to State	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
Clients Served by Veterans Status					
Yes, Veteran	0	0	0	0	0
No, Not Veteran	0	0	0	0	0
Declined to State	0	0	0	0	0
Not Applicable: Minor exempt from answering this question	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
Other Data County/Program Considers Relevant					
Clients Served By City of Residence					
Brooks	0	0	0	0	0
Clarksburg	0	0	0	0	0

Davis	4	5	5	2	16
Dunnigan	0	0	3	0	3
Esparto	2	1	0	0	3
Guinda	0	0	0	0	0
Knights Landing	1	0	0	0	1
Madison	0	0	0	0	0
Sacramento [board and care]	0	0	0	0	0
West Sacramento	9	9	10	8	36
Winters	3	0	0	1	4
Woodland	14	12	18	14	58
Yolo	0	0	0	0	0
Yolo County Unincorporated areas	0	1	0	2	3
Homeless*	0	2	0	0	2
Out of County	0	0	2	2	4
Declined to State	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
*Homeless persons are counted as part of the homeless community and not the locality where they are homeless					
MHSA Required Performance Measures: Demographics					
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer	33	28	37	29	127
Family Member of Mental Health Client/Consumer	0	0	0	0	0
Not Applicable	0	0	0	0	0
Prefer Not to Answer	0	0	0	0	0
MHSA Required Performance Measures: Outreach Tracking					
Outreach					
Number of outreach Events Held/Attended	28	32	43	35	138
Outreach Participant Demographics					
Total Outreach Participants	345	2,491	1,611	2,509	6,956
Outreach Setting					
Church	0	26	170	110	306
Clinic	43		6		49
Cultural Organization	50	782	760	500	2092
Faith-Based Organization	0				0
Family Resource Center	0	22			22
Law Enforcement Departments	0			31	31
Library	0				0
Mental/Behavioral Health Care	0	194		118	312

Other	132	1132	311	1238	2813
Primary Health Care	0			362	362
Public Transit Facility	0				0
Recreation Center	0			42	42
Residence	0				0
School	0	19	47	90	156
Senior Center	0	13			13
Shelter	0				0
Substance Use Treatment Location	0		7		7
Support Group	120	303	310	18	751
MHSA Required Performance Measures: MHSA Referral Tracking					
Number of Individuals Referred to Treatment					
Total Participants Referred	2	5	1	4	12
Total SMI Participants Referred	0	0	1	2	3
Kind of Treatment to which participants were referred (Screening and Referral Form Question 3)					
Behavioral/Mental Health	0	1	1	2	4
Substance Use Treatment	2	4	1	2	9
Both Behavioral/Mental Health and Substance Use Treatment	0	5	0	2	7
Treatment/Program Client was Referred To					
Spanish SUD Group	2	5	1	2	10
Psychiatry	0	1	1	2	4
Treatment Follow Through					
Participants who followed through on referral and engaged in treatment	0	3	2	4	9
Participants who did not engage in treatment to which they were referred.	2	2	0	0	4
Participants for which referral engagement data is not available.	0	0	0	0	0
Average Duration of Untreated Mental Illness					
Less than 1 month	3	0	0	2	5
1-2 Months	5	0	2	4	11
2-3 months	0	3	2	2	7
3–4 months	0	1	5	0	6
4–5 months	1	3	1	3	8
5–6 months	2	0	7	3	12
6–7 months	6	2	6	5	19
7–8 months	0	6	3	1	10
8–9 months	1	0	1	0	2
9–10 months	1	4	0	1	6
10–11 months	0	0	2	0	2

11–12 months	6	0	4	2	12
More than 12 months	4	3	3	5	15
Unable to determine	4	6	1	1	11
Not applicable	0	0	0	0	0
Average Interval between Referral and Participation in treatment /referred service					
Less than 1 month	27	19	31	24	101
1-2 months	6	7	5	4	22
2-3 months	0	0	0	1	1
3-4 months	0	0	0	0	0
4–5 months	0	0	0	0	0
5–6 months	0	0	0	0	0
6–7 months	0	0	0	0	0
7–8 months	0	0	0	0	0
8–9 months	0	0	0	0	0
9–10 months	0	0	0	0	0
10–11 months	0	0	0	0	0
11–12 months	0	0	0	0	0
More than 12 months	0	0	0	0	0
Participation in Treatment not Recorded	0	0	0		0
Treatment not Completed: Referral Closed	0	2	1	0	3

What were the program's key successes in the previous quarter?
Q1- We continue to hold our weekly platicas virtually and provided meaningful topics to educate the community regarding COVID/vaccinations, cultural resilience, immigration/DACA, health and wellness, mental health, and trauma. We hired 2 additional staff (1 BH Clinician and 1 Case Manager) with the additional funding we received. In the first quarter we have seen our wait list go down by 50%. Our number of visits increased to 717 individual visits from 408 in the last reporting quarter. Q2- We continue to hold our weekly platicas virtually and provided meaningful topics to educate the community regarding COVID/vaccinations, cultural resilience, immigration/DACA, health and wellness, mental health, and trauma. Provided 723 individual visits, 171 were case management and 437 were individual sessions. We also held groups with 57 participants over the three months. We completed a collaboration with Time of Change Organization holding 15 consecutive groups called A Mi Alcance with 15 participants. We also continue to collaborate with Yolo Hospice for a "Grupo de Duelo" on Grief and Loss. Q3- We continue to hold our weekly platicas virtually and provided meaningful topics to educate the community regarding COVID/vaccinations, cultural resilience, immigration/DACA, health and wellness, mental health, and trauma. Provided 723 individual visits, 171 were case management and 437 were individual sessions. We also held groups with 57 participants over the three months. We completed a collaboration with Time of Change Organization holding 15 consecutive groups called A Mi Alcance with 15 participants. We also continue to collaborate with Yolo Hospice for a "Grupo de Duelo" on Grief and Loss. Q4- We continue to hold our weekly platicas virtually and provided meaningful topics to educate the community regarding COVID/vaccinations, cultural resilience, immigration, health and wellness, mental health, and trauma. CREO provided a total of 2,612 visits to 127 unduplicated individuals and 302 returning clients. We add 1.5 additional promotoras through additional funding to expand our outreach services. The Promotoras work with the mobile medicine Team to provided services to 3 migrant centers in the surrounding areas. Platicas continued with new topics such as Anger Management, Afterschool and summer options for children, and College options for Youth.

What were some challenges or barriers this program encountered from the previous quarter?
Q1, Q2, Q3- Challenges with affordable housing, access to resources such as food. New challenges have been with organizations that are struggling to provide culturally relevant services for their population. CREO is offering to support with as much resource and translation as possible. Q4- Challenges with affordable housing, access to resources such as food.

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?
Q1, Q2, Q3, Q4- In this last quarter we have spent quite a bit of time working in collaboration with other community organizations such as Time of Change, Yolo Hospice, the Mind Institute, UC Davis, local school districts and Woodland Community College's Dream Center. We are continuing to collaborate and offer a Grief Group with Yolo Hospice and a Relationship/Communication Group with Time of Change. The Mexican Consulate continues to be an on-going partner and the Food Bank, as is our Health Education and Outreach programs at CommuniCare.

What are the key activities you expect this program to achieve in the following quarter?
Q1- We are expecting to reduce our number of clients on the wait list for services. We also expect to ramp up on resource acquisition as many people are currently struggling. We have a new Latinx SUD Navigator funded through another grant that will also work with the CREO Team to engage clients in SUD Treatment if needed. We are also looking forward to our new annual Dia de los Muertos event for the community. Q2, Q3- Our wait list for services has decreased slightly and we continue to work on that. Our new Latinx SUD Navigator funded through another grant has taken on 3 new referrals for support with SUD issues. We also hired a Supervisor and 1.5 Promotores through other funding to expand our Promotores program to offer support for CREO's full-time Promotora. Q4- Our wait list for services has decreased slightly and we continue to work on that. We will be preparing for on-going information provided to the community to reduce stigma around Substance Use issues and LGBTQ issues. CREO will also begin preparing for the next annual Dia de los Muertos event where we will hold a health and resource fair for the community.

Are the program's services and activities to change in the following quarter? If so, how?
Q1, Q2, Q3, Q4- Services will not change. We will continue to expand our outreach and begin to provide more community events to promote mental health.

Program: Latinx Outreach/Mental Health Promotores Program					
Provider: Rural Innovations in Social Economics Inc (RISE)					
	Q1	Q2	Q3	Q4	Full Year
MHSA-Required Performance Measures: Demographic Information					
Clients Served					
Total Client Contacts	111	248	155	189	703
New Clients: Not seen previously in this Fiscal Year)	47	59	15	33	154
Returning Clients: Returning from previous Quarter in same Fiscal Year	0	31	54	41	126
Individual Family Members Served	0	0	0	0	0
Clients Served: Prevention	44	58	15	33	150
Clients Served: Early Intervention	3	1	0	0	4
Clients Served By Age					
Children (0–15)	0	0	0	0	0

Transitional Age Youth (16-25)	8	15	3	8	34
Adult (26-59)	29	31	12	20	92
Older Adult (60+)	10	13	0	5	28
Declined to State	0	0	0	0	0
Not recorded /Field left blank	0	0	0	0	0
Client Race					
American Indian or Alaska Native	0	0	0	0	0
Asian	0	0	0	0	0
Black or African American	0	0	0	0	0
Native Hawaiian or other Pacific Islander	0	0	0	0	0
White (includes Non-Hispanic/Latino)	0	0	0	0	0
Other (Includes Hispanic/Latino)	47	59	15	33	154
More than one race	0	0	0	0	0
Declined to State	0	0	0	0	0
Race not recorded /Field left blank	0	0	0	0	0
Client Ethnicity					
Hispanic or Latino					
Caribbean	0	0	0	0	0
Central American	6	9	0	0	15
Mexican/Mexican-American/Chicano	41	50	15	33	139
Puerto Rico	0	0	0	0	0
South American	0	0	0	0	0
Other	0	0	0	0	0
Declined to State	0	0	0	0	0
Not recorded /Field left Blank	0	0	0	0	0
Non-Hispanic or Non-Latino					
African	0	0	0	0	0
Asian Indian/South Asian	0	0	0	0	0
Cambodian	0	0	0	0	0
Chinese	0	0	0	0	0
Eastern European	0	0	0	0	0
European	0	0	0	0	0
Filipino	0	0	0	0	0
Japanese	0	0	0	0	0
Korean	0	0	0	0	0
Middle Eastern	0	0	0	0	0
Vietnamese	0	0	0	0	0
Other	0	0	0	0	0
More than one ethnicity	0	0	0	0	0
Declined to state ethnicity	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0

Clients Served By Language Requested for Written Communication					
English	0	0	0	0	0
Spanish	47	59	15	33	154
Russian	0	0	0	0	0
“Other (Not a county threshold language) “	0	0	0	0	0
Declined to State	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
Clients Served by Language Requested for Spoken Communication					
English	0	0	0	0	0
Spanish	47	59	15	33	154
Russian	0	0	0	0	0
Other (Not a county threshold language)	0	0	0	0	0
Declined to State	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
Clients Served By Sexual Orientation					
Gay or Lesbian	3	4	0	3	10
Heterosexual or Straight	44	55	15	30	144
Bisexual	0	0	0	0	0
Questioning or unsure of sexual orientation	0	0	0	0	0
Queer	0	0	0	0	0
Another Sexual Orientation	0	0	0	0	0
Declined to State	0	0	0	0	0
Not Applicable	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
Clients Served With Physical Or Mental Impairment (Disability) Not a Result of Severe Mental Illness					
Yes, Disability Indicated	2	0	0	0	2
Communication Domain: Difficulty Seeing	0	0	0	0	0
Communication Domain: Difficulty hearing or having speech understood	0	0	0	0	0
Communication Domain: Other	0	0	0	0	0
Mental Domain: Not including mental illness (including but not limited to learning disabilities, developmental disabilities, or dementia)	0	0	0	0	0
Physical Mobility Domain: Physical or mobility issue	2	0	0	0	2
Chronic Health Condition: including but not limited to chronic pain	0	0	0	0	0
Other Disability:	0	0	0	0	0
No, Not disabled	45	59	0	0	104
Declined to State	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
Clients Served By Sex Assigned at Birth					
Males	47	59	15	33	154
Females	0	0	0	0	0

Declined to State	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
Clients Served By Gender Current Gender Identity					
Male	47	59	15	33	154
Female	0	0	0	0	0
Transgender	0	0	0	0	0
Genderqueer	0	0	0	0	0
Questioning or unsure of gender identity	0	0	0	0	0
Another Gender Identity	0	0	0	0	0
Not Applicable: Minor exempt from answering this question	0	0	0	0	0
Declined to State	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
Clients Served by Veterans Status					
Yes, Veteran	1	0	0	0	1
No, Not Veteran	46	59	15	33	153
Declined to State	0	0	0	0	0
Not Applicable: Minor exempt from answering this question	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
Other Data County/Program Considers Relevant					
Clients Served By City of Residence					
Brooks	4	0	0	4	8
Clarksburg	0	0	0	0	0
Davis	6	2	0	0	8
Dunnigan	4	6	0	6	16
Esparto	14	18	15	20	67
Guinda	4	6	0	0	10
Knights Landing	5	10	0	0	15
Madison	5	5	0	0	10
Sacramento [board and care]	0	0	0	0	0
West Sacramento	0	0	0	0	0
Winters	5	12	0	3	20
Woodland	0	0	0	0	0
Yolo	0	0	0	0	0
Yolo County Unincorporated areas	0	0	0	0	0
Homeless*	0	0	0	0	0
Out of County	0	0	0	0	0
Declined to State	0	0	0	0	0
Not recorded/Field left Blank	0	0	0	0	0
*Homeless persons are counted as part of the homeless community and not to the locality where they are homeless.					

MHSA Required Performance Measures: Demographics					
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer	0	0	0	0	0
Family Member of Mental Health Client/Consumer	0	0	0	0	0
Not Applicable	0	0	0	0	0
Prefer Not to Answer	0	0	0	0	0
MHSA Required Performance Measures: Outreach Tracking					
Outreach					
Number of outreach Events Held/Attended	4	6	10	8	28
Outreach Participant Demographics					
Total Outreach Participants	211	340	410	245	1206
Outreach Setting					
Church	0	2	1	0	3
Clinic	2	2	2	1	7
Cultural Organization	0	0	0	0	0
Faith-Based Organization	0	0	0	0	0
Family Resource Center	2	2	4	4	12
Law Enforcement Departments	0	0	0	0	0
Library	0	0	0	0	0
Mental/Behavioral Health Care	0	0	0	0	0
Other	0	0	2	3	5
Primary Health Care	0	0	0	0	0
Public Transit Facility	0	0	0	0	0
Recreation Center	0	0	0	0	0
Residence	0	0	0	0	0
School	0	0	1	0	1
Senior Center	0	0	0	0	0
Shelter	0	0	0	0	0
Substance Use Treatment Location	0	0	0	0	0
Support Group	0	0	0	0	0
MHSA Required Performance Measures: MHSA Referral Tracking					
Number of Individuals Referred to Treatment					
Total Participants Referred	3	0	0	0	3
Total SMI Participants Referred	0	0	0	0	0
Kind of Treatment to which participants were referred					
Behavioral/Mental Health	0	0	0	0	0
Substance Use Treatment	0	0	0	0	0
Both Behavioral/Mental Health and Substance Use Treatment	3	0	0	0	3
Treatment Follow Through					
Participants who followed through on referral and engaged in treatment	3	0	0	0	3

Participants who did not engage in treatment to which they were referred.	0	0	0	0	0
Participants for which referral engagement data is not available.	0	0	0	0	0
Average Duration of Untreated Mental Illness					
Less than 1 month	0	0	0	0	0
1–2 months	0	0	0	0	0
2–3 months	0	0	0	0	0
3–4 months	0	0	0	0	0
4–5 months	0	0	0	0	0
5–6 months	0	0	0	0	0
6–7 months	0	0	0	0	0
7–8 months	0	0	0	0	0
8–9 months	0	0	0	0	0
9–10 months	0	0	0	0	0
10–11 months	0	0	0	0	0
11–12 months	0	0	0	0	0
More than 12 months	0	0	0	0	0
Unable to Determine	3	0	0	0	3
Not Applicable	0	0	0	0	0
Average Interval between the referral and participation in treatment /referred service					
Less than 1 month	3	0	0	0	3
1–2 months	0	0	0	0	0
2–3 months	0	0	0	0	0
3–4 months	0	0	0	0	0
4–5 months	0	0	0	0	0
5–6 months	0	0	0	0	0
6–7 months	0	0	0	0	0
7–8 months	0	0	0	0	0
8–9 months	0	0	0	0	0
9–10 months	0	0	0	0	0
10–11 months	0	0	0	0	0
11–12 months	0	0	0	0	0
More than 12 months	0	0	0	0	0
Participation in treatment not recorded	0	0	0	0	0
Treatment not completed: referral closed	0	0	0	0	0

What were the program's key successes in the previous quarter?
Q1- Our team partnered with local organizations to provide information about mental health resources. We attended several COVID-19 Rapid Testing Sites in the rural communities to find ways to reach the Latino Male Head of household population. Our ability to leverage our existing relationships was a success for the quarter. Moreover, our team was successful in referring 3 Latino farmworkers to Mental Health services and all 3 have been connected to resources.

Q2- 2nd Quarter falls during holiday season. Our Latino Promotore team focused on the Latino Male Head of Household Farm workers to ensure they new about the various Holiday resources that were available to them. The main success for the quarter was providing Thanksgiving Turkey dinners and providing Christmas toys to participants for their families. Another success was our partnerships with Yolo County, UC Davis, Healthy Yolo, and Winters Healthcare in providing COVID testing and Vaccination information on site at local farms throughout Winters and the Capay Valley.

What were some challenges or barriers this program encountered from the previous quarter?
Q1- COVID is still the major barrier and challenges to reaching more latino males in the rural region. Many Farms and employers are hesitant in bringing in outside people to the worksite due to the pandemic. Prior to COVID our team had free reign of the various Farms throughout Yolo County. Our inability to connect with more people during the pandemic has continued to be our biggest challenge. Q2- The focus for the quarter was providing information and support for the Holiday Season. COVID still provided limited access to farms and our team was not able to make any mental health referrals in the quarter. We provided information regarding mental health but did not have enough consistent access to clients to receive any referrals.

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?
Q1- We partnered with the UC Davis ORALE Program. This program provides free rapid COVID testing throughout rural Yolo County and specifically target farmworkers and their families. Our team attended several testing dates to increase our outreach efforts to this hard to reach population. Q2- We partnered with Yolo County Supervisor Angel Barajas' office for the toy distributions, UC Davis, Healthy Yolo Together, and Winters Healthcare.

What are the key activities you expect this program to achieve in the following quarter?
Q1- The Holiday season is approaching and our team will have access to a larger population due to the various Holiday services. This will increase our outreach and direct service efforts in the upcoming quarter. Our goal is to identify and connect more individuals to mental health services. Q2- QRT 3 will focus on providing regular mental health services information with the goal of making some referrals and getting Latino Male of Head of Household participants connected to a mental health professional. Our hopes are to providing some Farmworker Events in March/April.

Are the program's services and activities to change in the following quarter? If so, how?
Q1, Q2- Programs and services will not change in the upcoming quarter. We project that services will increase in the upcoming quarters but services will not change.

Program: Public Media Campaigns
Provider: EMRL
During the fiscal year 21-22 the agency partnered with EMRL to develop materials and a website/landing page that would direct members of the public to mental health resources and tools. Itonlytakes.com was a campaign aimed at promoting health, wellness, and recovering after the COVID-19 pandemic. The website provided a collection of reminders (grounded in the California Surgeon General's Playbook for Stress), linked to local resources intended to help Yolo County residents improve their health and sense of well-being. The campaign also included activity cards and books, local television advertisements and signs throughout the community. 10,000 activity books were distributed to school districts and community based providers within Yolo County to distribute to children. 1,000 books of flashcards were also distributed to schools and community organizations in Yolo County. The books and cards were provided in English and Spanish. Over 22,000 individuals have visited the website.

Program: Senior Peer Support Program					
Provider: Yolo CARES					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Full Year
Total Client Contacts	62	44	27	16	149
New Clients: Not seen previously in this Fiscal Year)	3	3	3	2	11
Returning Clients: Returning from previous Quarter in same Fiscal Year	5	5	5	3	18
Clients Served: Prevention	4	3	3	2	12
Clients Served: Early Intervention	4	5	5	3	17
Clients Served By Age					
Older Adults (60+)	8	8	8	5	29
Client Race					
White (includes Non-Hispanic/Latino)	8	8	8	5	29
Clients Served By Language Requested for Written Communication					
English	8	8	8	5	29
Clients Served by Language Requested for Spoken Communication					
English	8	8	8	5	29
Clients Served By Sexual Orientation					
Heterosexual or Straight	7	6	6	5	24
Declined to State	1	2	2	0	5
Clients Served With Physical Or Mental Impairment (Disability) Not a Result of Severe Mental Illness					
Yes, Disability Indicated	2	3	2	4	11
Communication Domain: Difficulty Seeing	0	1	1	0	2
Communication Domain: Difficulty hearing or having speech understood	0	1	1	0	2
Physical Mobility Domain: Physical or mobility issue	0	3	3	4	10
Chronic Health Condition: including but not limited to chronic pain	0	0	4	3	7
Other disability:	1	1	1	0	3
Not recorded/Field left Blank	5	4	5	1	15
Clients Served By Sex Assigned at Birth					
Males	1	1	1	2	5
Females	7	7	7	3	24
Clients Served By Gender Current Gender Identity					
Male	1	1	1	2	5
Female	7	7	7	3	24
Clients Served by Veterans Status					
No, Not Veteran	8	8	8	5	29

Clients Served By City of Residence					
Davis	6	6	5	2	19
Knights Landing	1	1	1	1	4
Woodland	1	1	2	2	6
Clients Served By Relationship to Mental Health					
Mental Health Client/Consumer	3	4	3	1	11
Family Member of Mental Health Client/Consumer	0	0	2	0	2
Not Applicable	4	3	2	4	13
Prefer not to answer	1	1	1	0	3
MHSA Required Performance Measures: Outreach Tracking					
Outreach					
Number of outreach Events Held/Attended	6	8	5	0	19
Outreach Participant Demographics					
Total Outreach Participants	15	13	14	0	42
Outreach Setting					
Other	6	8	5	0	19
Treatment/Program Client was Referred To (Provider Defined ~ Add rows as necessary) (Screening and Referral Form Question 3)					
Northern American Mental Health	0	1	0	0	1

What were the program's key successes in the previous quarter?
Q1- Staff has focused on foundational efforts to strengthen the program with a clearer organizational structure and plan. Focus has been on relationship building, data capture, marketing planning, volunteer training, and clarifying protocols for client-volunteer interaction. Some key success points: 1. The SPC Coordinator has built close and trusting relationships with the volunteer pool. 2. The SPC Coordinator has increased one-to-one case management support to clients and volunteers. 3. The program provided coordinated volunteer education programs in October (Anticipatory Grief Education) and made plans for the November education (Mental Health First Aid). 4. The program launched a newsletter for SPC volunteer counselors to facilitate engagement and communication. A sampling of comments from SPC clients: "It's nice to visit and talk to her. Sometimes I don't know I'm lonely, but then it really perks me up." [It gives me] "someone to be with me and talk to me." "Every time [she is here] I feel better! I really enjoy Betty. She is really kind." Client stated she "looks forward to talking to her" [SPC volunteer] when something is bothering her. Client stated she feels encouraged to be with more people and learn new things. "It's so nice to know someone is there for you." Client stated that being comforted by her SPC volunteer lessens her anxiety. Q2- 1. Onboarded 3 new clients. 2. Onboarded 1 new SPC. 3. Started Anticipatory Grief Support Group. 4. Integrated reporting process into Galaxy Volunteer Management software with Volunteer Manager oversight. 5. Scheduled MSHA training for 1/26/22 - 1/27/22 with Tessa Smith. Q3 • - 1 peer client graduated from the program, client feel like she had her living circumstances and caregiver issues under control and didn't feel the need to reach out to her volunteer anymore.

- 80% of volunteers are acclimated to the volunteer website and actively updating hours
- Volunteer having been attending training with the volunteer manager on boundaries, death, and navigating family conflicts, improving their effectiveness with clients.
- Partnership with Hope Cooperative created for higher level clients

Q4- Until summer of 2022, the Senior Peer Companion (SPC – new name, same acronym) program was run as a mostly independent entity from other YoloCares volunteer programs. In the past year and a half, YoloCares has put a significant effort in organizing and upgrading its volunteer management.
Galaxy, an online platform for tracking volunteer records, opportunities, and hours, was implemented to streamline the assignment and tracking of all volunteer activities at YoloCares.
In Q4, decided to merge SPC with our larger volunteer management program. Andrew Moore, our Volunteer Manager, will assume SPC management responsibilities. YoloCares is also in the process of hiring a full-time, bilingual, Spanish-speaking SPC Coordinator, who will work on outreach and community engagement. These changes will transform the program from one .5 FTE coordinator to 1.5 FTE including the Volunteer Manager and SPC Coordinator.
These changes will help break down barriers between programs within the agency, and it will allow some of our volunteers in hospice and palliative care to consider becoming SPC volunteers, whereas before, the recruiting for SPC was separate from other volunteer recruitment. Consolidating our volunteer programs is already beginning to create more cohesion for our volunteers.
We identified a need for a bilingual, Spanish-speaking coordinator to help with our efforts in the rural populations and with migrant workers, while we also expand our outreach to the mostly English-speaking communities elsewhere in Yolo County.

What were some challenges or barriers this program encountered from the previous quarter?

Q1-
1.- Finding good matches between clients and volunteers. We have sometimes struggled to find the right shared backgrounds and personality matches to make a good fit between client and volunteer.

2. Finding a time for monthly volunteer meetings that will work for everyone or for the majority, so all volunteers stay up to date with education and news.
3. Increasing program census with the continuing challenges of the pandemic. People are reticent to meet in person, and interest in the program with virtual meetings is challenging to maintain.
4. Diversifying both the client and the volunteer bases.
5. The program has typically met weekly, but sometimes clients feel that is too frequent and sometime they cancel due to their depression or anxiety, which is frustrating for the volunteer. Some clients feel it is not enough.
6. Need MHSA support and guidance for working with and referring those in deep depression who don't really want to call someone else but who clearly need more help.

Q2-
1. Having to pull volunteers out of facilities due to increased restrictions and requirements.

2. Volunteers SPCs contracting COVID-19 and having to scale back participation or change to phone contact only.

3. Senior clients at high risk having to go to phone call interactions and challenge keeping their interest with no personal contact.

4. Experienced the death of an SPC volunteer counselor, and don't have enough current counselors for clients.

Q3-

1 client had a decline in health and was moved on to our Palliative Care Program.

- 1 client passed from COVID.
- "Senior Peer Counseling" as a program title seemed to hinder some older adults who felt they didn't need a counselor or already had one. Also, potential volunteers were intimidated by the idea of being a "counselor" when they didn't feel qualified. The program was explained deeper as an "expert listener" or "sounding board" and it is suggested it be renamed to Senior Peer Support.
- We need to produce a mass marketing effort with new program description and name, Senior Peer Support Program. Outreach needs to be included agency wide at all community engagement opportunities. A mail campaign will also be launched.

- The above changes are contingent on the budget increase submitted. The cost of the program is no longer sustainable for YoloCares as is, and the budget increase will allow for more program outreach and internal support.

Q4- With the departure of our previous SPC Coordinator, there has been some stagnation as we restructured program framework and reporting lines.
Until we were sure the program would be able to continue, we were unable to begin our search for a new Coordinator. That search is now underway.
With illnesses we have had rotations of employees with positive COVID-19 cases, ailments, etc. which has caused some delays in moving plans ahead.
Due to the rising COVID-19 cases, volunteers and clients are more hesitant to see people in person.

Did you partner with other programs/departments/providers to implement or deliver this program in the previous quarter? If yes, who?

Q1- No

Q2- The Senior Peer Counseling program began working extensively with Yolo Hospice's new Volunteer Manager, who integrated the SPCs into the rest of the Yolo Hospice online volunteer system, Galaxy, to help with recruitment going forward. The Volunteer Manager also worked with the program to ensure that all new volunteers are made aware of the SPC opportunity. The work streamlines the volunteer onboarding process, eliminating some previous barriers, and makes it easier and smoother to track volunteer hours and visits, as well as manage volunteer documentation.

Q3-
- Volunteer Manager provides support to SPC volunteers for onboarding and training on the volunteer website.
- We developed a partnership with Hope Cooperative to take in new referrals between agencies.

Q4- The Internal partnership between the previous SPC Coordinator and the Volunteer Manager (who provided support with SPC volunteer onboarding to the Galaxy volunteer website platform) helped us to see that the program would be better housed under the Volunteer Manager with the full-time SPC Coordinator reporting to him.
We are also in partnership with Hope Cooperative to take in new referrals.

What are the key activities you expect this program to achieve in the following quarter?

Q1-

1. - To increase volunteer confidence when working with difficult clients by providing more in person trainings, including guest speakers.
2. To increase volunteer and client census by putting 60 percent of time into Outreach and communications.
3. Develop a training tool kit for volunteers to reference when they are working with challenging clients.
4. Work with MHSA to create an interagency client referral process and plan to help overcome trust issues for clients starting new services.

Q2-

1. Focus on monthly training with both the Volunteer Manager and Yolo Hospice's Education Department to increase SPC volunteer confidence when working with difficult clients.

2. Continue work on a volunteer toolkit for SPCs to draw from when working with challenging clients or complex issues.

3. Implement two SPC-led groups: one to support homebound seniors with age-related issues via Zoom and one in-person group to support seniors with age-related issues who are able to travel for in-person services.

Q3-
Try to get the in-person support groups established.

Purpose of the group: Coffee and Transitions is a group that will provide support to older adults in Yolo County who need an outlet to discuss the ups and downs of aging. It will serve those who are isolated, lonely, or experiencing life transitions, and anyone who is looking for a supportive community.
Who is being served? Yolo County Older Adults aged 55 and older.
How are they served? These groups will be peer led by Senior Peer Counselor Volunteers who are trained on support group facilitation and will be held in Davis and Woodland.
Expected program impact: the need for an effective response to social isolation is greater than ever before due to the dramatic impact COVID-19 has had on the older adult population. Our hope is that seniors will walk away from these groups feeling heard and seen by others who are of similar age and have similar life experiences. We anticipate that seniors will gain a community in which they will be encouraged, provided resource information and facilitation, and be supported to continue to live as independently as possible.

Q4-

1. Hire bilingual (Spanish/English) SPC Coordinator for outreach and program facilitation.
2. Commence intensive outreach to churches, community centers and other centers of senior activity in our service area.
3. Design and distribute an outreach postcard to be sent to 8,000 seniors in Yolo County.
4. Recruit five (5) new clients and five (5) new volunteers in Q1

Are the program's services and activities to change in the following quarter? If so, how?

Q1- We anticipate the foundation of the program to stay the same in the coming quarter and year. The changes are intended to strengthen the foundation of the program and its goals.

Q2- There are no significant changes planned for program activities in the coming quarter. We are implementing the above training, support, and education protocols to better prepare SPCs for their volunteer work and to help make that work more satisfying for them. We hope to expand program numbers through an sustained education and outreach campaign throughout Yolo County, but that work is dependent on receiving additional funding to support costs.

Q3- The Senior Peer Counseling Coordinator left the agency for another opportunity. The Volunteer Manager is supporting the human resources side of the program and an MSW is currently coordinating the program. If the requested budget increase is approved, a search will begin immediately for a new Coordinator. In the coming year, we anticipate increased community engagement and program marketing, the commencement of Coffee & Transitions group(s), expanded volunteer training, and a continuation of the services we have provided for the past 4 years. Our internal structure and volunteer management platforms have been greatly strengthened in the past year, and we are poised to be able to accommodate an increase in program participation. However, we need to launch a major marketing and community engagement campaign to create that growth.

Q4- The services offered through the program and the activities clients and volunteers do together will not change in Q1. Changes are all structural and administrative in nature, and we believe these changes will help us better manage the program, recruit more participants, offer a wider variety of potential activities to clients and volunteers, and build stronger relationships with other community providers.
Structural changes planned for Q1, recap:

1. The SPC program will be overseen by the Volunteer Manager.
2. A Volunteer Coordinator will be hired to engage with prospective clients and volunteers throughout Yolo County (both English and Spanish speakers).
3. In response to the resistance we've heard from both clients and volunteers to the word *counselor*, we will change the name of the program from Senior Peer Counseling to Senior Peer Companions. We like this name better than Senior Peer Support, and it allows us to keep the familiar SPC acronym.

Appendix 5:

Documentation and Information Resources